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INTERNATIONAL AFFAIRS & BEST PRACTICE GUIDELINES

TRANSFORMING NURSING THROUGH KNOWLEDGE

Best Practice Guideline

FEBRUARY 2026

Addressing Anti-Black Racism in Nursing

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

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In the context of RNAO best practice guideline development, the term "conflict of interest" (COI) refers to situations in which an RNAO staff member or expert panel member's financial, professional, intellectual, personal, organizational or other relationships may compromise their ability to conduct panel work independently. Declarations of COI that might be construed as constituting a perceived and/or actual conflict were made by all members of the RNAO expert panel prior to their participation in guideline development work using a standard form. Expert panel members also updated their COI at the orientation meeting, the recommendation build meetings and prior to guideline publication. Any COI declared by an expert panel member was reviewed by the RNAO best practice guideline development and research team and expert panel co-chairs. No limiting conflicts were identified by members of the expert panel. See "Declarations of Conflicts of Interest Summary" under the "methodology documents" tab on the
BPG webpage.

Land acknowledgement
We recognize that RNAO's office is located on the traditional and unceded territory of the Huron-Wendat, Haudenosaunee, and the territory of the Mississaugas of the Credit. This territory was the subject of the Dish with One Spoon Wampum Belt Covenant, which is an agreement between the Iroquois Confederacy and the Ojibwe and allied nations to peaceably share and care for the resources around the Great Lakes. We also acknowledge that Toronto is covered by Treaty 13 under the Toronto Purchase Agreement with the Mississaugas of the Credit. Today, this land is still the home to many First Nations, Inuit and Métis peoples from across Turtle Island and we are grateful to have

the opportunity to work on this territory. By making a land acknowledgement we are taking part in an act of reconciliation, honouring the land and Indigenous heritage which dates back more than 10,000 years. We encourage readers to learn about the land where you reside and the treaties that are attached to it. Land acknowledgements are an act of reconciliation, and we must all do our part.

Africentric land acknowledgement
As people of Afrikan descent, we offer this land recognition in solidarity with the Indigenous peoples of Turtle Island, in the efforts and deliberate intentions toward decolonization.

We acknowledge the land of Turtle Island that was never meant to be owned. We recognize that most of the land that was entrusted to the Indigenous peoples was, in some cases, shared by choice, but all too often taken by force.

We recognize the historical colonialism – and the ongoing colonialism –that has led to the present-day situation where land acknowledgements are offered in place of land.

As people of Afrikan descent, many of us have come here by choice, while many are here as a result of historical force.

We acknowledge the complexities where we were promised land that was never given, by those whose it never was to give.

As people of Afrikan descent, we acknowledge the land of Turtle Island that sustains us, express deep gratitude to its Indigenous Peoples, and pledge to honour our dignity and divinity that ultimately connects us all.

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Addressing Anti-Black Racism in Nursing

Greetings from Doris Grinspun,

Chief Executive Officer, Registered Nurses' Association of Ontario

The Registered Nurses' Association of Ontario (RNAO) is delighted to present the new best practice guideline (BPG) Addressing Anti-Black Racism in Nursing. Evidence-based practice supports the excellence in service that health providers are committed to delivering every day.

We offer our heartfelt thanks to the many partners who made this BPG a reality. First, and most important, we thank the Government of Ontario that recognized, in 1999 RNAO's capacity to lead a program that has gained worldwide recognition and is committed to funding it. Our deepest gratitude to the co-chairs of the RNAO expert panel for their invaluable expertise and stewardship of this BPG:

- Dr. LaRon E. Nelson, RN, PhD, FNP, FNAP, FNYAM, FAAN, Independence Foundation Professor of Nursing, Yale University
- Dr. Bukola Salami, RN, PhD, FCAN, FAAN, Full Professor and Canada Research Chair (Tier 1) in Black and Racialized Peoples Health, Department of Community Health Sciences and Faculty of Nursing, University of Calgary

We also recognize Dr. Stephanie Buchanan (guideline development lead), RN Lyndsay Howitt (senior manager, guideline development and research), Glynis Gittens (guideline development project coordinator), RN Nafsin Nizum (associate director, guideline development and research) and the rest of the RNAO best practice guideline development and research team for their intense and expert work in the production of this BPG. Special thanks to the expert panel for generously providing their time, knowledge and perspective to deliver a rigorous and robust evidence-based resource that will guide the education and practice of millions of health providers. We couldn't have done it without you!

Successful uptake of BPGs requires a concerted effort from educators, clinicians, employers, policymakers, researchers and funders. The nursing and health communities, with their unwavering commitment and passion for excellence in patient care, provide the expertise and countless hours of voluntary work essential to developing new and next edition BPGs. Employers have responded enthusiastically by becoming Best Practice Spotlight Organizations® (BPSO®), joining more than 1,500 service and academic institutions in Canada and abroad, committed to implementing RNAO's BPGs. They have sponsored best practice champions, now numbering more than 150,000 nurses, other health professionals and people with lived experience—all eager to advance people-centred evidence-based care. BPSOs are also diligently monitoring and evaluating the impact of BPG implementation and sustainability on individuals, organizations, and health systems.

We invite you to share this BPG with nursing and all other team members, client navigators and advisors in the wider health systems and communities in which you work. We have so much to learn from one another. Together, we must ensure that the public has access to, and receives, the best possible health and social services, always.

Dr. Doris Grinspun, RN, BScN, MSN, PhD, LLD (hon), Dr (hc), DHC, DHC, FAAN, FCAN, O.ONT.
Chief Executive Officer and Founder of the Best Practices Guidelines Program

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How to use this document

Throughout this document, terms that are bolded and are marked with a superscript G (G) can be found in the **Glossary of terms** in **Appendix A**.

This healthy work environment **best practice guideline**G (BPG) is a comprehensive document designed to support **health and social service organizations**G and academic institutions in creating and sustaining positive work environments. It is not intended to be a manual or "how-to" guide; rather, it is a tool to guide best practices and enhance decision making for **nurses**G and nursing students, other members of the **interprofessional team**,G educators, health and social service organizations and academic institutions to address **anti-Black racism**G in nursing. This BPG should be reviewed and applied in accordance with the needs of individual health and social service organizations, academic institutions or other practice settings. We recommend that implementation be contextualized to reflect the needs and preferences of **Black**G nurses and Black nursing students within your organization and across the broader health system. This document provides evidence-based **recommendations**G and **good practice statements**G for organizational policy and education, developed after considering the following: a) the benefits and harms of interventions; b) the values and preferences of Black nurses and Black nursing students; and c) implications for **health equity**.G

Nurses, nursing students and other members of the interprofessional team, as well as educators and administrators who lead and facilitate practice changes, will find this document invaluable for developing policies, procedures, protocols and educational programs to support safe and healthy workplaces and learning environments. Clinicians in direct care will benefit from reviewing the recommendations and supporting evidence to guide their practice and that of others.

If your organization, integrated system of care or academic institution is adopting this BPG, the Registered Nurses' Association of Ontario (RNAO) recommends establishing change teams whose responsibilities include, but are not limited to, the following:

1. Conduct a gap/opportunity analysis: assess your existing policies, procedures, protocols and educational programs in relation to the good practice statements, recommendations and supporting discussions of evidence in this BPG, and identify any strengths, needs or gaps.

2. Note the recommendations and good practice statements applicable to your context and that can be used to address existing priorities, needs or gaps within your organization or academic institution.

3. Develop a plan for implementing recommendations and good practice statements, sustaining best practices and evaluating **outcomes**G by applying the Social Movement Action Framework (1,2) or the Knowledge-to-Action Framework (3).

Implementation scienceG resources, including the Leading Change Toolkit, are available online (4). A description of the Leading Change Toolkit can be found in **Appendix I**. For more information, see **Implementing RNAO guidelines**.

All RNAO BPGs are available for download, free of charge, from the RNAO website. To locate a particular BPG, search by keyword or browse by topic. Additional supplementary materials, such as **evidence profiles**[G] and search strategies related to each recommendation, can be found under the "methodology documents" tab on the BPG webpage.

RNAO has also curated a collection of publications that demonstrate the real-world impact of RNAO's BPGs. These publications are available for download, free of charge, at RNAO.ca/bpg/research-unit/open-library.

We are interested in hearing your feedback on this BPG and how you have implemented it. Please share your experiences with us at RNAO.ca/contact.

The over two-decade journey of RNAO BPGs is documented in the following resource: Grinspun D, Bajnok I, editors. Transforming nursing through knowledge: best practices for guideline development, implementation science, and evaluation. Toronto (ON): Registered Nurses' Association of Ontario (RNAO); 2018. Available at: RNAO.ca/bpg/transforming-nursing-through-knowledge.

Viewed through the lens of intersectionality, RNAO's health equity work is presented on its publicly available In Focus pages. Among these topics is a dedicated page that highlights work related to Black nurses at RNAO.ca/in-focus/black-nurses-and-rnao. In late 2024, RNAO's Health Equity Consortium, a joint effort of the Black Nurses Leading Change Interest Group, the Indigenous Nurses and Allies Interest Group, and the Rainbow Nursing Interest Group, published an article in the Canadian Journal of Nursing Research which provides critical insights into advancing health equity within nursing (5).

A note on terminology and language

Words used to describe and address anti-Black racism can vary across health-care disciplines, sectors and organizations, reflecting historical legacies, **power**,[G] **privilege**[G] and political and social sensitivities. When discussing **race**[G] and **racism**,[G] even frequently used terminology can evoke heightened emotions and lead to hostility because the language used is often fuelled by unaddressed trauma, hidden biases, emotions and assumptions that may be difficult to articulate (6). A universally agreed upon language on issues related to racism does not currently exist. Importantly, words and language change and evolve with time, analysis and **lived experiences**.[G] Therefore, the terminology and language used in this guideline is representative of the time, place and circumstances in which the guideline was developed.

The language used to discuss race, power, privilege, racism and **oppression**[G] carries deeply personal and context-specific significance and individuals who discuss these concepts have complex lived experiences and varying viewpoints. These experiences are often shaped by intersecting identities—such as **gender identity**,[G] **gender expression**,[G] socioeconomic status, **disability**,[G] **sexual orientation**,[G] and immigration status—which influence how racism is experienced and understood (7). When discussing these terms, it is important to openly acknowledge that these discussions may trigger heightened emotions among those involved. Furthermore, it is essential to acknowledge the emotional labour inherent in these discussions by creating a psychologically safe environment (6).

The following concepts are necessary to understand, interpret and implement this guideline:

Race and racism

Race is a complex and socially constructed idea that imparts social and material stratification (e.g., explicit socioeconomic difference across racialized groups) (8,9). Humans use descriptive classifications (such as age, height and physical attributes) to make sense of individual differences. However, these classifications become problematic when hierarchical values are assigned to them (9). In the past, race was used as a proxy to emphasize biological differences. Despite widespread recognition of the danger of attributing biological or cultural inferiority to race, and that race is indeed a **social construct**,[G] some scholars continue to reduce race and ethnicity to biology (9).

While differences in health outcomes across racial groups are frequently reported in health disparities research, these studies often fail to connect observed disparities to mechanisms of systemic racism that drive adverse health outcomes among racialized and other marginalized populations (9). Without this connection, investigators inadvertently support harmful narratives of biological essentialism or cultural inferiority that pathologize racial identities and inhibit health equity (9).

Race should not be used as a measure of biological difference, but rather as a proxy for exposure to systemic racism (9). Future studies must go beyond this proxy use and directly measure racism and its health impact at all social and environmental levels (10). To comprehensively assess racism across these domains, health and social service organizations should apply multi-level, dynamic **social-ecological models**[G] (see **Theoretical frameworks and guiding principles**). These frameworks facilitate a nuanced analysis of how racism impacts health care and health providers at the individual (intrapersonal), relational (interpersonal), community (institutional) and societal (systemic) levels, providing a foundation for evidence-based interventions and systemic change within health and social service organizations (10,11).

Black/Black race

"Black" and the concept of Black race are terms that continue to evolve and vary widely across the literature. Broadly, they refer to people with visibly darker skin pigmentation (12). In the Canadian context, "Black" typically refers to people of African or Caribbean heritage (12). Many organizations accept the term "Black," which depending on its use, can both obscure a range of identities as well as strengthen the connections between the identities it encompasses, including: African Canadian, People of African descent and Caribbean Canadian, among others (12). In the United States, Black people are often categorized as African American, Non-Hispanic Black, and Caribbean American. These categorizations reflect deep historical legacies and contemporary sociopolitical perspectives (13).

More recent approaches have emphasized self-identification, suggesting individuals may choose how they identify. However, this idea remains contentious for many members of the Black community, where Blackness is not viewed as a choice but as an embodied experience shaped by visible hereditary features that cannot be self-selected (13). Most importantly, the concept of self-identification raises the question "Who gets to define Blackness?". For example, individuals with complex ancestral histories may choose to identify as Black to honour cultural lineage or political ideologies but may not appear to be Black in some contexts (14). This perspective emphasizes that identity can be fluid, intersectional, and nuanced, particularly for multiracial people who may identify with more than one group (15). While self-identification can be both empowering and complex, in the context of health research, it is essential to clarify additional factors such as country of origin and other aspects of ethnicity, which allow for a deeper and more nuanced understanding of Black health (14). In the studies systematically reviewed for this guideline, participants identified as Black or as belonging to another racialized group. However, few studies provided details on how the researchers determined, defined or reported race. In the context of this guideline, all members of the expert panel self-identified as Black.

The existing body of literature that examines Black **health providers**[G] as a unique group is limited. Many of the studies referenced in this guideline categorize Black health providers within broader ethnic groups, such as People of Colour or as an "underrepresented" group (16). When referencing systemic and institutional discriminatory practices that affect a range of racialized groups, this guideline uses broad terms such as racism. This approach reflects current gaps in race-based data collection in Canadian research and may underrepresent the specificity of anti-Black experiences (17).

Anti-Black racism

Differences in language used to describe racism reflect our evolving understanding of how race and power manifest within institutions and society (18). Anti-Black racism describes the **discrimination**,[G] **microaggressions**,[G] **stereotypes**,[G] beliefs and attitudes directed at people of African descent and is deeply entrenched in Canadian institutions, policies and practices, impacting educational outcomes, career progression, and health outcomes to the extent that it is either functionally normalized or rendered invisible within society (19). It is rooted in a legacy of **colonialism**,[G] slavery and systemic exclusion from Canadian institutions (20) (see **Background context**). Anti-Black racism was first coined by Dr. Akua Benjamin, a Canadian scholar and professor of social work at Toronto Metropolitan University. The term specifically highlights Black experiences within a broader racial justice context (6). Similarly, anti-Blackness, a term often used in **critical race theory**[G] (see **Theoretical frameworks and guiding principles**), describes negative or threatening attitudes or practices directed at Black people socially and culturally (6). Within this guideline, anti-Black racism

and anti-Blackness are used interchangeably to describe racism specifically experienced by Black health or social service providers, where this group has been specifically highlighted in the literature. **Colourism**,[G] discrimination that favours lighter-skinned individuals over darker-skinned individuals within the same racial group, often intersects with but is distinct from anti-Black racism (21). It reinforces internal hierarchies that can shape Black people's experiences in health, educational, and professional settings (22,23).

Intersectionality

Intersectionality[G] is a critical framework for understanding how multiple social identities, such as race, gender identity and expression, sexual orientation, disability, socioeconomic status, age, and immigration status, intersect to shape unique experiences of oppression and privilege by highlighting that systems of power and discrimination overlap and compound, creating distinct and often intensified forms of **marginalization**[G] (24). Although intersectionality was formulated outside of the nursing discipline in the field of law, the framework has become an integral part of nursing research (25). In the context of anti-Black racism in nursing, intersectionality highlights how Black nurses with multiple intersecting identities, such as Black gender-diverse nurses and Black disabled nurses, often encounter additional stigma and structural exclusion. Intersectionality was applied as a theoretical framework when developing this guideline (see **Theoretical frameworks and guiding principles**).

Whiteness

Whiteness[G] refers to the practices and processes that encompass basic rights, values, beliefs, perspectives, and experiences assumed to be universal but only afforded to White people (26,27). In Canada and the United States, these norms have deeply influenced societal structures, contributing to systemic racism and the normalization and domination of White cultural ideologies and **White supremacy**.[G] These ideologies privilege some, while denying others, often with the justification of biological and social inferiority (27). In addition to the covert normalization of White cultural practices and structures, a tendency to deny the existence of racism has evolved into an ideology where a person may say they do not to see race and or skin colour (28), or racial "colour blindness" (29). While this stance may be viewed as an acceptable perspective used to avoid the discomfort many people experience when issues of racial discrimination are raised (6,29), it can be harmful, as it dismisses the lived experiences of racialized persons and further obscures inequities, violence and trauma (28). Given the subtle and insidious nature of Whiteness and colour blindness, this guideline will serve as an essential tool for health and social service organizations to explicitly name, recognize and challenge the embedded assumptions associated with these ideologies.

Health equity

Pursuing health equity requires an explicit focus on anti-Black racism, which is lacking in North America (30). Anti-Black racism subtly manifests in clinical interactions, institutional policies and public health systems, leading to health disparities, poor quality of care and patient mistrust despite well-meaning efforts to combat racism (30). While health equity initiatives emphasize social determinants of health and broad systemic reform, they often fail to explicitly identify and confront anti-Black racism, leaving specific impacts unaddressed and unnamed (30). A Public Health Agency of Canada report emphasizes anti-Black racism as a determinant of health, recognizing racism and discrimination against Black people as a key driver of health inequities (30). Therefore, health equity efforts must explicitly identify and address anti-racism and anti-Black racism strategies to avoid inadvertently perpetuating health inequities among Black people.

Unconscious bias

Unconscious bias,[G] defined as automatic, unintentional attitudes or stereotypes that influence behaviour (31), is frequently cited in the literature as a strategy to address racism in health-care, education and workplace settings. Research from the American health-care system has shown that unconscious bias (also referred to as implicit bias in this guideline) is shaped by structural racism (32). As such, recognizing one's own biases through self-reflection is a key step in making racism visible (33). Many studies included in this guideline focus on unconscious bias education to address discrimination or racism more broadly. However, it is important to acknowledge that concepts such as unconscious bias may sometimes serve as proxies for racism, to avoid naming racism or anti-Black racism explicitly. This can deflect attention and responsibility away from addressing structural racism directly.

Microaggressions

Microaggressions are intentional or unintentional acts of verbal and nonverbal slights, snubs or insults that are produced by both individuals and larger social groups, such as institutions. These actions convey hostile, derogatory or negative messages to individuals based solely upon their membership in a marginalized group (34). Unconscious bias can be expressed as microaggressions. Examples include saying to a Person of Colour with surprise, "you are so articulate" or making comments about "appropriate" styles of dress in a way that excludes certain racial groups. Although microaggressions may appear subtle, their cumulative impact can be deeply stressful for those who experience them, especially due to their pervasiveness and the ease at which accounts of microaggressions are denied or dismissed (34). Importantly, racism can be both a cause and a consequence of microaggressions and unconscious bias.

Dominant racial ideologies, shaped by education, media and culture, influence how individuals, including health providers, interact with one another. Microaggressions are often performed covertly, unacknowledged by perpetrators and fuelled by systemic racism (34). When microaggressions and patterns of exclusion go unchecked, they contribute to the marginalization of Black people and People of Colour, perpetuating racist behaviours (34).

The relationship between unconscious bias, microaggressions and racism is complex and multifaceted. Within this guideline, it is essential to recognize the interconnectedness of these concepts when addressing anti-Black racism in nursing.

For further details on terminology used in this BPG, refer to the **Glossary of terms** in **Appendix A**.

Please note that terminology is dependent on historical and cultural context. It is important to use respectful, contemporary language that aligns with the cultural context of a given place or group, reflecting the preferences and values of Black nurses and Black nursing students.

Purpose and scope

Purpose

RNAO's BPGs are systematically developed, evidence-based documents that include recommendations on specific clinical, healthy work environment and health system topics. They are intended for nurses, other members of the interprofessional team in direct care positions, educators, administrators and executives, policymakers and researchers in health and social service organizations and academic institutions. BPGs promote consistency, **cultural humility**[G] and excellence in clinical care, administrative policies, procedures and education, with the aim of achieving optimal health outcomes for people, communities, and the health system. RNAO aims to meet international reporting standards for clinical practice guidelines, including the standards outlined in the Appraisal of Guidelines for Research and Evaluation (AGREE II) Instrument and the Reporting Items for Practice Guidelines in HealThcare (RIGHT) statement (35,36).

Healthy work environments are practice settings that (a) maximize the health and well-being of nurses and other health workers and (b) improve organizational performance and patient, client, resident and societal outcomes. They comprise numerous components, including: physical, structural and policy components; professional and occupational components; and cognitive, psychological, sociological, and cultural components (37). These components, and the relationships among them, make them complex and multidimensional. Because it is the combination of factors and components that determines the nature of the work environment and influences individual experience, interventions to promote healthy work environments must target multiple levels and components of the system – and, indeed, the system itself (38).

The purpose of this healthy work environment guideline is to address anti-Black racism in nursing and improve inclusivity and retention of Black nurses and Black nursing students in health and social service organizations and academic institutions. This BPG highlights the harmful history of marginalization and discrimination experienced by Black nurses and Black nursing students, illuminating the impact of systemic racism in the nursing profession. **Advocacy**[G] and collaboration focused on eradicating anti-Black racism and racism more broadly are essential to achieving **equity**[G] and transformative change in nursing.

In October 2023, RNAO convened an expert panel to determine the purpose and scope of this BPG and to develop **research questions**[G] to inform the **systematic reviews**.[G] The RNAO expert panel included early-to-late career Black nurses and Black nursing students with knowledge and experience in all domains of practice: administration, clinical care, education, research and policy. Expert panel members represented a range of diverse health and social service organizations and academic institutions. They shared their experiences as Black nurses and Black nursing students working across the continuum of care, including (but not limited to) primary care, home and community care, acute care, rehabilitation and long-term care (LTC), as well as their experiences within academic institutions.

The RNAO best practice guideline development and research team and the RNAO expert panel completed a comprehensive review and analysis to determine the scope and priority research questions for this BPG (refer to supplementary materials under the "methodology documents" tab on the BPG webpage.

Scope

To determine the scope of this BPG, the RNAO best practice guideline development and research team conducted the following steps:

- conducted an environmental scan of existing guidelines and standards on the topic;
- undertook a scoping review of the literature to determine available evidence on addressing racism in health care broadly and anti-Black racism in nursing specifically;
- led 10 key informant interviews with Black nurses in leadership roles, including nursing researchers and nursing professors;
- held eight discussion groups with Black nurses, including front line nurses, advanced practice nurses, nurse managers and administrators, nursing professors and researchers, and Black nursing students; and
- consulted with the expert panel.

This BPG provides evidence-based recommendations and good practice statements for all nurses and nursing students across all domains of nursing practice (including clinical care, administration, education, policy and research). Within this broader context, this guideline provides specific focus on the experiences and needs of Black nurses and Black nursing students across all designations, practicing in all settings and sectors. These include, but are not limited to, public health, primary care, home and community care, mental health, acute care, LTC and educational settings. While the primary aim of this guideline is to eliminate anti-Black racism in nursing, the recommendations and good practice statements may be applied more broadly to address racism and discrimination experienced by all racialized health and social service providers.

Topics outside the scope of this best practice guideline

The following conditions and topics are not covered within the scope of this BPG:

- Anti-Black racism and racism experienced by people receiving care and their families.

Centring Black expertise: Positionality of the RNAO best practice guideline expert panel

The individuals below served as members of the expert panel that shaped the development of this guideline. Several panelists chose to include **positionality**[G] statements to provide context about their social location, lived experiences and professional lens as it relates to addressing anti-Black racism in nursing. Including these statements in the guideline promotes transparency and acknowledges the diverse perspectives that inform this work.

Dr. LaRon E. Nelson, RN, PhD, FNP, FNAP, FNYAM, FAAN
Expert panel co-chair
Independence foundation professor of nursing
Yale University
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Dr. Bukola Salami, RN, MN, PhD, FCAN, FAAN
Expert panel co-chair
Full professor
Tier 1 Canada Research Chair in Black and Racialized Peoples Health
Department of Community Health Sciences and Faculty of Nursing
University of Calgary
Calgary, AB

Professor Bukola Salami identifies as a Black African immigrant cisgender woman. She holds the rank of Full Professor and is a Tier 1 Canada Research Chair in Black and Racialized Peoples' Health.

Akil (Aakilah) Ade, RN
Palliative Care Nursing Supervisor
VHA Home HealthCare
Toronto, ON

I identify as a Canadian of African Caribbean diasporic heritage and occupy a role within nursing leadership, which shapes how I understand privilege. My social position affords me privilege and obligates me to be conscious of those who are marginalized. I engage this work from a position of personal lived experiences, while recognizing systemic barriers and tools for change and progress.

Dr. Patricia K. Bradley, RN, PhD, FAAN
Associate professor
Villanova University
Pennsylvania, USA

Bobbett Bradley, RN, BScN, MHM
Labour relations officer
Ontario Nurses Association
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Dr. Angela Cooper Brathwaite, RN, CM, PhD, O.Ont, FAAN, Dr. of the University
Adjunct professor & Graduate faculty member
Health Sciences Department, Ontario Tech University
Oshawa, ON

I am a Black nurse form Caribbean Origins. I have national and international experience in clinical practice, nursing education, research methodology, policy advocacy and expertise in leadership. My contributions to the RNAO Best Practice Guideline are based on my lived experience of racism, research knowledge acquired from conducting Anti-Black racism studies and critiquing the scholarly literature.

Damilola Iduye, RN, MN, MPH, PhD(c)
President, Pan-Canadian Association of Nurses of African Descent (PCANAD)
Senior Instructor, School of Nursing and Research Scholar, Healthy Population Institute
Dalhousie University
Halifax, NS

I have been a registered nurse for over 20 years and currently work as a teaching professor at the School of Nursing, Dalhousie University. I am also pursuing a PhD in Public Health Science at the Dalla Lana School of Public Health, University of Toronto, and my doctoral research focuses on the intersections of race, ethnicity, policy, immigration and citizenship status, structural racism, and health. My experiences as an African immigrant woman of Nigerian descent in Canada have profoundly shaped my understanding of power dynamics, social structures, systemic injustices, and oppression, as well as their impacts on the advancement of Black nurses and nursing students across Canada. The Pan-Canadian Association of Nurses of African Descent (PCANAD) mobilizes, supports, and connects nurses of African descent (That is individuals who identify as Black, African, and Afro-Caribbean, etc.) across the country to address anti-Black racism in nursing and to advocate for and lead systemic change that improves the health and well-being of all Black people in Canada, regardless of their individual social location.

Dr. Keisha Jefferies, RN, MN, PhD
Assistant professor, University research chair
Director of M-BRACe Research Hub
School of Nursing, Dalhousie University
Halifax, Nova Scotia

Tania Lafleur, RN, BScN, CDE (Oct 2023- Nov 2024)
Outpatient Chronic Disease Management Nurse Educator
Seneca College
RNAO NRNIG Chair

Christine Sipiwe Khiyaza, RN, BScN (Hons), PGDip, MScN
Kingston General Hospital
Kingston Health Science Centre
Kingston, ON

I identify as a Black African woman from Zimbabwe. I have almost 30 years of experience as a Registered Nurse (RN) in the UK and Canada. Working in multicultural health systems, where I directly faced anti-Black racism, has deeply shaped my career and strengthened my commitment to creating supportive and respectful environments for current and future nursing colleagues. My vision, as an expert panel member, is for nursing and patient care to become equitable, compassionate, fair, and inclusive in the future.

Chinyere Mbah
Nursing student
York University
Toronto, ON

Janet Montague, RN, BScN, MN, PhD(c)
Nursing Professor
Centennial College,
Toronto, ON
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I am a Black nursing professor and Program Coordinator at Centennial College, and a PhD candidate at Western University. My dissertation research examines Black students' experiences of belonging in Canadian nursing education, with particular attention to how power, racism, and structural inequities are reproduced within academic and clinical contexts. This positionality informs my approach to anti-racism scholarship and practice, centring the voices, knowledge, and lived realities of Black nursing students and professionals while advocating for systemic change.

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Ovie Onagbeboma is a West African-Caribbean, first-generation Canadian, cisgender Black woman nurse leader and scholar and serves as the Co-Founder and CEO of the Canadian Black Nurses Alliance (CBNA). Her positionality is shaped by over 11 years of leadership experience within acute care hospital settings in Canada, as well as her contributions as a co-author of publicly funded online educational resources focused on advancing nursing education and clinical assessment. Informed by Black scholarship and collective Black nursing advocacy, Ovie engages this work through a critical analysis of power, whiteness, and structural inequity, and commits to advancing accountability-driven approaches that move beyond race-neutral equity frameworks to meaningfully confront and dismantle anti-Black racism within nursing education, practice, and health systems.

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Overview of methodology: Good practice statements and recommendations

Good practice statements and recommendations

This BPG includes both good practice statements and graded recommendations. It has been developed using elements of the **Grading of Recommendations Assessment, Development and Evaluation**[G] (GRADE) and **Confidence in the Evidence from Reviews of Qualitative Research (CERQual)**[G] methods. Given the research landscape, and the nature of the research questions posed by the panel, unique methodological considerations were made when developing this guideline.

For more details, refer to our methodology published elsewhere as well as supplementary materials under the "methodology documents" tab on the BPG webpage (39).

Good practice statements

Good practice statements are actionable statements that should be done in practice (40). Good practice statements are developed through expert consensus drawing on existing literature including grey literature. To ensure their appropriate use, the expert panel must confirm that the following five criteria are met:

1. The message is necessary to communicate.
2. After considering all relevant outcomes and potential downstream consequences, implementing the good practice statement would result in large benefits and very small harms.
3. Conducting a systematic review to collect and summarize the evidence would be a poor use of time and energy.
4. There is a clear rationale for the action.
5. The statement is clear and actionable (40).

The expert panel must have a high level of certainty that the benefits of the good practice statement outweigh any potential harms. As a result, good practice statements are not based on a systematic review of the evidence nor do they receive a rating of the certainty in their evidence or a strength (i.e., a rating of conditional or strong, which is further discussed below) (41). While good practice statements may be supported by **indirect evidence**,[G] there must be a well-documented clear and explicit rationale connecting the indirect evidence to the statement (40). Good practice statements should be interpreted as strong recommendations emerging from a high certainty in the benefits of implementing the action (40). It is important to note that good practice statements are not produced when evidence is lacking, nor are they based solely on expert opinion.

Graded recommendations

Graded recommendations are also actionable statements; however, these statements are formed based on a direct or indirect link to a body of evidence found through the systematic review process (42). The recommendations are formulated as either strong or conditional by considering the certainty or confidence in the evidence, benefits and harms, values and preferences of people who are impacted by the recommendation and impact on health equity (see **Interpretation of evidence and recommendation statements**). The expert panel formulates recommendations using **Evidence-**

to-Decision (EtD) frameworks[G] through a process of informal consensus facilitated by the RNAO best practice guideline development and research team. Since the recommendations are explicitly linked to the body of evidence, the expert panel generally reaches a consensus (43). If consensus cannot be reached, formal voting methods are used to determine the action and strength of the recommendations (43,44).

Despite the fact that good practice statements and recommendations are developed differently, both provide comprehensive guidance on an action/intervention that should (or should not) be done (42). Therefore, both good practice statements and recommendations should follow the same process for implementation (see **Implementing RNAO guidelines**).

Research questions

The population, intervention, comparison, and outcomes **(PICO) research questions**[G] and population, phenomenon, and context **(PPC) research questions**[G] guide the evidence review process and subsequently inform the recommendations. PICO questions are addressed through systematic reviews of quantitative literature, while PPC questions are explored through systematic reviews of qualitative literature, known as **qualitative evidence syntheses**.[G]

The following are the priority research questions developed by the RNAO expert panel that informed the development of the recommendations in this BPG. Outcomes across questions included outcomes related to psychological safety, representation, education and patient outcomes.

- **Research question #1a**: What type of education should be recommended to address anti-Black racism in nursing?

  No additional question specific outcomes.

- **Research question #1b:** What are the values, preferences, barriers and facilitators associated with delivering education to address anti-Black racism in nursing?

  Outcomes: Not applicable.

- **Research question #2a:** What are the components of **mentorship**[G] programs for Black nurses, Black nursing students, as well as allies, that can help address anti-Black racism in nursing?

  Additional question specific outcomes: Outcomes related to human resources (HR) and escalation of grievances.

- **Research question #2b:** What are the values, preferences, barriers and facilitators associated with mentorship programs developed to address anti-Black racism in nursing?

  Outcomes: Not applicable.

Note: These priority research questions were developed by the RNAO expert panel to guide the systematic reviews of quantitative and qualitative literature. For the full PICO and PCC research questions, and details on how the RNAO expert panel prioritized the research questions and outcomes, please refer to our published methodology and the supplementary materials available under the "methodology documents" tab on the BPG webpage (39).

Summary of recommendations and good practice statements

Addressing anti-Black racism is a societal issue that requires collective action. While multilevel systemic change involves many sectors, the following recommendations and good practice statements focus on practical steps that health and social service organizations and academic institutions can take to confront racism within clinical and academic environments.

Recommendations and good practice statements	Strength of the recommendation
Education	
Good Practice Statement 1.0: It is good practice for all health and social service organizations and academic institutions to provide ongoing education to students, faculty and staff to address anti-Black racism in nursing.	**Not applicable***
Recommendation 1.0: The expert panel suggests that health and social service organizations and academic institutions provide interactive education that includes and/or promotes dialogue and engagement and/or reflection to address anti-Black racism in nursing.	**Conditional**
Recommendation 1.1: The expert panel suggests that health and social service organizations and academic institutions provide education programs led by experienced facilitators who foster authentic dialogue grounded in safety when addressing topics on anti-Black racism in nursing. Education programs may include: ▪ small and large group discussions ▪ critical self-reflection and self-sharing activities ▪ activities that challenge personal bias	**Conditional**
Organization and policy	
Good practice statement 2.0: It is good practice for executive leaders and managers to develop, implement and evaluate zero-tolerance policies regarding anti-Black racism in nursing.	**Not applicable***
Good practice statement 3.0: It is good practice for health and social service organizations and academic institutions to continually recognize the historical and contemporary contributions of Black nurses and other Black health professionals, particularly during Black History Month, African Heritage Month, and Caribbean Heritage Month.	**Not applicable***

Recommendations and good practice statements	Strength of the recommendation
Good practice statement 4.0: It is good practice for health and social service organizations and academic institutions to actively promote the retention, recruitment and career advancement of Black nurses and Black nursing students to increase representation of Black nurse leaders at all levels and in all sectors and settings.	**Not applicable***
Recommendation 2.0: The expert panel suggests that health and social service organizations and academic institutions establish formal mentorship programs to address anti-Black racism in nursing.	**Conditional**
Recommendation 2.1: The expert panel suggests that health and social service organizations and academic institutions provide formal mentorship programs for Black nurses and Black nursing students and include the following: ▪ mentor-mentee dyads that emphasize positive, empathetic relationships ▪ career progression and advancement strategies ▪ communication of expectations and goals	**Conditional**
Recommendation 2.2: The expert panel suggests that health and social service organizations and academic institutions provide formal mentorship programs for Black nurses and Black nursing students to address discrimination and racism and include one or both of the following: ▪ racially concordant mentors ▪ non-racially concordant mentors practicing cultural humility	**Conditional**
Good practice statement 5.0: It is good practice for executive leaders to establish anti-racism, diversity, equity, inclusion and belonging committees that include Black nurse leaders or Black representation from all levels of the health or social service organizations or academic institutions (e.g., HR, staff, alumni and executive leadership).	**Not applicable***

*Good practice statements are actionable statements that must be done in practice. They do not have a strength associated. For more information, refer to the **Overview of methodology**.

Interpretation of evidence and recommendation statements

This guideline used elements of GRADE and GRADE CERQual methods. GRADE and GRADE CERQual provide a transparent framework and a systematic approach for rating the certainty of **quantitative research**[G] and assessing confidence in **qualitative research**[G] and determining the strength of recommendations (45,46). For more details, refer to our published methodology as well as supplementary materials available under the "methodology documents" tab on the BPG webpage (39).

Certainty of evidence

The certainty of evidence (i.e., the level of confidence we have that an estimate of effect is true) for quantitative research was determined using GRADE methods (45). There are five criteria for assessing the certainty of quantitative research per outcome and per study design: risk of bias, inconsistency, indirectness, imprecision and publication bias. After synthesizing the evidence for each prioritized outcome, the certainty of evidence was assessed. The overall certainty was determined by considering the certainty of evidence across all prioritized outcomes per recommendation. GRADE categorizes the overall certainty of evidence as **high, moderate, low** or **very low** (see **Table 1** for the definition of these categories).

Table 1: Certainty of evidence

Certainty of evidence	Definition
High	We are very confident that the true effect lies close to that of the estimate of the effect.
Moderate	We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.
Low	Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect.
Very low	We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect.

Source: Reprinted with permission from: Schünemann H, Brozek J, Guyatt G, Oxman A, editors. Handbook for grading the quality of evidence and the strength of recommendations using the GRADE approach [Internet]. [place unknown: publisher unknown]; 2013 Oct [cited 2018 Aug 31]. Table 5.1, Quality of evidence grades. Available from: https://gdt.gradepro.org/app/handbook/handbook.html#h.9rdbelsnu4iy

Confidence in evidence

The confidence in evidence for qualitative research (i.e., the extent to which the review finding is a reasonable representation of the phenomenon of interest) was determined using elements of GRADE-CERQual methods (hereafter referred to as CERQual) (46). Similar to GRADE, there are four CERQual criteria to assess the confidence in qualitative findings related to a phenomenon of interest—methodological limitations, relevance, coherence and adequacy of data. An overall judgment of the confidence in qualitative evidence was then made per finding. CERQual categorizes the confidence in evidence as **high, moderate, low** or **very low**. See **Table 2** for the definitions of these categories.

Table 2: Confidence in evidence

Confidence in Evidence	Definition
High	It is highly likely that the finding is a reasonable representation of the phenomenon of interest.
Moderate	It is likely that the finding is a reasonable representation of the phenomenon of interest.
Low	It is possible that the review finding is a reasonable representation of the phenomenon of interest.
Very Low	It is not clear whether the review finding is a reasonable representation of the phenomenon of interest.

Source: Reprinted with permission from: Lewin S, Booth A, Glenton C, et al. Applying GRADE-CERQual to qualitative evidence synthesis findings: introduction to the series. Implement Sci. 2018;13(Suppl 1):1-10. Table 3, Description of level of confidence in a review finding in the CERQual approach; p. 6.

Note: The assigned certainty or confidence of evidence can be found directly below each recommendation statement. For more information on the process of determining the certainty or confidence of evidence and the documented decisions made by RNAO guideline development methodologists, please refer to supplementary materials under the "methodology documents" tab on the BPG webpage.

Strength of recommendations

The recommendations in this guideline were formulated as **strong** or **conditional** by considering the **certainty or confidence in evidence** and the balance of benefits and harms (for quantitative evidence) and values and preferences (for qualitative evidence) (see **Discussion of evidence** for definitions).

According to Schunemann et al., "A strong recommendation reflects the expert panel's confidence that the desirable effects of an intervention outweigh its undesirable effects (strong recommendation for an intervention) or that the undesirable effects of an intervention outweigh its desirable effects (strong recommendation against an intervention)" (45). In contrast, "A conditional recommendation reflects the expert panel's confidence that the desirable effects probably outweigh the undesirable effects (conditional recommendation for an intervention) or undesirable effects probably outweigh

desirable effects (conditional recommendation against an intervention), but some uncertainty exists" (45). **Table 3** outlines the implications of strong and conditional recommendations.

When the overall certainty of the evidence is high or moderate, the expert panel can be confident in the effects of the intervention, such that the benefits outweigh the harms and there is limited variability in the values and preferences of people. In this situation, expert panel members should expect a strong recommendation (47). However, when the overall certainty of the evidence is low or very low and there is uncertainty regarding the impact of the intervention of interest, expert panel members should expect conditional recommendations (47).

Table 3: Implications of strong and conditional recommendations.

Implications of strong and conditional recommendations		
Population	**Strong recommendation**	**Conditional recommendation**
For health providers	▪ The benefits of a recommended action outweigh the harms. Therefore, most people should receive the recommended course of action. ▪ There is little variability in values and preferences among people in this situation. Most people would want the recommended course of action and only a small portion would not. ▪ There is a need to consider people's circumstances, preferences and values.	▪ The benefits of a recommended course of action probably outweigh the harms. Therefore, the majority of people could receive the recommended course of action. ▪ There is greater variability in values and preferences, or there is uncertainty about typical values and preferences among people in this situation. The majority of people would want the suggested course of action but many would not. ▪ There is a need to consider people's circumstances, preferences and values more carefully than usual.
For policy-makers	▪ The recommendation can be adapted as policy in most situations.	▪ Policy-making will require substantial debate and involvement of many others impacted by the change. Policies are also more likely to vary between regions.
For researchers	▪ The recommendation is likely supported by high certainty evidence or other convincing judgments that make additional research unlikely to alter the recommendation.	▪ The recommendation is likely to be strengthened by additional research. An evaluation of the conditions and criteria that determined the conditional recommendation will help to identify possible research gaps.

Source: Adapted with permission from: Schünemann H, Brozek J, Guyatt G, Oxman A, editors. Handbook for grading the quality of evidence and the strength of recommendations using the GRADE approach [Internet]. [place unknown: publisher unknown]; 2013 Oct [cited 2020 May 11]. Table 6.1, Implications of strong and weak recommendations for different users of guidelines. Available from: https://gdt.gradepro.org/app/handbook/handbook.html#h.33qgws879zw

Note: The strength of each recommendation statement is detailed directly below it and in the **Summary of recommendations and good practice statements**. For more information on the process used by the expert panel to determine the strength of each recommendation, please refer to supplementary materials under the "methodology documents" tab on the BPG webpage.

Discussion of evidence

Each recommendation includes a discussion of evidence, which consists of the following main sections:

1. **Discussion of evidence:**
    a. For quantitative studies, this section identifies potential desirable and undesirable outcomes reported in the literature when a recommended practice is implemented.
    b. For qualitative studies, this section was grouped by theme, incorporating values and preferences that reflect the importance placed on outcomes associated with following a recommended practice.
2. **Expert panel justification of recommendation:** Provides a rationale for why the expert panel made the decision to rate a recommendation as strong or conditional.
3. **Implementation strategies:** Highlights practical information for nurses and other members of the interprofessional team to support implementation in practice. This section may include supporting evidence from the literature and/or from other sources (e.g., the RNAO expert panel).
4. **Supporting resources:** Includes a list of relevant resources (e.g., websites, books and organizations) that support the recommendations. Content listed in this section was assessed based on five criteria: relevancy, credibility, quality, accessibility and timeliness of publication (published within the last 10 years). Further details about this process and the five criteria are outlined in the supplementary materials under the "methodology documents" tab on the BPG webpage. The list is not exhaustive and the inclusion of a resource in one of these lists does not imply an endorsement from RNAO. Some recommendations may not have any identified supporting resources.

Note on health equity: RNAO guidelines typically include a health equity section within the discussion of evidence for each recommendation. This section outlines the potential impact on health equity across different populations and settings and identifies barriers to implementation in specific contexts. For this guideline, however, a separate health equity section was not included within the discussion of evidence. Instead, equity considerations were integrated throughout all stages of guideline development, from defining the guideline's purpose, to drafting research questions, to identifying barriers to implementation across diverse settings. This approach ensured that equity remained a foundational element in the development process.

Best practice guideline evaluation

As you implement the recommendations in this BPG, we ask you to consider how you will monitor and evaluate their impact.

Monitoring impact using race-based data

In 2020, RNAO's Black Nurses Task Force (BNTF) called on the College of Nurses of Ontario (CNO) to begin collecting race-based data to address systemic racism in nursing (17). In 2024, CNO launched its first Workforce Census, gathering identity-based data from over 31,000 Ontario nurses (48). The census serves as a foundational source of demographic and professional information on Ontario's nursing workforce, helping to make systemic barriers visible. As emphasized by the BNTF, the absence of disaggregated data perpetuates invisibility and allows racial inequities to remain unaddressed (48).

Despite progress, gaps remain. The lack of systematic race-based data collection limits the ability to evaluate the implementation and impact of this BPG (17). For example, turnover and dropout rates in health service organizations and academic institutions are routinely tracked, but without race-based and qualitative data (e.g., exit interviews), the drivers of racialized nurse attrition remain obscured. Research shows that racial discrimination in nursing, including barriers to employment and advancement, disproportionate disciplinary action, and workplace violence and harassment, has contributed to the attrition of racialized nurses (49–51). Measuring improvement in relation to equity-focused guidelines is more meaningful when race-based data is collected, as it enables the identification of disparities that might otherwise remain hidden.

Although racism experienced by people receiving care and their families is not within the scope of this BPG, collecting race-based data can also have an impact on patient outcomes and health equity. For example, greater **diversity**[G] in the nursing workforce is associated with improved maternal health outcomes across multiple racial and ethnic groups. Furthermore, within the Black community, increasing health-care representation fosters trust among Black patients, promoting culturally safe care (52). These findings demonstrate the tangible impact that a diverse nursing workforce can have on patient safety and quality of care, and highlight the importance of collecting high-quality, disaggregated race-based data to identify diversity gaps and evaluate interventions across all people receiving and giving care (53).

The Ontario Human Rights Code (OHRC) allows for the collection and analysis of data related to race and other protected grounds when it is done for purposes that align with the Code, such as monitoring discrimination, identifying and removing systemic barriers, addressing historical disadvantages and promoting substantive equality (54). The OHRC holds the position that data collection and analysis should take place when an organization has reason to believe that discrimination, systemic barriers or the continuation of historical disadvantages may exist. Furthermore, in the context of racial discrimination, collecting and analyzing such data can be a necessary and sometimes essential tool for determining whether rights under the Code are or may be infringed upon, and for guiding corrective action (54).

The Wellesley Institute's Consensus Statement on Race-Based Data for Health, endorsed by the OHRC, calls on all levels of the health system including governments, organizations and health providers to collaborate in building the capacity to collect, use and govern race-based data to address inequities and promote health (55). When collected and applied according to best practices, high-quality race-based data can advance equity by uncovering inequities; revealing effective approaches that can be scaled to improve access, quality and outcomes of care; ensuring monitoring and evaluation of interventions; and supporting **accountability**[G] for delivering equitable care and improving outcomes (55).

Currently, the collection of race, ethnicity and Indigenous identity data in the health-care sector is limited, and where data is available, collection methods often vary. However, resources and guidance are available for health and social service organizations to guide the data collection process. For example, the Canadian Institute for Health Information (CIHI) has developed minimum standards for collecting race-based and Indigenous identity data in health care throughout Canada. Such standards aim to support harmonized, high-quality data collection and to help identify and address health inequities related to racism (56). At the provincial level, Ontario Health, The Wellesley Institute and the Black Health Alliance developed complementary resources outlining strategies to foster an environment that supports the ethical collection of Black health data (57). Ontario Health also provides guidance on the collection and use of sociodemographic data to support broader equity-focused analyses beyond race (58).

To meaningfully monitor and evaluate this BPG's implementation, it is essential to understand how Black nurses and Black nursing students in various roles across sectors and settings experience changes in policy and practice in their environment, recognizing that these experiences may be shaped by intersecting identities such as gender identity and expression, disability, and sexual orientation and socioeconomic status. This requires collecting disaggregated race-based data and other sociodemographic data in a purposeful and ethical manner to capture how race, in combination with other intersecting identities, shapes the experiences of Black nurses and Black nursing students, and to assess whether implementation efforts are meaningfully impacting them. Without this, inequities shaped by race and other intersecting identities remain hidden, making equity-driven evaluation and action challenging.

Consistent with the Engagement, Governance, Access, and Protection (EGAP) Framework, race-based data and other sociodemographic data should be collected and used through meaningful and ongoing engagement with Black nurses and Black nursing students, community-informed governance of data processes, equitable access to collective data, and strong protections of privacy and informed consent (269). The framework states that such data must be used to illuminate and measure the effects of structural racism and to monitor and evaluate the effectiveness of interventions aimed at advancing equity.

The collection of race-based data and other sociodemographic data will support evidence-informed advocacy and ensure accountability to those the guideline intends to support. For resources on collecting race-based data and other sociodemographic data, see **Appendix C**.

Indicators for evaluating implementation: Structure, process, and outcome

The Donabedian model, which informs the development of indicators for evaluating quality health care, includes three categories: structure, process and outcome.

- **Structure** describes the required attributes of the health system or health and social service organization to ensure quality care. It includes physical resources, human resources, and information and financial resources.
- **Process** examines the health-care activities being provided to, for and with people or populations as part of the provision of quality care.
- **Outcome** analyzes the effect of quality care on the health status of people and populations, the health workforce, health and social service organizations, or health systems (59).

For more details, see the **monitor knowledge** use and **evaluate outcomes** sections in the Leading Change Toolkit (4).

The following indicators have been developed to support evaluation and quality improvements in health and social service organizations and academic institutions. Consider **Tables 4, 5** and **6** which provide a list of structure, process and outcome indicators along with their operational definitions, numerators and denominators. Each table also identifies if the indicator aligns with other evaluation measures in local, provincial, national and/or international organizations. Alignment is determined by comparing the following criteria with the developed indicators: the operational definition; if the indicator is nursing sensitive; and the inclusion and/or exclusion criteria. Depending upon the level of alignment, an indicator may be described to have full, partial or no alignment with external evaluation measures.

The following indicators will support quality improvement and evaluation. Select the indicators most relevant to the changes being made in practice, education and/or policy, based on BPG recommendations and good practice statements prioritized for implementation.

Table 4: Structure indicators

This table provides structure indicators associated with specific good practice statements that are related to human resources, educational recommendations or other organizational factors.

Recommendation or good practice statement	Structure indicators	Alignment with evaluation measures in other organizations
Good practice statement 1.0	Percentage of students, faculty and staff in the health or social service organization or academic institution who received education that supports addressing anti-Black racism **Numerator:** Number of students, faculty and staff in the health or social service organization or academic institution who received education that supports addressing anti-Black racism **Denominator:** Total number of students, faculty and staff in the health or social service organization or academic institution	New
Good practice statement 2.0	Percentage of organization-wide policies relevant to nursing practice, professional conduct, anti-racism, equity, inclusion and belonging that outline zero-tolerance for anti-Black racism **Numerator:** Number of relevant organization-wide policies that outline zero-tolerance for anti-Black racism **Denominator:** Total number of relevant organization-wide policies	New

Recommendation or good practice statement	Structure indicators	Alignment with evaluation measures in other organizations
Good practice statement 4.0	**For health and social service organizations**	
	Percentage of Black nurses in the organization **Numerator:** Number of Black nurses **Denominator:** Total number of nurses	Full alignment with College of Nurses of Ontario (CNO)
	Percentage of Black nurse leaders in the organization **Numerator:** Number of Black nurse leaders **Denominator:** Total number of nurse leaders	Full alignment with CNO
	For academic institutions Percentage of Black nursing students in the academic institution **Numerator:** Number of Black nursing students **Denominator:** Total number of nursing students	New
	Percentage of Black nursing faculty in the academic institution **Numerator:** Number of Black nursing faculty **Denominator:** Total number of nursing faculty	Full alignment with CNO
Good practice statement 5.0	Percentage of an anti-racism, diversity, equity, inclusion and belonging (ADEIB) committee that include at least one Black member from each level (e.g., HR, staff, alumni, executive leadership) of the organization or academic institution **Numerator:** Number of levels on the ADEIB committee that include at least one Black member **Denominator:** Total number of levels on the ADEIB committee	New

Table 5: Process indicators

This table provides a list of process indicators that support the evaluation of practice changes during implementation and corresponding process improvements. Process indicators are derived from BPG recommendations and good practice statements.

Recommendation or good practice statement	Process indicators	Alignment with evaluation measures in other organizations
Recommendations 1.0 and 1.1	Percentage of education programs that incorporated interactive education when addressing topics on anti-Black racism **Numerator:** Number of education programs that incorporated interactive education when addressing topics on anti-Black racism **Denominator:** Total number of education programs that include topics on addressing anti-Black racism	New
Good practice statement 2.0	Percentage of executive leaders, managers, students, faculty and staff who received training or orientation that included zero-tolerance policies on anti-Black racism **Numerator:** Number of executive leaders, managers, students, faculty and staff who received training or orientation that included zero-tolerance policies on anti-Black racism **Denominator:** Total number of executive leaders, managers, students, faculty and staff in the organization or academic institution	New
Good practice statement 3.0	Percentage of days within Black History, African and Caribbean Heritage Months where historical and contemporary contributions of Black nurses and other Black health-care professionals were recognized **Numerator:** Number of days within Black History, African and Caribbean Heritage Months where historical and contemporary contributions of Black nurses and other Black health-care professionals were recognized **Denominator:** Total number of days within Black History, African and Caribbean Heritage Months	New

Recommendation or good practice statement	Process indicators	Alignment with evaluation measures in other organizations
Good practice statement 3.0	Percentage of months where historical and contemporary contributions of Black nurses and other Black health-care professionals were recognized **Numerator:** Number of months where historical and contemporary contributions of Black nurses and other Black health-care professionals were recognized **Denominator:** Total number of months in the reporting period	New
Good practice statement 4.0	Percentage of recruitment strategies that promote increasing Black representation in nursing (nurses in various roles across settings and/or nursing students) **Numerator:** Number of recruitment strategies that promote increasing Black representation in nursing **Denominator:** Total number of nursing recruitment strategies	New
Recommendation 2.0	**For health and social service organizations** Percentage of nursing service areas in the organization engaged in formal mentorship initiatives that support nurses in addressing anti-Black racism **Numerator:** Number of nursing service areas engaged in formal mentorship initiatives **Denominator:** Total number of nursing service areas **For academic institutions** Percentage of nursing cohorts in the academic institution engaged in formal mentorship initiatives that support nursing students in addressing anti-Black racism **Numerator:** Number of nursing cohorts engaged in formal mentorship initiatives **Denominator:** Total number of nursing cohorts	New

Recommendation or good practice statement	Process indicators	Alignment with evaluation measures in other organizations
Recommendation 2.2	Percentage of mentees who were paired with a preferred mentor (racially concordant mentor or non-racially concordant mentor practicing cultural humility) when a preference was indicated **Numerator:** Number of mentees who were paired with a preferred mentor (racially concordant mentor or non-racially concordant mentor practicing cultural humility) when a preference was indicated **Denominator:** Total number of mentee-mentor dyads	New

Table 6: Outcome indicators

This table provides outcome indicators to assess the impact of implementing **evidence-based practice**[G] changes. Outcome indicators may be linked to the outcomes specified in the research questions or may capture broader anticipated outcomes resulting from the implementation of multiple recommendations and good practice statements.

Outcome indicators	Alignment with evaluation measures in other organizations
Percentage of education recipients who reported a positive experience with the provided education that supports addressing anti-Black racism **Numerator:** Number of education recipients who reported an overall positive experience with the provided education that supports addressing anti-Black racism **Denominator:** Total number of education recipients or total number of survey respondents	New
Percentage of education recipients who reported increased knowledge and awareness of anti-Black racism after receiving education **Numerator:** Number of education recipients who reported increased knowledge and awareness of anti-Black racism after receiving education **Denominator:** Total number of education recipients or total number of survey respondents	New

Outcome indicators	Alignment with evaluation measures in other organizations
Percentage of education recipients who reported confidence in addressing anti-Black racism after receiving education **Numerator:** Number of education recipients who reported confidence in addressing anti-Black racism after receiving education **Denominator:** Total number of education recipients or total number of survey respondents	New
Percentage of education recipients who reported commitment to change after receiving education that supports addressing anti-Black racism **Numerator:** Number of nurses who reported commitment to change after receiving education that supports addressing anti-Black racism **Denominator:** Total number of education recipients or total number of survey respondents	New
Percentage of people who reported an incident of anti-Black racism and had a positive experience with how it was addressed **Numerator:** Number of people who reported an incident of anti-Black racism and had a positive experience with how it was addressed **Denominator:** Total number of people who reported an incident of anti-Black racism	New
For health service organizations	
Percentage of Black nurses hired in the organization **Numerator:** Number of Black nurses hired **Denominator:** Total number of nurses who were hired	Partial alignment with CNO
Percentage of leadership positions filled internally by Black nurses **Numerator:** Number of leadership positions filled internally by Black nurses **Denominator:** Total number of leadership positions filled internally	Partial alignment with CNO
For academic institutions	
Percentage of newly enrolled Black nursing students in the academic institution **Numerator:** Number of newly enrolled Black nursing students **Denominator:** Total number of newly enrolled nursing students	New

Outcome indicators	Alignment with evaluation measures in other organizations
Percentage of mentees and mentors who reported a positive experience participating in the mentorship program **Numerator:** Number of mentees and mentors who reported a positive experience participating in the mentorship program **Denominator:** Total number of mentorship program participants or total number of survey respondents	New
Percentage of mentees who reported increased career advancement readiness after completing a mentorship program focused on addressing anti-Black racism **Numerator:** Number of mentees who reported increased career advancement readiness after completing a mentorship program **Denominator:** Total number of mentorship program participants or total number of survey respondents	New
Percentage of mentees who participated in professional development opportunities during mentorship **Numerator:** Number of mentees who participated in professional development opportunities during mentorship **Denominator:** Total number of mentorship program participants or total number of survey respondents	New
Percentage of Black nurses or nursing students who report a strong sense of belonging in their health or social service organization or academic institution **Numerator:** Number of Black nurses or nursing students who report a strong sense of belonging in their health or social service organization or academic institution **Denominator:** Total number of Black nurses or nursing students in the health or social service organization or academic institution or total number of survey respondents	Partial alignment with Statistics Canada
Percentage of Black nurses or nursing students who report experiencing racism in their health or social service organization or academic institution **Numerator:** Number of Black nurses or nursing students who report experiencing racism in their health or social service organization or academic institution **Denominator:** Total number of Black nurses or nursing students in the health or social service organization or academic institution or total number of survey respondents	Partial alignment with United Nations Sustainable Development Goals

Other RNAO resources for the evaluation and monitoring of BPGs:

Nursing Quality Indicators for Reporting and Evaluation® (NQuIRE®), a unique international data system housed by RNAO, allows **Best Practice Spotlight Organizations®**[G] (BPSOs®) to monitor and evaluate the impact of BPG implementation. The NQuIRE data system collects, compares and reports data on human resource structure indicators as well as guideline-specific, nursing-sensitive structure, process and outcome indicators. NQuIRE indicator definitions are aligned with available administrative data and existing indicators wherever possible, adhering to a "collect once, use many times" principle. By complementing other established and emerging repositories, NQuIRE strives to leverage reliable and valid measures, minimize the reporting burden and align evaluation measures to enable comparative analyses. The NQuIRE data system was launched in August 2012 to do the following: create and sustain evidence-based practice cultures; optimize the safety of people; improve health outcomes and engage staff in identifying relationships between practice and outcomes to advance quality; and advocate for resources and policy that support best practice changes (60).

RNAO Clinical Pathways™ are digitized recommendations and good practice statements embedded into electronic medical records through a third-party software. The ability to link structure and process measures with specific outcome measures helps determine the impact of BPG implementation on specific health outcomes.

Background context

The history of slavery in Canada and the United States is strongly connected to the migration of Black people. Between 1749 and 1782, many people of African descent in Canada were enslaved by American or English settlers and brought to Nova Scotia and other parts of Canada. Slavery in Canada was part of the broader system of slavery in the British Empire. It was not until 1833 that the Slavery Abolition Act ended slavery in most British colonies, including Canada. Despite the abolishment of slavery, Black people in Canada continued to contend with segregation, racism and discrimination throughout the twentieth century and into the twenty-first century (61).

Black nursing history

Black health providers, including Black nurses, have experienced anti-Black racism across the spectrum of education and practice in Canada (50). Cooper Brathwaite et al. contend that racism in nursing is deeply embedded in the profession's history (62). Although the first formal nursing school was established in St. Catharine's, Ontario in 1874, Black nursing students were denied admittance to nursing schools in Canada for sixty-six years, until 1940. Many were forced to travel to the United States to attain a nursing education, leaving a legacy of exclusion and discrimination (62).

Anti-Black racism in nursing has since manifested in many ways, including the overrepresentation of Black nurses in frontline roles and their underrepresentation in leadership positions (62). These systemic barriers can contribute to **internalized racism**,[G] where Black nurses may internalize negative stereotypes or anticipate bias, further impacting confidence, career progression and well-being (63). Jefferies et al.'s review was the first scoping review to chart the complex and multifaceted nature of racial discrimination encountered by Black nurses in Canada (50). The studies included in the scoping review reveal that these experiences occur both in everyday interactions as well as through discriminatory institutional processes, highlighting that even today anti-Black racism persists in Canadian health care and academia (50). The review also showed how racism is exacerbated by intersectional factors such as gender identity, class and nationality. For example, Ontario Human Rights Commission cases documented two Black nurses experiencing racism that was simultaneously gendered and classed (50). This illustrates how Black nurses who hold multiple intersecting identities may experience compounded forms of discrimination, produced by overlapping systems of oppression, including racism, sexism, transphobia, homophobia and **ableism**[G] which can intensify structural and interpersonal bias in education, hiring and career advancement (25,64,65). **Misogynoir**[G] is a term for intersecting discrimination experienced by Black women (66,67).

Beyond Canada, racism and discrimination continue to draw international attention. In 2015, the United Nations (UN) declared the International Decade of People of African Descent (2015-2024), aiming to address issues such as racial discrimination, **xenophobia**,[G] Afrophobia and other intolerances experienced by people of African descent (68). Although the initial effort represented a significant milestone in raising awareness of anti-Black racism and issues faced by people of African descent, it fell short of achieving transformative change. In 2024, the UN renewed its agreement and commitment to this effort. The new agreement emphasizes that urgent collective action is required to promote just and equitable societies and eradicate the cycle of historical injustices, systemic racism, discrimination and exclusion. Future strategies include, but are not limited to, advocating for meaningful participation of Black people in decision-making processes and supporting states in dismantling systemic racism (69,70).

The COVID-19 Pandemic and the very public murder of George Floyd perpetrated by law enforcement in Minnesota in 2020 brought global attention to the discriminatory practices affecting Black communities. A multivariate logistic regression analysis conducted by Gupta and Aitken revealed that Black individuals had the highest age-standardized mortality rate from COVID-19 at 49 deaths per 100,000 people, compared to 22 deaths per 100,000 people among non-racialized, non-Indigenous individuals (71). This study further revealed that low-income Black people were 3.5 times more likely to die from COVID-19 than low-income, non-racialized, non-Indigenous people (71). These disproportionate outcomes highlighted the deep-rooted health inequities and the ongoing impact of anti-Black racism in society, and specifically within health care, including the field of nursing.

Black Nurses Task Force Report

In 2022, a groundbreaking report from the RNAO Black Nurses Task Force (BNTF) concluded that structural racism and anti-Black racist practices are still prevalent in the nursing profession and within nursing schools (17). The report presented data from a survey conducted with 205 Black nurses that highlighted the need for education to address anti-Black racism, provide mentorship and financial support, change hiring practices, create diversity, equity and **inclusion**[G] committees and advocate for Black nurses (17). Most importantly, a key outcome stemming from the taskforce included the need to develop a best practice guideline to address anti-Black racism in nursing. To accelerate the body of knowledge in this area, it was deemed critically important to pursue this directive as no current evidence-based guideline exists to address inequities experienced by Black nurses in health care (17). This work also aligns with and is strengthened by RNAO's Health Equity Consortium, which brings together diverse partners from the **2SLGBTQI+**[G], Indigenous and Black community to advance collective action on health equity and dismantle systemic racism across the health system with an intersectional lens (5).

Current state of research

There is a lack of direct research on the topic of anti-Black racism in nursing (17,50,51,62,72). In a quality improvement study that explored strategies to address systemic racism and discrimination against Black nurses and Black nursing students in Ontario, Canada, Cooper Brathwaite et al. highlighted that Black nurses and Black nursing students are typically grouped with other racialized populations in research (e.g., Indigenous, Asian, Latino) (51). The results of their research highlight the importance of studying the Black population as a unique group to understand the specific difficulties and traumatic experiences of anti-Black racism and discrimination (51). Similarly, Jefferies et al.'s scoping review sheds light on the qualitative experiences of racism and discrimination experienced by Black nurses in Canada while also emphasizing the need for quantitative and mixed-methods research to further inform, evaluate and advance this topic (50). Jeffries also calls for research examining the ways disability, sexual orientation and other critical factors impact experiences of racism for Black nurses in Canada (50), as studies on this topic have not been explored in-depth in the existing literature. The limited number of Canadian studies focused on anti-Black racism has led to a reliance on studies from other countries, such as the United States and the United Kingdom (72). Similarly, in an exploratory qualitative research study reviewing Black nurses' experiences of anti-Black racism in Ontario, Canada, Prendergast et al. highlighted that the lack of Canadian research in this area may hinder the development of context-specific education, health-care policies and practices (72). Taken together, the limited research available in Canada addressing racism and anti-Black racism in nursing and health care more broadly underscores the critical importance of this BPG in advancing the evidence base to support nursing and health providers.

In this guideline, many of the research studies group Black health professionals into broader racialized groups such as **Black, Indigenous, and People of Colour (BIPOC)**,[G] visible minorities and underrepresented in medicine (URIM). When referencing systemic and institutional discriminatory practices where findings include a range of racialized groups, this guideline uses more general terms such as racism. While this disaggregation may underrepresent the specificity of anti-Black experiences, this approach is taken in consideration of the current gaps in race-based data collection in Canadian research (17).

To gain a deeper understanding on this topic, RNAO's guideline development and research team conducted a scoping review to explore the breadth of existing literature focused on racism in health care more broadly. The scoping review informed the pre-development phase of the guideline and was a precursor to subsequent systematic reviews and qualitative evidence syntheses that informed this guideline. The objectives of the review were to explore the following: 1) strategies devoted to addressing anti-Black racism in health care; 2) strategies to combat racism more broadly in health care; and 3) the experiences of Black health providers with racism. Findings from the scoping review further confirmed the scarcity of available Canadian and international research exploring anti-Black racism in the nursing field. Of the 174 studies included in the review, thirty-five studies explored racism in nursing broadly and only five studies directly explored anti-Black racism in nursing. Themes from the review included but were not limited to the importance of **interactive education**,[G] mentorship, advocacy, anti-Black racism policies and career progression into leadership roles.

Methodology

As there is limited available evidence focused specifically on addressing anti-Black racism in nursing, indirect evidence was included in the systematic reviews to answer the guideline's research questions. For example, the population of interest was broadened to include other health providers when limited or no evidence was available on nurses, and the intervention of interest was broadened to include studies that examined racism more broadly when limited or no evidence was available that examined anti-Black racism. Given the rich body of qualitative literature that examined anti-Black racism in nursing and the nature of the research questions posed by the panel, a qualitative evidence synthesis was completed and elements of GRADE CERQual were used to develop recommendations in conjunction with expert panel consensus (46).

For more information about the guideline development process, see the supplemental documents under the "methodology documents" tab on the BPG webpage.

Conclusion

In this healthy work environment BPG, the integration of both historical and contemporary perspectives of Black nurses and Black nursing students has informed the development of evidence-based recommendations and good practice statements aimed at improving equity in health-care workforce practices and policies. These recommendations are designed to help end the systemic racism experienced by Black nurses and Black nursing students, as well as by other health providers and students more broadly. Each recommendation and good practice statement in this guideline contributes to strategic action toward greater racial equity in the nursing profession.

Theoretical frameworks and guiding principles

The expert panel integrated several theoretical frameworks to guide the development process through an equity-focused lens, in addition to elements of GRADE and GRADE-CERQual methodologies that were used to assess the certainty and confidence of evidence and the strength of recommendations. These frameworks were instrumental in shaping how evidence was interpreted, particularly in identifying and addressing the structural and systemic dimensions of anti-Black racism that may not be fully captured through traditional evidence hierarchies. To learn more about these theoretical frameworks, see **Appendix D**.

Theoretical frameworks

Critical race theory

Critical race theory (CRT) provides a foundational lens for examining how historical and ongoing **systemic and structural racism**[G] contribute to the adverse outcomes experienced by Black individuals, particularly in health-care settings (59). Rooted in the Civil Rights Movement and legal scholarship, CRT emphasizes how racism influences social structures, practices and discourses (74,75). CRT highlights the need to reform nursing education, where entrenched systems often fail to critically engage with race and racism (76). CRT equips educators to create inclusive learning environments by actively rejecting colour blindness and amplifying the voices and experiences of historically marginalized individuals (76–78).

Quantitative critical race theory (QuantCrit) was developed to adapt CRT for analysis of quantitative research (79). QuantCrit challenges the assumption of objectivity in numerical data and emphasizes the importance of reflexivity, positionality and social justice in research. The five foundational principles of QuantCrit include: understanding the centrality of racism, recognizing that numbers are not neutral, acknowledging the social construction of categories including race, recognizing the subjective nature of research interpretations, and committing to eliminating racial oppression and promoting social justice. QuantCrit aims to foster racially conscious and equitable research practices, challenging traditional analytical frameworks and striving towards social justice (65).

Intersectionality

As a concept, intersectionality helps us understand how overlapping identities, such as race, gender identity and expression, sexual orientation, disability and class, result in multiple forms of oppression simultaneously, necessitating a holistic analysis of intersecting systems of power (24). Stemming from Kimberlé Crenshaw's seminal work, intersectionality challenges oversimplified narratives about oppression (81,82). In nursing, intersectionality reveals how racial and gendered hierarchies affect career progression, pay equity and recognition, particularly for non-White and immigrant nurses (82,83). In nursing research, the adoption of an intersectionality paradigm forces scholars to examine who is represented, how issues are examined and whose voices are prioritized in knowledge production (84,85). Intersectionality as a framework serves as a powerful tool for dismantling systems of oppression and promoting equity for all individuals. In nursing education, incorporating an intersectionality lens offers a transformative approach to curriculum development and pedagogy, promoting critical reflection about privilege, power, oppression and social identity (86). Additionally, integrative antiracism asserts that while multiple forms of oppression intersect, these social identities do not impact on an individual equally in every situation (87). For many Black people, race can be most salient among the oppressions at any given time (87).

Black Feminist Thought

Black Feminist Thought (BFT)[G] stands as a foundational framework for addressing anti-Black racism within nursing (88). Rooted in the lived experiences of Black women, BFT challenges dominant knowledge systems and emphasizes intersectionality, especially how class and gender shape experiences of oppression (89). It challenges White liberal feminism within nursing, recognizing the harm these ideologies can cause for nurses and the people they care for, and encourages multiple ways of knowing (90). BFT also emphasizes the co-creation of knowledge and encourages critical analysis of power (81). To effectively apply Black feminist thought in practice, it is important to attend to the diversity of lived experiences, systemic and individual racism, and to critically reflect on one's own identity and positions of privilege (91).

Social-ecological model

The social-ecological model is a systems-level interactive framework that describes how individual characteristics and environmental factors interact to influence changes to health and behaviour (92). The multifaceted theory considers multiple levels of influence at the intrapersonal, interpersonal, institutional, community and policy or systems levels (27,62,72). Originally introduced as a conceptual model to understand human development in the 1970s by Urie Bronfenbrenner, it was formalized as a theory a decade later. Building on this foundation, five levels of influence were developed: intrapersonal factors; interpersonal processes and primary groups; institutional factors; community factors; and public policy (93). The model below, adapted by the Center for the Study of Social Policy, incorporates similar levels and promotes an understanding of the dynamic factors that contribute to racial inequities (11). Applying the social-ecological model to racism allows for a deeper analysis of how structural, institutional and interpersonal forces shape health outcomes.

Figure 1: A Socio-ecological model of racism and anti-racism

Source: Reprinted with permission from: Centre for the Study of Social Policy. In: A Social-Ecological Model of Racism and Anti-Racism [Internet]. Washington (DC). Available from: https://cssp.org/wp-content/uploads/2025/03/Racism_Anti-Racism_Social_Ecological-Graphic_01112023.pdf

Integrating theoretical frameworks throughout the guideline development process

The theoretical frameworks played a central role in shaping the development of this guideline. Critical race theory (CRT) informed both the interpretation of evidence and the formulation of recommendations by centring the lived experiences of Black nurses and Black nursing students and highlighting power dynamics within health and social care. In response to pressing societal challenges, research and knowledge creation need innovative approaches that embrace different ways of knowing, especially those historically excluded from Western scientific traditions (94).

Adopting the principles of CRT fostered innovative thinking beyond traditional guideline development approaches. While conventional Eurocentric methodological approaches remain critical in the development of clinical guidelines, the unique nature of this topic required RNAO to account for the scarcity of "gold standard" quantitative studies, such as **randomized controlled trials**,[G] and to adopt methodological flexibility (94). Ultimately, applying CRT provided the RNAO guideline development and research team with a critical lens to more effectively interpret findings and to uncover the subtle influences of racism that may have gone unnoticed otherwise.

Considering intersectionality prompted meaningful discussions during expert panel meetings about how the proposed recommendations might affect different groups in diverse, intersecting but not always equal ways. Black Feminist Thought (BFT) fostered reflexivity among the guideline development and research team, and created space for critical examination of power, privilege and positionality. BFT also helped elevate the voices of Black nurses and Black nursing students, including those on the expert panel and those represented in the qualitative literature. The social-ecological model served as a framework for understanding the multiple, interconnected levels at which racism operates and must be addressed in the guideline.

For more information regarding the integration of these frameworks into the guideline development process, please see the "methodology documents" tab on the BPG webpage.

Guiding principles

Guiding principles[G] are overarching concepts that denote a philosophy, belief, value and/or standard of behaviour that nurses, members of the interprofessional team, and health and social service organizations should apply to their practice. These principles serve as foundational pillars, offering a comprehensive lens through which health providers can navigate and combat systemic inequities within health-care systems. The following guiding principles were selected by the expert panel and are considered foundational to implementing all recommendations and good practice statements in this BPG.

Accountability

Accountability refers to the extent to which individuals, groups, organizations and communities hold themselves responsible for achieving their goals and actions (6,95). Accountability can be externally imposed, through legal or organizational requirements; internally driven by moral, relational or faith-based values; or recognized as some combination of both. It exists on a continuum from institutional and organizational levels to the individual level. From a relational perspective, accountability is not only about doing what is right; it also involves how we respond when something goes wrong. To promote accountability, this guideline provides indicators to support the implementation and evaluation of recommendations and good practice statements. Health and social service providers, as well as the organizations in which they work, can utilize this guideline to confront racism, amplify Black voices and commit to structural change.

Advocacy

Advocacy against anti-Black racism requires a deliberate and sustained effort to dismantle systemic structures that perpetuate racial inequities (17). Researchers have called for intentional action that goes beyond passive awareness, urging active engagement in anti-racist practices, while confronting the longstanding marginalization of Black nurses and Black nursing students in Canadian educational and leadership contexts (17,51,62). The Canadian Nurses Association defines advocacy as "engaging others, exercising your voice and mobilizing evidence to influence policy and practice" (96). This

involves speaking up and speaking out against inequity and inequality, and acknowledging the importance of research, power and politics in moving the needle in policy-making (96). This BPG provides evidence-based guidance for health providers and health and social service organizations to support advocacy in anti-racism work.

Anti-oppression

Anti-oppression[G] aims to eliminate forms of oppression by analyzing and challenging power structures and empowering those who experience oppression (28). Nurses can integrate an anti-oppression lens into the implementation of the the good practice statements and recommendation statements and their practice by actively challenging power structures that perpetuate anti-Black racism and racism more broadly within health-care environments. This involves recognizing how intersectional inequities, such as those based on race, gender identity and expression and professional hierarchy, impact their colleagues and taking deliberate actions to dismantle these injustices by advocating for inclusive policies, supporting racialized colleagues and fostering a culture of accountability and **allyship**[G] (33).

Black race consciousness

Black race consciousness,[G] when used in the context of eliminating anti-Black racism in nursing, involves recognizing racial health disparities, reflecting on personal biases and understanding the historical and structural roots of systemic racism in health care (97,98). Historically, the Black experience in North America has been marred by centuries of slavery, segregation and discrimination, leading to deep-rooted structural inequalities and systemic racism within health-care systems and society more broadly (50,98,99). By fostering Black race consciousness among health providers, particularly nurses, interventions can be developed to resist and prevent anti-Black racism, ultimately working towards healing and protection from **racial trauma**[G] (100,101). In nursing practice, addressing race-based and racist assumptions involves strategies such as autoethnography, cultural immersion programs and bias training to help uncover unconscious biases and empower nurses to actively challenge systematic racism in their practice (102–104).

Culturally responsive pedagogy

Culturally responsive pedagogy[G] involves equipping health providers to engage with diverse cultural contexts within clinical practice (105). In nursing education, this pedagogy empowers students to challenge dominant narratives and encourage the integration of diverse voices (106,107). Culturally mediated instruction, a key component of culturally responsive teaching, integrates students' lived experiences into the learning process, fostering inclusive dialogue and respect for multiple worldviews (106). In its absence, academic institutions risk marginalizing diverse voices and hindering students' opportunities to develop an informed and empathetic worldview (108). Embedding culturally responsive pedagogy into nursing education can be used to address anti-Black racism in nursing by fostering inclusive educational environments that centre the lived experiences of Black nurses (see **Good practice statement 1.0**, **Recommendation 1.0** and **Recommendation 1.1**)

Empowerment

Empowerment[G] is a process by which people, organizations and communities gain power (109). In nursing, it reflects a quality whereby nurses have influence over their environment (109). Empowerment also refers to an ideology focused on increasing the power of a low-power group so that it becomes equal to that of a high-power group (109). In the context of racism, empowerment involves equipping individuals, organizations and institutions with the tools, supports and authority

needed to challenge and dismantle systemic and interpersonal racism within the health-care system (110). The goal of this guideline is to empower health and social service providers, organizations and academic institutions with the guidance to name and address discrimination, anti-Black racism and racism more broadly.

Trauma-informed approaches

To address anti-Black racism in nursing and health-care settings, **trauma-informed approaches**[G] must be integrated into both clinical practice and nursing education. Trauma-informed approaches acknowledge the pervasive impact of trauma, including racial trauma, on individuals' mental, physical, social and emotional well-being (17). Within the context of addressing anti-Black racism, these approaches provide a framework for understanding the unique experiences of racial trauma by acknowledging the cumulative effects of interpersonal and structural violence on individuals' lives and health (111). For nurses, structural discrimination often manifests as microaggressions, subtle yet impactful everyday interactions at interpersonal and institutional levels that convey **racial bias**,[G] undermine professional confidence and contribute to emotional distress among Black nurses and Black nursing students (112–114). Racial trauma encompasses various forms of discrimination, such as intimidation, degradation and dehumanization, which are often repeated and experienced cumulatively within racialized communities.

In nursing education, teaching strategies encompassing dialogue and discussion is often considered a cornerstone of anti-racism education; however, it can also be retraumatizing for some students and learners, particularly those who have experienced racism and discrimination (115). Trauma-informed approaches can therefore promote student well-being and reduce re-traumatization (116). Faculty development and wellness are also essential, as unresolved trauma can perpetuate harm (117). By adopting trauma-informed educational practices and applying this approach of the implementation of good practice statements and recommendation statements, faculty can create collaborative, relationship-based learning environments that prioritize trauma awareness and resilience building, fostering safe spaces for self-exploration and understanding (118). Embedding trauma-informed principles within health and social service organizations and academic institutions is therefore critical to supporting the success and well-being of Black nurses and Black nursing students.

Recommendations and good practice statements

Education

Good practice statement 1.0: It is good practice for all health and social service organizations and academic institutions to provide ongoing education to students, faculty and staff to address anti-Black racism in nursing.

Prioritizing education to address systemic racism and anti-Black racism in academia, as well as in health and social service organizations, is an important step to achieving true diversity and equity in these settings (27,72,119). In contemporary society, colour blindness, an ideology where a person chooses not to see race or skin colour (28), has led to racial inequities and has become embedded in social structures, leading to the dominance of White people and exclusion of racialized persons in leadership, policymaking, and nursing education (27,119). The consequence of decades of normalized marginalization has resulted in systemic racism and a lack of diversity in nursing education, affecting curriculum content, leadership and representation among both nursing students and educators who teach in universities or colleges (27,33,72). Therefore, education must be provided to students, faculty and staff to address anti-Black racism in nursing. This good practice statement provides guidance on advocating for anti-Black racism education, including the frequency of such education and the priority topic areas it should include. It is important to note that while providing education and training is critically important, research shows that education alone cannot erase anti-Black racism or systemic racism. Anti-Black racism infiltrates organizational practices and leadership requiring education and strategies at systemic, interpersonal, and institutional levels (120). More specific guidance on the modes of education and who should provide training and education are captured under **Recommendation 1.0** and **Recommendation 1.1**.

Education and training programs that incorporate accountability measures (e.g., retention and recruitment efforts) alongside advocacy and **activism**[G] are urgently needed in nursing schools and health and social service organizations (27,29,72). Sumpter contends that systemic racism in nursing education and health and social service organizations is often challenging to detect and is frequently disregarded (29). To address this, education and training programs need to incorporate both accountability measures and advocacy and activism, giving health and social service providers and students the strategies and tools required to uncover and challenge racism in all settings. In academia, empowering students to take ownership of their learning using approaches such as student-professor co-learning, can reduce power hierarchies and facilitate trust-building (29). Activism that includes community engagement with anti-racist organizations, and assignments that encourage students to research anti-racist organizations, can also help students and faculty overcome the guilt and discomfort associated with systemic racism and discrimination (29). Prendergast et al. stress the importance of implementing mandatory workshops for leaders of health and social service organizations with content that addresses anti-Black racism, implicit bias, racial trauma and workplace violence (72).

Good practice statement criteria

Is the message necessary to communicate?	**Yes.** Despite the growing acknowledgement that racism and discrimination exist, nurse educators have been criticized for their lack of readiness in addressing anti-racism, anti-discrimination and anti-oppression pedagogies in nursing curricula and in workplaces (26,121). Existing literature highlights significant gaps in nursing curricula and workplace settings focusing on anti-Black racism (26,27,33). These gaps perpetuate the devastating effects of undetected or ignored racism and discrimination (17,51,72). Studies have found a lack of formal and standardized education focused on addressing racism more broadly (33) and anti-Black racism specifically (72) in health and social service organizations. This good practice statement addresses this lack of knowledge about racism and discrimination.
After considering all relevant outcomes and potential downstream consequences, will implementing the good practice statement result in large benefits and very small harms?	**Yes.** Providing education to address anti-Black racism in nursing will strengthen the skills needed to identify and address racism (122–131). Education will be unequivocally beneficial since racism and discrimination have proven to have detrimental effects on people within health and social service organizations. Costs associated with this good practice statement include the necessary funding to provide education led by trained facilitators. However, cost is considered minimal in comparison to the anticipated benefits. After considering all outcomes associated with this good practice statement, the expert panel concluded that providing education to address anti-Black racism in nursing would result in large net benefits.

Is collecting and summarizing the evidence a poor use of time and energy?	**Yes.** A report from the Canadian Association of Schools of Nursing (CASN) (33) challenges schools of nursing to "(1) incorporate an anti-discriminatory pedagogy, (2) provide a culturally safe context for learning, and (3) educate students to actively challenge racism." In addition, the Black Nurses Task Force Report also strongly recommends education and building awareness among nurses and the broader public about the existence of racism (17). Racism and discrimination are unlawful in Ontario and Canada (132,133). For this reason, is not necessary to systematically review evidence to determine whether education to address anti-Black racism should be provided or not. **Note:** For jurisdictions other than Canada, it is important that health and social service organizations review local requirements and/or legislation and policies pertaining to racism and discrimination.
Is there a clear rationale for the action?	**Yes.** While additional research on the most effective type of education is still coming into focus, it is generally understood that education is necessary to improve skills, awareness, knowledge and understanding of racism and discrimination.
Is the statement clear and actionable?	**Yes.** The statement is clear and actionable as it provides specific direction to academic institutions and health and social service organizations regarding the provision of education to students, faculty and staff to address anti-Black racism in nursing.

Implementation strategies

Table 7: Implementation strategies from the expert panel

Topic	Details
Recipients of education	▪ Anti-racism education should be provided to nurses, nursing students and all health-care providers more broadly. ▪ It is important that executive leaders and managers participate in anti-Black racism education. ▪ Engage all nurse educators and facilitators in anti-Black racism education to deepen their awareness of the nuances of anti-Black racism (e.g., microaggressions that may not be visible to those who do not experience anti-Black racism).

Topic	Details
Education topics	To promote the development of core competencies in anti-racism, education on anti-Black racism needs to include topics such as: ▪ Advocacy ▪ Allyship ▪ Anti-racist pedagogy ▪ Black history and Black nursing history ▪ Black race consciousness ▪ Critical social perspectives (e.g. critical race theory) ▪ Equity ▪ Implicit biases embedded in teaching resources (e.g, skin assessments that fail to account for variations in skin tone among racialized populations) ▪ Intersectionality ▪ Microaggressions ▪ **Minority tax**[G] ▪ **Tokenism**[G] ▪ Trauma-informed approaches ▪ Types of racism and how to recognize racism ▪ **Unlearning**,[G] or the act of dismantling old patterns of thinking and behaviour (including unconscious biases) that perpetuate racism ▪ Social determinants of health ▪ **Structural determinants of health**[G] ▪ Whiteness, White supremacy and White privilege

Topic	Details
Other guidance	▪ Foster culturally safe(r) environments for discussing racism that prioritize flexibility and are not overly structured (refer to **Recommendation 1.1**). ▪ Health and social service organizations and academic institutions are to engage in anti-Black racism as well as anti-racism education planning to determine content and frequency (e.g., orientation, professional development, routine scheduling) using multi-modal and multi-phased approaches. ▪ Participating in anti-racism education is not a one-time achievement; completing a module or workshop alone does not make one anti-racist. Instead, anti-racism should be approached as an ongoing practice. ▪ Accreditation bodies and colleges must hold schools and organizations accountable for providing education to address anti-Black racism in nursing.

Implementation strategies from the literature

- Anti-racist pedagogy can be used as a framework for student-educator co-learning by intentionally re-shaping the classroom so that knowledge is constructed collaboratively. Through dialogue, both student and teacher learn simultaneously, removing dynamics of authority and power (134,135).
- Faculty and educators must engage in critical reflection, humility and life-long learning (135).
- Collaboration across disciplines and within the broader community is essential for building trust, amplifying marginalized voices and co-creating solutions to address systemic racism (136).
- As many health providers hold overlapping implicit biases, including those rooted in both racism and ableism (137), there is a clear need for education that addresses intersecting forms of discrimination.
- The longitudinal evaluation of anti-racist educational programs is critical to ensure strategies remain effective and result in organizational and behavioural change (138).

Supporting resources

Resource	Description
CASN Anti-Racism in Nursing Education Working Group. Promoting anti-racism in nursing education in Canada [Internet]. Ottawa (ON); 2023. Available from: https://www.casn.ca/wp-content/uploads/2023/05/Promoting-Anti-Racism-in-Nursing-Education-in-Canada.pdf	▪ A report from the Canadian Association of Schools of Nursing that outlines strategies to (1) incorporate anti-discriminatory pedagogy, (2) create a culturally safe learning environment, and (3) prepare students to actively challenge racism, while acknowledging how racism is often compounded by other intersecting forms of discrimination.
Centre for Integrative Anti-Racism Studies. Dismantling anti-Black racism in schooling, education, and beyond [Internet]. Toronto (ON): Centre for Integrative Anti-Racism Studies; 2023 [cited 2025 Dec 1]. Available from: https://www.oise.utoronto.ca/home/sites/default/files/2023-11/abr_resource_guide-final.pdf	▪ This resource booklet provides books, interviews, webinars, documentaries, articles, reports, toolkits and resources on the experiences of Black communities in Canada and the impacts of systemic anti-Black racism. It highlights: Black communities in Canada, Black feminism, anti-racist and anticolonial theory and teaching about race and racism.
Ontario Human Rights Commission. Call it out: Racism, racial discrimination and human rights [Internet]. Toronto (ON): Ontario Human Rights Commission; [cited 2025 Dec 1]. Available from: https://www3.ohrc.on.ca/en/learning/call-it-out-racism-racial-discrimination-and-human-rights	▪ This is a 30-minute interactive course that provides a foundational understanding of race, racial discrimination and human rights protections under the Human Rights Code of Ontario. It explores the historical roots of racism, clarifies key concepts such as race, racism and racial discrimination, and offers practical strategies for preventing and addressing racial discrimination.

Recommendation 1.0: The expert panel suggests that health and social service organizations and academic institutions provide interactive education that includes and/or promotes dialogue, engagement and/or reflection to address anti-Black racism in nursing.

- **Strength of the recommendation:** Conditional
- **Certainty of the evidence of effects:** Very low

Discussion of evidence:

Benefits and harms

While it is good practice to provide education to address anti-Black racism in nursing (see **Good practice statement 1.0**), the expert panel was interested in knowing what type of education should be recommended. A systematic review was conducted to compare the effectiveness of various educational strategies that address anti-Black racism within nursing. Due to limited literature available to directly answer this research question, the population was broadened to examine education provided to all health providers and health profession students rather than only nurses and nursing students. Similarly, the intervention was expanded to encompass education aimed at addressing racism broadly, rather than specifically anti-Black racism. The expert panel accounted for the indirectness of the evidence when grading its overall quality and considered this evidence sufficient to help answer the research question. As per GRADE methodology, directness is assessed based on the target population, intervention and outcomes of interest (45). For more details, refer to our methodology published elsewhere as well as supplementary materials under the "methodology documents" tab on the BPG webpage (39).

All retrieved studies focused on providing interactive education, which promotes engagement and critical thinking. It is a dynamic approach that fosters active participation and exchange of ideas among educators and participants through the lecture content. This method recognizes students' needs and encourages them to take an active role in their learning process (139). Interactive education formats and modes of delivery include, but are not limited to, **reflective practice**,[G] case studies, role play, simulation, virtual reality and small and large group discussions.

There were 16 quantitative studies that provided information about the effects of receiving anti-racist education. This included one cluster randomized controlled trial (RCT) (140), two **non-randomized studies**[G] with a comparison group (141,142) and 13 non-randomized single arm studies (122–131,143–145). In most studies, interactive education was provided to medical students, residents or physicians (123–127,129,130,140,141,143,145). In one study, education was provided to pharmacy residents (128) and in another study, education was provided to a diverse group of health-care providers (131). Nurses were recipients of education in four studies (122,131,142,144). Only one of the studies specifically examined the effects of providing education that addresses anti-Black racism in nursing; most addressed racism (broadly) or addressed proxy measures of racism (e.g., racial bias, microaggressions, etc.). Despite varied content, all employed interactive education methods. Examples of interactive education modalities included case studies, group discussions and opportunities to role-play responding to microaggressions in groups or using virtual reality. For further details of the interventions noted in the literature, please refer to the **Implementation strategies** below.

In one cluster RCT, where interactive modalities were used to deliver anti-racism education to internal medicine faculty, interactive education had no effect on participant's perceived vulnerability to personally engage in biased thoughts or actions, behaviour change and perceptions of workplace climate (i.e., factors that make a person feel safe, listened to, valued, respected and treated fairly in a learning or workplace environment) three months after the workshop (140). The study examined whether workshop effects varied by gender, race, credentials and institutional affiliation (private vs. public). However, no important distinctions were found (140).

While the evidence is very uncertain, interactive education may increase participants' confidence to speak up or take action against racism, support more inclusive hiring practice, increase empathy and improve satisfaction among learners. Ten non-randomized, single-arm studies examined changes in participants' confidence to intervene before and after receiving interactive education focused on addressing racial bias, racial microaggressions and racism more broadly (122–131). All studies reported increased confidence among participants following educational interventions. In one non-randomized study (141), search committee members within a school of medicine participated in an interactive workshop on implicit bias training. Following the workshop, there was an increase in the number of Black applicants to positions, but no important changes in the number of interviews or offers. In one non-randomized study of a virtual reality intervention for nursing leaders, designed to help them practice responding to anti-Black racism, the intervention group showed a greater increase in empathetic awareness compared to the control group (142). Six non-randomized, single-arm studies examined participant satisfaction after receiving interactive education aimed at broadly addressing racial bias, racial discrimination, racial microaggressions and racism (122,124,141,143–145). Despite variations in the questions used to assess satisfaction, as well as differences in the content and delivery of interactive education, most participants reported being satisfied with the education.

Patient outcomes (e.g., patient health outcomes, patient satisfaction) were identified by the panel as important; however, these outcomes were not measured in any of the included studies.

Only one study reported harms associated with interactive education. In this study, medical residents in a pediatric specialty program participated in role-play activities to practice addressing bias and racist incidents. The authors noted that participating in "role-play scenarios and discussions may trigger previously experienced racial trauma among participants and facilitators so facilitators should be prepared to support those individuals and each other during and after the workshops" (143).

The overall certainty of the evidence was rated as very low primarily due to extremely serious and serious risk of bias in the non-randomized studies, serious indirectness—given the absence of studies specifically addressing anti-Black racism in nursing—and very serious imprecision in one non-randomized study. There is a need for further high-quality research to increase the certainty of the evidence.

For more detailed information on the impact of interactive education to address racism in health care on the prioritized outcomes, refer to the evidence profile under the "methodology documents" tab on the BPG webpage.

Values and preferences

For information about people's values and preferences associated with providing interactive education to address anti-Black racism in nursing, see **Recommendation 1.1**.

Expert panel justification of recommendation

The expert panel noted that there may be benefits to providing education to address anti-Black racism in nursing using interactive modalities such as case studies, role-play or group discussion. Interactive education may result in increasing participants' confidence to speak up or take action against racism, enhance diversity in hiring and result in satisfaction among those receiving the education; however, the evidence supporting these outcomes is very uncertain. In addition, the evidence suggests that interactive education has no effect on workplace climate, knowledge and awareness of anti-racist concepts, and behavioural change. If facilitators are adequately prepared to support individuals receiving education, including people with lived experience of racial trauma, the expert panel believes that the benefits of providing interactive education to address anti-Black racism in nursing are still likely to outweigh the potential harms. Therefore, the expert panel determined the strength of the recommendation to be conditional.

Implementation strategies and supporting resources

For implementation strategies and supporting resources associated with **Recommendation 1.0** and **1.1**, see page 61.

Recommendation 1.1: The expert panel suggests that health and social service organizations and academic institutions provide education programs led by experienced facilitators who foster authentic dialogue grounded in safety when addressing topics on anti-Black racism in nursing. Education programs may include:

- small and large group discussion (confidence: moderate)
- critical self-reflection and self-sharing activities (confidence: moderate)
- activities that challenge personal bias (confidence: moderate)

Strength of the recommendation: Conditional

Confidence in evidence: Moderate

Discussion of evidence:

It is good practice to provide education to address anti-Black racism in nursing (see **Good practice statement 1.0**). The evidence suggests that interactive modalities should be used to provide education (see **Recommendation 1.0**). The expert panel therefore sought to offer additional guidance on how this education should be delivered.

A qualitative evidence synthesis was conducted to explore people's values and preferences associated with delivering education to address racism in health care. Due to the limited amount of research conducted in nursing, the population was broadened to examine the values and preferences of health providers and health profession students more broadly. The included studies focused on medical students (125,145, 153), counselling students (146,147), pharmacy students (148), medical school faculty (149), medical centre staff (150) and nurses and midwives (144). This evidence was considered sufficiently relevant by the expert panel to help answer the research questions. The expert panel assessed the relevance of evidence when grading its overall quality by considering the population, phenomenon of interest and setting (46).

For more information about the guideline development process, refer to our methodology published elsewhere as well as supplementary materials under the "methodology documents" tab on the BPG webpage (39).

There were 9 qualitative studies that informed this recommendation. Three themes were identified from qualitative literature and are described below. For further details regarding how education was delivered and participants' experiences in receiving education, refer to the **Implementation strategies** below.

Small and large group discussions

Evidence suggests many participants prefer that education to address racism integrates small and large group discussions. In the evidence, group discussions helped learners to actively reflect on, discuss and practice the concepts learned. Individuals expressed greater willingness to share their perspectives on sensitive topics in smaller groups. A participant expressed that "The actual discussion after the presentation was much more useful because it helped people to be able to speak towards their experiences" (146). After completing the course, another participant shared that "Having the discussion in the circles where we listened to each other speak about things so personal made me learn so much about so many members of our class that I would not have ever guessed before" (148).

There were five studies that addressed this theme (125,146,148–150), three of which were focused on educating medical students and faculty to address racism, unconscious bias and racial injustice in medicine. In another study, education was provided to graduate counselling students to promote self-awareness in addressing racial microaggressions. Finally, in one study, pharmacy students participated in an elective course focused on exposing students to the root causes of health disparities, contemporary factors that perpetuate disparities and evidence-based policies to reduce health disparities.

Participants valued the use of both small and large group discussions and emphasized the importance discussions being led by facilitators who have expertise creating safe spaces whilst navigating sensitive topics using interactive teaching methods (e.g., role play, simulation) (125,146,148–150). Learners connected their experiences and learning to the skills and expertise of the facilitator (125,146,148–150). Within these learning environments, participants appreciated facilitated education that included authentic dialogue and the use of case studies that included relatable scenarios based on the lived experiences of the participants (125,146,148–150). The emphasis on skilled facilitation has implications for the training and preparation of leaders, educators and faculty who are tasked with teaching about anti-Black racism and racism more broadly (33,72).

This review finding was graded as moderate confidence due to minor concerns related to methodological limitations of the included studies and moderate concerns related to relevance and adequacy of the data. Although the participants were counsellors, pharmacy students and medical students, differences in their clinical backgrounds are unlikely to have significantly affected the relevance of the findings for nurses. All studies focused on unconscious bias, anti-racism and microaggression training more broadly, however none specifically addressed anti-Black racism. There were no concerns related to coherence.

Critical self-reflection and self-sharing activities

While the term self-reflection is often used in nursing and other disciplines to evaluate personal and emotional experiences and responses, this practice may fail to address deeper systemic issues, such as racism (152). By contrast, critical self-reflection is an intentional process by which health providers analyze their own biases, beliefs, behaviours and assumptions to gain a greater understanding of how these factors influence their interactions with colleagues and people receiving care (152). Although critical self-reflection was not explicitly defined within the studies reviewed, the activities described in the education sessions align with its principles and the expert panel agreed to use the term critical self-reflection to refer to activities that draw attention to deeply rooted internal thoughts and emotions that foster bias, indifference and apathy towards oppressive structures and practices (152). In one study, a counselling student working on their master’s degree reflected on their experience following a cultural connections journalling activity, explaining, “I was able to critically think through things that I hear every day in my life as a [W]hite female living in a small town … This assignment allowed me to take a step outside of myself and examine these same responses from an African American male’s perspective and I was more aware of the fact that when they say, ‘Black lives matter,’ this isn’t an attack on all other races” (147).

In the four studies that spoke to the theme of critical self-reflection (144,147,148,153), education was provided to nurses and midwives, counsellors in training, medical students and pharmacy students. Participants were interested in activities that involved various dimensions of critical self-reflection. Preferred activities included critical self-reflective dialogue and reflecting on past experiences of unconscious bias. Participants also engaged in activities such as immersive role play and cultural connections to facilitate empathy through critical self-reflection.

The concept of self-sharing was a common element embedded within critical self-reflection activities. Self-sharing involves intentionally disclosing personal feelings, experiences and thoughts in a learning environment to build trust and connection with the goal of cultivating a deeper understanding of sensitive or complex topics (154). Individuals typically expressed greater willingness to share their perspectives on sensitive topics in smaller group settings.

The review finding was graded as moderate confidence due to minor concerns related to methodological limitations and relevance and moderate concerns about adequacy of the data. There were no concerns related to coherence.

Activities that challenge personal bias

Participants from three studies (145,147,148) valued engaging in educational activities (e.g., reflective journalling, simulated bystander intervention training and robust discussions) that challenged their personal biases and brought about genuine feelings of empathy for those who have been exposed to racism or discrimination. Learners were non-nurses (i.e., counsellors, pharmacy students, medical students and physicians) and participated in educational activities such as cultural character journalling, which involved choosing a character from a different background than their own and reflecting on their experiences throughout the semester. In one study, where pharmacy students engaged in topics exposing students to the root causes of health disparities, contemporary factors that perpetuate disparities and evidence-based policies to reduce health disparities, a student shared that "It truly is a sad moment as I write my last reflection in a class that I don't want to end. This class changed my life in many ways. I learned about my own biases and learned how to articulate what social determinants of health and equity are" (148). In another study medical students participated in Bystander Intervention Training (BiT), a simulation-based small-group training program designed to teach medical students and physicians how to tackle discrimination (145). Participants worked with an actor to practice behavioural interventions. For this training program, an important focus was placed on using one's own privilege to act as an ally.

The review finding was graded as moderate confidence due to minor concerns about methodological limitations and moderate concerns related to relevance and adequacy of the data. There were no concerns related to coherence.

For more detailed information on the grading of the evidence, please refer to the evidence profiles under the "methodology documents" tab on the BPG webpage.

Harms

While these educational strategies show promise, in one qualitative study (146) the authors noted that in many instances, trainees reported emotional experiences after receiving training (e.g., feeling guilty or helpless), but the triggers for these feelings often differed along racial and ethnic lines. While racialized trainees may have been reacting to the personal nature of microaggressions and the

resurfacing of painful memories, White trainees' difficulties during the training may have arisen due to grappling with concepts such as Whiteness, colour blindness and structural inequalities leading to anger, frustration, helplessness, guilt, or sadness. In experiential skills labs, particularly in dyadic or group formats, some White students reported feeling defensive or targeted, which they felt hindered their learning.

Expert panel justification of recommendation

Given the rich body of qualitative literature available in conjunction with the non-clinical nature of the guideline topic, the expert panel determined that this recommendation should be based solely on qualitative evidence, which represents a departure from traditional GRADE approaches. Based on moderate confidence in the evidence, the expert panel suggests that educational approaches to addressing anti-Black racism in nursing include small and large group discussions, critical self-reflection, self-sharing activities and exercises that challenge personal bias. However, the expert panel also emphasized the importance of this education being led by experienced, trained facilitators who can promote learning by fostering authentic dialogue and a sense of safety amongst learners. When a trained facilitator can provide this education, the expert panel believes that the potential benefits of these educational approaches outweigh the possible harms. After considering these factors, the expert panel issued a conditional recommendation.

Implementation strategies and supporting resources for Recommendations 1.0 and 1.1

Table 8: Implementation context and details from the evidence

Key intervention	Details from the evidence
Education content covered	▪ implicit or unconscious bias (including racial bias) and bias-reducing strategies (128,131,140,143,144,150,153,155) ▪ microaggressions (including racial microaggressions), and how to respond to microaggressions (122,124,126,127,129,130,146) ▪ identifying structural racism in health care (125,149,156) ▪ allyship (131,145) ▪ developing empathy (142,147) ▪ bystander intervention training (142,145) ▪ how to build more just and anti-racist health-care education (149)
Types of interactive educational modalities used	▪ tests to help learners understand and identify personal biases (140,141,155) ▪ case studies (122,124,130,131,140,146) ▪ group discussion (125,126,129,140,144–146,149,150,153,156) ▪ role play (123,124,126,128,143,145) ▪ self-reflection activities including journalling (124,128,144,146,147,149,153,156) ▪ virtual reality (142)

Key intervention	Details from the evidence
Contextual details that may impact implementation of interactive education	▪ having a small ratio of facilitators to participants to provide space for dialogue (124) ▪ formal incorporation of anti-racism education into student timetables (as it can be difficult for students to find time to participate in education if it is voluntary) (125,155) ▪ providing appropriate training for facilitators (126) ▪ having buy-in from system leaders (128,143,146) ▪ providing ample amount of time for education (129) ▪ developing workshops that can be delivered in-person or virtually (129) ▪ incorporating anti-racism content into high stakes assessments (such as licensing exams) (155)
Barriers and facilitators to delivering interactive education	**Barriers** ▪ One study noted the cost of delivering interactive education, particularly when using simulated patients to portray individuals expressing racial bias. To reduce expenses, the authors suggested using trained staff volunteers instead (127). ▪ Across four studies (146,153,156), participants referred to a fear of shame and shaming as a barrier to engaging with interactive anti-racism education. ▪ In another study (155,156), participants expressed feelings of discomfort and resentment recalling personal experiences of microaggressions during training, which could prevent students from engaging with the content. ▪ Learners also expressed a desire for more time in dialogue, an increase in small and large group discussions and hands-on practice allowing application of knowledge (146). **Facilitators** ▪ In three studies (149,155,156), a significant number of participants had a positive learning experience with open dialogue, intimate groups and an accepting environment where learning was scheduled over several weeks. ▪ In two studies (146,156), participants expressed the importance of diverse groups to enhance discussions and shared experiences.

Implementation strategies from the literature

- A report by the Canadian Association of Schools of Nursing (CASN) on racism in nursing suggests nursing schools provide a culturally safe context for learning and annual anti-racist training (33), which includes the following:
  - mandatory anti-racist and cultural safety education of nurses in leadership and faculty positions
  - training for students and faculty on racism and how to address it when it occurs
  - building anti-racism competencies into daily interactions with students
  - core anti-racist competencies that integrate concepts of power, privilege, and intersectionality to guide curricular changes
  - transformative educational approaches that include anti-racist pedagogy to counteract racism and discrimination, integrating intersectional approaches
  - anti racism teams and the creation of safe spaces for students to discuss racism related concerns

Supporting resources

Resource	Description
Alberta Civil Liberties Research Centre. Begin your journey in anti-racism learning [Internet]. Calgary (AB): Alberta Civil Liberties Research Centre; [cited 2025 Dec 1]. Available from: https://www.aclrc.com/issues/anti-racism/cared/begin/	▪ This education resource is for individuals intending to facilitate learning actions and for self-guided learning. ▪ Note: There is a fee to participate in certain aspects of this program.
Anti-Racist Discussion Pedagogy. An introductory guide to building an anti-racist pedagogy in any discipline through instructor reflection, clear communication guidelines, and inquiry-based discussion [Internet]. [Place unknown]: [Publisher unknown]; [cited 2025 Dec 1]. Available from: https://sph.unc.edu/wp-content/uploads/sites/112/2020/08/Anti_Racist_Discussion_Pedagogy__1.pdf	▪ A resource for instructors who desire to adopt an anti-racist discussion pedagogy in their classrooms. Much of the guide focuses on internal reflections instructors should undergo before asking students to reflect outwardly via class discussion.
Black Health Collaborative. Black health primer [Internet]. Toronto (ON): Black Health Collaborative; [cited 2025 Dec 1]. Available from: https://www.bhec.ca/bhp	▪ This program aims to transform medical and health professional education to improve the lives of Black communities. It was created in response to gaps in education and training and supports unlearning anti-Black racism. ▪ Note: This is a resource for which there is a fee.

Resource	Description
Teaching Tolerance. Let's talk discussing race, racism and other difficult topics with students [Internet]. Montgomery (AL): Southern Poverty Law Center; 2019 [cited 2025 Dec 1]. Available from: https://www.tolerance.org/sites/default/files/general/TT%20Difficult%20Conversations%20web.pdf	▪ A resource to help educators prepare to facilitate difficult conversations about race and racism.
Hartwell E. Creating anti-racist classroom environments through curriculum choices [Internet]. Black Lives Matter at School; 2025 Jul 4 [cited 2026 Jan 22]. Available from: https://blacklivesmatteratschool.org/creating-anti-racist-classroom-environments-through-curriculum-choices/	▪ The article focuses on the complexities of facilitating difficult conversations about race in the classroom. It outlines the challenges educators face, such as discomfort, potential conflict, and varying levels of understanding among students.
Kolbe M, Eppich W, Rudolph J, Meguerdichian M, Catena H, Cripps A, et al. Managing psychological safety in debriefings: A dynamic balancing act [Internet]. BMJ Simulation & Technology Enhanced Learning. 2020 [cited 2026 Jan 22]. Available from: https://pmc.ncbi.nlm.nih.gov/articles/PMC8936758/	▪ The paper provides a detailed definition of psychological safety and justifies its importance for debriefings. ▪ Specific strategies debriefers can use throughout the debriefing to build and maintain psychological safety are highlighted.
The Regents of the University of California. In: Anti-Racism Learning and Reflection Tool [Internet].[Place unknown]; c2021. Available from: https://hr.berkeley.edu/sites/ default/files/uc_coro-tool-2020_anti-racism_learning_and_reflection_tool-1_0.pdf	▪ This tool is designed to support individuals and organizations to foster anti-racist practices. The resource provides structured prompts and reflective exercises to help users examine personal biases, understand systemic racism and develop actionable strategies for creating inclusive environments.

Organization and policy

Good practice statement 2.0: It is good practice for executive leaders and managers to develop, implement and evaluate zero-tolerance policies regarding anti-Black racism in nursing.

Acknowledging the historical context of the term "zero-tolerance"

Within this good practice statement, the context, goals and implementation of zero-tolerance policies differs significantly from the historical use of the term within the education sector. Within the education sector, zero-tolerance policies were historically designed to enforce strict disciplinary rules for offences such as violence or substance possession, but overtime, were applied more broadly for minor misbehaviour without considering context or intent (157). Zero-tolerance policies within education have been criticized for their lack of flexibility and disproportionality impacting students from equity-deserving backgrounds (157). In contrast, the term "zero-tolerance" within this good practice statement serves to combat racism in health care and foster equity and justice by holding individuals accountable, while also promoting education, reflection and systemic change.

Zero-tolerance[G] policies for anti-Black racism are organization-wide policies that prohibit anti-Black racism and respond to all violations. These policies not only hold individuals accountable through clear consequences, but also promote education, reflection and systemic change by embedding anti-racism principles into an organization's culture and training. Health and social service organizations and academic institutions must create mechanisms to support the implementation of zero-tolerance policies for anti-Black racism, racism and discrimination more broadly (e.g., mandatory anti-racism training and clear reporting structures). They must also provide support for affected staff and students and transparently evaluate the role of these policies in creating institutional change (e.g., by tracking incidents of racism, responses and outcomes) (158).

Written policies are only effective in a climate where health providers and students feel safe to report instances of anti-Black racism and trust that their claims will be taken seriously without harm to their careers (158). Executive leaders and managers play a pivotal role in shaping organizational culture by embedding and enforcing zero-tolerance policies for anti-Black racism into workplace governance and operations.

Good practice statement criteria

Is the message necessary to communicate?	**Yes.** Studies have found that many health providers lack confidence in their organization's ability to address racism due to unclear reporting systems and inconsistent responses when racism is reported (17,159).

After considering all relevant outcomes and potential downstream consequences, will implementing the good practice statement result in large benefits and very small harms?	**Yes.** The enforcement of zero-tolerance policies establishes clear expectations and promotes accountability (159). In addition, it is expected that zero-tolerance policies that explicitly address anti-Black racism can help retain Black nurses who might otherwise leave due to workplace discrimination (160). In the 2020 Ontario survey by the Black Nurses Task Force, 205 nurses were surveyed, of which 81 per cent reported that racism had a moderate to severe impact on their mental health and 82 per cent experienced significant discomfort in educational and professional settings, underscoring the urgent need for systemic change (17). Implementing this good practice statement is not expected to require extensive resources. Additional resources may be required to provide mental health supports to nurses experiencing racism, but this cost is expected to be minimal in comparison to the costs associated with nurse turnover.
Is collecting and summarizing the evidence a poor use of time and energy?	**Yes.** Creating and enacting anti-racism policies within health and social service organizations and academic institutions is an ethical imperative (133) and aligns with federal and provincial human rights legislation (132,161). It is not necessary to systematically review evidence to determine this. The need for zero-tolerance policies to address racism in nursing is further outlined in Health Canada's Nursing Retention Toolkit: Improving the Working Lives of Nurses in Canada (160). **Note:** For countries other than Canada, it is important that health and social service organizations review local requirements, legislation and policies pertaining to racism and discrimination.
Is there a clear rationale for the action?	**Yes.** Developing clear organizational policies, which outline steps on how to report anti-Black racism and what supports are available for those experiencing racism, will help build trust and accountability (159).
Is the statement clear and actionable?	**Yes.** The statement is clear and actionable as it provides direction to executive leaders and managers within health and social service organizations and academic institutions regarding the development, implementation and evaluation of zero-tolerance policies for anti-Black racism.

Implementation strategies from the expert panel

Policy development

- Ensure organizational policies explicitly account for intersecting forms of discrimination, such as racism, ableism, sexism, homophobia, and transphobia, to address the unique experiences of Black nurses with multiple intersecting identities.
- Embed equity and anti-discrimination legislation applicable to local jurisdictions into organizational policies.
- Develop zero-tolerance policies in consultation with Black nurses and Black nursing students to ensure their lived experiences are reflected within the policy.
- Co-develop policies through discussion groups and advisory councils to support dissemination throughout the organization.
- Ground zero-tolerance policies in human rights legislation and frameworks.
- Clearly outline unacceptable behaviours and consequences with concrete examples and acknowledge that unintentional actions also cause harm and are illegal.
- Avoid the development of performative zero-tolerance policies without meaningful action and resolution.

Policy implementation

- Establish confidential and trauma-informed reporting mechanisms that ensure protection for those reporting incidents of racism and other intersecting discrimination. Do not place the burden on those harmed to justify why an incident violates the policy. Provide support for those impacted by racism (see **Appendix F**).
- Acknowledge reports of racism as valid experiences, initiate timely investigations, and apply appropriate consequences. Predetermined procedures should be outlined to ensure consistent and accountable follow-through.
- Educate executive leaders and managers on how to positively model and promptly respond to anti-Black racism and discrimination when reported.
- Introduce zero-tolerance policies during orientation for new staff and educate existing staff about the policy during ongoing professional development opportunities.
- Ensure all nurses and nursing students receive training to respond to and speak up in the moment as active bystanders when witnessing racism.
- To ensure meaningful change within health and social service organizations and academic institutions, implement zero-tolerance policies within a culture of learning where staff and students feel safe to admit and learn from their mistakes. Responses should focus on education and accountability to understand the impact of one's actions, repair harm, and rebuild trust. For more information on education to address anti-Black racism in nursing see **Good practice statement 1.0**.

Policy evaluation

- Establish key performance indicators that allow organizations to assess whether zero-tolerance policies are effective.
- Track incidents of racism, responses and outcomes.
- Monitor policy compliance by measuring whether action is taken in response to reported incidents.
- Rather than solely focusing on addressing individual acts of racism, zero-tolerance policies are to also track and address systemic patterns of racism within health and social service organizations and academic institutions.

Supporting resources

Resource	Description
Anti-Racism Directorate. Anti-racism directorate [Internet]. Toronto (ON): Government of Ontario; 2025 [cited 2025 Dec 1]. Available from: https://www.ontario.ca/page/anti-racism-directorate	▪ The Ontario Anti-Racism Directorate leads the government's anti-racism initiatives and works to identify, address and prevent systemic racism in government policy, legislation, programs and services.
Canadian Human Rights Act, RSC 1985, c H-6 [Internet]. Ottawa (ON): Government of Canada; [cited 2025 Dec 1]. Available from: https://laws-lois.justice.gc.ca/eng/acts/h-6/page-1.html	▪ The Canadian Human Rights Act prohibits discrimination based on race in areas under federal jurisdiction, including employment and therefore health-care organizations. ▪ Potentially intersecting forms of discrimination based on national or ethnic origin, religion, age, sex, sexual orientation, gender identity or expression and disability are also prohibited under the act.
Halkitis PN, Alexander L, Cipriani K, Finnegan J, Giles W, Lassiter T, et al. A statement of commitment to zero tolerance of harassment and discrimination in schools and programs of public health. Public Health Rep. 2020 Jul [cited 2025 Aug 13];135(4):534-8. Available from: https://journals.sagepub.com/doi/10.1177/0033354920921816	▪ A statement by the U.S.-based Association of Schools and Programs of Public Health committing to zero-tolerance of harassment and all forms discrimination.
Ontario Human Rights Code, RSO 1990, c H.19 [Internet]. Toronto (ON): Government of Ontario; [cited 2025 Dec 1]. Available from: https://www3.ohrc.on.ca/en/ontario-human-rights-code	▪ Provincial law in Ontario, Canada that guarantees equal rights and opportunities as well as freedom from racial discrimination and other intersecting forms of discrimination in areas including employment.

Resource	Description
Ontario Public Service. Anti-racism policy: An overview [Internet]. Toronto (ON): Government of Ontario; [cited 2025 Dec 1]. Available from: https://files.ontario.ca/anti-racism_policy_overview_eng.pdf	▪ An example of an anti-racism policy from the Ontario Public Service (OPS). OPS instituted a policy focused on building a diverse, inclusive, accessible and respectful workplace where every employee has a voice and the opportunity to fully contribute.
Reynolds NT. The role of regulatory boards in combating racism and promoting diversity. Journal of Medical Regulation. 2022; 108 (1): 32-44. Available from: https://doi.org/10.30770/2572-1852-108.1.32	▪ This article provides guidelines for medical boards to combat racism and reduce implicit bias in disciplinary proceedings.

Good practice statement 3.0: It is good practice for health and social service organizations and academic institutions to continually recognize the historical and contemporary contributions of Black nurses and other Black health professionals, particularly during Black History Month, African Heritage Month and Caribbean Heritage Month.

Black nurses in Canada and abroad have historically played a vital role in shaping the nursing profession, though their journeys have been marked by significant barriers. For example, pioneer and role model, Mary Seacole, one of the first widely recognized Black nurses in British history, defied racism and gender-based discrimination by independently travelling to Crimea and establishing the British Hotel to care for soldiers during the Crimean War in the 1850s, even after being rejected by the British War Office (162).

In Canada, historical records reveal a long history of segregation and racial discrimination within nursing (50). For example, it was not until the 1940s that Black nurses were permitted to train as nurses in Canada, even though the first Canadian nursing school opened in 1874. Exclusionary policies preventing Black women from entering nursing schools were dismantled owing to the mobilization of Black nurses and the early activism of both individuals and community-based groups (50).

While February is widely recognized as Black History Month in Canada, the panel acknowledged the diverse heritages of African and Caribbean communities, a recognition reflected within this good practice statements. In 1979, Toronto became the first Canadian city to recognize Black History Month after the Ontario Black History Society submitted a petition to the city of Toronto. Nova Scotia followed by observing its first Black History Month in 1988, later renaming it African Heritage Month in 1996 (163). By recognizing Black History, African Heritage and Caribbean Heritage Months in February and continually throughout the year, health and social service organizations and academic institutions can demonstrate a commitment to anti-Black racism and provide opportunities for staff, students and people receiving care to reflect on the historical and present impacts of racism in health care as well as the significant historical and contemporary contributions of Black nurses and other health providers.

Further information about the historical and contemporary contributions of Black nurses in Canada is outlined in the background of this guideline.

Good practice statement criteria

Is the message necessary to communicate?	**Yes.** This message is necessary to communicate as the telling of nursing history has largely been shaped by White, Eurocentric narratives which often overlook the contributions of racialized nurses (164,165). In a 2023 qualitative study by Hamhazi and Brown, racialized graduate nursing students in Canada expressed concerns that the history of Black, Indigenous, and racialized nurses is consistently absent from academic nursing curricula (165).

After considering all relevant outcomes and potential downstream consequences, will implementing the good practice statement result in large benefits and very small harms?	**Yes.** Implementing this good practice statement within health and social service organizations and academic institutions is anticipated to result in large net positive outcomes. Honouring the legacies and current contributions of Black nurses will help Black nurses and Black nursing students feel seen in the history of the profession and may inspire future Black generations to pursue careers in nursing (165). It also equips nurses and nursing students with an understanding of their own positionality within historical contexts, empowering them to advocate for change within the profession (166). By examining past injustices and systemic patterns of inequity, individuals can strengthen their ability to recognize and challenge ongoing inequities. When nursing students learn about the history of the nursing profession and reflect on the powerful contributions of Black nurses, they are positioned to disrupt dominant narratives, address imbalances of power and privilege and change the future of the profession (167). History is a vital tool for understanding the roots of inequities in health care (167). The specific costs will vary depending on the activities undertaken to recognize Black History, African Heritage and Caribbean Heritage Months within each organization or academic institution; however, extensive costs are not anticipated.
Is collecting and summarizing the evidence a poor use of time and energy?	**Yes.** In 2020, the Canadian Association of Schools of Nursing (CASN) called upon academic nursing institutions to integrate diverse histories to help dismantle racism within the profession (33). The Government of Canada also encourages Canadians to learn about Black communities during Black History Month and their contributions in shaping the history of Canada (61). As such, it is not necessary to systematically review evidence to determine the importance of acknowledging Black History, African Heritage and Caribbean Heritage Months. **Note:** For countries other than Canada, it is important that health and social service organizations and academic institutions review local histories, policies and equity-related mandates to ensure that efforts to recognize Black, African and Caribbean communities are grounded in their specific historical and cultural contexts.
Is there a clear rationale for the action?	**Yes.** Acknowledging and teaching about the historical and contemporary contributions of Black nurses, particularly during Black History, African Heritage and Caribbean Heritage Months, helps to recognize the impact of Black nurses on the profession, challenge systemic erasure and foster a more inclusive and equitable nursing culture.
Is the statement clear and actionable?	**Yes.** The statement is clear and actionable. Additional tips to support health services organizations and academic institutions implement this good practice statement are outlined below.

Implementation strategies from the expert panel

- Celebrate the accomplishment of Black nurses and Black nursing students on websites and social media, and in newsletters.
- Centre Black voices through storytelling during Black History, African Heritage and Caribbean Heritage Months.
- Encourage intergenerational storytelling sessions that bring together Black nurses and Black nursing students to share lived experiences, professional journeys, and communal knowledge. These sessions help honour and preserve historical contributions while making space for contemporary voices and future aspirations (168).
- Invite speakers with subject-matter expertise to speak to staff during Black History, African Heritage and Caribbean Heritage Months.
- Host social events that honour Black culture by featuring foods from diverse international Black communities.
- Share anti-racism learning resources during Black, African and Caribbean Heritage Months.
- Continue dialogues and conversations about Black history throughout the year. Use Black History, African Heritage and Caribbean Heritage Months as an opportunity to amplify long-term institutional initiatives focused on addressing anti-Black racism.

Supporting resources

Resource	Description
About Black History Month. In: Government of Canada. [place unknown]: Government of Canada; 2025. Available from: https://www.canada.ca/en/canadian-heritage/campaigns/black-history-month/about.html	▪ Government of Canada website that outlines the history of Black/African history month in Canada.
Black History Month. In: Canadian Association of Schools of Nursing (CASN). Ottawa (ON): CASN; [date unknown]. Available from: https://www.casn.ca/2025/01/black-history-month/	▪ Highlights the accomplishments of Black nursing pioneers in Canadian history.
Jefferies K, States C, MacLennan V, Helwig M, Gahagan J, Bernard WT, et al. Black nurses in the nursing profession in Canada: a scoping review. Int J Equity Health [Internet]. 2022 Jul 23 [cited 2025 Aug 13];21(1):102. Available from: https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-022-01673-w	▪ Scoping review that charts the existing evidence on Black nurses in the nursing profession in Canada.

Good practice statement 4.0: It is good practice for health and social service organizations and academic institutions to actively promote retention, recruitment and career advancement of Black nurses and Black nursing students to increase representation of Black nurse leaders at all levels and in all sectors and settings.

The historical and contemporary impacts of racism and discrimination have hindered efforts to recruit, retain, and invest in the nursing profession (169). While Black people represent 4.3 per cent of the Canadian population, Black nurses account for only 2.3 per cent of registered nurses in Canada (170,171). While this figure does not include other nursing designations (e.g., nurse practitioners, registered practical nurses or nursing students), nor does it account for the number of Black nurses in leadership positions, it reflects an underrepresentation of Black nurses relative to their proportion in the broader population (171).

Jefferies et al. emphasize the importance of diversifying the nursing workforce to attain positive patient outcomes in health care (50). Discrimination including intersectional discrimination impacts the career advancement of racialized nurses (50). A report from the College of Nurses of Ontario (CNO) capturing experiences of discrimination found that racialized nurses were underrepresented in leadership roles (48). For example, analyzing experience in 10-year intervals, there were a greater number of White nurses in leadership roles at every experience level. Among nurses with up to nine years of experience, 47 per cent identify as racialized. However, 36 per cent of leaders in this group are racialized, and 64 per cent are White. Cooper Brathwaite et al. highlight that in Canada, BIPOC nurses are an **underrepresented group(URG)/ underrepresented minority(URM)**[G] in faculty leadership positions, underscoring that racism is a barrier to career progression (51).

The scarcity of race-based disaggregated data impedes our ability to quantify the number of Black students enrolled in Canadian schools of nursing, including those students who do not complete nursing programs due to discrimination and abuse (50,171). Most importantly, the absence of race-based measures interferes with the development of a robust, equitable pathway for Black nurses entering the nursing profession (17). Without race-based outcome data, racism and discrimination 'go unnoticed' or are 'dismissed'(33).

Currently, racism and discrimination experienced by Black nurses are mainly captured in qualitative studies, studies with small sample sizes or anecdotally (50,119). One qualitative study exploring the experiences of Black undergraduate nursing students identified challenges with retention due to disengaging and hostile learning environments, systemic program barriers and challenges navigating disempowering learning environments (171). Specifically, students highlighted discrimination and microaggressions as contributing factors for withdrawing from the nursing program: "I always told my fellow Blacks that everything is not about racism, until it happened to me." (171). In the same study, Black students from other countries shared experiences of accent bias: "In podcast assignment feedback, the instructor said she appreciated everything I wrote, but she was deducting marks for my accent. She had no right. I questioned the unjustifiable accent mark deduction." These examples align with research indicating that Black nursing students experience anti-Black racism that differs from White students, and this contributes to attrition rates and failure of Black people to complete nursing programs (17).

Enacting benchmarks for ethnic minority students in nursing programs is a key strategy to increase representation within nursing schools (172). Ensuring accountability for these initiatives can involve the use of key performance indicators to measure change (172). While specific key performance indicators are lacking, the Canadian Association of Schools of Nursing report (33) emphasizes the need to prioritize student success by creating targeted numbers, reserving seats, and implementing outreach strategies to attain targets for equity-deserving populations. This will promote substantive change focused on addressing racism and privilege rather than symbolic gestures (26).

Good practice statement criteria

Is the message necessary to communicate?	**Yes.** Black nurses remain underrepresented across all levels of the health and social service system and in academic institutions in Ontario (17). Although race-based data is limited in Ontario, the inaugural CNO workforce census survey revealed that 6.8 per cent of respondents identified as Black. Despite a relatively low overall response rate (15 per cent), this data provides an important starting point for understanding racial representation within the nursing profession (48). Systemic barriers such as discrimination, exclusion from advancement opportunities and lack of mentorship opportunities continue to hinder career progression for Black nurses (17,172).
After considering all relevant outcomes and potential downstream consequences, will implementing the good practice statement result in large benefits and very small harms?	**Yes.** A qualitative survey conducted by the Black Nurses Task Force (17) explored the experiences of Black nurses and Black nursing students and a key theme that emerged was the implementation of mentorship and professional development programs to support retention and recruitment of Black employees (17). In addition, a more diverse workforce strengthens the capacity of health and social service organizations to serve diverse populations (48). For example, in the United States, a large cohort study assessing county-level representation of Black primary care providers (PCP) and their association with mortality-related outcomes reported that a 10 per cent increase in Black PCP representation was associated with higher life expectancy for Black individuals by 30.61 days (95 per cent CI, 19.13 to 42.44 days) (173). While potential harms that can arise from implementing this good practice statement are minimal, they can arise without critical reflection, adequate resources, mentoring or accountability (172). For example, a lack of organizational support or decision-making authority for anti-racism efforts can inadvertently retraumatize racialized staff (17). Furthermore, anti-racist reforms such as retention, recruitment and planning for career advancement may provoke institutional backlash when challenging dominant power structures (174).

After considering all relevant outcomes and potential downstream consequences, will implementing the good practice statement result in large benefits and very small harms? continued	Despite these risks, implementing transparent retention and recruitment strategies offers tangible markers of progress toward anti-racism in health and social service organizations and academic institutions (17) After, considering all implications associated with this good practice statement, the expert panel determined the benefits of promoting retention, recruitment and career advancement for Black nursing students and Black nurses far outweigh potential harms.
Is collecting and summarizing the evidence a poor use of time and energy?	**Yes.** In a report on anti-racism in education, the Canadian Association of Schools of Nursing (33) has highlighted the need for increased racial diversity among nursing educators and within the nursing profession. The report emphasizes the need to create targeted recruitment measures, reserving seats for equity-deserving candidates, and implementing out-reach efforts (33). A systematic review is not needed to determine whether the benefits of implementing this good practice statement outweigh the harms.
Is there a clear rationale for the action?	**Yes.** A diverse workforce brings valuable benefits to any organization, with minimal harms or additional costs and/or resources.
Is the statement clear and actionable?	**Yes.** The statement is clear and actionable. Additional tips to support health and social service organizations and academic institutions with the implementation of this good practice statement are outlined below.

Implementation strategies

From the literature

- Create policies to increase representation of racialized groups among students, faculty and staff in nursing schools (51,72,119).
- Develop retention and recruitment strategies with post-secondary institutions that include pipeline partnerships with secondary schools (175).
- Implement community-based recruitment efforts by engaging in career fairs specific to Black health and other culturally relevant events (17).
- Develop inclusive hiring committees (17).
- Promote organizational commitment to anti-racism, career advancement and mentorship programs for Black nurses and Black nursing students (33).
- Include Black nurse representation on hiring panels (17).
- Implement anti-Black racism, anti-racist and anti-bias training for hiring managers (17).
- Include Black nurses with intersecting identities in leadership and decision-making roles, such as Black 2SLGBTQI+ nurses and Black nurses with disabilities in recruitment and accessibility committees (176).
- Recognize and address the roots of resistance to racial equity initiatives by identifying whether concerns stem from individual, group, or organizational biases or misconceptions. For example, is backlash related to negative stereotypes toward minoritized groups (177)?
- Highlight the multifaceted organizational benefits of equity initiatives to build support and encourage allies to become change agents in driving organizational progress (178).

Supporting resources

Resource	Description
Canadian Centre for Diversity and Inclusion. Navigating race in Canadian workplaces: A toolkit for diversity and inclusion practitioners [Internet]. Toronto (ON): Canadian Centre for Diversity and Inclusion; 2018 [cited 2025 Dec 1]. Available from: https://new-api.ccdi.ca/wp-content/uploads/2025/06/20180731-toolkit-navigating-race-in-canadian-workplaces.pdf	▪ A resource to support diversity, equity and inclusion professionals lead conversations about race in the workplace.
Health Canada. Nursing retention toolkit: Improving the working lives of nurses in Canada [Internet]. Ottawa (ON): Health Canada; 2024 Mar [cited 2025 Nov 30]. Available from: https://www.canada.ca/content/dam/hc-sc/documents/services/health-care-system/health-human-resources/nursing-retention-toolkit-improving-working-lives-nurses/nursing-retention-toolkit-improving-working-lives-nurses.pdf	▪ This Canadian toolkit has been developed to support nursing retention. Created “by nurses, for nurses,” the toolkit draws on the expertise of the nursing community, evidence-based practice and current lived experiences of front-line nurses. Anti-racism resources are available within the toolkit.

Resource	Description
Agyekum MW, Boateng EA, Agyei-Baffour P. Recruitment of minorities into nursing: Best practices—a scoping review. Open J Nurs. 2022;12(10):747-65. Available from: https://www.scirp.org/pdf/ojn_2022102415554728.pdf	▪ This paper presents a scoping review that identifies and maps evidence of the best practices and timing for retention and recruitment of minorities in nursing.
Canadian Black Nurses Alliance. Mentoring for Black nurses: A retrospective report. Ottawa (ON): Canadian Black Nurses Alliance; 2025 Feb 28 [cited 2026 Jan 22]. Available from: https://canadianblacknursesalliance.org/wp-content/uploads/2025/04/2025-02-28-Final-CBNA-Mentoring-for-Black-Nurses-A-Retrospective-Report.pdf	▪ The report discusses the unique challenges faced by Black nursing students and professionals in Canada, emphasizing the critical role of mentorship in healthcare, particularly within the nursing profession.
European Network Against Racism. Intersectionality of discrimination in the workplace: Building policies to address all inequalities [Internet]. Brussels: European Network Against Racism; 2024 [cited 2026 Jan 14]. Available from: Fact-Sheet-Intersectionality-2024-FINAL-1.pdf	▪ This document explores intersectionality to better understand intersecting discrimination in the labour market and details intersectional policies in the workplace.

Recommendation 2.0: The expert panel suggests that health and social service organizations and academic institutions establish formal mentorship programs to address anti-Black racism in nursing.

Strength of the recommendation: Conditional

Certainty of the evidence of effects: Very low

Discussion of evidence

Benefits and harms

It is good practice for health and social service organizations and academic institutions to actively promote the retention, recruitment and career advancement of Black nurses and Black nursing students (see **Good practice statement 4.0**). The expert panel was interested in identifying the key components of mentorship programs and their effectiveness for Black nurses, Black nursing students and allies that can help address anti-Black racism in nursing. These programs were explored as a strategic approach to addressing anti-Black racism in nursing to enhance retention and recruitment efforts.

Within this guideline, mentorship is defined as a partnership in which knowledge, experience, skills and information are shared to foster the mentee's professional development and enhance the mentor's perspectives and knowledge (179). Mentorship is reported to serve two distinct functions: 1) career-related functions, which include **sponsorship**,[G] coaching, and promoting exposure and visibility; and 2) psychosocial or personal development, such as role modeling, friendship and counselling. Mentorship differs from supervision in that the mentee does not have a structured reporting relationship with the mentor, and competencies are not assessed or measured (180).

A systematic review was conducted to examine the effectiveness of various mentorship programs aimed at addressing anti-Black racism in nursing, compare them to the absence of such programs and identify the key components that make these programs effective. Due to the limited amount of literature available to directly answer this research question, a systematic search for indirect evidence was completed. The search was broadened to include mentorship programs for all health providers and health profession students from minority backgrounds. To be included, studies had to report the percentage of participants who identified as Black. The expert panel considered this evidence sufficient to help answer the research question. However, they accounted for the indirectness of the evidence when grading its overall quality, which, according to GRADE methodology, is assessed based on the relevance to the target population, intervention and outcomes of interest (45). For more details, refer to our methodology published elsewhere as well as supplementary materials under the "methodology documents" tab on the BPG webpage (39).

Although no evidence was found to compare the effectiveness of specific components within mentorship programs, all included studies that examined the effect of formal mentorship programs compared to no formal mentorship program (or informal mentorship) on the outcomes of interest. Formal mentorship programs are organized, structured initiatives implemented by health and social service organizations and academic institutions that pairs mentors and mentees with the goal of supporting the mentee's personal and professional development. These programs are distinct from informal mentoring relationships in that they often have defined objectives, processes and evaluation mechanisms (181).

There were eight quantitative studies included for this recommendation. These comprised two non-randomized studies with a comparison group (182,183) and six non-randomized single arm studies (184–189). In most studies, mentees were underrepresented pre-medical students, medical students or residents (182,184–188). In two studies, mentorship was provided to nurses or nursing students (183,189). While most studies discussed race and racial disparities within health professions, only one study developed their mentorship program using an anti-racism framework, ensuring that mentees were aware of key anti-racism concepts such as power, privilege, levels of oppression and intersectionality (185). Most mentorship programs were delivered in person, though some were offered virtually. Although a one-to-one mentor-mentee model was commonly used, several studies explored alternative mentorship structures. These included networked mentoring, where mentees were paired with both a faculty mentor and a peer mentor (183), and group mentorship models, such as those involving two physician mentors and four medical students, where senior students were expected to mentor their junior peers (188). All included studies focused on mentorship programs for health providers and students from minority backgrounds and none addressed mentorship for allies seeking to develop competencies to combat anti-Black racism or racism in health care more broadly. As such, this recommendation does not focus on mentorship for allies. For further details of the interventions noted in the literature, please refer to the **Implementation strategies** below.

The outcomes reported in the literature fall within the broader categories outlined in the PICO question. For details on how these outcomes align with the broader outcome categories, refer to the "methodology documents" tab on the BPG webpage.

Quantitative evidence suggests that formal mentorship programs may be associated with positive outcomes, although the certainty of the evidence is very low. Formal mentorship programs may enhance mentee's self-confidence (185,186) and their sense of support from mentors (185–188), increase mentee readiness for career advancement (189), increase mentee's awareness of people in the field who look like them (185,186), increase their leadership efficacy (189) and increase their understanding of career pathways (186). For mentors, studies reported enhanced cross-cultural skills (183) and an increase in confidence for peer mentors (183). Additionally, both mentors and mentees reported satisfaction with their mentorship experiences (182,184,188). One non-randomized study examined the outcome of matching to residency (182); medical students who participated in the mentorship program had a match rate to urology higher than the national average (80.2 per cent vs. 71.4 per cent).

Important outcomes that were identified by the expert panel included the following: human resource outcomes, escalation of grievances (e.g., reports of racism to a college or union) and the downstream impact of mentorship programs on patient outcomes. However, they were not mentioned in any of the studies.

No harms were reported in the studies.

The overall certainty of the evidence was rated as very low due to extremely serious or serious risk of bias in the non-randomized studies, and serious or very serious imprecision related to sample sizes.

For more detailed information on the impact on the prioritized outcomes of formal mentorship programs to address racism in health care, refer to the evidence profile under the "methodology documents" tab on the BPG webpage.

Values and preferences

From the systematic review evidence

For information about people's values and preferences associated with mentorship programs which address anti-Black racism in nursing, see **Recommendation 2.1** and **Recommendation 2.2**.

Expert panel justification of recommendation

The expert panel noted that implementing formal mentorship programs to address anti-Black racism in nursing may lead to improved outcomes related to psychological safety, representation, education and satisfaction. However, the certainty of this evidence is very low. The panel also recognized that implementing such programs requires dedicated resources, including funding, staffing, and institutional support, to ensure sustainability and effectiveness. After considering these factors, the expert panel issued a conditional recommendation.

Implementation strategies and supporting resources

For **Implementation strategies** and **Supporting resources** associated with **Recommendation 2.0, 2.1** and **2.2**, see page 87.

Recommendation 2.1: The expert panel suggests that health and social service organizations and academic institutions provide formal mentorship programs for Black nurses and Black nursing students and include the following:

- mentor-mentee dyads that emphasize positive, empathetic relationships (confidence: moderate)
- career progression and advancement strategies (confidence: moderate)
- communication of expectations and goals (confidence: moderate)

Strength of the recommendation: Conditional

Confidence in evidence: Moderate

Discussion of evidence

It is good practice for heath and social service organizations and academic institutions to actively promote the retention, recruitment and career advancement of Black nurses and Black nursing students (see **Good practice statement 4.0**), as well as implement formal mentorship programs, according to the evidence (see **Recommendation 2.0**). The expert panel sought to offer additional guidance on how mentorship programs should be structured to address anti-Black racism in nursing. This guidance, produced through qualitative evidence about people's values and preferences for the design of mentorship programs, informed **Recommendation 2.1** and **Recommendation 2.2**.

Given the limited evidence available that focuses specifically on people's preferences for mentorship programs to address anti-Black racism in nursing, a qualitative evidence synthesis was conducted to retrieve evidence regarding the preferences of Black or racialized health providers or health profession students regarding mentorship. This evidence was considered sufficiently relevant by the expert panel to inform the research question.

Ten qualitative studies informed this recommendation. Mentees were high school students interested in nursing (190), nursing students (183,191,192), nurses (193), medical students (182,194), women scientists in cancer research (195), physical therapy students (183,192,196) and occupational therapists (197). In all studies, a significant portion of mentees were Black, and in some studies, all participants were Black (190,191,193). The mentorship programs discussed in the articles did not explicitly state whether they were designed to address anti-Black racism within the profession or field; however, the role of mentorship in addressing racial disparities was discussed in all studies.

Mentor-mentee dyads that emphasize positive, empathetic relationships

Seven studies informed this review finding (183,190,191,193–196). In these studies, mentees appreciated mentors who were positive, supportive and empathetic and valued mentors who were flexible, trustworthy and knowledgeable, empowering their mentees to succeed in academic environments.

In one study, female medical students applying for a surgical residency program preferred mentors who were "approachable" and showed "interest in helping you" (194). Another formal program involved Black mentor-mentee pairs in a structured initiative aimed at positively influencing the lives of African-American nursing students by providing support, fostering character development, enhancing leadership skills and building self-confidence. Mentees in this program valued mentors who could "encourage and support you in your journey toward personal and academic success."

The findings from this review highlight the importance of designing mentorship programs that focus on building positive, empathetic mentor-mentee relationships to support personal, academic and professional growth.

The review finding was graded as moderate confidence due to moderate methodological limitations and minor concerns related to relevance of the data. There were no concerns related to coherence and adequacy of data.

Career progression and advancement strategies

In seven of the qualitative studies reviewed, mentees valued mentors who guided them through strategic decision-making about academic and career pathways they were not previously aware were available to them (182, 183, 192-196). Mentees and mentors were predominately Black and included nurses, medical students, women scientists in cancer research, doctor of physical therapy students and academic leaders.

One study used critical race theory as a guiding framework to explore how Black women who were academic nurse leaders perceived mentoring in academic nursing and the pivotal role it played in advancing their careers. A mentee stated, "The mentor I had in graduate school exposed me to nursing research and mentored me through a Ph.D. program. That exposure set the career path for me. Without her, I had no intention of doing the Ph.D. program" (193). In another study, a formal one-to-two-year mentorship program was offered that prioritized the recruitment of minority women scientists in cancer disparity research (6 of 16 mentees identified as African American) (195). Mentees shared that their mentors played a critical role in helping them navigate different career opportunities both within and outside of academia. Participation in the mentorship program allowed mentees to gain confidence in applying for jobs and graduate programs (195). The findings from the studies highlight the importance of designing mentorship programs for Black nurses and Black nursing students that incorporate strategies for career advancement to promote a diverse and equitable nursing workforce (193).

The review finding was graded as moderate confidence due to moderate methodological limitations and minor concerns related to relevance of the data. There were no concerns related to coherence and adequacy of data.

Communication of goals and expectations

Within four studies, participants preferred mentor-mentee approaches that involved setting explicit, clear goals, expectations and priorities for the relationship (182,183,190,197). Mentees desired relationships that were authentic, flexible and supported by ongoing open communication. Four of the studies included Black participants, while three of the studies included participants from other racialized communities. Participants were nurses, high school students, medical students, women scientists and occupational therapists.

In one study, a Black high school mentee described setting clear goals with the nurse mentors: "We set a goal of narrowing down the list of colleges and submit applications to those schools. Working on college essays, time management, saving, and working on studying were some of our goals" (190). In another study, Black and other racialized occupational therapist mentees shared, "It's not so much about liking my mentor ... You know being clear about what is it that we are, why are we in this relationship, what is the commitment I'm making and what are you expecting from me as a mentor" (197). Medical student mentees also valued authentic communication with one stating, "I also

enjoyed the authenticity and the vulnerability of many of the doctors. It's difficult to find a space in medicine where you can be yourself and I felt like I could be my authentic self…" (182). These findings highlight that clear and authentic communication between mentors and mentees are essential components of successful mentorship programs.

The review finding was graded as moderate confidence due to moderate methodological limitations and minor concerns related to relevance and adequacy of data. There were no concerns related to coherence.

For more detailed information on the grading of the evidence, please refer to the evidence profiles under the "methodology documents" tab on the BPG webpage.

Harms

In one study where a mentorship model was used that involved faculty mentors, peer mentors and mentees meeting together, the authors noted that faculty comfort with being able to engage in challenging conversations about race is vital, as peer mentors described that when faculty shied away from talking about racial incidents, the burden fell on them (183). In one study, participants described challenges navigating the foreign culture of graduate school and noted a shortage of minority role models, particularly racialized faculty (196).

Expert panel justification of recommendation

Given the rich body of qualitative literature available, in conjunction with the non-clinical nature of the guideline topic, the expert panel determined that this recommendation should be based solely on qualitative evidence, which represents a departure from traditional GRADE approaches. Based on the qualitative evidence, the expert panel suggests that formal mentorship programs for Black nurses and Black nursing students to address anti-Black racism in nursing are designed to include mentor-mentee dyads that emphasize positive, empathetic relationships; career progression and advancement strategies; and communication of goals and expectations. The confidence in this recommendation was rated moderate. The expert panel believes that the potential benefits of providing formal mentorship programs that incorporate these strategies outweigh the possible harms and as a result, the expert panel issued a conditional recommendation.

Implementation strategies and supporting resources

For implementation strategies and supporting resources associated with **Recommendation 2.0**, **2.1** and **2.2**, see page 87.

Recommendation 2.2: The expert panel suggests that health and social service organizations and academic institutions provide formal mentorship programs for Black nurses and Black nursing students to address discrimination and racism and include one or both of the following:

- racially concordant mentors (confidence: moderate)
- non-racially concordant mentors practicing cultural humility (confidence: moderate)

Strength of the recommendation: Conditional

Confidence in evidence: Moderate

Discussion of evidence

It is good practice for health and social service organizations and academic institutions to actively promote the retention, recruitment and career advancement of Black nurses and Black nursing students (see **Good practice statement 4.0**), as well as implement formal mentorship programs, according to the evidence (see **Recommendation 2.0**). The expert panel sought to offer additional guidance on how formal mentorship programs should be delivered to address anti-Black racism in nursing. This guidance, informed by qualitative evidence reflecting people's values and preferences regarding the design of mentorship programs, informed **Recommendation 2.1** and **Recommendation 2.2**.

A qualitative systematic review was conducted to retrieve evidence regarding the preferences of Black or racial minority health providers or health profession students regarding mentorship. This evidence was considered sufficiently relevant by the expert panel to inform the research question.

There were nine qualitative studies that informed this recommendation (183,192–199). Mentees were nursing students (183,192), medical students (194), women scientists in cancer research (195), occupational therapists (197,198), nurses (193), physiotherapy students (183,192,196) and social workers (199). In all studies, a significant portion of mentees were Black, and in two studies, all participants were Black (193,199). The mentorship programs discussed in the articles did not explicitly state whether they were designed to address anti-Black racism within the profession or field, however the role of mentorship in addressing racial disparities was discussed in all studies.

Racially concordant mentors and non-racially concordant mentors practicing cultural humility

The evidence suggests that formal mentorship programs to address anti-Black racism in nursing should integrate **racially concordant**[G] mentors and/or non-racially concordant mentors practicing cultural humility. Although the confidence in the evidence for each review findings was evaluated separately, they will be discussed together as they are conceptually interrelated.

The evidence suggests that many mentee participants preferred to be matched with mentors who were of the same race, ethnicity or culture, when available. Racially or culturally concordant mentor-mentee relationships provided mentees with a sense of like-mindedness related to experiences of racism and discrimination in academic and health-care settings. This preference was noted in seven studies where a significant proportion of participants were Black, with others from racialized communities (193–199).

In interviews in Atwal et al., Black occupational therapists explained their experiences of anti-Black racism. As one Black occupational therapist stated: "My identity, experiences and talents tend to be quite overlooked in comparison to my [W]hite colleagues. And my [W]hite colleagues don't face the barriers to moving up the career ladder that I do. Therefore, I need a BME [Black and minoritized ethnic] mentor. Only they can begin to understand and coach me to climb the ladder" (198). Another participant added "You need to experience being [B]lack … walk in my shoes to know where I can [and] want to go" (198). A third highlighted the importance of discussing issues of "discrimination and microaggressions with someone who looks like me, without judgement" (198), and another stated "I just feel as a Black person you want to be able to receive validation with regards to a vast majority of things, including culture, the way you were brought up" (198). Black women academic leaders also strongly valued racially concordant mentorship. One participant noted that being mentored by another Black nurse is very different from being mentored by someone from a different racial background, as they understand "your story, fears, your limitations" (193), creating a sense of kinship that made them feel seen and heard.

Some participants compared their experiences with their White peers, noting differences in support, mentoring and networking opportunities. Some discussed how the lack of Black faculty in nursing disadvantaged Black nurses and Black nursing students. One participant shared that "If you are White, you get people who look like you, looking out for you, from entering nursing school to your first job. They are supported and cared for. We do not have that; I did not have that. We need mentors early in our nursing careers. We especially need support and mentoring in early administrative roles" (193).

In the same study, Black nurse leaders stressed the importance of representation in leadership roles. One stated that "Early in my career, I longed to see someone who looked like me as a Chief Nursing Officer or dean. However, I get discouraged whenever I go to college, university-wide, or even state-level meetings and see only two or three other Black people at these leadership events. You feel like you do not belong" (193). Participants across studies expressed a strong preference for racially concordant mentors. However, they recognized that mentor-mentee racial concordance is not always possible due to the limited availability of Black mentors in academic and health and social service organizations.

Although racially concordant mentor mentee dyads are preferred, in the absence of racially concordant mentors, non-concordant mentor-mentee dyads can be considered. Seven studies contributing to this review finding emphasized that non-racially concordant mentors with an authentic understanding of cultural differences should be considered if racial concordance is not possible (183,192–196,198). Participants in these studies were primarily Black, with others from racialized communities. Black nurse leaders recounted positive experiences with White mentors. As one Black nurse leader recounted: "I earned tenure because the previous White dean took a chance on me and invested time and resources in supporting my success. Now, look at me. That is what I try to do for others like me" (193). Importantly, more than half of the participants in the same study spoke highly of the differences their authentic White allies and mentors made in their careers, especially when their support was public (193). One participant expressed that when White superiors and mentors consistently supported Black nurse leaders, it set an example for students, staff and faculty (193).

From the perspective of White medical students, racial identity was not a factor in choosing mentors. However, White participants recognized the importance of supporting racialized women. As one White faculty member said, “You have to look for the people who have been underrepresented, the people who have never had a voice and engage those people” (194). Women scientists in a formal mentorship program emphasized the importance of practicing cultural humility, stating that “Race is also important to me, but I think, as long as a mentor has an appreciation and understanding for people of other backgrounds, and I guess understands their role and how their bias might come into play, I think as long as there’s an awareness there that it’s okay for the most part” (195). Similarly, physiotherapy students acknowledged the discomfort of non-concordant mentors-mentee relationships (196). Some faculty mentors were outside of their comfort zone when discussing sensitive topics such as race. One faculty mentor described taking ‘a big leap’ to discuss racial incongruence of the mentoring dyad during the first mentor meeting (196). While research suggests that racially concordant mentorship is ideal, non-racially concordant mentors practicing cultural humility can still play a meaningful role in supporting racialized mentees in health and social service organizations and academic institutions.

No harms were identified in the studies.

Both review findings were graded as moderate confidence due to moderate methodological concerns and minor concerns regarding relevance. There were no concerns related to the coherence and adequacy of data.

For more detailed information on the grading of the evidence, please refer to the evidence profiles under the “methodology documents” tab on the BPG webpage.

Expert panel justification of recommendation

Given the rich body of qualitative literature available, in conjunction with the non-clinical nature of the guideline topic, the expert panel determined that this recommendation should be based solely on qualitative evidence, which represents a departure from traditional GRADE approaches. Based on the qualitative evidence, the expert panel suggests that formal mentorship programs for Black nurses and Black nursing students are designed to include racially concordant mentors and/or non-racially concordant mentors practicing cultural humility. However, the confidence in this recommendation was rated moderate. As a result, the expert panel issued a conditional recommendation.

Implementation strategies and supporting resources

For implementation strategies and supporting resources associated with **Recommendation 2.0, 2.1** and **2.2**, see page 87.

Implementation strategies and supporting resources for Recommendation 2.0, Recommendation 2.1 and Recommendation 2.2

Note: Recommendations should be implemented together whenever possible, given their interrelatedness.

Implementation strategies from the expert panel

- Provide structured training for mentors and mentees focused on anti-racism, with sustained organizational support.
- Empower mentees in the matching process, allowing them to express preferences, assess fit and compatibility and participate in selecting racially or culturally concordant mentors.
- Consider other intersecting identities when matching mentors and mentees such as gender identity and expression, sexuality and disability if disclosed.
- Establish clear criteria for mentor suitability, including cultural humility and anti-racism readiness, to ensure non-racially concordant mentors are equipped to support Black mentees effectively.
- Organizations must be mindful that while racially concordant mentorship can foster a sense of **belonging**[G] for mentees from underrepresented backgrounds, it may also contribute to a minority tax for mentors. This refers to the added responsibilities placed on mentors from marginalized groups, such as mentoring, diversity work or committee service, that are often undervalued in promotion and advancement processes. To mitigate this, organizations should recognize and formally credit and compensate mentorship contributions in performance evaluations and career development pathways.

Supporting Resources

Resource	Description
Mentorship Toolkit: Supporting mentors and mentees [Internet]. [Place unknown]: [Publisher unknown]; [cited 2025 Dec 1]. Available from: https://withit.org/wp-content/uploads/2024/03/WithIt-Toolkit-for-Mentees.pdf	▪ This Mentorship Toolkit, developed by the University of Wisconsin Faculty of Medicine, provides a framework, practical tools and resources that can support a successful mentoring relationship. This toolkit supports and nurtures both mentor and mentee.
Samari G, Bryant M, Grilo S. An anti-racism public health graduate program: Mentoring of students and igniting community. Pedagogy Health Promot. 2022;8(4):261-70. Available from: https://doi.org/10.1177/23733799221101540	▪ This paper discusses the Mentoring of Students and Igniting Community (MOSAIC) program that was founded in 2019 as a comprehensive and anti-racist faculty-to-student mentorship initiative for BIPOC and first-generation students. The program was created based on a scoping review of 20 university mentoring programs.

Table 9: Implementation context and details from the evidence

Key intervention	Details from the evidence
Structure of mentorship program	▪ While most mentorship programs were delivered in person, some were delivered virtually (182,183,185,187,192). ▪ While a one-to-one mentor-mentee mentorship model was frequently used, other mentorship models were used in some studies. They were as follows: ▫ networked mentoring (mentees were paired with a faculty mentor and a peer mentor) (183,196) ▫ mentees were paired with a "near-peer mentor" or, someone who had been in their shoes very recently (184,197,199) ▫ mentorship groups (consisting of two physician mentors and four medical students; senior medical students were expected to mentor more junior medical students) (188)
Length of the mentorship program	▪ In the studies examined, mentorship programs ranged from two days (182), to four months (189), to six months (183), to eight months (185) and to one to two years (186, 195).
Contextual details that may impact implementation of mentorship programs	▪ providing stipends for mentors (196) ▪ virtual delivery versus in person mentorship programs (virtual meetings may be more convenient but feel more formal) (196) ▪ continuously refining mentorship programs by seeking feedback from mentees and mentors (185)

Key intervention	Details from the evidence
Barriers and facilitators to delivering mentorship	**Barriers** ▪ In non-racially concordant mentor-mentee dyads, some mentors viewed career progression and discrimination through the lens of White privilege, driven by a view that Black health professionals must work harder than their White counterparts, which strained mentor-mentee relationships (193,197,199). ▪ Even with shared racial identity, mentors in leadership roles sometimes lacked capacity or influence in environments where racialized persons were underrepresented (197,199). ▪ Conflicting schedules, limited time and differing communication styles negatively impacted mentor-mentee engagement (190,191,195). **Facilitators** ▪ Mentees appreciated supportive mentor-mentee relationships that were authentic and grounded in trust, creating a safe space for relationships to flourish (182,183,192,197). ▪ Mentees expressed that meeting with mentors early in the relationship was an opportunity to build rapport and develop a personal connection (182,192). ▪ In two studies, mentees appreciated mentors who recognized the impact of their intersectional identities, such as gender identity, race, and ethnicity in the relationship (194,195). Based on personal mentoring goals, some relationships were strengthened by intersecting social identities.

Good practice statement 5.0: It is good practice for executive leaders to establish anti-racism, diversity, equity, inclusion and belonging committees that include Black nurse leaders or Black representation from all levels of the health or social service organizations or academic institutions (e.g., HR, staff, alumni and executive leadership).

Good practice statement criteria

Anti-racism, diversity, equity, **inclusion**,[G] and belonging committees, referred to below as ADEIB committees, are organized groups within health and social service organizations and academic institutions that are dedicated to advancing anti-racism, diversity, equity, inclusion and belonging by influencing policy and practice. Including representation from Black nurses and Black nurse leaders from all levels of an organization in ADEIB committees helps ensure their lived experiences and professional insights are incorporated into decision-making.

The discourse around equity, diversity and inclusion (EDI) has gained significant attention in public and academic spheres (200). An examination of the term "EDI" in the search engines Web of Science and Google Scholar between 2015 and 2021 revealed a rapid increase in scholarly interest (200), demonstrating a growing understanding of systemic inequities within society and a need for transformative change. At the same time, the language used to describe equity-focused organizational initiatives has been evolving due to an increased understanding of the systemic nature of racism and the need to foster belonging in health and social service organizations and academic institutions (201). While it is common to see reference to EDI committees or diversity, equity and inclusion (DEI) committees, committees are now being frequently renamed to include anti-racism and belonging in the acronym. Throughout this good practice statement, the term 'committee' is used when the ADEIB acronym was not present in the literature, but the authors were referring to similar committees or councils using alternative acronyms, such as EDI.

Good practice statement criteria

Is the message necessary to communicate?	**Yes.** Since 2023, ADEIB committees have faced growing political resistance, with over 400 bills introduced across the United States which aim to restrict equity-focused initiatives in government and education (202) and similar efforts felt in parts of Canada (203,204). It is therefore imperative to remain committed to advancing these efforts and recognizing their critical role in fostering inclusive, equitable and just environments.

After considering all relevant outcomes and potential downstream consequences, will implementing the good practice statement result in large benefits and very small harms?	**Yes.** Racism is structurally embedded in organizations. Without formal structures in place, such as ADEIB committees, anti-racism efforts risk being short-term, uncoordinated or ineffective (205). ADEIB committees can help organizations identify blind spots within policies and practices, shift institutional culture and hold organizations accountable to moving anti-racism efforts forward (206,207). Alexander et al. describes the creation of a Race Equity Work Team within their university's school of social work; the team's advocacy helped to change tenure and promotion procedures within the university (208). Gathers et al. further show how, when a council was established and structured to improve the diversity of medical residents, the number of interns recruited from groups traditionally unrepresented in medicine (e.g., American Indian, Alaska Native, Black/African American, Hispanic/Latino and Native Hawaiian/Pacific Islander) increased from 9.8 to 14.5 per cent (209). Although this research included other racialized groups, these examples illustrate how ADEIB committees, when empowered and supported, can drive institutional change. Individuals involved in ADEIB work often report a sense of purpose and fulfilment. In a study conducted with medical students, many found participation in the committee to be uplifting, and they took pride in advancing the committee's mission (210). Challenges to participation were also noted. Some participants reported time constraints were a barrier, and some Black participants found the work emotionally taxing due to personally identifying with the issues addressed (67 per cent of the 18 study participants were women and 28 per cent were Black) (210). Despite these difficulties, effective leadership, support and establishing psychological safety during committee meetings were described as resources to mitigate some of these challenges (210). Many examples of ADEIB committees exist within health and social service organizations and academic institutions (208,210,211) which suggests they are feasible to implement. A potential risk associated with ADEIB committees is they can become performative or tokenistic on the part of an organization or institution if committee members are not granted opportunities to meaningfully influence change (200). Institutions must empower committees to meaningfully influence change. Costs associated with this good practice statement include financial support for ADEIB committee-led initiatives and protected time for committee work (200,210). These costs are considered minimal in comparison to the anticipated benefits, such as student and staff retention within health and social service organizations and academic institutions. Taken together, the expert panel concluded that after considering all potential outcomes of ADEIB committees, the good practice statement is likely to result in large benefits and very small harms.

Is collecting and summarizing the evidence a poor use of time and energy?	**Yes.** A systematic review comparing the implementation of ADEIB committees within health and social service organizations or academic institutions compared to the alternative (not implementing ADEIB committees) is highly unlikely to show that the latter results in more positive outcomes. Collecting and summarizing the evidence in this context is a poor use of the limited time and energy of the guideline's expert panel. In addition, the need for this good practice statement has already been articulated in the 2022 Black Nurses Task Force Report which outlined a need to 1) establish diversity, equity and inclusion committees to oversee fairness in practices and investigate complaints of racism, and 2) ensure Back nurses are represented on committees and boards to allow them to contribute to decision-making processes that govern education and practice (17). **Note:** For countries other than Canada, it is important that health and social service organizations and academic institutions review their own historical, cultural and policy contexts when establishing ADEIB committees to ensure relevance and effectiveness.
Is there a clear rationale for the action?	**Yes.** ADEIB committees provide a formal avenue to hear from people, including Black nurses and Black nursing students, whose voices have historically been excluded. They also play a pivotal role in establishing organizational or institutional priorities for advancing anti-racism, equity, diversity, inclusion and belonging.
Is the statement clear and actionable?	**Yes.** The statement is clear and actionable. See the implementation strategies below for additional information on how health and social service organizations and academic institutions can implement ADEIB committees.

Implementation strategies

From the expert panel

- Develop a strategic ADEIB plan to communicate the committee's mission, goals, values and strategies to advance ADEIB efforts.
- Integrate an intersectional lens into all ADEIB committee activities by acknowledging and addressing the overlapping and compounding impacts of racism, gender discrimination, disability, socioeconomic inequities, sexual orientation, and other social identities.
- Develop metrics to evaluate the committee's impact on the organization's larger goals related to addressing anti-Black racism in health care.
- Engage ADEIB committees in retention, recruitment and hiring efforts.
- When negotiating collective bargaining agreements, unions can advocate for the inclusion of AEDIB committees within health and social service organizations.
- Consider compensating individuals who participate on these committees.

From the literature

- An effective committee possesses a clear purpose, an inclusive atmosphere, open communication, meaningful participation, shared leadership and a strong capacity for building consensus (210).
- ADEIB committees can benefit from a dedicated expert within the committee who can provide strategic leadership. The committee's leader can guide the committee to define its purpose, establish group norms, encourage participation, celebrate achievements and reflect on the committee's effectiveness (210).
- Anticipate the emotional impact that participation in ADEIB committees can have on members and establish strategies to help committee members recognize and process their emotions (210). Committee members may be personally impacted by the issues the committee is discussing. Others may encounter frustration if the committee's progress is slow or obstructed. To maintain morale, it may be valuable to for committees to identify a range of short-term and long-term goals so that small victories can be celebrated while the committee continues to pursue its long-term objectives (210).
- Tokenism may occur when racialized individuals are included in ADEIB committees for symbolic purposes rather than meaningful participation. This practice seriously undermines equity and inclusion and can lead to burnout, isolation and mistrust in organizational ADEIB efforts (212, 213).
- Provide dedicated resources and support to ADEIB committees, including protected time for committees and Black committee members to carry out their work (210).
- To avoid minority tax, provide compensation. For example, committee activity points could be applied toward career promotion and advancement, giving credit to individuals for their participation (214).
- It is essential that ADEIB committees include representation from executive leadership or leaders with decision-making authority within the organization or institution. Equally important is the inclusion of members from all levels of the organizational or academic hierarchy to ensure diverse perspectives and experiences are reflected. Within the committee itself, deliberate efforts should be made to dismantle hierarchical structures to foster psychological safety amongst committee members, encourage dialogue and promote collaborative decision making (215).
- In one study, participants involved in committee work emphasized the importance of recognizing that advocacy and change take time and require patience and perseverance (210).

Supporting resources

Resource	Description
Canadian Centre for Diversity and Inclusion. Creating a diversity, equity, and inclusion strategy: Toolkit for developing a strategy to enhance DEI in your organization [Internet]. Toronto (ON): Canadian Centre for Diversity and Inclusion; 2024 [cited 2025 Dec 1]. Available from: https://ccdi.ca/en/dei-strategy-toolkit	▪ Toolkit from the Canadian Centre for Diversity and Inclusion (CCDI) that provides guidance for small and large and public, non-profit or private sector employers on how to create a diversity, equity and inclusion strategy. ▪ The toolkit includes four sections on how to get started, gather information, set goals and objectives and develop an implementation plan.
Canadian Centre for Diversity and Inclusion (CCDI). Diversity, equity, and inclusion councils and committees: A toolkit to support an organization's DEI implementation goals. Toronto (ON): CCDI; 2023. Available from: https://new-api.ccdi.ca/wp-content/uploads/2025/06/dei-councils-toolkit-en.pdf	▪ Toolkit from the CCDI that supports the implementation of diversity, equity and inclusion goals within an organization through the creation of diversity, equity and inclusion committees and councils. ▪ The toolkit is organized into five sections focused on the following: 1) preparing the groundwork, 2) preparing a council framework and charter, 3) recruiting and onboarding a council, 4) launch, acting and communicating, and 5) measuring, analyzing and adjusting.
Registered Nurses' Association of Ontario (RNAO), Healthcare Excellence Canada (HEC). Leading change toolkit (4th ed.) [Internet]. Toronto, ON: RNAO; 2024. Available from: https://www.RNAO.ca/leading-change-toolkit	▪ RNAO implementation toolkit designed to help individuals and organizations lead and sustain meaningful change in health and social service organizations and academic institutions. ▪ Provides guidance on how to mobilize collective action, structure planning and implementation and build capacity in change leadership.

Research gaps and future implications

During the development of this guideline, it became apparent that there is a significant lack of research evaluating strategies to combat anti-Black racism within the nursing profession. This scarcity not only limits the development of effective interventions (216) but also reflects the reality that systemic racism remains embedded within health and social service organizations, research, academia and publishing (51,72). Historically, Whiteness has dominated nursing and nursing research, where dominant Western philosophies and methodologies have shaped frameworks and interpretations. As a result, research on race and culture has often relied on approaches grounded in Whiteness, leading to analyses and recommendations filtered through a White lens (217). Furthermore, existing gaps frequently overlook intersectionality, the ways race interacts with other identities such as gender, sexual orientation and disability, leaving compounded inequities unaddressed (217). William et al. note that the heterogeneity of experiences of racism within Black communities is often overlooked in health research, resulting in findings that fail to capture the nuanced ways intersecting factors contribute to inequities. Similarly, in a recent systematic review on intersectionality in nursing, Siira et al. found that studies varied widely in how the concept was applied. Few studies used real-world data; instead, many focused narrowly on race/ethnicity, gender and workplace roles rather than on 2SLGBTQI+ identities and other intersecting dimension of nurse identity (25). By prioritizing and funding research that centres anti-Black racism, and applies culturally sensitive and intersectional frameworks (218), the nursing field can take meaningful steps towards dismantling structural barriers, promoting equity, and fostering a more inclusive and just health-care system (204,205).

The RNAO best practice guideline development and research team, together with the expert panel, identified priority areas for future research. These areas are outlined in **Table 10**, which presents the research questions and outcomes (left-hand column), and priority research areas and corresponding gaps in the evidence (right-hand column) based on the systematic reviews that were conducted for each question. Notably, most of the existing research focused on broader topics associated with addressing racism (e.g., unconscious bias, microaggressions, discrimination), rather than anti-Black racism in nursing specifically. Black health providers and Black students were rarely identified as a unique group within the studies but were instead categorized within broader racialized groups such as BIPOC. Although scholarly research on anti-Black racism is gaining momentum in Canada, substantial gaps still exist. Future Canadian studies that explicitly address anti-Black racism in nursing would provide more targeted evidence to inform evidence-based polices and strategies to address anti-Blackness, discrimination and inequities in health and social service and academic organizations.

The list of research areas outlined in **Table 10** is not exhaustive; other areas of research will be required.

Table 10: Priority research areas and gaps per research question

Research question	Priority research area and gaps
Research question #1a: What type of education should be recommended to address anti-Black racism in nursing? **Outcomes:** Outcomes related to psychological safety, representation, competency/education and patient outcomes.	▪ Additional studies examining what types of education can be recommended to address anti-Black racism in nursing with a focus on outcomes related to psychological safety, representation, competency, education and patient outcomes. ▪ Research including licensed nurses and nursing students in all domains of practice, as the majority of research on this topic has been conducted in the field of medicine. ▪ Studies examining long-term behavioural change when education is provided.
Research question #1b: What are the values, preferences, barriers and facilitators associated with delivering education to address anti-Black racism in nursing? **Outcomes:** Not applicable.	▪ Additional studies examining the values, preferences, barriers associated with, and supports that enable delivering education to address anti-Black racism in nursing (according to those receiving education and those delivering it). ▪ There is little research in this area focusing on the nursing profession; most research in health care has been conducted within the field of medicine.

Research question	Priority research area and gaps
Research question #2a: What are the components of mentorship programs for Black nurses, Black nursing students, as well as allies, that can help address anti-Black racism in nursing? **Outcomes:** Outcomes related to psychological safety, human resources, representation, education, escalation of grievances and patient outcomes.	▪ More studies examining the components of mentorship programs for Black nurses and Black nursing students that can help address anti-Black racism in nursing, with a focus on outcomes related to psychological safety, human resources, representation, education, escalation of grievances and patient outcomes. No direct or indirect research was identified that examined the impact of mentorship programs on human resource outcomes and patient outcomes. ▪ More research examining the effect of mentorship programs for Black nursing students and Black nurses in all domains of practice is needed; within health care, most research on this topic has been conducted within the fields of medicine and academia. ▪ More studies examining the impact of incorporating anti-racism frameworks into mentorship programs; only one study explicitly incorporated this. ▪ Studies exploring the impact of mentorship programs for allies learning to effectively address racism in health care.
Research question #2b: What are the values, preferences, barriers and facilitators associated with mentorship programs developed to address anti-Black racism in nursing? **Outcomes:** Not applicable.	▪ More studies examining the values, preferences, barriers and facilitators associated with mentorship programs developed to address anti-Black racism in nursing (from the perspective of mentors and mentees).

Additional priority research areas identified by the expert panel

The areas noted below were not explored in the systematic reviews for this guideline; however, the expert panel has acknowledged a need for further research in the following areas:

- the mental health impact of anti-Black racism on Black nurses and Black nursing students;
- the impact of anti-Black racism on internationally educated nurses from predominantly Black countries who immigrate to Canada.
- the role of intersectionality in shaping experiences of anti-Black racism in nursing, including how overlapping identities such as gender identity and expression, disability, and sexual orientation compound inequities; and
- strategies and interventions that apply an intersectional lens to prevent, mitigate, and eliminate anti-Black racism in nursing.

Implementing RNAO guidelines

Implementing guidelines at the point of care is multi-faceted and challenging. It takes more than awareness and access to BPGs for practice to change: BPGs must be adapted for each practice setting in a systematic and participatory way to ensure that recommendations fit the local context (220). The Leading Change Toolkit (developed by RNAO in partnership with Healthcare Excellence Canada), provides evidence-informed processes for this (see **Appendix I**) (4).

The Leading Change Toolkit uses two complementary frameworks to guide evidence uptake and sustainability (see **Figure 2**). They can be used together to maximize and accelerate change.

Figure 2: The Leading Change Toolkit: Two complementary frameworks to accelerate your success

Source: Reprinted with permission from: Registered Nurses' Association of Ontario (RNAO), Healthcare Excellence Canada (HEC). Leading change toolkit [Internet]. 4th ed. Toronto (ON): RNAO; 2024. Available from: RNAO.ca/leading-change-toolkit

The Social Movement Action Framework (1,2) is descriptive and identifies the defining elements of a **social movement for knowledge uptake and sustainability**.[G] It integrates a bottom-up, people-led approach to change for a shared concern (or common cause) in which change agents and change

teams mobilize individual and collective action to achieve goals. The framework's elements—categorized as preconditions, key characteristics and outcomes—are dynamic, inter-related and develop spontaneously as the social movement evolves.

The Knowledge-to-Action Framework uses a process model of action cycle phases to systematically guide the adaptation of the new knowledge (e.g., a BPG) to the local context and implementation. This framework suggests identifying and using knowledge tools/products (such as guidelines) to determine gaps and begin the process of tailoring the new knowledge to local settings.

The Leading Change Toolkit is based on emerging evidence in health and social sciences that successful uptake and sustainability of best practice in health care is more likely when the following occurs:

- BPGs are selected for implementation through a participatory process led by change agents and change teams.
- The selected BPGs reflect priority areas for a shared concern that are credible, valued and meaningful, or an urgency for action.
- Others impacted by the change are identified and engaged throughout implementation to engage in individual and collective action.
- Receptivity for implementing BPGs, including environmental readiness, is assessed.
- Implementation strategies are tailored to the local context and designed to address barriers;
- Use of the BPG is monitored and sustained.
- Evaluation of the BPG's impact is embedded in the process to determine if the goals and outcomes have been met.
- There are adequate resources to complete all aspects of the uptake and sustainability of the BPG.
- The BPG is scaled up, out or deep, where possible, in order to widen its influence and create lasting health improvements.

RNAO is committed to widespread dissemination, implementation and sustainability of our BPGs. We use a systematic approach deploying various strategies, including:

1. The RNAO Best Practice Champion Network®, which powers the capacity of change agents to foster awareness, engagement, adoption and sustainability of BPGs. RNAO best practice champions are people and organizations who are passionate about implementing evidence-based practices and mobilize others so together they improve care and health through the integration of competencies as defined by RNAO's Best Practice Champions Competency Framework. Champions include nurses and other health professionals from all roles and health sectors, students, advocates, people with lived experience, and caregivers.

2. RNAO Clinical Pathways™ are digitized recommendations and good practice statements embedded into electronic medical records through a third-party software.

3. The BPSO® designation supports implementation at the organization and system levels. BPSOs focus on developing evidence-based cultures with the specific mandate to implement, evaluate and sustain multiple RNAO BPGs.

In addition, we offer annual capacity-building learning institutes on the implementation of practice change.

Information about our implementation strategies can be found at:

- RNAO Best Practice Champions Network®: RNAO.ca/bpg/get-involved/champions
- RNAO Clinical Pathways™: RNAO.ca/bpg/implementation/clinicalpathways
- RNAO BPSO®: RNAO.ca/bpg/bpso
- RNAO capacity-building learning institutes and other professional development opportunities: RNAO.ca/events

Appendix A: Glossary of terms

2SLGBTQI+:	An acronym for Two-Spirit lesbian, gay, bisexual, trans, queer and intersex people. The "+" is meant to be inclusive of other people who identify as a sexual or gender minority, such as (but not limited to): asexual, non-binary, pansexual and those questioning their sexual orientation or gender identity (221).
Ableism:	Prejudice and discrimination against people with a disability (222).
Accountability:	The extent to which individuals, groups, organizations and communities hold themselves responsible for achieving their goals and actions. Accountability can be externally imposed, through legal or organizational requirements; internally driven by moral, relational or faith-based values; or, recognized as some combination of both. From a relational perspective, accountability is not only about doing what is right; it also involves how we respond when something goes wrong (6,95).
Activism:	Activism involves taking deliberate action to drive social, political, economic, or environmental change. It spans a broad spectrum of efforts, including grassroots organizing, protests, lobbying, advocacy, and community engagement. Fundamentally, activism seeks to challenge existing systems, confront inequities, and elevate marginalized voices (223).
Advocacy:	"Advocacy involves engaging others, exercising your voice and mobilizing evidence to influence policy and practice" (96). This involves speaking up and speaking out against inequity and inequality, and acknowledging the importance of research, power and politics in moving the needle with policy options (96).
Ally/allyship:	A person who works to end systems of oppression that give that person privilege(s) over others based on arbitrary characteristics such as being a member of the dominant race or gender identity. Allies listen to, and are guided by, communities and individuals affected by oppression. Forms of oppression include: ableism, ageism, audism, classism, biphobia, homophobia, transphobia, racism, sexism and others (224).
Anti-Black racism:	Anti-Black racism describes the discrimination, microaggressions, stereotypes, beliefs and attitudes directed at people of African descent and is deeply entrenched in Canadian institutions, policies and practices, impacting educational outcomes, career progression and health outcomes to the extent that it is either functionally normalized or rendered invisible within society (19). Anti-Black racism is rooted in a legacy of colonialism, slavery and systemic exclusion from Canadian institutions (20). It is a term first coined by a Canadian scholar, Dr. Akua Benjamin, a Toronto Metropolitan University social work professor, and is specifically used to highlight Black experiences within a broader racial justice context (6).

Anti-oppression:	The lens through which one understands how institutional, social, cultural and economic issues influence opportunities for people to grow into their full potential and can result in systemic inequities for particular groups (225). Anti-oppression aims to eliminate forms of oppression by analyzing and challenging power structures and empowering those who experience oppression (28).
Belonging:	A level of comfort and security that employees experience within workplaces when they are included, accepted and supported. A sense of belonging supports high performance, employee engagement and well-being, encouraging team cohesion and the achievement of organizational goals (28).
Best practice guidelines (BPG):	"Best practice guidelines are systematically developed, evidence-based documents that include recommendations for nurses and the interprofessional team, educators, leaders and policy-makers, people and their families on specific clinical and healthy work environment topics. BPGs promote consistency and excellence in clinical care, health policies and health education, ultimately leading to optimal health outcomes for people and communities and the health system" (226).
Best Practice Spotlight Organization® (BPSO):	A health service or academic organization that has partnered formally with RNAO over a three-year time period with a goal of creating evidence-based practice cultures through the systematic implementation and outcome evaluation of multiple best practice guidelines (227). Upon successful completion of the first three-year time period, sites are recognized as designated. Following the pre-designation period, BPSOs are required to achieve deliverables and are redesignated on a biennial basis. The BPSO designation was launched in 2003 as a knowledge translation strategy. BPSOs have been established across all sectors with sites in Ontario and throughout the world.
Black or Black race:	Definitions of the term "Black" and Black race continue to evolve and vary widely in the literature. The term typically refers to people with visibly darker skin pigmentation. In Canada, "Black" designates people of African or Caribbean ancestry. Many organizations have now embraced the term "Black"; however, there are varying identities associated with the term, including African Canadian, People of African descent, Caribbean Canadian and others. Similarly, in the United States, Black people are described as African American and Non-Hispanic Black and Caribbean American. More recently, definitions have included the concept of self-identification, implying an element of choice. This is contentious to some members of the Black community who experience Blackness as a visual manifestation of oppression based on innate hereditary features that cannot be self-selected (4).

Black Feminist Thought (BFT):	An interpretive framework coined by Patricia Hill Collins drawn from prominent Black feminist thinkers such as Angela Davis, bell hooks, Alice Walker and Audre Lorde. It is a field of knowledge primarily focused on the experiences of Black women and an ideology of liberation rooted in Black women's experience, with the inclusive aim of disrupting oppressive social hierarchies for all people (200).
Black, Indigenous and People of Colour:	An umbrella term referring to Black people, Indigenous people and People of Colour. The term is generally used to represent the experiences of Indigenous and Black people however, many BIPOC people agree that using specific language in reference to racialized experience is preferred (28).
Black race consciousness:	Explicit acknowledgment of the workings of the Black experience, race and racism in social contexts or in one's personal life and society (229).
CERQual:	The Confidence in the Evidence from Reviews of Qualitative Research (CERQual) is a methodological approach to assess the amount of confidence that can be placed in findings from a body of qualitative evidence about an outcome of interest. The assessment provides a transparent means to decide if the review finding reasonably represents the phenomenon under study, which can facilitate guideline panels to make health recommendations (230). When using CERQual, four components contribute to the assessment of confidence in the evidence for each finding: 1. Methodological limitations, which look at issues in the design of the primary study or problems in the way it is conducted. 2. Relevance, whereby primary studies that support a finding are assessed together and a decision is made regarding the applicability of the findings to the population, phenomenon and setting outlined in the research question. 3. Coherence, whereby an assessment is made of whether the primary studies provide sufficient data and a convincing explanation for the review findings. 4. Adequacy of data, whereby an overall assessment is made about the richness and quantity of the data that support the review finding and phenomenon of interest (230).
Colonialism:	"The practice of domination where one nation occupies land for the purpose of subjugating, conquering, and exploiting the colonized territory and its people" (28). Colonization and anti-Black racism are inextricably intertwined. Anti-Black racism is rooted in negative attitudes towards Black people that emerged because of colonization and the transatlantic slave trade and Western societies belief in the inferiority of Black people. Over time, this legacy of oppression has led to social economic and political marginalization of Black people and communities (28,231).

Colourism:	Coined by Alice Walker in 1983 to describe preferential treatment toward individuals of the same racial group based solely on differences in skin tone (21). Colourism functions as a critical mechanism through which power and privilege are maintained both within and across Black communities, intersecting with Whiteness and systems of White supremacy (232). It significantly influences experiences of anti-Black racism in domains such as education, hiring, performance evaluation, and career advancement (22,23).
Critical race theory (CRT):	Critical race theory (CRT) can be traced to the early writings of Derrick Albert Bell Jr., and further developed by legal scholars such as Richard Delgado, Jean Stefanic and Kimberlé Crenshaw. It refers to "interrogating the role of race and racism in a society that emerged in the legal academy and spread to other fields of scholarship." CRT is a theory and social movement based on the premise that race is a social construct that is not based on biology that is used to oppress racialized persons (28,151,233,234).
Cultural humility:	Refers to a life-long commitment to critical self-reflection, mitigating power and institutional accountability by increasing awareness of biases and personal limitations (28).
Culturally responsive pedagogy:	A way to rethink instruction to improve the educational performance of racially, ethnically, and linguistically diverse students to facilitate meaningful and transformative learning opportunities (235).
Disability:	A physical, mental, intellectual, cognitive, sensory, learning or communication impairment, or a functional limitation, whether apparent or not, and permanent, temporary or episodic in nature, that hinders a person's full and equal participation in society when they face a barrier (222).
Discrimination:	The impartial treatment of an individual by unfairly denying a benefit or privilege enjoyed by others because of their race, gender, citizenship or other personal attribute (222).
Diversity:	The variety of identities found within an organization, group or society. Diversity is expressed through factors such as culture, religion, ethnicity, gender, sex, sexual orientation, age, education, language, ability, family status or socioeconomic status (222).
Empowerment:	Empowerment is a process by which people, organizations and communities gain power (109). In nursing, it reflects a quality whereby nurses have influence over their environment (109). Empowerment also refers to an ideology focused on increasing the power of a low power group so that it becomes equal to that of a high-power group (109). In the context of racism, empowerment involves equipping individuals, organization and institutions with the tools, supports and authority needed to challenge and dismantle systemic and interpersonal racism within the health-care system (110).

Equity:	The principle of recognizing individuals' unique experiences and circumstances and ensuring they have equitable access to the resources and opportunities necessary to achieve fair and just outcomes. Equity aims to eliminate disparities rooted in historical and contemporary injustices and oppression (222).
Evidence-based practice:	The integration of research evidence with clinical expertise and patient values. It unifies research evidence with clinical expertise and encourages the inclusion of patient preferences (236).
Evidence-to-Decision (EtD) frameworks:	A table that helps guideline panels make decisions when moving from evidence to recommendations. The purpose of the EtD framework is to summarize the research evidence, outline important factors that can determine the recommendation, inform panel members about the benefits and harms of each intervention considered and increase transparency about the decision-making process in the development of recommendations (45).
Evidence profile:	Allows presentation of key information about all relevant outcomes for a given health-care question (35). It presents information about the body of evidence (e.g., number of studies), the judgments about the underlying quality of evidence, key statistical results and the quality of evidence rating for each outcome (45).
External reviewer:	Individuals or groups who commit to reviewing and providing feedback on the draft RNAO best practice guideline prior to publication. External reviewers often include individuals or groups directly impacted by the guideline topic and recommendations (e.g., people accessing health services, people working in health service organizations or people with subject-matter expertise).
Gender identity:	Gender identity is each person's internal and individual experience of gender. It is their sense of being a woman, a man, both, neither, or anywhere along the gender spectrum. A person's gender identity may be the same as or different from their birth-assigned sex (237).
Gender expression:	Refers to the way a person publicly chooses to present their gender through their behaviour, appearance, name, or pronouns. Gender expression and identify align but are distinct and separate concepts (28).

Good practice statement:	Good practice statements are actionable statements that should be done in practice (40). To ensure their appropriate use, the expert panel must confirm that the following five criteria are met: 1. The message is necessary to communicate. 2. After considering all relevant outcomes and potential downstream consequences, implementing the good practice statement would result in large benefits and very small harms. 3. Conducting a systematic review to collect and summarize the evidence would be a poor use of time and energy. 4. There is a clear rationale for the action. 5. The statement is clear and actionable (40). The expert panel must have a high level of certainty that the benefits of the good practice statement outweigh any potential harms. As a result, good practice statements are not based on a systematic review of the evidence nor do they receive a rating of the certainty in their evidence or a strength (i.e., a rating of conditional or strong) (41). Good practice statements should be interpreted as strong recommendations as there is an underlying assumption that there is high certainty in the benefits of implementing the action (40). It is important to note that good practice statements are not made due to a lack of evidence, nor are they based on expert opinion.

Grading of Recommendations Assessment, Development and Evaluation (GRADE):	A methodological approach to assess the certainty of a body of evidence in a consistent and transparent way and to develop recommendations in a systematic way. The body of evidence across identified important and/or critical outcomes is evaluated based on the risk of bias, consistency of results, relevance of studies, precision of estimates, publication bias, large effect, dose-response and opposing confounding (45). When using GRADE, five components contribute to the assessment of confidence in the evidence for each outcome. These components are as follows: 1. Risk of bias, which focuses on flaws in the design of a study or problems in its execution. 2. Inconsistency, which looks at a body of evidence and assesses whether the results point in the same direction or if they are different. 3. Imprecision, which refers to the accuracy of results based on the number of participants and/or events included, and the width of the confidence intervals across a body of evidence. 4. Indirectness, whereby each primary study that supports an outcome is assessed and a decision is made regarding the applicability of the findings to the population, intervention and outcome outlined in the research question. 5. Publication bias, where a decision is made about whether the body of published literature for an outcome potentially includes only positive or statistically significant results (45).
Guiding principles:	Overarching concepts that denote a philosophy, belief, value and/or standard of behaviour that nurses, members of the interprofessional team and health service organizations should apply to their practice when implementing recommendations and good practice statements.
Health Equity:	Health equity means ensuring everyone has a fair and just opportunity to achieve their highest level of health and well-being. It involves removing avoidable and unfair differences among groups defined by social, economic, demographic, geographic, or other factors (e.g., sex, gender, ethnicity, disability, sexual orientation). Health and health equity are shaped by the conditions in which people are born, grow, live, work, play, and age, as well as biological factors. These conditions are influenced by structural determinants—political, legal, and economic systems—and social norms that govern the distribution of power and resources (238).

Health provider:	Refers to both regulated (e.g., nurses, physicians, dieticians and social workers) and unregulated (e.g., personal support workers) workers who are part of the interprofessional team. **Regulated health provider:** In Ontario, the Regulated Health Professional Act, 1991 (RHPA) provides a framework for regulating 26 health professions, outlining the scope of practice and the profession-specific controlled or authorized acts that each regulated professional is authorized to perform when providing health care and services (239). **Unregulated health provider:** Unregulated health providers fulfill a variety of roles in areas that are not subject to the RHPA. They are accountable to their employers but not to an external regulating professional body (such as the College of Nurses of Ontario). Unregulated health providers fulfill their roles and tasks that are determined by their employer. Unregulated health providers only have the authority to perform a controlled act as set out in the RHPA if the procedure falls under one of the exemptions set out in the Act (240).
Health and social service organizations:	Health service organizations are organizations delivering health-care services to defined communities or populations. This includes, but is not limited to, family health teams, home care organizations and hospitals. Social service organizations are organizations that assist people with social issues, including (but not limited to) housing, domestic violence and substance use.
Implementation science:	Defined as “the scientific study of methods to promote the systematic uptake of research findings and other evidence-based practices into routine practice, and, hence, to improve the quality and effectiveness of health services and care” (241).
Inclusion:	The practice of using proactive measures to create an environment where people feel welcomed, valued and respected, and to create a sense of belonging and engagement. This practice involves removing barriers so that each person has equal access to opportunities and resources and can achieve their full potential (222).
Indirect evidence:	As per GRADE methods, directness is judged based on the target population, intervention, and outcomes of interest (45). Evidence can be indirect if the populations differ from those of interest, the intervention tested differs from the intervention of interest or the outcomes differ from those of primary interest (45). When considering qualitative evidence, the concept of directness is referred to as relevance (207).
Internalized racism:	The acceptance of negative beliefs about one’s own racial identity, leading to feelings of inferiority and self-discrimination. It often involves anticipating prejudice and stems from systemic racial hierarchies and institutional discrimination (63).

Interactive education:	Interactive education promotes engagement and critical thinking. It is a dynamic approach that fosters active participation and exchange of ideas among educators and participants. This method recognizes students' needs and encourages them to take an active role in their learning process (139).
Interprofessional team:	A team comprised of multiple health providers (regulated and unregulated) who work collaboratively to deliver comprehensive and quality health services to people within, between and across health care (242). Key interprofessional team members may include: nurses, general practitioners, physicians, dietitians and pharmacists.
Intersectionality:	Coined by Kimberlé Crenshaw, intersectionality is "A way of understanding and analyzing the complexity in the world, in people, and in human experiences" (243). The events and conditions of social and political life and the self can seldom be understood as shaped by one factor. They are generally shaped by many factors in diverse and mutually influencing ways. When it comes to social inequality, people's lives and the organization of power in a given society are better understood as being shaped not by a single axis of social division, be it race or gender or class, but by many axes that work together and influence each other. Intersectionality as an analytic tool gives people better access to the complexity of the world and of themselves (81,82).
Lived experience:	First-hand experience and knowledge of the topic of interest either as a person, unpaid caregiver or advocate. People with lived experience are a diverse group with an array of backgrounds and experiences (249).
Marginalization:	Refers to a form of oppression in which a category of people are excluded from social life. It is "a social process by which individuals or groups are (intentionally or unintentionally) distanced from access to power and resources and constructed as insignificant, peripheral, or less valuable and/or privileged to a community or 'mainstream' society" (6).

Mentorship:	A partnership between a mentor and mentee in which knowledge, experience, skills and information are shared to foster the mentee's professional development and enhance the mentor's perspectives and knowledge (179). Mentorship is reported to serve two distinct functions: 1) career-related functions, including sponsorship, coaching, and promoting exposure and visibility; and 2) psychosocial or personal development, such as role modeling, friendship and counselling. Mentorship differs from supervision in that the mentee does not have a structured reporting relationship with the mentor, and competencies are not assessed or measured (180). Mentorship can be informal or formal. Formal mentorship programs are organized, structured initiatives implemented by an academic institution or health or social service organization that pairs mentors and mentees with the goal of supporting the mentee's personal and professional development. These programs are distinct from informal mentoring relationships in that they often have defined objectives, processes and evaluation mechanisms (181).
Microaggressions:	Intentional or unintentional acts of verbal, nonverbal and nonverbal slights, snubs or insults that are produced by both individuals and larger social groups, such as institutions. These actions convey hostile, derogatory or negative messages to individuals based solely upon their membership in a marginalized group (34).
Minority tax:	Term used to describe additional responsibilities imposed on individuals from minority groups to advance diversity efforts, along with experiences of racism, isolation, and inequities in critical areas such as mentorship, professional duties, and opportunities for advancement (244).
Misogynoir:	Term coined to describe the specific intersection of anti-Black racism and misogyny directed at Black women (66,67).
Non-randomized study:	A quantitative study estimating the effectiveness of an intervention, where participants are allocated to different interventions using methods that are not random (245).
Nurse:	Refers to registered nurses, licensed practical nurses (referred to as "registered practical nurses" in Ontario), registered psychiatric nurses and nurses in advanced practice roles, such as nurse practitioners and clinical nurse specialists (239).
Oppression:	Asymmetrical power relations, characterized by domination and subordination of a group by restricting access to social, economic and political resources (246). Systems of oppression refers to the networks of distinct intersecting institutions (e.g., healthcare, education, housing, employment) that perpetuate oppression of socially constructed groups by elevating the status of individuals who hold power and privilege. These systems manifest discrimination in varied ways and collectively marginalize certain groups, reinforcing health inequities (247).

Outcomes:	A dependent variable, or the clinical and/or functional status of a patient or population, used to assess if an intervention is successful. In GRADE, outcomes are prioritized based on whether they are: (a) critical for decision making, (b) important but not critical for decision making, or (c) not important. The use of these outcomes helps make literature searches and systematic reviews more focused (45).
PPC research question:	A framework to outline a qualitative research question. It specifies three components: 1. The population that is being studied. 2. Phenomena of interest that relate to a defined event, activity, experience or process. 3. Context, which is the setting or distinct characteristics (248).
PICO research question:	A framework to outline a focused question. PICO stands for four specific components: ▪ Patient or population that is being studied ▪ Intervention to be investigated ▪ Comparison or alternative intervention ▪ Outcome of interest (45)
Positionality:	Positionality is the culmination of how different aspects of our social identities (e.g., race, gender, class) interact with others' social identities (250).
Power:	The access to privilege in the form of knowledge, resources, information and decision-making authority that make life more comfortable (224).
Privilege:	Refers to a right or exemption from liability or duty, granted as a special benefit or advantage that is often unearned. Often in the form of unearned systemic forces that benefit some social groups over others in the form of racism, ageism, sexism, colonialism and classism. People are not always aware of the privilege they have (28,251).
Qualitative evidence synthesis:	A qualitative evidence synthesis is a type of systematic review that brings together the findings from primary qualitative research in a systematic way. The findings from a qualitative evidence synthesis can provide rich interpretations relating to the impact of a condition and can enable a greater understanding of the experiences, views, beliefs and priorities held by both individuals and groups for health care (252).
Qualitative research:	An approach to research that seeks to convey how human behaviour and experiences can be explained within the context of social structures and through the use of an interactive and subjective approach to investigate and describe phenomena (253).
Quantitative research:	An approach to research that investigates phenomena with tools that produce statistical measurements and/or numerical data (254).

Race:	Socially constructed cultural categorization schemes created to support worldviews that identify some groups of people as superior and some as inferior based on physical and behavioural differences (6).
Racial concordance:	Refers to individuals, such as a mentor and mentee, sharing the same racial identity (255).
Racial bias:	The primarily unconscious thoughts, preconceptions or experiences that cause people to think and act in prejudiced ways. Behaviour toward Black people is influenced by both explicit racial attitudes, traditionally assessed with self-reports and by implicit attitudes, which are automatically activated, typically without conscious awareness (256).
Racial trauma:	The cumulative harm caused by racism in the lives of racialized persons, including emotional, psychological, physical health, economic and social consequences stemming from multigenerational and historical trauma. When these experiences are repetitive and unresolved, they can lead to profound emotional pain and distress, overwhelming the ability of individuals and communities to cope, fostering feelings of powerlessness (257).
Racism:	Racism involves one group having the power to carry out systematic discrimination through the institutional policies and practices of the society and by shaping the cultural beliefs and values that support those racist policies and practices (6).
Randomized controlled trial (RCT):	An experiment in which the investigator assigns one or more interventions to participants who are randomly allocated to either the experimental group (receives intervention) and the comparison (conventional treatment) or control group (no intervention or placebo) (245).
Recommendation:	A course of action(s) that directly answers a research question. A recommendation is based on a systematic review of the literature and is made in consideration of its a) benefits and harms, b) values and preferences and c) health equity. All recommendations are given a strength—either **strong** or **conditional**—through panel consensus. It is important to note that recommendations should not be viewed as dictates, because recommendations cannot take into account all of the unique features of individual, organizational and clinical circumstances (45).
Research question:	A priority research area of practice, policy or education identified by expert panel members that requires evidence to answer. The research question may also aim to answer a topic area around which there is ambiguity or controversy. The research question informs the systematic review.

Reflective practice:	An intentional process of thinking, analyzing and learning, identifying one's learning needs and committing to a plan of action. In many jurisdictions, reflective practice is a legislated expectation and health professionals engage annually in reflective practice and development of a learning plan. This demonstrates a commitment to lifelong learning and continuing competency (239).
Sexual orientation:	Sexual orientation describes human sexuality, from gay and lesbian to bisexual and heterosexual orientations. Sexual orientation is distinct from sex, gender identity, and gender expression (237).
Social construction:	An idea that has been created and accepted by the people in a society (258). In the context of race, particularly the concept of Blackness, social construction is a socially invented category that evolves in response to historical, political, and economic conditions. It challenges the notion that race is a function of biological differences. In fact, when racial differences are viewed as biological and unchanging, there is typically less support for policies addressing racial inequities (259).
Social-ecological model:	The social-ecological model is a systems-level interactive framework that describes how individual characteristics and environmental factors interact to influence health and behavioural change (92). The multifaceted theory considers multiple levels of influence at the intrapersonal, interpersonal, institutional, community, and policy or systems levels (27,62,72).
Social movement for knowledge uptake and sustainability:	Individuals, groups and/or organizations who, as voluntary and intrinsically motivated change agents, mobilize to transform health outcomes (2).
Sponsorship:	A professional relationship in which a senior individual (the sponsor) actively leverages their social capital and power to advocate for and create career-advancing opportunities for a protégé(e). Unlike mentorship, which focuses on guidance and advice, sponsorship involves direct advocacy, such as recommending the protégé(e) for promotions, introducing them to key networks and championing their visibility in decision-making spaces (260).
Stereotypes:	An oversimplified categorization of groups based on negative or positive beliefs, ideas and associations. Racial stereotypes can lead to false assumptions about Black people, inadvertently perpetuating anti-Black racism (28).
Structural determinants of health:	Encompasses the social, economic and political systems that shape social stratification and determine individuals' socioeconomic positions within society (261).

Systematic review:	A comprehensive review of the literature that uses clearly formulated questions and systematic and explicit methods to identify, select and critically appraise relevant research. A systematic review collects and analyzes data from the included studies and presents them, sometimes using statistical methods (245). A systematic review of qualitative evidence is called a qualitative evidence synthesis. See qualitative evidence synthesis
Systemic and structural racism:	Systems (or levels) of racism that are deeply entrenched into laws, policies, rules and practices, often sanctioned by all levels of government. It is an interwoven and reciprocal relationship at all levels of society which operates together as a whole system. These levels are: 1. Micro-individual (within interactions between people). 2. Meso-Institutional (within institutions and systems of power). 3. Macro-structural or societal (among institutions and across society) (262). See racism
Tokenism:	The practice of making only a symbolic effort to include members of underrepresented racial or marginalized groups, such as hiring or promoting a small number of individuals without addressing systemic barriers or power imbalances. For instance, an all-White organization might employ one Black staff member to create the appearance of diversity rather than addressing systemic racial inequities in the workplace (263). Tokenism often creates a minority tax by placing disproportionate diversity-related responsibilities and emotional labor on underrepresented individuals, adding extra workload and stress without recognition or compensation (264).
Trauma-informed approaches:	Trauma-informed approaches are based on an understanding that many people who access health and social services have had experiences of trauma in their lives. Trauma-informed approaches are not focused on providing treatment for trauma; rather, the approach is applied to ensure people are not further traumatized while accessing care and services. Trauma-informed approaches are based on principles of safety, trustworthiness, collaboration and choice, empowerment and the building of strengths and skill (265).
Unconscious bias:	Attitudes or stereotypes that unconsciously shape perceptions or understanding of experiences, thereby affecting behaviour, interactions and decision-making (31). Unconscious bias is a broader umbrella term that encompasses all forms of unconscious bias, including implicit bias. Implicit bias specifically refers to social attitudes and stereotypes (e.g., affinity bias, name bias, gender bias). Throughout the guideline, the term unconscious bias is used interchangeably with the term implicit bias.

Underrepresented group (URG)/ Underrepresented minorities (URM):	Groups that are seldom equitably represented in positions of power and economic influence, including senior leadership and corporate boards. These groups often include, racialized groups, women, 2SLGBTQI+ people, and persons with disabilities (28).
Unlearning:	Refers to the process of intentionally and critically reflecting on and dismantling deeply ingrained bias, values and beliefs and racist assumptions (266).
Whiteness:	A term that conceptualizes practices and processes that include basic rights, values, beliefs, perspectives and experiences assumed to be shared by all but only afforded to White people. The creation of 'Whiteness' meant giving privileges to some, while denying them to others with the justification of biological and social inferiority (6).
White supremacy:	A belief or ideology that the actions or thoughts of White people are superior and thus, ought to dominate those of non-White people (6).
Xenophobia:	Extreme fear, dislike or hostility toward individuals or groups perceived as foreign or outside one's own social, cultural or national identity. It often manifests as prejudice, discrimination and exclusionary behaviours directed at immigrants or those considered "outsiders," and is rooted in perceptions that such individuals pose a threat to societal integrity or cultural norms (267).
Zero-tolerance policies:	In the context of anti-Black racism, zero-tolerance policies are organization-wide policies that prohibit and respond to all violations of anti-Black racism. They are intended to foster equity and justice by holding individuals accountable, while also promoting education, reflection and systemic change.

Appendix B: RNAO resources and foundational reading

This table outlines RNAO guidelines and resources that align with this best practice guideline.

Table 11: RNAO guidelines and resources

Topic	Resource(s)
2SLGBTQI+ Health Equity	▪ Registered Nurses' Association of Ontario (RNAO). Promoting 2SLGBTQI+ health equity [Internet]. Toronto (ON): RNAO; 2021. Available from: RNAO.ca/bpg/guidelines/promoting-2slgbtqi-health-equity
Implementation science, implementation frameworks and resources	▪ Registered Nurses' Association of Ontario (RNAO), Healthcare Excellence Canada (HEC). Leading change toolkit [Internet] (4th ed.). Toronto (ON): RNAO; 2024. Available from: RNAO.ca/leading-change-toolkit
Preventing violence, harassment and bullying against health workers	▪ Registered Nurses' Association of Ontario (RNAO). Preventing violence, harassment and bullying against health workers. [Internet]. 2nd ed. Toronto (ON): RNAO; 2019. Available from: RNAO.ca/bpg/guidelines/preventing-violence-harassment-and-bullying-against-health-workers
Developing and sustaining nursing leadership	▪ Registered Nurses' Association of Ontario (RNAO). Developing and sustaining nursing leadership. [Internet]. 2nd ed. Toronto (ON): RNAO; 2013. Available from: RNAO.ca/bpg/guidelines/developing-and-sustaining-nursing-leadership
Black Nurses Task Force report	▪ Registered Nurses' Association of Ontario (RNAO). Black nurses task force report: Acknowledging, addressing and tackling anti-Black racism and discrimination within the nursing profession [Internet]. Toronto (ON); 2022. Available from: https://rnao.ca/policy/library/black-nurses-task-force-report-acknowledging-addressing-and-tackling-anti-black

This table includes a list of other foundational resources selected by the expert panel related to addressing anti-Black racism in nursing. This list is not exhaustive.

Table 12: Foundational reading

Resource	Description
CASN Anti-Racism in Nursing Education Working Group. Promoting anti-racism in nursing education in Canada [Internet]. Ottawa (ON); 2023. Available from: https://www.casn.ca/wp-content/uploads/2023/05/CASN-Promoting-Anti-Racism-in-Nursing-Education-in-Canada_FINAL.pdf	▪ A report from the Canadian Association of Schools of Nursing that outlines strategies prepare students to actively challenge racism, while acknowledging how racism is often compounded by other intersecting forms of discrimination.
Canadian Nurses Association (CNA). CNA's key messages on anti-Black racism in nursing and health [Internet]. Ottawa (ON): CNA; 2020 [cited 2025 Dec 1]. Available from: https://www.cna-aiic.ca/en/policy-advocacy/policy-support-tools/fact-sheets	▪ The key messages and position statement on racism of the Canadian Nurses Association. ▪ This document provides key information for educators summarizing the impact of anti-Black racism on Black nurses and Black nursing students.
Canadian Nurses Association (CNA). Racism and discrimination among nurses in Canada and the impacts of the covid-19 pandemic: a scoping review [Internet]. Ottawa (ON): CNA; 2024. Available from: https://www.casn.ca/wp-content/uploads/2024/07/CNA_Racism_Discrimation_Nurses_E.pdf	▪ A scoping review examining the extent of racism and discrimination in nursing. ▪ Offers strategies, resources, and actions to build a more equitable and anti-racist health-care system.
Ontario Health. Ontario Health's equity, inclusion, diversity and anti-racism framework [Internet]. Toronto (ON): Ontario Health; 2025 [cited 2025 Dec 1]. Available from: https://www.ontariohealth.ca/system/equity/framework	▪ This framework addresses the impacts of anti-Indigenous and anti-Black racism to achieve better outcomes for all patients, families and providers within Ontario's health system. ▪ It offers a powerful roadmap for academic, health and social service organizations to embed equity and anti-racism interventions into curriculums and organizational cultures. ▪ The framework recognizes the need for Ontario Health to take an intersectional approach to this work.

Resource	Description
KPU anti-racism pedagogy toolkit: Creating a safe and supportive classroom environment [Internet]. Kwantlen Polytechnic University; [cited 2026 Jan 22]. Available from: https://kpu.pressbooks.pub/antiracismtoolkit/chapter/tool-creating-a-safe-and-supportive-classroom-environment	▪ The toolkit equips instructors and instructional teams to implement anti-racist pedagogy in their curriculum and teaching practice across all programs and courses. The toolkit underscores the importance of ongoing consultation with Indigenous communities and Elders, as well as BIPOC individuals and communities, to ensure that the toolkit and its implementation remain grounded in lived experiences and are informed by those most affected by racism. ▪ Contains resources related to: ▫ Intersectionality of race and disability ▫ Creating a safe and supportive classroom

Appendix C: Resources to support race-based data collection

Below is a table of resources that can provide guidance on collecting race-based data for the purposes of monitoring and evaluating the implementation of this BPG.

Table 13: Resources to support race-based data collection

Resource	Description
Black Health Equity Working Group. Engagement, Governance, Access, and Protection (EGAP): A data governance framework for health data collected from Black communities. 2021 [cited 2025 Aug 15]. Available from: blackhealthequity.ca	▪ This Ontario framework for health data collected from Black communities is organized around four core principles: Engagement, Governance, Access, and Protection (EGAP). ▪ EGAP provides a high-level governance structure to ensure that data is not just collected but used to drive meaningful change in systems and outcomes that affect Black populations.
Canadian Institute for Health Information. Guidance on the use of standards for race-based and Indigenous identity data collection and health reporting in Canada [Internet]. Ottawa (ON): Canadian Institute for Health Information; 2022 [cited 2025 Aug 15]. Available from: https://www.cihi.ca/sites/default/files/document/guidance-and-standards-for-race-based-and-indigenous-identity-data-en.pdf	▪ The Canadian Institute for Health Information (CIHI) has introduced pan-Canadian minimum standards for collecting race-based and Indigenous identity data within health systems to support consistent, high-quality, and comparable data across jurisdictions. ▪ These standards are accompanied by guidance for implementation and were adapted from Ontario's Data Standards for the Identification and Monitoring of Systemic Racism.

Resource	Description
College of Nurses of Ontario. Workforce census: Demographics and nursing practice report [Internet]. Toronto (ON): College of Nurses of Ontario; 2024 [cited 2025 Aug 15]. Available from: https://www.cno.org/assets/cno/documents/statistics/workforce-census-report-2024.pdf	▪ This report from the College of Nurses' of Ontario (CNO) provides insights into the intersection of identity and nursing practice in Ontario. ▪ Provides a reference for what types of professional details are collected alongside identity-based data to show the disaggregated distribution of nurses by categories such as race, employment sector, position, nurse type and years of experience.
Government of Ontario. Data standards for the identification and monitoring of systemic racism [Internet]. 2018 [cited 2025 Aug 15]. Available from: https://www.ontario.ca/document/data-standards-identification-and-monitoring-systemic-racism	▪ Outlines the Government of Ontario's standards for how to collect, manage and use personal information related to race in a way that promotes equity and protects individual privacy. ▪ These standards provide guidance on voluntary self-identification, community engagement, data security and reporting, all with the aim of identifying and addressing systemic racial disparities in services, programs and outcomes.
Ontario Health. Guidance for the collection and use of sociodemographic data for equity analytics [Internet]. Toronto (ON): Ontario Health; 2024 Jun [cited 2025 Dec 12]. Available from: https://www.ontariohealth.ca/system/equity/sociodemographic-data	▪ Provides guidance to support consistent, standardized, and ethical collection of a core set of sociodemographic data elements across health care encounters to enable comparability and equity-focused analysis. ▪ Outlines best practices for the use, governance, and protection of sociodemographic data to support evidence-informed decision-making and reduce health inequities.
Ontario Health; Wellesley Institute; Black Health Alliance. A Black health plan for Ontario: a call to action to reduce disparities and advance equity in Ontario [Internet]. Toronto (ON): Ontario Health; 2023 [cited 2025 Dec 12]. Available from: https://www.ontariohealth.ca/content/dam/ontariohealth/documents/black-health-plan.pdf	▪ Outlines three pillars focused on equitable pandemic response, equitable health system recovery, and sustained health equity for Black populations in Ontario. ▪ Sets out recommendations for governments, health system organizations, and providers to address anti-Black racism through targeted actions, accountability, and ethical use of race-based and sociodemographic data.

Resource	Description
Sinai Health; University Health Network – Social Medicine; Ontario Health Toronto. Guide to demographic data collection in healthcare settings: a comprehensive guide to planning and implementing demographic data collection in health care settings [Internet]. Ontario Health Toronto; 2023 Nov. [cited 2025 Aug 15]. Available from: https://torontohealthequity.ca/wp-content/uploads/2025/03/Implementation-Guide-Demographic-Data-Collection.pdf	▪ This document provides guidance for health service organizations on how to plan, implement and sustain demographic data collection efforts. ▪ The guide offers strategies for staff training and patient/client engagement, and includes tools for governance, privacy and evaluation. ▪ While it is primarily focused on patient and client data, its foundational concepts, privacy practices and engagement strategies can be adapted to support race-based data collection for staff and students.

Appendix D: Resources related to theoretical frameworks

The following resources provide deeper insight into the theoretical frameworks used to develop this guideline: Critical race theory, intersectionality, Black Feminist Thought and the social-ecological model.

Resource	Description
Critical race theory (CRT)	
Douglas D, Ndumbe-Eyoh S, Osei-Tutu K, Hamilton-Hinch BA, Watson-Creed G, Nnorom O, Dryden OH. Black Health Education Collaborative: the important role of Critical Race Theory in disrupting anti-Black racism in medical practice and education. CMAJ. 2022;194(41):E1422-24. Available from: https://nccdh.ca/resources/entry/black-health-education-collaborative-the-important-role-of-critical-race-theory-in-disrupting-anti-black-racism-in-medical-practice-and-education	▪ A concise two-page resource explaining why CRT is important in health education and practice, especially for addressing anti-Black racism.
Intersectionality	
National Collaborating Centre for Determinants of Health. Let's talk: Intersectionality. Antigonish (NS): NCCDH, St. Francis Xavier University; 2022. Available from: https://nccdh.ca/images/uploads/comments/NCCDH_Lets-Talk-Intersectionality_EN.pdf	▪ Introduces intersectionality as a framework for understanding how overlapping social identities and systems of oppression shape health outcomes and offers practical guidance for applying it to health care.
European Network Against Racism. Fact sheet: Intersectionality [Internet]. Brussels (BE): European Network Against Racism; 2024 [cited 2026 Jan 14]. Available from: https://www.enar-eu.org/wp-content/uploads/Fact-Sheet-Intersectionality-2024-FINAL.pdf	▪ This facts sheet explores the concept and theory of intersectionality to better understand what intersecting discrimination in the labor market looks like and what it means to develop and implement intersectional policies in the workplace.
Black Feminist Thought	
De Sousa I, Varcoe C. Centering Black feminist thought in nursing praxis. *Nurs Inq*. 2022;29(1):e12473. doi:10.1111/nin.12473. Available from: https://europepmc.org/articles/PMC9286449/	▪ This article advocates for integrating Black feminist thought into nursing to challenge systemic racism and promote equity through lived experiences.

Resource	Description
Social-ecological model	
Harper Browne C, O'Connor C. A social-ecological model of racism & anti-racism [Internet]. Washington (DC): Center for the Study of Social Policy; 2021 [cited 2025 Nov 26]. Available from: https://cssp.org/resource/a-social-ecological-model-of-racism-anti-racism/	▪ Presents a social-ecological framework for understanding how racism operates and can be addressed at individual, interpersonal, institutional and structural levels.

Appendix E: Sample policy for addressing bias against health providers or reassignment requests

An example of a policy that organizations can adapt to address bias against health providers, particularly in cases where people or families request a different provider based on the assigned provider's social characteristics, such as race.

Appendix: sample policy for appropriate management of patients' biased conduct or reassignment requests

I. Purpose

The purpose of this policy is to guide an appropri-ate response to patients' or their surrogates' biased conduct toward staff (clinicians, nurses, trainees, and ancillary staff), including patients' reassignment re-quests based on their assigned staff members' social identity characteristics, such as race, sex, and ethnicity, and to support affected staff while encouraging inci-dent reporting and tracking, data collection and review, and education and training. This policy is complemen-tary to Administrative Policy 16.04 Title: Patient Rights and Responsibilities, which sets an expectation that pa-tients will be considerate of the rights of other patients and this organization's workforce. Similarly, this policy aligns with this organization's ongoing diversity, equity, and inclusion activities and workplace violence and safety initiatives, which are intended to heighten aware-ness of bias on our campus and reduce its presence and effect on our workplace.

II. Statement of Policy

This organization prohibits discrimination on the basis of race, color, national origin, ancestry, age, dis-ability, medical condition, and, where applicable, mar-ital status, familial status, parental status, religion, sex-ual orientation, gender identity, gender expression, genetic information, political beliefs, and educational background or economic status. Consistent with this commitment, this organization is dedicated to protect-ing patient autonomy and the rights of all staff to a safe and productive work and learning environment that is free from bias, discrimination, harassment, and abuse based on their social identity characteristics, such as race, sex, and ethnicity. To meet these obligations, this policy sets forth a process to guide all staff in managing such behavior by patients, including patients' requests for reassignment based on the social identity character-istics of staff involved in their care. The policy includes the following 10 elements:

1. Assess the patient's medical condition
2. Assess the patient's or surrogate's decision-making capacity
3. Establish expectations for the provision of care
4. Options for responding to reassignment requests
    a. Determine the reasons for reassignment reques
    b. No compelled accommodation of patient reas-signment requests
    c. Accommodation of reassignment requests
    d. Reassignment requests involving trainees

5. Options for responding to patients' biased con-duct or reassignment requests deemed unethical or inappropriate
   a. Patient care agreements
   b. When agreement not followed by inpatients
   c. When agreement not followed by outpatients
6. Support for affected staff
7. Reporting
   a. Manager or supervisor responsibility
   b. Staff reporting procedures and guidelines
   c. Unusual occurrence report
8. Tracking and data collection
9. Data review
10. Education and training

III. Definitions

1. Social identity characteristics: race, ethnicity, color, religion, sex, gender identity or expression, sex-ual orientation, national origin (ancestry), disability, age, language, citizenship, or any other status pro-tected by applicable federal, state, or local law.
2. Clinical staff: medical personnel involved in a pa-tient's care, including but not limited to clinicians, nurses, and trainees (students and residents).
3. Ancillary staff: nonmedical personnel, including but not limited to porters, food service workers, and facilities engineers.
4. Staff: includes both clinical and ancillary staff.
5. Patients' biased conduct: inappropriate behavior, comments, jokes, and innuendo; epithets, slurs, or nega-tive stereotyping, whether spoken or written; displays of offensive materials; unwelcome physical contact based on staff members' social identity characteristics.

IV. Procedure

The urgent medical needs of each patient must guide staff and medical center decision making in cases that involve patients' biased conduct or requests for reassignment based on the staff members' social identity characteristics. When these circumstances arise, the affected staff or member of the clinic man-agement team should intervene immediately to evalu-ate the situation. The following processes should be followed in all instances:

1. **Assess the Patient's Medical Condition**
   Appropriate clinical staff should evaluate the pa-tient to determine the patient's clinical stability. If the patient is unstable, they must receive stabilizing treat-ment. If an unstable patient demands reassignment on the basis of the assigned clinical staff's social identity, other clinical staff may be permitted to conduct the pa-tient's initial evaluation. Under such circumstances, the patient must be informed that the assigned clinical staff remain responsible for the patient's treatment and that having other clinical staff perform the physical evalua-tion is done only under special circumstances, such as when a patient's medical condition requires a delay in the resolution to such a request.
2. **Assess Patient's or Surrogate's Decision-Making Capacity**
   If the patient is stable, their capacity must be as-sessed. If the patient lacks capacity, staffing and institu-tional decision making regarding the patient's biased conduct or reassignment request will be made on a case-by-case basis. If the patient has capacity, the fol-lowing procedures 3 to 6 should be followed in all instances.
3. **Establish Expectations for the Provision of Care**
   Affected staff or member of the clinic management team must attempt to set mutually acceptable expecta-tions for

the provision of care. If comfortable and prac-tical, involved staff should identify the biased conduct to the offender and request that it stop. In so doing, staff may discuss the behavior with the offending pa-tient and clarify why the specific behavior is problem-atic. The patient and his or her surrogate, family mem-bers, representatives, and visitors must be informed that biased conduct will not be tolerated.

If it is not comfortable or practical for involved staff to confront the offending patient directly, or if the staff member has done so and the biased conduct contin-ues, staff should promptly report this to their immedi-ate manager or supervisor or member of the manage-ment team as outlined herein (see IV.7. Reporting).

4. **Options for Responding to Reassignment Requests**

   a. Determine the Reasons for the Reassignment Re-quest. If the patient's biased conduct involves a reas-signment request, the reason(s) for the request must be determined. Examples of clinically and ethically appro-priate reasons for reassignment include requests for certain types of concordance (for example, language, religious, and sex concordance under certain circumstances [for example, for a sensitive examination] and requests that are manifestations of clinically significant conditions [for example, posttraumatic stress disor-der]). If the reasons for the patient's request are not clinically or ethically justified, then a decision should be made on a case-by-case basis with consideration of the patient's autonomy, antidiscrimination laws, and the medical center's duty to treat as outlined herein (see IV.5. Options for Responding to Patients' Biased Con-duct and Reassignment Requests Deemed Unethical or Inappropriate).

   b. No Compelled Accommodation of Patient Reas-signment Requests. The medical center will not force any clinical staff to treat or refrain from providing treat-ment to a patient who has requested reassignment on the basis of the clinical staff member's social identity characteristics.

   c. Accommodation of Reassignment Requests. If af-fected clinical staff wish to accommodate the patient's reassignment request, the decision is permissible if

      i. other appropriate medical personnel are available;

      ii. the clinical staff involved are comfortable with and agree to the decision;

      iii. accommodation can be made within the practi-cal constraints of providing appropriate care for other patients;

      iv. procedures (as outlined below) are in place to provide institutional support and guidance to the staff involved;

      v. no clinical staff are compelled by this organiza-tion to accommodate a patient's bias-based reassign-ment request without explicit consent; and

      vi. the decision does not compromise the provision of quality medical care.

   d. Reassignment Requests Involving Trainees. When bias-based patient conduct or reassignment requests in-volve trainees, the following should be done:

   i. Students should be exempted from further care of the patient unless they request to continue partici-pating in the patient's care; continued

care under such circumstances is permitted under relevant state law, and the attending physician and the clerkship director or nursing supervisors should be notified.

ii. Residents should continue treating the patient unless they request or consent to reassignment; and the residency site director is notified of the incident.

iii. In all cases, supervisors must determine how the trainee wishes to proceed, including assessing whether the trainee wishes to handle the situation without direct supervisor intervention, and inform the patient or sur-rogate that all clinicians and staff are properly trained, credentialed, and supervised. To provide the highest-quality care to all patients, the organization does not accommodate bias-based reassignment requests. The organization remains available to hear patients' concerns about care and will work tirelessly to provide pa-tients with care of the highest quality.

5. **Options for Responding to Patients' Biased Con-duct or Reassignment Requests Deemed Unethical or Inappropriate**
   Our mission at this organization includes caring for patients whose challenges may include behavioral is-sues that make it difficult, if not impossible, for them to receive care elsewhere. Even if a patient is transferred to another clinic or hospital to ensure a safe and re-spectful work environment for all staff, any patient pre-senting emergent concerns at the organization will be evaluated in the medical or psychiatric emergency de-partment or urgent care department. Nevertheless, if a patient engages in biased conduct or requests reas-signment for reasons deemed unethical or inappropri-ate, or is unable to follow patient agreements, the fol-lowing protocol should be followed to the extent practicable.

a. Patient Care Agreements. If face-to-face meet-ings with the patient to establish clear understandings of respectful interactions are unsuccessful in stopping repeated biased or disruptive behavior, development of a patient care agreement is appropriate to establish shared boundaries. These agreements should be de-veloped in appropriate cases to facilitate behavioral changes and signed by patient and clinical managers.

   The patient care agreement should include:

   i. a statement that the patient will abide by the pa tient care agreement terms, including the conse-quences of nonadherence (for example, required trans-fer of care to a different site);

   ii. identification and description of the specific con-duct that has led to the need for a patient care agreement;

   iii. a statement of the protocol to be followed for continuation of care or transfer of care to a site outside the organization that accepts responsibility for care if this is determined to be the best course of action;

   iv. a space for the patient's written suggestions of ways that he or she can avoid engaging in future biased conduct;

   v. a space for the patient to suggest ways for the organization to improve its methods of avoiding or ad-dressing conï¬,icts between patients and staff in ways that are respectful to both parties, and

consistent with the organization's mission;

vi. affirmation that patients with urgent or emer-gent medical or psychiatric needs may seek services at urgent care or the emergency department;

vii. a statement that the patient agrees with the pa-tient care agreement's terms and conditions for care, with a space for the signatures of the patient, clinical manager, and relevant physician or other designated staff member involved in the care, and the date of sign-ing; and viii. a signature line for the patients who do not agree with the patient care agreement's terms and con-ditions for care to attest to having reviewed the proto-cols and available options with staff.

The patient care agreement may include:

i. an expectation that the patient will communicate only with a designated clinical staff member to avoid miscommunication among staff and patients regarding complaints or problems; and

i. a treatment plan that specifies referral to behav-ioral health, case management, substance use treat-ment, or other relevant services as is appropriate.

b. If the Patient Care Agreement Is Not Followed by Inpatients. Inpatients or their surrogates may be in-formed by clinical staff, with support of the medical team, of their right to seek care elsewhere, and their responsibility not to engage in biased conduct. If the patient or surrogate, under circumstances that are non-emergent, continues to engage in biased conduct, then discharge as outlined herein should be considered and the behavioral response team, ethics committee, and risk management team should be consulted. If the pa-tient's behavior causes team members to feel unsafe, campus security should be involved to manage the sit-uation safely. Reporting requirements as outlined herein should also be followed (see IV.7. Reporting).

c. If the Patient Care Agreement Is Not Followed by Outpatients. Outpatients or their surrogates may be in-formed of their right to seek treatment elsewhere if they engage in biased conduct. Depending on the severity of the behavior or recurrent inability to follow an established patient care agreement (see IV.5.a. Patient Care Agree-ments) the patient may be transferred to an outside clinic following the processes of IV.5.a. herein, and other rele-vant standing policies at this organization.

6. **Support for Affected Staff**
Support should be offered to all involved staff when they experience patients' biased conduct. Appro-priate support may include debriefing with affected staff by a clearly designated staff member and the con-vening of a meeting of the staff involved in the patient's care to discuss the incident, evaluate how the team re-sponded, and discuss how best to address future pa-tient bias incidents. Individual and team counselling or support may be provided by the critical incidence re-sponse team in conjunction with the employee assis-tance program and the leadership in the specific unit.

7. **Reporting**
Persons who experience or observe patients' bi ased conduct must be permitted to report their con-cerns without fear of retaliation. Staff members may submit concerns in writing, in person, by e-mail, or by telephone, as described below. No person will be ad-versely affected in their employment as a result of re-porting a good-faith complaint of patient bias or for participating in any investigation. Investigations will be done as efficiently as possible and every effort will be made to ensure that complaints are resolved promptly and effectively.
    a. Manager or Supervisor Responsibility. Managers and supervisors have an affirmative duty under this pol-icy to protect staff from patients' biased conduct and to promptly report to their supervisor(s) any such inci-dents that they witnessed or become aware of within their own department or another department, regard-less of whether the alleged recipient of such conduct makes a formal complaint.
    b. Staff Reporting Procedures and Guidelines. This organization encourages staff to report any perceived incident of patients' biased conduct, regardless of the offending patient's identity or position. Anyone who believes that he or she is a victim of such conduct should do the following:
        i. If comfortable and practical, involved staff should identify the offensive behavior to the offender and re-quest that it stop.
        ii. If it is not comfortable or practical for involved staff to confront the offending patient directly or if the staff member has done so and the biased conduct con-tinues, involved staff should promptly report such con-duct to their immediate manager or supervisor or member of the clinic management team.
    c. Trainee Reporting. Reporting structures should ensure that students know where to seek assistance, and should account for the potential concern among trainees that reporting patient bias may negatively af-fect their evaluations or reputation.
    d. Incident Report. To facilitate the tracking of inci-dents, any person involved in the matter is encouraged to submit an unusual occurrence report.

8. **Tracking and Data Collection**
Patient bias incidents and reassignment requests will be tracked and documented on standardized forms and reported to the workplace safety and violence committee. This collected data should include, but is not limited to, the department where the incident oc-curred, how often these incidents occur, the medical center's response, the ultimate resolution, the effect on staff, how affected staff are supported, and how af-fected staff feel about the encounter and the medical center's response. Tracking and data collection sys-tems for trainees should be overseen by educational supervisors and reported both to school and hospital administrations.

9. **Data Review**
The workplace safety and violence committee will direct the collected information to the appropriate standing committees overseeing relevant matters, in-cluding the staff well-being committee, the dean's of-fice, and affiliated medical training institutions. These committees shall review all submitted reports on a reg-ular basis, update medical center policies as necessary, and make revised policies

available to all staff in a timely manner. Their annual reports to the hospital-wide performance improvement and patient safety committee, and the medical executive committee should include updates on these matters.

10. **Education and Training**
Bias-based demeaning behavior and reassignment requests can have a demoralizing effect on staff. Ad-vance knowledge and training about this organization's policies and procedures will better prepare staff to de-termine the appropriate course of action in these chal-lenging situations. Accordingly, this policy should be included in regular staff and trainee education pro-grams. These trainings should be designed to enhance staff knowledge and skills for identifying discriminatory behavior with the intent of reducing the common ten-dency to overlook these affronts as part of the job; in-crease staff awareness of available supports; enable staff to effectively manage patient bias interactions; and un-derstand the need and processes for reporting incidents.

V. Cross References

Administrative Policy 16.03 Patient/Visitor Grievance Policy

Administrative Policy 16.04 Patient Rights and Responsibilities

Administrative Policy 20.09 Primary Care Clinics: Transfer of Care of Disruptive or Threatening Patients

Source: Reprinted with permission from: Paul-Emile K, Critchfield JM, Wheeler M, De Bourmont S, Fernandez A. Addressing patient bias toward health care workers: recommendations for medical centers. Annals of Internal Medicine [Internet]. 2020 Sep 15 [cited 2025 Jul 2];173(6):468-73. Available from: https://www.acpjournals.org/doi/10.7326/M20-0176

Appendix F: Resources to support those experiencing anti-Black racism

The following resources are available to support individuals experiencing anti-Black racism.

Resource	Description
Across Boundaries: Mental health and addiction services for racialized communities [Internet]. Toronto (ON): Across Boundaries; [cited 2025 Nov 26]. Available from: https://acrossboundaries.ca/	▪ Across Boundaries provides equitable, inclusive and holistic mental health services for racialized people across the Greater Toronto Area. Across Boundaries acknowledges the impact of racism and anti-Black-racism on mental health.
Black Legal Action Centre. [Internet]. Toronto (ON): Black Legal Action Centre; [cited 2025 Nov 26]. Available from: https://www.blacklegalactioncentre.ca/about-blac/	▪ An independent not-for-profit community legal clinic that combats anti-Black racism by providing free legal services, conducting research, developing public legal education materials and engaging in law reform.
Black Wellness Network [Internet]. Toronto (ON). Black Wellness Network [cited 2025 Nov 28] Available from: https://blackwellnessnetwork.ca/#	▪ Through forums, webinars and virtual events, individuals can engage in open discussions, share personal experiences and access a network of professionals and peers who understand the unique struggles faced by the Black community.
Human Rights Legal Support Centre. [Internet]. Toronto (ON): Human Rights Legal Support Centre; [cited 2025 Nov 26]. Available from: https://hrlsc.on.ca/contact-hrlsc/	▪ Provides free legal assistance to individuals who believe they have experienced discrimination under the Ontario Human Rights Code.
Human Rights Tribunal of Ontario [Internet]. Toronto (ON): Tribunals Ontario; [cited 2025 Nov 26]. Available from: https://tribunalsontario.ca/hrto/	▪ The administrative tribunal that resolves claims of discrimination and harassment under the Ontario Human Rights Code.
Multicultural Mental Health Resource Centre [Internet] Montreal (QC): Multicultural Mental Health: [cited 2025 Nov 28] Available from: https://multiculturalmentalhealth.ca/	▪ The Multicultural Mental Health Resource Centre (MMHRC) seeks to improve the quality and availability of mental health services for people from diverse cultural and ethnic backgrounds, including immigrants, refugees and members of established ethnocultural communities. Addressing issues of language, culture, religion and other aspects of cultural diversity can promote greater equity in mental health care.

Resource	Description
Ontario Human Rights Commission [Internet]. Toronto (ON): Ontario Human Rights Commission; [cited 2025 Nov 26]. Available from: https://www.ohrc.on.ca/en	▪ Provides information about policies related to race-based discrimination and other human rights issues in Ontario.

Appendix G: Strategies to respond to microaggressions

The acronym VITALS (validate, inquire, take time, assume, leave opportunities, speak up) is designed to help individuals respond effectively to microaggressions by providing a structured approach for reflection and action. It can be used to pause, assess the situation and choose a response that aligns with one's values, ensuring communication remains respectful and constructive.

Responding to Microaggressions – Take the V.I.T.A.L.S.	
V - Validate your feelings and experiences ▪ ALWAYS start here	Don't try to talk yourself out of something that makes you uncomfortable – even if you aren't quite sure of the right terms/language for what has happened

I - Inquire to obtain more information/clarification
▪ Get curious
    ▫ Ask the person to elaborate
    ▫ Pretend you don't understand/Act confused
▪ "Call IN" Response #1
	"Could you say more about what you mean by that?"
	
	"When you said_____, what did you mean?"
	
	"I'm curious about _______."
	
	"I don't get it……."
	
	"Why is that funny? "

T - Take Time to mirror/reflect what the person says/emotes ▪ Mirror back what you heard AND the perceived emotions behind the statement. ▪ "Call IN" Response #2	"I think I heard you say ____________ (paraphrase their comments). Is that correct?" "It seems like you might be really ___ (insert description of emotion –> e.g. frustrated, angry, etc.)"
A - Assume the best of each other AND the need for clarity ▪ Assume the intent was probably not to harm while also acknowledging that the impact caused harm ▪ Separate the person from the action(s)/words ▪ Utilize Perspective-Taking ▪ "Call IN" Response #3	"I know you may not realize it, but when you ….., it made me feel ….." "I know you really care about …….but that comment really undermines those intentions." "What impact do you think this has on people?"

Responding to Microaggressions – Take the V.I.T.A.L.S.	
L - Leave Opportunities for follow up conversations ▪ It's okay to have a "freeze" moment ▪ It's not a sitcom! (i.e., may not resolve in one conversation) ▪ Never think of these occurrences as "one and done" situations ▪ "Call IN" Response #4	"Maybe we can talk a little more about this…" "I thought more about what you said, and I wanted to follow up with you…"
S – Speak Up for others affected by negative biases/microaggressions ▪ Be direct in naming the microaggression ▪ Clearly request a change in action ▪ "Call OUT" Response	"That's problematic because it's reinforcing negative stereotypes/implicit bias "I don't think that's appropriate because…" "That's not how we treat each other…"

Source: Reprinted with permission from: Walker VP, Hodges L, Perkins M, Sim M, Harris C. Taking the VITALS to interrupt microaggressions. MedEdPORTAL. 2022 Jan 19;11202.

The acronyms ACTION, ASSIST and ARISE can also be used recipients of microaggressions, those witnessing them (bystanders) and those responsible for them (sources) to address these situations.

RECIPIENT-action Approach	**Source-ASSIST Approach**	**Bystander-ARISE Approach**
Ask a clarifying question	Acknowledge your bias	Awareness of microaggression
Come from curiosity	Seek feedback	Respond with empathy (avoid judgment)
Tell what you observed	Say you are sorry	Inquiry of facts
Empact Exploration	Impact, not intent	Statements that start with “I”
Own thoughts and feelings	Say Thank You	Educate and Engage
Next steps		

Source: Reprinted with permission from: Ackerman-Barger K, Jacobs NN, Orozco R, London M. Addressing microaggressions in academic health: a workshop for inclusive excellence. MedEdPORTAL. 2021;17:11103. doi:10.15766/mep_2374-8265.11103.

Appendix H: Establishing brave spaces

This handout explains the concept of "Brave Spaces" and the roles of safety and comfort in dialogue. It introduces the Comfort Zone, Learning Edge and Unsafe Zone, highlighting how conflict and discomfort are essential for growth and learning. The visual emphasizes that moving beyond comfort fosters openness, courage and deeper understanding in conversations about diversity and social justice.

Establishing Braves Spaces: The Roles of Safety and Comfort in Dialogue

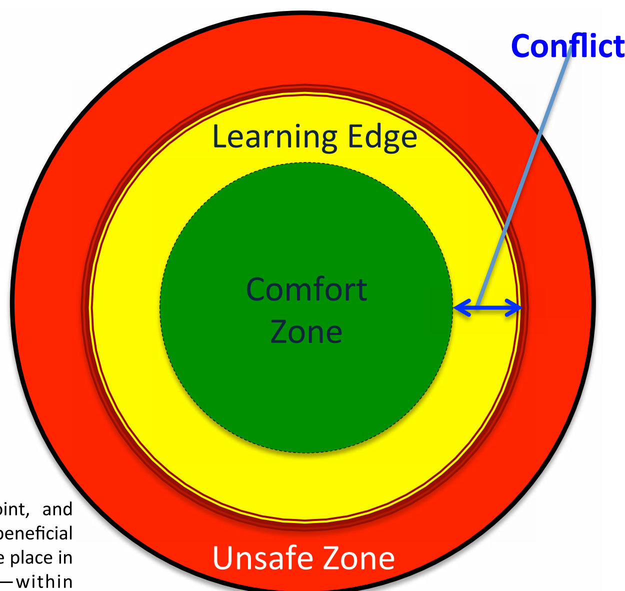
We want to create an environment in which we feel safe sharing our views, our experiences, and ourselves. To learn from each other, we need an environment that allows us to open up, to feel safe challenging ourselves and challenging each other.

Boostrom states, "learning necessarily involves not merely risk, but the pain of giving up a former condition in favor of a new way of seeing things." We seek to cultivate ***brave spaces*** rather than safe spaces for group learning about a broad range of diversity and social justice issues. By emphasizing the need for courage rather than the illusion of safety, we better position ourselves to accomplish our learning goals and more accurately reflect the nature of genuine dialogue regarding challenging and controversial topics.

Comfort Zone: We all have zones of comfort about different topics and experiences. The dialogue process asks us to move beyond our traditional areas of comfort so that we can open ourselves to new challenges, knowledge, and awareness. While remaining inside our comfort zone we are not being challenged, and thus we are not learning.

Moving outside our comfort zones requires *bravery* to constructively embrace conflict, which in turn we are learning through being challenged. However, if we move too far outside the comfort zone, we begin to resist new information and withdraw.

Conflict: Conflict of opinion, viewpoint, and understanding is a normal and even beneficial part of the dialogue process. It will take place in various ways within the group—within individuals, between individuals, or between groups. It may be overt or submerged in the group, present but not fully recognized. We are more likely to work with conflict when we bravely enter spaces and are committed to learning from the conflict present in the dialogue.



Learning Edges: We call the edge of our comfort zone the learning edge. When we are on the learning edge, we are most open to expanding our knowledge and understanding—as well as expanding our comfort zone itself.

Being on this edge requires a level of *courageousness and bravery* as it means that we may feel annoyed, angry, anxious, surprised, confused, defensive, or in some other way uncomfortable. These reactions are a natural part of the process of expanding our comfort zones, and when we recognize them as such, we can use them as part of the learning process—signaling to us that we are at the learning edge, ready to expand our knowledge and understanding.

The challenge is to recognize when we are on the learning edge, and then to *bravely* stay there with the discomfort we are experiencing to see what we can learn.

Conflict of understanding pushes our comfort zones and is a necessary and beneficial part of the dialogue process. It is our responsibility as participants in this dialogue to turn conflict and discomfort into learning and growth for everyone. One of the first steps in this direction involves *bravely* pushing our comfort zones and challenging ourselves to learn and grow.

The Program on Intergroup Relations—University of Michigan 2008

Arao, B., & Clemens, K. From safe spaces to brave spaces: A new way to frame dialogue around diversity and social justice. *The Art of Effective Facilitation*

Source: Reprinted with permission from: Walker VP, Hodges L, Perkins M, Sim M, Harris C. Taking the VITALS to interrupt microaggressions. MedEdPORTAL. 2022 Jan 19;11202.

Appendix I: Description of the Leading Change Toolkit

BPGs can only be successfully implemented and sustained if planning, resources, organizational and administrative supports are adequate and there is appropriate facilitation. Active engagement and involvement of formal and informal leaders (e.g., change agents and peer champions) are also essential. To encourage successful implementation and sustainability, an international expert panel of nurses, researchers, patient advocates, social movement activists and administrators has developed the Leading Change Toolkit (4) . The toolkit is based on available evidence, theoretical perspectives and consensus. We recommend the Leading Change Toolkit for guiding the implementation of any BPG in health-care or social service organizations, including academic centres.

The Leading Change Toolkit includes two frameworks—the Social Movement Action (SMA) Framework (1,2) and the Knowledge-to-Action (KTA) Framework (3)—for change agents and change teams leading the implementation and sustainability of BPGs. Both frameworks outline the concept of implementation and its inter-related components. As such, either the SMA or the KTA frameworks can be used to guide change initiatives, including the implementation of BPGs. Using both frameworks serves to enhance and accelerate change (1).

The SMA Framework includes elements of social movements for knowledge uptake and sustainability that have demonstrated powerful impact and long-term effects. Based upon the results of a concept analysis, the framework includes 16 elements categorized as preconditions (i.e., what must be in place prior to the occurrence of the social movement), key characteristics (i.e., what must be present for the social movement to occur) and outcomes (i.e., what will likely happen as a result of the social movement) (1,268). The three categories and elements of the SMA Framework are shown in **Figure 3**.

Figure 3: Social movement action framework

Sources: Reprinted with permission from: Grinspun D, Wallace K, Li SA, et al. Exploring social movement concepts and actions in a knowledge uptake and sustainability context: a concept analysis. Int J Nurs Sci. 2022 Oct;9(4):411-21; Grinspun D, Wallace K, Li SA, et al. Leading change through social movement. Registered Nurse Journal. 2020. Spring:32(1).

The KTA Framework is a planned cyclical approach to change that integrates two related components: the knowledge creation and the action cycle. The knowledge creation process is what researchers and guideline developers use to identify critical evidence results to create a knowledge product, like an RNAO BPG. The action cycle is comprised of seven phases in which the knowledge created is implemented, evaluated and sustained (3). Many of the action cycle phases may occur or need to be considered simultaneously. The KTA Framework is depicted in **Figure 4** (4).

Figure 4: Knowledge-to-action framework

Knowledge-to-action framework

Sources: Adapted with permission from: Graham ID, Logan J, Harrison MB, et al. Lost in translation: time for a map? J Contin Educ Health Prof [Internet]. 2006;26(1):13-24. Available from: https://journals.lww.com/jcehp/Abstract/2006/26010/Lost_in_knowledge_translation__Time_for_a_map_.3.aspx; Sraus SE, Tetroe J, Graham ID. (2013). Introduction Knowledge translation: What it is and what it isn't. In SE Straus, J Tetroe, ID Graham (Eds.), Knowledge Translation in Health Care, https://doi.org/10.1002/9781118413555.ch01

Implementing and sustaining BPGs to effect successful practice changes and positive health outcomes for people and their families, providers, organizations and systems is a complex undertaking. The Leading Change Toolkit is a foundational implementation resource for leading this process.

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RNAO wishes to acknowledge the following current and former RNAO staff members for their contributions in the development of this BPG: Deborah Baiden, Sukhi Brar, Amy Burt, Dr. Christina Medeiros and Priscilla Packiam.

In addition, RNAO is grateful to Master's practicum students Asmahan Hussein and Demarah Downie for their contributions in the development of this BPG.

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As a component of the guideline development process, feedback was obtained from participants across a wide range of health and and social service organizations, academic institutions, practice areas and sectors. Participants include nurses and members of the interprofessional team, educators, students, people with lived experience, knowledgeable administrators and funders of health services. **External reviewers**[G] representing diverse perspectives were also solicited for their feedback. RNAO wishes to acknowledge the following individuals for their contribution in reviewing this BPG. External reviewers have given consent to the publication of their names and relevant information in this BPG.

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In Fall 2025, a discussion group was also held with members of RNAO's Black Nurses Leading Change Interest Group to gather verbal feedback on the draft BPG. Discussions were robust and passionate and the group provided insightful feedback on critical areas that were subsequently incorporated within the guideline.

Ontario Health was also provided the opportunity to review the guideline and provided feedback.

Endorsements

February 25, 2026

Dr. Doris Grinspun, RN, BScN, MSN, PhD, LLD (hon), Dr (hc), DHC, DHC, FAAN, FCAN, O.ONT.
Chief Executive Officer and Founder of the Best Practices Guidelines Program
Registered Nurses' Association of Ontario
500-4211 Yonge St.
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Dear Dr. Grinspun,

On behalf of the Canadian Black Nurses Alliance (CBNA), we are proud to formally endorse the Registered Nurses' Association of Ontario's (RNAO) Best Practice Guideline, *Addressing Anti-Black Racism in Nursing*.

As a national organization dedicated to representing, advocating for, and empowering Black nurses and nursing students across Canada, CBNA recognizes this guideline as a pivotal and historic contribution to the profession. The development of an evidence-informed framework that directly addresses anti-Black racism within nursing signals meaningful progress toward accountability, structural transformation, and equity in healthcare systems.

For years, Black nurses and students across Canada have courageously articulated their lived experiences of anti-Black racism within educational, clinical, and institutional spaces. CBNA has worked alongside communities, academic partners, and health system leaders to amplify these realities and advocate for systemic change. This Best Practice Guideline represents an important step in translating that collective advocacy into actionable, profession-wide standards.

The principles and recommendations outlined in this guideline align deeply with CBNA's mission to advance leadership, mentorship, advocacy, and systemic change. This guideline provides organizations, leaders, and policymakers with actionable direction to move beyond acknowledgment toward measurable, equity-driven change.

We believe that the widespread implementation of *Addressing Anti-Black Racism in Nursing* will strengthen workplace cultures, improve the retention and advancement of Black nurses, and ultimately enhance the quality and safety of care delivered to communities across Canada. This Best Practice Guideline is an invaluable resource, one that empowers the profession to collectively build more inclusive, equitable, and healthy work environments for all.

CBNA commends RNAO for its leadership, courage, and unwavering commitment to embedding equity and anti-racism into professional standards and practice guidelines. We look forward to continued collaboration to advance equitable systems that support, protect, and empower all nurses to thrive.

Sincerely,

Ovie Onagbeboma RN

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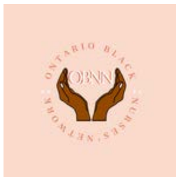

ONTARIO BLACK NURSES' NETWORK

To Network. To Learn. To Inspire.

Web: ontarioblacknursesnetwork.ca
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February 22nd, 2026

Dr. Doris Grinspun, RN, BScN, MSN, PhD, LLD (hon), Dr (hc), DHC, DHC, FAAN, FCAN, O.ONT.
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Dear Dr. Grinspun,

Letter of Endorsement: Addressing Anti-Black Racism in Nursing Best Practice Guideline

The Ontario Black Nurses' Network is pleased to offer our endorsement of the Registered Nurses' Association of Ontario's (RNAO) best practice guideline – *Addressing Anti-Black Racism in Nursing* Best Practice Guideline (BPG).

At the Ontario Black Nurses' Network, we are dedicated to supporting Black nurses and nursing students across the province. The evidence-supported principles and recommendations outlined in the *Addressing Anti-Black Racism in Nursing* guideline align closely with our commitment to advocacy, empowerment, scholarship, and leadership for Black nurses and nursing students across Ontario.

This practice guideline is an essential resource that will enable us to collectively affect change and to build a more inclusive, equitable, and healthy work environment. We commend the RNAO on its leadership and commitment to promoting guidelines that embody the principles of equity-focused guidelines.

Sincerely,

Shelly Philip LaForest, RN, BN, MN, CVAA(c), PhD candidate
Executive Director and Founder
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January 31, 2026

Dr. Doris Grinspun, RN, BScN, MSN, PhD, LLD (hon), Dr (hc), DHC, DHC, FAAN, FCAN, O.ONT.
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Re: Letter of Endorsement for the Addressing Anti-Black Racism in Nursing Best Practice Guideline

Dear Dr. Grinspun,

On behalf of the Pan-Canadian Association of Nurses of African Descent (PCANAD), it is my great pleasure to provide our endorsement of the Registered Nurses' Association of Ontario's (RNAO) best practice guideline titled "Addressing Anti-Black Racism in Nursing." We commend the RNAO's commitment to providing evidence-informed recommendations to eliminate anti-Black racism in the Canadian nursing landscape.

PCANAD is a federally incorporated, expanding grassroots not-for-profit organization aimed to serve as a collective voice for various provincial and jurisdictional organizations of nurses of African descent in Canada. Our objectives are to advocate for the health and well-being of people of African descent in Canada and to amplify the voices of nurses of African descent by promoting recruitment, retention, professional advancement, and representation in education, practice, administration, research, and policy.

At PCANAD, we are dedicated to supporting Black nurses and nursing students across the country, irrespective of their area of practice. The principles outlined in the *Addressing Anti-Black Racism in Nursing* guideline closely align with our commitment to advocating for and empowering Black nurses and nursing students nationally.

We congratulate the RNAO on its leadership and commitment to promoting guidelines that embody the principles of equity-focused initiatives in the Canadian nursing landscape. We believe this best practice guideline is a timely and invaluable resource. By implementing the *Addressing Anti-Black Racism in Nursing* guideline, we can collectively build more inclusive, equitable, and healthy work environments that promote the advancement of Black nurses and nursing students across Canada.

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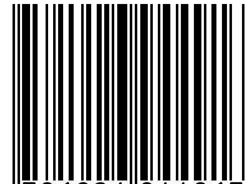
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