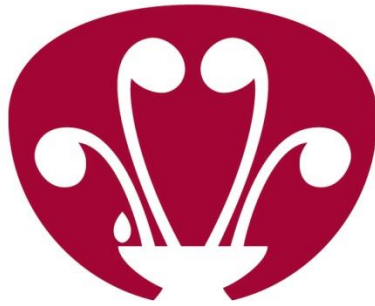




Nurses Association
OF NEW BRUNSWICK

Entry-Level Competencies for Nurse Practitioners



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INTRODUCTION AND BACKGROUND

The Entry-Level Competencies for Nurse Practitioners reflect the knowledge, skills, and judgement required of nurse practitioners to provide safe, competent, ethical and compassionate care. While specific roles and responsibilities may vary by context and **client**¹ population, this document outlines the essential **competencies** that all nurse practitioners must possess to be proficient when they begin practice.

The entry-level competencies outlined in this document were developed as part of a national analysis of three streams of nurse practitioner practice: Family/All Ages (Primary care), Adult and Child/Pediatric undertaken by the Canadian Council of Registered Nurse Regulators (CCRNRR).

The identified competencies were based on an extensive review of Canadian regulatory documents (e.g., provincial/ territorial competencies, **standards**, etc.), along with relevant research evidence and were validated through the practice analysis survey. See Appendix A for the process used by CCRNR in the development of the nurse practitioner entry-level competencies.

The CCRNR board established a national working group with representatives from all Canadian nursing regulatory bodies to coordinate all aspects of the practice analysis (Appendix B). In addition, a Research Advisory Committee (Appendix C) and three Subject Matter Expert panels (Appendix D) were established to support the project. Finally, twenty-seven nurse practitioners from the three streams of practice completed a pilot test of the practice analysis survey (Appendix E).

The entry level competencies outlined in this document are the product of the Nurse Practitioner Practice Analysis carried out between February 2014 and May 2015, and reflect the trends in nurse practitioner practice during that timeframe. Other factors have an impact on healthcare delivery, necessitating nurse practitioners to develop knowledge and skill to effectively address these issues in their practice. Some of these factors include cultural safety, the impact of power differentials in health service delivery with diverse populations, the increasing prevalence of concerns with mental health and addictions in Canada, and the recommendations of the Truth and Reconciliation Commission of Canada (2015).

In New Brunswick, nurse practitioners are Primary Health Care (PHC) nurse practitioners or Family/All Ages, therefore this document has been adapted to reflect expectations for nurse practitioner practice in New Brunswick.

¹Bolded words in the text are defined in the Glossary.



Purpose of the Entry-Level Competencies for Nurse Practitioners

Entry-level competencies are one of the sentinel documents used by regulatory bodies in the regulation of nurse practitioner practice for the purpose of:

- recognition and approval of nurse practitioner education programs,
- development and approval of nurse practitioner entry-level examinations,
- assessment of nurse practitioners' ongoing continuing **competence**, and
- providing information to the public, nurse practitioner education programs, government agencies, employers and other stakeholders on the regulatory expectations of nurse practitioner practice.

Profile of the Entry-Level Nurse Practitioner

Nurse practitioners are registered nurses with additional experience and nursing education at the Masters level, which enables them to autonomously diagnose, treat and manage acute and chronic² physical and mental illnesses. As advanced practice nurses, they use their in-depth nursing and clinical knowledge to analyze, synthesize and apply evidence to make decisions about their client's healthcare. They apply theory and knowledge from nursing and other disciplines to provide a comprehensive range of essential health services grounded in professional, ethical and legal standards within a holistic model of care. Nurse practitioners work collaboratively with their clients to establish measurable goals and identify gaps in health outcomes.

The principles of primary health care are foundational to nurse practitioner practice. These principles include accessibility, public participation, **health promotion**, use of appropriate technology and intersectoral **collaboration** (WHO, 1978). This lens of primary health care facilitates nurse practitioner practice with diverse client populations in a variety of contexts and practice settings including acute care, primary care, rehabilitative care, curative and supportive care, and palliative/end-of-life care.

In addition to their role in clinical care, nurse practitioners have the knowledge and skills to play a broader role in the healthcare system. They provide leadership and collaborate with multiple stakeholders to improve health outcomes at the individual client, community and population health levels. Nurse practitioners understand the unique health needs of diverse populations, and the values that impact their access to care.

² In Quebec, initial diagnoses of chronic illnesses are made by physicians in primary care.



Entry-level nurse practitioners require time and support from employers, mentors and the healthcare team to consolidate their knowledge, skills and judgment, develop their individual approach to care delivery and establish professional relationships. As they develop confidence in their clinical nurse practitioner role, they integrate and further develop their leadership, research and mentoring skills that are a critical part of nurse practitioner practice.

Assumptions

The nurse practitioner entry-level competencies are based on the following assumptions:

1. Nurse practitioner practice is grounded in values, knowledge and theories of nursing practice.
2. Entry-level competencies form the foundation for all aspects of nurse practitioner practice, and apply across diverse practice settings and client populations.
3. Entry-level competencies build and expand upon the competencies required of a registered nurse and address the knowledge, skills and abilities that are included in the nurse practitioner's **scope of practice**.
4. Nurse practitioners require graduate nursing education with a substantial clinical component.
5. Collaborative relationships with other healthcare providers involve both independent and shared decision making. All parties are accountable in the practice relationship as determined by their scopes of practice, educational backgrounds and competencies.



ENTRY-LEVEL COMPETENCIES

The entry-level competencies are organized into four competency categories: client care, quality improvement and research, leadership and education. The first competency area, client care, is further divided into six sub-competency categories, which reflects the importance of the clinical dimension of the nurse practitioner's professional role.

I. Client Care

A. Client Relationship Building and Communication

B. Assessment

C. Diagnosis

D. Management

E. Collaboration, Consultation and Referral

F. Health Promotion

II. Quality Improvement and Research

III. Leadership

IV. Education

A. Client, Community and Healthcare Team

B. Continuing Competence



COMPETENCY CATEGORY I. CLIENT CARE

A. Client Relationship Building and Communication

The competent, entry-level nurse practitioner uses appropriate communication strategies to create a safe and therapeutic environment for client care.

The nurse practitioner:

1. Clearly articulates the role of the nurse practitioner when interacting with the client.
2. Uses developmentally and culturally-appropriate communication techniques and tools.
3. Creates a safe environment for effective and trusting client interaction where privacy and confidentiality are maintained.
4. Uses relational strategies (e.g., open-ended questioning, fostering partnerships) to establish therapeutic relationships.
5. Provides culturally-safe care, integrating clients' beliefs and values in all client interactions.
6. Identifies personal beliefs and values and provides unbiased care.
7. Recognizes moral or ethical dilemmas, and takes appropriate action if necessary (e.g., consults with others and involves the legal system as required).
8. Documents relevant aspects of client care in the client record.

B. Assessment

*The competent, entry-level nurse practitioner integrates an **evidence-informed** knowledge base with advanced assessment skills to obtain the necessary information to identify client diagnoses, strengths, and needs.*

The nurse practitioner:

1. Establishes the reason for the client visit by:
 - a. Reviewing information relevant to the client visit (e.g., referral information, information from other healthcare providers, triage notes), if available.
 - b. Performing an observational assessment of the client's condition.



- c. Asking pertinent questions to establish the context for the client visit and to identify the chief presenting issue.
 - d. Identifying urgent, emergent, and life-threatening situations.
 - e. Establishing priorities of the client visit.
2. Completes a relevant health history appropriate to the client's presentation by:
- a. Collecting a health history such as symptoms, history of presenting issue, past medical and mental health history, family health history, pre-natal history, growth and development history, sexual history, allergies, and prescription and OTC medications, including **complementary and alternative therapies**.
 - b. Collecting relevant information specific to the client's psychosocial, behavioral, cultural, ethnic, spiritual, developmental life stage, and social **determinants of health**.
 - c. Determining the client's potential risk profile or actual risk behaviors (e.g., alcohol, illicit drugs and/or controlled substances, suicide or self-harm, abuse or neglect, falls, and infections).
 - d. Assessing client's strengths and health promotion, illness prevention, or risk reduction needs.
3. Performs an assessment by:
- a. Considering the client's presenting condition and health history; identifying the level of assessment (focused or comprehensive) required, and performing a review of the relevant body systems.
 - b. Selecting relevant assessment tools and techniques to examine the client.
 - c. Performing a relevant physical examination based on assessment findings and specific client characteristics (e.g., age, culture, developmental level, and functional ability).
 - d. Assessing mental health, cognitive status, and vulnerability using relevant assessment tools.
 - e. Integrating laboratory and diagnostic results with history and physical assessment findings.



C. Diagnosis

The competent, entry-level nurse practitioner is engaged in the diagnostic process and develops differential diagnoses through identification, analysis, and interpretation of findings from a variety of sources.

The nurse practitioner:

1. Determines differential diagnoses for acute, chronic, and life threatening conditions by:
 - a. Analyzing and interpreting multiple sources of data, including results of diagnostic and screening tests, health history, and physical examination.
 - b. Synthesizing assessment findings with scientific knowledge, determinants of health, knowledge of normal and abnormal states of health/illness, patient and population-level characteristics, epidemiology, and health risks.
 - c. Generating differential diagnoses.
 - d. Informing the patient of the rationale for ordering diagnostic tests.
 - e. Determining the most likely diagnoses based on clinical reasoning and available evidence.
 - f. Ordering and/or performing screening and diagnostic investigations using best available evidence to support or to rule out differential diagnoses.
 - g. Assuming responsibility for follow-up of test results.
 - h. Interpreting the results of screening and diagnostic investigations using evidence-informed clinical reasoning.
 - i. Confirming a diagnosis³.
2. Explains assessment findings and communicates a diagnosis to the client by:
 - a. Explaining results of clinical investigations.
 - b. Communicating diagnosis to the client, including implications for short- and long-term outcomes and prognosis.

³ NPs have the authority to diagnose a client's health condition autonomously according to their jurisdictional regulations.



- c. Ascertaining client understanding of information related to the clinical findings and the diagnosis.

D. Management

The competent, entry-level nurse practitioner, on the basis of assessment and diagnosis, formulates the most appropriate plan of care for the client, implementing evidence-informed therapeutic interventions in partnership with the client to optimize health.

The nurse practitioner:

1. Initiates interventions for the purpose of stabilizing the client in, urgent, emergent, and life-threatening situations (e.g., establishes and maintains airway, breathing and circulation; intervenes when suspecting suicidal ideation).
2. Formulates a plan of care based on diagnosis and evidence-informed practice by:
 - a. Determining and discussing options for managing the client's diagnosis while incorporating client considerations (e.g., socioeconomic factors, geography, and the client's developmental stage).
 - b. Selecting appropriate interventions, synthesizing information including determinants of health, evidence-informed practice, and client preferences.
 - c. Initiating and maintaining an appropriate plan of care (e.g. non-pharmacological interventions, pharmacological interventions, diagnostic tests, and **referrals**, as necessary).
 - d. Considering resource implications of therapeutic choices (e.g. cost, availability).
3. Provides pharmacological interventions, treatment, or therapy by:
 - a. Selecting pharmacotherapeutic options as indicated by the diagnosis and based on the determinants of health, evidence-informed practice, and client preference.
 - b. Counselling the client on pharmacotherapeutics, including rationale, cost, potential adverse effects, interactions, contraindications and precautions while ensuring the client understands the reasons to adhere to the prescribed regimen and required monitoring.



- c. Completing an accurate prescription(s) in accordance with applicable legislative, regulatory and institutional requirements.
 - d. Establishing a plan to monitor and evaluate the client's responses to medication therapy, so decisions can be made to continue, adjust or discontinue a medication.
 - e. Applying strategies to reduce the risk of harm involving controlled substances, including medication abuse, addiction, and drug diversion.
4. Provides non-pharmacological interventions, treatments, or therapies by:
- a. Selecting therapeutic options (including complementary and alternative approaches), as indicated by diagnosis based on determinants of health, evidence-informed practice, and client preference.
 - b. Counselling clients on therapeutic option(s), including rationale, potential risks and benefits, adverse effects, required after care, and follow-up.
 - c. Ordering required treatments (e.g., wound care, phlebotomy).
 - d. Discussing and arranging follow-up care, as required.
5. Performs invasive and non-invasive procedures by:
- a. Informing client about the procedure, including rationale, potential risks and benefits, adverse effects, and anticipated aftercare/follow-up.
 - b. Obtaining and documenting informed consent from the client.
 - c. Performing procedures using evidence-informed techniques.
 - d. Reviewing clinical findings and aftercare/follow-up.
6. Providing oversight of care across the continuum for clients with complex and/or chronic conditions.
7. Following up and providing ongoing management by:
- a. Developing a systematic and timely process for monitoring client progress.
 - b. Evaluating response to plan of care in collaboration with the client.
 - c. Revising the plan of care based on client's response and preferences.

E: Collaboration, Consultation, and Referral

*The competent, entry-level nurse practitioner identifies when collaboration, **consultation**, and referral are necessary for safe, competent, and comprehensive client care.*

The nurse practitioner:

1. Establishes collaborative relationships with healthcare providers and community-based services (e.g., school, police, child protection services, rehabilitation, and home care).
2. Provides recommendations or relevant treatment in response to consultation requests or incoming referrals.
3. Identifies any need for consultation and/or referral (e.g., to confirm a diagnosis, to augment a plan of care, to assume care when a client's health condition is beyond the nurse practitioner's individual competence or legal scope of practice).
4. Initiates a consultation and/or referral, specifying relevant information (e.g., client history, assessment findings, and diagnosis) and expectations.
5. Reviews consultation and/or referral recommendations with the client and integrates changes into plan of care as appropriate.

F. Health Promotion

The competent, entry-level nurse practitioner uses evidence and collaborates with community partners and other healthcare providers to optimize the health of individuals, families, communities, and populations.

The nurse practitioner:

1. Identifies individual, family, community and/or population strengths and health needs to collaboratively develop strategies to address issues.
2. Analyzes information from a variety of sources to determine population and environmental trends that have health implications.
3. Selects and implements evidence-informed strategies for health promotion and primary, secondary, and tertiary prevention.
4. Evaluates outcomes of selected health promotion strategies and revises the plan accordingly.



COMPETENCY CATEGORY II: QUALITY IMPROVEMENT AND RESEARCH

The competent, entry-level nurse practitioner uses evidence-informed practice, seeks to optimize client care and health service delivery, and participates in research.

The nurse practitioner:

1. Identifies, appraises, and applies research, practice guidelines, and current best practice.
2. Identifies the need for improvements in health service delivery.
3. Analyzes the implications (e.g., opportunity costs, unintended consequences) for the client and/or the system of implementing changes in practice.
4. Implements planned improvements in healthcare and delivery structures and processes.
5. Participates in quality improvement and evaluation of client care outcomes and health service delivery.
6. Identifies and manages risks to individual, families, populations, and the healthcare system to support quality improvement.
7. Reports **adverse events** to clients and/or appropriate authorities, in keeping with relevant legislation and organizational policies.
8. Analyzes factors that contribute to the occurrence of adverse events and **near misses** and develops strategies to mitigate risks.
9. Participates in research.
10. Contributes to the evaluation of the impact of nurse practitioner practice on client outcomes and healthcare delivery.



COMPETENCY CATEGORY III. LEADERSHIP

The competent entry-level nurse practitioner demonstrates leadership by using the nurse practitioner role to improve client care and facilitate system change.

The nurse practitioner:

1. Promotes the benefits of the nurse practitioner role in client care to other healthcare providers and stakeholders (e.g., employers, social and public service sectors, the public, legislators, and policy-makers).
2. Implements strategies to integrate and optimize the nurse practitioner role within healthcare teams and systems, to improve client care.
3. Coordinates interprofessional and intraprofessional teams, as needed, in the provision of client care.
4. Creates opportunities to learn with, from, and about other healthcare providers to optimize client care.
5. Contributes to team members' and other healthcare providers' knowledge, clinical skills, and client care (e.g., by responding to clinical questions and sharing evidence).
6. Identifies gaps in systems and/or opportunities to improve processes and practices, and provides evidence-informed recommendations for change.
7. Utilizes theories and seeks to improve skills in communication, negotiation, conflict resolution, coalition building, and change management.
8. Identifies the need and **advocates** for policy development to enhance client care.
9. Utilizes principles of program planning and development to optimize client care.



COMPETENCY CATEGORY IV. EDUCATION

The competent, entry-level nurse practitioner integrates formal and informal education into practice. This includes but is not limited to educating self, clients, the community, and members of the healthcare team.

Client, Community, and Healthcare Team Education

The nurse practitioner:

1. Assesses and prioritizes learning needs of intended recipients.
2. Applies relevant, theory-based, and evidence-informed content when providing education.
3. Utilizes applicable learning theories, develops education plans and selects appropriate delivery methods, considering available resources (e.g., human, material, and financial).
4. Disseminates knowledge, using appropriate delivery methods (e.g., pamphlets, visual aids, presentations, and publications).
5. Recognizes the need for and plans outcome measurements (e.g., obtaining client feedback; conducting pre- and post-surveys).

Continuing Competence

The nurse practitioner:

6. Engages in self-reflection to determine continuing education competence needs.
7. Engages in ongoing professional development.
8. Seeks mentorship opportunities to support own professional development.



GLOSSARY

Advanced nursing practice: “An umbrella term describing an advanced level of clinical nursing practice that maximizes the use of graduate educational preparation, in-depth nursing knowledge, and expertise in meeting the health needs of individuals, families, groups, communities and populations. It involves analyzing and synthesizing knowledge; understanding, interpreting and applying nursing theory and research; and developing and advancing nursing knowledge and the profession as a whole” (CNA, 2008).

Adverse event: An event that results in unintended harm to the client and is related to the care and/or service provided to the client, rather than the client’s underlying condition (CNA, 2010).

Advocate: To actively support a right and good cause; to support others in speaking for themselves; to speak on behalf of those who cannot speak for themselves (CNA, 2010).

Client: “Individuals, families, groups, populations or entire communities who require nursing expertise. The term “client” reflects the range of individuals and/or groups with whom nurses may be interacting. In some settings, other terms may be used such as patient or resident. In education, the client may also be a student; in administration, the client may also be an employee; and in research, the client is usually a subject or participant” (NANB, 2012).

Collaboration: “Client care involving joint communication and decision-making processes among the client, nurse practitioner and other members of a health-care team who work together to use their individual and shared knowledge and skills to provide optimum client-centred care. The health-care team works with clients toward the achievement of identified health outcomes, while respecting the unique qualities and abilities of each member of the group or team” (CNA, 2010).

Competence: The ability to integrate and apply the knowledge, skills, abilities and judgment required to practise safely and ethically with a designated client population in a specific nurse practitioner role and practice setting (CRNNS, 2011).



Competencies: The specific knowledge, skills, abilities, and judgment required for a nurse practitioner to practise safely and ethically with a designated client population in a specific role and practice setting (CRNNS, 2011).

Complementary and alternative therapies: “Complementary” therapies are practices used alongside mainstream health care while “alternative” therapies practices are practices used in place of mainstream health care practices (CRNBC, 2012).

Consultation: A request for another health professional’s advice on the care of a client. The goal is to enhance client (patient) care and/or improve the skills and confidence of the professional making the request (consultee). The consultant may or may not see the client directly. The responsibility for clinical outcomes remains with the consultee, who is free to accept or reject the advice of the consultant (CRNNS, 2011).

Cultural safety: “Cultural safety is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the healthcare system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care” (First Nations Health Authority, 2015).

Determinants of health: The range of social, economic, geographic and systemic factors that influence a person’s health status and outcomes. These factors include: access to appropriate health services, biology, coping abilities, culture, education, employment and working conditions, environment (natural and built, emotional and psychological), gender, genetics, health behaviours, income, lifestyle, and social status (CNA, 2010).

Evidence-informed practice: An approach to clinical practice that requires the nurse practitioner to conscientiously integrate critically appraised evidence with their experience and knowledge of contextual factors to decide (in consultation with clients) what best suits clients’ needs. Evidence may include, but is not limited to, published and unpublished research, clinical practice guidelines, consensus statements, expert advice, and quality assurance and patient safety data (CNA, 2010).



Health: “A state of complete physical, mental, spiritual and social well-being, and not merely the absence of disease” (WHO, 1948).

Health promotion: The process of enabling people to increase control over and improve their health. It embraces actions directed not only at strengthening the skills, confidence and capabilities of individuals, but also at changing social, environmental, political and economic conditions to alleviate their impact on public and individual health (CNA, 2010).

Referral: An explicit request for another health professional to become involved in the care of a client. Accountability for clinical outcomes is negotiated between the health care professionals involved (CRNNS, 2011).

Scope of practice: The roles, functions, and accountabilities that nurse practitioners are educated and authorized to perform, as established through legislated definitions of nurse practitioner practice, and complemented by standards, guidelines and policy positions issued by nursing regulators (CARNA, 2011).

Standards: Authoritative statements that describe the required behavior of every nurse practitioner, and are used to evaluate individual performance. They provide a benchmark below which performance is unacceptable (CNA, 2010).

REFERENCES

- Association of Registered Nurses of Newfoundland and Labrador. (2013). *Standards for nurse practitioner practice in Newfoundland and Labrador*. St. John's, NL: Author.
- Association of Registered Nurses of Prince Edward Island. (2012a). *Nurse practitioner standards for practice*. Charlottetown, PEI: Author.
- Association of Registered Nurses of Prince Edward Island. (2012b). *Nurse practitioner core competencies*. Charlottetown, PEI: Author.
- Bryant-Lukosius, D., & DiCenso, A. (2004). A framework for the introduction and evaluation of advanced practice nursing roles. *Journal of Advanced Nursing*, 48(5), 530-540.
- Canadian Council of Registered Nurse Regulators and Professional Examination Services. (2015). *Practice Analysis Study of Nurse Practitioners*. Beaverton, ON: Author.
- Canadian Nurses Association. (2008). *Code of Ethics for Registered Nurses*. Ottawa, ON: Author.
- Canadian Nurses Association. (2010). *Canadian Nurse Practitioner Core Competency Framework*. Retrieved from http://cnaaic.ca/~media/cna/files/en/competency_framework_2010_e.pdf
- College and Association of Registered Nurses of Alberta. (2011a). *Nurse practitioner (NP) competencies*. Edmonton, AB: Author.
- College and Association of Registered Nurses of Alberta. (2011b). *Scope of practice for nurse practitioners (NPs)*. Edmonton, AB: Author.
- Collège des médecins du Québec et Ordre des infirmières et infirmiers du Québec. (2013). *Lignes directrices : Pratique clinique de l'infirmière praticienne spécialisée en soins de première ligne* (2^e ed.). Montréal: Author.
- College of Registered Nurses of British Columbia. (2011). *Competencies required for nurse practitioners in British Columbia*. Vancouver, BC: Author.
- College of Registered Nurses of British Columbia. (2012a). *Professional standards for registered nurses and nurse practitioners*. Vancouver, BC: Author.
- College of Registered Nurses of British Columbia. (2012b). *Scope of practice for nurse Practitioners: Standards, limits and conditions*. Vancouver, BC: Author.



- College of Registered Nurses of Manitoba. (2011). *Competencies for nurse practitioners in Manitoba*. Winnipeg, MB: Author.
- College of Registered Nurses of Manitoba. (2009). *Standards of practice for registered nurses on the extended practice register*. Winnipeg, MB: Author.
- College of Registered Nurses of Nova Scotia. (2011). *Nurse practitioner competency framework*. Halifax, NS: Author.
- College of Registered Nurses of Nova Scotia. (2012). *2012 Nurse practitioner standards of practice*. Halifax, NS: Author.
- College of Registered Nurses of Nova Scotia. (2014). *2014 Nurse practitioner standards of practice*. Halifax, NS: Author.
- College of Nurses of Ontario. (2011). *Practice standards: Nurse practitioner*. Toronto: Author.
- DiCenso, A., Martin Misener, R., Bryant-Lukosius, D., Bourgeault, I., Kilpatrick, K., Donald, F., Charbonneau-Smith, R. (2010). Advanced practice nursing in Canada: Overview of a decision support synthesis. *Nursing Leadership, 23*(Special Issue), 15-34.
- Donald, F., Martin Misener, R., Bryant-Lukosius, D., Kilpatrick, K., Kaasalainen, S., Carter, DiCenso, A. (2010). The primary healthcare nurse practitioner role in Canada. *Nursing Leadership, 23*(Special Issue), 88-113.
- First Nations Health Authority. (2015). *Cultural Humility*. Retrieved from <http://www.fnha.ca/wellness/cultural-humility>
- Kilpatrick, K., Harbman, P., Carter, N., Martin Misener, R., Bryant-Lukosius, D., Donald, F., DiCenso, A. (2010). The acute care nurse practitioner role in Canada. *Nursing Leadership, 23*(Special Issue), 114-139.
- Martin Misener, R., Crawford, T., DiCenso, A., Akhtar-Danesh, N., Donald, F., Bryant-Lukosius, D., & Kaasalainen, S. (2010). *A survey of practice patterns of nurse practitioners in primary health care in Nova Scotia*. Halifax, NS: College of Registered Nurses of Nova Scotia and Dalhousie University School of Nursing.
- Nurses Association of New Brunswick. (2010). *Standards of practice for primary health care nurse practitioners*. Fredericton, NB: Author.



Nurses Association of New Brunswick. (2012). *Standards of Practice for Registered Nurses*.

Fredericton, NB: Author

Nursing Education Program Approval Board and College and Association of Registered Nurses of Alberta. (2011). *Standards for Alberta nursing education programs leading to initial entry to practice as a nurse practitioner*. Edmonton, AB: Author.

Registered Nurses Association of the Northwest Territories and Nunavut. (2011). *Practice and prescriptive guidelines for nurse practitioners*. Yellowknife, NWT: Author.

Saskatchewan Registered Nurses' Association. (2010). *Registered nurse (nurse practitioner) RN(NP) standards and core competencies*. Regina, SK: Author.

Truth and Reconciliation Commission of Canada. (2015). Truth and Reconciliation Commission of Canada: Calls to Action. Retrieved from [http://www.trc.ca/websites/trcinstitution/File/2015/Findings/Calls to Action English2.pdf](http://www.trc.ca/websites/trcinstitution/File/2015/Findings/Calls%20to%20Action_English2.pdf)

Yukon Registered Nurses Association. (2012). *Foundations for nurse practitioner practice in the Yukon*. Whitehorse, YT: Author.

World Health Organization. (1948). WHO definition of health. Retrieved from <http://www.who.int/about/definition/en/print.html>

World Health Organization. (1978). Declaration of Alma-Ata. Retrieved from http://www.who.int/publications/almaata_declaration_en.pdf



APPENDIX A

CCRNR Process for Development of Entry Level Competencies

In 2012, CCRNR embarked on a project to analyze nurse practitioner practice across Canada in three streams of practice (Adult, Family/All Ages and Pediatrics). The practice analysis was undertaken to inform future decisions about entry-to-practice exams in these three streams. The neonatal stream of practice was not included because the practice analysis was not intended to inform future decisions about a neonatal exam.

The CCRNR board established a national working group with representatives from all Canadian nursing regulatory bodies to coordinate all aspects of the nurse practitioner Practice Analysis (Appendix B). CCRNR was awarded funding from Employment and Social Development Canada. A Request for Proposals (RFP) was disseminated and an external research firm was contracted to conduct the nurse practitioner practice analysis. The practice analysis provided a comprehensive description of Canadian nurse practitioner practice in the Adult, Family/All Ages and Pediatric streams.

A research advisory committee (RAC) was established comprised of Canadian educators, researchers and an administrator with expertise in **advanced nursing practice** (Appendix C). The role of the RAC was to develop, revise and review competencies and behavioral indicators for entry-level nurse practitioners based on Canadian and international evidence.

Three subject matter expert panels (SMEs) were established to bring clinical expertise and to explore commonalities and differences across the three streams of NURSE PRACTITIONER practice included in the study. Twenty-seven panelists were selected from 180 applicants (Appendix D). Each panel was designed to provide a balanced representation of NURSE PRACTITIONER practice within each stream including years of experience, diverse practice settings, geographic location (urban/rural, province/territory) and other demographics. The SME panelists refined the behavioral indicators developed by the RAC through an iterative process to improve clarity and specificity of each indicator statement within four competency categories. This iterative process provided a mechanism for continual improvement of the competency categories and behavioral indicators.

The competency categories and behavioral indicators formed the practice analysis survey. The survey was designed to determine the frequency with which nurse practitioners performed each indicator in the previous 12 months and the seriousness of the consequences if the indicator was not performed competently.

After pilot testing and refining the survey, it was disseminated to all family/all ages, adult and pediatric nurse practitioners in Canada. The survey was sent to 3, 870 nurse practitioners; 909 responded for a 24.6% response rate, with representation from every jurisdiction in Canada. Results indicated that 54% of nurse practitioner respondents agreed that the framework provided a complete listing of entry-level competencies, and another 42% indicated that they mostly described entry-level competencies.



To determine the representativeness of the participating nurse practitioners, a non-respondent survey was conducted with all nurse practitioners from the original sample who had not completed the primary survey. The non-respondent survey was sent to 2,798 nurse practitioners and 554 responded for a 19.8% response rate.

A survey was sent to all Canadian nurse practitioner education programs to ascertain if there were any gaps between what is currently taught in nurse practitioner programs and what the practice analysis was describing as entry-level nurse practitioner practice. The majority of respondents indicated that their programs prepare nurse practitioner graduates to perform the competencies.

The working group analyzed the data from the Nurse Practitioner Practice Analysis and developed a document containing the draft nurse practitioner entry-level competencies. Most jurisdictions then engaged in further nurse practitioner and stakeholder consultation, including consulting with Neonatal nurse practitioners where applicable. Feedback from this consultation process was incorporated into the final draft.

For further information about the nurse practitioner Practice Analysis study, visit www.ccrnr.ca.

APPENDIX B

NURSE PRACTITIONER Practice Analysis Working Group Members

Paul Boudreau, RN
Association of Registered Nurses of Prince Edward Island

Odette Comeau Lavoie, RN, BScN, MAdEd
Nurses Association of New Brunswick

Donna Cooke, RN
Saskatchewan Registered Nurses' Association

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College of Registered Nurses of Nova Scotia

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Ordre des infirmières et infirmiers du Québec

Debra Elias, RN, MN
College of Registered Nurses of Manitoba

Lynda Finley, RN, MScN
Nurses Association of New Brunswick

Donna Harpell Hogg, RN, BScN, MS
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Carrie Huffman, RN, BScN
Yukon Registered Nurses Association

Rosanne Jabbour, RN, MHSc
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Judith Leprohon, RN, Ph.D.
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Association of Registered Nurses of Newfoundland and Labrador

Dr. Lynn Miller, DNP, NP
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Michelle Osmond, MScN, RN
Association of Registered Nurses of Newfoundland and Labrador

Dr. Christine Penney, RN, MPA, PhD
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Donna Stanley-Young RN, BScN, MN
Registered Nurses Association of Northwest Territories/Nunavut

Carolyn Trumper, BScN, MACT, RN
College and Association of Registered Nurses of Alberta

Suzanne Wowchuk, RN, MN, FRE
College of Registered Nurses of Manitoba



APPENDIX C

Research Advisory Committee

A research advisory committee (RAC) was established comprised of Canadian educators, researchers and an administrator with expertise in advanced nursing practice; four of whom were nurse practitioners. The role of the RAC was to develop, revise and review competencies and behavioral indicators for entry-level nurse practitioners based on Canadian and International evidence.

Dr. Faith Donald PhD, NP-PhC
Associate Professor, Ryerson University

Dr. Kathleen F. Hunter PhD, RN, NP, GNC(C), NCA
Associate Professor, University of Alberta
Nurse Practitioner Specialized Geriatric Services, Glenrose Hospital
Assistant Adjunct Professor Faculty of Medicine/Division of Geriatric Medicine

Dr. Kelley Kilpatrick PhD, RN
Assistant Professor, Université de Montréal

Dr. Mary McAllister, PhD, RN
Associate Chief, Nursing Practice - The Hospital for Sick Children

Dr. Ruth Martin-Misener, PhD, NP
Associate Professor, Dalhousie University

Dr. Esther Sangster-Gormley, PhD, RN
Associate Professor, University of Victoria

APPENDIX D

Subject Matter Expert Panels

Three subject matter expert panels (SMEs) were established to bring clinical expertise and to explore commonalities and differences across the three streams of nurse practitioner practice included in the practice analysis. Twenty-seven panelists were selected from 180 applicants. Each panel was designed to provide a balanced representation of nurse practitioner practice including years of experience, diverse practice settings, geographic location (urban/rural, province/territory) and other demographics within each stream. The SME panelists refined the behavioral indicators developed by the RAC through an iterative process to improve clarity and specificity of each indicator statement within four competency areas. This iterative process provided a mechanism for continual improvement of the competency areas and behavioral indicators.

Adult Subject Matter Expert Panel

Michelle Bech, BSN, MN, ACNP, NP(A)
Vancouver, BC,
Hospital Inpatient-Geriatric

Cynthia Kettle RN, BN, MN
St. John's, NF
Inpatient - Travelling Vascular Clinics to First Nations Communities/Vascular Surgery

Marilyn Oishi NP, BScN, MN
Edson, AB
Hospital-Inpatient / Home Care / LTC / Family Practice Office

Shannon McNamara, RN, MScN, SNP, CCNC (c)
Montreal, QC
Specialized Nurse Practitioner - Inpatient Cardiology and Cardiac Surgery

Teresa Ruston,
Edmonton, AB
Hospital -Ambulatory Clinic

Barbara K. Currie, MN, RN-NP
Halifax, NS
Inflammatory Bowel Disease Ambulatory Clinic



Mary Dimeo, RN(EC), BScN, MN, ENC(C), NP-Adult
Toronto, ON
Hospital Emergency Department

Veronique Belec,
Saint-Jérôme, QC
Hospital – Inpatient Nephrology

Pediatric Subject Matter Expert Panel

Sara Breitbart, RN(EC), MN, NP-Pediatrics
Toronto, ON
Hospital Inpatient / Ambulatory Clinic - Neurosurgery

Alissa Collingridge, MN, NP(P)
Vancouver, BC
NP Child & Youth Primary Care Clinic / Ambulatory Care

Susie McRae NP(P), MN-NP, RN,
Vancouver, BC
Ambulatory Clinic

Lisette Lockyer, RN, NP, ACNP (Child)
Calgary, AB
Hospital Inpatient / Ambulatory clinic / NP-Led Clinic – Child Trauma

Laura Jurasek, NP, MN
Edmonton, AB
Hospital Inpatient / Ambulatory clinic – Pediatric Neurology

Kristina Chapman, MN, NP, CPHON
Halifax, NS
Hospital Inpatient / Ambulatory clinic – Hematology/Oncology

Melissa Manning, RN, BScN, MN, NP
St. John's, NL
Pediatric Nurse Practitioner - Hospital

Dr. Vera Nenadovic, RN(EC), PhD
Toronto, ON
Hospital Inpatient – Epilepsy and Epilepsy Surgery Program



Family/All Ages Subject Matter Expert Panel

Karen Irving, FNP, MScN, BScN
Kamloops, BC
Primary Health Care Clinic - Aboriginal/Marginalized Populations

Jennifer Farrell, NP, BScN, MN:ANP, COHN
Edmonton, AB
Family Practice/Urgent Care, Addictions, Recovery Centre, Student Health Services

Jana Garinger, RN(NP), MN
Moose Jaw, SK
Primary Care - Immigrant Health

Susan T. McCowan, BSc, BN, MS(NP)
Selkirk, MN
Quick Care Clinic

Erin Kennedy, RN(EC), BScN, MScN, PHC-NP
Kitchner, ON
Emergency Department

Sophie Charland, BSc, MSc, IPSPL
Laval, QC
Family Practice Clinic

Dawn LeBlanc, MN, NP
Oromocto, NB
Canadian Armed Forces / Government of Canada
Military Clinic – Primary Health Clinic

Dr. Cheryl A. Smith, RN, NP, DNP
Amherst, NS
Long Term Care - co-Manager SOME Polypharmacy

Kelsey MacPhee, BScN, RN, MN, NP
O’Leary, PEI
Community Health Centre

Glenda Stagg Sturge, BN, RN, NP, MN
St. John’s, NL
Community Health Centre, Family Practice, Public Health

Jo-Anne Hubert, MN, NP
Yellowknife, NT
Director Primary Health Care - Yellowknife Health and Social Services Authority



APPENDIX E

Survey Pilot Testers

Coralie Buhler, MN, RN, NP
Winnipeg, MB
Adult

Kate Burkholder, NP- PHC
Blacks Harbour, NB
Family/All Ages

Jessica Caceres, MN, NP-PHC
Guelph, Ontario
Primary Care and Emergency

Elizabeth Cook, MN, NP, CDE
Yellowknife, NWT
Family/All Ages

Manon Couture, Inf. M. Sc., IPSPL
Varenes, Québec
Infirmière praticienne spécialisée en soins de première ligne (NP-Family All Ages)

Brenda Dawyduk, RN, NP, BN, MSc
Thompson, Manitoba
Family (specializing in Pediatrics)

Maria DeAngelis, MScN, NP
Toronto, Ontario
Pediatrics - GI transplant

Charlene Downey, RN, MN, CON(C), NP
St. John's, Newfoundland
Adult - Hematology and Stem Cell Transplants

Liane Dumais, IPS
Quebec, QC
Infirmière praticienne spécialisée en néphrologie (NP-Nephrology)



Beryl Dziedzic, MN, RN, NP
Lundar, MB
Family/All Ages

Kathryn Eager,
London, ON
Pediatrics

Celia Evanson, MN, NP
Rock Creek, BC
Family/All Ages

Wendy Gillespie, MN, NP
Edmonton, AB
Pediatric

Lynn Haslam, RN(EC), NP-Adult, MN, PANC(C), Certificate in Anesthesia Care
Toronto, ON
Adult

Laura Johnson, DNP, RN(NP)
Winnipeg, Manitoba
Adult

Karen T. Legg, RN, MN-NP
Halifax, NS
Adult - Neurology; Epilepsy

Stewart Maclennan, MN, NP
Edmonton, AB
University of Alberta - Lecturer
Correctional Health (Adult)

Kimberly Newton, RN-NP, MN:ANP, BScN, BACS
Middle Musquodoboit, NS
Family/All Ages

Alison Ross, MN, NP
Slave Lake, AB
Family/All Ages

Leland Sommer, RN(NP)
Balgonie, SK
Family/All Ages



Emily Tai, NP(P)
Vancouver, BC
Pediatric

Gregg Trueman, PhD, MN, NP
Calgary, Alberta
Adult Hospice Palliative Care/Chronic Pain and Adult Primary Care

Krista Van Roestel, BScN, MN, NP-Paediatrics
Toronto, ON
Pediatrics

Audrée Verville, IPS
Montréal, QC
Infirmière praticienne spécialisée en cardiologie (NP-Cardiology)

Heather Whittle, RN(EC), MScN, GDipNPAC
London, Ontario
Adult, Department of Anesthesia and Perioperative Medicine, Comprehensive Pain Program

Celina Woo, MN, NP(P)
Vancouver, BC
Division of Hematology/Oncology/BMT, Pediatric Inherited Bleeding Disorders Clinic

Linda Yearwood, RN, MSN, NP (A)
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