



COLLEGE AND ASSOCIATION OF NURSES
of the Northwest Territories and Nunavut

NATIONAL ENTRY-LEVEL COMPETENCIES for Nurse Practitioners 2023

This national version of the NP Entry-Level Competencies was endorsed by the CCRNR Board in November 2022 and published in December 2023 after reviews and approvals were completed by nursing regulators in each Canadian province and territory that is part of CCRNR. Visit the website of the nursing regulator in your province or territory for a copy of their NP Entry-Level Competencies. (Note: individual regulators' versions may have minor differences when compared to the national version because of terms or descriptions that are unique to some provinces or territories).

Canadian Council of

CCRNR
Registered Nurse Regulators





COLLEGE AND ASSOCIATION OF NURSES of the Northwest Territories and Nunavut

Office Location: 3rd Floor, 4921 49 Street Yellowknife, NT X1A 2N9

Monday Friday: 8:30 AM – 4:30 PM

Phone: 867-873-2745

Website: <https://cannn.ca/>



CCRNR commissioned the *Nurse Practitioner Regulation Framework Implementation Plan Project*, a multi-year, and multi-faceted project with a goal to implement a model for nurse practitioner regulation in Canada. The project consisted of six elements, one of which was updating the ELCs. A Steering Committee comprised of representatives from nursing regulatory jurisdictions across Canada was commissioned to update the NP entry-level competencies. These current revisions were informed by an environmental scan, literature reviews, and stakeholder consultation. The Registered Nurses Association of the Northwest Territories and Nunavut (RNANT/NU) Board of Directors approved the ELC's for NP in May 2023.



TABLE OF CONTENTS

Introduction	5
Profile of the Entry-Level Practitioner	5
Background	5
Purpose of the Entry-Level Competencies for Nurse Practitioners	6
ELCs and Entry-Level Nurse Practitioner Practice	6
Principles and Assumptions for Entry-Level Nurse Practitioner Practice	6
Structure	7
Nurse Practitioner Role-Based Competency Framework	7
1. Clinician	8
2. Leader	13
3. Advocate	15
4. Educator	17
5. Scholar	18
GLOSSARY - Description of Key Terms	19
Bibliography	22



INTRODUCTION

The Entry-Level Competencies (ELCs) for Nurse Practitioners reflect the foundational knowledge, skills, and judgement required of Nurse Practitioners to provide safe, competent, ethical, and compassionate care. While Nurse Practitioners' roles and responsibilities may vary by context and client population, this document outlines the competencies that all Nurse Practitioners must possess to be competent when they begin 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 and manage care across the life span in all practice settings. As advanced practice nurses, they use their in-depth knowledge and experience to analyze, synthesize, and apply evidence to make decisions. They apply theory and knowledge from nursing and other disciplines to provide a comprehensive range of essential services grounded in professional, ethical, and legal standards within a holistic model of care. Nurse Practitioners work across all domains of practice. They provide leadership and collaborate within and across communities, organizations, and populations to improve health and system outcomes. In some settings, Nurse Practitioners assume the role as the most responsible provider.

BACKGROUND

The Canadian Council of Registered Nurse Regulators (CCRNRR) first published ELCs for Nurse Practitioners in Canada in 2016. In 2020, CCRNRR initiated a process to update the ELCs, which are revised periodically to reflect evolving population needs, health system, and Nurse Practitioner practice. The current revisions were informed by an environmental scan, literature reviews, and stakeholder consultation, and also reflect inter-jurisdictional consistency to support workforce mobility requirements of the Canadian Free Trade Agreement.



PURPOSE OF THE ENTRY-LEVEL COMPETENCIES FOR NURSE PRACTITIONERS

Nurse Practitioner ELCs reflect the knowledge, skills, and judgement required of Nurse Practitioners to practice safely and ethically. They are used by regulatory bodies for a number of purposes, including but not limited to:

- Academic program approval/recognition
- Assessment of internationally educated applicants
- Assessment of applicants for the purpose of re-entry into the profession
- Practice advice/guidance to clinicians
- Reference for professional conduct matters
- Public and employer awareness of the practice expectations of Nurse Practitioners

ELCS AND ENTRY-LEVEL NURSE PRACTITIONER PRACTICE

Nurse Practitioner practice is dynamic and evolving. The Nurse Practitioner ELCs encompass and build on the competencies of a Registered Nurse and establish the foundation for Nurse Practitioner practice. While the ELCs define entry-level Nurse Practitioner practice, all Nurse Practitioners are ultimately accountable for meeting them throughout their careers.

A nurse practitioner is considered “entry-level” on initial registration or licensure. Their practice draws on a theoretical and experiential knowledge base shaped by their RN practice and their NP education program.

PRINCIPLES AND ASSUMPTIONS FOR ENTRY-LEVEL NURSE PRACTITIONER PRACTICE

The following overarching principles and assumptions inform how the ELCs influence the education and practice of entry-level Nurse Practitioners. The entry-level Nurse Practitioner:

- has a strong foundation in nursing theory, and knowledge of health and sciences, humanities, research, and ethics from formal graduate level programs
- practices autonomously within legislation, practice standards, ethics, and scope of practice in their jurisdiction
- works within their scope of practice, and seeks guidance when they encounter situations beyond their individual competence
- is prepared to practice safely, competently, compassionately, and ethically:
 - with all people across the lifespan,
 - with all clients - individuals, families, groups, communities, and populations,



- in all practice settings, and
- across all domains of practice
- uses evidence and applies critical thinking throughout all aspects of practice

STRUCTURE

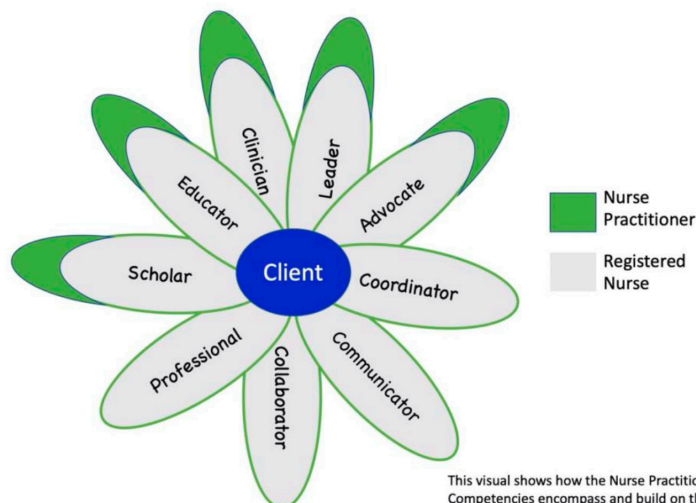
The revised ELCs were developed using a role-based framework that represents the multiple roles Nurse Practitioners assume when providing services in any practice setting. They are an interconnected set of competencies and indicators. For the sake of clarity and to avoid unnecessary repetition, key concepts are mentioned once and assumed to apply to all roles. While each role is presented separately, it is important to note that Nurse Practitioners may use aspects of more than one role at the same time.

The document is organized thematically in a role-based format, similar to the Registered Nurse Entry-level Competencies. The Nurse Practitioner Entry-Level Competencies encompass and build on the Registered Nurse Entry-Level Competencies, focusing on distinct entry-level competencies for Nurse Practitioners. The competencies are accompanied by performance indicators.

There are a total of 29 competencies grouped thematically under five roles:

- **Clinician**
- **Leader**
- **Advocate**
- **Educator**
- **Scholar**

NURSE PRACTITIONER ROLE-BASED COMPETENCY FRAMEWORK





I.0 CLINICIAN

Nurse Practitioners deliver safe, competent, compassionate, and ethical care across the lifespan with diverse populations and in a range of practice settings. Nurse Practitioners ground their care in evidence-informed practice and use critical inquiry in their advanced diagnostic and clinical reasoning.

ASSESSMENT

1.1 Establish the reasons for the **client**¹ encounter to determine the nature of the services required by the client

- a. Perform initial observational assessment of the client's condition
- b. Ask pertinent questions to establish the presenting issues
- c. Evaluate information relevant to the client's presenting concerns
- d. Prioritize routine, urgent, emergent, and life-threatening situations

1.2 Obtain informed consent according to legislation and regulatory requirements

- a. Co-create with client a shared understanding of scope of services, expectations, client's strengths and limitations, and priorities
- b. Support client to make informed decisions, discussing risks, benefits, alternatives, and consequences
- c. Obtain informed consent for the collection, use, and disclosure of personal and health information

1.3 Use critical inquiry to analyze and synthesize information from multiple sources to identify client needs and inform assessment and diagnosis

- a. Establish a shared understanding of client's culture, strengths, and limitations
- b. Integrate information specific to the client's biopsychosocial, behavioural, cultural, ethnic, and spiritual circumstances; current developmental life stage; gender expression; and social determinants of health, considering epidemiology and population-level characteristics
- c. Integrate findings from past and current health history and investigations
- d. Apply current, credible, and reliable research, literature, and standards to inform decision-making
- e. Collect pharmacological history, including over-the-counter products, and **complementary and alternative medicine**, natural health products, and traditional medicine
- f. Support client's wishes and directions related to advance care planning, and palliative and end-of-life care

¹ Key terms are highlighted in blue text and described at the end of the document.



1.4 Conduct an assessment that is relevant to the client's presentation to inform diagnostic decisions

- a. Determine the need for conducting a focused or comprehensive assessment
- b. Conduct an assessment using valid and reliable techniques and tools
- c. Conduct an assessment with sensitivity to client's culture, lived experiences, **gender identity**, sexuality, and personal expression
- d. Conduct a mental-health assessment, applying knowledge of emotional, psychological, and social measures of well-being
- e. Conduct a review of systems to identify pertinent presenting findings
- f. Order and perform screening and diagnostic investigations including **point-of-care tests**, applying principles of resource stewardship

DIAGNOSIS

1.5 Integrate critical inquiry and diagnostic reasoning to formulate differential diagnoses and final diagnoses

- a. Interpret the results of investigations
- b. Generate differential diagnoses based on data analysis
- c. Create a shared understanding of assessment findings, diagnoses, anticipated outcomes, and prognosis
- d. Determine the leading diagnosis based on clinical and diagnostic reasoning

MANAGEMENT

1.6 Use clinical reasoning to create a shared management plan based on diagnoses and the client's preferences and goals

- a. Examine, and explore with the client, options for managing the diagnoses
- b. Consider availability, cost, determinants of health, clinical efficacy, and potential client adherence to determine feasibility and sustainability of the management plan
- c. Determine and prioritize interventions integrating client goals and preferences, resources, and clinical urgency
- d. Provide and seek consultation from other professionals and organizations to support client management
- e. Use technology to deliver health care services after considering the appropriateness of virtual care services, environmental factors, the nature of the service, the security of the system, alternative approaches, and contingency plans
- f. Use electronic health records and tracking systems to accurately collect and document client information and delivery of health services

1.7 Prescribe and counsel clients on pharmacological and non-pharmacological interventions, across the life span

- a. Follow legislative, regulatory, and organization requirements, when prescribing pharmacological and non-pharmacological interventions



- b. Select evidence-informed pharmacological interventions based on diagnoses, concurrent client therapies, and available medication history, using drug-information systems
 - c. Utilize prescription monitoring and reporting programs according to jurisdictional and legislative requirements
 - d. Complete medication reconciliation to make clinical decisions based on an analysis of the client's current pharmacological and non-pharmacological therapy
 - e. Analyze polypharmacy to identify unnecessary and unsafe prescribing, and deprescribe where possible
 - f. Recommend or order non-pharmacological interventions and complimentary, alternative, and natural health products based on client preference, history, and cultural practice
 - g. Incorporate principles of pharmacological stewardship
 - h. Establish a monitoring plan for pharmacological and non-pharmacological interventions
 - i. Counsel client on pharmacological and non-pharmacological interventions, including indication, benefits, cost, potential adverse effects, interactions, contraindications, precautions, reasons to adhere to the prescribed regimen, required monitoring, and follow up
- 1.8 Perform invasive and non-invasive interventions as indicated by the management plan**
- a. Co-create with the client an understanding of procedures, including indications, potential risks and benefits, adverse effects, anticipated aftercare, and follow-up care
 - b. Perform procedures using evidence-informed techniques
 - c. Monitor and evaluate clinical findings, aftercare, and follow-up
 - d. Initiate interventions to stabilize the client in urgent, emergent, and life-threatening situations
- 1.9 Evaluate effectiveness of the management plan to identify required modifications and/or terminations of treatment**
- a. Develop a systematic and timely process for monitoring client progress, and follow-up on results and interventions
 - b. Evaluate responses to the management plan in collaboration with the client, and revise management plan as needed
 - c. Discuss and implement follow-up to facilitate continuity of care in collaboration with the client
 - d. Facilitate implementation of the management plan with the client, family, other health professionals, and community partners
 - e. Facilitate referral to another practitioner or service if the client would benefit from the consultation or if the client-care needs are beyond the NP's individual competence or scope of practice

COUNSELLING

1.10 Co-create a therapeutic counselling relationship that is conducive to optimal health outcomes

- a. Co-create with client a shared understanding of scope of services, expectations, client's strengths and limitations, and priorities
- b. Identify barriers that interfere with client's goals
- c. Utilize developmentally, socio-demographically, and culturally relevant communication techniques and tools
- d. Evaluate effectiveness of counselling relationship and refer to appropriate professionals, when needed



1.11 Provide counselling interventions as indicated by the management plan

- a. Integrate theories of cognitive and emotional development across the lifespan
- b. Identify impact of potential and real biases on the creation of safe spaces
- c. Integrate therapeutic use of self to facilitate an optimal experience and outcome for the client
- d. Anticipate and respond to the expression of intense emotions in a manner that facilitates a safe and effective resolution
- e. Consider the impact of client's personal and **contextual factors**
- f. Provide **trauma- and violence-informed care**
- g. Identify root causes of trauma, including **intergenerational trauma**, with the client and refer to appropriate professionals
- h. Manage transference and countertransference in therapeutic relationships

1.12 Apply harm-reduction strategies and evidence-informed practice to support clients with substance use disorder, while adhering to federal and provincial/territorial legislation and regulation

- a. Identify potential risks and signs of substance use disorder
- b. Co-create a harm-reduction management plan, considering treatment and intervention options
- c. Apply evidence-informed and safe prescribing practices when initiating and managing pharmacological and non-pharmacological interventions
- d. Adhere to legislation, regulation, and organizational policy related to the safe storage and handling of controlled drugs and substances
- e. Provide education on the safe storage and handling of controlled drugs and substances

TRANSITION OF CARE, DISCHARGE PLANNING, DOCUMENTATION

1.13 Lead admission, transition of care, and discharge planning that ensures continuity and safety of client care

- a. Collaborate with client to facilitate access to required resources, drug therapy, diagnostic tests, procedures, and follow-up to support the continuum of care
- b. Facilitate transfer of information to support continuity of care
- c. Facilitate client's access to community services and other system resources
- d. Monitor and modify the management plan based on the client's transition needs

1.14 Conduct record keeping activities, according to legislation and jurisdictional regulatory requirements

- a. Document all client encounters and rationale for actions to facilitate continuity of care
- b. Collect, disclose, use, and destroy health information according to privacy and confidentiality legislation, regulations, and jurisdictional regulatory standards
- c. Apply relevant security measures to records and documentation

1.15 Provide safe, ethical, and competent services as a self-employed practitioner

- a. Engage in ethical practices that adhere to jurisdictional and federal legislation, regulations, guidelines, and ethical standards for nursing



- b. Employ accurate, honest, and ethical billing and advertising practices
- c. Act as a health information custodian to ensure client information is secure and remains confidential
- d. Identify and manage potential and real conflicts of interest, always acting in the client's best interest

1.16 Employ evidence-informed virtual care strategies

- a. Articulate the risks and benefits of virtual care to confirm the client's informed consent to participate in a virtual care visit
- b. Maintain client's privacy during virtual encounters, and when transferring data and providing medical documents electronically
- c. Determine when the client's health concern can be managed virtually without delaying or fragmenting care
- d. Understand the limitations of virtual care when determining the need for in-person assessment and management
- e. Adapt history-taking and assessment techniques to effectively complete the virtual client assessment
- f. Use effective communication approaches in the virtual care environment
- g. Integrate health care technologies and communication platforms to deliver virtual care
- h. Adhere to requirements for communication and documentation for virtual client encounters



2.0 LEADER

Nurse Practitioners demonstrate collaborative leadership within the health care system locally, regionally, nationally, and globally. They are leaders in the development, implementation, and delivery of continuity-based, person-centred care. Nurse Practitioners serve as role models and mentors, demonstrating leadership to advance continuous improvement of client outcomes and health systems. They contribute to implementing and maintaining a high-quality health care system through innovation and policy development. They strive for a culture of excellence and facilitate the development of effective teams and communication within complex health systems.

2.1 Demonstrate leadership that contributes to high quality health care system

- a. Build partnerships with inter- and intra-professional and **intersectoral teams**, individuals, communities, and organizations to achieve common goals and shared vision
- b. Demonstrate situational awareness when conducting a critical analysis of individual, team, and organizational functioning
- c. Engage in, and encourage others in demonstrating transparent communications to support a culture of trust
- d. Use principles of team dynamics and conflict resolution to support effective collaboration
- e. Support, direct, educate, and mentor colleagues, students, and others to build capacity, competence, and confidence
- f. Share expertise within and across teams
- g. Demonstrate environmental, financial, and resource stewardship to promote a sustainable health system

2.2 Contribute to a culture of improvement, safety, and excellence

- a. Engage in environmental scanning to identify future needs of the client and/or health care system
- b. Participate in, and lead, quality and risk management initiatives to identify system issues and improve delivery of services
- c. Use established benchmarking and best practices to establish goals to facilitate system changes
- d. Develop, modify, and implement quality management tools and strategies to collect and track quality improvement data
- e. Recommend changes to enhance outcomes based on continuous quality improvement principles



- f. Communicate quality improvement outcome data and recommendations to advance knowledge, change practice, and enhance effectiveness of services
- g. Anticipate and respond to unfamiliar, complex, and unpredictable situations
- h. Advocate for policies for safe and healthy practice environments

2.3 Design, implement, and evaluate health promotion and disease prevention programs

- a. Engage in environmental scanning to anticipate global, public, and population health trends
- b. Propose health promotion and disease prevention programs based on trends, data, literature, identified client needs, and research
- c. Apply informatics when using data, information, and knowledge to engage in health surveillance activities
- d. Lead implementation of evidence-informed strategies for health promotion, and primary, secondary, and tertiary disease prevention programs
- e. Promote awareness of social determinants of health and important health issues
- f. Facilitate use of relevant public health resources
- g. Develop and implement disaster- and pandemic-planning protocols and policies
- h. Evaluate program and strategies and recommend modifications based on evidence-informed rationale



3.0 ADVOCATE

Nurse Practitioners influence and improve the health and well-being of their clients, communities, and the broader populations they serve. They address issues related to **health inequity**, culture, diversity, and inclusion to improve health outcomes and lead advocacy efforts to change policies and legislation.

3.1 Practice self-awareness to minimize personal **bias** based on social position and power

- a. Demonstrate cultural humility and examine own assumptions, beliefs, and privileges and challenge biases, stereotypes, and prejudice
- b. Address the effects of the unequal distribution of power and resources on the delivery of services
- c. Demonstrate respect, open, and effective dialogue, and mutual decision-making
- d. Evaluate and seek feedback on own behaviour

3.2 Contribute to a practice environment that is diverse, equitable, inclusive, and **culturally safe**

- a. Recognize that everyone has their own unique experiences of discrimination and oppression
- b. Demonstrate awareness of, and sensitivity to, client's culture, lived experiences, **gender identity**, sexuality, and personal expression
- c. Address situations when observing others behaving in a racist or discriminatory manner
- d. Integrate the client's understanding of health, well-being, and healing into the plan of care
- e. Involve the persons or communities that are important to the client
- f. Collaborate with local partners and communities, including interpreters and leaders
- g. Engage in critical dialogue with other stakeholders to create positive change

3.3 Provide culturally safe, **anti-racist care for Indigenous Peoples**

- a. Identify the historical and ongoing effects of **colonialism** and settlement on the health care experiences of Indigenous Peoples
- b. Acknowledge, analyze, and understand the ongoing negative and disproportionate effects of systemic and historical oppression on Indigenous Peoples
- c. Recognize that Indigenous languages, histories, heritage, cultural and healing practices, and **ways of knowing** may differ between Indigenous communities
- d. Demonstrate **cultural humility** and examine own values, assumptions, beliefs, and privileges that may impact the therapeutic relationship with Indigenous Peoples



- e. Utilize the principles of self-determination and support the Indigenous client in making decisions that affect how they want to live their life
- f. Acknowledge the Indigenous person's cultural identity, seek to understand their lived experience, and provide time and space needed for discussing needs and goals
- g. Identify, integrate, and facilitate the involvement of cultural resources, families, and others such as, community elders, traditional knowledge keepers, cultural navigators, and interpreters, when needed and/or requested
- h. Evaluate and seek feedback on own behaviour towards Indigenous Peoples

3.4 Promote equitable care and service delivery

- a. Navigate systemic barriers to enable access to resources
- b. Challenge biases and social structures related to systemic oppression
- c. Respond to the social, structural, political, and ecological determinants of health, well-being, and opportunities
- e. Address situations and systems of inequity and oppression within own sphere of influence
- f. Address impact of unequal distribution of power and resources on the delivery of services

3.5 Advocate for access to resources and for system changes that demonstrates cultural safety and humility

- a. Support the development of resources and education that address **anti-racism** and oppression
- b. Advocate for environments and policies that support equitable access to care
- c. Raise awareness of limitations and bias in information and systems
- d. Raise clients' awareness of their right to access quality care

3.6 Support the development of policies and legislation to improve health

- a. Understand the interdependence of policy and practice
- b. Recommend evidenced-informed strategies that influence policy changes
- c. Evaluate the impact of policies and legislation on health and health equity
- d. Communicate information from multiple sources in a logical and comprehensive, yet concise manner
- e. Contribute to the development of policies and legislation



4.0 EDUCATOR

Nurse Practitioners develop and provide education to a wide range of individuals, groups, communities, and organizations to enhance knowledge and influence nursing practice, health outcomes, and system change.

4.1 Develop and provide education to build capacity and enhance knowledge and skills

- a. Apply teaching and learning theories to develop, modify, deliver, implement, and evaluate education materials and programs
- a. Design evidence-informed educational material and program content
- a. Integrate technology to enhance learning experiences and information delivery
- a. Mentor others to develop skills to deliver education

4.2 Evaluate the learning and delivery methods to improve outcomes

- a. Develop and use evaluation instruments to evaluate knowledge acquisition
- a. Analyze and synthesize evaluation data to inform modifications to the education content and delivery approach
- a. Coach others in evaluating and improving education materials and outcomes



5.0 SCHOLAR

Nurse Practitioners seek out, participate in, and demonstrate leadership in research activities to evaluate, explore, and advance knowledge, and support **knowledge translation** in all domains of nursing.

5.1 Contribute to research initiatives to promote evidence-informed practice

- a. Seek out collaborative research relationships and partners
- b. Understand the connection between research and advanced practice
- c. Identify knowledge gaps to determine research priorities
- d. Adhere to ethical principles, including the **First Nations principles of ownership, control, access, and possession**
- e. Conduct research using valid and reliable methodologies
- f. Analyze research findings to draw valid and reliable conclusions

5.2 Promote knowledge translation of research findings to improve health care and system outcomes

- a. Discuss the practical benefits and possible applications of research with teams and partners
- b. Recommend where research findings can be integrated into practice
- c. Share research findings with clients, groups, communities, and organizations
- d. Apply research findings to develop standards, guidelines, practices, and policies that improve client care and strengthen health care systems
- e. Exhibit leadership in implementing new practice approaches based on research findings
- f. Model how research evidence is used to support practice and system changes



GLOSSARY

DESCRIPTION OF KEY TERMS	
Anti-racism (Anti- racist)	The practice of actively identifying, challenging, preventing, eliminating, and changing the values, structures, policies, programs, practices, and behaviours that perpetuate racism. It is more than just being “not racist” but involves taking action to create conditions of greater inclusion, equality, and justice. (Turpel-Lafond, 2020)
Bias	A way of thinking or operating based explicitly or implicitly on a stereotype or fixed image of a group of people. (Turpel-Lafond, 2020)
Client	The person, patient or resident who benefits from nursing care. A client may be an individual, a family, group, community or population. (Nurses Association of New Brunswick, 2016)
Co-create	Engaging in an intentional relationship for the purpose of creating something together. It goes beyond collaboration and client-focused care as it requires the dynamics of the relationship to build something. It means that clients and nurses are equal partners and share power in the relationship. (Hemberg & Bergdahl, 2019)
Colonialism	Colonialism occurs when groups of people come to a place or country, steal the land and resources from Indigenous peoples, and develop a set of laws and public processes that are designed to violate the human rights of the Indigenous peoples, violently suppress their governance, legal, social, and cultural structures, and force them to conform with the colonial state. (Turpel-Lafond, 2020)
Complementary and alternative medicine	The terms “complementary medicine” and “alternative medicine” refer to a broad set of health care practices that are not part of that country’s own traditional or conventional medicine and are not fully integrated into the dominant health care system. (World Health Organisation 2019) Terminology related to care practices and approaches continue to evolve; ‘integrative and functional medicine’ is emerging as a more inclusive term to replace ‘complementary and alternative medicine’. While functional medicine focuses on creating individualized therapies tailored to treat underlying causes of illness, integrative medicine seeks to understand the individual as a whole and applies many forms of therapy to improve wellness. (Allessi, 2019). As ‘integrative and functional medicine’ is not yet common nomenclature, the more traditional terminology ‘complementary and alternative medicine’ has been used.
Contextual factors	There are three layers of contextual factors <ul style="list-style-type: none">• Micro contextual factors involve the client’s immediate environment – their own health status, family, friends, and their physical environment.• Meso contextual factors involve the policies and processes embedded in the organization and health system that affect the client.• Macro contextual factors involve the larger socioeconomic and political context around the client – social and cultural values and beliefs, laws, and public policies. (ACOTRO, ACOTUP, & CAOT, 2021)



DESCRIPTION OF KEY TERMS

<p>Cultural humility*</p>	<p>A life-long process of self-reflection and self-critique. It is foundational to achieving a culturally safe environment. While western models of medicine typically begin with an examination of the patient, cultural humility begins with an in-depth examination of the provider’s assumptions, beliefs and privilege embedded in their own understanding and practice, as well as the goals of the patient-provider relationship. Undertaking cultural humility allows for Indigenous voices to be front and centre and promotes patient/provider relationships based on respect, open and effective dialogue, and mutual decision-making. This practice ensures Indigenous peoples are partners in the choices that impact them, and ensures they are party and present in their course of care. (Turpel-Lafond, 2020)</p>
<p>Culturally safe</p>	<p>Culturally ‘safe’ is a refinement to the concept of ‘cultural safety’. A competent NP does everything they can to provide culturally safe care. But they remain aware that they are in a position of power in relation to clients and some clients may never feel fully safe. The NP allows those who receive the service to determine what they consider to be safe. The NP supports them in drawing strength from their identity, culture, and community. Because cultural safety is unlikely to be fully achievable, we work toward it. (ACOTRO, ACOTUP, & CAOT, 2021) A culturally safe environment is physically, socially, emotionally and spiritually safe. There is recognition of, and respect for, the cultural identities of others, without challenge or denial of an individual’s identity, who they are, or what they need. Culturally unsafe environments diminish, demean, or disempower the cultural identity and well-being of an individual. (Turpel-Lafond, 2020)</p>
<p>First Nations principles of ownership, control, access, and possession</p>	<p>The First Nations principles of ownership, control, access, and possession – more commonly known as OCAP® – assert that First Nations have control over data collection processes, and that they own and control how this information can be used. https://fnigc.ca/about-fnigc/</p>
<p>Gender identity</p>	<p>A person’s internal and deeply felt sense of being man or woman, both, neither, or somewhere along the gender spectrum. A person’s gender identity may or may not align with the gender typically associated with the sex they were assigned at birth. Gender identity is not necessarily visible and is not related to sexual orientation (Government of Canada, 2019)</p>
<p>Health inequity</p>	<p>The presence of systematic disparities in health (or in the major social determinants of health) among groups with different social advantage/ disadvantage. (Turpel-Lafond, 2020)</p>
<p>Indigenous peoples</p>	<p>The first inhabitants of a geographic area. In Canada, Indigenous peoples include those who may identify as First Nations (status and non-status), Métis and/or Inuit (Turpel-Lafond, 2020)</p>
<p>Intergenerational trauma</p>	<p>Historic and contemporary trauma that has compounded over time and been passed from one generation to the next. The negative cumulative effects can impact individuals, families, communities, and entire populations, resulting in a legacy of physical, psychological, and economic disparities that persist across generations. For Indigenous peoples, the historical trauma includes trauma created as a result of the imposition of assimilative policies and laws aimed at attempted cultural genocide and continues to be built upon by contemporary forms of colonialism and discrimination. (Turpel-Lafond, 2020)</p>
<p>Intersectoral teams</p>	<p>Intersectoral collaboration is the joint action taken by health and other government sectors, as well as representatives from private, voluntary, and non-profit groups, to improve the health of populations. Intersectoral action takes different forms such as cooperative initiatives, alliances, coalitions or partnerships. https://cbpp-pcpe.phac-aspc.gc.ca</p>



DESCRIPTION OF KEY TERMS	
Knowledge translation	A dynamic and iterative process that includes synthesis, dissemination, exchange, and ethically-sound application of knowledge to improve the health of clients and provides more effective health services and products and strengthen the health care system. (Canadian Institutes of Health Research, 2016)
Point-of-care tests	Point-of-care testing (POCT) refers to diagnostic tests performed at or near the patient's location by health care professional or other qualified personnel. It can include tests conducted by the patient themselves at home or a community setting. (Cowling & Dolcine, 2017)
Trauma- and violence-Informed care*	Trauma- and violence-informed care (TVIC) expands on trauma informed care to account for the intersecting impacts of systemic and interpersonal violence and structural inequities on a person's life, emphasizing both historical and ongoing violence and their traumatic impacts. It shifts the focus to a person's experiences of past and current violence, so problems are seen as residing in both their psychological state, and social circumstances. (EQUIP Health Care, n.d.)
Virtual care	Virtual care refers to any interaction between client and/or members of their circle of care, occurring remotely, using any form of communication or information technology, with the aim of facilitating or maximizing the quality and effectiveness of client care. Virtual care technologies are those forms of technology that allows 'virtual' interactions with health care professionals to occur in real time, from virtually any location. Services provided using virtual care technologies range from simple to complex. Examples of simple technologies may include telephone, text, messenger, or email, etc. Examples of complex technologies may include, but are not limited to, live, two-way audio/video conferencing or virtual visits, teleradiology, telerobotics, remote control surgical instrumentation. (CMA, 2020)
Ways of knowing	Indicates the vast variety of knowledge that exists across diverse Indigenous communities and signals that learning goes beyond human interaction and relationships to include learning from other elements of creation such as the plant and animal nations, and to "objects" that many people consider to be inanimate. (Queens University Office of Indigenous Initiatives, 2020)

**Updates the description / definition in 2018 RN entry-level competencies*



BIBLIOGRAPHY

- Academy of Nutrition and Dietetics. (2021, March). *Essential practice competencies for the commission on dietetic registration's credentialed nutrition and dietetics practitioners*. <https://www.cdrnet.org/essential-practice-competencies-information>
- Allessi, G. (2019, December 19). *What's the difference between functional & integrative medicine?* Balanced Well-Being Healthcare. <https://www.balancedwellbeinghealthcare.com/whats-the-difference-between-functional-integrative-medicine/>
- American Association of Colleges of Nursing. (2018). *Defining scholarship for academic nursing task force: Consensus position statement*.
<https://www.aacnursing.org/Portals/42/News/Position-Statements/Defining-Scholarship.pdf>
- American Counselling Association. The Center for Counseling Practice, Policy, and Research. (2009). *ALGBTIC competencies for counseling LGBTQIQA*. https://www.counseling.org/docs/default-source/competencies/algbtic-competencies-for-counseling-lgbqiqa.pdf?sfvrsn=1c9c89e_14
- Association of Canadian Occupational Therapy Regulatory Organizations. (2021). *Competencies for occupational therapist in Canada*. <https://acotro-acore.org/wp-content/uploads/2021/11/OT-Competency-Document-EN-HiRes.pdf>
- British Columbia College of Nurses & Midwives. (2022, January). *Practice standard: Indigenous cultural safety, cultural humility, and antiracism*. <https://www.bccnm.ca/RN/PracticeStandards/Pages/CulturalSafetyHumility.aspx>
- Canadian Association of Schools of Nursing. (2012). *Nurse practitioner education in Canada. National framework of guiding principles & essential components*. <https://www.casn.ca/2014/12/nurse-practitioner-education-canada-national-framework-guiding-principles-essential-components/>
- Canadian Association of Schools of Nursing. (2015). *National nursing education framework. Final report*. <https://www.casn.ca/wp-content/uploads/2018/11/CASN-National-Education-Framwork-FINAL-2015.pdf>
- Canadian Council of Registered Nurse Regulators. (2015). *Practice Analysis Study of Nurse Practitioners*. <http://www.ccrnr.ca/assets/ccnr-practice-analysis-study-of-nurse-practitioners-report---final.pdf>
- Canadian Institutes of Health Research. (2016). *Knowledge translation*. <https://cihr-irsc.gc.ca/e/29418.html>
- Canadian Medical Association. (2020, February). *Virtual care: Recommendations for scaling up virtual medical services*. <https://www.cfpc.ca/CFPC/media/Images/PDF/VCTF-report-Final-ENG-Feb-11-20.pdf>
- Canadian Midwifery Regulators Consortium. (2008). *Canadian competencies for midwives*. http://cmrc-ccosf.ca/sites/default/files/pdf/National_Competencies_ENG_rev08.pdf
- Canadian Midwifery Regulators Consortium. (2020). *Canadian competencies for midwives*. https://cmrc-ccosf.ca/sites/default/files/pdf/CMRC%20competencies%20Dec%202020%20FINAL_3-e_Jan%202022.pdf
- Canadian Nurses Association. (2005, January). *Canadian nurse practitioner: Core competency framework*. <https://silo.tips/download/canadian-nurse-practitioner-core-competency-framework>
- Canadian Nurses Association. (2010, May). *Canadian nurse practitioner: Core competency framework*.



<https://www.cna-aiic.ca/en/nursing/advanced-nursing-practice/nurse-practitioners/nurse-practitioner-resources>

- Canadian Nurses Association. (2015). *Primary health care [Position statement]*. <https://www.cna-aiic.ca/en/policy-advocacy/policy-support-tools/primary-health-care>
- Canadian Nurses Association. (2017). *Code of ethics for registered nurses*. <https://www.cna-aiic.ca/en/nursing/regulated-nursing-in-canada/nursing-ethics>
- Canadian Nurses Association. (2019). *Advanced practice nursing: A pan-Canadian framework*. <https://www.cna-aiic.ca/en/nursing/advanced-nursing-practice>
- College of Nurses of Ontario. (2020). *Telepractice: Practice guideline*. https://www.cno.org/globalassets/docs/prac/41041_telephone.pdf
- College of Registered Psychotherapists of Ontario. (2012, March). *Entry-to-practice competency profile for registered psychotherapists*. <https://www.crpo.ca/wp-content/uploads/2017/08/RP-Competency-Profile.pdf>
- Collins, P. H. & Bilge, S. (2020). *Intersectionality 2nd Edition*. Polity Press.
- Combes, J. R., & Arespachoga, E. (2012). *Physician competencies for a 21st century health care system*. *Journal of Graduate Medical Education*, 4(3), 401–405. <https://doi.org/10.4300/JGME-04-03-33>
- Contino, D.S. (2004). *Leadership competencies: Knowledge, skills, and aptitudes nurses need to lead organizations effectively*. *Critical Care Nurse*, 24(3): 52-64. <https://doi.org/10.4037/ccn2004.24.3.52>
- Cowling, T. & Dolcine, B. (2017). *Environmental scan, point-of-care testing*. *Canadian Agency for Drugs and Technology in Health*. https://www.cadth.ca/sites/default/files/pdf/es0308_point_of_care_testing.pdf
- Curtis, E., Jone, R., Tipene-Lech, D., Walker, C., Loring, B., Paine, S. (2019). *Why cultural safety rather than cultural competence is required to achieve health equity: a literature review and recommended definition*. *International Journal for Equity in Health*, 18 (174). <https://doi.org/10.1186/s12939-019-1082-3>
- Emergency Nurses Association. (2019). *Emergency nurse practitioner competencies*. <https://www.ena.org/docs/default-source/education-document-library/enp-competencydraft>
- EQUIP Health Care. (n.d.). *Trauma- & violence-informed care (TVIC): A Tool for health & social service organizations & providers*. <https://equiphealthcare.ca/files/2021/05/GTV-EQUIP-Tool-TVIC-Spring2021.pdf>
- Frank, J.R., Snell, L., & Sherbino, J. (Eds). (2015). *CanMEDS 2015: Physician competency framework*. *Royal College of Physicians and Surgeons of Canada*. https://canmeds.royalcollege.ca/uploads/en/framework/CanMEDS%202015%20Framework_EN_Reduce_d.pdf
- Gaudry, A., & Lorenz, D. (2018). *Indigenization as inclusion, reconciliation, and decolonialization: Navigating the different visions for Indigenizing the Canadian academy*. *AlterNative: An International Journal of Indigenous Peoples*, 14 (3), 218-227. <https://doi.org/10.1177/1177180118785382>
- Ginwright, S. (2018, May 31). *The future of healing: shifting from trauma informed care to healing centered engagement*. *Medium*. <https://ginwright.medium.com/the-future-of-healing-shifting-from-trauma-informed-care-to-healing-centered-engagement-634f557ce69c>
- Government of Canada. (2015). *Truth & reconciliation commission of Canada's final report: Calls to action*. <https://www.rcaanc-cirnac.gc.ca/eng/1450124405592/1529106060525#chp2>



- Government of Canada and Public Health Agency of Canada. (2016). *Canadian best practices Portal: Collaborate across sectors and levels*. <https://cbpp-pcpe.phac-aspc.gc.ca/population-health-approach-organizing-framework/key-element-6-collaborate-across-sectors-and-levels/>
- Government of Canada. (2019). *Gender identity*. In *gender and sexual diversity glossary*. <https://www.btb.termiumplus.gc.ca/publications/diversite-diversity-eng.html#g>
- Hemberg, J. & Bergdahl, E. (2019). *Cocreation as a caring phenomenon - nurses' experiences in palliative home care*. *Journal of Holistic Nursing Practice*, 33, 273-284. <https://doi.org/10.1097/HNP.0000000000000342>
- Institute for Integrative Science and Health. *Two-Eyed Seeing*. <http://www.integrativescience.ca/Principles/TwoEyedSeeing/>
- International Council of Nurses. (2020). *Guidelines on advanced practice nursing 2020*. https://www.icn.ch/system/files/documents/2020-04/ICN_APN%20Report_EN_WEB.pdf
- Janamian, T., Crossland, L., & Wells, L. (2016). *On the road to value co-creation in health care: The role of consumers in defining the destination, planning the journey and sharing the drive*. *The Medical Journal of Australia*, 204 (7 Suppl), S12–S14. <https://doi.org/10.5694/mja16.00123>
- Kesten, K.S., & Beebe, S.L. (2021). *Competency frameworks for nurse practitioner residency and fellowship programs: Comparison, analysis, and recommendations*. *Journal of the American Association of Nurse Practitioners* 34 (1), 160–168. <https://pubmed.ncbi.nlm.nih.gov/33767119/>
- Kuipers, S. J., Cramm, J. M., & Nieboer, A. P. (2019). *The importance of patient-centered care and co-creation of care for satisfaction with care and physical and social well-being of patients with multi-morbidity in the primary care setting*. *BMC Health Services Research*, 19 (1), 2-9. <https://doi.org/10.1186/s12913-018-3818-y>
- Matshaka, L. (2021). *Self-reflection: A tool to enhance student nurses' authenticity in caring in a clinical setting in South Africa*. *International Journal of Africa Nursing Sciences*, 15. <https://doi.org/10.1016/j.ijans.2021.100324>
- National Health Service and Royal College of General Practitioners. (2020). *Core capabilities framework for advanced clinical practice (nurses) working in general practice/primary care in England*. <https://www.hee.nhs.uk/sites/default/files/documents/ACP%20Primary%20Care%20Nurse%20Fwk%202020.pdf>
- National Inquiry into Missing and Indigenous Women and Girls. (2019). *Reclaiming power and peace: The final report of the national inquiry into missing and indigenous women and girls*. <https://www.mmiwg-ffada.ca/>
- Nurses Association of New Brunswick. (2016). *Entry-Level competencies for nurse practitioners*. <https://www.nanb.nb.ca/wp-content/uploads/2022/08/NANB-EntryLevelCompetenciesNP-October2016-E.pdf>
- Nursing and Midwifery Board. (2021, March). *Nursing Practitioner and midwifery board nurse practitioner standards for practice*. <https://www.nursingmidwiferyboard.gov.au/codes-guidelines-statements/professional-standards/nurse-practitioner-standards-of-practice.aspx>
- Nursing Council of New Zealand. (2017, March). *Competencies for the nurse practitioner scope of practice*. https://www.nursingcouncil.org.nz/public/nursing/scopes_of_practice/nurse_practitioner/ncnz/nursing-section/nurse_practitioner.aspx
- Pollard, C.L., & Wild, C. (2014). *Nursing leadership competencies: Low-fidelity simulation as a*



- teaching strategy. *Nurse Education in Practice*, 14(6), 620-626. <https://doi.org/10.1016/j.nepr.2014.06.006>
- Provincial Health Services Authority and Office of Virtual Health Practice and Education. (2022, July). *Literature review summary: Virtual health competencies*. <http://www.phsa.ca/health-professionals-site/Documents/Office%20of%20Virtual%20Health/OVHCompetencyFrameworkLiteratureReview.pdf>
- Queens University Office of Indigenous Initiatives. (2020). *Ways of knowing*. <https://www.queensu.ca/indigenous/ways-knowing/about>
- Robinson, D., Masters, C., & Ansari, A. (2021). *The 5 Rs of cultural humility: A conceptual model for health care leaders*. *The American Journal of Medicine*, 134(2): 161-163. <https://doi.org/10.1016/j.amjmed.2020.09.029>
- Royal College of General Practitioners. (2015, November). *General practice advanced nurse practitioner competencies*. <https://sybwg.files.wordpress.com/2017/02/rcgp-np-competencies.pdf>
- Rumman, A., & Alheet, A.F. (2019). The role of researcher competencies in delivering successful research. *Information and Knowledge Management*, 9(1), 15-19. <https://www.iiste.org/Journals/index.php/IKM/article/view/45969/47849>
- Sevelius, J. M. (2013). *Gender affirmation: a framework for conceptualizing risk behaviour among transgender women of color*. *Sex Roles*, 68, 675-689. <https://doi.org/10.1007/s11199-012-0216-5>
- Sharma, R., Davidson, K.W., & Nochomotitz, M. (2019). *It's not just FaceTime: core competencies for the medical virtualist*. *Journal of Emergency Medicine*, 12(8). <https://doi.org/10.1186/s12245-019-0226-y>
- Special Committee on Competencies for Special Librarians. (2003). *Competencies for information professionals of the 21st century*. <https://dbiosla.org/Competencies%20for%20Information%20Professionals%20of%20the%2021st%20Century.pdf>
- The College of Family Physicians of Canada. (2017). *CanMEDS-Family medicine 2017: A competency framework for family physicians across the continuum*. <https://www.cfpc.ca/CFPC/media/Resources/Medical-Education/CanMEDS-Family-Medicine-2017-ENG.pdf>
- The National Organization of Nurse Practitioner Faculties. (2017). *Nurse practitioner core competencies content*. https://cdn.ymaws.com/www.nonpf.org/resource/resmgr/competencies/2017_NPCoreComps_with_Curric.pdf
- The National Organization of Nurse Practitioner Faculties. (2022). *Nurse practitioner role core competencies*. https://cdn.ymaws.com/www.nonpf.org/resource/resmgr/competencies/20220719_nonpf_np_role_core.pdf
- Thibault, G.E. (2020). *The future of health professions education: Emerging trends in the United States*. *FASEB BioAdvances*, 2:685-694. <https://faseb.onlinelibrary.wiley.com/doi/pdf/10.1096/fba.2020-00061>
- Turpel-Lafond, M. E. (2020, November). *In plain sight: addressing indigenous-specific racism and discrimination in B.C. Health Care Summary Report*. <https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Summary-Report.pdf>
- Van Oerle, S., Lievens, A., & Mahr, D. (2018). *Value co-creation in online healthcare communities: The impact of patients' reference frames on cure and care*. *Psychology and Marketing*, 35: 629-639. <https://doi.org/10.1002/mar.21111>
- World Health Organisation. (2019). *WHO global report on traditional and complimentary medicine*. <https://www.who.int/publications/i/item/978924151536>



COLLEGE AND ASSOCIATION OF NURSES
of the Northwest Territories and Nunavut

Office Location: 3rd Floor, 4921 49 Street Yellowknife, NT X1A 2N9
Monday Friday: 8:30 AM – 4:30 PM
Phone: 867-873-2745
Website: <https://cannn.ca/>