SASKATCHEWAN
RN
ASSOCIATION

Registered Nurse (Nurse Practitioner) Entry-Level Competencies

Approved by SRNA Council November 2, 2016
Pending Bylaw Changes before Implementation

The document has been released early to give stakeholders time to prepare for the new competencies.

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Introduction and Background

The Saskatchewan Registered Nurses' Association (SRNA) participated in the Canadian Council of Registered Nurse Regulators (CCRNR) Nurse Practitioner Practice Analysis and in the development of the national entry-level competencies for nurse practitioners. The SRNA worked with all jurisdictions to ensure the entry-level nurse practitioner competencies were consistent across Canada. The SRNA engaged in a broad jurisdictional consultation process with Registered Nurses (RN) and Registered Nurse (Nurse Practitioner)s [RN(NP)], educators, RN(NP) Advisory Working Group, and key stakeholders in order to validate that the national entry-level competencies reflect nurse practitioner practice in Saskatchewan.

Nurse practitioners in Saskatchewan must also be registered with the SRNA as an RN. The term nurse practitioner in Saskatchewan is used interchangeably with the term Registered Nurse (Nurse Practitioner) or RN(NP).

The entry-level competencies for nurse practitioners reflect the knowledge, skills, abilities and judgment required of nurse practitioners to provide safe, competent, ethical and compassionate care. While specific roles and responsibilities may vary by context and client population, this document outlines the essential competencies that all nurse practitioners must possess to be proficient when they begin practice in Saskatchewan.

The entry-level competencies outlined in this document were developed as part of a national analysis of three streams of nurse practitioner practice: (1) Family/All Ages (Primary care); (2) Adult; and (3) Child/Pediatric undertaken by the Canadian Council of Registered Nurse Regulators (CCRNR). The identified competencies were based on an extensive review of Canadian regulatory documents (provincial/territorial competencies, standards), 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, 27 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 health care 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 calls to action in the Truth and Reconciliation Commission of Canada (2015).

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, 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 chronic physical and mental illnesses within their legislated scope of practice. 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 health care. 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 and advocate to close gaps in health outcomes.

The principles of primary health care are foundational to nurse practitioner practice. The principles of primary health care determined by the World Health Organization are "accessibility, active public participation, health promotion and chronic disease prevention and management, the use of appropriate technology and innovation, intersectoral cooperation and collaboration" (Canadian Nurses Association, 2015, p. 1). 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, palliative and 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 health care 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.

Entry-level nurse practitioners require time and support from employers, mentors and the health care team to consolidate their knowledge, skills, abilities 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.

The RN(NP) entry-level competencies apply to initial 12 months of practice (Duchscher, 2008). The SRNA *RN(NP) Practice Standards* (2017) have been informed by the CCRNR NP Practice Analysis (2015) and build upon the foundations of the RN(NP) entry-level competencies.

The current SRNA *Registered Nurse (Nurse Practitioner) Entry-Level Competencies* are used in addition to the SRNA *Registered Nurse (Nurse Practitioner) Practice Standards*. These two documents replace the following:

- *Registered Nurse (Nurse Practitioner) RN(NP) Standards and Core Competencies*, (2011).
- *Clinical Expectations for RN(NP)s*, (2003).

Assumptions

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

- Nurse practitioner practice is grounded in values, knowledge and theories of nursing practice.
- Entry-level competencies form the foundation for all aspects of nurse practitioner practice, and apply across diverse practice settings and client populations.
- Entry-level competencies build and expand upon the competencies required of a registered nurse and address the knowledge, skills, abilities and judgment that are included in the nurse practitioner's legislated scope of practice.
- Nurse practitioners require graduate nursing education with a substantial clinical component.
- Collaborative relationships with other health care 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.

Competency Areas

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 professional role.

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.

1. Clearly articulate the role of the nurse practitioner when interacting with the client.
2. Use developmentally and culturally-appropriate communication techniques and tools.
3. Create a safe environment for effective and trusting client interaction where privacy and confidentiality are maintained.
4. Use relational strategies (e.g., open-ended questioning, fostering partnerships) to establish therapeutic relationships.
5. Provide culturally-safe care, integrating clients' cultural beliefs and values in all client interactions.
6. Identify personal beliefs and values and provide unbiased care.
7. Recognize moral or ethical dilemmas, and take appropriate action if necessary (e.g., consult with others, involve legal system).
8. Document relevant aspects of client care in 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.

1. Establish the reason for the client encounter
    a. Review information relevant to the client encounter (e.g., referral information, information from other health care providers, triage notes) if available.
    b. Perform initial observational assessment of the client's condition.
    c. Ask pertinent questions to establish the context for client encounter and chief presenting issue.
    d. Identify urgent, emergent, and life-threatening situations.
    e. Establish priorities of client encounter.
2. Complete relevant health history appropriate to the client's presentation
    a. Collect 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, prescription and OTC medications, and complementary therapies.
    b. Collect relevant information specific to the client's psychosocial, behavioral, cultural, ethnic, spiritual, developmental life stage, and social determinants of health.
    c. Determine 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, infections).
    d. Assess client's strengths and health promotion, illness prevention, or risk reduction needs.
3. Perform assessment
    a. Based on the client's presenting condition and health history, identify level of assessment (focused or comprehensive) required, and perform review of relevant systems.
    b. Select relevant assessment tools and techniques to examine the client.
    c. Perform a relevant physical examination based on assessment findings and specific client characteristics (e.g., age, culture, developmental level, functional ability).
    d. Assess mental health, cognitive status, and vulnerability using relevant assessment tools.
    e. Integrate 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.

1. Determine differential diagnoses for acute, chronic, and life threatening conditions
    a. Analyze and interpret multiple sources of data, including results of diagnostic and screening tests, health history, and physical examination.

b. Synthesize assessment findings with scientific knowledge, determinants of health, knowledge of normal and abnormal states of health/illness, patient and population-level characteristics, epidemiology, health risks.

c. Generate differential diagnoses.

d. Inform the client of the rationale for ordering diagnostic tests.

e. Determine most likely diagnoses based on clinical reasoning and available evidence.

f. Order and/or perform screening and diagnostic investigations using best available evidence to support or rule out differential diagnoses.

g. Assume responsibility for follow up of test results.

h. Interpret the results of screening and diagnostic investigations using evidence-informed clinical reasoning.

i. Confirm most likely diagnoses.

2. Explain assessment findings and communicate diagnosis to client

   a. Explain results of clinical investigations to client.

   b. Communicate diagnosis to client, including implications for short- and long-term outcomes and prognosis.

   c. Ascertain client understanding of information related to findings and diagnoses.

D. Treatment and 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.

1. Initiate interventions for the purpose of stabilizing the client in, urgent, emergent, and life-threatening situations (e.g., establish and maintain airway, breathing and circulation; suicidal ideation).

2. Formulate plan of care based on diagnosis and evidence-informed practice

   a. Determine and discuss options for managing the client's diagnosis, incorporating client considerations (e.g., socioeconomic factors, geography, developmental stage).

   b. Select appropriate interventions, synthesizing information including determinants of health, evidence-informed practice and client preferences.

   c. Initiate appropriate plan of care (e.g., non-pharmacological, pharmacological, diagnostic tests, referral).

   d. Consider resource implications of therapeutic choices (e.g., cost, availability).

3. Provide pharmacological interventions, treatment, or therapy

   a. Select pharmacotherapeutic options as indicated by diagnosis based on determinants of health, evidence-informed practice, and client preference.

   b. Counsel client on pharmacotherapeutics, including rationale, cost, potential adverse effects, interactions, contraindications and precautions as well as reasons to adhere to the prescribed regimen and required monitoring and follow-up.

   c. Complete accurate prescription(s) in accordance with applicable jurisdictional and institutional requirements.

d. Establish a plan to monitor client's responses to medication therapy and continue, adjust or discontinue a medication based on assessment of the client's response.

e. Apply strategies to reduce risk of harm involving controlled substances, including medication abuse, addiction, and diversion.

4. Provide non-pharmacological interventions, treatments, or therapies
    a. Select therapeutic options (including complementary and alternative approaches) as indicated by diagnosis based on determinants of health, evidence-informed practice, and client preference.
    b. Counsel client on therapeutic option(s), including rationale, potential risks and benefits, adverse effects, required aftercare, and follow-up.
    c. Order required treatments (e.g., wound care, phlebotomy).
    d. Discuss and arrange follow-up.
5. Perform invasive and non-invasive procedures
    a. Inform client about the procedure, including rationale, potential risks and benefits, adverse effects, and anticipated aftercare and follow-up.
    b. Obtain and document informed consent from the client.
    c. Perform procedures using evidence-informed techniques.
    d. Review clinical findings, aftercare, and follow-up.
6. Provide oversight of care across the continuum for clients with complex and/or chronic conditions.
7. Follow up and provide ongoing management
    a. Develop a systematic and timely process for monitoring client progress.
    b. Evaluate response to plan of care in collaboration with the client.
    c. Revise 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.

1. Establish collaborative relationships with health care providers and community-based services (e.g., school, police, child protection services, rehabilitation, home care).
2. Provide recommendations or relevant treatment in response to consultation requests or incoming referrals.
3. Identify 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. Initiate a consultation and/or referral, specifying relevant information (e.g., client history, assessment findings, diagnosis) and expectations.
5. Review consultation and/or referral recommendations with the client and integrate into plan of care as appropriate.

F. Health Promotion

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

1. Identify individual, family, community and/or population strengths and health needs to collaboratively develop strategies to address issues.
2. Analyze information from a variety of sources to determine population trends that have health implications.
3. Select and implement evidence-informed strategies for health promotion and primary, secondary, and tertiary prevention.
4. Evaluate outcomes of selected health promotion strategies and revise 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.

1. Identify, appraise, and apply research, practice guidelines, and current best practice.
2. Identify the need for improvements in health service delivery.
3. Analyze the implications (e.g., opportunity costs, unintended consequences) for the client and/or the system of implementing changes in practice.
4. Implement planned improvements in health care and delivery structures and processes.
5. Participate in quality improvement and evaluation of client care outcomes and health service delivery.
6. Identify and manage risks to individual, families, populations, and the health care system to support quality improvement.
7. Report adverse events to clients and/or appropriate authorities, in keeping with relevant legislation and organizational policies.
8. Analyze factors that contribute to the occurrence of adverse events and near misses and develop strategies to mitigate risks.
9. Participate in research.
10. Contribute to the evaluation of the impact of nurse practitioner practice on client outcomes and health care 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.

1. Promote the benefits of the nurse practitioner role in client care to other health care providers and stakeholders (e.g., employers, social and public service sectors, the public, legislators, policy-makers).
2. Implement strategies to integrate and optimize the nurse practitioner role within health care teams and systems to improve client care.
3. Coordinate interprofessional teams in the provision of client care.
4. Create opportunities to learn with, from, and about other health care providers to optimize client care.

5. Contribute to team members' and other health care providers' knowledge, clinical skills, and client care (e.g., by responding to clinical questions, sharing evidence).
6. Identify gaps and/or opportunities to improve processes and practices and provide evidence-informed recommendations for change.
7. Utilize theories of and skill in communication, negotiation, conflict resolution, coalition building, and change management.
8. Identify the need and advocate for policy development to enhance client care.
9. Participate in 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 health care team.

A. Client, Community, and Health Care Team Education

1. Assess and prioritize learning needs of intended recipients.
2. Apply relevant, theory-based, and evidence-informed content when providing education.
3. Utilize applicable learning theories, develop education plans and select appropriate delivery methods, considering available resources (e.g., human, material, financial).
4. Disseminate knowledge using appropriate delivery methods (e.g., pamphlets, visual aids, presentations, publications).
5. Recognize the need for and plan outcome measurements (e.g., obtaining client feedback, conduct pre- and post-surveys).

B. Continuing Competence

1. Engage in self-reflection to determine continuing education competence needs.
2. Engage in ongoing professional development.
3. Seek mentorship opportunities to support one's professional development.

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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 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

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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.

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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.

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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 -C-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, ON
Primary Care and Emergency

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

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

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

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

Charlene Downey, RN, MN, CON(C), NP
St. John's, NL
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, NP
London, ON
Pediatric

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, MB
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, AB
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, ON
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)
Hope, BC
Primary Care & Residential Care

Notes

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