Nurse Practitioner Association of Manitoba
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January 22, 2024

College of Registered Nurses of Manitoba (CRNM) Council
890 Pembina Highway
Winnipeg, MB R3M 2M8

Dear CRNM Council,

Re: Use and Distribution of Plagiarized Nurse Practitioner (NP) Entry-level Competencies by the Canadian Council of Registered Nurse Regulators (CCRNR)

We are in receipt of a response letter from Deb Elias, CEO/Registrar to the council letter (November 10, 2023) addressing the plagiarized NP competencies developed by CCRNR and adopted by CRNM indicating that such is manifestly untrue given a reference list is included. In addition, rational that best practice and a Delphi method was used to build the competencies, yet, at no time where NPs advised that competencies were reprinted from other professions (appendix A). Reprinting others material is not an accepted research or Delphi method – the root of the problem which undermines the honesty and integrity of self-regulation. The CCRNR NP competency project was led by a practical nurse who may not hold the expertise in graduate educated NP knowledge, skills, and judgment and thus unintentionally missed crediting words, ideas, or images in omitting direct quotes or relaying that consent was obtained from the original authors. A quasi Delphi technique may have been used but as the work is directly copied which lacked transparency for expert panels, focus groups, or NPs reviewing the reprinted competencies from other professions, the process was misleading and is dubious to suggest such is academically credible.

Given the methodology did not have NPs lead the competency project, we understand where a gap in knowledge or bias in creating NP role competencies may occur (i.e. NP led methodology differs from recruiting NPs to review surveys or participate in focus groups). More so, the deficit in Manitoba NPs who contributed to the adopted competencies remains elusive, given there is no transparency on the one Manitoba NP who serves on the national stakeholder advisory group for the NPR-FIPP project. As an example 4% (n=~12, not a significant or an accepted standard of representative sample size) of Manitoba NPs would indicate underrepresentation to inform NP regulation or governance such as entry-level competencies that are now used as a legal reference.

Given that NPs are the only health professionals in the world that do not self-regulate themselves, and where other professions attempt to use knowledge, skills, and judgment to regulate NPs, diligence of original work is critical as a matter of law for regulatory materials. A retraction of other professions' competencies relayed as NP-specific competencies is needed.

The reprinting of other health professionals' competencies, now published by CRNM, is a form of misinformation that distorts the publics and other health professionals understanding of NPs. The upholding of nurse self-regulation legislation that prohibits members from acting beyond the scope of practice of the regulated health profession, in the course of practising the profession, is at risk given NPs are not self-regulating NPs.

> *Self-regulation acknowledges that a profession itself is in the best position to regulate its registrants because their specialized body of knowledge makes external regulation difficult and impractical* (CRNM, 2002, 2018).

Such conduct jeopardizes the integrity of the nursing profession as a whole, and significantly harms NPs and nursing institutions in Canada. This conduct undermines nurse regulation and jeopardizes public and professional trust, and is causing harm for the NP profession.

The response provided by CEO Deb Elias has not provided the evidence that plagiarism is manifestly untrue, where a pattern of plagiarism within CRNM material published as original work exists (Appendix A). We are requesting that the entry-level NP competencies work be authenticated by an independent expert to determine the sources (competency identification & work done), a funding audit for this work, and an audit of the accountability for the College of Registered Nurses of Manitoba chief executive officer/registrar (policy CR-4 & EE-12) who was ultimately responsible for the creation and adoption of these competencies in Manitoba.

We are requesting an immediate full retraction of the CCRNR NP entry-level competencies to protect institutional integrity and prevent further harm to the NP profession and nursing self-regulation system.

Sincerely,

[redacted]

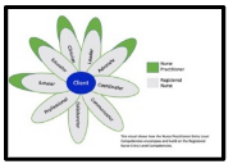
Cindy Fehr BSN, MEd, MScN, RN(NP) CEO,
Nurse Practitioner Association of Manitoba

[redacted]

Dr. Elsie Duff, RN(NP), senior policy consultant,
Nurse Practitioner Association of Manitoba

cc:
NPAM Board of Directors
Nurse Practitioner Associate of Canada Board of Directors
Minster of Health

Appendix A
Canadian Council of Registered Nurse Regulators NP Entry Level Competency 2023
Duplicates to other Health Professions



CCRNR NP vs RN competencies (64% difference from RN role)

*green color symbolizing NP scope should be significantly larger to differentiate from RN scope
e.g., advocate competencies NP =33 RN=14 should be 42% larger green color representing difference in scope, leader NP =23 RN=11 should be 48% larger green color representing difference in scope

CCRNR NP Competencies *** over 10% reprinted without evidence of credit or consent**	**Other Health Professions Competencies**
Co-create with client a shared understanding of scope of services, expectations client's strengths and limitations, and priorities.	Health Profession#1 - Co-create with clients a shared understanding of scope of services, expectations, and priorities.
Practice self-awareness to minimize personal bias based on social position and power	Health Profession #1 - Practise self-awareness to minimize personal bias and inequitable behaviour based on social position and power.
Demonstrate cultural humility and examine own assumptions, beliefs, and privileges and challenge biases, stereotypes, and prejudice.	Health Profession #1 - Demonstrate respect and humility when engaging with clients and integrate their understanding of health, well-being, healing, and occupation into the service plan.
Address the effects of the unequal distribution of power and resources on the delivery of services.	Health Profession #1 - Work to reduce the effects of the unequal distribution of power and resources on the delivery of occupational therapy services.
Provide culturally safe, anti-racist care for Indigenous Peoples. Contribute to a practice environment that is diverse, equitable, inclusive, and culturally safe.	Health Profession #1 - Contribute to a practice environment that is culturally safer, anti-racist, anti-ableist, and inclusive.
Identify the historical and ongoing effects of colonialism and settlement on the health care experiences of Indigenous Peoples.	Health Profession #1 - Identify the ongoing effects of colonization and settlement on occupational opportunities and services for Indigenous Peoples.
Acknowledge, analyze, and understand the ongoing negative and disproportionate effects of systemic and historical oppression on Indigenous Peoples.	Health Profession #1 - Analyse the effects of systemic and historical factors on people, groups, and their occupational possibilities.
Challenge biases and social structures related to systemic oppression.	Health Profession #1 - Challenge biases and social structures that privilege or marginalize people and communities.
Respond to the social, structural, political, and ecological determinants of health, well being, and opportunities.	Health Profession #1 - Respond to the social, structural, political, and ecological determinants of health, well-bei occupational opportunities.

Raise awareness of limitations and bias in information and systems. Raise clients' awareness of their right to access quality care.	Health Profession #1 - Raise awareness of limitations and bias in data, information, and systems.
Obtain informed consent according to legislation and regulatory requirements.	Health Profession #2 - Apply federal and provincial/territorial privacy legislation to the collection, use, storage, disclosure and destruction of personal health information.
Order and perform screening and diagnostic investigations including point-of-care tests, applying principles of resource stewardship.	Health Profession #3- Manages health care resources judiciously, including access to referral sources and the ordering of tests and treatments. Engage in the stewardship of health care resources
Follow legislative, regulatory, and organization requirements, when prescribing pharmacological and non-pharmacological interventions.	Health Profession #2 - Apply legal requirements to practice, including federal and provincial/territorial legislation, policies, by-laws, and standards.
Manage transference and countertransference in therapeutic relationships.	Health Profession #1 – Effectively manage the presence of transference or countertransference.
Demonstrate cultural humility and examine own values, assumptions, beliefs, and privileges that may impact the therapeutic relationship with Indigenous Peoples.	Health Profession #4 - Demonstrates cultural humility to establish a safe and respectful relationship with others.
Acknowledge the Indigenous person's cultural identity, seek to understand their lived experience, and provide time and space needed for discussing needs and goals.	Health Profession #4 - Acknowledge and incorporate into the plan of care Indigenous cultural rights, values, and practices, including ceremonies and protocols related to illness, birth, and death, where able.
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.	Health Profession #4 - Facilitate the involvement of the client's family and others (e.g., community and Elders, Indigenous cultural navigators, and interpreters) as needed and requested.
Identify knowledge gaps to determine research priorities.	Health Profession #5 - Identifies gaps in evidence to determine research priorities.
Conduct research using valid and reliable methodologies.	Health Profession #5 - Defines and establishes appropriate research methodology approaches (e.g. quantitative and qualitative methods).
Share research findings with clients, groups, communities, and organizations.	Health Profession #5 - Accurately and ethically shares research findings with a variety of audiences.
Evaluate effectiveness of counselling relationship and refer to appropriate professionals, when needed	Health Profession #6 - Maintain effective relationships. Refer to specific professional service where appropriate.
Anticipate and respond to the expression of intense emotions in a manner that facilitates a safe and effective resolution	Health Profession #6 - Anticipate and respond appropriately to the expression of intense emotions and help the client to understanding and management.

CRNM Standards for Nursing Education Programs (2024) Duplicates

CRNM Stand IV: EVALUATION AND PROGRAM EFFECTIVENESS a) *The approaches for evaluation of learners' performance articulated in the program plan facilitate achievement of the expected learner outcomes.* https://www.crnm.mb.ca/wp-content/uploads/2022/01/Standards-for-Nursing-Education-Program_Jan2024.pdf	*Other agency education accreditation standard:* *The approaches for evaluation of learners' performance articulated in the program plan facilitate achievement of the expected learner outcomes.* *(** not cited within the 2024 CRNM council approved December 2023 Standards for nursing education program).*

American Psychological Association. (2020). In *Publication manual of the American Psychological Association* (7th ed.). Washington, DC: Author.

"Plagiarism is the act of presenting the words, ideas, or images of another as one's own; it denies authors credit where credit is due. Whether deliberate or unintentional, plagiarism violates ethical standards in scholarship and has profound real-world effects. Authors who try to publish plagiarized work face rejection from publication, as well as possible sanction by professional bodies, censure in their place of employment, and/or exclusion from applying for federal funding" (p.21). "Writers who plagiarize disrespect the efforts of original authors by failing to acknowledge their contributions … and unfairly disregard those who exerted the effort to complete their own work" (p.254).

"To avoid plagiarism, provide appropriate credit to the source whenever you do the following:

- Paraphrase (i.e. state in your own words) the ideas of others
- Directly quote the words of others
- Reprint or adapt a table of figure, even images from the internet that are free
- Reprint a long text passage or commercially copyrighted test item (p. 255)".

"Reprinting means reproducing material exactly as it appeared originally, without modifications, in the way in which it was intended. *Adapting* refers to modifying material so that it is suitable for a new purpose. A copyright attribution is used instead of an author-date in-text citation to credit these works; authors need to seek and obtain explicit written permission from the copyright holder to reprint or adapt material, a process that can take substantial time and comes with no guarantee that the copyright holder will consent to the use. Because these polices are a matter of law, not specifically APA Style, all writers – even students whose work will note be formally published - should follow them" (p. 384-385).

College of
Registered Nurses
of Manitoba

Entry-Level Competencies (ELCs) for Registered Nurse (Nurse Practitioner)s or RN(NP)s

*These ELCs were created in collaboration with the **Canadian Council of Registered Nurse Regulators**.*

The College of Registered Nurses of Manitoba (the College) Council must, by regulation, establish standards of practice to regulate the quality of practice of registered nurses (RNs).

The Council approves practice directions which are written statements to enhance, explain, add or guide RNs with respect to matters described in the College of Registered Nurses General Regulations or any other matter relevant to registered nursing practice. Compliance with practice directions are required; these expectations also serve as a legal reference to describe reasonable and prudent nursing practice.

It is the responsibility of all registered nurses or RNs in Manitoba to understand all practice expectations and be accountable to apply them to their own nursing practice, regardless of roles or practice settings. Responsibility is the duty to satisfactorily complete your obligations. Accountability means being capable to explain why you did or did not meet these expectations.

The policies of employers do not relieve individual RNs of accountability for their own actions or the primary obligation to meet practice directions. An employer's policies should not require an RN to practise in a manner that violates practice directions.

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Published: 03/23/2023

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Introduction

The Entry-Level Competencies (ELCs) for RN(NP)s reflect the foundational knowledge, skills, and judgement required of RN(NP)s to provide safe, competent, ethical, and compassionate care. While RN(NP)s' roles and responsibilities may vary by context and client population, this document outlines the competencies that all RN(NP)s 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 Master's 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. RN(NP)s 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, RN(NP)s assume the role as the most responsible provider.

Background

The Canadian Council of Registered Nurse Regulators (CCRNR) first published ELCs for Nurse Practitioners in Canada in 2016. In 2020, CCRNR initiated a process to update the ELCs, which are revised periodically to reflect evolving population needs, health system, and RN(NP) 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 RN(NP)s

RN(NP)s ELCs reflect the knowledge, skills, and judgement required of RN(NP)s 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 RN(NP)s

ELCs and Entry-Level RN(NP) Practice

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

An RN(NP) 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 RN(NP) Practice

The following overarching principles and assumptions inform how the ELCs influence the education and practice of entry-level RN(NP)s. The entry-level RN(NP):

- 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

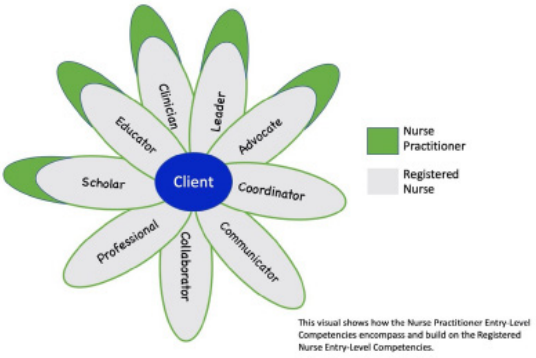
The revised ELCs were developed using a role-based framework that represents the multiple roles RN(NP)s assume when providing services in any practice setting. They are an interconnected set of competencies and indicators. For the sake of clarity and to avoid unnecessary repetition, key concepts are mentioned once and assumed to apply to all roles. While each role is presented separately, it is important to note that RN(NP)s 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 RN(NP) Entry-Level Competencies encompass and build on the Registered Nurse Entry-Level Competencies, focusing on distinct entry-level competencies for RN(NP)s. The competencies are accompanied by performance indicators.

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

1. Clinician
2. Leader
3. Advocate
4. Educator
5. Scholar

RN(NP) Role-based Competency Framework



This visual shows how the Nurse Practitioner Entry-Level Competencies encompass and build on the Registered Nurse Entry-Level Competencies.

1.0 CLINICIAN

RN(NP)s deliver safe, competent, compassionate, and ethical care across the lifespan with diverse populations and in a range of practice settings. RN(NP)s 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.

1.4 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 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 RN(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

RN(NP)s demonstrate collaborative leadership within the health care system locally, regionally, nationally, and globally. They lead the development, implementation, and delivery of continuity-based, person-centred care. RN(NP)s 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

RN(NP)s 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.

d. Address situations and systems of inequity and oppression within own sphere of influence.

e. 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

RN(NP)s 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.

b. Design evidence-informed educational material and program content.

c. Integrate technology to enhance learning experiences and information delivery.

d. 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.

b. Analyze and synthesize evaluation data to inform modifications to the education content and delivery approach.

c. Coach others in evaluating and improving education materials and outcomes.

5.0 SCHOLAR

RN(NP)s 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.

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 Organization 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:

- 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)

Cultural humility*: 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)

Culturally safe: Culturally 'safe' is a refinement to the concept of 'cultural safety'. A competent RN(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 RN(NP) allows those who receive the service to determine what they consider to be safe. The RN(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)

First Nations principles of ownership, control, access, and possession: 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/

Gender identity: 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)

Health inequity: 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)

Indigenous peoples: 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)

Intergenerational trauma: 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)

Intersectoral teams: 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

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, telerobotic, remote control surgical instrumentation. (CMA, 2020)

Way 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.

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January 19, 2024

SENT VIA EMAIL
ceo@nurspractitioner.ca

Cindy Fehr NP
Chief Executive Officer
Nurse Practitioner Association of Manitoba

Dear Ms. Fehr,

I am writing in response to your letter, dated November 10, 2023 (received on December 15, 2023) with respect to the "Use and Distribution of Plagiarized Nurse Practitioner (NP) Entry-level Competencies by the Canadian Council of Registered Nurse Regulators (CCRNR)".

In your letter, the Nurse Practitioner Association of Manitoba (NPAM) makes the following allegations:

1. The Nurse Practitioner (NP) entry-level competencies recently developed by CCRNR include plagiarized material;

2. Manitoba NPs had limited involvement in the creation of these entry-level competencies.

These allegations are manifestly untrue.

The process used to revise the NP entry-level competencies was based on best practices in competency development. I have provided further information about the process and methodology in Appendix A. With respect to your allegation of plagiarism, CCRNR's Nurse Practitioner Entry-Level Competencies Development Report provides a summary of this project. You will note that the last item pertains to an enhanced reference list which includes all sources used to refresh the NP entry-level competencies, even where in-text citations were not used. This reference list is also included starting on page 14 of the College's Entry-Level Competencies (ELCs) for Registered Nurse (Nurse Practitioner)s or RN(NP)s document.

As to your allegation that Manitoba NPs had limited involvement in the creation of the entry-level competencies, please refer to Appendix A which details the methodology used in the development of the NP entry-level competencies. You will note that one phase of this project was dedicated entirely to obtaining feedback from Canadian NPs and interest groups. CCRNR administered two separate surveys: one for individual NPs from across Canada, as well as one for NP interest groups, including NPAM.

As executive of NPAM, you will have had the opportunity to respond to both surveys: one as an individual NP and the other on behalf of NPAM as an interest group, and all interested parties had the opportunity to provide feedback on the CCRNR website.

The consultation process occurred between March and July 2022:

- March-May 2022: Focus groups with regulatory bodies, NP educators, and NPs
- June – July 2022: Jurisdictional interest group consultations (included NPAM)
    - Invitation/reminders sent to CEO@nursepractitioner.ca email:
        - June 16, 2022: Invitation email
        - June 28, 2022: First reminder email
        - July 11, 2022: Final reminder email
- June 2022: NP validation survey – sent to all NPs across Canada
- June 2022: Website feedback on CCRNR.ca

Manitoba NPs represent approximately 4% of the total population of NPs in Canada. Their survey submissions accounted for 14% of those received.

The survey responses were reviewed and considered prior to finalizing the entry-level competencies. Beyond this significant level of participation, a Manitoba RN(NP) also serves on the national stakeholder advisory group for the NPR-FIPP project.

As of December 2023, with the exception of Quebec, all jurisdictions have approved the NP entry-level competencies.

Both the CCRNR and CRNM maintain that the refreshed NP entry-level competencies adequately recognize the autonomous, independent, and advanced nature of NP practice in Canada.

Sincerely,

[redacted]
Deb Elias RN MN FRE *has authorized the use of electronic signature*
CEO/Registrar

Cc: Nurse Practitioner Association of Manitoba Board of Directors
- Chandra Hawkins, Interim-Chair & Irka Huley, Interim-Vice-Chair

Nurse Practitioner Association of Canada Council
- Laura Housden, NP Council Director & Chair

The Honorable Uzoma Asagwara, Minister of Health, Seniors and Long-Term Care

APPENDIX A – NP Entry-Level Competency Development Background

The processes used to revise the NP-ELCs conform to best practices in competency development (Campion et al. 2011; SHRM, 2013). While there are multiple ways in which to conduct a competency revision, the use of multiple data-collection methods and the application of an iterative development process (such as a Delphi study) to build consensus is recommended (Begley et al., 2020; Feng Yan-Ying et al., 2022). The Delphi method consists of several rounds of consultation including the administration of surveys to practitioner experts (Hoyt, 2010; Newman, 2022).

For this project, data was collected using a mixed-methods approach, employing subject-matter expert input throughout a three-phased Delphi study. Findings from each phase were presented to the CCRNR's Education Subcommittee for consideration to achieve a group consensus on proposed changes to the draft competencies (Feng Yan-Ying et al., 2022).

Round one of the Delphi study comprised focus groups to inform the roles-based model and to identify the differences between RN and NP competence, both at a proficiency level and within roles. Round two included a review of the draft competencies from the nursing regulatory bodies. Expert panelists also gave a voice to the perspectives of Indigenous, LGBTQIA2S+, the experience of racism, and cultural safety. Finally, Round three was completed using two surveys targeted to two separate subject-matter expert groups: NPs from across Canada, and NP interest groups (e.g.: associations, NP educators, other regulatory Colleges, and the general public).

The validation survey was sent to all NPs across Canada. The purpose of the survey was to assess the knowledge, skills, abilities, and judgement in the entry-level competencies by obtaining a rating of the competencies that are frequently performed. When validation surveys are done for entry-level competencies, participants are required to review each competency and indicator to confirm that they clearly and accurately define entry-level expectations of NPs practising across Canada. CCRNR heard from NPs about the importance of being involved in various aspects of the NPR-FIPP project - this is one of the many ways that NPs were involved.

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November 10, 2023

Lindsay Forest [redacted]
College of Registered Nurses of Manitoba (CRNM) Ministerial Appointment
890 Pembina Highway
Winnipeg, MB R3M 2M8

Dear Lindsay,

Re: Use and Distribution of Plagiarized Nurse Practitioner (NP) Entry-level Competencies by the Canadian Council of Registered Nurse Regulators (CCRNR)

It has come to our attention that within the adopted entry-level NP competencies, many have been copied from varied other health professionals' competencies and reapplied to NPs without due diligence or acknowledgement of original author. This differs from other credentialed health professions in Manitoba and nationally. Due to this copying, the CCRNR jurisdictional nurse regulators are using entry-level competencies from varied health professions for NP practice. We write to report this double standard and request a retraction of the entry-level NP competencies until a fulsome audit can be completed.

The competencies have been adopted and published as if original work, without standardized identification or testing. In essence, NP competencies have been plagiarized from elsewhere and are now being applied within the Canadian nursing regulatory standards system. It is important to note that Manitoba is one of a few jurisdictions that have officially adopted the new NP entry-level competencies.

The copying of other health professionals' competencies, now published by CCRNR and CRNM, also creates a double standard in the profession and possibly establishes a high-risk precedent. It has a cascading effect through the system, including into the academic sector. That is, applying competencies from other professions is a form of misinformation that distorts the publics and other health professionals understanding of NPs. Copyright infringement of other health professionals' competencies is also at issue. The upholding of nurse self-regulation legislation that prohibits members from acting beyond the scope of practice of the regulated health profession in the course of practising the profession is at risk given NPs are not self-regulating NPs. That is, there were limited Manitoba NPs involved in the creation of the CCRNR entry-level competencies, despite requesting to be involved in the development.

This lack of due diligence means that some competencies are not informed through nursing, or through credentialed NP standard professional review protocols. This differs from competencies that are identified by qualified professionals and tested through established standard steps, which is divergent from how other credentialed nurses are treated.

Such conduct jeopardizes the integrity of the nursing profession as a whole and the academic system generally, not merely NPs. Adopting others' professional competencies as NP competencies without due acknowledgement of original work harms NPs and nursing institutions in Canada. This conduct departs from

the obligatory professional, ethical, and legal standards to be upheld for public trust and within the university appointment systems for preceptors, instructors, guest lecturers, and professors.

This conduct also raises the spectre as to whether the same methods of developing nurse regulation have occurred elsewhere. If so, this is a much greater problem. If not, it illuminates a double standard by departing from the established rigour our nursing profession applies to develop competencies. In doing so, nurse regulators discriminated by selectively applying substandard ethics and rigor for one category of the nursing family (NPs), thus diminishing the trust in nurse self-regulation, which at its core values public safety and trust.

We believe this ethical breach requires reporting, transparency, and a response from the professional nursing sector as public trust and institutional integrity are at issue. Plagiarism is a serious breach and is causing harm. This conduct undermines nurse regulation and jeopardizes public and professional trust.

Given your ministerial appointed CRNM council position, we are writing to you to request that the entry-level NP competencies work be authenticated by an independent expert to determine the sources (competency identification & work done), a funding audit for this work, and an audit of the accountability for the College of Registered Nurses of Manitoba chief executive officer/registrar (policy CR-4 & EE-12) who was ultimately responsible for the creation and adoption of these competencies in Manitoba. As NPs with graduate education and in academic appointments among other leadership roles, we request an immediate full retraction of the CCRNR NP entry-level competencies to protect institutional integrity and prevent further harm to the NP profession and nursing self-regulation system.

Sincerely,

Cindy Fehr BSN, MEd, MScN, RN(NP) CEO,
Nurse Practitioner Association of Manitoba

Dr. Elsie Duff, RN(NP), senior policy consultant,
Nurse Practitioner Association of Manitoba

cc:
NPAM Board of Directors
Nurse Practitioner Association of Canada Board of Directors
Minister of Health