NURSE PRACTITIONERS

Entry-Level Competencies

Canadian Council of Registered Nurse Regulators (CCRNR) | adopted by BCCNM

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Revision Log

Revision Date	Revisions Made
January 2017	Published
January 2020	Revised to reflect amalgamation of Colleges
February 2021	Branding updated; references to BCCNP revised to BCCNM
February 21, 2023	Updated
June 27, 2024	Updated references

Contents

About BCCNM

The legal obligation of the British Columbia College of Nurses and Midwives (BCCNM) is to protect the public through the regulation of licensed practical nurses (LPNs), nurse practitioners (NPs), registered midwives (RMs), registered nurses (RNs), and registered psychiatric nurses (RPNs). This includes setting standards of practice, assessing nursing and midwifery education programs, and addressing complaints about BCCNM registrants.

Development & Structure of the Entry-Level Competencies

The Canadian Council of Registered Nurse Regulators (CCRNR) first published *Entry-Level Competencies (ELCs) for Nurse Practitioners in Canada* in 2016. The process to update the ELCs, which are the basis for the BCCNM *Entry-Level Competencies for Nurse Practitioners*[1] was led by CCRNR. The competencies are revised periodically to reflect evolving population needs, health system, and NP practice.

CCRNR commissioned the Nurse Practitioner Regulation Framework Implementation Plan Project, a multi-year, and multi-faceted project with a goal to implement a model for nurse practitioner regulation in Canada. The project consisted of six elements, one of which was updating the ELCs. A Steering Committee with representation from all Canadian NP regulatory bodies coordinated the work.

The current revisions were informed by an environmental scan, literature reviews, and stakeholder consultation. The updated ELCs also reflect inter-jurisdictional consistency to support workforce mobility requirements of the Canadian Free Trade Agreement.

The ELCs were developed using a role-based framework that represents the multiple roles NPs assume when providing services in any practice setting. The competencies and indicators are interconnected. Key concepts are mentioned once and assumed to apply to all roles. While each role is presented separately, it is important to note that NPs may use aspects of more than one role at the same time.

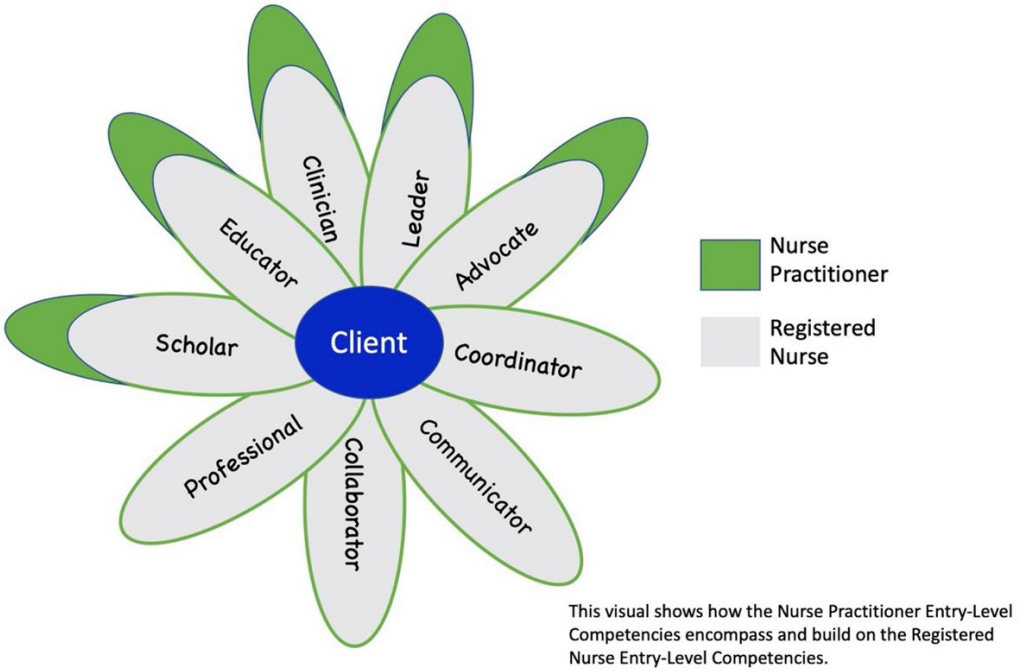
The ELCs are organized thematically in a role-based format similar to RN ELCs found on the BCCNM website. The NP ELCs encompass and build on the RN ELCs, focusing on distinct competencies for NPs. The competencies are accompanied by performance indicators.

There are a total of 29 competencies accompanied by performance indicators grouped thematically under five roles:

- Clinician
- Leader
- Advocate
- Educator
- Scholar

[1] Per the BCCNM Bylaws, 176(1), a practising nurse practitioner, in the course of practising nursing as a nurse practitioner may use the title "nurse practitioner," "registered nurse practitioner," "nurse," [or] "registered nurse."

The BC College of Nurses and Midwives Board approved the *Entry-Level Competencies for Nurse Practitioners* in January 2023 to be effective January 1, 2024.



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

Introduction

The ELCs for NPs reflect the foundational knowledge, skills, and judgement required of NPs to provide safe, competent, ethical, and compassionate care. While NP roles and responsibilities may vary by context and client population, the ELCs outline competencies that all NPs must possess to be competent when they begin practice as entry-level NPs. The ELCs define entry-level NP practice, and all NPs are ultimately accountable for meeting them throughout their careers.

A 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.

The ELCs are used by BCCNM and other external partners for several purposes, including but not limited to:

- Competency-based assessments
- Curriculum development
- Development of standards
- Exam development
- Information for the public and external partners
- NP education program review
- Practice assessment and measurement of initial applicants and current registrants
- Professional conduct review
- Practice consultation

BCCNM reviews nursing education programs/courses under the authority of the duties and objects of the college set out in the Health Professions Act (HPA) to establish the conditions or requirements for registration of a person as a registrant of the college.

The *Entry-Level Competencies for Nurse Practitioners* (2023) describes the expected competencies for entry-level NP practice in B.C. The competencies are used in BCCNM's review of the nurse practitioner education programs. Questions regarding the use of these competencies in education program review should be directed to educationprogramreview@bccnm.ca.

Profile of the Entry-Level Nurse Practitioner

Nurse practitioners are RNs with additional experience and nursing education at the master's level, which enable 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. NPs 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, NPs assume the role as the most responsible provider.

Principles and Assumptions for Entry-Level Nurse Practitioner Practice

The following overarching principles and assumptions apply to the education and practice of entry-level NPs. The entry-level 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,[2] practice standards,[3] professional standards,[4] ethics, and scope of practice[5] 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:

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[2] See Nurses and Nurse Practitioners Regulation, Health Professions Act 2020 (BC) Reg. 167/2020, https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/284_2008.

[3] See BCCNM, n.d., Practice Standards for Nurse Practitioners, https://www.bccnm.ca/NP/PracticeStandards/Pages/Default.aspx.

[4] See BCCNM, n.d., Professional Standards for Registered Nurses and Nurse Practitioners, https://www.bccnm.ca/NP/ProfessionalStandards/Pages/Default.aspx.

[5] See BCCNM, n.d., Scope of Practice for Nurse Practitioners: Standards, Limits, and Conditions, https://www.bccnm.ca/NP/ScopePractice/Pages/Default.aspx.

  - With people across the lifespan
  - With all clients – individuals, families, groups, communities, and populations
  - In all practice settings
  - Across all domains of practice
- Uses evidence and applies critical thinking throughout all aspects of practice

Ending Anti-Indigenous Racism

In 2017, health profession regulators in B.C., which included the previous nursing and midwifery colleges, pledged their commitment to making the health system more culturally safe for Indigenous[6] Peoples[7] in response to *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Healthcare*. One year later, when the three nursing regulators amalgamated to form the BC College of Nursing Professionals (BCCNP), one of BCCNMs legacy colleges, BCCNP made a commitment to cultural safety and humility in partnership with the First Nations Health Authority (FNHA). In September 2020, BCCNP and the College of Midwives of BC amalgamated to form BCCNM and the new BCCNM Board participated in a blanketing ceremony led by its Knowledge Carrier, Syexwáliya, to recognize the commitment to this ongoing work with *Chen Chen Stway* – standing and working to hold each other up and work together. BCCNM continues its commitment in its vision of safe, ethical person-centered care for everyone and builds on the knowledge and calls to action in the *Report of the Canadian Truth and Reconciliation Commission Calls to Action* (TRC, 2015) and recommendations from the *In Plain Sight* report.

Nurse practitioners have a responsibility to address racism and bias at the individual and systems levels. BCCNM expects the *Entry-Level Competencies for Nurse Practitioners* and the BCCNM *Indigenous Cultural Safety, Cultural Humility, and Anti-Racism*[8] Practice Standard will support nurse practitioners in playing a key role in addressing anti-Indigenous racism in healthcare.

Entry-Level Competencies and Indicators

1. CLINICIAN

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

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[6] Indigenous is used to be inclusive of all First Nations, Inuit, and Métis peoples as the original inhabitants and owners of the land prior to colonization in what is now called Canada.

[7] See BCCNM, n.d., Constructive Disruption to Indigenous-specific Racism amongst B.C. Nurse and Midwives, https://www.bccnm.ca/Documents/cultural_safety_humility/Constructive_Disruption_BCCNM_Commitment_to_Action.pdf.

[8] See BCCNM, (n.d.), *Indigenous Cultural Safety, Cultural Humility, and Anti-Racism* Practice Standard.

Assessment

1.1 Establish the reasons for the client 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, 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 healthcare services after considering the appropriateness of virtual care services, environmental factors, the nature of the service, the security of the system, alternative approaches, and contingency plans.

f. Use electronic health records and tracking systems to accurately collect and document client information and delivery of health services.

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

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

b. Select evidence-informed pharmacological interventions based on diagnoses, concurrent client therapies, and available medication history, using drug-information systems.

c. Utilize prescription monitoring and reporting programs according to jurisdictional and legislative requirements.

d. Complete medication reconciliation to make clinical decisions based on an analysis of the client's current pharmacological and non-pharmacological therapy.

e. Analyze polypharmacy to identify unnecessary and unsafe prescribing, and deprescribe where possible.

f. Recommend or order non-pharmacological interventions and complimentary, alternative, and natural health products based on client preference, history, and cultural practice.

g. Incorporate principles of pharmacological stewardship.

h. Establish a monitoring plan for pharmacological and non-pharmacological interventions.

i. Counsel client on pharmacological and non-pharmacological interventions, including indication, benefits, cost, potential adverse effects, interactions, contraindications, precautions, reasons to adhere to the prescribed regimen, required monitoring, and follow-up.

1.8 Perform invasive and non-invasive interventions as indicated by the management plan:

a. Co-create with the client an understanding of procedures, including indications, potential risks and benefits, adverse effects, anticipated aftercare, and follow-up care.

b. Perform procedures using evidence-informed techniques.

c. Monitor and evaluate clinical findings, aftercare, and follow-up.

d. Initiate interventions to stabilize the client in urgent, emergent, and life-threatening situations.

1.9 Evaluate effectiveness of the management plan to identify required modifications and/or terminations of treatment:

a. Develop a systematic and timely process for monitoring client progress, and follow up on results and interventions.

b. Evaluate responses to the management plan in collaboration with the client, and revise management plan as needed.

c. Discuss and implement follow-up to facilitate continuity of care in collaboration with the client.

d. Facilitate implementation of the management plan with the client, family, other health professionals, and community partners.

e. Facilitate referral to another practitioner or service if the client would benefit from the consultation or if the client-care needs are beyond the NP's individual competence or scope of practice.

Counselling

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

a. Co-create with client a shared understanding of scope of services, expectations, client's strengths and limitations, and priorities.

b. Identify barriers that interfere with client's goals.

c. Utilize developmentally, socio-demographically, and culturally relevant communication techniques and tools.

d. Evaluate effectiveness of counselling relationship and refer to appropriate professionals, when needed.

1.11 Provide counselling interventions as indicated by the management plan:

a. Integrate theories of cognitive and emotional development across the lifespan.

b. Identify impact of potential and real biases on the creation of safe spaces.

c. Integrate therapeutic use of self to facilitate an optimal experience and outcome for the client.

d. Anticipate and respond to the expression of intense emotions in a manner that facilitates a safe and effective resolution.

e. Consider the impact of client's personal and contextual factors.

f. Provide trauma- and violence-informed care.

g. Identify root causes of trauma, including intergenerational trauma, with the client and refer to appropriate professionals.

h. Manage transference and countertransference in therapeutic relationships.

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

a. Identify potential risks and signs of substance use disorder.

b. Co-create a harm-reduction management plan, considering treatment and intervention options.

c. Apply evidence-informed and safe prescribing practices when initiating and managing pharmacological and non-pharmacological interventions.

d. Adhere to legislation, regulation, and organizational policy related to the safe storage and handling of controlled drugs and substances.

e. Provide education on the safe storage and handling of controlled drugs and substances.

Transition of Care, Discharge Planning, Documentation

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

a. Collaborate with client to facilitate access to required resources, drug therapy, diagnostic tests, procedures, and follow up to support the continuum of care.

b. Facilitate transfer of information to support continuity of care.

c. Facilitate client's access to community services and other system resources.

d. Monitor and modify the management plan based on the client's transition needs.

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

a. Document all client encounters and rationale for actions to facilitate continuity of care.

b. Collect, disclose, use, and destroy health information according to privacy and confidentiality legislation, regulations, and jurisdictional regulatory standards.

c. Apply relevant security measures to records and documentation.

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

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

b. Employ accurate, honest, and ethical billing and advertising practices.

c. Act as a health information custodian to ensure client information is secure and remains confidential.

d. Identify and manage potential and real conflicts of interest, always acting in the client's best interest.

1.16 Employ evidence-informed virtual care strategies:

a. Articulate the risks and benefits of virtual care to confirm the client's informed consent to participate in a virtual care visit.

b. Maintain client's privacy during virtual encounters and when transferring data and providing medical documents electronically.

c. Determine when the client's health concern can be managed virtually without delaying or fragmenting care.

d. Understand the limitations of virtual care when determining the need for in-person assessment and management.

e. Adapt history-taking and assessment techniques to effectively complete the virtual client assessment.

f. Use effective communication approaches in the virtual care environment.

g. Integrate healthcare technologies and communication platforms to deliver virtual care.

h. Adhere to requirements for communication and documentation for virtual client encounters.

2. LEADER

Nurse practitioners demonstrate collaborative leadership within the healthcare system locally, regionally, nationally, and globally. They are leaders in the development, implementation, and delivery of continuity-based, person-centred care. Nurse practitioners serve as role models and mentors, demonstrating leadership to advance continuous improvement of client outcomes and health systems. They contribute to implementing and maintaining a high-quality healthcare 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 healthcare 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 healthcare 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. ADVOCATE

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

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

a. Demonstrate cultural humility and examine own assumptions, beliefs, and privileges and challenge biases, stereotypes, and prejudice.

b. Address the effects of the unequal distribution of power and resources on the delivery of services.

c. Demonstrate respect, open and effective dialogue, and mutual decision-making.

d. Evaluate and seek feedback on own behaviour.

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

a. Recognize that everyone has their own unique experiences of discrimination and oppression.

b. Demonstrate awareness of, and sensitivity to, client's culture, lived experiences, gender identity, sexuality, and personal expression.

c. Address situations when observing others behaving in a racist or discriminatory manner.

d. Integrate the client's understanding of health, well-being, and healing into the plan of care.

e. Involve the persons or communities that are important to the client.

f. Collaborate with local partners and communities, including interpreters and leaders.

g. Engage in critical dialogue with other stakeholders to create positive change.

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

a. Identify the historical and ongoing effects of colonialism and settlement on the healthcare 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. EDUCATOR

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

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

a. Apply teaching and learning theories to develop, modify, deliver, implement, and evaluate education materials and programs.

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. SCHOLAR

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

5.1 Contribute to research initiatives to promote evidence-informed practice:

a. Seek out collaborative research relationships and partners.

b. Understand the connection between research and advanced practice.

c. Identify knowledge gaps to determine research priorities.

d. Adhere to ethical principles, including the First Nations principles of ownership, control, access, and possession.

e. Conduct research using valid and reliable methodologies.

f. Analyze research findings to draw valid and reliable conclusions.

5.2 Promote knowledge translation of research findings to improve healthcare 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 healthcare systems.

e. Exhibit leadership in implementing new practice approaches based on research findings.

f. Model how research evidence is used to support practice and system changes.

Glossary

Description of Key Terms	
Anti-racism (Anti-racist)	The practice of actively identifying, challenging, preventing, eliminating, and changing the values, structures, policies, programs, practices, and behaviours that perpetuate racism. It is more than just being "not racist" but involves taking action to create conditions of greater inclusion, equality, and justice (Turpel-Lafond, 2020).
Bias	A way of thinking or operating based explicitly or implicitly on a stereotype or fixed image of a group of people (Turpel-Lafond, 2020).
Client	An individual, family, group, population, or entire community who requires nursing expertise. In some clinical settings, the client may be referred to as a patient or a resident. In research, the client may be referred to as a participant (BCCNM, n.d.).
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 healthcare practices that are not part of that country's own traditional or conventional medicine and are not fully integrated into the dominant healthcare system (World Health Organisation 2019). Terminology related to care practices and approaches continue to evolve; "integrative and functional medicine" is emerging as a more inclusive term to replace "complementary and alternative medicine." While functional medicine focuses on creating individualized therapies tailored to treat underlying causes of illness, integrative medicine seeks to understand the individual as a whole and applies many forms of therapy to improve wellness (Allessi, 2019). As "integrative and functional medicine" is not yet common nomenclature, the more traditional terminology "complementary and alternative medicine" has been used.

Description of Key Terms	
Contextual factors	There are three layers of contextual factors o Micro contextual factors involve the client's immediate environment – their own health status, family, friends, and their physical environment. o Meso contextual factors involve the policies and processes embedded in the organization and health system that affect the client. o 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 process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience (FNHA, n.d.).
Culturally safe	An outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the healthcare system. It results in an environment free of racism and discrimination, where people feel safe when receiving healthcare (FNHA, n.d.).
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	Differences in health status or in the distribution of health resources among different population groups dues to the social conditions in which people are born, grow, live, work and age (World Health Organization [WHO], 2017).
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).

Description of Key Terms	
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 healthcare 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 healthcare 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 Healthcare, 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 healthcare 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,

Description of Key Terms	
	or email, etc. Examples of complex technologies may include, but are not limited to, live, two-way audio/video conferencing or virtual visits, teleradiology, telerobotics, remote control surgical instrumentation (CMA, 2020).
Ways of knowing	Indicates the vast variety of knowledge that exists across diverse Indigenous communities and signals that learning goes beyond human interaction and relationships to include learning from other elements of creation such as the plant and animal nations, and to "objects" that many people consider to be inanimate(Queens University Office of Indigenous Initiatives, 2020) .

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

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