Entry-Level Competencies for Registered Nurses

BC CN &M

British Columbia College of Nurses & Midwives

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About This Document

The introduction provides information about how the British Columbia College of Nurses and Midwives (formerly the British Columbia College of Nursing Professionals) uses entry-level competencies for registered nurses to carry out BCCNM's public protection mandate under the B.C. Health Professions Act. The introduction is followed by four Parts:

Part 1 outlines the national processes for revising registered nurse entry-level competencies and presents the overarching principles with the revised competencies.

Part 2 discusses provincial consultation and elaborates upon changes in the organizing framework for the revised competencies.

Part 3 sets out key linkages between the revised competencies for each of the 3 sets of BCCNM Standards of Practice: A. Professional Standards; B. Practice Standards; and, C. Scope of Practice for Registered Nurses: Standards, Limits and Conditions.

Part 4 identifies key interpretative considerations within the B.C. provincial context that give emphasis to related competencies.

Appendices contain a glossary and references.

Introduction

Entry-level competencies (ELCs) establish part of the requirements for registration of a person as a member of the college under the B.C. Health Professions Act, Duties and Objects of a college 16 (2)(c) and 19 (m). From this regulatory perspective, graduates of registered nurse education programs recognized by BCCNM are expected to achieve the BCCNM entry-level competencies and the Standards of Practice and, therefore, be eligible to proceed in the BCCNM registration process.

Nursing regulatory bodies develop entry-level competencies primarily for use in relation to regulatory functions. This needs to be considered by those who may use the competencies for other purposes. BCCNM uses entry- level competencies consistently for the regulatory purpose of recognizing nurse education programs. The entry-level competencies are also used to assess applicants seeking re-instatement of registration and internationally educated applicants seeking registration; to provide input for registration examinations; as a reference point for regulatory practice consultation and professional conduct matters. They also help inform employers and the public about the practice expectations of entry-level registered nurses.

Part 1: National Revision Processes

The Registered Nurse Entry-Level Competencies (RN ELCs) have been revised through national processes since 2004. They are revised every five to seven years to keep the RN ELCs updated, relevant to nursing practice, and consistent among the jurisdictions, thereby supporting the workforce mobility requirements of the Canadian Agreement on Internal Trade.

In 2017, the Canadian Council of Registered Nurse Regulators (CCRNR) initiated a project to revise the RN ELCs. A Jurisdictional Working Group of Staff (WG) from 11 registered nurse regulators in Canada provided direction to the project consultant retained by CCRNR. The definition for entry-level competencies used in the project was *"an observable ability of a registered nurse at entry-level that integrates the knowledge, skills, abilities, and judgment required to practice nursing safely and ethically.* A client refers to a person or people who benefit from registered nursing care and, where the context requires, includes a substitute decision maker for the recipient of nursing services. Clients may be an individual, a family, group, community or population.

The national project consisted of four iterative phases of consultation:

1. Consultation and assessment of current competencies through nine national on-line focus groups; review of selected recent literature; and informal e-scan contributions from WG members.

2. Subject matter expert group (one from each jurisdiction) developed first draft of revisions.

3. Jurisdictional Webinars about the draft revisions followed by feedback from each jurisdiction.

4. National online survey of all registered nurses in the 11 participating jurisdictions about the importance and appropriate level of revised competencies.

After each consultation phase above, the WG considered the results to improve the draft competencies during five in person meetings, augmented by numerous teleconferences.

B.C. registered nurses in education and practice, as well as other B.C. stakeholders, participated in each consultation and feedback phase of the national project. BCCNM staff held several discussions with the Nursing Education Council of B.C. (NECBC) about the revisions as the project progressed. Staff communicated with, and obtained feedback from, the B.C. Ministry of Health, Nursing Policy Secretariat, and Provincial Health Authorities.

The sections that follow present the nationally developed principles and competencies approved by the BCCNM board to become effective on December 31, 2020 for regulatory purposes in British Columbia.

PRINCIPLES FOR REGISTERED NURSE ENTRY-LEVEL COMPETENCIES

The following overarching principles apply to the education and practice of entry-level registered nurses:

1. Requisite skills and abilities are required to attain the entry-level competencies.

2. The entry-level registered nurse (RN) is a beginning practitioner. It is unrealistic to expect an entry-level RN to function at the level of practice of an experienced RN.

3. The entry-level RN works within the registered nursing scope of practice, and appropriately seeks guidance when they encounter situations outside of their competence.

4. The entry-level RN is prepared as a generalist to practice safely, competently, compassionately, and ethically:

    -   in situations of health and illness,

    -   with all people across the lifespan,

    -   with all recipients of care: individuals, families, groups, communities, and populations,

    -   across diverse practice settings, and

    -   using evidence-informed practice.

5. The entry-level RN has a strong foundation in nursing theory, concepts and knowledge; health and sciences; humanities; research; and ethics from education at the baccalaureate level.

6. The entry-level RN practices autonomously within legislation, practice standards, ethics, and scope of practice in their jurisdiction.

7. The entry-level RN applies the critical thinking process throughout all aspects of practice.

REGISTERED NURSE ENTRY-LEVEL COMPETENCIES

The national project elaborated upon the CanMEDS (Frank, Snell & Sherbino, 2015) Physician Competency Framework developed by the Royal College of Physicians and Surgeons of Canada to organize the revised competencies in the following nine roles:

1. Clinician (RN)
2. Professional
3. Communicator
4. Collaborator
5. Coordinator
6. Leader
7. Advocate
8. Educator
9. Scholar

The "roles" in this framework represent a way to categorize competencies within broad themes and are not formal employment roles for positions or job descriptions in practice. Integration of all nine roles enables the entry-level RN to provide safe, competent, ethical, compassionate, and evidence-informed nursing care in diverse practice settings. Some concepts are relevant to multiple roles. For the sake of clarity and to avoid unnecessary repetition, some key concepts may be stated once and assumed to apply to all roles.

1. Clinician (Registered Nurse)

Registered nurses are clinicians who provide safe, competent, ethical, compassionate, and evidence-informed care across the lifespan in response to client needs. Registered nurses integrate knowledge, skills, judgment and professional values from nursing and other diverse sources into their practice.

No.	Competency
1.1	Provides safe, ethical, competent, compassionate, client-centred and evidence-informed nursing care across the lifespan in response to client needs.
1.2	Conducts a holistic nursing assessment to collect comprehensive information on client health status.
1.3	Uses principles of trauma-informed care which places priority on trauma survivors' safety, choice, and control.
1.4	Analyses and interprets data obtained in client assessment to inform ongoing decision-making about client health status.
1.5	Develops plans of care using critical inquiry to support professional judgment and reasoned decision-making.
1.6	Evaluates effectiveness of plan of care and modifies accordingly.
1.7	Anticipates actual and potential health risks and possible unintended outcomes.
1.8	Recognizes and responds immediately when client safety is affected.
1.9	Recognizes and responds immediately when client's condition is deteriorating
1.10	Prepares clients for and performs procedures, treatments, and follow up care.
1.11	Applies knowledge of pharmacology and principles of safe medication practice.
1.12	Implements evidence-informed practices of pain prevention, manages client's pain, and provides comfort through pharmacological and non-pharmacological interventions.
1.13	Implements therapeutic nursing interventions that contribute to the care and needs of the client.
1.14	Provides nursing care to meet palliative and end-of-life care needs.
1.15	Incorporates knowledge about ethical, legal, and regulatory implications of medical assistance in dying (MAiD) when providing nursing care.
1.16	Incorporates principles of harm reduction with respect to substance use and misuse into plans of care.

No.	Competency
1.17	Incorporates knowledge of epidemiological principles into plans of care.
1.18	Provides recovery-oriented nursing care in partnership with clients who experience a mental health condition and/or addiction.
1.19	Incorporates mental health promotion when providing nursing care.
1.20	Incorporates suicide prevention approaches when providing nursing care.
1.21	Incorporates knowledge from the health sciences, including anatomy, physiology, pathophysiology, psychopathology, pharmacology, microbiology, epidemiology, genetics, immunology, and nutrition.
1.22	Incorporates knowledge from nursing science, social sciences, humanities, and health-related research into plans of care.
1.23	Uses knowledge of the impact of evidence-informed registered nursing practice on client health outcomes.
1.24	Uses effective strategies to prevent, de-escalate, and manage disruptive, aggressive, or violent behaviour.
1.25	Uses strategies to promote wellness, to prevent illness, and to minimize disease and injury in clients, self, and others.
1.26	Adapts practice in response to the spiritual beliefs and cultural practices of clients.
1.27	Implements evidence-informed practices for infection prevention and control.

2.   Professional

Registered nurses are professionals who are committed to the health and well-being of clients. Registered nurses uphold the profession's practice standards[1] and ethics and are accountable to the public and the profession.

No.	Competency
2.1	Demonstrates accountability, accepts responsibility, and seeks assistance as necessary for decisions and actions within the legislated scope of practice.
2.2	Demonstrates professional behaviour, confidence, honesty, integrity, and respect in all interactions.
2.3	Exercises professional judgment when using agency policies and procedures, or when practising in their absence.

[1] In the regulatory jurisdiction of B.C., the profession's practice standards are the BCCNM Standards of Practice.

No.	Competency
2.4	Maintains client privacy, confidentiality, and security by complying with legislation, practice standards, ethics, and organizational policies.
2.5	Identifies the influence of personal values, beliefs, and positional power on clients and the health care team and acts to reduce bias and influences.
2.6	Establishes and maintains professional boundaries with clients and the health care team.
2.7	Identifies and addresses ethical and moral issues using ethical reasoning, seeking support when necessary.
2.8	Demonstrates professional judgment to ensure social media and information and communication technologies (ICTs) are used in a way that maintains public trust in the profession.
2.9	Adheres to the self-regulatory requirements of jurisdictional legislation to protect the public by assessing own practice and individual competence to identify learning needs[2]. developing a learning plan using a variety of sources seeking and using new knowledge that may enhance, support, or influence competence in practice Implementing and evaluating the effectiveness of the learning plan and developing future learning plans to maintain and enhance competence as a registered nurse.
2.10	Monitors and maintains own fitness to practice.
2.11	Adheres to the duty to report.
2.12	Distinguishes between the mandates of regulatory bodies, professional associations, and unions.
2.13	Recognizes, acts on, and reports, harmful incidences, near misses, and no harm incidences.
2.14	Recognizes, acts on, and reports actual and potential workplace and occupational safety risks.

3.   Communicator

Registered nurses are communicators who use a variety of strategies and relevant technologies to create and maintain professional relationships, share information, and foster therapeutic environments.

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[2] See BCCNM Quality Assurance Program and resources https://bccnm.ca/RN/QA/Pages/Default.aspx

No.	Competency
3.1	Introduces self to clients and health care team members by name, and professional designation (protected title).
3.2	Engages in active listening to understand and respond to the client's experience, preferences, and health goals.
3.3	Uses evidence-informed communication skills to build trusting, compassionate, and therapeutic relationships with clients.
3.4	Uses conflict resolution strategies to promote healthy relationships and optimal client outcomes.
3.5	Incorporates the process of relational practice to adapt communication skills.
3.6	Uses information and communication technologies (ICTs) to support communication.
3.7	Communicates effectively in complex and rapidly changing situations.
3.8	Documents and reports clearly, concisely, accurately, and in a timely manner.

4. Collaborator

Registered nurses are collaborators who play an integral role in the health care team partnership.

No.	Competency
4.1	Demonstrates collaborative professional relationships.
4.2	Initiates collaboration to support care planning and safe, continuous transitions from one health care facility to another, or to residential, community or home and self-care.
4.3	Determines their own professional and interprofessional role within the team by considering the roles, responsibilities, and the scope of practice of others.
4.4	Applies knowledge about the scopes of practice of each regulated nursing designation to strengthen intraprofessional collaboration that enhances contributions to client health and well-being.
4.5	Contributes to health care team functioning by applying group communication theory, principles, and group process skills.

5. Coordinator

Registered nurses coordinate point-of-care health service delivery with clients, the health care team, and other sectors to ensure continuous, safe care.

No.	Competency
5.1	Consults with clients and health care team members to make ongoing adjustments required by changes in the availability of services or client health status.
5.2	Monitors client care to help ensure needed services happen at the right time and in the correct sequence.
5.3	Organizes own workload, assigns nursing care, sets priorities, and demonstrates effective time management skills.
5.4	Demonstrates knowledge of the delegation process.
5.5	Participates in decision-making to manage client transfers within health care facilities.
5.6	Supports clients to navigate health care systems and other service sectors to optimize health and well-being.
5.7	Prepares clients for transitions in care.
5.8	Prepares clients for discharge.
5.9	Participates in emergency preparedness and disaster management.

6. Leader

Registered nurses are leaders who influence and inspire others to achieve optimal health outcomes for all.

No.	Competency
6.1	Acquires knowledge of the *Calls to Action of the Truth and Reconciliation Commission of Canada.*
6.2	Integrates continuous quality improvement principles and activities into nursing practice.
6.3	Participates in innovative client-centred care models.
6.4	Participates in creating and maintaining a healthy, respectful, and psychologically safe workplace.
6.5	Recognizes the impact of organizational culture and acts to enhance the quality of a professional and safe practice environment.
6.6	Demonstrates self-awareness through reflective practice and solicitation of feedback.
6.7	Takes action to support culturally safe practice environments.
6.8	Uses and allocates resources wisely.

No.	Competency
6.9	Provides constructive feedback to promote professional growth of other members of the health care team.
6.10	Demonstrates knowledge of the health care system and its impact on client care and professional practice.
6.11	Adapts practice to meet client care needs within a continually changing health care system.

7. Advocate

Registered nurses are advocates who support clients to voice their needs to achieve optimal health outcomes. Registered nurses also support clients who cannot advocate for themselves.

No.	Competency
7.1	Recognizes and takes action in situations where client safety is actually or potentially compromised.
7.2	Resolves questions about unclear orders, decisions, actions, or treatment.
7.3	Advocates for the use of Indigenous health knowledge and healing practices in collaboration with Indigenous healers and Elders consistent with the *Calls to Action of the Truth and Reconciliation Commission of Canada.*[3]
7.4	Advocates for health equity for all, particularly for vulnerable and/or diverse clients and populations.
7.5	Supports environmentally responsible practice.
7.6	Advocates for safe, competent, compassionate and ethical care for clients.
7.7	Supports and empowers clients in making informed decisions about their health care and respects their decisions.
7.8	Supports healthy public policy and principles of social justice.
7.9	Assesses that clients have an understanding and ability to be an active participant in their own care and facilitates appropriate strategies for clients who are unable to be fully involved.
7.10	Advocates for client's rights and ensures informed consent, guided by legislation, practice standards, and ethics.

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[3] Calls to Action #22: "We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients." (p. 3)

No.	Competency
7.11	Uses knowledge of population health, determinants of health, primary health care, and health promotion to achieve health equity.
7.12	Assesses client's understanding of informed consent, and implements actions when client is unable to provide informed consent.
7.13	Demonstrates knowledge of a substitute decision maker's role in providing informed consent and decision-making for client care.
7.14	Uses knowledge of health disparities and inequities to optimize health outcomes for all clients.

8. Educator

Registered nurses are educators who identify learning needs with clients and apply a broad range of educational strategies towards achieving optimal health outcomes.

No.	Competency
8.1	Develops an education plan with the client and team to address learning needs.
8.2	Applies strategies to optimize client health literacy.
8.3	Selects, develops, and uses relevant teaching and learning theories and strategies to address diverse clients and contexts, including lifespan, family, and cultural considerations.
8.4	Evaluates effectiveness of health teaching and revises education plan if necessary.
8.5	Assists clients to access, review, and evaluate information they retrieve using information and communication technologies (ICTs).

9. Scholar

Registered nurses are scholars who demonstrate a lifelong commitment to excellence in practice through critical inquiry, continuous learning, application of evidence to practice, and support of research activities.

No.	Competency
9.1	Uses best evidence to make informed decisions.
9.2	Translates knowledge from relevant sources into professional practice.
9.3	Engages in self-reflection to interact from a place of cultural humility and create culturally safe environments where clients perceive respect for their unique health care practices, preferences, and decisions.
9.4	Engages in activities to strengthen competence in nursing informatics.
9.5	Identifies and analyzes emerging evidence and technologies that may change, enhance, or support health care.
9.6	Uses knowledge about current and emerging community and global health care issues and trends to optimize client health outcomes.
9.7	Supports research activities and develops own research skills.
9.8	Engages in practices that contribute to lifelong learning.

Part 2: Provincial Consultation and Changes to the Organizing Framework

Following the completion of national work, the regulatory body in each jurisdiction validates and approves the RN ELCs to ensure they are consistent with legislation and the Standards of Nursing Practice in the jurisdiction. Provincial consultation in B.C. revealed that many registrants in practice and education, as well as BCCNM practice and policy consultants, identified an application challenge with the revised competencies. The BCCNM Professional Standards of Practice provided the organizing framework for the competencies since 2006. Participants viewed the latter organization as intuitive, familiar, and well aligned with other regulatory requirements. They identified the need to demonstrate a clear connection between revised competencies within the new roles-based framework and the Standards of Practice. Feedback indicated that several directions in the provincial health care system called for a foregrounding of pertinent entry-level competencies.

As a result, BCCNM developed the information in Parts 2-4 of this document to support interpretations about the breadth and depth of entry-level registered nurse practice. BCCNM convened a provincial working group of four nursing practice leaders and four nurse educators from across B.C. to advise on its development.

- Beuthin, Rosanne, RN, PhD, Clinical Nurse Specialist, End of Life Care (MAiD), Vancouver Island Health; Adjunct Professor University of Victoria School of Nursing

- Britten, Kelvin, RN, MN, Regional Practice Lead, Professional Practice Office, Interior Health, Kelowna

- Clark, Cynthia, RN, MSN, Regional Practice Initiatives Lead, Professional Practice, Vancouver Coastal Health

- Jackson, Cathryn, RN, MSN, Former Associate Director Undergraduate Programs; Coordinator Clinical Skills and Simulation Lab, School of Nursing, University of British Columbia

- Quee, Kathy, RN, MSN, Former Educator, British Columbia Institute of Technology

- Ryan, Shawna, RN, MN, BSN Program Coordinator, College of the Rockies

- Smith, Leona, RN(C), MSN, Professional Practice Leader Nursing Services, First Nations Health Authority (FNHA); Initial FNHA participants: Fiona Macleod, RN, BSN, MA, Former Community Health Practice Consultant, FNHA Interior Regional Nursing Team; Mona Gray, RN, BSN, MPH, Community Health Practice Consultant, FNHA Interior Regional Nursing Team.

- Zimmer, Lela, RN, PhD, Associate Professor, Undergraduate Programs Academic Leader, School of Nursing, University of Northern British Columbia

Based on provincial feedback and provincial working group advice, BCCNM created a visual with people at the center to portray the roles-based organizing framework for the revised competencies. Widespread B.C. feedback spoke to the importance of this conceptual view as modified from the national Jurisdictional Collaborative Process (2012). The presentation of the visual follows with an elaboration of selected roles and competencies that apply across areas of registered nurse practice.

Figure 1. Entry-level competencies for RNs in B.C.

Entry-level competencies for RNs in B.C.
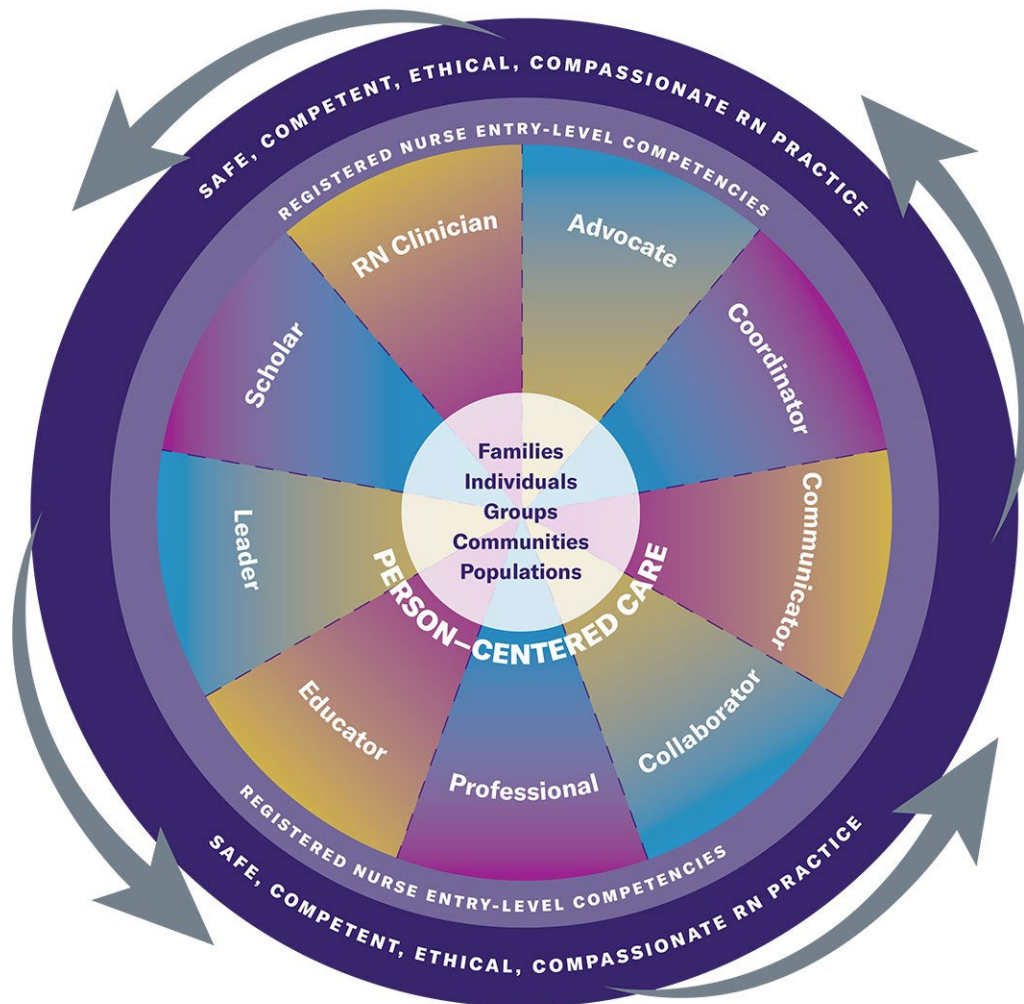
PERSON-CENTERED CARE

Person-centered care reflects that people retain control over their health care choices and are at the centre of decisions about their health, working alongside RNs to achieve optimal health outcomes. Person(s) and people involved in care may be individuals, families, groups, communities or populations. Person-Centered Care is a philosophical approach that recognizes people have a right to respect, dignity, and full participation in their health care. This translates into action when people are supported to make informed decisions and understand their health status, including prevention and health promotion activities they may undertake. Alternatively, people are respected and supported when they choose to live at risk. The cyclical nature of the visual and broken lines among roles illustrate that entry-level registered nurses use competencies from multiple roles in a synergistic

way during their everyday practice. The outer circle outcome is safe competent, ethical and compassionate registered nurse practice consistent with BCCNM's regulatory mandate.

ROLES

The national project added the Educator and Coordinator roles to the seven role CanMEDS (Frank, Snell & Sherbino, 2015) Physician Competency Framework. The **Educator role** at the point of care is woven throughout registered nurse practice to promote health and well being with people across the lifespan consistent with Principle 4 about the breadth of generalist preparation.

The **Coordinator Role** is based on feedback and literature provided by B.C. about the significance of competencies within this role. The role draws on the research of Davina Allen (2015a; 2015b) to illuminate the invisible work of nurses that Allen calls organizational work (Allen, 2014). Organizational work articulates that registered nurses manage multiple, ever changing components of health service delivery at the point of care. To accomplish organizational work, registered nurses engage with people, the health team and other sectors, to ensure continuous, safe, quality care in diverse settings.

The **Coordinator Role** of registered nurse practice at the point of care includes developing a composite picture of all the health services people are receiving; ensuring that required actions, people and materials are available in the right place at the right time; managing the flow of people services and beds; and planning transfers of care across multiple services. The Coordinator Role necessitates knowledge about the roles and responsibilities of health service delivery departments and other sectors in the community. The self-assessment competencies about knowing when to ask for help, consult with others, or involve those at other levels of authority are applicable.

The volume and complexity of the **Coordinator Role** is increasing with team models of care involving different nursing designations, health care aides, personal support workers or other care givers who may require guidance, direction or oversight (MacKinnon et al., 2018). The plans of health care for people evade standardization and require on the spot modification when changing circumstances at the point of care emerge in unpredictable ways (Allen, 2014). The resulting organizational work is largely invisible yet critical to prevent health service delivery gaps, omissions, or delays that compromise continuous, safe, quality health care. The use of evidence, clinical judgement and decision making on the spot when things are changing and unpredictable, is challenging for entry-level registered nurses who may be suddenly faced with this responsibility.

The Clinician Role elaborates on the knowledge base required for registered nurse entry-level practice. Provincial feedback requested that the knowledge base for entry-level registered nurse practice be clearly stated for interpretative purposes. Entry-level registered nurses attain a broad foundational knowledge in nursing and nursing related disciplines from degree credit courses at the baccalaureate level of academic study. Foundational knowledge supports generalist practice and provides for further development throughout the career of a registered nurse. The National Nursing Education Framework (Canadian Association of Schools of Nursing [CASN], 2015) further presents the essential components of baccalaureate nursing education. The revised entry-level competencies Principle 5 about foundational knowledge reflects this as well as Clinician Role competencies that

refer directly to incorporating knowledge in 1.21 and 1.22. Other competencies refer to the use of specific knowledge when providing registered nurse care (Clinician Role 1.3, 1.11, 1.16, 1.17; Advocate Role, 7.11, 7.13, 7.14; Scholar Role, 9.2, 9.6).

In accordance with Principle 4, the generalist preparation of entry-level registered nurses spans multiple areas of nursing practice across the lifespan. The foundational knowledge base includes knowledge about: health promotion, illness/injury prevention, and population health; altered health status, including acute and chronic physical and mental health conditions and substance use; rehabilitative care; palliative care; and end-of-life care. This applies across the lifespan from pregnancy and newborns, infants, children, youth, adolescents, young and older or senior adults.

The Scholar Role provides significant support for decision-making competence required in the registered nurse Clinician Role (1.4, 1.5) and the application of sound evidence about best practices. This includes the integration of continuous quality improvement principles and activities in nursing practice (Leader Role, 6.2). Evidence-informed practices are required in other roles including Clinician Role 1.27 about infection prevention and control, augmented by Scholar Role, 9.6. The scholarly approach of critical inquiry supports evidence informed entry-level registered nurses to use best evidence to inform decisions, appraise current evidence, translate knowledge from relevant sources into practice, and identify potential issues for nursing research. (Scholar Role 9.1; 9.2; 9.5; 9.7).

Several interrelated approaches to nursing practice are transferable across diverse practice settings, the lifespan and the life experiences of people to achieve generalist entry-level registered nurse competencies (Principles 4, 5 and 7). The examples of critical inquiry, critical thinking and relational inquiry are highlighted next. Both draw upon and support the Scholar Role as well as other roles of entry-level registered nurse practice.

CRITICAL INQUIRY AND CRITICAL THINKING

Critical inquiry and critical thinking are often used interchangeably although critical inquiry has emerged more recently (Raymond & Profetto-McGrath, 2020). Critical thinking prevails in the discourse about problem solving approaches that often follow discrete procedural type steps using a logic model. Critical thinking is a basis for decision-making and essential for safety in autonomous registered nurse practice. Entry-level registered nurses use best evidence to inform decision-making (Scholar Role, 9.1). Critical inquiry builds on critical thinking to emphasize an iterative, curiosity-minded, fluid approach that sheds light on "the spaces in between" what is more explicit. The provision of nursing care is an iterative process of critical inquiry that is not linear in nature (Clinician Role, 1.5). Entry-level registered nurses engage in critical inquiry to establish culturally safe, collaborative relationships with clients and other health care team members (Scholar Role, 9.3).

RELATIONAL INQUIRY

A relational inquiry approach to nursing practice draws on diverse theories, concepts and health care ethics to explore complex situations from different vantage points (Hartrick Doane & Varcoe, 2015). It is informed by multiple ways of knowing, nursing values and respect for client culture, preferences, values and health goals. Relational inquiry goes beyond individualistic approaches to practice and considers the broad contextual factors that often limit care provision, and in doing so, raise ethical

and moral dilemmas for nurses. Complexity is explored at three levels as a basis for action at the point of care: intrapersonal and self-reflective; interpersonal, between and among people; and contextual levels, about the ever changing system factors that impact health and health care provision (Hartrick Doane & Varcoe, 2015).

Reflection on practice to gain deeper understandings and question assumptions are essential to the art of nursing (Johnson & Thorne, 2020). Examining one's own knowledge, assumptions and "blind spots" can address negative discriminatory values and beliefs in society associated with certain cultures and groups of people (Varcoe, Browne, & Kang-Dhillon, 2020). Such relational practices shed light on stigma and other prevalent barriers to health care for people and hold potential for their correction. Relational inquiry involves a synthesis of entry-level competencies in the Professional, Communicator and Collaborator Roles (Professional Role 2.2, 2.5, 2.6, 2.7; Communicator Role 3.2, 3.3,3.5; Collaborator Role 4.1, 4.2)

Part 3: Key linkages between the revised Entry-Level Competencies and the three sets of BCCNM Standards of Practice

The three sets of BCCNM Standards of Practice are: A. Professional Standards; B. Practice Standards; and, C. Scope of Practice: Standards, Limits and Conditions. The alignment of the entry-level competencies with the Standards of Practice is essential to their interpretation and use in practice. In keeping with Principle 6, entry-level RNs practice autonomously within legislation, practice standards, ethics, and scope of practice in their jurisdiction. The latter falls within the mandate of nursing regulatory bodies. The Professional Role, 2.12 addresses the requirement for entry-level registered nurses to distinguish between the mandates of regulatory bodies, professional associations, and unions.

It is important to note other professional, ethical, and legal sources of knowledge required for safe, competent, ethical registered nursing practice. A BCCNM informational resource is available about *Legislation Relevant to Nurses' Practice.* Key linkages between the revised entry-level competencies and each of the three sets of Standards of Practice follow.

BCCNM regularly updates, reviews and revises all Standards of Practice. Readers are advised to check the BCCNM website for information about changes to the versions cited here.

BCCNM PROFESSIONAL STANDARDS FOR REGISTERED NURSES AND NURSE PRACTITIONERS

The Professional Standards provide an overall framework to promote, guide and direct the practice of registered nursing in B.C. The connections between the entry-level competencies and the Professional Standards holds importance beyond initial registration. A self-assessment in relation to the Professional Standards is one of the BCCNM quality assurance requirements for annual renewal of registration.

Entry-level competencies may be considered indicators of the clinical area of nursing practice in the Professional Standards, i.e., in direct care with people. Some registered nurse practice roles constitute advanced nursing practice and are not entry-level. These include formal roles in education, administration, and research. The formal education, administration, and research roles typically require practice experience and additional education beyond entry-level.

On the next page, Table 1 provides an index of the revised entry-level registered nurse competencies by the four Professional Standards for Registered Nurses and Nurse Practitioners. Each competency is indexed to one of the Professional Standards although a competency may apply to other Professional Standards. Other versions of this index may be valid because nurses integrate multiple competencies and apply them simultaneously during their practice.

Table 1. BCCNM Professional Standards for RNs and NPs: Clinical Area of Practice with Related RN ELCs by Role and Competency

Professional Standard	ELC Role and Competency Number(s)
1. Professional Responsibility and Accountability: Maintains standards of nursing practice and professional conduct determined by BCCNM.	Clinician: 1.1 Professional: 2.1; 2.2; 2.3; 2.8; 2.9; 2.10; 2.12 Collaborator: 4.3; 4.4 Leader: 6.9 Advocate: 7.1; 7.2 Scholar: 9.7; 9.8
2. Knowledge-Based Practice: Consistently applies knowledge, skills and judgement in nursing practice.	Clinician: all — 1.1 — 1.27 Communicator: 3.2; 3.4; 3.5; 3.6; 3.7; 3.8 Leader 6.10 Advocate: 7.11; 7.14 Educator: all - 8.1 to 8.5 Scholar: 9.1; 9.2; 9.4; 9.5; 9.6
3. Client-Focused Provision of Service: Provides nursing services and works with others to provide health care services in the best interest of clients.	Professional: 2.11; 2.13; 2.14 Collaborator: 4.1; 4.2; 4.5 Coordinator: all 5.1 to 5.9 Leader: 6.2; 6.3; 6.4; 6.5; 6.11 Advocate: 7.3
4. Ethical Practice: Understands, upholds and promotes the ethical standards of the nursing profession.	Professional: 2.4; 2.5; 2.6; 2.7; 2.8 Communicator: 3.1; 3.3 Collaborator: 4.1 Leader: 6.1; 6.6; 6.7; 6.8 Advocate: 7.4; 7.5; 7.6; 7.7; 7.8; 7.9;7.10; 7.12; 7.13 Scholar: 9.3; 9.7

BCCNM PRACTICE STANDARDS

The BCCNM Practice Standards are a series of short documents that augment other standards by setting out the requirements for specific aspects of nursing practice. Practice standards guide and direct registered nurses' practice and set out levels of performance that registrants are required to achieve in their practices. They are applicable to entry-level registered nurse education and student

practice learning. Employers use the practice standards as a touch stone to ensure patients receive safe and ethical care in accordance with prevailing standards.

The Practice Standards listed in Table 2 link to many roles and their related competencies. Each Practice Standard identifies principles followed by considerations for their application to nursing practice. Table 2 is limited to the nine practice standards that are not being revised at the time of this publication. Readers are advised to check the BCCNM website regularly for information about the most current revisions or new Practice Standards.

The competencies identified for a Practice Standard are those considered important to emphasize and foreground. This is intended to be an example of key linkages that is not all inclusive. Other competencies may apply in many instances. Additionally, there are numerous entry-level RN competencies about the broad knowledge and evidence-informed base that underpin the Practice Standards, e.g., Clinician 1.17; 1.19; 1.20; 1.21; 1.22; 1.23;1.25; 1.27; Collaborator 4.5; Leader, 6.1; 6.2; Advocate 7.3; 7.4; 7.8; 7.11; 7.14; Scholar 9.1; 9.2; 9.6.

Table 2. A Sample of BCCNM Practice Standards with Related RN ELCs by Role and Competency

BCCNM Practice Standard (Revision date)	ELC Role and Competency Number(s)
Appropriate Use of Titles (Aug 2015)	Communicator 3.1; 3.8
Boundaries in the Nurse - Client Relationship (July 2019)	Clinician 1.1;1.3; 1.18 Professional 2.2; 2.4; 2.5; 2.6; 2.7; 2.8 Communicator 3.1;3.2; 3.3 Collaborator 4.1; 4.3; 4.4 Coordinator 5.1; 5.7; 5.8 Leader 6.4; 6.5; 6.6; 6.7 Advocate 7.1 Scholar 9.3
Communicable Diseases: Preventing Nurse-to -Client Transmission (Jan 2013)	Clinician 1.1; 1.7; 1.8; 1.17; 1.25; 1.27 Professional 2.10; 2.11; 2.13; 2.14 Advocate 7.1; 7.6
Conflict of Interest (July 2019)	Clinician 1.1 Professional 2.2; 2.4; 2.5; 2.6; 2.7; 2.8 Communicator 3.4

BCCNM Practice Standard (Revision date)	ELC Role and Competency Number(s)
Consent (June 2013)	Clinician 1.1; 1.3; 1.10
	Communicator 3.8
	Collaborator 4.2
	Coordinator 5.2
	Advocate 7.1; 7.7; 7.9; 7.10; 7.12; 7.13
Documentation (June 2019)	Clinician 1.5; 1.6
	Professional 2.1; 2.8; 2.13; 2.14
	Communicator 3.8
	Advocate 7.1; 7.2; 7.10
Duty to Provide Care (June 2019)	Clinician encompasses 1.1-1.17
	Professional 2.1; 2.2; 2.7
	Advocate 7.1
Duty to Report (June 2019)	Clinician 1.8; 1.27
	Professional 2.11; 2.12; 2.13; 2.14
	Communicator 3.8
	Advocate 7.1
Privacy and Confidentiality (June 2019)	Clinician 1.8
	Professional 2.2; 2.4; 2.8
	Advocate 7.1

BCCNM SCOPE OF PRACTICE FOR REGISTERED NURSES: STANDARDS, LIMITS AND CONDITIONS

The Scope of Practice for Registered Nurses: Standards, Limits and Conditions (Scope of Practice) elaborates on the activities that registered nurses are educated and authorized to perform in legislation. Under the umbrella B.C. Health Professions Act, the Nurses (Registered) and Nurse Practitioner Regulation provides the legal definition of the Scope of Practice and assigns specific restricted activities to registered nurses.

Discussion in this document is limited to selected key high-level concepts in the BCCNM Scope of Practice related to entry-level registered nurses. It is essential to consider the extensive and detailed

information in the Regulation and BCCNM Scope of Practice: Standards, Limits and Conditions (pub. 433) to gain a full understanding of its concepts. See also the BCCNM web learning module Understanding the scope of practice. Entry-level registered nurses are expected to know how to access and use the latter sources.

Reserved Titles

The Regulation sets out reserved titles for nurses and who can legally use the title "registered nurse", as included in Communication Role (3.1) about introducing self with professional designation. The BCCNM Practice Standard on Appropriate Use of Titles expands on these requirements.

Controls on Practice

The Scope of Practice illustrates four levels of controls on the activities in the Regulation that registered nurse are authorized to perform (Figure 2 excerpted below). The first level of control is the legislation in the Regulation. Secondly, the nursing regulator sets standards, limits and conditions on practice that restrict the activities registered nurses perform. The third level is employers who set organizational policies and processes that may restrict practice activities. Lastly, individual registered nurse competence places further restrictions on the activities that a registered nurse should perform.

Figure 2. Controls on practice

Controls on Practice

4 INDIVIDUAL NURSE COMPETENCE
Responsibility of the nurse

3 ORGANIZATIONAL POLICIES
Responsibility of the organization

2 BCCNM STANDARDS, LIMITS & CONDITIONS
Responsibility of BCCNM

1 REGULATION & LEGISLATION
Health Professions Act, Nurses (Registered) and Nurse Practitioners Regulation, Nurses (Licensed Practical) Regulation, Nurses (Registered Psychiatric) Regulation
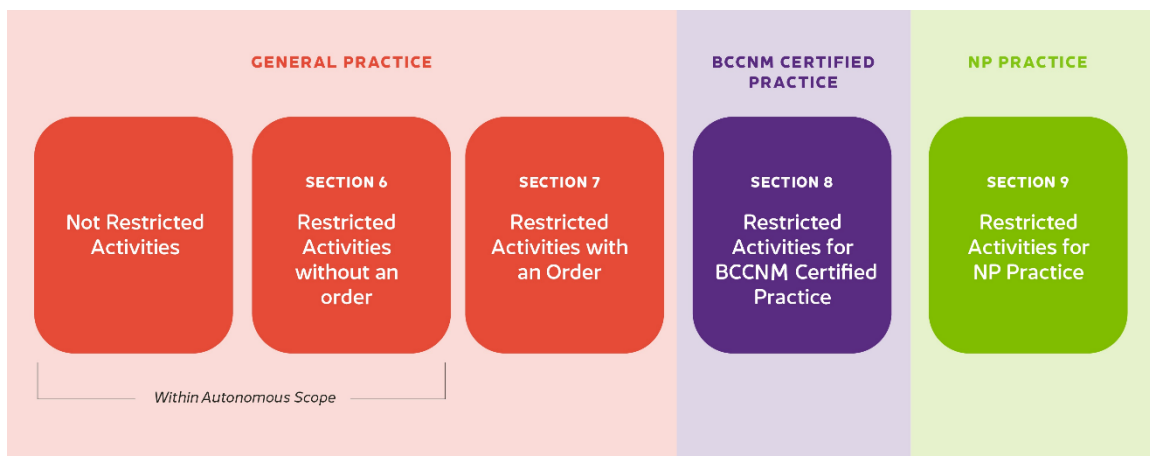Responsibility of the Ministry of Health

The Professional role competencies link to assessing and maintaining individual competence necessary for practising within the controls on practice. The ability of individual entry-level registered

nurses to assess their own competence and address their learning needs, incorporated in Professional Role (2.9) is essential to safe practice. Furthermore, entry-level registered nurses are expected to use professional judgement in relation to employer policies that may restrict, or not be developed for, their practice in a specific setting, as noted in Professional Role (2.3).

General Practice

The Regulation sets out three kinds of practice as illustrated in Figure 3 on the next page. Entry-level registered nurses carry out general practice activities, as identified in the Regulation, Sections 6 and 7. This is consistent with the regulatory requirement for a generalist education for initial registration purposes as in Principle 4. The BCCNM Scope of Practice outlines additional education requirements for registered nurses who may perform activities outside the scope of general practice. The competencies for these activities are attained after initial registration, e.g., certified practices in Section 8. Nurse practitioners have a broader scope of practice in Section 9 of the Regulation. Nurse practitioners have attained competencies in advanced nursing education at the master's level to perform the activities within their broader autonomous scope of practice.

Figure 3. How practice is described in the regulation

GENERAL PRACTICE | BCCNM CERTIFIED PRACTICE | NP PRACTICE

Not Restricted Activities

SECTION 6
Restricted Activities without an order

SECTION 7
Restricted Activities with an Order

SECTION 8
Restricted Activities for BCCNM Certified Practice

SECTION 9
Restricted Activities for NP Practice

Within Autonomous Scope

Activities for which BCCNM has stipulated conditions of additional education after initial registration typically fall beyond general practice. Nursing activities requiring "additional education" as a condition are not normally considered to be entry-level because they require additional knowledge, skills and judgement beyond that acquired in a baccalaureate level nursing program. The Collaborator Role encompasses the entry-level competencies to determine the registered nurses' role within the health care team by considering their own scope of practice, as well as others, and contribute to client health and well being.

Restricted Activities

The Regulation contains restricted activities defined as clinical activities that present a significant risk of harm to the public and therefore are reserved for specified health professions only. Section 6

includes those restricted activities that RNs are authorized to perform within their autonomous scope of practice.

The Scope of Practice, Section 7 identifies those restricted activities that RNs are authorized to perform with a specific order from an authorized health professional. When the RN is acting with a specific order, the decision-making to perform that activity is being made by the health professional giving the specific order. The RN has the responsibility to ensure that the order is appropriate and to perform the activity in a competent manner. Nevertheless, the accountability and responsibility for the assessment and determination of activities to meet the person's needs belongs to the health professional who is giving the order.

The Clinician Role competencies are integral for entry-level nurses to engage in general practice that includes activities that are restricted and not restricted. The latter may include activities carried out either with, or by giving, specific orders and acting within autonomous scope of practice. Clinician Role (1.10) pertains to restricted activities involved in performing procedures and treatments. Provisions to perform restricted activities in the Regulation and Scope of Practice establishes the legal basis for entry-level psychomotor nursing skills learning, including invasive procedures. Clinician Role, 1.11 about medications administered by any route is another example.

Autonomous Scope of Practice

Registered nurses act within their autonomous scope of practice when they independently make decisions about care and act independently to carry out such decisions. These decisions and actions must be ones the registered nurse is educated, competent and authorized to make. When acting within their autonomous scope of practice, it is imperative that registered nurses understand their level of accountability and responsibility to ensure their practice is consistent with the controls on practice in Figure 2.

The BCCNM Standards for Acting Within Autonomous Scope of Practice illustrate that decision making ability is essential for autonomous practice. Within autonomous scope of practice Section 6 activities, the registered nurse is solely accountable and responsible for the decisions made to perform activities required for care. BCCNM often establishes the requirement for a decision support tool to support registered nurse decision making. BCCNM also provides resources to support reflection upon and decision making about autonomous scope of practice.

Principles 3 and 6 for the entry-level competencies relate to expectations of the entry-level registered nurses to practice autonomously within the scope of registered nurse general practice in B. C. They are expected to seek guidance when they encounter situations outside of their competence. Entry-level registered nurses interpret and use current evidence to support their independent decisions and actions within autonomous scope of practice.

Medical Assistance in Dying

This part of the BCCNM Scope of Practice specifies that the role of registered nurses is limited to aiding a physician or nurse practitioner in the provision of medical assistance in dying. The Clinician

Role, 1.15, conveys that entry-level registered nurses apply knowledge about the ethical, legal, and regulatory implications of medical assistance in dying. From this knowledge base they enact a supportive role when providing nursing care to people who request medical assistance in dying. McMechan, Bruce & Beuthin (2019) describe student nurse learning experiences with medical assistance in dying and the implications for education.

The BCCNM Scope of Practice distinguishes end of life and palliative care relevant to entry-level Clinician Role, 1.14. The BCCNM Scope of Practice specifies the kinds of supportive actions in medical assistance in dying that entry-level registered nurses may take with clients and the health care team. It stipulates further standards plus a list of limits and conditions about what registered nurses are not legally authorized to do to support the provision of medical assistance in dying. The Scope of Practice outlines the steps to take by an RN to exercise a conscientious objection. The BCCNM Practice Standard: Duty to Provide Care is also applicable.

Delegation

The Coordinator Role, 5.4, states that entry-level RN demonstrate knowledge of the delegation process. This encompasses knowing the BCCNM definition of delegation and its legal basis. At this time, registered nurses delegate tasks to unregulated care provides and do not delegate to other regulated health professionals. See the BCCNM Practice Standard Delegating Tasks to Unregulated care Providers.

Part 4: Key Interpretative Considerations in the B.C. Provincial Context

This part identifies key interpretative considerations within the B.C. provincial context that give emphasis to related competencies. The selection is limited to five of the key directions identified in B.C. stakeholder feedback, B.C. provincial health care documents, websites and legislation: Indigenous cultural safety and humility; trauma-informed care; primary care and team-based care; mental health and substance use; and safety. They represent areas of health care practice that are evolving with shifting conceptual approaches and language. There is a simultaneous change in the discourse around them to effect a cultural change in health care approaches. References cited in this part are meant to represent a sampling of evidence and resources that inform knowledge regarding these areas. They are not meant to be exclusive or a requirement for education institutions to incorporate specifically in nursing education curricula.

INDIGENOUS CULTURAL SAFETY AND HUMILITY IN HEALTH PROFESSION REGULATION

All health profession regulators in B.C. signed a Declaration of Commitment with the First Nations Health Authority of B.C. to support cultural safety and humility towards making the health system more culturally safe for Indigenous[4] people. BCCNM continues its commitment in its vision of safe, ethical person-centered care for everyone.

The BCCNM commitment builds on the knowledge and calls to action in the *Report of the Canadian Truth and Reconciliation Commission Calls to Action* (TRC, 2015). The BCCNM web page on cultural safety and humility acknowledges that systemic racism and discrimination towards Indigenous people continues to adversely impact access to, and treatment in, health care services. Nurses play an essential role in addressing racism at the individual and systems level. Cultural safety requires nurses to acknowledge the power imbalances inherent in the health care system. This requires that nurses obtain a knowledge base about the historical, colonial origins of racism experienced by Indigenous people in Canada which is necessary to achieve Indigenous cultural safety. Cultural humility requires nurses to be reflective in their practice to understand personal and systemic biases and acknowledge oneself as a learner to understand another's experience.

BCCNM strives to promote self-reflection to understand personal and systemic biases. The First Nations Health Authority provides more information on the definitions of cultural safety, cultural humility and systemic racism along with learning resources.

The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls: Reclaiming Power and Place with the Calls for Justice (2018) documents the historical, multigenerational and intergenerational trauma to be addressed due to colonization. Colonization refers to methods the government of Canada used whereby Indigenous Peoples were stripped of their land rights, titles and resources, subjected to assimilation and in many cases to extermination

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

by way of death in residential schools and the Sixties scoop (National Inquiry into Missing and Murdered Indigenous Women and Girls [MMIWG], 2018).

As noted in the MMIWG Executive Summary (2018), Indigenous women are the heart of their nations and communities. Consequently, when Indigenous women and gender diverse people are taken from their communities due to violence, their absence has a huge impact from generation to generation that creates imbalance in their culture and ecosystem that so strongly depends on their matriarchs and younger generations.

More recently, the B.C. legislature enacted Bill 41- 2019 Declaration on the Rights of Indigenous Peoples Act (Government of British Columbia, 2019) based on the *United Nations Declaration on the Rights of Indigenous Peoples (*United Nations, 2007*).* This means that the B.C. government is going to enact the 47 articles or recommendations the general assembly of the United Nations has put into place for all Indigenous people in the world.

Entry-level education sets the stage for the next generation of registered nurse to attain the knowledge and competence required for cultural safety and humility for Indigenous people. The revised entry-level competencies draw on the Truth and Reconciliation Commission Calls to Action specifically (Leader Role, 6.1; Advocate Role, 7.3) and in competencies essential to understanding and achieving cultural safety and humility (Clinician Role, 1.3; Professional Role, 2.5, 2.7; Communicator Role, 3.2, 3.5; Leader Role, 6.6, 6.7; Advocate Role, 7.6, 7.8, 7.14; Scholar Role, 9.3).

TRAUMA-INFORMED PRACTICE

A key goal of trauma-informed practice is to minimize harm and prevent re-traumatization during health care experiences. Service providers, systems and organizations are trauma informed when they recognize the widespread impact of trauma and recognize promising paths for healing to occur; recognize the signs and symptoms of trauma in people; and responds by completely integrating knowledge about trauma into polices, procedures, practices and settings (B.C. Ministry of Health, 2017).

Traumatic experiences vary and the impact differs according to how traumatic experiences affect individual people. Trauma may range from a one - time overwhelming event, to many recurrent events over generations, described as five types of trauma in *Healing Families, Helping Systems: A Trauma-Informed Practice Guide for working with Children, Youth and Families* (B.C. Ministry of Children & Family Development, 2017). The latter document builds upon the *Aboriginal Policy and Practice Framework in British Columbia* (B.C. Ministry of Children & Family Development, 2015).

Entry-level registered nurses have knowledge about different types of trauma and its impact on people, including how intergenerational and historical trauma affects many Indigenous people during health care experiences. The *Trauma-informed Practice Guide* (B.C. Provincial Mental Health and Substance Use Planning Council, 2013) translates trauma-informed principles into practice strategies for health care professionals. Trauma-informed practices are essential to achieve cultural safety and humility.

Approaches to address stigma and discrimination in health care based on societal negative attitudes about people with mental health conditions and substance use are needed. A trauma-informed approach and stigma as a barrier, are two of the key perspectives underlying the Entry-to-Practice Mental Health and Addiction Competencies for Undergraduate Nursing Education in Canada (CASN & Canadian Federation of Mental Health Nurses [CFMHN], 2015).

Trauma-informed practice requires participation by the health care system and providers in the creation of emotionally and physically safe environments. Listening and connecting with people; working in collaboration with people from a strengths-based approach and ensuring people have choices in their care are essential to compassionate and trusting relationships. Clinician Role, 1.3, refers to this requirement specially; competencies from other roles need to be drawn upon simultaneously, such as, Communicator Role, 3.2, 3.3; Leader Role, 6.7; Advocate Role , 7.7, 7.8, 7.14; Scholar Role, 9.1, 9.3.

PRIMARY HEALTH CARE AND TEAM-BASED CARE

The B.C. government has initiated primary health care initiatives across the province that include a focus on team-based care. The goal is to ensure access to health care in communities close to where people live because "health care delivery must become more patient centred". Entry-level registered nurses understand the role of primary health care and the determinants of health in health delivery systems and its significance for population health. They facilitate ownership of a person's health and well-being by, in part, ensuring that people understand essential information and skills to be active participants in their own care.

In accordance with Principle 5, generalist education prepares entry-level registered nurses to practice in diverse settings including community clinics and home care. Additionally, Principle 5 calls for preparation to practice with people across the lifespan in different states of health and well being. Population groups that place considerable demand on the health care system, e.g., older adults, and those with chronic health conditions and co-morbidities, are addressed. Entry-level competencies in most roles apply, including Professional Role, 2.6 ; Communicator Role, 3.1; 3.2; Coordinator Role, 5.5, 5.7); Leader Role ,6.3; Advocate Role, 7.3, 7.4, 7.6, 7.7, 7.8, 7.9, 7.10,7.11; 7.14; Educator Role, 8.1-8.5; Scholar Role, 9.1, 9.2, 9.3, 9.5, 9.6.

Team-based care requires the application of knowledge about the legislated scopes of practice for other health professionals on the health care team. This includes the scopes of practice for members of all nursing designations and health care support workers. Additionally, registered nurses contribute to health care team functioning by incorporating knowledge about group theory and process skills. Competencies 4.1- 4.5 in the Collaborator Role articulate these requirements. The Coordinator Role, 5.1; 5.2; 5.6) encompasses working with the health care team and other sectors in the community to ensure continuous, safe care.

MENTAL HEALTH AND SUBSTANCE USE

A variety of mental health and substance use issues are prevalent in the province and across Canada. They may be short term conditions due to developmental, transitional or situations crises. Other mental health conditions are long term, chronic, or recurrent. Some have co-occurring mental illness

and substance use issues for which the root causes need to be addressed. Increases in life threatening opioid drug overdoses and deaths from fentanyl and other illicit drugs in B.C. led to the 2016 declaration of a public health emergency in the province. The B.C. Government developed a new Ministry of Mental Health and Addictions in 2017 to respond to this emergency. Numerous provincial strategies and resources have been developed https://www.healthlinkbc.ca/mental-health-substance-use

B.C. Mental Health and Substance Use Services (BCMHSUS) in the Provincial Health Services Authority provide a range of clinical and professional resources. B.C. has been a national leader in harm reduction strategies for substance use to keep people safe and minimize death, disease, and injury from high risk behaviour based on evidence. Harm reduction recognizes that people may continue to choose high risk behaviour despite the risks. Overdose prevention sites and supervised consumption services aimed at harm reduction exist in many B.C. health authorities. The B.C. Centre for Disease Control provides harm reduction guidelines and resources and a related site Toward the Heart. The Canadian Institute for Substance Use Research at the University of Victoria conducts research and other activities to promote health and reduce harm.

The entry-level registered nurse knowledge base and competencies encompass mental health, substance use and harm reduction as addressed directly in the Clinician Role, 1.16, 1.18, 1.19, 1.20. Competencies in other roles require approaches to health care based on peoples' choices and related evidence as in Communicator Role, 3.2, 3.3; Advocate Role, 7.4., 7.6; and Scholar Role, 9.3. Student practice learning experiences develop entry-level registered nurse competencies related to mental health and substance use issues across the lifespan.

SAFETY

Safety is highlighted in keeping with the mandate of BCCNM to protect the health and wellbeing of the public. The British Columbia Patient Safety and Quality Council (BCPSQC) views safety as one of seven quality dimensions required within the healthcare system. Safety within the B.C. healthcare context involves ensuring that the processes and environments to support actual and perceived physical, cultural and psychological safety needs are established (BCPSQC, 2020). This includes the extent that the services offered promote trust and that the processes in place prevent or minimize the harm that could unintentionally result from care delivery. The broad aspects of safety that encompass cultural safety, trauma-informed care and mental health are discussed previously in this document along with a delineation of related entry-level competencies.

Patient safety refers specifically to reduction and mitigation of unsafe acts within the healthcare system, as well as to the use of best practices shown to lead to optimal client outcomes (Canadian Patient Safety Institute [CPSI], n.d.-a). Entry-level RNs in British Columbia must be prepared to apply knowledge, skills and attitudes related to patient safety and to contribute to a shift in culture in our healthcare system from one of blame to one of openness and learning from the analyses of adverse events and near misses (BCPSQC, 2020; CASN & CPSI, 2018). Initiatives in B.C. health authorities have traditionally focused on incident reporting and patient safety reviews along with addressing patient concerns. More recently, a shift is becoming evident with a greater focus on cultural safety and humility as well as initiatives meant to empower and include people as partners in their health care.

To support nursing education programs in preparing new graduates to this level, CPSI has worked with CASN to develop national learning outcomes (2018) for graduates of baccalaureate nursing education programs. These learning outcomes fall into 6 domains that include contributing to a culture of patient safety, working in teams for patient safety, communicating effectively for patient safety, managing safety risks, optimizing human and environmental factors and recognizing, responding to and disclosing adverse events and near misses.

Key BCCNP resources to support registered nurses with safety include a variety of Practice Standards including (but not limited to) Boundaries in the Nurse Client Relationship, Communicable Diseases: Preventing Nurse-to-Client Transmission, Consent, Medication Administration and Duty to Report. In addition, BCCNM has resources for registered nurses on a variety of topics including Taking Action on Concerns About Practice and Reporting suspected impaired practice or narcotic diversion in the workplace

Entry-level registered nurse competencies that address safety include competencies within each of the roles: Clinician Role , 1.1, 1.3; 1.8, 1.11, 1.16, 1.24, 1.25, 1.27; Professional Role, 2.2, 2.3, 2.4, 2.5, 2.6, 2.7, 2.8, 2.11, 2.13 , 2.14; Communicator Role, 3.3, 3.4 , 3.8; Collaborator Role, 4.1, 4.2, 4.3, 4.4; Coordinator Role, 5.2, 5.6, 5.9; Leader Role, 6.1, 6.2, 6.3, 6.4, 6.5, 6.7, 6.10, 6.11; Advocate Role, 7.1, 7.2, 7.4, 7.5,7.6, 7.7, 7.10; Educator Role , 8.1, 8.2, 8.3, 8.5 and Scholar Role, 9.1, 9.2, 9.3. The attainment of the latter competencies by graduates of B.C. registered nurse baccalaureate education programs recognized by BCCNM supports the multiple dimensions of safety.

Appendix A: Glossary

Accountability
The obligation to acknowledge the professional, ethical, and legal aspects of one's activities and duties and to answer for the consequences and outcomes of one's actions. Accountability resides within an individual's role and can never be shared or delegated (Nova Scotia College of Nursing [NSCN], 2017).

Assigns
Refers to the Registered Nurse allocating the care of clients or client care activities among care providers in order to meet client care needs. Assignment occurs when the required care falls within the employing agency's policies and role descriptions and within the regulated health care provider's scope of practice. Assignment to unregulated care providers occurs when the required care falls within the employing agency's policies and role description (BCCNP, 2013).

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.).

Client-centred
Used interchangeably with person-centered in this document, in support of the transition towards the preferred language of person-centered care. The approach recognizes that people/clients have the right to respect, dignity and full participation in their healthcare. This translates into action when people are supported to make informed decision and understand their health status, including prevention and health promotion activities they may undertake (Alzheimer Society Canada, 2019).

Client Safety
Used interchangeably with patient safety in this document. The pursuit of the reduction and mitigation of unsafe acts within the healthcare system, as well as the use of best practices shown to lead to optimal client outcomes (CPSI, n.d.).

Compassionate
The sensitivity shown to understand another person's suffering, combined with a willingness to help and to promote the wellbeing of that person (Perez-Bret et al., 2016).

Competencies
Statements about the knowledge, skills, attitudes and judgments required to perform safely and ethically within an individual's nursing practice or in a designated role or setting (BCCNM, n.d.).

Competent
The demonstration of integrated knowledge, skills, attitudes s and judgment required to practise nursing safely and ethically (BCCNM, n.d.).

Conflict resolution
The various ways in which individuals or institutions address conflict (e.g., interpersonal, work) in order to move toward positive change and growth.

Effective conflict resolution requires critical reflection, diplomacy, and respect for diverse perspectives, interests, skills and abilities (BCCNP, 2015).

Continuous quality improvement

A continuous cycle of planning, implementing strategies, evaluating the effectiveness of these strategies, and reflection to see what further improvements can be made (College and Association of Registered Nurses of Alberta, 2013).

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 life-long learner when it comes to understanding another's experience (First Nations Health Authority [FNHA], 2016).

Culturally safe

Culturally safe care is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the healthcare system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care (FNHA, n.d.).

Delegate

To delegate refers to the sharing of authority with other health care providers to provide a particular aspect of care. Delegation among regulated care providers occurs when a restricted activity is within the scope of the delegating profession and outside the scope of the other profession (BCCNM, n.d.).

Determinants of health

Determinants of health are the broad range of personal, social, economic and environmental factors that determine individual and population health. These include income and social status, employment and working conditions, education and literacy, childhood experiences, physical environments, social supports and coping skills, healthy behaviours, access to health services, biology and genetic endowment, gender, culture and race/racism (Government of Canada, 2019).

Duty to report

Nurses have a legal and ethical obligation to report incompetent or impaired practice or unethical conduct of regulated health professionals. It is important for nurses to understand when to report, what to report and how to report, and to know what is legally and ethically required (BCCNP, 2019).

Environmentally responsible practice

Practice that supports environmental preservation and restoration to promote health and well-being (Canadian Nurses Association [CNA], 2017c).

Evidence-informed   The ongoing process that incorporates evidence from research, clinical expertise, client preferences, and other available resources to make nursing decisions with clients (CNA, 2018).

Fitness to practice   All the qualities and capabilities of an individual relevant to his or her capacity to practise as a nurse, including, but not limited to, any cognitive, physical, psychological or emotional condition, or a dependence on alcohol or drugs, that impairs his or her ability to practise nursing (BCCNM, n.d.).

Global health   The optimal well-being of all humans from the individual and the collective perspective and is considered a fundamental human right, which should be accessible to all (CNA, 2009).

Harm reduction   Policies, programs and practices to reduce the adverse health, social and economic consequences of legal and illegal drugs without necessarily reducing drug consumption (CNA, 2017b).

Harmful incidences   Safety events that result in harm to clients (CPSI, n.d.-b).

Health care team   A number of health care providers from different disciplines (often including both regulated professionals and unregulated workers) working together to provide care for and with persons, families, groups, communities or populations (CNA, 2017a).

Health disparities   Health disparities are differences in health status that occur among population groups defined by specific characteristics. They mostly result from inequalities in the distribution of the underlying determinants of health across populations (Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security, 2004).

Health inequities   Differences in health status or in the distribution of health resources among different population groups due to the social conditions in which people are born, grow, live, work and age (World Health Organization [WHO], 2017).

Health literacy   The degree to which an individual has the capacity to obtain, communicate, process, and understand basic health information and services to make appropriate health decisions (Centers for Disease Control and Prevention, n.d.).

Health promotion   The process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions (WHO, n.d.-a).

Holistic	A system of comprehensive or total patient care that considers the physical, emotional, social, economic, and spiritual needs of the person; his or her response to illness; and the effect of the illness on the ability to meet self-care needs (Jasemi et al., 2017).
Holistic Nursing Assessment	Refers to the Registered Nurse: Systematically gathering, sorting, organizing client data, and documenting the data in a retrievable format (Perry et al., 2018). Holistic assessment includes consideration of the physical, emotional, social, economic, and spiritual needs of the person; his or her response to illness; and the effect of the illness on the ability to meet self-care needs (Jasemi et al., 2017).
Information and communication technologies	A diverse set of technological tools and resources used to communicate, create, disseminate, store, and manage data and information. (United Nations Educational, Scientific and Cultural Organization, n.d.). They encompass all digital and analogue technologies that facilitate the capturing, processing, storage, and exchange of information via electronic communication (CASN & Canada Health Infoway [CHI], 2015).
Interprofessional team	Includes members of different healthcare disciplines working together towards common goals to meet the health care needs of people. Work within the team is divided based on the scope of practice of each discipline included in the team. Team members share information to support one another's work and to coordinate the plan of care. Interprofessional teams may include people and their family or caregivers as key team members (Canadian Health Services Research Foundation, 2012).
Medical Assistance in Dying (MAiD)	Refers to the situation where a person is allowed to request and receive, under limited circumstances, a substance intended to end their life. Only two forms of medical assistance in dying (MAiD) are permitted under the Criminal Code in Canada:

- • the administering by a medical practitioner or a nurse practitioner of a substance to a person at their request

- • the prescribing or providing by a medical practitioner or a nurse practitioner of a substance to a person at their request, for their self-administration (BCCNM, 2020b).

Near Miss	An event with the potential for harm or a safety incident that did not reach the client and therefore resulted in no harm (CPSI, n.d.-b).
No harm incidence	A patient safety incident that reached the patient, but caused no discernible harm (CPSI, n.d.-b).

Nursing informatics	The science and practice which integrates nursing, its information and knowledge, and their management, with information and communication technologies to promote the health of people, families, and communities worldwide (CASN & CHI, 2015).
Organizational culture	The shared ways of thinking, feeling, and behaving in healthcare organizations (Mannion & Davies, 2018) including the assumptions and values that members have about their organization (Sullivan, 2013).
Palliative care	An approach that improves the quality of day-today life for people experiencing a life-limiting illness and their families by preventing and relieving suffering of physical, psychological and spiritual pain or discomfort. This is achieved through a variety of activities including: early assessment and treatment, advocating for people, providing information, participating in decision-making, caring for and supporting people and their families or caregivers and collaborating with members of the health care team to ensure that people have their care and information needs met. (BCCNM, 2020b & WHO, n.d.-b).
Patient Safety	Used interchangeably with client safety in this document. The pursuit of the reduction and mitigation of unsafe acts within the healthcare system, as well as the use of best practices shown to lead to optimal client outcomes (CPSI, n.d.-a).
Person-centred	Used interchangeably with client-centered in this document, in support of the transition towards the preferred language of person-centered. The approach recognizes that people have a right to respect, dignity and full participation in their healthcare. This translates into action when people are supported to make informed decisions and understand their health status, including prevention and health promotion activities they may undertake (Alzheimer Society Canada, 2019).
Population health	An approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups. In order to reach these objectives, it looks at and acts upon the broad range of factors and conditions that have a strong influence on our health (Public Health Agency of Canada, 2013).
Positional power	The therapeutic nurse-person relationship is one of unequal power. This results from the dependence of people on the services provided by nurses and the nurse's unique knowledge, authority within the healthcare system, access to privileged information about people and ability to influence decisions. This power imbalance places people in a position of vulnerability. Nurses are responsible to recognize the imbalance of power and to be aware of the potential for people to feel intimidated or dependent (NSCN, 2019).

Primary health care	A focus on delivering person-centred services that include accessibility, active public participation, health promotion and chronic disease prevention and management, use of appropriate technology and innovation, and intersectoral cooperation and collaboration (CNA, 2015b).
Principles of harm reduction	Principles of harm reduction refer to Pragmatism, Human Rights, Focus on Harms, Maximize Intervention Options, Priority of Immediate Goals and Drug User Involvement (B.C. Ministry of Health, 2005).
Professional boundaries	The nurse-person relationship is conducted within boundaries that separate professional and therapeutic behaviour from non-professional and non-therapeutic behaviour (BCCNM, 2020a). Professional boundaries are the spaces between the nurse's power and the patient's vulnerability (National Council of State Boards of Nursing, 2018).
Professional presence	The demonstration of respect, confidence, integrity, optimism, passion, and empathy, in accordance with professional standards, guidelines, and ethics. This includes the nurses' verbal and nonverbal communications and the ability to articulate a positive role and professional image, including the use of name and title (NSCN, 2018)
Recovery oriented nursing care	A perspective that recognizes recovery as a personal process for people with mental health conditions or addictions to gain control, meaning and purpose in their lives (CASN, 2015).
Relational inquiry	An approach to nursing practice whereby the experiences of people are considered from varied philosophical vantage points. It involves conscious participation with people using relational skills including listening, questioning, empathy, mutuality, reciprocity, self observation, reflection, and a sensitivity to emotional contexts. Relational inquiry goes beyond individualistic approaches to practice and considers the broad and complex contextual factors that often limit care provision including exploration of these factors from intrapersonal, interpersonal and contextual viewpoints. (Hartrick Doane & Varcoe, 2015).
Research Skills	The research skills expected of entry-level RNs from their baccalaureate education are skills such as participating in research and evidence-informed activities. This includes identifying research questions, conducting literature searches related to practice, critical appraisal of search results and transferring evidence in nursing practice. These foundational skills allow RNs to promote quality care, to direct people to credible resources, to coach them

to interpret and evaluate information and to help them navigate the health care system (CASN, 2015, CNA, 2015a).

Safety	Reducing and mitigating acts within the health-care system that could cause harm, as well as using best practices for optimal patient outcomes (CPSI, n.d.-a).
Scope of practice	The activities that registered nurses are educated and authorized to perform, as set out in legislation and described by standards, limits, and conditions set by regulators (BCCNM, 2020).
Social justice	The fair distribution of society's benefits and responsibilities and their consequences. It focuses on the relative position of one social grouping in relation to others in society as well as in root causes of disparities and what can be done to eliminate them (CNA, 2017a).
Systemic racism	Refers to one social group having a disproportionate access to power and resources in society which leads to unfair inequalities between groups. In Canada, the historical legacy of governmental policies has caused Indigenous peoples to cease to exist as distinct legal, social, cultural, religious, and racial entities. This manifests itself in social isolation that limits or prevents political, social, and economic participation, or access to and participation in other social systems such as education and health. Systemic racism is a significant contributor to Indigenous peoples' lower health outcomes (Indigenous Health Working Group, 2016).
Therapeutic nursing intervention	Any treatment based on clinical judgement and knowledge which a nurse performs to enhance client outcomes (Butcher et al., 2018).
Therapeutic relationship	A relationship the nurse establishes and maintains with a person or people, through the use of professional knowledge, skills and attitudes, in order to provide nursing care that is expected to contribute to the well-being of people (CNA, 2017a). The therapeutic relationship is a planned, time-limited and goal-directed connection between the nurse and a person or people, for the purpose of meeting their health care needs (Nurses Association of New Brunswick, 2015).
Trauma-informed care	Used interchangeably with trauma-informed practice in this document. A strengths-based approach that is grounded in an understanding of and responsiveness to the impact of trauma and its links to substance use, mental illness, stigma and health care access barriers. Trauma-informed care includes recognizing this link, ensuring that people feel psychologically, physically and emotionally safe and are not re-traumatized by their care (BCMHSUS, n.d.; Hopper et al., 2010).

Appendix B: References

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