FRAMEWORK FOR THE

PRACTICE OF REGISTERED NURSES IN CANADA

2015

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Acknowledgments

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Introduction

Registered nurses (RNs) practise in all of Canada's provinces and territories across the five domains of practice: clinical care, education, administration, research and policy. In many health care settings, RNs care for people around the clock, seven days a week, while making vital contributions to positive **client**[1] outcomes, to the effective functioning of health-teams and to the sustainability of the health-care system. Provincial/territorial legislation and regulations are used to grant qualified nurses the legal authority to use the title "registered nurse" or "RN."

This framework seeks to promote a common understanding of RN practice among nurses, students and stakeholders in Canada (including other health professionals, employers, educators, policy-makers and the public). Given the large number of regulated and **unregulated care providers**, it is essential for policy-makers, decision-makers and employers to clearly understand RN competencies and contributions as well as to know when RN care is the most appropriate. In addition, the framework is meant to be a resource for RNs who are working with others to develop a health-care system that is more responsive to the needs and priorities of Canadians. In carrying out this goal, it is important to build on RNs' current practice in determining the roles RNs will assume to strengthen the system.

The framework contains the following key elements:

- ▸ Definition of the RN
- ▸ Theoretical Foundation of RN Practice
- ▸ Professional Practice
  - • Registration and Licensure
  - • Values
  - • Entry-level Competencies
  - • Educational Preparation
  - • Scope of Practice
  - • Continuing Competence
  - • Professional Conduct
- ▸ RN Careers
  - • Roles and Practice Settings
  - • Career Paths
- ▸ The Impact of RNs
- ▸ Looking to the Future

For the purposes of the framework, it is also important to acknowledge the dynamic nature of an RN's education, regulation and practice, which develop in response to population health needs, advancements in nursing knowledge and changes in the health-care system. Since regulation is set at the jurisdictional level (i.e., by the provinces and territories) slight variations in language and processes are inevitable; however, the principles shared in this document are pan-Canadian in scope.[2]

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1 Terms in bold are defined in the glossary.

2 The specific regulations for RNs in each province and territory can be found on the regulatory body websites listed at https://www.cna-aiic.ca/en/becoming-an-rn/regulation-of-rns/regulatory-bodies.

Key Elements of the Framework

DEFINITION OF THE RN

The Canadian Nurses Association defines the RN as follows:

> RNs are self-regulated health-care professionals who work autonomously and in collaboration with others to enable individuals, families, groups, communities and populations to achieve their optimal levels of **health**. At all stages of life, in situations of health, illness, injury and disability, RNs deliver direct health-care services, coordinate care and support clients in managing their own health. RNs contribute to the health-care system through their leadership across a wide range of settings in practice, education, administration, research and policy.

In Canada, the nursing profession consists of four regulated nursing groups: registered nurses (RNs), nurse practitioners (NPs),[3] licensed practical nurses[4] and registered psychiatric nurses.[5] RNs make up almost three-quarters of the regulated nursing workforce and are the country's largest single group of health-care providers (Canadian Institute for Health Information [CIHI], 2015).

The regulation of RNs is more specifically defined in jurisdictional legislation, e.g. in RN acts and other documents (such as standards of practice) developed by provincial and territorial regulatory bodies.

CONCEPTUAL FOUNDATION OF THE PRACTICE OF RNS

As Kozier et al. (2013) point out, "philosophical thinking provides the foundation for the development and critical analysis of nursing knowledge. Nursing knowledge is organized and communicated by using concepts, models, frameworks and theories (p. 62)." Four central concepts underpin the conceptual and theoretical frameworks for RNs. Frequently referred to as

the metaparadigm of the discipline, these concepts are (1) the person or client, (2) the environment, (3) health, and (4) nursing (Kozier et al., 2013; See Figure 1).

Figure 1. Metaparadigm of Nursing
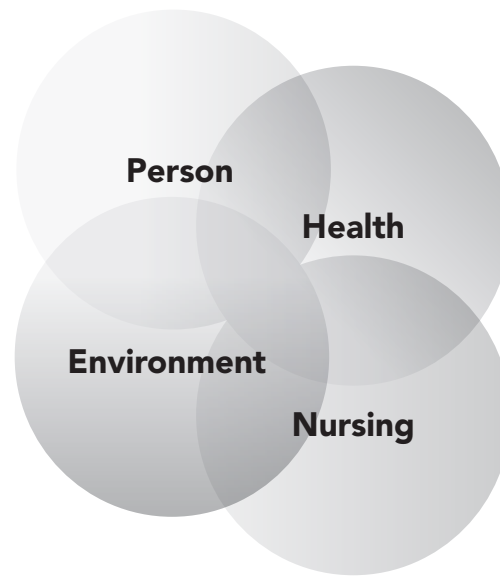
Source: Adapted from Ordre des infirmières et infirmiers du Québec, 2010, p. 7.

In the nursing metaparadigm, the person or client refers to the beneficiary of RN care, which may be an individual, family, group, community or population. RNs focus on wholeness, considering the biophysical, psychological, emotional, social, cultural and spiritual dimensions of the client. In addition, RNs are attentive to their clients' environment, taking

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3   This document excludes nurse practitioner (or RN in the extended class in Ontario) practice, which is covered in CNA's *Advanced Nursing Practice: A National Framework*.

4   In Ontario, the title used for a licensed practical nurse is "registered practical nurse."

5   Registered psychiatric nurses are currently educated and regulated only in British Columbia, Alberta, Saskatchewan, Manitoba and the Yukon.

into account the broader determinants of health, which include social, physical, psychological and economic factors that may affect them (Canadian Nurses Association [CNA], 2013). An RN's concern with health has many facets, including the levels of wellness, well-being and quality of life their clients' experience. The profession of nursing for RNs "encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles" (International Council of Nurses, 2014).

Nursing science is the foundation of nursing practice, although RNs use knowledge from a variety of sciences and humanities to inform their practice. These include basic science, social and behavioural sciences, psychology, complexity theory, etc.

PROFESSIONAL PRACTICE

Canadians have given the nursing profession the privilege of self-regulation. Provincial and territorial governments mandate and delegate to nursing regulatory bodies (by statute) the power to regulate themselves and to ensure the profession remains accountable to the public and to governments. Regulatory bodies achieve this mandate by ensuring that RNs are safe, competent and ethical practitioners through a variety of regulatory activities.

In return, the nursing profession is at all times expected to act in the best interest of the public. To maintain public protection, RNs engage in self-regulation as a profession and as individuals.

These mandated responsibilities for regulatory bodies and individual RNs also include governments, the public, educational institutions, employers, and other health-care professions and professionals (CNA, 2007). Some examples are shown in Table 1.

Table 1. Examples of self-regulatory activities of the nursing profession and individual RN

Profession (regulatory body)	Individual RN
Establishes registration and licensing processes	Meets initial and ongoing licensure/registration requirements
Establishes, monitors and enforces *standards* in ethics and practice	Adheres to the code of ethics and standards of nursing practice
Establishes and maintains the scope of RN practice as health-care delivery and nursing knowledge advances	Practises within the established scope of practice
Establishes nursing education standards and approves nursing education programs leading to initial entry to the profession	Graduates from an approved nursing program. Contributes to curriculum development Acts as a mentor and preceptor for nursing students
Establishes and maintains entry-level competencies required for initial registration	Demonstrates entry-level competencies by passing the pan-Canadian registration exam[6] Contributes to and delivers RN orientation programs
Establishes, monitors and maintains quality assurance and continuing competence requirements	Maintains and enhances practice fitness and competence Participates in continuous quality improvement initiatives
Establishes and maintains professional conduct review processes to investigate allegations/complaints and concerns about RNs' practice and implements disciplinary action as required	Upholds standards and ethical codes and reports concerns about unsafe, incompetent or unethical behaviour or care

6   Quebec has its own RN professional examination.

Registration and Licensure

Nursing regulatory bodies establish registration and **licensure** criteria for RNs, in consultation with other key provincial and territorial stakeholders. These stakeholders enable the regulatory bodies to determine whether applicants or members are eligible to practise in their jurisdiction. Eligibility criteria include making sure RNs entering the profession have the necessary knowledge, judgment, attributes and skills to provide safe, competent and ethical care. They also include requirements for demonstrating language proficiency, good character, **fitness to practise**, etc. (CNA, 2007). As part of the process of determining eligibility, regulators list the names of individuals who meet all registration/licensing requirements in an official register. Once registered, nurses are held accountable to the standards, limits and conditions established by their regulatory body.

Several jurisdictions have introduced their own jurisprudence component as a registration requirement. For instance, Nova Scotia's "jurisprudence examination measures an individual nurse's awareness of provincial and regulatory policies and any provincial and federal laws that would relate to nursing practice in Nova Scotia" (College of Registered Nurses of Nova Scotia [CRNNS], 2015, para. 2).

In terms of workforce mobility, the **Agreement on Internal Trade** stipulates that jurisdictional regulatory bodies recognize those licensed professionals who move between provinces and territories — effectively eliminating them from any labour barriers. As part of the mandate to protect the public, all regulatory bodies work collaboratively on harmonizing registration and licensure requirements to support such mobility, where possible.

RNs have title protection in all Canadian provinces and territories,[7] which means only a registered nurse can use "RN" when signing their name (e.g., Mary Jones, RN). Such title protections allow the public to distinguish between health-care providers who are authorized to practise and those who are non-practising or retired.

Values

The ethical values that underpin RN practice are expressed in standards and codes. One example, adopted by many regulatory bodies, is the CNA *Code of Ethics for Registered Nurses*, "a statement of the ethical[8] values of nurses and [their] commitments to persons receiving care, [which] is intended for nurses in all… domains of nursing practice and at all levels of decision-making" (CNA, 2008b, p. 1).

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7   In Canada, titles such as "registered nurse," "RN" and (in some jurisdictions) "nurse" are protected (CNA, 2007)

8   In this document, the terms "moral" and "ethical" are used interchangeably based on consultations with nurse ethicists and philosophers. We acknowledge that some individuals prefer to distinguish these terms.

The code identifies seven primary values that are central to the ethical practice of RNs:

▸ Providing safe, compassionate, competent and ethical care

▸ Promoting health and well-being

▸ Promoting and respecting informed decision-making

▸ Preserving dignity

▸ Maintaining privacy and confidentiality

▸ Promoting justice

▸ Being accountable

Nurses who use the CNA code of ethics bear the ethical responsibilities identified under each of these primary nursing values,[9] which apply to their interactions with individuals, families, groups, populations, communities and society as well as those with students, colleagues and other health-care professionals (See Appendix A for definitions of the values). CNA updates the code of ethics regularly to ensure that it remains current with social values and conditions affecting the public, RNs, other health-care providers and the health-care system.

Entry-Level Competencies

Competencies refer to the knowledge, skills, judgment and attributes required of an RN to practise safely and ethically in a designated role and setting (CNA, 2010). "From a regulatory perspective, the entry-level competencies serve the primary purpose of nursing education program approval by describing the competencies required for entry-level registered nurses to provide safe, competent, compassionate, and ethical nursing care in a variety of practice settings. The competencies also serve as a guide for curriculum development and for public and employer awareness of the practice expectations of entry-level registered nurses" (Canadian Council of Registered Nurse Regulators [CCRNR], 2012, p. 5).

The current competencies "reflect baccalaureate nursing education. They are client-centred, futuristic, and incorporate new developments in society, health care, nursing knowledge, and nursing practice. The competencies aim to ensure that entry-level registered nurses are able to function in today's realities and are well-equipped with the knowledge and skills to adapt to changes in health care and nursing" (CCRNR, 2012, p. 5). They are determined by each regulatory body's ongoing evaluation of the practice environment and further validated by data collected from new graduates and employers on required entry-level RN practice skills and roles.

Regulatory bodies assess entry-level competencies in the jurisdictions where nursing candidates have graduated[10] by evaluating nursing education programs and the Canadian registration exam. Candidates must pass this exam to obtain a license to practise in all Canadian provinces and territories outside Quebec, which has its own licensure exam. The exams are used to measure the competencies needed to perform safely and effectively as an entry-level RN (CCRNR, 2014).

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9   The value and responsibility statements in the code are numbered and lettered for ease of use rather than prioritization. The values are related and overlapping.

10   The specific requirements of each province and territory can be found on the regulators' websites.

Figure 2. Conceptual Framework for Organizing Competencies

Source: Adapted from Jurisdictional Competency Process, 2012, p. 9.

Entry-level **competency** statements are organized using a standards-based conceptual framework that emphasizes the regulatory purposes of the five competency categories (see Figure 2):

▸ Professional responsibility and accountability

▸ Knowledge-based practice

▸ Ethical practice

▸ Service to the public

▸ Self-Regulation

The examples in Appendix B show the entry-level competencies' breadth and depth. Although presented separately, RNs must be able to integrate and perform many competencies at the same time to ensure safe, effective and ethical practice (CCRNR, 2012).

Educational Preparation

Education programs for RNs prepare students for competent, safe, compassionate, and ethical practice and enable them to achieve the entry-to-practice competencies expected of new graduates. To attain all entry-level competencies, graduates must demonstrate wide-ranging skills and abilities. These include cognitive, behavioural, communicative and psychomotor skills, as are found, for example, in tasks requiring manual dexterity or appropriate responses in situations of stress or conflict. Many provincial and territorial nursing jurisdictions use these requisite skills to help prospective students and career advisors determine if nursing would be an appropriate career choice.

Basic nursing education in Canada has moved away from acquiring entry-level competencies through diploma programs (all provinces and territories outside Quebec that offer programs require a baccalaureate degree). Since this shift started only in the late 1990s, both diploma-prepared and baccalaureate-prepared RNs currently practise in Canada.

For the Canadian Association of Schools of Nursing (CASN), a "broad based baccalaureate education is warranted given the:

- increasing **complexity** in nursing and health care;
- rapidly expanding body of nursing and health-related knowledge;
- rapidly expanded use of digital technologies in knowledge transfer and utilization;
- need for 'life-long' learning in order to adapt to these changes and to provide a basis for advanced nursing education;
- accountability to the public for safe, competent, ethical, and effective nursing care;
- need to understand and practice nursing within the pluralistic social, cultural, and political contexts of Canadian society; and
- diversity across Canada including: demographic, socio-economic, cultural and geographic diversity" (2011a, p.1).

CASN finds that baccalaureate programs are needed to "provide the foundation for sound clinical reasoning and clinical judgment, critical thinking, and a strong ethical comportment in nursing" (2011a, p. 1).

In addition, learners in these programs are

> assisted to develop a broad knowledge base, and to critically reflect upon, integrate and thoughtfully apply various forms of knowledge in a range of health care settings. Learners develop abilities in professional reflection, self-evaluation, ethical decision-making, nursing practice and **interprofessional practice**. Baccalaureate programs prepare learners to identify, develop and incorporate professional values that respect and respond ethically and sensitively to social and cultural diversity. They foster an understanding of the role of nursing in promoting quality work environments that maximize patient safety. Programs prepare students to be aware of and respond to emerging themes such as new information technologies, and global citizenship. (2011a, p.1)

Research has also linked bachelor-educated RNs with improvements in patient safety and outcomes. An O'Brien Pallas et al. (2001) study of community-based health services found better health outcomes in people cared for by bachelor-educated RNs. Since 2002, several studies have tied the increased percentage of hospital RNs with baccalaureate degrees to decreased patient mortality (in-hospital and 30-day mortality, failure to rescue, congestive heart failure), lower rates of decubitus ulcers, post-operative deep vein thrombosis or pulmonary embolism and shorter length of stay (Yakusheva, Lindrooth, & Weiss, 2014; Aiken et al., 2014; Aiken et al., 2011; Aiken, Clarke, Cheung, Sloane, & Silber, 2003; Estabrooks, Midodzi, & Cummings, 2005; Friese, Lake, Aiken, Silber, & Sochalski, 2008; Tourangeau et al., 2007; Van den Heede et al., 2009). And, given that better

patient outcomes mean cost savings for the health-care system, a strong business case exists for increasing the proportion of baccalaureate-educated nurses to 80 per cent (Yakusheva et al., 2014).

In the last decade, many schools of nursing have increased the number of seats and developed additional programs in response to Canada's workplace needs. These programs, tailored to specific types of prospective RN students such as internationally educated nurses, graduates from other university disciplines or practical nursing programs, may

▸ use tools to assess prior learning and adapt requirements to individual needs (for internationally educated students);

▸ offer shorter times for completion by recognizing non-nursing courses and delivering year-round sessions (for second entry degree students); and

▸ employ bridging courses (for practical nurse graduates).

Practising RNs may also choose to pursue education at the master's, doctoral and post-doctoral levels. In terms of the skills acquired through advanced degrees, "at the Master's level, students build upon the knowledge and competencies acquired at the baccalaureate level. Emphasis is placed on developing the ability to analyze, critique, and use research and theory to further nursing practice. Provision is also made for examination of current issues in health care and the ethical values that influence decision-making. Core components of a Master's curriculum include definitive preparation designed to enable students to synthesize research, theory and practice at an advanced level. In addition to the core components the focus of Master's study

may include the preparation of nurses with advanced leadership skills in: clinical practice (e.g. Nurse Practitioner, Clinical Nurse Specialists); nursing education (academic and healthcare institutions); administration (institutional, community and educational); health policy and nursing research" (Canadian Association of Schools of Nursing, 2011b, p.1). As well, many nurses supplement their practice through studies outside of nursing (e.g., in education or health-care administration).

A variety of abbreviations designate the different levels and types of credentials that nurses may acquire. For example, BN denotes a bachelor of nursing, BScN a bachelor of science in nursing, MN a master's in nursing, DNP a doctor of nursing practice and PhD a doctor of philosophy. RNs may use both their regulatory designation and educational qualifications after their name (e.g., Mary Jones, RN, BScN, MN).

"Education is a powerful tool, emancipatory in fact. A nursing degree gave me opportunities for both transformative learning at an individual level and enhanced employment at a professional level. The practice of nursing requires a reflective practitioner who is clinically competent, socially just and morally astute. All of these components form the basis of a nursing degree. I have embraced these facets of my education and realized that I always want more. My nursing degree was a motivational educational event."

– **Pertice Moffitt, RN, PhD**

Scope of Practice

The RN scope of practice refers to the activities RNs are authorized, educated and competent to perform. Set out in provincial/territorial legislation and regulations, the RN scope of practice is complemented by standards, guidelines, policy positions and ethical standards from jurisdictional nursing regulatory bodies.

While such controls determine the overall scope and boundaries of practice for RNs as a professional group, other factors also influence the practice of the individual RN. These include client needs, the practice setting, requirements and policies of an employer and the RN's level of competence.

Many RN regulatory bodies have sought to clarify the RN scope of practice through visual diagrams (See Figure 3).

Figure 3. Scope of Practice Boundaries

Health professions or nursing legislation

Registered nurses profession regulation

Professional guidelines, standards & position statements

Employer policies

Individual RN competence

Client needs

Common ground exists between the scopes of practice of nurses and other health-care providers, with respect to both their unique and shared competencies. Mutual understanding is needed in these areas to promote role clarity and ensure that each provider is utilized properly. It is also crucial for achieving positive outcomes with clients and for establishing quality **interprofessional collaborative** teams.

When deciding about **nursing** practice and **staff mix** issues, a number of jurisdictions have developed tools that allow decision-makers to benefit from the broadest range of health-care professionals' knowledge and skills. For instance, a College of Nurses of

Ontario practice guideline, *RN and [Registered Practical Nurse] Practice: The Client, the Nurse and the Environment*, outlines expectations for nurses and highlights the "similarities and differences of foundational nursing knowledge,… its impact on autonomous practice[11] [and] nurses' accountabilities when collaborating with one another" (2014, p. 3). For instance, both RNs and registered practical nurses can care for clients who have been identified as less complex, more predictable and low risk for negative outcomes. As shown in Figure 4, "the more complex the care requirements, the greater the need for consultation and/or the need for an RN to provide the full spectrum of care" (CNO, 2014, p. 5).

Figure 4. Client Continuum

Less complex, more predictable, low risk for negative outcome(s)

Highly complex, unpredictable, high risk for negative outcome(s)

Autonomous RPN or RN practice

RN practice

Increasing need for RN consultation and collaboration
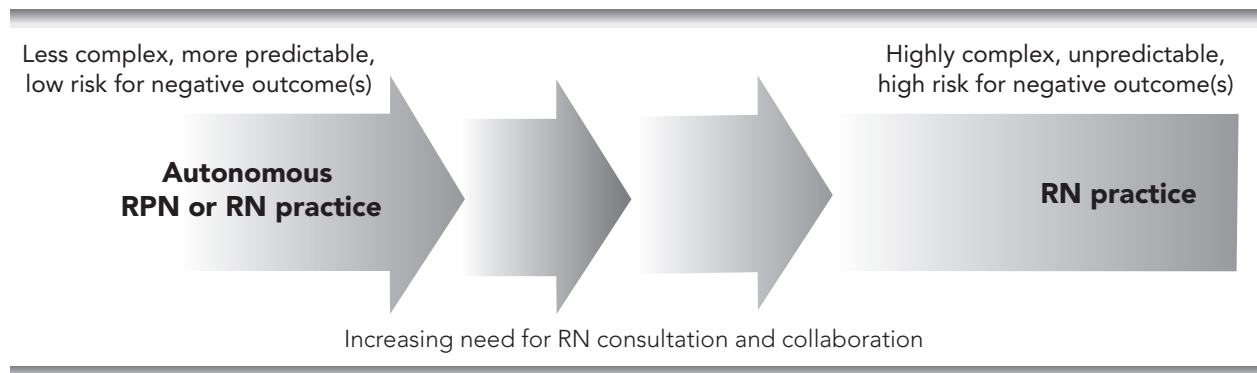
Source: College of Nurses of Ontario, 2014, p. 5.

11 Licensed practical nurses are not autonomous in all provinces and territories.

Similarly, the distinction between the practices of RNs and licensed practical nurses has been outlined in several nursing regulatory documents. These include a joint publication by the Nurses Association of New Brunswick and the Association of New Brunswick Licensed Practical Nurses that highlights and clarifies some key differences between RNs and licensed practical nurses in clinical practice. *Guidelines for Intraprofessional Collaboration: Registered Nurses and Licensed Practical Nurses Working Together* (2015) describes the scopes of each group and delineates the accountabilities and limits on their practices. In addition, CRNNS and the College of Licensed Practical Nurses of Nova Scotia's *Guidelines: Effective Utilization of [Registered Nurses] and [Licensed Practical Nurses] in a Collaborative Practice Environment* (2012) emphasizes the different values, knowledge, critical thinking skills, etc. of RNs and licensed practical nurses with the aim of achieving a "more effective collaboration and appropriate utilization" within that province's health-care system (p. 4).

Health experts have viewed such efforts to define nursing roles as a way to bring about a more cost-effective health-care system, since "working to optimal scope of practice means achieving the most effective configuration of professional roles as determined by other care professionals' relative competencies" (Nelson et al., 2014, p.22).

For the RN role itself, with their ability to comprehensively assess "a client's status and needs, RNs use their in-depth knowledge base and cognitive, critical thinking and decision-making skills 'to attend to both obvious and elusive cues, to note minimally discernible patterns in the data and to interpret and synthesize information' (CNA, 2002c). Through this surveillance, RNs are able to recognize complications before they become more serious and to intervene to reduce risk to the client and costs to the health-care system" (CNA, 2007b, p. 18).

RNs also have knowledge and skill from their baccalaureate education to participate in research and evidence-informed activities. "RNs have the foundational knowledge to identify practice research questions, [undertake research] and to use research results to provide a scientific rationale for nursing interventions, thereby promoting quality client care (CARNA, 2005; CNA, 2002c). This foundation also allows RNs to be 'knowledge navigators' by directing clients to credible resources, teaching them to interpret and evaluate information and helping them find their way in the health-care system" (CNA, 2007b, p. 19).

At the organizational level, employers and administrators can determine which activities to assign to an RN based on the complexity of a patient's care requirements and on the need for clinical expertise and judgment, critical thinking, analysis, problem-solving, decision-making, research utilization, resource management and leadership.

A useful tool for optimizing scopes of practice is the *Staff Mix Decision-making Framework for Quality Nursing Care* developed by CNA, the Canadian Council for Practical Nurse Regulators (CCPNR) and the Registered Psychiatric Nurses of Canada (RPNC) (see Figure 5). This comprehensive, evidence-informed resource presents a systematic approach to staff mix decision-making for all clinical practice settings. "The framework outlines key client factors, staff factors, organizational factors and outcome indicators to be considered when assessing, planning, implementing and evaluating staff mix decisions" (CNA, CCPNR, RPNC 2012, p.7).

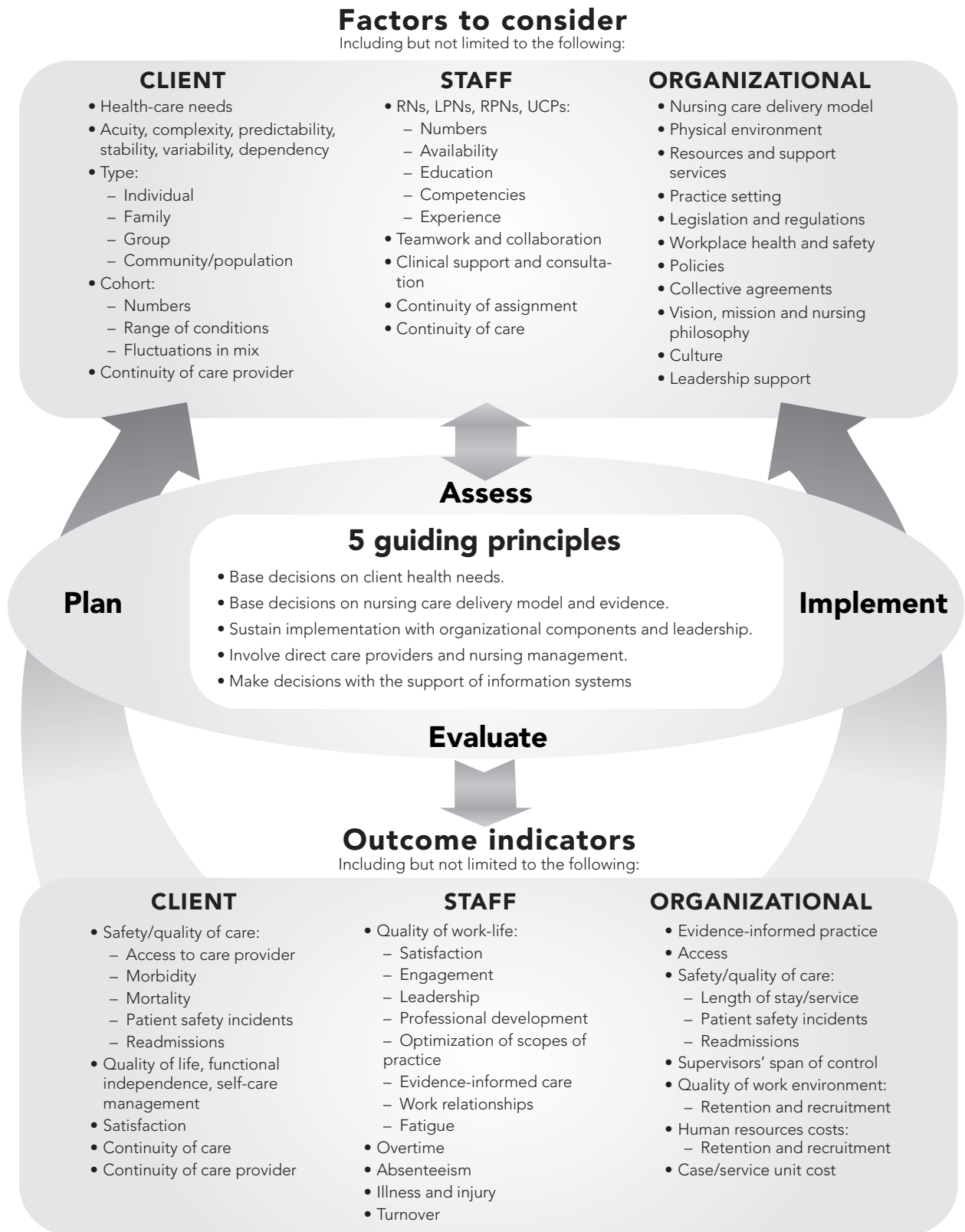## The Development of Expertise and Continuing Competence

RNs acquire, maintain and continually enhance their knowledge and skills for all aspects of their practice while ensuring the use of **evidence-informed decision-making**. Both formal and informal learning can be part of an RN's progression from novice to expert and help RNs respond to changing technologies, systems and theories as well as to specific client and career needs.

RNs develop expertise in their chosen areas of practice in several ways, including self-learning, post-RN specialty education programs, specialty **certification** (e.g., the CNA Certification Program),

mentorship programs, advanced academic education and **best practice guidelines** (e.g., Ontario's Best Practice Guidelines program, developed by the Registered Nurses' Association of Ontario [RNAO]). Best practice guidelines support nurses in moving from novices to experts (RNAO, 2001; Grinspun, Virani, & Bajnok, 2001). Standards and competencies have also been developed for most of the national nursing specialties and CASN has added to this growing list (e.g., palliative and end-of-life care, and public health nursing).

Continuing competence is also important for strengthening the quality nursing practice and increasing public confidence in the nursing profession. All provincial and territorial nursing regulatory bodies have **continuing competence programs** to help RNs demonstrate how they have maintained their competence, enhanced their practice and kept their skills relevant and current. To be eligible to renew their licensure/registration, RNs must meet continuing competence requirements each year. Often this process includes a reflective practice component in which an RN carries out a self-evaluation, receives peer feedback and develops, implements and evaluates a learning plan. Promoting continuing competence is an obligation shared by "individual nurses, professional and regulatory nursing organizations, employers, educational institutions and governments" (CNA, 2004, p. 1).

Figure 5. Staff Mix Decision-making Framework

Factors to consider
Including but not limited to the following:

CLIENT
- Health-care needs
- Acuity, complexity, predictability, stability, variability, dependency
- Type:
  – Individual
  – Family
  – Group
  – Community/population
- Cohort:
  – Numbers
  – Range of conditions
  – Fluctuations in mix
- Continuity of care provider

STAFF
- RNs, LPNs, RPNs, UCPs:
  – Numbers
  – Availability
  – Education
  – Competencies
  – Experience
- Teamwork and collaboration
- Clinical support and consultation
- Continuity of assignment
- Continuity of care

ORGANIZATIONAL
- Nursing care delivery model
- Physical environment
- Resources and support services
- Practice setting
- Legislation and regulations
- Workplace health and safety
- Policies
- Collective agreements
- Vision, mission and nursing philosophy
- Culture
- Leadership support

Assess

Plan

Implement

5 guiding principles
- Base decisions on client health needs.
- Base decisions on nursing care delivery model and evidence.
- Sustain implementation with organizational components and leadership.
- Involve direct care providers and nursing management.
- Make decisions with the support of information systems

Evaluate

Outcome indicators
Including but not limited to the following:

CLIENT
- Safety/quality of care:
  – Access to care provider
  – Morbidity
  – Mortality
  – Patient safety incidents
  – Readmissions
- Quality of life, functional independence, self-care management
- Satisfaction
- Continuity of care
- Continuity of care provider

STAFF
- Quality of work-life:
  – Satisfaction
  – Engagement
  – Leadership
  – Professional development
  – Optimization of scopes of practice
  – Evidence-informed care
  – Work relationships
  – Fatigue
- Overtime
- Absenteeism
- Illness and injury
- Turnover

ORGANIZATIONAL
- Evidence-informed practice
- Access
- Safety/quality of care:
  – Length of stay/service
  – Patient safety incidents
  – Readmissions
- Supervisors' span of control
- Quality of work environment:
  – Retention and recruitment
- Human resources costs:
  – Retention and recruitment
- Case/service unit cost

Professional Conduct

Provincial and territorial nursing regulatory bodies are responsible for regulating nurses to protect the public and for ensuring that the profession and its members are accountable for the delivery of safe, competent and ethical nursing care. Regulation refers not only to setting **standards** for nursing practice, but also to enforcing them by intervening on the public's behalf when practice or professional conduct is considered unacceptable.

All regulatory bodies define the practices that are unacceptable or the conduct deserving of sanction in accordance with their own legislation. These definitions are based on what are believed to be commonly regarded as departures from established professional standards or rules of practice.

For regulators to address unprofessional conduct or unacceptable practice, they must first be reported. Reporting such practices to regulators is the responsibility of all stakeholders including RNs, employers and patients.

Nursing regulatory bodies have processes in place to review serious concerns about professional conduct. These processes are meant to protect the public while ensuring that the principles of natural justice, including a nurse's right to be heard and right to be judged impartially, are respected.

RN CAREERS

Roles and Practice Settings

RN practice consists of diverse yet inter-related domains of activity, including clinical practice, education, administration, research and policy. RNs with positions outside of direct client-centred care support those who provide it while bringing leadership to the health system, collaborative practice, health care planning, and patient safety and promoting system-wide efficiency and effectiveness.

An RN's comprehensive knowledge base, commitment to lifelong learning and their understanding of clients and the health system, enable them to assume many different roles. RNs lead health-care teams, conduct formal research activities, manage nursing services, develop and deliver nursing education and contribute to the advancement of healthy public policy. They have the skill, expertise and capacity to lead, whether in enhancing client-centred care across the care continuum, directing interprofessional teams or implementing new policy. Nursing leadership is about critical thinking, action and advocacy — and RNs demonstrate these attributes in all roles and domains of nursing practice (CNA, 2009a). RN leadership strengthens our health services and health system while improving the health and well-being of the Canadians they serve (CARNA, 2011).

For many Canadians, the most familiar image of the RN is a hospital nurse, which is understandable given that hospitals are where 62 per cent of our RNs currently work (CIHI, 2015). Yet RNs practise in a wide variety of settings, including the following:

- residential care facilities
- community health centres
- independent practices (self-employed)
- faith communities
- workplaces (e.g., industry, mental health facilities)
- clinics
- schools, colleges and universities
- clients' homes
- "the streets"
- correctional facilities
- research institutes
- professional nursing and health-care organizations
- government agencies and departments

New roles and practice settings for RNs are continually being added in response to Canadians' health needs and the need to improve health service delivery. RNs work with diverse client populations, including Aboriginal Peoples, and in a variety of contexts and practice settings. They also play an increasing role in the community, providing primary care in RN-led clinics and as family practice nurses, community health nurses, nurse prescribers, RN First Call nurses and nurse navigators.

Health care is shifting in order to provide more person- and family-centred care. For caregivers, such an approach involves collaborating with patients and families to deliver "respectful, compassionate, culturally responsive care that meets [clients'] needs, values, cultural backgrounds and beliefs, and preferences" (Government of Saskatchewan, 2015, para. 1). To support this shift to person-centred care, RNs are leading the development of innovative strategies that empower patients to improve their quality of life while bringing cost-effective solutions to health care (CNA, 2014).

Increasingly, RNs are practising within and leading interprofessional teams. As team members RNs work with other regulated health-care providers, including physicians, pharmacists, physiotherapists, social workers, occupational therapists, and with **unregulated care providers** who support nursing care under their direction.

Team-based care is particularly important for managing the growing rate of chronic disease. More than 40 per cent of Canadian adults report having "at least one of seven common conditions — arthritis, cancer, emphysema or chronic obstructive pulmonary disease, diabetes, heart disease, high blood pressure, and mood disorders, not including depression" (Nasmith et al., 2010, p.13). As noted in much of the literature on the subject, "the role for nursing human resources is particularly clear in chronic disease management in primary care, because of the greater requirement for patient involvement and activation that is facilitated by team care" (CHSRF, 2012, p. ii).

Technology is also enabling new models of care delivery and advancing nursing practice. RNs are using telehealth, electronic health records, electronic documentation, decision support systems and other technologies to optimize clinical care, education, administration, research and other health system initiatives. It is essential that RNs continue to play an active role in the selection, design, deployment and evaluation of information and communication technology (ICT) solutions while, at the same time, be given opportunities to acquire ICT competencies to use in their practice (CNA, 2006).

Career Paths

As outlined above, entry-level RNs are prepared as generalists through a broad-based baccalaureate nursing education. Each graduate is ready to practise safely, competently, compassionately and ethically with individuals, families, groups, communities and populations in all stages of health and illness, at any point in the life cycle and in any setting.

Competencies evolve and develop over the course of an RN's career. As RNs acquire and hone their skills — both through practice and continuing professional education — they move along a continuum of practice from novice to expert.

To specialize as an RN means to focus on one field of nursing practice or health care while developing knowledge and skills in an aspect of nursing that goes beyond basic nursing education (Miller,

2002). Specialized practice[12] within any of the domains (clinical, research, administration, policy, education) may relate to

▸ client age (e.g., pediatrics, gerontology);

▸ client health problems (e.g., pain management, bereavement);

▸ diagnostic group (e.g., orthopaedics, vascular surgery);

▸ practice setting (e.g., clients' home, emergency department, school, government office, research institution); or

▸ type of care (e.g., primary care, palliative care, critical care, occupational health, public health or their combinations, e.g., pediatric oncology). (CNA, 2008a).

A number of RNs validate their competence in a given specialty by obtaining a credential that confirms their advanced knowledge and skills. Certification is one form of credentialing offered by employers, educational institutions, regulatory bodies and CNA. The CNA Certification Program currently recognizes 20 nursing specialty areas for national certification, and an RN who becomes CNA certified in one of these areas is entitled to use a specialty credential(s) after their name. For instance, an RN certified in cardiovascular nursing can use the CCN(C) designation (CNA, 2015).

In some provinces and territories, the terms "specialist," "specialty," "specialized practice," "specialization" and "certification" have particular meanings for regulatory purposes.

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12 The Canadian Network of Nursing Specialties represents a committed group of nurses who have joined one of 45 national associations in a specialty area of nursing.

Certain career paths require additional registration requirements. For example, through a combination of focused experience and graduate-level education, some RN practices are characterized as advanced nursing (CNA, 2008a). In Canada, the most recognized advanced roles are the clinical nurse specialist and the nurse practitioner.

Many RNs pursue policy and administration careers and assume formal leadership positions. These health-care/agency organizational careers, which can include the most senior executive positions, exist at local, regional, provincial/territorial and national levels. RNs who take up such careers often combine their initial nursing education with a master's degree in a non-nursing field such as in business or health administration.

My career path has taken me from volunteering in acute care and the emergency department as a teenager, working as a nurse in acute and palliative care, co-chairing a regional nursing practice council, working as a clinical nurse leader and professional practice consultant, and going back to school for my master's of nursing in advanced practice leadership, to my current role as manager for the office of the executive vice-presidents, chief operating officer and chief medical officer.

Along the way, various nurse leaders, including our chief nursing officer, have created opportunities for me to develop my skills as a nursing leader. They encouraged me to use my nursing voice and participate in activities related to providing good care across the continuum of health services and to building strategic partnerships internal and external to our organization — as they supported our staff to do their best while looking after their own health. In

my practice I often hear "you must miss being a real nurse," which is a phrase I welcome. It creates an opportunity to talk about what nursing is, as I work as a nurse every day. The assessment and empathic listening skills I developed as a direct care nurse in surgery and hospice support continue to ground me in my practice as a nursing leader, where I now influence practice changes in a broader systems context. I draw upon my clinical experiences daily, and I strive to continually integrate and consider patient, family and population health perspectives when supporting our organization's senior leaders in the decision-making process. Developing others is a responsibility I take very seriously. I'm always on the lookout to acknowledge the potential of other nursing leaders and to create opportunities to "take them with me" as they develop their capacity for influencing change in the complexities of our current health-care system.

– Christina Berlanda, RN, BSN

THE IMPACT OF RNS

RNs make a critical contribution to the health of Canadians and the health-care system. Research supports the correlation between direct RN care and positive client and system outcomes. For example, client outcomes consistently show that RN interventions have a positive effect across a variety of health-care settings. General improvements include

- clinical outcomes (control or management of symptoms such as fatigue, nausea and vomiting, dyspnea and pain);
- functional outcomes (physical and psychosocial functioning and self-care abilities);
- safety outcomes (adverse incidents and complications such as pressure ulcers, falls); and
- perceptual outcomes (satisfaction with nursing care and its results).

(Doran, 2003; White, Pringle, Doran, & McGillis Hall, 2005)

Among specific research studies, RN direct care outcomes include the following:

- Adding one patient to a nurse's workload increased the likelihood that an inpatient would die within 30 days of admission by 7 per cent (Aiken et al., 2014).
- Having a greater proportion of RNs relative to unlicensed assistive personnel is associated with fewer patient falls (Patrician et al., 2011).

- A cost-benefit analysis of school health services delivered by full-time RNs showed that society would gain $2.20 for every dollar invested (Wang et al., 2014).
- For hip-fracture patients, the odds of in-hospital mortality decreased by 0.16 for every additional full-time equivalent RN per patient day (Schilling, Goulet, & Dougherty, 2011).
- Increasing RN hours per patient day by 0.71 is associated with lowering the odds of an unplanned emergency room visit after discharge by 45 per cent (Bobay, Yakusheva, & Weiss, 2011).
- An 8 per cent rise in direct RN patient care is correlated with a 30 per cent improvement in patient scores on caregiver responsiveness (O'Connor, Ritchie, Drouin, & Covell, 2012).

Follow any opportunities to expand or enhance your knowledge and skill set. Don't be afraid to try something new. It's the opposite of pulling one thread and unravelling a sweater. Instead, you take hold of one strong thread and pick up others along the way to weave your own career tapestry. My thread began with a passion for emergency nursing, which was a springboard to many other nursing careers on land, air and sea.

– **Dorothy Latimer, RN**

- RNs reduce wait times and improve timely access by increasing the number of entry points to care, coordinating care and assisting patients in navigating the health-care system (CNA, 2009b).

- As RN staffing levels go up, the risk of hospital-acquired infections and the length of hospital stays go down (Dall, Chen, Seifert, Maddox, & Hogan, 2009).

- A systematic review and meta-analysis of 28 international studies, by the Agency for Healthcare Research and Quality (U.S. Dept. of Health and Human Services), found substantial evidence that increased RN staffing leads to better patient outcomes. These outcomes include lowering patients' odds for hospital-acquired pneumonia, hospital-related mortality (in intensive care units), unplanned extubation, respiratory failure, cardiac arrest and a lower risk of failure to rescue (in surgical patients) (Kane, Shamliyan, Mueller, Duval, & Wilt, 2007).

- Proactive nurse-led care models focusing on patients' preventive self-management of chronic disease are either more effective and equally or less costly, or equally effective and less costly than standard models of care (Browne, Birch, & Thabane, 2012).

- Each additional RN a hospital employs will save over $60,000 annually in medical costs and improved national productivity (accounting for 72 per cent of labour costs) (Dall et al., 2009).

- Increasing RN hours of care provided is associated with net cost savings through reduced length of hospital stays and avoided adverse outcomes (Needleman, Buerhaus, Stewart, Zelevinsky, & Mattke, 2006).

RNs require resources and support to deliver quality client-centred care and to positively influence client outcomes. A quality practice environment can ensure the delivery of "safe, compassionate, competent and ethical care while maximizing the health of clients and nurses" (CNA & CFNU, 2015, p. 1). Developing, supporting and maintaining quality practice environments is a responsibility shared by "individual [RNs], employers, regulatory bodies, professional associations, educational institutions, unions, health services delivery and accreditation organizations, governments and the public" (CNA & CFNU, 2015, p. 1).

RNs increase access and trust in the health system for people who may avoid mainstream services through a targeted universalism that promotes health, reduces harms and prevents illness in an equitable way. They create access to a significant range of health and social services for clients on the street who otherwise wouldn't have access. For example, as a street nurse, I provide evidence-based harm reduction services to clients in need while empowering them to get involved in safe practices to prevent the spread of infection and/or reduce harm.

– **Daniel Awshek, RN, BN, PHN**

LOOKING TO THE FUTURE

What does the future hold for Canada's RNs?

The National Expert Commission (NEC) believes that "prevention, early identification, and management of chronic diseases are fundamental to controlling future health care costs as our population ages. Healthy aging and chronic disease management both align well with the knowledge and practice of nurses" (NEC, 2012, p. 12).

Moving forward, RNs will increasingly

▸ lead individuals and communities in managing their own health;

▸ care for those who are ill and play a leadership role in helping clients manage chronic diseases;

▸ take on roles that include goal-setting, monitoring, coaching, telephone support and group education;

▸ assist clients in making their own decisions about their care, quality of life and health promotion at every stage of their lives; and

▸ help shift health education away from an illness treatment model to a focus on keeping people well while delivering the required care and support in the community.

We believe Canada's nurses must "intensify their role as leaders of system transformation, including a far-reaching overhaul of the ways we deploy and employ nurses. That will mean supporting and expecting every nurse to practice to the top of his or her scope of practice.

But the scope must also be expanded appropriately to meet changed and changing health needs, to encompass functions including, but not limited to, prescribing, and admitting and discharging patients across all types of health facilities" (NEC, 2012, p. 37).

"It is time to test the value of a nurse-led proactive, targeted model of comprehensive chronic care, with a physician as one member of a team, where all are doing what they do best and the nurse is enlisting all the health and social services that can augment the determinants of a person's health" (Browne, Birch, & Thabane, 2012, p. 29).

Moving forward, RNs will increasingly

▸ lead collaborative teams of health-care professionals and support staff;

▸ improve access to care as an entry point to health-promotion, disease-prevention and illness-care systems;

▸ contribute to better care by prescribing medications and working across the continuum of care;

▸ take a leadership role in addressing the social determinants of health; and

▸ advocate for health care sustainability through improved quality, efficiency and effectiveness.

"Canada's nurses can and must act in collaboration with other health professionals and system leaders to ensure better health, better care and better value for all Canadians. Through their sheer numbers and collective knowledge, nurses are a mighty force for change. Canadians expect nurses to harness that power and act" (NEC, 2012, p.1).

Moving forward, RNs will increasingly

▸ exercise leadership in all areas of the health-care system;

▸ take on roles as senior executives, educators, researchers and policy-makers in addition to direct clinical care.

Future RN leadership has been characterized by eight essential skills:

1. "a global perspective or mindset regarding healthcare and professional nursing issues;

2. technology skills which facilitate mobility and portability of relationships, interactions and operational processes;

3. expert decision-making skills rooted in empirical science;

4. the ability to create organization cultures that permeate quality health-care and patient/worker safety;

5. understanding and appropriately intervening in political processes;

6. highly developed collaborative and team building skills;

7. the ability to balance authenticity and performance expectations; and

8. being able to envision and proactively adapt to a healthcare system characterized by rapid change and chaos" (Huston's "Preparing Nurse Leaders for 2020" [as cited in CNA, 2009a, p. 6]).

Regardless of the direction health-care delivery takes in the future, RNs will play a crucial role within the system. History has made it clear that the RN role is dynamic, changing in response to many influences both inside and outside the profession. RNs are accountable for the quality and safety of care they deliver and for their role in shaping Canadian health care by bringing the nursing perspective to the health planning table. Most of all, RNs are and will continue to be accountable, ethical, competent and compassionate in each of their varied roles.

In the future health care must be approached as a collaborative team effort with nurses working in conjunction with other health professionals and community sources to ensure the best care for all Canadians.

– **Canadian Nursing Students'
Association**

Glossary

Agreement on Internal Trade. An intergovernmental agreement (1995) "to reduce and eliminate, to the extent possible, barriers to the free movement of persons, goods, services, and investment within Canada and to establish an open, efficient, and stable domestic market" (Internal Trade Secretariat, n.d., para. 1).

Best practice guidelines. "Recommendations that may evolve based on ongoing key expert experience, judgment, perspective and continued research (Health Canada, 2008). They are also known as systematically developed statements of recommended practice in a specific clinical or healthy work environment area, are based on best evidence, and are designed to provide direction to practitioners and managers in their clinical and management decision-making (Field & Lohr, 1990)" (RNAO, 2012, p. 7).

Certification. Through certification, an RN demonstrates competence in a nursing specialty by meeting predetermined standards established and confirmed by an organized, professional body. Note: in some provinces, the term *certification* has a particular meaning for regulatory purposes.

Client. The person, patient or resident who benefits from RN care. A client may be an individual, a family, group, community or population.

Competency. The integrated knowledge, skills, judgment and attributes required of an RN to practise safely and ethically in a designated role and setting. (Attributes include, but are not limited to, attitudes, values and beliefs.)

Complexity. "The degree to which a client's condition and/or situation is characterized or influenced by a range of variables (e.g. multiple medical diagnoses, impaired decision-making ability, challenging family dynamics) (CRNBC, 2011)" (CNA, CCPNR, & RPNC, 2012, p.3).

Continuing competence program. "A program that focuses on promoting the maintenance and acquirement of the competence of registered nurses throughout their careers" (CNA, 2000, p. 6).

Evidence-informed decision-making. "A continuous interactive process involving the explicit, conscientious and judicious consideration of the best available evidence to provide care. It is essential to optimize outcomes for individual clients, promote healthy communities and populations, improve clinical practice, achieve cost-effective nursing care and ensure accountability and transparency in decision-making within the health-care system" (CNA, 2010, p. 1).

Fitness to practise. "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" (CRNBC, 2015, p. 19).

Health. A "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 2006, para. 1). In March 2006, the CNA board of directors resolved to work toward including the concept of "spiritual well-being" within the WHO definition of health.

Interprofessional collaboration. "The process of developing and maintaining effective interprofessional working relationships with learners, practitioners, patients/clients, families and communities to enable optimal health outcomes. Elements of collaboration include respect, trust, shared decision making, and partnerships" (Canadian Interprofessional Health Collaborative, 2010, p. 8).

Licensure. The legislated process through which an RN is authorized to practise. Following an assessment of required competencies, a nurse may have his or her name and other relevant information entered into the nurses' register maintained by the regulatory body for nursing in a province or territory.

Nursing. "Encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping

health policy and in patient and health systems management, and education are also key nursing roles" (International Council of Nurses, 2014, para. 1).

Professional conduct review process. A process to address allegations of unacceptable conduct and practice by RNs that involves investigation and (possibly) discipline and appeals.

Staff mix. "The combination of different categories of health-care personnel employed for the provision of direct client care (McGillis Hall, 2004) in the context of a nursing care delivery model" (CNA, CCPNR, RPNC, 2012, p. 3).

Standard. "An expected and achievable level of performance against which actual performance can be compared. It is the minimum level of acceptable performance" (CRNBC, 2013, p. 5).

Unregulated care providers. "Paid health-care providers who are not registered with a regulatory body. They have no legally defined scope of practice, may or may not have a mandatory education requirement and do not have established standards of practice (College of Registered Nurses of Manitoba, 2010). They 'provide care that supports the client under the… [direct or indirect] supervision of a regulated nurse' (College and Association of Registered Nurses of Alberta, College of Licensed Practical Nurses of Alberta & College of Registered Psychiatric Nurses of Alberta, 2010, p. 2) 'and are accountable for their individual actions and decisions' (College of Registered Nurses of Nova Scotia, 2004, p. 10)" (CNA, CCPNR, RPNC, 2012, p. 4).

APPENDIX A: DEFINITIONS OF VALUES IN THE CNA CODE OF ETHICS FOR REGISTERED NURSES

Value

Being accountable. RNs[13] are accountable for their actions and answerable for their practice.

Maintaining privacy and confidentiality. RNs recognize the importance of privacy and confidentiality and safeguard personal, family and community information obtained in the context of a professional relationship.

Preserving dignity. RNs recognize and respect the intrinsic worth of each person.

Promoting and respecting informed decision-making. RNs recognize, respect and promote a person's right to be informed and make decisions.

Promoting health and well-being. RNs work with people to enable them to attain their highest possible level of health and well-being.

Promoting justice. RNs uphold principles of justice by safeguarding human rights, equity and fairness and by promoting the public good.

Providing safe, compassionate, competent and ethical care. RNs provide safe, compassionate, competent and ethical care.

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13 The term *nurse* used in the code of ethics is replaced in these definitions by RN.

APPENDIX B:
EXAMPLES OF REGULATORY BODY ENTRY-LEVEL RN COMPETENCY STATEMENTS

Professional Responsibility and Accountability

▸ Recognizes individual competence within the legislated scope of practice and seeks support and assistance as necessary

▸ Demonstrates critical inquiry in relation to new knowledge and to technologies that change, enhance or support nursing practice

Knowledge-based Practice

▸ Has a knowledge base in nursing science, social sciences, humanities and health-related research (e.g., culture, power relations, spirituality, philosophical and ethical reasoning)

▸ Has a knowledge base in the health sciences, including anatomy, physiology, pathophysiology, psychopathology, pharmacology, microbiology, epidemiology, genetics, immunology and nutrition

Ethical Practice

▸ Demonstrates ethical responsibilities and legal obligations related to maintaining client privacy, confidentiality and security in all forms of communication, including social media

▸ Demonstrates honesty, integrity and respect in all professional interactions

Service to the Public

▸ Enacts the principle that the primary purpose of the RN is to practise in the best interest of the public and to protect the public from harm

▸ Demonstrates leadership in the coordination of health care by

- assigning client care;
- delegating and evaluating the performance of selected health-care team members in carrying out delegated nursing activities; and
- facilitating continuity of client care.

Self-Regulation

▸ Distinguishes between the legislated scope of practice and the RN's individual competence

▸ Demonstrates continuing competence and preparedness to meet regulatory requirements by

- assessing one's own practice and individual competence to identify learning needs;

- developing a learning plan that uses a variety of resources (e.g., self-evaluation and peer feedback);

- seeking and using new knowledge that may enhance, support or influence competence in practice; and

- implementing and evaluating the effectiveness of one's learning plan and developing future learning plans to maintain and enhance one's competence as an RN.

References

Aiken, L. H., Cimiotti, J. P., Sloane, D. M., Smith, H. L., Flynn, L., & Neff, D. F. (2011). Effects of nurse staffing and nurse education on patient deaths in hospitals with different nurse work environments. *Medical Care, 49*, 1047-1053. doi:10.1097/MLR.0b013e3182330b6e

Aiken, L. H., Clarke, S. P., Cheung, R. B., Sloane, D. M., & Silber, J. H. (2003). Educational levels of hospital nurses and surgical patient mortality. *Journal of the American Medical Association, 290*, 1617-1623.

Aiken, L. H., Sloane, D. M., Bruyneel, L., Van den Heede, K., Griffiths, P., Busse, R.,… RN4CAST consortium. (2014). Nurse staffing and education and hospital mortality in nine European countries: A retrospective observational study. *Lancet, 383*, 1824-1830. doi:10.1016/S0140-6736(13)62631-8

Association of Registered Nurses of Newfoundland and Labrador. (2006). *Scope of nursing practice: Definition, decision-making and delegation.* St. John's: Author.

Berman, A., & Snyder, S. (2012). *Kozier and Erb's fundamentals of nursing: Concepts, process and practice* (9th ed.). Toronto: Pearson.

Blegen, M. A., Goode, C. J., Park, S. H., Vaughn, T., & Spetz, J. L. (2013). Baccalaureate education in nursing and patient outcomes. *Journal of Nursing Administration, 43*(2), 89-94.

Bobay, K., Yakusheva, O., & Weiss, M. (2011). Outcomes and cost analysis of the impact of unit-level nurse staffing on post-discharge utilization. *Nursing Economics*, *29*(2), 69-78, 87.

Browne, G., Birch, S., & Thabane, L. (2012). *Better care: An analysis of nursing and health system outcomes.* Ottawa: Canadian Health Services Research Foundation, Canadian Nurses Association.

Canadian Association of Schools of Nursing. (2011a). *Baccalaureate education and baccalaureate programs* [Position statement]. Ottawa: Author.

Canadian Association of Schools of Nursing. (2011b). *Master's level of nursing* [Position statement]. Ottawa: Author.

Canadian Council of Registered Nurse Regulators. (2012). *JCP entry-level registered nurse competencies.* Retrieved from http://www.ccrnr.ca/assets/jcp_rn_competencies_2012_edition.pdf

Canadian Council of Registered Nurse Regulators. (2015). *2015 NCLEX RN exam.* Retrieved from http://www.ccrnr.ca/index_files/CCRNRNCLEX.html

Canadian Health Services Research Foundation. (2012). *Evidence synthesis for the effectiveness of interprofessional teams in primary care.* Paper commissioned by the Canadian Nurses Association. Ottawa: Author.

Canadian Institute for Health Information. (2015). *Regulated nurses, 2014.* Ottawa: Author.

Canadian Interprofessional Health Collaborative. (2010). *A national interprofessional competency framework.* Vancouver: Author.

Canadian Museum of Civilization. (2004). A brief history of nursing in Canada from the establishment of New France to the present. Retrieved from http://www.historymuseum.ca/cmc/exhibitions/tresors/nursing/nchis01e.shtml

Canadian Nurses Association. (2000). *A national framework for continuing competence programs for registered nurses.* Ottawa: Author.

Canadian Nurses Association. (2002). *Discussion guide for the unique contribution of the registered nurse.* Ottawa: Author.

Canadian Nurses Association. (2004). *Promoting continuing competence for registered nurses* [Position statement]. Ottawa: Author.

Canadian Nurses Association. (2006). *Nursing information and knowledge management* [Position statement]. Ottawa: Author.

Canadian Nurses Association. (2007a). *Canadian regulatory framework for registered nurses* [Position statement]. Ottawa: Author.

Canadian Nurses Association. (2007b). *Framework for the practice of registered nurses in Canada.* Ottawa: Author.

Canadian Nurses Association. (2008a). *Advanced nursing practice: A national framework.* Ottawa: Author.

Canadian Nurses Association. (2008b). *Code of ethics for registered nurses.* Ottawa: Author.

Canadian Nurses Association. (2009a). *Nursing leadership* [Position statement]. Ottawa: Author.

Canadian Nurses Association. (2009b). *Registered nurses: On the front lines of wait times.* Ottawa: Author.

Canadian Nurses Association. (2010). *Evidence-informed decision-making and nursing practice* [Position statement]. Ottawa: Author

Canadian Nurses Association. (2013). *Social determinants of health* [Position statement]. Ottawa: Author.

Canadian Nurses Association. (2014). RN solutions in the care of older adults. Retrieved http://cna-aiic.ca/~/media/cna/files/en/person_and_family_care_older_adult_e.pdf

Canadian Nurses Association. (2015). Cardiovascular nursing. Retrieved from http://nurseone.ca/en/certification/what-is-certification/competencies-per-specialty-area/registered-certification-initials/cardiovascular-nursing

Canadian Nurses Association, Canadian Council for Practical Nurse Regulators, Registered Psychiatric Nurses of Canada. (2012). *Staff mix decision-making framework for quality nursing care.* Ottawa: Authors.

Canadian Nurses Association, Canadian Federation of Nurses Unions. (2015). *Practice environments: Maximizing outcomes for clients, nurses and organizations* [Joint position statement]. Ottawa: Authors.

College of Nurses of Ontario. (2014). *RN and RPN practice: The client, the nurse and the environment* [Practice guideline]. Retrieved from http://www.cno.org/Global/docs/prac/41062.pdf

College and Association of Registered Nurses of Alberta. (2011). *Scope of practice for registered nurses.* Edmonton: Author.

College of Registered Nurses of British Columbia [CRNBC]. (2013). *Professional standards for registered nurses and nurse practitioners.* Vancouver: Author.

CRNBC. (2015). *Competencies in the context of entry-level registered nurse practice in British Columbia.* Vancouver: Author.

College of Registered Nurses of Nova Scotia. (2015). Jurisprudence examination: The basics. Retrieved from http://www.crnns.ca/default.asp?id=190&sfield=content.id&search=6546&mn=414.1116.1128.23222.23225

College of Registered Nurses of Nova Scotia, College of Licensed Practical Nurses of Nova Scotia. (2012). *Guidelines: Effective utilization of RNs and LPNs in a collaborative practice environment.* Halifax: Authors.

Dall, T. M., Chen, Y. J., Seifert, R. F., Maddox, P. J., & Hogan, P. F. (2009). The economic value of professional nursing. *Medical Care, 47*, 97-104. doi:10.1097/MLR.0b013e3181844da8

Doran, D. M. (Ed.). (2003). *Nursing-sensitive outcomes: State of the science.* Sudbury, MA: Jones and Bartlett.

Estabrooks, C. A., Midodzi, W. K., & Cummings, G. G. (2005), The impact of hospital nursing characteristics on 30-day mortality. *Nursing Research, 54*, 74-84.

Friese, C. R., Lake, E. T., Aiken, L. H., Silber, J. H., & Sochalski, J. (2008). Hospital nurse practice environments and outcomes for surgical oncology patients. *Health Services Research, 43*, 1145-1163. doi:10.1111/j.1475-6773.2007.00825.x

Government of Saskatchewan. (2015). *Patient and family-centred care: Putting patients and families first.* Retrieved from https://www.saskatchewan.ca/live/health-and-healthy-living/health-care-provider-resources/saskatchewan-health-initiatives/patient-and-family-centred-care

Grinspun, D., Virani, T., & Bajnok, I. (2001). Nursing best practice guidelines: The RNAO (Registered Nurses' Association of Ontario) project. *Hospital Quarterly, 4*(2), 54-57.

Internal Trade Secretariat. (n.d.). Agreement on internal trade. Retrieved from http://www.ait-aci.ca/index_en.htm

International Council of Nurses. (2014). Definition of nursing. Retrieved from www.icn.ch/definition.htm

Jurisdictional Competency Process. (2012). *Competencies in the context of entry-level registered nurse practice.* Retrieved from the Canadian Council of Registered Nurse Regulators website: http://www.ccrnr.ca/assets/jcp_rn_competencies_2012_edition.pdf

Kane, R., Shamliyan, T. A., Mueller, C., Duval, S., & Wilt, T. J. (2007). The association of registered nurse staffing levels and patient outcomes: Systematic review and meta-analysis. *Medical Care, 45*, 1195-1204.

Kozier, B. J., Erb, G., Berman, A. T., Snyder, S., Buck, M., Yiu, L., & Stamler, L. L. (2013). *Fundamentals of Canadian nursing: Concepts, process, and practice* (3rd Canadian ed.). Toronto: Pearson Education Canada.

Miller, J. (2002). *Specialization in nursing: A background paper*. Final draft submitted to the Canadian Nurses Association. Unpublished manuscript.

Nasmith, L., Ballem, P., Baxter, R., Bergman, H., Colin-Thomé, D., Hebert, C.,… Zimmerman, B. (2010). *Transforming care for Canadians with chronic health conditions: Put people first, expect the best, manage for results.* Ottawa: Canadian Academy of Health Sciences.

National Expert Commission. (2012). *A nursing call to action: The health of our nation, the future of our health system.* Ottawa: Canadian Nurses Association.

Needleman, J., Buerhaus, P. I., Stewart, M., Zelevinsky, K., & Mattke, S. (2006). Nurse staffing in hospitals: Is there a business case for quality? *Health Affairs, 25,* 204-211. doi:10.1377/hlthaff.25.1.204

Nelson, S., Turnbull, J., Bainbridge, L., Caulfield, T., Hudon, G., Kendel, D.,… Sketris, I. (2014). *Optimizing scopes of practice: New models for a new health care system.* Ottawa: Canadian Academy of Health Sciences.

Nurses Association of New Brunswick, Association of New Brunswick Licensed Practical Nurses. (2015). *Guidelines for intraprofessional collaboration: Registered nurses and licensed practical nurses working together.* Retrieved from http://www.nanb.nb.ca/media/resource/NANB-GuidelinesIntraprofessionalCollaborationRNsandLPNsWorkingTogether-E-2015-10.pdf

O'Brien-Pallas, L. L., Doran, D. I., Murray, M., Cockerill, R., Sidani, S., Laurie-Shaw, B., & Lochhass-Gerlach, J. (2001). Evaluation of a client care delivery model, part 1: Variability in nursing utilization in community home nursing. *Nursing Economics, 19,* 267-276.

O'Brien-Pallas, L. L., Doran, D. I., Murray, M., Cockerill, R., Sidani, S., Laurie-Shaw, B., & Lochhass-Gerlach, J. (2002). Evaluation of a client care delivery model, part 2: Variability in client outcomes in community home nursing. *Nursing Economics, 20*, 13-21, 36.

O'Connor, P., Ritchie, J., Drouin, S., & Covell, C. L. (2012). Redesigning the workplace for 21st century healthcare. *Healthcare Quarterly, 15*, 30-35. doi:10.12927/hcq.2012.22844

Ordre des infirmières et infirmiers du Québec. (2010). *Outlook on the practice of nursing.* Retrieved from https://www.oiiq.org/sites/default/files/264NS_doc.pdf

Patrician, P. A., Loan, L., McCarthy, M., Fridman, M., Donaldson, N., Bingham, M., & Brosch, L. R. (2011). The association of shift-level nurse staffing with adverse patient events. *Journal of Nursing Administration, 41*(2), 64-70. doi:10.1097/NNA.0b013e31820594bf

Registered Nurses' Association of Ontario. (2012). *Toolkit: Implementation of best practice guidelines* (2nd ed.). Toronto: Author.

Schilling, P., Goulet, J. A., & Dougherty, P. (2011). Do higher hospital-wide nurse staffing levels reduce in-hospital mortality in elderly patients with hip fractures?: A pilot study. *Clinical Orthopedics and Related Research, 469*, 2932-2940. doi:10.1007/s11999-011-1917-8

Tourangeau, A. E., Doran. D. M., McGillis Hall, L., O'Brien Pallas, L., Pringle, D., Tu, J. V., & Cranley, L. A. (2007). Impact of hospital nursing care on 30-day mortality for acute medical patients. *Journal of Advanced Nursing, 57*, 32-44. doi:10.1111/j.1365-2648.2006.04084.x

Van den Heede K., Lesaffre E., Diya L., Vleugels, A., Clarke, S. P., Aiken, L. H., & Sermeus, W. (2009). The relationship between inpatient cardiac surgery mortality and nurse numbers and educational level: Analysis of administrative data. *International Journal of Nursing Studies, 46*, 796-803. doi:10.1016/j.ijnurstu.2008.12.018

Wang, L. Y., Vernon-Smiley, M., Gapinski, M. A., Desisto, M., Maughan, E., & Sheetz, A. (2014). Cost-benefit study of school nursing services. *JAMA Pediatrics, 168*, 642-648. doi:10.1001/jamapediatrics.2013.5441

White, P., Pringle, D., Doran, D., & McGillis Hall, L. (2005). The nursing and health outcomes project. *Canadian Nurse, 101*(9), 15-18.

World Health Organization. (2006). *Constitution of the World Health Organization* (45th ed. Suppl.). Retrieved from http://www.who.int/governance/eb/who_constitution_en.pdf

Yakusheva, O., Lindrooth, R., & Weiss, M. (2014). Economic evaluation of the 80% baccalaureate nurse workforce recommendation: A patient-level analysis. *Medical Care, 52*, 864-869.