



# Entry to Practice Competencies for Ontario Registered Nurses as of January 1, 2005

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# A Guide to Practice Decision-Making for Entry-Level Registered Nurses

## Purpose of this document:

This document contains the competencies Entry-Level RNs in Ontario are expected to possess as an outcome of their nursing education in order to provide the public with safe, effective and ethical care. The competencies serve as a guide to curriculum development and review, and inform the public and employers of what they may expect from Entry-Level RNs.

Practice decision-making is context specific and changes according to client and practice setting circumstances. Accordingly, this guide identifies expectations of Entry-Level RNs and quality practice settings, and is intended to assist Entry-Level RNs with practice decision-making. This guide also provides assistance to experienced nurses moving to new settings or roles, recognizing that although in a new setting or role, experienced nurses will bring established nursing practice competencies with them.

## Definition: The Entry-Level RN

A Registered Nurse who has graduated from the basic nursing program and is at the point of initial registration with the College of Nurses of Ontario.

## CNO Assumptions about Practice and the Entry-Level RN

1. Entry-level RNs possess the knowledge required to demonstrate the wide range of competencies listed in this document; however their experience in practising the competencies during their education will vary significantly and in some cases will be limited.
2. The foundation of professional practice is autonomy in decision-making and respect for clinical judgement.
3. Practice decisions are client specific, and must take into account the environment, the client's circumstances and the Entry-Level RN's knowledge and judgement.
4. Only expert nurses practise at or near the limits of practice (as noted in CNO's *Decision Guide: Determining the Appropriate Category of Care Provider*); therefore it is unrealistic to expect Entry-Level RNs to assume responsibilities at the limits of practice for the Registered Nurse.
5. The Entry-Level RN may be less efficient than experienced RNs (for example, they may require more time to provide a specific care intervention).
6. The Entry-Level RN will seek out the knowledge/information required to provide client care from the practice setting resources (e.g. Nurse Educator, colleague, etc.) or from external sources (e.g. research literature, CNO Practice Consultants, etc.).
7. The Entry-Level RN will identify learning needs and a plan to address them.
8. As regulated health professionals, RNs maintain commitments to each other including sharing their expertise and knowledge with one another, (e.g. through orientation programs and/or preceptoring) and referring to each other when they do not have the necessary competence to provide a specific part of the nursing care themselves (CNO's *Ethical Framework for Nurses in Ontario*).
9. Employers actively identify and respond to the needs of Entry-Level RNs for effective orientation to the practice setting and on-the-job resources for consultation and advice as the need arises.

## A. Expectations of the Entry-Level RN

### The Entry-Level RN is accountable for:

- Knowing and meeting the CNO standards of practice.
- Understanding the scope of practice/controlled acts model as documented in the *Nursing Act* (1991) and the *Regulated Health Professions Act* (1991)<sup>1</sup>.
- All client care he/she provides, and for decisions about assigning care to other care providers.
- Decisions regarding personal competency to provide care given the context and client circumstances, including decisions not to provide care when the condition of personal competency is not met.
- Actively identifying and asking questions of self, colleagues (including multidisciplinary) and clients.
- Applying a consistent framework to practice decision-making.
- The conscious and deliberate application of theory to practice via the use of critical thinking and problem solving skills.

### Critical Thinking and Decision-Making

Decision-making involves asking, and considering the answers to a number of questions. The skill and willingness to question has been called an “attitude of inquiry”<sup>2</sup>, and is a component of critical thinking. Critical thinking is integral to decision-making and includes the activities of organizing assessment information, recognizing patterns and compiling evidence to support the conclusions drawn.

## A Practice Decision-making Framework for the Entry-Level RN

The following questions provide a decision-making framework for the Entry-Level RN. The framework is applied after the client assessment is completed.

1. Do I need assistance to analyze the assessment data?
2. Based on the assessment data, what are the possible options of care, and the indications and contraindications for each?
3. Am I satisfied that the proposed care is appropriate for the client given the particular circumstances and the range of alternative options available?
4. Do I have the authority to provide the proposed care?
5. Am I competent to provide the proposed care?
6. Has the nursing care provided achieved the desired outcome(s)? (evaluation)

### Description of Framework

#### 1. *Do I need assistance to analyze the assessment data?*

Seeking assistance may contribute to the identification of gaps in knowledge and information, including whether or not the assessment is complete. For example, the entry-level RN assesses and records the amount of wound drainage from a post-operative client. Knowing the volume of drainage is an important piece of the post-op assessment, but without the knowledge of how much drainage is usual for clients having that type of surgery (as well as colour, consistency, etc.) the assessment is incomplete. Therefore the

<sup>1</sup> The practice of nursing is the promotion of health and the assessment of, the provision of care for, and the treatment of health conditions by supportive, preventive, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function. *The Nursing Act*, 1991.

<sup>2</sup> Case, B. (1994). Walking around the elephant: A critical-thinking strategy for decision-making. *The Journal of Continuing Education in Nursing*, 25 (3), 101-109.

entry-level RN may ask an experienced colleague for assistance to analyze the assessment data.

**2. *Based on the assessment data, what are the possible options of care and the indications and contraindications for each?***

The assessment data may lead to the identification of numerous options of care. Each care option is considered in terms of the client's needs and status, and what outcome the care aims to achieve. Identifying the indications and contraindications for each possible care option individualizes the care and helps to identify the care option likely to be the most effective for the client. Collaboration with the client is an important component of this step in decision-making.

**3. *Am I satisfied that the proposed care is appropriate for the client given the particular circumstances and the range of alternative options available?***

Knowing the full range of care options available in a specific practice setting for a particular client situation may present a challenge to the entry-level RN. Collaborating with a colleague may be beneficial in validating and confirming that the choice of care option is appropriate.

**4. *Do I have the authority to provide the proposed care? (e.g. is the care a controlled act procedure authorized to nursing?)***

Authority to provide nursing care is derived from the scope of practice for Registered Nurses outlined in both legislation and the standards of practice published by CNO.

Many of the care activities RNs provide arise from nursing's philosophy, theory and beliefs and are entirely within the decision-making realm of nursing. Such activities do not require an order from another regulated health professional. Examples of these activities are promoting clients' rights and

responsibilities; advocating for clients; conducting health assessments, and monitoring client status.

Other care activities provided by Entry-Level RNs have been designated by the RHPA as controlled acts. Of the 13 controlled acts listed in the RHPA, RNs are authorized to perform three. The initiation regulation under the RHPA permits RNs to "initiate", or "order" some of the controlled act procedures authorized to nursing (i.e. perform the procedure without an order from the physician or other authorized health practitioner providing the RN doing the initiating has the competence to do so safely)<sup>3</sup>. Otherwise, the performance of a controlled act requires an order from a physician, dentist, chiroprapist or midwife.

Even when care activities are not designated as controlled acts under the legislation, practice settings may have policies which require the RN to obtain an order to provide the care (e.g. discontinuing intravenous fluids).

**5. *Am I competent to provide the care? (That is, do I have the knowledge, skill and judgement required?)***

To answer this question, a self-assessment is helpful, and might include the following sub-questions:

- a) What is the intended outcome(s) of the care for the client?
- b) Do I know the anatomy and physiology relevant to the care?
- c) What are the benefits and known risks to the client?
- d) What is the predictability of the outcome(s)?
- e) Does my scope of practice permit me to manage the possible outcomes?
- f) Am I competent to manage all possible outcomes?
- g) What resources (personnel, materials) are available to assist me if needed?

<sup>3</sup> For detailed information about scope of practice/controlled acts see CNO documents such as: A Guide to Decide (1995); *The Regulated Health Professions Act: An Overview for Nursing* (1997) or "Competencies for Initiation of Controlled Act Procedures".

Depending on the outcome of the above self-assessment, the Entry-Level RN will now decide how to provide the care. Options include:

- providing the proposed care independently/autonomously
- consulting with a health team colleague about the proposed (or alternate) care
- asking a health team colleague to be present and offer advice while providing the care
- asking another RN to provide the care while the Entry-Level RN observes, or if no colleagues are available, informing the employer of inability to provide care\* (\*In this case the Entry-Level RN is then responsible for identifying a plan for attaining competence in the care).

As each of the three above options reflects a different level of independence, or practice autonomy, a brief discussion about practice autonomy is indicated.

## Professional Practice and Autonomy

Autonomy has been called the “hallmark of a profession”<sup>4</sup>. It has been defined as “an individual’s ability to independently carry out the responsibilities of the position without close supervision”<sup>5</sup>. As noted earlier in this document, RNs have the authority to provide care that falls within their scope of practice. That authority is independent of other health care professionals and therefore gives RNs the right to work autonomously.

Autonomy means “the freedom to act on what you know”<sup>6</sup>. Autonomy also means being free to seek whatever input into clinical decision-making the RN feels is appropriate. Autonomy is linked to competence because competence involves not only knowing, but “knowing that you know”. It is

therefore tied to the professional responsibility to identify what one knows or doesn’t know.

Entry-Level RNs may frequently choose to seek consultation, or provide care under the direction of an available colleague. As the complexity of care increases there may be a need for more consultation/collaboration. Complexity is a combination of five factors (complexity of care needs; predictability of outcome; the cognitive requirements necessary to provide the care, technical requirements, and the potential for a negative outcome (See the CNO Document: *A Decision Guide: Determining the Appropriate Category of Care Provider*).

Having decided on an option for providing the care the last step in the decision-making framework is considered.

### 6. *Has the nursing care achieved the desired outcome? (evaluation)*

Evaluation of client care involves a re-assessment of the client’s status and a determination of whether or not the desired outcomes of the care were achieved. If the outcomes were not achieved, or only partially achieved, the steps in the decision-making framework are repeated.

<sup>4</sup> Edwards, D. (1988). Increasing staff nurse autonomy: A key to nurse retention. *Journal of Pediatric Nursing*, 3(4), 265-268.

<sup>5</sup> Blanchfield, K.C. and Biordi, D.L. (1996). Power in practice: A study of nursing authority and autonomy. *Nursing Administration Quarterly*, 20 (3), 42-49.

<sup>6</sup> Kramer, M. & Schmalenberg, C. (1993). Learning from success: Autonomy and empowerment. *Nursing Management*, 24 (5), 58-64.

## B. Expectations of Quality Practice Settings

Employers share responsibility with the Entry-Level RN for the quality of care that clients receive. Employers have a responsibility to create practice environments with strong organizational attributes that support competent nurses to provide a quality outcome for the client<sup>7</sup>.

### Specific Expectations of Quality Practice Settings Include:

- Provision of position-specific education and professional development through such elements as an orientation and preceptorship program.
- Promoting an environment which encourages Entry-Level RNs to pose questions, engage in reflective practice and ask for consultation/assistance without being criticized.
- Staff scheduling that accommodates the needs of the Entry-Level RN, e.g. matching a Entry-Level RN with an experienced RN.
- Identifying the competencies required in a particular setting for positions of added responsibility (e.g. “in charge”) and providing an opportunity for the Entry-Level RN to meet them before being placed in such a position.
- Identifying and informing the Entry-Level RN of the resources available to provide expert advice/consultation.

### Applying the Practice Decision-Making Framework

The following clinical scenario may be used to illustrate the application of the decision-making framework. A diagram of the steps of the decision-making framework follows the scenario.

*You are working the night shift only one month after being hired as an RN on a busy medical/surgical floor. One of your clients is an 80 year old man two days post-operative from a heart valve replacement. You assess his vital signs and observe that he is short of breath,*

*with laboured respirations, he has had no urine output since your shift began, and he appears more confused than when you cared for him previously. You have some prn orders from the physician, including applying oxygen and inserting a foley catheter if necessary.*

**Assessment:** Vital signs, chest auscultation, output, mental status, edema

**Analyze the data.** Assistance needed? Yes—having difficulty making sense of the data. Change in vital signs are minimal, change in mental status subtle, chest sounds are difficult to hear, you have had minimal experience with similar client situations. Assessment not complete as don't know intake prior to your shift. You plan to seek assistance from a colleague.

**Identify options of care:** You tell your colleague that options include: a) sitting client in high fowler's position (which you already did); b) re-starting oxygen; c) inserting a foley catheter; d) Notifying the physician. You jointly agree on the indications and contraindications for each option.

**Choose the care option:** You decide re-starting the oxygen is a priority, and plan to review the plan with the client and seek his input. (You decide not to insert a foley catheter because there is no clinical rationale to do so at this time).

**Do I have the authority to provide the care:** Yes, have a physician's order for the oxygen.

**Am I competent to perform the care? (Can I manage the potential outcomes of care?)** Yes, familiar with physiological considerations re. oxygen, familiar with equipment and set-up. No immediate negative systemic outcomes expected related to oxygen.

<sup>7</sup> College of Nurses of Ontario (1998). *Building Quality Practice Settings, Practice Setting Consultation Program: An Information Guide*.

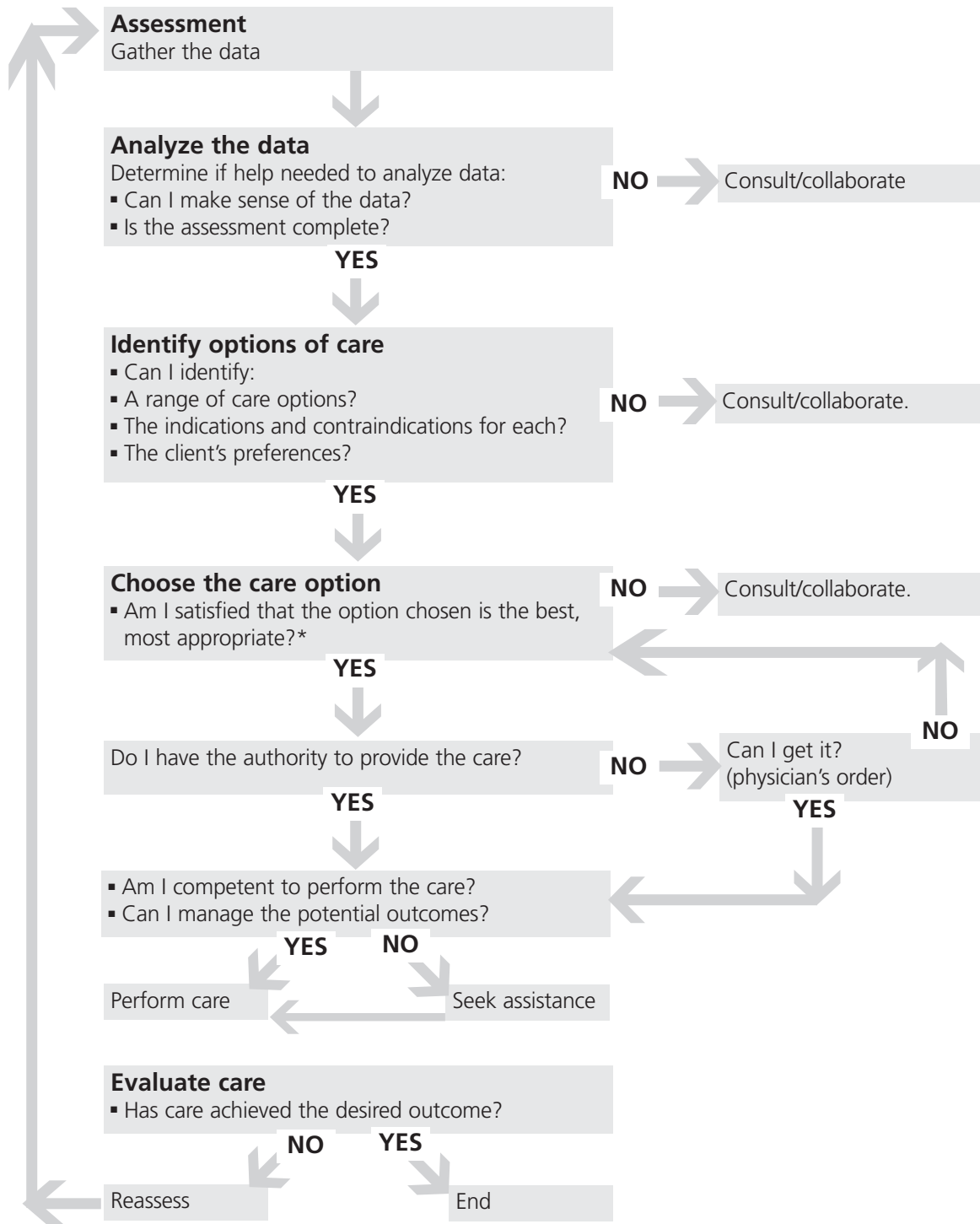
**Perform the care:** You start the oxygen.

**Evaluate the care:** You evaluate the client's response to the oxygen administration. If condition has improved (respirations less laboured, lung sounds improved, etc.) you continue the care, frequently assessing the client's status. If condition is unchanged, or has deteriorated you begin the steps of decision-making once again.

### **Summary**

This section has identified CNO's expectations of Entry-Level RNs and practice settings with regard to practice decision-making. The framework and elements to support autonomous practice decision-making have been described. Practice experience will further contribute to skill and confidence in making practice decisions that promote quality client outcomes.

## A Guide to Practice Decision Making for the Entry-Level Registered Nurse



\* The nurse's advocacy efforts may be required in situations where efforts to obtain a physician's order for the care option identified by the nurse as "the best and most appropriate" have been unsuccessful.

## Registered Nurse Entry to Practice Competencies

### Glossary of Terms

**Client:** The focus of the nurse's care; with whom the nurse is engaged in a professional therapeutic relationship. The client can be an individual, family, group, population or community.

**Collaborate:** To work together with one or more members of the health care team who each make a unique contribution to achieving a common goal. Each individual contributes from within the limits of her or his scope of practice.

**Community:** A group of people living in one place, neighbourhood or district, or sharing common characteristics/interests which bind them together, or having common health needs. The term community (when used to describe a client) does not mean providing care to an individual in the community. Nursing practice aimed at the community as a client involves assisting communities to identify, articulate and successfully manage their health concerns. It is concerned primarily with care that is continuing, rather than episodic. The focus is on the collective or common good, instead of an individual's health.

**Competence:** The ability of a nurse to integrate the professional attributes required to perform in a given role, situation, or practice setting. Professional attributes include, but are not limited to, knowledge, skill, judgement, values and beliefs.

**Competency Statements:** Descriptions of the expected performance behaviour that reflects the professional attributes required in a given nursing role, situation or practice setting.

**Critical Thinking:** Reasoning in which we analyze the use of language, formulate problems, clarify and explain assumptions, weigh evidence,

evaluate conclusions, discriminate between good and bad arguments, and seek to justify those facts and values that result in credible beliefs and actions.<sup>8</sup>

**Family:** People united by a common ancestry (biological families), acquisition (marriage or contract) or choice, and their friends.

**Group:** A set of individuals who have come together for a shared purpose.

**Habilitate:** To provide the means by which the client will be able to make her/himself fit or improve own health status.

**Individuals:** Single human beings throughout the lifespan, including neonates (birth to 28 days), infants (29 days to 1 year), children (1 year to 12 years), adolescents (13 to 18 years), adults (19-65 years) and elderly adults (65 years and older).

**Initiate:** To make the *decision* to carry out a procedure, or cause someone else to *carry out* a procedure (which is a controlled act) in the absence of a specific order or protocol written by another person. Initiate differs from "perform" in that perform means to carry out a procedure, while "initiating" refers to the *ordering* of a procedure. Performing occurs after the decision to carry out the procedure has been made.

**Participates:** To take part in. Participation is not an independent act; the nurse works in partnership with others when she/he is a participant. When participating in an activity, the nurse contributes, but is not the sole provider of the service being delivered.

**Partnership:** Refers to situations in which the nurse works with the client and other members of the health care team to achieve specific health outcomes for the client. Partnership implies consensus building in the determination of these outcomes.

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<sup>8</sup> Bandman, E. & Bandman, B. (1995). *Critical thinking in nursing* (2nd ed.). Appleton & Lange, Connecticut.

**Performs:** See initiate.

**Population:** *All* persons sharing a common health issue, problem or characteristic (e.g. all pregnant women; all people with TB; all people with bi-polar disorders). These people may or may not come together as a group.

**Predictable Outcomes:** Client health outcomes that can reasonably be expected to follow an anticipated path.

**Research:** Systematic inquiry that uses orderly scientific methods to answer questions or solve problems.<sup>9</sup> Conducting research involves formation of a researchable question, design of the research project, implementation of the project, and analysis and presentation of results. A nurse who assists in a research project by collecting information/data may be “participating” in research, but is not her/himself “conducting” research.

**Stable:** Situations in which the client’s health status can be predicted or anticipated. Interventions have predictable outcomes and/or a known level and range of negative outcomes.

**Scope of Practice:** The scope of practice for nursing in Ontario is set out in the *Nursing Act*. It is: “The practice of nursing is the promotion of health and the assessment of, the provision of care for, and the treatment of health conditions by supportive, preventive, therapeutic, palliative, and rehabilitative means in order to attain or maintain optimal function”.<sup>10</sup>

**Unpredictable Outcomes:** Client health outcomes that cannot reasonably be expected to follow an anticipated path.

**Unregulated Care Provider (UCP):** A family member, household member or paid individual who assists with or provides personal care, and may deliver some basic elements of

nursing care such as personal hygiene, dressing, feeding and assisting with medications. UCPs are not regulated health professionals under the *Regulated Health Professions Act*. They are accountable to their employer for their actions. They are also known as personal support workers (PSWs), health care aids (HCAs) or personal care providers (PCPs).

**Unstable:** Situations in which the client’s health status is fluctuating, with atypical responses. The care is complex, requiring frequent assessments, interventions and modifications. Interventions may have unpredictable outcomes and/or risks.

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<sup>9</sup> Polit, D., and Hungler, B.P. (1991). *Nursing research principles and methods*. (4th ed.). J.B. Lippincott, Philadelphia.

<sup>10</sup> The legislation also identifies three controlled acts for nursing which are those activities which could pose a risk of harm to individuals if done by an unqualified person.

# Entry to Practice Competencies for Registered Nurses in Ontario as of January 1, 2005

## Professional Standard #1: Professional Service to the Public

*Standard Statement: Each nurse provides, facilitates and promotes the best possible professional service. The nurse responds to the needs of consumers in a way that fosters trust, respect, collaboration and innovation.*

### Competencies Related to Standard 1:

- P-1 Forms partnerships with clients to achieve mutually agreed health outcomes with
- a) individuals:
    - i) neonates (stable and unstable)
    - ii) infants (stable and unstable)
    - iii) children (stable and unstable)
    - iv) adolescents (stable and unstable)
    - v) adults (stable and unstable)
    - vi) elderly adults (stable and unstable)
  - b) families (stable and unstable)
  - c) groups (stable and unstable)
  - d) populations (stable and unstable)
  - e) communities (stable and unstable)
- P-2 Promotes clients' rights and responsibilities:
- a) individuals;
  - b) families;
  - c) groups;
  - d) populations;
  - e) communities.
- P-3 Advocates for clients or the client's designated representative, especially when the client is unable to advocate for self:
- a) individuals;
  - b) families;
  - c) groups;
  - d) populations;
  - e) communities.
- P-4 Attends to trends in society, health and nursing which may result in changes to nursing practice by:
- a) monitoring and discussing trends and possible changes;
  - b) detailing and analyzing trends and possible changes;
  - c) developing strategies for changes in practice;
  - d) implementing strategies to change nursing practice.
- P-5 Supports professional efforts in nursing to achieve a healthier society (lobbying, health fairs, promoting principles of the Canada Health Act).
- P-6 Attends to health service needs availability by:
- a) identifying assets and gaps in health services;
  - b) planning and developing health services;
  - c) implementing health services;
  - d) evaluating recently instituted health services;
  - e) developing innovative approaches to service delivery.
- P-7 Collaborates with clients to perform a holistic assessment of the following needs:
- a) physical;
  - b) emotional;
  - c) psychological;
  - d) cognitive;
  - e) social;
  - f) spiritual;
  - g) developmental;
  - h) cultural;
  - i) information and education.
- P-8 Collaborates with clients to identify their health problems and issues:
- a) Stable;
  - b) Unstable.

- P-9 Develops plans to ensure continuity of care for clients as they move through the health care system.
- P-10 Negotiates with the client to determine when consultation is required with other health team members or other health related sectors.
- P-11 Makes formal referrals to other health team members and other health related sectors for clients who require consultation.
- P-12 Includes the family in clients' care delivery (with client's consent).
- P-13 Assists clients to establish and maintain satisfying and healthy relationships within the family and community:
- Stable;
  - Unstable.
- P-14 Supports clients to draw on own assets and resources for self-care and health promotion.
- P-15 Encourages clients to seek out support groups for mutual aid and support.
- P-16 Selects methods of communication which are appropriate to client circumstances and needs.
- P-17 Provides general health-related information to clients:
- individuals;
  - families;
  - groups;
  - populations;
  - communities.
- P-18 Manages physical resources in order to provide effective and efficient care (equipment, supplies, medication, linen).
- P-19 Co-ordinates health team members to ensure continuity of health services for clients.
- P-20 Directs and co-ordinates actions of others in emergency situations.
- P-21 Develops partnerships with nursing and health team members based on respect for the unique competencies of each team.
- P-22 Commits to the principle that the primary purpose of the professional nurse is to serve the public.

## Professional Standard #2: Knowledge

*Standard Statement: Each nurse possesses and continually acquires knowledge relevant to the professional service she or he provides.*

### Competencies Related to Standard 2:

- K-1 Demonstrates openness to new ideas which may change, enhance or support nursing practice.
- K-2 Reads and critiques research in nursing, health sciences and related disciplines (research articles and reports).
- K-3 Integrates research findings from nursing, health sciences & related disciplines into own nursing practice.
- K-4 Comprehends the impact of an agency's organizational culture on nursing practice.
- K-5 Presents nursing knowledge regarding the client in inter-disciplinary team interactions.
- K-6 Identifies important internal (attitudes, beliefs, values and perceptions) and external (family, social, environmental, and political) influences on health.
- K-7 Explains pathophysiological concepts in relation to:
  - a) normal and abnormal anatomy and physiology;
  - b) manifestations (client responses);
  - c) diagnostic procedures;
  - d) laboratory tests.
- K-8 Discusses the conceptual and theoretical basis for nursing interventions which reflects knowledge of the following:
  - a) change;
  - b) caring;
  - c) coping;
  - d) holistic care;
  - e) valuing;
  - f) teaching/learning;
  - g) technical skill acquisition and application;
  - h) interpersonal skill acquisition and application.
- K-9 Understands the overall organization of health care at the:
  - a) care setting level;
  - b) agency level;
  - c) regional/municipal level;
  - d) provincial/territorial level;
  - e) national level.
- K-10 Demonstrates knowledge of professional self-regulation including
  - a) the role and services of CNO, and
  - b) the role and services of other professional nursing organizations (e.g. RNAO, RPNAO, ONA).

### Professional Standard #3: Application of Knowledge

*Standard Statement: Each nurse continually strives to improve the application of professional knowledge.*

#### Competencies Related to Standard #3:

- A-1 Applies critical thinking skills in all practice activities.
- A-2 Contributes to health or nursing research by participating in:
  - a) identifying researchable questions;
  - b) reading and critiquing research reports;
  - c) conducting research;
  - d) collecting or assembling research data;
  - e) interpreting and integrating research findings into practice;
  - f) writing and revising research reports;
  - g) disseminating research findings.
- A-3 Uses his/her unit's usual assessment tools to guide data collection for assessing clients.
- A-4 Customizes standardized assessment tools to individualize them to the client's particular needs.
- A-5 Employs additional assessment tools and techniques for finer detail and discrimination.
- A-6 Consults with the literature, colleagues and other sources in selecting appropriate assessment tools and techniques.
- A-7 Performs comprehensive and holistic nursing assessments of the following clients:
  - a) individuals:
    - i) neonates (stable and unstable)
    - ii) infants (stable and unstable)
    - iii) children (stable and unstable)
    - iv) adolescents (stable and unstable)
    - v) adults (stable and unstable)
    - vi) elderly adults (stable and unstable)
  - b) families (stable and unstable)
  - c) groups (stable and unstable)
  - d) populations (stable and unstable)
  - e) communities (stable and unstable)
- A-8 Uses various techniques of data collection with clients:
  - a) observation;
  - b) interviewing;
  - c) inspection;
  - d) auscultation;
  - e) palpation.
- A-9 Refines and extends client assessment information by:
  - a) collecting data from a variety of sources (e.g. client, family, other health team members, and documentation);
  - b) using initial assessment findings to focus on additional and more detailed assessments;
  - c) identifying and incorporating the determinants of health (e.g. income, social status, education, employment, work conditions);
  - d) analyzing and interpreting data from client assessments.
- A-10 Anticipates potential health problems or issues and their resultant consequences for clients (stable and unstable).
- A-11 Makes clinical judgements regarding clients:
  - a) individuals:
    - i) neonates (stable and unstable)
    - ii) infants (stable and unstable)
    - iii) children (stable and unstable)
    - iv) adolescents (stable and unstable)
    - v) adults (stable and unstable)
    - vi) elderly adults (stable and unstable)
  - b) families (stable and unstable)
  - c) groups (stable and unstable)
  - d) populations (stable and unstable)
  - e) communities (stable and unstable)

- A-12 Collaborates with clients to develop a plan of care by:
- a) identifying expected outcomes (stable and unstable);
  - b) questioning and offering suggestions regarding approaches to care (stable and unstable);
  - c) reducing complex health problems into systematically manageable components (stable and unstable);
  - d) establishing priorities of nursing care (stable and unstable);
  - e) seeking information from relevant nursing research, experts and the literature (stable and unstable).
- A-13 Uses evidence-based knowledge from nursing, health sciences and related disciplines to select and individualize nursing interventions.
- A-14 Selects and implements nursing interventions which reflect a variety of theories (e.g. family theories, nursing theories, communication theories, system theories):
- a) individuals;
  - b) families;
  - c) groups;
  - d) populations;
  - e) communities.
- A-15 Performs nursing interventions as indicated by mutually established care plans:
- a) individuals:
    - i) neonates (stable and unstable)
    - ii) infants (stable and unstable)
    - iii) children (stable and unstable)
    - iv) adolescents (stable and unstable)
    - v) adults (stable and unstable)
    - vi) elderly adults (stable and unstable)
  - b) families (stable and unstable)
  - c) groups (stable and unstable)
  - d) populations (stable and unstable)
  - e) communities (stable and unstable)
- A-16 Deviates from care plan according to professional judgement.
- A-17 Performs a range of nursing interventions:
- a) Simple (e.g. assisting ambulation or hygiene, basic dressing changes, teaching relaxation);
  - b) Complex (e.g. facilitating group processes, debriefing critical incidents);
  - c) developing creative, innovative interventions that go beyond the established plan of care.
- A-18 Manages multiple nursing interventions simultaneously (stable and unstable).
- A-19 Assists clients to select choices which will support positive changes in their affect, cognition, and behaviour (stable and unstable).
- A-20 Performs nursing interventions (actions, treatments, techniques) which:
- a) promote health;
  - b) prevent disease and injury;
  - c) maintain and restore health;
  - d) promote habilitation;
  - e) provide palliation.
- A-21 Uses appropriate technology to perform safe, effective and efficient nursing interventions.
- A-22 Applies safety principles and protective devices consistently in client interactions.
- A-23 Responds appropriately to rapidly changing situations which affect client health or safety.
- A-24 Establishes and maintains a caring environment which supports clients to achieve health outcomes:
- a) individuals;
  - b) families;
  - c) groups;
  - d) populations;
  - e) communities.

- A–25 Employs a range and variety of communication skills appropriate to various clients:
- a) applies basic communication skills (e.g. listening, responding, restating, conflict resolution);
  - b) applies more complex communication skills (e.g. disclosure, confrontation, immediacy, contracting, counselling, crisis intervention).
- A–26 Individualizes health-related information to meet client's specialized needs:
- a) individuals:
    - i) neonates
    - ii) infants
    - iii) children
    - iv) adolescents
    - v) adults
    - vi) elderly adults )
  - b) families
  - c) groups
  - d) populations
  - e) communities
- A–27 Selects appropriate media and learning strategies to meet client learning needs:
- a) individuals;
  - b) families;
  - c) groups;
  - d) populations;
  - e) communities.
- A–28 Addresses clients' learning needs:
- a) assesses the learning needs of clients;
  - b) develops learning plans with clients;
  - c) implements simple learning plans for clients;
  - d) implements complex learning plans for clients;
  - e) verifies whether clients have grasped essential information and skills.
- A–29 Monitors status of clients in relation to anticipated outcomes (stable and unstable).
- A–30 Evaluates the effectiveness of nursing interventions, including learning plans, by comparing actual outcomes to anticipated outcomes (stable and unstable).
- A–31 Verifies evaluation findings with the client and other members of the health team (stable and unstable).
- A–32 Modifies and individualizes the learning plan, in collaboration with the client and according to evaluation findings (stable and unstable).
- A–33 Uses effective time management skills to organize workload (prioritizes, sets time frames, evaluates own work patterns).
- A–34 Uses basic computer skills to:
- a) document client care;
  - b) obtain/forward information within the agency;
  - c) obtain/forward information outside the agency.
- A–35 Uses computerized and other health and nursing information systems to:
- a) plan client care;
  - b) co-ordinate client care;
  - c) assess workloads and plan staffing.
- A–36 Assigns nursing workloads to others.
- A–37 Delegates nursing workloads to others.
- A–38 Provides direction to Unregulated Care Providers (UCPs), evaluates clients' responses to care provided by UCPs and contributes to the performance evaluation of UCPs.
- A–39 Promotes team problem-solving, decision-making and inter-disciplinary collaboration by:
- a) assessing shortfalls in nursing practice jointly;
  - b) planning collaborative interventions;
  - c) implementing new interdisciplinary strategies;

- d) evaluating impacts on clients and team members;
  - e) developing new and innovative working relationships.
- A-40 Uses conflict resolution skills to facilitate interdisciplinary health team interactions.
- A-41 Uses established communication protocols:
- a) within the practitioner's health care agency;
  - b) across agencies within the health system.
- A-42 Explains the relevance of internal (attitudes, beliefs, values and perceptions) and external (family, social, environmental, and political) influences on health, nursing practice and the role of the nurse.
- A-43 Critically appraises research evidence and applies relevant findings to the care of clients.
- A-44 Provides rationale for the clinical management of client problems integrating knowledge of selected pathophysiological concepts.
- A-45 Utilizes principles of primary health care to provide care to individuals and families in the community.
- A-46 Utilizes knowledge and expertise in health promotion, disease prevention and epidemiology to provide information to a range of stakeholders (e.g. clients, lay helpers, professionals, social and community agencies, professional associations and all levels of government).
- A-47 Plans/develops health programs based upon community assessment data in order to meet the health needs of the community.
- A-48 Utilizes techniques to reduce communicable disease risk factors in the community (e.g. surveillance, immunization, early case identification, contact tracing, episodic care, health education and case management).
- A-49 Applies social marketing techniques and skills to promote community health programs and healthy living.
- A-50 Promotes awareness of the role of the community health/public health nurse.
- A-51 Incorporates relevant research findings in health promotion activities (e.g. epidemiological, population demographics).
- A-52 Involves key stakeholders in health promotion activities.
- A-53 Incorporates appropriate cultural practices in health promotion activities.
- A-54 Promotes healthy lifestyle choices (e.g. healthy sexuality, dietary patterns, tobacco prevention).
- A-55 Encourages the client's use of safety measures to prevent injury (e.g. seat belts, play safety programs, helmets, smoke alarms, street proofing).

## Professional Standard #4: Ethics

*Standard Statement: Each nurse understands, upholds and promotes the ethical standards of the profession.*

### Competencies Related to Standard #4:

- |     |  |     |   |
|-----|--|-----|---|
| E-1 | Identifies effect of own values and assumptions on interactions with clients.  | E-5 | Reports situations which are potentially unsafe for clients.  |
| E-2 | Demonstrates behaviours which contribute to effective partnerships with clients (respect, empathy, honesty).                       | E-6 | For clients experiencing difficulty protecting self, provides support and protection.   |
| E-3 | Provides care that demonstrates sensitivity to client diversity (culture, race, age, sexual orientation, gender, beliefs, values). | E-7 | Maintains a distinction between social interaction and professional communication.  |
| E-4 | Supports clients while coming to decisions about their health care, then supports those decisions.                                 | E-8 | Shares appropriate information about client's care while respecting confidentiality.  |
|     |  | E-9 | Recognizes and reports situations which are potentially unsafe for health team members (abusive clients, faulty equipment, under-staffing). |

## Professional Standard #5: Continued Competence

*Standard Statement: Each nurse maintains competence while striving to improve the quality of her or his dimension of practice.*

### Competencies Related to Standard #5:

- |     |   |     |   |
|-----|---|-----|---|
| C-1 | Assesses on a continuing basis, own competencies related to:<br>a) knowledge;<br>b) skills;<br>c) attitudes;<br>d) judgement.   | C-3 | Attends to changes in the health system by:<br>a) recognizing changes affecting own practice and client care;<br>b) analyzing changes that affect own practice and client care;<br>c) implementing changes developed by others;<br>d) developing strategies to manage changes that affect own practice and client care. |
| C-2 | Seeks opportunities for professional growth which enhance competence (reading journals, attending-in-services, taking courses). | C-4 | Develops a network of collegial support   |

**Professional Standard #6: Professional Behaviour—Accountability/Responsibility**  
*Standard Statement: Each nurse is accountable to the public and responsible for ensuring that her/his practice and conduct meet legislative requirements and the standards of the profession.*

**Competencies Related to Standard #6:**

- |  |   |
|--|---|
| B-1 Practices in a manner consistent with:<br>a) professional standards of the regulatory body;<br>b) values and obligations to take action;<br>c) scope of practice within nursing;<br>d) provincial and federal legislation. | B-9 Participates in analyzing, developing, implementing and evaluating nursing practice and policy in the workplace:<br>a) at the care setting level;<br>b) at the agency level.        |
| B-2 Practices within legislated scope of practice.   | B-10 Promotes the continuing development of the discipline of nursing (e.g. joining/participating in professional associations, committee participation, writing for nursing journals). |
| B-3 Accepts accountability for own actions and decisions.  | B-11 Maintains clear, concise, accurate and timely records of client's care.  |
| B-4 Challenges questionable actions, orders, decisions made by other health team members.  | B-12 Exercises accountability for decisions which are delegated to others.  |
| B-5 Takes action on questionable orders, decisions or actions made by other health team members.   | B-13 Participates in quality assurance and improvement activities to enhance client care and nursing practice.  |
| B-6 Uses Standards of Practice to highlight own learning needs by:<br>a) identifying gaps in knowledge and skills;<br>b) evaluating own nursing practice;<br>c) taking action to update own competencies.                      | B-14 Collaborates as a member of an interdisciplinary health team.  |
| B-7 Recognizes limitations of own competence and seeks assistance when necessary.  | B-15 Supports other team members to practice to their full scope of practice.   |
| B-8 "Role models" professional behaviour with nursing students and others.   | B-16 Identifies how own values and assumptions affect the interactions between nursing and the interdisciplinary health team members.   |
|  | B-17 Recognizes the impact of change on other health team members.  |
|  | B-18 Provides constructive feedback to colleagues about client care.  |
|  | B-19 Collaborates with other health related sectors to achieve client health outcomes.  |

CNO welcomes feedback regarding this document. Please call the College of Nurses of Ontario at (416) 928-0900 or toll free in Ontario at 1-800-387-5526 with comments or questions.

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