



# The Role of Nurses in High Functioning Teams in Acute Care Settings



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# Executive Summary

Teamwork is a critical component of patient care. In Ontario, registered nurses (RNs) and registered practical nurses (RPNs) work together across sectors and services. In 2018, there were 155,808 nurses\* registered with the College of Nurses of Ontario (CNO): 105,098 RNs and 50,710 RPNs. Registered practical nurse positions are evenly distributed in hospitals, long-term care homes and community settings. This study focused on high functioning nurse teams in the acute care sector. The following key factors emerged from the findings:

- The RPN role has expanded over time in response to educational and entry-to-practice requirements.
- RPNs worked to full scope in high functioning teams and the role was consistently valued.
- Nurses shared common goals and demonstrated commitment to each other.
- Teams worked together using a buddy system and consistently shared patient data.
- There was open communication and ongoing dialogue in patient care.
- There was a high level of respect and trust between RPNs and RNs.
- High functioning teams used a fluid approach to patient care.
- Nurses work “independently but together” in providing patient care.
- There is a clear understanding of responsibility and roles in complex situations.
- Role clarity was enhanced by communication hubs and patient assignment tools.
- Nurses were able to identify subtle changes in patients and navigate the system.
- Nurses collaborated on plans and actions for patient care.
- Nurses supported each other throughout the day and ensured patient care was the principal focus of the care delivery model.
- The nurses’ roles were distinct but overlapped depending on the patient assignment.
- Teams had the ability to adjust assignments when patient needs changed.
- Supportive management is vital.
- Organizations recognized high functioning teams and engrained teamwork in their organizational culture.

\*throughout this report, the word nurse refers to RNs and RPNs unless otherwise specified.





# Background

Patient care in Canada is provided by two categories of nurses: registered nurses (RNs) and registered practical nurses (RPNs). The most common employment setting for nurses is acute care hospitals, followed by community care organizations and long-term care (LTC) facilities (College of Nurses of Ontario [CNO], 2017). Studies have examined the contribution of interdisciplinary care and collaborative practice to safe quality patient care (Butler et al., 2011). However, less is known about how effective nurse teams work together to care for complex patients in acute care.

To address this gap, we conducted a mixed methods study using appreciative inquiry to identify the factors that contribute to success in high functioning nurse teams. Baumann, Blythe, Norman, & Crea-Arsenio (2014) define effective teamwork as “. . . dependent on a clear perception of individual roles and responsibilities, established procedures, mutual trust and coordination” (p. 6). The study was guided by three main objectives:

- Profile the demographic and employment characteristics of the existing RPN workforce;
- Identify the role of the RPN in high functioning intra-professional nurse teams; and
- Assess how the RPN role contributes to the delivery of patient care in acute care settings across Ontario.

We examined a representative sample of high functioning nurse teams in hospitals across the province of Ontario. Our findings provide important information about how the role of the RPN complements the role of the RN in acute care settings. The term

“nurse” will be used throughout this report to refer to both RNs and RPNs, unless otherwise specified.

## The Changing Roles of Nurses

The role and scope of practice of both RNs and RPNs are regulated by the competencies for entry-level registered nurse practice as defined by the CNO (see Appendix A. RN and RPN Entry to Practice Competencies). As mandated by provincial legislation, the College is “accountable for public protection by ensuring nurses practice safely competently and ethically” (College of Nurses of Ontario, 2018c, p. 3). RNs and RPNs have shared areas of practice in the provision of patient care as well as independent responsibilities.

In order to become a registered nurse in Ontario, an individual needs to have passed the National Council Licensure Examination (NCLEX-RN) and either hold a baccalaureate degree in nursing from an accredited



university or have equivalent education approved by the College of Nurses of Ontario (CNO) (College of Nurses of Ontario, 2018a). The CNO became the regulatory body for RNs under the *Regulated Health Professions Act* in 1991 (College of Nurses of Ontario, 2018a). In 1998, the CNO standardized RN entry-to-practice (ETP) competencies, including the provision that RNs were required to have a baccalaureate nursing degree, made effective since 2005 (Council of Ontario Universities, 2010, p. 1). Previous to this change, completing a diploma in a college nursing program was sufficient for RN registration (Council of Ontario Universities, 2010, p. 1).

The current RN ETP competencies are described by 7 overarching principles and can be organized into 9 roles: Clinician, Professional, Communicator, Collaborator, Coordinator, Leader, Advocate, Educator, and Scholar (College of Nurses of Ontario, 2018). At a national level, RN ETP competencies are revised every 5 years by the Canadian Council of Registered Nurse Regulators

(CCRNRR) to maintain relevance with the current context of RN responsibilities; provincial regulatory bodies are tasked with matching these updates with their education and regulation standards (College of Nurses of Ontario, 2018a). The CNO has recently released a revised RN ETP competency framework in 2018 that takes effect in September 2020 (College of Nurses of Ontario, 2018a).

Currently in Ontario, accreditation as a RPN requires successful completion of the Canadian Practical Nurse Registration Examination (CPNRE) and either successful graduation from an approved practical nursing college program in Ontario or completion of an equivalent education program as assessed by the CNO (College of Nurses of Ontario, 2014). Historically, while practical nursing and training for such positions emerged in Ontario in 1938, the title and role of Registered Practical Nurse was first defined by the 1991 *Regulated Health Professions Act* and the ETP competencies for RPNs were instated in Ontario by the

CNO in 1999 (Registered Practical Nurses Association of Ontario, 2013). In 2001, the Ontario Ministry of Training, Colleges and Universities (MTCU) ratified the *Practical Nursing Program Standards* where RPNs are required to complete a practical nurse community college program designed from these ETP competencies, made effective in 2005 (Council of Ontario Universities, 2010, p. 1).

The RPN ETP competencies used today are based on the revisions made in 2008 by the Practical Nurse Program Committee and other stakeholders motivated by the need to articulate the difference between entry-level and ongoing nursing knowledge and competencies (College of Nurses of Ontario, 2014). The conceptual framework of RPN ETP competencies is organized into 4 categories: assessment, planning, implementation and evaluation (College of Nurses of Ontario, 2014). Updates and revisions have been made every 2-4 years to match evolving standards of practice and regulation for Controlled Acts (College of Nurses of

Ontario, 2014). Most recently, the Canadian Council for Practical Nurse Regulators (CCPNR) in 2018 issued a Request for Proposals for provincial jurisdictions in order to standardize RPN ETP competencies across the provinces in Canada (College of Nurses of Ontario, 2018b). The CNO has finalized updated interpretations and is currently working with PN educators to implement the new RPN ETP competencies by 2020 (PN Exam Transition Work Group, 2018). A public revision of the CNO RPN ETP competencies will be released in 2019 (PN Exam Transition Work Group, 2018). This is in line with the CCPNR's goal for an updated CPNRE to be in effect by 2022 (College of Nurses of Ontario, 2018b).

## Healthcare in Ontario

Ontario is home to more than 14.3 million people, of which five million are clustered in one major metropolitan area (Ministry of Finance, 2018). As the





population increases so does the demand for health services. Healthcare in Ontario includes acute care hospitals, LTC facilities, community and home care organizations and academic health science centers. There has been growing interest in the acute care setting regarding the composition, capacity and function of teams and their impact on the provision of care.

## The Importance of Teamwork

Early investigations of team-managed care began in the business sector and highlighted key facilitators of teamwork such as training, mutual trust and respect (Tarricone & Luca, 2002). Within the context of healthcare, Oldenburger, Baumann, & Banfield (2017) examined team functioning in medical disasters and determined setting, leadership in command structures and experience in training were significant for success, as were stress and the resulting coping mechanisms.

Research has also been conducted in nursing team dynamics. In their pilot study of high functioning nurse teams, Baumann, Blythe, Norman, & Crea-Arsenio (2014) looked at the contributions of RNs and RPNs working in teams, team characteristics and the types of decisions made. They identified various components of effective teamwork, including professional skills, being a team player, tolerance for ambiguity and understanding both scope of practice and the work environment. Participants cited the importance of communication, sharing and maintaining a strong patient focus. Other studies have noted the impact of age differences on teamwork (Moore, Prentice, & Salfi, 2017).

MacKinnon, Butcher, & Bruce (2018) discuss how the working relationships between RNs and Licensed Practical Nurses are changing as a result of new models of nursing care delivery being introduced in response to nursing shortages. In their study, the authors identify that RNs and LPNs primarily use skills to differentiate the tasks that they were each allowed to do in their community hospital settings

(MacKinnon, Butcher, & Bruce, 2018). In addition, both groups felt that the expanded LPN scope of practice resulted in fewer differences in skills and more attention to the LPN comfort level with respect to the stability or predictability of their patients, the latter being an important component of developing a collaborative team (MacKinnon et al., 2018).

Moore, Prentice, & Salfi (2017) examined the factors that influenced collaboration among RNs and RPNs at one acute care hospital in Canada using a mixed-methods study design. A critical facilitator to RN and RPN collaboration in this study was having both groups of nurses working to their full scope. This resulted in reduced role ambiguity, which contributes towards successful team functioning as role ambiguity can lead to workplace tension, lack of mutual trust, diminished professional identity and poor teamwork (Moore, Prentice, & Salfi, 2017).

Rochon, Heale, Hunt, & Parent (2015) specifically measured the level of nursing teamwork on each patient care unit of one acute care hospital in Ontario, Canada using the Nursing Teamwork Survey (Kalisch, Lee, & Rochman, 2010). This study explores the attributes of lower scoring units and teams and found that lower scores on the NTS tended to relate to younger nurses, less experience and a higher intention to leave (Rochon, Heale, Hunt, & Parent, 2015).

Effective teamwork is a critical component of providing safe patient care (Rochon, Heale, Hunt, & Parent, 2015). Salas, Sims, & Burke (2005) describes five core components of teamwork, which include team leadership, mutual performance monitoring, backup behavior, adaptability and team orientation. The authors also describe three supporting coordinating mechanisms, which are shared mental models, closed-loop communication and mutual trust (Salas, Sims, & Burke, 2005). For teamwork to be effective, all the core components and coordinating mechanisms must be evident in a team and occurring concurrently (Rochon,

Heale, Hunt, & Parent, 2015). Despite the literature to date, teamwork is an understudied area and findings across countries and settings are mixed (Kaiser, 2017; Rochon, Heale, Hunt, & Parent, 2015). Furthermore, the study sites vary, the number of participants is often small and generalizability of results is limited.

This study used a mixed methods design including a secondary analysis of the College of Nurses (CNO) registration database and semi-structured interviews with high-functioning nurse teams. The following research questions were addressed:

1. What are the characteristics of high functioning nurse teams?
2. How do high functioning teams work together?
3. How has the role of the RPN evolved over time?
4. What works? Mutual decision-making about complex patients.
5. How do organizations support/recognize high functioning teams?



# Methodology

An appreciative inquiry approach was used to identify how high functioning nurse teams function effectively to provide care to complex patients. Appreciative inquiry focuses on the positive facilitators in an organization's teamwork and management in order to suggest ways to amplify its effects (Cooperrider, Srivastva, Woodman, & Pasmore, 1987). A demographic questionnaire and a semi-structured interview were used as the main approaches to data collection.



## Sample and Setting

Twenty nurse teams working in acute care sites that consist of both RN and RPN members were sampled in one province. At each site, individual interviews were conducted with two nurses and one manager. In total there were 60 interviews. The range of acute care sites included large academic health science centers (Group A), medium-sized community hospitals (Group B) and small rural hospitals (Group C). Specifically, hospital size was based on the Ontario MOHTLC definition. Group A hospitals represent “general hospitals providing facilities for giving instruction to medical students of any university, as evidenced by a written agreement between the hospital and the university with which it is affiliated, and hospitals approved in writing by the Royal College of Physicians and Surgeons for providing post-graduate education leading to certification or a fellowship in one or more of the specialties recognized by the Royal College of Physicians and Surgeons”. Group B hospitals represent “general hospitals having no fewer than 100 beds”, and Group C hospitals represent “general hospitals having fewer than 100 beds” (Ministry of Health and Long-Term Care, 2015).

In order to ensure that the sample of acute care sites was representative of hospital size and urban and rural locations, a list of all 175 hospital sites in Ontario organized by region was created and each hospital site was categorized according to size (A, B, or C). Proposed hospital sites for this study were stratified by health region, size and location. Where two of the same group size hospital sites appeared within the same region, one of those sites was excluded. At least one hospital site was represented for each local health integration network (LHIN). Presently, the LHIN structure is undergoing reorganization by the Ontario MOHTLC, which may lead to the reconstruction and/or dissolution of the 14 health region stratification system used in this study.



Clinical managers were contacted at each site and asked to identify a RPN/RN team that is high functioning based on the following criteria: worked together with some regularity; recognized by peers as a high functioning team; included experienced staff; routinely shared care for more than one patient; and managed some patients that were considered “complex.” Once the team was selected, the clinical manager, RPN and RN were asked to complete a demographic questionnaire and participate in separate individual interviews.

## Data Analysis

Secondary analysis was conducted to calculate descriptive statistics of the CNO database in order to provide a snapshot of the RN and RPN workforce in 2018. The CNO database is an administrative

database based on the annual renewal of all nurses licensed to practice in the province, which collects demographic indicators including relevant practice and employment data. The CNO variables used in the analysis included nurse category, age, gender, employment status, and sector of employment.

The individual interviews of high functioning team members were recorded and transcribed and then coded into QSR NVivo 10 .0 (QSR International Pty Ltd, Doncaster, Victoria, Australia). Texts were interpreted through thematic analysis (Boyatzis, 1998). Preliminary coding was completed by three members of the research team who each coded several texts independently for comparison. Team members then collaborated to develop a refined scheme to code the transcripts. Major themes will be highlighted and key findings categorized under each thematic heading.





# Results

## Ontario's Nursing Workforce

In 2018, there were 155,808 nurses registered with the CNO, 105,098 RNs and 50,710 RPNs (College of Nurses of Ontario, 2018a). Of those, 91% of RNs and 89% of RPNs were employed in nursing. The gender distribution was 7% males for RNs and 9% males for RPNs (see Table 1).

**Table 1. Nurse Demographics (RN and RPN), CNO 2018**

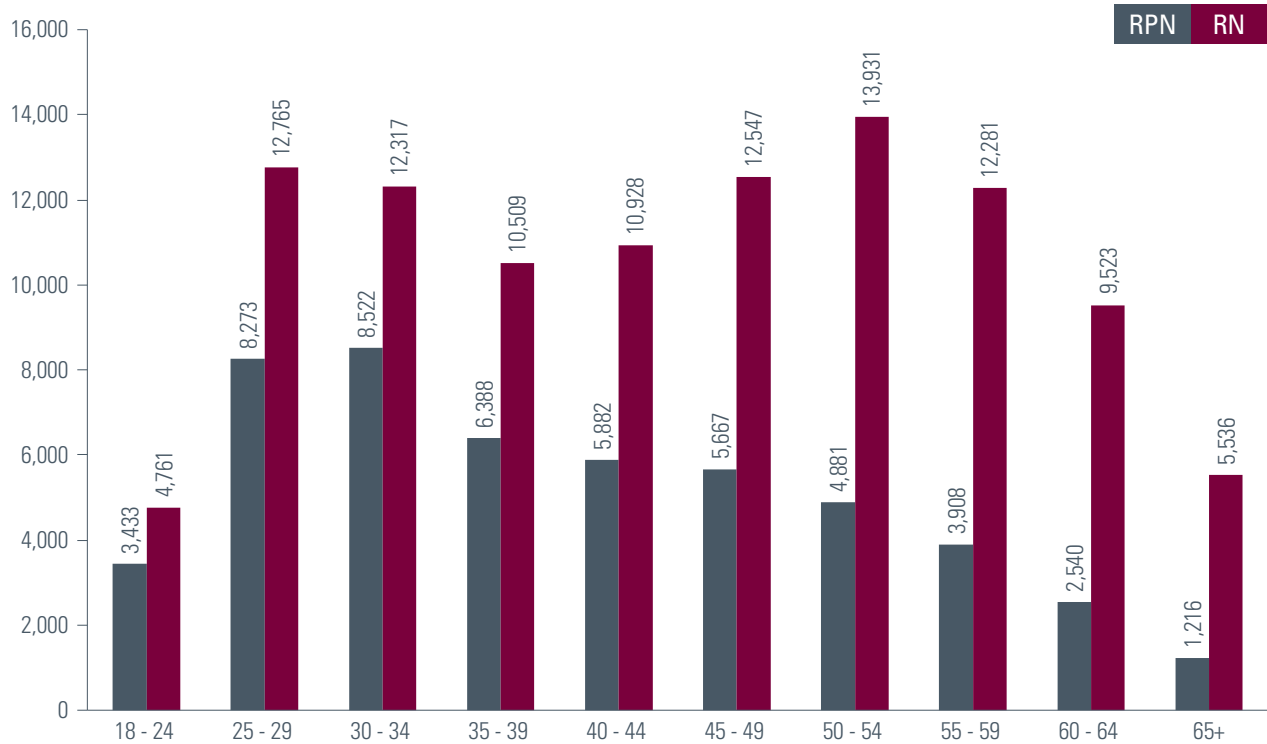
	RN	RPN
<b>Employment Status (%)</b>		
Registered With CNO	105,098 (100.0%)	50,710 (100.0%)
Employed in Nursing in Ontario	95,336 (90.7%)	45,171 (89.1%)
<b>Gender (%)</b>		
Male	7,700 (7.3%)	4,775 (9.4%)
Female	97,398 (92.6%)	45,935 (90.6%)

Source: CNO Member Demographics, 2018.

Figure 1 presents the age distribution of all registered RNs and RPNs in Ontario. The majority of RNs were in the 45-59 age group while the majority of RPNs were in the 25-39 age group.

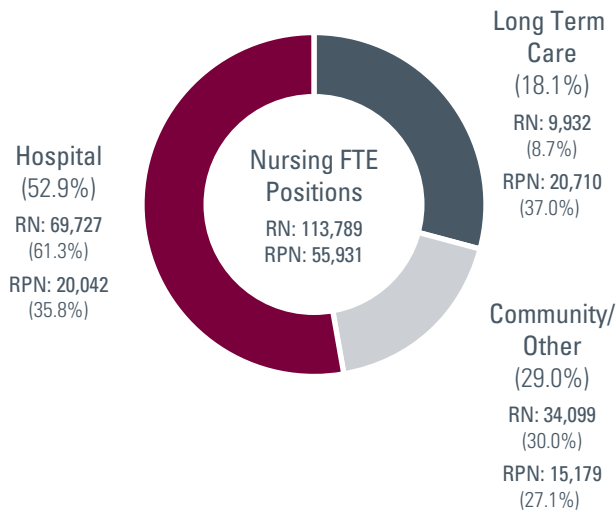


**Figure 1. Age distribution of Ontario Nurses, 2018**



Source: CNO Member Demographics, 2018.

**Figure 2. Nurse FTE Positions by Sector RN and RPN, 2018**



Source: CNO Nursing Employment Positions, 2018

Figure 2 displays the number of nursing positions by sector of employment for RNs and RPNs. As shown, the majority of RN full-time equivalent (FTE) positions were in hospitals settings (61%) followed by community and long-term care homes. For RPNs one third of the FTE positions were in LTCs and hospitals respectively, followed by community settings (CNO, 2018b).

## Interview Sample

The selected hospital sites varied in size from large academic health science centers (n=3) to mid-sized community hospitals (n=7) and small and rural hospitals (n=10). The majority of units were medical/surgical with some specialty areas that included maternal/child, palliative care, and geriatrics services (see

Appendix B). A total of 60 interviews were conducted with 20 RNs, 20 RPNs and 20 clinical managers. The interview sample of nurses was similar in gender and age distribution to the total population of nurses in the province. There was a wide range in years of experience working as a nurse among the interviewees. Close to half of participants had between 10 and 30 years of experience; one-quarter had less than 10 years experience and the remaining had over thirty years.

## What are the characteristics of high functioning nurse teams?

Building on earlier research, characteristics of high functioning nurse teams were confirmed by this study. Nurses affirmed the importance of attributes such as trust, respect, honesty, being a team player,

sharing common goals, supportive management and effective communication. Individual team members had a view of teamwork centered on positive working relationships. They talked about knowing each other's abilities, skills, strengths and deficits and being able to work seamlessly to provide quality patient care.

One clinical manager described the factors that contributed to the team being exemplary as "transparent communication, able to take risks in conversation with each other, view relationship more important than the moment, have strong relationship, level of commitment to each other, patient focused, and have a common goal which is focused on the patient" (K1-3). The nurses see each other as "working on a level playing field." An RN described it this way: "[RPNs] are totally independent workers like we are, they carry their only assignment, and if they have a question they can ask an RPN doesn't have to be an RN. The same as the RNs can ask RPNs a question." (M1).

In addition to the identified individual and team characteristics, many of the interviewees described organizational attributes that contributed to effective





teamwork. Some examples included having corporate policies in place that drive practice, increasing RPN practice to full scope and supporting learning through a variety of educational opportunities. Supportive management was identified as a key factor in effective team functioning. Nurse interviewees described having a manager who ensured adequate staffing on the units and did not question when nurses asked to “call-in” extra staff when needed as positive contributors to team functioning.

## How do high functioning teams work together?

Nurses were able to discuss their roles in each organization. The primary approach to the provision of care was a total patient care model where RNs and RPNs were each given their own patient assignment. Within this model, nurses described working “independently but together.” They would partner up to cover breaks and support each other throughout the day to ensure patient care was completed efficiently and effectively. Interviewees described their working relationships as fluid, collaborative and based on patient needs. One RPN interviewed commented on the efficiencies of working as a team: “if you have teamwork you finish faster, easier and smoother and it avoids patient and staff injury.”

Patient assignments were clearly delineated and were made through considering factors such as patient needs, nurse workload, unit geography and staff experience. A few of organizations used a formal tool for patient assignment. A key theme identified was flexibility in how the assignments were decided depending on the required skill set. There needed to be continuous input in environments where patient status was subject to rapid change. All interviewees indicated they were



working to full scope. However, the RPNs interviewed reported that if their patient's condition changed from stable and predictable to unstable and unpredictable, they were able to make a request to change their patient assignment. RPNs described consulting with colleagues to assist them when needed and asking colleagues to take over care if the complexity of the patient increased to beyond their scope.

High functioning teams identified consulting with each other about patient care on a regular and consistent basis. In many cases, when deciding who to ask for help, it was based on level of experience and expertise. Often the RPN would consult with the RN about patient care but sometimes the RN would ask the RPN, especially if the RPN had more experience working on the floor. Both RNs and RPNs were active participants in the orientation of new team members. One RPN interviewee said, "I can help new RNs learn new skills such as IVs."

A few of the nurses interviewed talked about working on a "buddy system" where they worked independently but if there is an issue, they would go to their buddy first to "bounce ideas off each other" before approaching the team lead. There was open communication and ongoing dialogue between team members regarding patient care decisions.

## How has the role of the RPN evolved over time?

Nurse interviewees were asked to describe how the role of the RPN has evolved over the past ten years from their perspective. All participants agreed that the RPN role has expanded over time in response to the changes in educational requirements and entry-to-practice competencies. The move to a two-year diploma program



in 2005 provided RPNs with additional education and clinical training and allowed organizations to increase their scope of practice. One manager described the change as follows: “From my perspective, 10 years ago the RPN was doing what PSW’s do now. RPNs could not look after any patient with complex needs. Now RPNs can look after any of our palliative care patients” (A3).

Another manager reported on how the increase in education supported the expansion of the RPN role within their team: “Here we use most responsible nurse model of care so that allows RPNs to be independent in their care, to provide leadership and to work within an interdisciplinary team and to dialogue with physicians and other team members.” (S3)

A few of the interviewees talked about how the RPN role changed over the course of their careers. One senior RPN described how she began her career as a nursing assistant: “My role when I graduated was as an Registered Nursing Assistant and I was not

considered a nurse. I could do the basics - bathing, toileting, brief changing, simple dressings, suppositories. Between 1992-93 we became RPNs and we had the name change which gave us the right to call ourselves a nurse. At that point, our scope of practice changed because we were asked to do medications, physical assessments, aseptic procedures here” (D2).

## What works? Mutual decision-making about complex patients.

In all situations, RNs and RPNs worked as a team to care for patients on a daily basis. They agreed on roles, they had awareness of each other’s scopes of practice and the knowledge and skill level of each team member. Many talked about a four step process—assess,

plan, implement and evaluate—and used continuous debriefing and/or team huddles as a communication tool.

One RPN working in labor and delivery reported that she is “[. . .] able to make decisions [because] I have a great support team and if I do have to go to them there’s always open communication and they are always supportive. I feel like we do make a lot of decisions but we are always supported”(H2).

In instances where patient acuity changed, the teams adapted their roles and work quickly and seamlessly to stabilize the patient. One RN gave the following case example:

A middle-aged female came into the floor with COPD and was assigned to the RPN. The patient was not monitored and had been talking when they first did bedside transfer of accountability. Later in the night she was not as communicative, and so the RPN rechecked her and couldn’t get her awake. She then

asked myself and the nurse from ER to come and do our assessments of her. We contacted the physician, took her downstairs where she was intubated and then transferred her to another hospital. The doctor came and did orders, the RPN put in the catheter, the ER -RN was getting her ready to be transported downstairs for intubation, the RPN went down to do the paper charting, and I did the transfer paperwork. We all worked as a team. (J1).

Nurses identified three main factors that contributed to how they functioned well as a team when there was a change in patient acuity. The first was their ability to recognize and predict change in the patient. The RPN interviewees all indicated that they knew when there was a change in their patients and needed to consult with the team lead. One RPN working in labor and delivery gave the following case example (H2):

I had a patient one time she was in ante partum, she was here for hypertension, I came





in and was assigned the patient but in the initial assessment I noticed that her blood pressure was elevated and it was consistently elevated so I told the co-facilitating nurse that I was not 100% comfortable that they weren't coming down with medications and the interventions that we were doing. . . that patient ended up being transferred where she was one-on-one and they did something with her that was outside of my scope. It's making sure we communicate when we think something is out of our scope.

"I have my assignment and I think there's a lot of responsibility on me to recognize when the acuity is outside my scope or moving in that direction and then I go to my charge nurse or the group and I will say this patient is destabilizing and we discuss from there." (S2 #2)

The second factor was their ability to effectively navigate the system and feeling empowered to act.

Nurses talked about knowing when to "call the doctor if the patient goes sour." They also described knowing who to call in the hospital when they needed help. An RPN working on a medicine floor described how he managed when his patient suddenly deteriorated (V2):

This one patient I had she was a bariatric patient, she was immobile and she also had a history of stroke. She had complete expressive deficit, she wasn't able to talk. We were treating her for sepsis, she was previously in ICU and had come back to the unit. . . One day when I came back from my break her husband was feeding her and she had aspirated, when I went to check on her she had aspirated. I called the code, called the doctors, called the RACE nurses. For me that was my first time having a patient go under like that. RNs came immediately and they are very aware of what they need to do.

The third factor identified by the interviewees was good communication among team members. One RPN stated



that she would “brainstorm with the RN to ensure nothing was missed and then collaborate on a plan and actions.” All nurse interviewees talked about working together to ensure the patient was safely managed and stable before resuming their other duties. In some cases, the patient was transferred to the RN because they became unstable.

## How do organizations support/recognize high functioning teams?

The nurse interviewees and their managers described organizational support through various mechanisms. There were formal supports in place that enhanced communication among team members such as team huddles, meetings and daily rounds. In each case, RNs and RPNs participated and provided reports on their patients. Another strategy identified by clinical managers was including RPNs on various committees throughout the hospital. For example, in one organization the RPN was on the nursing practice council where she acted as the point person for relaying information about changes in hospitals policies and procedures back to the unit.

Many of the organizations have targeted educational opportunities to support full scope of practice initiatives. Nurse interviewees talked about “doing education together” meaning both RNs and RPNs participated in educational activities to promote the increase in scope for RPNs. In most organizations, a professional practice/educator role was available to support staff in meeting their learning goals. Other organizations provided funding for RNs to learn about the RPN role and for RPN training to increase scope of practice.

In almost all the hospitals studied, awards were offered for individuals and not teams. Only one manager interviewed talked about recognizing staff members by showcasing the unit team to the whole organization. The manager described “how staff talk and recognize that C ward is rock solid and can count on them to just get things done” (O3). However, there were other forms of acknowledgement identified such as “kudos boards”, “a culture of kindness cart” and “notes [of recognition] posted on quality boards.” Many of the nurses interviewed talked about having staff celebrations and events either in the hospital or outside the workplace. This involved getting together, bringing in food, celebrating at people’s homes and socializing outside of work.



# Discussion and Conclusions

This report builds on a previous pilot study that began to identify the characteristics of effective nurse teams as the complexity of roles and responsibility changes. The research team approached twenty hospitals of different sizes located across the province and managers unequivocally were able to identify a team of RNs and RPNs functioning at a high level. Appreciative inquiry was used to examine how two cadres of nurses with different education and competencies can collaborate to provide comprehensive care to the clients they serve. This study demonstrated that both categories play a key role in caring for patients regardless of location or size of setting.

In Ontario the differences between RNs and RPNs are prescriptive and based on entry-level and ongoing nursing knowledge and competencies. High functioning teams clearly understood their explicit and shared responsibilities in the context of their scopes of practice. The study teams work collaboratively to meet the needs of the patient and use clinical judgment to assess and adjust responsibilities as patient needs increase in complexity. There are fundamental characteristics

required for teams to work well together. They include elements such as trust, respect, honesty, being a team player, sharing common goals, supportive management and effective communication. Role confidence, shared accountability and similar work ethics were also identified as contributors of high functioning teams.

When a team functions well, there is clarity of role and individual members are able to maximize the use of their knowledge to provide safe patient care. The RPN role is evolving and organizations are tasked with ensuring that the integration of new responsibilities is seamless. High functioning teams worked in organizations that valued teamwork. They had leaders who were supportive of their staff, appreciated team members and provided an environment conducive to collaboration in daily practice. Although the study sites did have some formal awards to recognize the importance of teamwork in caring for patients, the awards were primarily for individuals. This study provides evidence that teamwork is a critical component of patient care and RPNs are a critical component of care teams.





# Appendix A - RN and RPN Entry to Practice Competencies



## Entry-to-Practice **Competencies** for Registered Nurses

**This copy of the *Entry-to-Practice Competencies for Registered Nurses* will take effect September 2020.**

Revised December, 2018

In effect September 2020

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## Introduction

The College of Nurses of Ontario (CNO) is the regulatory body for nursing in Ontario. Through provincial government legislation (*Nursing Act, 1991* and *Regulated Health Professions Act, 1991*), CNO is accountable for public protection by ensuring nurses in Ontario practice safely, competently and ethically. CNO fulfills its mandate through a variety of regulatory activities including registration, maintaining standards of nursing practice and education, enforcing nursing standards, conducting continuing competence reviews and establishing competencies required for nursing practice.

Entry-to-practice competencies are the foundation for nursing practice. This document outlines the competencies measured for entry-level registered nurses (RNs) upon initial registration with CNO and entry to practice in Ontario. The competencies also guide the assessment of members' continuing competence for maintaining registration with CNO.

## Purpose of the document

The competencies for entry-level RN practice are established for the following purposes:

**Protection of the public:** Through government legislation (*Nursing Act, 1991* and *Regulated Health Professions Act, 1991*), CNO is mandated by the public to promote and ensure safe, competent and ethical nursing in Ontario.

**Practice references:** The competencies are used as a reference or resource to assist RNs to understand entry-level practice expectations and ongoing applications within their professional role.

**Approval of nursing education programs:** The competencies are used by CNO in evaluating baccalaureate nursing education programs to ensure the curriculum prepares graduates to successfully achieve professional practice standards before entry to practice.

**Registration and membership requirements:** The competencies are used by CNO to inform registration eligibility decisions.

**Legal Reference:** The legal definition of nursing practice included in the *Nursing Act, 1991* establishes the basis for the scope of practice in which any nurse may engage. The competencies are the expectations for RNs upon entry to practice in Ontario, and are used as a reference when evaluating the standard of care of registered nurses.

**Public information:** The competencies inform the public, employers, and other health care providers about registered nursing practice, and assist with accurate expectations for registered nursing practice at the entry level.

**Continuing competence:** In accordance with CNO's Quality Assurance Program, the competencies are used by members in the annual self-assessment of their nursing practice and development of professional learning goals.

## Document background

Entry-level competencies for RNs were first published by CNO in 2005 to align with the regulation change toward a university baccalaureate education requirement for RNs in Ontario. Since then, competencies have been revised every five years at a national level to ensure practice relevance and consistency between jurisdictions.

In 2017, the Canadian Council of Registered Nurse Regulators initiated the most recent review and revisions of entry-to-practice competencies for registered nurses in Canada. The initiative was led by a working group comprised of 11 provincial and territorial nursing regulatory bodies across the nation.

This new set of revisions are based on results of an environmental scan, literature reviews and stakeholder consultation. The regulatory body in each jurisdiction validates and approves the entry-to-practice competencies. They also confirm that the competencies are consistent with provincial and territorial legislation.<sup>1</sup>

## Overarching principles

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

<sup>1</sup> Consistency between jurisdictions supports the workforce mobility requirements of the Canadian Free Trade Agreement.

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1. Entry-level RNs are beginning practitioners. It is unrealistic to expect an entry-level RN to function at the level of practice of an experienced RN
2. Entry-level RNs work within the registered nursing scope of practice, and appropriately seek guidance when they encounter situations outside of their ability
3. Entry-level RNs must have the requisite skills and abilities to attain the entry-level competencies
4. Entry-level RNs are prepared as generalists to practice safely, competently, compassionately, and ethically:
  - in situations of health and illness
  - with all people across the lifespan
  - with all recipients of care: individuals, families, groups, communities and populations
  - across diverse practice settings
  - using evidence-informed practice
5. Entry-level RNs have a strong foundation in nursing theory, concepts and knowledge, health and sciences, humanities, research and ethics from education at the baccalaureate level
6. Entry-level RNs practice autonomously within legislation, practice standards, ethics and scope of practice in their jurisdiction
7. Entry-level RNs apply the critical thinking process throughout all aspects of practice

#### Definition of client

The client is the central focus of registered nursing practice. In the context of this document, "client" refers to a person who receives services from a registered nurse. In most circumstances, the client is an individual, but the client can also include family members or substitute decision-makers. A client can also be a group, community or population.

#### Competency framework

There is a total of 101 competencies organized thematically under nine roles:

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

Figure 1: Conceptual framework for organizing competencies<sup>2</sup>



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<sup>4</sup> College of Nurses of Ontario. *Entry-to-Practice Competencies for Registered Nurses*

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The model represents the multiple roles nurses assume when providing, safe, competent, ethical, compassionate and evidence-informed nursing care in any practice setting. Some concepts are relevant to multiple roles. For the sake of clarity, and to avoid unnecessary repetition, certain key concepts (for example, client-centred) are mentioned once and applied to all competencies.

**Bolded** terms are defined in the Glossary.

## 1. Clinician

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

- 1.1 Provides safe, ethical, competent, compassionate, **client-centred** and evidence-informed nursing care across the lifespan in response to client needs.
- 1.2 Conducts a **holistic** nursing **assessment** to collect comprehensive information on client health status.
- 1.3 Uses principles of **trauma-informed care** which places priority on trauma survivors' **safety**, choice, and control.
- 1.4 Analyses and interprets data obtained in client assessment to inform ongoing decision-making about client health status.
- 1.5 Develops plans of care using **critical inquiry** to support professional judgment and reasoned decision-making.
- 1.6 Evaluates effectiveness of **plan of care** and modifies accordingly.
- 1.7 Anticipates actual and potential health risks and possible unintended outcomes.
- 1.8 Recognizes and responds immediately when client safety is affected.
- 1.9 Recognizes and responds immediately when client's condition is deteriorating.
- 1.10 Prepares clients for and performs procedures, treatments, and follow up care.
- 1.11 Applies knowledge of pharmacology and principles of safe medication practice.
- 1.12 Implements evidence-informed practices of pain prevention, manages client's pain, and provides comfort through pharmacological

and non-pharmacological interventions.

- 1.13 Implements **therapeutic nursing interventions** that contribute to the care and needs of the client.
- 1.14 Provides nursing care to meet palliative and end-of-life care needs.
- 1.15 Incorporates knowledge about ethical, legal, and regulatory implications of medical assistance in dying (MAiD) when providing nursing care.
- 1.16 Incorporates principles of harm reduction with respect to substance use and misuse into plans of care.
- 1.17 Incorporates knowledge of epidemiological principles into plans of care.
- 1.18 Provides **recovery-oriented** nursing care in partnership with clients who experience a mental health condition and/or addiction.
- 1.19 Incorporates mental **health promotion** when providing nursing care.
- 1.20 Incorporates suicide prevention approaches when providing nursing care.
- 1.21 Incorporates knowledge from the health sciences, including anatomy, physiology, pathophysiology, psychopathology, pharmacology, microbiology, epidemiology, genetics, immunology, and nutrition.
- 1.22 Incorporates knowledge from nursing science, social sciences, humanities, and health-related research into plans of care.
- 1.23 Uses knowledge of the impact of evidence-informed registered nursing practice on client health outcomes.
- 1.24 Uses effective strategies to prevent, de-escalate, and manage disruptive, aggressive, or violent behaviour.
- 1.25 Uses strategies to promote wellness, to prevent illness, and to minimize disease and injury in clients, self, and others.
- 1.26 Adapts practice in response to the spiritual beliefs and cultural practices of clients.
- 1.27 Implements evidence-informed practices for infection prevention and control.

## 2. Professional

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



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- 2.1 Demonstrates **accountability**, accepts responsibility, and seeks assistance as necessary for decisions and actions within the legislated **scope of practice**.
- 2.2 Demonstrates a **professional presence**, and confidence, honesty, integrity, and respect in all interactions.
- 2.3 Exercises professional judgment when using agency policies and procedures, or when practising in their absence.
- 2.4 Maintains client privacy, confidentiality, and security by complying with legislation, practice standards, ethics, and organizational policies.
- 2.5 Identifies the influence of personal values, beliefs, and **positional power** on clients and the **health care team** and acts to reduce bias and influences.
- 2.6 Establishes and maintains **professional boundaries** with clients and the health care team.
- 2.7 Identifies and addresses ethical (moral) issues using ethical reasoning, seeking support when necessary.
- 2.8 Demonstrates professional judgment to ensure **social media** and **information and communication technologies (ICTs)** are used in a way that maintains public trust in the profession.
- 2.9 Adheres to the self-regulatory requirements of jurisdictional legislation to protect the public by
  - a) assessing own practice and individual competence to identify learning needs.
  - b) developing a learning plan using a variety of sources
  - c) seeking and using new knowledge that may enhance, support, or influence competence in practice
  - d) implementing and evaluating the effectiveness of the learning plan and developing future learning plans to maintain and enhance competence as a registered nurse.
- 2.10 Demonstrates **fitness to practice**.
- 2.11 Adheres to the duty to report.
- 2.12 Distinguishes between the mandates of regulatory bodies, professional associations, and unions.
- 2.13 Recognizes, acts on, and reports, **harmful incidences, near misses, and no harm incidences**.

- 2.14 Recognizes, acts on, and reports actual and potential workplace and occupational safety risks.

## 3. Communicator

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

- 3.1 Introduces self to clients and health care team members by first and last name, and professional designation (protected title).
- 3.2 Engages in active listening to understand and respond to the client's experience, preferences, and health goals.
- 3.3 Uses evidence-informed communication skills to build trusting, compassionate, and **therapeutic relationships** with clients.
- 3.4 Uses **conflict resolution** strategies to promote healthy relationships and optimal client outcomes.
- 3.5 Incorporates the process of **relational practice** to adapt communication skills.
- 3.6 Uses information and communication technologies (ICTs) to support communication.
- 3.7 Communicates effectively in complex and rapidly changing situations.
- 3.8 Documents and reports clearly, concisely, accurately, and in a timely manner.

## 4. Collaborator

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

- 4.1 Demonstrates collaborative professional relationships.
- 4.2 Initiates collaboration to support care planning and safe, continuous transitions from one health care facility to another, or to residential, community or home and self-care.
- 4.3 Determines their own professional and **interprofessional** role within the team by considering the roles, responsibilities, and the scope of practice of others.
- 4.4 Applies knowledge about the scopes of practice of each regulated nursing designation

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to strengthen intraprofessional collaboration that enhances contributions to client health and well-being.

- 4.5 Contributes to health care team functioning by applying group communication theory, principles, and group process skills.

## 5. Coordinator

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

- 5.1 Consults with clients and health care team members to make ongoing adjustments required by changes in the availability of services or client health status.
- 5.2 Monitors **client care** to help ensure needed services happen at the right time and in the correct sequence.
- 5.3 Organizes own workload, **assigns** nursing care, sets priorities, and demonstrates effective time management skills.
- 5.4 Demonstrates knowledge of the delegation process.
- 5.5 Participates in decision-making to manage client transfers within health care facilities.
- 5.6 Supports clients to navigate health care systems and other service sectors to optimize health and well-being.
- 5.7 Prepares clients for transitions in care.
- 5.8 Prepares clients for discharge.
- 5.9 Participates in emergency preparedness and disaster management.

## 6. Leader

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

- 6.1 Acquires knowledge of the Calls to Action of the Truth and Reconciliation Commission of Canada.
- 6.2 Integrates **continuous quality improvement** principles and activities into nursing practice.
- 6.3 Participates in innovative client-centred care models.
- 6.4 Participates in creating and maintaining a healthy, respectful, and psychologically safe workplace.

- 6.5 Recognizes the impact of **organizational culture** and acts to enhance the quality of a professional and safe practice environment.
- 6.6 Demonstrates self-awareness through reflective practice and solicitation of feedback.
- 6.7 Takes action to support culturally safe practice environments.
- 6.8 Uses and allocates resources wisely.
- 6.9 Provides constructive feedback to promote professional growth of other members of the health care team.
- 6.10 Demonstrates knowledge of the health care system and its impact on client care and professional practice.
- 6.11 Adapts practice to meet client care needs within a continually changing health care system.

## 7. Advocate

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

- 7.1 Recognizes and takes action in situations where client safety is actually or potentially compromised.
- 7.2 Resolves questions about unclear orders, decisions, actions, or treatment.
- 7.3 Advocates for the use of Indigenous health knowledge and healing practices in collaboration with Indigenous healers and Elders consistent with the Calls to Action of the Truth and Reconciliation Commission of Canada.
- 7.4 Advocates for health equity for all, particularly for vulnerable and/or diverse clients and populations.
- 7.5 Supports **environmentally responsible practice**.
- 7.6 Advocates for safe, competent, compassionate and ethical care for clients.
- 7.7 Supports and empowers clients in making informed decisions about their health care, and respects their decisions.
- 7.8 Supports healthy public policy and principles of **social justice**.
- 7.9 Assesses that clients have an understanding and ability to be an active participant in their own care, and facilitates appropriate strategies for clients who are unable to be fully involved.

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- 7.10 Advocates for client's rights and ensures informed consent, guided by legislation, practice standards, and ethics.
- 7.11 Uses knowledge of **population health, determinants of health, primary health care,** and health promotion to achieve health equity.
- 7.12 Assesses client's understanding of informed consent, and implements actions when client is unable to provide informed consent.
- 7.13 Demonstrates knowledge of a substitute decision maker's role in providing informed consent and decision-making for client care.
- 7.14 Uses knowledge of **health disparities** and inequities to optimize health outcomes for all clients.

## 8. Educator

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

- 8.1 Develops an education plan with the client and team to address learning needs.
- 8.2 Applies strategies to optimize client **health literacy.**
- 8.3 Selects, develops, and uses relevant teaching and learning theories and strategies to address diverse clients and contexts, including lifespan, family, and cultural considerations.
- 8.4 Evaluates effectiveness of health teaching and revises education plan if necessary.
- 8.5 Assists clients to access, review, and evaluate information they retrieve using information and communication technologies (ICTs).

## 9. Scholar

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

- 9.1 Uses best evidence to make informed decisions.
- 9.2 Translates knowledge from relevant sources into professional practice.
- 9.3 Engages in self-reflection to interact from

a place of **cultural humility** and create culturally safe environments where clients perceive respect for their unique health care practices, preferences, and decisions.

- 9.4 Engages in activities to strengthen competence in **nursing informatics.**
- 9.5 Identifies and analyzes emerging evidence and technologies that may change, enhance, or support health care.
- 9.6 Uses knowledge about current and emerging community and **global health** care issues and trends to optimize client health outcomes.
- 9.7 Supports research activities and develops own **research skills.**
- 9.8 Engages in practices that contribute to lifelong learning.

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## Glossary

### Accountability

The obligation to answer for the professional, ethical and legal responsibilities of one's activities and duties (Ellis & Hartley, 2009)

### Assessment

Systematically gathering, sorting, organizing and documenting data in a retrievable format. (Perry, Potter & Ostendorf, 2018)

### Assign

Assigning is determining or allocating responsibility for particular aspects of care that may include controlled and non-controlled act procedures. Assigning care may require nurses to supervise aspects of care or teach procedures. (College of Nurses of Ontario, 2007)

### Client

A client is a person with whom the nurse is engaged in a therapeutic relationship. In most circumstances, the client is an individual but the client may also include family members and/or substitute decision-makers. The client can also be a group (e.g., therapy), community (e.g., public health) or population (e.g., children with diabetes). (College of Nurses of Ontario, 2002)

### Client Centre

An approach in which clients are viewed as whole persons; it is not merely about delivering services where the client is located. Client centred care involves advocacy, empowerment, and respecting the client's autonomy, voice, self-determination, and participation in decision-making. (Registered Nurses Association of Ontario, 2006)

### Compassionate

Showing sensitivity in understanding another person's suffering, combined with a willingness to help and promote that person's well-being. (Perez-Bec, Alrisent & Rocafort, 2016).

### Competency

An observable ability of a registered nurse at entry level that integrates the knowledge, skills, abilities, and judgment required to practise nursing safely and ethically (Canadian Council of Registered Nurse Regulators, 2013, CanMEDS, 2015)

### Competent

The demonstration of integrated knowledge, skills, abilities and judgment required to practise nursing safely and ethically (College of Nurses of Ontario, 2018a)

### Conflict resolution

The various ways individuals or institutions address conflict (for example, interpersonal, work) to move toward positive change and growth (College of Registered Nurses of Nova Scotia, 2012)

### Continuous quality improvement

A continuous cycle of planning, implementing and evaluating the effectiveness of strategies, and reflecting to see what further improvements can be made (College and Association of Registered Nurses of Alberta, 2014)

### Critical inquiry

A process of purposive thinking and reflective reasoning through which practitioners examine ideas, assumptions, principles, conclusions, beliefs, and actions within a particular context. (Brum, 2005)

### Cultural humility

Cultural humility is a process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner regarding understanding another's experience. (First Nations Health Authority, 2018)

### Cultural safety

An outcome based on respectful engagement that recognizes and strives to address the health care system's inherent power imbalances. It results in an environment free of racism and discrimination, where people feel safe when receiving health care (First Nations Health Authority, 2018)

### Determinants of health

Factors that influence health beyond our individual genetics and lifestyle choices (Government of Canada, 2018)

### Environmentally responsible practice

Practice that supports environmental preservation and restoration while advocating for initiatives

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that reduce environmentally harmful practices to promote health and well-being. (Canadian Nurses Association, 2017b)

## Evidence-informed

How nursing decisions are made with clients, using an ongoing process that incorporates research, clinical expertise, client preferences and other available resources. (Canadian Nurses Association, 2010)

## Fitness to practice

Freedom from any cognitive, physical, psychological or emotional condition or dependence on alcohol or drugs that impairs ability to provide nursing care (Canadian Nurses Association, 2017a)

## Global Health

The optimal well-being of all humans from the individual and the collective perspectives. Health is considered a fundamental right and should be equally accessible to all (Canadian Nurses Association, 2017a)

## Harm Reduction

Policies, programs and practices to reduce adverse health, social and economic consequences of legal and illegal psychoactive drugs without necessarily reducing drug consumption (Canadian Nurses Association, 2017c)

## Harmful Incidence

A patient safety incident resulting in harm to patient (Canadian Patient Safety Institute, 2009)

## Health care team

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

## Health disparities

Differences in health status that occur among population groups defined by specific characteristics (Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security, 2004)

## Health Inequities

Differences in health status or distribution of health resources between different population groups, arising from social conditions in which people are born, grow, live, work and age (World Health Organization, 2017)

## Health literacy

The ability to access, comprehend, evaluate and communicate information as a way to promote, maintain and improve health in a variety of settings across the life-course (Rootman, & Gordon-El-Bihbirey, 2008)

## Health promotion

Enabling people to improve and increase control over their health by moving beyond individual behaviour toward a wide range of social and environmental interventions (World Health Organization, 2018a)

## Holistic

A system of comprehensive or total patient care that considers the physical, emotional, social, economic, and spiritual needs of the person, the response to illness, and the effect of the illness to meet self-care needs (Jasemi, Valizadeh, Azmannadeh & Keogh, 2017)

## Information and communication technologies (ICTs)

A diverse set of technological tools and resources used to communicate, create, disseminate, store, and manage information (Canadian Association of Schools of Nursing, Canada Health Infoway, 2012)

## Interprofessional

Members from different healthcare disciplines working together towards common goals to meet the client's health care needs (Canadian Health Services Research Foundation, 2012)

## Medical Assistance in Dying (MAID)

The situation in which a person seeks and obtains medical help to end their life. This can be achieved through either physician-assisted suicide or voluntary euthanasia (Government of Canada, 2016)

## Near miss

A client's safety incident that did not reach the client and therefore resulted in no harm (Canadian Patient Safety Institute, 2009)

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## **No harm incidence**

A patient safety incident that reached the patient but no discernible harm resulted. (Canadian Patient Safety Institute, 2009)

## **Nursing informatics**

Nursing informatics science and practice integrates nursing, information and knowledge, and their management, with information and communication technologies to promote health in people, families, and communities worldwide (Canadian Association of Schools of Nursing, Canada Health Infoway, 2012)

## **Organizational culture**

Member held assumptions and values about their organization that is different from one organization to the next (Sullivan, 2012)

## **Palliative care**

An approach that improves the quality of life of patients and their families facing problems associated with life-threatening illness, through preventing and relieving of suffering by means of early identification, impeccable assessment, and treatment of pain and other problems (for example, physical, psychosocial and spiritual) (World Health Organization, 2018b)

## **Plan of care**

A plan that includes priority nursing interventions to achieve client centered goals (College of Registered Nurses of Nova Scotia, 2017a)

## **Population health**

An approach to health that aims to improve the entire population's health and to reduce health inequities among population groups. To reach these objectives, it looks at and acts upon the broad range of factors and conditions that strongly influence our health (Public Health Agency of Canada, 2012)

## **Positional power**

The assumed authority or influence a person holds over others by virtue of the title of his or her position (College of Registered Nurses of Nova Scotia, 2017b)

## **Primary health care**

A focus on delivering client-centred services that

include accessibility, active public participation, health promotion and chronic disease prevention and management, use of appropriate technology and innovation, and intersectoral cooperation and collaboration (Canadian Nurses Association, 2015)

## **Professional Boundaries**

The point at which the relationship changes from professional and therapeutic to unprofessional and personal. It defines the limits of the professional role. Crossing a boundary means that the care provider is misusing the power in the relationship to meet personal needs, rather than the needs of the client, or behaving in an unprofessional manner with the client. The misuse of power does not have to be intentional to be considered a boundary crossing (CNO, 2006, RNAO, 2006)

## **Professional presence**

The demonstration of confidence, integrity, optimism, passion and empathy that aligns with legislation, practice standards, and ethics through verbal and nonverbal communications (Canadian Patient Safety Institute, 2017)

## **Recovery-oriented nursing care**

A perspective that recognizes recovery as a personal process for people with mental health conditions or addictions to gain control, meaning and purpose in their lives (Canadian Association of Schools of Nursing, 2015)

## **Relational practice**

Conscious participation with clients using listening, questioning, empathy, mutuality, reciprocity, self-observation, reflection and a sensitivity to emotional contexts (Deane, & Varcoe, 2007)

## **Research Skills**

The ability to critically appraise the various aspects of a scientific research study.

## **Safety**

The pursuit of the reduction and mitigation of unsafe acts within the healthcare system, as well as the use of best practices shown to lead to optimal patient outcomes (Canadian Patient Safety Institute, 2017)

## **Scope of practice**

Roles, functions, and accountabilities that

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registered nurses are legislated, educated, and authorized to perform, as defined in Section 3 of the Nursing Act, 1991: "The practice of nursing is the promotion of health and 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."

### **Social justice**

Studying and understanding the root causes and consequences of disparities regarding the unfair distribution of society's benefits and responsibilities by focusing on the relative position of one social grouping in relation to others (Canadian Nurses Association, 2017a)

### **Social media**

Software applications (web-based and mobile) allowing creation, engagement and sharing of new or existing content, through messaging or video chat, texting, blogging and other social media platforms (Bodell, & Hook, 2014)

### **Therapeutic nursing intervention**

Any treatment, based on clinical judgement and knowledge, a nurse performs to enhance client outcomes (Butcher, Bulechek, McCloskey Dochterman, & Wagner, 2019)

### **Therapeutic relationship**

A relationship a nurse establishes and maintains with a client, through the use of professional knowledge, skills and attitudes, to provide nursing care expected to contribute to the client's well-being (Canadian Nurses Association, 2017a)

### **Trauma-informed care**

A strengths-based framework grounded in the understanding of and responsiveness to the impact of trauma. The framework emphasizes physical, psychological, and emotional safety for both providers and survivors, and creates opportunities for survivors to rebuild a sense of control and empowerment (Hopper, Bassak, & Oliver, 2010)

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# Entry-to-Practice Competencies

For Ontario

Registered Practical Nurses

Revised: 2014



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## Preface

In Ontario, nursing is one profession with two categories: Registered Nurse (RN)<sup>1</sup> and Registered Practical Nurse (RPN). Nursing is a self-regulated profession, and through provincial and territorial legislation nursing regulatory bodies are accountable for the protection of the public. The College of Nurses of Ontario ensures that RNs and RPNs are safe, competent and ethical practitioners by establishing standards of practice, setting criteria for becoming a nurse in Ontario, administering a Quality Assurance Program and enforcing standards of practice and conduct.

There are areas of overlap between the two categories, but there are differences as well. These differences are based on entry-level and ongoing nursing knowledge and competencies. It is important to articulate these differences to ensure that the most appropriate care providers are matched with clients. It is also important that RNs and RPNs collaborate with one another to meet client care goals.

In the fall of 2008, the entry-to-practice team, the Practical Nurse Program Approval Committee and external stakeholders last revised the RPN entry-to-practice competencies. The RPN entry-to-practice competencies serve as a guide for public and employer awareness of practice expectations of entry-level RPNs. The document also provides a framework to develop educational requirements and curriculum development for academic institutions.

Entry-level nurses practice according to College practice documents, including *Professional Standards*, and *Ethics*.

This document sets out the competencies organized according to a conceptual framework consisting of the nursing process and regulatory principles, including professional responsibility and accountability, service to the public, self-regulation and ethical practice. The document also presents assumptions about the preparation and practice of entry-level RPNs, a guide to practice decision-making for entry-level RPNs, a profile of the newly graduated RPN within the context of practice, and

a glossary of terms and references to help readers understand and interpret the document.

## Assumptions

In developing the competency statements the following assumptions were made:

1. Entry-level RPNs possess the knowledge required to demonstrate the wide range of competencies in this document.
2. Entry-level RPNs are beginning practitioners whose level of autonomy and proficiency will grow through collaboration and support from the interprofessional health care team.
3. Entry-level RPNs are prepared to practise safely, competently and ethically in situations of health and illness with individuals across the lifespan.
4. Entry-level RPNs are prepared to practise safely, competently and ethically with individual clients, families, groups and communities.
5. Entry-level RPNs' practice decisions are client-specific and must take into account the environment, the client's circumstances and whether the client's needs can be met by the entry-level RPN.
6. Entry-level RPNs enter into practice with competencies that are transferable across diverse practice settings.
7. Entry-level RPNs have a knowledge base in nursing, health and social sciences, ethics, leadership and research.
8. Entry-level RPNs are committed to engaging in quality assurance practices, including Reflective Practice.
9. Entry-level RPNs use critical thinking skills to support clinical decision-making and reflect upon practice experiences.

## Entry-level RPN profile

The entry-level RPN is accountable for:

- All client care she or he provides.
- All decisions about assigning care to other care providers.
- Knowing and recognizing her or his competence level (knowledge, skill and judgment) when making decisions and providing care to clients. This includes making decisions to collaborate or alter assignments when her or his competence level does not meet the client's care needs.
- Knowing and meeting the College's standards of

<sup>1</sup> RNs include Nurse Practitioners and are considered RNs in the Extended Class.

- practice and entry-to-practice competencies.
- Understanding the scope of practice/controlled acts model as documented in the *Nursing Act, 1991* and the *Regulated Health Professions Act, 1991* (RHPA).
  - Understanding the roles and responsibilities as documented in the practice setting in which she or he is employed.
  - Actively identifying and asking questions of self, colleagues (including members of the interprofessional health care team) and clients.
  - Applying a consistent framework to practise decision-making.
  - The application of theory to practice via the use of critical thinking and problem-solving skills consistent with the RPN's educational preparation.
  - Providing safe, competent and ethical nursing care.

### Conceptual framework

The conceptual framework organizes the competencies into the four main categories of the nursing process:

- assessment
- planning
- implementation
- evaluation.

The nursing process is embedded into the framework that organizes the competencies. The conceptual framework facilitates dialogue across other jurisdictions. The nationally accepted Canadian Practical Nurse Registration Examination (CPNRE) competencies are designed using this framework.

The regulatory impact is identified by the arrows directed toward the nursing process and is divided into six categories:

- professional responsibility and accountability
- ethical practice
- service to the public
- self-regulation
- knowledge
- knowledge application.

The regulatory framework helps guide the RPN in making decisions related to client care in her or his practice.

### Knowledge and knowledge application

The competency statements listed under Assessment in the four categories show the specific **knowledge** base of the entry-level RPN.

The competency statements listed under Planning, Implementation and Evaluation show how this specific **knowledge can be applied** in the entry-level RPN's practice.

### Central figures in conceptual framework

As one can see, the client, nurse and interprofessional health care team overlap, illustrating their interconnection. The client is central to nursing practice and is depicted as one of the foci of the conceptual framework. The nurse is responsible for assessing her or his level of competence when caring for clients. The nurse needs to recognize the limitations of her or his individual experience and knowledge, and should seek guidance from experienced members of the interprofessional health care team when necessary. The interprofessional health care team collaborates to enhance the care delivered and to improve health care services.

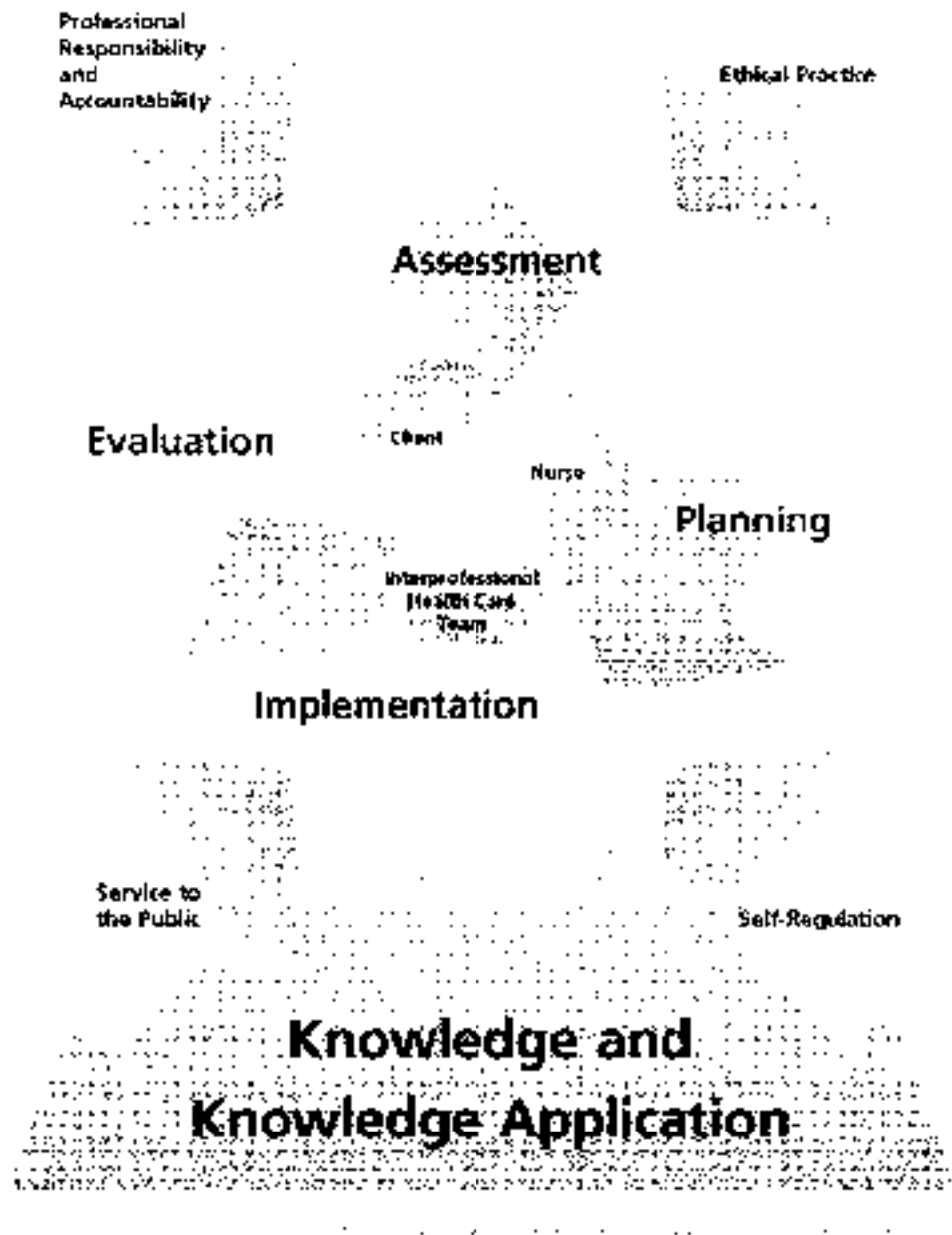
The diagram illustrates that there is no entry point and that no single category of competencies is more or less important than another category. It is recognized that safe, competent and ethical RPN practice requires the integration and performance of many competencies at the same time. Hence, the number of competencies and the order in which the competency statements are presented are not an indication of importance; rather, the framework is a means of presentation. It is recognized that many of the competency statements can be applied to each component of the nursing process; however, they are placed in an area that is thought to be most applicable.



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**Conceptual framework for organizing competencies for RPMs**


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### Competency statements (using nursing process and regulatory principles)

#### Professional Responsibility and Accountability

Demonstrates professional conduct; practises in accordance with legislation and the standards as determined by the regulatory body and the practice setting; and demonstrates that the primary duty is to the client to ensure consistently safe, competent and ethical care (*National competencies in the context of entry-level Registered Nurse practice, 2009*).

#### Assessment

1. Develops a therapeutic relationship with clients.
2. Identifies clients' health care needs in a caring environment that facilitates achieving mutually agreed health outcomes.
3. Collaborates with clients across the lifespan to perform a holistic nursing assessment.
4. Demonstrates knowledge in critical thinking and problem-solving skills.
5. Uses a theory-based approach.
6. Demonstrates knowledge in nursing, health and social sciences.
7. Promotes clients' rights and responsibilities by:
  - a) obtaining client consent prior to initiating nursing care
  - b) protecting clients' rights by respecting confidentiality, privacy, dignity and self-determination as part of the plan of care.
8. Recognizes the impact of an agency's organizational culture on nursing practice.
9. Assesses the appropriateness of assigning care to unregulated care providers (UCPs).
10. Reviews literature and consults with colleagues and other resources in selecting assessment tools or techniques.
11. Demonstrates knowledge of conflict-resolution skills.
12. Demonstrates knowledge of therapeutic communication.
13. Demonstrates knowledge of leadership skills and styles.
14. In collaboration with the client, identifies appropriate health teaching strategies that will enhance the client's learning.
15. Demonstrates knowledge of the determinants of health.

#### Planning

16. Advocates for clients' rights.
17. Encourages clients to draw upon their strengths and to identify appropriate resources within the community.
18. Develops a plan to incorporate critical thinking and problem-solving skills into all aspects of care.
19. Formulates clinical judgments that are consistent with clients' needs and priorities by responding to changing situations that affect clients' health and safety.
20. Analyzes and interprets initial assessment findings and collaborates with the client in developing approaches to nursing care.
21. Organizes workload and develops time-management skills to meet responsibilities.
22. Plans how to incorporate conflict-resolution skills when needed.
23. Selects communication techniques that are appropriate for the client's circumstances and needs.
24. Teaches UCPs based on assessment of learning needs.
25. Selects leadership skill and style that is appropriate to the situation.
26. Identifies potential health problems or issues and their consequences for clients.
27. In collaboration with the interprofessional health care team, refines and expands client assessment information by:
  - a) using initial assessment findings to focus on additional and more detailed assessments
  - b) analyzing and interpreting data from client assessments.
28. Collaborates with client to develop a plan of care by:
  - a) questioning and offering suggestions regarding approaches to care
  - b) seeking information from relevant nursing research, experts and the literature
  - c) developing a range of possible alternatives and approaches to care
  - d) establishing priorities of nursing care
  - e) identifying expected outcomes
  - f) incorporating health teaching strategies into care.

29. Collaborates with the interprofessional health care team in developing a client's plan of care.
30. Plans to incorporate the determinants of health into all aspects of care.

#### Implementation

31. Autonomously performs a wide range of nursing interventions (actions, treatments and techniques) that:
  - a) promote health
  - b) prevent disease and injury
  - c) maintain and restore health
  - d) promote rehabilitation
  - e) provide palliation.
32. Collaborates with client and interprofessional health care team to perform appropriate nursing interventions.
33. Implements appropriate administration and use of medication(s).
34. Using appropriate aseptic/sterile techniques, manages therapeutic nursing interventions (e.g., intravenous therapy, drainage tubes, and skin and wound care).
35. In collaboration with the client and interprofessional health care team, prepares client for surgical/diagnostic procedures, and provides postsurgical/diagnostic care.
36. Applies critical thinking and problem-solving skills in all aspects of nursing care.
37. Questions, clarifies and challenges unclear or questionable orders, decisions or actions made by other interprofessional health care team members.
38. With the client's consent, includes family and designated representative(s) in care delivery.
39. Uses appropriate technology to perform safe and efficient nursing interventions.
40. Encourages and supports healthy lifestyle choices.
41. Provides care that demonstrates an awareness of client diversity.
42. Maintains clear, concise, accurate and timely records of client's care.
43. Assigns care to UCPs.
44. Delegates controlled acts to UCPs, as appropriate.
45. Accountable for one's decisions and actions by:
  - a) practising within one's role and responsibilities

- b) verifying and clarifying policies, procedures and orders.

46. Applies conflict-resolution skills when needed.
47. Applies most appropriate therapeutic communication techniques.
48. Applies most appropriate leadership skills and style.
49. Implements identified health teaching strategies into client's learning.
50. Considers the determinants of health during all aspects of care.

#### Evaluation

51. Supports professional efforts in nursing to achieve a healthier population (e.g., advocating, attending health fairs and promoting principles of the *Canada Health Act*).
52. Evaluates and refines critical thinking and problem-solving skills in all aspects of nursing care.
53. Demonstrates openness to new ideas, which may change, enhance or support nursing practice.
54. Modifies plan of care according to one's knowledge, skill and judgment.
55. In collaboration with the interprofessional health care team, modifies and evaluates plan of care as needed.
56. Responds appropriately to rapidly changing situations.
57. Evaluates effects of organizational culture on nursing practice (e.g., generational differences).
58. Evaluates outcomes of care provided by UCPs.
59. Evaluates and refines conflict-resolution skills as needed.
60. Evaluates and refines therapeutic communication techniques as needed.
61. Evaluates and refines leadership skills and style as needed.
62. Evaluates client's learning and refines health teaching strategies as needed.

#### Ethical Practice

Demonstrates competence in professional judgments and practice decisions by applying principles implied in the ethical framework, and by using knowledge from many sources. Engages in critical thinking to inform clinical decision-

making, which includes both systematic and analytical processes, along with reflective and critical processes. Establishes therapeutic caring and culturally safe relationships with clients and health care team members based on appropriate relational boundaries and respect (*National competencies in the context of entry-level Registered Nurse practice, 2009*).

#### Assessment

63. Respects clients' diversity and decisions.
64. Identifies the effects of one's values, beliefs and personal experiences on the therapeutic nurse-client relationship.
65. Identifies how one's values, beliefs and assumptions affect interactions among members of the interprofessional health care team.
66. Understands the ethical framework of the therapeutic nurse-client relationship.
67. Demonstrates knowledge of the distinction between ethical responsibilities and legal rights and their relevance when providing nursing care.
68. Demonstrates knowledge of informed consent as it applies in multiple contexts.

#### Planning

69. Respects and preserves clients' rights based on a code of ethics or ethical framework (refer to the College's *Ethics* practice document for more information).
70. Shares appropriate information about clients' care with the interprofessional health care team while respecting confidentiality.
71. Establishes appropriate professional boundaries with clients including the distinction between social and therapeutic relationships.
72. Establishes and maintains a caring environment that supports clients in achieving optimal health outcomes, goals to manage illness or a peaceful death.

#### Implementation

73. Demonstrates behaviours that contribute to an effective and therapeutic nurse-client relationship.
74. Engages in relational practice through a variety of approaches that demonstrates caring behaviours appropriate for clients.

75. Uses an ethical reasoning and decision-making process to address situations of ethical distress and dilemmas.
76. Provides care for clients while being respectful of diversity.
77. Demonstrates support for clients making informed decisions about their health care, and respects those decisions.
78. Advocates for clients or their representatives, especially when they are unable to advocate for themselves.
79. Based on ethical and legal considerations, maintains client confidentiality in all forms of communication.
80. Uses relational knowledge and ethical principles when working with the interprofessional health care team to maximize collaborative client care.
81. Uses self-awareness to support compassionate and culturally safe client care.

#### Evaluation

82. Evaluates appropriate professional boundaries with clients, including the distinction between social and therapeutic relationships.
83. Recognizes and reports situations within the practice environment that are potentially unsafe.

#### Service to the Public

Demonstrates an understanding of the concept of public protection and the duty to practise nursing in collaboration with clients and other members of the health care team to provide and improve health care services in the best interests of the public (*National competencies in the context of entry-level Registered Nurse practice, 2009*).

#### Assessment

84. Monitors trends in nursing research and the health care environment that may result in changes to nursing knowledge and practice.
85. Identifies the unique role and competencies of each member of the interprofessional health care team.
86. Identifies the organization of the health care system at all levels:
  - a) organizational
  - b) municipal
  - c) provincial
  - d) national
  - e) international.

87. Identifies the needs of the unique community in the practice environment.

#### Planning

88. Develops a plan to respond to trends in nursing research and the health care environment that result in changes to nursing knowledge and practice.
89. Identifies one's limitations in nursing practice and consults others when necessary.
90. Develops a plan to incorporate the needs of the unique community in the practice environment.

#### Implementation

91. Responds to trends in nursing research and the health care environment.
92. Responds to the needs of the unique community in the practice environment.
93. Develops and maintains a partnership with the interprofessional health care team based on respect for the unique role and competencies of each member.
94. Enacts the principle that the primary purpose of the nurse are to practise in the best interest of the public and to protect the public from harm.
95. Manages physical resources to provide safe and ethical care.
96. Responds to changes in the health care environment through consultation and collaboration with the interprofessional health care team.
97. Presents nursing knowledge regarding the client in interprofessional health care team interactions.
98. Provides feedback to interprofessional health care team members about client care.

#### Evaluation

99. Evaluates response to trends in nursing research and the health care environment.
100. Evaluates and refines approaches in providing feedback to the interprofessional health care team.
101. Evaluates self-awareness that the primary aims of the nurse are to practise in the best interest of the public and to protect the public from harm.
102. Evaluates the appropriateness of the physical resources to provide effective and efficient care.

#### Self-Regulation

Demonstrates an understanding of professional self-regulation by developing and enhancing one's competence, ensuring consistently safe practice, and ensuring and maintaining one's fitness to practise. (*National competencies in the context of entry-level Registered Nurse practice, 2009*).

#### Assessment

103. Demonstrates professional behaviour with learners and the interprofessional health care team.
104. Demonstrates a professional presence and models professional behaviour.
105. Identifies changes in the health care system that affect one's nursing practice.
106. Uses the standards of practice to assess one's competence to identify gaps in knowledge, skill, judgment and attitude by:
- evaluating one's practice
  - taking action to seek assistance when necessary
  - assessing one's areas of strength and areas for improvement in accordance with the College's Quality Assurance Program.
107. Understands the purpose of research for evidence-informed practice.
108. Demonstrates knowledge of the different mandates of:
- the College and self-regulation
  - professional organizations (such as the Registered Practical Nurses Association of Ontario [RPNAC] and the Registered Nurses' Association of Ontario [RNAO])
  - unions.
109. Understands the impact and implications of informatics and technologies in health care.
110. Demonstrates knowledge of computer skills to do the following:
- document client care
  - obtain and forward information within the agency
  - obtain and forward information outside the agency
  - validate evidence-informed practice.

#### Planning

111. Seeks opportunities for professional growth that enhance competence (e.g., by creating and maintaining a learning plan).

112. Develops strategies to incorporate changes that affect one's nursing practice into the health care system.

**Implementation**

113. Demonstrates professional conduct by:
- a) adhering to the standards of practice of the profession
  - b) responding professionally to unacceptable behaviour
  - c) identifying and responding to incidents of unsafe practice or professional misconduct
  - d) documenting incidents and actions taken
  - e) participating in quality assurance activities (e.g., implementing components of a learning plan)
  - f) using informatics and technologies responsibly in the health care setting.
114. Promotes the continuing development of the profession of nursing (e.g., joining or participating in professional associations or committees, or engaging in scholarly activities).
115. Applies the practice-setting's policies and procedures into one's practice.
116. Responds to changes in the health care system that affect one's nursing practice.
117. Uses computer skills in a professional manner to do the following:
- a) document client care
  - b) obtain and forward information within the agency
  - c) obtain and forward information outside the agency
  - d) validate evidence-informed practice.
118. Responds in a professional manner to the impact and implications of informatics and technologies in health care.

**Evaluation**

119. Critiques and integrates research findings from nursing, and health and social sciences into one's practice by evaluating one's learning plan.
120. Evaluates changes in the health care system that affect one's nursing practice.
121. Evaluates the impact and implications of informatics and technologies in health care.

### Practice decision-making framework for entry-level RPNs

Practice decision-making is context-specific and changes according to client and practice-setting circumstances. It involves asking and considering the answers to a number of questions. Critical thinking is performed by the RPN at a level consistent with her or his educational preparation. 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.

The following questions provide a decision-making framework for the entry-level RPN:

1. Has the acuity of the client been established?
2. Is the assessment complete? Do I have a complete understanding of the data? Do I need to collaborate with the interprofessional team?
3. Based on the assessment data, what are the possible options of care? Do I know what the research indicates about each option or do I need to enquire about this? What are the indications and contraindications for each option?
4. Am I satisfied that the proposed care is appropriate for the client given the particular circumstances and range of options available?
5. Do I have the authority to provide the proposed care?
6. Am I competent to provide the proposed care?
7. Has the nursing care provided achieved the desired outcome(s)? (Evaluation)

#### Explanation

##### 1. Has the acuity of the client been established?

The competencies for entry-level RPNs reflect the expectation that practice will focus on the care of clients with less acute conditions. This means that for a client assignment to be appropriate for an entry-level RPN, the acuity of the client's condition must be determined by an individual with the competence to assess the client and make this determination.

(See Practice Guideline: *RN and RPN Practice: The Client, the Nurse and the Environment*)

##### 2. Is the assessment complete? Do I have a complete understanding of the data? Do I need to collaborate with the interprofessional team?

As indicated in competency 27:

*In collaboration with the health care team refines and extends client assessment information by*

- a) using initial assessment findings to focus on additional and more detailed assessments
- b) analyzing and interpreting data from client assessment.

In some instances, collaboration with another member of the interprofessional health care team may be needed because that health care team member's educational program and experience has provided her or him with an enhanced depth and breadth of knowledge. Also, seeking assistance may contribute to the identification of gaps in knowledge and information, including whether or not the assessment is complete.

##### 3. 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, the outcome the care aims to achieve and research findings about the option. Identifying the indications and contraindications for each possible care option involves considering the risks and benefits of each option and individualizing the care, which helps to identify the care option likely to be most effective for the client. Collaboration with the client is an important component of this step in decision-making.

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

Often the entry-level RPN will be unsure whether she or he is aware of the full range of care options available in a specific practice setting for a particular client situation. When this is the case, collaboration with another colleague is called for. In general, collaborating with a colleague may be beneficial in validating and confirming that all possible care options have been identified and the choice of care option is appropriate. If, during the collaboration, it is determined that the option selected is not the best, all the options must be re-evaluated. (See Practice Guideline: *RN and RPN Practice: The Client, the Nurse and the Environment*)

**5. Do I have the authority to provide the proposed care? Is the care a controlled act authorized to nursing?**

Authority to provide nursing care is derived from the scope of practice for nurses outlined in legislation and the standards of practice published by the College.

Many of the care activities RPNs provide arise from nursing's philosophy and theories and are entirely within the decision-making realm of nursing. Such activities do not require an order from another regulated health care 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 RPNs have been designated by the RHPA as controlled acts. Of the 14 controlled acts listed in the RHPA, RNs and RPNs are authorized to perform five. (See the *RHPA: Scope of Practice, Controlled Acts Model* document for more information.) Even when care activities are not designated as controlled acts under the legislation, particular practice settings may have policies that require the RPN to obtain an order to provide the care (e.g., discontinuing intravenous fluids).

**6. Am I competent to provide the care? (Do I have the knowledge, skill and judgment required?)**

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

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

Depending on the outcome of the above self-

assessment, the entry-level RPN will now decide how to provide the care. Options include:

- Providing the proposed care independently
- Collaborating with a health care team colleague about the proposed (or alternate) care
- Asking a health care team colleague to be present to offer advice and assistance while providing the care.
- Asking another colleague (RN or RPN) to provide the care while the entry-level RPN observes. If no colleagues are available, then informing the employer of inability to provide care.\*

(\*This is the only option if the RPN is unsure of her or his competence to provide the care or if it is outside the role and responsibility of an entry-level RPN. If the activity is within the role and responsibility of RPN practice at the health care facility of employment, but the nurse does not have the competence to provide the care, then she or he is responsible for developing a learning plan for attaining competence in the care.)

**Professional practice and autonomy**

Autonomy has been called the "hallmark of a profession."<sup>1</sup> It has been defined as "an individual's ability to independently carry out the responsibilities of the position without close supervision."<sup>2</sup> As noted earlier in this document, RPNs have the authority sometimes on an "in consultation" basis to provide care that falls within their scope of practice. That authority is independent of other health care professionals; RPNs work autonomously within their scope of practice.

Autonomy means "the freedom to act on what you know."<sup>3</sup> Autonomy also means recognising the responsibility to seek input into clinical decision-making for those competencies without an "in consultation" designation when necessary. Autonomy is linked to competence because competence involves not only knowing, but also "knowing that you know." It is therefore tied to the professional responsibility to identify what one knows and what one doesn't know. As the complexity of care increases there is often a need for more consultation or collaboration. Complexity

<sup>1</sup> Edwards, D. (1998). Increasing staff nurse autonomy: A key to nurse retention. *Journal of Pediatric Nursing*, 3(4), 265-268.

<sup>2</sup> Blanchfield, K. C. and Biordi, D. L. (1996). Power in practice: A study of nursing authority and autonomy. *Nursing Administration Quarterly*, 20 (3), 47-49.

<sup>3</sup> Kramer, M. & Schwalenberg, C. (1993). Learning from success: Autonomy and empowerment. *Nursing Management*, 24 (5), 58-64.



### A guide to practice decision-making for the entry-level RPN



\* 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.

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 *Decisions About Procedures and Authority, Revised 2006* practice document for more information.) Having decided on an option for providing the care, the last step in the decision-making framework is considered.

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

#### **7. Has the nursing care achieved the desired outcome? (Evaluation)**

Evaluation of client care involves a reassessment 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, then the steps in the decision-making framework are repeated.

#### **Expectations of quality practice settings**

Workplace settings that create practice environments with strong organizational attributes can support competent RPNs in providing a quality outcome for the client.

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 that encourages entry-level RPNs to pose questions, engage in reflective practice and ask for consultation or assistance without being criticized.
- Staff scheduling that accommodates the needs of the entry-level RPN, for example, matching an entry-level RPN with an experienced RPN.
- 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 RPN to meet them before being placed in such a position.
- Identifying, ensuring the availability of and informing the entry-level RPN of the resources available to provide expert advice/consultation.
- Implementing a professional development system that includes feedback/evaluation about the entry-level RPN's practice.

#### **Summary**

This section has identified the College's expectations of entry-level RPNs and practice settings with regard to decision-making in one's practice. It described the framework and elements to support autonomous decision-making in one's practice, consistent with the RPN's educational preparation and within the RPN's role and responsibilities within a health care facility. Practice experience will further contribute to skill and confidence in making practice decisions that promote quality client outcomes.

## Glossary

**Accountability:** The obligation to answer for the professional, ethical and legal responsibilities of one's activities and duties.

**Acuity:** A client's acuity level is based on the type and number of nursing interventions required for providing care in a 24-hour period.

**Advocate:** Actively supporting a right and good cause; supporting others for speaking for themselves or speaking on behalf of those who cannot speak for themselves.

**Boundary:** Professional boundaries are the defining lines that separate the therapeutic behaviour of an RPN from any behaviour that, well-intentioned or not, could reduce the benefit of nursing care to clients, families or communities.

**Client:** Individuals, families, groups or entire communities across the lifespan who require nursing expertise. In some clinical settings, the client may be referred to as a patient or resident.

**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/unique community:** An organized group of people bound together by ties of social, ethnic, cultural or occupational origin; or by geographic location.

**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, judgment, 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.

**Consult:** Seek information or advice from a person, book, etc.

**Consultation:** The act of an instance of consulting.

**Controlled acts:** Activities that are considered potentially harmful if performed by unqualified people. Members of regulated health professions are authorized to perform the specific controlled acts appropriate to their profession's scope of practice. Because some scopes of practice overlap, some professionals are authorized to perform the same, or parts of the same, controlled acts. Nursing is authorized to perform 5 of the 14 controlled acts that are identified in the RHPA.

**Critical thinking:** Reasoning in which one analyzes the use of language, formulates problems, clarifies and explains assumptions, weighs evidences, evaluate conclusions, discriminates between pros and cons, and seeks to justify those facts and values that result in credible beliefs and actions. Critical thinking is performed by the entry-level RPN at a level that is consistent with her or his educational preparation and scope of practice.

**Culture:** Includes, but is not restricted to age or generation, gender, sexual orientation, occupation and socioeconomic status, ethnic origin or migrant experience, religious or spiritual belief and disability.

**Delegate/delegation:** Delegation is a formal process that transfers authority to perform a controlled act. A regulated health professional who has the legislative authority and the competence to perform a procedure within one of the controlled acts can delegate it to others. This process includes educating, determining competence and establishing a process for assessing ongoing competence. A written record of the process must be kept by the nurse or employer.

If a procedure has been formally delegated to a nurse, then the nurse is authorized to perform that procedure once it is determined that it is appropriate for a particular client or group of clients.

**Determinants of health:** At every stage of life, health is determined by complex interactions among social and economic factors, the physical environment and individual behaviour. These factors are referred to as determinants of health. They do not exist in isolation from each other. These determinants, in combination, influence health status. The key determinants are income and social status, social support networks, education, employment or working conditions, social environments, physical environments, personal health practices and coping skills, healthy child development, biology and genetic endowment, health services, gender and culture.

**Diversity:** The concept of diversity encompasses acceptance and respect. It means understanding that each individual is unique, and recognizes our individual differences. These can be along the dimensions of race, ethnicity, gender, sexual orientation, socioeconomic status, age, physical abilities, religious beliefs, political beliefs or other ideologies. It is the exploration of these differences in a safe, positive and nurturing environment. It is about understanding each other and moving beyond simple tolerance to embracing and celebrating the rich dimensions of diversity contained within each individual.

**Entry-level RPN:** The beginning RPN at the point of initial registration with the College of Nurses of Ontario following graduation from a nursing education program and successful completion of the national RPN examination.

**Evidence-informed practice:** Practice that is based on successful strategies that improve client outcomes and are derived from a combination of various sources of evidence, including client perspective, research, national guidelines, policies, consensus statements, expert opinion and quality improvement data.

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

**Health care team:** Clients, families, health care professionals, paraprofessionals, students, volunteers and others who may be involved in providing care.

**Interprofessional:** The integration of concepts across different professions. An interprofessional team is a team of people with education in varying fields; such teams are common in complex environments such as health care (e.g., social workers, dietitians, nurses, physicians).

**Leadership:** Process of influencing people to accomplish common goals. The attributes of leadership include self-awareness, commitment to individual growth, ethical values and beliefs, presence, reflection and foresight, advocacy, integrity, intellectual energy, being involved, being open to new ideas, having confidence in one's capabilities, and a willingness to make an effort to guide and motivate others. Leadership is not limited to formal leadership roles.

**Learner:** A person studying nursing at the diploma, baccalaureate or graduate level; a nurse new to the profession; an experienced nurse entering a new practice setting; a nurse new to practice in Ontario; or an experienced nurse entering a new health discipline.

**Organizational culture:** The personality of the organization. Culture is comprised of the assumptions, values, norms and tangible signs (artifacts) of organization members and their behaviours.

**Partnerships:** 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.

**Populations:** All people sharing a common health issue, problem or characteristic. These people may or may not come together as a group.

**Relational practice:** An inquiry that is guided by conscious participation with clients using a number of relational skills including listening, questioning, empathy, mutuality, reciprocity, self-observation, reflection and a sensitivity to emotional contexts. Relational practice encompasses therapeutic nurse-client relationships and relationships among health care providers.

**Research:** Systematic inquiry that uses orderly scientific methods to answer questions or solve problems. Conducting research involves formation of a research 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 “conducting” research.

**Safety:** The reduction and mitigation of unsafe acts within the health care system; refers to both staff and patient safety. Staff safety includes, but is not limited to, prevention of musculoskeletal injury, prevention and management of aggressive behaviour, and infection control. Patient safety is the state of continuously working toward the avoidance, management and treatment of unsafe acts. Patient and staff safety can only occur within a supportive and nonblaming environment that looks at systems issues rather than blames individuals. The health and well-being of all clients and staff is a priority in a culture of safety environment.

**Scope of practice:** The scope of practice for nursing in Ontario is set out in the *Nursing Act, 1991*. “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.”

**Therapeutic relationships:** A relationship that is professional and therapeutic, and ensures the client’s needs are first and foremost. The relationship is based on trust, respect and intimacy and requires the appropriate use of the power inherent in the health care provider’s role. The professional relationship between RPNs and their clients is based on a recognition that clients (or their alternative decision-makers) are in the best position to make decisions about their lives when they are active and informed participants in the decision-making process.

**Unregulated care provider:** Paid providers who are neither registered nor licensed by a regulatory body. They have no legally defined scope of practice. Unregulated care providers do not have mandatory education or practice standards. Unregulated care providers include, but are not limited to, resident care attendants, home support workers, mental health workers, teaching assistants and community health representatives.

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# Appendix B - Description of Hospital Sites and Units with High-Functioning RN/RPN Teams

## \*Legend:

A = Academic Health Science Centres  
 B = Medium Sized Community hospitals  
 C = Small and Rural hospitals

Hospital Code	*Site Size	Description of Hospital	Description of Unit
A	B	Part of a multi-site organization with specialized acute, complex continuing care, allied health and ambulatory care services.	Palliative care unit where there is a mixture of palliative and continuing care patients. Has 34 staff members and four palliative physicians. Includes caring for people with life-threatening illness as well as pain and symptom management and end-of-life care.
B1	C	70-bed hospital serving more than 60 000 residents. Services include ambulatory care, cardio-respiratory, diagnostic imaging, dialysis, emergency, general medicine and surgery, intensive care, orthopedic surgery and mental health care.	Medicine unit that commonly treats problems such as cardiac, respiratory, stroke, and palliative care.
B2	C	70-bed hospital serving more than 60 000 residents. Services include ambulatory care, cardio-respiratory, diagnostic imaging, dialysis, emergency, general medicine and surgery, intensive care, orthopedic surgery and mental health care.	Surgery unit comprised of 3 recovery room bays and 5-day surgical daycare unit. Admitted patients stay on the 28-bed inpatient surgical floor. Types of surgery services include orthopedics, general surgery, obstetrics and gynaecology.



C	A	An acute care facility with 375 beds serving 250 000 residents. Employs nearly 2800 staff, 500 volunteers and 100 patient family advisors. Offers a variety of services and programs including cardiovascular and stroke, renal, mental health, cancer, critical care, trauma, emergency, and women and children's programs.	12-bed pediatric unit that can flex higher for seasonal variation. First floor has women and children's programs so sister units are physically nearby. Some staff are cross-trained for pediatrics, NICU and outpatient area. Also uses a resource pool and can utilize ICU staff. Run at 79% occupancy.
D	C	Part of a multi-site organization. This site offers an array of services including obstetrics, general medicine, surgery, and complex continuing care. There are 20 beds - 7 acute, 9 chronic, and 4 rehab. There is also emergency and ambulatory services.	Multi-designated unit with 20 beds; 9 rehab; 4 CCC; 7 acute. Four beds can be telemetry monitored.
E	B	Part of a multi-site organization. This site contains 457 patient beds and employs more than 2400 staff. Offers a wide array of inpatient and outpatient services.	Respiratory Medicine unit with 36-bed capacity, divided into 3 "pods" of 12-beds each.
G	B	Full-service community hospital with 264 beds. Focuses on emergency, childbirth, geriatrics, mental health, rehabilitation, medical and surgical services, and critical care services. Employs over 1900 healthcare professionals.	<p>This unit is a dedicated unit with purpose built beds for the ACE program – Acute care of the elderly</p> <p>Unit is 2 years old and is a 34 bed unit in a t-shape design- there are 3pods with nursing sub stations plus a central reception desk area. Teams assigned to each pod of the 3 wings use the sub station for that wing.</p> <p>All supplies and equipment for each pod is readily accessible in the pod</p> <p>Criteria for admission- over age of 70 , not from nursing home rather retirement and home. Goal is to get elderly patient well enough to return home. It is for Medicine patients only ; but do take overflow medicine patients if space available which is rare.</p>

H	B	Three-site community hospital with 329 beds. Programs include diagnostic and emergency services, acute care medicine and surgery, addictions and mental health, and childbirth and children's services.	Childbirth and children's program. Offers quality, patient centred care for pregnant women, infants, and children up to age 18.
I	B	Part of a multi-site organization. This site offers emergency, cardiology, complex care, regional stroke, geriatric assessment, diagnostic imaging, surgery, lab, mental health, and outpatient services.	Lung Assessment Unit is an outpatient clinic specifically for assessing patients who are suspected of having lung cancer. Run by an RN and RPN where the RN triages patients coming in and the RN and RPN divide the patient workload according to complexity of care as triaged by the RN.
J	C	Part of a multi-site organization. This 20+2 bed hospital offers an array of services including emergency, inpatient and outpatient services. 10 beds are for complex continuing care and 10 are for acute care (no pediatrics).	20-bed hospital that can flex up to 22. 10 beds are CCC, 10 acute care (no pediatrics). There are also emergency and ambulatory beds.
K1	C	Two-site facility serving over 60 000 residents. Offers a variety of services including diagnostic testing, dialysis, emergency, medical assistance in dying, medical day care, obstetrics, palliative care and surgery.	Unit is a 23 bed surgical (orthopedics and general surgery) and medicine/telemetry unit. A lot of ALC patients at present time. All MDs are family practitioners and care for own patients.
K2	C	Two-site facility serving over 60 000 residents. Offers a variety of services including diagnostic testing, dialysis, emergency, medical assistance in dying, medical day care, obstetrics, palliative care and surgery.	General Medicine and rehabilitation- 19 beds
M	B	Part of a multi-site organization. Provides primary and secondary care with a total of 192 beds. Offers a range of services including cardiology, emergency, medical, oncology, outpatient clinics, orthopedics, and surgery.	40-bed acute medicine unit with 20 telemetry beds. Split into 2 zones: acute stroke and general medicine. Combination of 85-staff including RNs, RPNs, PSWs, unit clerks, in-charge of patient care lead and facilitator role.

N	C	A community hospital offering an array of services including clinical nutrition, diabetes, diagnostic imaging, emergency, inpatient services, mental health, palliative care, laboratory testing, and pharmacy.	14-bed medical unit and 7-bed emergency department. LTC centre attached to hospital. 16 RNs float between medical unit and emergency, and 13 RPNs float between the medical unit and LTC centre. One manager for all services in the hospital.
O	C	Part of a multi-site academic health sciences centre. This community hospital serves over 65 000 residents with programs such as medicine, ICU, emergency, outpatient, mental health, medical diagnostics, surgery, and obstetrics and gynecology. This hospital has 55 beds. They have a primary care physician model so all MDs follow their patients. This “assists with continuity of care”. They have some allied health professionals from Monday to Friday but after hours and weekends it is mainly nursing staff.	25 bed medical-surgical unit. Current patient population includes acute medicine with varying medical issues, complex continuing care, ALC patients and some surgical patients.
Q	A	An academic health sciences centre specializing in trauma care. Has 1325 inpatient beds, of that 627 are actively for acute care.	The staff for the 2 units are shared and rotate through these 2 units over the rotation (ie 10 weeks on one unit and 7 weeks on the other) There is a team leader on each unit and one manager for the two. There is also an educator assigned to the 2 units. Each unit is 28 beds with 14 rooms on each corridor and a central nursing station.
R	C	Part of one organization that has two sites. This regional hospital provides a variety of inpatient and outpatient programs and services including diabetes clinic, diagnostic imaging, emergency laboratory, physiotherapy, and pharmacy. This site has 18 medical/surgical/pediatrics/combined care beds as well as an emergency department.	ER is open 24 hours 7 days a week. Inpatient care area has 15 OBS and co-located hospice suite. There are also visiting specialists (e.g. endoscopy clinic) from nearby areas.

S	C	Part of multi-site hospital organization. This site offers an array of services including emergency services, geriatric emergency management team, inpatient medicine, nutrition, obstetrics, Ontario breast screening, outpatient oncology, palliative care, pulmonary rehabilitation, and surgery. There are 39 in-patient beds at this hospital.	15-bed unit emergency department staffed by mostly RNs and also 1 RPN per shift. Unit is divided into “bay areas”, which are designated by geography first.
U	A	Part of a multi-site organization. A regional centre specializing in cardiac and vascular care, neuroscience, trauma and burn treatment, stroke and rehabilitation. Has 607 beds.	Neurosurgical unit, cares for patients with any pathology of the brain, includes many different types. Variety of patient population as young as 16 (adult size) to endless age. Interprofessional team of RNs, RPNs, therapy staff, nurse practitioners, physician assistants, along with neurosurgeons and neurosurgical residents. 26 beds. 16 ward-level beds and 10 step-down level (SDU) beds. SDU has 7 beds in one area and is a wide open space where higher level of care patients are cared for. Also has observational unit with 3 beds, which are step down from step down unit until ready to transfer to ward.
V	A	Part of a multi-site organization. Host hospital for the Regional Cancer Program but also includes general medical/surgical units and a community Emergency Department. Joint replacement surgery commonly takes place at this site.	Acute medical, clinical teaching unit, caring for patients with a variety of diagnoses including (but not limited to) diabetes, dementia, acute coronary syndrome, arrhythmias, heart failure, pneumonia, stroke, asthma, and COPD.



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