Report on the Canadian Council of Registered Nurse Regulators' Nurse Practitioner Examination Practice Analysis

Prepared for:
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Introduction

The Canadian Council of Registered Nurse Regulators (CCRNR) was formed in 2011 to promote excellence in professional nursing regulation. CCRNR consists of representatives from across Canada's 12 provincial/territorial bodies who regulate the practice of registered nurses and nurse practitioners, and guide interprovincial/territorial, national, and global regulatory matters for nursing regulation.

CCRNR has partnered with Meazure Learning to develop a licensure examination for the national nurse practitioner entry-to-practice model in Canada. One of the crucial foundational documents for a defensible assessment examination is a practice analysis. A practice analysis is a rigorous evidence-based investigation of the essential competencies needFed to be successful in a given profession.

CCRNR completed a nurse practitioner practice analysis in 2015 to serve as the foundation for the Canadian Nurse Practitioner Examination: Family/All Ages (CNPE F/AA). Several changes have occurred since 2015 from both a practice and a regulatory perspective, most notably the planned transition to a nurse practitioner regulatory model where, at entry to practice, nurse practitioners will have the foundational knowledge, skills, and judgement to provide client care across practice settings and client populations.

This report describes the process used to develop and validate an updated practice analysis that meets the current needs of the CCRNR. This process followed best practice guidelines for testing and examination outlined in *the Standards for Educational and Psychological Testing* and the *National Commission for Certifying Agencies (NCCA) Standards for the Accreditation of Certification Programs.*

The project consisted of four main phases that are described in detail below:

- Stage One: Conduct Research on Similar or Related Documents and Prepare Report
- Stage Two: Create Initial Draft of Practice Analysis Document with Input from Subject Matter Experts
- Stage Three: National Validation Survey
- Stage Four: Final Approval of Nurse Practitioner Examination Practice Analysis Document

Stage One: Conduct Research on Similar or Related Documents and Prepare Report

The first stage of the project established expectations for practice analysis updates and resulted in a framework for future project tasks. A project kickoff meeting was held on March 10, 2023. Following this meeting, an Advisory Committee was formed to provide guidance and subject matter expertise for the project.

Project Kickoff Meeting – March 10, 2023

A virtual project kickoff meeting was held on March 10, 2023. This meeting set the context for the project and to clarify project expectations. CCRNR representatives at the meeting included Lynn Power (Executive Director, College of Registered Nurses of Newfoundland and Labrador), Cynthia Johansen (Registrar & Chief Executive Officer, British Columbia College of Nurses and Midwives), and Beth Ann Kelly (Executive Coordinator, Canadian Council of Registered Nurse Regulators). The meeting was led by Chris Beauchamp (VP of Psychometrics, Meazure Learning).

The meeting resulted in two key project goals:

1. The practice analysis will be consistent with CCRNR's most recently approved entry-level competencies (ELCs). Although the practice analysis document is developed to support an examination program, it was understood that the content of the practice analysis should be consistent with the ELCs. To limit conflicts between the updated practice analysis and the existing ELCs, it was established that:

    - All practice analysis statements should be testable in a written examination format.
    - The purpose of the practice analysis document is to 1) assist with the development and approval of examination content and 2) help test-takers prepare to take the examination by clarifying test content.
    - The ELCs document will not be edited in any way.

2. An Advisory Committee of 6-10 subject matter experts (at least one per jurisdiction) should be created to provide technical and content expertise for the project. All committee members were nurse practitioners. To ensure appropriate representation, the attendees determined that the Advisory Committee would:

    - Be geographically diverse.
    - Represent a range of stakeholders (e.g., practitioners, educators).
    - Contain a strong representation of newer practitioners.
    - Include representation from minority groups.
    - Use terms of reference developed by CCRNR in consultation with Meazure Learning.

Forming the Nurse Practitioner Practice Analysis Project Advisory Committee (NP PAPAC)

The jurisdictions that use (or will use) the Canadian nurse practitioner examination nominated one or more representatives for the committee to provide guidance and subject matter expertise. The committee was named the Nurse Practitioner Practice Analysis Project Advisory Committee (NP PAPAC). NP PAPAC members are provided in Table 1. Supporting the committee from CCRNR were Lynn Power (Executive Director, College of Registered Nurses of Newfoundland and Labrador), Jill Kovacs (Project Manager, CCRNR), and Eugenia Afolabi (Communications Consultant, CCRNR). The NPR-FIPP Steering Committee (representing the jurisdictional regulatory bodies) discussed the NPs who were put forward as options for the committee and selected 10 NPs based on the above criteria, also ensuring representation of Francophone/ French speaking, rural and urban practice settings, and regulatory experience.

A kickoff meeting was held virtually on September 7, 2023. The purpose of this meeting was to:

1. Allow committee members to introduce themselves.
2. Establish guiding principles for the conduct of the committee.
3. Orient the group to the purpose of the project.
4. Explain the difference between the practice analysis project and the ELC project.
5. Discuss the project plan.

At this meeting it was established that the NP PAPAC would oversee the project and review information prepared by Meazure Learning for updating the practice analysis. Specifically, the committee was tasked with:

- Providing oversight on data gathering and processes to perform the practice analysis.
- Participating in reviewing existing documentation relevant to the practice analysis, including the most recent CCRNR practice analysis (2015) and the recently revised ELCs.
- Ensuring that the practice analysis will feed into the test plan and blueprint.
- Validating that practice statements are pertinent to nurse practitioner practice in Canada.

It was determined that the NP PAPAC would report to the Nurse Practitioners Regulation Framework Implementation Plan Project (NRP-FIPP) Steering Committee, which reports directly to the CCRNR Board of Directors.

Table 1. Composition of the NP Practice Analysis Project Advisory Committee (NP PAPAC)

Name	Jurisdiction
Kelvin Bei	British Columbia
Jill Larocque	Alberta
Lori Penner	Saskatchewan
Naomi Nickerson	Manitoba
Chantal Rioux	Ontario
Kristine Turnbull	Ontario
Krista Cormier	New Brunswick
Marge Ancliffe	Nova Scotia
Gail Macartney	Prince Edward Island
Heather Tracey Michelin	Newfoundland and Labrador

Background Research

To begin the process of effectively establishing the practice analysis, Meazure Learning conducted an environmental scan and literature review to understand the knowledge, skills, and abilities required for safe and competent practice of nurse practitioners. Based on this background research, Meazure Learning would provide recommendations for establishing the content of the practice analysis.

This research process explored existing practice analyses, ELCs, and standards of practice for nurse practitioners from around the world. The research was limited to English-speaking countries that regulate nurse practitioners, specifically Canada, the United States, the United Kingdom, Australia, and New Zealand. This review had two goals:

1. Establish the expectations of nurse practitioners in Canada and internationally using existing resources.
2. Create an understanding of the global expectations for nurse practitioners.
3. Build an evidence-based organizing framework for the practice analysis project.

Existing documents were categorized into three domains of practice:

1. Process – where different categories were organized based on steps in a process (e.g., the nursing process).
2. Role –where different categories were organized based on the roles of the job incumbents.
3. Hybrid – where the document is organized from both a process and a role perspective. Typically, the clinical role is subdivided into process elements.

The documents and their categorization are included in Table 2. A PowerPoint Summary was also submitted to CCRNR.

NP-PAPAC Review of Background Research – October 22, 2023

The NP-PAPAC met virtually on October 23, 2023 to discuss the findings from the background research. The discussion focused on the organizing framework for the practice analysis project. Committee members were provided with an overview of the background research along with all the source documents.

The committee decided that the organizing framework would need to:

- Efficiently organize NP Practice areas
- Allow for meaningful feedback on strengths and areas for improvement to NP candidates who do not pass the examination.

No final decision on the framework was required at this meeting, but committee members were advised that an organizing framework would be the first major discussion point at the next meeting.

Table 2. Documents reviewed as part of the background research phase of the practice analysis project.

Organization	Document	Country	Date	Classification
Canadian Council of Registered Nurse Regulators	Blueprint for the Canadian Nurse Practitioner Examination: Family/All Ages	CAN	2018	Hybrid (Role and Process)
Canadian Council of Registered Nurse Regulators	Nurse Practitioner Entry-Level Competencies	CAN	2023	Role
The National Organization of Nurse Practitioner Faculties	Nurse Practitioner Core Competencies	USA	2022	Process
American Association of Nurse Practitioners	Standards of Practice for Nurse Practitioners	USA	2022	Process
Royal College of General Practitioners	General Practice Advanced Nurse Practitioner Competencies	UK	2015	Role
Royal College of General Practitioners	Core Capabilities Framework for Advanced Clinical Practice (Nurses) Working in General Practice / Primary Care in England	UK	2020	Process
Royal College of Nursing	Advanced Level Nursing Practice Competencies	UK	2018	Role
Nursing Council of New Zealand	Competencies for the Nurse Practitioner: Scope of Practice	NZ	2017	Process
Nursing and Midwifery Board of Australia	Nurse Practitioner Standards for Practice	AUS	2021	Hybrid (Role by Process)
Australian Nursing & Midwifery Council	National Competency Standards for the Nurse Practitioner	AUS	2006	Process

Stage Two: Create Initial Draft of Practice Analysis Document with Input from Subject Matter Experts

The second stage of the project resulted in an initial framework for creating the practice analysis for NPs. This draft framework was agreed upon collectively by the NP PAPAC.

In-person NP PAPAC Meeting – November 30, 2023

The NP PAPAC met in person in Ottawa, Ontario from November 30 through December 3, 2023. The purpose of this meeting was to develop an initial draft of the practice analysis document. All committee members were in attendance.

The first key decision at the meeting was to decide on an organizational framework to inform the practice analysis. The existing NP Practice Analysis document from 2015 employed a hybrid approach. In this approach, larger categories were organized by role, while the larger clinical care section was subdivided by process. This approach was also employed in CCRNR's most recent ELCs. After deliberation on the relative strengths and weaknesses of each approach, the group unanimously decided to adopt the following hybrid framework to support the practice analysis update:

Domain Area I. Clinician
Entry-level nurse practitioners (NPs) deliver safe, competent, compassionate, and ethical care with diverse populations and in a range of practice settings. NPs ground their care in evidence-informed practice and use critical inquiry in their advanced diagnostic and clinical reasoning.

A. Assessment
B. Diagnosis
C. Management
D. Counselling
E. Transition of Care, Discharge Planning, and Documentation

Domain Area II. Quality Improvement and Research/Scholar
Entry-level nurse practitioners (NPs) use evidence, participate in research and Continuous Quality Improvement, and support knowledge translation.

Domain Area III. Leader
Entry-level nurse practitioners (NPs) demonstrate collaborative leadership within the health care system. NPs strive for a culture of excellence and facilitate the development of effective teams and communication within complex health systems.

Domain Area IV. Educator
Entry-level nurse practitioners (NPs) develop and provide education to a wide range of clients to enhance healthcare knowledge and influence positive outcomes.

Domain Area V. Advocate
Entry-level nurse practitioners (NPs) understand the issues related to health inequity, diversity and inclusion in order to advocate for change to improve health. This includes client's culture, lived experience, gender identity, sexuality, and personal expression.

In addition, the group developed a Glossary of Terms to provide clarity on the intent of certain key terms. The full draft of the practice analysis document is provided in the appendix below.

Post meeting follow-up

Following the conclusion of the in-person meeting, the group exchanged additional information via e-mail and met virtually in January 2024 to finalize the document. These exchanges included finalizing glossary terms. In addition, the CCRNR Project Manager and Communications Consultant reviewed the final draft for spelling, formatting, and consistency.

Stage Three: National Validation Survey

The next stage of the project involved a national survey to support the conclusions of the NP PAPAC and to validate the proposed organizational framework for updating the NP practice analysis.

Survey Methodology and Sampling

In consultation with CCRNR, Meazure Learning developed a survey methodology and a sampling plan. The overall population is presented in Table 3 and represents every nurse practitioner in Canada (except Quebec) who is currently registered/licensed. The survey was delivered in both English and French, and respondents could choose the language version. The survey was delivered online through SurveyMonkey.

The CCRNR Communications Consultant developed a survey introduction that described the purpose and goal of the survey. Various national stakeholders were asked to recruit NPs to participate in the survey. In addition, the project team developed a list of demographic questions to determine if the survey response sample was representative of the larger NP population in Canada. These demographic questions were designed to be aligned with the ELC project so that comparisons could be made.

Based on agreed-upon best practices, for each practice statement, respondents were asked to provide two ratings:

IMPORTANCE: How important is this practice statement for the SAFE and COMPETENT PERFORMANCE of an **entry-level nurse practitioner** in Canada?
Not applicable

1. Not important
2. Minimally important
3. Somewhat important
4. Important
5. Critical

FREQUENCY: How often is this practice statement DEMONSTRATED by an **entry-level nurse practitioner** in Canada?
Not applicable

1. Never
2. Less than once per month
3. At least monthly
4. At least weekly
5. Daily

Throughout the survey, respondents could access the glossary of terms developed by the NP PAPAC. Participants could also take the survey in multiple sittings provided they continued the survey on the same device.

Prior to being launched, the survey was reviewed by Meazure Learning, the CCRNR project staff and members of the NP PAPAC. The French version was reviewed by bilingual NP PAPAC members.

Survey Response Rate

The survey was administered from March 20, 2024, to April 24, 2024. With the assistance of the regulatory bodies (including emailing the survey to registrants and sending planned reminders), 9,210 nurse practitioners were invited to complete the survey. A total of 1,148 respondents completed the survey in full yielding a 12.5% response rate.

Based on Canadian census data, along with input from the NP PAPAC and the NRP-FIPP group the sample of respondents to this survey are representative of the larger NP population. As a result, the results from this survey can be generalized to the larger population of Canadian NPs.

Table 3. Number of Nurse Practitioners currently registered/licensed in Canada (except Quebec)

Jurisdiction	Family-All Ages	Adult	Pediatrics	Neonatal	Other	Total NP Registrants
British Columbia	953	51	16			1,020
Alberta	550	285	36	29	37	937
Saskatchewan	356	7	5	7	1	376
Manitoba	311	11	4			326
Ontario	4,024	782	281		27	5,114
New Brunswick	419					419
Nova Scotia	377	41	7	11		436
Prince Edward Island					122	122
Newfoundland and Labrador	287	20	2			309
Yukon						27
Northwest Territories and Nunavut					124	124
Total	**7,277**	**1,197**	**351**	**47**	**311**	**9,210**

*Data collected from regulatory bodies in April/May 2024. Some nurse practitioners may be registered in more than one jurisdiction.

Demographic Variables

Respondents were asked to select their preferred language to complete the survey (English or French) and were then asked eight demographic questions.

Table 4. Survey completion language

Response	n	%
English	1,132	98.6%
French	16	1.4%

According to the 2021 Canadian census, not including the province of Quebec, 3.2% of Canadians identify as French speaking. The lower percentage on this survey could be due to the fact that many bilingual nurse practitioner may have chosen to complete the survey in English.

Table 5. Are you currently (or within the last 12 months) registered/licensed as a nurse practitioner in a Canadian jurisdiction?

Response	n	%
Yes	1,148	100.0%
No	0	0.0%

All respondents were currently registered/licensed as an NP in Canada.

Table 6. What is your primary province/territory of residence? AND in which jurisdiction(s) are you currently practicing as a nurse practitioner?

Jurisdiction	Living (%)	Practicing (%)	All NPs (%)	Canada (excl. QC) (%)
ON	63.1%	64.3%	55.5%	50.1%
AB	9.7%	11.8%	10.2%	15.1%
BC	9.3%	9.8%	11.1%	17.6%
NS	5.2%	5.9%	4.7%	3.4%
SK	3.7%	5.0%	4.1%	3.9%
MB	3.0%	4.4%	3.5%	4.6%
NB	2.0%	3.0%	4.6%	2.7%
NL	1.3%	2.2%	3.4%	1.7%
PE	1.1%	1.7%	1.3%	0.6%
NT	0.8%	1.0%	1.3%	0.1%
NU	0.1%	1.6%		0.1%
QC	0.6%	0.1%	N/A	N/A
YT	0.1%	0.2%	0.3%	0.1%
N/A	0.1%	0.1%	N/A	N/A
Total	100.0%	100.0%	100.0%	**100.0%**

There was a high degree of overlap between jurisdiction of residence and jurisdiction of employment, although there were some cases of nurse practitioners providing virtual services in another jurisdiction or living near another jurisdiction. As a result, the second (“What is your primary province/territory of residence”) and third (“In which jurisdiction(s) are you currently practicing as a nurse practitioner?”) demographic questions were combined onto one table.

Although there were some minor differences, as seen in the table above there was a relatively high degree of consistency between the jurisdictional distribution of survey respondents, the distribution of all NPs, and the distribution of the Canadian population (not including Quebec).

Table 7. How long have you been practicing as a nurse practitioner?

Response	n	%
Less than 2 years	148	12.9%
2-5 years	188	16.4%
6-10 years	244	21.3%
More than 10 years	568	49.5%
No response	0	0.0%

Respondents were split evenly between those with more than 10 years of experience (49.5%) and those with less than 10 years of experience (50,5%).

Table 8. What is your current practice setting as a nurse practitioner?

Response	n	%
Urban (population greater than 1,000)	824	71.8%
Both	191	16.6%
Rural (population less than 1,000)	132	11.5%
No response	1	0.1%

Most respondents reported living in an urban setting with a population of greater than 1,000 (71.8%).

Table 9. In which stream(s) are you currently licensed/registered/certified as a nurse practitioner?

Response	n	%
Family-All ages / Primary Care	876	76.3%
Adult	229	19.9%
Pediatric	65	5.7%
Neonatology	22	1.9%
No response	2	0.2%

Over 75% of respondents identified as working in the family-all ages/primary care group, and based on registration information provided by the regulatory bodies, this group of respondents represents the largest proportion of registered NPs in Canada (79%).

Table 10. What is your current practice domain(s)?

Response	n	%
Direct Care	1,131	98.5%
Education	287	25.0%
Administration	193	16.8%
Research	148	12.9%
Policy	93	8.1%
No response	2	0.2%

Almost all respondents indicated working in direct care.

Table 11. What is your primary place of practice?

Response	n	%
Primary Health Care	505	44.0%
Hospital	341	29.7%
Other (please specify)	139	12.1%
Community Health	85	7.4%
Nursing Home / Long Term Care	61	5.3%
No response	17	1.5%

Almost 75% of respondents indicated that they worked in a primary health care facility or in a hospital. In addition, 12.1% of respondents selected “Other”. The most common practice areas specified by participants who selected “Other” were addictions and withdrawal management, ambulatory care, oncology, corrections, or telemedicine/virtual care.

Table 12. In your current practice, have you had a preceptor/mentor relationship with a new NP graduate (i.e., graduated less than 2 years ago)?

Response	n	%
Yes	606	52.8%
No	542	47.2%

Over 50% of respondents indicated that they currently preceptor or mentor a new NP graduate.

Table 13. Rate of preceptorship/mentorship by years of experience

Response	n	% of respondents preceptoring/mentoring
Less than 2 years	148	18.9%
2-5 years	188	43.1%
6-10 years	244	57.4%
More than 10 years	568	62.9%
Total	1,148	52.8%

There were some key differences in preceptor/mentor responses based on years of experience. The rate of preceptoring/mentoring increases along with years of experience. For example, almost 63% of respondents with more than ten years of experience reported precepting/mentoring new NP graduates. Although many respondents had enough years of experience to be considered experienced practitioners, their work with new NP graduates allowed them to rate practice statements from the perspective of a recent graduate.

Importance and Frequency Ratings

The average importance and frequency ratings are provided for each practice statement. Specifically,

IMPORTANCE: How important is this practice statement for the SAFE and COMPETENT PERFORMANCE of an **entry-level nurse practitioner** in Canada?
Not applicable
1. Not important
2. Minimally important
3. Somewhat important
4. Important
5. Critical

FREQUENCY: How often is this practice statement DEMONSTRATED by an **entry-level nurse practitioner** in Canada?
Not applicable
1. Never
2. Less than once per month
3. At least monthly
4. At least weekly
5. Daily

In addition, a criticality index was calculated based on multiplying importance by frequency [Crit (IxF)].

Table 14. Average importance and frequency ratings: Domain I. Clinician - A. Assessment

Subdomain	Competency	Sub Competency	Avg Imp.	Avg Freq.	Crit (IxF)
A. Assessment	1. Establish the reason for the client encounter	1A.1.a Ask pertinent questions to establish the presenting issues	4.73	4.95	23.39
A. Assessment	1. Establish the reason for the client encounter	1A.1.b Evaluate information relevant to the client's presenting concerns	4.67	4.94	23.07
A. Assessment	1. Establish the reason for the client encounter	1A.1.c Prioritize routine, urgent, emergent, and life-threatening situations	4.87	4.85	23.61
A. Assessment	1. Establish the reason for the client encounter	1A.1.d Perform initial assessment of the client's condition	4.61	4.92	22.69
A. Assessment	2. Obtain informed consent according to legislation and regulatory requirements	1A.2.a Support client to make informed decisions, discussing risks, benefits, alternatives, and consequences	4.44	4.77	21.20
A. Assessment	2. Obtain informed consent according to legislation and regulatory requirements	1A.2.b Obtain informed consent for the collection, use and disclosure of personal and health information	4.35	4.44	19.31
A. Assessment	3. Use critical inquiry to analyze and synthesize information to identify client needs, and to inform assessment and diagnosis	1A.3.a Integrate information specific to the client's biopsychosocial, behavioral, cultural, ethnic, spiritual, circumstances, current developmental life stage, gender expression and social determinants of health considering epidemiology and population-level characteristics	4.20	4.73	19.86
A. Assessment	3. Use critical inquiry to analyze and synthesize information to identify client needs, and to inform assessment and diagnosis	1A.3.b Integrate findings from past and current health history and investigations	4.39	4.81	21.15
A. Assessment	3. Use critical inquiry to analyze and synthesize information to identify client needs, and to inform assessment and diagnosis	1A.3.c Apply current, credible, and reliable research, literature, and standards to inform decision-making	4.36	4.73	20.62
A. Assessment	3. Use critical inquiry to analyze and synthesize information to identify client needs, and to inform assessment and diagnosis	1A.3.d Incorporate pharmacological history	4.43	4.84	21.46
A. Assessment	3. Use critical inquiry to analyze and synthesize information to identify client needs, and to inform assessment and diagnosis	1A.3.e Integrate client's wishes and directions related to advanced care planning, and palliative and end-of-life care	4.35	3.74	16.27

A. Assessment	4. Conduct an assessment that is relevant to the client's presentation to inform diagnostic decisions	1A.4.a Determine the need for conducting a focused or comprehensive assessment	4.49	4.90	21.99
A. Assessment	4. Conduct an assessment that is relevant to the client's presentation to inform diagnostic decisions	1A.4.b Conduct an assessment using valid and reliable techniques and tools	4.43	4.85	21.53
A. Assessment	4. Conduct an assessment that is relevant to the client's presentation to inform diagnostic decisions	1A.4.c Conduct an assessment with sensitivity to client's culture, lived experiences, gender identity, sexuality, and personal expression	4.27	4.72	20.18
A. Assessment	4. Conduct an assessment that is relevant to the client's presentation to inform diagnostic decisions	1A.4.d Conduct a mental health assessment, applying knowledge of emotional, psychological, and social measures of well-being	4.24	4.52	19.15
A. Assessment	4. Conduct an assessment that is relevant to the client's presentation to inform diagnostic decisions	1A.4.e Conduct a review of systems to identify pertinent presenting findings	4.42	4.80	21.22
A. Assessment	4. Conduct an assessment that is relevant to the client's presentation to inform diagnostic decisions	1A.4.f Order and perform screening and diagnostic investigations, applying principles of resource stewardship	4.39	4.79	21.03
A. Assessment	4. Conduct an assessment that is relevant to the client's presentation to inform diagnostic decisions	1A.4.e Conduct a review of systems to identify pertinent presenting findings	4.42	4.80	21.22
A. Assessment	4. Conduct an assessment that is relevant to the client's presentation to inform diagnostic decisions	1A.4.f Order and perform screening and diagnostic investigations, applying principles of resource stewardship	4.39	4.79	21.03

Table 15. Average importance and frequency ratings: Domain I. Clinician - B. Diagnosis

Subdomain	Competency	Sub Competency	Avg Imp.	Avg Freq.	Crit (IxF)
B. Diagnosis	1. Integrate critical inquiry and diagnostic reasoning to formulate differential and most likely diagnoses	1B.1.a Interpret the results of investigations	4.62	4.89	22.58
B. Diagnosis	1. Integrate critical inquiry and diagnostic reasoning to formulate differential and most likely diagnoses	1B.1.b Formulate differential diagnoses	4.54	4.89	22.18
B. Diagnosis	1. Integrate critical inquiry and diagnostic reasoning to formulate differential and most likely diagnoses	1B.1.c Ascertain the client's understanding of assessment findings, diagnosis, anticipated outcomes, and prognosis	4.30	4.83	20.73

B. Diagnosis	1. Integrate critical inquiry and diagnostic reasoning to formulate differential and most likely diagnoses	1B.1.d Determine the most likely diagnoses based on clinical and diagnostic reasoning	4.60	4.90	22.52

Table 16. Average importance and frequency ratings: Domain I. Clinician - C. Management

Subdomain	Competency	Sub Competency	Avg Imp.	Avg Freq.	Crit (IxF)
C. Management	1. Use clinical reasoning to create a care plan based on diagnoses and the client's informed consent, preferences and goals	1C.1.a Examine, and explore with the client, options for managing the diagnoses	4.26	4.76	20.25
C. Management	1. Use clinical reasoning to create a care plan based on diagnoses and the client's informed consent, preferences and goals	1C.1.b Consider availability, cost, determinants of health, clinical efficacy, and potential client adherence to determine feasibility and sustainability of the care plan	4.11	4.61	18.93
C. Management	1. Use clinical reasoning to create a care plan based on diagnoses and the client's informed consent, preferences and goals	1C.1.c Address barriers that interfere with client's goals	4.11	4.56	18.74
C. Management	1. Use clinical reasoning to create a care plan based on diagnoses and the client's informed consent, preferences and goals	1C.1.d Determine and prioritize interventions integrating client goals and preferences, resources, and clinical urgency	4.28	4.70	20.11
C. Management	1. Use clinical reasoning to create a care plan based on diagnoses and the client's informed consent, preferences and goals	1C.1.e Provide and seek consultation from other professionals and organizations to support the care plan	4.21	4.38	18.43
C. Management	2. Prescribe and counsel clients on pharmacological and non-pharmacological interventions, across the life span	1C.2.a Complete accurate prescriptions in accordance with applicable jurisdictional and organizational requirements	4.73	4.88	23.07
C. Management	2. Prescribe and counsel clients on pharmacological and non-pharmacological interventions, across the life span	1C.2.b Select evidence-informed pharmacological interventions based on diagnoses, concurrent client therapies, and available medication history, using drug-information systems	4.61	4.88	22.48
C. Management	2. Prescribe and counsel clients on pharmacological and non-pharmacological interventions, across the life span	1C.2.c Complete medication reconciliation to make clinical decisions based on an analysis of the client's current pharmacological and non-pharmacological therapy	4.38	4.48	19.61

C. Management	2. Prescribe and counsel clients on pharmacological and non-pharmacological interventions, across the life span	1C.2.d Analyze polypharmacy to identify unnecessary and unsafe prescribing, and deprescribing where possible	4.28	4.29	18.34
C. Management	2. Prescribe and counsel clients on pharmacological and non-pharmacological interventions, across the life span	1C.2.e Incorporate principles of pharmacological stewardship	4.15	4.51	18.71
C. Management	2. Prescribe and counsel clients on pharmacological and non-pharmacological interventions, across the life span	1C.2.f Establish a monitoring plan for pharmacological and non-pharmacological interventions	4.19	4.47	18.74
C. Management	2. Prescribe and counsel clients on pharmacological and non-pharmacological interventions, across the life span	1C.2.g Counsel client on indications, benefits, cost, potential adverse effects, interactions, contraindications, precautions, adherence, required monitoring and follow-up	4.33	4.68	20.24
C. Management	3. Perform invasive and non-invasive interventions as indicated by the care plan	1C.3.a Explain procedures, including indications, potential risks and benefits, adverse effects, anticipated aftercare and follow up care	4.38	4.35	19.04
C. Management	3. Perform invasive and non-invasive interventions as indicated by the care plan	1C.3.b Perform procedures using evidence-informed techniques	4.36	4.14	18.02
C. Management	3. Perform invasive and non-invasive interventions as indicated by the care plan	1C.3.c Monitor and evaluate clinical findings, aftercare and follow up	4.34	4.34	18.84
C. Management	3. Perform invasive and non-invasive interventions as indicated by the care plan	1C.3.d Perform interventions to stabilize the client in urgent, emergent, and life-threatening situations	4.66	3.71	17.30

Table 17. Average importance and frequency ratings: Domain I. Clinician – D. Counselling

Subdomain	Competency	Sub Competency	Avg Imp.	Avg Freq.	Crit (IxF)
D. Counselling	1. Create a therapeutic relationship that is conducive to optimal health outcomes	1D.1.a Utilize developmentally, socio-demographically, and culturally relevant strategies, communication and counselling techniques and tools	4.04	4.44	17.94
D. Counselling	1. Create a therapeutic relationship that is	1D.1.b Evaluate effectiveness of therapeutic relationship and refer to	4.06	4.26	17.31

	conducive to optimal health outcomes	appropriate professionals, as needed			
D. Counselling	2. Provide therapeutic interventions as indicated by the care plan	1D.2.a Address impacts of potential and real biases on the creation of safe spaces	3.90	4.00	15.59
D. Counselling	2. Provide therapeutic interventions as indicated by the care plan	1D.2.b Integrate therapeutic counselling techniques to facilitate an optimal experience and outcome for the client	3.93	4.27	16.76
D. Counselling	2. Provide therapeutic interventions as indicated by the care plan	1D.2.c Recognize and respond to the expression of intense emotions in a manner that facilitates a safe and effective resolution	4.13	4.07	16.82
D. Counselling	2. Provide therapeutic interventions as indicated by the care plan	1D.2.d Provide trauma and violence informed care	4.11	3.97	16.32
D. Counselling	2. Provide therapeutic interventions as indicated by the care plan	1D.2.e Identify root causes of trauma, including intergenerational trauma, with the client	3.79	3.51	13.28
D. Counselling	3. Apply harm-reduction strategies and evidence-informed practice to support clients with substance use disorder, while adhering to federal and provincial/territorial legislation and regulation	1D.3.a Identify potential risks and signs of substance use disorders	4.18	3.96	16.55
D. Counselling	3. Apply harm-reduction …	1D.3.b Develop a harm-reduction care plan, considering treatment and intervention options	4.02	3.59	14.42
D. Counselling	3. Apply harm-reduction …	1D.3.c Apply evidence-informed and safe prescribing practices when initiating and managing pharmacological and non-pharmacological interventions	4.41	4.39	19.37
D. Counselling	3. Apply harm-reduction …	1D.3.d Adhere to legislation, regulation, and organizational policy related to the safe storage and handling of controlled drugs and substances	4.45	4.19	18.62
D. Counselling	3. Apply harm-reduction …	1D.3.e Provide education on the safe storage and handling of controlled drugs and substances	4.17	3.76	15.67

Table 18. Average importance and frequency ratings: Domain I. Clinician – E. Transition of Care, Discharge Planning, and Documentation

Subdomain	Competency	Sub Competency	Avg Imp.	Avg Freq.	Crit (IxF)

E. Transition of Care, Discharge Planning, and Documentation	1. Lead admission, transition of care, and discharge planning that ensures continuity and safety of client care	1E.1.a Collaborate with client to facilitate access to required resources, drug therapy, diagnostic tests, procedures, and follow up to support the continuum of care	4.15	4.24	17.62
E. Transition of Care, Discharge Planning, and Documentation	1. Lead admission, transition of care, and discharge planning that ensures continuity and safety of client care	1E.1.b Facilitate transfer of information to support continuity of care	4.14	4.05	16.78
E. Transition of Care, Discharge Planning, and Documentation	1. Lead admission, transition of care, and discharge planning that ensures continuity and safety of client care	1E.1.c Facilitate client's access to community services and other system resources	4.01	3.99	15.98
E. Transition of Care, Discharge Planning, and Documentation	1. Lead admission, transition of care, and discharge planning that ensures continuity and safety of client care	1E.1.d Modify the care plan based on the client's transition needs	4.07	3.88	15.81
E. Transition of Care, Discharge Planning, and Documentation	2. Conduct record keeping activities, according to legislation and jurisdictional regulatory requirements	1E.2.a Document all client encounters and rationale for actions	4.61	4.95	22.83
E. Transition of Care, Discharge Planning, and Documentation	2. Conduct record keeping activities, according to legislation and jurisdictional regulatory requirements	1E.2.b Collect, disclose, use, and destroy health information according to privacy and confidentiality legislation, regulations and provincial/territorial regulatory standards	4.47	4.70	21.05
E. Transition of Care, Discharge Planning, and Documentation	2. Conduct record keeping activities, according to legislation and jurisdictional regulatory requirements	1E.2.c Apply relevant security measures to records and documentation	4.51	4.83	21.75
E. Transition of Care, Discharge Planning, and Documentation	2. Conduct record keeping activities, according to legislation and jurisdictional regulatory requirements	1E.2.d Recognize role as a health information custodian to ensure client information is secure and remains confidential	4.50	4.82	21.68
E. Transition of Care, Discharge Planning, and Documentation	3. Provide safe, ethical, and competent services as a self-employed practitioner	1E.3.a Employ accurate, honest, and ethical billing and advertising practices	4.24	4.18	17.73
E. Transition of Care, Discharge Planning, and Documentation	4. Employ evidence-informed virtual care strategies	1E.4.a Articulate the risks and benefits of virtual care to confirm the client's informed consent to participate in a virtual care visit	4.13	4.11	16.98

E. Transition of Care, Discharge Planning, and Documentation	4. Employ evidence-informed virtual care strategies	1E.4.b Maintain client's privacy during virtual encounters, and when transferring data and providing medical documents electronically	4.42	4.26	18.83
E. Transition of Care, Discharge Planning, and Documentation	4. Employ evidence-informed virtual care strategies	1E.4.c Determine when the client's health concern can be managed virtually without delaying or fragmenting care	4.25	4.18	17.77
E. Transition of Care, Discharge Planning, and Documentation	4. Employ evidence-informed virtual care strategies	1E.4.d Demonstrate an understanding of the limitations of virtual care when determining the need for in-person assessment and management	4.35	4.21	18.28
E. Transition of Care, Discharge Planning, and Documentation	4. Employ evidence-informed virtual care strategies	1E.4.e Adapt history-taking and assessment techniques to effectively complete the virtual client assessment	4.22	4.19	17.68
E. Transition of Care, Discharge Planning, and Documentation	4. Employ evidence-informed virtual care strategies	1E.4.f Use effective communication approaches in the virtual care environment	4.19	4.22	17.70
E. Transition of Care, Discharge Planning, and Documentation	4. Employ evidence-informed virtual care strategies	1E.4.g Integrate health care technologies and communication platforms to deliver virtual care	3.95	3.98	15.73

Table 19. Average importance and frequency ratings: Domain II. Quality Improvement and Research/Scholar

Doman	Sub Competency	Avg Imp.	Avg Freq.	Crit (IxF)
Domain Area II. Quality Improvement And Research/Scholar	2.1 Identifies gaps, appraises and applies evidence-informed resources, understands research methodologies	3.71	3.44	12.73
Domain Area II. Quality Improvement And Research/Scholar	2.2 Discusses the practical benefits and possible applications of research with teams and partners	3.46	3.00	10.38
Domain Area II. Quality Improvement And Research/Scholar	2.3 Recommends where research findings can be integrated into practice	3.62	3.11	11.27
Domain Area II. Quality Improvement And Research/Scholar	2.4 Applies ethical principles and analyzes the context when implementing evidence-informed practice	3.95	3.73	14.71
Domain Area II. Quality Improvement And Research/Scholar	2.5 Disseminates knowledge and evidence-informed findings with clients, teams and partners	3.81	3.65	13.91
Domain Area II. Quality Improvement And Research/Scholar	2.6 Uses data and available forms of technology to identify risks and create opportunities to mitigate harm	3.83	3.58	13.73

Table 20. Average importance and frequency ratings: Domain III. Leader

Doman	Sub Competency	Avg Imp.	Avg Freq.	Crit (IxF)
Domain Area III. Leader	3.1 Engages in leadership to contribute to a culture of continuous improvement, safety and excellence	3.68	3.48	12.80
Domain Area III. Leader	3.2 Builds partnerships to optimize health-care delivery	3.85	3.60	13.86
Domain Area III. Leader	3.3 Uses principles of team dynamics, conflict resolution and change management to support effective collaboration and communication	3.97	3.93	15.58
Domain Area III. Leader	3.4 Demonstrates awareness of tools and resources, and contributes to strategies for responding to disasters and unpredictable situations	3.65	2.90	10.61

Table 21. Average importance and frequency ratings: Domain IV. Educator

Doman	Sub Competency	Avg Imp.	Avg Freq.	Crit (IxF)
Domain Area IV. Educator	4.1 Develops and provides educational resources	3.36	2.91	9.80
Domain Area IV. Educator	4.2 Evaluates learning and delivery methods to improve outcomes	3.47	2.92	10.12
Domain Area IV. Educator	4.3 Develops and uses evidence-informed strategies and technologies to enhance learning	3.60	3.15	11.33

Table 22. Average importance and frequency ratings: Domain V. Advocate

Doman	Sub Competency	Avg Imp.	Avg Freq.	Crit (IxF)
Domain Area V. Advocate	5.1 Demonstrates self-awareness and cultural humility to mitigate risk based on personal bias	4.12	4.37	18.00
Domain Area V. Advocate	5.2 Contributes to a practice environment that is diverse, equitable, inclusive and culturally safe	4.17	4.52	18.86
Domain Area V. Advocate	5.3 Promotes equitable care and service delivery	4.23	4.51	19.09
Domain Area V. Advocate	5.4 Advocates for client access to resources and system changes	4.03	3.86	15.57
Domain Area V. Advocate	5.5 Navigates systems acknowledging the interdependence of policy, practice and systemic issues	3.77	3.64	13.72
Domain Area V. Advocate	5.6 Identifies and manages potential and real conflicts of interests, always acting in the client's best interest	4.14	4.02	16.66

Post-Survey Subject Matter Expert review – May 27, 2024

On May 27, 2024, the NP PAPAC met virtually to discuss the survey results. The meeting had two goals:

1. Confirm that the sample of respondents represented the larger population of NPs in Canada.
2. Decide on how to proceed with statements with lower criticality ratings.

Following the review of the demographic findings, the NP PAPAC concluded that the results were representative and could be used to inform the remaining processes. In total, 15 practice statements were discussed.

Although all practice statements were open for discussion, the group focused primarily on practice statements with a criticality rating of less than 15. Although there is no agreed-upon metric in the industry, practice statements with a combined criticality rating of under 15 are an indicator that survey respondents, as a group, did not widely support this statement. A rating of under 15 would occur when a practice statement had a criticality and/or importance rating of less than 4. This could be for several reasons, including a belief that it does not apply to practice or that the statement is not understood. For these practice statements, the group had the option to delete, modify, or retain the practice statements.

Table 23. Flagged Practice Statements and Corresponding Decisions

Domain	Subdomain	Comp.	Sub Comp	Crit (IxF)	Decision
Domain Area I. Clinician	D. Counselling	2. Provide therapeutic interventions as indicated by the care plan	1D.2.e Identify root causes of trauma, including intergenerational trauma, with the client	13.28	Practice statement edited to "Identify the presence of trauma, including intergenerational trauma, with the client."
Domain Area I. Clinician	D. Counselling	3. Apply harm-reduction …	1D.3.b Develop a harm-reduction care plan, considering treatment and intervention options	14.42	Retain as is.
Domain Area II. Quality Improvement And Research/Scholar			2.1 Identifies gaps, appraises and applies evidence-informed resources, understands research methodologies	12.73	Retain as is.
Domain Area II. Quality Improvement And Research/Scholar			2.2 Discusses the practical benefits and possible applications of research with teams and partners	10.38	Retain as is.
Domain Area II. Quality Improvement And Research/Scholar			2.3 Recommends where research findings can be integrated into practice	11.27	Retain as is.
Domain Area II. Quality Improvement And Research/Scholar			2.4 Applies ethical principles and analyzes the context when implementing evidence-informed practice	14.71	Retain as is.

Domain Area II. Quality Improvement And Research/Scholar			2.5 Disseminates knowledge and evidence-informed findings with clients, teams and partners	13.91	Retain as is.
Domain Area II. Quality Improvement And Research/Scholar			2.6 Uses data and available forms of technology to identify risks and create opportunities to mitigate harm	13.73	Retain as is.
Domain Area III. Leader			3.1 Engages in leadership to contribute to a culture of continuous improvement, safety and excellence	12.80	Retain as is.
Domain Area III. Leader			3.2 Builds partnerships to optimize health-care delivery	13.86	Retain as is.
Domain Area III. Leader			3.4 Demonstrates awareness of tools and resources, and contributes to strategies for responding to disasters and unpredictable situations	10.61	Retain as is.
Domain Area IV. Educator			4.1 Develops and provides educational resources	9.80	Retain as is.
Domain Area IV. Educator			4.2 Evaluates learning and delivery methods to improve outcomes	10.12	Retain as is.
Domain Area IV. Educator			4.3 Develops and uses evidence-informed strategies and technologies to enhance learning	11.33	Retain as is.
Domain Area V. Advocate			5.5 Navigates systems acknowledging the interdependence of policy, practice and systemic issues	13.72	Edit to “Navigates various systems affecting client care, acknowledging the interdependence of policy, practice and systemic issues.”

NRP-FIPP Consultation – June 13, 2024

On June 13, 2024, Meazure Learning met virtually with the NRP-FIPP Steering Committee to provide an update on the work completed to date and collect input on the decisions made by the NP PAPAC committee. In advance of the meeting, the group inquired whether there were any differences in Importance and Frequency ratings between different NP practice categories or streams. This data would help inform other initiatives being conducted by the NRP-FIPP.

To investigate category or stream-related differences, Meazure Learning conducted an analysis of Criticality ratings (IxF) across three practice categories: 1) Family All Ages/Primary care (F/AA, n=876), 2) Adult (n=229) and 3) Pediatric (Ped, n=65). There were only 22 respondents who were part of the Neonatal stream. Given the small size of the Neonatal group, it would not be possible to conduct a stream-related analysis with the neonatal group. Additionally, due to differences in sample sizes across groups and the relatively small overall sample sizes, traditional indices of statistical significance would not be optimal. As a result, the 10 practice statements with the largest stream-related differences are shown. Beyond the top 10, differences were very small and most likely due to random variations rather than a real effect.

The full results from that analysis are provided in Appendix A.

Table 24. Largest Differences by Practice Category or Stream

Domain	Subdomain	Comp.	Sub Comp	Crit (IxF)	Difference
Domain Area I. Clinician	A. Assessment	3. Use critical inquiry to analyze and synthesize information to identify client needs, and to inform assessment and diagnosis	1A.3.a Integrate information specific to the client's biopsychosocial, behavioral, cultural, ethnic, spiritual, circumstances, current developmental life stage, gender expression and social determinants of health considering epidemiology and population-level characteristics	19.86	Adult (17.7) > Ped (15.7)
Domain Area I. Clinician	A. Assessment	4. Conduct an assessment that is relevant to the client's presentation to inform diagnostic decisions	1A.4.d Conduct a mental health assessment, applying knowledge of emotional, psychological, and social measures of well-being	19.15	F/AA (19.7) > Adult (17.4)
Domain Area I. Clinician	C. Management	2. Prescribe and counsel clients on pharmacological and non-pharmacological interventions, across the life span	1C.2.g Counsel client on indications, benefits, cost, potential adverse effects, interactions, contraindications, precautions, adherence, required monitoring and follow-up	20.24	Adult (20.7) > Peds (18.8)
Domain Area I. Clinician	C. Management	3. Perform invasive and non-invasive interventions as indicated by the care plan	1C.3.c Monitor and evaluate clinical findings, aftercare and follow up	18.84	Ped (20.4) > F/AA (18.7)
Domain Area I. Clinician	D. Counselling	2. Provide therapeutic interventions as indicated by the care plan	1D.2.d Provide trauma and violence informed care	16.32	Peds (17.5) > Adult (14.9)
Domain Area I. Clinician	D. Counselling	3. Apply harm-reduction strategies and evidence-informed practice to support clients with substance use disorder, while adhering to federal and provincial/territorial legislation and regulation	1D.3.a Identify potential risks and signs of substance use disorders	16.55	Adult (16.9) > Ped (14.5)
Domain Area I. Clinician	D. Counselling	3. Apply harm-reduction strategies and evidence-informed practice to support clients with	1D.3.b Develop a harm-reduction care plan, considering treatment and intervention options	14.42	Adult (14.7) > Ped (13.0)

		substance use disorder, while adhering to federal and provincial/territorial legislation and regulation			
Domain Area I. Clinician	E. Transition of Care, Discharge Planning, and Documentation	4. Employ evidence-informed virtual care strategies	1E.4.c Determine when the client's health concern can be managed virtually without delaying or fragmenting care	17.77	Adult (18.3) > Ped (16.5)
Domain Area IV. Educator			4.3 Develops and uses evidence-informed strategies and technologies to enhance learning	11.33	Adult (11.6) > Ped (9.2)

The practice category or stream-related differences are relatively small and do not attain a level of statistical significance (one-tail $p<0.05$). As a result, from a statistical perspective, there are no systematic or meaningful practice category or stream differences between Family-all ages/Primary care, Adult and Pediatric.

Stage Four: Final Approval of Nurse Practitioner Examination Practice Analysis Document

The final, CCRNR approved, practice analysis statements are found in Appendix B.

Next Steps

In terms of the Canadian licensure examination for nurse practitioners, several activities will follow. These include:

- Creating an examination blueprint that will contain information on topics such as examination weighting by practice analysis domains, number and type of questions, question format, and item taxonomy.
- Remapping the existing item bank to the new practice analysis framework. This work will require input from subject matter experts.
- Conducting an inventory of the remapped item bank vis-à-vis the blueprint to identify areas where gaps may exist. To address any gaps, targeted item writing sessions will be conducted.

Conclusion

According to the testing standards, once a practice analysis is completed, it must be reviewed and updated on a regular basis. Additionally, the document should be reviewed annually if there are significant changes to the profession including new legislation, scope changes or advances in technology.

Appendix A: Comparison of Criticality (IxF) ratings across Family-All Ages / Primary Care, Adult, and Pediatric Categories or Streams

Sub Comp	Total		F/AA – Primary Care		Adult		Pediatric	
	Mean	n	Mean	n	Mean	n	Mean	n
1A.1.a Ask pertinent questions to establish the presenting issues	23.39	808	23.43	597	23.24	167	23.22	52
1A.1.b Evaluate information relevant to the client's presenting concerns	23.07	809	23.14	598	22.85	167	23.01	52
1A.1.c Prioritize routine, urgent, emergent and life-threatening situations	23.61	808	23.67	598	23.36	167	23.62	51
1A.1.d Perform initial assessment of the client's condition	22.69	799	22.75	591	22.37	164	23.05	52
1A.2.a Support client to make informed decisions, discussing risks, benefits, alternatives and consequences	21.20	803	21.63	595	20.28	166	20.16	51
1A.2.b Obtain informed consent for the collection, use and disclosure of personal and health information	19.31	794	19.60	590	18.83	164	18.67	50
1A.3.a Integrate information specific to the client's biopsychosocial, behavioral, cultural, ethnic, spiritual, circumstances, current developmental life stage, gender expression and social determinants of health considering epidemiology and population-level characteristics	19.86	804	20.03	597	19.10	165	20.28	51
1A.3.b Integrate findings from past and current health history and investigations	21.15	804	21.13	598	21.08	164	21.68	52
1A.3.c Apply current, credible, and reliable research, literature and standards to inform decision-making	20.62	803	20.84	597	19.96	164	19.96	51
1A.3.d Incorporate pharmacological history	21.46	802	21.54	597	21.52	163	20.53	52
1A.3.e Integrate client's wishes and directions related to advanced care planning, and palliative and end-of-life care	16.27	784	16.08	582	17.67	160	15.65	50
1A.4.a Determine the need for conducting a focused or comprehensive assessment	21.99	803	22.02	594	21.74	166	22.16	52
1A.4.b Conduct an assessment using valid and reliable techniques and tools	21.53	806	21.55	597	21.08	166	22.22	52
1A.4.c Conduct an assessment with sensitivity to client's culture, lived experiences, gender identity, sexuality, and personal expression	20.18	802	20.37	598	19.57	166	20.39	51
1A.4.d Conduct a mental health assessment, applying knowledge of emotional, psychological, and social measures of well-being	19.15	801	19.70	595	17.41	166	18.29	52
1A.4.e Conduct a review of systems to identify pertinent presenting findings	21.22	805	21.16	596	20.91	166	21.89	52
1A.4.f Order and perform screening and diagnostic investigations , applying principles of resource stewardship	21.03	805	21.10	596	20.52	166	20.39	52
1B.1.a Interpret the results of investigations	22.58	809	22.59	599	22.67	167	22.29	52
1B.1.b Formulate differential diagnoses	22.18	809	22.19	599	22.04	167	21.87	52
1B.1.c Ascertain the client's understanding of assessment findings, diagnosis, anticipated outcomes, and prognosis	20.73	808	20.87	599	20.31	167	20.98	52
1B.1.d Determine the most likely diagnoses based on clinical and diagnostic reasoning	22.52	809	22.55	599	22.44	167	22.04	52
1C.1.a Examine, and explore with the client, options for managing the diagnoses	20.25	800	20.51	594	19.79	165	19.77	52
1C.1.b Consider availability, cost, determinants of health, clinical efficacy, and potential client adherence to determine feasibility and sustainability of the care plan	18.93	800	19.38	594	18.10	165	18.27	52
1C.1.c Address barriers that interfere with client's goals	18.74	802	18.98	596	18.35	165	18.12	52

1C.1.d Determine and prioritize interventions integrating client goals and preferences, resources, and clinical urgency	20.11	802	20.45	595	19.51	164	19.65	52
1C.1.e Provide and seek consultation from other professionals and organizations to support the care plan	18.43	798	18.50	592	18.33	162	18.52	52
1C.2.a Complete accurate prescriptions in accordance with applicable jurisdictional and organizational requirements	23.07	793	23.22	587	22.70	162	22.42	51
1C.2.b Select evidence-informed pharmacological interventions based on diagnoses, concurrent client therapies, and available medication history, using drug-information systems	22.48	795	22.57	592	22.37	161	21.69	50
1C.2.c Complete medication reconciliation to make clinical decisions based on an analysis of the client's current pharmacological and non-pharmacological therapy	19.61	801	19.48	596	20.06	162	20.27	51
1C.2.d Analyze polypharmacy to identify unnecessary and unsafe prescribing, and deprescribing where possible	18.34	803	18.18	597	18.33	163	19.25	51
1C.2.e Incorporate principles of pharmacological stewardship	18.71	803	18.90	596	18.01	163	18.15	51
1C.2.f Establish a monitoring plan for pharmacological and non-pharmacological interventions	18.74	802	18.94	595	17.87	163	18.82	51
1C.2.g Counsel client on indications, benefits, cost, potential adverse effects, interactions, contraindications, precautions, adherence, required monitoring and follow-up	20.24	804	20.73	597	19.13	164	18.80	51
1C.3.a Explain procedures, including indications, potential risks and benefits, adverse effects, anticipated aftercare and follow up care	19.04	802	19.09	593	18.65	165	20.18	52
1C.3.b Perform procedures using evidence-informed techniques	18.02	792	18.07	590	17.39	160	18.65	50
1C.3.c Monitor and evaluate clinical findings, aftercare and follow up	18.84	798	18.72	591	18.87	164	20.47	51
1C.3.d Perform interventions to stabilize the client in urgent, emergent, and life-threatening situations	17.30	777	16.98	573	18.05	161	18.06	51
1D.1.a Utilize developmentally, socio-demographically, and culturally relevant strategies, communication and counselling techniques and tools	17.94	792	18.18	588	16.73	162	19.59	50
1D.1.b Evaluate effectiveness of therapeutic relationship and refer to appropriate professionals, as needed	17.31	794	17.47	589	16.93	162	17.94	50
1D.2.a Address impacts of potential and real biases on the creation of safe spaces	15.59	793	15.79	589	14.99	163	16.63	51
1D.2.b Integrate therapeutic counselling techniques to facilitate an optimal experience and outcome for the client	16.76	799	17.06	595	15.94	163	16.89	52
1D.2.c Recognize and respond to the expression of intense emotions in a manner that facilitates a safe and effective resolution	16.82	801	17.02	596	16.65	161	16.86	50
1D.2.d Provide trauma and violence informed care	16.32	780	16.67	582	14.90	155	17.45	50
1D.2.e Identify root causes of trauma, including intergenerational trauma, with the client	13.28	773	13.51	578	12.60	154	14.04	50
1D.3.a Identify potential risks and signs of substance use disorders	16.55	786	16.85	587	16.35	162	14.47	47
1D.3.b Develop a harm-reduction care plan, considering treatment and intervention options	14.42	781	14.70	589	13.86	158	13.01	46
1D.3.c Apply evidence-informed and safe prescribing practices when initiating and managing pharmacological and non-pharmacological interventions	19.37	795	19.55	594	18.65	161	19.83	47
1D.3.d Adhere to legislation, regulation, and organizational policy related to the safe storage and handling of controlled drugs and substances	18.62	753	18.81	564	18.40	152	18.68	44
1D.3.e Provide education on the safe storage and handling of controlled drugs and substances	15.67	753	15.92	569	15.10	149	16.52	44
1E.1.a Collaborate with client to facilitate access to required resources, drug therapy, diagnostic tests, procedures, and follow up to support the continuum of care	17.62	777	17.73	574	17.61	161	17.27	49

1E.1.b Facilitate transfer of information to support continuity of care	16.78	772	16.46	570	17.96	161	17.16	49
1E.1.c Facilitate client's access to community services and other system resources	15.98	784	16.03	579	16.29	164	15.96	49
1E.1.d Modify the care plan based on the client's transition needs	15.81	781	15.81	576	16.31	164	15.69	49
1E.2.a Document all client encounters and rationale for actions	22.83	812	22.90	601	22.61	167	23.28	52
1E.2.b Collect, disclose, use, and destroy health information according to privacy and confidentiality legislation, regulations and provincial/territorial regulatory standards	21.05	796	21.18	587	20.82	165	21.13	51
1E.2.c Apply relevant security measures to records and documentation	21.75	795	21.87	588	21.52	163	21.95	52
1E.2.d Recognize role as a health information custodian to ensure client information is secure and remains confidential	21.68	805	21.75	597	21.38	165	22.54	52
1E.3.a Employ accurate, honest, and ethical billing and advertising practices	17.73	563	18.19	421	16.67	114	17.46	38
1E.4.a Articulate the risks and benefits of virtual care to confirm the client's informed consent to participate in a virtual care visit	16.98	728	17.42	553	16.16	143	15.78	48
1E.4.b Maintain client's privacy during virtual encounters, and when transferring data and providing medical documents electronically	18.83	728	19.24	553	17.61	144	18.32	47
1E.4.c Determine when the client's health concern can be managed virtually without delaying or fragmenting care	17.77	726	18.23	552	16.82	141	16.46	49
1E.4.d Demonstrate an understanding of the limitations of virtual care when determining the need for in-person assessment and management	18.28	726	18.70	552	17.47	141	17.14	49
1E.4.e Adapt history-taking and assessment techniques to effectively complete the virtual client assessment	17.68	722	18.08	550	16.89	140	16.64	49
1E.4.f Use effective communication approaches in the virtual care environment	17.70	724	18.01	550	17.15	140	16.91	49
1E.4.g Integrate health care technologies and communication platforms to deliver virtual care	15.73	705	16.05	534	15.28	138	15.43	48
1E.4.h Adhere to requirements for communication and documentation for virtual client encounters	18.13	723	18.45	550	17.29	140	18.14	48
2.1 Identifies gaps, appraises and applies evidence-informed resources, understands research methodologies	12.73	794	12.76	589	12.71	163	12.99	51
2.2 Discusses the practical benefits and possible applications of research with teams and partners	10.38	780	10.27	576	10.65	162	10.87	51
2.3 Recommends where research findings can be integrated into practice	11.27	790	11.25	581	11.21	165	11.36	52
2.4 Applies ethical principles and analyzes the context when implementing evidence-informed practice	14.71	800	14.98	593	14.13	165	14.50	52
2.5 Disseminates knowledge and evidence-informed findings with clients, teams and partners	13.91	802	14.06	593	13.70	167	13.59	52
2.6 Uses data and available forms of technology to identify risks and create opportunities to mitigate harm	13.73	790	13.96	586	13.07	162	13.77	52
3.1 Engages in leadership to contribute to a culture of continuous improvement, safety and excellence	12.80	800	12.84	590	12.74	167	12.74	52
3.2 Builds partnerships to optimize health-care delivery	13.86	801	13.91	593	13.81	165	13.78	52
3.3 Uses principles of team dynamics, conflict resolution and change management to support effective collaboration and communication	15.58	807	15.49	598	15.84	167	15.12	51
3.4 Demonstrates awareness of tools and resources, and contributes to strategies for responding to disasters and unpredictable situations	10.61	786	10.78	580	10.40	165	10.31	49
4.1 Develops and provides educational resources	9.80	785	10.19	578	9.20	163	8.73	50
4.2 Evaluates learning and delivery methods to improve outcomes	10.12	790	10.40	583	9.77	164	8.75	50

4.3 Develops and uses evidence-informed strategies and technologies to enhance learning	11.33	789	11.68	584	11.23	162	9.19	50
5.1 Demonstrates self-awareness and cultural humility to mitigate risk based on personal bias	18.00	796	18.26	588	17.11	164	17.77	51
5.2 Contributes to a practice environment that is diverse, equitable, inclusive and culturally safe	18.86	800	19.02	593	18.45	164	18.63	51
5.3 Promotes equitable care and service delivery	19.09	802	19.23	594	18.74	166	19.67	51
5.4 Advocates for client access to resources and system changes	15.57	796	15.73	589	15.47	165	15.27	51
5.5 Navigates systems acknowledging the interdependence of policy, practice and systemic issues	13.72	784	13.89	579	13.24	164	13.03	51
5.6 Identifies and manages potential and real conflicts of interests, always acting in the client's best interest	16.66	795	16.66	588	17.08	165	16.14	50

Appendix B – Practice Analysis Statements

DOMAINS

Preamble

Nurse Practitioners are Registered Nurses with additional experience and nursing education at the Masters level, which enables them to autonomously diagnose and manage care across the lifespan in all practice settings. As advanced practice nurses, they use their in-depth knowledge and experience to analyze, synthesize, and apply evidence to make decisions. They apply theory and knowledge from nursing and other disciplines to provide a comprehensive range of essential services grounded in professional, ethical, and legal standards within a holistic model of care. Nurse Practitioners work across all domains of practice. They provide leadership and collaborate within and across communities, organizations, and populations to improve health and system outcomes. In some settings, Nurse Practitioners assume the role as the most responsible provider.

DOMAIN AREA I. CLINICIAN

Entry-level nurse practitioners (NPs) deliver safe, competent, compassionate, and ethical care with diverse populations and in a range of practice settings. NPs ground their care in evidence-informed practice and use critical inquiry in their advanced diagnostic and clinical reasoning.

A. Assessment

1. Establish the reason for the client encounter	
a. Ask pertinent questions to establish the presenting issues	I.A.1.a
b. Evaluate information relevant to the client's presenting concerns	I.A.1.b
c. Prioritize routine, urgent, emergent and life-threatening situations	I.A.1.c
d. Perform initial assessment of the client's condition	I.A.1.d

2. Obtain informed consent according to legislation and regulatory requirements	
a. Support client to make informed decisions, discussing risks, benefits, alternatives and consequences	I.A.2.a
b. Obtain informed consent for the collection, use and disclosure of personal and health information	I.A.2.b

3. Use critical inquiry to analyze and synthesize information to identify client needs, and to inform assessment and diagnosis	
a. Integrate information specific to the client's biopsychosocial, behavioral, cultural, ethnic, spiritual, circumstances, current developmental life stage, gender expression and social determinants of health considering epidemiology and population-level characteristics	I.A.3.a
b. Integrate findings from past and current health history and investigations	I.A.3.b
c. Apply current, credible, and reliable research, literature and standards to inform decision-making	I.A.3.c
d. Incorporate pharmacological history	I.A.3.d
e. Integrate client's wishes and directions related to advanced care planning, and palliative and end-of-life care	I.A.3.e

4. Conduct an assessment that is relevant to the client's presentation to inform diagnostic decisions	
a. Determine the need for conducting a focused or comprehensive assessment	I.A.4.a
b. Conduct an assessment using valid and reliable techniques and tools	I.A.4.b
c. Conduct an assessment with sensitivity to client's culture, lived experiences, gender identity, sexuality, and personal expression	I.A.4.c
d. Conduct a mental health assessment, applying knowledge of emotional, psychological, and social measures of well-being	I.A.4.d
e. Conduct a review of systems to identify pertinent presenting findings	I.A.4.e
f. Order and perform screening and diagnostic investigations, applying principles of resource stewardship	I.A.4.f

B. Diagnosis

1. **Integrate critical inquiry and diagnostic reasoning to formulate differential and most likely diagnoses**	
a. Interpret the results of investigations	I.B.1.a
b. Formulate differential diagnoses	I.B.1.b
c. Ascertain the client's understanding of assessment findings, diagnosis, anticipated outcomes, and prognosis	I.B.1.c
d. Determine the most likely diagnoses based on clinical and diagnostic reasoning	I.B.1.d

C. Management

1. **Use clinical reasoning to create a care plan based on diagnoses and the client's informed consent, preferences and goals**	
a. Examine, and explore with the client, options for managing the diagnoses	I.C.1.a
b. Consider availability, cost, determinants of health, clinical efficacy, and potential client adherence to determine feasibility and sustainability of the care plan	I.C.1.b
c. Address barriers that interfere with client's goals	I.C.1.c
d. Determine and prioritize interventions integrating client goals and preferences, resources, and clinical urgency	I.C.1.d
e. Provide and seek consultation from other professionals and organizations to support the care plan	I.C.1.e

2. Prescribe and counsel clients on pharmacological and non-pharmacological interventions, across the life span	
a. Complete accurate prescriptions in accordance with applicable jurisdictional and organizational requirements	I.C.2.a
b. Select evidence-informed pharmacological interventions based on diagnoses, concurrent client therapies, and available medication history, using drug-information systems	I.C.2.b
c. Complete medication reconciliation to make clinical decisions based on an analysis of the client's current pharmacological and non-pharmacological therapy	I.C.2.c
d. Analyze polypharmacy to identify unnecessary and unsafe prescribing, and deprescribing where possible	I.C.2.d
e. Incorporate principles of pharmacological stewardship	I.C.2.e
f. Establish a monitoring plan for pharmacological and non-pharmacological interventions	I.C.2.f
g. Counsel client on indications, benefits, cost, potential adverse effects, interactions, contraindications, precautions, adherence, required monitoring and follow-up	I.C.2.g

3. Perform invasive and non-invasive interventions as indicated by the care plan	
a. Explain procedures, including indications, potential risks and benefits, adverse effects, anticipated aftercare and follow up care	I.C.3.a
b. Perform procedures using evidence-informed techniques	I.C.3.b
c. Monitor and evaluate clinical findings, aftercare and follow up	I.C.3.c
d. Perform interventions to stabilize the client in urgent, emergent, and life-threatening situations	I.C.3.d

D. Counselling

1. Create a therapeutic relationship that is conducive to optimal health outcomes	
a. Utilize developmentally, socio-demographically, and culturally relevant strategies, communication and counselling techniques and tools	I.D.1.a
b. Evaluate effectiveness of therapeutic relationship and refer to appropriate professionals, as needed	I.D.1.b

2. Provide therapeutic interventions as indicated by the care plan	
a. Address impacts of potential and real biases on the creation of safe spaces	I.D.2.a
b. Integrate therapeutic counselling techniques to facilitate an optimal experience and outcome for the client	I.D.2.b
c. Recognize and respond to the expression of intense emotions in a manner that facilitates a safe and effective resolution	I.D.2.c
d. Provide trauma and violence informed care	I.D.2.d
e. Identify the presence of trauma, including intergenerational trauma, with the client	I.D.2.e

3. Apply harm-reduction strategies and evidence-informed practice to support clients with substance use disorder, while adhering to federal and provincial/territorial legislation and regulation	
a. Identify potential risks and signs of substance use disorders	I.D.3.a
b. Develop a harm-reduction care plan, considering treatment and intervention options	I.D.3.b
c. Apply evidence-informed and safe prescribing practices when initiating and managing pharmacological and non-pharmacological interventions	I.D.3.c
d. Adhere to legislation, regulation, and organizational policy related to the safe storage and handling of controlled drugs and substances	I.D.3.d
e. Provide education on the safe storage and handling of controlled drugs and substances	I.D.3.e

E. Transition of Care, Discharge Planning, and Documentation

1. Lead admission, transition of care, and discharge planning that ensures continuity and safety of client care	
a. Collaborate with client to facilitate access to required resources, drug therapy, diagnostic tests, procedures, and follow up to support the continuum of care	I.E.1.a
b. Facilitate transfer of information to support continuity of care	I.E.1.b
c. Facilitate client's access to community services and other system resources	I.E.1.c
d. Modify the care plan based on the client's transition needs	I.E.1.d

2. Conduct record keeping activities, according to legislation and jurisdictional regulatory requirements	
a. Document all client encounters and rationale for actions	I.E.2.a
b. Collect, disclose, use, and destroy health information according to privacy and confidentiality legislation, regulations and provincial/territorial regulatory standards	I.E.2.b
c. Apply relevant security measures to records and documentation	I.E.2.c
d. Recognize role as a health information custodian to ensure client information is secure and remains confidential	I.E.2.d

3. Provide safe, ethical, and competent services as a self-employed practitioner	
a. Employ accurate, honest, and ethical billing and advertising practices	I.E.3.a

4. Employ evidence-informed virtual care strategies	
a. Articulate the risks and benefits of virtual care to confirm the client's informed consent to participate in a virtual care visit	I.E.4.a
b. Maintain client's privacy during virtual encounters, and when transferring data and providing medical documents electronically	I.E.4.b
c. Determine when the client's health concern can be managed virtually without delaying or fragmenting care	I.E.4.c
d. Demonstrate an understanding of the limitations of virtual care when determining the need for in-person assessment and management	I.E.4.d
e. Adapt history-taking and assessment techniques to effectively complete the virtual client assessment	I.E.4.e
f. Use effective communication approaches in the virtual care environment	I.E.4.f

g. Integrate health care technologies and communication platforms to deliver virtual care	I.E.4.g
h. Adhere to requirements for communication and documentation for virtual client encounters	I.E.4.h

DOMAIN AREA II. QUALITY IMPROVEMENT AND RESEARCH/SCHOLAR

Entry-level nurse practitioners (NPs) use evidence, participate in research and Continuous Quality Improvement, and support knowledge translation.

1. Identifies gaps, appraises and applies evidence-informed resources, understands research methodologies	II.1
2. Discusses the practical benefits and possible applications of research with teams and partners	II.2
3. Recommends where research findings can be integrated into practice	II.3
4. Applies ethical principles and analyzes the context when implementing evidence-informed practice	II.4
5. Disseminates knowledge and evidence-informed findings with clients, teams and partners	II.5
6. Uses data and available forms of technology to identify risks and create opportunities to mitigate harm	II.6

DOMAIN AREA III. LEADER

Entry-level nurse practitioners (NPs) demonstrate collaborative leadership within the health care system. NPs strive for a culture of excellence and facilitate the development of effective teams and communication within complex health systems.

1. Engages in leadership to contribute to a culture of continuous improvement, safety and excellence	III.1
2. Builds partnerships to optimize health-care delivery	III.2
3. Uses principles of team dynamics, conflict resolution and change management to support effective collaboration and communication	III.3
4. Demonstrates awareness of tools and resources, and contributes to strategies for responding to disasters and unpredictable situations	III.4

DOMAIN AREA IV. EDUCATOR

Entry-level nurse practitioners (NPs) develop and provide education to a wide range of clients to enhance healthcare knowledge and influence positive outcomes.

Client, Community and Health-Care Team Education	
1. Develops and provides educational resources	IV.1
2. Evaluates learning and delivery methods to improve outcomes	IV.2
3. Develops and uses evidence-informed strategies and technologies to enhance learning	IV.3

DOMAIN AREA V. ADVOCATE

Entry-level nurse practitioners (NPs) understand the issues related to health inequity, diversity and inclusion in order to advocate for change to improve health. This includes client's culture, lived experience, gender identity, sexuality, and personal expression.

1. Demonstrates self-awareness and cultural humility to mitigate risk based on personal bias	V.1
2. Contributes to a practice environment that is diverse, equitable, inclusive and culturally safe	V.2
3. Promotes equitable care and service delivery	V.3
4. Advocates for client access to resources and system changes	V.4
5. Navigates various systems affecting client care acknowledging the interdependence of policy, practice and systemic issues	V.5
6. Identifies and manages potential and real conflicts of interests, always acting in the client's best interest	V.6