College of Registered Nurses of Alberta

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Entry-level Competencies for Nurse Practitioners

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The College and Association of Registered Nurses of Alberta (CARNA) is operating as the College of Registered Nurses of Alberta (CRNA).

This document is based on the Canadian Council of Registered Nurse Regulators (CCRNR) revised *Entry-level Competencies for Nurse Practitioners* (ELCs for NPs), which the CCRNR board endorsed on November 7, 2022. The CCRNR ELCs for NPs reflect inter-jurisdictional consistency to support the workforce mobility requirements of the Canadian Free Trade Agreement.

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Introduction

The entry-level competencies (ELCs) for nurse practitioners (NPs) reflect the foundational knowledge, skills and judgement required of NPs to provide safe, competent, ethical and compassionate care. While NPs' roles and responsibilities may vary by context and **CLIENT**[1] population, this document outlines the competencies that all NPs must possess to be competent when they begin practice.

Profile of the Entry-level NP

NPs are registered nurses (RNs) with additional experience and nursing education at the master's level, which prepares them to autonomously diagnose and manage care across the lifespan in a range of 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. NPs 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, NPs assume the role as the most responsible provider.

Purpose of the ELCs for NPs

NP ELCs reflect the knowledge, skills and judgement required of NPs to practise safely and ethically. Regulatory bodies use ELCs for a number of purposes, including but not limited to the following:

- approval/recognition of NP academic education programs
- assessment of internationally educated applicants
- assessment of applicants for the purpose of re-entry into the profession
- practice advice/guidance to clinicians
- reference for professional conduct matters
- public and employer awareness of the practice expectations of NPs

ELCs and Entry-level NP Practice

NP practice is dynamic and evolving. The NP ELCs encompass and build on the competencies of an RN and establish the foundation for NP practice. While the ELCs define entry-level NP practice, all NPs are accountable for meeting them throughout their careers.

[1] Words and phrases displayed in **BOLD CAPITALS** upon first mention are defined in the Glossary.

A nurse practitioner is considered "entry-level" on initial registration or licensure. Their practice draws on a theoretical and experiential knowledge base shaped by their RN practice and their NP education program. Entry-level NPs may require additional support from the employer and health-care team.

Principles and Assumptions for Entry-level NP Practice

The following overarching principles and assumptions inform how the ELCs influence the education and practice of entry-level NPs. The entry-level NP

- has a strong foundation in nursing theory and knowledge of health and sciences, humanities, research and ethics from formal graduate level programs;
- practises autonomously within legislation, practice standards, ethics and scope of practice in their jurisdiction;
- works within their scope of practice, and seeks guidance when they encounter situations beyond their individual competence;
- is prepared to practise safely, competently, compassionately and ethically
  - with all people across the lifespan,
  - with all clients - individuals, families, groups, communities and populations,
  - in a range of practice settings, and
  - across all domains of practice; and
- uses evidence and applies critical thinking throughout all aspects of practice.

Structure

The ELCs use a role-based framework that represents the multiple roles NPs assume when providing services in any practice setting. They are an interconnected set of competencies and indicators. For the sake of clarity and to avoid unnecessary repetition, key concepts are mentioned once and assumed to apply to all roles. While each role is presented separately, it is important to note that NPs may use aspects of more than one role at the same time.

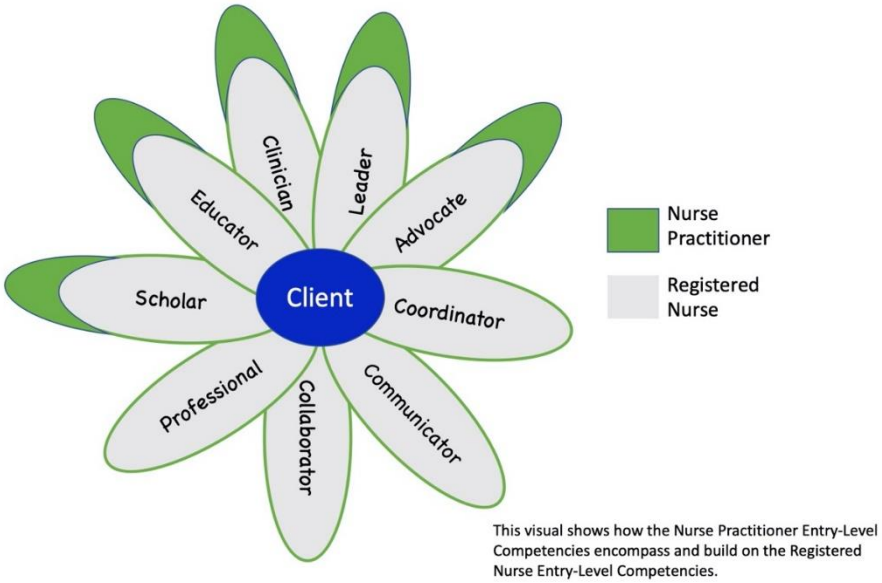
NP Role-based Competency Framework

Organized thematically in a role-based format, this document is similar to the RN ELCs. The NP ELCs encompass and build on the RN ELCs, focusing on distinct competencies for NPs. Performance indicators accompany the competencies.

There are a total of 29 competencies grouped thematically under five roles:

1. Clinician
2. Leader

3. Advocate
4. Educator
5. Scholar



Adapted from the Royal College of General Practitioners (2015).

Competencies

Competency Category 1: Clinician

NPs deliver safe, competent, compassionate and ethical care across the lifespan with diverse populations and in a range of practice settings. NPs ground their care in evidence-informed practice and use critical thinking in their advanced diagnostic and clinical reasoning.

Assessment

1.1. Establish the reasons for the client encounter to determine the nature of the services required by the client:

- **a.** Perform initial observational assessment of the client's condition.
- **b.** Ask pertinent questions to establish the presenting issues.
- **c.** Evaluate information relevant to the client's presenting concerns.
- **d.** Prioritize routine, urgent, emergent and life-threatening situations.

1.2. Obtain informed consent according to legislation and regulatory requirements:

- **a.** **CO-CREATE** with the client a shared understanding of scope of services, expectations, the client's strengths and limitations, and priorities.
- **b.** Support the client to make informed decisions, discussing risks, benefits, alternatives and consequences.
- **c.** Obtain informed consent for the collection, use and disclosure of personal and health information.

1.3. Use critical thinking to analyze and synthesize information from multiple sources to identify client needs and inform assessment and diagnosis:

- **a.** Establish a shared understanding of the client's culture, strengths and limitations.
- **b.** Integrate information specific to the client's biopsychosocial, behavioral, cultural, ethnic and spiritual circumstances, current developmental life stage, gender expression, and social determinants of health, considering epidemiology and population-level characteristics.
- **c.** Integrate findings from past and current health history and investigations.
- **d.** Apply current, credible and reliable research, literature and standards to inform decision-making.
- **e.** Collect pharmacological history, including over-the-counter products and **COMPLEMENTARY AND ALTERNATIVE MEDICINE** (prescribed and non-prescribed), including natural health products and traditional medicine.
- **f.** Support the client's wishes and directions related to advance care planning, and palliative and end-of-life care.

1.4. 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.
- **b.** Conduct an assessment using valid and reliable techniques and tools.

c. Conduct an assessment with sensitivity to client's culture, lived experiences, **GENDER IDENTITY**, sexuality and personal expression.

d. Conduct a mental-health assessment, applying knowledge of emotional, psychological and social measures of well-being.

e. Conduct a review of systems to identify pertinent presenting findings.

f. Order and perform screening and diagnostic investigations, including **POINT-OF-CARE TESTING**, applying principles of resource stewardship.

Diagnosis

1.5. Integrate critical thinking and diagnostic reasoning to formulate differential diagnoses and final diagnoses:

a. Interpret the results of investigations.

b. Generate **DIFFERENTIAL DIAGNOSES** based on data analysis.

c. Create a shared understanding of assessment findings, diagnoses, anticipated outcomes and prognosis.

d. Determine the leading diagnosis based on clinical and diagnostic reasoning.

Management

1.6. Use clinical reasoning to create a shared management plan based on diagnoses and the client's preferences and goals:

a. Examine, and explore with the client, options for managing the diagnoses.

b. Consider availability, cost, determinants of health, clinical efficacy and potential client adherence to determine feasibility and sustainability of the management plan.

c. Determine and prioritize interventions integrating the client's goals and preferences, resources and clinical urgency.

d. Provide and seek consultation from other professionals and organizations to support client management.

e. Use technology to deliver health-care services after considering the appropriateness of **VIRTUAL CARE** services, environmental factors, the nature of the service, the security of the system, alternative approaches and contingency plans.

f. Use electronic health records and tracking systems to accurately collect and document client information and delivery of health services.

1.7. Prescribe and counsel clients on pharmacological and non-pharmacological interventions across the lifespan:

a. Follow legislative, regulatory and organizational requirements, when prescribing pharmacological and non-pharmacological interventions.

b. Select evidence-informed pharmacological interventions based on diagnoses, concurrent client therapies and available medication history, using drug-information systems.

c. Utilize prescription monitoring and reporting programs according to jurisdictional and legislative requirements.

d. Complete medication reconciliation to make clinical decisions based on an analysis of the client's current pharmacological and non-pharmacological therapy.

e. Analyze **POLYPHARMACY** to identify unnecessary and unsafe prescribing, and deprescribe where possible.

f. Recommend or order evidence-informed non-pharmacological interventions and complementary, alternative and natural health products based on client preference, history and cultural practice.

g. Incorporate principles of pharmacological stewardship.

h. Establish a monitoring plan for pharmacological and non-pharmacological interventions.

i. Counsel the client on pharmacological and non-pharmacological interventions, including indication, benefits, cost, potential adverse effects, interactions, contraindications, precautions, reasons to adhere to the prescribed regimen, required monitoring and follow-up.

1.8. Perform invasive and non-invasive interventions appropriate to the area of practice as indicated by the management plan and according to the standards of practice:

a. Co-create with the client an understanding of procedures, including indications, potential risks and benefits, adverse effects, anticipated aftercare and follow-up care.

b. Must have the competency to perform the procedure using evidence-informed techniques.

c. Monitor and evaluate clinical findings, aftercare and follow-up.

d. Initiate interventions to stabilize the client in urgent, emergent and life-threatening situations.

1.9. Evaluate effectiveness of the management plan to identify required modifications and/or terminations of treatment:

a. Develop a systematic and timely process for monitoring the client's progress, and follow-up on results and interventions.

b. Evaluate responses to the management plan in collaboration with the client and revise the management plan as needed.

c. Discuss and implement follow-up to facilitate continuity of care in collaboration with the client.

d. Facilitate implementation of the management plan with the client, family, other health professionals and community partners.

e. Facilitate referral to another practitioner or service if the client would benefit from the consultation, or if the client-care needs are beyond the NP's individual competence or scope of practice.

Counselling

1.10. Develop a therapeutic counselling relationship that is conducive to optimal health outcomes:

a. Develop with the client a shared understanding of scope of services, expectations, client's strengths and limitations, and priorities.

b. Identify barriers that interfere with client's goals.

c. Use developmentally, socio-demographically and culturally relevant communication techniques and tools.

d. Evaluate effectiveness of the counselling relationship and refer to appropriate professionals when needed.

1.11. Provide counselling interventions as indicated by the management plan:

a. Integrate theories of cognitive and emotional development across the lifespan.

b. Identify impact of potential and real **BIASES** for the creation of safe spaces.

c. Integrate **THERAPEUTIC USE OF SELF** to facilitate an optimal experience and outcome for the client.

d. Anticipate and respond to the expression of intense emotions in a manner that facilitates a safe and effective resolution.

e. Consider the impact of the client's personal and **CONTEXTUAL FACTORS**.

f. Provide care using **TRAUMA AND VIOLENCE-INFORMED APPROACHES**.

g. Identify root causes of trauma, including **INTERGENERATIONAL TRAUMA**, with the client and refer to appropriate professionals.

h. Manage **TRANSFERENCE** and **COUNTERTRANSFERENCE** in therapeutic relationships.

1.12. Apply harm-reduction strategies and **CULTURALLY SAFE** evidence-informed practices 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 disorder.
- **b.** Co-create a harm-reduction management plan, considering treatment and intervention options.
- **c.** Apply evidence-informed and safe prescribing practices when initiating and managing pharmacological and non-pharmacological interventions.
- **d.** Adhere to legislation, regulation and organizational policy related to the safe storage and handling of controlled drugs and substances.
- **e.** Provide education on the safe storage and handling of controlled drugs and substances.

Transition of Care, Discharge Planning and Documentation

1.13. Lead admission, transition of care (including ending the therapeutic nurse-client relationship) 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.
- **b.** Facilitate transfer of information to support continuity of care.
- **c.** Facilitate client's access to community services and other system resources.
- **d.** Monitor and modify the management plan based on the client's transition needs.

1.14. Conduct record keeping activities, according to legislation and jurisdictional regulatory requirements:

- **a.** Document all client encounters and rationale for actions to facilitate continuity of care.
- **b.** Access, collect, disclose, use, store, retain and destroy personal and health information according to all legislation, regulations and jurisdictional regulatory standards (e.g., occupational health and safety, freedom of information, protection of privacy, etc.).
- **c.** Apply relevant security measures to records and documentation.

1.15. Provide safe, ethical and competent services as a self-employed practitioner:

- **a.** Engage in ethical practices that adhere to jurisdictional and federal legislation, regulations, guidelines and ethical standards for nursing.
- **b.** Use accurate, honest and ethical billing and advertising practices.

c. Act as a health information custodian to ensure client information is secure and remains confidential.

d. Identify and manage potential and real conflicts of interest, always acting in the client's best interest.

1.16. Use 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.

b. Maintain client's privacy during virtual encounters, and when transferring data and providing medical documents electronically.

c. Determine when the client's health concern can be managed virtually without delaying or fragmenting care.

d. Understand the limitations of virtual care when determining the need for in-person assessment and management.

e. Adapt history-taking and assessment techniques to effectively complete the virtual client assessment.

f. Use effective communication approaches in the virtual care environment.

g. Integrate health-care technologies and communication platforms to deliver virtual care.

h. Adhere to requirements for communication and documentation for virtual client encounters.

Competency Category 2: Leader

NPs demonstrate collaborative leadership within the health-care system locally, regionally, nationally and globally. They are leaders in the development, implementation and delivery of continuity-based person-centered care. NPs serve as role models and mentors, demonstrating leadership to advance continuous improvement of client outcomes and health systems. They contribute to implementing and maintaining a high-quality health-care system through innovation and policy development. They strive for a culture of excellence and facilitate the development of effective teams and communication within complex health systems.

2.1 Demonstrate leadership that contributes to high quality health-care system:

a. Build partnerships with inter- and intra-professional and **INTERSECTORAL TEAMS**, individuals, communities and organizations to achieve common goals and shared vision.

- **b.** Demonstrate situational awareness when conducting a critical analysis of individual, team and organizational functioning.
- **c.** Engage in and encourage others in demonstrating transparent communications to support a culture of trust.
- **d.** Use principles of team dynamics and conflict resolution to support effective collaboration.
- **e.** Support, direct, educate and mentor colleagues, students and others to build capacity, competence and confidence.
- **f.** Share expertise within and across teams.
- **g.** Demonstrate environmental, financial and resource stewardship to promote a sustainable health system.

2.2 Contribute to a culture of improvement, safety and excellence:

- **a.** Engage in environmental scanning to identify future needs of the client and/or health-care system.
- **b.** Participate in and lead quality and risk management initiatives to identify system issues and improve delivery of services.
- **c.** Use established benchmarking and best practices to establish goals to facilitate system changes.
- **d.** Develop, modify and implement quality management tools and strategies to collect and track quality improvement data.
- **e.** Recommend changes to enhance outcomes based on continuous quality improvement principles.
- **f.** Communicate quality improvement outcome data and recommendations to advance knowledge, change practice and enhance effectiveness of services.
- **g.** Anticipate and respond to unfamiliar, complex and unpredictable situations.
- **h.** Advocate for policies for safe and healthy practice environments.

2.3 Design, implement and evaluate health promotion and disease prevention programs:

- **a.** Engage in environmental scanning to anticipate global, public and population health trends.
- **b.** Propose health promotion and disease prevention programs based on trends, data, literature, identified client needs and research.
- **c.** Apply informatics when using data, information and knowledge to engage in health surveillance activities.

d. Lead implementation of evidence-informed strategies for health promotion, and primary, secondary and tertiary disease prevention programs.

e. Promote awareness of social determinants of health and important health issues.

f. Facilitate use of relevant public health resources.

g. Develop and implement disaster- and pandemic-planning protocols and policies.

h. Evaluate programs and strategies, and recommend modifications based on evidence-informed rationale.

Competency Category 3: Advocate

NPs influence and improve the health and well-being of their clients, communities and the broader populations they serve. They address issues related to **HEALTH INEQUITY**, culture, diversity and inclusion to improve health outcomes and lead advocacy efforts to change policies and legislation.

3.1 Practise self-awareness to minimize personal bias based on social position and power:

a. Demonstrate **CULTURAL HUMILITY** and examine own assumptions, beliefs, and privileges, and challenge biases, stereotypes and prejudice.

b. Address the effects of the unequal distribution of power and resources on the delivery of services.

c. Demonstrate respect, open and effective dialogue, and mutual decision-making.

d. Evaluate and seek feedback on own behaviour.

3.2 Contribute to a practice environment that is diverse, equitable, inclusive and psychologically and culturally safe.

a. Recognize that everyone has their own unique experiences of discrimination and oppression.

b. Demonstrate awareness of and sensitivity to the client's culture, lived experiences, gender identity, sexuality and personal expression.

c. Address situations when observing others behaving in a racist or discriminatory manner.

d. Integrate the client's understanding of health, well-being and healing into the plan of care.

e. Involve the persons or communities that are important to the client.

f. Collaborate with local partners and communities, including interpreters and leaders.

g. Engage in critical dialogue with other stakeholders to create positive change.

3.3 Provide culturally safe, **ANTI-RACIST** care for **INDIGENOUS PEOPLES**:

a. Identify the historical and ongoing effects of **COLONIALISM** and settlement on the health-care experiences of Indigenous Peoples.

b. Acknowledge, analyze and understand the ongoing negative and disproportionate effects of systemic and historical oppression on Indigenous Peoples.

c. Recognize that Indigenous languages, histories, heritage, cultural and healing practices, and **WAYS OF KNOWING** may differ between Indigenous communities.

d. Demonstrate cultural humility and examine own values, assumptions, beliefs and privileges that may impact the therapeutic relationship with Indigenous Peoples.

e. Utilize the principles of self-determination and support the Indigenous client in making decisions that affect how they want to live their life.

f. Acknowledge the Indigenous person's cultural identity, seek to understand their lived experience, and provide time and space needed for discussing needs and goals.

g. Identify, integrate and facilitate the involvement of cultural resources, families and others such as community elders, traditional knowledge keepers, cultural navigators and interpreters when needed and/or requested.

h. Evaluate and seek feedback on own behaviour towards Indigenous Peoples.

3.4 Promote equitable care and service delivery:

a. Navigate systemic barriers to enable access to resources.

b. Challenge biases and social structures related to systemic oppression.

c. Respond to the social, structural, political and ecological determinants of health, well-being and opportunities.

d. Address situations and systems of inequity and oppression within own sphere of influence.

e. Address impact of unequal distribution of power and resources on the delivery of services.

3.5 Advocate for access to resources and for system changes that demonstrates cultural safety and humility:

a. Support the development of resources and education that address **ANTI-RACISM** and oppression.

b. Advocate for environments and policies that support equitable access to care.

c. Raise awareness of limitations and bias in information and systems.

d. Raise clients' awareness of their right to access quality care.

3.6 Support the development of policies and legislation to improve health:

a. Understand the interdependence of policy and practice.

b. Recommend evidenced-informed strategies that influence policy changes.

c. Evaluate the impact of policies and legislation on health and health equity.

d. Communicate information from multiple sources in a logical and comprehensive, yet concise manner.

e. Contribute to the development of policies and legislation.

Competency Category 4: Educator

NPs develop and provide education to a wide range of individuals, groups, communities and organizations to enhance knowledge and influence nursing practice, health outcomes and system change.

4.1 Develop and provide education to build capacity and enhance knowledge and skills:

a. Apply teaching and learning theories to develop, modify, deliver, implement and evaluate education materials and programs.

b. Design evidence-informed educational material and program content.

c. Integrate technology to enhance learning experiences and information delivery.

d. Mentor others to develop skills to deliver education.

4.2 Evaluate the learning and delivery methods to improve outcomes:

a. Develop and use evaluation instruments to evaluate knowledge acquisition.

b. Analyze and synthesize evaluation data to inform modifications to the education content and delivery approach.

c. Coach others in evaluating and improving education materials and outcomes.

Competency Category 5: Scholar

NPs seek out, participate in and demonstrate leadership in research activities to evaluate, explore and advance knowledge, and support **KNOWLEDGE TRANSLATION** in all domains of nursing.

5.1 Contribute to research initiatives to promote evidence-informed practice:

- **a.** Seek out collaborative research relationships and partners.
- **b.** Understand the connection between research and advanced practice.
- **c.** Identify knowledge gaps to determine research priorities.
- **d.** Adhere to ethical principles, including the **FIRST NATIONS PRINCIPLES OF OWNERSHIP, CONTROL, ACCESS AND POSSESSION**.
- **e.** Conduct research using valid and reliable methodologies.
- **f.** Analyze research findings to draw valid and reliable conclusions.

5.2 Promote knowledge translation of research findings to improve health care and system outcomes:

- **a.** Discuss the practical benefits and possible applications of research with teams and partners.
- **b.** Recommend integration of research findings into practice.
- **c.** Share research findings with clients, groups, communities and organizations.
- **d.** Apply research findings to develop standards, guidelines, practices and policies that improve client care and strengthen health-care systems.
- **e.** Exhibit leadership in implementing new practice approaches based on research findings.
- **f.** Use research evidence to support practice and system changes.

Glossary

ANTI-RACISM (ANTI-RACIST) – The practice of actively identifying, challenging, preventing, eliminating and changing the values, structures, policies, programs, practices and behaviours that perpetuate racism. It is more than just being "not racist" but involves taking action to create conditions of greater inclusion, equality and justice (Turpel-Lafond, 2020).

BIASES – Ways of thinking or operating based explicitly or implicitly on a stereotype or fixed image of a group of people (Turpel-Lafond, 2020).

CLIENT(S) – The term client(s) can refer to patients, residents, families, groups, communities and populations.

CO-CREATE – Engaging in an intentional relationship for the purpose of creating something together. It goes beyond collaboration and client-focused care, as it requires the dynamics of the relationship to build something. It means that clients and nurses are equal partners and share power in the relationship (Hemberg & Bergdahl, 2019).

COLONIALISM – Occurs when groups of people come to a place or country, steal the land and resources from Indigenous Peoples, and develop a set of laws and public processes that are designed to violate the human rights of the Indigenous Peoples, violently suppress their governance, legal, social and cultural structures, and force them to conform with the colonial state (Turpel-Lafond, 2020).

COMPLEMENTARY AND ALTERNATIVE MEDICINE – The terms "complementary medicine" and "alternative medicine" refer to a broad set of health-care practices that are not part of that country's own traditional or conventional medicine and are not fully integrated into the dominant health-care system (World Health Organization, 2019).

CONTEXTUAL FACTORS – There are three layers of contextual factors:

- Micro contextual factors involve the client's immediate environment – their own health status, family, friends and their physical environment.
- Meso contextual factors involve the policies and processes embedded in the organization and health system that affect the client.
- Macro contextual factors involve the larger socioeconomic and political context around the client – social and cultural values and beliefs, laws and public policies.

(Association of Canadian Occupational Therapy Regulatory Organizations, Association of Canadian Occupational Therapy University Programs, & College of Occupational Therapists of Ontario, 2021)

COUNTERTRANSFERENCE – The nurses' reactions to a client that are based on the nurses' unconscious needs, conflicts, problems and views of the world (Austin & Boyd, 2010).

CULTURAL HUMILITY – "A process of openness, self-awareness, being egoless, and incorporating self-reflection and critique after willingly interacting with diverse individuals" (Foronda et al., 2016).

CULTURALLY SAFE – An outcome based on respectful engagement free from racism and discrimination so that the patient is a powerful player, not a passive receiver of health care (Yeung, 2016).

DIFFERENTIAL DIAGNOSIS – A list of conditions that share the same symptoms to help make a final diagnosis (official diagnosis). The differential diagnosis will direct the NP to offer tests to rule out conditions and lead them to find the cause of the symptoms. (Cleveland Clinic, N.D.).

FIRST NATIONS PRINCIPLES OF OWNERSHIP, CONTROL, ACCESS AND POSSESSION – (More commonly known as OCAP®) Asserts that First Nations have control over data collection processes, and that they own and control how this information can be used (First Nations Information Governance Centre, n.d.).

GENDER IDENTITY – A person's internal and deeply felt sense of being man or woman, both, neither or somewhere along the gender spectrum. A person's gender identity may or may not align with the gender typically associated with the sex they were assigned at birth. Gender identity is not necessarily visible and is not related to sexual orientation (Government of Canada, 2019).

HEALTH INEQUITY – The presence of systematic disparities in health (or in the major social determinants of health) among groups with different social advantage/disadvantage (Turpel-Lafond, 2020).

INDIGENOUS PEOPLES – The first inhabitants of a geographic area. In Canada, Indigenous Peoples include those who may identify as First Nations (status and non-status), Métis and/or Inuit (Turpel-Lafond, 2020).

INTERGENERATIONAL TRAUMA – Historic and contemporary trauma that has compounded over time and been passed from one generation to the next. The negative cumulative effects can impact individuals, families, communities and entire populations, resulting in a legacy of physical, psychological and economic disparities that persist across generations. For Indigenous Peoples, the historical trauma includes trauma created as a result of the imposition of assimilative policies and laws aimed at attempted cultural genocide and continues to be built upon by contemporary forms of colonialism and discrimination (Turpel-Lafond, 2020).

INTERSECTORAL TEAMS – A group of people from different sectors of society working together to improve the health of populations. Intersectoral collaboration is the joint action taken by health and other government sectors, as well as representatives from private, voluntary and non-profit groups to improve the health of populations. Intersectoral action takes different

forms such as cooperative initiatives, alliances, coalitions or partnerships (Government of Canada, Public Health Agency, 2016.).

KNOWLEDGE TRANSLATION – A dynamic and iterative process that includes synthesis, dissemination, exchange and ethically-sound application of knowledge to improve the health of clients and provides more effective health services and products and strengthen the health-care system (Canadian Institutes of Health Research, 2016).

POLYPHARMACY – The routine use of four or more over-the-counter, prescription and/or traditional medications at the same time by a patient (World Health Organization, 2017).

POINT-OF-CARE TESTING – Refers to diagnostic tests performed at or near the patient's location by health-care professional or other qualified personnel. It can include tests conducted by the patient themselves at home or a community setting (Cowling & Dolcine, 2017).

THERAPEUTIC USE OF SELF – A values-based skill that practitioners possess to the benefit of the client (Currid & Pennington, 2010).

TRANSFERENCE – The client's experience of feelings toward the nurse that were originally held toward significant others in their life (Halter, 2014).

TRAUMA AND VIOLENCE-INFORMED APPROACHES – Policies and practices regarding the provision of services and programming that include a violence informed approach, work to minimize harm to victims of violence, and aid healing and justice (Ponic et al., 2016).

VIRTUAL CARE – Refers to any interaction between client and/or members of their circle of care, occurring remotely, using any form of communication or information technology, with the aim of facilitating or maximizing the quality and effectiveness of client care (Alberta Virtual Care Working Group, 2021). Virtual care technologies are those forms of technology that allows 'virtual' interactions with health-care professionals to occur in real time from virtually any location. Services provided using virtual care technologies range from simple to complex. Examples of simple technologies may include telephone, text, messenger or email, etc. Examples of complex technologies may include, but are not limited to, live, two-way audio/video conferencing or virtual visits, teleradiology, telerobotics, remote control surgical instrumentation (CMA, 2020).

WAYS OF KNOWING – Indicates the vast variety of knowledge that exists across diverse Indigenous communities and signals that learning goes beyond human interaction and relationships to include learning from other elements of creation such as the plant and animal nations, and to "objects" that many people consider to be inanimate (Queen's University, Office of Indigenous Initiatives, 2020).

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