

2006

# SCOPE OF NURSING PRACTICE: DEFINITION, DECISION-MAKING & DELEGATION



Association of  
**Registered Nurses**  
of Newfoundland  
and Labrador



The Regulatory Document was approved by ARNNL Council in 2006 and replaces *Scope of Practice* (1995) and *Advanced Nursing Medical Nursing Shared Skills* (1993).

## Acknowledgements

Members of the ARNNL Scope of Practice Committee:

*Glenda Compton, BN, MN*

Eastern Regional Integrated Health Authority

*Brenda Tobin, RN, MN*

Centre for Nursing Studies-Eastern Regional Integrated Health Authority

*Patricia Rodgers, RN, BVocEd, CNCC(c)*

General Hospital, Eastern Regional Integrated Health Authority

*Sherry McCarthy, BN, RN*

Health & Community Services, Western Regional Integrated Health Authority

*Kathy Chubbs, RN*

Labrador Health Centre, Labrador-Grenfell Regional Integrated Health Authority

*Lynn Power, RN, MN*

Association of Registered Nurses of Newfoundland & Labrador Resource

In addition to this document, ARNNL has a number of other publications that provide direction to nurses and their employers on scope of nursing practice. They can be downloaded free from the ARNNL website, [www.amnl.ca](http://www.amnl.ca), or are available at cost from ARNNL Office.

- *Guidelines Regarding Shared Scope of Practice with Licensed Practical Nurses (2000).*
- *Performance of Nursing Procedures by Support Workers in Community Settings (2003).*
- *Competencies in the Context of Entry-Level Registered Nurse Practice, 2007-2010 (2006)*
- *The Professional Regulatory Framework for Nurse Practitioners Province of Newfoundland and Labrador (2001, currently under review).*



## Table of Contents

Acknowledgments .....	i
Introduction .....	1
Scope of Nursing Practice: Definition .....	2
Scope of Nursing Practice: Decision-Making Process .....	6
Scope of Nursing Practice: Delegation .....	11
Resource List .....	12
Appendix A Definitions .....	14
Appendix B Broad Stakeholder Responsibilities .....	16
Appendix C Scope of Nursing Practice Review Template .....	17
Appendix D Specific Registered Nurse Responsibilities .....	18
Appendix E Specific Agency Responsibilities .....	19
Appendix F Guidelines for the Development of Educational Programs for Specialty and/or Shared Nursing Competencies .....	20



## Introduction

The primary mandate of the Association of Registered Nurses of Newfoundland and Labrador (ARNNL) is to act as an advocate for the public in the delivery of safe, competent, and ethical nursing care. Rapid advancements in health knowledge and technology, along with the introduction of new approaches to health care delivery and new types of health care workers, have necessitated that the ARNNL engage in an ongoing review of its process for defining and determining the scope of nursing practice.

This new ARNNL document, **Scope of Nursing Practice: Definition, Decision-Making, & Delegation**, defines the scope of practice for Registered Nurses in Newfoundland and Labrador and outlines the decision-making framework that agencies are to use when they are evaluating the merit of introducing specific nursing competencies within the practice of nurses employed in their organization. As such, this document serves as the interpretation for:

### **Nursing Practice Standard**

Registered Nurses must *“function within the legally recognized scope of practice of nursing and within all relevant legislation.”*

This new scope of practice decision-making framework delegates the decision-making authority for specialty and shared competencies from the ARNNL, College of Physicians and Surgeons of Newfoundland and Labrador (CPSNL), and any other applicable health professional regulatory associations, to the agency(s) and registered nurses involved in incorporating the particular competency into nursing practice. The framework is based upon a principle-based approach to professional practice and outlines individual registered nurse and agency accountabilities.

The principles are illustrated as a series of questions and/or criteria designed to stimulate critical evaluation of any proposed scope of nursing practice changes. Agencies must develop or adopt a standard review process for their organization as a means of ensuring a consistent, comprehensive, and professional review of all requests to change the scope of nursing practice. This review must be done in accordance with the ARNNL principles outlined in this document. A step-by-step process is presented to promote consistency between agencies/health care authorities. This process is designed to ensure public safety and competent nursing practice by mandating that input be sought from all relevant professionals, contextual issues are thoroughly explored, and the necessary safeguards, including nursing education and policy, are established.

This document is divided into three sections. In the first section the scope of nursing practice is described. The second addresses the process for scope of practice decision-making related to specialty, shared, and new/emerging nursing competencies. The third section provides specific direction to nurses, employers, and other health professionals on the processes for delegation of specific competencies to registered nurses.



# Scope of Nursing Practice: Definition

## **Nursing Practice**

The scope of nursing practice is defined as the range of roles, *functions, responsibilities, and activities which registered nurses are educated and authorized to perform.*

The broad scope of nursing practice reflects all of the roles and activities undertaken by registered nurses to address the full range of human experiences and responses to health and illness. This includes: health promotion, health protection, health maintenance, health restoration, rehabilitation, and palliation.

Nursing practice is directed towards the goal of assisting clients to achieve and maintain optimal health in order to maximize quality of life across the lifespan (ARNNL, 1995; CNA, 2002). Client, referring also to patient and resident, is defined as an individual, a family, a group of individuals, a community, or a population. Nursing practice is accomplished through:

- Utilization of nursing knowledge through the application of critical thinking, judgment and skill. It is grounded in the principles of nursing, medicine, social and public health sciences and expressed as the art of nursing.
- Adoption of a holistic approach to care, addressing the biological, psychological, social, and spiritual needs of clients.
- Promotion of client self-reliance and self-determination by actively involving the client as a partner in all aspects of care.
- Use of nursing theories to define and organize practice and the nursing process to comprehensively assess, diagnose, plan, implement, evaluate, and document client care.
- Application of the model of nursing care delivery adopted within the agency or practice setting.
- Collaboration with other members of the health care team and partnering with diverse sectors of the community.
- Advocating for and/or creating quality health care systems, population health, and healthy public policy.
- Adherence to relevant legislation, professional guidelines, including the *Standards for Nursing Practice in Newfoundland and Labrador* (ARNNL, 1995) and the *Code of Ethics for Registered Nurses* (CNA, 2002), and in accordance with applicable employer policies.

To be responsive to the evolving health-related needs of the public, the boundaries of the scope of nursing practice must be flexible. Nursing practice takes place in the context of continuing change and development resulting from advances in research and technology, the introduction of new approaches to care delivery, and a greater variety of practitioners sharing more areas of common ability. The dynamic nature of the health care environment requires that nurses respond to client's needs by continually expanding their knowledge and skills and making judgments about the limits of their practice.

The overall scope of nursing practice refers to the outer limits or boundaries for the profession and everything therein. The actual scope of practice of individual nurses is always narrower than that of the scope of the nursing profession as a whole. The scope of practice of the individual nurse is influenced by the nurses' knowledge, practice setting, employer requirements, and client needs (CNA, 2002c). It is often described in job descriptions and/or illustrated in practice settings as competencies.



### Advanced Nursing Practice (ANP)

ANP roles have evolved in response to the changing needs of clients and society, and trends in the delivery of health care. Advanced nursing practice is within the regulated scope of nursing practice, however, advanced practice nurses constantly challenge and extend the boundaries of nursing practice.

At a national level, the Canadian Nurses Association (CNA) and jurisdictional members, including ARNNL, have approved concepts put forth in *Advanced Nursing Practice – A National Framework* (2002). This document defines Advanced Nursing Practice and identifies nine characteristics of ANP that must be consistently evident for a practice to be considered advanced. In this way the CNA ANP framework contributes to defining the boundaries of the scope of nursing practice.

Some advanced nursing practice competencies include activities that, in the past, were exclusive to the scope of another health care profession (e.g. prescriptive authority). Nurse practitioner (NP) roles are in this category. In Newfoundland and Labrador, NP roles are the most prominent ANP roles. Nurses in NP roles have moved along the continuum of experience and education and have acquired new competencies that are incorporated into their practice. These roles are examples of how the scope of nursing practice changes over time. ARNNL, through the *Registered Nurses Act and Regulations*, recognizes and licenses NPs - Primary Health Care and NPs – Specialist. The NP license is a regulatory safeguard that addresses public protection and authorizes NP practice in the new competency areas of health assessment, diagnosis, treatment, and health care management. NPs are also authorized to perform activities approved through delegation of function, provided the appropriate criteria are met as outlined in this document.

For further information on advanced practice competencies see the most recent version of the ARNNL's, *The Professional Regulatory Framework for Nurse Practitioners Province of Newfoundland and Labrador*.

### Competencies

Competencies are defined as the *integrated knowledge, skills, attitudes, and judgment required to safely and effectively practice nursing*. Competencies are more specific than scope of practice statements and reflect what is required of the registered nurse to function in a specific role or practice setting. The term competency, versus the word skill, reflects the level of critical thinking and knowledge involved in nursing interventions.

### Classification

Nursing competencies are classified into four categories:

- **Entry to Practice Nursing Competencies** are identified as the knowledge, attitudes, judgment, critical thinking, communication, and psychomotor interventions, expected of the entry-level registered nurse. These competencies are acquired through a basic nursing education program and are in accordance with the Requirements outlined in the current version of the ARNNL document, *Competencies in the Context of Entry-Level Registered Nurse Practice*.

*Examples:* wound care, counseling, and health assessment.

- **Specialty Nursing Competencies** are identified as activities currently practiced and new/emerging interventions that involve a higher level of complexity than entry level competencies in application and/or critical thinking. The concepts underlying these competencies may have been introduced in a basic nursing education program but further learning and/or experience must be obtained through continuing education before these competencies can be implemented in clinical practice.

*Examples:* removal of chest tubes, administering chemotherapy, changing established outer tracheotomy tubes, counseling clients with acute mental illness, community development, and competencies used in emerging roles such as complementary therapy (e.g. healing touch), esthetic services (e.g. collagen therapy), and select skills needed for roles involving advanced technology such as telehealth.



In keeping with the direction of the Canadian Nurses Association, the label advanced is reserved for **advanced** practice roles e.g. Clinical Nurse Specialist or Nurse Practitioner. Nursing competencies that had been classified as advanced nursing and/or medical nursing shared skills, as well as new and emerging interventions, are re-named as specialty competencies.

- **Shared Competencies** are identified as health related client interventions that are determined to be within the scope of practice of more than one health care profession. These competencies may be shared between nursing and other disciplines such as medicine or allied health professionals. Shared competencies may be performed by either professional(s) competent in the skill and authorized to do so through agency policy.

*Examples:* Medication administration is a shared competency of Registered Nurses and Licensed Practical Nurses. Maintenance of airways is a shared competency with Respiratory Therapists. Immunization is a shared competency with Physicians. Counseling is a shared competency with Social Workers.

- **Non-Delegated Competencies** are identified as activities that are articulated in legislation, or directives arising out of legislation e.g. regulations and/or agency by-laws, to be the exclusive domain of a particular profession or professions. Authority to perform competencies in this category by members of another discipline requires a change in the related legislation or delegation of function. Collaboration with the ARNNL and other relevant professional regulatory authorities (e.g. CPSNL) is required before a nurse can perform competencies identified to be non-delegated. (**See page 11** for more information).

*Examples:* prescriptive authority, examination of individuals detained under the Mental Health Act.

### Portability

Portability refers to the ability of a nurse, who is competent in a particular intervention, to safely perform the competency with a different client population or in another practice setting. The decision to perform a competency in a different area of practice must reflect best practices, self-assessment of competency, and be supported by agency policy. If these criteria are not met, the competency should not be considered portable. Before a nurse performs any competency, he/she must be familiar with the policies and guidelines for performing the competency within the specific setting and seek required information and support if he/she has not obtained proficiency in the relevant competency.

*Examples:* If a nurse obtains proficiency in the competency of venipuncture or irrigation of a nephrostomy tube while employed in an institution, he/she can continue to perform these skills in the community, if the practice is supported as a nursing intervention in the new setting. Likewise, the nurse moving from community health into an institution may be able to continue to provide immunizations. The skill of removing central venous catheter lines may be deemed to be portable for a nurse transferring from ICU to a medical unit, if he/she maintains competency and the practice is supporting by agency policy.

### Listing

A provincial ARNNL list of specialty, shared or non-delegated competencies is no longer collected or published. The ARNNL document, *Advanced Nursing and Medical Nursing Shared Skills*, which included a list of advanced and medical nursing shared skills has been rescinded. RNs are expected to be aware of the competencies for which they are proficient and are approved for nursing in their area of practice. Agencies are expected to keep a record of the competencies that are approved to be within the scope of practice for nurses within their own health authority.

Non-delegated competencies are identified within the numerous pieces of legislation, regulations, and by-laws for the various disciplines and health related organizations in our province. There is no consolidated provincial listing of non-delegated competencies. ARNNL consultants are available to any agency wishing assistance in determining if a particular competency may be restricted to another discipline and/or if a competency is appropriate to consider for nursing. ARNNL will continue to develop and identify competencies required for initial RN and NP licensure purposes, in collaboration with the schools of nursing and other stakeholders.





### Role Preparation

Nurses obtain the competencies required to practice nursing through basic and continuing education, including formal and informal learning opportunities. Basic nursing education programs prepare generalists, rather than specialists, to engage in beginning nursing practice. Basic nursing education includes academic content in nursing, the humanities, and the physical and social sciences. This knowledge is utilized in providing evidence-based or best-practice nursing care to clients in various practice settings throughout the basic nursing program. These programs enable students to acquire the knowledge, skills, and attitudes required for entry-level practice and to pursue life-long learning. For more information see the current version of the ARNNL document, *Competencies in the Context of Entry-Level Registered Nurse Practice* and/or contact one of the provincial schools of nursing.

Nursing practice ranges on a continuum from novice to expert (Benner, 1984). Beginning practitioners enter nursing practice at the novice level. Nurses develop along this continuum through experience and continuing formal and informal education. Informal education includes active involvement in such activities as: self-directed reading/study; unit level presentations; case study analysis; attendance at workshops, seminars, in-services, nursing rounds; and membership in special interest groups. Formal continuing education programs include post-basic courses and certificate and degree programs.

Nurses are accountable to obtain and maintain continuing competency within their defined roles through a commitment to life-long learning. It is also the responsibility of the RN to assess his/her own competence to perform required nursing functions and to make judgments about any limitations of their practice. When aspects of care are beyond their level of competence, he/she must seek additional education or experience (ARNNL, *Standards for Nursing Practice*).

*Examples:* Nurses may be taught the fundamentals of caring for a client requiring peritoneal dialysis, to initiate an IV, or to administer immunizations in their basic education program. However, before they are deemed competent to perform the skill in practice, they may require additional education and practice, which includes both theoretical education and supervised practice. (see Appendix F for more information).

### Practice Settings

Nursing is practiced in a variety of settings and in diverse roles, for example: direct care provider, educator, manager, researcher, community developer, counselor, consultant, and public policy developer. Nurses may be employers, employees, private practitioners, and/or volunteers.

The practice of nursing involves working with individuals, families, groups, communities, and populations. Nursing practice may range from one-on-one interventions, up to and including policy development to meet the needs of an entire population. Services range from episodic illness-focused care to health promotion across the lifespan based on the principles of primary health care.

### Continuity of Nursing Care

Continuity of care refers to consistent quality nursing services across settings and/or within settings. Continuity of nursing services across settings refers to the provision of consistent client care practices between agencies for example, the hospital and community. Continuity of nursing services within settings promotes consistent client care practices among nurses in the same setting, for example, between ICU and a medical unit, between nurses in two different community health districts or two long term care facilities.

There may however be significant differences in the availability of resources and expertise to support safe and competent performance of a particular competency by nurses in different settings. When scope of practice decisions are made in one setting or area of practice, consideration must be given to the ability of nursing staff to meet the client's ongoing nursing needs across and/or within the continuum of care.

*Examples:* A client has an abdominal drainage system inserted while in hospital but is a permanent resident of a rural long-term care facility. Education on the required nursing care and relevant policy information is shared with the nursing staff in the long term care facility in advance of the client's transfer or, a client with diabetes who is managing his own insulin requirements at home, is supported to continue self care while in hospital.



## Scope of Nursing Practice: Decision-Making Process

In the past ARNNL approved all scope of nursing practice changes. This process was extensive, time consuming, and often requiring the approval of other relevant disciplines thus resulting in delayed implementation. Nursing skills approved through this process were identified in an ARNNL centralized list. The list was neither exhaustive nor exclusive and did not capture the complexity or holistic philosophy of nursing practice. The legislation governing the practice of nursing in our province does not mandate this level of detail or approach to determining the scope of nursing practice. Consequently, ARNNL has introduced a more flexible framework to address scope of practice requests. The new decision-making framework recognizes:

- ARNNL's responsibility to set the parameters for scope of practice decision making to promote safe, competent and ethical nursing practice
- Registered Nurses' professional accountability for their own practice, and
- Agencies/health authorities responsibility to provide quality health care services in response to client needs, available resources, and internal quality initiatives (see Appendix B for more details).

ARNNL's new framework outlines the process whereby decision-making authority within the categories of specialty and shared competencies moves from the ARNNL, the College of Physicians and Surgeons of Newfoundland and Labrador, and any other applicable health professional regulatory association, to the agency(s) and registered nurses involved in incorporating the particular competency into nursing practice. Scope of practice decisions made within the health care agency must involve collaboration between the management/leadership team and registered nurse(s), as well as other relevant health care professional(s). As appropriate, communication may also be required between health care professionals across the continuum (e.g. between different agencies/departments/programs if client care is to be provided in different settings).

A collaborative agency-nursing based approach to determining specialty and shared nursing competencies supports and recognizes:

- efficient and timely resolution of practice requests;
- diversity of client care needs and resources available within different health care agencies;
- autonomy in decision making based upon best practices and professional accountability recognizing the clinical expertise at the agency level;
- agency specific identification of required competencies, in keeping with its own client population needs and quality initiatives;
- efficient use of healthcare resources, and the contribution of all health care professionals and;
- ARNNL's mandate to set the standards which govern nursing practice and agencies' mandate to determine appropriate clinical competencies required for the practice of their nursing staff.

### **Exceptions**

Decision-making regarding performance of non-delegated competencies identified in provincial legislation cannot be made at the agency level. ARNNL and other relevant professional associations must continue to be involved in such scope of practice changes. The decision-making processes in this section also do not apply to the introduction of new and emerging nursing roles, such as nurse practitioner, First Assist, or Clinical Nurse Specialist. Agencies wishing to explore role changes must continue to seek input from ARNNL and any other pertinent professional regulatory bodies. Self-employed nurses are also required to seek counsel from ARNNL.



## Principles for Decision-Making

The determination of the most appropriate practitioner to provide a specific health service or to perform an intervention will depend upon client needs, competency of available professionals, and the context of practice. Agency decisions regarding specialty and shared competencies for nurses must reflect safe and competent care, the best interest of the client, and be supported by all applicable legislation, standards, guidelines, and policies. The decision making process utilized to assign a competency to a discipline must recognize the unique and shared competencies of all professionals and promote optimal use of resources. Scope of practice decisions at the agency level should be time constant and not based solely upon convenience for various health care professionals (American Nurses Association, 2003; Canadian Medical Association, 2001; CNA, 2002b). The Scope of Practice principles are outlined in Table 1.

## Table 1: Scope of Practice Principles

**ARNNL supports RNs performing specialty and/or shared competencies when the following Principles are met:**

### Principles:

1. *Adherence to Legislation and Standards* - Scope of practice decisions must reflect ARNNL's public protection mandate and adhere to relevant legislation and provincial and applicable national practice standards.
2. *Support for Client Needs/ Benefits* - There is an identified client need; the nursing and client advantages of introducing the practice into nursing scope of practice are validated.
3. *Evidence-Based* - The decision is supported by research and/or clinical evidence.
4. *Involves Collaboration* - Input and participation in decision-making is sought from all those impacted by the decision; decisions promote, and not detract from, a spirit of co-operation and teamwork among care providers (ARNNL, 1994; 2000).
5. *Supported by Education and Authorized by Agency* - Nurses obtain/maintain the necessary competency and have agency authorization to perform the competency.
6. *Includes an Evaluation Component* - The impact of the decision in relation to quality care and nursing services is evaluated on an ongoing basis.

## Process for Decision Making

Agencies must develop or adopt a standard review process for their organization that reflects adherence to the ARNNL principles outlined above, as a means of ensuring a consistent, comprehensive, and professional review of all scope of nursing practice requests. This includes the identification of the agency authority and procedure whereby scope of practice requests are submitted, reviewed, and approved. Figure 1 depicts the process to be followed. A sample of the procedure or review criteria used by ARNNL is provided in Appendix C. The agency's process must be established before any new decisions about performance of specialty nursing competencies are reviewed. The established agency process should be supported through nursing policy and readily available within all applicable practice settings.



Figure 1-Process for Scope of Practice Decision Making



Agencies are responsible for creating practice environments that support quality client care. The agency process for scope of practice decision-making must reflect the responsibilities of health care agencies and RNs professional accountability. Appendices D and E summarize the responsibilities for RNs and agencies respectively. If an agency or RN requires assistance in interpreting whether a particular competency is appropriate to consider with-in the scope of nursing practice, they may consult the ARNNL.

Table 2 presents a step-by-step process for reviewing scope of practice requests. This process is designed to ensure public safety and competent nursing practice by mandating that input has been sought from all relevant professionals, contextual issues are thoroughly explored, and the necessary safeguards, including nursing education and policy, are established. To promote consistency between agencies and health authorities, agencies are encouraged to use this information as a template to develop their own process.

**Table 2: Process: Scope of Nursing Practice Decision-Making**

The decision to add or delete a competency is not made by the individual nurse. Rather, it is a decision made in collaboration with nursing management/leadership and requires administrative support (e.g. policy) for implementation and ongoing evaluation of the merit of nurses continuing to perform the competency.

**Pre-requisite Criteria:**

- Standard approval process for the agency is established. **Note:** Self-Employed nurses are required to seek counsel from ARNNL.
- Competency in question is reviewed to ensure it is not an act restricted in legislation or identified within provincial or national standards to be outside the scope of nursing practice.

## Step 1 Assessment

Is the competency reasonable, appropriate, and consistent with research or best practice evidence and the current professional practice of nursing?

Using an *approved agency process* that reflects ARNNL's guiding principles, agencies must:

### 1. Assess Benefits and Risks:

The benefits and risks and/or possible client complications of adding the competency, and the consequences of not adding the competency to the scope of nursing practice:

- 1.1 The client need for and value of having RN's perform the identified competency.
- 1.2 The presence or absence of required clinical supports to perform the procedure, intervene, and manage potential risks (includes human, technical and other resources).
- 1.3 The potential need for the competency to be performed by nursing staff in another setting or area of practice.

### 2. Assess Situation:

The appropriateness of adding the new competency in the particular setting for the specific client or group of clients.

- 2.1 The status of the client(s) and predictability of outcomes.
- 2.2 The overall care requirements/complexity of care (nature of the technical requirements, nature and extent of nursing and medical involvement required).
- 2.3 Current literature on the topic and/or other practice environments which support the integration of the new competency in like practice settings.
- 2.4 Peers, other professionals, and the professional association(s) are consulted as necessary.
- 2.5 As relevant, other agencies/settings that are or will be involved in the client's care are consulted.

### 3. Assess Supports:

The opportunity to acquire the knowledge and skill to safely add the competency, including the management of potential complications.

- 3.1 The level of underlying knowledge required or the ability for the nurse to expand current knowledge, to perform the new procedure.
- 3.2 The opportunity to incorporate the new procedure in the core nursing competencies required in the practice setting.
- 3.3 The frequency with which the procedure will be required in the practice setting (constant, sporadic, seldom), and the opportunity to maintain competence.
- 3.4 The availability of skilled professionals to teach the procedure and supervise practice.
- 3.5 The ongoing care needs of the client. Will nurses in other settings or areas of practice require this competency in order to meet the client's needs across the continuum?
- 3.6 The ability of nursing to perform the competency based on workload and/or staffing arrangements.

## Step 2 Implementation

If the competency is deemed to be appropriate, reasonable and consistent with professional practice, proceed to implementation.

### Criteria for implementation

1. There must be a written employer policy supporting the competency as a nursing activity and defining the accepted procedure including any conditions and/or restrictions on implementation.
2. There must be an educational program of theory and clinical practice to support the nurse to obtain competence in performing the intervention (see Appendix F).
3. There must be an approved method of determining competency at the completion of the educational program. Agencies must determine what is reasonable with respect to verification of initial competency assessment, reassessment (as necessary), and recording of competency.



4. The agency must ensure appropriate resources are available during implementation of the new competency as nurses gain experience and develop proficiency, and as required to maintain competency (e.g. mentors).
5. Maintenance of competency in the performance of a specialty competency is the responsibility of the individual nurse.
6. The agency must periodically review the value of nurses performing the competency in regards to clinical outcomes and efficient use of resources.
7. The agency must establish a mechanism for expedient resolution when differing opinions about a discipline performing a particular competency arise.
8. As appropriate, the agency should communicate and share resources with other agencies and health professionals to support continuity of nursing services across the continuum.

\* Adapted with permission from Nursing Association of New Brunswick (2000)

### Emergency and Unique Situations

There may be select circumstances when individual practitioners (e.g. regional nurses) or practitioners within specialty teams (e.g. Neonatal Resuscitation Team) are required to perform competencies outside of the approved scope of nursing practice within an agency. This practice should only occur in emergency and/or unexpected situations where there is no other authorized health professional available to perform the competency.

*Examples:* Providing medical care during an emergency such as administration of emergency drugs and initiation of an intravenous infusion in a code or during a medevac; performing select skills in remote or rural areas in the absence of a physician (e.g. delivering a baby); treating a client's symptoms during an acute incident without medical authorization (e.g. atropine for symptomatic bradycardia, glucagon for diabetic in crisis).

A general approval to allow for the unexpected performance of competencies, not designated as nursing practice, in emergency and/or unique situations must be granted by the relevant agency(s), is situation specific, and is not transferable. Agencies employing registered nurses in situations or in roles where they may be required to perform competencies that are not designated as nursing practice must develop policies and procedures to provide guidance to nurses in these situations. Direction and authorization can be granted through the use of interdisciplinary collaborative agency approved assessment and treatment guidelines, medical directives, pre-printed orders. These protocols may include orders for the administration of select medications. Direction should also be given for competencies that may be performed under indirect supervision including supervision offered through telecommunication systems. Performance of competencies not designated as nursing practice during emergency and unique situations must be monitored. If an act becomes a routine activity, formal approval to have the intervention included in the scope of nursing practice of nursing within that agency must be initiated.

Nurses performing competencies not designated as nursing practice in emergency/unique situations are expected to:

- Follow the approved policies and best practice procedures for all interventions.
- Implement required follow-up actions, including documentation and communication with appropriate health care professionals.
- Seek guidance from appropriate sources whenever possible.
- Provide the best care that circumstances, experience, and education permit (CNA, 2002b).
- Collaborate with appropriate agency management/leadership teams to ensure that policies and guidelines to direct practice in these circumstances are valid and current.
- Advocate for practice environments that have the necessary resources to provide safe, competent, ethical, cost effective, and cost efficient care (CNA, 2002b).

## Scope of Nursing Practice: Delegation

Legislation and/or directives arising from legislation such as regulations or by-laws may identify activities that are exclusive to select health care professional groups. For example, the legislative authority for prescribing in NL is referenced in Acts pertaining to nurse practitioners, physicians, dentists, and veterinarians. Agency by-laws and policies may also limit responsibility for the performance of certain competencies to specific health professionals. For example, in some long-term care facilities by-laws identify which professionals are authorized to order restraints, and in acute care hospitals who has the authority to order diagnostic procedures. Agency client care policies may also limit the practice of certain competencies to a particular profession(s), for example who can administer blood products, perform HIV testing, or assess a new client.

There is no comprehensive consolidated list of competencies that are non-delegated to nursing. The identification of competencies within this category can be obtained through a review of regulatory documents and/or by contacting appropriate authorities such as provincial government, health care organizations' nursing/interdisciplinary councils or practice committees, agency management, and/or regulatory bodies for the disciplines involved, including ARNNL. Authority to perform **Non-Delegated Competencies** by members of another discipline requires delegation of function. Decisions regarding performance of non delegated acts, restricted through provincial legislation, cannot be made at the agency level.

Delegation is defined as *the formal transference of authority to perform a specific function in selected situations* (CNPS, 2000). Delegation can only be authorized by either a person competent in the competency and authorized to transfer the authority and/or by a body(s) granted the authority to approve the delegation.

There are three situations where delegation is required:

1. *Provincial legislation* - The competency in question is limited to a particular discipline in legislation, e.g. Pharmacy Act identifies who can prescribe; ARNNL Regulations outline NP practice. Delegation or the decision to introduce into nursing a competency restricted in legislation **cannot** occur at the agency level. The transference of authority in this situation must occur at the level of the provincial government and the appropriate regulatory body(s), with input from other relevant stakeholders.
2. *Agency specific situations* - The competency in question is limited to a particular discipline(s) within agency policy or in organizational by-laws, e.g. hospital by-laws restrict who can admit and discharge clients, agency policy may limit the practice of allergy testing to nurses in specific roles, or policies may identify practice settings where a nurse may initiate select treatments without a medical order (e.g. regional nurses). The decision to delegate a competency in this category must occur at the agency /health authority level between administration and nursing leadership within the agency, with input from other relevant stakeholders.
3. *Client specific situations* - The competency in question is not identified as a restricted practice in legislation, agency policy, or by-laws however the intervention has not been previously recognized to be within the scope of nursing practice in the agency (no policy or nursing education). There is a client specific need identified for nursing to now perform the intervention for example, administering select treatments for a palliative client. The decision to delegate a competency within this category must occur at the individual and agency/unit level. With agency support and education, the delegation occurs between the competent practitioner(s) and the nurse(s) who will be required to perform the competency. Competencies delegated in this situation are client specific and non-transferable. If the intervention becomes common practice i.e. requiring numerous RNs to perform for several clients, the Scope of Practice Decision-Making process outlined in the previous section should be initiated.



## Resource List

- Alberta Association of Registered Nurses. (1998). *Determining the Appropriate Scope of Nursing Practice for Particular Practice Settings: Guidelines for Registered Nurses*. Edmonton, AB: Author.
- American Nurses Association. (2003, January). *Nursing: Scope and Standards of Practice (Draft)*. Retrieved February, 2003, from <http://www.nursingworld.org>
- Association of Registered Nurses of Newfoundland and Labrador. (1995a). *Duty to Report Inappropriate Behavior: Guidelines*. St. John's, NL: Author.
- Association of Registered Nurses of Newfoundland and Labrador. (1994). *The Delegation of a Medical Skill to the Registered Nurse for Palliative Purposes: Guideline*. St. John's, NL: Author.
- Association of Registered Nurses of Newfoundland and Labrador. (1995b). *Protocol Regarding Concerns About Quality of Client Care: Position Statement*. St. John's, NL: Author.
- Association of Registered Nurses of Newfoundland and Labrador. (1998). *Competencies Required by Registered Nurses for Entry to Nursing Practice*. St. John's, NL: Author.
- Association of Registered Nurses of Newfoundland and Labrador. (1995c). *Standards for Nursing Practice in Newfoundland and Labrador*. St. John's, NL: Author.
- Association of Registered Nurses of Newfoundland and Labrador. (2000). *Guidelines Regarding Shared Scope of Practice with Licensed Practical Nurses*. St. John's, NL: Author.
- Association of Registered Nurses of Newfoundland and Labrador. (1990). *Newfoundland and Labrador Registered Nurses Act*. St. John's, NL: Author.
- Baumann, A., O'Brien-Pallas, L., Armstrong-Stassen, M., Blythe, J., Bourbonnais, R., Cameron, S., Doran, D.I., Kerr, M., McGillis-Hall, L., Vezina, M., Butt, M., & Ryan, L. (2002). *Commitment and care: The benefits of a healthy workplace for nurses, their patients, and the system*. Canadian Health Services Research Foundation. Canada.
- Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. Menio Park, CA: Addison-Wesley.
- Canadian Medical Association. (2001). *Scopes of Practice*. Retrieved October 17, 2002, from [http://www.cma.ca/cma/common/displayPage\\_stand/2002/01-21](http://www.cma.ca/cma/common/displayPage_stand/2002/01-21)
- Canadian Nurses Association (CNA) (2002a). *Advanced Nursing Practice: A National Framework*. Ottawa: Author.
- Canadian Nurses Association. (2002b). *Code of Ethics for Registered Nurses*. Ottawa: Author.
- Canadian Nurses Association. (2002c). *Discussion Guide for The Unique Contribution of The Registered Nurse*. Ottawa: Author.
- Canadian Nurses Association. (2001a). *Quality Professional Practice Environments for Registered Nurses: Position Statement*. Ottawa: Author.
- Canadian Nurses Association. (2001b). *Self-regulation: Safeguarding the privilege*. *Nursing Now*. Ottawa: Author.





Canadian Nurses Protective Society (CNPS) (2000). Delegation to other Health Care Workers. *InfoLAW*, 9 (2).

College of Nurses of Ontario. (2000). *The Regulated Health Professions Act, Part B: Scope of Practice, Controlled Acts Model*. Toronto, ON: Author.

Manitoba Association of Registered Nurses & The College of Physicians and Surgeons of Manitoba. (2000, December). *Guideline for Shared Competencies and Delegated Physician Services*. Manitoba: Author.

Nurses Association of New Brunswick. (2000). *Decision-Making in Clinical Nursing Practice*. Fredericton, NB: Author.

Registered Nurses Association of British Columbia. (1992). *Guidelines for Specialized Nursing Skills and Delegated Medical Functions*. Vancouver, BC: Author.

Registered Nurses of Nova Scotia. (1999). *Guidelines for Shared Competencies & Delegated Medical Functions*. Halifax, NS: Author.



## Appendix A — Definitions

**Accountability:** Being answerable for decisions and actions taken.

**Advanced Nursing Practice (ANP):** The umbrella term used to describe an advanced level of nursing education and practice that maximizes the use of in depth nursing knowledge and skill in meeting the health needs of clients (adopted by the Canadian Nurses Association and approved by the ARNNL). In this way, ANP extends the boundaries of the scope of nursing practice and, contributes to nursing knowledge and the development and advancement of the profession.

**Assignment:** The process of determining and appointing the most appropriate health care professional to perform a competency that is within the scope of practice of those involved.

**Basic Nursing Education:** Formal education required for entry into the nursing profession. A baccalaureate degree is the current standard required for entry to nursing practice in Newfoundland and Labrador.

**Certification:** A voluntary and periodic process (re-certification) by which an organized professional body confirms that a registered nurse has demonstrated competence in a nursing specialty by having met predetermined standards of that specialty (CNA, 1992).

**Co-assignment:** The process of assigning the care of a client between two or more professionals. This is done to ensure that the client's care needs can be met by a professional in accordance with their scope of practice and/or level of proficiency.

**Competencies:** The integrated knowledge, skills, attitudes, and judgment required to safely and effectively practice nursing. Competencies are more specific than scope of practice statements and reflect skills required of the Registered Nurse to function in a specific role or practice setting. Nurses obtain the competencies required to practice nursing through basic and continuing education, including formal and informal learning experiences.

**Complementary or Alternate Therapies:** Refers to non-conventional methods of enhancing health through interventions that may involve diet and nutrition, mind-body therapies, traditional therapies, pharmaceutical or biological treatments, manual healing, and/or herbal therapies (CNA, 1999). These approaches are not specific to any one discipline and may also be used by individuals who are not health care professionals.

**Continuing Nursing Education:** Learning experiences organized by the nurse, facility, agency, or educational institution undertaken by a registered nurse to enhance his or her nursing competencies.

**Delegation:** The formal transference of authority to perform a specific function in selected situations (CNPS, 2000). Delegation of function is necessary if a nurse is required to perform a competency that is not recognized as being within the scope of nursing practice.

**Emerging Competencies:** Competencies or nursing interventions that arise over time as a result of new knowledge, technology, and client needs.

**Entry to Practice Nursing Competencies:** The knowledge, attitudes, judgment, critical thinking, communication, and psychomotor skills, expected of the entry-level Registered Nurse. These competencies are acquired through a basic nursing education program and are in accordance with the requirements outlined in the current version of the ARNNL document, *Competencies in the Context of Entry-Level Registered Nurse Practice, 2013-18*.



**Formal Education:** A structured program of education that involves theory, practice, and assessment of competency. Theory is defined and guided by learning objectives. Practical supervision is offered through educators.

**Informal Education:** Learning activities initiated within the area of practice that may involve theory and/or practical supervision. Theory is usually obtained through self-directed learning such as reviewing current literature and policies or observation/demonstration. Practical experience is gained through mentoring.

**Non-Delegated Competencies:** Activities that are articulated in legislation, or directives arising out of legislation e.g. regulations and/or agency by-laws, to be the exclusive domain of a particular profession or professions. Authority to perform competencies in this category by members of another discipline requires a change in the related legislation or formal delegation of function.

**Novice Nurse:** Nurses who are either new graduates or nurses who have moved into a new area of practice.

**Portability:** Refers to the ability of a nurse, who is competent in a particular skill, to safely perform the activity with a different client population, in another agency, or in another work area.

**Responsibility:** The obligation to fulfill the terms of implied or contractual agreements.

**Shared Competencies:** Health-related client interventions that are determined to be within the scope of practice of more than one health care profession. The competencies may be shared between nursing and other disciplines, such as medicine or allied health professionals.

**Specialty Nursing Competencies:** Activities, both currently practiced and new and emerging interventions that involves a higher level of complexity in application and/or critical thinking than entry level or basic competencies. The concepts underlying these competencies may have been introduced in a basic nursing education program but further learning and/or experience must be obtained through continuing education before these competencies can be implemented in clinical practice. Nursing competencies that had been classified as advanced nursing and/or medical nursing shared skills as well as new and *emerging* skills, will be re-named collectively as specialty competencies.

**Supervision:** Direct or indirect supervision by an individual proficient in the performance of the activity in a designated role and setting.

**Direct supervision:** The identified supervisor is immediately present to direct and guide performance of the procedure/activity/intervention and to regulate, manage, evaluate performance or follow up on performance.

**Indirect supervision:** The identified supervisor is not immediately present during performance of a procedure/activity/intervention but is available upon request to guide, evaluate, or follow up on performance.



## Appendix B — Broad Stakeholder Responsibilities

### **ARNNL**

The Association of Registered Nurses of Newfoundland and Labrador (ARNNL) is the professional organization representing all Registered Nurses in the province. In pursuit of its vision, “Healthy People in Newfoundland and Labrador,” ARNNL exists so there will be excellence in nursing, public protection, quality health care, and healthy public policy. The ARNNL has been granted the legislative authority to regulate the practice of nursing in this province. The statutory responsibility for the regulation of professional nursing is outlined in the Registered Nurses Act, RSN R-9 (1990) and ARNNL By-laws and Regulations.

The ARNNL assists nurses in fulfilling their professional obligation to provide safe, competent, and ethical nursing care through a number of activities that aim to promote good nursing practice and prevent poor nursing practice. This includes establishment of Standards for Practice, defining the principles for determining the scope of nursing practice, providing direction to members and others about how to address questions regarding scope of nursing practice, and establishing guidelines on delegation of competencies to nursing from other health care professional groups and from nursing to other health care provider groups.

### **Registered Nurse**

Self-regulation means nurses regulating the practice of nursing to ensure that safe, competent, and ethical nursing care is provided to the public (CNA, 2001b). Nurses are accountable for judgments made and actions taken in the course of their practice. In addition, each nurse owes the same duty of care to his/her self as well as to others. This includes the responsibility to engage in life-long learning to maintain competence, and to take care of his/her own physical, mental, and emotional well-being (ARNNL, 1995, Nursing Practice Standard).

Standards of practice are the authoritative statements by which the profession describes its values and expectations and are the benchmark for which its practitioners are held accountable. The principles and processes put forth in this document serve as the interpretation for the Nursing Practice Standard: Registered Nurses must *function within the legally recognized scope of practice of nursing and within all relevant legislation*.

### **Agency/Health Authority**

As partners in providing quality client care, agencies share responsibility for creating quality professional practice environments to support safe, competent and ethical nursing practice. The quality of the professional practice environment, including the availability of adequate support systems, affects the ability of the nurse to work to his/her full scope of practice (Baumann, et al, 2001). Agencies are responsible to provide required learning opportunities, guidance through management and policies, and leadership in scope of practice decision-making.



## Appendix C — Scope of Nursing Practice Review Template

When agencies/health authorities and Registered Nurses are considering whether to include a particular competency to the scope of nursing practice, ARNNL recommends that the following criteria be assessed.

1. **Location** - All areas where the requested practice change will be implemented are identified and the implications for performance within each area are thoroughly explored, e.g. program(s) and department(s). Consider potential impact upon external agencies or professionals i.e. will the competency need to be implemented by RNs in another setting/agency?
2. **Leadership** - Documented support from the appropriate stakeholders has been obtained e.g. manager(s), nursing bodies, and other disciplines including as required, the Medical Chief for the requesting Department/Program and the medical advisory committee for the agency.
3. **Committees** - All pertinent internal committees are identified and correspondence is established (e.g. nursing practice, pharmacy, medical advisory, interdisciplinary).
4. **Evidence** - Supporting literature is obtained including relevant standards of practice (e.g. Special Interest Group guidelines or certification standards) and current research to support the request.
5. **Nursing examples** - Information from any other local, provincial or national nursing departments that have already incorporated the request into the scope of nursing practice is obtained. Lessons learned are reviewed.
6. **Feasibility** - Consider the proposed implementation time frame. Is the request urgent and/or a time limited client need? If so, consider client specific delegation. Is extensive education needed? Will there be enough opportunities to perform the intervention to maintain competency?
7. **Education** - A viable educational plan is identified, i.e. identification of who will provide instruction and supervision, methods of instruction, and processes for validation of competence.
8. **Benefits and Risks** - The advantages and disadvantages of introducing the nursing practice for both client and nursing are identified and evaluated.
9. **Evaluation** - Methods for evaluating outcomes are in place (i.e. process for determining client impact, original and ongoing RN competency, effect upon other departments and/or external agencies).



## Appendix D — Specific Registered Nurse Responsibilities

Scope of Practice decisions must reflect that the **RN** is:

- expected to participate in relevant scope of practice agency discussions and decisions;
- primarily responsible to clients;
- accountable for assessment, planning, implementation, and evaluation of nursing care;
- responsible for identifying and addressing any personal or social issues that might impede his/her fitness to practice;
- responsible for questioning policies and procedures and the performance of activities that are not consistent with therapeutic client outcomes, best practice, and/or safety standards;
- responsible for reporting and/or acting upon practices and situations that may adversely affect client care (ARNNL Protocol Regarding Concerns About Patient Care, 1993);
- expected to collaborate and communicate with other members of the health care team and advocate for and participate in quality improvement activities;
- responsible for identifying his/her own learning needs and utilizing available resources to attain, maintain, and enhance competency in the required role/function; and
- responsible for ongoing self-assessment of his/her competency and proficiency to perform an intervention in a setting or area of practice.



## Appendix E — Specific Agency Responsibilities

When agencies are **considering** if it is appropriate for a nurse to perform a specialty or shared competency they must consider:

- if performance of the competency by RNs is currently restricted in legislation, guidelines, or policy;
- if implementation of the competency can be accomplished in keeping with ARNNL's guiding principles and process for decision-making;
- the client needs, best interests, and consent (where appropriate);
- the best practice research and information;
- the context of practice, including availability of educational support;
- current practitioner competencies and availability; and
- efficient use of human resources.

When agencies **support** a particular competency to become a component of nursing practice within their organization they must:

- follow the agency approval process for implementing scope of practice changes including documentation of collaborative decision making and communication to all relevant parties;
- develop relevant nursing policies and practice guidelines that are consistent with professional competencies and the legislated scopes of practice;
- develop/adopt and provide a program of study that adheres to ARNNL's educational preparation guidelines outlined in Appendix F;
- establish processes for determining initial and ongoing competency in the performance of the intervention, portability, and the role of nursing students, nurses in orientation, new graduates, and/or nurses moving into new areas;
- evaluate the ongoing need for and performance of approved competencies and/or the addition of new competencies;
- develop mechanisms for monitoring and implementing quality improvement measures as required;
- address any concerns that may emerge that could negatively impact therapeutic patient/client outcomes and safety standards;
- assess available resources (human and material) across the continuum as relevant; and
- support consistency in nursing services by communicating and sharing resources (e.g. teaching material) with appropriate nursing and other care providers across the continuum.



## Appendix F — Guidelines for the Development of Educational Programs for Speciality and/or Shared Nursing Competencies

Once the appropriate approval has been obtained to add a new competency to the scope of nursing practice, or for nursing staff that are not currently competent to perform a shared skill, agencies need to develop/adopt a quality educational program. The educational program must address the following.

### 1. Educational Preparation

Educational programs must include both theoretical and practical components.

Theoretical Component includes:

- (a) Anatomy/ Client profile
- (b) Physiology /Community resources
- (c) Pathophysiology/ Community need
- (d) Principles underlying the Procedure/ Program  
Nursing implications and expected Client/Population outcomes
- (e) Evaluation process and documentation requirements

Practical Component includes:

- (a) Supervised practice
- (b) Demonstrated competence

The format for providing the required education is at the discretion of the agency. The education program can be provided using a variety of instructional methods either alone or in combination. Examples include:

- Lecture,
- Video/audio tape,
- Computer assisted learning,
- Independent study with clearly defined instructional objectives, learning activities, and resources,
- Case studies, and
- Demonstration, observation, and return demonstration

### 2. Competency assessment

The method of determining competency is at the discretion of the agency in accordance with the requirements and standards of the agency's nursing department. Attainment of competency may be determined through a variety of methods. Examples include:

- demonstration,
  - observation and return demonstration (can include assessment through video technology,
  - clinical demonstration under supervision
  - written testing - the decision to use a written test of competency is at the discretion of the agency, and/or
  - a combination of the above.
3. It is the responsibility of the agency/health authorities to designate instructors proficient in the particular skill to conduct the program of instruction.
  4. It is the responsibility of the agency/health authority to determine an appropriate method of recording initial and ongoing competence (e.g. performance appraisals).
  5. Maintenance of competency in the performance of all relevant nursing competencies is the responsibility of the individual nurse. Retesting of competency may be required if the nurse and/or the agency/health authority deems it is necessary.

Basic nursing students may only perform competencies that are approved for implementation by their school of nursing and by the specific agency in which they are obtaining their clinical experience.









55 Military Road  
St. John's  
NL | Canada  
A1C 2C5  
Tel (709) 753-6040  
1 (800) 563-3200 (NL only)  
Fax (709) 753-4940  
info@arnnl.ca  
arnnl.ca