



APPENDIX B

Practice Component

Literature Review Report

Advanced Nursing Practice and the Primary Health Care Nurse Practitioner: Title, Scope, and Role

December 23, 2004

A Discussion Paper
Prepared for the Canadian Nurse Practitioner Initiative
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Funding for the Canadian Nurse Practitioner Initiative was provided by Health Canada.

L'Initiative canadienne sur les infirmières et les infirmiers praticiens est financée par Santé Canada.

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December 2004

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Executive Summary

This paper was commissioned by the Canadian Nurse Practitioner Initiative (CNPI) to facilitate discussion and to help work towards building a national consensus on the definition of the primary health care nurse practitioner (PHCNP) in Canada, including title, scope, and role—essential elements required to facilitate its integration and sustainability in Canada’s health care system.

This discussion paper is divided into five main sections followed by the conclusion:

- Advanced Nursing Practice (ANP)
- Advanced Nursing Practice and the Nurse Practitioner – An International Perspective
- ANP Titles and Roles: Focus on Canada
- Primary Health Care Nurse Practitioners across Canada
- Role and Scope of PHCNPs Compared to Other RNs

The term “advanced nursing practice” (ANP) along with the roles it encompasses as well as the roles it does not is described in the first section. It has been noted in the literature that there is ongoing confusion within the nursing community regarding the meaning of the term, scope, and role of the ANP. Despite research that demonstrates the significant contributions that advanced practice nurses make to client care, satisfaction, and positive health outcomes, inconsistency in title, scope and role have led to vulnerability of the role within Canada. A consistent definition helps ensure a general understanding of the concept itself by nurses, other health professionals, administrators, policymakers, and the public; provides clarity for future development of the ANP scope and role; and facilitates sustainability over time.

The second section provides a broad overview of international and national definitions or descriptions of advanced nursing practice including the nurse practitioner. Definitions reviewed included, but were not limited to, the International Council of Nurses (ICN), the Royal College of Nurses of Australia, the New Zealand Nurses Organization, United Kingdom Council of Nurses, American Academy of Nurse Practitioners, and the Canadian Nurses Association (CNA). In reviewing the definitions, there was remarkable congruence among them respecting key concepts used to describe advanced practice nurses including *expert or advanced nursing knowledge, complex decision-making skills, collaborative practice, and advanced clinical competencies*. Additionally, similarities were found among the definitions respecting the foundational competencies of ANP such as clinical, research, leadership, collaboration, and change agent—which are the CNA core competencies for ANP. Differences in the definitions included titles used to describe advanced practice roles, for example CNS and NP are used in both Canada and the United States while higher level practitioner or advanced practitioner is used in the United Kingdom. Some differences were also noted in educational preparation, with some organizations clearly stating that graduate education is a requirement for advanced practice nursing while others such as the ICN recommend master’s preparation. While the CNA states that graduate education is the minimum requirement for ANP in Canada,

the PHCNP (defined as ANP by the CNA) is not consistently prepared at the graduate level in this country.

Advanced nursing practice roles in Canada are described in the third section, including the evolution of the clinical nurse specialist and nurse practitioner role. Similarities and differences are described between the clinical nurse specialist (CNS) and the nurse practitioner, and between the primary health care nurse practitioner and the acute care nurse practitioner (ACNP). While CNS and NP roles are captured under the ANP umbrella as defined by the CNA, the majority of PHCNPs—unlike the CNS and ACNP—are not prepared at the graduate level. This inconsistency has led to some debate in this country as to whether the NP role is an ANP role. Another key distinction between the NP and CNS role is regulatory authority. To date, only NPs have been granted additional regulatory authority in relation to the extended health services that the NP may provide to clients such as diagnosing, ordering laboratory tests and prescribing medication. Seven jurisdictions in Canada have legislation, which gives PHCNPs the authority to perform these services, while three other provinces have legislation pending. Furthermore, three provinces currently have legislation, which grants additional authorities to ACNPs.

Similarities and differences among jurisdictions respecting PHCNP title, scope, and role are discussed in the fourth section. Nurse practitioner or NP is a protected title in all jurisdictions with pending or actual primary health care practitioner legislation (currently eight jurisdictions) with the exception of Ontario and Manitoba. However, the former is considering NP title protection in the future.

To competently perform the role, PHCNPs are RNs with “expert”, “advanced”, or “enhanced” nursing knowledge and competencies or skills gained by additional education and experience; they are “generalists” who provide “comprehensive” or “full range” of health services “across the lifespan”, “to clients in all developmental stages”, / “to individuals, families, groups and communities”; they practise in a variety of health care settings including, but not limited to, hospital outpatient and emergency departments, long-term care facilities, community health centres, family physician/group practice offices; they practise autonomously or collaboratively (and/or in consultation, formal and informal); and they deliver “primary health care services” including health promotion, disease and injury prevention, and coordination and management of care.

Further, PHCNPs may make and communicate a diagnosis; order and interpret screening and diagnostic tests; and select, recommend, prescribe and monitor the effectiveness of drugs and interventions/treatments. In some provinces and territories, PHCNPs are permitted to distribute or dispense medications as part of the additional authority granted to NPs in those jurisdictions. Parameters or boundaries on scope of practice authorities are varied across the country and range from prescriptive lists of drugs and diagnostic tests listed in regulation to more open-ended prescribing authorities (e.g., may prescribe from the provincial drug formulary).

The fifth and final section distinguishes differences between the roles of the PHCNP and RN. While the PHCNP and RN have an overlapping scope of practice, and may perform similar roles, there are two key distinctions. First, the PHCNP possesses advanced knowledge and decision-making skills gained through additional clinical practice, education and experience which enables the PHCNP to provide a more in-depth

assessment and analysis of the client's health status, and devise a comprehensive treatment plan for their clients. The second distinction is that, although other registered nurses may be expert or specialized nurses and have the ability through medical directives or delegation to provide expanded or extended services outside of their scope of practice, they do not have the authority to perform these functions autonomously. It is this legislated authority which gives NPs greater autonomy in decision-making and in performing these health services, while ultimately retaining a higher accountability for patient / client outcomes.

1. Introduction

This paper, commissioned by the Canadian Nurse Practitioner Initiative, is intended to inform discussion on advanced nursing practice roles in Canada, with particular emphasis on the primary health care nurse practitioner (PHCNP). Further, the paper is intended to facilitate the development of a national definition of the term PHCNP including title, role, and scope of practice.

The paper provides an overview of the definitions used to describe the term advanced nursing practice from a national and international perspective and the roles it encompasses, with a focus on identifying similarities among the definitions described. A discussion of the importance of having a consistent definition is described, along with the impact on sustaining the role of the primary health care nurse practitioner. Advanced practice roles in Canada will be highlighted, including a brief description of how these roles evolved, with specific emphasis on the clinical nurse specialist and the nurse practitioner including the PHCNP and the acute care nurse practitioner (ACNP). The variety of terms used to describe primary health care nurse practitioners as identified by nursing licensing bodies will be provided with an overview of their scope and role. The differences between RNs and NPs are also examined, including distinctions between extended, expanded or specialized nursing roles and advanced practice nursing roles as they relate to RNs and NPs. Some of the issues affecting the implementation of the NP role will be described. An in-depth discussion of facilitators and barriers and practice models are addressed in separate papers.

2. Advanced Nursing Practice

The term advanced nursing practice (ANP) has been used by the nursing profession for decades to describe nurses with advanced education and competencies in the field of nursing. However, there remains confusion in the nursing community regarding the meaning of the term, and toward the scope and role of advanced practice nurses (Jamieson & Williams, 2002; Patterson & Haddad, 1992; Dunn, 1997; Kohr, 1998; Roschkov, Urquhart, Rebeyka, & Scherr, 2004). Despite numerous studies illustrating the significant contributions that advanced practice nurses (APN) have made to enhancing quality care and improving health outcomes (Brooten, Youngblut, Kutcher, & Bobo, 2004; Canadian Health Services Research Foundation, CHSRF, 2002; Horrocks, Anderson, & Salisbury, 2002), sustaining the role has proven to be a challenge, particularly when organizations are facing budget cuts (Dunn & Nicklin, 1995). Variability in title, scope and role has contributed to this vulnerability (De Grasse & Nicklin, 2001). Having a consistent definition of the role is important for several reasons: it helps ensure general understanding of the concept itself by nurses, other health professionals, administrators, policymakers, and the public; it provides clarity for future development of the ANP scope and role, and it facilitates sustainability over time (Jamieson & Williams, 2002; De Grasse & Nicklin 2001; Alcock, 1996).

To facilitate understanding of advanced nursing practice, the definitions for the two key concepts within the term itself, namely *advanced* and *practice*, are examined. Patterson and Haddad (1992), using a definition from Webster's dictionary, define *advanced* as "an improvement or moving forward", and *practice* as "the putting knowledge to actual use

or exercise of any profession.” Dunn (1997) cites the Webster definitions as well as alternate British definitions for the terms, but remarks that the Webster definitions “... provide a more accurate description of how nursing can be moved forward to become advanced practice” (p. 814).

In using these definitions, Patterson and Haddad (1992) state that nursing practice is constantly evolving in response to changes in the environment such as the emergence of new technologies, advances in research, and changes in the populations. They conclude that the combined concepts of *advanced practice* describe nursing practitioners who “...engage in activities which contribute to and improve nursing knowledge and practice” and “define the boundaries of their practice within the philosophical beliefs intrinsic to their profession in order to meet the demands of nursing, patients, and society” (p. 18–19). Dunn (1997) describes advanced practice nursing as pioneering, with the boundaries of practice adjusting or changing as new roles evolve and, in so doing, advance the profession of nursing.

Similarly, Sutton and Smith (1995), state that advanced nurse practitioners are client-centered and focused on enhancing the positive outcomes for their clients. They “constantly stretch the boundaries of nursing practice” not only by addressing immediate client situations, but also anticipating future situations that can impact client outcomes (p. 1040). Further, Woods (1997) describes advanced practice as a “multi-faceted clinical role, functioning in collaborative relationships with other disciplines” (p. 821). It is perhaps the ability of APNs to apply their advanced nursing and related knowledge, their critical thinking skills and judgment, and their clinical expertise, while using a collaborative approach to care, which has resulted in advanced practice nurses demonstrating time and time again in the literature the positive effect their services have on enhancing quality care, positively impacting health outcomes, and providing care comparable to physicians (CHSRF, 2002; Walsh, 1999).

These concepts of knowledge enhancement, improving practice, pioneering, evolving roles, and adjusting boundaries in response to the needs of clients underpin the practice of the advanced practice nurse. With constant advances in science and technology the health care system is ever-changing and requires a “knowledge worker” rather than a task-oriented worker. Nursing by its nature “...is heavily dependent on knowledge – both in its production and its use in patient care” (Ketefian, Redman, Hanucharunkul, Masterson, & Neves, 2001, p. 160). Advanced practice nurses in particular are well positioned to meet these changing demands. Further, as Turner and Keyzer (2002) state, “the generation and processing of knowledge is the major source of power fueling new economies and a new division in health care” (p. 19). As such, the nurse practitioner and other advanced nursing practice roles should flourish in a health care environment which places more emphasis on the individual health care provider for service delivery and less on the boundaries of traditional work setting. As these boundaries have been expanded with access to the Internet, the scope of how services are delivered and to whom has also grown. Other drivers that influence and shape the development of advanced practice roles include unmet health needs of individuals, groups and society; health human resource supply and demand; scientific evidence of effectiveness; and government policy (Ketfian et al., 2001).

Alcock (1996) suggests that consistency in advanced practice titles, standards, and education is needed to enhance protection of the public and the advancement of the profession. However, as Hamric (1996) points out, advanced nursing practice roles do differ, not only with respect to titles that fall under this “umbrella term”, but also with respect to competencies required in those roles. She suggests that it is “. . .both necessary and preferable to retain varied job titles that reflect . . .actual practice, rather than reduce all APNs to one title” (p. 47).

Numerous roles with a variety of titles are identified or described in the literature as being advanced practice roles. “The most recognized advanced nursing practice role in Canada is the clinical nurse specialist” (Canadian Nurses Association, CNA, 2003a). Other roles cited in the Canadian and U.S. literature as advanced practice include primary health care nurse practitioner, acute care nurse practitioner, expanded role nurse, physician assistant, registered nurse first assistant / registered nurse surgical assistant, nurse midwife, nurse administrator, nursing coordinator, case manager, public health nurse, parish nurse, lithotripsy nurse and transplant nurse, to name only a few (Dunn, 1997; Dunn & Nicklin, 1995; Hamric, 1996; ARNNL, 1997; CNA, 1997). Many of these roles have emerged in tertiary care facilities or in specialized practice environments in response to unmet needs of specific patient populations.

In an effort to distinguish advanced practice roles from other nursing roles, Hanson and Hamric (2003) identify three stages in the evolution of advanced practice roles. The “stages in evolution” are also intended to facilitate clarity in the meaning of advanced nursing practice both within and outside of the nursing profession (p. 203). The three stages are:

1. *Specialty Development in Practice Settings Stage* – characterized by nurses responding to unmet health care needs and developing specialized practices to address those unmet needs;
2. *Organized Specialty Training Stage* – characterized by the development of formal and informal training programs often at the workplace to assist nurses in acquiring the skills needed to provide their specialized services; and
3. *Standardization and Emergence of Graduate Education* – characterized by enhanced regulatory frameworks and educational programs to ensure competent practice in recognition of increasingly complex practice associated with the specialty’s expanding knowledge base (pp. 203-204).

Given the variety of roles identified in the literature as advanced nursing practice, a model such as this one is helpful in determining true advanced nursing practice roles from other nursing roles. In using this model, roles such as the clinical nurse specialist (CNS) and nurse practitioner (NP), particularly in the United States where graduate nursing education is a requirement for practice, have clearly evolved into advanced nursing practice roles. On the other hand, other nursing roles have not yet matured to this level and may not surpass the second stage of the model (Hanson & Hamric, 2003). Roles such as lithotripsy nurse, registered nurse first assistant, and parish nurse are examples of the latter case.

As Hanson and Hamric (2003) point out, not all roles develop into advanced practice roles, including those with graduate preparation. They comment that it is important not to value one role over another, as all nursing roles are important and contribute to the advancement of the profession. A recent paper by Pauly, Shreiber, MacDonald, Davidson, Crickmore, Moss, et al. (2004), recommends that “recognition and development of a variety of nursing roles, including ANPs, are critical to attracting and retaining nurses by providing leadership in practice as well as opportunities for career mobility and development” (p. 56).

3. Advanced Nursing Practice and the Nurse Practitioner – An International Perspective

There are numerous definitions of the term *advanced nursing practice* or *advanced practice nurse* in use by national and international nursing associations and regulatory bodies. In reviewing these definitions, there is a recognizable congruence within the literature and among the definitions themselves with respect to key concepts that define advanced nursing practice. For example, concepts such as *expert* or *advanced nursing knowledge*, *complex decision-making skills*, *collaborative practice*, and *advanced clinical competencies* are identified in many of the definitions. To demonstrate this general consistency, a sampling of national definitions or descriptors of the terms *advanced nursing practice* and *nurse practitioner* is provided here, starting from the broad international perspective of the International Council of Nurses (ICN) and leading to a brief discussion of each definition and relevant context.

3.1 International

In 2002, the International Council of Nurses (ICN) issued a position statement wherein they present a definition for *Nurse Practitioner / Advanced Practice Nurse* to facilitate consistency and provide a better understanding of this emerging role, namely:

“a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and / or country in which s/he is credentialed to practice. A master’s degree is recommended for entry-level” (ICN, 2002).

This broad definition highlights some of the key attributes of the advanced practice nurse including “expert knowledge”, “complex decision-making skills” and “clinical competencies for expanded practice”.

The definition is deliberately qualified within the educational component, where a “master’s degree is recommended” rather than required. This may in part be influenced by the inconsistency in educational preparation of nurse practitioners around the world, including Canada. Another point of interest respecting this definition is the title itself, that is, it references a specific ANP role—that of nurse practitioner, or NP. Perhaps this reference to the NP is intended to affirm that nurse practitioners are advanced practice nurses. As discussed in this section, in many countries, nurse practitioners have only recently been identified in national documents as advanced nurse practitioners, and in

others such as Israel, it is a new and expanding role (Riba, Greenberger, & Reeches, 2004).

The ICN position statement also identifies advanced practice characteristics, which describe the “nature” of the advanced practice role. These characteristics are:

- Integrates research, education, practice and management;
- High degree of professional autonomy and independent practice;
- Case management / own case load;
- Advanced health assessment skills, decision-making skills and diagnostic reasoning skills;
- Recognized advanced clinical competencies;
- Provision of consultant services to health providers;
- Plans implements and evaluates programs; and
- Recognized first point of contact for clients.

3.2 United Kingdom

In 1994, in an effort to differentiate advanced practice from other levels of nursing practice, the United Kingdom Central Council (UKCC) now called the Nursing and Midwifery Council (NMC) identified three levels of nursing practice: professional or primary; specialist; and advanced (Carroll, 2002; Casteldine, 1991). Albarran and Whittle (1995) describe these three levels as follows:

1. The *professional or primary level* equates to the period of practice after initial registration where practice and skills are confirmed and develop over time. Most nurses remain in this domain of practice.
2. *Specialist level* is attained by completing additional education and gaining expertise in a specialty area of practice. Educational programs are designed to increase the ability to make more autonomous decisions in clinical practice.
3. Nurses at the *advanced practice level* must have specialist status and have additional education at the master’s level. Practitioners at the advanced level are expected to provide direct patient care and push the boundaries of practice.

Casteldine (1991) states that advanced practitioners fulfill five key roles: clinician, educator, researcher, leader, and consultant. Although these roles are not specifically identified by the UKCC, Albarran and Whittle (1995) point out that they are inherent in the description and required for effective performance in the role. It should also be noted that these roles are also identified in the ICN position statement.

More recently, the UKCC, in response to rapidly changing practice environments, evolving roles requiring greater responsibility, and the emergence of new titles such as “nurse practitioner”, decided to re-examine the specialist and advanced practice registration framework (UKCC, 2002). As a result of this work, the *higher-level practice* (HLP) descriptor and standards were identified. Key characteristics (UKCC, 2002, p. 8) are that higher level practitioners:

- Use their knowledge and skills as the foundation for further development of their practice;

- Have in-depth knowledge in areas such as therapeutics, biological, social and epidemiology;
- Use complex reasoning, critical thinking, reflection and analysis to inform their clinical practice, judgment and decision-making;
- Are change agents / leaders;
- Focus on the individual(s), group(s), and / or community(ies);
- Integrate research, education, and management into their role; and
- Are engaged in partnerships that are flexible and cross boundaries.

As Casteldine (2002) remarks, higher level practice *is* advanced practice. He recommends that the terms *advanced practice/advanced practitioner* be used rather than higher level practice by the NMC to facilitate consistency, particularly because these terms are used in a similar fashion by a number of countries around the world including Australia, the United States and Canada.

3.3 Australia and New Zealand

Consistent with the ICN and UKCC / NMC, the Royal College of Nurses of Australia (RCNA, 1999, under review) define advanced practice nursing as a

“...level of practice that utilizes extended and expanded skills, experience and knowledge” with practitioners who are *“...educationally prepared at post-graduate level and may work in a specialist or generalist capacity.”* Further *“the basis of advanced practice is the high degree of knowledge, skill, and experience that is applied within the nurse-patient / client relationship to achieve optimal outcomes through critical analysis, problem solving and accurate decision-making.”*

The RCNA state that the nurse practitioner role is based in advanced practice nursing, and is expanded through legislation and regulation by granting additional authorities such as prescribing, referrals, and admitting privileges. Consistent with the United Kingdom and the ICN definitions, the APN role in Australia requires the nurse to assume responsibilities associated with research, education, consulting and leadership, in addition to the clinical role.

The New Zealand Nurses Organization (NZNO, 2000) Position Statement on Advanced Nursing Practice complements the RCNA, U.K., and ICN definitions / models of advanced nursing practice. The NZNO state that functions of the advanced nursing practice role include *“education, research, leadership and consultancy, however, the role must also include a direct practice component.”* They further clarify that being an “expert-by-experience” or being accepted to perform more delegated medical functions or tasks does not equate to advanced practice. Prescriptive authority is considered to be a feature of advanced practice, but may or may not be part of the role of all advanced nurses. As Christensen (1999) notes, if advanced practice nurses are performing aspects of care that have traditionally been performed by other health care professionals such as prescriptive authority, it *“...should be embedded within an integrated advanced practice role”* (p. 9).

In 2001, both Australia and New Zealand registered their first NPs (Turner & Keyzer, 2002; Harris, Smith, & Betts, 2003). As these new roles evolve in these nations, efforts are being made to reach consensus on the scope and role of nurse practitioners. For example, the National Nursing Organizations of Australia (NNOA) endorsed a *National Consensus Statement on Nurse Practitioners* in October 2003. This statement identifies nurse practitioners as nurses prepared at a master's level or equivalent for the clinical practice area. They are members of multidisciplinary teams and their role is "characterized by clinical assessment and therapeutic management of health and illness presentations within their scope of practice" and may include ordering diagnostic tests, prescription of drugs, and referral to other health care providers (NNOA, 2003).

The Nursing Council of New Zealand (NCNZ, 2004) Scope of Practice Statement is similar to that of the NNOA but more prescriptive, likely because the NCNZ is the regulatory or licensing body for nurses in New Zealand, whereas the NNOA is a federation of nursing organizations. The NCNZ describe nurse practitioners as "expert nurses" who may work independently or in collaboration "within a specific area of practice incorporating advanced knowledge and skills" and specifies master's preparation or equivalent as a pre-requisite for NP registration in New Zealand. The scope of practice of NPs (NCNZ, 2004) includes:

- Promotion of health and prevention of disease;
- Assessment and management of health needs; and
- Diagnosing, ordering, conducting and interpreting diagnostic and laboratory tests and administering therapies.

3.4 United States

In the United States, the American Nurses Association (ANA) describes advanced practice nurses as registered nurses with advanced educational preparation and clinical practice competencies which go beyond the basic nursing education required for all RNs. The ANA describe four distinct APN roles; Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), Certified Nurse Midwife (CNM), and Certified Registered Nurses Anesthetist (CRNA) (ANA, 2004; Hanson & Hamric, 2003).

The ANA Social Policy Statement (1995) highlighted three features of the advanced practice nurse (Hamric, 1996, p. 46). These features are:

1. *Specialization*—concentrating or focusing on one aspect of nursing;
2. *Expansion*—acquiring new knowledge and competencies to competently perform skills which overlap with medicine; and
3. *Advancement*—integration of evidence-based knowledge that occurs as a part of graduate education in nursing.

Hamric (1996) distinguishes between "specialization in nursing and advanced nursing." She defines specialization as "concentration in a selected clinical area of practice" (p. 43). In keeping with the U.K model, Hamric clarifies that although specialization is a feature of advanced practice nursing, it does not in itself equate to advanced nursing practice. Other characteristics must also be demonstrated, such as having a direct clinical practice role and advanced education at the graduate level. Interestingly, with the recent

regulation of NPs in New Zealand, the emphasis on retaining a clinical focus as a “foundational competency” for the role is considered essential by practitioners to ensure the purpose of the role is not undermined, that is, “to provide advanced clinical expertise at the bedside” and “a career structure that encourages nurses to remain in clinical settings” (Harris, Smith, & Betts, 2003, p. 29).

The American Academy of Nurse Practitioners (AANP) Position Statement titled *Nurse Practitioners as an Advanced Practice Nurse Role* (AANP, 2002) is congruent with the definitions of advanced practice from other countries highlighted previously. The AANP states:

“Advanced practice nurses make independent and collaborative health care decision. They are expert clinicians engaged in active clinical practice. The advanced practice nurse demonstrates leadership as a consultant, educator, administrator, and researcher. An important leadership function of all advanced practice nurses is participation in legislative and professional activities to promote professional advancement and health related social policies.”

3.5 Canada

The Canadian Nurses Association (CNA) National Framework for Advanced Nursing Practice (2002) defines the term *advanced nursing practice* (ANP) broadly:

“ANP is an umbrella term. It describes an advanced level of nursing practice that maximizes the use of in-depth nursing knowledge and skill in meeting the health needs of clients (individuals, families, groups, populations, or entire communities). In this way, ANP extends the boundaries of nursing’s scope of practice and contributes to nursing knowledge and the development and advancement of the profession.”

In congruence with the international definitions, the CNA has also identified competencies that are the foundation of ANP. These include clinical competencies, research, leadership, collaboration, and change agent. As well, the CNA has identified both the clinical nurse specialist and the nurse practitioner as two established advanced nursing practice roles in Canada (CNA, 2003a; CNA 2003b). MacDonald et al. (2004) note that by referring to the NP as an advanced practice nurse, the ICN appear to equate advanced practice to “extended practice” defined by them as the additional regulatory authorities required to diagnose or prescribe. This is a clear distinction from Canada, where the CNS role is defined as an advanced nursing practice role based on the “application of advanced nursing knowledge”, rather than on the performance of “extended practice” functions (p. 7). The CNS does not typically engage in activities such as diagnosing and prescribing, and thus unlike the NP does not require additional regulatory authority (College of Nurses of Ontario, CNO, 2003a). Distinctions between the CNS and NP roles are discussed in more detail later in this paper.

The CNA has also clearly stated that a graduate degree in nursing is the “minimal educational preparation for ANP” (p. 8). Although not all APNs in Canada are prepared at the graduate level, which has been a source of debate as to whether the PHCNP is an advanced nursing practice role, an increasing number of universities are offering graduate

education in nursing, thereby providing more opportunities for nurses to more easily acquire the entry-level competencies required for advanced practice (CNA, 2002). With respect to the international context, the CNA position on graduate education is similar to that of New Zealand, the United States, and the United Kingdom, where graduate education is a requirement for advanced practice nurses.

The CNA has also identified nine characteristics of ANP, which are “consistently evident in practice.” These characteristics of ANP are consistent with international definitions and include:

- Expert and specialized practice grounded in knowledge that comes from nursing theory and other theoretical foundations, experience and research;
- Deliberate, purposeful and integrated use of in-depth nursing knowledge, research, and clinical expertise, and integration of knowledge from other disciplines;
- Depth and breadth of knowledge enabling the nurse to provide an ever-increasing range of strategies to meet the complex needs of clients;
- Ability to explain the theoretical, empirical, ethical and experiential foundations of nursing practice;
- Contribution to the understanding and development of evidence-based nursing knowledge through involvement in research and the evaluation and utilization of relevant research findings;
- Influence upon the practice of nurses by facilitating the integration of research-based knowledge into practice;
- Planning, coordinating, implementing and evaluating programs to meet client needs through partnerships and intersectoral collaboration;
- Ability to critically analyze and influence health policy; and
- Substantive autonomy and independence, with a high level of accountability.

This framework represents a national consensus on advanced nursing practice as it was developed in partnership with nursing associations and regulatory bodies across the country. In a recent British Columbia study by Pauly et Al. (2004), the CNA framework was compared to nurses’ understanding of advanced nursing practice. The authors conclude that the CNA framework is “clear, relevant, and concise”, and should not be revised to include “extended, expanded, specialized or expert” nursing roles that share “only some aspects of ANP” (p. 55).

4. ANP Titles and Roles: Focus on Canada

The nurse practitioner (NP) and clinical nurse specialist (CNS) are the two most common advanced nursing practice roles in Canada. Although other expanded or specialized roles exist in Canada, these roles do not meet the criteria for advanced nursing practice as identified by the Canadian Nurses Association. The three-stage model described earlier in this paper as developed by Hanson and Hamric (2003) is helpful in understanding why not all expanded or specialized roles are truly “advanced practice”. However, while this model is helpful in distinguishing among advanced practice roles and other extended or specialized roles, applying it to the Canadian context becomes more challenging for a

number of reasons. First, the terms *specialized* and *extended* are used to describe not only some advanced nursing practice roles, but also roles that are not considered to be advanced practice as defined by the CNA. In addition, the practice of nursing regulatory bodies to “grandparent” nurses who do not have advanced education but do have extensive working experience into advanced practice roles as defined by the CNA, has occurred and continues to occur throughout Canada as nurse practitioner legislation is introduced. Finally, graduate education for nurse practitioners, while recommended in a number of jurisdictions as the minimum educational preparation and is consistent with the CNA ANP framework (2002), is not currently a pre-requisite for entry-level practice to primary health care nurse practitioner roles in Canada.

More discussion related to these issues follows in this and in an upcoming section on the primary health care nurse practitioner and the scope of practice of other registered nurses. The focus of this section is on the NP (which is inclusive of the primary health care nurse practitioner or PHCNP and the acute care nurse practitioner or ACNP) and on the CNS, and includes a historical overview of their development and comparison of the roles.

4.1 The Clinical Nurse Specialist

According to Pinelli (1997), Clinical Nurse Specialists were first identified in the 1940s, and the role later formalized in the 1950s through the development and implementation of university nursing education programs in the United States, and later with graduate education in the 1980s. In Canada, the first graduate education program for CNS was developed in the 1970s (Pinelli, 1997). The CNS role was developed by nurse educators primarily to enhance or improve nursing care by bringing expert practice to direct patient care at the bedside, expert indirect care to other nurses through role modeling and consultation, and to provide an avenue for those nurses who wished to advance, but remain at the bedside (Pinelli, 1997; Dunn, 1997).

As an advanced practice nurse, the CNS performs many roles or domains of practice including clinical practitioner, educator, researcher, consultant, leader, change agent, and case manager (Rose, All, & Gresham, 2003). The degree to which a CNS implements these roles is driven by the practice setting and the need of clients. Specialization, a key characteristic of the CNS, provides the practitioner with in-depth knowledge, skills and judgment and “...helps foster the advancement of that particular specialty from a patient, family, staff, organization, and system perspective” (Clinical Nurse Specialist Interest Group, CNSIG, 2004). Clinical nurse specialists are employed in a variety of practice settings in Canada, but given their clinical specialization, primarily work in the acute care sector.

In 2003, the CNA published a Position Statement on the Clinical Nurse Specialist. In addition to the roles or domains of practice identified previously, the position statement includes the following key components. The CNS:

- Improves access to integrated and coordinated health care;
- Advances the profession through contributing to the development of nursing knowledge and evidence-based practice;
- Holds a graduate degree in nursing with expertise in clinical nursing specialty;

- Possesses in-depth knowledge, and skills, advanced judgment and clinical experience in a nursing specialty; and
- Assists in the resolution of complex health care issues.

The CNS role in the United States is similarly defined. According to the National Association of Clinical Nurse Specialists (NACNS, 2004), the CNS “independently provides theory and research-based care to clients facilitating attainment of health goals, works with nurses to advance nursing practice to improve outcomes cost-effectively, and/or provides clinical expertise to effect system-wide changes in organizations to improve programs of care...and holds a graduate degree in nursing” (p. 178).

4.2 Nurse Practitioner

Unlike the CNS role, the nurse practitioner (NP) role was not developed by nurse educators to enhance nursing, but rather first evolved in the United States and later in Canada in response to a shortage of primary health care physicians in rural and remote areas (Dunn, 1997; Pinelli 1997; de Leon-Demaré, Chalmers, & Askin, 1999). In the early 1970s, the Canadian government funded a number of Canadian university nursing education programs to facilitate the development of the NP role. By the early 1980s however, with an increasing supply of physicians, lack of a legislative framework and remuneration structures, and little public understanding of the NP role, the last NP education program closed in 1983 (Nurse Practitioner Association of Ontario, NPAO, 2004a). While numerous studies at this time demonstrated the benefits of nurse practitioners pertaining to cost effectiveness and patient satisfaction, these evaluations focused on the “...medical replacement functions of the nurse and not the wider primary health care services that nurses can deliver” (de Leon-Demaré, Chalmers, & Askin, 1999, p. 50). This lack of recognition of the nursing component within the NP role was a significant factor in the closing of NP programs, resulting in a physician replacement or physician assistant stigma perpetuated in part by increasing resistance to the role from both the medical and nursing communities (de Leon-Demaré, Chalmers, & Askin, 1999).

In 1993, the Ontario government decided to reintroduce NPs as a vehicle to improve access to primary health care. In 1997 the first NP legislation in Canada was introduced in Ontario with the proclamation of the Expanded Nursing Services for Patients Act. This legislation gave NPs the authority to communicate a diagnosis, order specific diagnostic and other laboratory tests, prescribe drugs and order treatments (CNO, 2004).

As highlighted earlier in this paper, definitions or descriptions of the nurse practitioner exist in several countries. This is also true within Canada. In June 2003, the Canadian Nurses Association published a Position Statement titled *The Nurse Practitioner*. Key attributes of the nurse practitioner identified in this statement include:

- The NP is an advanced practice nurse whose practice is focused on providing services to manage the health needs of individuals, families, groups and communities.
- The NP role is grounded in the nursing profession’s values, knowledge, theories and practice and is a role that complements, rather than replaces, other health care providers.

Further characteristics of NPs in Canada are that they:

- Have the potential to contribute significantly to new models of health care based on the principles of primary health care;
- Integrate into their practice elements such as diagnosing and treating health problems and prescribing drugs;
- Work autonomously, from initiating the care process to monitoring health outcomes;
- Work in collaboration with other health care professionals;
- Practise in a variety of settings including community, acute care and long-term care; and
- Require in-depth knowledge of nursing gained through the additional clinical practice education, and experience. The completion of a graduate degree is the most effective means of acquiring NP competencies.

This broad definition shares common features with national and international definitions for nurse practitioner as described previously, in that it:

- Identifies the nurse practitioner as an advanced practice nurse, “grounded in nursing” in the performance of his / her role;
- Identifies the expanded or extended aspect of the role by referencing competencies which traditionally fall outside the scope of nursing, such as diagnosing, treating, and prescribing drugs; and
- Highlights autonomous and collaborative practice.

4.3 Distinctions between CNS and NP

Even though both the CNS and NP are identified as advanced nursing practice roles in Canada, three notable distinctions are highlighted: educational preparation, role or domain of practice, and regulation. The CNA ANP framework (2002) endorses graduate education as the minimum preparation for the ANP, and the CNA NP position statement (2003b) clearly identifies graduate education as the means of acquiring competencies necessary to practise as an NP. Currently the educational preparation for primary health care NPs across the country ranges from a minimum of a registered nurse diploma with additional education and experience to graduate preparation, while the CNS and acute care nurse practitioner are prepared at the graduate level (Canadian Association of Schools of Nursing, CASN, 2004). This gap in educational preparation is slowly being addressed in Canada by some nursing regulatory bodies such as those in British Columbia (BC), New Brunswick (NB), Newfoundland and Labrador (NL), which all recommend graduate preparation for entry-level primary health care nurse practitioner practice (Registered Nurse Association of British Columbia, RNABC, 2004; Nurses Association of New Brunswick, NANB, 1999; Association of Registered Nurses of Newfoundland and Labrador, ARNNL, 1997). Additionally, CASN is recommending a master’s degree in nursing as a minimum requirement to prepare nurse practitioners for advanced nursing practice (CASN, 2004).

As noted previously a consistent feature of advanced practice nurses is the role or domains of practice (clinical, education, research, consultant, and leader / change agent) (CNA 2003a; Casteldine 1991; NZNO, 2000). A second distinction between the CNS and NP is in relation to these domains. According to Roschkov et al., 2004, the CNS and NP “function in each domain differently and with varying degrees of expertise” and the percentage of time spent in these roles varies. For example, the CNS may spend only 10% to 20% of his or her time providing direct clinical care, while the NP may spend closer to 80%. This difference in how the NP and CNS practise may be in part driven by practitioner’s expertise as the authors suggest, but it may also be context-driven, that is, unmet patient/client needs and employer expectations/job description may require greater time spent in the clinical domain. The personal preference of the practitioner may also play a role.

A final distinction between nurse practitioners and clinical nurse specialists is that, to date in Canada, only NPs have been granted additional regulatory authority to perform acts or services which fall outside of the traditional scope of nursing practice. It is possible that in the future, as roles continue to evolve and new roles emerge, additional regulatory authority may be granted to other advanced nursing practice roles (CNO, 2003a). It has been suggested in the literature by numerous authors that the CNS role and the NP role be merged, equally as many authors however have opposed that view (Plager, Conger, & Craig, 2003; Deane, 1997). The three distinctions discussed in this section provide the reader with information to consider in facilitating consistency in advanced nursing practice roles in Canada.

4.4 Distinction between Primary Health Care NPs and Acute Care NPs

Two nurse practitioner roles are prevalent in Canada, the primary health care nurse practitioner (PHCNP) and the acute care nurse practitioner (ACNP). The latter role is sometimes referred to as specialty nurse practitioner (SNP) in jurisdictions in Canada where the role is formally regulated such as Quebec (PQ), Nova Scotia (NS), and Newfoundland and Labrador (CNA 2004; Province of Nova Scotia, 2001; Province of Newfoundland and Labrador 1998). There are several differences between these two roles. First, primary health care nurse practitioners currently practise primarily in community-based settings, such as community health centres, family physician offices, and long-term care centres (Woods 1997; Nurse Practitioner Association of Manitoba, 2004). Acute care or specialty nurse practitioners, by virtue of their title and specialization, are employed mostly in acute care facilities such as hospitals (NPAO, 2004b). With changes in the broader health care system, such as the removal of regulatory barriers under public hospital and long-term care facility statutes, which recently occurred in Ontario (Province of Ontario, 2003), more and more PHCNPs are working in non-traditional practice settings such as acute care facilities including emergency and out-patient departments. Similarly, with the increasing acuity and complexity in the care needs of an aging population, ACNPs may in the future be more commonly found in other specialized areas of care such as long-term care centres.

Second, while NPs in both roles perform similar functions such as diagnosing conditions and treating and managing health problems, primary health care nurse practitioners tend to be generalists. As such, PHCNPs often provide health services such as health

promotion and disease prevention, and treatment of episodic and chronic conditions to clients across the lifespan. Conversely, acute care nurse practitioners are more specialized, and focus on specific patient populations such as neonatal, cardiology, and palliative care. For the ACNP, health problems tend to be higher in complexity requiring more in-depth knowledge of the specific disease entities.

Third, as stated earlier, variability exists in the educational preparation between PHCNPs and ACNPs. The PHCNP education ranges from a registered nurse diploma preparation with additional education and experience to graduate preparation, while the vast majority of ACNPs are prepared at the graduate level. Regardless of the educational preparation, the PHCNP must meet the entry-level competencies for PHCNP practice as set by each nursing regulatory body within in Canada.

Finally, perhaps the most significant difference between these roles is regulation (see Table 1 - Primary Health Care Nurse Practitioner – Status of Legislation). Seven provinces and territories (Newfoundland and Labrador, Nova Scotia, New Brunswick, Ontario, Saskatchewan, Alberta, and NorthWest Territories) have established a regulatory framework for PHCNPs, while three provinces have legislation pending (Prince Edward Island, Manitoba and British Columbia), and the remainder are exploring PHCNP regulation (Yukon, and Quebec). It should be noted that the Yukon currently has broad legislation, which allows for nurse practitioners to function in advanced practice roles. The legislation, however, does not create a separate roster for NPs. Currently, the only employer of NPs in the Yukon is the government, and it is through a scope of practice document endorsed by government and the Yukon Registered Nurses Association (YRNA) that NPs are enabled to practice. To facilitate consistency with other jurisdictions and to ensure consistency within the Yukon as new NP roles emerge, the Association has embarked on a consultation process to determine if new regulations are required specific to the NP role (YRNA, 2004). The Quebec Order of Nurses is exploring the establishment of primary care nurse practitioners to address the untenable situation that nurses working in the north face on a daily basis. As often the sole provider of health care services in the region, they address common health problems, which include diagnosing and treating clients, but in doing so these nurses step outside the legal boundaries of nursing practice as defined in the Nurses Act (QON, 2004).

Table 1 - Primary Health Care Nurse Practitioner – Status of Legislation

Jurisdiction	Legislation	Pending	Exploring
N.W.T. & Nunavut	X		
Yukon			X
B.C.		X (by 2005)	
Alta.	X		
Sask.	X		
Man.		X (by 2004)	
Ont.	X		
Que.			X
N.B.	X		
P.E.I.		X (by 2005)	
N.S.	X		

Nfld and Labrador	X		
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Three provinces have ACNP legislation (Newfoundland and Labrador, Nova Scotia and Quebec), and one province is actively examining the regulation of the role (Ontario, CNO, 2003a). In the remaining provinces that have nurses practicing in ACNP roles, these nurses are currently regulated in the same category or class as other registered nurses and are granted additional authority to prescribe and order diagnostic tests, for example, through delegation / medical directives.

Despite these differences, the CNA in partnership with the provincial nursing associations and regulatory colleges in Canada developed entry-level competencies for all NPs (acute and primary) and recognized three distinct streams of practice; family / all ages (PHCNP), adult (ACNP), and pediatric (ACNP). The competencies for the NP streams are based on the principles of primary health care. The development of a family/all ages examination to evaluate entry-level competencies has begun (CNA, 2004).

Having a clear understanding of the similarities and differences respecting these advanced nursing practice roles (namely the CNS, PHCNP, and ACNP) is essential in supporting the successful integration and sustainability of these roles in the Canadian health care system. In addition, these distinctions facilitate more effective and efficient decision-making by the public, other health care professionals, and policymakers regarding health care services provided by these practitioners. For example, by having a greater understanding of these APN roles:

- The public may be more likely to know what to expect when accessing services from APNs;
- Health care professionals may work more collaboratively with APNs and more readily make referrals to and / or accept referrals from APNs; and
- Policy makers may be better equipped to make decisions to enable APNs to the practice to the fullest extent of their scope of practice.

5. Primary Health Care Nurse Practitioners across Canada

While the CNA definition of the nurse practitioner is helpful in facilitating understanding of the role and scope of practice, the regulation of the nurse practitioners is a provincial responsibility. Therefore, in order to safeguard the public, each jurisdiction in Canada has the authority as granted by government in their respective province or territory and the responsibility to identify titles, define the role and scope of practice, set standards for the profession, and define entry requirements.

Information on titles, role and scope are not consistently available when determining similarities and differences among provinces regarding how nurse practitioners are defined or described. Therefore, a variety of sources were reviewed where required, including provincial and territorial legislation, regulation, standards of practice, competency documents, press releases, fact sheets, and articles in newsletters / journals. A compilation of this information is presented in the Appendix, which is a synopsis of the current information gathered in each jurisdiction where PHCNP legislation already exists or is pending. The table in the Appendix identifies role, scope, and degree of autonomy in

practice. In addition, in those jurisdictions with ACNP / SNP legislation, the title and description of the role is provided.

5.1 Similarities

There are numerous similarities respecting the role and scope of nurse practitioners in jurisdictions in Canada that either have primary health care nurse practitioner legislation or have proposed legislation. Consistently, NPs are defined as registered nurses with “expert”, “advanced”, or “enhanced” nursing knowledge and competencies or skills. In New Brunswick and Prince Edward Island (pending) the NP is referred to as a “generalist”. Although this concept of generalist is not explicitly stated in other jurisdictions, it is implied by using phrases such as provides “comprehensive” or “full range” of health services “across the lifespan” (British Columbia, pending), “to individuals, families, groups and communities” (Alberta, Saskatchewan, Manitoba, pending), and “to clients in all developmental stages, and to families and communities” (Ontario).

In reviewing jurisdictional information, there are many similarities regarding implementation of the NP role. For example, practising collaboratively (autonomously and/or in consultation, formal and informal) with other health professionals is a common feature of the role. The role also specifies the delivery of “primary health care services” such as:

- Health promotion;
- Disease and injury prevention; and
- Coordination and management of care, which includes management of acute episodic illnesses (curative services) and certain chronic diseases (rehabilitative and supportive services).

To facilitate the implementation of the nurse practitioner role—for example to manage episodic illnesses or chronic conditions—additional authority or an “expanded scope of practice” is granted through legislation. Again, a number of similarities are found among the jurisdictions. For example, in all jurisdictions with legislation or proposed legislation the nurse practitioner may:

- Make and communicate a diagnosis;
- Order and interpret screening and diagnostic tests; and
- Select, recommend, prescribe and monitor the effectiveness of drugs and interventions / treatments.

Only nurse practitioners in Northwest Territories (N.W.T.), B.C. (pending), Alberta and Saskatchewan are permitted to distribute or dispense medications as part of the additional authority granted to NPs in those jurisdictions.

5.2 Differences

5.2.1 Titles

The title used to describe a primary health care nurse practitioner (PHCNP) in jurisdictions with legislation or pending legislation was varied (See Table 2 -

Jurisdictional Titles with Pending or Established PHCNP Legislation). Titles included registered nurse–nurse practitioner or RN (NP) in N.W.T. and Saskatchewan, registered nurse–extended practice or RN (EP) in Manitoba, registered nurse–extended class or RN (EC) in Ontario (ON), nurse practitioner (NP) or primary health care nurse practitioner (PHCNP) in Nova Scotia and nurse practitioner – primary health care (NP-PHC) in Newfoundland and Labrador.

Table 2 - Jurisdictional Titles with Pending or Established PHCNP Legislation

Jurisdiction	Title	Acronym
N.W.T. & Nunavut	Nurse Practitioner or Registered Nurse - Nurse Practitioner	NP or RN (NP)
British Columbia (pending)	Nurse Practitioner or Registered Nurse Practitioner	NP or RNP
Alberta	Nurse Practitioner	NP
Saskatchewan	Registered Nurse - Nurse Practitioner	RN (NP)
Manitoba (pending)	Registered Nurse (Extended Practice)	RN (EP).
Ontario	Registered Nurse (Extended Class)	RN (EC)
New Brunswick	Nurse Practitioner	NP
Nova Scotia	Nurse Practitioner or Primary Health Care Nurse Practitioner	NP or PHCNP
Prince Edward Island (pending)	Nurse Practitioner or Registered Nurse - Nurse Practitioner	NP, RNNP or RN(NP)
Newfoundland and Labrador	Nurse Practitioner -Primary Health Care	NP - PHC

This variability in title is partly explained by the nomenclature used for the nurse practitioner as entered on the roster in the registering province. For example, in Alberta while the title nurse practitioner is used, nurse practitioners are registered on the extended practice roster (Alberta Association of Registered Nurses, AARN, 2002a). The title *nurse practitioner* is protected in all jurisdictions with the exception of Manitoba and Ontario. However, the College of Nurses of Ontario (CNO) is currently exploring the regulation of acute care nurse practitioners and title protection of the term *nurse practitioner* (CNO, 2003b). Consistency in title is an important component in facilitating public, employer, and other health professional understanding of the purpose and scope of practice of the nurse practitioner role (CNO, 2003a; Offredy, 1999).

In reviewing the titles for NP across the country the term “NP” appears in all titles with the exception of Ontario and Manitoba. These provinces chose broader categories to identify members who are primary health care nurse practitioners, that is “extended

class” or RN (EC), and “extended practice” or RN (EP), respectively. In developing the regulatory framework for primary health care nurse practitioners in Ontario in the 1990s, the College of Nurses of Ontario chose the title RN (EC), as the intention at that time was to be open to the evolution and regulation of other extended practice roles in the future such as nurse anesthetist or nurse midwife (CNO, 2003b). In Manitoba¹, although the original proposed title for the role changed from registered nurse advanced practice or RN (AP) to registered nurse extended practice RN (EP), one of the original drivers for the development of the role was the “increasing recognition of the significant role that registered nurses already contribute in various health services areas and delivery models, in a variety of contexts” (CRNM, 2002, p. 14). Thus, given the variability in setting and context in which the role could potentially evolve, a broader title was likely chosen to acknowledge its future evolution.

Using the term *extended* in the regulatory nomenclature may create confusion with respect to clearly defining NPs as advanced practice nurses, particularly when the term *extended* or *expanded* is used in workplaces in Canada and in other countries to describe nurses who are expert or specialized practitioners, but who are not advanced practice nurses (MacDonald et al., 2004; Albarran & Whittle, 1995). It is clear, as discussed below, that regulatory colleges use the term *extended* to specifically refer to those health care services that NPs provide which require additional regulatory authority beyond the scope of other RNs, such as diagnosing, prescribing, and treating (AARN, 2002; CNO, 2003a; and CRNM, 2003 & 2004a).

5.2.2 Scope

Another significant difference among jurisdictions respecting PHCNPs relates to the parameters or boundaries and limitations placed on the additional authorities or “expanded scope”. These boundaries for practice are specified in a variety of sources and vary across the country, ranging from specifications in legislation to policy documents. The processes to update the additional authorities or scope of the NP also vary, and may include extensive multi-stakeholder consultation, statutory committee approval, and board or council approval. In each case, these processes may be subject to the approval of provincial or territorial government.

For example, marked variability exists with respect to prescriptive and diagnostic authority. In some jurisdictions such as Ontario and Newfoundland and Labrador, NPs may order only those drugs and lab tests that are listed in regulations. In Ontario for example, in order to change or update the list, extensive consultation is conducted, followed by College Council approval; finally, government cabinet approval is required. In other jurisdictions drugs and diagnostic tests are listed in Schedules and vary in their breadth. For example, in Nova Scotia the specific drugs the NP can order are listed in “Practice Schedules” approved by the Diagnostic and Therapeutics Committee (College of Registered Nurses of Nova Scotia, CRNNS, 2004). In New Brunswick, classifications of drugs as defined in the provincial drug formulary with exceptions or exclusions listed in schedules (NANB, 2002a; NANB 2004). These lists of drug and diagnostic tests may

¹ Extended Practice Regulations are pending and anticipated to be approved by government by the end of 2004 (CRNM, retrieved December 13, 2004 from <http://www.cnm.mb.ca/extendinfo.php>).

be updated or revised by a multi-stakeholder statutory committee (e.g., Nova Scotia, New Brunswick, and pending in Manitoba), and in some instances require final government approval (New Brunswick, Manitoba, NorthWest Territories) (NANB, 2002b; CRNM 2004a; Government of N.W.T., 2003). Finally, other provinces (e.g., Saskatchewan, Alberta, and pending in British Columbia) give NPs even broader prescriptive and diagnostic authority, permitting access to the schedules within the provincial drug formulary for prescribing purposes accessed by other medical professionals, and more broadly defining diagnostic authority by not limiting to specific tests listed in regulation or on a practice schedule (Saskatchewan Registered Nurses Association, SRNA, 2003; AARN, 2002b; Ministry of Health Services, 2004). In essence, the more difficult the process to change or update prescriptive and diagnostic authority, the more limitations are placed on the NP's scope of practice. In comparison to Canada, NPs have very broad prescribing authority and in most states are able to prescribe narcotics (Pearson, 2004). Health Canada is currently considering granting NPs prescriptive authority of controlled substances including narcotics (Government of Canada, 2004).

5.2.3 *Autonomy*

Another difference among jurisdictions is the degree or extent of consultation or collaboration required for nurse practitioner role implementation. The literature suggests collaboration with other health professionals, in particular physicians, as one of the key facilitators to enabling NPs to practice to their full scope (IBM Consulting Services, 2003). While the concepts of NPs practising autonomously and collaboratively are common across the country, expectations for collaboration and consultation vary significantly and range from more restrictive models of collaboration and consultation where the nurse practitioner practice is bound or limited by legal formal practice agreements as specified in legislation to more open models where the nurse practitioner drives the amount of collaboration and consultation based on client needs and practitioner knowledge.

Like specifications for prescriptive and diagnostic authority, the requirement for collaboration may be specified in legislation, regulation and/or board or council policy (e.g., standards or competency documents). For example, in Nova Scotia, NP legislation requires a formal collaborative practice agreement among the collaborative practice team member, that is, the nurse practitioners and physician partners (CRNNS, 2004; CRNNS, 2003). The CRNNS collaborative practice agreements are prescriptive and include the drugs, laboratory tests that the NP may order, and may also include additional expectations for consultation (CRNNS, 2004). While the existence of formal collaborative practice agreements can be considered a facilitator in many ways in that it clearly identifies scope of practice of the NP and expectations for consultation, these agreements may also serve as a barrier to practice, particularly if agreement is not reached respecting which drugs the NP can prescribe or which lab tests the NP can order. In Nova Scotia, for example, the nurse practitioner cannot practice without a signed and endorsed collaborative practice agreement.

In Newfoundland and Labrador, expectations for consultation are specified in the NP Regulations and are also quite prescriptive (Province of Newfoundland and Labrador, 1998), while in New Brunswick the *Nursing Act* (NANB, 2002b) states that no NP can

practice unless he or she has “reasonable access to a medical practitioner for the purposes of consultation” (Section 10.4). In this case, confirmation of “reasonable access” must be reported to the registrar on an annual basis and documented in writing between the parties involved (Section 10.5 (1) and (2)). In Ontario, the *Nursing Act* specifies that the RN (EC)/NP cannot communicate a diagnosis unless he or she “...has complied with the prescribed standards of practice respecting consultation with members of other health professions” (Province of Ontario, 1991). While on the surface this sounds overly prescriptive, in practice the standards of practice for the RN (EC) for consultation essentially place parameters around *when* the nurse should consult rather than making it an expectation for the nurse to consult with a physician every time she or he communicates a diagnosis. It should also be noted that the standards as a policy document are amended from time to time by the CNO Council, and do not require government approval before being enacted.

For Manitoba, Saskatchewan, Alberta and British Columbia, expectations for collaboration and/or consultation are specified in the provincial standards and competency documents (CRNM, 2004b; SRNA 2003; AARN 2002b; RNABC 2004). Expectations are clearly defined in these documents, but unlike Newfoundland and Labrador, Nova Scotia and New Brunswick, the expectations do not constitute binding legislative requirements. This gives NPs more flexibility in operationalizing these expectations to their specific context of practice. Similarly, the Northwest Territories does not specify formal collaboration in legislation (Government of N.W.T., 2003).

5.3 Discussion

Although there are a number of similarities respecting PHCNPs (most significantly that all PHCNPs are registered nurses that have advanced or enhanced knowledge, the NP title is protected in most jurisdictions, and the role and additional authorities or scope is generally consistent) there remains significant variability across the country respecting how the PHCNP scope is implemented. This variability is derived from the regulatory framework, which guides NP implementation such as limitations on scope of practice through restrictive drug and lab lists, and the degree of autonomy or independence in practice such as requirements to enter a formal collaborative practice agreement or submit in writing to the regulatory body the name of the collaborating physician partner. Limitations placed on scope of practice and decreased independence and autonomy in NP decision-making can lead to dissatisfaction and conflict, and hinder the ability of the NP to successfully implement his or her role (Sidani, Irvine, & DiCenso, 2000; Woods, 1997).

Clear definition of advanced nursing practice roles, such as that of the primary health care nurse practitioner, is a key facilitator to successful role implementation (Sidani et al., 2000; IBM Consulting Services, 2003). The IBM study (2003), which examined the integration of primary health care nurse practitioners in Ontario, found that a significant number of NPs reported their role was clearly defined (80%). These NPs also reported that they were “more likely to work within their full scope of practice”, “not be limited to certain types of patients,” and “spend more time doing clinical work and less on non-clinical and clerical work” (p. 10). Alternatively, NPs who reported that their role was

narrower also reported less satisfaction with their ability to work to full scope of practice in their workplace, and with their role in the decision-making process.

Attitudes of other health professionals about the NP role can also impact its successful implementation in the practice setting. Gooden and Jackson (2004) examined the attitudes of registered nurses towards nurse practitioners in the state of Illinois. These authors found that RNs had a good understanding of the NP role, sought out the NP for advice, and perceived NPs as being receptive to their approaches to patient care. However, RNs perceived “that NPs did not adequately understand the RN role and that NPs had limited respect for RNs” (p. 363). The authors conclude that greater exposure of these two nurse groups to one another would enhance their understanding of each other’s role and their ability to provide optimal care to their patients/clients. In the U.K., Walsh (1999) compared perceptions of caring by NPs and other RNs. NPs and RNs compared favorably overall on the items identified on the caring dimension scale. However, one difference of interest is related to the score on the “activities of daily living” item, where RNs scored higher than NPs in that they rated it more important. As NP practice emerges and moves beyond “traditional nursing practice”, NPs will expect RNs to carry out these caring activities, which could potentially lead to resentment of the NP (p. 41). As NP roles emerge in Canada it is important to pay attention to differences in how RNs and NPs work, and to develop and implement strategies to enhance understanding of the NP role. This is important because anecdotal data is suggesting that NPs in Canada believe they are resented by their RN colleagues and that their role is not well understood.

Attitudes and perceptions of physicians towards NPs also affect successful role integration. For example, in the recent IBM study (2003), physicians working with NPs identified “the structure of the MD-NP relationship as a strong barrier to NP integration”. Although the nature of this issue was not clarified by the MD survey data, it may be directly related to concerns physicians expressed in the survey respecting liability and responsibility for RNs in the practice setting (p. 21). Perceptions, which categorize NPs as “doctor assistants” or as being unsuitable to serve as the primary provider of health services still prevail (Ryan, 1998). These perceptions can be detrimental as they demonstrate a lack of understanding of the NP role, and do not recognize the NP legal scope of practice or the autonomous and collaborative nature of their role. While written practice agreements may be helpful to some extent in addressing these concerns, it is important that they are not overly prescriptive as to limit the ability of NPs to practise to their full scope.

Additionally, in papers by De Grasse and Nicklin (2001) and Dunn and Nicklin (1995) which examined advanced nursing practice roles in acute care settings, these authors noted that the practice setting plays a key role in influencing and shaping the development of advanced practice roles. They suggest that the development of clear policies such as guidelines/standards and job descriptions within organizations informs others, and helps to decrease role confusion and role ambiguity. This in turn leads to more successful integration of these advanced practice roles in organizations. Further, in Ontario, although restrictions on prescribing authority and ability to independently refer to specialists have been noted to impact positive role implementation of the PHCNP, despite these limitations, the existence of a legislative framework has been found to promote role clarity (Sidani et al., 2000).

In 2001 the Centre for Nursing Studies in collaboration with the Institute for the Advancement of Public Policy published a report examining the nature of the extended / expanded role nursing role in Canada. At the time of this report, only three provinces had PHCNP legislation. The authors noted that there was consistency in the scope of practice parameters that guided implementation of these roles in those jurisdictions. In jurisdictions without legislation, the extended/expanded roles varied significantly and were operationalized through medical directives. The increased number of jurisdictions with actual or proposed legislation may be seen to bode well for the successful integration of PHCNPs in Canada. Despite the differences in prescriptive and diagnostic authorities and degree of autonomy, the approach of having legislation rather than relying on medical directives to enable practice provides a solid foundation for establishing consistency in the role. This is especially true with federal and provincial responsibilities to facilitate labour mobility of nurses across Canada, as identified in mutual recognition agreement as endorsed by nursing regulatory bodies.

6. Role and Scope of PHCNPs Compared to Other RNs

As stated previously, “the registered nurse scope of practice is the foundation for the nurse practitioner scope of practice” (AARN). Nurse practitioners and registered nurses have an overlapping scope of practice and may perform similar roles in the practice setting including:

- Assessing patient / client;
- Promoting health;
- Preventing disease or injury;
- Providing treatments and interventions;
- Teaching and counseling;
- Coordinating care;
- Supervising, managing or administering the provision of health services; and
- Engaging in research.

NPs are RNs with “advanced knowledge and decision-making skills” gained through “additional clinical practice, education and experience.” Although RNs and NPs have a shared scope of practice as identified above, the needs of the patient population being served will in part determine who the most appropriate provider is in a given practice setting (SRNA, 2004). Additionally, the two are distinguished by the way in which the NP and RN implement their role in the practice setting because of the advanced knowledge of the NP. The roles differ primarily because of the enhanced or extensive nursing and related knowledge in science and other fields, gained through additional education and experience that the NP typically possesses. For example, with respect to client assessment, the Alberta Association of Registered Nurses identify “assessment of the patient/client” as being within the scope of practice of the RN, while “in-depth, comprehensive assessment of the patient/client” is identified as the NP scope of practice. The “in-depth and comprehensive assessment” is a direct outcome of the advanced nursing and related knowledge and experience of NPs. Additionally, PHCNPs are better equipped to address more complex care needs of the clients because of their advanced

knowledge by anticipating problems, and/or asking the appropriate questions to facilitate a more in-depth assessment and establish an appropriate treatment plan.

The most distinguishing feature between RN and NP scope of practice is related to NPs legislated “extended” authority and its related autonomy. In other words, NPs possess expanded regulatory authority respecting diagnosing health conditions, ordering laboratory and diagnostic tests, and prescribing treatments and medications, and managing acute and chronic conditions. As the New Brunswick Nurses Association states, “...this authority is what makes the practice of nurse practitioners different from that of all other registered nurses” (NANB, 2002a, p. 2). Although other registered nurses such as registered nurse first assistants, transplant nurses or gastroenterology nurses may be expert or specialized nurses and have the ability through medical directives or delegation to provide expanded or extended services outside of their scope of practice, they do not have the authority to perform these functions autonomously. With legislated authority, NPs have greater autonomy in decision-making and, in performing these health services; they retain higher accountability for patient/client outcomes (CRNNS, 2003).

7. Conclusion

The Canadian Nurse Practitioner Initiative commissioned this paper to stimulate and guide discussion on advanced nursing practice as it relates to primary health care nurse practitioners and other nursing roles from both an international and national perspective. Moreover, this discussion paper is intended to help build consensus towards a national definition of the primary health care nurse practitioner in Canada—with particular emphasis on title, scope and role—required to facilitate its sustainability in Canada’s health care system.

Reference to a consistent definition is important as it informs nurses, other health professionals, administrators, policymakers, and the public about the role; it provides clarity for future development of the scope and role; and it facilitates sustainability of the role over time. While differences exist among definitions used to describe advanced nursing practice internationally, and among advanced nursing practice roles in Canada, these differences are not insurmountable and centre on educational preparation and additional regulatory authority. Efforts are being made by national and provincial nursing bodies in Canada to address gaps in educational preparation among these advanced nursing roles. It is important to note that additional regulatory authority for all current and emerging advanced practice roles may not be required or appropriate. Additional authority is required if the APN is engaged in activities such as autonomously diagnosing diseases / conditions and prescribing drugs.

The similarities and differences between the PHCNPs and other nursing roles were also discussed. While many similarities exist between PHCNPs and RNs—for example all PHCNPs are RNs, and both PHCNPs and RNs may work in similar roles, there are significant differences. These differences are related to two key areas.

- First, the PHCNP possesses advanced nursing and related scientific knowledge and additional experience beyond that of most RNs; and

- Second, PHCNPs have additional regulatory authority, which gives them the ability to autonomously diagnose, prescribe and treat clients with common chronic or acute episodic health conditions.

On completing the literature review and environmental scan, remarkable consistency with some differences were found among jurisdictions with either pending or actual legislation for PHCNPs. Highlighted are key consistencies and, where appropriate, differences in the term, scope and role of the PHCNP across the country. This information is intended to serve as a common reference point in the discussion to facilitate consensus on a national PHCNP definition.

Title

- Nurse practitioner or NP is a protected title in all jurisdictions with pending or actual primary health care practitioner legislation (currently eight jurisdictions) with the exception of Ontario and Manitoba. However, the former is considering NP title protection in the future.²

Role:

To competently perform the role, PHCNPs:

- Are RNs with “expert”, “advanced”, or “enhanced” nursing knowledge and competencies or skills gained by additional educations and experience³;
- Are “generalists” who provide “comprehensive” or “full range” of health services “across the lifespan” / “clients in all developmental stages”/ “to individuals, families, groups and communities”;
- Practise in a variety of health care settings including, but not limited to, hospital out-patient and emergency department, long-term care facilities, community health centres, family physician / group practice offices;
- Practise autonomously or collaboratively (and / or in consultation, formal and informal)⁴; and
- Deliver “primary health care services” including:
 - Health promotion;
 - Disease and injury prevention; and
 - Coordination and management of care that includes management of acute episodic illnesses (curative services) and certain chronic diseases (rehabilitative and supportive services).

Scope (Additional Authorities)

Further, PHCNPs:

² RN(EP) and RN(EC) are used in Manitoba and Ontario, respectively to identify PHCNPs. In both provinces these broader categories enable the regulation of future advanced practice roles.

³ Educational preparation is varied across the country and ranges from RN diploma to graduate education. Regardless of the educational preparation, all PHCNPs in Canada are expected to meet the entry-level requirements as set by their respective nursing regulatory body before they are allowed to practice.

⁴ The degree of autonomy of the PHCNP is affected by the parameters or boundaries placed on scope of practice and requirements for formal collaboration or consultation with physicians.

- Make and communicate a diagnosis;
- Order and interpret screening and diagnostic tests; and
- Select, recommend, prescribe and monitor the effectiveness of drugs and interventions / treatments.

In some provinces and territories, PHCNPs are permitted to distribute or dispense medications as part of the additional authority granted to NPs in those jurisdictions. Parameters or boundaries on scope of practice authorities are varied across the country and range from prescriptive lists of drugs and diagnostic tests listed in regulation to more open-ended prescribing authorities (e.g., prescribe from provincial drug formulary).

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Appendix

Jurisdictional Definition / Descriptor of the Primary Health Care Nurse Practitioner

Jurisdiction	Title	Definition / Role of PHCNP & Definition of ACNP (where applicable)	Scope of Practice of PHCNP (Additional Authority)	Collaborative practice requirement PHCNP
Newfoundland and Labrador	<p>Nurse Practitioner - Primary Health Care (NP - PHC) and Nurse Practitioner – Specialist (NP-S).</p> <p>“Nurse Practitioner” and “NP” designation protected.</p>	<p>The Nurse Practitioner - Primary Health Care (NP-PHC) is a Registered Nurse with advanced preparation in nursing and medical science who practises within a primary health care model. The NP-PHC:</p> <ul style="list-style-type: none"> Provides comprehensive nursing care to individuals, families and communities which includes health promotion, illness prevention, supportive, curative, and rehabilitative care; Provides holistic care with a client case load and acts as a catalyst to mobilize individuals, families and communities to assume responsibility for their own health; Selects modes of care and technology based on the client’s health needs, and tailored to the client’s social, economic and cultural resources; 	<p>The PHCNP may:</p> <ul style="list-style-type: none"> diagnose certain conditions and communicate a diagnosis as specified in regulations; and order diagnostic tests and prescription drugs as specified in regulations; <p>(Source: ARNNL Nurse Practitioner Regulations 65/98 retrieved from http://www.gov.nf.ca/hoa/regulations/rc980065.htm)</p>	<p>A nurse practitioner</p> <p>(a) shall establish and document a collaborative working relationship with a primary care physician; and</p> <p>(b) may establish working relationships with other health professionals,</p> <p>for the purposes of consultation.</p> <p>(Source: ARNNL NP Regulations 65/98, Section 3 http://www.gov.nf.ca/hoa/regulations/rc980065.htm)</p> <p>Expectations and Process for consultation specified in sections 3 – 9 of the NP Regulations)</p>

Jurisdiction	Title	Definition / Role of PHCNP & Definition of ACNP (where applicable)	Scope of Practice of PHCNP (Additional Authority)	Collaborative practice requirement PHCNP
		<ul style="list-style-type: none"> • As a member of an interdisciplinary/ intersectoral team, practices both autonomously and collaboratively; and • Functions in the advanced practice roles of practitioner, educator and leader. (ARNNL Position Statement on APNP, http://www.arnnl.nf.ca/links/position_statement_-_advanced_practice_nurse_practitioner_-_primary_health_care.htm) • The Nurse Practitioner - Specialist (NP-S) is a Registered Nurse with advanced preparation in nursing and medical sciences who practises health care management for a specific population of clients. The NP-S: <ul style="list-style-type: none"> • Provides comprehensive care to individuals and families which includes health promotion, illness prevention, supportive, curative and rehabilitative care; • As a member of an interdisciplinary health 		

Jurisdiction	Title	Definition / Role of PHCNP & Definition of ACNP (where applicable)	Scope of Practice of PHCNP (Additional Authority)	Collaborative practice requirement PHCNP
		<p>care team, practices autonomously and collaboratively;</p> <ul style="list-style-type: none"> • Works in secondary or tertiary settings; and • Functions in the advanced practice roles of practitioner, educator and leader. (ARNNL Position Statement on APNP – Specialist http://www.arnnl.nf.ca/links/position_statement_-_advanced_practice_nurse_practitioner_-_specialist.htm). 		
Nova Scotia	<p>Nurse Practitioner or N.P. or NP, or Primary Health Care Nurse Practitioner</p> <p>Specialty Nurse Practitioner</p> <p>NP title</p>	<p>Nurse practitioner is a registered nurse whose name appears in the primary health care nurse practitioner class or the specialty nurse practitioner class pursuant to the Registered Nurses Regulations (2001) and is a member of a collaborative practice team.</p> <p>Primary health care nurse practitioner is a nurse practitioner who as a member of a collaborative practice team provides primary health care</p>	<p>Practice of a nurse practitioner: the practice in which a nurse practitioner may, subject to a collaborative practice agreement and in accordance with standards of practice of nurse practitioners,</p> <p>(i) Make a diagnosis identifying a disease, disorder or condition. (ii) Communicate the diagnosis to the client. (iii) Order and interpret screening and diagnostic tests approved through the process set out in the regulations.</p>	<p>Collaborative Practice Agreement is a legislative requirement for NP practice in NS. (Source: <i>Registered Nurses Act, 2001</i>)</p>

Jurisdiction	Title	Definition / Role of PHCNP & Definition of ACNP (where applicable)	Scope of Practice of PHCNP (Additional Authority)	Collaborative practice requirement PHCNP
	protected	<p>services including:</p> <ul style="list-style-type: none"> • health promotion and disease prevention; acute episodic care; continuing care of chronic conditions; and • the education and advocacy relevant to the foregoing. <p>Specialty nurse practitioner is a nurse practitioner who provides specialized health care services including:</p> <ol style="list-style-type: none"> 1. health promotion, illness and injury prevention; 2. coordination and management of acute and emergent health problems; and 3. education and advocacy to a designated client population group requiring focused health and illness care. (Source: CRNNS Nurse Practitioner Definitions, http://www.crnns.ca/default.asp?id=190&pagesize=1&sfld=content.id&search=1508&mn=414.70.81.412) and An Act Respecting the Practice of Registered Nurses Act, 2001, www.gov.ca/legislature/leg 	<p>(iv) Select, recommend, prescribe and monitor the effectiveness of drugs and interventions approved through the process set out in the regulations.</p> <p>Perform such procedures approved through the process set out in the Registered Nurses Regulations (2001).</p> <p>(Source: Nurse Practitioner Definitions, http://www.crnns.ca/default.asp?id=190&pagesize=1&sfld=content.id&search=1508&mn=414.70.81.412)</p>	

Jurisdiction	Title	Definition / Role of PHCNP & Definition of ACNP (where applicable)	Scope of Practice of PHCNP (Additional Authority)	Collaborative practice requirement PHCNP
<p>Prince Edward Island</p> <p>(legislation pending 2005)</p> <p>Note: The Bill (No. 14) received Royal Assent on December 16, 2004, however the Act will not be proclaimed until Regulations are approved (Source: ANPEI, http://www.anpei.ca/default.asp?mn=1.10).</p>	<p>Nurse Practitioner (NP) or Registered Nurse – Nurse Practitioner or RNNP / RN(NP)</p> <p>Title protection proposed</p>	<p>c/statutes/regisnur.htm</p> <p>PHC-NP is a generalist who offers comprehensive and continuous care to clients (e.g., individual, family, groups and community) across the health continuum and throughout the client's lifespan. The NP provides comprehensive primary health care services including:</p> <ul style="list-style-type: none"> • Health promotion; • Disease and injury prevention; • Curative; • Rehabilitative and supportive services to clients in all health settings. <p>As a member of the interdisciplinary health team, the NP is both autonomous and collaborative in nature. (Personal Communication, Rob Calnan, November, 2004)</p>	<p>The "practice of a NP" may include:</p> <ul style="list-style-type: none"> • Diagnose or assess a disease, disorder or condition, and communicate the diagnosis or assessment to the client; • Order and interpret screening and diagnostic tests; • Select, prescribe and monitor the effectiveness of drugs as authorized under Section 14.1 of the Pharmacy Act; and • Order the application of forms of energy. <p>(Source: Registered Nurses Act, http://www.assembly.pe.ca/bills/pdf_chapter/62/2/chapter-15.pdf)</p>	<p>No specifications for collaboration in legislation, but may be prescribed in Regulations which are currently pending.</p>
<p>New Brunswick</p>	<p>Nurse Practitioner (NP)</p> <p>Protected title</p>	<p>A nurse practitioner is a registered nurse. The nurse practitioner in primary health care is a generalist who offers comprehensive and continuous care to clients (e.g., individual, family, groups and community) across the health continuum and throughout the client's lifespan.</p>	<p>The "practice of a nurse practitioner" may include:</p> <ul style="list-style-type: none"> • Diagnose or assess a disease, disorder or condition, and communicate the diagnosis or assessment to the client; • Order and interpret screening and diagnostic 	<p>The NB Nursing Act (1984 amended 2002) states that no NP can practice unless he or she has "reasonable access to a medical practitioner for the purposes of consultation" (Section 10.4). In this case, confirmation of "reasonable access" must be reported to the Registrar on an annual basis and documented in</p>

Jurisdiction	Title	Definition / Role of PHCNP & Definition of ACNP (where applicable)	Scope of Practice of PHCNP (Additional Authority)	Collaborative practice requirement PHCNP
		<p>The nurse practitioner provides comprehensive primary health care services including:</p> <ul style="list-style-type: none"> • Health promotion; • Disease and injury prevention; • Curative; and • Rehabilitative and supportive services to clients in all health settings. <p>As a member of the interdisciplinary health team, the nurse practitioner role is both autonomous and collaborative in nature. (Source NANB, 2002, Standards & Competencies for NPs retrieved from http://www.nanb.nb.ca/pdf_e/Publications/General_Publication/CompetenciesStandardsPracticeNP2.pdf)</p>	<p>tests;</p> <ul style="list-style-type: none"> • Select, prescribe and monitor the effectiveness of drugs; and • Order the application of forms of energy. <p>This authority is delimited by the NP Schedules for Ordering and is what makes the practice of nurse practitioners different from that of all other registered nurses.</p> <p>(Source NANB, 2002, Standards & Competencies for NPs retrieved from http://www.nanb.nb.ca/pdf_e/Publications/General_Publications/CompetenciesStandardsPracticeNP2.pdf) and NANB Nurse Practitioner Schedules for Ordering (2004 – Revised) retrieved from http://www.nanb.nb.ca/pdf_e/Publications/General_Publications/NPSchedulesE.pdf).</p>	<p>writing between the parties involved (Section 10.5 (1) and (2)). A formal collaborative practice agreement detailing scope and expectations for consultation is not required.</p> <p>Expectations for consultation are outlined in the NANB Standards and Competencies document. (Source NANB, 2002, Standards & Competencies for NPs retrieved from http://www.nanb.nb.ca/pdf_e/Publications/General_Publications/CompetenciesStandardsPracticeNP2.pdf)</p>
Quebec	<p>No primary NP legislation, but being explored.</p> <p>Specialist NP, but no</p>	<p>The nurse holds a certificate of specialization in one of three specialties (neonatology, nephrology, and cardiology). The NP is granted additional authority to perform one or more of the additional acts specified in legislation.</p>	N/A	N/A

Jurisdiction	Title	Definition / Role of PHCNP & Definition of ACNP (where applicable)	Scope of Practice of PHCNP (Additional Authority)	Collaborative practice requirement PHCNP
	title protection	<p>Five additional activities:</p> <ul style="list-style-type: none"> • Prescribing diagnostic examination; • Using diagnostic techniques that are invasive or entail risks; • Prescribing medications and other substances; • Prescribing medical treatment; and • Using techniques or applying medical treatments that are invasive or entail risk of injury <p>Conditions in which additional acts may be performed are specified in regulation.</p> <p>(Source CNA, Leg. Reg Framework, page, 7, October 2004)</p>		
Ontario	<p>RN(EC)</p> <p>RN(EC title is protected, but not “nurse practitioner or NP”</p>	<p>The RN(EC)s has advanced knowledge and decision-making skills in health assessment, diagnosis, therapeutics, health care management and community development and planning. The RN(EC) assesses and provides health services to clients in all developmental stages, and to families and communities.</p>	<p>RN(EC)s may:</p> <ul style="list-style-type: none"> • Communicate a diagnosis; • Prescribe drugs as defined in regulations; • Order treatments; • Order lab and diagnostic tests as defined in regulations. <p>(Source: CNO 2004,</p>	<p>RN(EC)s are required as per the <i>Nurses Act (1991)</i> to practice in accordance with the consultation standard specified in the <i>RN(EC) Standards of Practice (2004)</i>. The CNO does not require a formal collaborative practice agreement as a requirement for practice.</p>

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		<p>RN(EC)s provide comprehensive health services that encompass:</p> <ul style="list-style-type: none"> • Treatment on episodic illness and injuries; • Identification and management of chronic, stable conditions; • Prevention of disease and injury; • Health promotion and education; • Rehabilitation; • Continuity of care; and • Support services. <p>(Source: CNO, 2004, http://www.cno.org/docs/reg/45025_fsExtendedclass.pdf)</p>	<p>http://www.cno.org/docs/reg/45025_fsExtendedclass.pdf</p>	
<p>Manitoba (Legislation pending– anticipated Dec/04)</p>	<p>Registered Nurse (Extended Practice) or RN(EP). RN(EP) title protected</p>	<p>RN(EP) is a registered nurse with “advanced knowledge” who provides a full range of primary health care services to individuals, families and communities. Health services include:</p> <ul style="list-style-type: none"> • assessment and diagnosis; • client care management; and • population health and illness and injury prevention. <p>RN(EP)s work in partnership</p>	<p>RN(EP) may:</p> <ul style="list-style-type: none"> • communicate a diagnosis; • order and receive reports of screening and diagnostic tests as designated in regulations; • Prescribe drugs as designated in regulations; and • Perform minor surgical procedures designated in regulations. <p>(Source: CRNM Draft Extended Practice Regulation retrieved from</p>	<p>Competencies require RN(EP) to consult / collaborate/ and/or refer to physicians and other health care providers and social support resources as appropriate in the assessment and management of client health / illness status. (Source: CRNM Draft Standards of Practice, 2004 retrieved from http://www.crnmb.ca/downloads/rn_ep_standards_of_practice.pdf).</p>

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		with physicians and other health care professionals to provide care in a variety of health care settings. (Source: CRNM Draft Extended Practice Regulation retrieved from http://www.crnmb.ca/downloads/ep_reg-board_approved.pdf and CRNM Competencies for the RN(EP) retrieved from http://www.crnmb.ca/downloads/competenciesepboard_approved.pdf)	http://www.crnmb.ca/downloads/ep_reg-board_approved.pdf	
Saskatchewan	Registered Nurse Practitioner RN(NP) Title is protected	RN(NP)s are RNs with enhanced knowledge of nursing, gained through additional clinical practice, education and experience. They integrate elements such as diagnosing, treating health problems and prescribing drugs into their nursing practice. The RN(NP): <ul style="list-style-type: none"> • Is focused on providing services to manage the health needs of individuals, families, groups and communities. • Works autonomously from initiating the care process to monitoring health outcomes. • Is an integral member 	The RN(NP) may: <ul style="list-style-type: none"> • Order, perform, receive and interpret tests; • Prescribe and dispense drugs; • Perform minor surgical and invasive procedures; and • Diagnose and treat common medical disorders. Scope of Practice is broad, e.g., may prescribe drugs identified on the Saskatchewan Formulary published by Saskatchewan Health. Exclusions to scope are specified in the RN(NP) Standards (Source: <i>RN(NP) Standards & Core Competencies, 2003</i> http://www.srna.org/practice/nurs)	<i>RN(NP) Standards & Core Competencies (2003) outline clinical expectations regarding consultation and referrals. Recommend consultation with a family physician as appropriate.</i>

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		<p>of the health care team who provide and coordinate initial, continuing and comprehensive advanced nursing services in rural, remote and urban areas of the province; and</p> <ul style="list-style-type: none"> • Serve the ethno-culturally diverse populations of Saskatchewan across the continuum of health-care <p>RN(NP)s provide a spectrum of health services encompassing:</p> <ul style="list-style-type: none"> • Health promotion and maintenance of wellness; • Illness and injury prevention; and • Health care management of common acute and chronic illnesses. <p>(Source: <i>RN(NP) Standards & Core Competencies, 2003</i> http://www.srna.org/practice/nurse_competencies.pdf and SRNA Fact Sheet retrieved November 2004 from http://www.srna.org/communications/pdf/2004_SAHO_fact_sh)</p>	<p>e_competencies.pdf)</p>	

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Alberta	<p>Nurse Practitioner is a protected title.</p> <p>NPs Extended practice roster</p>	<p>eet.pdf)</p> <p>A nurse practitioner (NP) is a registered nurse (RN) whose practice is focused on providing services to manage the health needs of individuals, families, groups, and communities. The nurse practitioner role:</p> <ul style="list-style-type: none"> • Is grounded in the nursing profession's values, knowledge, theories, and practice; • Complements, rather than replaces, other health care providers. <p>Nurse practitioners:</p> <ul style="list-style-type: none"> • Have the potential to contribute significantly to new models of health care based on the principles of primary health care (PHC). • Integrate into their practice elements such as diagnosing and treating health problems, and prescribing drugs. • Work autonomously, from initiating the care process to collaborating with other health care professionals. • Practice in a variety of 	<p>Acts that can be performed by the NP are defined in the <i>Alberta Public Health Act Regulation (126/2002, section 1)</i> and include:</p> <ul style="list-style-type: none"> Diagnose and treat; Order and perform lab, radiological, and other diagnostic tests and interpret results; and Prescribe drugs as defined in the <i>Pharmaceutical Profession Act</i>. <p>The NP can also distribute drugs in communities if no pharmacist available and prescribe any drug on Schedules 1, 2, or 3 (latter two are non-prescription drugs) of Alberta Drug Formulary and order any lab/ diagnostic test.</p> <p>Source: AARN, 2002, Nurse Practitioner Competencies http://www.nurses.ab.ca/pdf/Nurse-Practitioner-Competencies.pdf; AARN 1995 & 2000, Prescribing and Distributing Guidelines for Registered Nurses in Advanced Nursing Practice Providing Primary Health Care Services)</p>	<p>Consultation and collaboration Identified as an expectation in Standards.</p> <p>Regulation also permits independent practice of NPs.</p>

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		<p>community acute care and long-term care settings. These include, but are not limited to, community health centres, nursing outposts, specialty units and clinics, emergency departments, and long-term care facilities.</p> <p>Source: AARN, 2002, Nurse Practitioner Competencies http://www.nurses.ab.ca/pdf/Nurse-Practitioner-Competencies.pdf</p>		
<p>British Columbia</p> <p>Legislation pending – Spring 2005</p>	<p>Nurse Practitioner (NP) or Registered Nurse Practitioner</p> <p>Protected titles</p>	<p>Nurse practitioners are registered nurses whose practice is grounded in professional nursing values, knowledge and theories. Their practice is advanced in the application of in-depth knowledge and theory from nursing and related fields, including experiential knowledge gained from clinical practice experience as registered nurses.</p> <p>The health services provided by nurse practitioners include:</p> <ul style="list-style-type: none"> • Health promotion and maintenance of wellness; 	<p>The nurse practitioner under proposed regulations may:</p> <ul style="list-style-type: none"> • Make a diagnosis identifying a disease, disorder, or condition as the cause of the signs or symptoms of the individual; • Set or cast a closed simple fracture of a bone, or reduce a dislocation of a joint; • Apply x-ray for diagnostic imaging purposes, except computerized axial tomography; • Give an order to apply specific forms of energy, i.e., ultrasound for 	<p>The RNABC Standards for Nurse Practitioner Physician Consultation describe the consultation process and prescribe when consultation should occur.</p> <p>Source: RNABC, A Regulatory Framework For Nurse Practitioners, October 2004 retrieved from http://www.rnabc.bc.ca/pdf/NP_regulatory_framework.pdf.</p>

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		<ul style="list-style-type: none"> • Illness and injury prevention; and • Health care management of acute and chronic illnesses, including ordering diagnostic investigations and prescribing treatment (including medications). <p>Nurse practitioners collaborate with other members of the health care team to improve client health outcomes by increasing accessibility to health care services, expanding clients' health care options and filling gaps in health care delivery</p> <p>Three streams: The nurse practitioner (family) provides health care services to persons across the life span, including newborns, children, adolescents, adults, pregnant and postpartum women and older adults.</p> <p>The nurse practitioner (adult) provides health care services to young, middle-aged and older adults. Care of older</p>	<p>diagnostic or imaging purposes, and x-ray for computerized axial tomography; and</p> <ul style="list-style-type: none"> • Prescribe, administer, or give an order to dispense a drug that is specified in Schedule I or II of B.C. <i>Drug Schedules Regulation</i> (1998). <p>Source: Ministry of Health Services, Draft Nurses (Registered) and Nurse Practitioners Regulations, November 2, 2004, retrieved from http://www.healthservices.gov.bc.ca/leg/pdfs/Proposed_Nurses_and_NPs_Reg_Nov_2004.pdf</p>	

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		<p>adolescents may also be provided by a nurse practitioner (adult) in some instances when the adolescent's development and/or life style may more approximate that of an adult.</p> <p>The nurse practitioner (pediatric) provides health care services to children from newborn infants to toddlers to school aged children to adolescents. In some instances the nurse practitioner (pediatric) may provide care to young adults based on developmental age or where the young adult</p> <p>Source: RNABC, <i>A Regulatory Framework For Nurse Practitioners</i>, retrieved October 3004, from http://www.rnabc.bc.ca/pdf/NP_regulatory_framework.pdf</p>		
Yukon	<p>NP is not a legislated role. Legislation broad enough to encompass NP practice</p> <p>Community Nurse Practitioners</p>	<p>Community Nurse Practitioners (CNPs) are registered nurses with appropriate additional education, working in an expanded role in the community and are employed by government. The legislation governing the practice of nursing is broad enough to permit RNs to work in this expanded role and by adhering</p>	<p>Community Nurse Practitioners (CNPs) are permitted to:</p> <ul style="list-style-type: none"> • Diagnose / communicate their assessments, • Order, perform and interpret specified screening and diagnostic tests; and • Prescribe drugs and perform other procedures. 	N/A

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	is not a protected title Consideration of separate regulations for NP role currently being explored.	to policy and the Medical Services Branch Scope of Practice deliver services outside the scope of other RNs. Source: YRNA, Nurse Practitioners and Issues for the Yukon, August, 2004.	Source: YRNA, Nurse Practitioners and Issues for the Yukon, August, 2004.	
Northwest Territories & Nunavut	“N.P.” / “nurse practitioner” or “R.N. (N.P.)” Title is protected.	The NP is a RN with advanced knowledge who provides a variety of services to clients. Similar to other RNs the NP may engage in: <ul style="list-style-type: none"> • Promotion, maintenance and restoration of health; • Prevention and alleviation of illness; • Care for the terminally ill and the dying; and • Coordination of health care services. The NP is granted additional authorities to carry out the above functions (See additional authorities). Source: RNANT/NU, Nursing Profession Act, 2003 (in force)	In addition to the scope of practice of all RNs, a nurse practitioner using advanced knowledge, skills, and judgment may: <ul style="list-style-type: none"> • Make a diagnosis identifying a disease, disorder or condition; • Communicate a diagnosis to a patient; • Order and interpret screening and diagnostic tests authorized in guidelines approved by the Minister • Select, recommend, supply, prescribe, monitor the effectiveness of drugs as authorized in guidelines approved by the Minister; and • Perform other procedures that are authorized in 	Not specified in legislation. Specific collaborative practice requirements or expectations for consultation may be specified in regulations, by-laws, and guidelines as approved by the Minister. To date, no specific requirements for collaboration specified in regulations.

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		January 1, 2004) retrieved December 11, 2004, from http://www.justice.gov.nt.ca/PDF/ACTS/Nursing_Profession.pdf	guidelines approved by the Minister. Source: RNANT/ NU, <i>Nursing Profession Act, 2003</i> (in force January 1, 2004) retrieved December 11, 2004, from http://www.justice.gov.nt.ca/PDF/ACTS/Nursing_Profession.pdf	