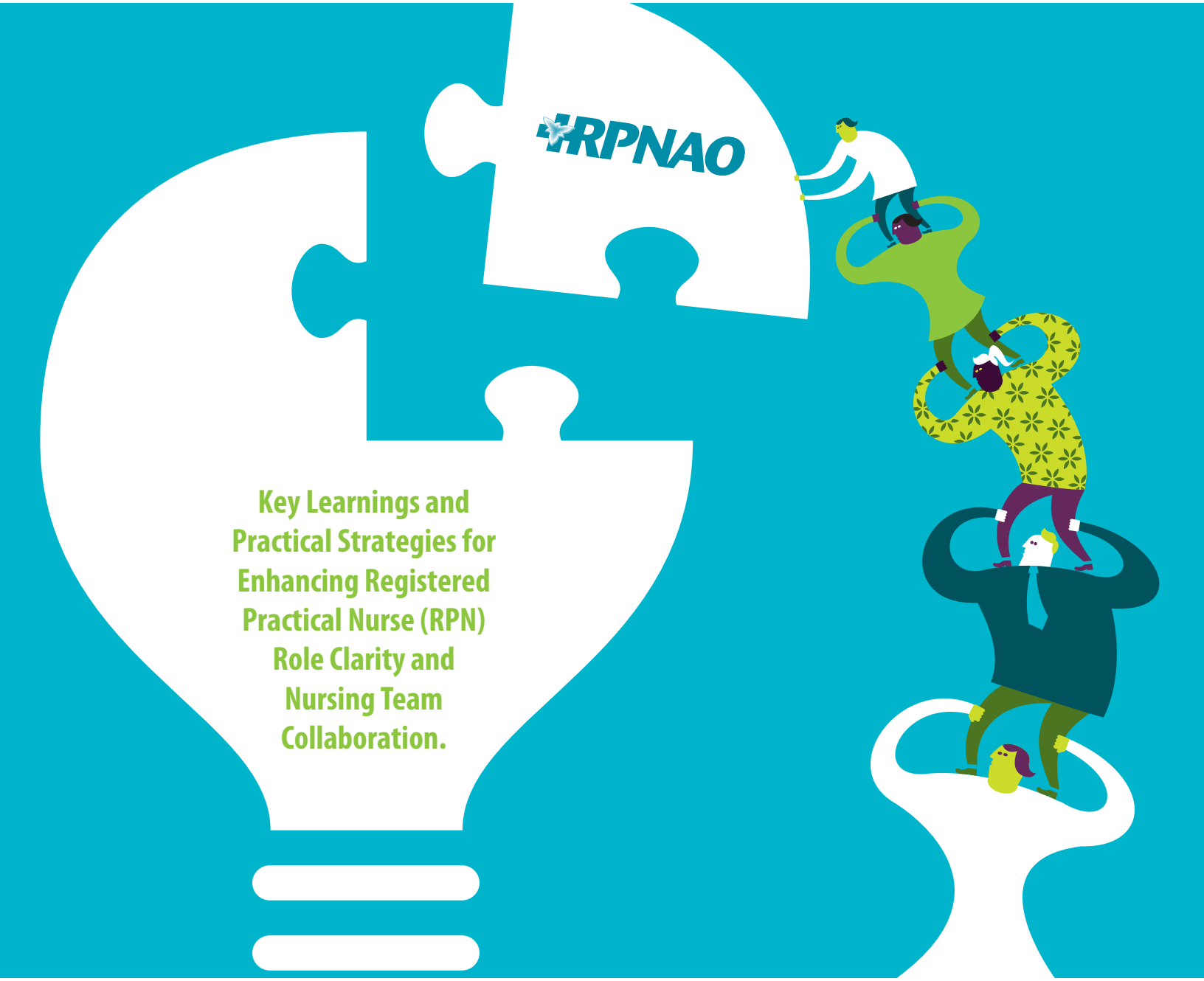
THE REGISTERED PRACTICAL
NURSES ASSOCIATION OF ONTARIO

FEBRUARY 2014

It's All About Synergies.

Understanding the Role of the Registered Practical Nurse in Ontario's Health Care System



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The Registered Practical Nurse Role Clarity Questionnaire© (RPN-RCQ)© and instructions for use and scoring may be obtained, free of charge, from the Registered Practical Nurses Association of Ontario.

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Executive Summary

Background

Since the early 2000s, there have been significant changes to the Registered Practical Nurse (RPN)[1] and Registered Nurse (RN) roles in Ontario. In 2005, changes to the basic entry-to-practice educational requirements for both RPNs and RNs came into effect with a 2-year diploma required for RPNs and a baccalaureate degree in nursing required for RNs. Additionally in 2005, changes to the Nursing Act (1991) allowed for a broader role for RPNs (e.g., initiation of controlled acts).

In 2005, changes to the basic entry-to-practice educational requirements for both RPNs and RNs came into effect with a 2-year diploma required for RPNs and a baccalaureate degree in nursing required for RNs.

Changes to educational preparation and scope of practice, coupled with variations in nursing care delivery models, have resulted in varying degrees of role ambiguity and, in some instances, role conflict. In order to better understand the factors that contribute to role clarity or role confusion, the Registered Practical Nurses Association (RPNAO) launched a provincial project titled *It's All About Synergies: Understanding the Role of the Registered Practical Nurse in Ontario's Health Care System*.

Purpose

The purpose of this project was to invite nurses (RPNs and RNs), nurse leaders, nursing faculty, and other health care experts from around Ontario to share their knowledge and insights regarding the critical factors that support or hinder the appropriate utilization of RPNs and their ability to work to their full scope of practice as members of intra- and interprofessional health care teams.

Goal

The goal of this project was to develop an increased understanding of the factors that contribute to confusion regarding the RPN role and overlapping scope of practice of the RPN and RN roles. The knowledge gained would be used to generate strategies that may assist in decreasing the degree of ambiguity associated with the RPN role and role functioning in order to optimize the contribution of RPNs in the provision of high-quality patient care within and across the health care system.

Key Messages Emanating from the Findings

1. The RPN is viewed as a valuable member of the health care team in the provision of quality patient care.
2. Although frequently used, the phrase *scope of practice* is not well understood, with most nurses describing scope of practice in terms of tasks or what they are allowed to do in their practice settings.
3. There continue to exist many misconceptions and old truths, among RPNs and RNs regarding the RPN scope of practice, which contributes to role confusion, underutilization of RPNs (e.g., the misconception that RPNs must work under the direct supervision of RN), and inappropriate utilization (e.g., when RPNs are assigned to patients outside of their scope of practice).
4. Leadership plays a vital role in setting expectations regarding scope of practice, collaboration, and respect within the practice setting.

1 In Ontario, RPN refers to the role and title of the Registered Practical Nurse. The RPN role is similar in scope and function to that of the Licensed Practical Nurse (LPN) found in other Canadian provinces and often cited in the literature. For the purposes of this report, the terms RPN and LPN will be considered synonymous and used interchangeably.

5. Nursing care delivery models based on principles of collaboration and partnership allow for optimal teamwork, respect, and knowledge sharing.
6. Organizational practices (e.g., policies, procedures, role descriptions, models of care) play a key role in determining the appropriate utilization of the RPN role.
7. Given the significant degree of overlap between the RPN and RN roles, many nurses and nursing leaders are uncomfortable with the resulting ambiguity and would like a list of who can do what to cover all possible scenarios. There is a need to be comfortable with an informed "it depends" answer and discussion.

Suggested Practices for Enhancing Registered Practical Nurse Role Clarity and Nursing Team Collaboration

The following suggested practices are based on the key messages drawn from findings:

1. Intraprofessional basic educational opportunities to facilitate shared learning opportunities for RPN and RN students regarding nursing scope of practice, collaborative practice models, and RPN and RN roles in the provision of quality patient care for diverse patient populations within a wide variety of practice settings.
2. Updates from the regulatory body, which outline in practical language any changes to
   a. relevant legislation (e.g., Nursing Act, Regulated Health Professions Act, Regulated Health Professions Statute Law Amendment Act);
   b. basic entry-to-practice competencies (e.g., expectations for new nurses), and basic nursing educational program curricula (e.g., curricula content for RPN and RN programs);
   c. relevant practice standards and guidelines regarding nursing scope of practice (e.g., decision making regarding the appropriate level of care provider).
3. Organizational development strategies that allow for ongoing education, clarification, and dialogue regarding scope of practice and organization-specific implications for practice and provision of healthcare services that address the following:
   a. scope of practice discussions during orientation for all new employees (e.g., nurses, nurse leaders, members of the interprofessional team) to provide clarity regarding role expectations based on patient population care needs and organizational practices;
   b. change management strategies and skills required by leaders of nursing teams to address scope of practice, role clarity, and nursing team collaboration and communication at the program and unit level;
   c. leadership skills and strategies to enhance ongoing dialogue, at all levels of the organization, to monitor the evolving care needs of the various patient populations, the education and competencies of health care providers', and the context of care, in order to determine and validate the appropriate care providers level required to meet current and future patient care needs.
4. Research and program evaluation studies to increase understanding in areas such as enablers and barriers to optimal scope of practice, the characteristics of high-functioning nursing teams, nursing models of care delivery, and the impact on outcomes at the patient, nurse, organization, profession, and system levels.
5. Collaboration among professional nursing organizations to acknowledge and embrace the overlapping nature of the RPN and RN roles, along with the distinct and collective contributions of the roles to patient care and health system performance.

Section 1: The Project

The Main Drivers

Since the early 2000s, there have been significant changes to the Registered Practical Nurse (RPN)[2] and Registered Nurse (RN) roles in Ontario. In 2005, changes to the basic entry-to-practice educational requirements for both RPNs and RNs came into effect with a 2-year diploma required for RPNs and a baccalaureate degree in nursing required for RNs. Additionally in 2005, changes to the Nursing Act (1991) allowed for a broader role for RPNs (e.g., initiation of controlled acts).

In Ontario, nursing is one profession with two categories: Registered Practical Nurse (RPN) and Registered Nurse (RN)…They combine nursing skill, knowledge and judgment and are experts of nursing care at the bedside. There are areas of overlap between the two categories, but there are differences as well. These differences are based on entry-level and ongoing nursing knowledge and competencies

(Registered Practical Nurses Association of Ontario, 2013)

Changes to educational preparation and scope of practice, coupled with variations in nursing care delivery models, have resulted in varying degrees of role ambiguity and, in some instances, role conflict. In order to better understand the factors that contribute to role clarity or role confusion, the Registered Practical Nurses Association of Ontario (RPNAO) launched a provincial project titled *It's All About Synergies: Understanding the Role of the RPN in Ontario's Health Care System*.

Purpose

The purpose of this project was to invite nurses (RPNs and RNs), nurse leaders, nursing faculty, and other health care experts from Ontario to share their knowledge and insights regarding the critical factors that support or hinder the appropriate utilization of RPNs, and their ability to work to their full scope of practice as members of intra- and interprofessional health care teams.

Synergy is defined as the combined effort being greater than parts: the working together of two or more people, organizations, or things, especially when the result is greater than the sum of their individual effects or capabilities. (www.merrian-webster.com, n.d.)

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Goal

The goal of this project was to develop an increased understanding of the factors that contribute to clarity and confusion regarding the RPN role and overlapping scope of practice between RPN and RN roles. The knowledge gained would be used to generate strategies that may assist in decreasing the degree of ambiguity associated with RPN role and role functioning in order to optimize the contribution of RPNs in the provision of high-quality patient care within and across the health care system.

Scope

The scope of the project was specific to the factors that contribute to role clarity, ambiguity, and confusion within nursing teams that consist of both RPNs and RNs. The project also extended to exploring the elements that may contribute to and facilitate effectiveness in RPN and RN collaborative practice. The topic of nursing skill mix (i.e., the complement or combination of different nursing designations in the provision of care and decision making regarding skill mix) was deemed beyond the scope of this project.

Intended Audience

The information contained in this report is intended for use by leaders of nursing teams, nursing faculty, and RPNs and RNs in all practice settings, sectors, and domains of practice. The resources can be used by nurses in formal and informal leadership roles within nursing and interprofessional teams, clinical educators, and professional practice leaders. Additionally, the resources can be used by nursing faculty in the design and delivery of nursing curricula and clinical placement learning opportunities.

Overview of the Document

Beyond the rationale and scope of this project as outlined above, this document continues three distinct yet interconnected sections:

- Section 2: Current State – Review of the relevant literature that informed the various stages of the project;
- Section 3: Methods and Results – Description of the methods used in the consultation process and the results, including quantitative and qualitative data analyses and key messages;
- Section 4: Resource – Explanation of tools and resources that can be used by RPNs and RNs in a wide range of practice settings and educational programs. The tools and resources are designed to assist with assessing and evaluating scope of practice issues and mitigating areas of ambiguity with the goal of enhancing role clarity, team collaboration, and coordination of patient care.

Section 2: Background

Two Distinct Roles With Overlapping Areas of Accountability

Nursing in Ontario is a self-regulated, autonomous profession with multiple designations and registration categories under the protected title of Nurse: Registered Practical Nurse (RPN), Registered Nurse (RN), and Registered Nurse Extended Class (RN(EC)). All types of nurse are accountable to a single regulatory body, the College of Nurses of Ontario (CNO).

Despite the fact that the role of the practical nurse has been in existence since the 1940s, and currently 25% of all nurses registered in Ontario are RPNs (College of Nurses of Ontario [CNO], 2013b), there is a paucity of literature describing the RPN role, contributions of the role in patient care[3], and the nuances of the intraprofessional relationship (e.g., role clarity, overlap, collaboration) with their RN colleagues.

The lack of literature regarding role clarity between RPNs and RNs is a curious gap considering the long-standing presence of both RPNs and RNs in the vast majority of practice settings and sectors.

Although the RPN is a distinct designation within the nursing profession, the role is often described in comparison to the RN role, specifically what RPNs can or cannot do in practice as compared to RNs (Kelsey, 2006). This focus on tasks and what is excluded from the role does not allow for a full appreciation or awareness of the knowledge,

> The phenomenon of RN-RPN role ambiguity might best be described as a *wicked problem*, in that it is a social or cultural problem that is difficult or impossible to solve due to incomplete or contradictory knowledge, the sheer number of people and opinions involved, and the interconnected nature of this problems with other problems. (www.wickedproblems.com)
>
> Some problems are so complex that you have to be highly intelligent and well informed just to be undecided about them.
> (Laurence J. Peter)

3 For the purposes of this report, the term patient *will refer to patients, residents, clients, and communities who receive nursing care provided by RPNs and RNs.*

critical thinking, and skill sets that are included within the basic educational preparation and ongoing competencies required of the RPN.

Globally, the introduction of new roles and the expansion of existing roles has contributed to the blurring of perceptions of what constitutes a nurse, what different categories of nurses can do, and the effects on patient outcomes (Currie & Carr-Hill, 2012). When applied to the confusion regarding the RPN and RN roles, this may result in either underutilization (e.g., limited or restricted scope of practice) or overutilization (e.g., inappropriate use beyond authorized scope of practice) of the RPN role.

Globally, the introduction of new roles and the expansion of existing roles has contributed to the blurring of perceptions of what constitutes a nurse, what different categories of nurses can do, and the effects on patient outcomes (Currie & Carr-Hill, 2012).

The combination of the predicted shortage of RNs, changes to basic educational preparation for both RPNs and RNs, evolving patient care needs, and fiscal realities faced by health care organizations has resulted in the proliferation of care delivery models consisting of both RPNs and RNs and. in some practice settings, the addition of unregulated care providers.

Although there is a significant amount of evidence to support the benefits of higher proportions of RN staffing for patient outcomes, it is important to note that the majority of studies are conducted in the United States and, more specifically, are not reflective of the roles and competencies of RPNs and RNs in Ontario. An additional limitation of the current literature is the paucity of studies focusing on the impact of a nursing dyad model, despite the prevalence of this model in health care organizations across various sectors. This reinforces the importance of studies relevant to different regional settings that focus not only on individual roles, but how care is organized to allow the roles to build collaboratively in order to achieve optimal patient outcomes (Unruh, 2003).

The lack of literature describing the RPN–RN dyad and its impact on patient care and team performance impedes evidence-based decision making, the development of consistent practices and principles, and research regarding the appropriate utilization of nursing roles in the delivery of patient care across all sectors and practice settings.

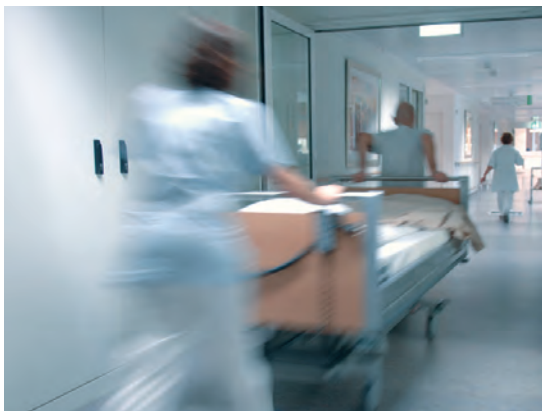
Role Ambiguity Leads to Role Conflict

There is widespread and inconsistent use of terms such as *role clarity, role conflict, role ambiguity, role conformity, role extension*. Role theory provides a useful framework for understanding these complex ideas. Using a theatrical metaphor to explain role theory, Biddle (1986) described actors (people) performing parts (roles) with written scripts (expectations) that are understood and adhered to by all. The degree of role clarity (or consensus) is determined by the level of agreement among the players regarding the expectations of behaviours associated with the role.

Role conflict is defined as the level of congruence or compatibility in the requirements of the role and the conditions that either enable or hinder the achievement of those requirements. (Rizzo, House, & Lirtzman, 1970).

Role ambiguity involves deficient or inconsistent information about the expected role behaviours and can originate from organizational or individual sources (e.g., multiple lines of authority). Role ambiguity can be about what is required, how responsibilities are to be met, whose expectations of the role are to be met, and the uncertainty of the effects of actions on the individual, the role, or the organization (King & King, 1990).

Role conflict and ambiguity can be either objective (i.e., absence of adequate role information in the practice setting) or subjective (i.e., internal perceptions of the individual in the role). Both types have been found to be related to decreased role satisfaction and increased role tension (Lyons, 1971).



The rationale for role extension within nursing is to meet the changing needs of patient populations and provide continuity of care.

Within complex organizations, role conformity or the pressure to conform to role expectations can be exerted by individuals with greater sources of power or authority (Miles, 1977). Research has demonstrated that the effects of role conflict include increased stress, decreased role satisfaction and decreased performance (Biddle, 1986; Lyons, 1971; Rizzo et al., 1970).

Specific to nursing roles, Daly and Carnwell (2003) described role extension as the inclusion of particular skills or practices not previously associated with the role. They defined role expansion as additional skills and areas of practice encompassed within a specialist role, involving greater degrees of accountability and autonomy. Although role extension generally tends to involve areas of practice from another profession (e.g., medicine), the RPN role can be viewed as an example of role extension within the nursing profession, as it now includes areas of practice and skills that were previously the sole domain of the RN. The same can be said for the RN role, which now includes areas of practice and skills that were previously the sole domain of medicine. The rationale for role extension within nursing is to meet the changing needs of patient populations and provide continuity of care.

Scope of Practice: A Useful Definition

Scope of practice is defined as health care professionals optimizing the full range of their roles, responsibilities and functions that they are educated, competent and authorized to perform.

Health Authorities Health Professions Act Regulations Review Committee, 2002

Scope of Practice: Not Well Understood

In Ontario, as legislated by the Nursing Act (1991) and regulated through the College of Nurses of Ontario, the scope of practice for RPNs is detailed through entry-level competencies (CNO, 2011a) for RNs through national entry-to-practice competencies (CNO, 2009). Although significant areas of overlap exist for the two categories of nurses, differences in accountability can be identified in terms of the depth, breadth, and scope of involvement with patient care.

The scope of practice for nurses (RPNs and RNs) is also referred to, albeit narrowly, in the Regulated Health Professions Act (1991), which lists the controlled acts that nurses are authorized to perform (CNO, 2011b). No longer do detailed lists of nursing skills, treatments, or interventions exist, as nurses work in varied settings and with both stable and complex patients. Therefore, despite the continued expressed request for a single, generic skill list, this is not feasible; competence is a nurse's ability relative to the nurse's role, situation, and practice setting.

Scope of practice is a term used by a variety of clinical and nonclinical stakeholder groups, such as legislators, regulators, nursing faculty, administrators, researchers, and health care practitioners. Yet despite its widespread use, there is no commonly agreed-upon definition, leading to the term being used inconsistently and in a way open to interpretation, contributing to role ambiguity and role tension. The ambiguity associated with overlapping scopes of practice leads to confusion not only among health care professionals, but also patients and by extension the public (Malloch & Ridenour, 2014).

Besner et al. (2005) noted that nurses have had difficulty in differentiating between full scope of practice (e.g., knowledge base, critical thinking skills) and the various tasks and activities they perform as part of care delivery. The reduction of scope of practice to a description of tasks or functions is problematic in that it contributes to role confusion due to the significant degree of overlapping patient care-related functions performed by RPNs and RNs. More importantly, this reduction of scope of practice unintentionally devalues the depth and breadth of the knowledge required and utilized by nurses (White et al., 2008). The focus should change from tasks to focusing on competencies to reflect the complexity of knowledge, judgement, and critical thinking required of nurses to support clinical decision making (Health Authorities Health Professions Act Regulations Review Committee, 2002).

Barriers and Enablers to Optimal Scope of Practice

Several studies have focused on the enablers and barriers to scope of practice with a commonly reported finding that RNs are more likely to report working to full scope of practice (Besner et al., 2005), whereas few LPNs report working at full scope of practice (Harris et al, 2013; Health Authorities Health Professions Act Regulations Review Committee, 2002; Meuller et al., 2012; Scholes & Vaughan, 2002; Shimoni & Barrington, 2012).

Table 1 provides a summary of the enablers and barriers commonly described in the literature and reinforced by the qualitative data generated through this project.

Table 1: Summary of Enablers and Barriers Described in Literature

FACTORS	ENABLERS TO FULL SCOPE OF PRACTICE	BARRIERS TO FULL SCOPE OF PRACTICE
Individual Knowledge and Experience	Work experience:– greater amount of experience and diversity of experiences.	Awareness of changes to scope of practice: extent of lack of awareness by nurses, other professions, and organizational leadership will determine extent of barriers.
	Basic education programs: these programs provide knowledge that prepares nurses for diverse patient needs, communication skills, and teams.	Generational differences: different cohorts come with differing levels of education, awareness, and willingness to accept changes to the LPN role; this applies equally to RN and LPN cohorts.
	Personal desire and motivation: a willingness to assume additional responsibilities and learning opportunities.	Perceptions of patient needs: inconsistent and unclear definition of acuity and predictability contributes to confusion in determining appropriate care provider.
Team	Team environment: a high degree of team acceptance of the RPN role .	Team environment: role territoriality, lack of respect, resistance leading to inappropriate patient assignments, underutilization or inappropriate assignments to team members; lack of collaboration and assistance.
	Team-based education: understanding of the roles and similarities and differences between them.	Resistance to role changes: associated with fears of being replaced; inability to differentiate between roles due to focus on degree of tasks and functions shared by both roles.
	Communication: respectful, timely, and complete communication regarding expectations and patient care requirements.	Communication: ineffective, incomplete communication regarding expectations and patient care requirements.
Organizational	Organizational support: Role descriptions, policies, and procedures reflect full scope of practice.	Policies and procedures: old rules in play that are no longer reflective of current legislative, regulatory, or practice guidelines.
	Support from formal and informal leaders: LPNs are supposed in areas such as patient assignments, accessing professional development and educational opportunities, and participation on internal committees.	Access to RNs: Lack of availability of RNs to help with patient care-related issues may be due to involvement in care coordination and other functions. Workload: heavy workloads create time pressures and an inability to work at full scope of practice.
Regulatory	Regulatory documents: competencies and accountabilities, along with expectations for maintaining competence, are provided; resources are available to guide decision making (e.g., appropriate care provider).	Overlap in roles and skills: RPNs and RNs struggle with defining their full scope of practice beyond a description of tasks.

Section 3: Methods and Results

Expert Panel

This project was supported by a Role Clarity Expert Panel made up of RPNs and RNs involved with direct care, hospital administration and leadership, long-term care, home health care, public health, and primary care sectors. The panel also included nursing faculty from RPN and RN programs at the college and university levels.

Design

This project was approached as a large-scale consultation using a mixed methods approach that included an online survey involving RPNs and RNs as well as nursing faculty from RPN and RN basic entry programs. In addition to the survey, focus groups (n=10) were held with nurse leaders. A focus group strategy among attendees at the 2013 RPNAO Annual General Meeting and Conference gathered commentary from approximately 90 individuals, predominantly RPNs in practice, education, administration.

Individuals were invited to participate using a variety of web-based recruitment approaches such as Facebook, Twitter, and snowball sampling via personal and professional networks (e.g., RPNAO and Professional Practice Network of Ontario listservs). The use of social networking sites allows for timely and cost-effective recruitment of participants while maintaining confidentiality (Bhutta, 2012; Fenner et al., 2012; O'Connor, Jackson, Goldsmith, & Skirton, 2013). The project spanned 11 months from February 2013 to December 2013.

Methods

The Registered Practical Nurse Role Clarity Questionnaire ©

The Registered Practical Nurse Role Clarity Questionnaire© (RPN-RCQ©) was developed to address the lack of published instruments reflecting the uniqueness of the RPN role, legislation, and standards, as well as issues specific to role ambiguity experienced in Ontario and the project goals.

Two surveys were developed: The General Nurse version was targeted toward nurses in various practice settings and the Nursing Faculty version was targeted towards nursing faculty.

The initial items were developed based on a review of relevant literature and input from the Role Clarity Expert Panel members regarding the issues commonly experienced specific to RPN and RN role clarity and ambiguity. Two surveys were developed: The General Nurse version was targeted toward nurses in various practice settings and the Nursing Faculty version was targeted towards nursing faculty.

In both the General Nurse and the Nursing Faculty versions of the RPN-RCQ©, space was provided for respondents to add commentary related to the other sections of the survey. This allowed for qualitative data and analysis to complement the quantitative data gathered through the various items.

The survey presented a list of statements on role clarity with four options to indicate level of agreement (*strongly disagree, disagree, agree, strongly agree*). The option of *I don't know* was also provided, as role clarity (or confusion or ambiguity) may be a function of personal knowledge. Learning the extent of limitations in knowledge was deemed important to the findings.

The draft surveys were reviewed by RPNs and RNs recruited by members of the Role Clarity Expert Panel. They assessed the items for content validity (i.e., relevance to the topic) and clarity (i.e., clear wording of items and instructions). A total of 21 external reviews were completed and returned, representing nurses from direct care, administration, and academic and education roles. Reviewer feedback resulted in the elimination of two items that had been included on both the General Nursing and Nursing Faculty versions of the survey.

Post-hoc psychometric testing of the General Nursing version of the survey (n = 1101) was conducted to further test the validity of the items. Psychometric testing was not conducted on the Nursing Faculty version due to the limited number of returned surveys (n = 48).

Details regarding results of the psychometric testing of the RPN-RCQ©, instructions for use and scoring can be obtained from RPNAO.

Focus Groups

Ten focus groups were conducted to gain an increased understanding of the unique perspectives of nurses who provide leadership to RPNs and RNs. The focus groups were held by teleconference or in-person depending on participant scheduling and availability. A consistent semi-structured interview approach was used by experienced focus group facilitators (see Appendix A). A total of 47 nurse leaders participated in the focus groups with representation from hospitals (e.g., acute care, complex continuing care and rehabilitation, mental health), long-term care, public health unit, and home health care agencies.

Ten focus groups were conducted to gain an increased understanding of the unique perspectives of nurses who provide leadership to RPNs and RNs.

Results

A total of 1,101 General Nurse surveys and 48 Nursing Faculty surveys were submitted. Respondents reported working in various health sectors (e.g., hospital, long-term care, community, primary care, public health) and domains of practice (e.g., direct care, administration, education and research). Due to the consultative nature of the project design and the approaches used for participant engagement and recruitment, no specific denominator is able to be determined, and therefore a response rate is moot.

General Nurse Survey Participants

Of the 1,101 respondents, 60% (n = 661) were RPNs, and the remaining 29% (n = 317) were RNs. Further, 75% (n = 722) of the respondents were direct care staff, with 25% (n = 235) classified as administration (inclusive of managers, directors, and clinical educators). It is important to note that the administration category included both RNs (n = 158; 67%) and RPNs (n = 77; 33%).

The majority of respondents were employed in the hospital sector (58%), followed by long-term care (20%), community (11%), public health (5%), and primary care (5%). Of the RPNs, 61% were educated at the diploma level and 39% were educated at the certificate level. A large proportion of the RNs were educated at the baccalaureate level (44%), followed by the diploma level (28%) and graduate-level preparation (28%). The majority of nurses (RPNs and RNs) had over 15 years of experience (45%), with 28% mid-career (i.e., 6 to 15 years) and another 28% early career (i.e., 5 years or less). Missing data (i.e., a response to a particular question was not entered by a participant) ranged from 11% to 14% and accounts for totals in the following tables that may not sum to 100%. See Table 2: Respondent Demographics for General Nurse Survey.

Nurse Faculty Survey Participants

Of the 48 nursing faculty respondents, 85% were RNs. The majority of participants were educated at the master's level (58%), followed by the doctoral level (14.5%) and baccalaureate level (12%). Most respondents worked within college programs, with involvement in classroom and clinical teaching. There was equal representation from both undergraduate RN and RPN programs. Missing data ranged from 6% to 10%. See Table 3: Respondent Demographics for Nursing Faculty Survey.

Table 2: Respondent Demographics for General Nurse Survey

PROFESSIONAL DESIGNATION	FREQUENCY	%
RN	317	28.8
RPN	661	60.0
Total	978	88.8
Missing*	123	11.0
EDUCATIONAL PREPARATION		
RPN diploma	386	35.1
RPN certificate	247	22.4
RN diploma	99	9.0
Baccalaureate	155	14.1
Graduate	97	8.8
Total	984	89.4
Missing*	117	11.0
ROLE		
Direct care staff	722	65.6
Clinical manager	78	7.1
Administrator/director/executive	91	8.3
Clinical educator	66	6.0
Total	957	86.9
Missing*	144	13.0
PRACTICE SETTING		
Hospital	565	51.3
LTC	195	17.7
Community	103	9.4
Primary Care	49	4.5
Public Health	50	4.5
Total	974	88.5
Missing*	127	11.0

Table 3: Respondent Demographics for Nurse Faculty Survey

PROFESSIONAL DESIGNATION	FREQUENCY	%
RN	41	85.4
RPN	2	4.0
Total	43	89.8
Missing*	5	10.0
EDUCATIONAL PREPARATION		
RN diploma	2	4.0
Baccalaureate	6	12.5
Master's degree	28	58.3
Doctorate	7	14.5
Total	43	89.3
Missing*	5	10.0
TEACHING ROLE (CHOOSE ALL THAT APPLY)		
Faculty, college and university programs	9	2.0
Faculty college program	21	46.6
Faculty, university program	12	26.6
Classroom only (including hybrid and distance education)	2	4.0
Clinical instruction and supervision only	3	6.0
Classroom and clinical instruction	22	48.9
Missing *	3	6.0
PROGRAM TYPE (CHOOSE ALL THAT APPLY)		
Undergraduate RN program	22	53.7
Practical Nursing Program	22	53.7
RPN-RN Bridge Program	6	14.6
Post-RN degree completion	3	7.3
Missing*		

**Missing = A response was not entered on the survey. This accounts for totals not representing 100%. Multiple responses in the Nurse Faculty survey account for totals that exceed 100%.*

Presentation of Results

The four Likert-type options for the questionnaire statements (*strongly disagree, disagree, agree, strongly agree*) were grouped into two categories based on level of disagreement (i.e., *strongly disagree and disagree*) and agreement (i.e., *strongly agree and agree*). Selections of I *don't know* were retained as a distinct category.

Results are presented as a percentage frequency distribution, depicting the percentage of responses for each category. Rounding in the tables may result in totals not precisely totalling100%.

Analysis of variance, also known as ANOVA, was computed for various demographic categories to determine if response differences were statistically significant. Findings indicated there were no statistically significant differences between the responses from the clinical manager, administrator or director, and clinical educator groups. Therefore, the responses from these three groups were combined under the new label of *Admin*. This allowed for comparison between direct care roles (RPN and RN) and nondirect care roles (Admin).

The survey results provide insight regarding the RPN and RN roles and role ambiguity in four areas: (a) knowledge regarding the RPN role and scope of practice, (b) teamwork and respect, (c) the role of leadership, and (d) organizational factors and impacts.

Although no statistically significant difference between the responses of RPNs and RNs was found, the results for these designations have been kept distinct to allow for comparison.

No statistically significant differences in survey responses were found based on sector (hospital, long-term care, community, public health, and primary care) or region (rural versus urban practice setting).

The results are presented according to the four categories of respondents: Admin (RPNs and RNs in clinical manager, administrator or director, and clinical educator roles), RPN (direct care), RN (direct care), and nursing faculty.

Examples of comments reflective of main qualitative themes derived from survey comments and focus groups are also provided.

Summary of Key Findings

The survey results provide insight regarding the RPN and RN roles and role ambiguity in four areas: (a) knowledge regarding the RPN role and scope of practice, (b) teamwork and respect, (c) the role of leadership, and (d) organizational factors and impacts.

Variations in Knowledge: RPN Role and Scope of Practice

Regarding the statement "The RPN role is clear," the Admin, RN, and RPN respondents were in general agreement, with levels of agreement ranging from 53% (Admin) to 48% (RN) and 46% (RPN). In contrast, the Nursing Faculty group had the lowest level of agreement (17%). As for awareness of the controlled acts for nursing, the majority of respondents across all categories had moderate to low levels of agreement with the statement "The RPN can perform the same controlled acts as the RN," with responses ranging from 48% (Nursing Faculty) to 30.4% (RN).

This variation in knowledge about roles and scope of practice was also apparent in the responses to items regarding the degree to which RPNs and RNs are knowledgeable about the role and scope of practice of the other's role. Overall, there was a higher level of agreement across all categories that RPNs are knowledgeable about the RN role and scope of practice, with responses ranging from 65% to 76%. In contrast, there were much lower levels of agreement regarding RN knowledge about the RPN role and scope of practice, with levels of agreement ranging from 23% to 37%.

As RNs (i.e., direct care, administration, and clinical educators) often provide leadership to the nursing team and clinical placements, including the matching of care provider to patient(s), this perceived gap in knowledge may contribute to underutilization or inappropriate utilization of RPNs and increased role tensions. See Table 4: Knowledge of the RPN Role and Scope of Practice.

Comments highlighting the variation in knowledge about the RPN role and scope of practice are shown in Table 5.

Table 4: Knowledge of the RPN Role and Scope of Practice

	STRONGLY DISAGREE AND DISAGREE %	I DON'T KNOW %	STRONGLY AGREE AND AGREE %	N
The role of the RPN is clear.				
Admin	38.0	9.0	53.0	234
RN	43.6	8.5	47.9	188
RPN	44.0	10.2	45.8	519
Nursing Faculty	79.0	4.0	17.0	47
The RPN can perform the same controlled acts as the RN.				
Admin	51.8	11.2	37.0	233
RN	64.4	5.3	30.3	188
RPN	54.3	9.9	35.8	525
Nursing Faculty	42.0	10.0	48.0	48
RNs are familiar with the scope of the RPN role.				
Admin	62.8	14.5	22.6	234
RN	61.6	15.1	23.3	185
RPN	63.2	13.0	23.8	516
Nursing Faculty	81.0	6.0	13.0	47
The RPN role has evolved to include practices that were previously exclusive to the RN role.				
Admin	3.4	5.2	91.4	233
RN	6.9	3.7	89.3	187
RPN	3.9	2.9	93.3	521
Nursing Faculty	6.0	2.0	92.0	48
RPNs are familiar with the scope of the RN role.				
Admin	23.4	12.8	63.8	235
RN	23.6	11.3	65.1	186
RPN	19.1	12.4	68.4	523
Nursing Faculty	52.0	13.0	35.0	48
RPNs are knowledgeable about the role of the RN.				
Admin	15.6	8.7	75.8	231
RN	17.4	9.2	73.4	184
RPN	14.9	15.2	69.9	521
Nursing Faculty	N/A	N/A	N/A	N/A
RNs are knowledgeable about the role of the RPN.				
Admin	46.7	16.3	36.9	233
RN	58.0	10.2	31.7	186
RPN	51.2	18.4	30.5	522
Nursing Faculty	N/A	N/A	N/A	N/A

N/A = item not included on Nurse Faculty survey. Rounding may result in totals not precisely at 100%.

Table 5: RPN Role and Scope of Practice

COMMENTS	SOURCE
I believe that role clarity needs to begin in the educational institution. In the college where I work, this could be done better. There is some resistance by the BScN faculty to understanding and accepting the new role of the RPN.	**Nursing Faculty**
RPNs continue to be perceived by the RN as practitioners who can only do the less complex and more routine tasks similar to hierarchical practice models used 20 to 30 years prior. There is little appetite to fully explore the many qualities RPNs bring to the practice setting. RNs continue to express feeling "displaced" by RPNs, without recognizing the unique scope of practice each brings to the clinical setting.	**Manager**
There needs to be more teaching in the universities as to what the RPN role is. I have heard on many occasions new BScN students say RPNs are much less qualified and will only work in long-term care settings. This is not only false, but even in long-term care facilities the RPNs are acting charge nurses.	**RPN**
I expect an RPN to know what they aren't allowed to do in an institution.	**RN**
Many RPNs did not understand the changes in their scope that occurred several years ago and are still somewhat resistant to practicing to full scope. They feel like it's added work or assuming the work of the RN. Nurses are still very task orientated and have trouble distinguishing heavy tasks from higher patient acuity.	**Clinical Educator**
Most RPNs working were hired years ago. At that time, several technical skills were not part of the educational programs. Now that these skills are considered as basic entry-to-practice skills, it is pivotal for RPNs to take the lead to improve. There is a huge gap between the generations of RPNs produced in terms of knowledge, skills, judgement, and attitude.	**RPN**
Sometimes with the "older" RNs, they don't understand how the "new" RPN program has changed and the knowledge and experience that the "new" RPN has and is capable of doing. Sometimes we are still referred to as "just an RPN."	**RPN**

An Issue of Respect

Consistently, across all categories, there were moderate to high levels of agreement regarding the degree of teamwork and respect required between RPNs and RNs. Further, RPNs were viewed as equally contributing team members sought out by members of the health care team and managers for assistance in problem solving. There were also high levels of agreement that RPNs and RNs show consideration and respect for each other and have trust in the expertise of one another. Further, participants agreed that generally there is harmony within the nursing team. These results are of interest, as they are not consistent with the qualitative comments provided in the survey and those generated in the focus groups. See Table 6: Teamwork and Respect.

Comments highlighting the issue of respect for the RPN role are shown in Table 7.

Table 6: Teamwork and Respect

	STRONGLY DISAGREE AND DISAGREE %	I DON'T KNOW %	STRONGLY AGREE AND AGREE %	N
The RPN is regarded as an equally contributing member of the health care team.				
Admin	18.9	5.6	75.6	233
RN	22.0	3.7	74.4	187
RPN	26.4	5.0	68.7	520
Nursing Faculty	21.0	13.0	46.0	48
The culture of the practice setting determines whose knowledge is valued, who gets listened to.				
Admin	12.5	12.9	74.6	232
RN	20.4	16.1	63.4	186
RPN	15.1	16.8	68.1	517
Nursing Faculty	14.0	8.0	77.0	48
RPNs and RNs show consideration and respect for each other.				
Admin	23.7	15.8	65.0	234
RN	21.7	9.2	69.2	185
RPN	21.6	13.0	65.2	523
Nursing Faculty	N/A	N/A	N/A	N/A
Generally, there is harmony between RPNs and RNs.				
Admin	25.3	12.4	62.3	233
RN	26.9	11.2	59.9	187
RPN	32.3	12.7	55.0	518
Nursing Faculty	N/A	N/A	N/A	N/A
RPNs and RNs trust in the expertise of one another.				
Admin	23.5	20.1	56.4	234
RN	30.7	14.5	54.8	186
RPN	26.1	16.7	57.2	521
Nursing Faculty	N/A	N/A	N/A	N/A
RPNs are sought out by members of the health care team for help with problems.				
Admin	21.0	15.4	63.6	234
RN	21.7	14.7	63.6	184
RPN	18.0	14.2	67.7	521
Nursing Faculty	N/A	N/A	N/A	N/A
RPNs are sought out by managers for help with problems.				
Admin	23.3	17.7	59.0	232
RN	26.0	15.2	58.7	184
RPN	27.0	19.2	53.8	522
Nursing Faculty	N/A	N/A	N/A	N/A

N/A = item not included on Nursing Faculty survey

Table 7: Comments About Respect

COMMENTS	SOURCE
I have been teaching in clinical placements for many years with students and I am seeing more positive changes in the culture of acceptance for changing roles.	**Nursing Faculty**
Some of the faculty in the BScN program here where I work would NEVER want to teach in the PN program and see it as beneath their qualifications somehow.	**Nursing Faculty**
RPN stigma has skewed many managers' knowledge of the RPN role, which in turn disallows RPNs to work to their full potential.	**Manager**
I don't think the leaders value the RPNs for their skill mix; they are viewed as a cheaper source of labour.	**RN**
Working as a health care coordinator, as an RPN, I have come across doctors who can be quite rude towards my staff and myself when they find out we are RPNs and not RNs. Doctors need to be educated as this can be insulting and demeaning.	**RPN**
My experience has been that RNs (especially new BScN RNs) have no idea what the RPN role is and do not respect the RPN judgement or assessment skills.	**RPN**
I once had a nurse manager tell me I was too intelligent to be an RPN; I was RN material. I found this really insulting because to me it suggested RPNs were stupid.	**RPN**

The Vital Role of Leadership

There was strong agreement across Admin, RPN, and RN categories, ranging from 58% to 73%, that those in leadership positions (e.g., chief nursing officers, directors, and managers) understand what is meant by the term *scope of practice* and also understand the difference between the RPN and RN roles.

Clinical educators and nursing faculty were also considered to have a good understanding of what is meant by the term scope of practice and the difference between the RPN and RN roles. Of interest was the higher percentage of *I don't know* responses for the item regarding clinical educators' ability to explain the difference between RPNs and RNs, ranging from 23.3% (Admin) to 27% (RN). Due to the significant role of clinical educators in the orientation, education, and ongoing professional development of nursing staff and leadership in practice initiatives, it is important to ensure those in clinical educator roles not only have the requisite knowledge regarding RPN roles but are able to demonstrate their knowledge verbally and through their interactions with the entire interprofessional team.

The higher levels of *I don't know* from those in administrative and direct care roles (RNs and RPNs) regarding nursing faculty knowledge of RPN and RN roles is not surprising due to the limited direct contact between these roles.

There was consensus and high levels of agreement (> 70% for all items) regarding the role of leadership in enabling RN and RPN functioning. Consistently, leadership was viewed as playing a key role in facilitating good relationships, setting the tone and clarifying expectations regarding behaviours, and ensuring patient assignments are appropriate based on patient needs and provider competencies. Leadership was also seen as having a key role in promoting RPN participation in project work and/or on committees. See Table 8: The Role of Leadership.

Comments highlighting the role of leadership are shown in Table 9.

Table 8: The Role of Leadership

	STRONGLY DISAGREE AND DISAGREE %	I DON'T KNOW %	STRONGLY AGREE AND AGREE %	N
Those in leadership positions (e.g. unit manager, chief nursing officer, program directors) have a good understanding of nursing scope of practice.				
Admin	18.1	18.1	63.8	232
RN	20.9	17.2	61.9	186
RPN	26.1	16.1	57.8	521
Nursing Faculty	N/A	N/A	N/A	N/A
Those in leadership positions have a good understanding of the difference between RPNs and RNs.				
Admin	17.3	17.6	63.1	233
RN	20.5	9.9	59.6	186
RPN	25.5	20.9	54.5	521
Nursing Faculty	N/A	N/A	N/A	N/A
Clinical educators have a good understanding of what is meant by "nursing scope of practice."				
Admin	9.9	16.8	73.3	232
RN	8.0	22.0	69.9	186
RPN	8.5	20.2	71.3	519
Nursing Faculty	N/A	N/A	N/A	N/A
Clinical educators are able to explain the difference between RPNs and RNs.				
Admin	13.1	23.3	61.6	232
RN	12.4	26.9	60.8	186
RPN	13.5	24.7	61.9	519
Nursing Faculty	N/A	N/A	N/A	N/A
Nursing faculty are able to explain the difference between RPNs and RNs.				
Admin	18.8	30.8	50.4	234
RN	21.5	30.6	47.8	186
RPN	21.5	23.9	54.6	519
Nursing Faculty	31.0	4.0	58.4	48
Nursing faculty have a good understanding of what is meant by "nursing scope of practice."				
Admin	12.9	20.9	66.2	234
RN	8.6	25.8	65.6	186
RPN	9.8	21.8	68.4	519
Nursing Faculty	12.0	6.0	81.0	48

N/A = item not included on Nursing Faculty survey

Table 9: Role of Leadership

COMMENTS	SOURCE
Across levels of management, there is confusion about the RPN scope of practice, unless managers make a concerted effort to investigate that information, change the role descriptions, and educate employees and lead the change in the role.	**Nursing Faculty**
It is up to the leadership to inform themselves and their teams about the RPN role and how it is to be fully utilized on individual units. If the leaders are not clear, the units will most certainly not be clear.	**Manager**
Leaders, especially senior leadership, have a dramatic impact on finalizing the organization's policies regarding RPN scope of practice.	**Director/Executive**
There is a blurring of role clarity between RNs and RPNs, and it can be difficult to define when and why either an RN or an RPN is necessary. How do I determine a realistic staffing mix? With RPNs doing so much more, what does the RN do that is distinctive from the RPN?	**Manager**
Leadership should always be updated about the new scope and then be able to inform staff of the changes and why.	**RPN**

Organizational Practices Contributing to the Issue

There were high levels of agreement (58% to 83%) that organizational factors such as reorganization and job uncertainty have had a negative impact on the way RPNs and RNs work together and with the perception that fiscal realities have resulted in the replacement of RNs with RPNs.

Although there was moderate to high levels of agreement (50% to 66%) that scope of practice and models of care are viewed as an organizational priority, less than 30% of respondents agreed that the integration of the increased scope of the RPN role had gone smoothly within their organization.

This is also reflected in the high level of agreement (> 80% for all categories) that there is wide variability in how the RPN role is enacted (e.g., from unit to unit, by program, regionally).

The nursing care delivery model in place was viewed as having a role in determining the scope of practice for RPNs and RNs. There were low levels of agreement (33% to 44%) regarding the ability of RPNs to fully utilize the knowledge and skills gained in the educational program within the practice setting, which creates barriers to optimizing the scope of practice, knowledge, and skills of RPNs. See Table 10: Organizational Practices.

Comments highlighting the organizational factors are shown in Table 11.

Table 10: Organizational Practices

	STRONGLY DISAGREE AND DISAGREE %	I DON'T KNOW %	STRONGLY AGREE AND AGREE %	N
RPNs are allowed to function to their full scope of practice (e.g., no old policies restricting scope).				
Admin	33.0	16.3	50.6	233
RN	38.6	15.2	46.2	184
RPN	37.9	13.3	49.4	517
Nursing Faculty	63.0	16.0	21.0	48
Scope of practice and models of care are viewed as a priority in our organization.				
Admin	20.9	18.4	60.7	234
RN	20.6	23.8	65.7	185
RPN	24.6	25.8	49.6	520
Nursing Faculty	N/A	N/A	N/A	N/A
Integrating the new role (i.e., increased scope of practice) of the RPN has been smooth.				
Admin	45.9	25.8	28.4	233
RN	47.8	29.0	23.1	186
RPN	49.7	22.6	27.4	521
Nursing Faculty	N/A	N/A	N/A	N/A
There is little difference in what RPNs are educated to do in their school and what they are allowed to do in the practice setting.				
Admin	35.7	27.0	37.3	233
RN	34.4	26.3	39.2	186
RPN	36.2	23.2	40.6	522
Nursing Faculty	41.0	26.0	34.0	47
The knowledge and experience gained in RPN educational programs are fully utilized in the practice setting.				
Admin	37.4	21.9	40.7	233
RN	31.3	33.0	35.7	185
RPN	34.2	22.3	43.5	520
Nursing Faculty	41.0	25.0	33.0	48
There is wide variability in how the full scope of the role of the RPN is enacted (e.g., unit to unit; regionally, by program)				
Admin	8.2	8.6	83.3	233
RN	9.0	6.9	84.2	189
RPN	8.8	7.7	82.6	521
Nursing Faculty	4.0	2.0	94.0	48

Continued on page 24

Table 10: Organizational Practices *(continued from page 23)*

	STRONGLY DISAGREE/DISAGREE %	I DON'T KNOW %	STRONGLY AGREE/AGREE %	N
Organizational factors (e.g., reorganization and job uncertainty) have had a negative impact on the way RPNs and RNs work together.				
Admin	23.2	21.9	54.9	233
RN	17.3	22.6	60.1	186
RPN	22.4	19.0	58.7	522
Nursing Faculty	6.0	10.0	83.0	48
The nursing care delivery model in place (e.g., total patient care, primary nursing, team nursing) plays a role in determining the scope of practice for the RN and the RPN.				
Admin	21.4	18.5	62.1	233
RN	25.2	23.1	51.6	186
RPN	23.3	20.9	47.7	522
Nursing Faculty	N/A	N/A	N/A	N/A
Fiscal realities have resulted in replacing RNs with RPNs.				
Admin	24.0	13.0	63.0	230
RN	29.8	14.3	66.0	182
RPN	19.9	14.5	65.6	518
Nursing Faculty	N/A	N/A	N/A	N/A
Fiscal realities have resulted in replacing RPNs with unregulated care providers.				
Admin	31.3	17.6	51.0	233
RN	31.5	20.9	47.6	187
RPN	27.7	17.1	55.1	519
Nursing Faculty	N/A	N/A	N/A	N/A

N/A = item not included on Nursing Faculty survey

Table 11: Organizational Factor

COMMENTS	SOURCE
Can be difficult managing patient assignments. Charge nurses need more education on the three-factor framework.	**RN**
They want to work to full scope of practice but the organization limits them. On acute units with high acuity, we are setting the RPN up for failure as only a select few patients meet the criteria for predictability.	**Manager**
As an educator, I now see RPNs developing with a strong sense of identity and professional confidence. It is the culture within the health care system that seems to stifle this.	**Nurse Educator**
A major issue contributing to ambiguity in my opinion is that the current practice environment contains two diverse groups of RPNs: those that were educated in the old system and have done some upgrades, and those that have graduated from new diploma programs. The old group is basically practicing like personal support workers who give meds, versus new graduates who are anxious to practice at full scope but are held back by organizational policies.	**Nurse Educator**
The scope of practice for RPNs in the hospital where I work is excellent. I have avoided applying for positions in hospitals where I know that I cannot utilize my full scope of practice.	**RPN**

A Closer Look at the "*I don't know*" Responses

Although the results depicting the levels of agreement or disagreement were revealing, so too were the *I don't know* responses. These responses ranged from as low as 2% (i.e., the RPN role has evolved to include practices that were previously exclusive to the RN only) to as high as 33% (i.e., the knowledge and experience gained in the RPN educational programs are fully utilized in the practice setting). The highest percentage of *I don't know* responses were regarding organizational practices (see Table 10), with 1 7% to 33% of respondents choosing *I don't know* for seven of the10 items in this area.

In addition to the content areas that elicited a higher number of *I don't know* responses, the items about roles that were marked by responses of uncertainty were also of interest. For the majority of items that elicited a high number of *I don't know* responses, there was fairly equal distribution among the Admin, RN, and RPN categories. Again, this was particularly evident in the items associated with organizational practices (see Table 10). As those in administrative roles provide leadership in regards to organizational systems, processes, and practices such as role descriptions, models of care, and policies, to have high numbers of *I don't know* responses from this cohort indicate the need for targeted strategies for education, information, and change management supports for those providing leadership to nursing teams.

Summary of Key Messages

1. The RPN role is viewed as a valuable member of the health care team in the provision of quality patient care.
2. Although frequently used, the phrase *scope of practice* is not well understood, with most nurses describing scope of practice in terms of tasks or what they are allowed to do in their practice settings.

The RPN role is viewed as a valuable member of the health care team in the provision of quality patient care.

3. There continue to exist many misconceptions and old truths, held by both RPNs and RNs, regarding the RPN scope of practice, which contributes to role confusion and underutilization of RPNs (e.g,. the misconception that RPNs must work under the direct supervision of RN).
4. Leadership has a vital role in setting expectations regarding scope of practice, collaboration, and respect within the practice setting.
5. Nursing care delivery models based on principles of collaboration and partnership allow for optimal teamwork, respect, and knowledge sharing.
6. Organizational practices (e.g., policies, procedures, role descriptions, models of care) play a key role in determining the appropriate utilization of RPNs.
7. Given the significant degree of overlap between the RPN and RN roles, many nurses and nursing leaders are uncomfortable with the resulting ambiguity and would like a list of who can do what to cover all possible scenarios.

Suggested Practices for Enhancing RPN Role Clarity and Nursing Team Collaboration

The following suggested practices are based on the key messages drawn from the survey findings and focus groups:

1. Intraprofessional basic educational opportunities to facilitate shared learning opportunities for RPN and RN students regarding nursing scope of practice, collaborative practice models, and RPN and RN roles in the provision of quality patient care for diverse patient populations within a wide variety of practice settings.
2. Updates from the regulatory body, which outline in practical language any changes to
   a. relevant legislation (e.g., Nursing Act, Regulated Health Professions Act, Regulated Health Professions Statute Law Amendment Act);
   b. basic entry-to-practice competencies (e.g., expectations for new nurses), and basic nursing educational program curricula (e.g., curricula content for RPN and RN programs);
   c. relevant practice standards and guidelines regarding nursing scope of practice (e.g., decision making regarding the appropriate level of care provider).
3. Organizational development strategies that allow for ongoing education, clarification, and dialogue regarding scope of practice and organization-specific implications for practice and provision of healthcare services that address the following:
   a. scope of practice discussions during orientation for all new employees (e.g., nurses, nurse leaders, members of the interprofessional team) to provide clarity regarding role expectations based on patient population care needs and organizational practices;

b. change management strategies and skills required by leaders of nursing teams to address scope of practice, role clarity, and nursing team collaboration and communication at the program and unit level;

c. leadership skills and strategies to enhance ongoing dialogue, at all levels of the organization, to monitor the evolving care needs of the various patient populations, the education and competencies of health care providers, and the context of care, in order to determine and validate the appropriate care providers level required to meet current and future patient care needs.

4. Research and program evaluation studies to increase understanding in areas such as enablers and barriers to optimal scope of practice, the characteristics of high-functioning nursing teams, nursing models of care delivery, and the impact on outcomes at the patient, nurse, organization, profession, and system levels.

5. Collaboration among professional nursing organizations to acknowledge and embrace the overlapping nature of the RPN and RN roles, along with the distinct and collective contributions of the roles to patient care and health system performance.

Scopes of practice will continue to evolve over time to meet the changing needs of patient populations and the health care system.

The Timeliness of the Project... and the Benefits of Getting It Right

Throughout the various phases of this project – from the creation of the Role Clarity Expert Panel to the administration of the survey and focus groups, participants commented on the timeliness of the project and the importance of tackling the issue. The significant changes to educational preparation, scope of practice, practice competencies, and intra- and interprofessional models of care necessitate the tackling of this *wicked problem* in a formal and overt manner. Commonly expressed concerns about "not getting it right" included the potential negative impacts on patient safety, role satisfaction (for both RPNs and RNs), and recruitment and retention of RPNs.

Scopes of practice will continue to evolve over time to meet the changing needs of patient populations and the health care system. Increased clarity regarding roles and responsibilities is essential in order to support decision making and the optimal utilization of nursing resources (Alberta Association of Registered Nurses, Registered Psychiatric Nurses Association of Alberta, & College of Licensed Practical Nurses of Alberta, 2003)

The quantitative and qualitative findings of this project can contribute to understandings of the enablers and barriers to optimizing the scope of practice for RPNs in Ontario within the boundaries of legislative, regulatory, and professional standards. The resources contained in the following section can be used for creating opportunities for dialogue with the goal of enabling increased understanding of the unique and overlapping scopes of practice within nursing and enhancing team functioning – all ultimately contributing to quality practice settings, safe patient care, and quality outcomes.

Section 4: Resources

A key deliverable in this project was to suggest resources that may be useful in achieving role clarity. The resources included are representative of themes generated from the survey results and focus groups. Although the resources are primarily targeted for use in practice settings, the exercises can also be easily adapted for use within nursing curricula for RN and RPN educational programs.

The resources are designed to assist with determining current levels of knowledge, perceptions regarding scope and patient care needs, and identification of strategies to address any gaps.

The Ontario Context

- College of Nurses of Ontario – Three Factor Framework

Getting to the Facts

- Myth busters: The biggest myths and old truths
- Q & A: Common questions about RPNs and scope of practice

Determining Team Knowledge and Understanding

- Assessment of staff awareness and perceptions
- Creating dialogue about the distinct and overlapping nature of roles
- Assessment of current organizational policies, procedures, and practices

Assessing the Patient Factor

- Some quick and easy exercises
- Clarifying commonly used terms
- The Patient Care Needs Assessment (PCNA) Tool

Enhancing Nurse to Nurse Professional Communication

- Collaboration vs. consultation
- Nursing Huddles: Creating opportunities for role clarity and team collaboration

How to Know if it's Going Well

- Proposed indicators for monitoring and evaluation

Additional Resources for Determining the Most Appropriate Care Provider

- Guidelines: Effective Utilization of RNs and LPNs in a Collaborative Practice Environment

The Ontario Context

The College of Nurses of Ontario – Three Factor Framework

Developed by the College of Nurses of Ontario (2011c), the Three-Factor Framework is a useful resource to support decision-making regarding the appropriate level of care provider (RN or RPN). The framework takes into consideration not only the patient care needs but also factors regarding the nurse and the environment, i.e., the context in which the care is being delivered. It is the consideration of all three factors that allows for effective decision-making and appropriate utilization of both RPNs and RNs in the provision of safe, quality patient care.

All factors are viewed along a continuum (e.g., less to highly complex care needs, more to less stable environments), and it is the continuum that determines the degree of autonomous practice for RPNs. For example, it is within the RPN scope of practice to care for patients with complex care needs when in collaboration with RNs. However, RPNs can function autonomously in the care of less complex patients. As the complexity of patients increases, there is the need and expectation for greater consultation and collaboration with RN colleagues. For patients with highly complex care needs, the RN is the most appropriate care provider. As with all the factors, it is the point along the continuum (see Figure 1) that needs to be considered when determining whether it is within the scope of practice for RPNs.

For more information on how to apply the Three Factor Framework Webcast (approximately 15 minutes): College of Nurses of Ontario. RN and RPN Practice: The Client, the Nurse and the Environment. Available online via College of Nurses website: http://www.cno.org/en/learn-about-standards- guidelines/educational-tools/webcasts/rn-and-rpn-practice- the-nurse-the-client-and-the-environment-webcast/

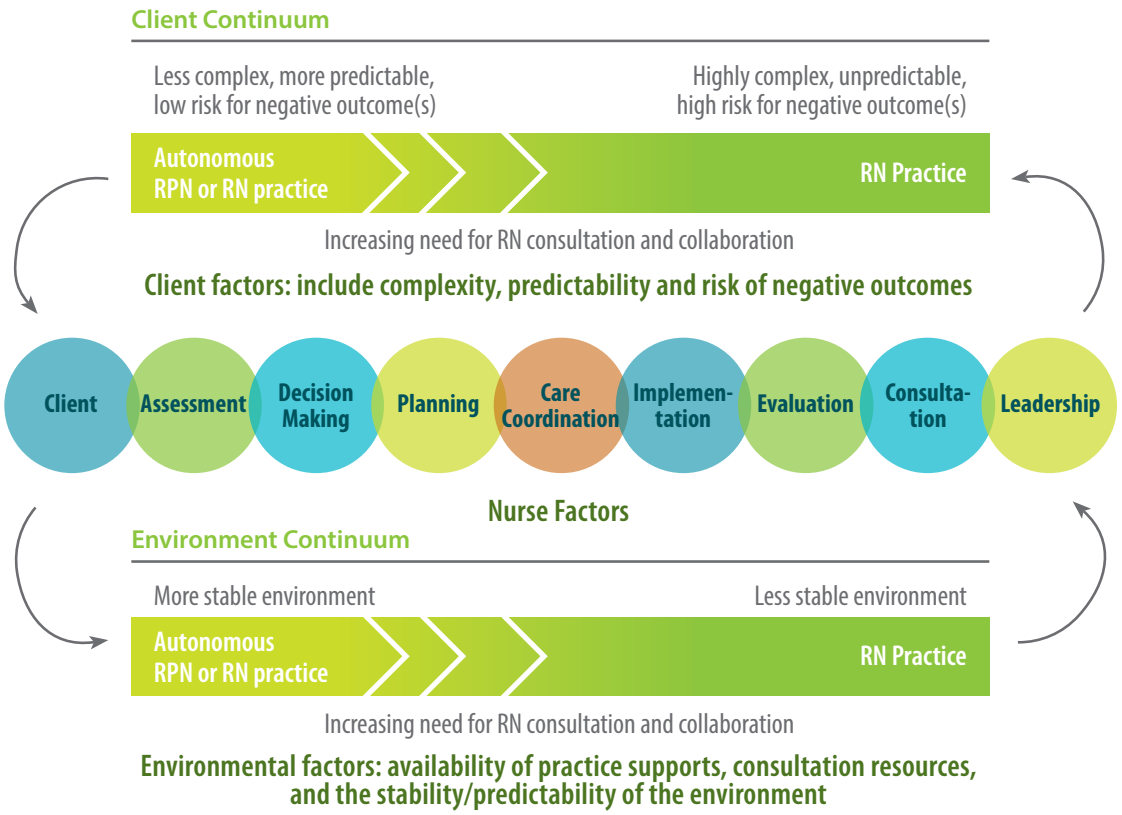


Figure 1: Adapted from "RN and RPN Practice: The Client, the Nurse and the Environment," College of Nurses, 2011c, p. X. Copyright 2011 by College of Nurses.

Getting to the Facts

Myths Busters – The Biggest Myths and Old Truths

The myths were taken directly from the project findings. The facts are supported by legislated and regulatory statements (acts, entry-level competencies, professional statements).

Myths Busters

MYTH	FACT
The current RPN diploma program is just like the old RN diploma program.	As per the College of Nurses of Ontario Professional Standard (Knowledge), RPN and RN basic educational programs, current and past, have consistently reflected the following principles: • RPNs, RNs, and Nurse Practitioners (NPs) study from the same body of nursing knowledge. • RPNs study for a shorter period of time than RNs and NPs. They have a more focused or basic foundation of knowledge in clinical practice, decision-making, critical thinking, research, and leadership. • RNs and NPs study for a longer period of time to achieve a greater breadth and depth of knowledge in clinical practice, decision making, critical thinking, research utilization, leadership, health care delivery systems and resource management. • All nurses add to their basic education and foundational knowledge by pursuing ongoing learning throughout their careers (CNO, 2002). As the competencies have evolved, so have the basic educational programs for both RPN and RN nursing programs. The revised basic entry-to-practice competencies are used to guide the curricula for RPN and RN educational programs. See References for links to: • National Competencies in the Context of Entry-Level Registering Nurse Practice (CNO, 2009) • Entry-to-Practice Competencies for Ontario Registered Practical Nurses (CNO, 2011a)

Continued on page 31

Myths Busters *(continued from page 30)*

MYTH	FACT
Scope of practice is defined by what you are allowed to do.	From a regulatory perspective, scope of practice is a broad description of what the profession is educated in and authorized to do and not just about functions and tasks. Although a very commonly used (one might say misused) phrase, there is no one commonly accepted definition for scope of practice. A useful definition for scope of practice includes elements reflecting regulatory, education, and personal components such as: Scope of practice is defined as health care professionals optimizing the full range of their roles, responsibilities and functions that they are educated, competent and authorized to perform (Health Authorities Health Professions Act Regulations Review Committee, 2002). There is a difference between legislated scope of practice as described above and individual scope of practice based on the individual nurse's own level of competency (CNO, 2011b).
The Controlled Acts do not apply equally to RPNs.	The controlled acts authorized to Nursing apply equally to RPNs and RNs. An RN or RPN may perform a procedure within the controlled acts authorized to nursing if it is prescribed by a physician, dentist, chiropodist, midwife, or NP; or if it is initiated by an RPN or RN in accordance with conditions identified in the regulation (CNO, 2011b).
RNs are ultimately accountable for the care provided by RPNs.	RNs are not accountable for the practices or actions taken by RPNs. Each individual nurse (RPN or RN) is solely accountable for the care provided to her or his patients and all decisions she or he makes regarding care. Each individual nurse is accountable for ensuring she or he has the required knowledge and skills to provide care; identifying when patient care needs are beyond her or his current knowledge, skill, and competency level; and communicating this to the appropriate member of the care team or organization.
As nurses, RPNs and RNs understand each other's roles.	There are currently four generations of nurses working together in the various practice settings, with four different basic educational program levels: (RPN certificate, RPN diploma, RN diploma, and RN baccalaureate degree). Based on what the perceived truth was during early career development, this is the truth or mental model that many nurses are still functioning under. Outside of educational programs, there are little to no opportunities for practicing nurses to be updated, informed, or engaged regarding the changes to roles, knowledge, skills, and entry-to-practice competencies. The very existence of role tension, confusion, and ambiguity indicates that there is a need for dialogue within nursing about the two distinct, yet interconnected designations within the nursing profession.

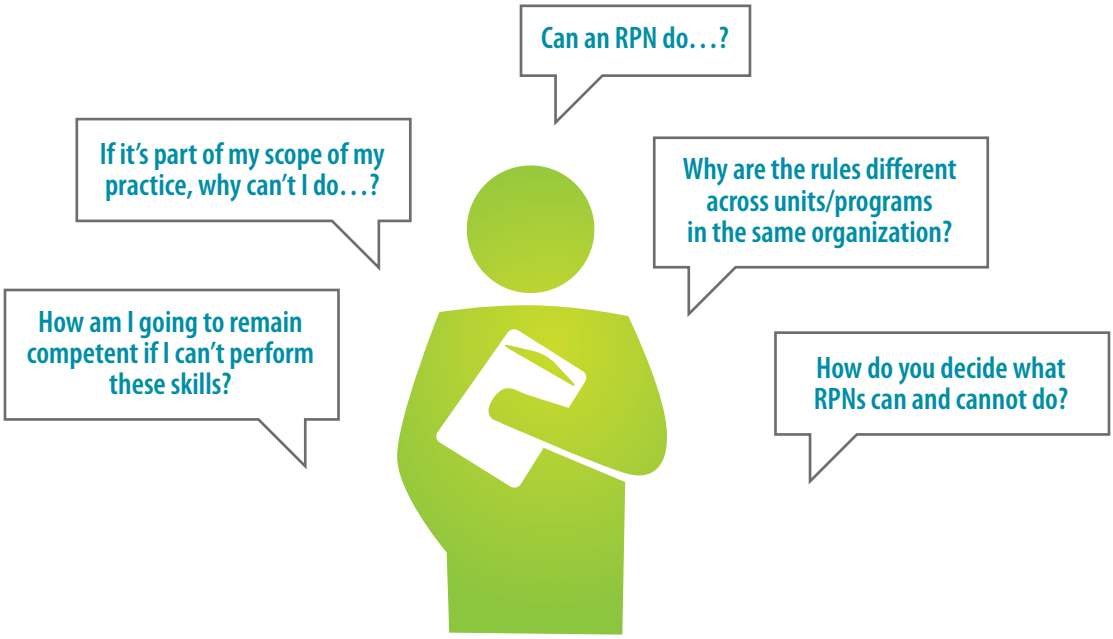
Continued on page 32

Myths Busters *(continued from page 31)*

MYTH	FACT
RPNs must work under the direct supervision of an RN. **RPNs are assistants to the RN.**	In Ontario, RPNs are self-regulated, autonomous professionals and therefore have the capability to practice without direct supervision based on: 1. patient care needs 2. personal competency – The RPN has the knowledge and skills required to function without supervision or assistance. Where various designations of nurse exists (RPN, RN, or NP), it is logical that outcomes (patient and work life) are more positive when nurses work in collaboration. Nurses assist each other. No regulatory direction exists that compels an RPN in an assistant role to the RN.
RPNs only work in long-term care; they do not work in hospitals.	RPNs provide care in all sectors: hospitals, long-term care, community and home care, public health and primary care, as well as in private practices. Within the hospital sector, RPN roles are less likely to be included in areas such as Emergency and Critical Care areas due to the nature of patient population and care needs (e.g., less stability and predictability of outcomes); however, some RPN roles have been successfully developed in these areas in Ontario. Based on the patient population, there may be a higher ratio of RPN to RN in areas such as rehabilitation, complex continuing care, home health care and a lower ratio of RPN to RN in areas where there are higher populations of patients with unpredictable outcomes. While some RPNs are providing care in some higher acuity areas due to a collaborative model of care, they are most likely to be found engaged in autonomous practice in more predictable environments.

Most Common Questions about RPNs and Scope of Practice

Suggested responses to the most common questions about RPNs and scope of practice.



Common Questions about RPNs and Scope of Practice

QUESTION	KEY MESSAGES FOR CONSIDERATION
Can RPNs do…?	*"It depends"* Although "it depends" could be seen as a frustrating answer, it really does depend on a variety of factors. The following questions should be considered before decision-making regarding RPN scope of practice: 1. What is the intervention being requested? Is it within scope of practice for the RPN role? 2. Why is it being requested? 3. What patient population would this apply to? 4. What is the patient-specific need this would address? 5. What aspect(s) of patient care needs would this benefit or enhance? 6. Does this happen frequently enough to ensure competency and quality? 7. What knowledge, judgement, and skill is required? 8. What are the risks? 9. Are their sufficient resources available to manage outcomes?

Continued on page 34

Common Questions about RPNs and Scope of Practice *(continued from page 33)*

QUESTION	KEY MESSAGES FOR CONSIDERATION
Why are the rules different across practice settings, programs, and regions in the same organization?	As each area, region, or program may provide care to very distinct patient populations with distinct needs, so then will be the required competencies for RPNs and RNs providing care in those areas. It's about what the patient population needs and the ability to maintain competency (How often is the skill required? Is there critical mass for maintaining competency?); it's not about what the provider (nurse) is educated in or competent to do. For example, although care of patients with IVs is within the scope of practice for RPNs, if on a particular unit (e.g., Mental Health, Complex Continuing Care), this particular intervention is required very infrequently, this may then be assigned to RNs only to ensure there is a smaller, core group that maintains competency in this area. Note: This same principle applies equally to all health care professionals, including RNs, to ensure the provision of safe, high-quality care.
What factors into the decision about RPN scope of practice at the organizational level?	1. Patient care needs and health status guide consideration for changes to scope of practice. 2. Consideration is then given to determine degree of support/guidance in the following areas: a. Legislation (e.g., RHPA, Bill 179) b. Regulation (e.g., professional standards and guidelines) c. Evidence-based guidelines d. Patient population needs (e.g., benefits, risks, frequency) e. Provider characteristics (e.g., education, experience) f. Organizational supports available
If it's part of my scope of my practice, why can't I do…?	For one of two reasons: 1. It's not needed or required by the patient population. 2. The intervention does not occur frequently enough to ensure that all nursing staff will be able to maintain competency and quality. In these cases, it may then be decided to restrict the intervention to one role to optimize competency and quality or to request the assistance of another unit or team.
How am I going to remain competent if I can't perform these skills?	Competence is defined as the nurse's ability to use knowledge, skill, judgment, attitudes, values, and beliefs "to perform in a given role or situation and in a specific practice setting" (CNO, 2002, p. 5). Employers are obliged to provide staff with educational opportunities to ensure they have the necessary knowledge and skills to meet the patient population's care needs. Employers are not obligated to provide staff with educational opportunities to maintain competencies for all knowledge and skills provided in educational programs. For example, an RPN who is competent in starting IVs transfers to a Rehab unit with little or no requirement for IVs. The employer is obligated to ensure the RPN has the knowledge and skills required to provide care for rehab patients, but is not obligated to provide the RPN with opportunities to maintain competency in IVs, if that particular skill is not required in that practice setting. Employers do not select candidates based on tasks but rather on overall knowledge, critical thinking skills, and experience they bring to the position for which they have applied.

Determining Team Knowledge and Understanding

The presence of role ambiguity or role tension is a result of one or more contributing factors. In order to determine the most effective strategies to resolve or minimize the degree of role ambiguity, it is important to determine the contributing factor(s).

Reflection Question:

What are the touch points, issues, and scenarios where role ambiguity seems to appear? Reflect on and discuss why ambiguity exists?

a. Patient assignment process and delivery of patient care

b. Inconsistent messages (e.g., outdated role descriptions, policies, and procedures)

c. Varying practices within the organization

d. Changes to current practices, policies, and procedures

e. Introduction of RPN role (new to skill mix complement)

Assessment of Staff Awareness and Perceptions

The Registered Practical Nurse Role Clarity Questionnaire© (RPN-RCQ©)

In order to determine strategies for addressing role ambiguity, it is important to first determine the starting point: what are the current perceptions of staff (RPNs and RNs) regarding roles and role clarity?

The use of a confidential survey is an easy and cost-effective way to obtain staff input. This survey can be done as part of initial assessment to determine specifics areas for focused intervention. This survey can also be used in ongoing monitoring or evaluation to determine the impact of any interventions or strategies employed to address role ambiguity at the team, program, or organizational levels.

A scan of instruments specific to role clarity revealed the lack of an existing survey that would reflect the unique roles, legislation, standards, as well as the issues specific to role ambiguity experienced in Ontario. Therefore, the RPN Role Clarity Questionnaire© (RPN-RCQ©) was developed. The initial items were developed based on a review of relevant literature and input from nursing leaders from across the sectors, regarding the issues commonly experienced specific to RPN role ambiguity.

The RPN-RCQ© can be completed in less than 30 minutes by RPNs, RNs, managers/administrators, or other members of the interprofessional team as deemed necessary. The results can provide insight into areas for targeted intervention (e.g., education, policy review, and team communication).

Contact RPNAO to access the RPN Role Clarity Questionnaire© (RPN-RCQ©) for survey items and scoring instructions.

Tel: (905) 602-4664

Toll Free: 1 (877) 602-4664

www.rpnao.org

Creating Dialogue About the Distinct and Overlapping Nature of Roles

Role clarification among health care professionals, including RPNs and RNs, is important as roles can overlap and potentially cause conflict. Clarifying each other's role in the contribution to patient care and embracing the overlap can help to decrease intra-team conflict, mitigate role ambiguity, and build trust between team members.

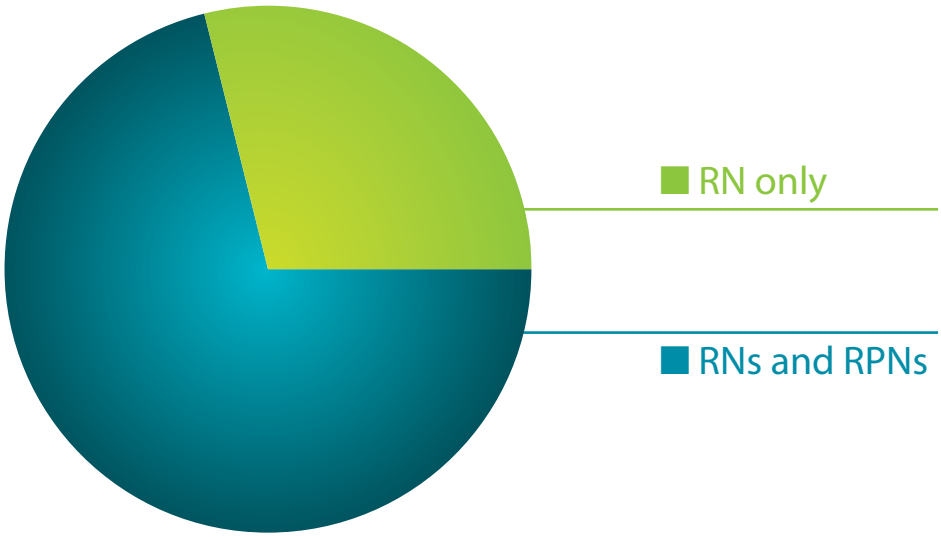
Role clarification among health care professionals, including RPNs and RNs, is important as roles can overlap and potentially cause conflict.

Exercise Purpose: To promote dialogue regarding the distinct and overlapping roles within the nursing team and embrace the overlapping areas where both RPNs and RNs have a significant role in provision of health care services and patient outcomes. This exercise can be adapted to include other roles within the interprofessional team (e.g., personal support workers, physiotherapists, rehabilitation assistants, etc.).

Instructions:

1. Assemble members of the team.
2. Using Figure 2 as a template, draw a large circle with one delineated wedge. Note that the size of the wedge in Figure 2 is for display only. The size of the wedge will vary, depending on the patient population and setting.
3. Have RPNs and RNs describe the patient care needs and required nursing functions that they both perform and the areas where both RPNs and RNs contribute to patient care and interprofessional teamwork. Include examples on the diagram.
4. Within the RN wedge, have both RPNs and RNs describe what they consider to be the roles, functions, and patient care scenarios that are outside the scope for RPNs and therefore the sole the domain of RNs. Include examples on the diagram.

Figure 2: Roles and Functions



Assessment of Current Organizational Policies, Procedures, and Practices

Functioning to full scope of practice is often determined by organizational policies and procedures. To ensure the optimization of all nursing professionals, it is important to ensure that organizational policies and procedures are reflective of internal and external requirements and guidelines.

Recommendations from National Bodies

The Canadian Nursing Advisory Committee Report (2002) Recommendation I (19) states that: All employers should abandon the practice of regulating nursing practice and should put in place policies that will allow each Registered Nurse, Licensed Practical Nurse* and Registered Psychiatric Nurse to function to the maximum of her or his professional practice abilities according to the respective provincial/territorial licensing body.

Regulators are urged to work with nurses, employers, unions, educators and governments to maximize the scopes of practice of Registered Nurses, Licensed Practical Nurses and Registered Psychiatric Nurses in all settings and jurisdictions, as appropriate, given the acuity and complexity of patients, residents, clients, and/or families in the setting. (p.38)

Institute of Medicine (2011): The Future of Nursing – Leading change, Advancing Health. Key message 1: Nurses should practice to the full extent of their education and training. "Nurses have the opportunity to play a central role in transforming the healthcare system…If the system is to capitalize on this opportunity, however, the constraints of outdated polices, regulations and cultural barriers, including those related to scope of practice, will have to be lifted." (p. 85)

Policies Reflective of Desired Practice

In order to support the smooth introduction or extension of the RPN role within organizations or programs, it is important to ensure that all documents specific to roles, practices, policies, and procedures are consistent with the desired future state, including legislation and regulatory guidelines. Consistent messaging will minimize the degree of role ambiguity and enhance role clarity within the nursing and interprofessional team.

Suggested Exercise: Policy and Procedures

1. **Review all existing patient care related policy and procedures that specify RN only.**
2. **Determine if the intent and language of the policy or procedure is reflective of:**
   a. **Legislation: Scope of practice, controlled acts**
   b. **Regulation: Standards of practice, practice guidelines**
   c. **Education: Basic entry-to-practice competencies for both RPNs and RNs**
   d. **Patient population needs: Population demographics, most common diagnoses, co-morbidities, and care needs, including trends in acuity and complexity**
   e. **Organization: Programs and resources to support care and care providers**
3. **Determine which policies and procedures require updating in order to reflect current practice.**
4. **Where appropriate, change wording from Registered Nurse to "Nurse" to be inclusive of both RPNs and RNs.**

Suggested Exercise: Role Descriptions

1. **Review existing RPN and RN role descriptions, position descriptions, and employment postings.**
2. **Determine if the intent and language is reflective of:**
   a. **Legislation: Scope of practice, controlled acts**
   b. **Regulation: Standards of practice, practice guidelines**
   c. **Education: Basic entry-to-practice competencies for both RPNs and RNs**
   d. **Organizational programs, patient populations**
3. **Determine the changes required to reflect internal and external standards and requirements.**

Assessing the Patient Factor

Teams would benefit from scrutinizing how individual members of the team define and therefore apply the terms to distinct patient populations and profiles.

According to the College of Nurses of Ontario Three-Factor Framework (2011c), the assignment of the appropriate level of care provider to patients or groups of patients requires an assessment of patient characteristics. This process creates the most common scenarios for role ambiguity and tension. Although the items in the table below are widely used, exact meanings are often based on individual interpretation and past experience. This can create the over or underutilization of RPNs in the delivery of patient care. Teams would benefit from scrutinizing how individual members of the team define and therefore apply the terms to distinct patient populations and profiles.

The following exercises are intended to provide opportunities for teams to engage in dialogue that is specific to each practice setting, patient population, and nursing team characteristic, while still taking into consideration the legislative, regulatory, and organizational requirements.

Clarifying Commonly Used Terms

Exercise Purpose: To determine the extent staff share a common view on their assessment of patients' needs and status.

Instructions:

1. Take a sample from the current patient population that staff are currently providing care for; would everyone share a common awareness of a distinct term that would generally describe the health care needs?
2. Using the following definitions, have staff independently assess each patient or patient group (of inpatients, case load, residents, families).
3. Instruct staff that there is no expected right answer.
4. Compare assessments to determine the degree of consensus: how similar was the selection of terms for the patient assessments/ratings?
5. Debrief by discussing the degree of commonalities and differences and the impact this may have on determining assignments, roles, and the appropriate level of care provider.

Clarifying Commonly Used Terms

Clarifying Commonly Used Terms

TERM	DEFINITION	EXAMPLE PATIENT/GROUP
Stable	Steady, not fluctuating; not liable to change	
Acute	Patient condition that is deemed to be extremely serious or severe	
Complex	Consisting of two or more interconnected parts in an intricate arrangement. Complexity can extend beyond health care needs but could also include complex discharge requirements, family dynamics, and ongoing care needs	
Predictable Outcomes	Something that is easy to foresee or anticipate, i.e., outcomes that can reasonably be expected to follow an anticipated path with respect to timing and nature	
Unpredictable Outcomes	Outcomes that cannot reasonably be expected to follow an anticipated path with respect to timing and nature	
Unanticipated	Not anticipated* **Anticipated = to expect something; to think or be fairly sure that something will happen*	
Uncharacteristic	A distinguishing feature or quality that is unusual for a given person or situation	
Heavy	Refers to the degree of intensity of workload or work effort required to meet care needs. This may relate to the number of interventions involved to meet care needs and/or the physical effort required	

Deciding on Acuity

The attributes of acuity are the severity and intensity of care needs, and can also reflect provider impacts such as nursing care needs and workload (Brennan & Daly, 2009).

Exercise Purpose: To generate dialogue regarding staff perceptions of terms commonly used to describe patient level of acuity, nursing care needs, and associated workload. This exercise can be done as a verbal exercise within the group, or as a paper based exercise done independently and results compared.

Instructions:

1. Ask participants to answer true or false to the statements below.
2. Compare results to determine the degree of consensus: how similar were the answers?
3. Debrief by discussing the degree of commonalities and differences and the impacts this may have on determining assignments and roles; come to a consensus/shared understanding on how this applies to distinct patient populations.

Patient/Population Characteristics

PATIENT/POPULATION CHARACTERISTICS	TRUE	FALSE
Patients with high acuity will also have low predictability.		
If a patient is considered complex, they will also be acutely ill.		
Patients can be "heavy" (e.g., have a number of care requirements) and yet not be acutely ill.		
Patients can be complex yet have very predictable outcomes.		
Patients with complex care needs are also quite "heavy" in terms of workload.		
Patients that are stable have high predictable outcomes.		
Unpredictable is the same as unanticipated or uncharacteristic.		
Other examples for discussion:		

The "Typical" Patient/Care Scenario

Exercise Purpose: To develop a shared awareness of the overall patient population based on terms commonly used to describe patient status and care needs. This can then be used to as a guide to support matching of patient needs to the appropriate level of care provider

Instructions:

1. With your overall patient population (e.g., orthopedic patients, rehabilitation patients, complex continuing care, mental health, long term care residents, home care profiles, community programs/groups, etc.), brainstorm examples for each of the terms.
2. Come to consensus on the typical patient characteristics and patient care scenarios that would fall within each category.

Terms

TERM	DEFINITION	EXAMPLE OF OUR TYPICAL PATIENT
Stable	Steady, not fluctuating; not liable to change	
Acute	Extremely serious or severe	
Complex	Consisting of two or more interconnected parts in an intricate arrangement. Complexity can extend beyond health care needs but could also include complex discharge requirements, family dynamics, and ongoing care needs.	
Predictable Outcomes	Something that is easy to anticipate, i.e., outcomes that can reasonably be expected to follow an anticipated path with respect to timing and nature.	
Unpredictable Outcomes	Outcomes that cannot reasonably be expected to follow an anticipated path with respect to timing and nature.	
Heavy	Refers to the degree of intensity of workload or work effort required to meet care needs. This may relate to the number of interventions involved to meet care needs and/or the physical effort required.	

The PCNA provides an objective assessment of a patient's status in order to best determine the appropriate level of care provider.

The Patient Care Needs Assessment (PCNA) Tool

The Patient Care Needs Assessment (PCNA) is a 14-item tool developed as component of the RN/RPN Utilization Toolkit (Blastorah et al., 2010). The PCNA provides an objective assessment of a patient's status in order to best determine the appropriate level of care provider.

Statistical analysis conducted on the PCNA revealed the following:

a) Items assessing the need for frequent monitoring for complications and reassessment and revision to the patient's plan of care were most strongly associated with both *patient stability and predictability* (e.g., PCNA items 1-6)

b) Items related to revision of the plan of care, patient and family support needs, and supporting patients or families with decision-making were strongly associated with patient *complexity* (e.g. PCNA items 6, 9-10).

c) Items related to increased monitoring, increased adjustment in the plan of care, high-risk interventions, support needs and complex patient or family decisions were also strongly associated with *risk for negative outcomes*.

For more information: A copy of the RN/RPN Utilization Toolkit (2009) is located on the RPNAO website via http://www.rpnao.org/sites/default/files/RN_RPN_Utilization_Toolkit_(Apr30)_0.pdf

Blastorah, M., Alvarado, K., Duhn, L., Flint, F., McGrath, P., & VanDeVelde-Coke, S. (2010). Development and evaluation of an RN/RPN utilization toolkit. Nursing Leadership, 23, 33-55.

Enhancing Nurse to Nurse Professional Communication

Each RPN or RN has a professional accountability to recognize when the situation is outside her or his personal comfort or competency level (e.g., novice to expert) and therefore requires consultation or the seeking of advice from a colleague with the required knowledge, judgement, and skills.

Collaboration vs. Consultation

Collaboration is the ongoing process of team members working together through the use of timely and effective communication. The very nature of providing safe, effective, and quality care to patients requires frequent, effective, and timely collaboration among all members of the interprofessional team.

Consultation is the active process of seeking out advice or direction from colleagues recognized for their knowledge and expertise in order to address a specific question or problem. Consultation may occur face-to-face or over the telephone and as required.

Each RPN or RN has a professional accountability to recognize when the situation is outside her or his personal comfort or competency level (e.g., novice to expert) and therefore requires consultation or the seeking of advice from a colleague with the required knowledge, judgement, and skills. Scenarios may include a novice or experienced RPN seeking advice from a RN colleague due to changes in patient status or a novice RN (e.g., novice in mental health or wound management) seeking advice from an experienced RPN.

Depending on the patient needs, competency level of the individual nurse and other resources, there are various outcomes from the consultation process (see Figure 3):

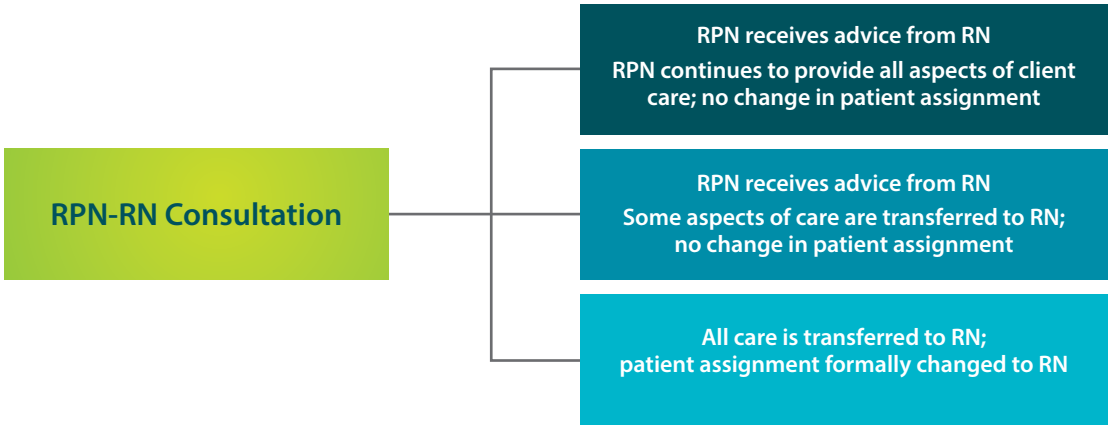


Figure 3: Adapted from "Working Together: A Framework for the Registered Nurse and Licensed Practical Nurse," Nurses Association of New Brunswick & Association of New Brunswick Licensed Practical Nurses, 2009.

Similar in concept to the interprofessional team huddle, a nursing team huddle is a short, quick, meeting that is held once per shift for the purpose of providing a dedicated time for members of the nursing team to share information, ask questions, and identify potential issues that may require increased collaboration and consultation.

Nursing Huddles: Creating Opportunities for Role Clarity and Team Collaboration

As in football, before every play, there is a quick huddle for the purpose of communicating the plan and ensuring that everyone is clear as to their role. Huddles create opportunities not only for sharing information but also for enhancing relationships among members of the health care team and creating a culture of safety through collaboration and conversation (Provost, Lanham, Leykum, McDaniel, & Pugh, 2014).

Similar in concept to the interprofessional team huddle, a nursing team huddle is a short, quick, meeting that is held once per shift for the purpose of providing a dedicated time for members of the nursing team to share information, ask questions, and identify potential issues that may require increased collaboration and consultation. Nursing huddles can be done face-to-face or in the case of community-based teams, can also be done effectively via conference calls. The huddle provides a brief time to check-in and focus on specific areas such as: key information for share, potential areas of concern or need for assistance.

Tips for Effective Huddles

1. Huddles should last no more than 15 minutes.
2. Huddles should be scheduled at the same time every shift to establish a routine.
3. Huddles are mandatory in that the time is viewed as being critical to team functioning and care delivery.
4. Run face-to-face huddles while standing up in a circle; this will keep them brief.
5. Ensure each person participates.
6. Keep huddles focused on key information team members need to know, e.g., any "hot spots" or areas of concern, need for assistance, or changes required to the plan of care.

Examples of effective team huddles:

Planned care huddle:
http://www.youtube.comwatch?v=Wttxm7jAnb4

Huddles at TEGH:
http://www.youtube.com/watch?v=LunfjIpC76Y

Improving Care Management through Interprofessional Huddles:
http://www.youtube.com/watch?v=g1lfssbJVHE

How to Know if it's Going Well

Proposed Indicators for Monitoring and Evaluation

As the needs of patient populations continue to evolve along with changes to roles and health care contexts, indicators provide a useful way to continuously monitor areas such as role ambiguity.

Indicators provide a quantitative, evidence-based foundation for clinicians and organizations to monitor and evaluate what happens to patients as a consequence of how well professional and organizational systems function (Mainz, 2003). In order to determine the impacts of any interventions applied to address role ambiguity, it is important to determine what indicators will provide information regarding the current state.

As the needs of patient populations continue to evolve along with changes to roles and health care contexts, indicators provide a useful way to continuously monitor areas such as role ambiguity.

The patient and staff related examples were generated from survey results and focus group consultations and are reflective of outcomes described in a variety of publications and reports (e.g., Canadian Nurses Association, 2012; Health Authorities Health Professions Act Regulations Review Committee, 2002; Kenney, 2001).

Patient-Related Indicators

METRIC	DESCRIPTION	RATIONALE
Patient Transfers	Number of transfers to higher level of care (e.g., from Long-Term Care to Acute Care; inpatient unit to critical care; home care to acute care).	
Adverse Events	The number of harmful and undesired effects resulting from a medication or other intervention(s), resulting in some degree of harm to the patient.	May reflect the quality of monitoring, the effectiveness of actions taken once early complications are recognized, or both; appropriateness of assignment and level of care provider; degree of consultation and/or collaboration within the team
Failure to Rescue	Failure to rescue (e.g., failure to prevent a clinically important deterioration). Provides a measure of the responsiveness of care providers to changes in patient status while under their care.	
Patient Satisfaction	Using eight dimensions of patient-centred care as framework for monitoring patient satisfaction: access, continuity and transition, coordination of care, emotional support, physical comfort, information and education, family involvement and respect for patient preferences.	Indication of appropriate level of care provider along the patient journey; ability to meet patient needs; allowing for continuity of care and care provider.

Staff-Related Indicators

METRIC	DESCRIPTION	RATIONALE
Changes to patient assignment; * appropriate care provider	The frequency of changes required to level of care provider within the assignment.	The frequency of changes required to patient assignment provides an indication of the level of patient acuity and predictability and/or level of disagreement among staff regarding the most appropriate care provider
Satisfaction with assignments	Degree of satisfaction expressed by RPNs and RNs regarding the patient assignment	Expressed dissatisfaction with assignment (e.g., fairness, equity, appropriateness) and the amount of time required to resolve can have a negative impact on care delivery and team work.
Attrition	Number of RPN staff who voluntarily terminate employment	May serve as a proxy for RPN dissatisfaction
Sick time	Increase in RPN-related sick time	May serve as a proxy for RPN dissatisfaction
Staff Engagement	The degree to which employees feel passionate about their jobs and are committed to the organization.	May serve as a proxy for RPN satisfaction and feelings of being respected
Communication	Effective and timely communication between members of the nursing and interprofessional team regarding patient care needs and changes in patient status.	Evidence linking adverse events to poor team communication, team ineffectiveness and lack of collaboration (Page, 2004)
Teamwork/ Collaboration	RPNs and RNs working together in order to achieve a goal (e.g., high-quality, safe care) and demonstrated willingness to assist others	

**Patient assignments are most often associated with hospital, long-term care and home care practice settings. Terms for other sectors may include caseload, rosters, or programs targeted to specific groups or health issues.*

Additional Resources: Determining the Appropriate Care Provider

Guidelines: Effective Utilization of RNs and LPNs in a Collaborative Practice Environment

Developed in 2012, by the College of Registered Nurses of Nova Scotia and the College of Licensed Practical Nurses of Nova Scotia, the Guidelines: Effective Utilization of RNs and LPNs in a Collaborative Practice Environment are adapted from College of Nurses of Ontario RN and RPN Practice: The Client, the Nurse and the Environment and the Three Factor Framework. The guidelines contain several case studies and practice scenarios that address matching patient needs with the care provider and the need for ongoing assessment and collaboration.

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Appendix A

Appendix A

Focus Group Questions

1. What does the phrase practicing to "full scope of practice" mean to you?
2. What are the scenarios that cause the greatest concern and tensions specific to the area of scope of practice?
3. What would be helpful to you in your role as leaders to address this complex issue?
4. Metrics: how do you know they are working well or not working well?
5. Do you have additional thoughts on the issue of role clarity for RNs and RPNs?

Notes

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