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nnagra3@uwo.ca

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Closing the educational gap in a Canadian health authority: Implementing a Licensed Practical Nurse introduction/scope optimization framework

by

Navdeep Nagra

AN ORGANIZATIONAL IMPROVEMENT PLAN

SUBMITTED TO THE SCHOOL OF GRADUATE AND POSTDOCTORAL STUDIES

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Abstract

As a problem of practice, there is a lack of educational preparedness among Licensed Practical Nurses (LPNs) for entry-to-practice positions with specialty patient populations. A large health authority that serves specialty patient populations, referred to hereafter as Organization M, is hiring LPNs in place of Registered Nurses due to nursing shortages. The literature reveals that the level of education possessed by nurses affects the quality of patient care and safety (Needleman, 2017). This Organizational Improvement Plan (OIP) focuses on determining how to address LPNs' lack of educational preparedness for entry-to-practice positions with specialty patient populations. A critical organizational analysis identifies that there are many drawbacks to hiring LPNs and not providing them with the additional education/skills training they require to work competently with specialty patient populations. The analysis identifies multiple factors that leaders must consider prior to hiring LPNs or optimizing their scope of practice. The OIP determines that the only feasible solution is for Organization M to identify and provide LPN with the additional education/skills training they require. An LPN Introduction/Scope Optimization (LISO) framework is created to provide guidance to leaders about the factors necessary to judiciously hire LPNs or optimize their scope of practice. The aim of the LISO framework is to ensure LPNs in Organization M receive the additional education/skills training they require to provide safe and competent care. Through the implementation of the LISO framework, LPNs will be able to work to their optimal scope of practice when working with specialty patient populations.

Keywords: licensed practical nurse, additional education, skills training, scope optimization, specialty patient population

Executive Summary

As a problem of practice, there is a lack of educational preparedness among Licensed Practical Nurses (LPNs) for entry-to-practice positions with specialty patient populations. This Organization Improvement Plan (OIP) focuses on a large health authority, referred to hereafter as Organization M, which serves specialty patient populations. Organization M is hiring LPNs who are not workplace ready as they have minimal education and training with specialty patient populations. Thus, this OIP focuses on determining how to address LPNs' lack of educational preparedness for entry-to-practice positions with specialty patient populations.

Chapter 1 begins by exploring the vision, mission, history, and organizational structure of Organization M and how they relate to this problem of practice. Furthermore, authentic transformational leadership is the identified approach to lead the change to address this problem, as it engages key stakeholders to work collaboratively. Additionally, there is an analysis of the various factors that compel the need to address this problem of practice. Because it perceives nursing as a process rather than a series of tasks, a feminist lens is chosen to view this problem. This lens synchronizes with the conceptual framework, the Donabedian model, and views nursing education as being connected to the quality of care and patient outcomes. Accordingly, a literature review validates that the level of education that nurses have affects the quality of patient care and safety (Needleman, 2017). Chapter 1 ends with an examination of change readiness that reveals that Organization M is willing to address this problem of practice.

Chapter 2 begins by outlining how strategies from authentic transformational leadership will engage, motivate, and empower key stakeholders to propel the change forward. The Nine-Phase Change Process Model for Leading Conscious Transformation

is the chosen framework for leading the change process as it aligns with the approach of authentic transformational leadership. An analysis using the open systems theory highlights that there are several disadvantages to hiring LPNs and not providing them with the additional education they need. Subsequently, a further analysis using the Congruence Model uncovers factors that help identify the additional education/ skills training LPNs require. Accordingly, two solutions for change are appraised, and the only feasible option is for Organization M to identify and provide LPNs with the education they need. Lastly, ethical considerations establish that Organization M has a moral responsibility to ensure its nurses possess the knowledge and skills required to provide safe and competent care.

Chapter 3 examines how to implement the change. An LPN Introduction/Scope Optimization (LISO) framework is created from the factors uncovered in Chapter 2 to implement the change. Having the LISO framework endorsed and adopted so that it can be applied across Organization M is the priority. Thus, there is consideration of the potential reactions and barriers for change, and identification of probable solutions to keep the change moving forward. Furthermore, timelines are outlined with the Nine-Phase Change Process Model, which coordinates with steps in the LISO framework to implement the change. Additionally, Bennett's Hierarchy Evaluation model is used to create an evaluation plan of the change process and result. Chapter 3 concludes by outlining a plan for effective communication during the change process.

The ultimate goal of this OIP is that the implementation of the LISO framework will result in LPNs acquiring the knowledge and skills they need to provide safe quality care for specialty patient populations.

Acknowledgments

Mom and Dad, I am dedicating this OIP to you. Mom, you gave up your MBA to immigrate to Canada to provide a better life for us (before we even existed), after fighting so hard to be the only woman in your program. Dad, you also sacrificed your education to provide for your family. Regardless, you both have emphasized the importance of education and have always supported me to complete my educational pursuits. I am grateful to you for the opportunities you provided me to get to this point here in my life, thank you! I hope one day I will be able to do the same for my children.

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This journey was not easy and really pushed me to do my absolute best. I am grateful for having this experience and I'm glad I have finally done it! The biggest learning experience I am taking away from this is to bet on myself.

"Only those who will risk going too far can possibly find out how far one can go."

— T.S. Eliot

Table of Contents

Abstract ... ii
Executive Summary ... iii
Acknowledgments ... v
List of Figures ... viii
Definition of Terms ... ix
Chapter 1: Exploring the Educational Gaps and its Effects in Organization M – Introduction and Problem ... 11
Organization Context ... 12
  Vision, Mission, and Goals ... 13
  Historical and Cultural Context ... 14
  Organizational Structure ... 14
  Department Context ... 16
Leadership Position and Lens Statement ... 17
Leadership Problem of Practice ... 18
Framing the Problem of Practice ... 20
  Historical Overview of Problem of Practice ... 20
  Organizational Theory ... 22
  Conceptual Framework ... 24
  Critical Appraisal of Nursing Education and Patient Outcomes ... 25
  PESTE Analysis ... 27
  Internal Factors ... 30
  External Factors ... 31
Questions Emerging from the Problem of Practice ... 32
  Challenges ... 32
Leadership-Focused Vision for Change ... 35
  Gap Between Current and Desired State ... 35
  Priorities for Change to Construct Future State ... 36
Organizational Change Readiness ... 37
  Assessing Organizational Readiness ... 37
  Competing Forces ... 38
Chapter 1 Conclusion ... 39
Chapter 2: Leading, Analyzing, and Planning to Close the Educational Gap ... 40
Leadership Approaches for Change ... 40
  Transformational Leadership ... 40
  Authentic Leadership ... 42
  Authentic Transformational Leadership ... 43
Leadership Framework ... 44
  Nine-Phase Change Process Model ... 45

Critical Organizational Analysis 48
Open Systems Theory 49
Congruence Model 50
Potential Solutions 56
Practical Nursing Curriculum Change 57
Organization M Providing the Additional Education/Skills Training 62
Ethical Considerations and Challenges 67
Chapter 2 Conclusion 70
Chapter 3: Implementing, Evaluating, and Communicating the LISO Framework 67
Plan for Implementing the LISO Framework 71
Goals 71
Priorities 71
Benefits of the Change Plan 73
Stakeholder Reactions and Solutions 75
Personnel to Engage/Empower 80
Supports and Resources 81
Potential Implementation Issues 82
Build Momentum 83
Limitations and Potential Solutions 84
The Change Process Framework and Plan for Monitoring and Evaluation 85
The Nine-Phase Change Process Model and Timeline for Implementation 85
Tools to Monitor and Evaluate Change 87
Pre-implementation evaluation 87
Post-implementation evaluation/monitoring. 89
Change Process Communication Plan 92
Pre-change Approval 92
Constructing the Need for Change 93
Midstream Change and Milestone Updates 94
Confirming/Celebrating the Success 96
Chapter 3: Conclusion 97
Future Considerations and Next Steps 98
References 100
Appendix A 106

List of Figures

Figure 1. Modified Organization Structure..15

Figure 2. The Donabedian Model for Quality of Health Care.. 24

Figure 3. Nine-Phase Change Process Model for Leading Conscious Transformation….45

Figure 4. Congruence Model.. 51

Figure 5. Proposed Organization Structure.. 75

Figure 6. Bennett's Hierarchy Evaluation Model 89

Definition of Terms

Autonomous Practice: This is a nurse having the ability to carry out certain restricted nursing activities without the supervision of, or an order from, an authorized health professional.

College of Nursing Regulation: This is the regulatory body for LPNs. Its main purpose is to protect the public through setting standards of practice, assessing practical nursing education programs in Province C, and regulating LPN practice.

Entry to Practice Position: This is a position where an individual has met the educational, competency, and experience-related qualifications required to practice nursing.

Expanded Scope: This is when the College of Nursing Regulation allows nurses to carry out activities that they were not previously able to perform.

Health Authority: A governance structure set up by the provincial government that is responsible for the administration and delivery of health services in a geographical area.

Hospital: An institution providing nursing care and treatment for ill or injured individuals.

Inpatient Centre: A setting where patients reside for necessary treatment for a disease or a severe episode of illness for a short period of time and where patients are discharged as soon as they are healthy and stable.

LPN: This is a Licensed Practical Nurse in Province C who has 16–18 months of post-secondary education in nursing and who can only provide care to patients who have stable or predictable conditions.

Nursing Activities: The procedures, activities, and actions nurses carry out to achieve an outcome and for which they are accountable.

Nursing Skills Mix: This is when an employer has nurses of different education levels working together, e.g., baccalaureate-prepared nurses such as RNs working with nurses who do not have a baccalaureate degree such as LPNs.

Optimize Scope of Practice: To expand the ability of nurses to carry out additional procedures and actions that are permitted by their regulatory college. This is also referred to as scope optimization.

Optimal Scope of Practice: This is when nurses are permitted by their employer to carry out all of the procedures and actions they are trained for and competent to perform.

Outpatient Setting: A setting that does not require an overnight stay, such as a clinic or associated facility that patients visit for diagnosis or treatment.

Patient Outcomes: Changes in the health of a patient that result from health care interventions (i.e., patient fully recovering, patient partially recovering, patient becoming more ill, or patient dying).

Patient Populations: Areas where patients have a similar age range, similar disease, or a similar technique that they will be undergoing for treatment.

Practice Leader: An individual in a leadership position who manages the practice of nurses in his/her setting.

Programs: Hospitals, inpatient centres, and outpatient settings in Organization M that deliver care to specialty patient populations and include the Cancer Agency, Children's Hospital, Mental Health & Addiction Services, and Women's Hospital & Health Centre.

RN: A Registered Nurse in Province C who has a baccalaureate in nursing and can provide care to any patient.

Services: These are services that Organization M operates and manages and are provided either directly through Organization M's programs or are funded to be provided through Regional Health Authorities.

Scope of Practice: The procedures and actions nurses are authorized to perform by their regulatory college (captured in the scope of practice document) if employer policy permits it, and if the nurse has the competence.

Scope Optimization: This is expanding the ability of nurses to carry out additional procedures and actions that are permitted by their regulatory college. This is also referred to as optimize scope of practice.

Specialty Patient Populations: Areas where patients have more complex needs due to their age range (i.e., pediatrics), type of disease (i.e., cancer or mental health and addictions), or techniques required for treatment (i.e., maternity or the operational room).

Chapter 1: Exploring the Educational Gaps and its Effects in Organization M

Introduction and Problem

In attempts to provide quality health care, most provinces in Canada require that Registered Nurses (RNs) must now have a baccalaureate degree. However, due to a demand for nurses over the years there has been an increase in nurses, known as Licensed Practical Nurses (LPNs), who complete only 16–18 months of education and are employed across various health settings in Canada (College of Nursing Regulation, 2018). The College of Nursing Regulation (see Definition of Terms) enables LPNs to work in a variety of clinical areas and conduct various nursing activities that they will not have learned in school, with the condition that they receive additional education prior to carrying out these nursing activities or working in these settings (College of Nursing Regulation, 2001). Thus, the responsibility to provide LPNs with this additional education is being placed on the employer.

Due to the shortage of RNs, employers for specialty patient populations are beginning to hire greater numbers of LPNs. Specialty patient populations are areas where patients have complex diseases such as cancer, mental health or addiction problems, or are in complex areas such as the operating room, maternity, and pediatric settings. However, health authorities such as Organization M are finding that upon hiring LPNs, they are not workplace ready with regard to specialty patient populations. Specifically, the College of Nursing Regulation outlines in the LPN scope of practice document (see Definition of Terms) that LPNs require additional education to perform certain nursing activities that are necessary for specialty patient populations. As a problem of practice, there is a lack of educational preparedness among Licensed Practical Nurses for entry-to-practice positions with specialty patient populations.

This first chapter reviews Organization M's context including its vision, history, culture, and organizational structure. Moreover, my leadership philosophy is reviewed along with the approach I will use to address this problem. Consequently, the factors shaping the problem of practice are examined. Specifically, a feminist lens is used to analyze the problem. Accordingly, the Donabedian model is the conceptual framework utilized to frame this problem. Additionally, questions emerging from this problem are considered along with the leadership-focused vision for change. Lastly, organizational change readiness is assessed, and communicating the need for change is examined.

Organization Context

Organization M is a large health authority in Canada that provides health care through its specialized services and programs across Province C (Organization M, 2018). The services that Organization M operates and manages include Emergency Health Services, Provincial Renal Services, Provincial Transplant Services, Cardiac Services, Perinatal Services, Disease Control Services, Information and Technology Management Services, and Hospital Pharmacy Services. Organization M provides these services either directly through its programs or funds them to be provided through Regional Health Authorities.

The programs in Organization M are offered through hospitals, inpatient centres, and outpatient settings. These programs provide care and services to specialty patient populations that are unique and require specialized care. The programs that Organization M operates and manages include the Cancer Care Program, Children's Hospital, Mental Health & Addictions Programs, and Women's Hospital & Health Centre. This problem of practice focuses on LPNs who lack the knowledge and skills required to work in Organization M's programs.

Organization M’s mandate is determined by the Ministry of Health, which outlines its strategic direction. Organization M’s mandate is to ensure planning, accessibility, coordination, efficiency, effectiveness, and quality of health care through its services. Organization M is primarily responsible for the corporate governance of its specialized health care services and programs, detailed above, through the development and management of expectations through funding allocations and performance agreements.

Organization M differs from other health authorities in Province C. Regional Health Authorities have a regional jurisdiction, whereas Organization M provides its services and programs throughout the province and mostly in collaboration with the Regional Health Authorities. Additionally, Organization M’s programs and services develop and set the provincial policies and standards for all Regional Health Authorities in Province C.

Vision, Mission, and Goals

Sowell (2007) describes vision as an organization’s sense of how it works and what it builds on. The vision of Organization M is to constantly provide excellence in health across this province. Hence, it is important that all health care providers in Organization M have the training and education required to work with specialty patient populations in order to provide the best care possible. Talbot (2003) states that an organization’s mission is the statement of values it strives to live up to and bases its standards on. Organization M’s mission is to produce province-wide health results together through caring, learning and leading. It has five core values: to respect people, be compassionate, dare to innovate, cultivate partnerships, and serve with purpose (Organization M, 2018). The vision and mission of Organization M align with its historical and cultural context.

Historical and Cultural Context

Organization M was created in 2001 and is a health service provider publicly funded by the Ministry of Health to provide quality health care for specialty patient populations across Province C. Organization M focuses on providing evidence-based care and, as a result, it is currently the largest health research organization in this province. It has a culture of being a teaching and learning organization, as its programs and services provide training to many health care providers such as registered nursing students, medical students and residents, and pharmacy students. Specifically, Organization M provides training and education (partnering with post-secondary programs) to more than 4,000 students in health care professions annually in its specialized patient populations through clinical practicum placements and preceptorship. Historically, Organization M's programs have not provided LPN students with clinical or preceptorship placements as they did not hire LPNs. Organization M's programs have only employed RNs and Registered Psychiatric Nurses (RPNs) in nursing roles, in alignment with its mandate and vision of providing high quality services, as educationally RNs and RPNs have been the most highly qualified nurses, with baccalaureate degrees. Thus, in order to maintain the culture and history of Organization M, it is important to address the problem of practice to meet the need for more nurses and thus the hiring of competent LPNs.

Organizational Structure

Organization M is a distributed organization, which is publicly funded and takes direction from the Ministry of Health. Buller (2015) describes a distributed organization as one where power is shared among a group of individuals while retaining a loose hierarchical structure. Unlike decentralized organizations, not everyone in a distributed organization possesses equal power and the upper ranks have the right to veto decisions made by lower ranks; however,

decision-making is intended to be a shared process through empowerment and delegation (Buller, 2015). The upper ranks of Organization M include the board of directors, CEO, the Vice Presidents of the various programs/services, and the Chief Financial, Legal, and Communication Officers. Each of Organization M's programs has its own set of Vice Presidents and these are not accountable to any of the other programs in Organization M (see Figure 1).

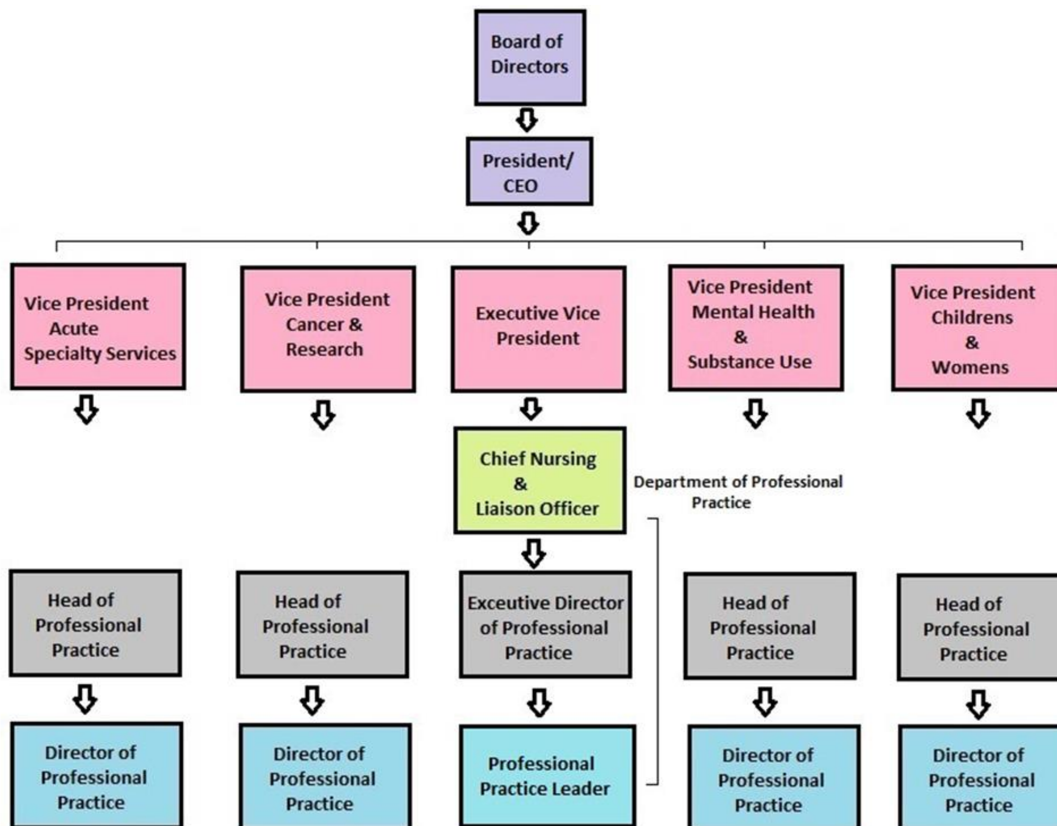

Figure 1. Modified Organization Structure. Adapted from "Organization M Org Chart [PDF]" by Organization M, 2017. Retrieved from: Website.

Hence, the Department of Professional Practice (bottom of middle column) has no formal authority over the directors of professional practice, as they report up within their own program. Consequently, being a distributed organization results in each program viewing itself as its own entity which leads to a lack of engagement with the Department of Professional Practice. Thus,

this requires the Department of Professional Practice to utilize leadership strategies that engage the directors of professional practice to work collaboratively.

Department Context

My role at Organization M is as a Professional Practice Leader for the Department of Professional Practice. The Chief Nursing & Liaison Officer is responsible for the Department of Professional Practice at Organization M (see Figure 1). The Chief Nursing & Liaison Officer works with the Ministry of Health of Province C to ensure that the practice of nurses at Organization M is aligned with the Ministry's vision and requirements. The scope of the Department of Professional Practice at Organization M includes leadership, education, research, and practice. Specifically, practice entails integrating new roles for nurses or their expanded scope into practice. Expanded scope is when the College of Nursing Regulation approves nurses to carry out activities that they were hitherto not approved to carry out (see Definition of Terms). In these instances, the Executive Director of Professional Practice approves these activities for Organization M and provides direction to the professional practice leaders to work with the directors of professional practice to create policy, education, and supporting practice documents for nurses (my role/responsibility). The aim of the Department of Professional Practice is to provide nurses with the supports they need in order to be able to competently carry out these new activities. Hence, the Department of Professional Practice also focuses on promoting best practice initiatives through the creation of policy and clinical education, and collaborates with other regional health authorities to promote consistency of practice across the province. As mentioned above, due to being a distributed organization, the Department of Professional Practice has no formal authority to instruct the directors of professional practice to carry out changes or new initiatives. Thus, increasing collaboration and engagement with the directors of

professional practice is vital in my role. Consequently, I have adopted a leadership style that promotes engagement and collaboration.

Leadership Position and Lens Statement

My professional background entails a variety of different roles including working as a frontline nurse in Organization M, as clinical associate for a university, and as a Nursing Supervisor in Organization M. Through my roles, I have strived to empower others to achieve mutual goals.

My career began as a frontline nurse in Organization M. This role helped me understand the functions of a nurse, along with the power dynamics present in nursing. It provided me with the opportunity to reflect on leadership qualities that I appreciated such as honesty, respect, transparency, and following through with what was said. This also enabled me to identify authentic transformational leadership as my leadership style. Transformational leaders engage with their colleagues and followers to create "performance beyond ordinary expectations as they transmit a sense of mission, stimulate learning experiences, and arouse new ways of thinking" (Hater & Bass, 1988, p.695). Thus, to achieve this, authentic transformational leaders use effective communication skills and build quality relationships with team members.

I moved into my first leadership role as a Clinical Associate. Through this position, I learned that the willingness and ability to perform tasks will vary for each individual and that there is no single communication style that will work with everyone (Northouse, 2016). I came to understand that effective communication builds relational skills as the individual feels understood, valued, and heard. Hence, effective communication is an important skill I attempt to employ.

After working as a Clinical Associate, I returned to work in Organization M as a Nursing Supervisor. Through this role, I learned the value of creating quality relationships with the staff. Day, Davis, and Fitchett (2007) report that leaders make effective decisions when they are aware of the strengths of their team and utilize these strengths for decision-making. As a result, I strive to have the best possible relationship with individuals I work with in order to be able to help them reach their full potential.

Through my role as a Professional Practice Leader, I have gained a further appreciation for authentic transformational leadership. As a Professional Practice Leader, I must use strategies to engage the directors of professional practice to create change. The approach of authentic transformational leadership promotes this engagement while keeping the values of Organization M at the forefront.

Zhu, Avolio, Riggio, and Sosik (2011) outline that authentic transformational leadership empowers team members to increase their awareness of what is right and raises higher moral maturity in those members. This is accomplished by leading by example and utilizing moral values on a higher level in my own practice (Zhu et al., 2011). The use of authentic transformational leadership allows me to utilize a collaborative approach to communicate, plan, and organize for change across the organization. Accordingly, Chapter 2 further elaborates on the qualities of an authentic transformational leader and the strategies I will use to move this change forward. The next section will review the problem of practice and why there is a need for change.

Leadership Problem of Practice

As a problem of practice, there is a lack of educational preparedness among Licensed Practical Nurses for entry-to-practice positions with specialty patient populations. The Practical

Nursing curriculum in Province C reveals that LPNs have minimal education about specialty patient populations (e.g., cancer care or mental health & addictions) and are not acquiring all of the education and skills required to care for these populations. To fill nursing shortages, Organization M has been hiring LPNs who can only work with patients who are considered to be in a stable or predictable condition. Due to the complexity of the patient populations in Organization M, some LPNs are often assigned simple activities, which include tasks that can be completed by non-nursing staff. As a result, these LPNs are reporting they are not satisfied with their role because they are not working to their optimal scope of practice (see Definition of Terms). The College of Nursing Regulation states that LPNs have a variety of skills and tasks they can perform once their employer provides additional education. Organization M, however, has not previously had to provide additional education as RNs are educated and trained through their nursing education programs to carry out these activities. Consequently, Organization M does not provide any formal theoretical or skills courses for LPNs to acquire the additional education needed to better understand their specialty patient populations, and work to their optimal scope of practice.

There are many factors and phenomena that contribute to this problem. There is an increasing shortage of RNs due to various factors including the baby boomer population aging and RNs retiring (Wilcox, 2016). As a result, this has led to the role of LPNs evolving and for their scope to grow in carrying out nursing activities that their role did not originally include. The scope and role of LPNs is continuing to change. In 2015 the College of Nursing Regulation reported that LPNs are no longer required to work under the supervision of RNs, and are able to engage in autonomous practice once their employers have created appropriate policies (College of Nursing Regulation, n.d.). Moreover, the Practical Nursing curriculum that the practical

nursing education programs utilize in Province C does not encompass the need for LPNs to have a deep theoretical understanding of specialty patient populations. Nor does the Practical Nursing curriculum encompass all of the nursing activities that LPNs are approved to carry out as practical nursing education is meant to be short, which leaves the responsibility for educating LPNs about these nursing activities to the employer. As a result, there are LPNs working in Organization M who require additional education. Hence, this Organizational Improvement Plan (OIP) focuses on how to address LPNs' lack of educational preparedness for entry-to-practice positions with specialty patient populations. Therefore, it is necessary to review the factors that frame this problem.

Framing the Problem of Practice

Historical Overview of Problem of Practice

The history of nursing education has evolved over time in Canada. In 1874, the first hospital school for Canadian nurses was created (Baker, Guest, Jorgenson, & Crosby, 2012). Over the following years, doctors began recognizing the impact of nurse competency on patient outcomes (Gibbon, 1947 as cited in Baker et al., 2012) and, as a result, began advocating for university education for nurses. In 1919, the University of British Columbia created a ten-year baccalaureate degree program in nursing, which was the first not only in Canada but the British Empire (Davidson Dick & Cragg, 2003). However, this model of the nursing baccalaureate degree only required nurses to take their first- and last-year courses in university while they spent the intervening years in a hospital school (Baker et al., 2012).

The Canadian Nurses Association (CNA) and the Canadian Medical Association (CMA) collaborated in 1927 to conduct research on nursing schools (Baker et al., 2012). The report included recommendations that:

1. University training schools for nurses' award degrees in the place of diplomas;
2. Nursing schools be integrated to the general education system imbued with the same philosophies as other schools; and
3. Entry-to-practice standards for nursing be increased (Baker et al., 2012; Fleming, 1932).

Due to the implementation of the recommendations from this report, many universities across Canada now offer baccalaureate degrees for RNs (Baker et al., 2012) and all provinces except Quebec require a baccalaureate degree as entry-for-practice for RNs (Canadian Nurses Association, 2015). The Canadian Nurses Association (2015) reports that the variables that led to RNs requiring a baccalaureate degree included:

1. The growing complexity in health care and nursing;
2. The increasing body of health and nursing-related knowledge;
3. The accountability of safe, ethical, effective, and competent nursing care to the public; and
4. The need to have a foundation in sound critical thinking, clinical judgement, clinical reasoning, and a robust ethical comportment in nursing.

Baker et al. (2012) highlight nursing education as a key component in the quality of health care in Canada and, as a result, the Canadian Association of Schools of Nursing has been focusing on improving the quality of nursing education.

Due to the shortages of RNs, there is an increase in LPNs who practice nursing in Province C after 16–18 months education, and in other provinces across Canada after one to two years of education (College of Nursing Regulation, n.d.). Prior to 1945, LPNs were known as auxiliary workers in Canada, who were trained on-the-job in hospitals and nursing homes to

meet nursing service needs (College of Nursing Regulation, n.d.). Through this role, their function was to assist nurses. In 1965, the Province C Practical Nurses Act established the Council of Licensed Practical Nurses as the licensing body for LPNs and they were then recognized as a self-regulating profession (College of Nursing Regulation, n.d.). The LPN's role and function has evolved to that of a nurse in Province C and across Canada. These care providers are now known as health care professionals who mostly work in frontline nursing roles for a variety of clients at all stages of life, including in health promotion, long-term care, acute care, and palliative care (College of Nursing Regulation, n.d.). Similar to the situation in Canada, Aiken et al. (2017) report that there has been an increase of concern regarding the quality of care in English hospitals since they began phasing in Associate Nurses (similar to LPNs), who have 18 months of education and training. To add to this concern, there are particular organizational perspectives that normalize interchanging RNs and LPNs without concern for the quality of care.

Organizational Theory

Max Webber indicates that bureaucracy is a process of rationality as it creates a clear division of duties and activities (Gerth & Mill, 1946). As a result, the goal of bureaucracy is to ensure precision, reliability, and efficiency through a structure of hierarchy that is governed by rules (Gerth & Mill, 1946). A study by the BCNU and UPN (2009) stated that nursing work is hierarchical in nature and some respondents reported that there is a pecking order (as cited in Croft & Cash, 2012). Webber suggests that bureaucracy focuses on depersonalization and an oppressive routine in order to be rational (Gerth & Mill, 1946). Moreover, bureaucratic structures compel leaders to be disciplined, methodical, and prudent in order to create conformity with fixed patterns of actions for their followers (Merton, 2004).

Through a bureaucratic lens, nursing can be viewed as a set of tasks or activities that need to be performed, and any individual can carry out these activities as long as they are regulated by their professional body to do so. As a result, operations managers are hiring LPNs instead of RNs as their professional body enables them to perform similar nursing activities. However, LPNs do not have the same theoretical education to understand patient needs for specialty patient populations. Although LPNs may be able to perform the same tasks, their clinical judgment and critical thinking differs from RNs due to the lack of theoretical education. Parkin (2009) reports that bureaucracy is prevalent in health organizations and perpetuates procedures and routines. Therefore, a bureaucratic lens adds to this problem of practice as it views nursing tasks separately rather than viewing them as part of the nursing process and thus interconnected.

The feminist organizational perspective questions ingrained values and beliefs that make organizational policies, priorities, practices, structures, styles, and incentives (Manning, 2013). The feminist theory of the web of inclusion utilizes feminine skills such as empathy and collaboration to highlight that everything is connected (Manning, 2013). Through a feminist lens, nursing is viewed as a process rather than a series of tasks. This lens acknowledges that the level of education a nurse has is connected to the quality and depth of the nurse understanding patient needs and carrying out nursing tasks. The feminine traits of leadership are similar to those in authentic transformational leadership (Rutherford, 2001), and align with my leadership style and Organization M's values. Viewing this problem of practice through a feminist lens accentuates the need to ensure that nurses have the education and training needed to provide quality care to patients in Organization M. This lens also synchronizes with the conceptual framework framing this problem.

Conceptual Framework

A quality improvement conceptual framework is used to shape this problem of practice in alignment with Organization M's vision to provide the best health care all of the time. Donabedian (1966) implied that solely relying on outcomes as the measures for the quality of care in the medical profession has many limitations. Donabedian (1966) rather implies that the processes of care, settings of where care takes place, and the qualifications that support the provision of care, should be examined along with outcomes. This led to the development of the Donabedian Model, which examines and evaluates the quality of health care through structures, processes, and outcomes (see Figure 2).

Figure 2. The Donabedian Model for Quality of Health Care. Adapted from "*Long-term care quality: historical overview and current initiatives*" [PDF] by J. Capitman, W. Leutz, C. Bishop, and R. Casler, 2005. Washington, DC: National Quality Forum.

Structures. As can be seen in Figure 2, structures denote the ability of the nurse to respond to patient needs. This encompasses many variables including the environment in which the nurse works, the resources available for the nurse to do his/her job, the nursing activities that the nurse is approved to carry out in that setting, and the level of education the nurse has to understand his/her patients' needs and to carry out the nursing activities required. This OIP will focus on the level of education of nurses as the variable for the nurse's ability to respond to patient needs.

Processes. This part of the model includes the nursing activities carried out with regard to patient needs. The types of nursing activities that a nurse can carry out will depend on the structures in place, such as the education and training the nurse has received to perform these activities. Moreover, the amount of education and training will affect the level of competency in performing the nursing activity. Consequently, this will also affect the quality of the nursing activity performed, which will affect the outcome for the patient.

Outcomes. These are the consequences of nursing activities, which lead to changes in the patient's functional, physical, and/or psycho-social status. Patients' health outcomes are impacted by these activities. For instance, a nursing activity that is performed incorrectly may lead to negative consequences for the patient.

This framework embeds the feminist organizational lens and views nursing as a process where everything is connected. This problem of practice is shaped by the educational level of nurses as it affects their ability to provide quality care, which impacts patient outcomes. There is extensive literature that examines the level of nursing education's impact on patient outcomes, which is important to review.

Critical Appraisal of Nursing Education and Patient Outcomes

The literature demonstrates that the education nurses have affects the quality of patient care and safety. As per Cho et al. (2015), research at hospitals in Western countries such as the United States, Canada, Belgium and other European countries demonstrates that the level of nurse education is associated with patient deaths. Moreover, many studies reveal a higher proportion of nurses to be linked with lower patient mortality (Cho et al., 2015). Aiken et al. (2014) carried out a retrospective observational study in nine European countries and found that for every ten percent increase in baccalaureate nurses there was a seven percent decrease in

patient deaths. Similarly, a study conducted by Cho et al. (2015) in South Korea, examining nurse staffing mix with patient outcomes, found similar results with the level of nurse education as a factor related to patient deaths. Additionally, the Canadian Nurses Association (2015) reports that since 2002 many studies have linked the increase of baccalaureate-prepared RNs in hospitals with decreased patient mortality, decreased rates of pulmonary embolism, lower rates of postoperative deep vein thrombosis, decreased rates of decubitus ulcer, and decreased length of stay in the hospital.

More recently, Aiken et al. (2017) conducted a study and found that having a nursing skills mix leads to risking adverse patient outcomes and causing preventable deaths. Hence, Aiken et al. (2017) caution policy makers to consider patient outcomes prior to changing the nursing skills mix and introducing nurses with lower levels of education and training. Furthermore, Needleman (2017) highlights that studies of nursing skills mix demonstrate that patient care and patient safety are put at risk when nurses do not have the education and training needed to perform their job, and it is crucial for health care administrators and policy makers to act on this to ensure reliable, safe, and effective delivery of care.

The findings in the literature are consistent with the conceptual framework where the level of nurses' education affects the quality of care provided, which affects patients' outcomes. As indicated in most studies, it is evident that hiring nurses with more education (RNs in Canada) leads to better patient outcomes. Traditionally, Organization M has only hired RNs or baccalaureate-prepared RPNs and, therefore, has not considered providing additional education to nurses upon entry-to-practice positions. However, due to the increase in the shortages of RNs, the aging nursing population, and an increase in the patient population, employers such as Organization M are compelled to hire LPNs who have minimal education about specialty patient

populations. For LPNs to provide quality nursing care they must be provided with additional education, which enables them to understand these patient populations and the skills to work with them competently. Hence, it is important to determine how to address LPNs' lack of educational preparedness for entry-to-practice positions with specialty patient populations.

PESTE Analysis

Jie (2005) explains that PESTE is an environmental analysis that examines the impacts of each of its components on an organization. The following section examines the components of PESTE on this problem of practice.

Political. The Ministry of Health primarily funds Organization M and is the most influential stakeholder, as leaders in Organization M report to the Ministry of Health. A recent "Priority Recommendation" report written by Author X (2018), an employee of the Ministry of Health in Province C, highlights that LPNs are not working to their optimal scope of practice and that there are inconsistencies among the use of LPNs across health authorities in the province. Accordingly, Author X (2018) reports there will be collaboration with stakeholders to work on optimizing the scope of practice (see Definition of Terms) of LPNs and improving their utilization in various settings. Moreover, this author indicates that the Nurses Union also supports the optimization of LPNs' roles in practice settings and has a process in place to address inconsistencies across health authorities. As a result, there are groups of nursing leaders in Province C, including myself from Organization M, who are beginning to examine the scope of practice of LPNs in all of Province C's health authorities. Thus, identifying the additional skills needed by LPNs to work with specialty patient populations will align with the Ministry of Health's recommendations.

Economic. The increasing trend to hire LPNs across Organization M is also driven by the cost of LPNs, as their wages are less than RNs. Likewise, many nurses choose to complete their practical nurse education and training as it is much shorter in duration than the training and education to become a RN; therefore, they pay less for their tuition and start earning wages sooner. Hence, the increase in nursing shortages and increase in health care operational costs has led to an increase in hiring LPNs for all patient population areas. However, Needleman et al. (2006) suggest that although having more highly educated nurses initially increase the costs of an organization, as they must pay higher wages, there are significant cost savings in the long term, as patients have a reduced length of stay and fewer adverse outcomes when under care. Furthermore, Needleman (2017) reports that hospitals with a higher proportion of RNs save costs as the additional education and training that RNs receive allows them to detect and prevent complications in patients. Hence, as the literature indicates, increasing the education of nurses will increase patient outcomes positively. Consequently, identifying the additional education and skills LPNs need in order to work in areas across Organization M, and identifying how they can receive this, will improve the quality of patient care, which will reduce costs.

Social. Wilcox (2016) reveals that as the baby boomer nurses (born from 1946 to 1964) are retiring, there is an increase in millennial nurses and generation Z nurses (born after 1981). Moreover, Wilcox (2016) suggests that by the year 2020, over 46 percent of nurses will be millennials. Lavoie-Tremblay et al. (2008) report that the top reason for millennials leaving their position was a lack of challenge and an appeal to learn new skills (as cited in Wilcox, 2016). Boston College (2014) reports that millennials find meaning in their job and ranked this as the most important factor in job success (as cited in Wilcox, 2014). As a result, millennials are willing to leave an employer to find more meaningful work (Wilcox, 2014). Additionally, Smith-

Trudeau (2016) suggests that nurses begin to feel committed to an organization when they feel empowered and have a sense of belonging. Author X (2018) reports that LPNs in Province C have expressed they want to support patients better (i.e., find meaning in their work). St. Denis (2016) reports that if millennial nurses are unable to do the things that they came into nursing to do (which includes affecting patient care and making a difference), they will move on to another organization that will enable them to do this. Therefore, as seen from these studies, in order to retain the LPNs in Organization M, it is important to identify and provide LPNs with the additional education needed for them to work to their full scope and provide quality care.

Technological. Through technology, patients are becoming more active partners in their health care assessment and treatment as they are able to search for information on the internet (Servellen, 2009). Schwartz et al.'s (2006) study found that over 90 percent of patients who used the internet attempted to verify information given to them by their health care team (as cited in Servellen, 2009). The information found by patients through the internet is not always reliable or current, and patients may not be aware they are being misinformed (Servellen, 2009). Thus, it is imperative that all nurses are knowledgeable about the diseases and treatments for specialty patient populations and are able to provide accurate information when answering questions or providing patient education. A lack of knowledge may lead to nurses misinforming the patient (or the family), which will reflect poorly on the quality of nurses hired in the organization and may lead to patients mistrusting the organization.

Environmental. Studies indicate that health settings that have more nurses with a richer skills mix (i.e., baccalaureate-prepared nurses) are more likely to have low job-related burnout rates, and will have nurses who are more satisfied with their jobs (Aiken et al., 2014). Moreover, a richer skills mix of nurses is linked to a reduced turnover of nurses, which contributes to a

better environment of providing quality patient care and saving costs for the organization (Aiken et al., 2014). Additionally, the authors report that their study found health settings that have a higher number of nurses with a baccalaureate degree had higher patient satisfaction ratings, and nurses were more likely to rate the quality of care provided in their environment as higher along with the patient safety culture. Hence, increasing the education and skills training of LPNs will improve the quality of the environment for both patients and nurses.

Internal Factors

An environmental scan completed recently across Organization M demonstrated some internal factors that were shaping this problem of practice. The scan identified:

1. The specialty patient populations areas that employ LPNs;
2. Activities that LPNs are currently not able to do (as they require additional education); and
3. Nursing activities the practice leaders would like LPNs to be doing in the future, once they have received additional education.

The scan indicated that LPNs are currently working in the following specialty areas: oncology (cancer care), mental health and addictions, some pediatric settings, and in operating rooms. The scan also demonstrated that LPNs in these settings are not carrying out nursing activities that are part of their scope of practice as they have not received the additional education required to carry out these activities. Moreover, the LPNs expressed to their nursing leaders that they would like to be doing more nursing activities that are part of their scope of practice. Similarly, practice leaders also expressed that they would like LPNs to be doing additional nursing activities and working to their optimal scope of practice. However, the practice leaders were unsure of how to provide the LPNs with the additional education needed, and were also hesitant due to the time

and resources required to provide this additional education. Aligning with the principles of authentic transformational leadership, it is important to empower the LPNs by providing them with the additional education/skills training they need so that they can carry out more nursing activities.

External Factors

There are also several external factors shaping this problem of practice. On a macro level, other provinces across Canada provide specific guidance in the entry-to-practice competencies document for LPNs to have knowledge and skills for specialty patient population areas. Additionally, some provinces provide courses through post-secondary institutions where LPNs can gain additional education and skills to work with specialty patient populations. Province C currently does not have any courses that LPNs can take to work with specialty patient populations in Organization M. Moreover, the Practical Nursing curriculum for Province C was reviewed and updated in 2017, and the changes made to the curriculum do not include additional education for specialty patient populations. As a result, other health authorities across Province C have began creating courses to provide LPNs with additional education to support to them to work to their optimal scope of practice. This has led to inconsistent training for LPNs as different health authorities are providing different education. It additionally highlights that Organization M is currently not doing anything to support LPNs to gain additional education. Being an authentic transformational leader, it is important to provide LPNs with the additional education/skills training they need so that they can work to their highest potential.

The next section will explore questions that have emerged from further examining this problem of practice.

Questions Emerging from the Problem of Practice

As the literature demonstrates, the level of education a nurse has affects the quality of care provided and patient outcomes; as a result, several questions arise. Should Organization M be hiring LPNs as they are not workplace ready? What are the ethical implications? Whose responsibility is it to provide LPNs with the additional education/skills training? How will this OIP be perceived in Organization M? It is important to further examine these questions.

Challenges

Hiring LPNs. Considering the factors shaping this problem of practice, discussed above, it is important to contemplate whether LPNs should be working with specialty patient populations such as those in Organization M. As literature demonstrates, having a richer nursing skills mix leads to better patient outcomes, and hiring LPNs who require additional education lowers the skills mix. Due to the increase in nursing shortages, one may argue that it is better to have a nurse who is less qualified than having no nurse.

Ethical Implications. It is also important to reflect on the ethical implications of hiring nurses with a lower skills mix and not providing them with the additional education they need. As discussed earlier, the Canadian Nurses Association (2015) highlights that there is accountability for safe, ethical, and competent nursing practice to the public, which includes accountability from the nursing association, nursing regulatory body, employer, and the individual nurse. Organization M must consider the ethical implications of being aware that LPNs require additional education, are not receiving it, and yet are providing patient care. Moreover, Organization M strives to constantly provide quality care and by not addressing this problem of practice it is impeding its ability to do that.

Responsibility. It is important to consider whose responsibility it is to provide LPNs with additional education. Practical nursing programs are deemed to be vocational educational training (VET) programs that are offered through post-secondary institutions in Province C. In the 1960s, the Canadian government began creating higher educational institutions, which focused on vocational training in attempt to meet the growing demands of local businesses and industry (Hogan & Trotter, 2013). Hooge (2015) indicates that VET programs are different to other educational programs as they are intended to have strong connections to the labour market and with employers. Gelsli et al. (2016) indicate that the goal of VET is to meet the needs of the workforce and labour market by supporting students to develop the necessary skills, competencies, and knowledge for the intended occupational area. VET programs must ultimately foster innovation and enable newly graduated students to be successful in their workplace (Hooge, 2015). Tornabeni and Miller (2008) report that, traditionally, practice and academia in nursing have not worked together to address workforce issues, which has resulted in a lack of productivity and innovation for the nursing profession. This continues to appear to be the case, as LPNs are not workplace ready for Organization M.

Practical nursing programs are not proving LPNs with the additional education that they need, as the Practical Nursing curriculum set out by the College of Nursing Regulation does not direct them to. As a result, the practical nursing programs are not meeting their purpose of ensuring that newly graduated LPNs are able to be successful in Organization M. Additionally, the College of Nursing Regulation has a duty to protect the public by ensuring that LPNs are competent in providing nursing care. Stating vague messages such as "nurses can engage in nursing activities after additional education" without clarifying how that education should be delivered and how to determine competency leads employers to question whether the nurses

have the knowledge and skills required. The lack of clear direction in how this additional education should be delivered leaves ambiguity around who is responsible for providing LPNs with this additional education. Moreover, it also creates ambiguity to what is considered to be a sufficient amount of education for nurses to be competent. Hence, this creates a lack of assurance that the LPN is truly competent to perform these nursing tasks, which creates an opportunity to jeopardize patient care. Ultimately, Organization M is responsible for ensuring that its nurses are competent and have the education required to deliver safe and quality patient care.

Perception of OIP. It is vital to consider how this OIP will be received if implementation is anticipated. As mentioned earlier, many operations managers want to hire and optimize the scope of practice for LPNs for multiple reasons, including the increase in shortages of RNs and the cost savings due to the lower wages of LPNs. For this reason, this OIP will be of particular interest to operations managers. However, there may be some hesitancy about implementing this OIP due to costs, as operations managers are trying to save money by hiring LPNs and may not want to spend extra money providing additional education. Moreover, this OIP will be of particular interest to practice leaders across Organization M, as it is their responsibility to ensure that nurses have the education and supports in place to provide safe quality care. If the implementation of this OIP is ineffective, then other solutions in Organization M will have to be sought out as it is Organization M's responsibility to provide quality patient care. Overlooking this problem of practice will allow the problem to grow and may even create additional problems for the organization. In order for Organization M to be at its desired state, it must address this problem of practice. Hence, it is important to explore the leadership-focused vision for change.

Leadership-Focused Vision for Change

Gap Between Current and Desired State

Armenakis, Harris, and Field (1999) indicate that in order for an organization to be ready to change there must be a clear gap identified between the current state and the future desired state. In its current state, many of Organization M's programs now employ LPNs to some degree. The operations leaders in Organization M are hiring LPNs in positions that were traditionally held by RNs and encompassed a variety of nursing activities. However, due to the lack of education that LPNs receive about specialty patient populations, and their ability to only work with patients who have stable or predictable states of health, this puts further restrictions on the nursing activities that they can do, and restricts the patients for whom they can provide care. This results in some patients not achieving the best possible health care, which is contrary to the vision of Organization M. Additionally, as the literature demonstrates, the lack of education that nurses have impacts the quality of care that patients receive and their health outcomes. In order for Organization M to constantly be at its desired state of providing quality care and solutions for excellent health, it must ensure that its nurses are competent – that they encompass the skills and knowledge to work with speciality patient populations.

Additionally, Organization M must support its staff to gain the education and skills needed to provide the best quality of care. Through my role as a Professional Practice Leader for Organization M, I aim to bring Organization M to its desired state – where LPNs will be provided with additional education so they can work to their optimal scope of practice and have the knowledge and skills to provide quality patient care. As a leader in Organization M, I have an ethical responsibility to ensure that nurses have the education and skills they need to provide safe

care, and by using strategies of authentic transformational leadership I will engage and motivate others to address this problem of practice.

Priorities for Change to Construct Future State

The priorities for change include raising awareness of the need to provide LPNs with additional education. Armenakis et al. (1999) imply that for an organization to be ready for change, its people must believe that the proposed change is appropriate. This will be achieved by engaging and collaborating with the directors of professional practice and their operations colleagues.

There is a strong interest from operations leaders to hire and retain LPNs; however, they are not aware of the implications that this problem of practice has on Organization M, as operations' role is to manage costs and ensure efficiency. As a result, operations leaders view this problem of practice through a bureaucratic lens and do not see the priority for providing LPNs with additional education, as they do not see it being connected to the quality of care being provided. It is critical that they are able to see this through the feminist lens – that nursing education is connected to the quality of care provided and patient outcomes. Moreover, the directors of professional practice are responsible for ensuring that nurses are practising safely, competently, following best practice, and are thus able to understand that the education a nurse receives affects the quality of patient care he/she provides. Therefore, it is important that the directors of professional practice are aware of the implications of not providing LPNs with additional education and must help communicate this to their operations colleagues.

Collaborating with and informing the key stakeholders of Organization M will enable them to support the change and recognize how the change will benefit them (Armenakis et al., 1999). Examining what additional education LPNs need and how they can receive this will

balance both the needs of operations and professional practice leaders. It will give LPNs an opportunity to expand their scope in Organization M while professional practice will be assured that nurses are fully competent, and patients are receiving the best possible care.

Organizational Change Readiness

Assessing Organizational Readiness

In order for Organization M to efficiently address this problem of practice, it must be open and ready for change. Cawsey, Deszca, and Ingols (2016) suggest that organizational change readiness can be determined through four key points:

1. The previous experience the organization has had with change;
2. How adaptable and flexible the organization culture is;
3. The level of involvement by leadership in preparing the change; and
4. The confidence that organization members have in their leaders.

Previous experience and adaptability. Organization M has recently gone through change in expanding the scope of practice for RNs, and both practice leaders and nurses have had a positive experience with this change. The positive change experience has also created a positive organizational mood (Cawsey et al., 2016). However, Organization M is currently preparing for change in moving to the electronic health record system and has invested a lot of time and money to move this forward. As a result, addressing this problem may not be viewed as a priority until the electronic health record system has been implemented.

Senior leadership involvement. Senior managers are interested in addressing this problem, and there is executive support for the change, which is contributing to openness for the change (Cawsey et al., 2016). The Chief Nursing & Liaison Officer and Executive Director for Professional Practice recognize the operational appeal of hiring LPNs. However, they are also

mindful of the necessity that nurses working with specialty patient populations require adequate training and education, and that it is important not to hire nurses who jeopardize patient outcomes or do not provide the best possible care. They view this problem from the feminist organizational lens where providing LPNs with the education they need will improve the quality of care provided and patient outcomes. Therefore, they display readiness in finding solutions to how LPNs can gain the additional knowledge and skills needed to work to their full scope with stable or predictable patients in Organization M.

Confidence in leadership. The Chief Nursing & Liaison Officer and Executive Director for Professional Practice are trusted leaders who work collaboratively with leaders of all different levels in Organization M and contribute to credibility for change (Cawsey et al., 2016).

Additionally, as discussed above, this problem affects leaders and staff nurses, and it will be of particular interest to these groups to move forward by addressing this problem. Overall, Organization M demonstrates readiness for change to address this problem as there are many forces driving this change.

Competing Forces

There are competing internal and external forces that are shaping the readiness for change. As mentioned above, operations leaders have a greater interest in hiring LPNs and professional practice leaders need to ensure that nurses are providing safe, quality care. Moreover, LPNs are expressing that they would like to carry out more nursing activities. The Ministry of Health has identified that the scope of practice for LPNs must be optimized to ensure they are working to their full potential to address nursing shortages and delays in health care. Additionally, other health authorities in Province C have begun exploring options to provide

LPNs with additional education. Hence, both internal and external forces are shaping Organization M for change to consider how to provide LPNs with additional education.

Chapter 1 Conclusion

Organization M is a large health authority that provides care to specialty patient populations and strives to provide the best possible health care all the time. Due to nursing shortages and cost benefits, operations leaders in Organization M have been hiring LPNs, who do not have the education to work with specialty patient populations. As the literature indicates, hiring nurses with a lower skills mix leads to an increase in adverse patient outcomes and death. In order for Organization M to be meeting its vision of providing the best possible care all the time, it is vital to consider how to address LPNs' lack of educational preparedness for entry-to-practice positions with specialty patient populations. The role of professional practice in Organization M is to ensure that nurses have the skills and education they need to provide safe and quality care. The executive leaders of professional practice support addressing this problem of practice. The next chapter will explore a framework for leading the change process, possible solutions for change, and leadership approaches for change.

Chapter 2: Leading, Analyzing, and Planning to Close the Educational Gap

This chapter begins by exploring approaches from authentic transformational leadership to propel the change forward. The Nine-Phase Change Process Model for Leading Conscious Transformation is examined as the framework that will be used to lead change. Next, the open systems theory and Congruence Model are utilized to conduct an organizational analysis to assess the need for change. Furthermore, potential solutions are considered to address LPNs' lack of educational preparedness for entry-to-practice positions with specialty patient populations, with one chosen for implementation. Lastly, ethical considerations and challenges are highlighted, which compel Organization M to address this problem of practice.

Leadership Approaches for Change

A key dimension of my role as a professional practice leader is relationship management with other key stakeholders (i.e., directors of professional practice and practice leaders) in Organization M. Myers et al. (2016) indicate that relationship management occurs through communication, motivation, collaboration, and influence. Consequently, my personal leadership philosophy and the values of Organization M align with leadership approaches that focus on being authentic, ethical, building engaging relationships, and empowering staff. Therefore, I will be using approaches from authentic transformational leadership to lead this change and will explore strategies from transformational leadership and authentic leadership.

Transformational Leadership

As a professional practice leader, it is vital to build connections with the directors of professional practice to increase morale in the organization to work collaboratively. True transformational leaders are authentic and exhibit the behavioural components of individualized

consideration, idealized influence, intellectual stimulation, and inspirational motivation (Zhu et al., 2011).

McCleskey (2014) suggests that individual consideration is important for transformational leaders. Myers et al. (2016) report that a transformational leader puts attention on interpersonal relationships by engaging, motivating and empowering their followers. Empowerment is termed as a personal sense of self-efficacy and self-determination (Myers et al., 2016). I will be considerate by being available and supporting the key stakeholders to understand the problem of practice and need for change (i.e., directors of professional practice, practice leaders, nurses). I will also be empathetic by listening to and understanding any concerns expressed by the directors, practice leaders, or nurses. Furthermore, strategies that I will apply to empower them include providing access to knowledge, information and expertise, and providing them with the resources they need to better understand the problem and need for change (Myers et al., 2016).

I aim to convey idealized influence through various strategies. Being a strong role model through persistence and leading by example will contribute to idealized influence. I will remain positive and determined, even when it is difficult, to demonstrate I am vested in addressing this problem (Day, Davis, & Fitchett, 2007). Anderson and Ackerman Anderson (2001) report that a transformational leader establishes a vision that provides clear direction and motivation for change. Being passionate about Organization M's vision, to employ nurses who have the education required to work with specialty patient populations in order to provide the best possible care, will also motivate key stakeholders to adopt this vision and support the change.

Transformational leadership also aims to help followers reach their full potential by the leader being attentive to their motives, needs, and providing intellectual stimulation (Hater &

Bass, 1988). As discussed in Chapter 1, LPNs have identified that they would like to carry out more nursing activities, and practice leaders have identified they would like for LPNs to be able to do more. Therefore, addressing this problem of practice will be attending to the needs of both LPNs and practice leaders as it focuses on their concerns. This also addresses the motives of the directors of professional practice, which is to ensure that practice leaders are supported, and nurses in their programs are working safely and to their optimal scope of practice. Providing opportunities to all different levels of staff to be engaged in the change process will help create intellectual stimulation. Moreover, encouraging and allowing staff to be creative with the strategies to address the problem will also provide intellectual stimulation (Bass & Steidlmeier, 1999).

Additionally, inspirational motivation will empower others to be engaged in shared goals (Bass & Steidlmeier, 1999). Myers et al. (2016) suggest transformational leaders not only instill the vision in a group, but also help followers with their goals to attain the vision. I will achieve this by setting clear goals, timelines, assigning tasks, and outlining the steps needed to move forward with the change. Where possible, I will assign tasks based on the individuals' strengths and interests (Bass & Steidlmeier, 1999). Providing meaningful opportunities to key stakeholders where they are able to accomplish tasks to create the change will enable them to adopt the vision and motivate them to move the change forward.

Authentic Leadership

Authenticity is important to me as a leader, and I define it as being true to oneself through self-reflection and self-awareness. Avolio, Walumbwa, and Weber (2009) explain that authentic leadership has four components: self-awareness, balanced processing, relational transparency, and internalized moral perspective. Zhu et al. (2011) report that authentic leaders demonstrate

self-awareness, transparency, and fairness when making decisions. Hence, it is important I am aware of my own strengths and limitations in order to be genuine and make sound decisions (Day, Davis, & Fitchett, 2007). Ferrin and Dirks (2002) indicate trust is a vital factor to have between a leader and its followers. By being authentic and demonstrating consistency between my words and actions, I will be able to establish trust with key stakeholders (Zhu et al., 2011). Likewise, a study by Myers et al. (2016) reports that leaders with traits such as integrity, trustworthiness, openness, and accountability lead to better staff morale in nursing teams. Hence, Zhu et al. (2011) emphasize that authenticity is a necessary component for authentic transformational leadership.

Authentic Transformational Leadership

Authentic transformational leaders increase awareness of what is right and important, and help followers move beyond their self-interests to what is good for the organization (Bass & Steidlmeier, 1999). Moreover, Burns (1978) suggests that in order for a leader to be truly transformational they must be morally uplifting. This aligns with recommendations by Zhu et al. (2011), who suggest that authentic transformational leaders promote ethical process, policies, and procedures. As discussed above in Chapter 1, ignoring this problem of practice means LPNs in Organization M are not providing the best possible care as they do not have theoretical education about specialty patient populations. Authentic transformational leadership will help foster an ethical climate in the organization, and promote the need to address this problem of practice in order to be able to provide the best possible care in Organization M. Furthermore, authentic transformational leadership will promote the directors of professional practice, operations leaders, practice leaders, and nurses to develop their own set of moral principles (Zhu et al., 2011). This will build an ethical climate, which will create a shared vision amongst the

directors of professional practice and operations leaders in Organization M to address the problem and move forward with change. Thus, it is important to review the framework to lead this change.

Leadership Framework

I will be working the directors of professional practice to initiate change, which can be viewed as both institutional and external, as I do not directly work in the programs of Organization M. Through my past experiences, I have encountered initial resistance from directors when suggesting new initiatives. Kezar (2014) reports that changes that are created from the outside of an organization are viewed with more suspicion than those created internally. Therefore, it is important to work collaboratively with the directors of professional practice and explain the logic behind the change (Kezar, 2014). The force driving this change is the need to be proactive in determining how to address LPNs' lack of educational preparedness for entry-to-practice positions with specialty patient populations. Kezar (2014) indicates that in order to be proactive, leaders must respond strategically by engaging the appropriate stakeholders and having a well-defined understanding of the strengths, weaknesses and priorities.

As identified in Chapter 1, there is currently poor engagement from the directors of professional practice, who are key stakeholders for change. Conscious change leadership promotes the engagement and collaboration of key stakeholders to create change (Anderson & Ackerman Anderson, 2001). The Nine-Phase Change Process Model for Leading Conscious Transformation by Anderson and Ackerman Anderson (2001) is the framework used to lead this change as it aligns with Organization M's mission of leading and learning together and encompasses the principles of authentic transformational leadership.

Nine-Phase Change Process Model

I will use the Nine-Phase Change Process Model for Leading Conscious Transformation (see Figure 3) to frame the change as, through the nine steps, I will be able to plan for, design, implement, and evaluate the change. Although this model has nine steps, Anderson and Ackerman Anderson (2001) report that not all change leaders will go through all nine, and that some steps may occur simultaneously, and some steps may take longer than others.

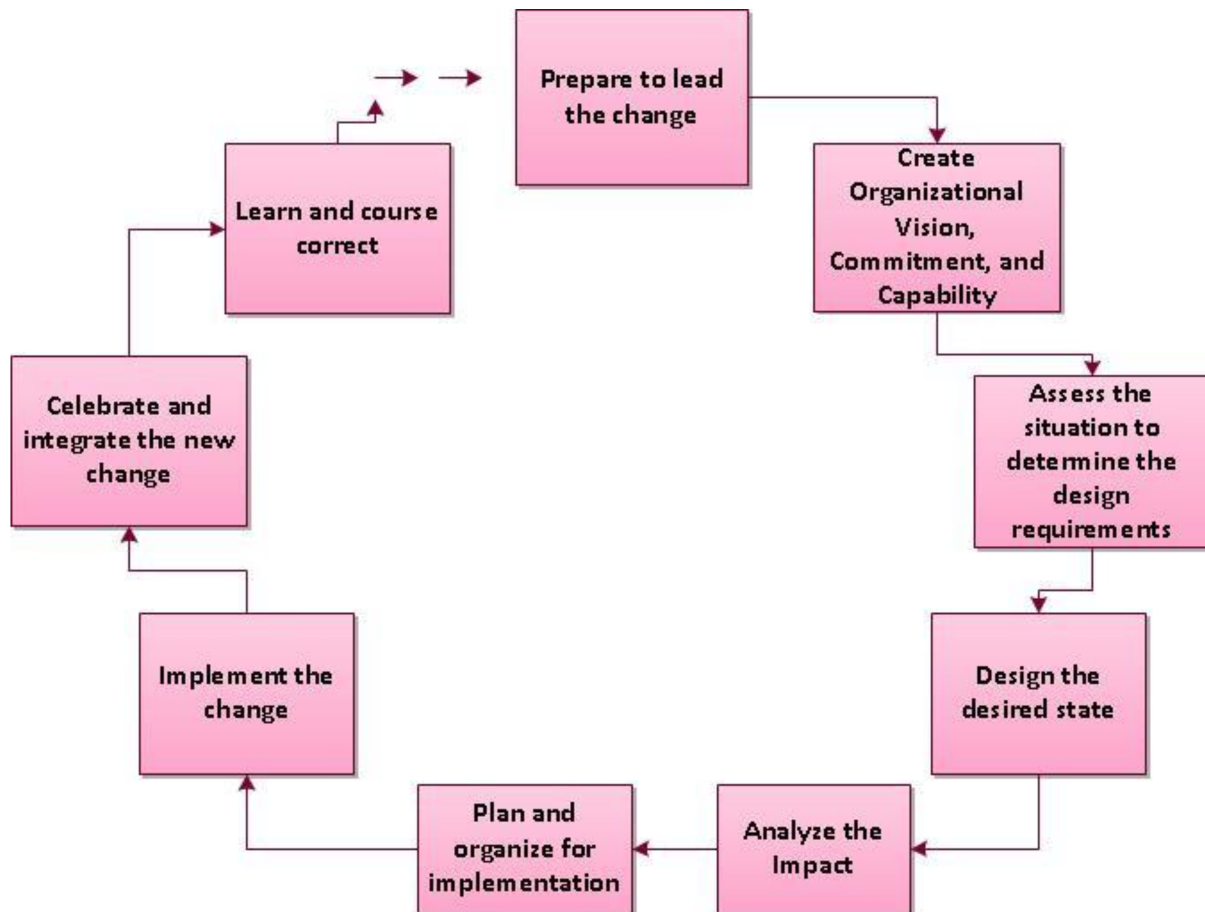

Figure 3. Nine-Phase Change Process Model for Leading Conscious Transformation. Adapted from "*Beyond change management: advanced strategies for today's transformational leaders*" by D. Anderson and L. Ackerman Anderson, 2001. San Francisco: Jossey-Bass/Pfeiffer.

Anderson and Ackerman Anderson (2001) explain that through conscious change leadership the leader consciously designs the change process to engage key stakeholders, including staff and leaders from all levels, at the beginning of the change process. This enables

individuals from all levels to work together from the beginning, which capitalizes on their human potential and creates an environment that allows the organization to respond to dynamic changes quickly and effectively (Anderson & Ackerman Anderson, 2001). Moreover, a conscious change leader shares power and works collaboratively with others to bring transformation. The conscious change leader achieves these nine steps through three main functions of knowing, doing, and being, which are examined below.

Knowing. This entails the first step – prepare to lead the change – as it refers to the topics that the leader needs to know and be aware of (Anderson & Ackerman Anderson, 2001). Thus, this step includes identifying the factors examined in Chapter 1. It includes knowing the drivers of change, the culture of the organization and how it needs to be influenced, identifying key stakeholders, how the change will be perceived and its impact, and creating a change strategy with involvement from key individuals from the beginning (Anderson & Ackerman Anderson, 2001). This aligns with the principles of authentic transformational leadership as leaders create change by engaging, empowering, and working collaboratively with their followers (Bass & Steidlmeier, 1999). Consequently, engaging key stakeholders from the beginning will encourage them in being dedicated to move the change process ahead.

Doing. This includes steps two to five and refers to the change leader putting his/her competencies into action (Anderson & Ackerman Anderson, 2001). It includes the leader defining the change, communicating the need for change, engaging the whole organization (i.e., all of the programs) in shaping the change and working together to create a shared vision, designing and facilitating the change, and creating conditions for success (Anderson & Ackerman Anderson, 2001).

There will be various strategies used to create organizational vision, commitment, and capability (step two). Transformational leaders provide their followers with the necessary information to understand the need for change, which engages them to collaboratively create change (Dunham & Klafehn, 1990). Additionally, Bass and Steidlmeier (1999) state that "authentic transformational leaders persuade others on the merits of the issues" (p.189). Presenting the data analyzed in Chapter 1 (e.g., the PESTE analysis, the literature review findings, findings of the environmental scan, and the Priority Recommendations report) at meetings with the directors of professional practice and operations leaders will raise awareness of the need for change (Kezar, 2014). Additionally, it is important that I create opportunities for this information to be shared among all levels of staff – to establish organization-wide understanding of the need to move forward with change.

Consequently, I will engage all levels of staff to achieve these steps: assess the situation to determine design requirements (step three), design the required state (step four), and analyze the impact (step five). As mentioned earlier in this chapter, providing opportunities to all different levels of staff to be engaged in the change process will help establish intellectual stimulation. Furthermore, Buller (2015) emphasizes that leaders cannot bring proactive change alone and rather must work with staff even from the lowest levels possible to bring change. Moreover, involving stakeholders from all different levels and listening to multiple perspectives creates a culture of innovation and change (Buller, 2015) which contributes to intellectual stimulation. Therefore, I will engage staff from all levels to design the change through the creation of working groups (Kezar, 2014). Bass and Steidlmeier (1999) indicate that authentic transformational leaders provide opportunities to their followers to generate solutions by questioning assumptions. Consequently, ongoing organization-wide conversations assist in

organizations adopting new ways of thinking (Kezar, 2014). Working groups will empower leaders and staff across the organization to have a voice in designing the change which will motivate them to proceed with implementing the change.

Being. Anderson and Ackerman Anderson (2001) report this refers to the leader being conscious of his/her mindset and behavior, and is the most important for these steps: plan and organize for implementation (step six), implement the change (step seven), celebrate and integrate the new state (step eight), and learn and course-correct (step nine). It requires the leader differentiating perception from reality when planning and organizing for implementation (Anderson & Ackerman Anderson, 2001). It also means that the leader is authentic and models the change while leading it, by being fully present and getting to the truth for situations (Anderson & Ackerman Anderson, 2001). Lastly, it includes the leader taking responsibility for wanted and unwanted results and making better decisions to correct the path of change (Anderson & Ackerman Anderson, 2001). Next, the gaps present in Organization M will be examined to identify the change needed.

Critical Organizational Analysis

Cawsey et al. (2016) report internal and external environments are constantly changing in organizations; therefore, they require leaders to perform an organizational analysis to determine actions. Frequently, the need to adjust the internal environment to align with the external environment is missed in practice (Cawsey et al., 2016). Hence, change leaders must understand the intricacies and interrelatedness of the components in an organization, and prepare to respond to the external environment (Cawsey et al., 2016). Nadler and Tushman’s model will be utilized to conduct an organizational analysis to identify gaps to prepare for readiness, as their model

aligns with the feminist organizational lens (identified in Chapter 1), which views everything as being interconnected.

Open Systems Theory

Nadler and Tushman (1980) indicate that the congruence model stems from the open systems theory. They define systems as elements that are interrelated, which impact each other during change. Open systems are defined as elements that "make up a mechanism that takes input from the environment, subjects it to some form of transformation process, and produces output" (Nadler & Tushman, 1980, p.37). The open systems theory suggests that organizations consist of the characteristics of internal interdependence, capacity for feedback, equilibrium, equifinality, and adaption. Some of these characteristics are examined below in relation to gaps present in Organization M.

Internal Interdependence. This is where change in one part of the organization has repercussions to its other parts (Nadler & Tushman, 1980). Nadler and Tushman (1980) explain that changing the skill level of those hired to do a job will affect the productiveness of the organization. Organization M currently has programs where LPNs are hired into positions that have been traditionally held by RNs. Additionally, as identified in Chapter 1, these LPNs can only work with stable or predictable patients. Therefore, it is important to assess whether LPNs are able to provide care for all of types of patients in their area of employment, and how this affects productiveness of Organization M.

Capacity for Feedback. This is achieved by viewing the output and effectiveness in an organization (Nadler & Tushman, 1980). Although there is no current data, it is important that Organization M reviews the effectiveness of employing nurses with lower education and limited skills into jobs that have been held by nurses with higher levels of education and skills, and how

this impacts Organization M's output such as costs, patient satisfaction, and patient outcomes (Nadler & Tushman, 1980).

Equilibrium. This is described as a constant state of balance, and as a result when one group is not as efficient, other groups must overcompensate (Nadler & Tushman, 1980). As mentioned in Chapter 1, both LPNs and practice leaders have identified that LPNs are only carrying out basic nursing activities and there is a demand to do more. Thus, this highlights that LPNs are unable to be as efficient as RNs in their nursing roles. Hence, it is important to consider what effects this has on the RNs as they carry out more nursing activities and providing care for patients with higher acuity. Specifically, it is necessary to clarify how it impacts RNs workload, and whether RNs compensate for the shortfall of LPNs due to their limitations.

Adaptation. In order for an organization to survive, its input and output must maintain balance with its environment (Nadler & Tushman, 1980). Operations leaders in Organization M are facing a time of nursing shortages due to RNs retiring and increasing costs in health care. They have adapted by hiring LPNs who cost less than RNs; however, they also have less education and fewer skills, and can only care for patients who have stable or predictable states of health. As a result, LPNs are not able to carry out many nursing activities as they require additional education/skills training. In order to adapt, Organization M must determine what additional education/skills training LPNs require in order to provide safe patient care, and how to provide this to LPNs.

Congruence Model

Nadler and Tushman (1980) identify that the open systems theory offers a way of viewing the organization in a more complex manner; however, it has limitations as a problem-solving tool. Thus, Nadler and Tushman (1980) constructed the Congruence Model (Figure 4),

which focuses on system properties of interrelatedness and the transformation process. It views the organization as comprising of components that are interdependent, and that need to be congruent in order for an organization to be effective. I will use the Congruence Model (Figure 4) to further diagnose and analyze needed changes in Organization M.

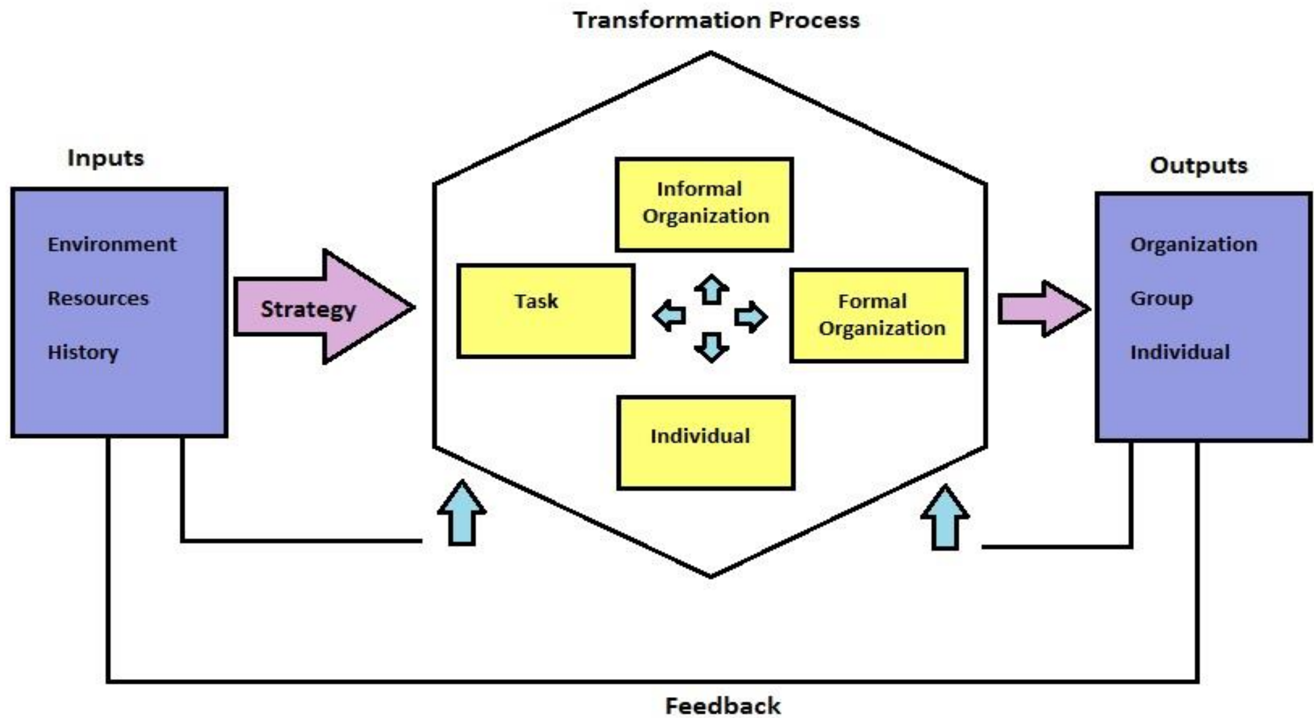

Figure 4. Congruence Model. Adapted from "A Model for Diagnosing Organizational Behavior" by D. Nadler and M. Tushman, 1980. *Organizational Dynamics, 9*(2), 35–51.

Inputs. Nadler and Tushman (1980) identify inputs as the given factors confronting the organization. Elements such as the environment, resources, organizational history and culture, and strategy comprise the inputs.

Environment. This consists of factors including the market, competitors, government bodies, regulatory bodies, and labour unions (Nadler & Tushman, 1980). The environment affects the organization as (a) it makes demands on the organization through the market, (b) places restrictions on the organization through regulatory and political regulation, and (c) provides opportunities with what the organization can explore. Anderson and Ackerman

Anderson (2001) identify similar factors that drive the need for change in an organization. Change drivers include political drivers and economic drivers affecting the marketplace for success.

Political Drivers. An important driver for this change is the recommendations in the report written by an employee of the Ministry of Health, which recommends optimizing the scope of practice for LPNs in Province C (Author X, 2018). As noted in Chapter 1, in order for LPNs to work to their optimal scope of practice they need to be provided with additional education. Organization M reports to the Ministry of Health and therefore must assess and incorporate the recommendations made by Author X (an employee of the Ministry). Additionally, Organization M prioritizes the recommendations made by the Ministry of Health and therefore sees this problem of practice as a priority that needs to be explored further.

Drivers affecting marketplace for success. Butcher and MacKinnon (2015) indicate that there are gaps in nursing positions due to the aging population and closure of nursing hospital training and diploma programs, which have led to nursing shortages. As a result, with the expanded scope and lower cost of LPNs, they are being hired into these positions (Butcher & MacKinnon, 2015). However, it is important that Organization M has qualified nurses to provide quality care across the province. As identified in Chapter 1, employing staff who are not utilized to their best potential is not cost effective for the organization and does not create a desirable workplace for staff. Additionally, these factors affect patient care and patient outcomes. In order for Organization M to hire and retain LPNs who can provide quality care and work to their optimal scope of practice, Organization M must determine what additional education/skills training they need and how it can be provided.

Resources. Nadler and Tushman (1980) suggest that organizational resources include technology, information, employees, and capital along with other elements. Leaders must consider the quality of resources, and whether they are flexible and can be fixed or reshaped (Nadler & Tushman, 1980). LPNs employed in Organization M have limited education and skills to work with specialty patient populations, which affect their ability to carry out nursing activities to provide patient care. LPNs have the ability to carry out more nursing activities once they receive additional education/skills training. Hence, it is possible to improve the quality and quantity of care LPNs can provide once they receive this.

History. This consists of the past events that affect the current function the organization such as past strategic events, impacts of change, impacts of leadership, and ability in responding to crises. As the change readiness findings in Chapter 1 demonstrate, Organization M has been able to positively respond to change in the past and is currently planning on undergoing change to the electronic health record, in attempts to improve the quality of patient care. Additionally, the Chief Nursing Officer and Executive Director for Professional Practice understand the vitality of having educated and skilled nurses providing safe patient care and support the need for change. These leaders are respected across Organization M and are able to provide credibility to move forward with change.

Strategy. This is the tactics utilized in an organization to meet its mission and defines how the work will be done by the organization, and the outputs it will produce (Nadler & Tushman, 1980). As per the change readiness findings in Chapter 1, leaders from various different levels in Organization M are interested in addressing this problem of practice as they are aware that change is needed. As a result, they are interested in determining how to utilize

LPNs to their optimal potential, and thus how to provide LPNs with additional education/skills training.

Transformation process. This is where the components in an organization are combined to produce the outputs, which include the informal organization, formal organization, individuals, and tasks (Nadler & Tushman, 1980).

Informal Organization. These are the implicit and unrecorded understandings that influence processes, arrangements, and structures in an organization (Nadler & Tushman, 1980). Operations leaders in Organization M have been more cost-oriented and as a result have been hiring LPNs without consulting professional practice while disregarding the quality of nursing skills or care LPNs can provide for patients. Butcher and MacKinnon (2015) emphasize the importance of recognizing that RNs and LPNs have differences in their thinking, knowledge, and reasoning skills. Thus, it is important to acknowledge, clarify, and examine these differences (Butcher & MacKinnon, 2015) prior to hiring LPNs into positions traditionally held by RNs. As indicated in Chapter 1, operations and professional practice must work closely together and focus on improving the quality of the skills and education LPNs have to provide quality care versus solely saving costs.

Formal Organization. These are the process and structures in place that construct the organizational design (Nadler & Tushman, 1980). Currently, there is not a model of care framework in place to support the roles of LPNs or optimize their scope of practice in Organization M. Furthermore, Organization M does not have any policies that support LPN scope optimization. Additionally, the job description for LPNs is very vague and does not outline the need for additional education. In order to move forward with change, formal processes such

as a model of care framework must be in place, and policies and job descriptions must be revised to reflect the desired state for LPNs.

Traditionally, RNs in Organization M have worked with patients in all states of health; therefore, patient needs in specific programs have not been formally identified. Since LPNs can only work with stable or predictable patients, it is important to be aware of patient needs. As identified in Chapter 1's structures for the conceptual framework, in order for a nurse to respond to the patient's needs, they must have the ability to critically think and respond appropriately. It is important to determine the type of patients that LPNs can provide care for based on patient acuity, and to ensure that LPNs are equipped to respond and provide competent care to these patients. Therefore, each program in Organization M must determine patient needs and their acuity level so that the program can establish and provide LPNs with the knowledge and skills needed to work within their program. For example, oncology will have to define what the needs are of stable or predictable patients in their setting.

Butcher and MacKinnon (2015) highlight that as the role of LPNs expands, their competencies are also expanding and it is important to clearly define the scope of LPNs versus RNs in order to have a better understanding of the differences between each role. Thus, once a program has determined its patients' needs, it must determine what competencies are required to work with these patients. The program can then compare the required competencies to their LPNs' current competencies. This will identify any existing gaps and provide a clear picture of the education and skills required for LPNs to work with their patients.

Individual. Junk, Houle, and Pong (1995) argue that workforce demands have caused a shift from hiring the most qualified individuals to the most appropriately trained. Currently, LPNs in Organization M are not the most highly skilled nurses nor the most appropriately

trained. As identified in Chapter 1's conceptual framework, in order for LPNs to have the skills, knowledge, and abilities to carry out nursing activities with regard to patient needs, they must receive additional education/skills training.

Task. This is the fundamental work that is completed by the organization to accomplish its strategy (Cawsey et al., 2016). Practice leaders in Organization M have identified that they would like LPNs to be carrying out more tasks; however, these tasks have not been outlined. Once the programs identify the competencies that LPNs require to work with their patients, they will have a better understanding of what tasks LPNs can perform. Once LPNs receive the additional education/skills training needed they will be able to carry out these tasks and provide better quality care.

Outputs. Providing LPNs with the additional education they need will not only enable the organization to utilize them better, it will also enable LPNs to feel more satisfied in their positions. This also aligns with my goal as an authentic transformational leader, to provide LPNs with the skills and education they need to reach their full potential. Moreover, receiving the additional education will improve the quality of patient care they provide in alignment with Organization M's vision. Most importantly, the aim is that this will result in positive patient outcomes. Hence, the next section will examine potential solutions for how LPNs can receive the additional education/skills training they need in order to work to their optimal scope of practice with specialty patient populations.

Potential Solutions

As recognized in the transformation process above, Organization M's practice leaders must identify their patients' needs and the competencies LPNs require to provide safe care to these patients, and then determine the additional education/skills training LPNs need to meet

these competencies. Once the additional education/skills training is identified, then the question of how LPNs can be provided with this additional education/skills training must be addressed. Hence, two solutions for change are examined. The first solution examined is Organization M determining the additional education/skills training that LPNs need and then working with the College of Nursing Regulation to change the Practical Nursing Curriculum by incorporating the additional education/skills training. The alternative solution examined is Organization M providing the additional education/skills training that LPNs need once it has determined the additional education/skills training needed. The implications for each solution are explored to determine the best solution with which to move forward.

Practical Nursing Curriculum Change

The first solution for Organization M to consider is working with the College of Nursing Regulation to change the Practical Nursing (PN) curriculum to include the additional education/skills training that LPNs need once it has determined what additional education/skills training is needed. The College of Nursing Regulation is responsible for establishing the requirements for the PN curriculum that PN educational programs are required to follow (CNR, 2017). The College of Nursing Regulation also enforces these curriculum requirements through the evaluation and recognition of the PN education programs in Province C (CNR, 2017). Hence, the College of Nursing Regulation has the ability to change the PN curriculum to include the additional education that Organization M identifies is needed for LPNs.

Resources. This solution will require Organization M to utilize resources to determine what additional education/skills training LPNs need. Integrating and implementing the additional education will require resources from other stakeholders such as the College of Nursing Regulation, Ministry of Advanced Education, PN education programs, and PN students.

Time. Identifying what additional education/skills training LPNs need will take about three months. As mentioned above, LPNs can only work with patients who have stable or predictable states of health. Therefore, practice leaders will need to determine which types of patients in their programs would fall into this category through determining their needs. The practice leaders will then identify the competencies that LPNs require to work with these patient needs. Subsequently, a gaps analysis will be carried out where the current competencies of LPNs are compared to the required competencies. This will be achieved by me working with the practice leaders to create a survey that assesses their current competencies. Time will be spent by LPNs to complete the survey; however, they can do this during their shift and it will take about 15 to 20 minutes to complete. Comparing the results of the survey with the required competencies will clarify the additional education/skills training LPNs need. These surveys will utilize an empathetic and collaborative approach by also allowing LPNs to express the additional education they would like to acquire.

It will take a minimum of four years to incorporate the additional education/skills training LPNs need into the PN curriculum. The Ministry of Advanced Education in Province C recently worked with the College of Nursing Regulation and PN education programs to update the PN curriculum, which was published in November 2017. The College of Nursing Regulation did inform professional practice leaders, such as me, that the additional education requirements for LPNs to work to their optimal scope of practice had not been integrated into the new curriculum, and that there was no plan to change the revised curriculum. Moreover, there were changes made to the scope of practice for LPNs in 2015 and it took over two years for the PN curriculum to be reviewed. Furthermore, the previous curriculum was published in 2011; hence, it will take a minimum of four years before the curriculum is reviewed, published, and implemented again.

Additionally, with this solution, PN education programs will have to extend the length of the PN program to integrate the additional education, and as a result, LPNs will have to spend more time completing their education program.

Technological. An electronic program such as redcap will be utilized to create and implement the surveys. This will require nurses to have access to a computer and the internet. Having the survey completed electronically will enable easy access to the survey and the results.

Changes to the PN curriculum will require the College of Nursing Regulation to update its website and documents to reflect the changes. It will also require PN education programs to revise their curriculum content and create additional courses to incorporate the additional education that LPNs need.

Human Resources. Identifying the additional education/skills training that LPNs need will not require any additional human resources in Organization M as the survey can be created by the practice leaders and myself. Moreover, the practice leaders will work with the directors of professional practice and frontline nurses (i.e. LPNs and RNs) to determine their patients' needs, and the competencies LPNs require to work with these patients.

Incorporating the curriculum changes will require the College of Nursing Regulation staff to work on changing the educational requirements for PN education programs. It will additionally require the Ministry of Advanced Education to create a committee to review the changes and to incorporate these into the PN curriculum. Additionally, PN education programs will require the faculty to incorporate the curriculum changes into its courses. The additional education may also lead to supplementary courses being created, which will require a need for more faculty recruitment.

Fiscal. Organization M will incur minimal cost to create the surveys as they will be created on an online program that is free for employees to use. Additionally, costs can also be saved by providing LPNs with time to complete the survey during downtime on their shift. As a result, there will be no additional costs associated with the creation and completion of the surveys. There will also be no additional costs associated with practice leaders determining their patients' needs and the required competencies for LPNs.

The College of Nursing regulation will incur costs for the time/human resources it takes to revise the education requirement documents and advise the educational programs about the changes. Moreover, the PN education programs will also incur costs with the resources needed to revise the PN education curriculum and courses. Consequently, there will be financial implications for PN students as they will be paying more tuition fees for the additional education and will incur a wage loss as they will need to be in school for a longer period of time prior to entering the workforce.

Advantages. There are many advantages associated with this solution. Financially, this solution is cost effective as Organization M will be incurring minimal cost as PN education programs will be providing the additional education and PN students will be primarily responsible to pay for this. Furthermore, LPNs will be receiving the additional education they need to work with specialty populations and to their optimal scope of practice prior to entering the workforce. This will also ensure that LPNs have the same standard of education and level of competence when entering the workforce. Consequently, LPNs will be practice ready and will be a more effective resource for Organization M to utilize. Most importantly, upon entering the workforce, LPNs will be able to provide safe and quality care while working to their optimal scope of practice.

Disadvantages. There are many disadvantages associated with this solution. Organization M does not have any formal authority to make the College of Nursing Regulation or PN education programs change the PN curriculum. Moreover, historically, PN education programs were known as nursing assistant programs, which were meant to be short term as the goal was for the nurse assistants to supplement nurses in a cost-effective way (Butcher & MacKinnon, 2015). Likewise, the PN education programs are meant to be short and focus on basic nursing skills (Butcher & MacKinnon, 2015), and implementing this solution will increase the length of PN education.

As a result, this will increase costs for PN students as they will have to pay more in tuition fees for their program, which will take longer to complete. Practice leaders in Province C identified that many students from disadvantaged communities are becoming LPNs due to the short time required to complete the educational program and the ability to have an income quickly. Similarly, Polesel (2010) describes that vocational education training programs in Australia are heavily used by young individuals from disadvantaged groups. Accordingly, Schwarz and Leibold (2014) suggest barriers that prevent diploma nurses from going back to school to receive their baccalaureate degree includes the cost associated with tuition fees and a lack of income, family constraints, and lack of financial assistance. Therefore, this solution may prevent students from pursing the PN education program and may potentially add to the nursing shortage in Province C.

Implications. The PN curriculum in Province C was recently reviewed and revised. The College of Nursing Regulation informed professional practice leaders that the PN curriculum review did not identify the need for PN students to receive specialty education in their PN education program. As discussed in Chapter 1, the College of Nursing Regulation indicates that

if employers want LPNs to carry out activities that are part of their scope of practice but not fully covered through their training programs, then the LPNs could complete additional education in order to perform these activities. The College of Nursing Regulation verbally clarified with me that additional education is not something the nurse would be able to complete on his/her own, i.e., self-study; rather, it requires an independent external evaluation of competencies, and does not need to be a formal course. This indicates that the College of Nursing Regulation does not believe the additional education that LPNs require needs to be integrated into their PN education program. Moreover, since the curriculum has recently undergone review, the next review will be in a minimum of three to four years and therefore this solution will take at least four years to implement. In addition to Organization M not having any authority to implement the change, this solution will not address the current educational/skills gap present in a timely manner.

Organization M Providing the Additional Education/Skills Training

The alternative solution is for Organization M to determine what additional education/skills training LPNs need, creating the education courses, and then providing LPNs with the additional education/skills training. As clarified above, the College of Nursing Regulation has indicated that its additional education requirements for LPNs only require an independent external evaluation. Hence, Organization M creating and providing the additional education will fulfill the additional education requirements that the College of Nursing Regulation has placed on LPNs. This solution would require Organization M to differentiate the theoretical knowledge LPNs need versus the additional technical skills LPNs need to learn.

Tyne (2018) highlights that LPNs do not receive the same theoretical foundation that RNs receive, which affects their ability to critically think and to deliver competent and safe patient care. Furthermore, Price (2015) suggests that nurses must be able to connect the disease

process to the patient's signs and symptoms. As outlined in Chapter 1, the PN curriculum provides minimal theoretical education about specialty patient populations. Therefore, it is important that Organization M provides LPNs with theoretical knowledge for the specialty areas they work in. Since each program has its own specialty patient population, each program will be responsible for creating its own theoretical knowledge courses. For example, the practice leaders of oncology will create cancer-related theoretical courses to offer to their LPNs and this will differ from the theoretical knowledge courses that practice leaders in mental health will create to offer to their LPNs. Moreover, these theoretical knowledge courses can be delivered online as they do not require hands-on learning.

In order for a nurse to be competent, he/she must have the knowledge and technical skills to carry out the task (Price, 2015). Technical training is defined as training that leads to performance outcomes that result in recalling, understanding, and applying skills (Silberman, 2007). The College of Nursing Regulation has outlined there are many tasks LPNs can perform once they have received additional education, which requires learning technical skills. Thus, it is important that Organization M also creates and provides courses where LPNs can learn these technical skills. Technical skills are learnt through illustration, observation, and hands-on experience (Flin, Youngson, & Yule, 2015). Therefore, these courses would require in-person training in order for LPNs to gain the hands-on experience.

Resources. In addition to the resources required for Organization M to determine the additional education/skills LPNs need (outlined in solution one), this solution will use multiple resources in creating and providing the education to the LPNs.

Time. This solution will also require some time to implement once Organization M has determined what additional education is required. However, this solution will take less time than

solution one as Organization M has the formal authority to initiate this solution at any time and could potentially start implementing it within a year. The most time will be consumed in creating the educational content for the courses. There will also be time spent validating the educational content and having it approved. Moreover, once the educational content is approved, there will be time spent on determining how to deliver the course. The theoretical knowledge courses will require time for the online courses to be built, whereas the technical skills courses will require practice leaders/educators spending time to teach the courses. Lastly, there will be time spent by the LPNs to complete the courses.

Technological. As outlined above, the theoretical courses can be delivered through Organization M's online learning platform. This will require Organization M to utilize computers and the internet to create the online courses. It will also require LPNs to utilize computers and the internet to access and complete the courses. Providing the courses through an online learning platform will diminish the need to have someone physically teach the course. It will also provide LPNs with easy access to the course as they could take the course when they are available and from a location that is convenient for them.

Human Resources. Creating and providing the additional education to LPNs will utilize many human resources in Organization M. This will require practice leaders along with other staff from each program to create educational content. Moreover, directors of professional practice will be required to approve the educational content, and operations leaders will need to approve the costs associated with the creation and delivery of the course. Additionally, staff from the learning department will create the online theoretical knowledge courses. In contrast, for the technical skills courses, practice leaders/educators will have to be physically available to teach the courses. Most importantly, LPNs will have to be available to complete the courses.

Fiscal. This solution will require Organization M to incur all of the cost for creating and implementing the courses. The creation of the course content will not incur much cost as it is the role of professional practice leaders and practice leaders to create educational resources. It is also the role of the learning department to create online courses; however, they may have different priorities that may need to be negotiated with operations leaders. Hence Organization M will incur little cost in creating the courses. The greatest cost incurred will be associated with providing the education as Organization M must pay LPNs their wages for their time in completing the education. Additionally, Organization M will incur costs in providing training materials such as pens, paper, and other equipment needed for the technical skills training. Therefore, this solution will be the costliest for Organization M.

Advantages. There are many advantages to implementing this particular solution. The first benefit is that the LPNs in Organization M will be able to receive the additional education they need to provide safe and better-quality care. There are also advantages to Organization M specifically creating and providing the additional education. Organization M could determine the timeline for creating and delivering the education, and would not have to rely on external stakeholders to move this change forward to close the educational gap.

Furthermore, Organization M providing the education/skills training will ensure LPNs are receiving the education/skills required to work in their patient populations. Moreover, Butcher and MacKinnon (2015) highlight the importance of having highly-skilled educators for LPNs. The practice leaders and educators who will be creating the course content have years of experience and knowledge working with these specialty patient populations, and can create quality educational content.

Additionally, LPNs will not have any financial loss as their wages will be paid, which will enable all LPNs to complete the additional education/skills training, regardless of their financial circumstances. As the literature suggests, providing LPNs with such opportunities would be empowering as it increases morale and job satisfaction (Aiken et al., 2014), which aligns with the goals of authentic transformational leadership. Lastly, LPNs will be a more effective resource for Organization M as they are able to carry out more nursing activities.

Disadvantages. There are also several disadvantages associated with implementing this solution. A big disadvantage is that Organization M will incur cost to provide LPNs with the additional education/skills training, which will affect the budget of operations leaders. In addition to the cost, it will increase the work for the practice leaders/educators and professional practice leaders who will spend a great amount of time creating content for the courses. Moreover, this solution will not result in LPNs being workplace ready once they have completed their PN education program. As a result, Organization M will be continuing to hire under-educated/under-skilled LPNs. The LPNs will only be workplace ready for Organization M once they have completed the additional education provided and funded by Organization M. Most importantly, LPNs will not be receiving standardized education to optimize their scope of practice as it will be dependent on the education provided by their health authority.

Implications. Pynes and Lombardi (2012) report that organizations that are not progressive are destined for quick failure. Pynes and Lombardi (2012) indicate that health care environments are constantly facing political and financial factors, and progress is needed to survive these environmental stressors. Pynes and Lombardi (2012) emphasize that moving forward with change is essential for an organization in order to reach equilibrium and to survive.

Thus, it is important the Organization M is able to respond to this problem and find a solution to move forward with change in a timely manner.

Butcher and MacKinnon (2015) highlight that employers have been voicing the necessity to review PN education as they are in need of nurses to provide care for increasingly complex patients. As identified in solution one, the CNR is not planning on expanding the PN education and Organization M does not have any formal authority to change the PN curriculum to include the additional education that LPNs need. Thus, solution two is the only solution that Organization M has the authority and ability to implement in a reasonable time. Although LPNs will not receive standardized additional education across the province due to the health authorities creating their own education, it is safer that they have some education over none. Levine (1997) identifies that although providing training on the job is costly for an organization, it leads to a higher return in investment for the organization as it produces skilled workers. Therefore, through this solution, Organization M will be investing in producing skilled LPNs to work with its specialty patient populations to provide safe and quality patient care while working to their optimal scope of practice. Hence, it is important to consider the ethical challenges present in moving forward with the chosen solution.

Chapter 3: Implementing, Evaluating, and Communicating the LISO Framework

The previous two chapters have explored factors contributing to the problem of practice, the need for change, the leadership approach to change, and a chosen solution to move the change forward. Specifically, Chapter 2 concludes Organization M will determine, create, and provide LPNs with the additional education/skills training they need to be workplace ready. Thus, this chapter focuses on the change implementation plan. An LPN Introduction/Scope Optimization (LISO) framework is created to provide guidance to leaders of the factors

necessary to provide LPNs with the additional education/skills training they need. Goals, priorities, benefits, potential reactions, and limitations to the implementation of the LISO framework are discussed. Additionally, the Nine-Phase Change Process model is explored to identify the steps and timeline for change. Moreover, Bennett's Hierarchy Evaluation model is explored for monitoring and evaluating the change. Lastly, a plan to communicate the need for change and the change process is examined.

Ethical Considerations and Challenges

As identified earlier in this chapter, the Nine-Phase Change Process Model encompasses the philosophies of authentic transformational leadership, which includes raising moral awareness. Thus, using strategies from both conscious change leadership and authentic transformational leadership will help me overcome ethical challenges and constraints.

The first challenge to consider, which was expressed in Chapter 1, is that operations leaders may have different priorities and may not view providing LPNs with additional education/skills training a high priority. Moreover, as discussed in Chapter 1, managers have expressed that it is the role of nursing educational programs to ensure that nurses are practice ready, and they may not view it as the role of Organization M to provide the additional education. Through the utilization of strategies from authentic transformational leadership such as moral courage, I will confront tough environmental pressures and focus on working with leaders to do what is ethical (Zhu et al., 2011). I will help leaders develop moral principles by identifying the ethical implications of Organization M not providing LPNs with additional education.

As discussed earlier in this chapter, I will increase awareness of and justify what is important and right, and help leaders move past their self-interests to what is virtuous for the

organization, patients and their families. Therefore, leaders must consider the effects of knowing that LPNs require additional education but are not receiving it, and yet are providing patient care. More importantly, as highlighted in Chapter 1, it is also important for leaders to consider the effects of hiring nurses with a lower skills mix, which the literature demonstrates is harmful to patient outcomes, and yet the organization is not taking any action to rectify this. The Canadian Nurses Association (2015) indicates that employers are responsible to the public for providing competent, ethical, and safe nursing practice. Hence, Organization M is ethically responsible to ensure that its nurses have the education and skills to provide safe and competent care to the public.

Additionally, as discussed in Chapter 1, leaders may be hesitant to move forward with change due to the time needed to implement the change. For example, many LPNs and practice leaders are busy and may not have time to complete the competencies assessment. Furthermore, traditionally practice leaders have expressed concerns with providing additional education due to time and costs. However, the directors of professional practice and professional practice leaders have a duty to ensure that nurses have the education/skills training they need to perform safe patient care. Additionally, practice leaders and LPNs are ethically accountable for providing safe and competent care to their patients. Anderson and Ackerman Anderson (2001) highlight that conscious change leaders have an ethical motivation to do the right thing for the whole organization and community; thus, they will look past immediate profit and make changes for the greater good. Therefore, raising the ethical climate in Organization M and focusing on the greater good of the public, which is to receive safe and competent nursing care, will enable leaders to move forward and support the proposed solution.

Chapter 2 Conclusion

This chapter outlines the specific approaches from authentic transformational leadership that will be used to engage and empower others to address this problem of practice. Authentic transformational leadership not only aligns with my personal leadership style but also aligns with the values of Organization M of respect, collaboration, and leading and learning together. The Nine-Phase Change Process Model for Leading Conscious Transformation is used as the framework to further highlight how I will engage with others to lead this change. Moreover, the open systems theory and Congruence Model are utilized to explore gaps and determining what needs to change in Organization M to move this change forward. This critical organizational analysis highlights that leaders must identify patient needs, formally define the competencies LPNs require to work with these patients, and then determine the additional education/skills training that LPNs need to meet these competencies. Two solutions are explored in this chapter to move forward for change. Organization M providing LPNs with the additional education/skills training is the chosen solution as, essentially, it is the only solution that Organization M has the authority to implement. Ultimately, Organization M has an ethical responsibility to provide safe and competent nursing care to the public; thus, it must move forward with change and provide LPNs with the additional education/skills training they need. The next chapter will outline the change implementation plan.

Plan for Implementing the LISO Framework

Goals

Consistent with the conceptual framework in Chapter 1, the goals for the implementation of this OIP are that all LPNs in Organization M:

1. Consistently receive the additional education/skills training they need to provide safe and competent care;
2. Are working to their optimal scope of practice relevant to their patient population; and
3. Are providing the best care possible to improve patient states of health.

These goals align with the vision of Organization M, and align with the recommendations made by the Ministry of Health in relation to LPN practice. These goals also align with the principles of authentic transformational leadership, to enable LPNs to work to their full potential. The implementation of this OIP will not only address the current problem of LPNs not being workplace ready, but will be a solution for the future when looking to hire more LPNs. In order to achieve these goals, it is important to have a consistent approach in determining and optimizing the role of LPNs in all programs across Organization M. Priorities to achieve these goals are explored next.

Priorities

Kelly, Vottero, and McAuliffe (2014) define high-reliability organizations in health care as organizations that provide consistent care at an extraordinary level of quality over an extended period of time. Organization M's vision aligns with Kelly et al.'s (2014) definition of a high-reliability organization. Furthermore, Kelly et al. (2014) suggest that high-reliability organizations have a culture of safety, where every health care worker is mindful to provide safe and competent care to prevent patients from acquiring any harm by the care provided. These

organizations continue to increase the quality of care through responding effectively to failure and standardizing excellence throughout the organization (Kelly et al., 2014).

Hence, it is important that the programs in Organization M have a standardized approach to determine the suitability of hiring LPNs and providing them with the additional education and skills training they need to work to their optimal scope of practice with their patient population. Prior to determining what additional education/skills training LPNs need and how Organization M can provide this, it is important to determine whether adding or changing the role of LPNs is appropriate given that they can only work with stable or predictable patients. The LISO Framework (see Appendix A) utilizes the solution selected in Chapter 2 and highlights the process required for programs to determine if introducing/changing the role of LPNs is appropriate with their patient population, and how to provide LPNs with the additional education/skills training needed to be workplace ready for their patient population.

Therefore, the first priority for change is to have the LISO framework implemented across the programs of Organization M. In order to have the directors of professional practice implement the LISO framework, it must be endorsed by senior leadership (i.e., heads of professional practice and the Chief Nursing Officer) in Organization M. Once the LISO framework has been endorsed by senior leadership, the next priority is to socialize the LISO framework and gain buy-in from the directors of professional practice and operations leaders across Organization M. Once the LISO framework has been socialized and adopted, the priority is to implement the LISO framework in the programs where LPNs are currently working and would like to do more. This will ensure there is a consistent approach to providing LPNs with the additional education/skills training they need to provide safe and competent care while working

to their optimal scope of practice; and patients in Organization M are receiving the best care possible at all times from the LPNs in Organization M.

Benefits of the Change Plan

There are many benefits to implementing the change, and in particular following the LISO framework. The LISO framework permits a consistent process for determining the role of LPNs, the additional education they need, and how to provide that education. Additionally, the LISO framework embeds the principles of authentic transformational leadership as it encourages collaboration amongst all levels of staff. It drives operational leadership to consult with professional practice and other stakeholders (i.e., floor nurses) prior to hiring LPNs or changing their scope, which was identified as a gap in the critical organization analysis in Chapter 2. Bryant-Lukosius and Dicenso (2004) report that engaging multiple stakeholders from the beginning will enable them to inform, reflect, learn, and improve the work to be done. The LISO framework will allow for a collaborative process from the beginning, which aligns with my approach as an authentic transformational leader.

Furthermore, the critical organizational analysis in Chapter 2 identifies that there are political drivers and marketplace drivers, which are pushing for more utilization of LPNs and for LPNs to be working at their optimal scope of practice. The implementation of the LISO framework is in alignment with Ministry of Health recommendations on using LPNs appropriately and optimizing their scope of practice. It also assists operations leaders who are wanting to hire LPNs due to nursing shortages or budget constraints.

As identified in Chapter 1, both LPNs and practice leaders in Organization M had expressed that they would like LPNs to be able to do more. Thus, the implementation of the LISO framework will also benefit LPNs who are currently working in Organization M as it will

enable them to receive the education/skills training they need to provide safe and competent care, and work to their optimal scope of practice within their patient population. As a result, the practice leaders will also benefit as they are able to utilize LPNs to a greater potential. Additionally, the Professional Practice Department and directors of professional practice in Organization M will benefit as they can ensure the LPNs in Organization M are providing safe and competent care. This also supports my goal as an authentic transformational leader, which is to help others meet their needs. Lastly, this aligns with Organization M's vision that patients are receiving the best care possible from the LPNs in Organization M. In order to ensure successful implementation of the LISO framework, a clear reporting relationship between the directors of professional practice and myself is required.

Organizational Chart

The Modified Organization Structure (Figure 1) presented in Chapter 1 reflects the current organization structure, where there is no reporting relationship present between the Department of Professional Practice and the directors of professional practice. Alternatively, the LISO framework suggests the directors of professional practice must collaborate with the Department of Professional Practice when implementing the change. Swindle, Selig, Rutledge, Whiteside-Mansell, and Curran (2018) report that the success of an intervention is affected by the fidelity of how it is delivered. Fidelity refers to the extent to which the intervention was implemented following the original protocol (Swindle et al., 2018). Thus, it is important the programs follow the steps of the LISO framework accurately. The Department of Professional Practice will be leading this change and in order to provide support, ensure high fidelity, and keep the change moving forward, it is vital that there is a formal reporting relationship present. Therefore, the Proposed Organization Structure (Figure 5) suggests the directors of professional

practice will report up to the Department of Professional Practice when implementing the change.

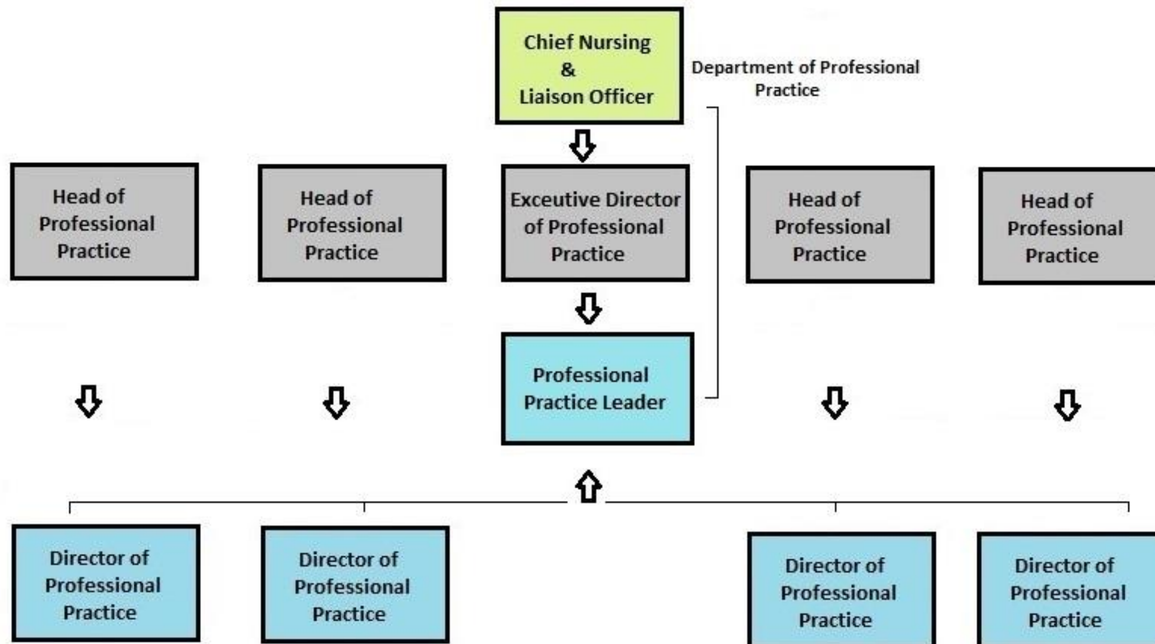

Figure 5. Proposed Organization Structure. Adapted from "Organization M Org Chart" [PDF] by Organization M, 2017. Retrieved from: Website.

This proposed structure will enable me to monitor fidelity, progress, and intervene when problems arise, to help keep the change moving forward. Hence, it is important to consider stakeholder reactions and potential solutions.

Stakeholder Reactions and Solutions

Cawsey et al. (2016) suggest that change leaders must be able to adapt plans as events unfold as a "one-size-fits-all approach" may not work (p.392). Similarly, Honig (2009) suggests that leaders must consider the differences in knowledge, beliefs, and values present between stakeholders when implementing change. Consequently, not all stakeholders may agree with the change plan, and alternative approaches may need to be considered to move the plan forward (Cawsey et al., 2016). Stakeholders in Organization M may have varying reactions to the

suggested steps in the LISO framework. Accordingly, Browne and Wildaysky (1983) indicate a leader cannot always anticipate everything; for those things that the leader can anticipate, it is vital to determine ahead of time how to deal with it to move the change forward. Consequently, it is important to anticipate possible reactions from stakeholders and an alternative plan to move the change forward.

RN Reaction. The nurses in Organization M (RNs) who have traditionally held the positions into which LPNs are being hired may not agree with the introduction or scope optimization of LPNs. The RNs may feel a threat as there will be fewer RNs required with the presence of LPN positions. RNs may also perceive that there is more responsibility for them as they will need to work with more acute patients. A study by Rhéaume et al. (2015) examined the perceptions of RNs and their roles when working with LPNs. The RNs expressed that they were no longer doing aspects of patient care that they had gone to nursing school for, as these are now being completed by the LPNs, and they now focus on higher-level tasks (Rhéaume et al., 2015).

As an authentic transformational leader, it is vital to demonstrate empathy by listening to the RNs' concerns and clarifying my intentions. It is also critical to assure RNs that they are valued members of the organization and the intent of the LISO framework is not to replace their jobs, but to ensure there are enough nurses in Organization M to provide safe and competent care with the nursing shortages present. Additionally, Endacott et al. (2018) and Lavander, Suhonen, Turkki, and Merilainen (2018) report that RNs often lack understanding about the role and limitations of LPNs. Accordingly, the LISO framework embeds principles of conscious change leadership and suggests that RNs are engaged from the beginning of the change plan. This will allow RNs to express their concerns, be aware of why there is a change in the care model, what the new role of LPNs will be, and how it will benefit patient care. Engaging RNs from the

beginning will permit them to provide input and have a clear understanding of what their role will be in relation to the LPN role.

LPN Reaction. As identified in Chapter 1, LPNs in Organization M have expressed that they would like to be able to do more and, therefore, will be on board with their scope optimization. However, some LPNs may feel they do not need additional education/skills training. Endacott et al. (2018) found that enrolled nurses in Australia (similar to LPNs in Canada) perceive that they operate more equally to RNs and often carry out nursing tasks they are unprepared for. Hence, LPNs may feel that they do not need to complete the additional education/skills training as they may feel they already have the knowledge/skills needed to perform the nursing activities.

As identified in the LISO framework, it is vital to assess the competencies LPNs currently possess to ensure they are only receiving the additional education/skills training they need. Through authentic transformational leadership, LPNs will feel that the additional education/skills training is empowering them to gain the skills they do not possess so they can provide safe and competent patient care. Thus, listening to the concerns of LPNs, acknowledging the knowledge/skills they already have, and explaining the need for the additional education/skills training will demonstrate empathy and help them move forward with change.

Practice Leader. As identified in Chapter 1, a scan conducted in Organization M identified that practice leaders would like LPNs to be able to carry out more nursing activities. Consequently, practice leaders will be in support of LPN scope optimization, although they may have concerns with the LISO framework. The steps identified in the LISO framework of determining the additional education/skills training that LPNs need and then providing it will create more work for practice leaders. As a result, they may feel that all of the work required is

not necessary or they may not know how to tackle it. Additionally, they may be getting some resistance from RNs to move forward with the change. In such circumstances, it is essential to use empathy by collaborating with the practice leaders from the very beginning and listening to what their perceived barriers are, and aiding them in mitigating these barriers. It is imperative that I work with the practice leaders to resolve barriers before moving forward with change.

Directors of professional practice. In order to move forward with change, it is vital the directors of professional practice agree with the implementation plan, specifically the LISO framework. Some challenges that may be posed by the directors of professional practice include not having the support by operations leaders, or the resources or the time to follow the process in the LISO framework. Furthermore, they may not agree with the proposed organizational structure where they are accountable to report to the Department of Professional Practice. As an authentic transformational leader, I will address this by listening and providing rationale for the proposed structure, which is to ensure that supports are place to monitor and move the change forward in a consistent manner. The proposed structure would relieve the directors of some responsibility and place more accountability on the Department of Professional Practice to help problem-solve when challenges arise, such as the lack of operational endorsement. Additionally, I will support the directors by being a resource to help with the work required with the practice leaders to move the change forward. Utilizing principles of authentic transformational leadership, including collaboration and empowerment, will help mitigate these concerns and permit the directors to endorse the LISO framework and the proposed organization structure.

Operations Leaders. In order to implement this change, it is vital that operational leadership endorses the process as they will bear the costs for the change. The critical organizational analysis in Chapter 2 identifies that operational leadership has not been working

with professional practice when hiring LPNs. Consequently, operational leadership may perceive the process identified in the LISO framework is not necessary or is too costly. Moreover, Endacott et al. (2018) report that it is often assumed that enrolled nurses (LPNs) and RNs can have similar roles despite the differences in their educational preparation. Thus, operations leaders may not understand the need for change, and may not view the problem as a potential patient safety issue that requires change. Alternatively, operations leaders may see a need for change but may not have the budget to implement the change.

Cawsey et al. (2016) report that when individuals can see the benefits of the change outweighing the costs and the change being successful, they are more likely to take a risk and invest in the change. As a result, it is vital to work closely with operations leaders to help them understand the need for and benefit of implementing the LISO framework to provide LPNs with the additional education they need. It may be necessary to collect and present data, such as the gaps between the competencies LPNs currently have and the competencies LPNs could possess, to demonstrate the benefit of the change.

As an authentic transformational leader, I will work collaboratively with operations leaders and attend to their concerns by exploring alternative cost-effective options for how LPNs can receive the additional education/skills training needed. Considering alternative options may be required, such as adapting courses/skills training that currently exist in Organization M for RNs, and/or using existing courses from other health authorities in Province C. Using existing courses will also allow for LPNs to receive the same education as LPNs in other health authorities. However, since Organization M leads care for specialty patient populations, there may be limited education available to use. Next, I will explore the strategies I will use to engage and empower personnel.

Personnel to Engage/Empower

Browne and Wildaysky (1983) highlight that during the implementation phase, some individuals may not comply with the change, which can delay things or cause unwanted effects. For this reason, Browne and Wildaysky (1983) draw attention to engaging as many stakeholders as possible from early on, in order to gain their perspectives and identify barriers that may be potential issues. Cawsey et al. (2016) highlight that change agents must identify the critical individuals who bond with others to transform the context of change and tip it into another reality. Additionally, as identified in Chapter 2 through the Nine- Phase Change Process model, it is important to ideally engage as many stakeholders as possible from the beginning to empower them to be part of the change. As outlined in Chapter 2, this can be achieved through the creation of new groups or utilizing currently existing networks. The professional practice office network consists of directors and practice leaders across Organization M, and is chaired by me. This network is an ideal avenue to engage the practice leaders and directors to support the need and plan for change. Having LPN scope optimization as a standing agenda item that will be discussed every meeting will allow everyone to work collaboratively and enhance their understanding of the change required, and build endorsement for the implementation of the LISO framework. Through this network, I can identify key individuals who are in support for change and create LISO committees (one for each program) that work on implementing this change.

Cawsey et al. (2016) emphasize that the success of change is greater when a bottom-up approach is taken where a broader spectrum of individuals, including those from frontline, understand what the change entails, why it is occurring, and how they are able to contribute to the success for change. Thus, the LISO committees would consist of a variety of stakeholders including directors, practice leaders, and frontline RNs and LPNs in each program. Each LISO

committee will work on strategies to implement the LISO framework in their program. As discussed in Chapter 2, engaging members from all different levels aligns with authentic transformational leadership and increases the likelihood for buy-in for change across the organization. Additionally, it allows everyone to work together to identify strategies to move the change forward (e.g., what the course content will consist of and how to deliver it). Consequently, it is important to consider the supports and resources required to implement this change.

Supports and Resources

As identified in Chapter 2 when exploring the possible solution for change, the implementation of the LISO framework will require the utilization of many different resources.

Time. Time will be a vital resource when determining patient populations, identifying the competencies LPNs require to work with their patients, assessing the competencies LPNs currently have, and determining the additional education/skills training that LPNs need to work safely and completely with these patient populations. Time will also be a major resource to create the theoretical knowledge and skills training courses, and when providing LPNs with the education/skills training.

Human. Implementing this change will require multiple human resources. The Department of Professional Practice, particularly myself, will be responsible for leading the change and working continuously to move it forward working collaboratively with the directors of professional practice. Practice leaders will be working with LPNs to determine their competencies and the additional education they need. Learning specialists will be required to create the online theoretical courses. Additionally, nurse educators will be required to provide LPNs with the skills training needed.

Technological. The use of technology will be critical in implementing the LISO framework. Computers, internet, and surveying programs are required to assess the current competencies of LPNs. Additionally, theoretical courses will be made through computer software. Moreover, LPNs will require access to computers and the internet to complete the theoretical courses.

Financial. There is a large cost associated with implementing this plan as Organization M will have to pay for all of the resources. There will be some cost incurred for the time (the salary) of the directors and practice leaders to determine their patient populations and the competencies required of LPNs to work with these populations. There will also be cost for the time (the salary) of practice leaders to create the additional education content, and a greater cost for the learning department to create the theoretical courses. Significant cost will be incurred when providing LPNs with the additional education/skills training as LPNs will be paid for their time spent completing the additional education/skills training, and there will also be cost to backfill the LPNs so they can have the time off for education. Along with considering the resources required for this change, it is also important to anticipate potential issues that may rise during implementation.

Potential Implementation Issues

As identified in Organizational Change Readiness in Chapter 1, Organization M is preparing for change as it is moving to the electronic health record, and implementing this change may not be viewed as a priority. Likewise, some directors and operations leaders may feel there is too much change occurring at once. This may be mitigated by emphasizing the political factors driving the change, emphasizing the risks associated to not implementing the change, and leveraging support from senior leadership to move forward with the change.

There may also be implementation issues from operational leadership in programs due to the costs associated. There may be operations leaders who hired LPNs as they cost less than RNs, and the costs associated with implementing LISO framework will contradict their motive for hiring LPNs. Cawsey et al. (2016) report that although change should not be pushed and rather should evolve, there may be situations where cooperation is absent, and top-down support is required. Thus, having the LISO framework endorsed by senior leadership in Organization M prior to working with the operations leaders is important as it will demonstrate the importance of the change and help gain buy-in. Additionally, determining strategies to build momentum will also help gain buy-in across the organization.

Build Momentum

Cawsey et al. (2016) suggest that momentum for change can be created by looking at long-term goals that align with the long-term interests of stakeholders. Additionally, Anderson and Ackerman Anderson (2001) report that change leaders build momentum through the creation of appropriate plans that guide the change process to the desired outcomes. Benchmarks for the short-term goals include the LISO framework being endorsed by senior leadership, the LISO framework being socialized among the directors of professional practice and operations leaders, and there being significant buy-in from the directors of professional practice and operations leaders. The benchmarks for medium-term goals are that programs have begun work on implementing the LISO framework to provide LPNs with the additional education they need, and the directors are reporting to me the progress, challenges, and what assistance is needed for implementation. Lastly, the long-term goals and benchmarks for change are all programs with LPNs have implemented the LISO framework, and all LPNs in Organization M are working to their optimal scope of practice while providing safe and competent patient care. Along with the

identifying goals, it is important to consider limitations and potential solutions to move the change forward.

Limitations and Potential Solutions

The first constraint to implement this change is the time it will require. As mentioned above, Organization M is moving to the electronic health record, which is currently a priority for the organization and is being led by the Department of Professional Practice. It is part of my role to support the programs with the transition to the electronic health record. Consequently, I will have to be mindful to manage time in my team in order to have the time to lead this change, as there are other competing priorities in my team.

The scope of this change also presents a challenge. Organization M is a large health authority that extends across Province C and it may be difficult for me to track implementation and provide support if the programs are simultaneously implementing the change. The LISO committees will assist me with keeping track of implementation and executing the work that needs to be done to move this change forward.

Lastly, the biggest limitation present is the need for the endorsement of senior leadership. As identified above, the Department of Professional Practice does not have any formal authority to implement change within the programs. Therefore, if I do not gain formal support from senior leadership to endorse the change, I have no leverage to work with the directors of professional practice or operations leaders to move this change forward. The Chief Nursing Officer understands the need for change, and is in support for implementing the LISO framework and bringing it forward to the senior leadership team for endorsement. Anderson and Ackerman Anderson (2001) indicate, obstacles and distractions often arise during the change process and it is important for the conscious leader to remain committed despite the challenges to create the

change. Acknowledging the limitations and finding solutions to move past these will enable me to move forward with and implement the change. Hence, the plan to implement the change is explored next.

The Change Process Framework and Plan for Monitoring and Evaluation

The Nine-Phase Change Process Model and Timeline for Implementation

The Nine-Phase Change Process Model highlights a generic progression of how change occurs in an organization over time (Anderson & Ackerman Anderson, 2001). Once the LISO framework has been approved and socialized in Organization M, each program will use the Nine-Phase Change Process Model to implement change as the LISO framework embeds the change process outlined in this model. The following timeline is anticipated for the programs to carry out the following steps of this model with the LISO framework.

October 2019 – August 2020. During this timeframe, the program leaders will:

1. Prepare to lead the change. Anderson and Ackerman Anderson (2001) report that this step includes creating the justification for change, identifying initial desired outcomes, and assessing the capacity and readiness for successful change. This requires the programs to *identify the current model of care, and determine the gaps and need for a new model of care (LPN role).*
2. Create organizational vision, commitment, and capability. This step includes building an understanding of the justification for change and the change approach (i.e., LPN integration), building a shared vision for change, and increasing readiness for change (Anderson & Ackerman Anderson, 2001). This will be accomplished as the programs will *identify stakeholders that have been engaged, and show evidence of their support for the new model of care.*

3. Assess the situation to determine design requirements. This step requires examining the current situation to determine the requirements to design the change. To achieve this, the programs must *identify risks and goals with the new model of care*, *identify the needs of the patient population, and define the new model of care and LPN role.*
4. Design the required state. This step requires the programs to *identify the competencies required for the LPN role*.
5. Analyze the impact. In this step, the programs will i*dentify the current state of LPN competencies*, *determine gaps between current state and required competencies for LPNs,* and *identify the knowledge/skills LPNs need to meet the required competencies*. Once a program has analyzed the impact, it is important to consider the given metrics if LPN introduction or scope optimization is still appropriate.

August 2020 – December 2020. This timeframe includes the 'organize for implementation' step. Anderson and Ackerman Anderson (2001) report that here leaders are identifying the actions needed to implement the change and creating the plan. Thus, the programs will *plan implementation strategies for LPNs to acquire required competencies.* This includes the programs creating the theoretical courses and skills-training curriculum to provide LPNs with the additional education they need.

January 2021 – February 2021. During this timeframe, the programs will:

1. Implement the change. Here, the programs will *initiate the education/skills training for LPNs to acquire the required competencies.* This step entails LPNs receiving all of the additional education/skills training they need to work in their new role.
2. Celebrate and integrate the new state. Through this step, leaders support integration of the new state and celebrate the achievement of reaching the desired state (Anderson &

Ackerman Anderson, 2001). Here, the programs will *initiate the LPN role implementation plan*.

January 2021 – July 2021. Learn and course-correct. In this phase, the programs conduct *evaluation of the LPN education, their new role, and the new model of care*. This consists of the leader building a system to assess and improve the new state, and learning from the change process (Anderson & Ackerman Anderson, 2001). In order to achieve this final step, it is important to create a plan to monitor and evaluate change.

Tools to Monitor and Evaluate Change

The purpose of evaluation and monitoring is to track the objectives and outputs of an intervention (Markiewicz & Patrick, 2015). There are multiple objectives related to providing LPNs with the additional education/skills training, including: (a) to have LPNs learn the knowledge and skills needed to possess the competencies required to work in their patient population; (b) to have LPNs better trained to work with specialty patient populations; and (c) to increase positive patient outcomes. Miner (2009) specifies that rigorous evaluation helps answer the following questions: (a) is the knowledge being taught actually making a difference to the learner (LPNs), (b) how can course content be refined to achieve better results, and (c) to what extent are the learners (LPNs) applying this information in practice? Accordingly, a good evaluation model will help determine if these objectives are met and will help leaders with the learn and course-correct phase outlined above.

Pre-implementation evaluation. In order to truly evaluate the future state, it is important there is an evaluation of the current state. Weston (2008) suggests that a single statistic does not provide any information, as there is nothing to compare to. Therefore, it is important

that a pre-implementation evaluation is done in order to understand whether change has truly made a difference when evaluating post-implementation.

Arthur, Bennett, Edens, and Bell (2003) indicate that a needs analysis enables an organization to determine what the nursing needs are and if the problem can be addressed through additional education or training. Moreover, a needs assessment helps an organization determine which individuals need additional education and what an individual must learn to carry out his/her job effectively (Arthur et al., 2003). As identified in Chapter 1, an environmental scan completed in Organization M has already identified the areas where LPNs are working and the nursing activities that LPNs are currently not performing, which they could perform with additional education.

Additionally, surveys will be used to further determine the competencies for which LPNs require additional education/skills training. The World Bank (2004) reports that mini-surveys are a quick and cost-effective method to obtain feedback to provide information needed to make a decision. I will work with the practice leaders to create the surveys. As an authentic transformational leader, working with the practice leaders to assess the perception of LPNs from the beginning will allow individuals from different levels to provide input and be involved in the change process from the beginning. Moreover, these surveys will provide information of change readiness from LPNs. Examining the results from the survey and comparing them to the required competencies for the LPN role will identify the competency gaps present and will help determine the additional education/skills training that LPNs need.

Furthermore, a work-plan will be created that outlines the steps in the LISO framework that will be used by the LISO committees. The work-plan will display the actions required to move forward with change and the individuals who are responsible for these actions. As

mentioned in Chapter 2, providing clear direction and assigning tasks based on the individuals' strengths and interests will contribute to inspirational motivation. Through regular check-ins with the LISO committees, I will be able to monitor the change process and gauge where each program is in the change process.

Post-implementation evaluation/monitoring. In order to determine if implementation is leading to the desired outcomes for change, it is important to monitor and evaluate the change. Patton (2008) outlines that Bennett's Hierarchy Evaluation Model works well in education-oriented interventions. Moreover, McCawley (2001) suggests that Bennett's model is a helpful evaluation tool as it identifies indicators, highlights factors that will produce useful evaluation of data, and outlines an organized method for data collection and measuring progress (as cited in Miner, 2009). For these reasons, I will be adapting Bennett's Hierarchy Evaluation model (see Figure 6) to monitor and evaluate the change that will help the program leaders and myself learn and course-correct.

Figure 6. Bennett's Hierarchy Evaluation Model. Adapted from "Up the hierarchy" by C. Bennett, 1975, *Journal of Extension, 13* (2), 7–12.

Inputs. This refers to the resources used to create the courses and skills training outlined above. This includes the time and costs associated with practice leaders developing the course content, and the costs associated with the Learning & Development team creating the online theoretical courses. The costs incurred paying the LPNs to complete the education rather than working in their role upon hiring would also be considered, along with the costs for clinical staff teaching the hands-on-skills course.

***Activities*.** This refers to what activities are being done, hence the additional education/skills training. The evaluation will examine if the number of courses created for each specialty area are sufficient, and if the creation of these courses is sufficient to help LPNs possess the competencies required for their new role. This would be determined through the end-of-course evaluations. Six-month post-education surveys of LPNs will also be conducted assessing LPN competencies, and the results from the surveys will be compared to the results of the pre-implementation survey and the required competencies.

***Participation*.** This refers to the target audience, number of participants and the duration of their participation. The target audience would be LPNs taking the specific courses for the specialty area they are hired into, e.g., taking cancer care courses when being hired into or having their scope optimized while working in oncology. All LPNs who are hired into any specialty area will be expected to complete the theoretical (online) education prior to working with patients. The online courses will be offered all year round and can be completed at anytime from anywhere. The hands-on-skills course(s) will also be taught frequently. The evaluation would be also determined through the six-month post education surveys by comparing the results to the baseline assessment.

Reactions. This would be assessing the immediate reaction of the LPNs completing each course. The goal is to create courses that LPNs find easy to understand, interesting, informative, and addressing topics they had not learned (or did not have enough education about) during their practical nurse training education. The objective of these courses is to provide them with the knowledge/skills they need to possess the competencies required to perform their new role. The reactions would be determined through course evaluation surveys, which will be offered immediately after the course is completed.

KASA. This refers to the knowledge, attitude, skills, and aspiration of the LPNs. It is key to know if the LPNs believe that they have the knowledge and theoretical skills to work with these specific populations after completing the courses – if they are confident and competent to work with this patient population. It is also critical to determine whether the LPNs feel they now possess the competencies required to perform their role. This would also be evaluated through course evaluation surveys.

Practice change. This refers to whether the courses are able to produce results and provide LPNs with the additional required competencies they need to possess to work in their specialty area. A practice change will demonstrate that LPNs are applying the theoretical knowledge and skills they have gained from their courses into practice, and have a deeper understanding of their patient population and of their own nursing practice. This additionally would be determined through a six-month post-education environmental scan being compared to the baseline environmental scan.

Impact. This is the outcome of the practice change. I will want to know if patients and families believe and/or report if they have had better service, and if there is an improvement in patient outcomes. This could be determined through measuring rates of adverse events,

secondary diseases, nosocomial infections, admission rates to hospital, length of stay, and comparing current results to pre-implementation rates. Moreover, it is important to evaluate if the programs are observing or reporting a decrease in cost due to an increase in positive patient outcomes. Cost-benefit and cost-effectiveness analysis will be utilized to determine if the cost required for this changed is justified through the impacts and outcomes (World Bank, 2004). The next and final section of this OIP will examine the plan to communicate the change process.

Change Process Communication Plan

Cawsey et al. (2016) report that leaders must develop a good communication change plan to prevent rumours and misinformation from being socialized across the organization. A good communication change plan will: (a) demonstrate the case for change throughout the organization; (b) permit others to understand the effect the change will have; (c) communicate any structural or job modifications that affect the current state; and (d) keep others informed about the progress throughout the change process (Cawsey et al., 2016). Furthermore, Cawsey et al. (2016) suggest there are four phases of a communication change plan:

1. Pre-change approval;
2. Constructing the need for change;
3. Midstream change and milestone updates; and
4. Confirming/celebrating success.

I will explore the strategies I will utilize in each phase to communicate and move forward with change.

Pre-change Approval

In this phase, a leader must persuade top management that change is required (Cawsey et al. 2016). Consequently, in this phase, the leader targets individuals who have the authority

and/or influence to approve the change (Cawsey et. al, 2016). It is essential to present that the change is aligned with the plan, priorities, and goals of the organization (Cawsey et al. 2016). As identified earlier, the Chief Nursing Officer is in support of the LISO framework, and my first priority is to have the LISO framework and the proposed organizational structure endorsed by senior leadership. This will be achieved through a face-to-face presentation as this is the most effective way to communicate (Cawsey et. al, 2016), and will allow senior leadership to directly ask me questions and clarify misconceptions.

The plan is to present the LISO framework to the senior leadership team in early September 2019. While presenting the LISO framework to senior leadership, I will use the strategies discussed in Chapter 2 for the step *create organizational vision, commitment, and capability.* Thus, I will present the findings about nursing education impacting patient outcomes along with the results from the environmental scan, which will display that this change is aligned with Organization M's vision of providing the best care possible. Additionally, I will highlight the drivers for change discussed in Chapter 2 as these will demonstrate that this change is aligned with the plans, goals and priorities of the organization. Once senior leadership has endorsed the LISO framework, it will be important to construct the need for change and gain support from the directors of professional practice and operations leaders.

Constructing the Need for Change

This phase requires the leader to provide an explanation of the issues and drivers convincing other key stakeholders of the need for change to occur (Cawsey et al., 2016). Hence, performing the same presentation done for senior leadership at the professional practice network meeting will construct the need and urgency for change. The plan is to present the LISO

framework to the professional practice network in September 2019, once I have obtained endorsement from the senior leadership team.

Furthermore, Cawsey et al. (2016) report that communicating comparative data will help build awareness for the need for change. As mentioned in Chapter 2, I will present the data examined in Chapter 1 to raise awareness of the need for change. Hence, I will also highlight that the other health authorities in Province C are creating courses to provide additional education to LPNs. This will motivate leaders to support the implementation of the LISO framework so that LPNs in Organization M can also receive the additional education they need. Moreover, Cawsey et al. (2016) report that the leader must articulate and clarify the vision and specific steps of the change plan. Consequently, the LISO framework outlines the steps required to achieve the desired state of providing LPNs with the additional education/skills training they need to provide safe and competent patient care while working to their optimal scope of practice.

As mentioned in Chapter 2, I will create working groups so that all levels of staff can be engaged to design the change. Hence, I will ask for members in the network to volunteer to be on the LISO committees to help lead change for their respective program. This will give all members the opportunity to be engaged in leading the change from the beginning, and will permit them to identify frontline nurses who can also be engaged to lead change. Next, I will review the communication strategy during the change process.

Midstream Change and Milestone Updates

This phase requires extensive communication to employees and management about the context of the change in order for them to understand the new roles, systems, and structures (Cawsey et al., 2016). Moreover, employees will want specific information provided to them regarding how the future will look, how things will operate, and how the change affects their

jobs (Cawsey et al., 2016). Furthermore, it is important to communicate the achievement of milestones and the progress made in order to retain excitement and enthusiasm about the change (Cawsey et al., 2016). Therefore, purposeful strategies are required to communicate the information.

Strategies of communication to program nurses. As identified above, LPN introduction/scope optimization will affect the roles of LPNs and RNs. The RNs may feel that their jobs are at threat and the LPNs may feel offended that they require additional education to work to their optimal scope of practice. It will be important to use an empathetic approach and communicate to the RNs and LPNs from the beginning that the purpose of this change is to ensure that there are enough nurses present at all times to provide the best care possible. In alignment with authentic transformational leadership, empowering messages will be communicated to RNs and LPNs. Communicating to RNs – that this change will reduce their workload and give them more time to provide care as they will not have to do double the work when working short – will help them understand the benefit of change. Providing LPNs with a similar message – that this will enable them to do more as they will have the knowledge and skills required – will allow them to see the benefit of change.

Cawsey et al. (2016) explain that face-to-face communication is important, especially when there is uncertainty. Therefore, offering nurses the opportunity to contribute and clarify their views face-to-face will result in better engagement and lead to better support for change (Lewis, 2011). Moreover, providing them with the opportunity to hear directly from leadership and clarify concerns about the change will lead to more positive reactions and reduce chances of miscommunication (Cawsey et al., 2016). Thus, it will be important to ensure that during these meetings the practice leaders are present to provide information and clarify concerns.

Multiple platforms will be utilized to communicate the progress and milestones of change. These include providing updates at staff meetings when a milestone has been achieved, highlighting milestones and achievements in staff newsletters and team sites, and emailing staff with progress updates.

Strategies of communication to leaders. It will be important to communicate the progress and milestones of change with the operations leaders, directors of professional practice, and practice leaders. Similar strategies will be used to communicate progress as identified above, including the leaders' news, and blanket emails. Additionally, regular updates will be provided at the professional practice office network meetings, to which operations leaders will also be invited. During these meeting updates, LISO committee members will highlight where they are in their work-plan. Moreover, Cawsey et al. (2016) express that leaders must receive communication regarding the attitudes and acceptance of change. Consequently, it will also be important to highlight any misconceptions that are arising and the plan to resolve these misconceptions (Cawsey et al., 2016).

Strategies of communication to senior leadership. Platforms such as leaders' news and progress emails will provide updates to senior leadership regarding the progress of change and milestones that are being achieved. In addition, briefing notes highlighting milestones can also be provided to senior leadership. Lastly, I may also attend the senior leadership meetings to provide face-to-face updates regarding the progress of change. Consequently, it will also be important to communicate the result of implementation.

Confirming/Celebrating the Success

In this phase, I will be communicating that the change has been implemented in these programs and celebrating its success (Cawsey et al., 2016). This can be achieved through the

platforms identified earlier including newsletters, emails, and face-to-face communication at meetings. Cawsey et al. (2016) report that although celebration is important it is often undervalued by leaders. I plan to celebrate by providing treats at the face-to-face meetings when communicating the change has been implemented. I will also write personalized 'thank you' letters to the LISO committee members and the other key stakeholders who helped lead the change and ensured its success.

Chapter 3: Conclusion

This chapter discusses the steps and considerations required to move forward with change. Implementing the LISO framework across Organization M is the solution identified. During the implementation of this framework, a change to the organizational structure is proposed where I will be leading the change and the directors of professional practice will report to me. Consequently, considering the potential reactions, barriers, and limitations for change and identifying possible solutions will facilitate the change moving forward. The Nine-Phase Change Process Model is embedded in the LISO framework to implement the change and is explored with the implementation timeline. It is critical to evaluate the LISO framework, along with the new model of care after each program implementation, to make improvements to ensure continuous success for other programs that utilize it. Accordingly, Bennett's Hierarchy Evaluation model will be utilized to ensure that there is thorough monitoring and evaluation of the change process, and end result. Furthermore, a good communication plan is critical to ensuring that there is understanding, adoption, and success of the change; thus, various communication strategies are explored. Creating an effective implementation plan will result in the success of the change implementation.

Future Considerations and Next Steps

This OIP focuses on the gaps present that prevent LPNs from being workplace ready to work in Organization M. Specifically, LPNs are not educationally prepared to work to their optimal scope of practice for entry-to-practice positions with specialty patient populations. Thus, this OIP examines how to address LPNs' lack of educational preparedness for entry-to-practice positions with specialty patient populations. In order for Organization M to meet its vision, to provide the best care possible at all times, it is imperative that its nurses are educationally prepared to provide safe and competent care. Through implementation of the LISO framework, the programs in Organization M will be able to identify the additional education/skills training LPNs need and then create the courses to provide it.

To ensure that programs are following the steps identified in the LISO framework it will be important to evaluate fidelity to understand its true effectiveness. Once fidelity is determined, it is vital to evaluate if this framework is effective in providing LPNs with the additional education/skills training they need. Additionally, it is critical to determine if the new role of LPNs is sustainable and meeting the desired outcomes of providing safe and competent care. If the new role of LPNs is sustainable, then alternative options of enabling LPNs to be workplace ready for speciality patient populations must be considered.

Advocating to the Ministry of Health, for provincial funding for nursing education programs to provide the additional education must be considered, as it is their role to ensure that graduates are workplace ready. Moreover, working with the College of Nursing Regulation to highlight the specific competencies that LPNs must possess to work with specialty patient populations will help push nursing education programs to consider providing the additional education. Nursing education has moved away from hospital training schools; hence, it is not

Organization M's role to provide education to enable nurses to be workplace ready. Organization M will provide the additional education in the interim to close the gap present and to ensure that patients are receiving safe care, and the best care possible.

Next steps include creating a strategy in the interim to standardize the education created by health authorities – to ensure that all LPNs in Province C receive consistent education/skills training. Addressing this problem of practice will bring Organization M to its desired state of all of nurses having the knowledge and skills needed to provide the best quality of care.

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Appendix A

LPN Introduction/Scope Optimization Framework

Steps	Actions
Identify the current model of care	Who is currently in the team, e.g., RN/ RPN? What is the current role of LPNs?
Identify the gaps and the need for a change in the model of care.	What are the gaps in care? Identify patient needs that would be better met with the introduction or scope optimization of the LPN Role.
Identify the stakeholders that have been engaged and support the change in model of care.	Who is leading the change? Who has been consulted and is in support of the change in the model of care? Operational leadership: Department of Professional Practice: Physicians/Nurse Practitioners: Program Nurses (e.g., RN):
Identify risks and opportunities with the change in model of care.	What are the risks associated with LPN introduction/scope optimization? What are the opportunities/goals?
Identify needs of the patient population.	Identify the Patient Population – are they stable and/or predictable? How are you identifying patient populations? What are the needs of stable and/or predictable patients? What standard interventions do you have in place?
Define the LPN Role.	What tasks/nursing activities will LPNs carry out? What responsibilities will they have? What policies are in place to support this? What policies need to be created to support this? How will they manage patients who are no longer stable and/or predictable?
Identify the competencies required for the LPN Role.	What knowledge, skills, judgement, and attitude do LPNs require to meet patient needs?
Identify the current state of LPN competencies.	Which of the required competencies do LPNs currently possess? What is the percentage of the competencies they currently possess?

Determine gaps between current state and required competencies for LPNs.	Which of the required competencies do LPNs not currently possess? What is the percentage of the competencies they do not currently possess? For which competencies do they need additional education/skills training? Is LPN introduction/scope optimization appropriate with this patient population?
Identify the knowledge/skills LPNs need to meet the required competencies.	What additional theoretical knowledge do LPNs need to learn to address the gap in required competencies? What additional skills do LPNs need to learn?
Plan implementation strategies for LPNs to acquire required competencies.	What content from other health authorities can you use? Who will make the educational content? Who will validate the content? How will this educational content/skills training be provided to LPNs?
Initiate the education/skills training for LPNs to acquire required competencies.	Education/skills training plan
Initiate LPN role implementation plan.	What is the work plan? What mentoring/coaching is being provided and how often?
Evaluation of LPN education, role, and the new model of care.	How effective was the education in providing LPNs with the competencies required to perform their role? How has this role impacted patient outcomes and quality of care, i.e., adverse events, secondary diseases, nosocomial infections, admission rates to hospital, length of stay? What are the metrics? What needs to change to improve this new model?
Long-term monitoring of LPN role and model of care.	How do the metrics support this model? What is the sustainability plan?

Note. Adapted from “A Framework for the Introduction and Evaluation of Advanced Practice Nursing Roles” by D. Bryant-Lukosius, and A. Dicenso, 2004, *Journal of Advanced Nursing*, *48*(5), p. 530–540.