# Who Am I and What Do I Do?
# A Hermeneutic Phenomenological Study on the Experience of RNs and RPNs Working in the Same Environment.

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## Abstract

The aim of this study was to explore the lived experiences of registered nurses (RNs) and registered practical nurses (RPNs) working in intraprofessional dual-scope work environments. The study was conducted using a hermeneutic phenomenological approach. Conversational interviewing was conducted with a purposeful sample of nine nurses who worked in an intraprofessional care area. Two themes emerged from the participant conversations: The Dance and The Fissure. The Dance displays the experiences of empathy, comradery and teamwork lived by the nurses working in the dual-scope environment. The Fissure displays the lived experiences of role ambiguity and challenges nursing in a dual-scope environment. There is importance in giving voice to the stories of the nurses working in the shared care areas, allowing insight into emotions, integrity and wisdom. This research has given light to various issues in the shared care areas for both RNs and RPNs and has provided implications for nursing practice, nursing education, and nursing research.



*Keywords: role ambiguity, collaboration, empathy, nursing, registered nurses, registered practical nurses*

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## Table of Contents

## List of Figures

# Chapter 1: Introduction

Nursing is an art form. It is love and it is caring. It is the hand that holds the dying; it is the spoon that feeds the hungry child; it is the ear that listens to the stories of the broken. Nursing embraces life and death with open arms. Nursing is what I do and who I am; nursing is part of my identity. When I decided to become a nurse, I accepted a role, a career, an art form in which I have been involved for 18 years. I have never questioned my choice to become a nurse.

When I first decided I would go to graduate school to obtain my master's degree, I knew I wanted to undertake a research stream. I have always been inquisitive in nature and have great passion for the nursing field. Initially, I was unsure which area of nursing I would research, but I knew I would conduct research in nursing as being a nurse is part of my identity. Jones et al. (2014) writes that when completing and presenting findings on a phenomenon under study, the researcher must describe to the reader their own positionality. This unveiling of researcher identity allows the reader to have knowledge of what the researcher brings to the process, such as social identities, positionality, power relationships, and research pre-understandings (Jones et al., 2014). To bring my identity to this research, I did much thinking and self-reflection about my roles as a nurse and an educator and began to see a common experience regarding the issues of role ambiguity, role conflict, intraprofessional relationships, challenges related to scope of practice among registered nurses (RNs) and registered practical nurses (RPNs), and what I perceive as the instability of the nursing work environment. I wondered if these issues existed for other nurses. Was this a perception that only I possessed? Was this occurring in different areas of the nursing world? From my experiences as a working RN and educator, I have observed that scope of practice is an area of discussion from the breakroom to the boardroom. I actively

reflected on these observations and asked those around me in the nursing world if they had felt, witnessed, or experienced the same thing. The answer was yes.

Mahler et al. (2014) describe the term intraprofessional as collaboration and co-operation within one's profession group, where the term interprofessional implies co-operation and collaboration in the context of the other professionals working together. My interest in intraprofessional nursing work environments does not simply stem from learning about the experience in its entirety, but also from a desire to gain a greater appreciation of the perceived gap between the two nursing scopes of RNs and RPNs. In the College of Nurses of Ontario (CNO) practice guideline, *RN and RPN Practice: The Client, the Nurse and the Environment* (2014), the following is written about the scope of practice for nursing:

> The practice of nursing is the promotion of health and the assessment of, the provision of, care for, and the treatment of, health conditions by supportive, preventive, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function. Practice is so broad and varied that no one nurse is expected to be competent to carry out all the activities within the legal scope of practice; hence, the notion of "full scope of practice" is unlikely. (p. 4)

The main assumption that I have regarding my area of study is that there is role ambiguity between RNs and RPNs. I believe this to be true from personal experience because I have worked in a shared scope environment. Role ambiguity is described as a lack of clear and accurate knowledge, understanding, or expectations of the roles of others and of self (O' Brien-Pallas et al., 2010; Tarrant & Sabo, 2010). Within health care, a shared scope environment is a patient care area where both RNs and RPNs work and provide care to a similar patient

population. Currently, I do not have full insight into the shared scope environment, because I have not worked in such an environment in 11 years. Although I may not have a recent understanding of what exactly that experience may be like, I maintain some appreciation for it because of my previous work in a shared scope environment. The possibility that role ambiguity, intraprofessional challenges, and volatile work environments do not exist is something that I consider often. I should not assume that something that I have experienced has been experienced by all.

In respect to my worldview, I believe that an individual can only know and understand what has been experienced. I do not know what someone else feels, thinks, or understands; only that individual has embodied that experience. Despite the limitations of my experience, I am willing to attempt to understand the views of others. My worldview is structured by the fact that I am a registered nurse and I continue to learn, develop, and change, as I assume that others do in relation to their experiences. I believe that to know or understand a person, it is important to take time to engage with one another and to share our experiences. I feel that the retelling of past and present experiences gives insight and creates shared meaning, thus allowing for greater knowledge of the experience under study. The goal of my research is to bring an understanding of lived experiences and how that meaning is shared. This sharing is how I believe we can understand the world around us. The act of attempting to glimpse participants' experiences and give voice to their story through hermeneutic phenomenology will, in turn, allow for sharing and growth through an interpretive lens. The goal for my research is to support understanding of the lived experiences of nurses in an intraprofessional environment and how the meaning of those experiences is shared.

When a researcher attempts to understand the experience of others, it is important for the researcher to understand the phenomenon under study. This pre-understanding is not only for the researcher, but also for those who will potentially read my document. It will provide information that will allow the reader to hopefully gain insight (Van Manen, 1998). Pre-understanding is both an active and a passive practice in which a researcher reflects on what is already understood about a phenomenon and what has been experienced. The completion of research will thus enhance my personal knowledge on the experience under study (Van Manen, 1998).

In Ontario, we have two general streams of nurses: RPNs and RNs. I am an RN. From what I have observed, felt, heard, learned, and questioned over the last three years, I believe there is a misunderstanding of nursing roles within the health care and educational settings. I have heard claims that RPNs will replace RNs, that RNs are all managers, and that there is no difference between RNs and RPNs in the clinical setting. I have experienced tension among nurses working in the same clinical setting who are providing similar care. I have heard discussion among nursing regarding pay inequality and the similarities of the two nursing roles at the bedside.

Through a preliminary review of the literature surrounding RN and RPN education, practice, and role ambiguity, I discovered the following details that provide support for my interest in role ambiguity. The CNO's (2015) *Practice Standard: Professional Standards* indicates that “nurse refers to a Registered Practical Nurse (RPN), Registered Nurse (RN) and Nurse Practitioner (NP)" (p. 3). This the use of the term “nurse” by the CNO renders differences in the roles indistinguishable, contributes additionally to role ambiguity, and suggests that even the CNO, as the regulatory body for all the nursing classes, makes no distinction among the nursing roles. We are all referred to as nurses, with shared privileges and scopes. According to

the CNO, there are four controlled acts that both RNs and RPNs can perform under the guidance of the Regulated Healthcare Professions Act (RHPA) of 1991 (CNO, 2017) (see Figure 1). Nurse practitioners (NPs) also have the right to perform these controlled acts, but for the purpose of this research study, I will not be examining the role or scope of extended-class RNs, a category that includes NPs. The four acts designated to be performed by both RNs and RPNs can be carried out with proper education and understanding of the procedure at hand (CNO, 2017). The lack of clear delineation among the shared acts allows for confusion concerning differentiation between the two roles.

Nursing in Ontario is a profession with a legal scope of practice determined by the scope of practice statement created by the CNO from the controlled acts outlined by the RHPA of 1991 and the Nursing Act, 1991 (see Figure 2), which give nurses the authority to perform the designated acts. Being part of the professional body of nurses does not give all practicing nurses the right to perform all prescribed procedures, as a nurse must be competent, knowledgeable, and have the judgement to perform a task. The ability to negotiate one's own capabilities is essential to the provision of safe care within the scope of practice authorized to the profession of nursing.

The CNO practice guideline, *RN and RPN Practice: The Client, the Nurse and the Environment*, describes controlled acts as care activities that may have the potential to cause harm if performed by someone who does not possess the knowledge, insight, and judgement to perform such a task (CNO, 2014).

A study conducted by Butcher and MacKinnon (2015) found complex links among education, educational programs, relationships between RNs and RPNs, and the role of nursing knowledge. Another study found that role ambiguity results from inconsistent information about

the expected role behaviour originating from organizations and individuals (Lankshear et al., 2016). The preliminary findings of these two studies specifically guided me to into research involving the experience of role ambiguity among nurses working in an intraprofessional environment.

This study was completed using hermeneutic phenomenology. Van Manen (1998) has written that "anything that presents itself to consciousness is potentially of interest in phenomenology, whether the object is real or imagined, empirically measurable or subjectively felt" (p. 9). I have felt the presence of role ambiguity among nurses working together intraprofessionally, and I have experienced role ambiguity working in an intraprofessional environment. Van Manen (1998) has further stated that "the phenomenologist knows that one's own experiences are also the possible experiences of others" (p. 54). I have worked in intraprofessional environments and wondered if my experiences were shared with others. This interest in the working together and collaboration of RNs and RPNs led me to consider research and to phenomenology, where I could use my past knowledge, together with an openness to the knowledge and experience of others, to provide greater understanding of shared scope environments.

The purpose of this hermeneutic phenomenological study was to explore the lived experiences of nurses working in an intraprofessional nursing scope environment in an acute care hospital setting. This study explored the experiences of the intraprofessional scope of practice of both RNs and RPNs working in the same care environment. The main research question was the following: What is the perceived experience of registered nurses and registered practical nurses working together in an intraprofessional work environment in an acute care hospital setting? A

secondary question in relation to the topic is the following: How has the experience shaped your role as a nurse?

# Chapter Two: Literature Review

The literature review for this study was completed in an effort to discover and learn about information and gaps in regard to the experience of nursing in an intraprofessional environment. For this literature review, information was collected broadly from published and unpublished works, grey literature, news media articles, organizational websites, and the world wide web. Searches were completed using the Brock University James A. Gibson Library Supersearch, an internet-based research tool that enables users to query the contents of multiple library catalogues and databases. Key search terms included nurs* AND role ambig* AND role clarity AND scope AND practice AND intraprofessional AND interprofessional. There were no limits for dates of publication, but the entire search was limited to documents written in English and available as full text. Hand searching of found documents was completed once initial documents were collected to pursue any additional information that may have been missed in the online search process.

## Education Requirements

Since 2005, RNs in Ontario have been required to obtain a baccalaureate degree to meet the entry to practice requirements (Registered Nurses Association of Ontario [RNAO], 2018). According to Butcher and Mackinnon (2015), since the full implementation of baccalaureate education for entry to practice the province of Ontario has had an increase in RN shortages, which has led to greater expectations and utilization of RPNs in acute care settings. In 2002, the education requirements of RPNs changed from a certificate program ranging from 12 to18 months to a two-year diploma program offered at colleges (Lankshear et al., 2016). RNs receive a comprehensive education that has depth in critical thinking, clinical practice, research, and

theory (RNAO, 2018). RNs are knowledgeable in the application of nursing science principles to guide their clinical decision-making and judgment (Jackson t al., 2014). It is important to acknowledge that in Ontario “Registered Practical Nurse” is the title used for the RPN role, where other provinces and countries may refer to the role to as licensed practical nurses (LPNs) or licensed vocational nurses (LVNs). For this paper, the label "RPN" will be used throughout.

Due to war, short educational programs (approximately one year in length) were developed for nursing assistants and aides in the earlier part of the last century (Butcher & MacKinnon, 2015). These shortened educational programs were created as a temporary fix to make up for the shortage of RNs who had gone to war (World War I and World War II) (Butcher & MacKinnon, 2015). Once the wars ended, the nursing shortage remained and the programs were continued out of necessity (Butcher & MacKinnon, 2015). Nursing aides/assistants eventually were termed "practical nurses." They graduated faster and therefore entered the workforce more quickly than RNs. They also received less pay (Butcher & MacKinnon, 2015). From the last century onward, RPNs have continued to work when there have been RN shortages, with a primary focus on working within residential care facilities (Butcher & MacKinnon, 2015).

**Professional Identity**

Having a professional identity is part of nursing. It is taught in school and incorporated into councils, meetings, and the general workplace. Professional identity is relevant to nursing in the health care setting because it contributes to self-esteem and self-concept as an individual, which, in turn, affect retention (Johnson et al., 2012). Johnson et al. (2012) have written that "The link between professional identity formation and retention is yet to be fully evaluated by

the nursing profession; however, the logic is that a congruent professional identity may lead to a positive personal and professional image" (p. 564).

An article written by Dery et al. (2015) on role theory and the importance of defined roles discussed how one's functional perspective of predetermined behaviours and activities set forth for a designated role influences outcome of enacted scope of nursing practice. The implication is that having clearly defined characteristics and duties for a role allows an individual to understand the role. Role ambiguity or lack of identity contributes to decreased job satisfaction, interrelated work tension, lower organizational confidence, a sense of futility, increased absenteeism, and employee turnover as a result of a lack of value for individual roles (O' Brien-Pallas et al., 2010; Tarrant & Sabo, 2010). Role ambiguity is often present for new nurses that are starting their careers directly out of school; initial support provided by a preceptor for a designated orientation period is typically provided (Rush et al., 2013). Rush et al.'s (2013) integrative review of best practices of formal new graduate nurse transition programs found that orientation programs for new nurses could range from less than four weeks to more than three months with a preceptor. During this transitory period nurses are beginning to learn about their roles and defining characteristics while being fully immersed in the environment as a new professional.

**Nursing Scope of Practice**

Nursing scope of practice pertains to functions, actions, and procedures related to care that are legally authorized by a governing body (Ganz et al., 2016). The range of controlled acts that nurses may perform is based on education, competency, experience, training, laws, and regulatory bodies (Ganz et al., 2016). The position statement of the Canadian Nurses Association (CNA) (2011) on intraprofessional collaboration describes scope of practice as having defined

knowledge, competency, and skills that nurses are legislated and educated to perform as identified by regulatory bodies.

The CNO (2018) has created a fact sheet that outlines legislation and regulations in regard to nursing scope of practice. According to the Nursing Act of 1991,

> The practice of nursing is the promotion of health and assessment of, the provision of care for and the treatment of health conditions by supportive, preventative, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function. (p. 1)

In Ontario, the overarching profession of nursing is split into a general class, which consists of RNs and RPNs, and an extended class which consists of NPs (CNO, 2018). From my experience as a working RN and educator, I have observed that scope of practice is an area of discussion from the breakroom to the boardroom. The profession of nursing is complicated because of the overlapping of roles, lack of clear delineation of nursing roles in terms of technical skills, and the inability to articulate scope (Dewitt, 2009). In a recent literature review conducted by Feringa et al. (2018), they suggested that there are issues surrounding nursing scope in respect to nurses potentially working below scope, nurses working beyond scope, nurses having overlapping scopes, and nurses being deployed inappropriately. Feringa et al. (2018) have recommended that nurses need to have a good understanding of scope of practice and that nurses work at their scope of practice in regard to their training, education, and interest in order to remain competent. Additionally, Feringa et al. (2018) have recommended that legislation reflect the evolving role(s), which would give clarity to the expanding and changing nursing practice and scope, as

well as continue progression in the area of providing information regarding nursing scope of practice and nursing education.

Research conducted by Boblin et al. (2008) suggested that regulatory bodies and employers struggle in defining the similarities and differences between RNs and RPNs when deciding who should provide care for which patient. A 2010 study from Sydney, Australia, by Eagar et al. described reluctance toward teamwork, conflict, and lack of clarity for nursing scope of practice as issues that participants highlighted. Eagar et al. (2010) found that enrolled nurses (ENs), which are equivalent in Australia to RPNs/LPNs in Canada, felt frustration and despair surrounding their workload and scope of practice. There was discussion by ENs of pay disparities between RNs and ENs and a perception by ENs that there was no delineation of roles (Eagar et al., 2010).

The CNA has a position statement on staffing and delivery of safe nursing care. In this document, there is a decision-making framework for deciding who should be providing care for which client. The decision framework has the care provider, manager, or deciding leader examine three main components: the client, the competencies of the care provider, and the practice environment (CNA, 2003). In the CNA (2003) position statement, four key points are addressed and described as essential to safe nursing care:

> Decision-making is based on having the appropriate number of positions and the competencies required to ensure safe, competent and ethical care...Nurse administrators and managers (including supervisors, middle and senior managers) are responsible for ensuring the appropriate staff mix... Legislative, professional and organizational parameters are respected...The safety of clients must never be compromised by

> substituting less qualified workers when the competencies of a registered nurse are required. (p. 1)

The CNO's (2014) similar guideline, titled *RN and RPN Practice: The Client, the Nurse and the Environment*, was created in an effort to assist nurses and employers on the decision to utilize an RN or RPN for specific patient care. This practice guideline includes a three-factor framework through which one can assess the right care provider for the correct patient care provision based on complexity, predictability, and risk for negative outcomes (CNO, 2014). (Figures 4 and 5 contain the CNO's visual representation of the client continuum and the environmental continuum of care). This framework considers client factors, nurse factors, and environmental factors in care decision-making (CNO, 2014.) The increased complexity of medical issues and the dynamic nature of the care environment create a need for patient care by a skilled RN (CNO, 2014). However, since technical and cognitive components of care cannot be separated, care decisions are based on the most appropriate care provider, which also requires consideration of the cognitive and technical experiences of the RN and/or RPN (CNO, 2014). This is congruent with findings from Baumann et al. (2014), who discussed how nurses rely on one another's experience and expertise in a particular care area, rather than simply role designation and formal education.

In 2002, the CNO (2009) revised its professional standards for nurses and outlined more definite descriptors of the indicator section for RNs in regard to knowledge, knowledge application, and leadership. The CNO (2018) document, *Decisions about procedures and authority,* can be used in conjunction with practice standards in the form of a decision tree (see Figure 6), which details an algorithm for nurses to utilize in deciding whether they have sufficient skill, knowledge, and are competent to perform a task. Despite all of the available

decision-making tools, role confusion still remains; thus, leaving the challenge of determining the correct nursing role for specific client care. A reason that challenges exist in regard to eliminating role confusion and ambiguity is that the process for determining which of the nursing roles should provide patient care is not simply based on role classification/education but entails choosing the care provider who is best suited for the job. For example, an RPN who has worked on a patient care unit for 20 years and has experience performing multiple tasks may be much more competent than a new RN who has barely worked three months and has yet to develop the skills, competence, and confidence required. Taking this scenario into consideration gives insight into the complexity in choosing care providers who are most appropriate in a field with numerous overlapping skills. These role decisions are multifactorial and not necessarily easily defined. In a document created by the Registered Practical Nurses Association of Ontario (RPNAO) in 2014 entitled *It's all about synergies*, describes concerns surrounding how nursing practice for both RNs and RPNs in Ontario is not well understood, a problem that the RPNAO relates to a lack of clearly defined roles and the current lack of a concrete list of nursing skills, treatments, and procedures specific to the separate nursing roles. The RPNAO (2014) has suggested that there is much complexity in the decision-making process in regard to scope for RNs and RPNs, with the understanding that there exists a need for flexibility in the process. The vastness of nursing roles and abilities is dependent on not only education, but also knowledge, experience, competence, and the care environment, thus leaving flexibility for interpretation regarding the nurse, client, and environment.

**Role Clarity and Role Ambiguity**

In health care, multiple areas of shared scope environments exist. These areas simply do not exist in nursing but are also shared among the differing health care professions (CNA, 2011). The CNA (2011) acknowledges that it is essential to have a sound understanding of the scope of practice of nurses and of all health care professionals in order to promote role clarity and proper utilization of the correct professional for the required task. As described in the first chapter, role ambiguity is a lack of clear and accurate knowledge or understanding of others' and one's own expectation of roles (O' Brien-Pallas et al., 2010; Tarrant & Sabo, 2010).

Dery et al. (2015) has described role stress in nursing as attributable to role ambiguity and role conflict. In 2014, Oelke et al. published a study on evolving roles in primary care medical settings and found that role ambiguity was evident in all primary care networks in Alberta and that there was a lack of role clarity between RNs and LPNs. O' Brien-Pallas and colleagues (2010) pan-Canadian study on the impacts and determinants of nurse turnover reported that not only is ambiguity present between RNs and RPNs, but role confusion, role conflict and lack of understanding also spread to the interprofessional team and clients. Lankshear et al. (2016) have described role clarity as agreement on behaviours and role expectations and suggested that role ambiguity occurs when there is lack of clarity in behaviour or role from individuals or organizations. In Pryor's (2007) study of ambiguity in the rehabilitation setting, she found the presence of role blurring and uncertainty surrounding roles and that this presence led to ineffective utilization of the nursing team members in patient care. In a study completed by McGillis Hall (2003) that investigated nursing staff mix and outcomes, it was reported that regardless of the type of healthcare provider working with RNs in the care area, there continued to be perceived role ambiguity and role conflict (for example, but not

limited to a respiratory therapist and an RN with the running, monitoring of a ventilated patient, and or a physiotherapist and an RN or RPN in regard to rehab related activities), however that may in fact have come as a result of mergers and restructuring occurring at the time of her study.

**Collaboration and Teamwork**

Hastings and colleagues (2016) noted that interprofessional collaboration allows different professional groups to work together and incorporate knowledge into care. Part of the CNA's (2011) position statement on interprofessional collaboration reads, "Teams of health-care professionals working in collaboration will ensure that patients can access the most appropriate health-care provider at the right time and in the right place" (p. 1). Nova Scotia College of Nurses (2013) described intraprofessional collaboration as most often occurring among nursing professionals when consultation and information seeking are needed to increase the required knowledge and experience in a particular care setting. When there is a lack of communication and collaboration among the interprofessional and intraprofessional health care team, risk of patient harm is increased, satisfaction with care is decreased, and deficiencies and duplications in care occur (Hastings et al., 2016). Dewitt (2009) has written that misconceptions about scope of practice are barriers to effective collaboration. Education that incorporates and involves intraprofessional and interprofessional collaboration contributes to safe, quality patient care (Harper & Patsy, 2016). When there is a lack of role clarity in the workplace, it can contribute to decreased collaboration among the nursing care team (Moore & Prentice, 2015). Baumann et al. (2014) studied high-functioning nurse teams and found that teams that utilized experience, unique skillsets, nurse preferences, sharing of ideas, and common goals contributed to collaboration and teamwork.

**Recent Issues**

In late 2015 and early 2016, after Windsor Regional Hospital in southwestern Ontario commenced with the elimination of approximately 100 RN positions and moved forward with plans to introduce 80 RPNs to its facility, a backlash from both the public and the media took place. An article published on January 12, 2016 in The Windsor Star newspaper received a response from Linda Keirl, an RPN on the board of directors for the Registered Practical Nurses Association of Ontario, Oldcastle Region. In her rebuttal, she wrote that the article had suggested that RPNs are lower paid versions of RNs and that patients would be at a greater risk if cared for by RPNs, describing these comments as misinformed and counterproductive to building and creating positive working relationships between RNs and RPNs (Keirl, 2016). Furthermore, she emphasized the need to end the myths surrounding RN and RPN strain, the need for greater understanding about the differing roles, and more emphasis on how one role is no more important than the other.

In a media release from the Registered Nurses Association of Ontario (RNAO) in June 2017, Doris Grinspun, the RNAO's chief executive officer, blamed the government for the decrease in RNs in hospitals due to its emphasis on the financial bottom line. Grinspun conveyed that there is extensive evidence about the need for the expert RNs to provide complex care for clients (RNAO, 2017). Grinspun relayed that the replacement of RNs with less qualified health workers will lead to poor outcomes for clients and higher financial costs for the system in the end (RNAO, 2017). Grinspun’s commentary may have potentially contributed to nursing role conflict.

In March 2016, St. Joseph's Healthcare, which is a hospital in Hamilton Ontario, decided that it was going to replace RN positions with RPNs, which meant the removal of 60 RN positions and the addition of 38 RPNs (Frketich, 2016). Government cuts and financial strain were the cause of the modifications, though adding to the distress caused by the shuffle was the trial of incorporating the RPNs into the neonatal intensive care unit (NICU) (Frketich, 2016). St. Joseph's Healthcare Hamilton had planned to replace specialised, trained RNs with RPNs, with teams to consist of four RNs and one RPN (Frketich, 2016). Issues discussed in Frketich's (2016) news article pertained to the training and positioning of RPNs in a role for which they were not educated or trained. RPNs are trained and educated to work with stable and predictable patients, whereas RNs are trained to work with complex and unpredictable patients (Frketich, 2016). The NICU is a complex, unpredictable environment that may facilitate a skill mix of RNs and RPNs at times, but that can change in a matter of seconds, which would leave staff unsupported and patients at risk (Frketich, 2016). This phasing out of RNs and replacement with RPNs could potentially add to continued tension between the two nursing roles and create further misunderstanding of the differences and similarities of the two roles

**Summary**

The review of the literature suggests considerable role ambiguity between the RN and RPN roles, which contributes to lack of role clarity for those practicing nursing in the general class. Some research has been completed in the area of RNs working with unregulated health care professionals and collaborations between RNs and extended-class RNs. However, there is an apparent lack of research on the experiences of RNs and RPNs working together intraprofessionally and a lack of research on role ambiguity among RNs and RPNs working together, thus justifying my investigation (Feringa et al., 2018; Johnson et al., 2012).

# Chapter Three: Methodology

The methodology used in this research study is phenomenology, specifically hermeneutic phenomenology. This chapter initially discusses phenomenology in a broad sense, while the later section is specific to hermeneutics. This chapter also addresses the study sites, participant recruitment, the participants, the data collection process, the data analysis process, and study rigor.

## Phenomenology

Phenomenology is an umbrella term that includes both philosophical and research approaches and is essentially the study of lived experience (Van Manen, 1998). Phenomenology has strong philosophical underpinnings that rely deeply on the writings of Husserl, Heidegger, Dilthey, Aoki, Gadamer, Brentano, Levinas, Derrida, Blanchot, Sartre, and Merleau-Ponty (Creswell & Poth, 2018; J. Engel, personal communication, May 22, 2018; Van Manen, 1998). According to Creswell and Poth (2018), phenomenology is a common method used for research in the fields of health science, nursing, sociology, psychology, and education. The beginnings of phenomenological research stem from Edmund Husserl, who is often referred to as the father of phenomenology (Kafle, 2011). Husserl's initial work was mathematically focused until he became interested in philosophy and became a student under Franz Brentano, where he developed his ideas on subjective focus (Kafle, 2011; Laverty, 2003). Husserl's fascination with the phenomenological method was related to its promise of a new science of being, within which one reaches through meanings to penetrate reality more deeply (Laverty, 2003).

Phenomenology attempts to ask what one's experience is like for the purpose of enlightening and clarifying the appearance of phenomena or the meaning that phenomena have

in everyday life experience. Van Manen (1998) has described the phenomenological method as a response to how individuals orient themselves to a lived experience while at the same time questioning the way in which individuals experience a phenomenon. Phenomenology is not simply the retelling of someone's story but is in fact the act of interpreting and immersing one's self into the experience that is lived. Phenomenology is the chosen method when the researcher is interested in interpreting or describing the lived experience of a particular phenomenon that participants have in common, thereby articulating meaning of the phenomenon under investigation (Creswell & Poth, 2018; Laverty, 2003).

**Hermeneutic Phenomenology**

Hermeneutic phenomenology stems from the work of Martin Heidegger, a pupil of Husserl's who had the goal of unveiling the world through the experiences of those who are telling life world stories (Kafle, 2011). Van Manen (1998) has described hermeneutic phenomenology primarily as a philosophically underpinned method for questioning a particular phenomenon rather than specifically examining or drawing out answers in regard to the particular experience. Through research conversations, discovering and finding new and uncharted treasures is a possibility. Questions in the conversational interviews allow for exploration, newfound data, openings, insights, and understandings that the researcher and participant may have and have yet to discover or explore. Conversation leads to perceptions and meanings of the experienced phenomena.

Thirsk and Clark (2017) suggest that through the everyday experiences of the participants we, as researchers, learn about the thing or phenomenon under study. The goal of phenomenology is not to dwell on the subjective experiences of individual participants but rather

to articulate the thing or phenomenon itself through the lenses of the participants' experiences (Thirsk & Clark, 2017). The researcher's pre-understandings of the phenomenon enable a deeper delve into these experiences, while a balance is struck between what is already known by the researcher and what can or will be learned. Unlike descriptive phenomenology, where the aim is the articulation of essence or what cannot be reduced further, the emphasis on meaning and interpretation enables contradictory findings in hermeneutic phenomenology to emerge during the research. This acknowledges the understanding of the researcher that there can be multiple views and complexities associated with a phenomenon (Thirsk & Clark, 2017).

Kafle (2011) has described hermeneutic phenomenology as void of a systematic method. The only guidelines are the active relationship of six research activities. First, the researcher needs a commitment to an abiding concern (Kafle, 2011; Van Manen, 1998). Second, the researcher should have an interest in the phenomenon under study (Kafle, 2011; Van Manen, 1998). Third, the phenomenon under investigation must be an experience that has been lived by the participant (Kafle, 2011; Van Manen, 1998). The fourth activity is the creative undertaking of describing the phenomenon by means of writing and rewriting by the researcher (Kafle, 2011; Van Manen, 1998). The fifth activity is to remain oriented toward and resilient with the phenomenon under investigation and with the sixth activity the researcher needs to consider the many facets of the phenomenon in its entirety (Kafle, 2011; Van Manen, 1998).

After the preliminary literature review it was clear that there was little research on the phenomenon of the experience of RNs and RPNs working in an intraprofessional setting. I conducted research using hermeneutic phenomenology because it allows for in-depth articulation on a phenomenon as potentially complex as a shared scope environment, from the perspectives of those who have lived the experience. My own experience with intraprofessional nursing led

me to wonder about this phenomenon and provided what writers such as Thirsk and Clark suggest (2017) is a foundation for hermeneutic phenomenological inquiry. Thirsk and Clark (2017) write that the researcher's personal experience with the phenomenon is an asset to understanding the participant's experience with the phenomenon.

> Understanding a complex intervention requires researchers to incorporate their personal reflections in analysis of data—drawing on their hunches, disciplinary background, and theoretical and substantive knowledge rather than dismissing such contributions as being biased. Previous experience and understanding of a topic does not prevent a researcher from being open to new understanding of the topic but is an asset that enables the researcher to be better prepared for understanding. (p. 5)

Hermeneutic phenomenology enabled me, as the researcher, to gain a better understanding of the phenomenon and to gain insight into the phenomenon of nurses working in a shared scope setting.

**Participant Recruitment**

For this study, purposeful sampling was used. Purposeful sampling involves selection of participants who have information about or experience with a particular phenomenon in which the researcher is interested. Therefore, participants must be experts in the phenomenon under investigation (Glesne, 2016). To obtain participants who were experts in the phenomenon under study, I required the participants to meet the following requirements:

1. A participant needed to be currently working as an RPN or RN.

2. A participant needed to be currently working in an intraprofessional care area (a care area where both RNs and RPNs practice).
3. A participant needed to have been working in a mixed scope care area (an area where both RNs and RPNs work) for a minimum of six months.

Participants were recruited by means of a recruitment flyer (Appendix A) and a Facebook post (Appendix B). Recruitment flyers were placed on bulletin boards in nursing stations and staff rooms in six acute care units at a community hospital in southern Ontario in the beginning of February 2019. A Facebook post of the recruitment flyer was posted on my personal Facebook page, which was made shareable to the public. The Facebook post was posted in early February 2019 and remained posted until the recruitment process was complete, which was near the end of March 2019. Initially, the intent was to conduct 15-minute information sessions at the proposed research site to provide possible participants with information about the study. During the information sessions, I would have provided coffee and donuts as a thank you for allowing my presence and disrupting the workflow; however, the initial participant recruitment site declined the sessions, allowing only the posting of recruitment flyers.

Once a participant base was formed, enrolled participants were able to refer additional participants to the study if they desired, a technique of participant gathering called snowball sampling (Jones et al., 2014). The snowball sampling technique refers to the creation of a rolled snowball that initially starts off small but gains in size as it travels and spreads across the "yard," or in this case participants (Jones et al., 2014). Once a conversational interview was completed with a participant, the participant was offered a nomination letter that they could share with other potential participants if they so desired. If a non-participant (someone that did not participate in the study) requested a nomination letter for an interested person, the non-participant would have

also been sent the letter. However, no participant or non-participant requested the nomination letter (Appendix C). I initially anticipated that I would need six to eight participants to find repetition in the conversational data (Van Manen, 1998), and in the end I had a total of nine participants.

Initially, the goal was to recruit all the study participants from one hospital site. However, when initial recruitment began, this did not happen. With the initial recruitment site, responses were received from three study candidates, thus creating the need to expand recruitment, which led to the Facebook post. Participants in this study all met the inclusion criteria, but they did not all work at the same hospital. Participants worked at six hospitals in Ontario, Canada. The shared scope care areas where participants worked varied and included the emergency department, surgical floors, general medicine, palliative care, spine care, and endocrinology. The variation in location and department generated insights into the experiences that were shared, especially for evidence that spanned multiple locations and care areas. Participants were recruited into the study until repetition had occurred in the information being shared, and not new information was being brought forth during the conversations.

Once a study candidate had shown interest in participating in the study, the candidate was given the choice of where the candidate would feel most comfortable having the conversational interview. Participants were offered locations, such as a coffee shop, the library, a diner, or the hospital, and they could also select a telephone interview. With this style of data collection, where the conversations take place is not always important, in this particular study did not involve field observation (Jones et. al, 2014). My goal with the participant conversations was to allow for a relaxed, mutually agreed upon setting that was devoid of harm. Potential harm could have been perceived fear or anxiety related to reprimand from coworkers if conversations were

overheard at or near a workplace setting. Participant comfort and safety were and are greatly valued, and, as the researcher, my goal was to provide and maintain a private environment that allowed for ease of interaction. I also had generalized concern for my own personal safety. It was important that I also felt safe and comfortable in the location where the interviews took place. While face-to-face research conversations were initially proposed, all participants declined face-to-face conversations in preference for telephone conversations. Having telephone conversations created less need for worry about my physical safety or the safety of my participants because all of the conversational interviews were held over the telephone at the request of each participant. There was still the potential for harm if a participant was overheard on the telephone, as the conversation could potentially be reported or used in some form to cause harm to the participants. Participants were reminded that confidentiality could not be guaranteed because I did not have control of their environment (refer to Appendix D for the letter of information and consent).

**Study Site**

Access to the initial recruitment site was gained through my insider status with one hospital in Ontario. Since I was doing research with nurses, about a nursing experience that I had experienced, I had insider status. An individual with insider status is one who is already involved in, related to, works with, or has established connections in the area where research may occur (Glesne, 2016; Jones et al., 2014). I was familiar with the work climate of the health institution, I had a pre-existing rapport with the staff throughout the institution, and I often had contact with administrators within the institution. These avenues assisted with the process of gaining access to participants at the initial research site. According to Glesne (2016) this research is considered "backyard research." It should be noted that I do not work in an area that has intraprofessional

collaboration because of the acuity of my care area and that the nurses who participated in my study were from units other than my own with whom I did not have pre-existing relationships. This eliminated the issue of potential coercion because the participants did not have any previously relationship with me and should not have felt pressure or obligation to participate in the study. Participants were also informed that in the letter of information and consent that participation was voluntary and that withdrawal from the study would in no way affect their employment or any other work-related or professional status (Appendix D).

The process of participant recruitment started immediately following the approval of my thesis proposal, with applications sent to both the Brock University Ethics Review Board (Appendix E) and the hospital ethics review board (Appendix F). To maximize my time, impending deadlines, and visibility, I sought additional approval to post my research flyer on Facebook. I then resubmitted my application to the Brock University Ethics Review Board and was given approval on February 2, 2019 to share my flyer on Facebook with notes (Appendix G for amended clearance from Brock University).

**Data Collection**

In hermeneutic phenomenology, the primary interest is everyday life as experienced by others (Leonard, 1994). Human perceptions become written words, which are then studied and interpreted in order to discover meaning (Leonard, 1994). These life meanings are hidden because they are often taken for granted and go unnoticed in the everydayness of life (Leonard, 1994). In hermeneutic phenomenology, data can be collected from a variety of sources, including interviews, diaries, and stories through which everyday experiences of the phenomenon are recounted (Leonard, 1994). Although everyday lived experience is often taken for granted,

through the process of reflection, the researcher achieves insight into the lived world (Leonard, 1994) of others and of themselves.

For this research study, I conducted conversational interviews for the data collection process as it aligned with the methodology of hermeneutic phenomenology through the act of co-creation. New knowledge is not able to fully emerge if old knowledge is not questioned, thus requiring the researcher to be open and inquisitive (Guzys et al., 2015). For this study, co-creation occurred through conversational interviewing and open discussion with participants, through which various perceptions and meanings of shared scope environments emerged. Flood (2010) wrote that co-creation is the result of meaning creating between the researched and the researcher, rather then simply doe the purpose of fulfilling an agenda or factors which work to influence descriptions. Laverty (2003) cites Gadamer (1960/1998) as understanding co-creation in hermeneutics is realized between the researcher and participant, when meaning is found through reading, writing reflectively and interpretations. Laverty cites van Manen (1997) whom found the act of writing to force the writer to develop a "reflective attitude", causing them to write in a "deeply collective" manner. Co-creation continued throughout the research process through reflexive journaling and through analysis of the transcripts of the conversations with the participants, which allowed me to be able to understand and interpret the phenomenon in different ways.

Conversational interviewing is a free-flowing, non-conforming interview style (Lavrakas, 2008). Van Manen (1998) has described the art of hermeneutic conversations as the ability to maintain openness and to keep the interviewer and researcher oriented to the topic under discussion, which is the experience of the phenomenon.

This style of interviewing the participant is more closely similar to a conversation one might have with a colleague or a friend, where guiding questions are utilized to give direction to the interview, but not to inhibit its growth and movement (Lavrakas, 2008). As compared with descriptive phenomenology, hermeneutic phenomenology actively acknowledges the researcher's position in the interpretive process as a co-participant (Laverty, 2003). As a co-participant, the researcher actively constructs meaning from the experiences of the participants (Laverty, 2003). Member checking was not used in this study and will be discussed in the study rigor section of this paper.

Hermeneutic phenomenological interviewing has two main purposes. Stylistically, the researcher asks the participants to be explicit and concrete in their description of the experience at hand, this was done by asking clarifying and probing questions throughout the conversations (Van Manen, 1998). As Van Manen (1998) has suggested, I also allowed for conversational pauses and silences, probed deeper into stories by asking for explanations and greater details about the experience, and at times asked a new question when the participant veered within the conversation. During the conversational interviewing process, I remained aware of participants' tonality, pace and language use as these factors provide insight into the meanings and significance of what is being shared in the conversation. Conversational interviews can be both intense and in-depth. They allow the researcher and participant to be led by the topic, rather than by the question (Jones et al., 2014).

When I conducted the conversational interviews, although I used a set of predetermined guiding questions surrounding the topic, the interviews were conversations and often took their own path (Appendix H). The purpose of the conversational interviews was for both the participant and me to gain an understanding about the phenomenon or experience. This process

of expanding and clarifying allowed the participants and me to be co-researchers during the conversations, with both of us shaping the discussion and co-constructing (Jones et al., 2014) the experience. All conversations were digitally recorded, and I took handwritten notes in regard to what was being discussed in an effort to expand upon topics brought up by the participant and to further explore the meaning behind certain words, phrases, and stories (Appendix I). To ensure that I was able to maintain the same format from interview to interview, I completed an audit trail. An audit trail is a report of the research steps and process from the beginning through development to the reporting of findings (Jones et al., 2014). Maintaining a consistent interview format and setup allowed for consistency in the interviewing process from participant to participant. Each participant was informed that the entirety of the telephone conversation would be recorded prior to the start of recording. Consent was obtained over the telephone after I had read the letter of information and consent aloud to the potential participant. Once consent was obtained, this was acknowledged on the consent form and dated. The signed consent form was then returned to the individual folder created for the participant.

In preparation for the interviewing process, it was determined that if a participant became upset and wanted to end the interview, I would comply with the wishes of the participant and refer the participant to support services.

**The Participants**

Initially, I was unsure how the participants would find their way to my research. Finally, someone contacted me indicating an interest in participating, followed by another person and then another. As previously mentioned, I had a total of nine participants. The nine participant

conversations provided an abundance of stories and anecdotes, easily leading to repetition in the experiences of the participants (Jones et al., 2014).

With the nine individual participants, there was variation in age, education, gender, and current work environment, what was important for all the participants was the shared experience of working in a dual-scope nursing environment. In this study, there were eight females and one male, with their nursing experience ranging from 5 to 45 years. There were four RNs and five RPNs, with interviews lasting between 23 minutes and 68 minutes in length. The average conversation length was approximately 40 minutes.

Each participant was initially assigned a number, such as Nurse 01, and these were later changed to a non-gendered pseudonym picked at random from a list of non-gender-specific names. This was done to protect the anonymity of each participant. For each participant, I created a specific folder that was labeled only by their pseudonym.

Throughout the research process, great effort was made to ensure that data was collected with both privacy and confidentiality and that participants who entered the study remained anonymous. I have maintained the privacy of the collected data by keeping all records in a locked cabinet in my office, for which I alone possess the key. All recordings were collected on my laptop, which is password protected and only accessible by me.

## Participant Descriptions

### *Taylor*

Taylor is an RN who began nursing outside of Canada and was educated internationally. Taylor came to Canada in 2007, began a nursing career as an RPN while concurrently attending

a bridging program (a university or college affiliated with a university nursing program that educates RPNs to become RNs), and subsequently graduated as an RN. Taylor is currently in a master's degree program and decided to participate in the study because Taylor indicated the need to support a fellow student. Taylor has worked in the field of nursing for 12 years and is currently working on a neurology, nephrology, and endocrinology floor.

***Riley***

Riley is an RPN who graduated from nursing school in the 2000's and has worked on an orthopaedic and spine unit for the last five years. Currently, Riley is enrolled in an RPN-to-RN bridging program. Riley contacted me after seeing my post on Facebook and decided to participate. Riley offered the perspective of an RPN and RN student.

***Morgan***

Morgan is an RN who graduated from a diploma nursing program in the 2000's and has no plan to upgrade to a nursing degree. Morgan contacted me to participate in the study after seeing my post on Facebook. Morgan has been working as an RN for 18 years on an orthopaedic and spine unit. Morgan has worked on the same unit for all 18 years and has worked through many organizational nursing model restructurings.

***Julian***

Julian is an RPN who graduated in the 2000's. Prior to being an RPN, Julian worked as a personal support worker. Julian is currently enrolled in an RPN-to-RN bridging program. Julian has been accepted into a master's degree program that will start in the fall. Currently, Julian has worked as an RPN on a palliative care floor for the past five years. Julian is also completing a

student placement in an RN bridging program on an acute care unit. Julian contacted me to participate in this study after seeing my recruitment flyer and sent me a text message.

### *Hunter*

Hunter is an RN who graduated from nursing school in the 1990's. Hunter has a Bachelor of Science in Nursing degree and has had a varied career. Currently, Hunter is working in the emergency department in a community hospital. Hunter contacted me to participate in this study after seeing my recruitment flyer and sent me a text message.

### *Frances*

Frances has been an RPN since the 2000's. Currently, Frances is working in the emergency department in a community hospital and is enrolled in an RPN-to-RN bridging program. Frances contacted me to participate in the study via email from my recruitment flyer.

### *Avery*

Avery is an RPN who originally completed an RN assistant certificate program from the Ontario government in the 1970's. By default, Avery became an RPN in the 1980s and has completed many upgrading courses, such as medication administration, wound care, intravenous therapy, and others. Avery currently works on a complex continuing care floor and primary care medical/surgical floor in a community hospital. Avery contacted me via text message after reading my Facebook post.

### *Cameron*

Cameron is an RN who graduated in the 2000's with a Bachelor of Science in Nursing. Currently, Cameron is working on a pre- and post-operative surgical unit. Cameron has worked on a surgical unit in a community hospital since 2003. Cameron contacted me via text message after reading my recruitment flyer.

### *Dana*

Dana is an RPN who graduated from nursing school in the 2000's. Currently, Dana is enrolled in an RPN-to-RN bridging program and is working on a surgical floor in a community hospital. Dana saw my recruitment flyer and contacted me via text message to participate in the study.

## Data Analysis and Representation

Van Manen (1998) suggests that there are generally three phases in which the researcher works to isolate themes. First, there is the holistic, or what is called the "sententious," approach. In this initial phase, the researcher reads the text as a whole and asks what sententious phrases capture meaning and significance from the text in its entirety (Van Manen, 1998). In the second phase, a selective approach is used in which the researcher reads or listens to the text several times, attempting to uncover or find statements, phrases, and essentials specific to the phenomena under study. These statements are then circled, underlined, or highlighted by the researcher (Van Manen, 1998). The third phase of isolating thematic statements entails a detailed line-by-line approach to the data, where the researcher completes a detailed reading, looking at

every sentence cluster in detail and asking what these sentences or clusters reveal (Van Manen, 1998).

I followed a process of analysis similar to that of Van Manen (1998) by first taking a sententious approach in reviewing the text as a whole. Next, I used a selective approach where I read the texts over and over and identified, circled, highlighted, underlined, and took notes of the statements being read (Van Manen, 1998). Finally, I engaged in detailed reading, where I considered what had been revealed from the entirety of the texts. The data was analysed throughout the research process. In hermeneutic phenomenology, the researcher is interested in allowing the reader to form their own conclusions (Van Manen, 1998). My data is displayed within the study through direct quotes from the participants and through interpretations; this provides rationale for the themes that developed from the analysis process (Van Manen, 1998).

**Study Rigor**

In qualitative research, the term "trustworthiness" is used to describe the paradigmatic means by which a study is assessed to ensure high quality or goodness, otherwise known as "study rigor" (Jones et al., 2014). Rashotte and Jensen (2007) discuss challenges in their article in relation to hermeneutic phenomenological research, causing one to stop and query: how do we as researchers give honor to the stories told by participants?

> How can we do justice to stories about what has happened to particular participants at a particular time and place? Whose voice should be heard in the analysis and writing when new understandings come into the clearing? How can we preserve the diversity and character of our topic without reducing them to sameness? (Rashotte & Jensen, 2007 p. 96)

For this research study, my attempt to give validity to the research was through the criterion of credibility and plausibility. Credibility and plausibility are related to validity or truth in how the researcher presents the phenomenon (Jones et al., 2014).

> Doing this type of research means that events and lives are affirmed as being worth telling and thus worth living and serves as a form of moral education. Asking others to tell about their lived experiences implies value, attributes reality, and confers affirmation of choice on both the individual(s) and the communities of which they are a part. (Rashoote & Jensen, 2007 p.102)

The term "credibility" refers to how the researcher can ensure rigor and articulate how it is achieved (Morse, 2015). The credibility of my study is demonstrated by the utilization of peer and expert reviews and the richness of the data after redundancy and repetition were found within the data collection process (Creswell & Poth, 2018; Sparkes & Smith, 2014). Peer review was utilized as a trustworthiness strategy (Glesne, 2016). I shared and discussed interpretations and rudimentary themes on the phenomenon under investigation with my supervisor and my supervisory committee, all of whom are experts in various forms of qualitative research. My supervisory committee provided guidance, feedback, and revision suggestions that both guided and challenged my process, thinking, and skill. Credibility achieves trustworthiness by the use of others to confirm findings.

The term “plausibility” aims to address whether findings can be true given the available knowledge (Jones et al., 2014). According to Thirsk and Clark (2017) accurately portraying the world of the participant is not necessary, because the aim with hermeneutic phenomenology is to articulate the phenomena under study. It is essential, as the researcher, to have a deep understanding that there is never only one truth and that the truth discovered through

interpretation is plausible. This plausibility is shown through reflexive journaling and the representation of participant quotations so that the reader is able to also make further interpretation from the participant quotations (Jones et al., 2014), as well as to understand the processes by which the researcher arrived at interpretation. Plausibility achieves trustworthiness by seeking to address that findings are true with the given knowledge.

The following trustworthiness techniques were used to examine the rigor of my study: displaying direct quotations from participants, bridling, memos, audit trail, ethics approval, and peer review (Jones et al., 2014). In the phenomenological method, the researcher begins the research with the process of pre-reflection (Creswell & Poth, 2018). For this study, I used a trustworthiness technique called bridling as a method of being reflexive throughout my research process. The term "bridling" was coined by Swedish researcher Karin Dahlberg (2008) to describe what phenomenological researchers should do with their assumptions and pre-understandings of a phenomenon. The goal of bridling is to acknowledge, reflect on, and understand one's assumptions as a researcher of a phenomenon. With awareness of one's assumptions and preconceived notions, one can pull back from or loosen assumptions when needed to further understand what is given in the experiences and meanings shared by participants. One can never completely remove oneself from the phenomena under study, but by bridling, the researcher has some control over their influence and can remain aware of the preconceived notions and understandings in an effort to not influence the conversation. Bridling makes the researcher examine assumptions, biases, and notions while allowing the presence and acknowledgment of thoughts and ideas through reflexive questioning. Ellett (2011), in reference to Dahlberg, Dahlberg, and Nystrom (2008) to explain the process of bridling, suggests that one bridles in order to allow restraint of one's pre-understanding, such as personal beliefs, thoughts,

theories, and assumptions that may mislead and limit the researcher. Bridling is also about understanding the whole of the phenomenon and not simply what was previously understood. By examining a phenomenon in its wholeness, one can restrain oneself from understanding too quickly and carelessly (Ellett, 2011). Bridling requires an open and alert attitude; the researcher waits for the phenomenon to display itself in the relationship and looks forward rather than backward, which allows the phenomenon to present itself through the art of reflexivity and questioning throughout the entirety of the research process (Ellett, 2011). Ellett (2011) has given an example of bridling:

> What does it mean to bridle, to truly bridle? I know it is different from bracketing in that we not only look back- but forward. We put aside our assumptions, first guesses to continue questioning. But what if we come back around to where we first began? Why even go through this process- this questioning? Does it bring clarity or, as I sometimes find- more confusion? I have a difficult time focusing in on one thing; my mind has a tendency to wonder and to wander. I am very curious- always have been, probably always will; it's gotten me in trouble many times. It seems that I do not come to a conclusion when I bridle...is this what was intended? Dahlberg (2008) tells us the "the things themselves … are always something more than what meets the eye" (p. 121). The core of "phenomenology, hermeneutics and lifeworld research" is an openness to the things themselves which "means to not make definite what is indefinite" (p.121–22). She speaks of bridling as a way of not imposing ourselves on things—"we do not make definite what is indefinite" (p. 121). When I bridle, am I keeping things indefinite and is this a good thing? Don't

> we need to come to a conclusion, an end? Is it good, is it healthy to keep questioning and not settle? (Ellett, 2011 p. 6)

In addition to bridling, through reflexive journaling and note taking, I engaged in memo writing throughout my study process, which involved writing down questions, thoughts, discoveries, feeling, ideas, and assumptions that I ascertained throughout the research process (Jones et al., 2014; Glesne, 2016). I used memo writing and reflexive journaling to keep track of my thought patterns, discoveries, changes, and process. A reflexive journal is a working document that a researcher uses to reflect on the experience and process of the research and to build, expand, and question personal thoughts and assumptions that may have been discovered through the process of memo writing (Jones et al., 2014). Refer to Appendix I for memo writing and examples of reflexive journaling.

An audit trail is a trustworthiness strategy whereby the researcher creates a continuous internal review of processes that occurred during the research to allow the researcher to replicate any condition or procedures as desired (Guest et al., 2012). As mentioned earlier in this chapter, the audit trail was completed by means of notetaking and documenting the research process, allowing for transparency (Guest et al., 2012). Within this study, quotes and interpretations are displayed, allowing the reader to understand the basis for the researcher's interpretations.

Thirsk and Clark (2007) refer to Gadamer when looking at the idea of using member checking with participants as a trustworthiness strategy. Member checking is when a researcher takes interpretations or drafts of research to a participant(s) to gather their opinion on whether the researcher has effectively captured the participant’s voice (Jones et al., 2014). For this study I did not use member checking. Although participants may have experienced the same

phenomena, they may not have experienced it in the same way (Thirsk & Clark, 2017). Member checking can be problematic as participants may not recognize their individual subjective experience among the many experiences in a study, thus leading to possible lack of identity of the interpretations of the experience (Thirsk & Clark, 2017).

Ethics review board approval was sought and received prior to study commencement. Approval was sought and received from both the Brock University Ethics Review Board and the ethics review board of the hospital from which participants were recruited.

**Summary**

This chapter has provided a detailed description and rationale of the methods used in my research project. In this chapter, I have discussed phenomenology, hermeneutic phenomenology, the research site, participant recruitment techniques, the participants, data collection procedures, data analysis, data representation, and study rigor.

# Chapter 4: The Findings

Theme development is an in-depth process that involves an artful extraction of the overall context of discussions (Braun & Clark, 2006). To bring life to the stories of the participants, I spent many days reviewing, reading and reliving the conversations that I had with the participants, so much so that I could hear their voices in my head as I read and reread their stories. The purpose of this study was to explore the lived experience of nurses working in an intraprofessional nursing scope environment in an acute care hospital setting. The main research question was: What is the perceived experience of registered nurses and registered practical nurses working together in an intraprofessional work environment in an acute care hospital setting? The secondary question was: How has the experience shaped your role as a nurse? This sub question was asked to all of the participants during their conversational interview. The question was meant as introspective and for the reader of this study to draw their own conclusions on how the experience of intraprofessional nursing could or does shape ones role as a nurse. The findings presented resulted from the analysis of the conversations with the nine participants, who are currently working in a shared scope nursing environment. Two overarching themes emerged during thematic analysis: The Dance and The Fissure. In this chapter, the findings will be presented, followed by a summary.

## The Dance

A common thread that I discovered throughout the interviews was the presence of comradery and collaboration. There was this almost dance-like teamwork of partnership that many of the participants described. How do you dance with another? It is a movement, shared and exchanged through interpretation and instinct, or through guidance and steps. It can be a

predictable exchange of assigned duties. It can be elegant and assured or it can be sporadic and disjointed, and there are times when the lead and partner roles are required to change.

When speaking about the rewards and challenges of this dance, Avery (RPN) viewed RNs and RPNs as a team, whose rhythm and exchange of movements benefit the team by working together, supporting one another, and providing care together. “We work together for the care of a patient.”

Dancing, like nursing, often follows pattern and process in which each partner has a role and they collaborate. The term “collaboration” came up often in reference to how RNs and RPNs supported one another and worked together. Frances (RPN) shared how the collaboration between an RN and RPN can occur in patient care. The reliance on one another to provide the appropriate level of care is evident in this type of patient care experience.

> If a patient is not in my scope of practice [but they are assigned to me as an RPN], I can collaborate with an RN to help do things, but I would be primarily responsible for the patient. So, your patient is still on a monitor, but you are still the nurse [RPN] and now the RN is going to be responsible for the monitor, so that's when collaboration comes in.

Collaboration between RNs and RPNs was part of Morgan's (RN) experience of working in the shared scope environment. Morgan talked about being partnered with an RPN.

> You're helping each other out; it's just like I need help with my patients and they [RPN] need help with their patients…and if their patient is crashing, I take over.

This constant ebb and flow of care reverberated throughout the experiences that the nurses shared. Collaboration was expressed as an almost reflexive response; an exchanging of roles and duties completed in a symbiotic fashion by the nurses on the unit.

In addition to the exchange of roles and patient care, support was provided by nurses to one another in other ways. Cameron (RN) talked about how support meant growth and benefit to the patient care team.

> I feel that we do help one another with both growth and development. I think that we have a large group of nurses that are RPNs and it seems like they have been studying forever to get their RN [degree]….Watching them come to the floor and have pre-grads sharing stories of their experiences, all of which in time will lead back to our hospital and lead back to our floor. You know, helping them (RPNs who are studying) along the process…So, those are some positive things and I like to see their growth.

For Cameron, the perception of nurses working hard to improve their education and learn from one another was not simply something felt as a personal goal or achievement, but also an achievement for the hospital environment, the patients and the healthcare team.

There was a sense of pride in many of the conversations. In the conversation I had with Taylor (RN) about interactions between RNs and RPNs, it emerged that having pride in one's work led to respect among the nurses working together.

> There is so much respect for each other. Every RPN and RN have pride in what they do. When they know that a skill is something that is beyond their scope, they easily communicate that to another nurse or to the RN. They might say, ‘I'm not very sure about

> this. Maybe you can help me figure this out' or, 'if you were to do this, how would you?' And I think there is a very good relationship amongst us. It is something that I really like about my unit.

Taylor's experience of working in a shared scope nursing environment has led to open communication and the sharing of ideas and skills, contributing to teamwork and collaboration, and, in turn, benefitting the work environment.

Riley (RPN) mentioned the ease of communication between the two types of nurses and the ability to express the need for help; for Riley, being able to ask for help was "positive" in the workplace.

> I see a positive type of challenge in the workplace, like if you're having a difficult time with your patient or something and you ask for help, and maybe an RN can take over, and they are usually willing to.

Riley suggested that when one had a challenging patient care assignment and help from an RN was required, the ability to get help, request assistance or hand over the patient assignment occurred with relative ease, like that of a practiced dance, in which the dancers are comfortable with each other's moves and expectations. On Taylor and Riley's care units, the teamwork and collaboration between the RNs and RPNs resulted in a comfortable shared scope environment. Dana (RPN) added about this process of shared care, or the dance.

> If the [patient needs] are too complex for the scope of the RPN, then they can be reassigned, or you can work side by side with an RN on your shift to make sure that everything is okay. So, if I am assigned to a patient [who required care that was beyond

> my scope], I would let the RN know about the patient. I would keep the patient. I'd let them [the RN] know that I have medications that I cannot administer, and they would just help me out. And I would be there most of time, learning something new.

For Dana, teamwork was important for skillful practice. She described being able to ask for help and guidance when it was needed from a fellow nurse, while at the same time acquiring knowledge and gaining experience. This sharing of skills and knowledge in the work environment meant that there was an easy rhythmicity, in which there was awareness of ideas, help, and experience, but not necessarily of position or regulatory status. Hunter (RN) spoke about the experience of being an RN working with RPNs.

> It is just like talking to peers. I don't think it [the nursing role] comes up in conversation all that frequently. Who is, or what is an RN or RPN?

Hunter further suggested that it was often not known which care provider was an RN or RPN at first glance, except for when one was asked to dispense certain medications, such as Morphine or Lasix, through a rapid intravenous bolus.

Within this theme, there was the presence of mutual respect between those who filled the two types of nursing roles. There were moments of encouragement and there were times when patient care required someone in a different nursing role. This collaboration was accomplished with the flexibility and knowledge that professional nurses possess. This reliance on one another was felt in the many shared examples of teamwork, respect, collaboration and encouragement.

**The Fissure**

The concept of division is concrete. It is a fissure in the ground or in the side of a volcano. With nursing, the divide is not always so easily seen. What can happen is that on the surface there appears to be only a crack or a small opening, but this separation runs deep into the ground, resulting from an underlying rift caused by pulling and tension. What is left is an apparent cleft in the surface which has the potential to expand. Participants' lived experiences of the divide and challenges were often mentioned in the conversations; there was discussion of nursing roles, role substitution, role clarity, role inconsistencies between organizations, the changing RPN role and differing policies regarding scope at healthcare institutions.

Role substitution was a common thread throughout the conversations. Both Julian (RPN) and Avery (RPN) spoke of times when there was not an RN available to fill the RN role on their units and an RPN was assigned for the shift to replace the RN. They further indicated that if an RPN was not available, the unit charge nurse or manager would assign a PSW to replace the RPN line for the shift. Julian described the negative aspects of this substitution and how it compromised professional identity.

> It makes it [the work environment] confusing, toxic, stressful because it's basically saying, ‘I only need you when I don't have anybody else. Then I can factor you in.’ and I won't even get into the fact that when there's no RPN we are getting a PSW, because that is something that is not even registered.

Healthcare institutions staffing units with RPNs instead of RNs when RNs were not available was something that the participants felt caused confusion and resentment, making them feel as though they were replaceable and perhaps at risk of losing their positions. As Julian spoke about

the practice of substitution and its impact, it was in a rapid, staccato voice. ‘just shake my head in disbelief.’ Avery (RPN) discussed role substitution.

> Last night I worked as an RN, so I didn't work as an RN (Avery, who is an RPN replaced the scheduled RN). I worked as myself, as an RPN, and I went and got help. So, when a patient becomes critical, I can't look after them. I get worried about the patient and I phone the doctor and then I leave the ward and go over to the ICU to ask the RN to come and help, get the IVs going and stuff, and then monitor the patient on the ward. So, what's happened in the last little while is they can't find staff, so they just to put a body there. They bring in an RPN. They can't find staff. Nowhere. We are short-staffed. Big time.

Avery (RPN) shared the experience of how the changes implemented by government over the years had affected work morale and culture. Avery specifically addressed the experience of working as a nurse in the 1990s, using the term ‘Bob Rae days’, in reference to governmental changes made to the healthcare system and to nursing that were disruptive and contentious.

> Let's go back to 1992. Great days [sarcastically, implying that the work environment was in fact not great]. We lost our paediatric wing; we lost a lot of RNs. Okay. At that time, they were very, very angry because they lost their jobs. So, we went through hell with those girls. I understood. They felt dread and everything else. Everything started changing, right, and we were educating ourselves, keeping ourselves up to date. These girls [RNs] always felt that there was a place for us, but it was not to do their jobs. I still work with some of those RNs and they still make sure that RPNs are put in their place. The animosity is still present. I can remember one of the RNs, when all the changes

> happened, she took her fist and pounded it on the wall and screamed that she hated us. That wasn't fair. It was awful what we went through back then and it wasn't our fault.

Several of the participants shared their experiences from the 1990s and early 2000s, when RPNs were brought in to replace RNs and when RPNs were then removed and replaced with RNs. This losing and gaining of both RN and RPN positions contributed to the uncertainty regarding the perceived flexibility of the work environment and the probability that when the desired inclination arose, either position might be in jeopardy of change or loss.

Frances (RPN) described a change in the nursing work climate with the expansion of the RPNs' scope of duties. It is potentially scary and intimidating for the RNs.

> They're [RNs] worried about their jobs. When you have an RPN making thirty dollars an hour and an RN making forty-five dollars an hour, and the scope is so similar, I think that the RNs are worried that they are going to get pushed out; but I think there is a place for both of us in the work environment.

Frances emphasized that, even though the roles were similar, they were not the same, and that there was a place for both RNs and RPNs in the different care areas to perform tasks that fitted the given scope of practice and the health condition of the patient. However, despite the sense that there was a place for both RNs and RPNs, several participants expressed a need to defend their individual nursing roles. Many of them spoke of a necessity to define their roles, education and nursing experience to patients and coworkers. At the same time, they also insisted that they should not have to label and explain who they were as nurses. Taylor (RN) spoke of the experience of working as a nurse on a shared care nursing floor.

> Unfortunately, I must give them my background, so they can be more confident or even know that I am an RN. They [patients and families] try to question you on what your background is and ‘who you are to tell me [patients and families] these things’, and they [patient and families] will ask you if you're an RPN or an RN. ‘Where did you go to school?’ And I must tell them. I know that I don't need to, but I feel that if I am at the other end, I must ask that I would appreciate if the nurse will just be very honest, so that I can lay down my expectations. So, I tell them that I used to be an RPN, and a midwife back in my home country. I came here and had to do my nursing again. That kind of creates confidence and trust that is being built between the patient and myself.

There was a sense of resignation in Taylor's words. This need to repeatedly explain one's role as a nurse was uncomfortable but needed to be done to allay the concerns of patients and their families. It was, therefore, something Taylor accepted, perhaps due to having worked both as an RN and an RPN. Taylor further described what it was like to have one's nursing role questioned by patients and families.

> I can see a difference in how nurses respond when a patient is not really doing well and I must come in, and I must introduce myself and I am always being asked if I am an RPN or an RN. And once I say I'm an RN, you can see a change in their face. There is a sort of relief in the face of the family or the patient, because probably in their mind, they are thinking, ‘Okay, this person can do more or knows more in what to do to help me get better or to help my family get better.’

Taylor expressed appreciation for the challenges associated with the process of handing over care from an RPN to an RN, while also understanding how it could affect one's sense of self-worth.

> And when I was an RPN, I also felt this frustration because in my mind I think I can also do the things that an RN can do, but I also know that my knowledge is limited. So are my skills. I also know that it's not doable [to keep the patient]. I must give it to an RN, and this is very insulting, to be honest. When I was an RPN, it was very insulting.

With Taylor's experience of transitioning patient care from the RPN to the RN, there was an appreciation of the sentiments experienced during the process, because Taylor had been in both the RPN and the RN role. Taylor advocated for the RPNs because of the experience of both roles. "Now when I'm being asked about the nursing roles, I try to advocate for RPNs because I've been in their shoes".

Frances (RPN) expanded further on this sense of a fissure by sharing the experience of how organizational structure was used to describe one nursing role as opposed to the other.

> When the RNAO all came out with their slogan you know the one that was very demeaning to RPNs and was basically saying. ‘RNs give the best or better care, so we should only be having RNs’ … at that point we kind of got a lot of backlash as to why RPNs are in the emergency department. We've been actually removed from the emergency department before and then we always manage to be brought back in and it feels like maybe you're not trusted in your department to be able to manage your patients and you feel like they don't value the education that we have received and the skills that

> we do possess. It just makes you feel like you are not a real nurse. We get that a lot. ‘Oh, you are an RPN; you are not a real nurse.’

Frances shared this experience with many pauses and sighs as she described the lack of trust to which she had often been exposed in her RPN role. For Frances, this lack of trust in RPNs was difficult at times.

The pay inequity was mentioned in all the conversations. Pay inequity is not only emotionally draining; it also causes resentment, which can contribute to division. When conversing with Hunter (RN), I asked about the challenges and rewards of the work environment. This was when Hunter spoke about the pay difference.

> You know, it just seems that the pay scale is very uneven, for the amount of work they do and the pay they actually get. When I'm working alongside somebody, you know, who seems to have a good knowledge base, and then you find out they are an RPN, you know, my thoughts are, ‘Oh you're not getting paid as much to work alongside me [RN]. And you should be.’ The only thing that really bothers me is that they don't get paid enough and they are asked to do the exact same job.

In Hunter's words, there was a sense of understanding of what it was like to do the same things and be paid less. It was clear that this understanding of RPNs, or empathy for what it was like to experience inequality in compensation for similar duties, was perceived by Hunter as unfair and nonsensical.

Every participant with whom I spoke had had a similar experience of the bedside roles of nurses in a shared scope environment, and what it was like as far as care and duties were

concerned on the units. "I can have the exact same patients on my shift [as an RN]. If one is more complex than they will switch that one out" (Dana, RPN). Avery (RPN) also described this similarity in roles.

> We are the same, other than administration [paperwork]; we are all nurses looking after the safety and wellbeing of the patients on the floor. We are both assessing, both administering meds and both supposedly doing care.

Dana and Avery both described the sameness of the RN and RPNs' roles in their shared nursing environments; however, they both described how the sameness ended with pay rates and job titles, leading to resentment and growth of the fissure between the two roles.

During my conversation with Julia (RPN), the question arose as to how the two nursing roles differed and how they were the same. Julian (RPN) said, "Now all is pretty much exactly the same, except for a few medications, that I have to give them [gives examples] …That's pretty much the biggest difference." Morgan (RN) and Julian's (RPN) experiences aligned. Morgan shared the following: "On our unit, RNs and RPNs pretty much work side by side and in the same capacity. We don't really differentiate on what patients each nurse gets. We just kind of assign." Cameron (RN) continued these sentiments.

> You know what, I can be 100% honest, sometimes I must ask someone, “Are you an RN or RPN?” because I don't know. I really can't say that on my floor that there is a huge division between RNs and RPNs' [roles and duties]. It's very blurred. I don't see the difference.

Taylor's (RN) description was similar to Cameron's (RN). First, like I told you, you will not know who is the RPN and who is the RN until it is crunch time [referring to dramatic change in patient acuity when the advanced skills set of an RN is required].

The similarity of the skills and duties of the two nursing roles was apparent throughout the conversations with the participants, yet the two sets of nurses were both aware that they were not the same; thus, an element of confusion remained. The similarities were also described by Hunter (RN), who spoke about working in the emergency department and how there were certain areas in which RNs and RPNs worked side by side and there were areas in which only RNs could work based on patient acuity. However, when speaking in reference to the shared care areas of the emergency department, Hunter described the actuality of the differing types of nurses working in the shared care area.

> And so, we don't differentiate in those two particular areas. We don't differentiate. We do all of the same things, take your bloodwork, you assess, you give medications. The only time the role actually differs would be the medication. They're [RPNs] sort of limited to give certain medications and that's when they'll come up to us [RNs] and ask us to hang a particular medication…most of the time when I go in, I don't know who is an RPN and who is an RN… They do all the same things we [RNs] do. Look I can't tell the difference in most critical situations.

Hunter's experience of working with RPNs in the emergency department in shared care areas indicated a sense of confusion regarding the RN and RPNs' roles, where role difference was not obvious unless a specific need arose. Similarly, Frances is an RPN who works in the emergency department and has seen what tasks are performed by RPNs and which ones are performed by

RNs, and the lack of skill differentiation. "The skill sets are similar; I mean, we all put in catheters, we all give insulin, and we all start heparin drips." Riley (RPN) expanded on the experience of the other participants by explaining how the differences in the shared scope roles were subtle but present.

> I think that our roles are somewhat the same, to be honest. It's an acute floor and its post-op care management. I don't think we vary when it comes to what we do on the ward to step down [a transitional care area for patient that may continue to require specialized monitoring, but no longer require care in the intensive care unit.]. I think we're pretty much on the same playing field. It's just different. Sometimes when it comes to medications, RNs can do an IV, push medication through an IV set, where RPNs are not allowed to be pushing IV meds because we're not trained in to do that.

As each participant spoke about the sameness of the roles of the nurses working on the units, it was said matter-of-factly, spoken as if ‘this is how it is, this is how it works’. However, this does not mean it was accepted and appreciated. Riley described this division of care between the two-nursing role with reluctance to accept the practice as fair.

> Whenever we receive transfers from the ICU as per the hospital policy, it [the patient] is supposed to go to a registered nurse. At times RPNs are not always partnered up with a registered nurse. We are usually partnered up with another RPN. So, you would not be receiving the ICU transfer because they require an RN to provide care for them. Sometimes I find this a little bit unfair, because I think there are certain very good RPNs who have very good strengths and knowledge about nursing and have very good experience with critical care. You may not have any identification of an RN, but we do

> understand what it's like and what we can do for our patients, and how we can advocate for these things. We know, when one of our patients is not feeling well, where to go from there. Sometimes I do see that our RNs get it a little bit better.

Many participants indicated a sense of knowing that there were times when it was more appropriate for patients to be cared for by an RN; however, the issue was not addressed equally or consistently across units, care areas and organizations. These inconsistencies led the nurses to discuss the flexible circumstances that made it possible for RPNs to have a certain patient population for one day or one hour, but not the next, with the justification of convenience or time. Frances (RPN), who works in the emergency department, spoke about constraints in the environment and the effect it had on working within one's assigned scope of practice.

> So, maybe I am assigned that patient based on the fact that symptoms that they initially presented with in their test results were okay, say, but then that takes a turn, or maybe we just made that decision too early and we didn't see that coming… So, at that point I'm responsible for that patient, but then I do a secondary ECG because the doctor asks for one then we find that there's something going on with that, at which point we are to transfer care to an RN and then there isn't one always readily available. So, they still may have to stay [under the care of an RPN] that least for another 10-20 minutes until that RN can take over. So that's what I mean when I say, ‘getting pushed out of your comfort zone.’

For Frances, there are times of strain and discomfort in being an RPN in the emergency department. Frances noted that at times RPNs were stretched beyond the normal scope of practice out of necessity, putting Frances in a position of working beyond the legislated scope.

Cameron (RN) similarly articulated the inconsistencies that nurses were facing in a shared scope environment. Cameron (RN) reflected on rules and policy flexibility, based on shortages that increased the stress levels of staff on units.

> Same thing goes with when you have an RPN, and their patient is not doing well. It [the patient] really should be transferred over to the care of an RN. But now we have found that we are really busy, we are short-staffed. So, hey, I'm going to do a check with you [RPN] and say, 'Hey, are you doing okay? I know this patient, and this is what the doctor said. These are the interventions that we're doing. Do you feel comfortable right now? And I [RN] will do all the things that are technically out of your [RPN] scope of practice.' And then that nurse either says yes or no. Now we have the rules that this is the way it is going to work, and then you have, okay, well, now we're, you know, in a little bit of a crunch and our rules change to become a little bit more fluid because we're adapting to our situation.

Cameron's reflection drew attention to the concern that, although it was known, or should be known, that the patient might no longer be appropriate for RPN care, the RPN sometimes needed to keep that patient because there was no other option due to a staffing shortage.

Morgan (RN) described how there were times when RPNs kept their patient assignments even though the health status of the patients had changed to unstable and when predictable outcomes were no longer clear.

> When an RPN has a patient that might become unstable, most of the time they [RPNs] don't want to cause trouble or be seen as incapable, so they just keep the patient, even though care should be transferred over to an RN.

Morgan's description of when and why care might be transferred from RPN to RN contained a sense that changing a patient assignment would indicate that the RPN was not able to manage the assignment, causing the RPN's role to lose its value in that moment. Riley (RPN) also commented on this sense of role defence when describing keeping a patient assignment that should be transferred to an RN.

> So, I like having critical patients. I need the experience and have that understanding of what I need to do for them and how I can continue to provide care for them. I think that's important because it opens up your knowledge and your skills as an RPN, so at times when I do get patients that should be going to an RN, I keep them.

When an RPN chose to keep a patient assignment even though the level of care required had moved beyond their scope, this was done to prove worth; that is, it was a way of defending the value of the RPN's role.

Inconsistencies were revealed at a deeper level when Julian (RPN) spoke about RPNs who worked at the care the facility at which Julian was employed. Julian noted that there was a discrepancy and inconsistency in expectations, even within the RPNs' scope. Julian described how many RPNs were not working to full scope by choice and would leave other RPNs to complete the patient care that was required.

> RPNs are working to full scope, but they can refuse to. For example, I mean, if I am supposed to give an intravenous therapy, I can elect whether or not I would like to do that. So, I can if I want to work to full scope, but if I don't feel like it, they don't force you to. So, some RPNs work to full scope and others choose not to, and they make the same money. It's an unwritten rule. Technically, a lot of the RPNs that are certificate RPNs, not

> diploma RPNs, are the ones that don't want the training, because they don't get paid enough to do it. That's honestly what they say. They refuse to do it. And they just say, 'I can't do that, so can you do this for me? Can you do this IV for me?' and they make it very stressful.

Julian gave examples of inconsistent practices within the environment and how the inconsistency caused stress in the workplace. The picking and the choosing of scope fulfilment on any given day by RPNs and the organising and leaving of some staff to do more work than others on top of an already full patient assignment, added stress to the work environment.

When it came to working side by side on the nursing units, other issues were brought forward that the participants thought contributed to the fissures, such as the union and differing skill sets within the nursing roles and between organizations. In reflecting on an earlier part of our conversation about RNs and RPNs as all being nurses, Frances (RPN) commented that RNs and RPNs were not even in the same union.

> You know we [RPNs and RNs] are all in different unions; there is one for RNs, the Ontario Nurses Association, so why aren't RPNs included in that? And maybe [having RNs and RPNs in the same union] that would help with this division.

For Frances, having separate organizations for nurses, such as the Ontario Nurses Association, Service Employees International Union, Canadian Union of Public Employees, RNAO and WeRPN Registered Practical Nurses Association of Ontario, could further the divide nurses. Cameron (RN) added that the variation in the extent to which the nursing scope of practice was used within different institutions contributed to the divide among the different types of nurses and created further challenges.

> So, I hear, ‘Well, you know at this hospital it's different for us.’ And you don't have the same unions. So, there are different rules that come along with the union and different holidays – stuff like that. So not having that same union and all that kind of thing puts a little bit more of a wedge, a little bit more of a separation, between the us [RN] and the them [RPN]…. They [RPNs] are calling themselves nurses but they're not allowed on our [RN] side of the fence.

Cameron's experience is reflective of the divide that is placed between nurses at the organizational level. For both Cameron (RN) and Frances (RPN), the experience of multiple unions within the workplace and separate supportive organization outside of the workplace for the two nursing roles contributed to the separation of the two types of nursing staff.

Frances (RPN) shared that the lack of role clarity and confusion around the two nursing roles led to inconsistency in expectations regarding what skills should be practised in her hospital care area by RPNs.

> So, I think a lot of the challenges comes from the fact that there is no real black-and-white list of skills. So, for example, for myself, I can do phlebotomy, I have been trained to do a phlebotomy, but another RPN might not have that added skill. So, then the RNs are kind of confused. Sometimes they are, like, ‘That RPN can do that, so why can't you do it?’ So, I guess the challenge there is that the RNs don't really know specifically what we can do. Okay, like all RNs can do this and all RPNs can do that. It's not like that. It's based on knowledge, novice, proficiency. You know, the 35-year nurse is obviously more comfortable in certain situations than the five-year nurse would be. So, there's no black and white. And I think that can get confusing.

These inconsistencies contribute to a lack of understanding of how and when certain skills can be used and tasks can be done, as well as by whom, and why RPNs are performing certain tasks one day and not the next. Many of the participants expressed a need for consistency and guidance regarding the RNs and RPNs' roles to avoid issues within the environment. Morgan (RN) added to the issue of role confusion and lack of role clarity when discussing the experience of RPNs transitioning back onto the hospital unit, and the nurses on the unit not having a full understanding of what the two roles would look like working together.

> It was different because it was an infusion of new faces. I think we had, like, four or five new hires, and then it was kind of a scramble to try and figure out how we were going to work together again. So, are we going to stick to making the assignments lighter, or are we going to stick to what other floors do with RPNs? From what I heard, on other floors. It's different. So, some floors' RPNs aren't allowed to hang IV narcotics. Some of them aren't allowed to give certain medications. So, there's a lot of restrictions on RPNs on other floors. So, when we had RPNs come to our floor, we were scrambling. We were asking questions as a team. I'm sure it was all taken care of by our manager and educator, but we all had questions, like ‘how are we were gonna handle assignments?’ I think, so I guess, that in the end we just scrapped all those restrictions that RPNs had on other floors and we just said, ‘just do whatever you're comfortable with doing.’ And a lot of RNs do exactly what the RPNs do and the RPNs do exactly what the RNs do.

Morgan described this lack of specific delineation of roles as a reaction to a change that occurred quickly and was put in place in order to support the organizational change. Both Morgan and Frances noted that the lack of clear roles and duties caused confusion regarding the roles of RNs and RPNs in a shared care area.

**Summary**

These two themes: The Dance and The Fissure show differences and similarities with the nursing roles. With The Dance there is an undeniable potential for nurses to work together for common goals and the care of patient, and this is done. This nursing dance develops and modifies with nurses in the environment, thus reflecting the importance of collaboration between the two nursing roles to patient care.

With The Fissure, the participants' experience of working in a nursing environment in which RNs and RPNs shared a similar patient population could be confusing and inconsistent at times leading to role confusion and role ambiguity in the dual-scope nursing environment. All the nurses who participated in this study spoke about not having a full grasp of what it was that fully separated or differentiated the two roles in the same work environment.

Within the theme of The Fissure, there was a recurrence of the division of the two-nursing roles. This divide was present in all the experiences shared by the participants. Their experiences yielded insights into the perceptions and feelings that perpetuated division. This division was expressed through comments about pay inequity, role substitutions, role defence, organizational and union differences, facility differences in terms of scope and public perception of the RN and RPN roles. In the next chapter, the findings will be discussed in relation to the existing literature. Implications for practice, research and education will be addressed, as well as study limitations.

# Chapter 5: Discussion

In this chapter, the findings from the participant conversational interviews are discussed in relation to the literature and the two main themes that were identified, namely The Dance and The Fissure. The strengths and limitations of the study are then described, followed by recommendations for nursing practice, education and future research.

## Theme One: The Dance

The first theme that emerged from the analysis was The Dance, which encompassed a shared space, times and roles that involves rhythm, comradery, teamwork, communication, shared goals, trust and respect in a shared scope nursing environment.

### *Comradery, teamwork and communication.*

The emphasis in this theme is the collaboration of RNs and RPNs. Descriptions of collaboration and comradery were pronounced throughout all the conversations and there is a definite presence of teamwork between the RNs and RPNs. The nurses working together in the shared patient care areas support one another, not only at the bedside, but also with growth, development and knowledge. This finding is consistent with Moore and Prentice's (2015) case study of the experience of collaboration among oncology nurses. Moore and Prentice also found that nurses collaborate with one another to plan, organize and provide care for their patients.

The sense of teamwork and collaboration felt by the participants also aligned with Dougherty and Larson's (2010) study on nurse-nurse collaboration. Dougherty and Larson identified five factors that contribute to collaboration among nurses working together: problem solving, communication, coordination, shared process and professionalism. The findings of the

current study suggested that there may be relationship between collaboration among nurses and positive outcomes for patients because of an easy rhythm of teamwork and communication, which, in turn, could potentially lead to an improved work environment and patient safety. Clark and Springer (2012) reported similar findings, suggesting that nurses feel valued when they work in a supportive team environment and have found that effective collaboration can lead to the possibility of better patient outcomes and greater patient safety. In short, collaboration, teamwork and communication appear to be important components in the shared nursing environment, contributing to both nurses' job satisfaction and patients' safety.

***Trust, respect and shared goals.***

Having pride in one's work, compassion and mutual respect adds to the teamwork relationship in the shared scope environment. The participants in this study suggested that this was achieved through sharing learning experiences, providing guidance, and helping one another as required. As Gosby (2014) noted in a discussion of collaborative environments, respect for one another is crucial in collaboration and that when a collaborative environment exists among nurses, it grows from trust and respect among colleagues.

Pride, compassion and mutual respect in one's work, work environment and with one another contributes to building relationships and trust. The findings of Liao et al. (2015) on nurse-nurse collaboration indicated that nursing work environments that have conflict management, common goals, communication, coordination, professionalism and autonomy have improved collaboration among nurses. Collaboration was not only important to the nursing environment in achieving quality patient care but was also found to contribute to having a positive work environment in which the nurses were able to work collaboratively regardless of

formal designation. Ylitörmänen et al. (2019) found a strong association between nurse–nurse collaboration and job satisfaction. Furthermore, nurses who collaborated well were more satisfied with their roles than those who did not. Moore and colleagues (2015) research on the meaning of collaboration also highlighted that collaboration among nurses is multifaceted and born from shared decision-making, mutual trust and respect, active communication and an inclination toward a mutual goal. Collaboration, teamwork, communication, shared goals, trust and respect were all essential elements that were present in the shared care areas in which the participants worked, which facilitated a dance-like flow on the care units.

In reflecting on the original purpose of this study, the goal was to explore the experience of RNs and RPNs working together in a shared scope environment. The presence of understanding and empathy among RNs and RPNs was not a concept that I encountered in my initial literature search; nonetheless, this is a common thread in the experience of the participants in this study. The concept of empathy constitutes a subtle reminder of what nurses' do, which is, in the most rudimentary sense, provision of care and, with that, care for one another. Caring and compassion are an integral aspect of nursing as a whole and vital to our practice. Caring and compassion brings with it a body of emotions and responses that come from working in and experiencing the shared scope environment.

The finding of empathy is supported by Baumann et al. (2014), who found that nurses relied on one another for expertise, experience and guidance, with little regard for specific role designations. All the conversations reflected the ebb and flow of care and the learning and reliance that characterized teamwork within their care areas. The findings of this study also align with those of Hastings et al. (2016), who examined team-based care models and suggested that

professional groups working collaboratively enabled nurses to provide sustained high-quality care.

## Theme Two: The Fissure

The second theme that emerged during the analysis was The Fissure. The Fissure is representative of the divide and the underlying and at times overt challenges that are found in a shared scope nursing work environment. The fissure was reflected by many sentiments given by the participants. These sentiments described moments of anger, frustration and resentment regarding the inequalities in the work environment between the nursing roles. The inequalities discussed were role ambiguity, pay inequity, organizational restructuring and policies.

### *Role ambiguity*

A prominent finding in the study is the existence of role ambiguity with respect to the two nursing roles. Role clarity is perhaps present in some care areas in which specific limitations and policies clearly define the roles of care providers; however, this was not the experience in the bedside care areas in which most of the participants worked. At times, there is a lack of understanding by both the RNs and RPNs on the separation and delineation of the two nursing roles in the shared work environment. Although there was some discussion in the conversational interviews about understanding RNs' and RPNs' professional role and limitations, the concept of having the ability to fully understand where and when the skill limit was reached is not consistent, and there are times when the scope of a participant's role is stretched (RPN) or disregarded (RN). This finding is supported by Eager et al.'s (2010) study of the role conflict about scope of practice experienced by enrolled nurses in the United Kingdom (enrolled nurse or EN is the title used in some countries and is a nursing role comparable to the RPN role in

Ontario, Canada). Eager et al. (2010) encountered frustration and despair from the ENs regarding workload and a perceived lack of respect for the EN role that affected communication among nurses with differing roles.

When looking at clarity, inconsistencies and roles, there is frequently an inability to differentiate the role of RNs and RPNs at the bedside. Patients and nurses alike perceive sameness in the actual duties of bedside care, with little difference in the actual care which contributes to role ambiguity, role confusion, and role conflict. In her 2003 study on nursing staff mix, McGillis Hall reported that RNs experienced high levels of role conflict in mixed staff care areas. Furthermore, the Registered Practical Nurses Association of Ontario (2014) acknowledged that nursing practice for RNs and RPNs in Ontario was not clearly defined, which could cause role confusion and ambiguity. As reported by Lankshear et al. (2016), role ambiguity occurs when there are unclear roles, expectations and clarity regarding behaviours. This finding is supported by Oelke et al.'s (2014) study of the evolving role of the nurse. Oelke et al. (2014) found that role ambiguity existed when nurses lacked clarity in their care roles in medical units. With a lack of role clarity in patient care areas where nurses are completing similar work it is important to remember that nursing roles are not simply differentiated in terms of duties and skills, but also by preparatory education and experiences. RNs complete a comprehensive four-year university degree in nursing that allows for the development of a deeper knowledge base to draw from in clinical practice, with the utilization of critical thinking and research (RNAO, 2020). Where RPNs complete a two-year nursing programme at the college level, which is comparably less extensive, and more task focused (RNAO, 2020). RNs study nursing education for a longer period, which enhances the depth and breadth of their nursing knowledge as compared to RPN preparation.

Pryor (2007), who conducted a study on role ambiguity in a rehabilitation care setting, noted three factors that could contribute to role ambiguity: limited formal preparation, differing perceptions of the roles of RNs and ENs (RPNs) and the inability to identify specific roles for RNs. In their study on role clarity, Lankshear et al. (2016) found that, in general, RPNs were more knowledgeable about the role of the RNs and their scope than the RNs were about the RPNs' role and scope of practice in the care environment, Tarrant and Sabo (2010), who conducted a study on role conflict and role ambiguity, found that both confusion and ambiguity contributed to stress among nurses. Butcher and Mackinnon (2015), affirmed the existence of role ambiguity amongst the nursing professions and noted the complexity of the relationship stems from differences between nursing education and knowledge, which in turn leads to complexities and complications in the relationship and an understanding of the RNs' and RPNs' roles. The findings in this study suggest that both RNs and RPNs would like to have defined skill lists and policies in which the roles and duties are outlined and consistent across agencies.

Baumann et al. (2014) found that nurses relied on one another for their expertise, experience and guidance, with little regard for specific role designations. This reliance was discussed by the participants in my study when reflecting on the ebb and flow of care, and the learning about and confidence in teamwork within their care areas. The findings of this study also align with those of Hastings et al. (2016), who examined team-based care models and suggested that when professional groups work collaboratively, this enables nurses to provide sustained high-quality care.

### *Pay inequity*

The issue of pay inequity was discussed by many of the participants in the conversations, and how the pay inequity can cause a sense of inequality and create tension between RNs and RPNs when providing similar tasks. This divide can be experienced as tension at times between RNs and RPNs when they are working side by side, depending upon one another, and apparently administering the same types of patient care. The findings of Eagar et al. (2010) highlighted the pay disparity between RNs and RPNs as a factor that can lead to frustration and despair in the work environment. Jones (2002), in his position paper on practical nurses in the UK, observes that practical nurses are at times seen as second-class contributors in the nursing field, when a great deal of patient care would not be accomplished without their skills and abilities, this finding was discussed by some participants in my study in reference to the lack of appreciation for the skill set that many RPNs do have. Moreover, in reflection on the conversations had with my participants surrounding the similarities between the two types of nurses, the participants felt that the lack of pay equity could be viewed as a lack of appreciation for the RPN.

### *Impact of and organizational restructuring*

When describing the changing dynamics of the hospital units, the participants relived feelings that came with nurses being made to leave hospital units over the years due to organizational restructuring of nursing care delivery models and layoffs of nurses. In the 1990s, in Ontario, RNs were replaced with RPNs and in another organizational restructuring that occurred in the 2000s the RPNs were removed from certain care units and replaced with RNs. The organizational restructuring and layoff of nurses was initially driven by the need for cost containment. Moore and Prentice (2015) suggested that organizational structure and restructuring

affected collaboration among the nurses working in the restructured care areas, as the change in dynamics can makes those in the environment unsure of what the changes bring to the care area for the nurses involved. Again, the feelings of sadness, loss and grief were re-experienced when the nurses were brought back into the care areas due to further restructuring by organizations. In addition to loss and grieving, the possibility of reorganization creates a sense of fear and intimidation, as nurses worry that their positions may cease to be required.

### *Role substitution and organizational policies*

A common thread throughout the many conversations was the topic of role substitution, which occurs when one role was substituted with a less qualified role. This practice evokes feelings of confusion, leading to toxic and stressful work environments. When role substitution occurred, the nurses felt they were not valued for their role, but rather a flexible convenience that had to change to fit the current need, leading to role confusion and resentment. The participants mentioned discrepancies in the skill sets that were utilized by facilities and organizations, whereby guidelines and policies at one organisation were inconsistent with those of another. This finding is supported by Baumann et al. (2014), who, in their Ontario-centric study, found a lack of clearly defined differences between the two nursing scopes, and that the nursing roles and duties were inconsistently enacted across organizations. Adding to the divide identified in this study was perception of some participants about the public's knowledge and opinions of nursing roles and the materials created by associations such as, but not limited to, the RNAO and Ontario Nurses Association (ONA), which appears to strengthen the RN role, while simultaneously demeaning the role of the RPN. As well as the divide imposed by associations such as the RNAO, which is available for RNs and advanced practice nurses, and the Registered Practical

Nurses Association of Ontario, which represents RPNs, and unions, which represent different groups of nurses.

***Role defence***

This element relates to the perceived need to defend nursing roles, education and experience to patients and coworkers. Through the conversations with the RNs and the RPNs it was obvious that there is a perceived division of roles as being related to organizational limitations, expectations, and policy. The participants spoke about families or patients asking questions about the roles and the education level of their care providers. Butcher and MacKinnon (2015) found that tension existed surrounding the relationships, context and beliefs about the RPN role with respect to educational hierarchies and class. Some of the participants in my study said that the perceived lack of respect was further enhanced by the 2019 RNAO campaign titled “Ontario needs more RNs”, which was created in effort to promote the utilization of RNs in healthcare (RNAO, 2019). This campaign included the promotion of evidence that patient mortality and complications decreased, while quality of care and positive health outcomes increased when care was provided by RNs (RNAO, 2019). Although this campaign was created to promote RN care, it leaves some RPNs feeling as though they were not trusted to provide quality care, that their education might be viewed as not valued and that they are not a "real nurse."

The expanding scope of the RPN’s role, and inconsistent rules and policies among different organizations contributes to a lack of understanding and perceived lack of respect described by some participants in this study. The participants spoke about the bedside nursing role of RNs and RPNs in a shared scope environment was very similar and often not

differentiated when patient care assignments were made. Inconsistencies and flexible circumstances lead to role confusion and, in turn, lead to RPNs sometimes being pushed beyond their skill level. An interesting example of inconsistency was in the care areas, where nurses in the study were not required to work to full scope and could decide whether to perform a task that was deemed within their scope, leaving other nurses to provide the care that was required. Inconsistency of scope enactment and patient assignments contributes to a lack of understanding of enacted skill set for nurses, especially when the prescribed scope of one's duties changes from one organisation to the next, which creates a lack of understanding of one's role as a nurse and of the other nursing roles.

**Recommendations for Practice**

Many of the study participants suggested that a clear set of guidelines needed to be developed at facilities which will clearly delineate roles for nurses. This could be done by defining specific duties or care actions and allocating nurses to specific areas, with supporting rationale. Having a concrete, standardized decision-making process might facilitate a consistent approach to delineating care for the appropriate population. The utilization of a decision-making tool, such as the College of Nurses of Ontario's (2018) decision tree (see figure 4), with specific direction given to the enacted nursing scope, could aid in giving nurses clear guidelines regarding who should be providing care. The current College of Nurses of Ontario's (CNO) (2018) decision tree would benefit from a revision that includes the stability and predictability of the client, such as health parameters (vital signs, examples of when to consult etc.) and outcomes. Decisive care decisions need to be made by team leaders, in which clear expectations are consistent concerning who would be best suited to caring for the patient. Having clear expectations and a pre-emptive understanding of the possibility of change in patient complexity

and outcome predictability might allow for an ease in the transfer of care to the care provider that is most appropriate.

The participants discussed the delineation of roles at the organizational level, and the differing unions, nursing associations and pay rates for similar duties. The participants felt that having RNs and RPNs in the same union would decrease policy challenges and allow for better communication between the two nursing sets. Moreover, the participants spoke about how having supportive professional associations such as RNAO and RPNAO could be inclusive of all nurses, thus decreasing the separation of the classes that the divide creates. At the hospital level, the implementation of teambuilding and information sessions on role and role development could contribute to mutual respect and clarity, especially in volatile times when organizational changes are occurring in the work environment. Open communication by management and educators to all healthcare providers about organizational changes resulting in changes to the RN and RPN roles would provide clarity, because it is important for both RNs and RPNs to understand what is occurring and how nursing roles are being affected in the work environment.

**Recommendations for Education**

An important aspect of having clarity in the shared scope nursing environment is that of providing education about the nursing roles throughout the educational process in colleges and universities. Having standardized nursing education about the shared scope, in both RN and RPN programmes, would enable future nurses to understand how the two roles work together and support one another in the patient care environment. The participants in this study found that a lack of communication about role changes or skill sets was an issue in the workplace; thus, having continued updates and education about role modification in the workplace would

facilitate greater understanding and less confusion regarding what skills those in other roles might or might not have. Although this might already exist in some organizations, the study participants found this to be an area that needed improvement.

**Recommendations for Future Research**

Nursing role ambiguity could be further examined with RNs and RPNs. Conducting focus groups with RNs and RPNs to discuss the challenges and benefits of the shared nursing environment could yield valuable insight into the work climate. Future research into the shared nursing environment would also benefit from an examination of the policies and structures of organizations to explore how nursing care delivery models are created within organizations. An additional area that could be examined is student nurses' level of understanding of the shared scope and how the two roles fit together. An examination of university and college curricula might lead to knowledge about the current level of education provided to the two nursing groups. This could be done by examining what information is provided to nursing students about the shared scope in their jurisdiction and across Canada, and how the roles are different and how the two sets of nurses work together.

**Limitations**

One limitation of this study was that participant recruitment was only advertised to one province. The findings therefore represent the experiences of participants from only one part of the province and country and may not represent that of all Canadian and /or the global experience of nursing in an intraprofessional environment. However, the thick description of the findings provided an understanding of the participants' experiences. At the time of this study, several of the participants were in the process of bridging into an RN role from an RPN role,

therefore these participants may have different views from other RPNs who were not advancing their education.

## Conclusion

Compassion, empathy and respect were found among the two nursing roles in the same environment, but there was also the presence of role ambiguity and ideas about ways in which this ambiguity could be decreased. The situation of nurses working in a shared environment is unlikely to change any time soon; however, the understanding of the culture and the two roles in the shared care environment could change for the better. Collaboration, teamwork, communication, shared goals, trust and respect were found to be components that added to the dance of nurses on care units. On the other hand, issues of role ambiguity, pay inequity, organizational restructuring, role substitution, policy and role defence contributed to a fissure between the two nursing roles.

This study provides new perspectives and insights into the lived experience of nurses working in the shared scope environment. The findings indicate the presence of role ambiguity among RNs and RPNs in a shared care area and highlight the need for a more in-depth understanding of the two nursing roles. These findings also highlight the presence of inconsistency in role expectations experienced by the nurses in differing organizations, work environments, leading to further role ambiguity.

**Reflection and Final Thoughts**

When I started on this adventure in October 2017, I had not envisioned the degree to which this research project would consume my thoughts, time, energy and home life. This project has given me the gift of insight and the privilege of knowledge gained, as well as respect for the experience of the participants who are currently at work providing care. What I found most interesting in the course of this project was the surprises that I encountered in experiences shared by the participants.

I am tired but inspired by my life. I feel joy and supported by my family, who sit in the backyard around the fire pit while I have often sat at the dining room table typing and trying to block out the sounds. I am tired and excited to be in this position. The fear is leaving. The panic is still hidden, but the end is in sight. My mother-in-law asked me yesterday about my thesis, what it is like, and I said to her: “It's like a marathon – exhausting and long.” Thinking about that now I laugh to myself, because I do not run; I therefore really cannot compare this to a marathon, but I can imagine it. My imagination has brought me to this moment here today, and my imagination and constant questioning has kept me on my toes – ever a learner, never satisfied.

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**Figure 1**

Regulated Health Professions Act, 1991: Controlled acts

"A "controlled act" is any one of the following done with respect to an individual:

1. Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis.
2. Performing a procedure on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, or in or below the surfaces of the teeth, including the scaling of teeth.
3. Setting or casting a fracture of a bone or a dislocation of a joint.
4. Moving the joints of the spine beyond the individual's usual physiological range of motion using a fast, low amplitude thrust.
5. Administering a substance by injection or inhalation.
6. Putting an instrument, hand or finger,
    i. beyond the external ear canal,
    ii. beyond the point in the nasal passages where they normally narrow,
    iii. beyond the larynx,
    iv. beyond the opening of the urethra,
    v. beyond the labia majora,
    vi. beyond the anal verge, or
    vii. into an artificial opening into the body.
7. Applying or ordering the application of a form of energy prescribed by the regulations under this Act.
8. Prescribing, dispensing, selling or compounding a drug as defined in the *Drug and Pharmacies Regulation Act*, or supervising the part of a pharmacy where such drugs are kept.
9. Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eyeglasses other than simple magnifiers.
10. Prescribing a hearing aid for a hearing-impaired person.
11. Fitting or dispensing a dental prosthesis, orthodontic or periodontal appliance or a device used inside the mouth to protect teeth from abnormal functioning.
12. Managing labour or conducting the delivery of a baby.
13. Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response.
14. Treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning. 1991, c. 18, s. 27 (2); 2007, c. 10, Sched. L, s. 32; 2007, c. 10, Sched. R, s. 19 (1)." (p. 9)

From “The Regulated Health Professions Act” (1991, c. 18) p. 9. (https://www.ontario.ca/laws/statute/91r18?search=Regulated+health+profession) In the public domain.

**Figure 2**

Nursing Act, 1991 Scope of practice statement

"The practice of nursing is the promotion of health and the assessment of, the provision of care for and the treatment of health conditions by supportive, preventive, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function. 1991, c. 32, s. 3." (P. 1)

Nursing Act, 1991 Authorized Acts:

"In the course of engaging in the practice of nursing, a member, other than a member described in section 5.1, is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to perform the following:

1. Performing a prescribed procedure below the dermis or a mucous membrane.
2. Administering a substance by injection or inhalation.
3. Putting an instrument, hand or finger,
    i. beyond the external ear canal,
    ii. beyond the point in the nasal passages where they normally narrow,
    iii. beyond the larynx,
    iv. beyond the opening of the urethra,
    v. beyond the labia majora,
    vi. beyond the anal verge, or
    vii. into an artificial opening into the body.
4. Treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning.
5. Dispensing a drug. 1991, c. 32, s. 4; 2009, c. 26, s. 18 (1, 2); 2007, c. 10, Sched. R, s. 16." (p.1)

From “Legislation and regulation: An introduction to the Nursing Act, 1991” College of Nurses of Ontario, 2018, p. 1(http://www.cno.org/globalassets/docs/prac/41064_fsnursingact.pdf )

**Figure 3**

Canadian Nurses Association: Position Statement: Staffing decisions for the delivery of safe nursing care: Framework for Decision-making.

“Achieving optimal client outcomes is the central criterion for evaluation of staffing mix. Further criteria include preventing errors and achieving a quality professional practice environment that attracts and retains excellent staff. These criteria comprise three categories that provide a framework for decision-making related to staffing15 across the Canadian Nurses Association of health care settings in Canada.

**Client**

- Health care needs of the client are of primary concern when making decisions related to staff mix.
- Care assignments are influenced by the complexity of the health care needs of the client and by the predictability of outcomes in response to care provided. The more complex, acute and unpredictable, the more necessary it is to have care provided by RNs. "Reassignment of care may be necessary when a patient's health status changes and the assigned practitioner is no longer able to meet the client's needs."16

**Care Provider Competencies**

- Care providers must have the competencies required to assess the client care situation, to understand the underlying contributing factors, to problem solve and intervene appropriately, to anticipate client needs, "to predict the outcome of an intervention, and to…respond with alternate interventions in the event of a lack of response or an untoward response to the intervention."17
- Care providers whose competencies match the needs for care are the appropriate care providers. For example, when client conditions are stable and non-acute, the skills of a licensed practical nurse may be appropriate. When the client condition becomes more complex or acute, the skills of a RN are more appropriate. When the client is a family with complex issues, a community or a population, the competencies of a RN are required.
- Care providers are accountable to assess their own competencies, to recognize client health needs and to consult with someone more knowledgeable when a client situation demands expertise beyond their competency level or scope of practice. The right staff mix ensures there is someone available to provide the consultation.
- RNs have an in-depth and extensive knowledge base that is reflected in a broad scope of practice. They are the most comprehensive, productive, versatile, flexible and diversified of all nursing care providers18 and can meet client needs at both basic and complex levels of care, whether in remote or populous settings.
- Competencies of care providers are affected by many factors. These include education, experience, professional development opportunities and familiarity with the setting.

- A clear understanding of the characteristics and competencies of the RN role is essential to ensure an appropriate staff mix in all health care settings.

**The Practice Environment**

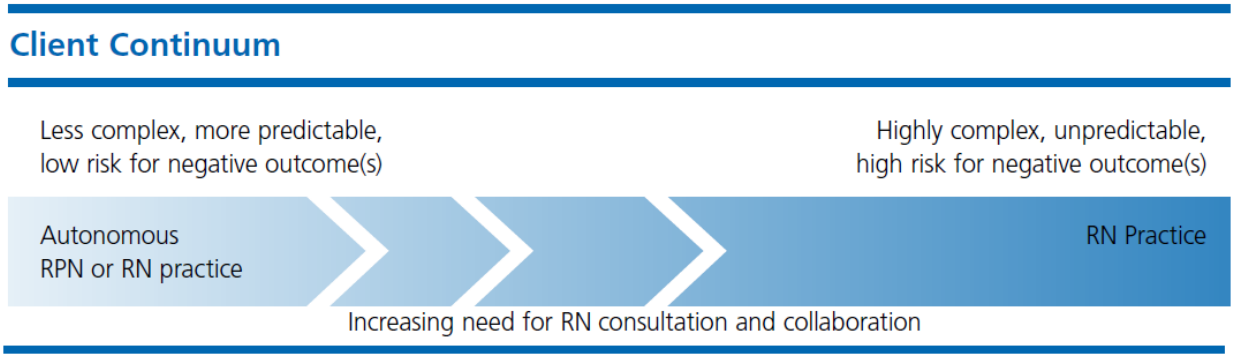
- Practice environments affect client outcomes.19 Staffing decisions made on the basis of client needs and care provider competencies need to be addressed within the context of the professional practice environment.
- In a quality practice environment, staff will have the supports – including a sufficient number of experienced RNs to provide mentoring, supervision and consultation – as well as sufficient staff to provide indirect care services, in order to allow for flexibility of staffing models.
- RNs who are asked to work in unfamiliar settings must identify the match between their own competencies and the health needs of the clients, as well as the environmental supports available to them, in order to determine if they are able to provide safe nursing care. This occurs, for example, when RNs (whether with advanced or minimal experience) are reassigned to meet a temporary staffing need.
- In a complex setting, where there is a high rate of client turnover, high client acuity and a high frequency of unpredictable events, there is a greater need for RNs.
- There is a need for all nursing providers to understand and communicate the policy related to their scope of practice within their work environment." (p.2-4).

  The above information was borrowed from the 2003 Position statement: Staffing decisions for the delivery of safe nursing care pages 2-4, and Retrieved from:

From "Position statement: Staffing decisions for the delivery of safe nursing care" Canadian Nurses Association 2013 p. 2-4 (https://www.cna-aiic.ca/-/media/cna/files/en/ps67_staffing_decisions_delivery_safe_nursing_care_june_2003_e.p)

**Figure 4**

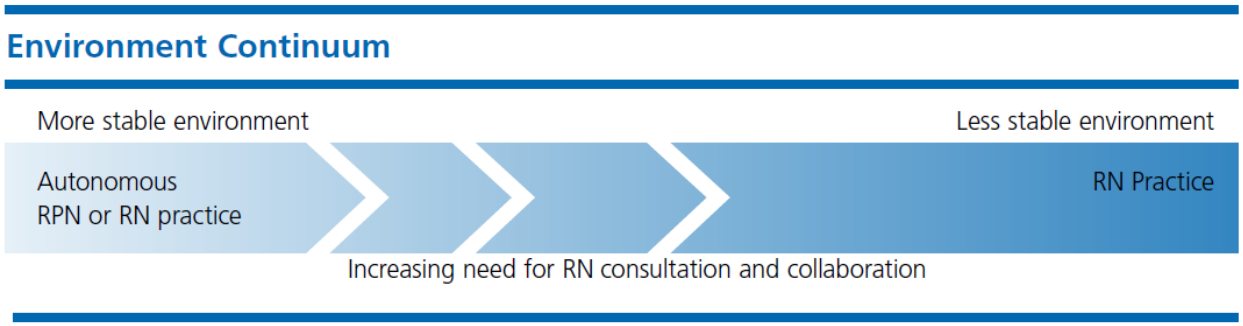
Client continuum




From "RN and RPN practice: The client, the nurse and the environment" College of Nurses of Ontario 2014 p. 4 (http://www.cno.org/globalassets/docs/prac/41062.pdf) Copyright 2014 by the College of Nurses of Ontario.

**Figure 5**

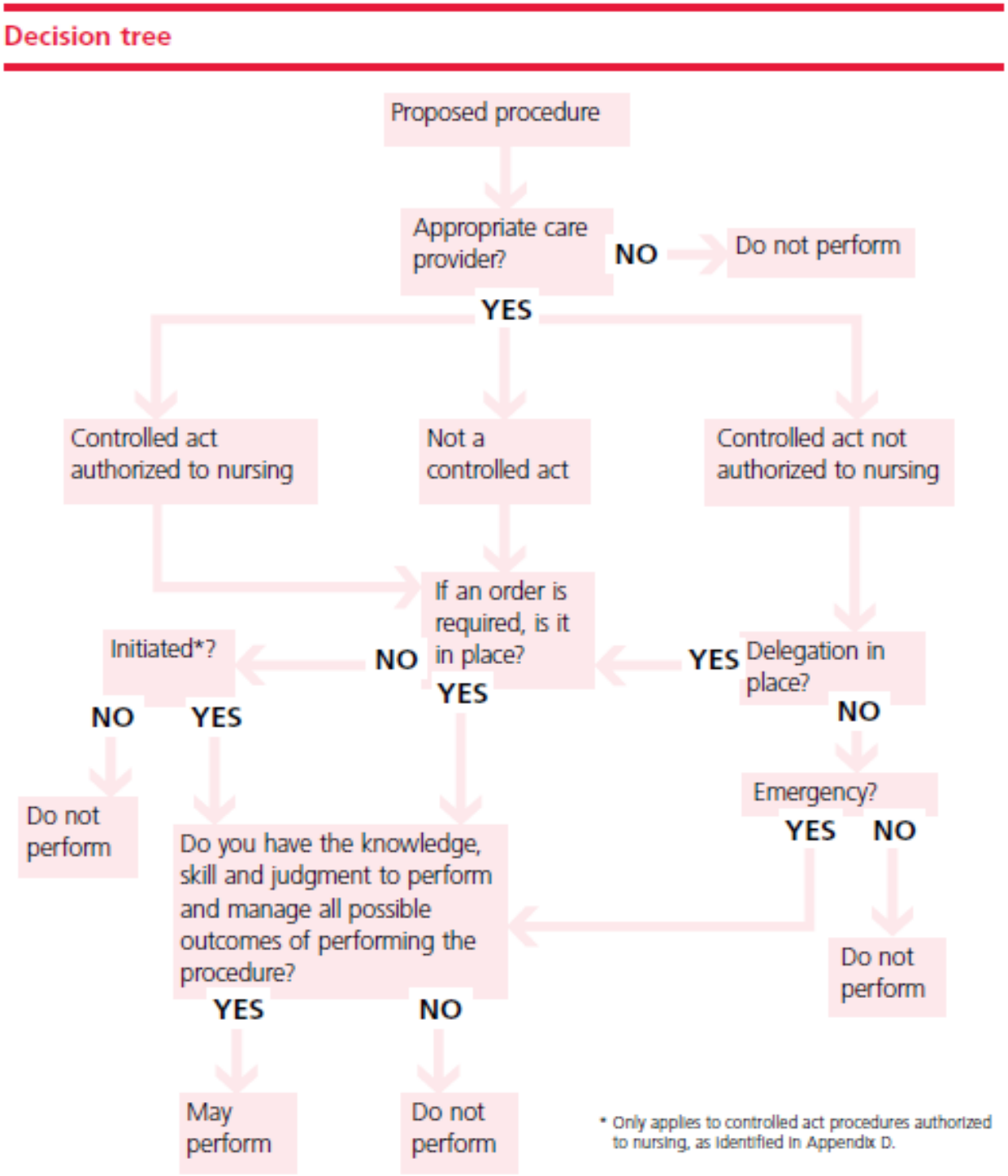
Environmental continuum




From "RN and RPN practice: The client, the nurse and the environment" College of Nurses of Ontario 2014 p. 11 (http://www.cno.org/globalassets/docs/prac/41062.pdf) Copyright 2014 by the College of Nurses of Ontario.

**Figure 6**

Decision tree




From "Decisions about procedure and authority" College of Nurses of Ontario 2018 p. 10 (http://www.cno.org/globalassets/docs/prac/41071_decisions.pdf) Copyright 2018 by the College of Nurses of Ontario.

**Appendix A: Recruitment Flyer**

# ATTENTION RPNS AND RNS

Are you an **RPN or RN** that is currently working in an intraprofessional work environment (a care area where both **RNs & RPNs** provide nursing care.) If you are, I want to invite you to have conversations about your experience.

Brock University

Please share your perspective experience of working in a mixed nursing scope (**RPNs & RNs** practicing) environment, by participating in a study entitled:

**Who am I and what do I do**: A research study on the experience of **RNs & RPNs** working in the same environment.

**Your involvement will entail private and confidential conversations.**

If you would like to participate in this research study, please contact:

Kristina Nelson RN, BScN, Graduate Student
T: 905-746-0490
Email: kn17ot@brocku.ca

OR

Jane Moore, RN, PhD, CCRN, APN
Brock University, Department of Nursing
T: 905-688-5550 ext. 4189
Email: jane.moore@brocku.ca

## Appendix B: Facebook post

**Should prospective participants choose to interact with the posting in any way (e.g., commenting on or "liking" the post), their privacy and confidentiality may be compromised.**

This study has been reviewed and received ethics clearance through the Research Ethics Board at Brock University FILE: 18-119 – MOORE
This study has been reviewed and received ethics clearance through the Research Ethics Board at Halton Healthcare FILE: 2019-002

# ATTENTION RPNs & RNs

Are you an **RPN or RN** that is currently working in an intraprofessional work environment (a care area where both **RNs & RPNs** provide nursing care.) If you are, I want to invite you to have conversations about your experience.

Brock University

Please share your perspective experience of working in a mixed nursing scope (**RPNs & RNs** practicing) environment, by participating in a study entitled: **Who am I and what do I do**: A research study on the experience of **RNs & RPNs** working in the same environment.

**Your involvement will entail private & confidential conversations.**

To participate in this study, please contact:
Kristina Nelson RN, BScN, Graduate Student
T: 905-746-0490
E: kn17ot@brocku.ca

AND/OR

Jane Moore, RN, PhD, CCRN, APN
Brock University, Department of Nursing
T: 905-688-5550 ext 4189
E: jane.moore@brocku.ca

## Appendix C: Nomination form

Dear participant, if you are aware of an individual who fits the requirements of this study and may have interest in participating this would greatly be appreciated. You may share with your perspective nominee my contact information, the requirement letter and the study invitation.

Thank you

Kristina Nelson

905-746-0490

Kn17ot@brocku.ca

**Appendix D: Letter of information and consent form**

# Letter of Information and Consent

**Title of Study:** Who am I and what do I do? A hermeneutic phenomenological study on the experience of RNs and RPNs working in the same environment.

**RESEARCHERS:**
Kristina Nelson, RN, BScN, Graduate Student
T: 905-746-0490
Email: kn17ot@brocku.ca

Jane Moore, RN, PhD, CCRN, APN
Brock University, Department of Nursing
T: 905-688-5550 ext. 4189 F: 905-688-6658
Email: jane.moore@brocku.ca

**INVITATION**
You are invited to participate in a study on the experience of nursing in an intraprofessional environment. The purpose of this hermeneutic phenomenological study is to explore the experience of nurses working in an intraprofessional nursing scope environment. This study will explore the experience of intraprofessional scope mix of both registered nurses and registered practical nurses working in the same care environment. The study consists of an interview in person or on the telephone.

**WHAT'S INVOLVED**
If you agree to participate in the study, you will be asked to share your experience of working in a dual scope nursing environment. I will arrange an interview with you that will take approximately 60 minutes and will take place on a date and at a time of your preference.

**POTENTIAL BENEFITS AND RISKS**
You may or may not receive any direct benefit from being in this study. Information learned from this study may enhance nursing knowledge and contribute to future research. There are no known or anticipated risks associated with participation in this study.

**CONFIDENTIALITY**
All information is confidential and all identifying information will be removed from the transcripts. You will be identified only by a pseudonym and only the investigators will have access to the identifying information associated with each pseudonym. Ffurthermore, because our interest is in responses of the entire group of participants, you will not be identified individually in any way in written reports of this research.

Data collected during this study will be stored for seven years in a locked cabinet, in a locked office of one of the investigators, after which time all data will be shredded and discarded. Access to this data will be restricted to Kristina Nelson and Dr. Moore.

**VOLUNTARY PARTICIPATION**

Participation in this study is voluntary. If you wish, you may decline to answer any questions or participate in any component of the study. Further, you may decide to withdraw from this study at any time and may do so without any penalty or loss of benefits to which you are entitled. Please note that your decision to participate in this study will in no way influence your employment or work relationships.

**PUBLICATION OF RESULTS**
Results of this study may be published in professional journals and presented at conferences.

**CONTACT INFORMATION AND ETHICS CLEARANCE**
If you have any questions about this study or your rights as a participant, please contact Kristina Nelson at 905-746-0490 and/or Dr. Jane Moore at 905-688-5550 (ext. 4189); Dr. Kimberly Maich, Chair of Brock University Research Ethics Board (REB) at 905-688-5550 (ext.4716).

This study has been reviewed and received ethics clearance through the Research Ethics Board at Brock University [insert file #]. If you have any comments or concerns about your rights as a research participant, please contact the Research Ethics Office at (905) 688-5550 Ext. 3035, reb@brocku.ca.

**CONSENT**
I agree to participate in this study described above. I have made this decision based on the information I have read in the Information-Consent Letter. I have had the opportunity to receive any additional details I wanted about the study and understand that I may ask questions in the future. I understand that I may withdraw this consent at any time. I will receive a signed copy of this form.

**A) If participating in person or through telephone interview, please sign and date the consent below:**

_____ _____

Print Name of Participant Signature Date

My signature means that I have explained the study to the participant named about I have answered all questions.

_____ _____

Print Name of Person Obtaining Consent Signature Date

## Appendix E: Initial ethical clearance from Brock University REB

**Brock University**

Research Ethics Office Tel:
905-688-5550 ext. 3035

Email: reb@brocku.ca

Social Science Research Ethics Board

### Certificate of Ethics Clearance for Human Participant Research

| | | | |
|---|---|---|---|
| DATE: | 1/15/2019 | | |
| PRINCIPAL INVESTIGATOR: | MOORE, Jane - Nursing | | |
| FILE: | 18-119 - MOORE | | |
| TYPE: | Masters Thesis/Project | STUDENT: | Kristina Nelson |
| | | SUPERVISOR: | Jane Moore |

TITLE: Who am I and what do I do? A hermeneutic phenomenological study on the experience of RNs and RPNs working together in the same environment

**ETHICS CLEARANCE GRANTED**

Type of Clearance: NEW Expiry Date: 1/1/2020

The Brock University Social Science Research Ethics Board has reviewed the above named research proposal and considers the procedures, as described by the applicant, to conform to the University's ethical standards and the Tri-Council Policy Statement. Clearance granted from 1/15/2019 to 1/1/2020.

The Tri-Council Policy Statement requires that ongoing research be monitored by, at a minimum, an annual report. Should your project extend beyond the expiry date, you are required to submit a Renewal form before 1/1/2020. Continued clearance is contingent on timely submission of reports.

To comply with the Tri-Council Policy Statement, you must also submit a final report upon completion of your project. All report forms can be found on the Research Ethics web page at http://www.brocku.ca/research/policies-and-forms/research-forms.

In addition, throughout your research, you must report promptly to the REB:

a) Changes increasing the risk to the participant(s) and/or affecting significantly the conduct of the study;
b) All adverse and/or unanticipated experiences or events that may have real or potential unfavourable implications for participants;
c) New information that may adversely affect the safety of the participants or the conduct of the study;
d) Any changes in your source of funding or new funding to a previously unfunded project.

We wish you success with your research.

Approved: Lynn Dempsey

Lynn Dempsey, Chair
Social Science Research Ethics Board

Robert Steinbauer, Chair
Social Science Research Ethics Board

**Note:** Brock University is accountable for the research carried out in its own jurisdiction or under its auspices and may refuse certain research even though the REB has found it ethically acceptable.

If research participants are in the care of a health facility, at a school, or other institution or community organization, it is the responsibility of the Principal Investigator to ensure that the ethical guidelines and clearance of those facilities or institutions are obtained and filed with the REB prior to the initiation of research at that site.

# Appendix F: Ethical clearance granted from hospital REB

Halton Healthcare
GEORGETOWN · MILTON · OAKVILLE

30-Jan-2019

Ms. Kristina Nelson, RN
BScN, Graduate Student
Brock University

Dear Ms. Nelson,

**Re: 2019-002 'Who am I and What do I do?' A hermeneutic phenomenological study on the experience of RPNs working together in the same environment**

| | |
|---|---|
| **Expiry Date:** | **30-January-2020** |
| **Meeting Date:** | **28-November-2018** |
| **Initial Approval Date:** | **30-January-2019** |

The Halton Healthcare Research Ethics Board approved the above mentioned study as it has been found to comply with relevant research ethics guidelines, as well as the Ontario Personal Health Information Protection Act (PHIPA), 2004.

| | |
|---|---|
| **Documents Approved:** | **Study Poster**<br>**Letter of Information and Consent Form** |
| **Documents Acknowledged:** | **Certificate of Ethics Clearance for Human Participants Research (Brock University) -1/15/2019** |

The Halton Healthcare Research Ethics Board operates in compliance with the Tri-Council Policy Statement; ICH Guideline for Good Clinical Practice E6(R1); Ontario Personal Health Information Protection Act (2004); Part C Division 5 of the Food and Drug Regulations; Part 4 of the Natural Health Products Regulations and the Medical Devices Regulations of Health Canada. The approval and the views of the REB have been documented in writing. The REB has reviewed and approved the clinical trial protocol and informed consent form for the trial which is to be conducted by the qualified investigator named in the letter.

Furthermore, members of the Research Ethics Board who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB.

Best wishes on the successful completion of your project

Sincerely,

Dr. Paul Zalzal
Chair, Research Ethics Board

**Brock University**

Research Ethics Office Tel:
905-688-5550 ext. 3035

Email: reb@brocku.ca

Social Science Research Ethics Board

# Appendix G: Modified ethical clearance from Brock University REB

## Certificate of Ethics Clearance for Human Participant Research

| | | | |
|---|---|---|---|
| DATE: | February 7, 2019 | | |
| PRINCIPAL INVESTIGATOR: | MOORE, Jane - Nursing | | |
| FILE: | 18-119 - MOORE | | |
| TYPE: | Masters Thesis/Project | STUDENT: | Kristina Nelson |
| | | SUPERVISOR: | Jane Moore |

TITLE: Who am I and what do I do? A hermeneutic phenomenological study on the experience of RNs and RPNs working together in the same environment

**ETHICS CLEARANCE GRANTED**

Type of Clearance: MODIFICATION Expiry Date: 1/1/2020

The Brock University Social Sciences Research Ethics Board has reviewed the above named research proposal and considers the procedures, as described by the applicant, to conform to the University's ethical standards and the Tri-Council Policy Statement.

Modification: Recruit using Facebook.

The Tri-Council Policy Statement requires that ongoing research be monitored by, at a minimum, an annual report. Should your project extend beyond the expiry date, you are required to submit a Renewal form before **1/1/2020**. Continued clearance is contingent on timely submission of reports.

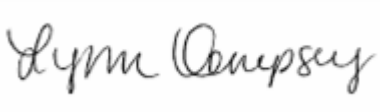
To comply with the Tri-Council Policy Statement, you must also submit a final report upon completion of your project. All report forms can be found on the Research Ethics web page at http://www.brocku.ca/research/policies-and-forms/research-forms.

In addition, throughout your research, you must report promptly to the REB:

a) Changes increasing the risk to the participant(s) and/or affecting significantly the conduct of the study;
b) All adverse and/or unanticipated experiences or events that may have real or potential unfavourable implications for participants;
c) New information that may adversely affect the safety of the participants or the conduct of the study;
d) Any changes in your source of funding or new funding to a previously unfunded project.

We wish you success with your research.

Approved:



Lynn Dempsey, Chair
Social Science Research Ethics Board

Robert Steinbauer, Chair
Social Science Research Ethics Board

**Note:** Brock University is accountable for the research carried out in its own jurisdiction or under its auspices and may refuse certain research even though the REB has found it ethically acceptable.

If research participants are in the care of a health facility, at a school, or other institution or community organization, it is the responsibility of the Principal Investigator to ensure that the ethical guidelines and clearance of those facilities or institutions are obtained and filed with the REB prior to the initiation of research at that site.

**Appendix H: Interview Guide and Telephone Script**

- Formal greeting
- Inform participant that this phone call interview will be recorded and will continue to be recorded throughout the process of information, consent and the actual interview.
- I will ask the participant if I have their permission to record them, if they are agreeable I will continue the process, if they are not agreeable I will thank them for their time and end the conversation.
- I am starting the recording.
- I am going to read you the letter of information and consent, this will take several minutes. After I have completed reading the letter of information and consent I am going to ask you if you have any questions or concerns that need to be addressed and if you would give informed consent.
- Here I will read the letter of information and consent.
- Here I will ask the participant the following question: Do I have your informed consent to participate in this study?
- Thank you for agreeing to participate in my study entitled: Who am I and what do I do.
- During our interview conversation, please do not hesitate to ask me to repeat any questions that seem unclear to you. As a reminder to you this conversation is being recorded so that I can transcribe our conversation later. It is important to emphasize that I cannot assure you of confidentiality and privacy if there are others in your immediate area who may overhear your responses.
- Are you ready to begin?

The following is a list of question that I will use during my conversational interviews: Please keep in mind this is a guide because in phenomenological research the conversation guides the discussion and not the questions.

1. Can you tell me about your career as a nurse and what type of nurse you are?
2. Tell me about your educational background and when did you graduate?
3. Tell me about your role as a Nurse RN/RPN on this unit?
4. How does your nursing role differ, and/or how is your role the same as other nurses working in your unit?
5. What are interactions like between RNs and RPNs?
6. Describe for me your experiences working with RN\RPNs?
7. Describe any challenges or rewards that have come from your experience in working in an intraprofessional work environment.
8. What would you do to make changes to the current work environment, if any?
9. Is there anything else you would like to add?

## Appendix I: Audit Checklist and Sample of Notes

- ❑ Potential participant contacts researcher.
- ❑ Location, date, time and mode of communication decided.
- ❑ Preprinting of individual letters of information and consent.
- ❑ Individualized note papers were readied for the individual conversations.