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The role of the enrolled nurse in the Australian nursing workforce: A mixed methods study

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Abstract

Background

The enrolled nurse (EN) is the second-level regulated nursing role in Australia. It was designed to support and assist the registered nurse (RN) role by providing more hands-on, practical bedside nursing care. Despite many reports and research papers indicating that this role is integral to the nursing workforce, persistent challenges have been identified. Exploring the role of the EN will provide a greater understanding through the perspective of the EN as an individual, as a member of the nursing team and within the hospital or facility and the nursing profession. This will inform the development of strategies to address the continuing challenges and ensure the role is effective and valued.

Aim

This study aims to gain a better understanding of the role of the EN in the Australian nursing workforce.

Methods

A sequential multiphase exploratory mixed methods research design was used. It commenced with 10 focus groups in 2019, followed by the development and administration of a self-administered questionnaire in 2020. This resulted in 400 completed questionnaires. The results were analysed through the lens of the philosophical assumptions of pragmatism and the transformative approach, and the conceptual framework of organisational behaviour.

Findings

The qualitative data captured three themes: the EN as an individual, the EN in the workplace and the EN in the profession. These themes aligned with the three analysis levels of the conceptual framework of organisational behaviour: the individual, the team and the organisation. The results from the questionnaire reinforced these themes. The findings identified significantly different perspectives and expectations between the nursing roles.

At an individual level, ENs were driven by intrinsic and extrinsic motivators, with the primary motivator *being a nurse*. Extrinsic motivators were influenced by the behaviours, attitudes and feedback provided by others in the nursing and wider healthcare workforce. These influenced levels of job satisfaction, occupational stress in the team and

organisational culture in the working environment. At a professional level, the title does not reflect the role, and there are no career pathways.

Discussion

The success and value of ENs are influenced by their intrinsic and extrinsic motivators and three key determinants: that the EN understands their role, that the RN understands their role when working with an EN and that the organisation provides opportunities for the EN and understands how the nursing team needs to work to ensure all nursing roles can work within their respective scope and standards of practice. When these three determinants align, there is job satisfaction, minimal occupational stress and the EN feels valued. Collectively, these create an environment with pull factors.

Conversely, in environments where any one of the three determinants is absent, there is a lack of job satisfaction, increased occupational stress, the potential for the nursing roles to work outside their scope and standards of practice, and poor organisational culture, where the EN does not feel valued in their role. Collectively, these create an environment with push factors.

At the professional level, there is a need for the nursing profession to better recognise the EN within the structure of the nursing team, as the perception is that it is a transitional role to becoming an RN. This requires greater clarity on how the nursing roles collaborate in the practice of nursing. Once that is established, for the nursing profession to construct a career pathway with accompanying qualifications, financial remuneration and titles that reflect the qualification and experience required for the EN role.

Conclusion

This research identifies why there are recurrent challenges surrounding the EN role. It demonstrates that there is a need to examine the nursing roles and how they work together in the practice of nursing to create effective and sustained change. Changes at the professional level that create a structure recognising the role and enabling ENs to create a career as ENs are also needed.

Keywords

Nursing workforce, nursing workforce planning, enrolled nurse scope of practice, registered nurse role, team nursing

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Certification

I, Rebecca Jane Leon, declare that this thesis, submitted in fulfilment of the requirements for the award of Doctor of Philosophy in the School of Nursing, University of Wollongong, is wholly my own work unless otherwise referenced or acknowledged. The document has not been submitted for qualifications at any other academic institution.

Signed:

Date: 27 January 2023

Study outputs to date

Peer-reviewed publications

Leon, R. J., Lapkin, S., Fields, L. & Moroney, T. (2022) Developing a self-administered questionnaire: Methods and considerations. *Nurse Researcher*, *30*(3), 36–45. https://doi.org/10.7748/nr.2022.e1848

Leon, R. J., Moroney, T., Fields, L. & Lapkin, S. (2022). Exploring the role of the second-level regulated nurse in the Australian nursing workforce: An integrative review. *Contemporary Nurse*, *58*(4), 285–295. https://doi.org/10.1080/10376178.2022.2107040

Leon, R. J., Moroney, T., Fields, L. & Lapkin, S. (2022). The enrolled nurse in midwifery: A cause for concern? *Australian Midwifery News*, *30*(1), 36–37. https://search.informit.org/doi/10.3316/informit.677954991665925

Presentations

Leon, R.J., Moroney, T., Lapkin, S., & Fields, L. (9-11August 2023). *The role of the enrolled nurse: A journey to recognition* [Oral presentation]. National Nursing Forum 2023, Adelaide, Australia.

Leon, R. J., Lapkin, S., Moroney, T., & Fields, L. (11-12 May 2023). *The role of the enrolled nurse: Where to from here?* [Oral presentation]. International Congress of innovation and leadership in nursing and midwifery, Perth, Australia.

Leon, R. J., Moroney, T., Fields, L. & Lapkin, S. (9 December 2020). *The role of the enrolled nurse in the Australian health care context* [Oral presentation]. Nursing Research Conference, University of Wollongong, Australia.

Leon, R. J., Lapkin, S., Fields, L. & Moroney, T. (27 November 2019). *Developing a meaningful questionnaire* [Oral presentation]. Nursing Research Conference, University of Wollongong, Australia.

Leon, R. J., Moroney, T., Fields, L. & Lapkin, S. (20 September 2019). *Valuing enrolled nurses: An exploratory sequential mixed methods study to better understand the role of the enrolled nurse in the Australian health care context* [Oral presentation]. Enrolled Nurses Professional Association, Newcastle, Australia.

Leon, R. J., Moroney, T., Fields, L. & Lapkin, S. (28 June 2018). *Valuing enrolled nurses: An exploratory sequential mixed methods study to better understand the role of the enrolled nurse in the Australian health care context* [Oral presentation]. Nursing Research Conference, University of Wollongong, Australia.

Abbreviations

AHPRA	Australian Health Practitioner Regulation Agency
AIN	assistant in nursing
ANA	American Nurses Association
ANMAC	Australian Nursing and Midwifery Accreditation Council
ANOVA	analysis of variance
ASEN	advanced skilled enrolled nurse
BM	bachelor of midwifery
BN	bachelor of nursing
COSMIN	COnsensus-Based Standards for the Selection of Health Measurement INstruments
CSHSC	Community Services & Health Skills Council
CVI	content validity index
EEN	endorsed enrolled nurse
EFA	exploratory factor analysis
EN	enrolled nurse
FG	focus group
HREC	human research ethics committee
I-CVI	individual content validity index
KMO	Kaiser-Meyer-Olkin
LPN	licenced practical nurse
MM	mixed methods
MMAT	Mixed Methods Appraisal Tool
NFLPN	National Federation of Licensed Practical Nurses
NHMRC	The National Health and Medical Research Council
NMBA	Nursing and Midwifery Board of Australia
NSW	New South Wales
NZ	New Zealand
OB	organisational behaviour
OECD	Organisation for Economic Co-operation and Development
PCA	principal components analysis
PhD	Doctor of Philosophy

PIS	participant information sheet
RM	registered midwife
RN	registered nurse
RPN	registered practical nurse
RPNAO	Registered Practical Nurses Association of Ontario
S8s	Schedule 8 medications
S-CVI	scale content validity index
SD	standard deviation
SOP	scope of practice
SPSS	Statistical Package for the Social Sciences
UHCW	unregulated healthcare worker
UK	United Kingdom
USA	United States of America
WW2	Second World War

Glossary of terms

closed-ended question	A question with a predefined list of possible answers.
Education of Nurses Inquiry	New South Wales Committee of Inquiry into the Education of Nurses, 1970. Also known as the Truskett report.
EN cohort	Study cohort comprising only enrolled nurse participants.
enrolled nurse	A second-level regulated nursing role. The role has several titles both within Australia and internationally. It has been known as a 'registered practice nurse', 'licensed practical nurse', 'division 2 nurse' and 'licensed vocational nurse', and historically as an 'assistant in nursing' and 'nursing aide'. For this paper, the term 'enrolled nurse' will be used.
industrial award	Is a legal document that outlines the minimum pay rates and conditions of employment (Fair Work Ombudsman)
OECD	The Organisation for Economic Co-operation and Development is an international organisation comprised of 38 countries that works to build better policies for better lives. Its goal is to shape policies that foster prosperity, equality, opportunity and wellbeing for all (OECD, 2011).
occupational stress	The study of psychological stress occurring in the workplace (Kalliath et al., 2014, p. 225).
job satisfaction	The individual's affective (emotional) reaction to their job, and how much pleasure or happiness they derive from it (Kalliath et al., 2014, p. 203).
open-ended question	This question type asks the participant to provide an answer in their own words.

non-EN cohort	Study cohort comprising only non-enrolled nurse participants; assistants in nursing/midwifery and registered nurses/midwives employed as clinicians, managers and educators in clinical and non-clinical roles.
S8s	Schedule 8 medications are medications that are required by law to be locked in a drug cupboard. There are specific requirements for prescribing and administering these medications under each state and territory's Poisons Act.
special grade	This is a specialist role established by the employer. It has a defined criteria requiring a post-registration qualification and minimum number of years post-registration as an enrolled nurse (NSW Nurses & Midwives Association, 2022).
supervision	"Is defined as access, in all contexts of care, at all times, either directly or indirectly to professional supervision to a named and accessible RN for support and guidance of the practice of an EN. • Direct supervision is when the supervisor is actually present and personally observes, works with, guides and directs the person who is being supervised. • Indirect supervision is when the supervisor works in the same facility or organisation as the supervised person, but does not constantly observe their activities. The supervisor must be available for reasonable access. What is reasonable will depend on the context, the needs of the person receiving care and the needs of the person who is being supervised." (Nurses & Midwifery Board of Australia [NMBA] 2016, p. 9)

unregulated healthcare worker	An unregulated healthcare worker has no defined minimum education or regulatory requirements. This is an encompassing term that can include personal care assistants and assistants in nursing/midwifery. The role supports the registered nurse/registered midwife and/or enrolled nurse with patients' personal needs, which can include bathing, dressing, feeding and documentation. In Australia, this role is predominately used in the aged care sector.
qual	Notation for indicating a qualitative method.
quan	Notation for indicating a quantitative method.
role	A person's function in a particular situation (Soanes & Hawker, 2005, p. 893).

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Chapter 1: The role of the enrolled nurse

1.1 Introduction

The enrolled nurse (EN) is the second-level regulated nursing role in Australia, with similar roles in other Organisation for Economic Co-operation and Development (OECD) countries, such as the United States of America (USA), Canada and New Zealand (NZ). (Lucas et al., 2021). Health systems are both complex and multifaceted, with various public and private service providers supported by a large and diverse workforce (Borkowski, 2016). The workforce within these health systems comprises of a variety of occupations made up of both regulated professionals and unregulated support staff and volunteers. Within Australia, registered nurses (RN), registered midwives (RM) and ENs form the largest regulated group in the healthcare workforce. There were 429,258 RNs, RMs and ENs registered and employed in Australia in 2021. This was three times more than the next largest registered and employed health profession in Australia, medical practitioners (129,066), during the same period (Australian Health Practitioner Regulation Agency [AHPRA] & National Boards, 2021).

The EN was designed to support and assist the RN, the first-level regulated nursing role, by providing more hands-on, practical bedside nursing care. (Albani et al., 2006). Despite a plethora of reports and research papers indicating that the EN role is integral to the nursing workforce, many authors identified persistent challenges experienced by ENs. (Leon et al., 2022; Lucas et al., 2021). These challenges include confusion and a lack of role delineation between the EN and RN roles, ENs feeling undervalued, inconsistent standards for practice for ENs and lack of career progression for the EN as an EN (Leon et al., 2022; Lucas et al., 2021). Exploring the role of ENs will provide a greater understanding of the role which will enable clearer delineation between the nursing roles within the nursing workforce. This would assist workforce planning, education providers with the development of nursing qualifications, funding models at a strategic level and rostering at the ward operational level (Duckett, 2000), and importantly, the EN feeling valued in their role. As a purported integral member of the nursing workforce, this requires capturing not only the experiences and perspectives of ENs, but also the nursing workforce with whom ENs work, and how the role is placed from a nursing organisation and professional level.

1.2 Research aim and objectives

This study aims to gain a better understanding of the role of ENs in the Australian nursing workforce. Therefore, it was prudent to examine the following research question: what is the role of the EN in the Australian nursing workforce? A multiphase exploratory sequential mixed methods (MM) research design was conducted.

1.3 Thesis structure

Section 1.3 provides the structure of the thesis by describing each of the eight chapters. Several peer-reviewed publications are also associated with this work and have been identified where appropriate.

Chapter 1 introduces the role of the EN, their education requirements and their current place in the nursing workforce. The international, historical and contemporary perspectives since the role's inception are presented to provide a context and opportunity to learn. It captures the varying titles used to name the second-level nurse role and concludes with a rationale for the need to gain a better understanding of the role of the EN in the Australian nursing workforce.

Chapter 2 critiques the Australian literature with some international context. It presents three themes: understanding the EN's scope of practice (SOP), standardised practice and career development. The literature has suggested that discussion is required regarding the role of the EN within the Australian nursing workforce. Chapter 2 is informed by the following publication (see Appendix A):

> Leon, R. J., Moroney, T., Fields, L. & Lapkin, S. (2022). Exploring the role of the second-level regulated nurse in the Australian nursing workforce: An integrative review. *Contemporary Nurse*, *58*(4), 285–295. https://doi.org/10.1080/10376178.2022.2107040

Chapter 3 presents the research design used for this study, a multiphase exploratory sequential MM approach. It explores the researcher's approach and discusses the ontological, epistemological and methodological approaches used to frame the development of the study design, analysis and, subsequently, the study findings. The discussion includes how the philosophical assumptions of pragmatism and the transformative approach support the decision-making used to inform the

recommendations. The rationale and application of the research design, using the conceptual framework of organisational behaviour (OB) as a lens to analyse the data, is also described.

Chapter 4 presents the research design and findings for Phase 1—the qualitative phase of this three-phase MM study. In the multiphase exploratory sequential MM research design, Phase 1 is the qualitative phase, and the data captured from this phase has a greater emphasis on addressing the aim and objectives of this study. Focus groups were the qualitative tool used. Three themes emerged from Phase 1: the EN as an individual, the EN in the workplace and the EN in the profession.

Chapter 5 presents Phase 2 of the multiphase exploratory sequential MM research design. Phase 2 includes the research methodology for developing and validating the self-administered questionnaire used in Phase 3 (see Chapter 6). A structured framework with five steps was used: (1) the preliminary considerations; (2) drafting the questionnaire; (3) an expert panel review; (4) a pilot of the questionnaire; and (5) the reliability analysis. Chapter 5 also acknowledges the limitations of not testing for factor structure, dimensional analysis or internal consistency. The following publication informs Chapter 5 (see Appendix B):

> Leon, R. J., Lapkin, S., Fields, L. & Moroney, T. (2022) Developing a self-administered questionnaire: Methods and considerations. *Nurse Researcher*, *30*(3), 36–45. https://doi.org/10.7748/nr.2022.e1848

Chapter 6 presents the research design and findings for Phase 3—the quantitative phase. A quantitative tool, the self-administered questionnaire, was used. A wealth of data was captured, providing the opportunity to develop a comprehensive picture of the role of the EN from the perspective of the EN, other nursing roles and the role in the broader Australian nursing profession.

Chapter 7 presents the discussion and analysis of the integrated findings from Phases 1 and 3. The study identifies new insights, including the influence of intrinsic and extrinsic motivators on ENs' experiences and perceptions of their role. It also identifies key determinants that need to coexist to increase job satisfaction, decrease occupational stress and create a positive organisational culture. From a professional level, there is a need to review professional opportunities, including a career pathway for ENs as ENs.

Chapter 8 presents the conclusion and recommendations resulting from the analysis and discussion. Using the pragmatic and transformational philosophical assumptions as the platform through which the recommendations were constructed, the recommendations are also aligned to the OB's three units of analysis: the individual, the team, and the organisation and professional levels.

1.4 Enrolled nurse titles

The title for the role of the EN has been inconsistent in Australia, differed between countries and changed over time (see Table 1.1). For this thesis, the term 'EN' refers to the second-level regulated nursing role.

Table 1.1: National and international enrolled nurse titles

Title	Era	Country	Reference
Assistant in nursing	1940s–1950s	Australia	Albani et al. (2006)
Nurse aide	1960s	Australia	Albani et al. (2006)
Registered nurse Division 2 nurse	1980s–1990s	Victoria, Australia	Nielsen, (1997)
Enrolled nurse	1980s–present	Australia	Australian Nursing & Midwifery Council, (2002)
Endorsed enrolled nurse	2004–2010	Australia (some states)	Manwarring & Passlow, (2004), Nursing and Midwifery Board of Australia, (2018a)
LPN	1940s–present	Canada (except Ontario)	Macleod et al. (2017)
Certificated nursing assistant	1930s–1950s	Canada	RPNAO, (n.d.)
Registered nursing assistant	1960s	Ontario, Canada	RPNAO, (n.d.)
Registered practical nurse	1990s–present	Ontario, Canada	RPNAO, (n.d.)
LPN	1940s–present	United States of America (some states)	National Association of LPNs, (n.d.)
Licensed vocational nurse	1980s–present	United States of America (some states)	National Association of LPNs, (n.d.)

Note. LPN = licensed practical nurse; RPNAO = Registered Practical Nurses Association of Ontario.

1.5 Enrolled nursing internationally

In the late 1930s, there was an international shortage of RNs, creating a need to increase the capacity to provide bedside nursing care, which was further exacerbated by the effects of the Second World War (WW2) (Brown, 1994; Registered Practical Nurses Association of Ontario [RPNAO], n.d.; Statement of functions of the licenced practical nurse, 1957). A second-level regulated nursing role was created to support this shortage. This was the beginning of the role in countries such as Canada, the United Kingdom (UK) and the USA (Brown, 1994; RPNAO, n.d.; Statement of functions of the licenced practical nurse, 1957). There was a considered response to the role's development, with each of these countries formally introducing a second-level regulated nursing role with a governance structure and dedicated training program (Brown, 1994; RPNAO, n.d.; Statement of functions of the licenced practical nurse, 1957). These countries were identified as they are all members of the OECD (2011) with comparable nursing workforce structures (Brown, 1994; RPNAO, n.d.; Statement of functions of the licenced practical nurse, 1957).

In Canada, the role was created in 1938 with a six-month training program (RPNAO, n.d.). The shortage of RNs in Canada continued, and in 1946, an inquiry was conducted to examine practical nursing in all provincial hospitals/facilities (RPNAO, n.d.). The result of this inquiry was the establishment of training schools with a nine-month program for the licensed practical nurse (LPN), and the *Nursing Act, 1991*, was officially amended to include this role (RPNAO, n.d.). In 1958, the Association of Certified Nursing Assistants of Ontario was formed to provide certificated nursing assistants with a professional voice, the education program was extended to 10 months, and the title was changed to RN assistant (RPNAO, n.d.). In the 1990s, medication administration was added to the SOP, and the required entry-level education was extended to 18 months (RPNAO, n.d.). In Ontario, the title was formally changed again from RN assistant to registered practical nurse (RPN), and the chief nursing officer published the entry-to-practice competencies for RPNs, which acknowledged the changed competencies and title (RPNAO, n.d.). Practical nurses are referred to as LPNs, except in Ontario, where they are now referred to as RPNs (Macleod et al., 2017). The ongoing evolution of the role demonstrates that Canada continues to analyse its scope and position in the nursing workforce.

In the UK, changes were made to the *Nurses' Act 1943*, which formalised the role of the EN (Brown, 1994). A two-year training program was implemented, and the scope of the role was defined as assisting the RN in practical nursing care (Brown, 1994). In the 1980s, there was significant debate about maintaining the role, because it was evolving into being very similar to the role of the RN, creating a lack of clarity around role delineation. It was felt that a single-level nursing registration would eliminate role confusion (Glasper & Rushforth, 1998; United Kingdom Central Council for Nursing, Midwifery & Health Visiting, 1987). This resulted in the United Kingdom Central Council for Nursing, Midwifery & Health Visiting announcing the Project 2000 initiative (Glasper, 2016). EN training would be discontinued, and through natural attrition, the RN would be the only regulated nursing role in the UK. ENs were provided with the opportunity to complete further studies and become an RN or remain an EN until they left/retired from nursing (Dowswell et al., 1998).

Subsequently, the UK identified that removing the EN workforce created a gap in bedside nursing care (Glasper, 2016). This gap was filled with a 'nursing associate' role, but with increased scrutiny and a need to bridge the gap, a formalised model of education and training was reintroduced. *Raising the Bar. Shape of Caring: A Review of the Future Education and Training of Registered Nurses and Care Assistants* was commissioned by Health Education England, and it re-emphasised concerns from across the nursing profession that the replacement for RNs, which had been conducted by cheaper ENs, was now by cheaper non-nurses (Willis, 2015). The absence of the EN role identified the need for a second-level role that the health care assistant had been unable to fill; the challenge for the UK was how to define that role (Glasper, 2016). The nursing associate (NA) role was created and has become a pathway into the nursing workforce, especially for the healthcare support workers (King et al., 2022; Traynor et al., 2020).

In the USA, having established the equivalent role to the EN (the LPN), the nursing profession identified the need to minimise the increasing confusion and provide clearer role delineation between LPNs and RNs (Statement of Functions of the Licensed Practical Nurse, 1957). This resulted in a collective statement published by the Executive Board of the National Federation of Licensed Practical Nurses (NFLPN) and the Board of Directors of the American Nurses Association (ANA) (Statement of Functions of the Licensed Practical Nurse, 1957). This had minimal success because, in the late 1950s and early

1960s, there was increased agitation from nurses who wanted increased autonomy and clarification between the two roles (Merton, 1962).

The purpose of the LPN's role was questioned, which was further compounded by the expansion of the RN's SOP while the EN's scope remained unchanged, with the RN representing nursing on state practice boards and the voice of the EN silent (Merton, 1962). This generated discussion about what the practice of nursing was and who should conduct that practice (Merton, 1962). Etta Rasmussen (1962), a recognised nursing academic and longstanding member of the ANA, stated that the difference between the RN and EN roles was in 'the degree of responsibility for the function, not a difference in function. This is not like the relationship between the physician and the nurse, the generic functions of the paired occupational groups are connected but remain distinctive' (p. 72). The 'degree of responsibility' was determined by the differing education and legal responsibilities of the RN and EN roles (Merton, 1962; Rasmussen, 1962). The ANA established the NFLPN to support the continued development of LPNs and provide clear role delineation. Once established, the NFLPN pushed for its autonomy (Merton, 1962, p. 72). The outcome of this structure was that the LPN's role remains functional in the USA.

In NZ, after decade-long deliberations, consultations and lobbying from ENs, in 2010, the Nursing Council of New Zealand determined to maintain the role, expand the scope and standardise the title to 'EN' (Enrolled Nurses Here To Stay—Finally, 2010). Since this determination, the literature has demonstrated that the role has evolved, and in 2020, a national learning framework to support newly graduated ENs transition into practice was implemented—the Enrolled Nurse Supported Into Practice Program (Gordon, 2020). The next step for NZ ENs is a comprehensive review of their SOP, with significant lobbying from the NZ Enrolled Nurse Section to move from the requirement that ENs work under the direction of an RN to partnering with RNs (Longmore, 2022).

A systematic review of healthcare professionals' perspectives on ENs, practical and other second-level nursing roles was conducted by UK authors, capturing qualitative studies from across OECD countries (Lucas et al., 2021b). This review provided a summation of the perspectives from several countries and identified that the role of the EN has faced the same issues over decades and that these issues were not isolated to one country or health system (Lucas et al., 2021b). The findings from the review completed by Lucas et

al. (2021b) aligned with the review of the role of the EN in the Australian context (Leon et al., 2022). Section 1.6 focusses on the role of the EN in Australia.

1.6 Enrolled nurses in Australia

ENs were introduced into the Australian nursing workforce in 1943 for the same reasons they were introduced in other countries: a shortfall of RNs in the healthcare workforce, which was further affected by WW2 (Albani et al., 2006). The recommendation to cover the nursing shortfall was to introduce a second-level nurse, called an 'assistant in nursing' (AIN) (Albani et al., 2006). Unlike their international counterparts, Australia did not develop a specific education program (Albani et al., 2006). An EN was someone who failed the RN training but wanted to continue nursing (Albani et al., 2006).

Despite not having specific entry-level education, the role was formalised under the *Nurses' Act 1943 (NSW)* with the introduction of the Enrolled Nurses Committee (Institute of Hospital Matrons of New South Wales [NSW] & Australian Capital Territory Committee to Consider All Aspects of Nursing, 1969, p. 32). The committee reported to the General Nursing Council. Its duties included educating and examining ENs for admission to the roll, a formal record of the ENs in the nursing workforce, and the disciplinary jurisdiction required for those ENs who did not practice to the required standard or whose behaviour was considered misconduct (Institute of Hospital Matrons of New South Wales [NSW] & Australian Capital Territory Committee to Consider All Aspects of Nursing, 1969, p. 32). Inconsistent terminology has been used in the literature, with the second-level nurse being called an 'AIN' and the committee referred to as the 'ENs Committee'. This was unclear, and there was no explanation for this anomaly, suggesting that this is the first of many inconsistencies surrounding the role.

There were reports in other nursing literature that the EN role was introduced in Australia in the 1950s because of a need to improve the supply of nursing-related services, which was supported by migrants arriving in Australia with nursing experience (Dewdney, 1972). It is difficult to ascertain which date (1943 or the 1950s) is valid. Another discrepancy concerns when the admission roll for ENs was formalised. One source identified that the skills and experience of ENs were formally recognised with the establishment of the Nurses Registration Board NSW roll for AINs (ENs) in 1953 (Albani et al., 2006, pp. 2–3); however, the Institute of Hospital Matrons of NSW and Australian Capital Territory Committee to Consider All Aspects of Nursing (1969, p. 32)

indicated that this occurred in 1943 with the establishment of the Enrolled Nurses Committee. This may be considered insignificant because it occurred over 60 years ago; however, it provides the beginnings of the legacy of confusion and inconsistency surrounding the EN role.

Education of ENs remained nursing students who failed their RN programs but wanted to continue nursing (Albani et al., 2006). This established a negative perspective of the EN's role, which still permeates the workforce (Leon et al., 2019). It was not until 1958 that the second-level nurse was further developed at state and territory levels, not at the national level, with a defined education program established and recognised by the Nurses Registration Board NSW (Albani et al., 2006). In NSW the program included a one-year formal hospital-based education program specifically for ENs, with a minimum of 75 hours of theory (Albani et al., 2006). This signalled a change in the educational requirements for the role, minimising the stigma that ENs were nurses who failed to be RNs (Leon et al., 2019).

In 1970, the *Report of the Committee Appointed by the Minister for Health to Inquire Into the Education of Nurses, June 1970* also triggered an exploration of alternatives to the hospital employment apprenticeship model for RNs (NSW Committee of Inquiry Into The Education of Nurses [Education of Nurses Inquiry], 1970). Ultimately, this resulted in the pre-registration nursing education of RNs being moved from the hospital into the tertiary education sector in the 1980s. This move significantly affected the role of ENs because by moving student RNs into the tertiary education sector, a marked gap in the nursing workforce was created in the clinical sector (Education of Nurses Inquiry, 1970; Pratt & Russell, 2002). Pre-registration RN nursing students were no longer contributing to the workforce and, therefore, in most settings, this gap was filled by ENs, whose training continued in the hospital system (Education of Nurses Inquiry, 1970; Pratt & Russell, 2002). This resulted in a 44.0% increase in the EN workforce compared to a 29.0% increase in RNs during the same timeframe (Grant & Lapsley, 1987, 1990).

The next significant influence on the EN role in Australia was the call for standardised education and practice across the states and territories. Several Australian reviews and reports focused on entry-level education, including the New South Wales Committee of Inquiry into the Education of Nurses (Education of Nurses Inquiry, 1970) and standards of practice for ENs. There was one persistent recommendation: expanding the EN SOP

to include administering defined medications (Australian Nursing Council, 2002; Manwarring & Passlow, 2004; McEwan, 2008; Working Group on Aged Care Worker Qualifications of the National Aged Care Forum, 2001). The significance of this recommendation fundamentally changed how ENs perceived their role and how their role was perceived by others in the workplace. It also reinforced the perception that the EN and RN roles were essentially the same, with the EN role just a cheaper version (Eagar et al., 2010; Jacob et al., 2014a; Leon et al., 2019).

There were also attempts to more clearly articulate supervision requirements of the EN role. In the National Competency Standards for the Enrolled Nurse the phrase used was 'under the direction and supervision of the registered nurse' (Australian Nursing & Midwifery Council [ANMC], 2002, p. 2). This changed in the Enrolled Nurse Standards for Practice where it stated 'the EN to work under the direct and indirect supervision of the RN' (NMBA, 2016 p. 2). This shift moved the role of the EN to work more independently through indirect supervision.

Another fundamental change was the introduction of national regulation for the RN and EN roles through national registration under the *Accreditation under the Health Practitioner Regulation National Law Act* (Australian Health Practitioner Regulation Agency [AHPRA], 2011). Until this time regulation and registration of the nursing roles was state based. The AIN role has not been regulated, and is not listed as a nursing role on the AHPRA register (APHRA, 2011).

Key reviews and reports that have contributed to changes in the education and SOP for the role of ENs in Australia include:

- *A Review of the Current Role of Enrolled Nurses in the Aged Care Sector: Future Directions* (Working Group on Aged Care Worker Qualifications of the National Aged Care Forum, 2001)
- *National Competency Standards for the Enrolled Nurse* (ANMC, 2002)
- *National Review of Nursing Education 2002: Our Duty of Care* (Heath, 2002)
- *The Patient Profession: Time for Action. Report on the Inquiry Into Nursing* (Senate Community Affairs References Committee Secretariat, 2002)
- *An examination of the role and function of the enrolled nurse and revision of competency standards: Final report.* (Australian Nursing Council, 2002)

- ‘Selected Review of Nurse Regulation’ in the *National Review of Nursing Education 2002: Nursing Regulation and Practice* (Chiarella, 2002)
- The national *HLT07 Health Training Package* (Community Services & Health Skills Council [CSHSC], 2007)
- *Accreditation under the Health Practitioner Regulation National Law Act* (AHPRA, 2011)
- *Enrolled Nurse Standards for Practice* (NMBA, 2016)
- *Enrolled Nurse Accreditation Standards 2017* (Australian Nursing & Midwifery Accreditation Council [ANMAC], 2017)
- *Decision-Making Framework Summary: Nursing* (NMBA, 2020).

These reports and reviews resulted in a national entry-level education program with national accreditation requirements for education providers, national scope and standards of practice for ENs, and national registration.

1.7 Summary: The role of the enrolled nurse

The impetus for the role of the EN internationally and in Australia occurred at a similar time for similar reasons: the need for increased bedside nursing care exacerbated by the effects of WW2. The difference between Australia and other countries that introduced the role, was that Australia did not formalise the role through a specific entry-level education program and governance structure until 15 years after its introduction.

A review of the role’s development identified that the challenges experienced in the Australian nursing workforce were also experienced in other countries. Indeed, the challenges were often identified and experienced in other countries before they were identified and experienced in Australia. Unfortunately, these challenges continue decade after decade. A summary table capturing the main themes and key activities of the role from 1940 to 2019 identified in the literature has been collated (see Supplement A). Studies have been conducted and documented, reports have been commissioned, and recommendations implemented; however, there remains confusion and a lack of role delineation between the EN and RN roles. Internationally, the role of the EN has been questioned, especially compared to the role of the RN, with the UK removing EN role from the nursing workforce.

In Australia, the EN workforce has had a nationally standardised education program, registration and accreditation standards for over 10 years (AHPRA, 2011; ANMAC, 2017; CSHSC, 2007; NMBA, 2016). Despite this national structure, there are persistent challenges and confusion around the role in the nursing workforce, especially at a time of changing complexity and dynamics in the healthcare environment. Section 1.8 presents the Australian nursing workforce data, which reflects the narrative surrounding the role of the EN.

1.8 Australian enrolled nurse workforce data

Available data indicates the highest nursing workforce growth (154.6%) over a 10-year timeframe (2011/2012 to 2020/2021) was in dual EN and RN registrations—that is, ENs who have studied to become an RN and maintained their EN registration (Australian Health Regulation Practitioner Agency and National Boards, 2012, 2021) (see Table 1.2). As a key nursing role, this data prompts the need to understand what is contributing to limited growth in the EN workforce and significant growth in dual EN/RN registrations.

Table 1.2: Registration by nursing roles between 2011/2012 and 2020/2021

Role	2011/2012[a]	2020/2021[b]	Growth (%)
Enrolled nurses	60,967	74,059	21.5
Dual registered & enrolled nurses	3,947	10,050	154.6
Registered nurses	237,331	345,149	45.4
Total nursing workforce	302,245	429,258	42.0

Note.

[a] Australian Health Regulation Practitioner Agency and National Boards (2012, p. 152).

[b] Australian Health Regulation Practitioner Agency and National Boards (2021, p. 25).

As a key nursing role, the plethora of reports and research papers indicate that the EN role is considered integral to the nursing workforce. The continued lack of role clarity despite the national education, scope and standards of practice, together with the workforce data, prompts the need to explore the EN role further.

1.9 The preliminary study

In 2016, research was conducted in a large NSW metropolitan public health service. The local health service identified a shortage of ENs, despite the health service's commitment to training, recruiting and employing diploma of nursing graduates. At the time of the research, 12,500 staff were employed by the health service, of which 504 were ENs (Leon

et al., 2019). The study aimed to improve our understanding of whether the investment in education and training had affected the retention of ENs (Leon et al., 2019). The results indicated that it was not the investment into education and training but the work environment that resulted in ENs feeling undervalued and underutilised, confusion with the ENs' SOP, a lack of standardised practice across the health service, and identifying that an EN professional development pathway would support the retention of ENs (Leon et al., 2019).

The study also identified a lack of a specific EN transition program from entry-level graduation into the working environment, continuing professional development opportunities or career pathways (Leon et al., 2019). What was available was predominately provided at the ward level or self-initiated. An additional finding was a false assumption that all ENs aspired to become RNs (Leon et al., 2019). That study prompted this Doctor of Philosophy (PhD) study because further research was needed to ensure a sustained EN workforce who feel valued in their role.

During this time, the researcher also received an anonymous handwritten letter. The author had gone to the trouble of paying for a postage stamp and posting. It was not sent through internal mail, which would have incurred no postal costs. The letter stated:

> I recently heard there was a [XXX] health service questionnaire Valuing Enrolled Nurses, it's nice that this has happened, but I am sure a lot of us would be to [*sic*] worried about the boomerang effect it would have on us—RNs, AINs, etc. Doctors believe we are the robots of the health team, [and] not many respect us or acknowledge us for our hard work. I've been in the NSW Health Service for over 30 years—I've not seen a big change, [and] I work harder than RNs, we pay the same registration fees, we miss out on in-services, recognition and a lot of respect. There is [*sic*] never any opportunities given to us and we often are overlooked by management. It will never change. (Personal communication, 29 February 2015)

This letter added to the researcher's personal motivation to explore and understand the role of the EN. The letter reinforced why this work needed to be not just about workforce numbers but the experiences, expectations and perceptions of the people that make up the nursing workforce: the ENs, RNs and AINs. Whilst the preliminary study and the letter were motivators for this study, the delay between the completion of the preliminary study

and the completion of this study was the impact of the COVID-19 pandemic on the working role and environment of the researcher.

1.10 Chapter summary

The narrative of the development of the EN role and the workforce data collectively raises many questions and concerns about the sustainability and viability of the role of the EN in the Australian nursing workforce. When the role was removed in the UK, a void in nursing care was created, which they are now trying to fill (British Medical Association, 2020; Glasper, 2016). In the USA and NZ, there was serious consideration regarding the need for the second-level role; however, to date, the role continues (Enrolled Nurses Here To Stay—Finally, 2010; Statement of Functions of the Licensed Practical Nurse, 1957). In Australia, the nursing workforce needs to understand their respective roles and each other's roles to ensure safe, quality patient care where the members of the nursing workforce feel valued. There is a clear need *to gain a better understanding of the role of the EN in the Australian nursing workforce*. The more circumspect may consider that the lack of progression of the EN role might indicate a subtle means to phase it out. A greater understanding of key issues affecting this role would support the development of strategies to address any persistent challenges and ensure the role is effectively used as an integral member of nursing teams. However, there are a considerable number of questions without reliable answers, which lead to assumptions, perceptions, myths and continued confusion. Answering these questions would provide an informed understanding of the role of the EN in Australia, which can inform strategies to effect change. Chapter 2 provides a comprehensive literature review to establish a clear direction for this study.

Chapter 2: Literature review

2.1 Introduction

It is important to ensure that Australia's large and complex healthcare system is supported by the most appropriately skilled and qualified workforce. The lack of growth of the EN workforce, as demonstrated by the data (see Table 1.3), and the persistent challenges (see Supplement A) around the role, prompt the need to gain a better understanding of the role of the EN in the Australian nursing workforce.

A critical review of the literature is vital for ascertaining what has already been identified and explored around the role, any unanswered questions, the persistent challenges and potentially what is contributing to the lack of growth and continued confusion. Chapter 2 outlines the search strategies, types of literature included and a critical review of the literature. The findings are grouped into three key themes: understanding the ENs' SOP, standardised practice and career development. Each theme is discussed with a summary of the key challenges, concluding with the identified gaps. Chapter 2 is informed by the following peer-reviewed publication (see AppendixA):

Leon, R. J., Moroney, T., Fields, L. & Lapkin, S. (2022). Exploring the role of the second-level regulated nurse in the Australian nursing workforce: An integrative review. *Contemporary Nurse*, *58*(4), 285–295. https://doi.org/10.1080/10376178.2022.2107040

2.2 Methods

The integrative review method was chosen as it allows for the combination of data from diverse methodologies (Soares et al., 2014). This enables an expanded knowledge base which is a key strategy to enhance the rigour of the results. A seven-step framework (Dhollande et al., 2021) was employed to conduct the review as follows: (1) write the review question; (2) determine the search strategy; (3) critical appraisal of search results; (4) summarise the search results; (5) data extraction and reduction; (6) analysis; and (7) conclusions and implications.

2.2.1 Review question

The SPIDER template (Methley et al., 2014) (see Table 2.1) was used to search, identify, critically appraise and summarise existing evidence to answer the following review question: what are the key issues impacting the role of the EN in the Australian nursing workforce?

Table 2.1: Elements of the SPIDER review question

Elements of SPIDER	Descriptor
Sample	Enrolled nurses
Phenomenon of **i**nterest	Key issues affecting the enrolled nurse workforce
Design	Integrative
Evaluation	Any workforce-related outcomes
Research type	Peer-reviewed research papers, scholarly and published government documents, grey literature and government data

2.2.2 Search strategy

Keywords, index terms and truncated terms (*), including 'enrolled nurs*', 'division 2 nurs*', 'second level nurs*', 'scope of practice', 'workforce', 'retention', 'nurs* attitudes', 'job satisfaction' and 'retraining', were combined using Boolean operators. The search strategy was applied in the major databases, CINAHL, SAGE, MEDLINE and ProQuest Central, with the defined inclusion and exclusion criteria (see Table 2.2). The full strategy for the MEDLINE database is shown in Appendix C. The search for grey literature was conducted using Google Scholar and relevant industry and government websites. The search was conducted in 2019 and revisited in 2021.

Table 2.2: Inclusion and exclusion criteria

Inclusion	Exclusion
• 2010 to present • Referred to the enrolled nurse role in Australia • Published in the English language	• Referred to clinical research topics • Published in a language other than English • Ambiguous about the nursing role • Exclusively related to other nursing roles

2.2.3 Critical appraisal: Search results

To ensure the integrative review was comprehensive and reliable the identification, screening, eligibility and final inclusion of papers followed the Preferred Reporting Items for Systematic Reviews and Meta-Analysis 2020 model (Page et al., 2021) (see Figure

2.1). The titles and abstracts were screened by two reviewers working independently, rating each paper as 'potentially relevant' or 'irrelevant'. Full-text articles were retrieved and reviewed independently by two authors. There was convergence in the study selection and critical appraisal between the two independent reviewers, so there was no need to consult a third reviewer.

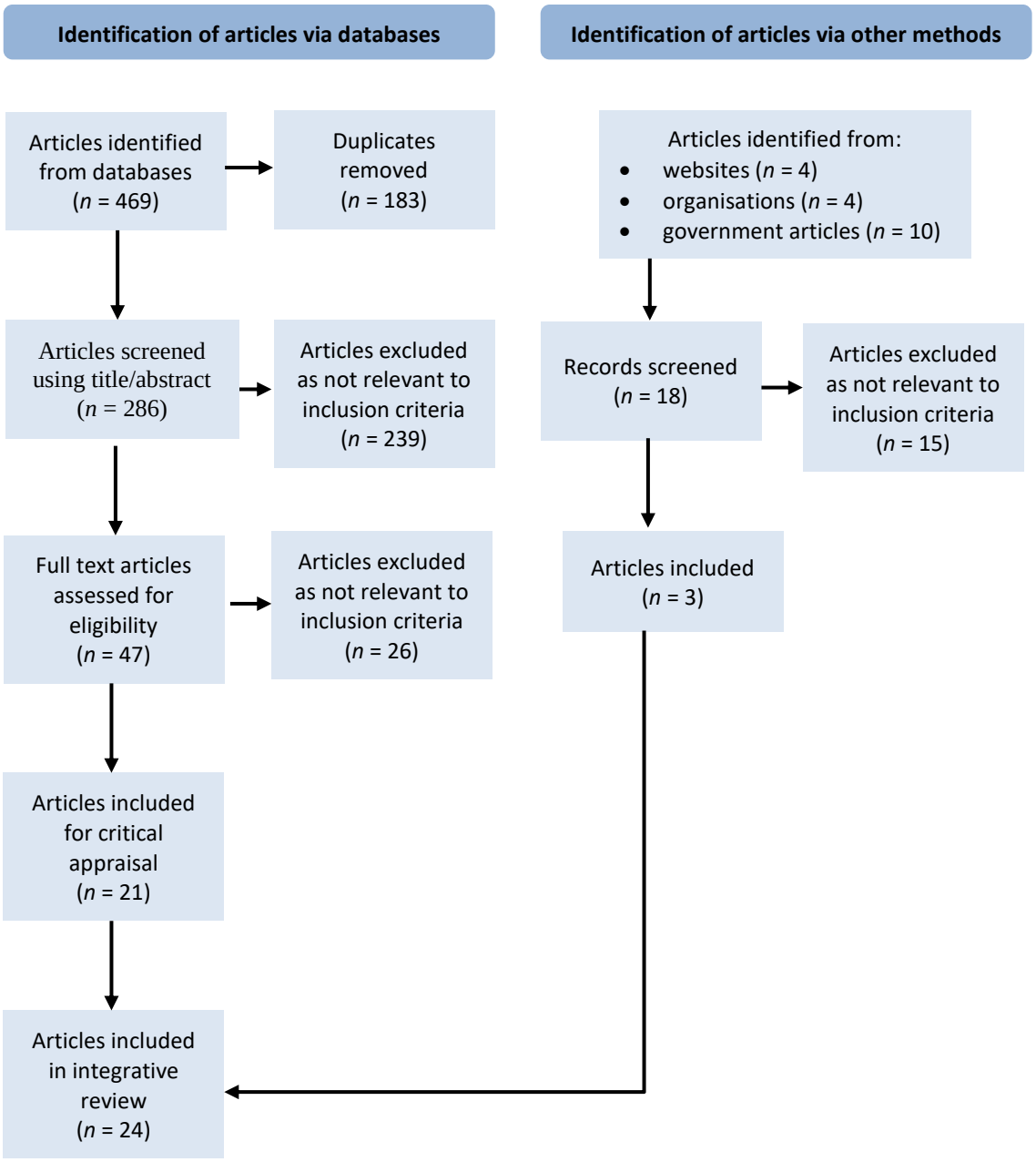


Figure 2.1: Literature search results

Note. Adapted from the Preferred Reporting Items for Systematic Reviews and Meta-Analysis 2020 model (Page et al., 2021).

The Mixed Methods Appraisal Tool (MMAT) version 2018 (Hong et al., 2018) was used to appraise the quality of both empirical and non-empirical articles. Articles that were not research-based were mapped against the aim of the review (see Appendix D).

2.2.4 Summary: Search results

Once articles and documents were identified, their reference lists were also reviewed, with all duplicates removed. This strategy was designed to identify a range of articles, including peer-reviewed research papers, scholarly and published government documents, grey literature and government data.

2.2.5 Data extraction

A structured format was used for data extraction with the following details: author(s) (country), year published, research design, a summary of key findings and theme(s).

2.2.6 Analysis

A thematic analysis was used to organise and synthesise the results. Initial codes were manually identified through key phrases and categories. These codes were then grouped and organised into tentative themes, which were further consolidated into the final themes. The analysis was an iterative and reflective process involving the identification of themes through careful reading and re-reading of each article (Rice & Ezzy, 1999).

2.3 Results

A total of 24 papers, of which 12 were assessed as high quality against the MMAT (Hong et al., 2018), were included in the review. Using the integrative review methodology, all papers were included, even though the quality varied (see Figure 2.1).

2.3.1 Key themes

Three key themes were identified: understanding the ENs' SOP, standardised practice and career development. Details of the coding and theme formation are summarised in Appendix E. Section 2.3.1 discusses each theme in the context of the EN role in the Australian nursing workforce.

2.3.1.1 Theme 1: Understanding the enrolled nurse's scope of practice

The term 'SOP' is used to describe what the ENs' role is qualified to do in relation to nursing practice. The sheer volume of literature exploring and, at times, attempting to provide clarity demonstrates that a greater understanding of the EN role is required

(Armitage et al., 2015; Blay & Smith, 2020; Eagar et al., 2010; Endacott et al., 2018; Jacob et al., 2012, 2013, 2014b, 2014c; Kerr et al., 2012; Leon et al., 2019; Lucas et al., 2021b; McKenna et al., 2019, Schwartz, 2019).

Two key events, arguably, created the most significant enhancement to the ENs' SOP, both of which could be perceived as moving the role into the historical domains off the RN role. However, despite these events occurring over 10 years ago, they continue to contribute to a lack of understanding of the ENs' SOP. First, there was the administration of defined medications. This recommendation came from a review of the aged care sector, which identified a need for their workforce to be more qualified (Working Group on Aged Care Worker Qualifications of the National Aged Care Forum, 2001). The review failed to recognise that a more qualified nursing role, the RN, already existed. The implementation of this expanded SOP was not standardised and occurred based on state and territory legislation (McEwan, 2008). This resulted in less, not more clarity into the ENs' SOP, and added complexity with how the EN now worked with the RN (Jacob et al., 2013, 2014c). It also contributed to the perception and feeling that ENs were rostered in place of RNs because they were cheaper (Eagar et al., 2010; Jacob et al., 2014a; Leon et al., 2019).

The second event was the inclusion of their entry-level education into the National Health Training Package (CSHSC, 2007). This not only standardised entry-level education, but it also purported that lifting the qualification to a diploma would better prepare the EN for a wider SOP, including critical thinking skills, with elective units of mentoring, research and care coordination (CSHSC, 2007; Jacob et al., 2014a, 2014b, 2014c; Schwartz, 2019). The challenge with preparing for a wider SOP was the lack of understanding and standardised practice with the existing SOP. The lack of understanding compounded by the ENs' enhanced SOP resulted in tension between ENs and RNs (Schwartz, 2019), ENs feeling bullied, stressed and harassed (Eager et al., 2010) and not feeling valued in their role (Leon et al., 2019).

2.3.1.2 Theme 2: Standardised practice

The level of understanding of the ENs' SOP informs nursing practice; therefore, any confusion could contribute to a lack of role delineation, especially between the EN and RN roles. The perceived lack of differences between the EN and RN roles are well-documented (Armitage et al., 2015; Eagar et al., 2010; Endacott et al., 2018; Jacob

et al., 2012, 2014c; Leon et al., 2019). Furthermore, when the national education standards for the EN were introduced in 2007 (CSHSC, 2007), differences in the SOP between the ENs and RNs narrowed, contributing to further role confusion (Eager et al., 2010; Jacob et al., 2012; Leon et al., 2019). In addition, there were now ENs with different skill levels, with the key difference being their entry-level education (Jacob et al., 2014a). Research continued to focus on the education of the EN role (Jacob et al., 2014a), with no evidence of a discussion on the responsibilities of the nursing roles, and how they work together in the practice of nursing.

ENs often regarded their practice to be very similar to that of an RN, and many RNs also believed that the EN works to the level the RN. The perception that the EN and RN roles are the same, was well-established and continues to permeate through the research (Eager et al., 2010; Endacott et al., 2018; Jacob et al., 2012; Leon et al., 2019; Lucas et al., 2021b). In contrast, there was limited literature that drew a distinction between the roles. Difference that were cited focussed on complexity of tasks and skill mix (Jacob et al., 2012, 2016).

Further confusion was also identified with the unregulated healthcare worker (UHCW) within the nursing team, commonly referred to as an AIN. Experiences from some ENs identified that they felt either threatened by the unregulated 'nursing workforce' or were being treated like them (Leon et al., 2019; McKenna et al., 2019). There was not the same volume of literature, as there was for the RN versus EN, but there was enough to identify that the UHCW 'nurse' is impacting on the EN role and creating further confusion in the dynamics of the nursing team and different expectations on the nursing practice of the EN.

A consequence of this confusion is the lack of standardised practice for the EN role. ENs expressed concern about the inconsistency in what they were qualified to do versus what they were allowed or expected to do. This variation in expectations and role function occurred between states and territories, health districts, wards and units within an institution, and even when working with different RNs on the same shift (Eager et al., 2010; Leon et al., 2019).

2.3.1.3 Theme 3: Career development

The final theme identified that the main career development opportunity for an EN is to transition to an RN role. This was supported by the volume of literature which explores study pathways and analyses this transition, (Birks et al., 2010; Brown et al., 2015; Cubit & Lopez, 2012; Hutchinson et al., 2011; Ralph et al., 2013; Tower et al., 2015), as well as the workforce data demonstrating that the highest growth is the dual EN and RN registrations (see Table 1.3).

It was common for ENs to feel that they were not real nurses and not valued as a nurse, as the EN role is perceived to be of lesser value, unless they become an RN (Leon et al., 2019). A number of studies explored reasons and influences behind why an EN would choose to study further to become an RN (Hutchinson et al., 2011; Ralph et al., 2013). There was little consideration in the literature for career development to support ENs to remain as ENs, although it may be argued that there are professional opportunities for the EN to become an Advanced Skilled EN (ASEN). An ASEN is an EN who has completed post-registration qualifications and/or demonstrated identified competency progression (Government of Western Australia, Department of Health and Nursing and Midwifery Office, n.d.; Nursing and Midwfiery Office, 2018). A challenge to this role is its national inconsistency, as demonstrated by the State based requirements and assessment models (Government of Western Australia, Department of Health and Nursing and Midwifery Office, n.d.; Nursing and Midwfiery Office, 2018) and that there is not a national standards for practice for the ASEN role (NMBA). These factors could contribute that in practice, the ASEN is not realistically achieved and presents minimal career opportunities (Leon et al., 2019; McKenna et al., 2019; Schwartz, 2019).

'Push' factors that influence the career pathway for the EN to become an RN were defined as negative emotions towards the EN's role that actively pushed them to become an RN (Ralph et al., 2013). These included limited opportunities for professional development and career advancement in the EN role (Leon et al., 2019; Ralph et al., 2013), a lack of understanding and definition of the ENs' SOP, role confusion, ambiguity about their role, a lack of encouragement, and role erosion (Armitage et al., 2015; Eagar et al., 2010; Endacott et al., 2018; Hutchinson et al., 2011; Jacob et al., 2012; Leon et al., 2019; Ralph et al., 2013). In contrast, 'pull' factors are defined as positive influences that retain an EN in their role. There were no Australian articles that referenced or described pull factors. Similarly, there was limited discussion in the literature on the importance of designing

education and training that encouraged professional development for ENs as ENs. Although it was suggested that with appropriate planning, training and management, the EN role could be expanded to diversify across areas of health care (Jacob et al., 2013) and into specific areas, including assessment, care and clinical management (Cusack et al., 2015).

2.4 Discussion

The review found that a lack of understanding of the EN's role contributes to a lack of standardised practice and role confusion; and limited career development opportunities for the EN as an EN (see Figure 2.2). These findings are consistent with studies involving second-level nursing roles in other OECD countries (Lucas et al., 2021b).

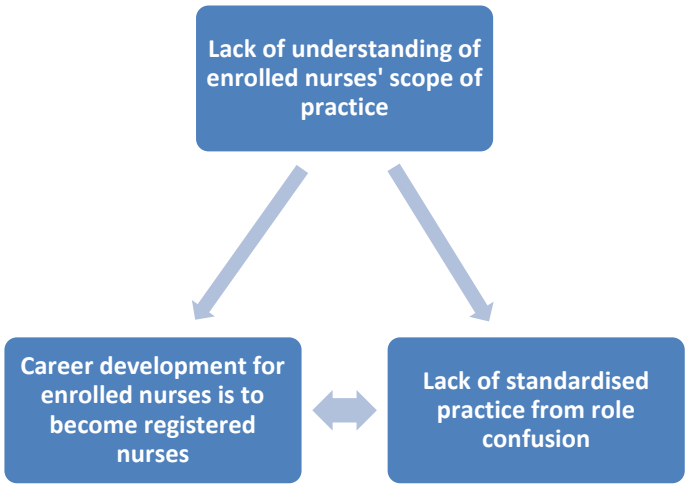


Figure 2.2: The current enrolled nurse role

Role confusion predominately occurs between the EN and the RN as there are tasks which both roles complete, for example, medication administration. In addition, there is also skill overlap between the EN and the UHCW, such as the AIN. This combination of factors leads to a lack of standardised practice for the EN. As a result, ENs are not always utilised for the knowledge and skills to which they are qualified.

ENs who chose to remain as ENs identified limited opportunities for professional development and career advancement as an EN. There are provisions in place for an ASEN role; however, it does not translate into a career pathway for the EN. This informs an expectation within the nursing workforce that an EN would not want to remain an EN; instead, they will study further and become an RN. This is evidenced by the registration data and the focus and volume of research published on the transition of ENs to the RN

role. Collectively, this provides a rationale for the lack of career development opportunities for the EN to stay as an EN.

The discussion in the literature attempts to explain the continuing diversity and challenges that surround the EN role. Factors include the challenges of retention of ENs, an ageing workforce, the complexity of rural and aged care services (Cusack et al., 2015; Jacob et al., 2013; Leon et al., 2019) and economic imperatives (Jacob et al., 2013). These are all generic factors and do not provide tangible solutions to the challenges that surround the EN role. Most importantly, they do not address the lack of understanding of the ENs' SOP by the nursing workforce. A pragmatic approach is required to ensure the ENs' SOP translates into standardised ways of working for the EN within the nursing workforce.

Change will require the alignment of local management and organisational policies and procedures that are cognisant with the national requirements. The volume of literature reaffirming the challenges, without solutions, demonstrates that this change has not yet occurred. The evidence, both within Australia and internationally, identifies a need for clear delineation between each of the regulated and unregulated nursing roles. Importantly, there is a need to have a conversation about the nursing roles and establish models of care where the nursing roles complement and work together in the practice of nursing. This conversation occurred in both the UK and NZ, with very different outcomes. The UK phased out the second-level nursing role (UKCCNMH, 1987), whilst NZ made the decision to maintain it (Editor, 2009). Australia has the opportunity to learn from other countries' experiences as it works to improve the understanding of the EN role.

2.5 Limitations of this review

While the strength of the integrated review methodology lies in the ability to identify, critically appraise and summarise evidence from a wide variety of articles, there are some limitations inherent in this approach that must be acknowledged. Firstly, the review was limited to the Australian context since 2010, with limited reference to other OECD countries with a similar second-level nursing role. In addition, other efforts to address the challenges facing the EN workforce may have been implemented but not published and therefore not captured in this review. Despite these limitations, well-established methods to enhance the credibility of the findings and the identified themes were used to summarise key challenges facing the EN role in the Australian nursing workforce.

2.6 Chapter summary

An integrative review of the literature was conducted to explore the EN role in the Australian nursing workforce. Despite a plethora of reports and research papers indicating that this role is integral to the nursing workforce there is a lack of role clarity and delineation, especially with the RN. The highest nursing workforce increase is also in the dual EN/RN registrations.

Acknowledging that there may be other contributing factors, the review identified three key themes: understanding the ENs' SOP, standardised practice and career development. It is postulated that a lack of understanding of the ENs' SOP contributes to the lack of standardised practice and role confusion. The final theme identified that the main career development opportunity for an EN is to transition to an RN role, which is supported by the dual registrations. These findings are consistent with OECD countries that have a similar nursing model and are also experiencing nursing workforce shortages.

The conclusions drawn from the literature reinforce the need to conduct further research into better understanding the EN role with the purpose of using the evidence to develop strategies that effect change. This could be realised with literature that demonstrates an EN workforce that is understood, utilised for the knowledge and education to which they are qualified, has a professional pathway as an EN and arguably, most importantly, feels valued in their role.

Chapter 3: Methodology

3.1 Introduction

Chapter 3 details the methodology used in this study. The rationale for a multiphase exploratory sequential MM research design using the OB conceptual framework is presented. Incorporated in the discussion are the ontological, epistemological and methodological approaches that frame the development of the study design, analysis and, subsequently, the findings. The discussion also examines how the philosophical assumptions of pragmatism and the transformative approach support the decision-making that informs the final recommendations.

For any study, it is important to acknowledge and address the ethical considerations because they ensure rigour in the research design, data collection, data analysis and interpretation. The approaches used to enhance the credibility, reliability and validity of the research findings are also explained. Chapter 3 concludes with a summary of the research design approach, justifying why it was used and demonstrating how the multiphase exploratory sequential MM research design was developed and used to scaffold this study. Phases 1 to 3 of this study are then described in Chapters 4, 5 and 6.

3.2 Background

The literature review (see Chapter 2) demonstrated that there continues to be a lack of understanding of ENs' SOP within Australia. The literature has illustrated continuing confusion and lack of standardisation that results in ENs feeling devalued and having poor career prospects, with minimal, if any, literature on ENs prospering and growing as ENs.

The methodologies used in the literature have been predominately either qualitative or quantitative, without the strengths of combining both into a MM research design. This study used a multiphase exploratory sequential MM research design so it could take advantage of the combined strengths from qualitative and quantitative methods. The grey literature available included commissioned reports and reviews and government documents that continue to make recommendations and changes in an endeavour to nationalise, formalise and standardise the EN role. The research and perpetual reviews

have demonstrated that the challenges persist despite the changes to the national structure over 10 years ago.

3.2.1 Research aim, question and objectives

This study aims to gain a better understanding of the EN's role in the Australian nursing workforce. Therefore, the research question is: what is the role of the EN in the Australian nursing workforce? Table 3.1 presents the overarching study aim and question, with the objective and question for each of the respective phases of the MM study.

Table 3.1: Research aim, question and objectives

	Study aim To gain a better understanding of the role of the EN in the Australian nursing workforce. **Research question** What is the role of the EN in the Australian nursing workforce?		
	Phase 1 – Qualitative	**Phase 2 – Development**	**Phase 3 – Quantitative**
Phase objective	To explore nurses' experiences, perceptions and expectations about the role of the EN by conducting focus groups.	To develop a self-administered questionnaire.	To determine the characteristics of the role of the EN in the Australian nursing workforce by conducting a cross-sectional study. To investigate the association between demographic and professional factors with nurses' experiences, perceptions and expectations of the role of the EN in the Australian nursing workforce.
Phase question	What are nurses' experiences, perceptions and expectations about the role of the EN in the Australian nursing workforce?		What are the characteristics of the role of the EN in the Australian nursing workforce? What is the relationship between nurses' demographics and professional characteristics and their experiences, perceptions and expectations of the role of the EN in the Australian nursing workforce?

Note. EN = enrolled nurse.

3.3 Mixed methods research design

MM research design was well-documented in studies from different disciplines and corners of the world around the late 1980s (Creswell & Plano Clark, 2018). Until then, quantitative and qualitative methods were used quite distinctly from each other, with quantitative methods associated with the positivist paradigm and considered the dominant methodology (Teddlie & Tashakkori, 2009). Comparatively, qualitative methods were associated with the constructivism paradigm and perceived very much as the lesser methodology (Teddlie & Tashakkori, 2009). MM emerged as a third methodological movement and was predominately associated with the pragmatist paradigm, especially in the social and behavioural sciences (Teddlie & Tashakkori, 2009). Authors from a number of disciplines (Creswell & Plano Clark, 2018) identified the value of mixing quantitative and qualitative methodologies in the same study. Nursing was one of these disciplines, with Morse (1991) describing the sequential or simultaneous combination of quantitative and qualitative methods in the same study and calling it 'methodological triangulation'.

MM as a research design continued to evolve creating its own world view, vocabulary and techniques, with more accurate core characteristics defined (Creswell and Plano Clark, 2018, p. 5). These characteristics are that the researcher collects and analyses both quantitative and qualitative data rigorously in response to research questions and hypotheses, integrates (or mixes) the two forms of data and their results, organises these procedures into specific research designs that provide the logic and procedures for conducting the study, and frames these procedures within theory and philosophy.

The premise of MM is the ability to combine quantitative and qualitative research methods in the same study to develop a greater breadth and depth of understanding of the research topic. MM has matured, resulting in three refined core research designs:

- explanatory sequential design
- exploratory sequential design
- convergent design (Creswell & Plano Clark, 2018, p. 59).

3.3.1 Notation system

A nursing researcher devised a notation system to clarify the discussion of MM designs (Morse, 1991). This notation system evolved and was adopted by the MM community. It clearly describes for the reader the focus and flow of a MM study. The notation system uses ‘quan’ to represent a quantitative method and ‘qual’ to represent a qualitative method in a study. The abbreviated terms are predictive; however, the use of four letters is deliberate because MM does not place one methodology over the other. Having the same number of letters conveys that the two methods have an equal status (Creswell & Plano Clark, 2018). However, there may be a primary and secondary method within a study, which is shown using capital and lowercase letters. A plus sign (+) indicates that the methods occur at the same time, and an arrow (→) indicates a sequence (Creswell & Plano Clark, 2018). Table 3.2 explains each core design and how they would be written using the notation system. If this study were described using the notation system, it would be QUAL → quan.

Table 3.2: Core mixed methods research designs

Core design	Description	Notation
Explanatory sequential	• The two methods are implemented in a sequence. • The quantitative method occurs first and has a greater emphasis on addressing the purpose of the study. • The qualitative method follows and is used to help explain the results of the first method.	QUAN → qual
	• If a sequence is required but with an emphasis on the second method, the notation would have the first method in lowercase and the second in uppercase.	quan → QUAL
Exploratory sequential	• The two methods are implemented in a sequence. • The qualitative method occurs first and has a greater emphasis on addressing the purpose of the study. • The quantitative method follows and is used to help measure the results of the first method.	QUAL → quan
	• If the sequence is required but with an emphasis on the second method, the notation would have the first method in lowercase and the second in uppercase.	qual → QUAN
Convergent	• Both methods are implemented simultaneously. • Both methods have equal emphasis. • The results of each method are converged.	QUAN + QUAL
	• If one method is depicted in lowercase, both methods have been implemented simultaneously, but one has more emphasis than the other. • They are considered unequal. • The results of each method are still converged.	QUAN + qual quan + QUAL

Note. quan = quantitative, qual = qualitative. Adapted from Creswell and Plano Clark (2018, p. 63).

3.3.2 Exploratory sequential mixed methods research design

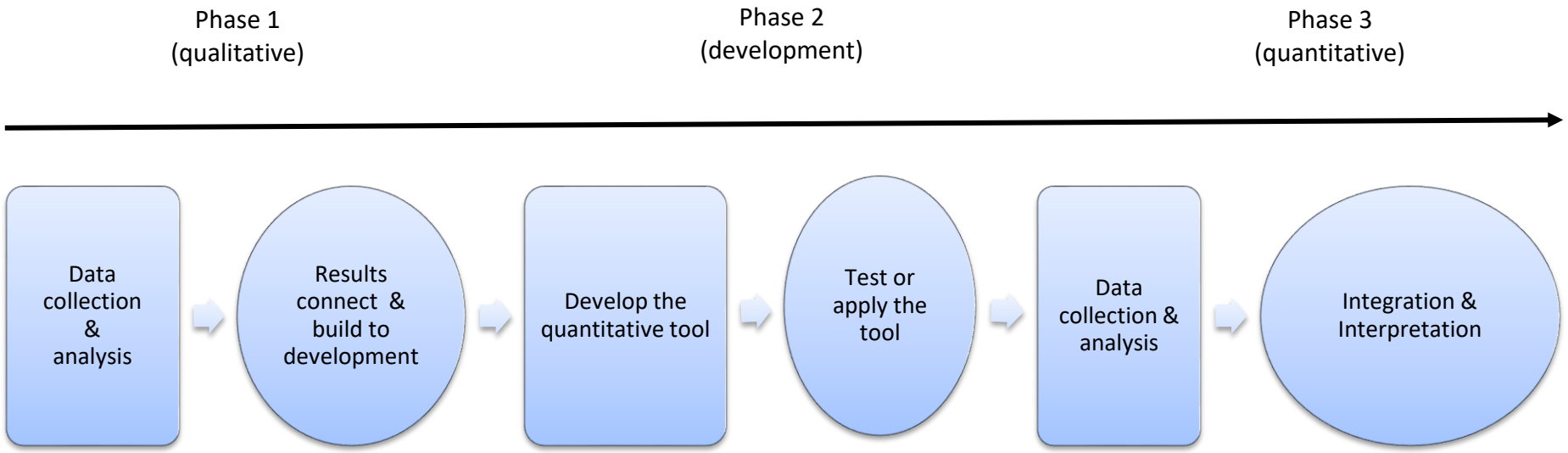
The choice of the research methodology is pivotal to yielding results that will inform strategies for the nursing workforce. The literature has clearly demonstrated that the same challenges have continued for the EN role since its inception (Supplement A). Therefore, different actions and strategies need to be developed and implemented; otherwise, the same discussion will continue. A qualitative approach alone would provide a narrative around the role, but the limitation would be not knowing how far the responses were felt and experienced through the healthcare system. In isolation, this method does not provide the breadth of answers required to address the challenges identified. Further, using only quantitative methods would restrict the data to workforce analytics and trends and, therefore, would also not provide any depth of answers to the identified challenges. Combining the strengths of qualitative and quantitative research methods in one study will enable answers that capture the depth, breadth, perceptions, experiences and

expectations of the Australian nursing workforce regarding the EN role. The phases are described as follows:

1. Phase 1 (the qualitative phase) provides the opportunity to capture the cohort's nuances, feelings, perceptions, terminology and experiences regarding the study's aim and objectives. In this study, focus groups were used as the qualitative data collection tool.
2. Phase 2 (the development phase) uses the themes, terminology and phrases from the participants in Phase 1 to develop the quantitative tool. Using the data from phase one increases the likelihood of a relevant, reliable and validated data collection tool, and builds from one qualitative dataset to the quantitative data set.
3. Phase 3 (the quantitative method) provides the opportunity to measure the nuances, feelings, perceptions and experiences identified in Phase 1 on a greater scale. In this study, a self-administered questionnaire was used as the quantitative data collection tool (Creswell & Plano Clark, 2018; Teddlie & Tashakkori, 2009).

3.3.2.1 Data integration

Data integration for this study used the triangulation or comparison of data sets approach. This approach analyses the data separately and then combines at the point of interpretation by checking for agreement or disagreement (Johnson et al., 2019). Figure 3.1 provides a visual representation depicting the phases, demonstrates the building from one dataset to another and the transition between the phases of the multiphase exploratory sequential MM research design that was used for this study. This sequencing resulted in a more comprehensive and relevant body of evidence to address the aim and objectives of this study.



Note. Adapted from Creswell and Plano Clark (2018, p. 66).

Figure 3.1: A multiphase exploratory sequential mixed methods research design

3.3.2.2 Phase 1 research design: Focus groups

Focus groups were used for the qualitative data collection in Phase 1 of the study. They have been identified as particularly suited to exploratory research and have been well-documented for their use in health research (Chronic Care Network, 2016; Cronin, 2011; Redmond & Curtis, 2009; Then et al., 2014; Webb & Kevern, 2001), especially when used as the initial means to capture themes and ideas that are further explored in a larger quantitative survey (Redmond & Curtis, 2009). Focus groups are discussions designed to elicit perceptions, experiences and opinions on a defined topic in a safe environment (Krueger & Casey, 2000). The strength of focus groups is that they allow the exploration of opinions, beliefs and experiences to be shared in a group (Then et al., 2014; Webb & Kevern, 2001) and for member checking to occur.

Member checking is a strategy that was used to verify concepts creating confirmability (Denzin & Lincoln, 2018). When used with focus groups, member checking enables participants to trigger one another's experiences and concepts, creating confirmability (Denzin & Lincoln, 2018). This was achieved by the researcher reaffirming their understanding and seeking clarification of concepts posed by the focus groups' participants. This also enables participants to confirm, refute or build upon what is shared by others (Then et al., 2014; Webb & Kevern, 2001).

Interviews were considered a potential qualitative data collection tool for this study because they can also produce rich narratives. However, there is the potential to capture limited perspectives of individuals' experiences and world views (Connelly, 2015). With this consideration, the choice of focus groups was deliberate because the data generated from group interactions and discussions might not have been captured from interviews (Connelly, 2015). The researcher is also an experienced facilitator and skilled in allowing group dynamics to enrich and grow discussions, which provided an opportunity for participants' thoughts and experiences to be triggered, further enhancing the discussions and results (Connelly, 2015; Krueger & Casey, 2000; Then et al., 2014)

Face-to-face focus groups reduce discrimination against participants who do not have access to computers or technology skills. Further, conducting face-to-face focus groups enables the researcher to observe group dynamics and peer influences—it is not what is said but what is not said within the group that is also informative (Then et al., 2014).

Participants did not need to have a minimum level of reading or writing skills, and apart from their time, there was no impost of cost because the researcher travelled to the participants. Focus groups allowed the researcher to collect rich, in-depth data and for the participants to share, change or expand on their opinions following discussions with other participants.

Conversely, the disadvantages of focus groups are predominately related to the dynamics of the group. Some groups may be lethargic and dull, or participants may be reluctant to express their opinions if they do not feel safe or if there is a dominant or aggressive participant who may influence or overpower the group. Another disadvantage is that stressful or sensitive issues may limit group discussions and participant disclosures. Additionally, participants may be reluctant to express their opinions to others, especially if they do not feel safe or that they are in a trusted environment (Connelly, 2015; Krueger & Casey, 2000; Then et al., 2014).

A limitation is that data in a group discussion is more challenging to transcribe and analyse because participants in a group discussion often interject and talk over each other. Consideration also needs to be made of participants' accents, which may be harder to capture and transcribe in the context of a group discussion. It is important to ensure that any comments by the group are interpreted within the social and environmental context in which they are given (Cronin, 2011; Krueger & Casey, 2000; Then et al., 2014). Nevertheless, it was felt that the advantages of focus groups outweighed the disadvantages and that most of the disadvantages were managed or at least minimised through facilitation skills and planning.

Once the focus groups had been conducted a preliminary analysis of the data was conducted. This was then presented to approximately 50 ENs as a peer review process. The ENs involved in this process came from metropolitan, regional and rural locations, with varied demographics in age and length of experience. A peer review process supports the transferability of the findings and a level of dependability of the data (refer to 3.6.1) (Denzin & Lincoln, 2018). The ENs response was consistent with the preliminary findings.

3.3.2.3 Phase 2 research design: Development of the self-administered question

A descriptive cross-sectional survey design with a self-administered questionnaire is a systematic method of capturing information at a given time from a specific population (Lapkin et al., 2012). It is widely used in nursing research either as a single tool for collecting data or as part of a collection of tools. Behavioural and social sciences' researchers prefer this method as it considers psychological and social phenomena that cannot be measured through observation (DeVellis, 2017). A well-developed and validated questionnaire provides a highly effective, inexpensive and efficient method of collecting information such as knowledge, beliefs, attitudes and behaviours (Timmins, 2015).

However, significant methodological errors are common in published research, despite many publications and sources of information providing methodological guidelines for developing questionnaires (Chiarotto et al., 2018). A factor contributing to methodological errors is that most publications do not provide a clear process for researchers who want to develop a self-administered questionnaire (Timmins, 2015, Younas & Porr, 2018). The details required to critique a questionnaire's applicability to a study are also often unavailable. This is unsurprising, considering the development of a questionnaire is a time-consuming, iterative process, so important methodological steps are either overlooked or poorly reported. When authors provide specific details, there is a tendency for them to focus on complex statistical approaches (DeMars, 2018), which can be daunting for nurse researchers or nurses seeking a pragmatic approach.

Time and effort invested in developing a questionnaire are rewarded by a strengthened tool that enhances the quality and credibility of research findings. The development of the questionnaire for this study is detailed in Chapter 5.

3.3.2.4 Phase 3 research design: Self-administered questionnaire

A self-administered questionnaire was used for data collection because it was considered the most efficient and cost-effective way to collect data anonymously from a large geographical area (Polgar & Thomas, 2008). Additionally, this modality can potentially improve the response rate because there is less burden on participants compared to researcher-driven telephone calls or face-to-face versions of the same questionnaire (Lapkin et al., 2012). However, a limitation of web-based questionnaires is that participants require access to a technological device. Therefore, hard copy questionnaires

were also made available with a return addressed postage-paid envelope to ensure all participants had the opportunity to participate. A request for a hard-copy questionnaire was either made through the local contact person, or directly to the researcher through the contact details in the Participant Information Sheet (PIS) (Appendix F) and on the flyer (Appendix G).

Assuring anonymity in this study was vital because the questions related to the participants' professions and work environments. The participants needed to have confidence that there would be no connection to their workplace and employment. This facilitated open and honest responses, which may otherwise have been guarded.

3.3.2.5 Strengths

The greatest strength of the MM research design is its sequencing because it reduces researcher bias. Researcher bias occurs when the researcher influences the data collected through what is asked or how it is asked (Creswell & Plano Clark, 2018). The researcher's language, perceptions and experiences can potentially infiltrate the tools. However, researcher bias is mitigated using the participants' language, perceptions and experiences from Phase 1 to develop the tool (Creswell & Plano Clark, 2018). This sequence resulted in a more robust, reliable and validated tool, which was used in Phase 3 and, in turn, enhanced the credibility of the findings.

Sample sizing also needs to be considered. Phase 1 (qualitative) included a smaller and more purposeful sample group of participants, while Phase 3 (quantitative) had a larger sample size, allowing the researcher to augment and generalise the results. The two samples came from the same population, which was a strength, with the first sample group also invited to participate in the quantitative phase (Creswell & Plano Clark, 2018). There are quantitative-biased participants, and although the primary focus of this design was the qualitative method (QUAL $\rightarrow$ quan), the quantitative method engaged those participants. Therefore, using both methods provided an opportunity for a greater audience (Creswell & Plano Clark, 2018).

There are several advantages of focus groups ranging from the benefits of group interactions to the participants not requiring technology or literacy skills. A key to successful focus groups is ensuring the group is homogenous and that the participants have similar characteristics. Thus, the invitations were sent out separately and the focus

groups were conducted separately to remove any perceived or real positional power imbalances between EN and non-EN cohorts. This facilitated an environment for the EN cohort to feel they had a voice (i.e., an opportunity to feel empowered to speak), which is a key consideration of the transformative approach. Providing a safe environment where the participants' thoughts, experiences and opinions were valued (Connelly, 2015; Krueger & Casey, 2000; Then et al., 2014) also created an environment where the participants felt safe to share their opinions and experiences, which may be refuted or reaffirmed by the group.

Another strength identified by Creswell and Plano Clark (2018) was that separate phases provide clarity when describing, implementing and reporting the results. Finally, using both methods in one study counterbalances the weaknesses of using either method alone.

3.3.2.6 Challenges

A key challenge of a multiphase exploratory sequential MM design is that it requires the researcher to schedule more time for a study (Creswell & Plano Clark, 2018). This study addressed this challenge by allocating defined time for each of the three phases, including the requirement to submit an amended ethics application after Phase 1. This was required because the tool for Phase 3 could not be provided on the initial ethics application, as the data from Phase 1 was used to inform the content and development of the questionnaire. It also needs to be noted that any ethics application process includes variables outside the researcher's control.

Another challenge of a MM research design is that the researcher needs skills in both methods. Within this study, the qualitative tool requires thematic analysis and synthesis skills, and the quantitative tool requires descriptive and inferential statistical analysis skills. There is also the skill of integrating the analysis from each method into the final discussion. Acknowledging the required depth and breadth of skills was important to ensure the supervisory team covered the skill set to support and guide the researcher.

3.3.3 Philosophical assumptions

It is important to understand the philosophical assumptions that provide a foundation for the research and its methodological approach to gain a greater comprehension of the results of a MM study. These are referred to as 'world views' or 'paradigms' (Creswell & Plano Clark, 2018). Section 3.3.3 explains the philosophical assumptions chosen for

this study, pragmatism and the transformative approach, and their application to this study.

3.3.3.1 Pragmatism

Pragmatism has been described by some authors of MM studies as finding a middle ground to workable solutions (Creswell & Plano Clark, 2018; Teddlie & Tashakkori, 2009). It prefers doing (action) rather than thinking (philosophising). The epistemology of pragmatism is practicality—that is, collecting data to determine what will address the challenges identified by the study. Pragmatism uses qualitative and quantitative methods by taking the narrative from the qualitative method and the numerical from the quantitative method to inform workable solutions to longstanding philosophical problems. A key component of pragmatism is that it places value on both objective and subjective knowledge. This allows the lived experiences to be captured and included. Pragmatism focuses on the consequences of research and the importance of the problem or question rather than the research method. It accepts that knowledge is constructed by experiences from the world in which one lives (Creswell & Plano Clark, 2018; Teddlie & Tashakkori, 2009). Focus groups enable participants to share their experiences and contribute subjective knowledge, understanding and perceptions.

As early as 1970, with the Education of Nurses Inquiry (1970), the need to provide clear delineation between the RN and EN roles was identified as a priority for the nursing profession. As evidenced by the literature, this problem has continued and still exists (Supplement A). There continues to be much consideration of the role, as evidenced by the reports and documents at the policy and professional levels (see Section 1.6). However, the literature has demonstrated that similar challenges have continued since the role's inception (see Supplement A). The outcomes expected from the recommendations and changes from the plethora of reports have not translated into practice.

The researcher felt that pragmatism, as the main philosophical assumption, provided the best opportunity to identify workable solutions to the longstanding lack of understanding of the EN role within the Australian nursing workforce. Another benefit of the pragmatism approach is that axiology provides the opportunity to include all objective and subjective perspectives, because it values the lived experience.

3.3.3.2 Transformative approach

The other key concern surrounding the role was ENs' feelings of value as ENs. Therefore, it was prudent to also apply an advocacy/participatory or transformative approach through the analysis. This philosophical approach is influenced by political concerns, empowerment, marginalisation and other factors contributing to marginalisation. It focuses on the need for social justice, empowerment and the pursuit of human rights (Creswell & Plano Clark, 2018). In a transformative approach, the axiology is based on social justice and concerns the value of the individual EN rather than the role as a whole (Creswell & Plano Clark, 2018). Although of note, how the EN role is treated also places value on the individual EN.

The transformative approach uses a participatory methodology with study participants engaged in the research process (Creswell & Plano Clark, 2018). The multiphase exploratory sequential MM research design does this well, because the participants' language, perceptions and experiences are used in the development phase (Phase 2). The development phase also provides further involvement of participants through review by an expert panel and piloting of the quantitative tool.

The transformative approach takes an explicitly value-oriented approach to research derived from cultural values and specifically endorses values such as democracy, freedom, equality and progress (Creswell & Plano Clark, 2018). The literature has demonstrated that in addition to the confusion around the role of the EN, there are clear feelings of the role being undervalued and ENs feeling undervalued (Gibson & Heartfield, 2003, 2005; Jacob et al., 2012; Kenny & Duckett, 2005). The following three statements were captured from ENs over 35 years and demonstrate the persistent sentiment of how ENs feel in their role as ENs:

- 'We are valuable members of the nursing profession, and we would like to be taken seriously' (Evans, 1994, p. 26).
- 'After changing jobs I concluded that being a nurse wasn't my problem, but being an enrolled nurse was' (Kenny & Duckett, 2005, p. 426).
- 'I felt that I was being dismissed because I was an enrolled nurse' (Leon et al., 2019, p. 126).

By ensuring the focus groups were conducted separately for the EN and non-EN cohorts, a safe environment was provided for the participants to share their thoughts, feelings and experiences without the perceived power imbalances.

3.3.3.3 Summary of philosophical assumptions

The best opportunity to find workable solutions was to incorporate both the philosophical assumptions of pragmatism and the transformative approach into the multiphase exploratory sequential MM research design. This would address not only the structure of the role but also the feelings around the role and the negative lived experiences of many ENs that have pervaded the nursing profession for over 60 years. Failure to provide workable solutions will result in the same sentiments in another 10, 20 or 30 years. A summary of the two paradigms, their respective philosophical assumptions and their implications for practice are presented in Table 3.3.

Table 3.3: Elements of the paradigms and implications for practice

Philosophical question	Pragmatism	Transformative
Ontology (the nature of the reality)	Singular and multiple realities, diverse viewpoints (e.g., researchers test hypotheses and provide multiple perspectives)	Multifaceted and based on different social and cultural positions (e.g., researchers recognise different power positionalities in a society)
Epistemology (the relationship between the researcher and what is being researched)	Practicality (e.g., researchers collect objective and subjective data and identify what will address the research question)	Collaboration (e.g., researchers actively involve participants as collaborators, build trust and honour participant standpoints)
Axiology (the role of values)	Multiple stances (e.g., researchers include biased and unbiased perspectives, and values are important when interpreting the results)	Based on human rights and social justice for all (e.g., researchers begin with and advocate for this premise)
Methodology (the research process)	Combining (e.g., researchers collect qualitative and quantitative data and integrate the results)	Participatory (e.g., researchers collect qualitative and quantitative data and involve participants in all research stages)
Rhetoric (the research language)	Formal and informal (e.g., researchers may employ formal and informal writing styles)	Advocacy, activist-oriented (e.g., researchers use language that will help facilitate change and advocate for human rights and social justice)

Note. Adapted from Creswell and Plano Clark (2018) and Teddlie and Tashakkori (2009).

3.4 Conceptual framework: Organisational behaviour

OB was used as the conceptual framework, together with philosophical assumptions, to create a scaffold for analysing the data and supporting what is needed to effect change. OB is an applied behavioural science that systematically studies individuals, groups and organisations to create an organisation that engenders a high level of performance (Kalliath et al., 2014; Robbins et al., 2008; Wood et al., 2013).

The origins of OB can be traced back to several philosophers and academics, including the Greek philosopher Plato and his essence of leadership, Aristotle and his persuasive communication, Adam Smith's organisational structure based on the division of labour in 1776, and the Industrial Revolution, which resulted in large factories employing many workers (Borkowski, 2016; McShane & Von Glinow, 2005; Wood et al., 2013). Behavioural disciplines, as they are known today, had not been named or defined; however, there was evidently much consideration of how to improve the organisation and structure of work to ensure high levels of performance.

OB evolved more formally as its own field of study due to large companies employing large numbers of people. At the time, the focus was on efficient productivity. In 1911, Frederick Winslow Taylor believed that efficiency was achieved by creating jobs that economised time, human energy and other productive resources (Borkowski, 2016). 'Taylorism', as it became known, influenced Henry Ford, who developed the very successful and efficient assembly line for the Model T car (Borkowski, 2016, p. 6). However, while the primary focus was efficiency, Taylor attempted to bring the human element into the equation, writing that:

> the manager must give some special incentive to his men [*sic*] beyond that which is given to the average of the trade … this special incentive should be accompanied by that personal consideration for, and friendly contact with, his workmen [*sic*] which comes only from a genuine and kindly interest in the welfare of those under him. (cited in Borkowski, 2016, pp. 6–7)

The human element did not receive any traction until the Hawthorn studies in 1924 to 1933 (Borkowski, 2016; Bowditch et al., 2008). The Hawthorne Plant of the Western Electric Company in Illinois was the site for several experiments that demonstrated the influence of human factors on worker productivity (Borkowski, 2016; Bowditch et al.,

2008). This ongoing thinking around what happens when people work together and what influences productivity, morale and group dynamics made a significant contribution to the development of OB. It resulted in OB being identified as a distinct field of study in the 1940s (Borkowski, 2016; McShane & Von Glinow, 2005; Wood et al., 2013). OB has continued to build on contributions from several behavioural disciplines, predominately psychology, sociology, social psychology, anthropology and political science (Robbins et al., 2008). This has resulted in a more robust overarching discipline of OB that recognises and relates from the individual (psychology) to the group (sociology, social psychology and anthropology) through to the organisation (social psychology, anthropology and political science) (McShane & Von Glinow, 2005; Robbins et al., 2008). Figure 3.2 presents an overview of how the behavioural sciences map into OB, their contributions and their units of analysis.

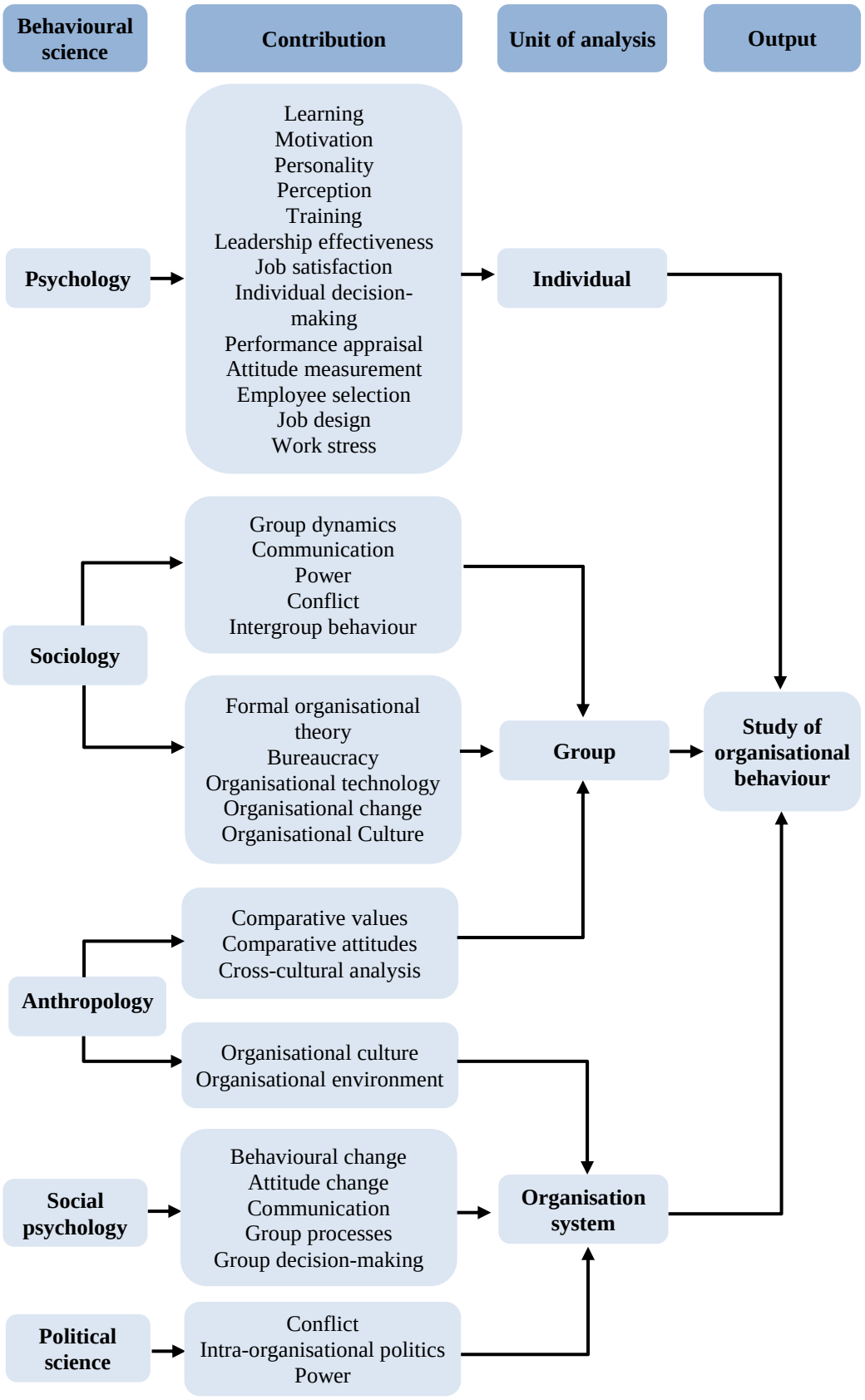


Figure 3.2: The relationship of the organisational behaviour framework with the behavioural sciences

Note. Adapted from Robbins et al. (2008, p. 12).

3.4.1 Organisational behaviour and the healthcare industry

Health care is one of the largest service-driven industries in the modern world. Each segment of this industry employs a mix of health-related clinical and non-clinical occupations, all requiring different entry-level education and skills (Borkowski, 2016). Effective communication, motivation, leadership, teamwork and a positive organisational culture are all elements required for a healthcare industry to provide safe, quality, personalised care and, as an industry, support and empower its staff (Borkowski, 2016). These elements are key contributions from the behavioural sciences that make up OB.

The conceptual framework of OB is divided into three units of analysis: the individual, the group and the organisation (Kalliath et al., 2014). The application of OB as the conceptual framework for this study provided a lens to explore and better understand the role of the EN within the Australian nursing workforce. The units of analysis also provided a structure to organise the data into meaningful groups that mirrored the natural structure of the nursing workforce. The three units of OB analysis that aligned with the structure of the nursing workforce are graphically depicted in Figure 3.3.

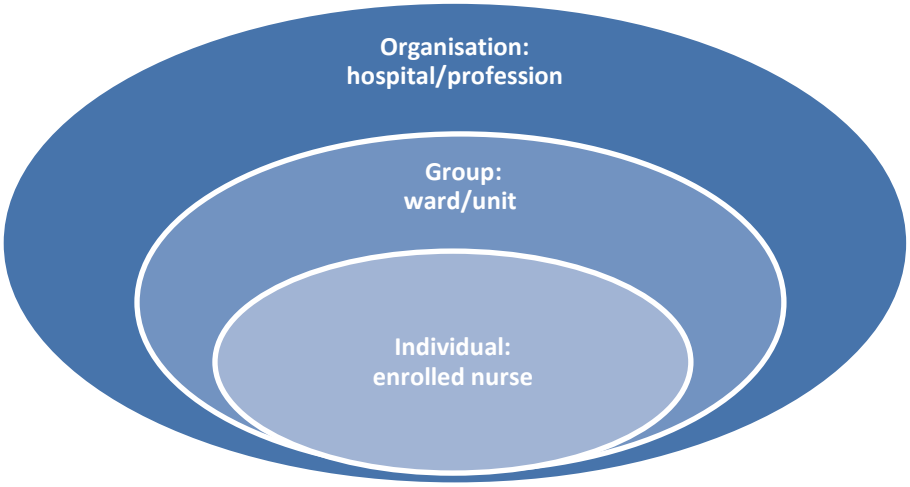


Figure 3.3: How the three units of analysis within the organisational behaviour framework relate to the role of the enrolled nurse

3.4.1.1 The individual: The enrolled nurse

Job satisfaction has been identified as a key contributor to not only an individual's wellbeing, sense of achievement and motivation in the workplace, but also at the organisational level as individuals with job satisfaction will be more productive (Kalliath et al., 2014, p. 203). For these reasons it is fundamental to understand what contributes to

an ENs' level of job satisfaction. In this study, 'job satisfaction' is defined as 'the individual's affective (emotional) reaction to their job, and how much pleasure or happiness they derive from it' (Kalliath et al., 2014, p. 203). Other factors that contribute to job satisfaction are job analysis and job design. Job analysis is the knowledge, skills and abilities required for the EN to complete their role in a manner that provides them with pleasure and happiness; job design is the structure, content and configuration of work tasks and roles (Wood et al., 2013). As OB is a study of behavioural sciences exploring the role of the EN from the perspectives, experiences and expectations of the nursing workforce will provide an understanding of what influences an ENs level of job satisfaction.

3.4.1.2 The group: The ward/unit

The EN is a member of a nursing team that can include RNs and AINs. The EN is also a member of the broader multidisciplinary team, including medical officers, allied health professionals and support staff. There is a need to explore occupational stress to analyse how the EN works within a group. For this study, 'occupational stress' is defined as 'the study of psychological stress occurring in the workplace' (Kalliath et al., 2014, p. 225). Occupational stress is determined by how the requirements of the job match or do not match the skills of individuals as team members, how the team works together and the groups dynamics (Wood et al., 2013). This is a key concept because the EN role was not designed to work autonomously, as stated in the NMBA's (2016) *Enrolled Nurse Standards for Practice*:

> The EN works with the RN as part of the health care team and demonstrates competence in the provision of person-centred care. Core practice generally requires the EN to work under the direct or indirect supervision of the RN. At all times, the EN retains responsibility for his/her actions and remains accountable in providing delegated nursing care. The need for the EN to have a named and accessible RN at all times and in all contexts of care for support and guidance is critical to patient safety. (p. 2)

Therefore, to explore the group/team aspect of the EN role, it is important to understand how the roles within the nursing team work together and the place of the EN in the wider multidisciplinary team. To understand the longstanding challenge of feeling valued in their role as an EN, the OB unit of analysis of the group, together with the philosophical

assumptions, creates the opportunity to explore and analyse group dynamics which influences the levels of occupational stress. This includes the effects of support, work allocation, supervision, value and empowerment.

3.4.1.3 The organisation: hospital/profession

The individual relates to the hospital, facility or health service in which they work; however, the hospital or facility should operationalise the professional policies, standards and structures as determined at the professional level. The influence of OB at the organisational level includes organisational structure, the relationships between different departments, organisational development and change (i.e., the internal capacity of the organisation to accomplish its mission), and organisational culture (i.e., the values, assumptions and meanings shared by staff) (Wood et al., 2013). Collectively, this creates an organisational culture of the nursing workforce. To effect change there is a need to understand what creates and influences organisational culture of the nursing workforce, as there is a direct impact on the role of the EN. The challenges highlighted in the literature require a pragmatic approach to analysing this level.

When combined with the multiphase exploratory sequential MM research design, the qualitative method captures the depth of the narrative across each of the three units of OB analysis. The analysis is further enhanced by including the quantitative method, which provides the opportunity to measure the breadth of the challenges. The philosophical assumptions of pragmatism and the transformative approach, together with the OB conceptual framework, provide the lens through which the data is collected, analysed, integrated and interpreted. This will provide a structure to inform recommendations to effect real and sustained change. The relationship between the aspects of this study is shown in Figure 3.4.

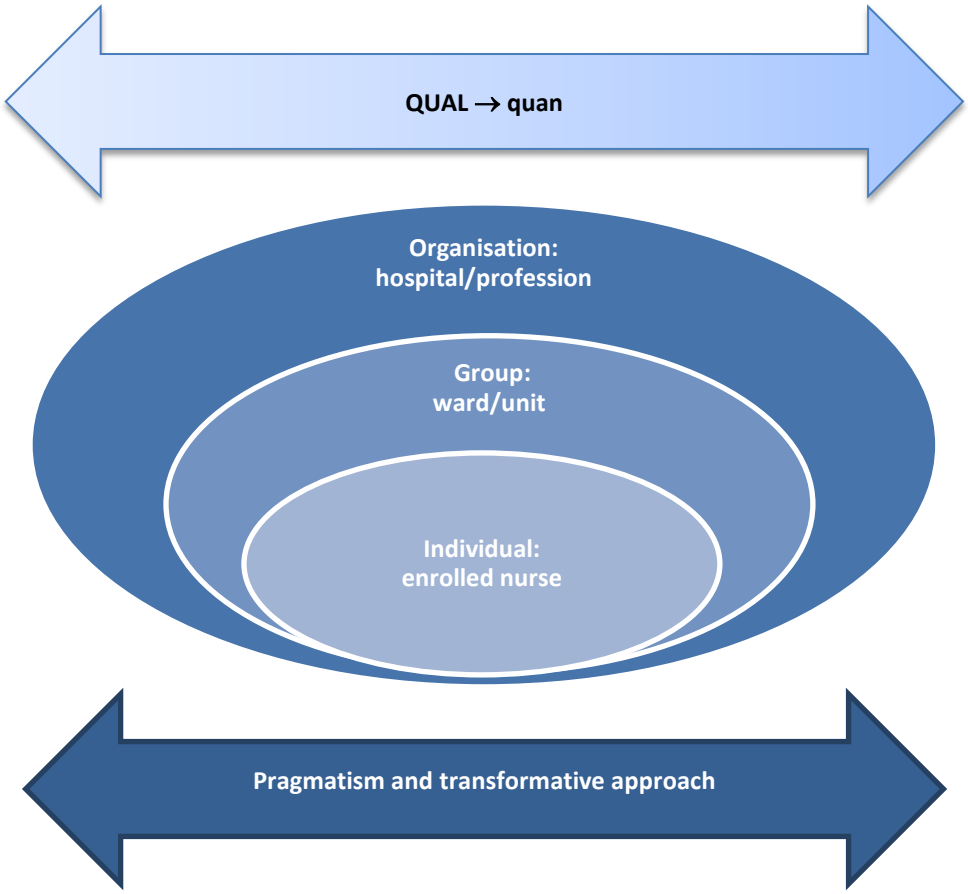


Figure 3.4: The relationship between the organisational behaviour framework, philosophical assumptions and research design

3.5 Ethical considerations

The ethical aspects of this research project were approved by the South Western Sydney Local Health District and the University of Wollongong human research ethics committees (HREC). This study was considered a low and negligible risk. The HREC for the doctoral study is H18/097, and it was approved on 13 June 2018. This study was carried out following the *National Statement on Ethical Conduct in Human Research 2007* (The National Health and Medical Research Council [NHMRC], 2015), which was developed to protect the interests of people who agree to participate in human research studies. An initial ethics application was made, with a submission for an amendment after Phase 2, once the questionnaire was developed.

Section 3.5 describes the ethical considerations with specific reference to each phase of the study. It is important to address ethical considerations for each phase of the research

because, although similar, using different data collection methods requires specific attention.

3.5.1 Participants: Inclusion and exclusion criteria

All nursing staff, regardless of their role, who were employed by the participating Australian health services, or a financial member of the participating professional associations, were invited to participate in the study. This included AINs, ENs and RNs employed in clinical and non-clinical roles for example managers and educators. There was no specific exclusion criterion. The enrolled nurse professional associations were invited to participate in the study because the focus of the study was the role of the EN, and their membership is ENs. In contrast to the health services where the EN number is a fifth of the workforce, as detailed in Table 1.2.

Participants were divided into two cohorts for Phase 1 and for the comparative analysis. Cohort one included the ENs (EN cohort), and cohort two included the AINs and RNs (Non-EN cohort).

3.5.1.1 Enrolled nurse cohort

ENs whose details were available on the participating health services' staffing databases and professional bodies' membership databases were invited to participate via email. This included ENs employed in both clinical and non-clinical roles.

3.5.1.2 Non-enrolled nurse cohort

All nursing staff (except ENs) whose details were available on the participating health services' staffing databases were invited to participate via email. This cohort included AINs and RNs employed as clinicians, managers and educators in clinical and non-clinical roles, for example, directors of nursing and midwifery, nurse managers, nursing unit managers, nurse educators, clinical nurse educators, clinical nurse consultants, clinical nurse specialists. Any RMs who participated were also included in the non-EN cohort.

3.5.2 Informed consent

Site-specific approvals for study participation and questionnaire distribution were obtained from each participating hospital or organisation's HREC. All participants were provided with a PIS (see Appendix F) detailing the study and clearly indicating that their participation was voluntary. For phase one signed consent forms (see Appendix H) for

each participant were obtained at the beginning of each focus group, and they were verbally reminded that participation was voluntary and that they could withdraw at any time. Participants were also informed that if they chose to withdraw, any recorded statements could not be removed during the data transcription because individual participants were not identified through the discussions. No participants withdrew from any of the focus groups. For phase three, the quantitative phase, returning the completed questionnaire was deemed to signify full acceptance and consent to participate in the study.

3.5.3 Confidentiality and privacy

Information obtained through this study remains confidential and only accessible to the research team. All information is stored on a password-protected computer in a password-protected file and will be disposed of in a confidential and irreversible manner as per South Western Sydney and University of Wollongong's policies. Generalised results were presented as a report to the participating health services' directors of nursing and midwifery, the executive of the professional associations and the Nursing and Midwifery office, NSW Ministry of Health, and a number of publication and conferences. No identifying data was included in any report.

A contact person was identified from each participating health service and professional association. The role of the contact person was to distribute the invitation to participate in the study, coordinate the logistics of the focus groups and distribute the self-administered questionnaire. This ensured that no participant information was provided to the researcher and that the researcher could not unduly influence participation.

Specific steps were implemented to ensure the confidentiality and privacy of focus group participants. Focus groups were recorded on a digital voice recorder and transcribed verbatim, minus any identifying information (e.g., names of people or wards/units) by an independent transcriber. This removed any ability for the researcher to recognise a participant through their voice or include identifying information in any analysis.

For the questionnaire, no personal or identifying information was collected. The questionnaire was designed and administered in SurveyMonkey, a commercial survey service. Data from the hard copy questionnaires were entered, and the hard copy questionnaires were securely destroyed. Participants were informed that once they

submitted the questionnaire, their responses could not be withdrawn because they were collected with no identifiers, reinforcing the anonymous nature of the study.

3.5.4 Data storage and record retention

All data and materials related to the study will be kept for five years after its completion, as required by The National Health and Medical Research Council (NHMRC, 2015). They will then be destroyed, with records in electronic format deleted by reformatting or rewriting to ensure the data and any pointers in the system are inaccessible (NHMRC, 2015).

Signed consent forms (see Appendix H) from Phase 1 were scanned and stored electronically on a password-protected computer in a password-protected file, with the hard copies then destroyed. The digital recordings were deleted after the transcripts were prepared and checked for accuracy. Any hard copy questionnaires from Phase 3 were destroyed once the data had been entered into SurveyMonkey.

3.5.5 Potential risks to participants

This study was considered a low and negligible risk by the Human Research Ethics Committee, however, several potential risks needed to be mitigated. These included participant distress, time inconvenience of participation and the risk of being identified.

3.5.5.1 Distress

Due to the nature of the discussions there was a potential for participants to become distressed with the conversation arising from the focus groups. A progressive, supportive approach was used by the researcher, who had extensive experience facilitating group discussions and, as an experienced emergency department RN, also had extensive experience in dealing with people in distress. The specific concern was for the EN cohort because of the longstanding experiences of ENs being dismissed because they were ENs, as evidenced by the literature (Evans, 1994; Kenny & Duckett, 2005; Leon et al., 2019).

Depending on the severity of the distress, several options were available, including asking if the participant(s) would like to stop the discussion, turning off the recording, asking if the distressed participant would like to remove themselves from the group, taking the participant aside to have a one-on-one discussion, referring them to their respective employee assistance program, and/or identifying a support person they would like contacted, as well as ensuring that the researcher checked in with them after the session.

This occurred in one of the EN cohort's focus groups. A young, inexperienced EN became distressed while sharing their experiences and perceptions of belittling, harassment and excessive workload. The group comprised a mix of older and experienced ENs who were very supportive and created a nurturing and safe environment. The group paused to allow the EN to compose themselves, but the young EN wanted to continue. The young EN felt safe and supported while sharing and received validation of their personal and distressing experiences. When the researcher followed up, the young EN shared that some of the older and experienced ENs from the focus group had been in contact. The EN was now experiencing a level of professional support, mentorship and guidance that had previously been absent.

3.5.5.2 Time inconvenience

The focus groups were coordinated with a local contact to ensure they were scheduled around existing meetings and organisation requirements and to minimise the effects on time and inconvenience for participants. Participants were also informed that the group would last approximately 45 minutes, and should they need to leave, they were free to do so. Notifying participants about the timeframe for focus groups ensures they are informed so they can plan their involvement, as there is greater engagement when a participant is informed and has a level of control (Redmond & Curtis, 2009; Then et al., 2014).

3.5.5.3 Being identified

Participants were informed that participation was voluntary. Participation in both the focus groups and the questionnaire was anonymous. No attendance lists were collected for the focus groups, and there was no identifying information collected on the questionnaire. Participants were reassured that the information they shared was solely for the purpose of the study and that there would be no repercussions with their respective employer(s). Feedback on the focus group discussions was not provided to the employer(s). Any identifying information was removed on transcription. Participants were informed that once their comments were recorded or their questionnaires received their data could not be removed from the dataset because it had been collected with no identifying elements.

3.6 Assessment of rigour

A key component of good research is incorporating procedures to ensure the validity of the data and, subsequently, the findings. The assessments of rigour differs with each mode

of research design (Creswell & Plano Clark, 2018). Therefore, the assessment of rigour for each phase has been detailed separately.

3.6.1 Phase 1 assessment of rigour

The goal of the assessment of rigour within qualitative research is to 'build trustworthiness and place enough rigour in the methods so that the researcher is certain of the results, and the consumer is confident enough to implement, or to move forward, building on the results' (Guba & Lincoln, 1985, cited in Denzin & Lincoln, 2018, p. 814). This is achieved by validating hard data and verifying soft data. 'Hard data' is described as concrete and permanent phenomena, while 'soft data' involves experiential phenomena (Denzin & Lincoln, 2018). Most qualitative research methods capture both hard and soft data, with a predominance of one type of data over the other (Denzin & Lincoln, 2018). This study predominately captured soft data because, through focus groups, participants shared their experiences, perceptions and expectations.

With the understanding that the majority of the data would be soft data, strategies were implemented through the research design that assessed for credibility, transferability, dependability and confirmability (Creswell & Plano Clark, 2018; Johnson & Rasulova, 2017). Some assessment strategies overlap and are relevant to several principles. These have been detailed with their application to this study in Table 4.1.

Table 4.1: Phase 1—qualitative rigour assessment

Principle	Assessment strategy	Application to this study
Credibility (authentic representations of experiences)	Sampling	Stratified sampling was used to select where the focus groups were conducted so that they represented the characteristics of the cohorts being studied (Braun & Clarke, 2013) (see Section 3.7.1).
	Saturation	Saturation occurs when no new information is being captured from the focus groups (Connelly, 2015; Krueger & Casey, 2000). The rationale for the number of focus groups required to achieve saturation is detailed in Section 3.7.1.
	Peer debriefing	This involves discussions and interpretations with the supervisory team and the researcher's colleagues.
	Structural coherence	This involves ensuring a coherent narrative structure through the themes so there were no inconsistencies between the data and the interpretations.
	Using quotes	This involves checking the interpretations against the verbatim quotes from the focus groups.
Confirmability (the extent to which the biases, motivations, interests or perspectives of the inquirer influence the interpretations)	Audit trail	The methods of data gathering, analysis and interpretation (see Sections 3.7, 3.8 and 3.9, respectively) were all documented, enabling another researcher to understand the process and findings. In this study, the audit trail commenced with the conscious decision to use focus groups, stratified sampling, coding and determining themes and their application to the organisational behaviour conceptual framework. It also captured the allocation of a contact person to coordinate the logistics of the focus groups, removing any real or perceived researcher bias.
	Ethics	Ethics is twofold. Traditional ethical issues included confidentiality, informed consent and the ability to withdraw from the study. Moral ethics required the researcher to treat the participants' experiences, perspectives and expectations with trust and respect. (see Section 3.5).
	Systematic coding and data reduction	The thematic analysis was conducted using the seven steps described by Braun and Clarke (2013, pp. 202–203) (see Section 3.9.1).
Dependability (consistent data collection to ensure repeatability)	Mechanically recorded data	All focus groups were recorded and transcribed verbatim (see Section 3.8.3).
	Audit check	The methods of data gathering, analysis and interpretation (see Sections 3.7, 3.8 and 3.9, respectively) were all documented, enabling another researcher to understand the process and findings.
	A code–recode procedure	The researcher coded each focus group and then returned to check the coding by reading and re-reading the transcripts (see Section 3.9.1).

Principle	Assessment strategy	Application to this study
	Writing up	The research plan was checked with the supervisory team.
	Inter-rater reliability	The same questioning route was used for all focus groups, ensuring consistency in the context, content and transferability (see Section 3.8.3).
	Peer review	On completion of the focus groups, a preliminary analysis of the enrolled nurse cohort data was collated and presented to approximately 50 enrolled nurses, confirming the credibility, dependability and confirmability of the findings (see Section 3.3.2.2).
Transferability (descriptions and findings are sufficient to draw similarities with another context)	Saturation	Saturation occurs when no new information is being captured from the focus groups (Connelly, 2015; Krueger & Casey, 2000). The rationale for the number of focus groups required to achieve saturation is detailed in Section 3.7.1.
	Member checking	When used with focus groups, member checking enabled participants to trigger one another's experiences and verifiy concepts, creating confirmability (see Section 3.3.2.2).
	Comparison of sample demographic data	The characteristics of the research participants were comparable to the nursing workforce (see Section 4.2.1).
	Audit trail	The methods of data gathering, analysis and interpretation (see Sections 3.7, 3.8 and 3.9, respectively) were all documented, enabling another researcher to understand the process and findings. In this study, the audit trail commenced with the conscious decision to use focus groups, stratified sampling, coding and determining themes and their applications to the organisational behaviour conceptual framework. It also captured the allocation of a contact person to coordinate the logistics of the focus groups, removing any real or perceived researcher bias.

Note. Adapted from Denzin and Lincoln (2018) and Johnson and Rasulova (2017).

3.6.2 Phases 2 & 3 assessment of rigour

For the quantitative method (Phases 2 and 3), the assessment of rigour focuses on face validity, content validity, inter-rater reliability, construct validity, reliability and internal consistency (Mokkink et al., 2010). It has been detailed in Section 5.3 as it was assessed during the development of the self-administered questionnaire.

3.7 Settings and participants

Participants in the study were purposefully selected because of the nature and aim of the study. Each interested public and private health service and the national and state professional associations for ENs were contacted through identified contact persons.

3.7.1 Phase 1 settings and participants

The focus groups were conducted in metropolitan and regional public and private health services across NSW. Stratified sampling was used to select where they were conducted. This sampling technique involves the selection of settings to represent the characteristics of the cohorts being studied (Braun & Clarke, 2013). Diversity within the EN and the non-EN workforce includes age, gender, ethnicity, geographical region (metropolitan, regional or rural), employment type (acute, residential or community) and type of health service employer (public, private or non-government organisation). Stratified sampling ensures that this diversity is captured. A challenge of focus groups is ensuring that the number of participants per group is sufficient enough to enable interactions and discussions and that participants do not feel like they are being interviewed but are not too large that each participant cannot contribute to the discussions (Connelly, 2015). Therefore, the focus groups were not scheduled at any small rural or remote sites because it was identified that there were not enough ENs to hold a focus group. With this reasoning, focus groups were scheduled at the following sites:

- a private health service at a regional acute and non-acute facility
- a private health service at a metropolitan non-acute facility
- a public health service at a large metropolitan acute facility
- a public health service at a medium metropolitan acute facility
- a public health service at a large regional acute facility
- a public health service at a medium regional acute facility.

The key was ensuring enough sites were selected through stratified sampling to enable the participants to attend. Then, through the focus group discussions, that saturation in information and experiences were reached. Saturation occurs when no new information is being captured from the focus groups (Connelly, 2015; Krueger & Casey, 2000). A general consensus in the literature is that three to five focus groups per cohort are ideal; two groups may only provide the same or opposing themes, with the researcher not knowing what is 'normal' (Connelly, 2015; Krueger & Casey, 2000). Six focus groups were scheduled per cohort (one focus group per cohort at each site) to ensure there was a perspective from each of the sites noted above.

3.7.2 Phase 3 settings and participants

The setting for the questionnaire was all health services, and the professional associations who had agreed to participate. The questionnaires were sent to services who had and who had not held focus groups, and was open to all nursing staff regardless of their role. The contact persons were emailed the link to the questionnaire (see Appendix O), the PIS relevant to the questionnaire (see Appendix M), the flyer (see Appendix G) and an email invitation (see Appendix L) for distribution within their respective health services and professional associations. The PIS informed the participants of the aim and objectives of the study and reassured them that participation was voluntary and that their employment would not be affected whether or not they chose to participate.

3.8 Recruitment and data collection

3.8.1 Recruitment strategies

An initial invitation was sent to several public and private health organisations and the national and state professional associations for ENs. Given that the members of the two professional associations were spread across the country and state, the professional associations' members as a collective were invited to participate in the questionnaire through their membership. Information about the focus groups was circulated through the membership. This allowed members who worked at any organisation where a focus group was conducted to participate.

An excellent response was received, which included 13 metropolitan sites. This was too many metropolitan sites for the purposes of the focus groups because it would capture a metropolitan-biased discussion and not represent the characteristics of the cohorts being

studied. Therefore, sites were identified for the focus groups using the stratified sampling technique. (see Section 3.7). The other sites were notified that they would be contacted for the distribution of the questionnaire later in the study.

A contact person was identified by the director of nursing and midwifery or equivalent. The logistics of the ethics, dates, times and rooms were finalised through the contact person, who also circulated the email invitation (see Appendix I) with the PIS (see Appendix F). A flyer (see Appendix J) and the PIS (see Appendix F) were circulated throughout the facility, and the focus groups were noted at nurse managers' meetings. The focus groups were scheduled in consultation with local management to minimise operational effects while giving staff the opportunity to participate. Times were scheduled during the middle of the day at most sites, which increased staffing levels in the wards/units due to shift changes, creating further opportunities for staff to attend.

The contact person also supported the recruitment to complete the questionnaire. The flyer (Appendix G), email invitation (Appendix L), PIS (Appendix M) and a link to the self-administered questionnaire (Appendix O) were distributed by the contact person. This removed any participant details being provided to the researcher. Hard copy questionnaires were also made available with a return addressed postage-paid envelope to ensure all participants had the opportunity to participate. A request for a hard-copy questionnaire was either made through the local contact person, or directly to the researcher through the contact details in the Participant Information Sheet (PIS) (Appendix F) and on the flyer (Appendix G).

3.8.2 Increasing the response rate

A range of evidence-based strategies was used to maximise the response rate. This started with the study-specific development and validation of the questionnaire, which ensured credibility (see Chapter 5). It has been identified that there is greater engagement when a participant is informed of what to expect regarding the research participation burden (M. Hutchinson & Sutherland, 2019). A step in the development process was to pilot the questionnaire (see Sections 5.3.4, 5.4.4), which enabled the completion time to be captured. This was averaged, and the approximate time to complete the questionnaire was communicated through the recruitment materials.

The use of a local contact person was also a strategy to improve the response rate. A local contact person was key to supporting the recruitment because it removed the researcher from direct contact with the participants (Polgar & Thomas, 2008). This selection of strategies, contrasted with focusing on one recruitment strategy, helped increase the response rate.

3.8.3 Data collection – focus groups

The focus groups were recorded on a digital voice recorder. This enabled the researcher to fully engage with the focus group participants and not be distracted by taking notes. The focus groups were semi-structured with predetermined key questions (Appendix P), also known as a 'questioning route' (Krueger & Casey, 2000). The same questioning route was used for each cohort but contextualised to the audience. Questions were developed by turning the study aim and objectives from statements into questions. This ensured that the discussions stayed on track and were relevant to the study. The key to moderating the focus groups was to ensure the discussions remained aligned with the study and were respectful of all parties and their experiences but did not curtail the discussions or allow them to go off track (Krueger & Casey, 2000). Focus groups were completed between 21 August 2018 and 01 November 2018.

3.8.3.1 Optimising the data collection

A key strategy to optimise the data collected from the focus groups was to ensure they were homogenous—that is, the two cohorts were separated, removing any power positionalities. The researcher needs to be organised and ensure the discussion remains on track because any lack of control could lead to discussions of irrelevant issues and waste valuable time. Other strategies involve the required planning because, logistically, focus groups can be more challenging to organise due to location and time constraints (Then et al., 2014). This was minimised by identifying a local contact who assisted with the logistics.

The number of participants also contributes to the success of a discussion. Several authors have identified ideal group sizes, with the greatest consensus being four at a minimum and 12 as the maximum (Connelly, 2015; Cronin, 2011; Krueger & Casey, 2000). Therefore, by using focus groups in this study, the researcher could not include remote sites because there were not enough staff available for a focus group. Interviews in this environment would have been an advantage. However, this was mitigated because remote

participants were still afforded the opportunity to participate in the study through the questionnaire in Phase 3.

3.8.4 Data collection – self-administered questionnaire

Data were collected using the self-administered questionnaire developed as described in Chapter 5 and occurred between 20 May 2019 to 30 June 2019. A reminder email was sent second weekly during this period.

3.9 Data analysis

As detailed in Figure 3.1, the data from each phase was analysed separately, and then combined at the point of interpretation. Section 3.9 details the analysis for each phase.

3.9.1 Focus groups – data analysis

Data from the focus groups were analysed using thematic analysis. This is the process of generating meaning from the data collected without any pre-existing criteria (Braun & Clarke, 2013). QSR NVivo 12 software (QSR International, Doncaster Road, Victoria, Australia) was used to assist the thematic analysis, which was conducted using the following seven steps as described by Braun and Clarke (2013, pp. 202–203):

1. Transcription—the recordings were transcribed verbatim, except for any identifying markers. Names of people or places were removed and replaced with a generic term, for example, ‘place’ or ‘name’.
2. Reading and familiarisation—the transcripts were read and re-read, noting any phrases or statements of potential interest. This also enabled the researcher to gain a feel for the data in the context in which it was given.
3. Coding—initial coding was completed separately for each focus group. The codes were then sorted into those of similar context and ideas. This process highlighted any codes that were repetitive or very similar in meaning. It also identified what was not a code due to a lack of references or if a code did not relate to the study’s aim and objectives. A lack of references was defined as any code that was referenced in less than three focus groups across the cohorts. This process ensured a level of rigour and standardisation of what was included or excluded.
4. Searching for themes—the themes’ names became more clearly identified by refining the codes.

5. Reviewing themes—the themes were mapped to each other to identify whether there was a hierarchical or lateral thematic structure. This process resulted in the development of a visual representation of the themes. It also differentiated themes from sub-themes.
6. Defining and naming themes—each theme and sub-theme name was determined by identifying a collective term or phrase that captured the sentiment or was a main thread through the codes and sub-themes.
7. Writing—the analysis was finalised

3.9.2 Questionnaire – quantitative data analysis

Data from the questionnaire were summarised using descriptive statistical analysis such as frequency distributions, measures of central tendency and dispersion. Inferential statistical analyses, including *t*-tests and analysis of variance (ANOVA), were used to compare differences in respondents' experiences, perceptions and expectations of the EN's role based on demographics and professional characteristics. Cross-tabulation and Pearson's chi-squared test were used to examine associations between relevant factors. A p value $< .05$ was considered statistically significant. All analyses were conducted using IBM SPSS Statistics (Version 28).

3.9.3 Questionnaire – qualitative data analysis

The data from the questionnaire items that required open-ended responses were analysed using the same thematic analysis approach used for the qualitative data in Phase 1 (see Section 3.9), ensuring a consistent approach across both datasets. This involved reading and becoming familiar with the responses, coding, searching and reviewing themes, and defining and naming themes (Braun & Clarke, 2013).

3.9.4 Data integration

Data integration for this study used the triangulation or comparison of data sets approach. This approach analyses the data separately and then combines at the point of interpretation by checking for agreement or disagreement (Johnson et al., 2019). Figure 3.1 provides a visual representation depicting the phases, demonstrates the building from one dataset to another and the transition between the phases of the multiphase exploratory sequential MM research design that was used for this study. This sequencing resulted in a more comprehensive and relevant body of evidence to address the aim and objectives of this study.

3.10 Chapter summary

A structured methodology provides a road map through which the researcher can navigate the study and ensure all ethical considerations are covered. This study used the multiphase exploratory sequential MM research design with the OB conceptual framework as the lens through which the data was analysed, integrated and presented. The discussion also includes how the philosophical assumptions of pragmatism and the transformative approach inform the final recommendations.

Chapter 4 presents the research design and findings from Phase 1 (the qualitative phase). It is the first chapter to demonstrate how the conceptual framework supports the body of evidence.

Chapter 4: Phase 1—qualitative findings

4.1 Introduction

Chapter 4 presents and discusses the research key qualitative findings (Phase 1). In the multiphase exploratory sequential MM research design the qualitative phase (QUAL) provides the foundation and focus because the data collected is used to inform Phases 2 and 3 of this study.

4.2 Findings

Once the data were collected, the findings were analysed. Section 4.2 provides this analysis.

4.2.1 Participants' demographics

As discussed in Section 3.7.1, stratified sampling was used to determine where the focus groups were conducted. A total of 12 focus groups were scheduled, six per cohort. However, only 10 (five per cohort) were conducted due to no attendance at one site, which comprised two focus groups, one per cohort. The average length of each focus group was 45 minutes. The EN cohort focus groups had a total of 30 participants, of which two were male (6.7%) and the remainder were female (93.3%). The groups comprised ENs with and without medication administration rights and those enrolled in a bachelor of nursing (BN). The non-EN cohort focus groups had a total of 28 participants, of which two were male (7.0%) and the remainder were female (93.0%). These groups comprised RNs who worked in education, management and clinical roles, with a small number of RMs in education and clinical roles. No AINs or assistants in midwifery participated in the focus groups. The gender representation from both cohorts (93.0% female and 7.0% male) was proportionally consistent with the Australian nursing profession captured in 2020 to 2021, with 88.4% female and 11.6% male (AHPRA & National Board, 2021, p. 27). The detailed breakdown per site, organisation and cohort is presented in Table 4.2.

Table 4.2: Focus group participants

Site	Organisation	Enrolled nurses	Non-enrolled nurses
Large metropolitan acute facility	Public	7	6
Medium metropolitan acute facility	Public	6	3
Regional acute and non-acute facility	Private	10	3
Metropolitan non-acute facility	Private	4	4
Large regional acute facility	Public	0	0
Medium regional acute facility	Public	3	12
	Total	30	28

4.2.2 Thematic analysis

Section 4.2.2 presents the results of the thematic analysis from the focus groups. There was an iterative approach to the thematic analysis supported by the QRS NVivo 12 software. There was consistency with evidence across the dataset, with themes identified in several focus groups, in the same cohort and across both cohorts. The analysis identified three themes: 'the EN as the individual', 'the EN in the workplace' and 'the EN in the profession'. The code book is presented in Appendix K. Collectively, the themes provide a rich, coherent and meaningful picture of dominant patterns from the data. They also described the role of the EN in the Australian nursing workforce from the participants' perspectives. A visual representation of the collective themes is presented in Figure 4.1. A Venn diagram was used because the EN as an individual was directly affected by the EN in the workplace. Then both the EN as an individual and the EN in the workplace are within the nursing profession, hence the outer circle is the EN in the profession. Sections 4.2.3 to 4.2.5 present the focus and scope of each theme, with the definitions and analyses of the evidence drawn from the dataset.

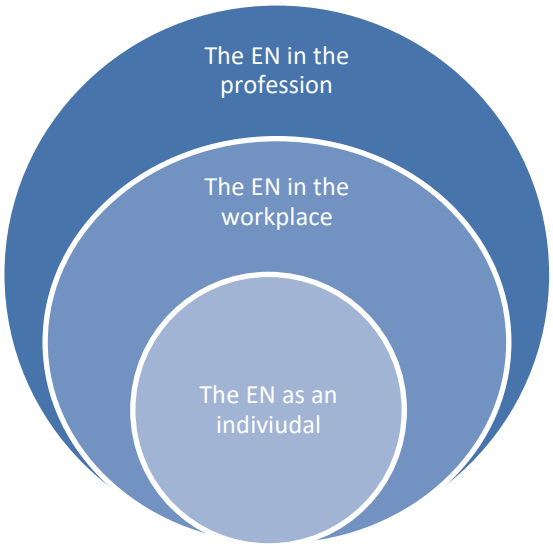


Figure 4.1: Visual representation of the collective themes

Note. EN = enrolled nurse.

4.2.3 Theme: The enrolled nurse as an individual

The first theme, 'the EN as an individual', presents the voice of the EN as they shared their thoughts, feelings and experiences of being an EN in the Australian nursing workforce. This theme focuses on the EN's perspective of their role and how they believe other members of the nursing workforce perceive them. It was important for the EN to be considered a nurse in their own right, and specifically, not as an assistant to others. As a nurse, they wanted to help people who were sick, injured, vulnerable and in need. The EN was predominately focused on the care they provided. However, there was a level of confusion within the EN cohort about their role as an EN, which stemmed from what some believed they could do in their role. This belief was informed and reinforced by the conflicting and mixed messages they received from other nursing roles and the organisations in which they worked. The EN is allocated work under the understanding of both cohorts that they do not have the accountability or responsibility for their work. The EN also experienced a lack of acknowledgement for their work by other members of the nursing and multidisciplinary teams. It was not uncommon for the EN to be treated as *an assistant* but be allocated their own *patient load* with no or minimal supervision, giving mixed messages and creating confusion.

For the EN, '*being a nurse*' (EN focus group [FG] 1; EN FG3; EN FG5) was critical to their self-identity and sense of being valued, but for the majority of EN participants, their identity as an EN was unclear. This was because of the lack of clarity around what their

role is and what they are qualified to do. This led them to perceive, understand and, in some cases, expect that their role was, essentially, the same role as the RN.

There was a general agreement within the EN cohort that their title did not provide any clarity or reflect their role. Further affecting 'the EN as an individual' was that they did not feel trusted. These experiences, shared by EN participants, suggest that they were not valued despite their knowledge, skills, loyalty and longevity to an organisation.

This theme, 'the EN as an individual', was captured in two sub-themes: 'self-identity' and 'trusted'. Collectively, they depict the EN as an individual from the ENs' perspective. Figure 4.2 provides a diagrammatic representation of the theme 'the EN as an individual'. It has been depicted in a stacked Venn diagram to visualise the building and overlapping of the relationships from the theme into the sub-themes. 'The EN as an individual' felt very strongly that there should be more clarity regarding their role and that, if it were better understood, there would be a stronger identity that they were a nurse. There would also be a greater appreciation for their role and what they do for others. The 'trusted' sub-theme is in the outer circle because it encompasses all aspects that 'the EN as an individual' strives to achieve, as being a trusted member of the healthcare team is very important to them. Collectively, the influence of the ENs' 'self-identity' determines how 'trusted' the EN is as an individual and, consequently, how valued they feel.

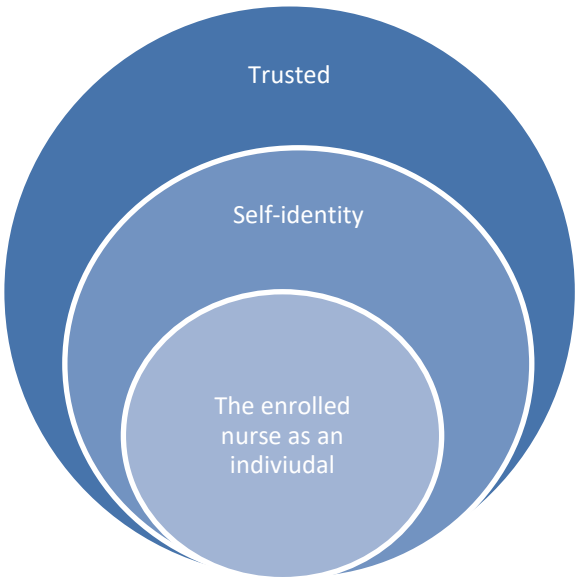


Figure 4.2: A diagrammatic representation of the 'the enrolled nurse as an individual' theme

4.2.3.1 Self-Identity

'Self-identity' is about who a person is and how they perceive themselves as an individual (Soanes & Hawker, 2005). For many EN participants, '*being a nurse*' (EN FG1; EN FG3; EN FG5) was the foundation of their 'self-identity' and gave them a sense of purpose. EN participants were driven by their intrinsic motivators; for example, '*being a nurse'* was important to them because caring for others gave them a sense of purpose. Their 'self-identity' was not linked to a level or a status, but to work and be recognised as a nurse: '*I walk out of here, my heads up because I've done something for 20 people today*' (EN FG1), and *'I've always wanted to be a nurse'* (EN FG 5).

However, for some ENs, their 'self-identity' had a greater reliance on extrinsic motivators, which were influenced by a level of confusion, especially between the EN and RN roles. This confusion generated mixed and conflicting messages. It was perpetuated because the skill set of the EN, especially when their SOP included administering defined medications, overlapped with the RNs' skill set. The following quotes captured the sentiment of many participants that, in their belief, '*there is not much difference between ENs and RNs, it's just a nurse*' (EN FG5), *'The thing I don't get in my ward is that I'm not allowed to hold the keys'* (EN FG3), and '*there is no EN or RN…just the more experienced and senior nurses'* (EN FG1). This perspective permeated several aspects of their role and influenced how many ENs perceived themselves in the nursing workforce, especially for those EN participants who relied on extrinsic motivators for their job satisfaction. This perspective also influenced the ENs' expectations from others because it placed the EN and RN in the same role: '*just a nurse*' (EN FG2).

A consequence of the perspective that both roles are '*just nurses*' (EN FG2) was that ENs were not paid an equivalent salary to RNs, which affected the ENs' 'self-identity' and made them question their value in the workforce. This was further fuelled when ENs were allocated work and patient loads that made them feel like they were working as an RN, '*well, sometimes I got to stop thinking about it … what my hourly rate is compared to some of them, and I'm doing exactly the same thing; it hurts a little bit*' (EN FG2).

For EN participants, the title 'EN' also contributed to their 'self-identity' in the nursing profession and was another extrinsic motivator towards their job satisfaction because it enabled outward recognition. The title 'enrolled' was problematic because they believed it did not describe or reflect what they did. This was reinforced when patients and other

nursing and midwifery staff questioned its meaning. For the EN who was striving to understand their place in the nursing workforce and establish their 'self-identity', the ambiguous title appeared to devalue their role in the nursing profession: '*What does the word "enrolled" actually mean (i.e., you are enrolled in a course?) ... people still ask, what does it mean? The multitude of names indicates disunity within the profession, and is this professional?*' (EN FG 5).

Further complicating their 'self-identity' was the regulatory change that removed the endorsement from their title, which for the endorsed EN (EEN), returned them to being called an EN overnight without explanation. This occurred in 2010 with the change to national registration and the need to standardise the title across Australia (AHPRA, 2011). It was communicated in a newsletter from the NMBA (2018a) after several enquiries about the endorsement (the 'E'). For many ENs who had completed further studies, the endorsement (the 'E') gave them a sense of pride and provided an outward recognition of the difference between the EN and the EEN. The removal of the 'E' from their title created confusion and affected their 'self-identity', as they struggled with any outward acknowledgements and differentiations that recognised their efforts. The following quotation from a participant is one of many expressing the frustration and angst generated by the change in title: '*I told her "I'm an EEN, not just an EN* (EN FG1), and *'an EEN, I worked hard for that E"* ' (EN FG5). The language used by the EN participant, '*I told her ... "not just ... worked hard"* ' demonstrated the passion and motivation behind what a title represents for an individual. Despite the removal of the 'E', ENs still refer to themselves an EEN, '*I'm an endorsed enrolled nurse not an enrolled nurse*' (EN FG3) and *I'm an EEN, not just an EN* (EN FG1). The effects on these ENs' 'self-identity' is apparent.

Another example where the EN participants' 'self-identity' was negatively affected by their title and lack of outward recognition was when they completed additional studies that led to advanced or extended practice. One EN participant stated, '*I did extra study to become an [ASEN]; however, I am still called an EN. There has been very little recognition*' (EN FG2). The title, 'EN', was the same for all ENs regardless of their education, qualifications and years of experience. Their level of passion and emotion stressed the importance of, at a minimum, identifying the difference between those ENs who are qualified or not qualified to administer defined medications. The EN participants believed their title was an outward expression of who they were, what they had achieved,

how they had contributed to the nursing team and, most importantly, their motivation for '*being a nurse*' (EN FG1; EN FG3; EN FG5). 'Self-identity' of EN participants and being recognised as a *nurse* strongly connected to their feeling of being valued, which was further reinforced when they were 'trusted'.

4.2.3.2 Trusted

Being 'trusted' was a term used many times by the EN participants. To feel 'trusted' was to be considered reliable, honest in their dealings and a valued team member. This was all-encompassing, and for the EN, related to being perceived by their colleagues as *a nurse*:

> *So, that's the point when it comes to being valued. There is only a small group who actually see me as another nurse, not an EN or an EEN; they just see me as, well, 'you're a nurse like me*'. (EN FG5)

For the EN participants, it was '*about trust [and] about people who've got your back*' (EN FG3). The EN participants associated trust with their role as a *nurse* and being valued members of the nursing workforce. When the EN participants felt they were not 'trusted', they did not feel valued. An example of how trust links with being valued is the 'drug keys'. Each hospital or facility ward/unit has a set of keys that opens the Schedule 8 medications (S8s) cupboard, which, under each state and territory Poison's Act, is the RN's responsibility. For many ENs, because of the confusing messages they received about their role, these keys had become a symbol of trust, not about the legislation:

> *It always amazed me … I've been there on the ward [for] 20 years, and I'm not allowed to touch the key because you need an RN to get the drugs out, right, yet they will trust someone who is on the casual pool, who they have never laid eyes on in their whole life, and they're walking around with the whole S8 keys by themselves.* (EN FG5)

This EN participant used the language '*not allowed … trust someone … never laid eyes on in their whole life*', which illustrated their strong feelings of not being 'trusted' despite their longstanding employment with the organisation. This was particularly upsetting for the EN, especially in comparison to RNs, who appeared to be 'trusted' immediately. It also reinforced the ENs' perception that they were not 'trusted' despite their experience and loyalty to the ward.

Another example of not feeling 'trusted' was the lack of respect and acknowledgement of the ENs' knowledge, skills and experiences:

> *I tell them what I think is right, and they won't believe me, so then they'll go and ask someone else, but I have done lots of training. I know I am right, and if I'm not, I will go and ask the right answer, but yeah, most times, I know the right answer, and they won't believe me. And that I find very humiliating*. (EN FG5)

This example reinforced that for the EN to be 'trusted' was to be believed and to have their knowledge valued. The outcome of not being believed was that the EN found the experience '*very humiliating*' (EN FG5). The EN was incredulous that others challenged and questioned their knowledge; the phrase '*they won't believe me*' (EN FG5) was repeated twice in the same paragraph.

There was also the perception that the EN was '*an assistant*' or a '*dog's body*' (EN FG5) rather than a 'trusted' member of the nursing team. This perception was not only because of how the ENs were treated but also by what was said to them by others in the healthcare workforce, '*You are not an RN so you are not going to get this'* (EN FG2). This affected the ENs' feelings of worth and their 'self-identity', especially when the EN had demonstrated a commitment to ensuring they were adequately trained, reliable and willing to help:

> *They put me floating, right, and then one of the midwives were [sic] like to me, 'oh good, you can slave us, you can slave us'. She kept saying it … I can help you, but just don't use the word 'slave'. It made me feel worthless … it just didn't make me feel good*. (EN FG1)

Again, the ENs' language (i.e., '*they won't believe me*', '*very humiliating*', '*as a dog's body*', and '*slave … feel worthless*' [EN FG1]) reinforced the ENs' belief that they were not 'trusted' and, therefore, not a valued member of the nursing team and profession.

This experience was not isolated and made the EN participants feel less of a *nurse,* not valued, not needed, not 'trusted', put down and dismissed. The experiences were always associated with their role as an EN; for example, '*well, you're an EN, so that's why you don't know what's happening, or you're an EN, that's why you don't know this*' (EN FG5). The ENs understood the message that they could not be trusted because they

were ENs. Therefore, it is not surprising that this level of dismissiveness affected the ENs' feelings of being valued:

> *I would never disrespect an RN; there are times you think, 'well, hang on a minute, you know, I might be an EN, but I've got more experience, and please don't put me down and treat me like I'm nothing*'. (EN FG5)

These feelings, together with previous examples where EN participants stated that they '*feel worthless … very humiliating*' [EN FG1] collectively paint a picture of a workforce who do not feel 'trusted' or valued. This was further reinforced by some EN participants when they were redeployed to assist in other wards within their respective hospitals. One EN participant was met with, '*oh, no RN; you are enrolled. Bullshit. I don't need the EN … we don't want no [sic] EN; we want the RN*' (EN FG1). For an EN whose intrinsic motivation is to *be a nurse,* and be 'trusted' and respected, to be met with this language and sentiment reaffirmed to them that their role was not valued or respected.

4.2.3.3 Summary

The findings have demonstrated that the ENs' primary motivation was to '*be a nurse*' (EN FG1), which was the foundation of their 'self-identity'. However, the examples in this theme illustrated a confused 'self-identity', which was reinforced by how other members of the nursing workforce treated the EN participants. Their confusion then informed what the EN considered their 'self-identity' and that their role was similar if not the same as the RN. For many EN participants, being perceived as an RN reinforced their extrinsic motivation of needing to be recognised. There was a general agreement within the EN cohort that their title did not depict or represent their knowledge, skills and experiences. However, the lack of outward recognition was much stronger because all ENs are called ENs, with no differentiation that acknowledged further education and experience.

Feeling 'trusted' was the overarching element contributing to EN participants' 'self-identity' and feeling of being valued. The experiences shared indicated that they did not feel 'trusted' despite their loyalty and longevity to an organisation and that others in the healthcare workforce did not trust the ENs' knowledge, skills and experiences. The experiences shared by the EN participants all culminated in 'the EN as an individual' needing to rely heavily on their intrinsic motivation of '*being a nurse*' (EN FG1; EN FG3;

EN FG5) because they had a confused ‘self-identity’ and did not always feel ‘trusted’. The ‘EN as an individual’ is not designed to work alone, so it was equally important to capture other members of the nursing teams’ perspectives. This led to the second theme, which placed the ‘EN in the workplace’ and captured both the EN and non-ENs cohorts’ perspectives of working together.

4.2.4 Theme: The enrolled nurse in the workplace

The second theme, ‘the EN in the workplace’, presents the perspectives, experiences and opinions from both the EN and non-EN cohorts as they shared what it was like to work together. This theme builds upon the first theme by identifying how the inconsistent messaging and confusion about the role of the EN affected the ENs’ perceptions of their ‘self-identity’ and not feeling ‘trusted’ in their role.

By exploring how the EN and non-EN participants work together, there is a spotlight on each cohort’s understanding of the EN role and how work is shared and allocated. ‘The EN in the workplace’ theme captures the participants’ dynamics and expectations, which demonstrated a lack of understanding of the EN role. The term ‘teamwork’ was used by the participants from both cohorts, but examples suggested a limited shared understanding of this concept. For the EN, part of ‘*being a nurse*’ (EN FG1; EN FG3; EN FG5) was being a member of the nursing team and teamwork. Teamwork for the EN involved working with the RN by helping and ensuring the patients’ needs were met. For the non-EN cohort, there were various examples of what was perceived to be ‘teamwork’. This implies that teamwork was not commonly understood or consistently applied in practice. Inconsistency in the implementation of teamwork, together with confusion about the role of the EN, resulted in a lack of standardised practice for the EN cohort. This was demonstrated by EN participants not being allowed to practice their skills between wards despite their qualifications and assessed competencies, reinforcing the confusion experienced by both cohorts. The consequence was that ENs felt frustrated with a decreased level of job satisfaction because they were not allowed to practice to their full scope, reinforcing their value or lack thereof.

‘The EN in the workplace’ discusses the experiences and attitudes from both cohorts’ perspectives towards the supervision of the EN. There was a disconnect between what was understood as the required level of supervision of the EN by the RN and what occurred in practice. The disconnect was directly linked to the understanding of the EN

role and how it fitted into the nursing team. Despite the EN being perceived and treated as '*an assistant*' (EN FG4; EN FG5), implying that a level of supervision was required, they were allocated their own '*patient load*' (EN FG4), a phrase used by both cohorts to describe the allocation of patients to ENs with minimal or no supervision from RNs. On further examination, it was also identified that many non-EN participants '*really resent*' (non-EN FG5) having the responsibility of supervising the ENs. Collectively, this created a working environment with occupational stress.

There were three sub-themes in the 'EN in the workplace' theme: 'confusion', 'teamwork in practice' and 'supervision in practice'. These three sub-themes did not stand alone but were integrally connected. This theme is depicted in a stacked Venn diagram to visually represent how each sub-theme was connected to the main theme and each other (see Figure 4.3). The sub-theme 'confusion' was related to the role of the EN, which was pivotal to how 'the EN in the workplace' was allocated work and the lack of standardised practice for the EN. The lack of clarity informed the varying interpretations of 'teamwork in practice', which in turn informed the varying interpretations of 'supervision in practice'.

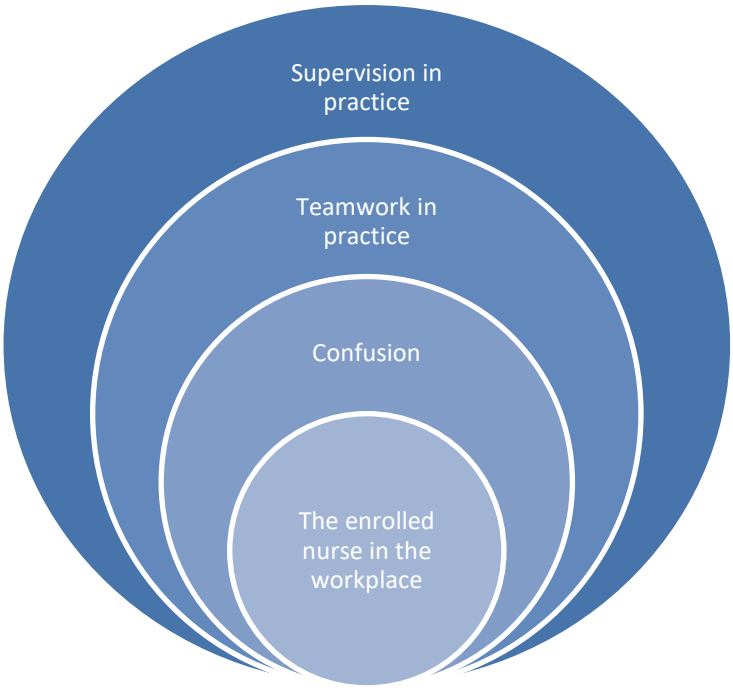


Figure 4.3: A diagrammatic representation of the 'the enrolled nurse in the workplace' theme

4.2.4.1 Confusion

It was not just the EN participants who believed the EN and RN roles were similar, if not the same. Non-EN participants also believed the two roles were similar, if not equivalent. This was reflected by statements suggesting that there was '*no difference*' (non-EN RN FG2), '*they do everything, and I think we see them as one of us*' (non-EN RN FG5) and informed by expectations like '*you kind of just expect them to do the same as us, and to know the same as us*' (non-EN RN FG3). This expectation reinforced two aspects of the RN and EN roles, the 'doing' ('*do the same as us*') and the 'knowing' ('*know the same as us*'). Both of these non-EN participants also used the phrases 'us' ('*one of us*' and '*same as us*'). This implied that the non-EN cohort perceived the collective group of RNs and ENs as the same, relating back to the concept that they are all *just nurses*.

The understanding that both the EN and RN roles '*do the same*' translated into practice through the allocation of work. One example shared by a non-EN participant suggested that because ENs work in a ward with heparin infusions, they may '*give heparin infusions*' (non-EN RN FG1). This expectation was a direct consequence of not understanding the EN role and expecting the EN and RN roles to do the same:

> *Some of the medication they can't give, and we had to look it up … We found that it is only RNs that can initiate those medications, and then we found out, oh, what can ENs do … we were very confused; It said they can't give heparin infusions as well, and on the ward, we have had many heparin infusions*. (non-EN RN FG1)

This is an example experience highlighted the 'confusion' and risk to all concerned regarding what medications the EN may and may not administer: '*we found out, oh, what can ENs do!*' (non-EN RN FG1). The '*oh*' in this statement was made with an exclamation and element of surprise, reinforcing the previous statement by a non-EN participant who '*expect[ed] them to do the same as us*' (non-EN RN FG3).

The concern this experience highlighted is also related to the second aspect, which is the expectation that the knowledge base of the EN is that they '*know the same as us [the RN]*' (non-EN RN FG3). The example above demonstrated how the lack of understanding informed assumptions about which medications ENs may and may not administer. It highlighted how easy it is to assume that the EN and RN have the same knowledge base.

This, coupled with what is happening in the clinical environment, reaffirms the concern expressed by a non-EN participant: '*they don't know what they don't know*' (non-EN RN FG1). However, this can be applied to other roles, not just the EN.

Other aspects of confusion were demonstrated through the lack of standardised practice, which stemmed from a lack of understanding of the EN role and what they were qualified to do. For the EN, there was a lack of consistency between what they were allowed to do and what they were qualified to do: '*one minute, you're allowed; the next minute, you're not*' (EN FG2). The lack of standardised practice was not just apparent between states and territories or hospitals but even within hospitals, as demonstrated by one of many examples shared by the EN participants: *'[in] some wards, I am allowed to do an [indwelling catheter] and [in] some wards, I am not allowed to do an [indwelling catheter]. Some wards are allowed to do this, and some wards aren't allowed*' (EN FG5). It is clear from the lack of standardisation in practice and confusion about the role that neither the EN nor the non-EN participants had a clear understanding of what the EN role was qualified to do.

Many non-EN participants firmly believed that it was the EN's responsibility to know and share what they were qualified to do:

> *Are you allowed to do this? Give me a clear yes or no. Because I think they would have to know all these things from their training course; then, that way, it's not left … to me to make the decision on whether they can or cannot do something*. (non-EN RN FG5)

This expectation and practice implied that the non-EN cohort believed they were absolved from any responsibility (e.g., '*it's not left … to me to make the decision*'). In contrast, the experience of the EN was that when they did provide details about what they were not qualified to do, they were treated with disdain by the non-ENs: '*I've turned around and said, "I'm technically not allowed to do that", and then, when you stand up for yourself, it's like they put you down, say, "move, get out of the way, I'll do it"*' (EN FG5). This is another example of the work environment that decreases job satisfaction and creates occupational stress because the EN is not respected for their integrity but pushed aside.

Another layer of 'confusion' for EN participants was experienced by those who completed further education appropriate to their role but were not supported or allowed

to use the knowledge and practice the skills: '*We get extra money for it, but we can't use the skills that we learnt in it because the hospital won't let us*' (EN FG5). The juxtaposition for this EN participant was that the industrial award recognised the qualification and the EN received '*extra money*', but local processes and procedures were not in place to support the EN working to their capability and qualification.

There was also confusion about why ENs work in maternity services. The non-EN cohort believed ENs were not appropriately educated to work in maternity services, '*which I don't know what they train in because it is an enrolled nurse, not an enrolled midwife'* (non-EN RM FG1) and *'I know that the EN during their course that they don't actually come to maternity and do any days, like, they don't actually do any clinical placement'* (non-EN RM FG1). In addition to a lack of education for the speciality, several participants questioned the role of the EN in maternity services, for example, '*we register differently as nurses and midwives'* (non-EN RM FG1) and *'I still up to now do not understand what their role is, even when they are taking a patient load'* (non-EN RM FG1). The sense from the RMs were that the EN also did not understand their role in this professional area '*I try and ask them, and they also don't seem to know their own scope of practice and are themselves really struggling to work in the maternity field*' (non-EN RM FG1).

This 'confusion' leads to distrust: '*I think there have been numerous times within maternity where people don't trust their [the EN] judgement'* (non-EN RN FG1). ENs were working in maternity services to work in a different capacity from RNs. There was no clarity about their education and what they were qualified to do in this professional setting, which was compounded by the fact that they were not trusted by the RMs.

'Confusion' was both implicit and explicit. It started with an understanding from both cohorts that the EN and RN roles were the same. This 'confusion' then informed a lack of understanding of what medications the EN could administer. The example provided was implicit, as the practice that if a medication was common in the ward where the EN worked, the EN could administer it was flawed but real. In contrast, the confusion exhibited through a lack of standardised practice was an explicit example of confusion. Medication administration, lack of standardised practice, further education and professional development, and working in maternity services were all examples of 'confusion' and provided the foundation that informed 'teamwork in practice'.

4.2.4.2 Teamwork in practice

Working together as a team was important to many participants because it resulted in a '*holistic outcome to the patient*' (EN FG2). For the participants, teamwork was about how members of the nursing team approached working together and whether or not there was a recognition that everyone had a place in the team. The participants' application and experiences of 'teamwork in practice' suggested there was no standardisation or common understanding of teamwork.

Working together made work a positive experience for some participants, resulting in them feeling valued in their roles and as members of the team. This was experienced by participants from both cohorts and is illustrated by the following examples:

> *I work with a great bunch of RNs, and I have been for 15 years, and we equally trust each other.* (EN FG3)
>
> *We're very fortunate we've got a very good team here ... a very good team that works very cohesively and ... there's not really any single person that you would single out that you know you could do without, or it doesn't enhance the experience. I mean, everyone works well together; everyone works to share the load*. (non-EN RN FG3)

This participants suggested specific attributes that result in good teamwork: '*trust each other'* (EN FG4) and '*very cohesively ... works well together ... share the load*' (non-EN RN FG3). Good teamwork was also attributed to the EN feeling 'trusted' and acknowledged, as discussed from the EN participants' perspective in 'the EN as an individual' (see Section 4.2.3). In this working environment, there is job satisfaction and minimal occupational stress.

In contrast, a common experience of 'teamwork in practice' was when the EN and the non-EN had their own patient loads and allocations: '*I am working with [name] today, and we've got patients one to 10, so I will look after patients one to five, and she'll look after patients six to 10, and we'll meet in the middle*' (non-EN RN FG5). 'Meeting in the middle' may imply that they can call on each other for assistance ('*she can come to me, or if I need a hand, I'll ask her to help me*' [non-EN RN FG4]), or it may be explicit that there is no assistance for each other when '*you have some nurses that say this is your lot and I'm not helping you with anything; they are your responsibility*' (EN FG5). In

practice, the analysis suggests that both the EN and non-EN worked independently, reinforcing the assumption that the EN and RN roles are the same. These experiences indicated that for many participants, there was a clear disconnect between the definition of 'teamwork' and its application in practice.

When the two roles worked independently, an onus was placed on the EN to identify and alert the RN if there was a problem or concern with one of their patients. This was a concern for some non-EN participants: '*they are expecting the EN to report back … my issue here is if the EN doesn't know that she [sic] doesn't know something*' (non-EN RN FG1). Allocating the work and patient load in a manner that results in the two roles working independently of one another risks safe quality patient care because the EN may not know there is something of concern, it also risks the EN working outside their SOP.

An important element of working together in a nursing team was the *conversations* about how to work together: '*I don't know that those conversations are actually being valued in the workplace about how … to best work with each other*' (non-EN RN FG5). The key concern was not just that *those conversations* were not occurring but that they were not *valued.* There was no recognition of the value of information transfer between members of the nursing team about their work. In contrast, another experience shared by participants of 'teamwork in practice' was when the EN and RN worked together. The following example illustrated how work was allocated between the two roles and the discussion and conscious decisions about what work needed to be completed together and what work could be completed alone:

> *I'll do a four-bedded room and a single room, and she'll do a four-bedded room and a single room, just in terms of medications; and if it is morning shift, we try and get all the sponges, cause a lot of our patients are sponges because they're heavy, um, can't walk or anything. So, we try and get all sponges done together, and then we go on to do the showers together. That's sort of how it works. And, um, in terms of notes, we just do whosever's meds we do; we do their notes. That's how we sort of break it down*. (non-EN RN FG1)

In this example of teamwork, there was a greater opportunity to discuss the patients' needs and any questions and concerns from the EN; thereby capturing any anomalies that may

present themselves with any of the patients. This example demonstrated that working together enabled some work to be completed independently, but the risk of the '*EN not knowing that they do not know'* (non-EN RN FG5) was diminished.

Some EN participants suggested the division between the nursing roles within the nursing team was because they did not know what each member of the team was qualified to do: '*your division starts from that moment because the team's not going to work as a team if the team doesn't know what each person is capable of doing*' (EN FG3) and *'I don't know that even RNs even know what their role is'* (non-EN RN FG4).. This led to some non-EN participants wanting to work only in areas where there were no ENs, for example, '*it was easier in [the intensive care unit] where it is all RNs … same, it's nice to work in [the] birthing unit because you know who you are working with … there's no asking, "are you allowed to give this"*' (non-EN RN FG1). The confusion about the EN role contributed to the divide in the nursing team, which was experienced by both cohorts.

Further, there were participants who found that 'teamwork' did not exist in their workplace: '*there's no teamwork*' (EN FG5). This could be attributed to a number of reasons. For some participants, the absence of teamwork was because '*the concept of team is just not even in our vocabulary anymore as nursing*' (non-EN FG5) and it is not current practice. Other participants found that the absence of teamwork resulted in '*working in isolation*' (non-EN RN FG5), and there were those participants who felt that work allocation was '*very task-oriented*' (non-EN RN FG5).

Despite the 'confusion' about the role of the EN and the various interpretations of teamwork, there was a clear disparity in workload and allocation of patients for 'the EN in the workplace'. The participants' understanding and use of the term 'workload' referred to the allocation of work to the individual. In most examples shared by the participants, the EN carried a greater load, with the disparity in workload being acknowledged by both cohorts, '*ENs should be given a fair workload*' (EN FG1; EN FG4; EN FG5). A non-EN participant experienced firsthand and recognised the disparity when there was the inability to cover an EN shift with an EN, so the RN was asked to cover the EN shift:

> *We have an EN who takes eight patients, who is getting paid less than we are, taking more patients, and they always have to take the confused rooms because*

> *they are closer to the desk and the RNs may have to run out. So, they have crap night shifts, really, really crappy night shifts. Honestly, I've done over time as like the EN because the EN called in sick; it's a really crappy shift, honestly*. (non-EN RN FG1)

In this experience, the non-EN participant identified several factors contributing to the workload disparity and how the EN was treated. Initially, the reference was to the volume of work (i.e., '*eight patients*'), which was then associated with the patient complexity, that is the level of care that is required, as the patients were in '*the confused rooms … closer to the desk*'. This detailed description paints a picture of the volume and complexity that was allocated not to any nurse on shift but specifically to the EN on shift. These factors were then compounded when combined with the assumption that the EN would manage and carry the load as '*the RNs may have to run out*'. These few words identified that the EN might not have help and direct or indirect supervision from the RN. Further, the issue of pay disparity was also acknowledged, suggesting that the EN works harder for less money (i.e., '*getting paid less*').

This experience by the non-EN participant was not isolated. Experiences shared by many EN participants suggested that it was common practice to allocate the EN heavier workloads, for example, '*doing everything by yourself … with at least nine patients it's going to be a problem … every night shift without a doubt I get put in that room … they need constant care; they are constantly climbing out of bed*' (EN FG5). The data indicated that despite the disparity in the workload allocated to the EN being acknowledged by both cohorts, it was an acceptable practice. This practice was in the context of clear 'confusion' about the EN role and what they are qualified to do. These experiences provided further examples of 'teamwork in practice' and introduced the concept of 'supervision in practice'.

4.2.4.3 Supervision in practice

There were several interpretations of the supervision of the EN in the workplace, and it was often left to the RN's discretion. Supervision was understood to be a '*very, very loose word that, um, supervision … they only see them [the EN] at handover, and they are their supervisor. So, that's a very loose term*' (non-EN RN FG2). This suggests that many non-EN participants did not understand their role and responsibilities in supervising the EN, although there was agreement that supervision needed to occur. This contradicted the

practice of the EN '*taking a patient load*' (non-EN RN FG3), resulting in minimal or no supervision. A non-EN participant observed that '*if they are taking a patient load, the way that it happens in maternity, no one is overseeing anything*' (non-EN RM FG1). This was another area of confusion because there was a genuine disconnect between how work was allocated and how the EN's work was supervised. This confusion resulted in a level of concern, with a non-EN participant saying:

> *we're told that it's the RNs who're responsible for the EN's patients. That's kind of scary when you have someone doing their own thing, and you're not watching them, and you know that if it all boils down, that's your patient*. (non-EN RN FG1)

The abdication of responsibility was captured by an EN participant: '*I know, ultimately, the RN's responsible at the end of the day*' (EN FG5). This practice translated to the non-EN cohort providing minimal or no supervision but accepting responsibility for the EN's work.

The understanding that the RN was to take responsibility '*for the ENs patients*' also influenced how they felt about working with the EN. The following participants summed up the feelings of many non-EN participants with the following statements:

> *I think a lot of confusion stems from the fact that no one teaches the RN how to work out if something's in someone's scope of practice or not*. (non-EN RN FG4)

> *I just want to say … across the board, RNs really resent having to be responsible for somebody else. Part of that [is] not knowing what their role is and what the expectations of the RN are, but for RNs, I can do my work but, but I don't want to be responsible for someone else's work, and they don't see. A lot of them really resent having to, in theory, or whatever that means, whatever that means is to be responsible for her [sic] work as well*. (non-EN RN FG5)

This statement presented a clear negative tone about the working relationship between the EN and RN, demonstrated by the language used (e.g., '*really resent*'). It presented another example of 'confusion', openly confessing to '*not knowing what their [the EN] role is*'. It also reiterated the non-ENs' lack of understanding of their role when working with an EN (i.e., '*not knowing … what the expectations of the RN are … whatever that*

means is to be responsible for her [sic] work'). The concepts of supervision and responsibility were clearly confused.

4.2.4.4 Summary

'Confusion' and a lack of understanding of the EN's role was the starting point that directly affected 'the EN in the workplace'. The level of 'confusion' resulted in a lack of standardised practice, preventing ENs from working to their full potential and increasing the misconception that the EN and RN roles are the same. It also informed how the nursing roles work together as a team. There were several examples of teamwork provided by participants. When teamwork worked well, there was respect and value for all members of the nursing team. Other variations of teamwork elicited negative feelings and attitudes, demonstrated through the language used. Some participants preferred a nursing team without an EN because of the 'confusion' about the role.

Further, there was a clear disconnect between taking responsibility and the level of supervision. Participants from both cohorts accepted that the RN took responsibility for the EN's patient care, and both cohorts demonstrated through clear examples that there was minimal or no supervision of the EN by the RN. 'The EN in the workplace' was influenced by 'confusion' about the EN role, which informed how teamwork and supervision were practised. 'The EN in the workplace' provided the foundation for the theme 'the EN in the profession'.

4.2.5 Theme: The enrolled nurse in the profession

The final theme was 'the EN in the profession'. This theme captured the EN participants' experiences, frustrations and confusion as they endeavoured to establish their role within the nursing profession. It also captured the non-EN participants' expectations of professional development for the EN and their support for better recognition through the EN industrial award. This theme placed the role of 'the EN in the profession'.

The analysis identified that the role of 'the EN in the profession' was diminished. There were different perspectives between the EN and non-EN participants and how they understood the role of 'the EN in the profession'. There was a strong sentiment from the non-EN participants that the EN role was a pathway to becoming an RN rather than a professional nursing role in its own right. However, as previously identified, for the ENs, it was about '*being a nurse*' (EN FG1; EN FG3; EN FG5). This disconnect contributed

to the lack of status and opportunities for ENs and how they are valued in the nursing profession.

For ‘the EN in the profession’, there was a severe lack of career options, with EN participants identifying that it was difficult for them to develop a career as an EN. They felt their options were to retire, study further to become an RN or remain an EN with little possibility of career progression. In particular, those ENs with years of experience felt their options were limited, especially those who did not want to complete further study to become an RN. Retirement was also identified as an expectation for those ENs who had not completed the education to administer defined medications. Although a decreasing group, there was a definite lack of understanding within the profession regarding how to work with and allocate work to this subgroup of ENs.

RNs believed knowledgeable and skilled ENs were wasted in their role and expected them to study towards becoming an RN. Participants also identified that the EN industrial award provides no financial incentives, no framework for professional development and minimal recognition for an ENs’ years of service. However, despite these barriers, a lack of financial incentives and recognition of experience, the results reinforced the influence of the ENs’ intrinsic motivators, as they were engaged and interested in education and professional development to become better ENs because it provided them personal satisfaction and currency in practice.

The sub-themes contributing to this theme were ‘career pathway’ and ‘lack of recognition’. A visual representation is included in Figure 4.4. In contrast to the other themes, where a stacked Venn diagram was used, this theme is represented with a basic Venn diagram. The basic Venn diagram demonstrates overlapping and an interconnected relationship between the sub-themes, not building from one sub-theme to the next.

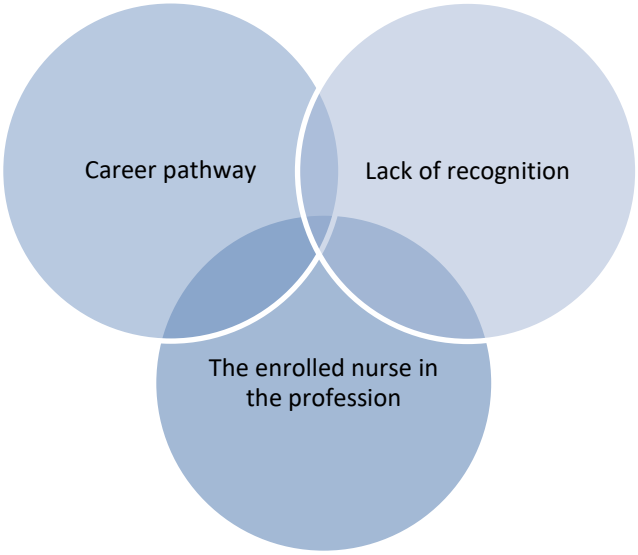


Figure 4.4: A diagrammatic representation of the 'the enrolled nurse in the profession' theme

4.2.5.1 Career pathway

A 'career pathway' is considered a progression in a profession. For the EN participants, there were predominately three options in their pathway: '*to retire*' (EN FG2; EN FG3; EN FG5), to study further and become an RN, or to stay in their current role. The third option came with the acceptance and acknowledgement that there was little progression and limited opportunities with this choice. The decision to retire was shared by several participants, *'I'm looking at retirement'* (EN FG4) and *'seriously considering retirement'* (EN FG5). One participant provided some clarification as to why they wanted to retire: *'[I am] seriously considering [the] retirement option as [I] have no job satisfaction as an EN and [my] professional voice is not valued*' (EN FG2). The level of job satisfaction was a key driver for the choices of ENs.

The current EN workforce still includes some ENs who are not qualified to administer defined medications. This has resulted in a lack of understanding within the profession about what to do with these ENs, and for these ENs, one EN participant described how they are being utilised in the nursing team, '*I'm treated like an AIN*' (EN FG4) The sentiment that they are of a lesser value to ENs who are endorsed to administer defined medications was reinforced by some participants who felt the option of retirement was the answer for minimising this confusion: '*In the next few years, there should not even be any ENs without medication endorsement as they should all be trained or retire out of the*

industry' (EN FG2). There was also the sentiment that these ENs added to the diminished perspective of the EN role, *'those ENs who cannot give medications, they need to retire, as it is not good for the rest of us, as they can't work part of a team* (EN FG 1).

There were several reasons identified as to why an EN should complete further study and become an RN. The first reason was predominately shared by EN participants but also observed by non-EN participants. The blatant message was that there was something wrong with any EN who chose to stay an EN:

> *There are some RNs … 'why don't you become an RN' and then when you say, 'I am happy being an EN', and they, like, say, 'but you can do more as an RN', and they just push that on you like you're not good enough*. (EN FG5)

The concept that an EN could be '*happy being an EN*' (EN FG1; EN FG5) was actively discouraged by the non-EN participants. Further reinforcing the messaging experienced by the EN participants was the observation and acknowledgement from the non-EN participants: '*because of that constant "you can become an RN, so you should, because you're good", we're losing a lot of ENs*' (non-EN RN FG4). The good EN was not allowed to stay a good EN. The language used to describe the experience was active and aggressive: '*they just push … "you can do more as an RN"*' (EN FG5), and '*[it is] constant*' (non-EN RN FG4). This diminished the role of 'the EN in the profession', reinforcing the perception that the EN role is a stepping stone to becoming an RN, not a role in its own right.

Another reason came from the EN participants who felt they needed to complete the RN training to gain career satisfaction. It was an intrinsic motivation: '*I feel that I need to, personally me, I need to take that one step further so I can get career satisfaction*' (EN FG2) and *'the only thing is that as an EN, there is no scope forward is there unless you do an RN'* (EN FG5) There was a strong sentiment from some of the EN participants that 'career satisfaction' could not be achieved as an EN and that their only option was to become an RN. However, many of these statements were subsequently qualified by ENs with statements such as, '*I enjoyed being an EN but*' (EN FG2). The '*but*' was followed by descriptions of no support or progression for them in their role as an EN, resulting in no career satisfaction. The assumption by the ENs who chose this path was that they would gain career satisfaction as an RN.

The last reason involved financial remuneration and that RNs earn more than ENs: '*I do think it's a financial incentive there; you could be earning better money*' (non-EN RN FG4) and '*If they want to keep them as Enrolled Nurses it needs to be financially attractive to them to stay in that role'* (non-EN RN FG4). This was the perspective of non-EN participants, not the ENs. There was no evidence from the EN participants that the option to study further and become an RN was driven by the fact that they would earn more money. However, as previously captured, many EN participants believed they were doing the same role, so they should be paid the same as RNs.

In summary, there appears to be no career pathway for the EN as an EN. It does not exist and is not considered important. The EN was left with three choices: to retire, to study further and become an RN, or to continue in their current role. The EN participants who were studying to become RNs believed that was how they would achieve 'career satisfaction'. Despite the non-EN participants sharing that an EN becomes an RN because of the monetary difference, the EN participants felt they should be paid the same as an RN because they were doing the same tasks. Finally, there was no acknowledgement or celebration for the EN who was '*happy being an EN*' and would embrace career opportunities as an EN. Section 4.2.5.2 discusses the lack of recognition of the EN role within the nursing profession.

4.2.5.2 Lack of recognition

'Lack of recognition' for the role of the EN occurred when their qualifications and experience through progression and monetary recompense in the EN industrial award were not recognised. This was evident when participants described the education they had completed but could not practice and limitations of the EN industrial awards, which failed to recognise knowledge and experience. EN participants were interested in education and appeared to value it, as illustrated by those who had completed all that was available to them. Education, in this context, was not about career progression but rather personal development and achievement, driven by intrinsic motivators. This was illustrated by one EN participant who said, '*I have accreditation with everything; I just continue as an EN*' (EN FG1). The EN participants also ensured they maintained currency in their practice: '*stay educated, stay educated [because] things have changed*' (EN FG1).

Frustration was experienced by ENs who had completed further education but were prevented from using their knowledge and skills: '*we get extra money for it, but we can't*

use the skills that we learnt in it because the hospital won't let us' (EN FG5). This demonstrated a lack of understanding by senior staff in the hospital who informed local policies and procedures and was related to the 'confusion' demonstrated by 'the EN in the workplace' theme (see Section 4.2.4). It also indicated that the lack of understanding was not just held at an individual or ward level but at the organisational (hospital or facility) level, where policies and practices are written and endorsed.

Education can create false expectations; if an EN can enrol in and complete a course, the implied message is that they could then practice that skill. Despite triage being outside the EN's SOP, an EN participant had enrolled in and completed the training: '*I did a triage course. Well, I'm not allowed to use it*' (EN FG2). This practice further reinforced the mixed messaging the ENs received regarding their role and what they were qualified to do versus what they were allowed to do.

'The EN in the profession' was not only shaped by the ENs' education and opportunities but also by the industrial award structure with which the role is aligned. EN participants' experience was that their industrial award did not support career progression with a financial framework and that there was minimal recognition of education, qualifications and years of experience. Both cohorts recognised the inadequate monetary compensation against years of experience. For example, one participant stated, '*that would be something to look at, wouldn't it, to keep the same as the RN, to keep the payroll going up*' (non-EN RN FG4), and another expressed, '*why the EN can't … have a grade, you know, six, seven, eight, you know, but why have five only*' (EN FG2).

There was a consensus between both cohorts that the pay scale of the EN was inadequate. The non-EN cohort supported the need to revise the incremental stages and increase the pay scale in the industrial award for the EN, for example, '*I think they need to look at the pay of ENs, and they need to give them more money*' (non-EN RN FG4). It was believed that more money would retain ENs in the workforce, which also reinforced one of the reasons why ENs study further to become an RN, especially '*if they want to keep them as ENs, it needs to be financially attractive to them to stay in that role*' (non-EN RN FG4). There was an overall agreement that ENs needed to be paid more money.

The industrial award for the EN includes a 'special grade'. This is a specialist role, not a personal regrade. Several EN participants either had or had attempted to progress their

careers through the special grade; however, none were successful*: 'the thing that I've lost along the way is the special grade for some unknown reason' (EN FG1)*

> *'I actually wrote a letter to [name] and requested him to inform me of what I needed to do to qualify for the special grade but I never got a reply … that kind of hurts when we've got no special grade … it's not recognised. To me, it's just not recognised' (EN FG2).*

These experiences demonstrated that even though there is provision for the special grade in the industrial award, it has either disappeared or has not been recognised. The participants' experience was that the EN industrial award does not support, recognise or facilitate their professional development and career progression as an 'EN in the profession'.

4.2.5.3 Summary

'The EN in the profession' theme identified that there was no 'career pathway' for the EN that provided professional fulfilment or career progression as an EN. The EN has three options: to retire, study further and become an RN, or stay in their current role. The expectations by the non-EN workforce were that if the individual was a good EN, they should study further and become an RN; thus, the role of the EN was considered a stepping stone, not a distinct professional role within the nursing workforce. EN participants were engaged in education; however, their experience and education were only for personal satisfaction and maintaining currency in practice because of a 'lack of recognition'. Another example of 'the EN in the profession' was the 'lack of recognition' in the EN industrial award. The limited options it provides were not supported locally within hospitals and were considered out of reach to the EN. It does not create a framework to support a career pathway for the EN. Both cohorts also acknowledged that the EN industrial award needed revising to better reflect and recognise 'the EN in the profession'.

4.3 Chapter summary

Chapter 4 presented the results from the qualitative phase of the study into the role of the EN in the Australian nursing workforce. The results identified three themes: 'the EN as an individual', 'the EN in the workplace' and 'the EN in the profession'. The first theme, 'the EN as an individual', reflected the role of the EN from the EN participants'

perspectives. It demonstrated that what was most important to the EN was that they were perceived as a *nurse*, although there was a clear consensus that their current title does not reflect their role. The importance of being a nurse was linked to the experiences that contributed to them feeling 'trusted'. There was an expectation that their knowledge, skills and experience should be 'trusted'. However, the experiences shared by the participants all culminated in 'the EN as an individual' having a confused 'self-identity' and that they often did not feel 'trusted' and valued in their role as an EN.

The second theme was 'the EN in the workplace', which demonstrated that the foundation for the role of 'the EN in the workplace' was built on 'confusion' and a lack of understanding of the EN role. This 'confusion' created a disconnect in behaviours, expectations and experiences by the EN and non-EN participants. The varied practices of how the participants collaborated as a nursing team were also a result of the lack of understanding of the role of the EN. Teamwork was an ambiguous concept that resulted in workload disparity and a lack of supervision and support for ENs. For the few participants that experienced teamwork, there was a level of respect and value that was not shared and experienced by others.

The final theme described 'the EN in the profession'. This theme identified that there was no 'career pathway' for the EN that provided professional fulfilment and career satisfaction. The ENs' options were to retire, study further and become an RN or stay in their current role. EN participants were engaged in education; however, if they did not want to become an RN, the education they completed only provided personal satisfaction and currency in practice. The lack of professional development and career pathway was reinforced by the 'lack of recognition' for the role, which was also illustrated by the EN industrial award's limited financial framework to support 'the EN in the profession'. Chapter 5 presents the research methodology used to develop and validate the questionnaire for Phase 3, which was used to further explore the results from Chapter 4.

Chapter 5: Phase 2—development

5.1 Introduction

Chapter 5 presents the second phase of the multiphase exploratory sequential MM research design. It describes the structured process used to develop and validate a self-administered questionnaire to be used in Phase 3 of the study.

Chapter 5 begins with an overview of the methodology, followed by a consideration of the key principles of questionnaire design adopted for this study. This will be followed by details of the process used for the data analysis and evidence of the assessment for face validity, content validity, construct validity and reliability testing. It concludes with a description of the final questionnaire and a chapter summary. Chapter 5 is based on the following publication (see Appendix B):

Leon, R. J., Lapkin, S., Fields, L. & Moroney, T. (2022) Developing a self-administered questionnaire: Methods and considerations. *Nurse Researcher*, *30*(3), 36–45. https://doi.org/10.7748/nr.2022.e1848

5.2 Aim

In Phase 2 of the study, the aim was to develop a self-administered questionnaire with the important concepts of its development being the assessment of face, content and construct validity and reliability testing. Other factors considered included question styles, comprehension and acquiescent bias. A self-administered questionnaire was considered the most efficient and cost effective way to collect data from a large geographical area. The questionnaire was developed as a component of this multiphase exploratory sequential MM study. The benefit of this design was the sequence of the study's phases, with the qualitative phase conducted first. This enabled the main themes, language and context to be used to inform the development of the self-administered questionnaire.

5.3 Methodology

The structured process to develop a new questionnaire was adapted from DeVellis (2017) and Younas and Porr (2018). It comprised five main steps: (1) preliminary considerations, including assessing existing tools and qualitative data, if available; (2) draft the questionnaire; (3) review by an expert panel; (4) pilot the questionnaire; and (5) the

reliability analysis (see Table 5.1). Table 5.1 also includes examples of the application of these steps to this study.

Table 5.1: Developing a questionnaire instrument

Step	Process	Application
1. Preliminary considerations	• Theory • Literature • Qualitative data (if available)	An appropriate questionnaire did not exist in full or part. Qualitative data from the focus groups were used to identify key themes, language and context.
2. Draft the questionnaire	• Number of items • Redundancy • Question styles • Acquiescent bias • Comprehension • Face validity	The initial pool had 106 items. The final questionnaire had 49 items. Question styles used were 23 multiple-choice questions, 20 Likert scale questions, and six free-text questions, including two negatively worded items to minimise acquiescent bias. Face validity was assessed by reviewing the questions against the aim/objectives.
3. Review by an expert panel	• Content validity • Comprehension • Readability • Redundancy • Inter-rater reliability	Six expert panel members were used; therefore, the individual content validity reference was 0.80. Relevance ranged from 0.75 to 1.00 (M = 0.97). Clarity ranged from 0.25 to 1.00 (M = 0.89). Consistency between the panel members determined inter-rater reliability.
4. Piloting the questionnaire	• Construct validity	Construct validity was assessed by the responses from the pilot participants. Instructions were clear as a facility firewall required the hard copy option to be used, with success.
5. Reliability analysis	• Reliability testing • Internal consistency	Reliability was assessed in terms of the degree of interrelatedness and correlations among the items in relation to the construct being measured.

Note. Adapted from DeVellis (2017).

To ensure terminology was consistent, definitions from the COnsensus-Based Standards for the Selection of Health Measurement INstruments (COSMIN) taxonomy (Mokkink et al., 2010) were used through the development of the questionnaire (see Table 5.2).

Table 5.2: Relevant definitions adapted from the COSMIN taxonomy

Term	Definition	Step
Face validity	The degree to which the items of a questionnaire appear (on 'face value') as though they are an adequate reflection of the construct (concept) to be measured	Step 2: the draft questions were assessed against the construct of the study
Content validity	The ability of a questionnaire to adequately cover all relevant topics of the construct (concept) to be measured	Step 3: calculated from the expert panel's responses
Inter-rater reliability	The degree to which there is agreement and consistency among participants who rate, code or assess the same questionnaire	Step 3: assessed through the expert panel's responses and ratings for each item
Construct validity	The degree to which the scores on a questionnaire are consistent with the hypotheses, based on the assumption that the questionnaire validly measures the construct	Step 4: assessed through the pilot participants' responses
Reliability	The proportion of the total variance in the measurements due to 'true' differences between participants	Step 5: assessed using data obtained from a sample of sufficient size recruited from the population of interest
Internal consistency	A measure of how well the different items that comprise the questionnaire are interrelated or assess the construct of interest	

Note. Adapted from Mokkink et al. (2010).

Sections 5.3.1 to 5.3.5 detail the five steps used to develop the questionnaire.

5.3.1 Step 1: Preliminary considerations

The use of a previously developed, reliable and validated questionnaire is preferred as it ensures findings are credible, builds on existing knowledge and enables the findings to be generalised to other populations and settings (Timmins, 2015). A questionnaire should only be developed if no existing questionnaire is available or those that are available are inappropriate. It is therefore important to start with a comprehensive search of the literature to determine if a questionnaire could be adopted for this study. The main considerations included relevance to the study objectives, clarity of the items and evidence of validity (Beatty et al., 2019). If a questionnaire or part thereof meets the needs of the study, permission must be sought from the original authors.

5.3.2 Step 2: Draft the questionnaire

By Step 2, the construct of interest and purpose of the questionnaire has been determined by this point. It is important here to focus on the construct rather than specific content.

This ensures the researcher does not eliminate items too early which would risk losing the essence of the construct.

The first draft should be comprehensive enough to address the research's aim and objectives. A strategy to achieve this is to write statements in varying ways, then subtly change words and phraseology. This enables different perspectives to be captured in the items. The challenge of the first draft is not to focus on quality or clarity or be restrictive. An ideal number of items is three to four times the final number (DeVellis, 2017).

The next step is to refine the items into questions, with consideration to the most appropriate question style. Different question styles elicit different information, so it is important to ensure the response options address the research's aim. Common options include multiple choice, Likert scale and free text questions. Three aspects need to be incorporated into this step:

5.3.2.1 Comprehension

This can affect the quality of the data. When writing questions, seven potential comprehension problems have been identified: grammatical ambiguity, excessive complexity, faulty progression, vague concepts, vague quantifiers, unfamiliar terms, and false inferences (Tourangeau et al., 2000). These problems can be avoided by using terminology and language identified in the relevant literature, and if available, incorporate the language, phrases and context from the qualitative data.

5.3.2.2 Acquiescent bias

This is when participants tend to agree with the question or statement, regardless of its content. It can be minimised using a combination of positively and negatively worded items (Groves et al., 2009), and by providing an even number of response options in Likert scales. However, there is increasing evidence that challenges the use of negatively worded questions, such as: 'I feel ENs are not a valued member of the nursing team.' Negatively worded questions increases the complexity of their grammar and decreases their readability, which diminishes their potential advantages (Suárez-Álvarez et al., 2018). Careful consideration is therefore needed when determining which questions are the most suitable to be negatively worded.

5.3.2.3 Face validity

This is the degree to which a questionnaire appears to measure the construct of interest. Consideration as to the appropriateness of assessing for face validity needs to be made relevant to the construct of interest. It is assessed by reviewing the questions against the research's aim and objectives (DeVellis, 2017).

5.3.3 Step 3: Review by an expert panel

Assessment of the content validity and inter-rater reliability by an expert panel will increase the trustworthiness in the results. This step provides another opportunity to receive feedback on the comprehension of the questions. It is important that the expert panel represents the main population of interest. Each panel member is provided with a feedback toolkit, which included some demographic questions so the panel can be described, the draft questionnaire, a rating scale and instructions. The panel is asked to use a scale of 'low', 'medium' and 'high' to rate each question on how relevant it is to the research aim, its clarity, its conciseness and whether it is ambiguous. It also asks the panel to identify any repetition, redundancy or omissions (Willis, 2020).

A content validity index (CVI) for each individual item (I-CVI) and an overall scale CVI (S-CVI) are then calculated. For six or more panel members, the recommended I-CVI is 0.80, which demonstrates universal agreement (Polit & Tatano Beck, 2006). The questions should be revised and adjusted according to the CVI results. It is recommended that if there are significant changes to the questions in this step, the questionnaire be reviewed by the expert panel again. Although this step may be perceived as delaying the study, it provides assurance about the relevance and clarity of the final questionnaire. The structure and process of the expert panel also assesses for inter-rater agreement (reliability) through the consistency of the panel members' responses and ratings for each item.

5.3.4 Step 4: Pilot the questionnaire

Piloting the questionnaire assesses it for construct validity and is conducted with a representative sample of the population of interest. Pilot participants are provided with the invitation, PIS and the questionnaire (Appendices J; K; L). They are asked to work through the questionnaire and provide feedback on the method of distribution. This step provides another opportunity to capture any inconsistencies or concerns about the

questions and the instrument itself, as well as any excessive complexity, vague concepts and faulty progression (Tourangeau et al., 2000).

Most online survey distribution tools measure the time each participant takes to complete the questionnaire. Potential participants of the main study can be provided with the average time taken by the pilot participants, giving them an informed understanding of the time required to participate in the study, which may assist with recruitment.

5.3.5 Step 5: Reliability analysis

Exploratory factor analysis (EFA) is considered the most appropriate method of establishing the reliability of self-reporting questionnaires (Williams, 2010). The aim of this step is to reduce the number of items into clusters of interrelating items and evaluate the internal consistency reliability of the questionnaire. Data required for this procedure are obtained after the pilot test by administering the questionnaire to a large sample that is representative of the population of interest.

Reliability analysis is a complex, multivariate analysis procedure that requires the use of statistical software such as SPSS, SAS, Stata and R. The first step is to test the appropriateness of the data for factor analysis by determining sampling adequacy and verifying that the items are sufficiently intercorrelated. As a general rule of thumb, an absolute minimum for undertaking reliability analysis is 100 respondents (Mundfrom et al., 2005). Additionally, the suitability of the data for factor analysis is based on the values of the Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy and Bartlett's test of sphericity. Values of KMO range from 0 to 1, with a KMO greater than 0.5 and a statistically significant X^2 value for the Bartlett's test of sphericity ($p < 0.05$) sought to justify the use of EFA (Williams, 2010).

The next step was to extract factors with the aim of explaining the maximum amount of common variance using the smallest possible number of explanatory constructs. Principal components analysis (PCA) is considered the most psychometrically sound procedure for this process, particularly when no priori factor structure exists (Egbert & Staples, 2019).

An initial step is to examine the correlation coefficients, with loading values lower than 0.30 suggestive of multicollinearity—a situation where the variables are correlated with each other or the dependent variable, resulting in a less reliable questionnaire (Alin, 2010).

Kaiser's criteria (eigenvalues > 1 rule), the scree test, the cumulative percent of variance extracted and parallel analysis are used to determine the number of factors to retain (Braeken & Van Assen, 2017). In most cases, it is necessary to perform several iterations of the PCA, with item reduction achieved by assessing the pattern matrix for items loading poorly onto the extracted factors. A decision can be made, for example, to only retain coefficients if they are equal to or greater than 0.5 and to discard items that cross-load onto two or more factors. The face validity of each of the items loading onto factors during the process must also be assessed.

Cronbach's alpha (α) is then used to assess the internal consistency reliability for each item of the subscale and the total scale. Values greater than or equal to 0.7 are considered acceptable with those less than 0.5 unacceptable (Kılıç, 2016). Each item of the subscale must be reviewed to determine whether Cronbach's alpha for the subscale would be substantially improved if the item were deleted.

The last step was to interpret the results and label the identified factors with meaningful names or themes that reflected the theoretical or conceptual intent.

5.4 Results

Section 5.4 details the application of the structured process in the development of the self-administered questionnaire for this study.

5.4.1 Step 1: Preliminary considerations

The literature search identified several studies (Endacott et al., 2018; Jacob et al., 2017; Leon et al., 2019; Tranter et al., 2011) that used a questionnaire or cross-sectional design to examine issues related to the EN role in the Australian nursing workforce. Further analysis determined none of them used a questionnaire that was relevant or could be adapted for the study. Therefore, developing a questionnaire was warranted.

5.4.2 Step 2: Draft the questionnaire

Findings from the qualitative phase informed the first draft, with the terminology, questions and statements captured directly from the focus groups. An initial pool of 106 items was developed and further refined to a final questionnaire of 49 items: 23 multiple choice questions, 20 Likert scale questions and six free text questions. The analysis of the free text responses was managed in line with the qualitative data (see Section 4.6); therefore, the challenge of analysis was outweighed by the benefits of enriching the data.

To minimise acquiescent bias, any Likert scales that sought an opinion (e.g., 'I feel ENs are not a valued member of the nursing team') were given definitive choices through an even number of response options. Response options were: 'strongly disagree', 'disagree', 'agree', and 'strongly agree'. Conversely, if the statement related to something that participants may not have experienced (e.g., 'ENs are being rostered in place of registered nurses, because they are cheaper') a midpoint option was provided. Response options were: 'never', 'sometimes', 'unsure', 'mostly' and 'always'.

Careful consideration was given to the incorporation of negatively worded questions, with only two questions written in that structure. It was decided rewording other questions negatively would increase the complexity of the question and grammar structure too much, making the questionnaire less comprehensible.

Once the questionnaire was drafted, the questions were mapped against the construct of interest, research aim and objectives. Together with a review by the researcher, this ensured the questionnaire would capture responses that on 'face' value met the needs of this study.

5.4.3 Step 3: Review by an expert panel

Six expert panel members were identified based on their expertise and involvement with ENs, their diverse roles in health services and their geographical locations. Their responses in relation to the relevance and clarity of the items were used to calculate I-CVI and S-CVI. The areas of conciseness and ambiguity were not used in the calculations but were still valuable, as they assisted panel members to determine and construct their thoughts and opinions about the questions and the questioning styles. This method is widely used in nursing research (Polit & Tatano Beck, 2006).

5.4.3.1 Relevance

The I-CVI responses for relevance ranged from 0.75 to 1.00 (M = 0.97). Three questions scored below 0.80 (see Supplement B). These items were reviewed and rephrased accordingly. Table 5.3 shows as an example of a question, score, the panel's response and researcher's response.

Table 5.3: Question development—response regarding 'relevance'

Question	Score	Panel response	Researcher response
Question 9: Are you a member of any of the following professional associations? Tick all that apply.	0.75	They may want to know what this has to do with the scope of practice.	The study is much bigger than just the scope of practice. This question remained with minor rewording in response to panel members' comments.

5.4.3.2 Clarity

The I-CVI responses regarding clarity ranged from 0.25 to 1.00 (M = 0.89). Nine questions scored below 0.80 (see Supplement C). These were reviewed and rephrased accordingly. Table 5.4 shows an example of a question, score, the panel's response and researcher's response.

Table 5.4: Question development—response regarding 'clarity'

Question	Score	Panel response	Researcher response
Question 4: Which age bracket are you in?	0.25	The question and options do not align.	The question asked participants to identify the age bracket, and the options provided were in year brackets. The question was rephrased.

There were no repetitions, redundancies or omissions identified. The consistency in responses from the expert panel indicated inter-rater reliability. The revised questions and statements were not reassessed by the expert panel, as the changes were predominately grammatical in nature. The final questionnaire was drafted and built into the survey instrument SurveyMonkey.

5.4.4 Step 4: Piloting the questionnaire

Twelve participants were emailed a link to the questionnaire with a request to complete it as per the instructions and report any concerns in relation to functionality and flow. It was during this process that one health service's firewalls were found to restrict the ability to open the link. This concerns was rectified by contacting the relevant information technology department. A benefit of this barrier was the instructions and subsequent process in the email invitation (Appendix K) to request a hard copy were tested and required no modifications.

Participants took an average of 10 minutes to complete the questionnaire. This information was included in the study's questionnaire PIS (Appendix L). There were no changes to the questions and responses as a result of piloting the questionnaire. It was therefore finalised, ready for distribution.

5.4.5 Step 5: Reliability analysis

Participants (n = 253) who completed all 20 Likert scale questions were used for reliability analysis. Sampling adequacy was acceptable, with a KMO measure of sampling adequacy of 0.68 and Bartlett's Test of Sphericity reaching statistical significance (X^2 = 2,289.60, $p < 0.001$). This demonstrates the data were suitable for factor analysis.

The first unrotated principal component revealed seven factors with an eigenvalue greater than one, accounting for 70.9% of the variance in the correlation matrix. The point of inflexion on the scree plot was consistent with the seven-factor solution. Through several iterations of PCA, promax (oblique) was conducted. Analysis of the results revealed three items on factor 6 had negative average covariance and so they were excluded from further analysis.

The final iteration resulted in a 15 item, five-factor solution accounting for a cumulative variance of 74.1%. In this solution, each factor only retained items that fitted the specified criteria and all had loading greater than 0.60. Analysis of the internal consistency showed moderate to high reliability in all factors: α was 0.85, 0.79, 0.93, 0.89 and 0.59 for the five factors and 0.64 for the total scale. Appendix M provides details of the loadings of each of the items on the correlation matrix, the mean responses for each item, their labels (names) and Cronbach's α for each subscale.

5.5 Discussion

It is recommended to use or refine an existing questionnaire rather than develop a new one, to ensure findings are credible (Timmins, 2015). However, if one does not exist, using a structured process to develop a questionnaire, as described here, ensures important concepts such as comprehension, question styles and acquiescent bias are addressed. Success involves striking a balance between reducing the burden on participants and collecting comprehensive data.

In this study, content validity was established by quantifying responses from the expert panel and calculating the CVI (Polit & Tatano Beck, 2006). These ratings were used to determine the accuracy, clarity and appropriateness of the items. There are other methods for assessing content validity—the key is to find one that is available to the researcher and provides a level of confidence in the calculations.

The benefit of pilot testing is highlighted by the fact that issues related to firewalls were identified and rectified before administering the questionnaire. This was important in enhancing the credibility and dependability of data collection. Reliability testing was established by using EFA to identify the number of constructs and the underlying factor structure. This resulted in a parsimonious, 15-item, five-factor questionnaire with adequate internal consistency and construct validity. Reliability testing is an important step in developing questionnaires, as it provides the means to establish if the number of factors found in one sample can be replicated in another sample based on the same or across different populations.

Additional time and effort are required to follow the sequential and linear steps necessary to develop and validate a self-administered questionnaire. While this may seem unnecessary and unappealing, the final product is a questionnaire that captures more valid and reliable data. This reinforces the value of this time. Using a structured process assists in accommodating the additional work, as it prepares and guides the researcher through the steps required.

5.6 Limitations

This process is limited to the development of a self-administered questionnaire. It does not consider issues related to further psychometric analysis of measurement properties (including Rasch analysis) that are informed by Classical Test Theory and Response Theory. Questionnaire design is also an iterative process and further refinements could be made in future studies.

5.7 Chapter summary

Self-administered questionnaires are a common method of collecting data in nursing research, but their development can be daunting. To ensure credibility of findings, it is recommended to use or refine an existing questionnaire rather than developing a new one (Timmins, 2015). However, because no such questionnaire existed, using a structured

process to develop a questionnaire (as described in Chapter 5) ensured key concepts, such as comprehension, question styles and acquiescent bias, were addressed. A successful questionnaire strikes a balance between reducing participant burden and the comprehensiveness of the data collected.

In this study, content validity was established by quantifying responses from the expert panel and calculating the CVI (Polit & Tatano Beck, 2006). These ratings were used to determine the accuracy, relevance and clarity of the items. There are other alternative methods for assessing content validity; however, the key is to find a method that is available to the researcher and provides a level of confidence in the calculations.

The benefit of pilot testing was highlighted by the fact that issues related to network security firewalls were identified and rectified before administering the questionnaire. This was important in enhancing the credibility and dependability of the data collection. Reliability testing was established by identifying the number of constructs and the underlying factor structure using EFA. This resulted in a 15-item, 5-factor questionnaire with adequate internal consistency and construct validity. Reliability testing was an important step in questionnaire development because it provided the means to establish whether the number of factors found in one sample could be replicated in another based on the same or across different populations.

It is acknowledged that additional time and effort were required to follow the sequential and linear steps for developing and validating a self-administered questionnaire. While this may seem unnecessary and unappealing, the final product was a questionnaire that captured more valid and reliable data, reinforcing the value of this additional time. A structured process helped factor in the additional work because it prepared and guided the researcher through the steps required.

Chapter 6 presents the final phase of this study, Phase 3, which used the developed questionnaire to capture the quantitative data.

Chapter 6: Phase 3—quantitative findings

6.1 Introduction

Chapter 6 presents and discusses the quantitative findings (Phase 3). In the multiphase exploratory sequential MM research design, Phase 3 is the quantitative phase (quan) which builds on and further explores the QUAL findings (Phase 1). It needs to be noted that although this is the quantitative phase, there was an opportunity for the participants to provide free-text and open-ended responses. The thematic analysis of these responses is also presented in Chapter 6. An integrated discussion that connects the qualitative and quantitative findings of the MM research is presented in Chapter 7.

6.2 Results

6.2.1 Sample size

In total, 403 questionnaires were returned, with 400 completed and included in the analyses; the remaining three were incomplete and excluded from further analyses. A sample size estimation was calculated based on the 4-point Likert scale response format as continuous data. It was postulated that for the continuous variable, the level of acceptable error was 3.0% (i.e., $d = 0.12$), and the standard deviation (*SD*) was 1.15 (i.e., $SD = 1.15$), based on pilot data. A minimum of 353 respondents were required, assuming a significance level (α) of .05. Therefore, 400 completed questionnaires (36.3% [$n = 145$] from the EN cohort and 63.8% [$n = 255$] from the non-EN cohort) used for analysis were considered sufficient.

6.2.2 Participant demographics

A summary of the participants' demographics is shown in Table 6.1. The sample had more females and fewer males across both cohorts than the Australian nursing workforce (AHPRA & National Boards, 2019). The question of age was asked in groups consistent with the generational age brackets (Christopher et al., 2018; Van Rossem, 2019). This enabled subgroup analyses if there was any statistical significance from the participants based on generational age brackets. However, there was none, so no further analysis based on these age categories was conducted.

Table 6.1: Participant demographics

Characteristic	All participants (*N* = 400)		Enrolled nurse cohort (*n* = 145)		Non-enrolled nurse cohort (*n* = 255)		National data[c]
	%	*N*	%	*n*	%	*n*	%
Gender							
Female	91.3	365	91.7	133	91.0	232	88.7
Male	8.3	33	8.3	12	8.2	21	11.3
Indeterminate/intersex/unspecified[a]	0.5	2	0.0	0	0.8	2	0.0
Age bracket (age in years)[b]							
1965–1979 (40–54) generation X	36.8	147	33.1	48	38.8	99	32.2
1944–1964 (55–75) baby boomers	35.3	141	45.5	66	29.4	75	27.4
1980–1994 (25–39) generation Y	23.8	95	17.9	26	27.1	69	35.8
1995–2015 (4–24) generation Z	4.3	17	3.4	5	4.7	12	4.6

Note.
[a] The gender terminology was determined by the Australian Government (2015, p. 4) guidelines on the recognition of sex and gender.
[b] Using the generational age brackets, there was no direct correlation with the age groupings of the national data, resulting in the Australian Health Regulation Practitioner Agency 35–44 age group being proportioned accordingly.
[c] This data was sourced from the Australian Health Regulation Practitioner Agency and National Boards (2019).

6.2.3 Professional characteristics

Professional characteristics gathered from the participants who responded to the questionnaire included role, length of experience, area of specialty, highest level of education, location and sector in which they worked. This resulted in a wide breadth and depth of experience and location data.

6.2.3.1 Current role characteristics

The largest cohort was the non-ENs (63.75%, *n* = 255), of which 91.4% (*n* = 233) were RNs, 7.4% (*n* = 19) RMs and 1.2% (*n* = 3) AINs and assistants in midwifery. Of the EN cohort (36.25%, *n* = 145), the majority were ENs with medication administration rights (91.0%, *n* = 133), and a smaller group did not have medication administration rights (8.3%, *n* = 12).

6.2.3.2 Length of experience

Within the EN cohort (*n* = 145), there was a consistent distribution, with 39.3% (*n* = 57) having ≥ 21 years and 40.7% (*n* = 59) having 0 to 10 years of experience in the nursing workforce. The mid-range of 11 to 20 years of experience had 20.0% (*n* = 29) EN participants.

In contrast, the majority of the non-EN cohort had > 21 years of experience (53.72%, *n* = 137), with the remaining groups (11 to 20 years [18.4%, *n* = 47] and 0 to 10 years of experience [25.5%, *n* = 65]) more evenly distributed. Of the non-EN cohort, 2.4% (*n* = 6) did not respond to this question.

6.2.3.3 Area of specialty

Given the diverse areas of work in nursing, participants were asked to identify the specialty area in which they worked. A list of more detailed options was provided, and participants were asked to choose all that applied, with the open-ended option of 'other (please specify)'. The more detailed options were grouped to support the analysis. 'Acute facility' included acute medical, surgical, critical care, perioperative and acute aged care and any participant that selected 'whole of hospital'. 'Outpatients' included community, clinics and general practice. 'Paediatrics' was not combined with other areas. 'Mental health' included mental and drug health, as many participants identified both specialties. 'Midwifery' included maternity settings and child and family health services, and 'aged care' included both low- and high-care aged care facilities. A comparison of participants' responses based on their area of specialty is provided in Table 6.2.

Table 6.2: Areas of nursing

Areas of nursing	All participants (*N* = 400)		Enrolled nurse cohort (*n* = 145)		Non-enrolled nurse cohort (*n* = 255)	
	%	*N*	%	*n*	%	*n*
Acute facility	44.5	178	49.0	71	42.0	107
Outpatients	10.3	41	15.2	22	7.5	19
Paediatrics	9.8	39	9.7	14	9.8	25
Mental health	6.8	27	13.8	20	2.7	7
Midwifery	6.0	24	2.8	4	7.8	20
Aged care	5.3	21	8.3	12	3.5	9
Missing data	17.5	70	1.4	2	26.7	68

Most of the participants from both cohorts work in an acute facility. The next most selected area for the EN cohort was outpatients, closely followed by mental health. For the non-EN cohort, the next area was paediatrics. It was noted that this question had the largest missing data of all the demographic questions (17.5%, *n* = 70), especially from the non-EN cohort (26.7%, *n* = 68). This may be attributed to and reflect the diversity of

where nurses' work and the inability of the participant to identify an area to which they could relate and reliably answer, although an open-ended option was provided.

6.2.3.4 Highest education level

Participants held qualifications from hospital-trained certificates (9.5%, *N* = 38) through to a PhD (0.8%, *N* = 3), representing the various education levels on the Australian Qualifications Framework (Australian Qualifications Framework Council, 2013). For the purposes of analysis, the multiple levels were grouped into entry-level education and post-registration qualifications for both cohorts. This further grouping identified that the majority of the EN cohort held entry-level qualifications (75.2%, *n* = 109), and the remaining participants had completed an advanced diploma or above (24.8%, *n* = 36). In contrast, more than half of the non-EN cohort had completed post-registration level qualifications (59.6%, *n* = 152), from graduate certificates to a PhD, and 38.1% (*n* = 97) had completed entry-level studies up to a BN.

6.2.3.5 Location and sector

Most participants were from NSW, with participants from every state and territory in the EN cohort and every state and territory except the Northern Territory in the non-EN cohort (see Table 6.3).

Table 6.3: Participants' current state/territory work locations

State/territory	All participants (*N* = 400)		Enrolled nurse cohort (*n* = 145)		Non-enrolled nurse cohort (*n* = 255)	
	%	*N*	%	*n*	%	*n*
New South Wales	84.3	337	71.7	104	91.4	233
Victoria	4.5	18	7.6	11	2.8	7
Queensland	4.3	17	8.3	12	1.9	5
Western Australia	3.0	12	4.8	7	1.9	5
South Australia	1.8	7	4.1	6	0.4	1
Tasmania	1.3	5	1.4	2	1.2	3
Australian Capital Territory	0.8	3	1.4	2	0.4	1
Northern Territory	0.3	1	0.7	1	0.0	0

Many participants (53.8%, *N* = 215) worked in a metropolitan location, which is consistent with the density of the population (Australian Bureau of Statistics, 2020). The participants that indicated 'other (please specify)' worked across multiple locations. The

geographical location was further grouped into metropolitan and regional, which identified that the EN cohort was almost equally represented from both metropolitan (48.3%, *n* = 70) and regional (51.7%, *n* = 75) locations. The non-EN cohort, although not as equally divided, demonstrated a clear representation from both locations, with 56.9% (*n* = 145) from metropolitan and 40.3% (*n* = 103) from regional locations.

Another opportunity to ensure the results represented the Australian nursing workforce was the spread across sectors, with 86.5% (*N* = 86.5) working in a public health service, which continues to be the largest employer of health professionals (Australian Institute of Health and Welfare, 2022). The next most selected sector was private health services (10.8%, *N* = 43), with a much smaller representation from non-government organisations (1.8%, *N* = 7) and educational institutions (1.0%, *N* = 4).

6.2.3.6 Summary

The majority of the participants who completed the questionnaire came from NSW (84.3%, *N* = 337) and worked in a public health service (86.5%, *N* = 346). They were mostly female (91.3%, *N* = 365) and over the age of 40 (72.1%, *N* = 288). However, age did not correlate with experience, as a third of the participants over the age of 40 had less than 10 years of experience (31.0%, *N* = 124), suggesting that mature age women are entering the nursing profession. More than half of the non-EN cohort held a post-registration qualification (59.6%, *n* = 152) compared to the EN cohort, with less than a quarter of the participants (24.8%, *n* = 36) holding a post-registration qualification.

With the study specific to the role of the EN, extrapolating the EN demographics, the majority of the EN cohort came from NSW (71.7%, *n* = 127) and worked in the public health service (80.7%, *n* = 132). Most were female (91.7%, *n* = 163), with 78.6% (*n* = 140) of the EN cohort over 40 years old. However, age did not correlate with years of experience, with many participants over 40 years old (39.3%, *n* = 70) having less than 10 years of experience. This indicates that mature age women are qualifying as ENs, with the majority of the EN cohort holding an entry-level qualification (75.2%, *n* = 109) and not completing post-registration qualifications. There was a fairly equal geographical representation, with just over half from regional locations (51.7%, *n* = 92) and almost half working in metropolitan locations (48.3%, *n* = 86). There was also a spread across work areas, providing a thorough breadth of experience. These demographics demonstrate that

the findings have captured the breadth and depth of the EN workforce, providing a level of confidence and credibility that the results represent the greater nursing workforce.

6.2.4 The enrolled nurse as an individual - enrolled nurse cohort–only questions

Section 6.2.4 presents the findings from the questions specific to the professional identity and career progression of the ENs from the perspectives of the ENs. These questions were only answered by the EN cohort and represent the EN as an individual.

6.2.4.1 Professional association membership

EN participants were asked whether they were a member of a professional association. The majority of participants were a member of at least one professional association (60.0%, $n = 87$), with 40.0% ($n = 58$) members of an EN-specific professional association. The following comment was made concerning EN membership of professional associations: '*the ENPA [Enrolled Nurse Professional Association NSW] seems to be a backyard operation, and the other organisations such as the New South Wales Nurses and Midwifery Association [NSWNMA] treat ENs with much less significance than RNs*' (EN). However, some ENs did perceive value in belonging to a clinical specialty professional association (20.0%, $n = 29$), as captured by the 'other' category.

6.2.4.2 Leaving or staying in the endorsed nurse role

EN participants were asked three questions about their intentions or consideration to leave or stay in their EN role. The first question addressed whether they had considered working towards a BN or a bachelor of midwifery (BM) within the next five years. The second question addressed whether they had considered leaving their role and why, and the third question covered their reasons for staying in their EN role.

6.2.4.2.1 Consideration of enrolment in a bachelor of nursing or midwifery

Many ENs (56.6%, $n = 82$) were not (or did not intend) to enrol in a BN or BM. No ENs who completed the questionnaire were enrolled in a BM. There were 18.6% ($n = 27$) currently enrolled in a BN, with 13.8% ($n = 20$) considering enrolment but not yet enrolled and 11.0% ($n = 16$) undecided. Collectively, this translates to a potential 43.4% ($n = 63$) of ENs leaving their roles to become RNs. This provides some explanation of the workforce data that represents an increase in dual EN/RN registrations (see Table 1.3).

6.2.4.2.2 Considered leaving their role

EN participants were asked whether they had considered leaving their EN role, of which the majority responded yes (53.5%, *n* = 77). A follow-up question was asked, seeking reasons and further clarification. This was a stem question with the opportunity to choose more than one response and 'other (please specify)'. A third of the participants (29.0%, *n* = 42) had considered leaving their EN role because they felt their role was not valued, followed by limited career opportunities (27%, *n* = 39) and feeling like their professional voice was not valued or considered (22.1%, *n* = 32). Consideration to become an RN featured relatively low (15.9%, *n* = 23), with only 2.8% (*n* = 4) indicating that they had never intended to stay an EN (see Table 6.4). Comments captured in the open-ended option reaffirmed these findings: '*essentially an AIN role*' (EN); '*constantly asked or pressured to complete things that are not in my job description as an [EN]*' (EN); '*made to feel worthless*' (EN); and '*you are undervalued, ignored, disrespected and often have the patients of highest acuity and complexity whilst also apparently being the least qualified? A little odd*' (EN).

The reasons listed in Table 6.4 are considered push factors (negative experiences resulting in the EN either considering or actually leaving their role and transitioning to the RN role) (Ralph et al., 2013).

Table 6.4: Reasons considered for leaving the enrolled nurse role

Reason[a]	Enrolled nurse cohort (*n* = 145)	
	%	*n*
The EN role is not valued	29.0	42
Limited career progression as an EN	27.0	39
Professional voice is not valued or considered	22.1	32
The EN role is not understood	20.0	29
Clinical judgement is not valued or considered	18.0	26
Workload issues	17.2	25
Bullying and harassment within the workplace	16.6	24
To become a registered nurse	15.9	23
Financial reasons (not enough pay)	15.9	23
Finding there is increased responsibility as an EN	12.4	18
Feeling no job satisfaction as an EN	8.3	12
Retirement	6.2	9
To become a registered midwife	2.8	4
I had no intention of staying an EN	2.8	4

Note. [a] Participants were invited to respond with as many options as they felt applied to them; EN = enrolled nurse.

6.2.4.2.3 Reasons to stay in their role

In contrast, many ENs (41.8%, *n* = 64) intended to stay in their EN roles. These ENs felt their professional voice and clinical judgement were both valued and considered (see Table 6.5). There was no significant association between reasons to stay in their role, length of time in the role, area in which they worked and geographical locations.

Table 6.5: Reasons to stay in the enrolled nurse role

Reason[a]	Enrolled nurse cohort (*n* = 145)	
	%	*n*
Professional voice is valued and considered	21.6	33
Clinical judgement is valued and considered	20.3	31
Opportunities for career progression as an enrolled nurse	17.0	26
Family/personal circumstances	15.7	24
Improved teamwork	14.4	22
Financial incentives	11.1	17

Note. [a] Participants were invited to respond with as many options as they felt applied to them.

The top three reasons the EN participants identified for remaining in their roles were also the top five reasons ENs cited for why they had considered leaving their role. This suggests that a key determinant between considering leaving and staying was the environment and with whom the EN works. The ENs who planned on staying in their roles worked in teams and environments where they felt professionally and clinically valued and experienced opportunities for career progression as an EN. This was also supported by the open-ended responses, for example, '*it's what I know and feedback is that I'm good at my work*' (EN) and '*opportunities to work in different clinics*' (EN). These reasons are considered pull factors (redefined for the purposes of this study to positive experiences resulting in the EN remaining in their role as an EN) (see Section 7.1).

The financial incentives to stay were further clarified in the context that studying to become an RN is cost prohibitive: '*the cost of the course to progress to Registered Nurse*' (EN). This feedback suggests that these EN participants would have considered leaving their roles had it not been for the financial implications.

6.2.4.3 Summary

Less than half of the EN cohort participants were members of an EN-specific professional association (40.0%, *n* = 58). The majority of ENs had no intention to study further to become an RN or RM (56.6%, *n* = 82), with a small number undecided or unable to pursue that pathway due to the associated costs. While more than half had no intention of being an RN or RM, they had considered leaving their roles as ENs (53.5%, *n* = 77), citing

push factors where they did not feel valued and that there was no career structure or opportunities for them. In contrast, many ENs (41.8%, $n = 64$) intended to stay ENs, citing pull factors. There was no correlation between their demographics or professional characteristics with these factors.

6.2.5 The enrolled nurse in the workplace and the profession - the enrolled nurse role

Section 6.2.5 analyses the findings when comparing the responses between the EN and non-EN cohorts, with the questions open to all participants. These questions explored the expectations, experiences and perceptions of the role of the EN in the workplace, and how the nursing roles work together. It also provides insight into the role in the nursing profession.

6.2.5.1 Their title

The current title of the role is 'EN', one title, regardless of qualifications and experience. Participants were asked whether they felt the title reflected the role. Almost three-fifths of the participants (58.5%, $N = 234$) were either unsure (17.5%, $N = 68$) or responded 'no' (42.8%, $N = 166$), the title did not reflect the EN role. The responses provided a clear indication from participants that the title needs to differentiate between those ENs who can and those who cannot administer defined medications. The additional education required to be able to administer defined medications was not compulsory (Kimberley, 2004), and there remains a minority of ENs in the nursing workforce who do not hold this qualification. Within this study, there were 8.3% ($N = 12$). However, with the introduction of the national *HLT07 Health Training Package* in 2007 (CSHSC, 2007) all EN graduates from this point were qualified to administer defined medications.

The majority of participants (71.4%, $N = 167$) recommended reverting to the titles of EEN and EN. The EEN title was removed to standardise the title nationally, however this change was not communicated, except for a small notification in a newsletter (NMBA, 2018a) after a number of enquiries had been received.

Separate from medication endorsement, the same title does not recognise those ENs who have studied further to become an ASEN; for example, one participant stated, '*I am still called an EN, there has been very little recognition'* (EN). These ENs had completed an advanced diploma of nursing with the aim of furthering their knowledge and skills. There

was a consensus from both cohorts of the need to differentiate the knowledge, skills and qualifications of the ENs, with participants from both cohorts providing suggestions in the free-text answers, including:

> *ASEN for specialty trained [ENs]—with minimum 3 [years of experience], EEN for medication endorsed—must be able to give [intravenous] medication, EN for non-medication endorsed*. (non-EN)
> *[It] doesn't matter what the title is, but differentiation [is] important so other staff know what an EN can be expected to do*. (EN)

6.2.5.1.1 Summary: Their title

There was a consensus between both cohorts that the current title, EN, did not differentiate the knowledge, skills and qualifications of ENs. Key differences that needed to be clearer were between those ENs' who were qualified to administer defined medications and those who were not, and those ENs who had studied further to become ASENs.

6.2.5.2 Perceptions of allocated workloads

Four statements were presented to all participants regarding the allocated workload of the EN. The findings revealed that the EN cohort had a significantly stronger agreement than the non-EN cohort ($p < .001$) with the statement, 'the EN does everything except for the S8s, and they are allocated workloads as a RN' (see Table 6.6). A one-way ANOVA revealed statistically significant differences based on the professional characteristics of education level ($F(9,362) = [6.442]$, $p < .001$) and length of time in role ($F(4,367) = [2.229]$, $p < .05$). Post hoc tests using Tukey's HSD indicated that ENs with an Advanced Diploma had a significantly higher mean score (2.80 ±0.77) compared to ENs with up to a Diploma (2.45 ±0.94), RNs with up to a Bachelor's degree (2.02 ±0.88) and RNs with a postgraduate degree (1.66 ±0.97). Furthermore, the results showed that those with 21 years and above (2.47 ±0.93) had stronger agreement with the statement followed by those with 11-20 years of experience (2.26 ±0.94), and then those with 0-10 years of experience (2.19 ±0.96).

The open-ended responses captured further details, with some EN participants correcting the statement 'except for S8s' because they administered S8 medications. On further analysis of this group, there was a mix of age brackets, years of experience, sectors and

metropolitan and regional locations, indicating that this practice is not confined to the level of experience, sector or location. Comments included: '*I do S8s*' (EN); '*I work in a facility where EENs actually administer S8 medications*' (non-EN); '*We do S8s, we do pt [patient] pca [patient controlled analgesia], do cannulas, do piccs [peripherally inserted central catheter] [and] do wound infusions*' (EN); and '*EEN's do S8's on our ward*' (EN). In summary, from the EN cohort's perspective, they do everything except S8s and are allocated workloads as RNs, with some ENs also administering S8 medications.

Table 6.6: Comparison between cohorts concerning allocated workloads

Question	EN cohort (*n* = 145) (*M* ± *SD*)	Non-EN cohort (*n* = 255) (*M* ± *SD*)	*t*-test[a]		
			t	*df*	Sig. (2-tailed)
19(1): Understanding that ENs *are* allocated workloads as registered nurses	3.20 ± 0.92	2.45 ± 0.84	8.09	370	$p < .001$
19(2): Understanding that ENs *are* allocated workloads as registered midwives	2.53 ± 1.05	2.05 ± 0.81	4.63	333	$p < .001$
19(3): Understanding that ENs *should be* allocated workloads as registered nurses	2.48 ± 0.91	2.22 ± 0.82	2.75	351	$p > .05$
19(4): Understanding that ENs *should be* allocated workloads as registered midwives	2.10 ± 0.87	1.93 ± 0.78	1.80	328	$p > .05$

Note. [a] for equality of means; EN = enrolled nurse.

In the statements concerning the midwifery setting and working with RMs, there is a need to acknowledge the small sample size of EN participants who worked in the midwifery setting (2.8%, $n = 4$) and RMs who completed the questionnaire (7.8%, $n = 20$). However, the findings represent the perception of all participants, not just those who worked in the midwifery area—that is, participants' perceptions but not necessarily lived professional experiences. Analysis of the findings revealed that the EN cohort had a significantly stronger agreement than the non-EN cohort ($p < .001$) with the statement, 'the EN does everything except for the S8s, and they are allocated workloads as a RM' (see Table 6.6). A comparison of the responses based on demographics or professional characteristics indicated no significant differences. The open-ended responses further supported the findings that there was some confusion in the non-EN cohort, with multiple comments

like '*I feel their role is often blurred and used as midwifery replacement*' (non-EN [RM]) and '*they are not the same—this needs to be better understood*' (non-EN [RM]).

The findings revealed no statistically significant difference between the cohorts regarding the statement, 'the EN does everything except for the S8s, and they should be allocated a workload as a RN' and that the EN 'should be allocated a workload as a RM except for the S8 medications' (see Table 6.6). However, some ENs believed work allocation should not be based on the role but on the education level and experience; for example, ENs '*should be allocated work according to training and experience*' (EN). The practice of work being allocated to ENs based on experience and length of service, not on the role, was also observed by non-EN participants, with comments like '*I think ENs are often allocated to the work of a [RN] due to the perceptions, misperceptions, of their [SOP]. This is often determined by [the] length of service and being seen as being very competent clinically*' (non-EN). However, some participants were very clear about the EN role compared to the RN role, as demonstrated by the following statements: '*ENs are not cheap RNs and therefore we should not be made to do the work of an RN*' (EN), and '*an EN is not an RN*' (non-EN).

6.2.5.2.1 Summary: Perceptions of allocated workloads

The perception of the ENs' allocated workload identified a significant difference between the EN and non-EN cohorts regarding the two statements that reflected current practice. The EN cohort strongly believed they were allocated workloads as RNs and RMs except for S8 medications, with some participants clarifying in the open-ended comments that ENs administer S8 medications. There was a greater agreement between the cohorts that ENs should not be allocated work as RNs or RMs. The contrast was in the free-text comments, with some participants identifying that work allocation was and should be based on experience levels, not the role, while other participants were very clear that the EN and RN are not the same roles.

6.2.5.3 Clinical judgement is valued and considered

Participants were asked whether the ENs' clinical judgement is valued and considered by members of the multidisciplinary team. This was a closed-ended question, with the majority of participants responding 'yes' (75.5%, $N = 304$) and 17.8% ($N = 72$) responding 'no'. A one-way ANOVA revealed statistically significant differences based on the participants' education levels ($F(9,362) = [3.871]$, $p < .001$). The scores were

higher for RNs with up to a Bachelor's degree (0.94 ±0.24) and RNs with a postgraduate degree (0.78 ±0.43) and lowest for ENs with an Advanced Diploma (0.62 ±0.50). Participants who responded 'no' were then asked whether 'the ENs' clinical judgement should be valued and considered' by members of the multidisciplinary team. Again, a closed-ended question was provided, with the vast majority (94.4%, *n* = 68) believing that an ENs' clinical judgement should be valued and considered and a minority responding that 'no' (5.6%, *n* = 4), an ENs' clinical judgement should not be valued and considered

Participants were given the opportunity to describe (through open-ended responses) what needs to happen to ensure ENs' clinical judgement is valued and considered. The EN cohort identified that changing attitudes towards ENs, a better understanding of the EN role and recognition of ENs' knowledge and experience were required. Specific comments included '*being seen as a nurse*' (EN); '*respect [for] EN's judgement, RNs often feel intimidated by our decisions' (EN); and 'more education on what [ENs] can actually do within their [SOP] because it's very broad*' (EN).

In contrast, key themes from the non-EN cohort focused on the lack of understanding of the EN role and a sole voice calling for less judgement and more recognition of experience. Examples included '*I feel their role is not well defined. I honestly do not understand their role very clearly*' (non-EN); a '*greater understanding of the role and its scope*' (non-EN); and '*less judgement by RNs. An EN/EEN with many years of experience knows more than an RN with years of experience*' (non-EN).

Those participants (1.6%, *n* = 4) who believed the ENs' clinical judgement should not be valued and considered were all from the non-EN cohort and identified as RNs in clinical and education roles. They worked in the public health service in NSW, with a range of years of experience from < 10 years to > 31 years. They supported their responses with the following comments: '*ENs are unable to critically think and assess patients*' (non-EN); '*only performed the bedside role of the nurse and has not integrated the practice with theory*' (non-EN); and '*constantly work outside there (sic) scope of practice and don't like to admit they are ENs*' (non-EN).

6.2.5.3.1 Summary: Clinical judgement is valued and considered

There was an overwhelming response indicating that ENs' clinical judgement either is or should be valued and considered. However, a lack of understanding from the non-EN cohort was identified by both cohorts as the barrier to this occurring. There was a significant difference based on participants' education levels, and a small minority of participants from the non-EN cohort did not believe the ENs' clinical judgement should be valued and considered.

6.2.5.4 Having a professional voice

For the purposes of this study and to avoid ambiguity, participants were provided with a definition of a 'professional voice' within the questionnaire (see Appendix O, Question 23). It was defined as when thoughts, opinions and ideas are heard and respected in forums. Participants were asked if ENs have a professional voice. This was a closed-ended question, with the majority of participants responding 'yes' (74.3%, N = 300) compared to 18.3% (N = 76) responding 'no'. A one-way ANOVA revealed a statistically significant difference based on the participants' education levels ($F(9, 360) = [2.233]$, $p < .05$). Further post-hoc tests indicated that the mean score for enrolled nurses with up to a Diploma (0.78 ±0.42) was significantly higher than those with an Advanced Diploma (0.66 ±0.48). However, the mean scores for RNs with up to a Bachelor's degree (0.94 ±0.25) and RNs with a postgraduate degree (0.87 ±0.28) were significantly higher than those of enrolled nurses with up to a Diploma (0.78 ±0.42). The effect size was moderate (partial eta squared = 0.10). These findings suggest that the more educated the EN the less they feel they have a professional voice, however the non-EN cohort strongly feels the EN has a professional voice.

The participants who responded 'no', the EN does not have a professional voice, were then asked whether the EN should have a professional voice. Again, for this closed-ended question, almost all participants from this group (97.3%, n = 74) believed that ENs should have a professional voice, with a small minority (2.7%, n = 2) responding with 'no', ENs should not have a professional voice.

From the open-ended responses, the EN cohort cited the poor attitudes of other nurses towards ENs, a lack of respect and not being valued as the reasons ENs did not have a professional voice. This was encapsulated by the following statement: '*to not be treated as a leper, RNs think they are better than us. I find it hard to make a suggestion*' (EN).

However, some EN participants provided suggestions to enable ENs to have a professional voice, including having ENs on panels, actively seeking their input and advertising '*for ENs to nominate and participate in forums and committees*' (EN). In contrast, key themes from the non-EN cohort related to respect from the ENs for the RNs and respect for ENs by RNs, with a call for a clear SOP for the EN role. Some participants were unsure how this could change. Two comments that differed from the key themes and were in total contrast to each other were: '*the need to be empowered to attend meetings and provided with assertiveness training*' (non-EN); and '*really??? As per the definition above … There is no allocated time for an EN to participate in anything other than direct clinical care (obs [observations], meds [medications], showers, etc.)*' (non-EN).

An EN with > 31 years of experience, who had trained in the hospital system and did not have medication administration rights, stated:

> *Everyone that works in health must learn to appreciate all their colleagues [sic] contributions, roles and limitations. As we all are a part of a team and all should work together to achieve the end result. That is to care for all whom [sic] come through our doors seeking care and understanding. Do so by respecting all people always regardless of the needs and role[s] they preform [sic]*. (EN)

The two participants who felt that ENs should not have a professional voice were both RNs. Their primary response was that ENs have a lower education level, with one participant adding, '*they have a lack of respect for RN*' (non-EN).

6.2.5.4.1 Summary: Having a professional voice

The majority of the participants indicated that ENs have a professional voice or should have a professional voice. The key themes from both cohorts related to being/feeling valued and the need to respect each other, with a significant difference based on the participants' education levels. The small minority of participants who did not believe ENs should have a professional voice also indicated that ENs' clinical judgement should not be valued or considered.

6.2.5.5 Working as part of the nursing team

The term 'nursing team' can mean different things to different people. Therefore, the participants were given two different question styles to ensure the researcher understood

what ‘nursing team’ meant to the participants. The first question was open-ended and asked participants to describe a nursing team and how work was allocated within the team; the second question provided five response options.

There was a clear division in the responses, with half the participants describing a ‘nursing team’ as working together and the other half describing it as patient allocation. Phrases used to describe working together as a team included ‘*like-minded health professionals working together*’ (non-EN), ‘*work together for the betterment and positive health outcomes for the patient*’ (non-EN), and ‘*all categories of nurse[s] working together to provide quality patient care*’ (EN). In contrast, those participants who described patient allocation used the following phrases: ‘*working with their own patient load*’ (non-EN), ‘*allocated a patient load*’ (EN), and ‘*patient allocation is based on acuity*’ (non-EN). Many participants who described patient allocation qualified their response that patient allocation is based on skill sets and experience, not title, for example, ‘*work allocated by experience, not to [the] title’* (EN).

Free-text responses reminded the researcher of the importance of respecting and valuing each team member. Participants described that ‘*the voice of all team members is valuable and should be sought and heard*’ (non-EN), ‘*unfair*’(EN) workload allocations for ENs and that the EN felt ‘*blamed*’ and ‘*disrespected*’ (EN).

The division between teamwork and patient allocation was further supported by the closed-ended question. The findings replicated the division of working together versus patient allocation, with 47.8% (N = 191) describing that they were allocated to a number of patients and worked together, in contrast to 41.0% (N = 164) having either a patient load or individual patient allocation. A small number of participants (8.8%, N = 3) did not work in a nursing team but with task allocation. Further analysis between the two cohorts revealed that 35.2% (n = 51) of the EN cohort identified that they worked as part of the nursing team, in contrast to 54.9% (n = 140) of the non-EN cohort. The reverse was found with the description of patient allocation, with 53.8% (n = 78) of the EN cohort indicating that they were allocated patients, in contrast with 33.8% (n = 86) of the non-EN cohort.

6.2.5.5.1 Summary: Working as part of the nursing team

There was a clear difference between the two cohorts in their understanding and experience of how ENs work as part of the nursing team. The responses to the open-ended question were replicated in the closed-ended question. The majority of open-ended responses identified that workload was allocated based on skills and experience, *not the title*. This further reinforced the perception that the EN and RN roles are essentially the same, differentiated by titles not their tasks. This was captured succinctly by one participant: '*allocated by RN and EENs having a workload and AINs being a float*' (non-EN). The underlying context of the EN feeling or not feeling valued was also woven through the responses. This led to the next question, which asked whether the EN was a valued team member.

6.2.5.6 Valued team members

Four statements were presented to participants concerning how valued they felt the role of the EN was as a team member. This question was negatively worded, with responses ranging from 'strongly agree' to 'strongly disagree'. Section 6.2.5.6 presents the analysis of these statements.

The EN cohort disagreed more strongly than the non-EN cohort ($p < .001$) with the statement, 'I feel ENs are not a valued member of the multidisciplinary healthcare team' (see Table 6.7). Similarly, the EN cohort disagreed more strongly than the non-EN cohort ($p < .001$) with the statement, 'I feel ENs are not a valued member of the nursing team' (see Table 6.7).

Table 6.7: Comparison between cohorts concerning valued team members

Question	EN cohort (n = 145) ($M \pm SD$)	Non-EN cohort (n = 255) ($M \pm SD$)	t-test[a]		
			t	df	Sig. (2-tailed)
30(1): I feel ENs are not a valued member of the multidisciplinary health care team	2.72 ± 0.94	3.19 ± 0.81	4.71	323	$p < .001$
30(2): I feel ENs are not a valued member of the nursing team	2.77 ± 0.91	3.35 ± 0.70	6.38	322	$p < .001$

Note. [a] for equality of means; EN = enrolled nurses.

The non-EN cohort's answers were negatively (left) skewed to the statement, 'I would rather work with RNs only', with the majority (74.1%, n = 109) disagreeing or strongly disagreeing. This was not influenced by demographics or professional characteristics.

Although not significant, there was a preference from participants in regional locations to work with RNs only.

The final statement in this scale concerned only working with RMs. Again, there is an acknowledgement that this question was open to all participants who may not have had lived experiences in midwifery. The non-EN cohort's answers were negatively (left) skewed to the statement, 'I would rather work with RMs only', with the majority (70.6%, n = 181) either disagreeing or strongly disagreeing. The open-ended responses from RMs in the non-EN cohort reinforced that the midwifery setting is not a place for the EN role: '*midwifery is a specialist skill, the EEN I have been involved with work no different to a Midwife and yet they have been trained differently*' (non-EN [RM]); '*complex women and babies++, I don't need to spend more time I don't have looking after someone else's patients too*' (non-EN [RM]); and '*it puts extra pressure on RMs*' (non-EN [RM]). The RM responses suggested that RMs would like to work with RMs and that the other non-EN cohort (RNs and AINs) had created the negatively skewed result.

The open-ended responses reinforce the significant finding that the EN cohort members do not feel like valued members of multidisciplinary or nursing teams. Some comments indicated that their experience '*depends on who[m] you work with, and their attitudes of ENs, some have the impression we are not capable or below them*' (EN) and '*on the area of nursing*' (EN). In contrast, non-ENs felt ENs were valued members of the multidisciplinary and nursing teams, with many responses simply stating, '*a valuable member of the team*' (non-EN). For the minority of ENs who did feel valued, they felt they had to prove themselves to gain respect to feel valued: '*I find that my role within my work team has become valued and I feel I have gained respect after proving that I work within my [SOP] and deliver great patient care*' (EN).

6.2.5.6.1 Summary: Valued team members

There was a significant difference between the two cohorts concerning ENs being valued team members. The EN cohort did not feel they were valued as members of the multidisciplinary or nursing teams. In contrast, the non-EN cohort felt ENs were valued members of both teams. Regarding an RN- or RM-only workforce, there was no significant difference, although the open-ended responses did not support the quantitative analysis. Those participants who provided open-ended responses indicating that RNs

preferred working with RNs and that RMs preferred working with RMs were from regional locations.

6.2.5.7 Required supervision

Four statements were presented to both cohorts concerning participants' experiences and perceptions of the level and type of supervision afforded the EN role. The participants were asked to respond on a Likert scale ranging from 'never' (1) to 'always' (5). A midpoint of 'unsure' was provided as a response option due to the nature of the statements. Section 6.2.5.7 presents the data analysis.

Descriptive analysis indicated that both cohorts were positively (right) skewed to the statement, 'the EN works under the direct supervision of a RN/RM (i.e., when the RN/RM is actually present and personally observes, works with, guides and delegates to the EN'). The majority of the EN cohort (57.8%, $n = 84$) responded 'never' or 'sometimes', with a small number 'unsure' (1.4%, $n = 2$) and 16.3% ($n = 24$) responding with either 'mostly' or 'always'. The majority of the non-EN cohort also responded 'never' or 'sometimes' (58.7%, $n = 150$), a small number were 'unsure' (5.3%, $n = 14$), and a similar proportion to the EN cohort responded 'mostly' or 'always' (17.4%, $n = 44$).

Further analysis of the findings revealed a similar response from both cohorts, the EN cohort ($M = 2.37$, $SD = 1.19$) and the non-EN cohort ($M = 2.39$, $SD = 1.04$), with the statement that ENs work under direct supervision from RNs/RMs ($t(–.144) = 1.22$, $p = .886$). This was a shared understanding for both cohorts and was not influenced by demographics or professional characteristics. However, participants indicated that less direct supervision was in place in midwifery and aged care, with the greatest direct supervision provided in the acute facility and mental health areas.

Indirect supervision was described as when the RM/RM works in the same ward, facility or organisation but does not constantly observe the ENs' activities. Descriptive analysis of the data indicated that the EN cohort's answers were negatively (left) skewed to the statement, 'the EN works with indirect supervision from the RN/RM', with 16.4% ($n = 24$) responding 'never' or 'sometimes', 4.1% ($n = 6$) 'unsure', 56.4% ($n = 82$) responding with either 'mostly' or 'always', and 23.1% ($n = 33$) missing data. The non-EN cohort's answers were also negatively (left) skewed, with 2.0% ($n = 5$) responding 'never', 13.8% ($n = 35$) 'sometimes', 7.7% ($n = 20$) 'unsure', 58.7% ($n = 150$) either

'mostly' or 'always' and 17.8% (n = 45) missing data. Further analysis of the findings revealed that there was a similar response from both cohorts, the EN cohort (M = 3.75, SD = 1.20) and the non-EN cohort (M = 3.66, SD = 1.02), with the statement that ENs work under indirect supervision from RNs/RMs (t(.720) = 3.126, p = .472). This was a shared understanding for both cohorts and was not influenced by demographics or professional characteristics.

The EN cohort had a significantly stronger disagreement than the non-EN cohort with the statement, 'the EN works with no more or less supervision than a RN/RM' (F(9,307) = [3.907], p < .001). The open-ended responses from both cohorts indicated that the level of supervision was not related to the role but to the '*level of experience of the EN/RN*' (EN and non-EN) (see Table 6.8).

Table 6.8: Comparison between cohorts concerning the level of supervision

Question	EN cohort (n = 145) ($M \pm SD$)	Non-EN cohort (n = 255) ($M \pm SD$)	t-test[a]		
			t	df	Sig. (2-tailed)
31(3): The EN works with no more or less supervision than a registered nurse/registered midwife	2.75 ± 1.31	3.33 ± 1.23	–0.80	315	p < .001
31(4): Registered nurses/registered midwives resent having to be responsible for somebody else's work	3.28 ± 1.33	3.57 ± 1.06	–2.3	316	p < .05

Note. [a] for equality of means; EN = enrolled nurse.

When asked to respond to the statement, 'RMs/RMs resent having to be responsible for somebody else's work (e.g., I can do my work, but I don't want to be responsible for someone else's work'), the findings revealed mixed experiences from the EN cohort compared to the non-EN cohort, who 'mostly' or 'always' felt that RNs/RMs resented having to be responsible for somebody else's work (p < .05) (see Table 6.8). Further analysis indicated a statistically significant difference based on participants' education levels (F(9,308) = [2.426], p < .05) and sectors (F(3,314) = [4.201], p < .05). The open-ended responses were very clear, with many comments supporting the analysis, including '*the resentment of having to supervise other staff can be evident*' (non-EN), and '*RNs are told that they are responsible for the ENs and AINs and we have to check their [sic] doing things correctly*' (non-EN).

When specifically related to the RM's role, there was a similar train of thought, as captured by the following statement: '*midwives do not have time to supervise an EEN … they do not want to take the responsibility for another*' (non-EN [RM]). Although most of the comments related to the RN/RM resenting being responsible for the EN, there were a few comments indicating the reverse, for example, '*ENs resent being supervised by RNs, "I don't want to work together, let's just split the patients"* ' (EN).

6.2.5.7.1 Summary: Required supervision

The EN cohort indicated that they predominately worked under indirect rather than direct supervision, which was supported by the non-EN cohort. However, there was a significant difference between the cohorts in response to working with no more or less supervision than an RN/RM. Some ENs did not feel they should be supervised, and depending on their experience level, they did the supervising. Comparatively, the predominant feeling from the non-EN cohort was that they (RNs/RMs) were responsible for the ENs' work, which built resentment.

6.2.5.8 Understanding their scope of practice

An initial close-ended question with six options asked participants who were responsible for knowing the ENs' SOP. Participants were given the opportunity to tick more than one response. The majority of participants identified that ENs need to know their SOP (77.0%, *N* = 308), closely followed by RNs (68.8%, *N* = 275) (see Table 6.9).

Table 6.9: Responsibility for knowing the enrolled nurses' scope of practice

Role	All participants (*N* = 400)		EN cohort (*n* = 145)		Non-EN cohort (*n* = 255)	
	%	*N*	%	*n*	%	*n*
Assistants in nursing	29.8	119	18.6	27	36.1	92
Assistants in midwifery	28.3	113	17.2	25	34.5	88
EN	77.0	308	77.9	113	76.5	195
Registered nurse	68.8	275	63.4	92	71.8	183
Registered midwife	52.0	208	42.7	62	57.3	146
Other (please specify)	22.0	88	15.2	22	25.9	66

Note. EN = enrolled nurse.

The comments revealed three key messages. First, everyone needs to understand each other's roles; for example, '*every member of the team SHOULD be aware of each others*

[sic] [SOP] for safe & efficient [patient] care' (EN). Second, it is the EN's responsibility; for example, '*ENs need to make others aware if directed to undertake a task that it is outwith [sic] their scope'* (EN). Third, there needs to be a resource to inform the EN's SOP; for example, '*it is good to know where to find the information*' (EN).

Further clarification from participants around understanding the EN's SOP was captured through five statements on a Likert scale, with response options ranging from 'strongly disagree' (1) to 'strongly agree' (5).

When asked to respond to the statement, 'I feel ENs have a clear understanding of their SOP', analysis of the findings revealed that the EN cohort (M = 3.16, SD ± 0.64) believed they had a clear understanding of their SOP, in comparison to the non-EN cohort (M = 2.78, SD ± 0.71), creating a significant difference ($t(325) = -4.89$, $p < .001$). The free-text comments supported this finding; for example, '*I think that the lines have become a little blurred since the addition of medication endorsement [sic]*' (non-EN). A comment from an EN participant provided a different perceptive to the point: '*ENs have a clear understanding of their [SOP] however [sic] for some adhering to that is a separate issue*' (EN). This would support the non-EN perspective that, in practice, ENs are not working within their SOP.

To the statement, 'I feel ENs are supported to work within their SOP', descriptive analysis of the data revealed that the EN cohort was negatively (left) skewed, with the majority of the cohort (54.4%, n = 79) either agreeing or strongly agreeing and a quarter (25.8%, n = 37) either disagreeing or strongly disagreeing. The non-EN cohort was also negatively (left) skewed, with the majority of the cohort (59.1%, n = 151) either agreeing or strongly agreeing and, like the EN cohort, a quarter of non-EN participants (25.1%, n = 64) either disagreeing or strongly disagreeing. A level of clarification was provided by the following statement: '*I think there is increasingly mudding [sic] of the waters and unfair expectations*' (non-EN). Further analysis of the findings revealed that both cohorts believed ENs are supported to work within their SOP.

A descriptive analysis of the data revealed that the EN cohort was negatively (left) skewed, with 30.6% (n = 44) either agreeing or strongly agreeing and 48.3% (n = 70) either disagreeing or strongly disagreeing with the statement, 'I feel AINs have a clear understanding of ENs' SOP'. Comparatively, the non-EN cohort was positively (right)

skewed, with the majority of the cohort either disagreeing or strongly disagreeing (53.0%, *n* = 135) and 29.5% (*n* = 75) either agreeing or strongly agreeing. Further analysis using independent samples revealed no significant difference between the EN group (M = 2.30, SD = 0.75) and non-EN cohort (M = 2.25, SD = 0.72).

Descriptive data analysis revealed that the EN cohort was approximately normally distributed in their responses to the statement, 'I feel RNs have a clear understanding of ENs' SOP', with 44.9% (*n* = 65) either agreeing or strongly agreeing and 34.7% (*n* = 50) either disagreeing or strongly disagreeing with the statement. The non-EN cohort was also approximately normally distributed, with 47.0% (*n* = 120) either agreeing or strongly agreeing and 37.7% (*n* = 96) either disagreeing or strongly disagreeing. The following comments supported the responses: '*as a former EN and from working with ENs, they know their scope of practice; however other nurses and health professionals do not understand*' (non-EN); and the distribution could be attributed to the lack of standardised practice, '*what RNs perceive as the EN SOP varies from department to department*' (EN). Further analysis of the findings revealed insignificant differences in their responses and a shared understanding that was not influenced by demographics or professional characteristics.

While acknowledging that the following statement was open to all participants, descriptive data analysis revealed that the EN cohort was approximately normally distributed in their responses to the statement, 'I feel RMs have a clear understanding of ENs' SOP', with 38.8% (*n* = 56) either agreeing or strongly agreeing and 38.1% (*n* = 55) either disagreeing or strongly disagreeing. The non-EN cohort was also approximately normally distributed, with 42.9% (*n* = 109) either agreeing or strongly agreeing and 36.1% (*n* = 92) either disagreeing or strongly disagreeing with the statement. Further analysis of the findings revealed that both cohorts believed RMs had a clear understanding of ENs' SOP, with no significant difference based on demographics or professional characteristics. The opportunity for further clarification in free-text comments focused on the difference in education levels between nurses and midwives: '*I think it is difficult when an EN is working in maternity as this specialty requires additional training and there is limited support for the EN or the [RM] working with the [EN]*' (non-EN [RM]).

6.2.5.8.1 Summary: Understanding their scope of practice

There was a clear expectation that ENs need to understand their SOP. However, there was a significant divide between the cohorts, with ENs feeling they understood their SOP and non-ENs disagreeing. Despite this, there was a consensus that ENs were supported to work within their SOP and that the remaining roles in the nursing/midwifery team understood ENs' SOP. A lack of standardised practice was reflected in the free-text comments, and in the maternity context, a general consensus was that RMs did not understand the ENs' and were concerned about the education preparation of the EN role for this specialty profession.

6.2.5.9 Financial implications

Participants were asked to respond to three statements concerning financial implications for the EN role. A descriptive analysis of the data in response to the statement, 'ENs are being rostered in place of RN/RMs because they are cheaper', revealed that half the EN cohort (51.7%, $n = 75$) responded with either 'mostly' or 'always', 19.0% ($n = 28$) with 'unsure' and 9.5% ($n = 14$) with 'never'. The majority of the non-EN cohort responded with either 'mostly' or 'always' (54.2%, n = 138), similar to the EN cohort. The remainder of the non-EN cohort responded with 'unsure' (17.4%, $n = 44$) or 'never' (13.0%, $n = 33$). Further analysis revealed minimal differences between the two cohorts, with no influence from demographics or professional characteristics.

A significant difference was revealed between the two cohorts in response to the statement, 'the ENs' pay reflects the SOP of ENs'. The EN cohort did not believe their pay reflected their SOP, while the non-EN cohort believed it did ($p < .001$). However, this finding was not influenced by demographics or professional characteristics (see Table 6.10).

Table 6.10: Financial implications for the enrolled nurse role

Question	EN cohort ($n = 145$) ($M \pm SD$)	Non-EN cohort ($n = 255$) ($M \pm SD$)	*t*-test[a]		
			t	*df*	Sig. (2-tailed)
35(1): ENs' pay reflects the scope of practice of ENs	3.22 ± 0.818	2.64 ± 0.702	–6.758	324	$p < .001$
35(2): Greater financial incentives would keep ENs as ENs	3.21 ± 0.927	2.74 ± 0.681	–5.262	323	$p < .001$

Note. [a] for equality of means; EN = enrolled nurse.

Participants' responses to the final statement, 'greater financial incentives would keep ENs as ENs', revealed a significant difference between the two cohorts ($p < .001$). The EN cohort had a stronger belief that greater financial incentives would keep them in their role as ENs compared to the non-EN cohort. This finding was not influenced by demographics or professional characteristics (see Table 6.9). The free-text comments captured the diversity of feelings towards the EN role; for example, '*become an RN if [you] want better pay*' (non-EN); and '*EN/EENs do not receive wages that reflect their work practice, ethics, clinical experience and valued patient care*' (non-EN). Echoing previous responses concerning the recognition of experience, this was also captured in relation to financial remuneration: '*for the [EN] and years of experience should hold a higher pay rate than what they get now*' (EN). A strong statement from one participant further reinforced the intrinsic motivators identified by many ENs: '*I do not work for the money I work for the satisfaction. As far as money keeping me as an EEN I see myself as a nurse first and I am comfortable with being a nurse*' (EN).

6.2.5.9.1 Summary: Financial implications

There was a general consensus between all participants that ENs were being used as a replacement for the RN/RM roles because they are cheaper. However, when further exploring financial implications for ENs, there was a significant difference between the two cohorts, with the EN cohort believing their current pay and financial incentives were insufficient to retain them in their role. In contrast, the non-EN cohort believed they were sufficient and that if an EN wanted financial growth, they should become an RN. Acknowledgement of ENs' experience was also identified, with the intrinsic motivation of being a nurse stronger than the extrinsic motivation of financial remuneration.

6.2.6 Qualitative findings

The final question in the questionnaire was open-ended, giving participants the opportunity to add any further thoughts, ideas and insights. A thematic analysis was conducted using the same methodology as Phase 1 to ensure consistency (see Section 4.6). A total of 20.5% ($N = 82$) of participants responded. Three key themes were identified and have been detailed in Section 6.2.6.

6.2.6.1 Value of the enrolled nurse role

The majority of responses reflect sentiments from the participants about the value of the EN's role. There was a clear indication that the role '*should be more valued*' (non-EN) and that value is aligned with experience: '*ENs' with years of experience should be more valued*' (EN). The EN's value was evident for those participants that would like to see more ENs in the workforce ('*we need more [ENs]*' [non-EN]), although there seemed to be some challenges with recruitment: '*I would like to employ more EENs. We have advertised many times for casuals and not received any responses. I am starting to wonder whether they exist*' (non-EN [RM management]). The sentiments above contrasted with a statement from the following participant, who represented a number of participants: '*I keep reading there's a push to get more ENs working. I feel like I speak on behalf of so many [RMs/RNs] when I say "please don't!!!"*' (non-EN [RM clinical]). On further analysis, the comments about recruitment challenges and pleading for no more ENs were both made by RMs; however, the participants were management and clinical, respectively. This suggests there are different perspectives between management and clinicians, which could also influence the perception that ENs are being used as cheaper RNs/RMs: '*I'm already doing the same job … even though my pay grade is much lower*' (EN). This leads to the second theme, which was confusion about the role, especially between the EN and RN roles, although there was an indication that ENs are also confused with AINs. This confusion has resulted in a lack of standardised practice for ENs.

6.2.6.2 Confusion and lack of standardised practice

Participants described confusion about the scope and standards of practice for the EN role, especially between the EN and RN: '*ambiguity about the roles of RNs and ENs is widespread in clinical setting[s] and this desperately needs to be addressed*' (non-EN). This confusion has led to a lack of standardised practice. Participants described very different experiences between states despite national standards of practice: '*in [Queensland it] was well defined and appreciated however after two years in the [Northern Territory] I feel like a glorified AIN*' (EN); and '*in Victoria in the private hospital sector I felt that ENs were more highly regarded than those in the public sector in Queensland*' (EN). The differences were not just experienced between states but also locally: '*I believe that the scope of the EN has to be more clearly defined and not left to individual facilities to determine*' (non-EN). Further, a lack of understanding by RNs and their role when working with ENs was captured, specifically in their supervision role: '*I*

am concerned that RNs are not always providing the level of direction and supervision that they should be. Why not? Is an important question to have answered' (non-EN).

6.2.6.3 Career opportunities and limitations

There are career limitations for ENs, and a key factor contributing to these limitations and creating boundaries is the current career structure. Participants from both cohorts referenced creating a career structure modelled on the RN structure with clinical nurse specialist and clinical nurse consultant equivalent roles, for example, '*add special grades of qualifications to ENs such as RNs can (CNS [clinical nurse educator], Educators etc.)*' (EN), and '*special grades should be remunerated properly and opened up more to reflect higher grades of duty/scope in practice*' (non-EN). It was recognised that the '*special grade*' is not a consistent role across all states and territories. There was also a continued focus on the need to improve the recognition of ENs' years of experience.

6.2.6.4 Summary: Qualitative findings

The final question in the questionnaire gave participants the opportunity to provide any further clarifications or comments and, as such, was free-text. This question resulted in three key themes: the value of the EN role, confusion and lack of standardised practice, and career opportunities. There was no new information identified in these responses, just reinforcement and the opportunity for participants to provide narratives describing their experiences, feelings and perceptions. The value of the EN role was reflected both positively and negatively. There was confusion predominately in distinguishing between the EN and RN roles, although confusion with the AIN role was also found. The confusion resulted in a lack of standardised practice, despite national standards. Finally, there was a strong sentiment that the EN career structure should be modelled on the RN structure, which would provide an incentive and recognition for years of experience.

The articulation of one EN represented many; this EN succinctly captured the essence of being an EN in the Australian nursing workforce:

> *As an EN I sometimes feel undervalued when workshops are advertised and RNs have top billing to attend. I also feel undervalued when RNs are mentioned as the primary team members when [ENs] have provided as much input as the RN or other members of the multidisciplinary team. As an EN I feel judged as I have not got a degree in nursing. I personally feel that nursing at all levels is a choice and*

hospital base learning would be more beneficial. I would have considered doing my RN if study and work where [sic] implemented to apply new skills in a hospital setting. Placement and lab practice is not the same as learning as you work. (EN)

6.3 Limitations

A limitation of the self-administered questionnaire was the heavy reliance on emails for distribution. This was mitigated by ensuring that each participating service and professional association nominated a contact person. The contact person locally distributed the questionnaire, avoiding email details being provided to the researcher. This also enabled the contact person to market the study through posters and local means of communication to capture staff that did not have readily available email access. This provided a moderate level of success, with 15.6% (n = 63) of responses returned in hard copy format.

6.4 Chapter summary

A wealth of data was captured from the questionnaire providing a comprehensive picture of the role of the EN in the Australian nursing workforce from the perspective of the EN and other nursing roles (non-EN cohort). The participants' demographics and professional characteristics, together with the saturation of themes, supported the ability to infer the findings across the greater Australian nursing workforce. ENs wanted to remain ENs with the opportunity to develop further. Many statements demonstrated that there were significantly different perspectives and expectations between the cohorts, which would influence the ENs' level of job satisfaction, occupational stress in the team and organisational culture in the working environment. The opportunity for the participant to provide additional information and clarification in the final open-ended free-text question resulted in the reiteration of previous results. The supporting and opposing experiences and perceptions enabled the researcher to analyse further and integrate the qualitative results from Chapter 4 (Phase 1) and the findings from Chapter 6 (Phase 3) to develop recommendations to effect pragmatic and transformative changes. The integrated discussion is presented in Chapter 7, with the recommendations and conclusion in Chapter 8.

Chapter 7: Discussion

7.1 Introduction

This study aimed to gain a better understanding of the EN role in the Australian nursing workforce. Therefore, the research question was: what is the role of the EN in the Australian nursing workforce? The motivation for this research was a combination of findings from a preliminary study into the effects of education on the recruitment and retention of ENs (Leon et al., 2019), the workforce growth of ENs compared to the significant growth in EN/RN dual registrations (AHPRA & National Boards, 2012, 2021), and an emotional, heartfelt admission from an EN who acknowledged that there are good intentions to improve the EN role, but they feel nothing has changed (see Section 1.9).

An exploratory MM study was designed, using the knowledge from the literature of persistent and recurrent challenges around this role (see Chapter 2 and Supplement A). The research design was detailed in Chapter 3, along with the study methods, conceptual framework and philosophical assumptions. The results from Phases 1 and 3, and the literature, were integrated and synthesised through the lens of the OB conceptual framework with the focus group results (QUAL) used as the foundation. The data integration matrix that informed the discussion is provided in Appendix Q. This is based on the triangulation or comparison of data sets approach (Johnson et al., 2019), as described in Section 3.3.2.1 and Figure 3.1.

The application of OB as the conceptual framework with its three units of analysis, individual, group/team and organisation, provided a construct that aligned the data with the natural structure of the nursing workforce, namely the individual nurse, the nursing team, the facility/institution and the nursing profession. The individual unit of analysis captured the experience and perspectives of the EN role as identified by the EN cohort. Through this lens, the findings have identified the importance of intrinsic and extrinsic motivators on ENs' level of job satisfaction.

The second unit of analysis was the group/team, which discussed the experiences and perspectives of both the EN and non-EN cohorts, especially regarding how they feel when working together and the effects on the EN role. Push factors, as defined by Ralph et al. (2013), were those negative emotions and experiences towards ENs that 'actively' push

them to become RNs. These have been well-documented in the research and identified in this research. The push factors, identified through this study, may contribute to the perception that ENs do not want to stay in their role. In contrast, this study found that pull factors exist, For the purpose of this study the researcher redefined Ralph et al.'s (2013) pull factors as those emotions and experiences of ENs that retain them in their role. However, their existence relies on the working environment in which ENs work.

The final unit of analysis was the organisation, which explored the experiences and perspectives of both cohorts at the facility/institution and professional levels. The national standardisation of the role has not been achieved. There is also a lack of career progression for the EN, with the focus continuing to be on the transitioning EN to RN. Each of these units was discussed in the context of the integrated results from both the qualitative and quantitative phases, together with the literature.

The overall findings reinforced the challenges captured in the literature (see Chapter 2), and new insights have enabled a better understanding of the role of the EN in the Australian nursing workforce. The application of the OB framework helped identify these insights. At the individual level, the influence of ENs' intrinsic and extrinsic motivators on their experiences, perceptions and experiences affect their job satisfaction. At the group level, pull factors exist; however, they depend on key determinants that influence levels of job satisfaction, occupational stress and occupational culture within the ward and hospital or facility levels. A better understanding of the role of the EN at the individual and group levels could improve ENs' experiences and levels of job satisfaction. However, changes at the professional level will have the greatest effect on the EN role as a workforce in nursing and multidisciplinary healthcare teams. Experiences and expectations of the EN in the midwifery setting were also identified, including a lack of understanding by ENs and RMs about the EN role and place in the midwifery workforce. Section 7.2 presents the collective demographics from the qualitative and quantitative phases of this study. Section 7.3 explores the role of the EN, and Section 7.4 provides insights into ENs' role in the midwifery workforce. Finally, Section 7.5 summarises Chapter 7.

7.2 The participants

The participants of this study were from the Australian nursing workforce. The majority of participants were female, which is consistent with the national data (AHPRA, 2019), with representation across all age groups (see Table 6.3). There was representation from all nursing roles, AINs, ENs and RNs in clinical and non-clinical positions, public and private health organisations, and each state and territory (see Table 6.3). The depth and breadth of responses enabled the researcher to generalise the findings across the greater Australian nursing workforce. This provided a level of confidence in the validity, reliability and credibility of the proposed recommendations. Additionally, despite focusing on the nursing workforce, a small number of RMs and ENs who worked in the midwifery workforce participated in this study. This provided important insights regarding the role of the EN in the midwifery workforce.

7.3 The enrolled nurse as an individual

Job satisfaction was defined as ENs' affective reactions to their jobs and the level of happiness it provides them (see Section 3.4.1.1). It was important to the ENs because it informed how they felt about themselves in their roles and their feelings of being valued and respected. This study identified a link between their levels of job satisfaction and their intrinsic and extrinsic motivators. While all ENs had both intrinsic and extrinsic motivators, understanding their influence on the individual EN and the differences between them will inform the pragmatic and transformative changes required to ensure the continuing and persistent challenges experienced by ENs are addressed.

7.3.1 Intrinsic motivators

ENs' desire to work as ENs was driven by intrinsic motivators with the primary motivator, being a nurse. Intrinsic motivators involve completing tasks or actions for the pleasure of accomplishment (Bowditch et al., 2008). They are intangible in nature and identified through feelings of accomplishment, growth, success and esteem (Bowditch et al., 2008). For the majority of ENs in this study, being a nurse meant caring for others through direct patient care (see Section 4.2.3). This made them happy and gave them a sense of purpose and identity. It also provided them with job satisfaction because they felt a sense of accomplishment about what they had achieved in their role. A higher sense of job satisfaction has been associated with strong intrinsic motivators (Cerasoli et al., 2014; Iley, 2004; Putra et al., 2017) and a clear sense of purpose.

Job satisfaction is informed by job analysis and job design. Job analysis is the knowledge and skills required for the role, and job design is the configuration of tasks and roles (see Section 3.4) (Wood et al., 2013). Together with job satisfaction, these were fundamental to the individual unit of OB analysis and provided a greater understanding of what is needed to create a level of job satisfaction for the EN. The findings identified two key groups of ENs, the majority of ENs who understood their role and the second, smaller group who did not understand their role (see Sections 4.2.3, 6.2.5.2, 6.2.5.7 and 6.2.5.8). For the second group, the lack of understanding translated into a confusing job analysis and job design, with the EN role predominately confusing themselves with the RN role, which has been the findings from previous research (Endacott et al., 2018; Jacob et al., 2012; Leon et al., 2019; Lucas et al., 2021b). This resulted in a lower level of job satisfaction for this group of EN participants.

While the intrinsic motivators were the same for both EN groups, the key difference, their level of understanding of their role, influenced the value ENs placed on their intrinsic motivators. For some ENs, there was a stronger reliance on satisfying their extrinsic motivators to achieve the same level of job satisfaction. This, in turn, directly affected their sense of purpose, their identity as a nurse and whether or not they felt valued in their role (Leon et al., 2019; Lucas et al., 2021b).

7.3.2 Extrinsic motivators

Extrinsic motivators are external rewards that are received for certain behaviours, known as a 'means-ends relationship' (Bowditch et al., 2008, p. 93). For the ENs, extrinsic motivators were provided through the behaviour, attitudes and feedback of others in the nursing workforce and the wider healthcare workforce (see Sections 4.2.3; 4.2.4, 6.2.5.2, 6.2.5.5, 6.2.5.7 and 6.2.5.8). As such, they also played a role in providing the EN with job satisfaction. The level of understanding of their role as ENs influenced which extrinsic motivators were required to provide job satisfaction.

This study identified that for the EN who understood their role, their extrinsic motivators were satisfied when they worked in a team that respected and valued their work, supported them to work within their scope and standards of practice, and rewarded them for their knowledge and skills. In contrast, when these ENs worked in an environment where their role was not understood, there was a strong probability that they were allocated work outside their scope and standards of practice. In these situations, the EN participants relied

heavily on their intrinsic motivators because their extrinsic motivators, external rewards and recognition, were not provided, causing the ENs to not feel respected or valued in their role (Leon et al., 2019). Whilst focussing on the individual level, this cannot be isolated from the EN in the working environment, as the role of the EN was not designed to work alone (NMBA, 2016 p. 2). Teamwork, which is discussed further in section 7.4, is as an area that needs work within Australia and internationally from the individual, working environment and nursing professional levels (Anderson et al., 2019; Goh et al., 2020; Havaei et al., 2019; Moore et al., 2019).

For those EN participants who did not understand their role, they appeared to rely more heavily on their extrinsic rather than intrinsic motivators. These ENs expected to be allocated a patient load with minimal or no supervision and resented being supervised (see Sections 4.2.4.3 and 6.2.5.7). ENs in this study who could not differentiate between the roles of the EN and RN often felt restricted, disrespected and devalued when required to work within their scope and standards of practice. In contrast, the work environment where neither the ENs nor the team understood the EN's role enabled ENs to work outside their scope and standards of practice. Their extrinsic motivators were met in this environment, leading them to feel valued with a high level of job satisfaction. The effects of the work environment on the EN aligned with the research concerning motivators (Gagné & Deci, 2005; Ryan & Deci, 2000). The difference between the EN understanding and not understanding their role has not clearly been differentiated in the research to date that identified role confusion between the EN and RN roles, and the EN feeling devalued (Eager et al., 2010; Jacob et al., 2012; Leon et al., 2019).

7.3.3 Summary

Intrinsic motivators were identified as the initial impetus for an EN. The majority of ENs had strong intrinsic motivators, and providing direct patient care, that they felt made a difference, was enough to provide them with job satisfaction. However, some ENs struggled to work in environments where there was a lack of understanding of the EN role. Some ENs also relied more heavily on their extrinsic motivators to provide them with the same level of job satisfaction. Key determinants for any EN were their working environment and the nursing team in which they work, as that was where work was allocated and a level of supervision was determined. As a nursing profession, understanding the influence of intrinsic and extrinsic motivators will inform the transformative approach to any recommendations.

7.4 The enrolled nurse in the working environment

The work environment for the EN involves working with AINs, ENs and RNs and within the broader multidisciplinary team. From an OB perspective, the job match of the skills of individuals as team members and how the team works together collectively influence the level of occupational stress (see Section 3.4.1) (Wood et al., 2013). Push and pull factors have been identified as directly affecting the role of the EN. Push factors have been defined as negative experiences that result in the EN either considering leaving or actually leaving their role and transitioning to the RN role (Ralph et al., 2013). For the purpose of this study the researcher redefined Ralph et al.'s (2013) pull factors as those emotions and experiences of ENs that retain them in their role. However, their existence relies on the working environment in which ENs work.

Building on Ralph et al.'s (2013) understanding of push factors and redefining the pull factors will inform changes at the team level to ensure the continuing and persistent challenges experienced by ENs are addressed. It will also provide an opportunity to learn from working environments where job satisfaction is high and occupational stress is low.

7.4.1 Push factors

The push factors captured in this study have been previously researched and documented (see Chapter 2). For the EN participants, push factors occurred in working environments where their role was not understood, which for some, created a lack of standardised practice (see Section 4.2.4, 6.2.5.2 and 6.2.6.2). Push factors also included role confusion (Endacott et al., 2018; Jacob et al., 2012; Leon et al., 2019; Lucas et al., 2021b) which influences the perceptions of allocated workloads (6.2.5.2) and levels of supervision (6.2.5.7), ambiguity about their role (Armitage et al., 2015; Endacott et al., 2018; Leon et al., 2019; Ralph et al., 2013), a lack of teamwork and limited opportunities for career development as an EN (Leon et al., 2019; McKenna et al., 2019; Schwartz, 2019), with active encouragement for the career pathway of EN to RN (see Section 4.2.5.1 and 6.2.5.9). Workforce data from the last 10 years has indicated significant growth in EN/RN dual registrations (154.6%) (see Table 1.3), suggesting that the nursing workforce is not retaining ENs as ENs and that there is greater encouragement and structure to support them in becoming RNs. This demonstrates that any strategies to support the EN transition to the RN workforce are succeeding, as that is approximately four times the RN workforce growth and seven times the EN workforce growth (see Table 1.3). There is also evidence

that the level of education of the participants impacts on their experiences and responses. Those EN participants with post-registration qualifications feel that their clinical judgment and professional voice are not valued and considered (6.2.5.3, 6.2.5.4). This is consistent with those participants who identified that they are unable to work to their scope of practice (4.2.5.2). They also indicated that they are allocated workload like a RN (6.2.5.2). The push factors and workforce data have further reinforced the perception that the EN role is a stepping stone to becoming an RN (Leon et al., 2019). Identifying and addressing push factors should result in a decrease in those ENs either considering leaving or leaving the role because they feel pushed out.

7.4.2 Pull factors

Pull factors have not been fully explored to date; however, this study found that pull factors existed for almost half the EN participants (see Table 6.5). These participants cited that they experienced their professional voice and clinical judgement being both valued and considered. They experienced improved teamwork and opportunities for career development. Working together and understanding each other's role has been identified as key to successful teamwork and quality patient care (Anderson, et al., 2019; Goh et al., 2020; Havaei et al., 2019). These pull factors reinforced the ENs' extrinsic motivators of being respected, valued and supported. They were created by the work environment and with whom the ENs worked, resulting in high job satisfaction and low levels of occupational stress. By applying the philosophical assumptions of pragmatism and the transformative approach, there is an opportunity to explore further these pull factors and any others that value, empower and support ENs to grow and develop in their role as ENs.

7.4.3 Summary

The findings suggested that push factors have influenced the significant growth in EN/RN dual registrations over the past 10 years (see Table 1.3). However, this study redefined pull factors and found they existed for almost half the EN participants. The study identified that push or pull factors influence individual ENs to either stay or consider leaving/leave their role. Push and pull factors depend on key determinants: the EN understanding their role, the RN understanding the role of the EN and their role when working with an EN, and the organisation providing opportunities for the EN and understanding how the nursing team needs to work to ensure all nursing roles can work within their respective scope and standards of practice.

7.5 The enrolled nurse in the nursing profession

The EN role was directly affected by changes at the professional level approximately 10 to 15 years ago. These changes occurred at a national level and resulted in standardised entry-level education, national registration, a national scope and standards of practice, and a standardised title (AHPRA, 2011; ANMAC, 2017; CSHSC, 2007; NMBA, 2016; NMBA, 2018a). Collectively, these changes should have provided the organisational development and changes for the internal capacity of the organisation (profession) to accomplish its mission (Wood et al., 2013).

However, the findings from this study, coupled with the literature (Eager et al., 2010; Endacott et al., 2018; Jacob et al., 2012; Leon et al., 2019; Lucas et al., 2021b), suggested that a national standard for the EN role has not been achieved (see Sections 4.2.4, 6.2.5.5 and 6.2.6.2) and that the title (see Sections 4.2.3 and 6.2.5.1), in particular, does not represent the role. It is apparent, from this study, that there is an assumption that ENs understand their role, RNs understand the role of the EN and understand their role when working and supervising ENs, and the professional scope and standards were implemented consistently across Australia. While this did exist in some working environments, the findings demonstrated that there were enough working environments where the perspective and understanding between the two cohorts were significantly different, affecting the organisational structure and culture. An example is that the EN cohort had a significantly stronger agreement than the non-EN cohort with the statement, ‘the EN does everything except for the S8s, and they are allocated workloads as a RN’ (see Section 6.2.5.2).

The perception and expectation of the EN working as an RN would then influence the understanding of the level of supervision required. The EN cohort had a significantly stronger disagreement than the non-EN cohort with the statement, ‘the EN works with no more or less supervision than a RN/RM’ (see Section 6.2.5.7). The confused understanding of the EN’s role (Armitage et al., 2015; Eagar et al., 2010; Endacott et al., 2018; Jacob et al., 2012, 2014c; Leon et al., 2019) and how they work in the nursing team (Anderson et al., 2019; Goh et al., 2020; Havaei et al., 2019; Moore et al., 2019) has previously been identified. Therefore, it is not surprising that current career development and opportunities could be perceived as actively encouraging (pushing) ENs to become RNs.

7.5.1 Career development

Career progression for the EN continues to focus on transitioning ENs to RNs, as demonstrated by comments from participants in this study (see Sections 4.2.5.1 and 6.2.6.3) and the published research in this area (Birks et al., 2010; Brown et al., 2015; Cubit & Lopez, 2012; Hutchinson et al., 2011; Ralph et al., 2013; Tower et al., 2015), (see Section 2.3.1.3). However, there is minimal focus on the EN who wants to create a career for themselves as an EN. Those ENs who studied further and completed courses, including an advanced diploma of nursing, found themselves in situations where they could not practice with their advanced qualifications as identified in previous research (Leon et al., 2019; McKenna et al., 2019; Ralph et al., 2013; Schwartz, 2019) (see Sections 4.2.3.1, 4.2.5.2 and 6.2.5.1). This lack of recognition for the advanced qualification suggests that, in fact, the EN participants' intrinsic motivator (to be the best nurse they can be) drives them to complete additional studies rather than the extrinsic motivator of positive financial implications. It could be suggested that the nursing profession is actually averse to creating a career for ENs as ENs. The nursing profession needs to clearly determine the role of the EN in the nursing workforce.

7.5.2 Their title

Confusion is created by the title 'EN', with responses from the qualitative phase and the majority of the questionnaire participants indicating the need for a change (see Sections 4.2.3.1 and 6.2.5.1. There was minimal reference in the literature questioning what the title means (Schwartz, 2019). However, what was available was consistent with the sentiment of the participants.

Confusion in the title has created a number of challenges for nursing teams because it does not differentiate the qualifications and experience of an EN. Further, it does not provide any recognition of any advanced qualifications and experience. Recognition is a key extrinsic motivator for ENs. Therefore, any change needs to create an organisational culture that provides an outward recognition of the qualifications and experience of the EN and a clearer delineation of the EN's scope and standards of practice. This would demonstrate to the EN that the nursing profession recognises and values the role and that the role is integral to the nursing workforce.

7.5.3 Summary

The ongoing challenges identified by this study and the literature indicate that changes made to date by the nursing profession, especially key national changes, have not been enough to support the EN role and articulate its place in the nursing profession. It is suggested that there is a need to more clearly determine how the nursing roles work together in the nursing practice for the nursing profession to recognise the EN role as the second-level regulated nursing role within the structure of the nursing team. Once that is determined, there will be an opportunity to construct a career pathway with accompanying qualifications, financial remuneration and titles that reflect and recognise the qualifications and experience required for the EN role.

7.6 The role of the enrolled nurse internationally

There continues to be research and ongoing analysis of the effectiveness of the second-level regulated nursing role (Moore et al., 2019; Leon et al., 2019;Lucas et al., 2021a). Whilst there has been discussion and debate, it appears UK is the only country that has phased out the role from the nursing workforce. This resulted in a void, which was filled by the nursing associate. A role that was created and has become a pathway into the nursing workforce, especially for the healthcare support workers (King et al., 2022; Traynor et al., 2020). The experience from the UK suggests that a second-level regulated nursing role is required.

The ongoing research in Canada and the USA identifies the need to focus on team nursing and collaborative practice models (Havaei et al., 2019; Moore et al., 2019). Canada updated its entry-level competencies for LPNs in 2019 in response to the changing health care environment (Canadian Council for Practical Nurse Regulators, 2019). However, there continues to be evidence that if there are two levels of regulated nursing roles working together, there is the need to improve team based nursing (Havaei et al., 2019). This was echoed in the USA which acknowledged the lack of research on collaborative practice between the two regulated nursing roles (Moore et al., 2019).

Given the number of countries that have two regulated nursing roles there appears a paucity of research on how the roles effectively work together in the practice of nursing for effective and safe patient care. Whilst focussing on the Australian role, it is prudent to learn from others when determining recommendations and future directions for the role of the EN in the Australian nursing workforce.

7.7 The enrolled nurse in the Australian midwifery workforce

Although the study focused on the EN role in the nursing workforce, a small number of EN participants (4.6%, *n* = 8) worked in the midwifery workforce, and some RMs (8.8%, *n* = 25) also participated in the study. This provided the ability to capture the essence of the EN role as a member of the midwifery team and start a conversation about the EN role in the Australian midwifery workforce.

There was significant confusion from both cohorts about why ENs work in midwifery because '*we register differently as nurses and midwives' (non-EN FG1)* (see Section 4.2.4.1). The confusion has been supported by a lack of detail in the education, literature and regulatory field and is creating a lack of job satisfaction for the EN and occupational stress for the team. There has been minimal literature on the effects or experiences of ENs as members of the midwifery workforce or RMs working with ENs. If an RM were to refer to the *Midwife Standards for Practice* (NMBA, 2018b) for guidance, they would find no mention of supervising ENs. This suggests that the EN role started working in this environment due to the necessity at the organisational level, perhaps influenced by a lack of midwives or costs associated with an exclusive RM workforce. From the organisational level, there appears little insight that midwifery and nursing are different professions with differing education and registration requirements and scope and standards for practice.

This study identified that at the professional level, there is a need to determine the future of the EN role in the midwifery workforce. However, the more immediate necessity is to determine a minimum level of education required for the EN role and how the RM works and supervises the EN. The responsibilities of both roles and how they work together should be articulated within their respective EN and RM SOPs, together with the models of care, to provide support and guidance from the professional level.

7.7.1 Summary

The challenges experienced by the role of the EN in the midwifery workforce can only be addressed at the professional level. Further work is required in this working arrangement because, at face value, it appears that the EN role in the midwifery workforce is following the same path of role confusion, role ambiguity, lack of professional development and career pathway that has plagued the EN in the nursing workforce since

the inception of the role. Section 7.6 informed the following publication (see Supplement D):

Leon, R. J., Moroney, T., Fields, L. & Lapkin, S. (2022). The enrolled nurse in midwifery: A cause for concern? *Midwifery News*, Spring, 32-33

7.8 Chapter summary

The ongoing challenges identified by this study and the literature indicate that changes made to date by the nursing profession, especially key national changes, have not been enough to support the EN role and articulate its place in the nursing profession. This study has identified that the ideal working environment for the EN role in the current nursing structure occurs when the following determinants coexist: the EN understands their role, the RN understands their role when working with an EN, and the organisation provides opportunities for the EN and understands how the nursing team can ensure all nursing roles are working within their respective scope and standards of practice. This environment respects the intrinsic and extrinsic motivators of ENs, creating pull factors that influence the individual EN to stay in their role and, in turn, increasing job satisfaction, decreasing occupational stress and nurturing an organisational culture that facilitates safe, quality patient care. At a professional level, there is a lack of career development opportunities, which can only be addressed through changes to the nursing structure, the title and the industrial award. Chapter 8 provides the recommendations based on this study's findings, the strengths and limitations of this study and the next steps for the role of the EN in the Australian nursing workforce.

Chapter 8: Conclusion and recommendations

8.1 Introduction

This study aimed to gain a better understanding of the role of the EN in the Australian nursing workforce because the literature identified persistent challenges with role confusion, lack of role clarity and delineation between the EN and RN roles, and an assumption that the career pathway for the EN is to become an RN (see Chapter 2). This professional environment has contributed to limited growth in the EN workforce, significant growth in EN/RN dual registrations (see Table 1.3), a confused nursing workforce and ENs not feeling valued. The research aimed to gain a greater understanding of key issues affecting the EN role that would support the development of strategies to address the persistent challenges and ensure the role is effectively utilised as an integral member of the nursing team.

Using a MM approach, this study into the role of the EN in the Australian nursing workforce enabled a depth and breadth of knowledge, experiences and expectations from ENs and non-ENs to be captured. These were analysed by applying the philosophical assumptions of pragmatism and the transformative approach and through the lens of the OB framework. The area of focus for the findings, discussion and recommendations aligned with the OB units of analysis of individual job satisfaction, occupational stress within the team and organisational structure of the nursing profession at the professional level, see Section 3.4.1. and Appendix Q. The findings enabled recommendations to be aligned to the OB levels of analysis which may offer a significant opportunity to effect real change.

New insights have been identified, including the importance and influence of ENs' intrinsic and extrinsic motivators and evidence of three key determinants. Collectively, these influence how valued ENs feel. Additionally, this study has demonstrated why role confusion is a recurring theme in the literature. At the professional level, the overarching problem is the current nursing structure. While this was not an area of focus, emerging concerns about the EN role in the Australian midwifery workforce were also captured.

Chapter 8 addresses the research questions, articulates the significance of the research, captures international experiences of the role and provides recommendations to inform a pragmatic and transformative change for the EN role in the Australian nursing workforce.

8.2 The role of the enrolled nurse in the Australian nursing workforce

The findings demonstrated that several factors influenced the sense of value experienced by ENs. These included ENs' intrinsic and extrinsic motivators and three key determinants: the EN's understanding of their role, scope and standards of practice; the RN's understanding of the role of the EN and their role when working with an EN; and the organisation's understanding and recognition of the EN role. When these three determinants aligned, there was increased job satisfaction and decreased occupational stress and the EN felt valued. Collectively, these created an environment with pull factors, the positive experiences that provide ENs with reasons to stay in their roles as ENs. To date, pull factors have been postulated but not described in the research literature. Conversely, in environments where any of the three determinants were absent, there was a lack of job satisfaction, higher occupational stress and the potential for ENs to work outside their scope and standards of practice. It was shown that this working environment could result in poor organisational culture, where, importantly, the EN does not feel valued in their role.

Understanding the influence of ENs' motivators and their determinants provides an opportunity to redesign a working environment with improved job satisfaction, minimal occupational stress and a positive organisational culture. These findings inform the recommendations (see Section 8.8), which could have a positive effect on the individual EN, increasing their sense of value and likelihood of remaining within the EN profession. Ultimately, this can only improve safe, quality care for patients.

While the above opportunities will have a localised positive effect on the individual, they do not address the challenges faced by the EN at the professional level. This requires redesigning and rethinking the EN role in the nursing structure. The EN role is not designed to work alone; given this, there needs to be an examination of all nursing roles (AIN, EN and RN) and how they work together in the practice of nursing. Any changes at the individual, ward and facility/institution levels will not address the lack of a career pathway and structure for the EN to remain an EN. This study and previous literature have identified that the majority of ENs want a career as an EN; however, what has been

demonstrated is that the expectation and current career pathway for ENs are to become RNs. Developing a career pathway for ENs that recognises and rewards ENs as ENs will be the ultimate change that is required and will be an outward demonstration that ENs are valued members of the nursing profession.

For the role of the EN to be an integral and valued member of the nursing workforce, the nursing profession must:

- provide clarity between the nursing roles with defined parameters in their scope and standards of practice
- create a career structure that maintains the EN role and includes a defined education pathway where the required knowledge, skills and experience are recognised and able to be practised as a standardised approach
- establish industrial nursing awards that represent financial remuneration that recognises the knowledge, skills and experience of the EN and aligns with the career structure
- use titles that provide clarity and recognise the progression of the EN on their career structure.

8.3 The role of the enrolled nurse in the Australian midwifery workforce

While this study focused on the EN role in the nursing workforce, data were collected from RMs and ENs who worked in the midwifery workforce. This data provided enough evidence to indicate that challenges are emerging that are not dissimilar to the persistent challenges identified in the EN role in the nursing workforce. The movement of the EN into the midwifery profession infers a need for a second-level role, also reinforced by the practice of recruiting ENs into the maternity environment. By acknowledging this need, there is now an opportunity to design a role and avoid the same persistent challenges as the EN role is experiencing in the nursing workforce. These findings informed the following publication:

Leon, R. J., Moroney, T., Fields, L. & Lapkin, S. (2022). The enrolled nurse in midwifery: A cause for concern? *Australian Midwifery News*, *30*(1), 36–37. https://search.informit.org/doi/10.3316/informit.677954991665925

8.4 Research significance

This research has identified why there are recurrent challenges surrounding the EN role and that there is a need to examine the nursing roles (RN, EN and AIN) and how they work together in the practice of nursing to create a sustained change. Changes at the professional level that creates an organisational nursing structure which recognises the role and enable ENs to form a career as an EN are needed.

While changes at the professional level are outside the influence of the individual, ward and hospital/facility, changes can also occur at these levels that will have a positive effect on the EN role. The findings have shown that creating a work environment that recognises the intrinsic and extrinsic motivators and includes the key determinates results in increased job satisfaction, decreased occupational stress and an organisational culture that makes ENs feel valued, which can only support safe, quality care of patients. This understanding enables pragmatic recommendations that can be implemented without significant investment because they already exist in some environments.

8.5 International experiences

The second-level regulated nursing role exists in other OECD countries. Similar challenges and experiences have been documented in those countries. While the continuance of the role has been debated in some countries, the UK has phased out the EN role. This resulted in an RN and health care assistant workforce (Glasper 2016). It then became apparent that the health care assistant role was inadequate, and as a result, a nursing associate role was introduced (Lucas et al., 2021a). The experience in the UK suggests that a second-level regulated nursing role is required in the nursing workforce.

NZ experienced a protracted debate that resulted in the decision to keep the EN role (Enrolled Nurses Here To Stay—Finally, 2010). This decision triggered a comprehensive review of the scope and standards of practice and how the role works with the RN role. The key to this review is that the role is being examined in the context of how it works with the RN and not in isolation. How the two roles work together in the practice of nursing is a consistent theme, as it was also captured in the research from Canada and the USA (Havaei et al., 2019; Moore et al., 2019). While other countries continue to describe and present persistent challenges, in the literature, Australia has the opportunity to learn from these experiences for the EN role and lead the way as it navigates towards an

improved nursing workforce structure where each nursing role is valued and recognised for the work they contribute.

8.6 Research strengths

Conscious steps were applied throughout this research to strengthen the credibility of the findings and the transferability of the recommendations. This started with the choice of an exploratory MM research design. This design uses both qualitative and quantitative data collection methods, which counterbalances any weaknesses from using one method alone (Creswell & Plano Clark, 2018). It also enables data to be collected from a greater audience, demonstrated by the number of questionnaire participants above what was considered sufficient (see Section 6.2.1).

Incorporating both the philosophical assumptions of pragmatism and the transformative approach into the exploratory MM research design enabled the collection of both objective and subjective data. The assumptions of pragmatism are especially suited to the MM design because they take the narrative from the qualitative data and the numerical from the quantitative data to inform workable solutions to longstanding philosophical problems (Creswell & Plano Clark, 2018; Teddlie & Tashakkori, 2009). Coupled with the value-oriented transformative approach, the lived experiences and perceptions of the participants created a realistic picture of the EN role, which were used to inform the development of recommendations that are both workable and value-oriented.

The OB framework is an applied behavioural science that systematically studies individuals, groups and organisations to create an organisation that engenders high performance (Kalliath et al., 2014; Robbins et al., 2008; Wood et al., 2013). These three levels align with the nursing workforce structure of the individual EN, the ward/unit in which they work and the facility/institution and professional level that influences how they can work and progress. Therefore, in addition to applying the philosophical assumptions for analysing the data, the OB conceptual framework enabled the findings to be aligned with the nursing structure, informing workable recommendations.

Another strength of this study was the development and validation of the quantitative data collection tool. Using a structured process (see Chapter 5) this involved assessing for face, content and construct validity, inter-rater reliability, reliability testing and internal

consistency. This process developed a questionnaire that captured more relevant, valid and reliable data.

A local contact person was identified for both phases of the data collection (focus groups and questionnaires). This role was a pivotal conduit between the researcher and the service/professional organisations. Specific benefits of this role included the local endorsement of the study, the ability to schedule focus groups that enabled staff to attend, and the local distribution of the questionnaires, further reinforcing the anonymity of the participants. At no point did the researcher have access to or influence over the participants.

This research was strengthened by specific points and actions along the study's progression, from the choice of the research design, philosophical assumptions and conceptual framework to the questionnaire development and use of a local contact to support and facilitate the data collection from both phases. This approach supported the credibility of the findings and the transferability of the recommendations of this study.

8.7 Research limitations

In addition to the strengths of this study, the researcher acknowledges some limitations that could have affected the findings. The workforce data included EN/RN dual registrations (see table 1.3). However, the figures do not extrapolate the RN/RM and EN/RM dual registrations because the research focused on nursing, not the midwifery workforce. Further, those participants who hold dual registrations could have different experiences and perspectives that were not explicitly identified in this study.

In Phase 1 of this research, the focus groups were all conducted in NSW. While the locations were determined through stratified sampling, a limitation of only one state could have affected the data used to develop the self-administered questionnaire for Phase 3.

Phase 2 of this research developed the self-administered questionnaire. In its development, issues relating to psychometric analyses of measurement properties, including Rasch analyses that are informed by Classical Test Theory and Response Theory, were not considered.

A limitation of Phase 3, the distribution of the questionnaire, was the heavy reliance on emails. This was mitigated by ensuring each participating service and professional

association had a contact person. The contact person locally distributed the questionnaire, avoiding email details being provided to the researcher, and was a local means of communication to capture staff that did not have readily available email access. This provided a moderate level of success, with 15.6% (n = 63) of the returned questionnaires being in hard copy.

8.8 Recommendations for change and further research

The aim of this study has been achieved, with the findings providing a better understanding of what is occurring in the work environment for an EN to feel valued and explanations for the lack of understanding of the role. Recommendations to create work environments where ENs feel valued and address this lack of understanding need to be informed by the findings of the study and consider the complexity of the healthcare environment, which is currently navigating the ongoing effects of the COVID-19 pandemic, budget constraints and workforce challenges.

An overarching recommendation is that the role of the EN cannot be looked at in isolation of the other nursing roles. Clarifying the EN role or determining its required level of supervision needs to be done when also considering the RN and AIN roles' scope of practice and how the roles work together in the practice of nursing. Focussing on the EN role will not achieve the change that is required. It also needs to be noted that the role of the EN was not designed to work alone (NMBA, 2016 p. 2), further reinforcing the need to explore how the nursing roles, regulated and unregulated, work together. This is in keeping with the levels of OB with the professional level all encompassing of the three levels, see Figure 3.3 and Section 3.4.1.

8.8.1 The enrolled nurse in the nursing profession

8.8.1.1 The Australian nursing profession needs to determine the nursing roles (currently enrolled nurse, registered nurse and assistant in nursing) in the nursing workforce

This will require comprehensive professional and industrial consultations. There is a need to acknowledge the overlap between nursing roles but ensure clear lines of delineation. Role clarity requires more explicit descriptions of accountability, acceptable patient allocation and acceptable levels of supervision. There is a need to be cautious and not

turn nursing roles into task lists. There is also a need for more explicit descriptions of the defined scope of medications and procedures.

Once the nursing roles are determined, updates should be made to the required titles, standards for practice for each role and entry-level education requirements. This will require comprehensive communication and an implementation plan to ensure that all involved in the nursing workforce are aware of the changes.

There is currently a third role in the nursing workforce, the AIN. In the context of the above discussions and conclusions, there needs to be consideration on whether this should also be a regulated nursing role.

8.8.1.2 Develop a career structure that is supported by the appropriate industrial award and titles that represent and recognise different levels of qualifications and experience

The majority of ENs want a career structure that supports them as an EN. This structure could be similar to the RN structure, which includes roles that recognise or require specialised knowledge, skills, qualifications and experience. There is also the opportunity to provide professional progression roles structured like a clinical nurse specialist role for RNs. The top level of the EN career structure could overlap with the first level of the RN career. This would recognise the overlap in nursing roles and the experienced EN, who, in reality, supports the new graduate RNs.

8.8.1.3 Change the enrolled nurse title to represent the role accurately

A title change will require a change in legislation; however, it is clear the title needs to be reviewed, with consideration to several titles to reflect and align with defined levels of post-entry qualifications and the EN's length of experience. Examples from participants included RPNs or LPNs (which would acknowledge that the role is more hands-on, reflecting the intrinsic motivation of *being a nurse* but also regulated) or ASENs, which would recognise additional qualifications and skill sets and differentiate the role from entry-level positions.

8.8.1.4 Facilities and institutions should update their policies and practices to be consistent with the national structure

Facility/institution nursing administrations should review the skill mix, rostering practices, patient allocation and supervision practices and expectations to ensure ENs and

RNs can work as a nursing team in a manner consistent with the NMBA's (2016) *Enrolled Nurse Standards for Practice*. Once this is established at the facility/institution level, a structure should be developed that provides education, support and opportunities at the ward/unit nursing management level. It would also be beneficial to provide a national list of medications (or families of medications) to avoid individual and organisational interpretations and assumptions. In combination, this will support standardised practice and consistency within the nursing workforce.

8.8.1.5 Provide extrinsic motivators, predominately recognition

Develop strategies that recognise the knowledge, skills and experience of the EN, as well as support and celebrate them as an EN, include revising their title, providing career development opportunities, introducing roles that recognise ENs' knowledge, skills and experience while maintaining their SOP (e.g., facilitators for student/new graduate ENs and AINs), and ensuring recognition through the ability to practice to their qualification level.

8.8.2 The enrolled nurse in the working environment

8.8.2.1 Explore and enhance the provision of pull factors

The findings have demonstrated that pull factors include the ENs' professional voice and clinical judgement being valued and considered, opportunities for career progression and improved teamwork exist. These can only exist where the role is understood by members of the multidisciplinary and nursing teams. Therefore, work is needed at the hospital/facility, ward and individual levels to address the lack of understanding to create pull factors. This will require education, mentoring and support, alongside updates to facilities' and institutions' policies and practices to be consistent with the national structure (see Section 8.8.1.4). Further research also needs to explore pull factors. This will enable a counterbalance to the consistent research publications that have reinforced the evidence and effects of push factors.

8.8.2.2 Improve registered nurses' understanding of the enrolled nurse's role

Incorporating the scope and standards of practice for nursing roles and how they work together in the practice of nursing into the BN curriculum is recommended. Further, an education package that clearly describes the EN role and what is/is not included in their scope should be developed and supported with specific examples. This could be

distributed to hospitals/facilities to incorporate into existing education for RNs. Push factors will not shift to pull factors without a change in understanding of the EN role.

8.8.2.3 Ensure all registered nurses understand their role in supervision and delegation when working with enrolled nurses

Ensure RN education pathways include explicit information about how the RN supervises and delegates work to support EN practice. This could incorporate opportunities to practice and develop these skills. Further, incorporate explicit delegation/supervision of the EN role into the BN students' curriculum and clinical placement.

8.8.3 The enrolled nurse as an individual

8.8.3.1 Ensure all enrolled nurses understand their role, scope and standards of practice

Ensure the EN training package has an early focus on their SOP, and their place in the nursing team. Any clinical placement experience must be supported by an RN who understands the EN's SOP. Clinical placements could also be supported by experienced ENs' who understand their role and SOP.

8.8.4 The enrolled nurse in the midwifery workforce

The research also identified challenges that are emerging in the midwifery workforce (see Section 8.3); if these are addressed now, it will increase job satisfaction, decrease occupational stress, improve organisational culture and avoid the professional challenges that have been identified in the nursing workforce. There is an opportunity to design the midwifery workforce and the roles required to support safe, quality care of mothers and babies.

8.8.4.1 Short-term: Reduce confusion in the maternity setting regarding the place of the enrolled nurse and how the registered midwife works with the enrolled nurse

This could be achieved by:

1. revising the NMBA's (NMBA, 2018b) *Midwife Standards for Practice* to incorporate the RMs' role in working with and supervising an EN
2. developing education and mentoring for RMs on teamwork, appropriate patient allocation and supervision when working with an EN

3. determining a minimum level of education and qualification for ENs who work in the midwifery setting
4. revising the NMBA's (NMBA, 2016) *Enrolled Nurse Standards for Practice* to incorporate their role in the midwifery setting.

8.8.4.2 Long-term: Reduce confusion in the maternity setting regarding the place of the enrolled nurse

This could be achieved by:

1. conducting research to determine the skill sets and roles required in the midwifery setting
2. (if there is a need for a second- and/or third-level regulated role) considering, at a professional level, the minimum education required, standards for practice in midwifery, title, career structure and recognition in the industrial awards, with clear delineation between all roles.

8.9 Next steps

An improved understanding of the role of the EN in the nursing workforce will provide opportunities to share what has been learnt and develop strategies to implement changes for improvement. Duckett (2000) identified that without clarifying the role of the nurse or providing a clear delineation between the levels within the nursing workforce, any workforce planning would challenge education providers, funding models at a strategic level and rostering at the ward operational level. This study has indicated that little has changed and identifies why there is confusion, providing the nursing profession with the opportunity to make pragmatic changes. There is a need to stop, reflect and plan an approach to both the nursing and midwifery professions and the levels of nursing and midwifery roles in their respective workforces.

The impetus for this research was to gain a better understanding of the EN's role to inform recommendations so that the current challenges and experiences of ENs are not perpetuated. While some actions can occur at a local level, real change is required at the professional level. The EN who submitted a heartfelt letter needs to be given hope and confidence that maybe, if not for them but for the newer generation of ENs, there will be real change.

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Appendix C: MEDLINE search terms for full-text articles

Table C1.1: MEDLINE search terms

Search no.	Search terms	Result
1	Enrolled nurs*	13,660
2	Division 2 nurs*	10,434
3	Second level nurs*	5556
4	1 OR 2 OR 3	28,468
5	Scope of practice	14,372
6	Nurs* attitudes	96,331
7	Retraining	5235
8	Job satisfaction	31,782
9	5 OR 6 OR 7 OR 8	142,528
10	4 AND 9	3163
11	Limit # 10 to (English summary and yr = '2010–current')	2169
12	Limit # 11 Geography: Australia	45
13	Retrieved for further analysis based on title and abstract	5
	Included in review	**5**

Note * = truncated terms

Included in the review

Cubit, K. & Lopez, V. (2012). Qualitative study of enrolled nurses transition to registered nurses. *Journal of Advanced Nursing*, *68*(1), 206–211. https://doi.org/10.1111/j.1365-2648.2011.05729.x

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Appendix D: List of included literature, Mixed Methods Appraisal Tool score and theme

Table D1.1: List of included literature

Author(s) (Country)	Year	Research design	Summary of key findings	Score[a]	Theme[b]
Birks et al. (Australia)	2010	Descriptive exploratory	EN to RN: More students chose non-metropolitan over metropolitan areas for locations to practice.	High	2.3.1.3
Eager et al. (Australia)	2010	Qualitative (focus groups)	Lack of understanding of the EN's SOP results in team disunity and conflict towards the EN.	Moderate	2.3.1.1
Hutchinson et al. (Australia)	2011	Qualitative (focus groups)	EN to RN: Endorsed ENs grapple with their dual identities, have difficulty reconciling their academic and clinical competencies, and struggle to assimilate with academic learning environments.	High	2.3.1.3
Cubit & Lopez (Australia)	2012	Qualitative (focus groups)	EN to RN: Newly graduated RNs who were previously ENs preferred not to be identified as having previous nursing experience because they feared being treated as already capable of practising as RNs.	High	2.3.1.1, 2.3.1.3
Jacob et al. (Australia)	2012	Literature review	Differences identified between RNs and ENs included registration requirements, educational preparation, supervisory requirements and role expectations.	N/A	2.3.1.1
Kerr et al. (Australia)	2012	Quantitative (survey and examination of incident reports)	The majority of participants supported ENs administering medications. However, differences in opinion were observed between RNs and ENs in their understanding of responsibility and accountability.	High	2.3.1.1
Jacob et al. (Australia)	2013	Literature review	A brief history of the EN role in Australia and emerging issues. Due to the ENs' enhanced SOP, better role delineation is required with the RN role.	N/A	2.3.1.1, 2.3.1.2
Ralph et al. (Australia)	2013	Literature review	EN to RN: Three themes were identified—moving from EN, adapting to the bachelor of nursing and transitioning to RN.	N/A	2.3.1.3
Jacob et al. (Australia)	2014a	Exploratory qualitative (semi-structured interviews)	Comparisons of the education required for RNs and ENs. The central theme was that the educational approach varies based on the nursing award being studied.	High	2.3.1.1, 2.3.1.3
Jacob et al. (Australia)	2014b	Quantitative (survey)	Confusion exists regarding the RN and EN roles on graduation, with no specific role identified for the EN.	High	2.3.1.2

Author(s) (Country)	Year	Research design	Summary of key findings	Score[a]	Theme[b]
Jacob et al. (Australia)	2014c	Exploratory qualitative (cross-sectional survey)	Progression of EN education to the diploma level has resulted in significant changes to ENs' skills, knowledge and critical thinking abilities. The EN diploma has narrowed the differences between RNs and ENs.	High	2.3.1.1, 2.3.1.2.
Armitage et al. (Australia)	2015	Qualitative (written responses)	Three major themes were identified: role delineation, practice issues and professional issues. The findings indicated that ongoing education is required to gain a better understanding of the ENs' SOP.	Low	2.3.1.1.
Brown et al. (Australia)	2015	Exploratory qualitative (interviews)	EN to RN: Three main themes were identified—a new scope of practice, perceptions of capability, and building on experience and knowledge.	High	2.3.1.3.
Cusack et al. (Australia)	2015	Literature review	There is limited discussion in the literature on strategies to ensure effective implementation of the EN with an advanced skills role. There is minimal research on the effectiveness of these roles in enhancing patient care and increasing workforce flexibility and efficiency.	N/A	2.3.1.3.
Tower et al. (Australia)	2015	Integrative review	EN to RN: Students struggled with academic and institutional challenges, becoming learners, managing conflicting demands of outside life and developing a student identity and experienced threats to their sense of professional identity.	N/A	2.3.1.3.
Jacob et al. (Australia)	2016	Interpretative qualitative (semi-structured interviews)	Career expectations differed, with ENs having limited advancement opportunities and RNs having greater career options. Health organisations were unprepared to accommodate increased ENs' SOP and limited work practice through policies stipulating who could perform procedures.	High	2.3.1.1, 2.3.1.2, 2.3.1.3.
Nursing and Midwifery Board of Australia (Australia)	2016	National regulatory board	*Enrolled Nurse Standards for Practice.* These are the core practice standards that provide a national framework for assessing EN practice.	N/A	2.3.1.1.
ANMAC (Australia)	2017	Government document	EN accreditation standards. ANMAC accreditation evaluates whether education providers can ensure their program graduates have the common and transferable skills, knowledge, behaviours and attitudes as articulated in the EN Standards for Practice.	N/A	2.3.1.1.
Endacott et al. (Australia)	2018	Exploratory descriptive (cross-sectional survey)	ENs understood and practised their SOP; RNs did not understand ENs' SOP. Clarifying the roles and SOPs between RNs and ENs is important. Explicit differences in capability, responsibility and accountability between the roles must be clearly articulated to create harmony.	High	2.3.1.1, 2.3.1.2.

Author(s) (Country)	Year	Research design	Summary of key findings	Score[a]	Theme[b]
Leon et al. (Australia)	2019	Explanatory mixed methods (focus groups and questionnaire)	Retention of ENs was influenced by inconsistent SOP, confusion in their SOP and a lack of career progression.	High	2.3.1.1, 2.3.1.2, 2.3.1.3.
McKenna et al. (Australia)	2019	Qualitative (focus groups and individual interviews)	ENs work in diverse practice contexts with differing SOP. Confusion existed regarding ENs' SOP. Care of unstable patients was considered outside ENs' SOP. ENs supervised nursing assistants and new RNs. The lack of a career pathway was considered a limitation to ENs.	High	2.3.1.1, 2.3.1.2, 2.3.1.3.
Schwartz (Australia)	2019	Government document	EN's title does not represent their role. There are few career benefits for ENs as ENs. The specificity in the diploma of nursing competencies should provide employers with knowledge of new EN graduates' tasks. ENs' SOP has increased over the last decade. There is confusion about the limits to their practice, and at times, it blurs with the RN.	N/A	2.3.1.1, 2.3.1.2, 2.3.1.3.
Blay & Smith (Australia)	2020	Integrative review	The continued debate around ENs' SOP contributes to confusion and discriminatory practices, negatively affecting recruitment and retention.	N/A	2.3.1.1.
Lucas et al. (United Kingdom)	2021b	Literature review	Although conducted by United Kingdom authors, the review captured Australian literature. The synthesis demonstrated dichotomies where some second-level nursing roles were devalued, and others had increasing scope and responsibility. The analytic themes suggested that second-level nurses have faced the same issues over decades with little change. Perceptions of second-level nursing roles are primarily influenced by meso (organisational level) and micro (individual/behavioural) factors.	N/A	2.3.1.1, 2.3.1.2.

Note.
EN = enrolled nurse; RN = registered nurse; SOP = scope of practice; N/A = not applicable.
[a] This provides the Mixed Methods Appraisal Tool score.
[b.] The theme cross references to the themes identified in the literature review, see Chapter 2.

Appendix E: Thematic analysis of the literature review findings

Table E1.1: Thematic analysis of the literature review findings

	Author(s) (Country)	Year	Text Segment	Code	Theme
1.	Birks et al. (Australia)	2010	'Exploration and comparison of these characteristics raise a number of issues for discussion, particularly in relation to conversion of level 2 (enrolled) nurses to level 1 (registered) status...'	DEV - EN to RN	3
2.	Eager et al. (Australia)	2010	'The scope of practice issue, conflict and the perceived lack of respect for EN experience and skills was raised by all three of the EN groups…'	SOP - conflict	1
3.	Hutchinson et al. (Australia)	2011	'The findings of this study complement and build upon previous research exploring the EN to BN transition.'	DEV - EN to RN	3
4.	Cubit & Lopez (Australia)	2012	'ENs preferred not to be identified as having previous nursing experience…they feared being treated by their nurse managers as already capable of practicing as RN.'	SOP - confused DEV - EN to RN	1 3
5.	Jacob et al. (Australia)	2012	'A review of the articles identified differences and similarities between registered nurses and ENs across four major areas: registration, educational preparation, supervision requirements and role delineation.'	SOP - roles SOP - supervision RC - role delineation DEV - education prep	1 2 3
6.	Kerr et al. (Australia)	2012	'…approximately one-third of RNs reported a clear understanding of the course requirements for an EN to be granted endorsement for medication administration…'	SOP - medications	1
7.	Jacob et al. (Australia)	2013	'A change in scope of practice for nurses has been primarily driven by staff shortages and economic pressures.'	SOP	1
			'Although education preparation has improved to support the change, the increase in enrolled nurses' scope of practice has invariably led to role confusion and overlap with that of the registered nurse.'	RC - EN to RN	2

8.	Ralph et al. (Australia)	2013	‘Reasons for enrolling in a nursing degree are chiefly aspirational as ENs view the BN program as the primary means for achieving their goals of working with higher and increased responsibility, developing their career, and experiencing more job satisfaction.’	DEV - EN to RN	3
9.	Jacob et al. (Australia)	2014a	‘This ‘closing of the gap’ between degree and diploma students' knowledge and skill levels was supported by most educators, suggesting that changes to diploma education for ENs have decreased differences between ENs and RNs.’ ‘The academic content of EN education, both certificate and diploma, provided a solid preparation for undergraduate study.’	SOP - EN to RN DEV - career	1 3
10.	Jacob et al. (Australia)	2014b	‘Although basic nursing care was undertaken by both graduate enrolled and registered nurses, no specific role was identified for ENs.’	RC - role delineation	2
11.	Jacob et al. (Australia)	2014c	‘Changes to scope of practice guidelines and educational preparation have greatly enhanced abilities of ENs to function at higher levels within the health care system, undertaking aspects of nursing roles previously only held by RNs.’ ‘Variations in training for ENs have resulted in different skill and knowledge levels for nurses accredited at the same level.’	SOP - changes RC - EN levels	1 2
12.	Armitage et al. (Australia)	2015	‘These findings indicate that ongoing education on the different roles and scope of practice of ENs and RNs is required…’	SOP - clarity RC - role delineation	1 2
13.	Brown et al. (Australia)	2015	‘One participant expressed surprise in ‘struggling with time management’ in the registered nurse role because ‘I’ve been an enrolled nurse for a long time, but I found I have struggled a little bit with my time management because they’re just much, much busier wards.’	DEV - EN to RN	3
14.	Cusack et al. (Australia)	2015	‘There is limited discussion in the literature on strategies to ensure effective implementation of the EN with advanced skills role’.	DEV - EN advanced	3

15.	Tower et al. (Australia)	2015	‘Themes emerged that suggested students struggled with academic and institutional challenges, becoming learners, managing conflicting demands of outside life, developing a student identity and experienced threat to their sense of professional identity’.	DEV - EN to RN	3
16.	Jacob et al. (Australia)	2016	‘Other EN educators felt that diploma ENs should be able to care for any patient, despite how acutely ill….this is seen, in part due to increasing knowledge and ability of ENs to administer medications…’	SOP - medications	1
			‘Changes to EN education to diploma level had resulted in many similarities between roles of diploma EN and degree prepared nurses.’	RC - role delineation	2
			‘RNs were felt to have greater career advancement than ENs.’	DEV - career	3
17.	Nursing and Midwifery Board of Australia (Australia)	2016	Standards for Practice: Enrolled Nurses. ‘The Standards for Practice: Enrolled nurses are the core practice standards that provide the framework for assessing enrolled nurse practice.’	SOP	1
18.	Australian Nursing and Midwifery Accreditation Council (Australia)	2017	EN accreditation standards. ‘Australian Nursing and Midwifery Accreditation Council evaluates whether education providers, on the evidence they provide, can ensure program graduates have the common and transferable skills, knowledge, behaviours and attitudes as articulated in the relevant national competency standards or standards for practice.’	SOP	1
19.	Endacott et al. (Australia)	2018	‘ENs in this survey understood their scope of practice and mostly did not undertake tasks for which they were unprepared.	SOP - understood by EN	1
			‘Enrolled nurse survey respondents believed that they operated equally to many RNs.’	RC - EN to RN	2

20.	Leon et al. (Australia)	2019	‘Confusion and lack of clarity around the ENs’ scope of practice was a concern for safe and quality person centred care…’ ‘A perception from the EN was that they do the same work as an RN…’ ‘The lack of standardised practice across the HS contributed to their feelings of being undervalued and underutilised’. ‘ENs’ participated in education and training for self-satisfaction and personal interest, not for their career progression.’	SOP - lack of clarity RC - EN to RN RC - lack of standardised practice DEV - career	1 2 3
21.	McKenna et al. (Australia)	2019	‘Whilst most ENs understood their scope of practice, they felt they were not able to work to their full scope of practice’. ‘Confusion also existed within the EN cohort about differences between themselves and RNs. Many described common skills being performed by both groups’. ‘Many ENs saw that the only career pathway for them was to convert to an RN role.’	SOP - limited RC - EN to RN DEV - EN to RN	1 2 3
22.	Schwartz, (Australia)	2019	‘Over the last ten years, the scope of practice of the enrolled nurse has grown and at the same time, the scope of practice of the registered nurse has not. This has caused role blurring between the two roles and some professional tension.’ ‘It seems that additional study at the vocational education and training level brings few career benefits.’	SOP - expanded RC - EN to RN DEV - as an EN	1 2 3
23.	Blay & Smith, (Australia)	2020	‘…continued debate around scope of practice had led to confusion and discrimination.’	SOP - confusion	1
24.	Lucas et al. (UK)	2021	‘Four analytic themes were identified: undifferentiated role; efficient but limited; subordinated task-doers; and a broadening scope and strengthen identity. The analytic themes in this synthesis suggest that second-level nurses have faced the same issues over decades with little change’.	SOP - broadening RC - undifferentiated	1, 2

Note. EN = enrolled nurse; RN = registered nurse; SOP = scope of practice; DEV = career development; RC = role confusion;; BN = bachelor of nursing

Appendix F: Master Participant Information Sheet

[Insert site logo]
Participant Information Sheet
Valuing enrolled nurses

[Insert site name]

Title	*Valuing Enrolled Nurses: An Exploratory Sequential Mixed Methods Study to Better Understand the Role of the Enrolled Nurse in the Australian Healthcare Context*
Short title	*Valuing Enrolled Nurses: The Role of the Enrolled Nurse*
Protocol number	[Insert protocol number]
Principal investigator	Rebecca Leon
Location	*[Insert location]*

Part 1: What does my participation involve?

1. Introduction

You are invited to take part in this research project: *Valuing Enrolled Nurses: An Exploratory Sequential Mixed Methods Study to Better Understand the Role of the Enrolled Nurse in the Australian Healthcare Context*. This is because you are a member of the nursing and midwifery workforce. The research project is aiming to gain a better understanding of the role of the enrolled nurse (EN) in the Australian healthcare context.

This research is being conducted because evidence continues to identify confusion around the role of the EN, lack of professional development and that ENs feel undervalued and underutilised. This information, together with continued EN workforce shortages, reinforced the need for further research to ensure a valued and sustainable EN workforce. As a result, this project will explore your ideas and perceptions of the role of the EN.

This Participant Information Sheet tells you about the research project. It explains what is involved. Knowing what is involved will help you decide whether you want to take part in the research.

Please read this information carefully. Ask questions about anything that you do not understand or want to know more about. Before deciding whether or not to take part, you might want to talk about it with a relative or friend.

Participation in this research is voluntary. If you do not wish to take part, you do not have to. If you decide you want to take part in the research project, you will be asked to sign the consent section. By signing it, you are telling us that you:

- understand what you have read
- consent to take part in the research project.

You will be given a copy of this Participant Information Sheet to keep.

2. What is the purpose of this research?

The aim of this study is to better understand the role of the EN in the Australian healthcare context. Therefore, the objectives are to:

- clearly define the EN's scope of practice
- delineate the role of the EN from other nursing roles
- explore what professional development and a career pathway for ENs is
- explore the professional voice of ENs and the value of their role.

Everyone has a right to feel valued and to have a place in the world. Within the healthcare team, this translates to each member feeling they are valued and can contribute to the best outcome for the patient. Evidence continues to identify confusion around the role of the EN, the lack of professional development and that the ENs feel undervalued and underutilised. This information, together with continued EN workforce shortages, reinforced the need for further research to ensure a valued and sustainable EN workforce. As a result, this project will explore your ideas and perceptions of the role of the EN.

The results of the study will provide a better understanding of the role of the EN. This, in turn, will support increased awareness and provide evidence to support the development of strategies to improve the professional nature of the role of the EN. The ultimate benefit is a valued and sustained, not declining, EN workforce.

The results of this research will be used by the Principal Investigator, Rebecca Leon, to obtain a Doctor of Philosophy in Health Sciences.

3. What does participation in this research involve?

Participation involves the opportunity to be involved in a focus group and then later complete a questionnaire.

There will be two defined groups. Group 1 will be ENs, and Group 2 will be other nursing and midwifery staff (this may include registered nurses and registered midwives who may be working in clinical, education or management positions and assistants in nursing).

The project is divided into two phases:

1. Focus groups
2. Questionnaire

Phase 1: Focus groups

Focus groups will be scheduled to capture a diverse range of work environments—public and private health services in metropolitan, regional and rural areas. Focus groups will be held separately for each of the groups identified above. An invitation to participate in a focus group will be sent via email to nursing and midwifery staff who have an active email address with participating health services and professional associations. Information will also be circulated on a flyer to capture those nursing and midwifery staff without email addresses.

All those participating in a focus group will be asked to sign a consent form. By signing it, you are telling us that you:

- understand what you have read
- consent to take part in the recorded focus group.

It is anticipated that the focus groups will take approximately 45 minutes. They will be located within the facility and scheduled in consultation with local management to minimise operational impact while facilitating staff the opportunity to participate.

Phase 2: Questionnaire

The data from the focus groups will be used to develop two questionnaires—one for each group. These will be circulated to all nursing and midwifery staff who have an active email account in the participating health services and professional associations. Hard copies will be made available on request. You will only need to complete the questionnaire once. Consent will be implied when you complete and submit your questionnaire. There will not be a separate consent form that you need to complete.

This research project has been designed to make sure the researcher interprets the results in a fair and appropriate way.

There are no costs associated with participating in this research project, nor will you be paid.

4. What do I have to do?

Participate in one focus group.

A focus group for ENs will be held: [Insert details included in the site-specific version]

A focus group for other nursing and midwifery staff will be held: [Insert details included in the site-specific document]

The focus group will provide information to draft a questionnaire. Once the questionnaire has been prepared, we will also ask that you complete the questionnaire.

5. Do I have to take part in this research project?

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, any data collected cannot be withdrawn.

If you do decide to take part, you will be given this Participant Information Sheet, and if you participate in a focus group, you will be asked to complete a consent form. You will be given a copy of both to keep.

Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your relationship with [insert institution name].

6. What are the possible benefits of taking part?

We cannot guarantee or promise that you will receive any benefits from this research; however, possible benefits may include a better understanding of the role of the EN. This, in turn, will support increased awareness and provide evidence to support the development of strategies to improve the professional nature of the role of the EN, improving the working relationship within the nursing/midwifery workforce because everyone will have a clearer understanding of their respective roles and scope of practice. Within the healthcare team, this translates to each member feeling they are valued and

can contribute to the best outcome for the patient. The ultimate benefit is a valued and sustained EN workforce.

7. What are the possible risks and disadvantages of taking part?

Risks to the participants may include the following:

- Time inconvenience of participation—to minimise the effects on time and inconvenience, focus groups will be coordinated with a local contact to ensure they are scheduled around existing meetings and organisation requirements.
- Participant distress—due to the nature of the discussion, there is a risk, albeit unlikely, that you may become distressed as a result of your participation in the research. A progressive, supportive approach will be applied by the researcher if you are becoming distressed. This will begin with an acknowledgement of your distress and requesting whether you would like to have a break, at which time the recording of the focus group will be stopped. You may choose not to continue. You will be offered a support person, asked if there is anyone that can be contacted and referred to your respective employee assistance program or other appropriate support.

8. What if I withdraw from this research project?

You may leave a focus group at any time. Please note that if you take part and then withdraw your recorded comments in a focus group or your submitted questionnaire will not be retrievable because it is received de-identified.

Part 2: How is the research project being conducted?

9. What will happen to information about me?

All aspects of the study, including the results, will be confidential, and only the researcher will have access to this information. If you participate in a focus group, any information that has the potential to identify you or another person or setting (e.g., a ward or unit, or names of people) will be removed on transcription.

Signed consent forms and any hard copy questionnaires will be scanned and stored electronically on a password-protected computer in a password-protected file. Only the members of the research team will have access to these files. Paper copies will be disposed of securely.

De-identified transcripts will be stored electronically (password-protected). The digital recordings of the focus groups will be deleted once transcripts have been prepared and checked for accuracy.

All data and materials related to the study will be kept for five years after completion of the study as required by The National Health and Medical Research Council. All computer files will be destroyed/deleted five years after the completion of the project. Records in electronic format will be destroyed/deleted by reformatting or rewriting to ensure the data and any 'pointers' in the system are inaccessible.

It is anticipated that the results of this research project will be published and/or presented in a variety of forums. In any publication and/or presentation, information will be provided in such a way that you cannot be identified. A thesis will be written, together with a report of the findings and any recommendations submitted to each participating health services' director of nursing and midwifery, the Nursing and Midwifery office of the NSW Ministry of Health, and the executive of each of the participating professional associations. At all times and in any publication and/or presentation, information will be provided in such a way that you cannot be identified.

10. Who is organising and funding the research?

This research project is being conducted by Rebecca Leon as her thesis for a Doctor of Philosophy in Health Sciences through the University of Wollongong.

This project is not being funded.

11. Who has reviewed the research project?

All research in Australia involving humans is reviewed by an independent group of people called a human research ethics committee (HREC). The ethical aspects of this research project have been approved by the HREC of South Western Sydney Local Health District.

This project will be carried out according to the *National Statement on Ethical Conduct in Human Research 2007* (NHMRC, 2015). This statement has been developed to protect the interests of people who agree to participate in human research studies.

12. Further information and whom to contact

The person you may need to contact will depend on the nature of your query.

If you want any further information concerning this project, you can contact the principal investigator at or via email at rjl701@uowmail.edu.au

13. Complaints contact person

This study has been approved by the South Western Sydney Local Health District HREC. Any person with concerns or complaints about the conduct of this study should contact the Research and Ethics Office at Liverpool Hospital Locked Bag 7103, Liverpool BC NSW 1871, or via phone at 02 8738 8304, fax at 02 8738 8310, email at swslhd-ethics@health.nsw.gov.au, or their website at http://www.swslhd.nsw.gov.au/ethics/default.html, and quote HE18/097.

Thank you for taking the time to consider this study.

If you wish to take part in it, please sign the attached consent form.

This information sheet is for you to keep.

Appendix G: Questionnaire flyer

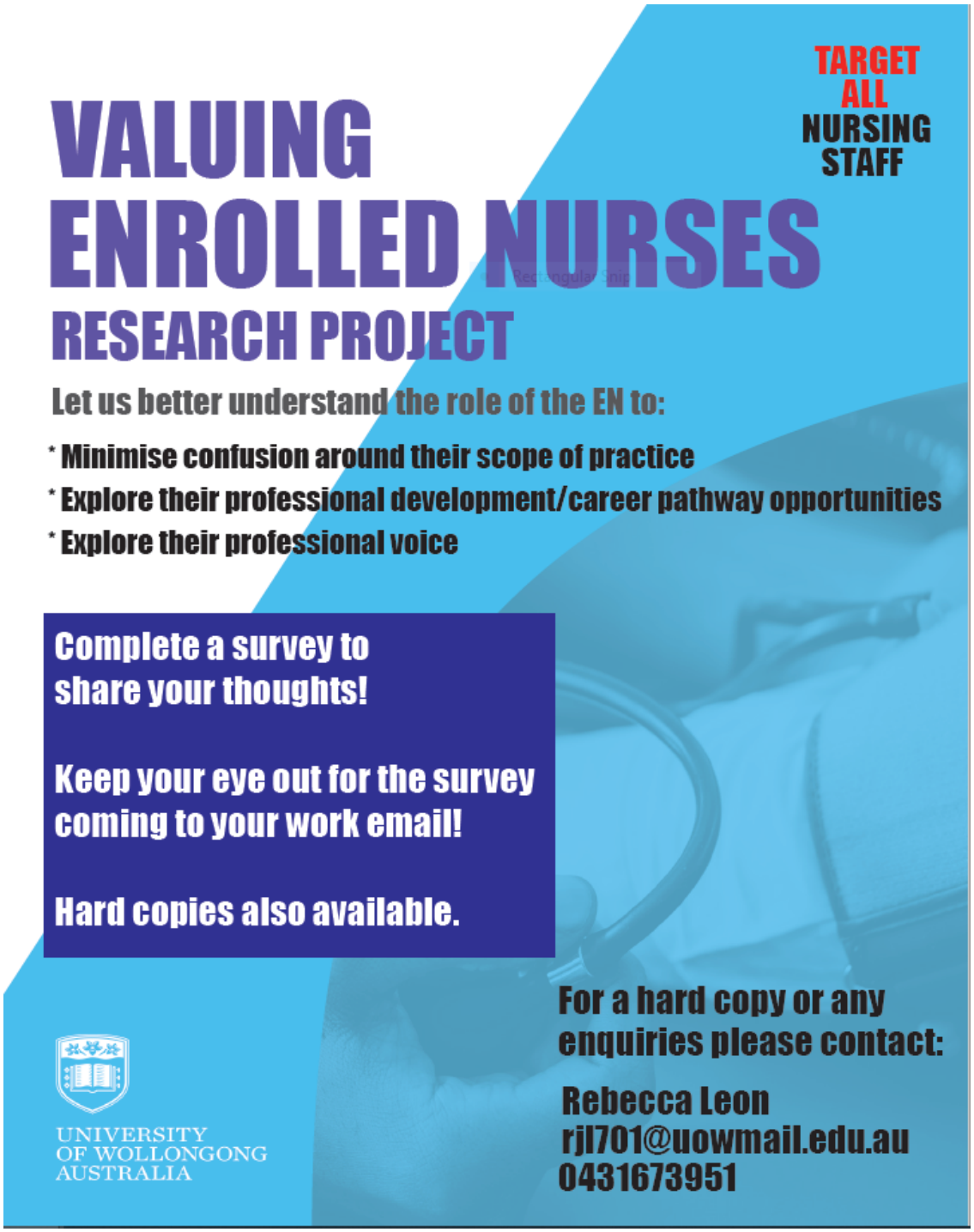

Figure G1.1: Questionnaire flyer

Appendix H: Focus group consent form

[Insert site logo]

[Insert site name]

Consent Form

[To be used in conjunction with a Participant Information Sheet]

Valuing Enrolled Nurses: An Exploratory Sequential Mixed Methods Study to Better Understand the Role of the Enrolled Nurse in the Australian Healthcare Context

1. I,_____
   of_____
   agree to participate in the study described in the Participant Information Sheet attached to this form.
2. I acknowledge that I have read the Participant Information Sheet, which explains why I have been selected, the aims of the study and the nature and the possible risks of the investigation, and the statement has been explained to me to my satisfaction.
3. Before signing this consent form, I have been given the opportunity of asking any questions relating to any possible physical and mental harm I might suffer as a result of my participation, and I have received satisfactory answers.
4. I understand that I can withdraw from the study at any time without prejudice to my relationship with the *[insert site]*.
5. I agree that research data gathered from the results of the study may be published, provided that I cannot be identified.
6. I acknowledge receipt of a copy of this consent form and the Participant Information Sheet.

_____ _____ _____

Signature of participant (please PRINT name) **Date**

_____ _____ _____

Signature of witness (please PRINT name) **Date**

_____ _____ _____

Signature of investigator (please PRINT name) **Date**

Appendix I: Focus group email invitation

Email template for focus groups

Subject line: Invitation to participate in the Valuing Enrolled Nurses Research Project

Dear colleagues,

You are invited to take part in a research project: *Valuing Enrolled Nurses: The Role of the Enrolled Nurse*. The aim of this research is to gain a better understanding of the role of the EN in the Australian healthcare context. You are invited to participate in a focus group.

Please find attached the following:

- Participant Information Sheet—this document provides you with detailed information about the research project.
- Consent form—you will be required to complete this consent form if you participate in a focus group.

The focus group for enrolled nurses will be held:

The focus group for other nursing and midwifery staff will be held:

Participation is entirely voluntary. The privacy and anonymity of all participants will be maintained at all times.

The ethical aspects of this research project have been approved by the Human Research Ethics Committee of the South Western Sydney Local Health District.

If you would like to participate in this study or require further information, please contact Rebecca Leon on Ph: or email: rjl701@uow.edu.au

Appendix J: Focus group flyer

Figure J1.1: Focus group flyer

Appendix K: Code book—the role of the enrolled nurse

Table K1.1: Code book—the role of the enrolled nurse

Name	Description	Focus groups	References
The EN as an individual	From the perspective of the EN, what they perceive as their role, identity and titles that culminate in their value as an individual EN.	10	384
Identity	Captures being a nurse and the title of the EN.	10	87
Assistants in nursing in the workplace	Comparison of EN to the assistant in nursing and the difference in their identity and place in the team.	5	10
Identity as a nurse	The characteristics of a nurse that identify and capture being a nurse.	6	48
Title	The name of the role.	9	28
Valued	From the perspective of the EN, how they feel and are valued.	10	297
Cheaper than RN	EN believes they are working as an RN but paid less.	5	14
Knowledge	Includes education to increase knowledge and understanding/respecting the knowledge of the EN.	3	48
Professional voice	When thoughts, opinions and ideas are heard and respected in forums.	7	22
Trust	Honest, sincere, reliable.	10	35
Years of experience	Length of time as an EN is or is not acknowledged.	3	20
The EN in the workplace	This captures how the EN works in the unit. It includes workload, confusion and supervision of the EN.	10	1003
Confusion	Inability to determine which role, predominately between the EN and RN roles.	10	737
Not understanding the EN role	Participants do not understand the EN scope and standards for practice.	10	193
EN expectations	What is expected of the EN in their nursing practice.	8	51
EN medications	The role of the EN to administer defined medications.	9	70
Expectations of doctors	What the doctors expect of the ENs.	5	13
Expectations of RNs	What the RNs expect of the ENs.	10	106
Lack of standardisation	Inability to practice their nursing skills consistently.	9	60
Midwifery	Profession that is focussed on the care of pregnant women and their babies.	3	28

Name	Description	Focus groups	References
Only RNs and registered midwives	If there were no ENs, everyone would know what they needed to do.	1	2
RNs' scope of practice	The RNs' scope of nursing practice.	6	14
Same as RN	The perception that the EN and RN work the same in their nursing practice.	10	43
Disparity in work	The difference in workload between the RN and EN roles.	3	30
Workload	The heavy load of the ENs.	3	30
Supervision in practice	The supervision of the EN by the RN.	10	236
Patient load	Discussion about patient load demonstrates the lack of supervision in practice.	10	71
Responsibility for actions	Accountability for their nursing practice.	8	34
The EN in the profession	This captures career pathway options for the EN and how they are recognised.	10	321
Career pathway	Includes retirement and transitioning to the RN role.	10	170
Education for an EN	Education that is specific for the EN role.	10	113
Transitioning to the RN role	ENs who are studying to become an RN.	10	36
Recognition	Captures industrial awards and education.	10	151
Completed education (not allowed to to practice the skill)	There is no recognition for the EN when they have completed further education.	4	27
Culture	How the role of the EN is recognised and treated in the workplace.	8	80
EN industrial award	A legal document that outlines the pay and conditions of employment.	4	26
Money to support education	The need to cover education costs	4	17
Team	All aspects of working in a team and how we work together (or not)—the good and bad experiences or not in clinical judgement.	10	159
Teamwork	How members of the nursing workforce and multidisciplinary team work together.	10	120
Not relevant	EN's perspective of nursing students.	3	24
Not relevant	Patients' perspective of the EN from the EN.	2	5

Note. EN = enrolled nurse; RN = registered nurse.

Appendix L: Questionnaire email invitation

Email template for the questionnaire

Subject line: Invitation to participate in the Valuing Enrolled Nurses Research Project

Dear colleagues,

You are invited to take part in a research project: *Valuing Enrolled Nurses: The Role of the Enrolled Nurse*. The aim of this research is to gain a better understanding of the role of the EN in the Australian healthcare context. You are invited to participate in a questionnaire.

Please find attached the following:

- Participant Information Sheet—this document provides you with detailed information about the research project.
- Link to the questionnaire—click on this link to take you to the questionnaire. It is anticipated that it will take you approximately 10 minutes.

Participation is entirely voluntary. The privacy and anonymity of all participants will be maintained at all times. No identifying information is requested in the questionnaire.

The ethical aspects of this research project have been approved by the Human Research Ethics Committee of South Western Sydney Local Health District.

If you would like to participate in this study or require further information, please contact Rebecca Leon on Ph: 02 or email: rjl701@uow.edu.au

Appendix M: Questionnaire Participant Information Sheet

[Insert site logo]

Participant Information Sheet

Valuing enrolled nurses

[Insert site name]

Title	*Valuing Enrolled Nurses: An Exploratory Sequential Mixed Methods Study to Better Understand the Role of the Enrolled Nurse in the Australian Healthcare Context*
Short title	*Valuing Enrolled Nurses: The Role of the Enrolled Nurse*
Protocol number	[Insert protocol number]
Principal investigator	Rebecca Leon
Location	*[Insert location]*

Part 1: What does my participation involve?

1. Introduction

You are invited to take part in this research project: *Valuing Enrolled Nurses: An Exploratory Sequential Mixed Methods Study to Better Understand the Role of the Enrolled Nurse in the Australian Healthcare Context*. You have received this invitation because you are a member of the nursing and midwifery workforce. The research project is aiming to gain a better understanding of the role of the enrolled nurse (EN) in the Australian healthcare context.

This research is being conducted because evidence continues to identify confusion around the role of the EN, the lack of professional development and that ENs feel undervalued and underutilised. This information, together with continued EN workforce shortages, reinforced the need for further research to ensure a valued and sustainable EN workforce. As a result, this project will explore your ideas and perceptions of the role of the EN.

This Participant Information Sheet tells you about the research project. It explains what is involved. Knowing what is involved will help you decide if you want to take part in the research.

Please read this information carefully. Ask questions about anything that you do not understand or want to know more about. Before deciding whether or not to take part, you might want to talk about it with a relative or friend.

Participation in this research is voluntary. If you do not wish to take part, you do not have to.

You may keep a copy of this Participant Information Sheet.

2. What is the purpose of this research?

Evidence continues to identify confusion around the role of the EN, the lack of professional development and that the ENs feel undervalued and underutilised. This information, together with continued EN workforce shortages, reinforced the need for further research to ensure a valued and sustainable EN workforce. As a result, this project will explore your ideas and perceptions of the role of the EN.

The aim of this study is to gain a better understanding of the role of the EN in the Australian healthcare context. Therefore, the objectives are to:

- clearly define the EN's scope of practice
- delineate the role of the EN from other nursing roles
- explore what professional development and a career pathway for ENs is
- explore the professional voice of ENs and the value of their role.

The results of the study will provide a better understanding of the role of the EN. This, in turn, will support increased awareness and provide evidence to support the development of strategies to improve the professional nature of the role of the EN. The ultimate benefit is a valued and sustained, not declining EN workforce.

The results of this research will be used by the Principal Investigator, Rebecca Leon, to obtain a Doctor of Philosophy in Health Sciences.

3. What does participation in this research involve?

The project is divided into two phases:

1. Focus groups
2. Questionnaire

Phase 1: Focus groups

Focus groups have been conducted across New South Wales, both in public and private health services. In total, 12 focus groups were conducted: six specifically for ENs and six for all other nursing and midwifery staff. The data collected from these focus groups have been collated and used to develop the questionnaire.

Phase 2: Questionnaire

You are now invited to participate in this research by completing the questionnaire. The questions have been developed from the information received during the focus groups. A single link to a survey will be circulated, by way of invitation, to all nursing and midwifery staff who have an active email account in the participating health services and professional associations. A hard copy will be made available on request. You will only need to complete the questionnaire once. Consent is implied by the completion and submission of your questionnaire. There is no separate consent form that you need to complete.

There are no costs associated with participating in this research project, nor will you be paid.

4. What do I have to do?

Complete the questionnaire via the link in your email.

If you have a problem with the link or prefer to complete a hard copy questionnaire, please contact the principal investigator at rjl701@uowmail.edu.au or by phone at 8738 5753. A hard copy survey with a reply paid pre-addressed envelope will be sent to you.

5. Do I have to take part in this research project?

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, any data collected cannot be withdrawn.

If you do decide to take part, you will be given this Participant Information Sheet, and if you participate in a focus group, you will be asked to complete a consent form. You will be given a copy of both to keep.

Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your relationship with [insert institution].

6. What are the possible benefits of taking part?

We cannot guarantee or promise that you will receive any benefits from this research; however, possible benefits may include a better understanding of the role of the EN. This, in turn, will support increased awareness and provide evidence to support the development of strategies to improve the professional nature of the role of the EN and improve the working relationship within the nursing/midwifery workforce because everyone will have a clearer understanding of their respective roles and scope of practice. Within the healthcare team, this translates to each member feeling they are valued and can contribute to the best outcome for the patient. The ultimate benefit is a valued and sustained EN workforce.

7. What are the possible risks and disadvantages of taking part?

Risks to the participants may be time inconvenience of participation. The questionnaire has been designed to take approximately 10 minutes.

8. What if I withdraw from this research project?

You may choose not to submit the questionnaire; however, once you have submitted this electronically, your responses will not be retrievable as they are received de-identified.

Part 2: How is the research project being conducted?

9. What will happen to information about me?

All aspects of the study, including the results, will be confidential, and only the researcher will have access to this information. If you participated in a focus group, any information that has the potential to identify you or another person or setting (e.g., a ward or unit, or names of people) has been removed on transcription.

Any hard copy questionnaires will be scanned and stored electronically on a password-protected computer in a password-protected file. Only the members of the research team will have access to these files. Paper copies will be disposed of securely.

De-identified transcripts will be stored electronically (password-protected). The digital recordings of the focus groups will be deleted once transcripts have been prepared and checked for accuracy. The consent forms from the focus groups have been scanned and stored electronically in a password-protected computer in a password-protected file. Only

the members of the research team will have access to these files. Paper copies have been disposed of securely.

All data and materials related to the study will be kept for five years after the completion of the study, as required by The National Health and Medical Research Council. All computer files will be destroyed/deleted five years after the completion of the project. Records in electronic format will be destroyed/deleted by reformatting or rewriting to ensure the data and any 'pointers' in the system are inaccessible.

It is anticipated that the results of this research project will be published and/or presented in a variety of forums. In any publication and/or presentation, information will be provided in such a way that you cannot be identified. A thesis will be written, together with a report of the findings and any recommendations submitted to each participating health services' director of nursing and midwifery, the Nursing and Midwifery office of the NSW Ministry of Health and the executive of each of the participating professional associations. At all times and in any publication and/or presentation, information will be provided in such a way that you cannot be identified.

10. Who is organising and funding the research?

This research project is being conducted by Rebecca Leon as her thesis for a Doctor of Philosophy in Health Sciences through the University of Wollongong. This project is not being funded.

11. Who has reviewed the research project?

All research in Australia involving humans is reviewed by an independent group of people called a human research ethics committee (HREC). The ethical aspects of this research project have been approved by the HREC of the South Western Sydney Local Health District.

This project will be carried out according to the *National Statement on Ethical Conduct in Human Research 2007* (NHMRC, 2015). This statement has been developed to protect the interests of people who agree to participate in human research studies.

12. Further information and whom to contact

The person you may need to contact will depend on the nature of your query.

If you want any further information concerning this project, you can contact the principal investigator at or via email at rjl701@uowmail.edu.au

13. Complaints contact person

This study has been approved by the South Western Sydney Local Health District HREC. Any person with concerns or complaints about the conduct of this study should contact the Research and Ethics Office at Liverpool Hospital Locked Bag 7103, Liverpool BC NSW 1871, or via phone at 02 8738 8304, fax at 02 8738 8310, email at swslhd-ethics@health.nsw.gov.au or their website at http://www.swslhd.nsw.gov.au/ethics/default.html, and quote HE18/097.

Thank you for taking the time to consider this study.

If you wish to take part in it, please sign the attached consent form.

Appendix N: Correlation matrix (principal components analysis with promax—oblique)

Table M1.1: Correlation matrix

(*n* = 253)	Factor loadings					Communalities	*M* ± *SD*
Item	**1**	**2**	**3**	**4**	**5**	h^2	
ENs' SOP (α = 0.85)							
1. I feel RNs have a clear understanding of the EN's SOP.	0.91					0.84	2.53 ± 0.72
2. I feel RMs have a clear understanding of the EN's SOP.	0.90					0.81	2.50 ± 0.69
3. I feel assistants in nursing have a clear understanding of the EN's SOP.	0.72					0.50	2.26 ± 0.70
3. I feel ENs have a clear understanding of their SOP.	0.71					0.61	2.89 ± 0.70
5. I feel ENs are supported to work within their SOP.	0.64					0.59	2.72 ± 0.67
Administration of S8s (α = 0.79)							
6. The EN does everything except for the S8s and should be allocated a workload as a RM.		0.89				0.77	3.03 ± 0.83
7. The EN does everything except for the S8s and should be allocated a workload as a RN.		0.84				0.71	2.74 ± 0.87
8. The EN does everything except S8s, and they are allocated a workload as a RM.		0.74				0.63	2.76 ± 0.95
9. The EN does everything except for the S8s, and they are allocated a workload as a RN.		0.63				0.65	2.32 ± 0.97
Teamwork (α = 0.93)							
10. I would rather work with RNs only.			0.95			0.93	3.33 ± 0.71
11. I would rather work with RMs only.			0.95			0.93	3.32 ± 0.74
Valuing the EN (α = 0.89)							
12. I feel ENs are not valued members of the multidisciplinary healthcare team.				0.94		0.86	3.00 ± 0.89
13. I feel ENs are not valued members of the nursing team.				0.91		0.88	3.14 ± 0.83
Remuneration (α = 0.59)							
14. Greater financial incentives would keep ENs as ENs.					0.85	0.68	2.92 ± 0.82
15. The EN's pay reflects the SOP of ENs.					0.79	0.73	2.85 ± 0.80
Eigenvalues	4.08	2.71	1.91	1.41	1.01		
Explained variance	27.21	18.08	12.71	9.42	6.70		

Note. EN = enrolled nurse; SOP = scope of practice; RN = registered nurse; RM = registered midwife; S8s = Schedule 8 medications.

Appendix O: Self-administered questionnaire

Valuing enrolled nurses

Questionnaire for enrolled nurses and other nursing/midwifery staff

In 2018, focus groups were conducted across NSW at both public and private health services. The data from these focus groups have been used to develop this questionnaire.

There are no right or wrong responses; please respond based on your experiences, perceptions, beliefs and opinions. Your comments will contribute to a better understanding of the role of the enrolled nurse. This survey will take you approximately 10 minutes to complete.

Participation is voluntary, and all information is confidential and anonymous.

Please note that once your responses are submitted, they cannot be removed from the dataset.

Please complete the questionnaire by marking the box that corresponds to your answer. Some questions will allow you to choose more than one answer, in which case, please choose all that apply.

Section A: Demographics

1. In which sector do you work?
   - □ Public health service
   - □ Private health service
   - □ Non-government organisation (NGO)
   - □ Other, please specify_____

2. In which state/territory do you currently work?
   - □ Australian Capital Territory
   - □ New South Wales
   - □ Northern Territory
   - □ Queensland
   - □ South Australia
   - □ Tasmania
   - □ Victoria
   - □ Western Australia

3. What gender do you identify as?
   - □ Male
   - □ Female
   - □ Indeterminate/intersex/unspecified

4. When were you born?
   - □ Pre-1943 and 1943
   - □ 1944–1964
   - □ 1965–1979
   - □ 1980–1994
   - □ 1995–2015

5. What best describes your current role? (If they tick any of the registered nurse options, go to Question 6, otherwise, go straight to Question 7)
   - □ Assistant in nursing/midwifery
   - □ Enrolled nurse with medication administration rights—clinical role
   - □ Enrolled nurse with medication administration rights—non-clinical role
   - □ Enrolled nurse without medication administration rights—clinical role
   - □ Enrolled nurse without medication administration rights—non-clinical role
   - □ Registered nurse—clinical role
   - □ Registered nurse—management role
   - □ Registered nurse—education role
   - □ Registered midwife—clinical role
   - □ Registered midwife—management role
   - □ Registered midwife—education role
   - □ Other, please specify_____

6. Were you an enrolled nurse before you became a registered nurse or midwife?
   - □ Yes
   - □ No

7. What is the highest level of education for your role?
   - □ Hospital-trained
   - □ Certificate III
   - □ Certificate IV
   - □ Diploma
   - □ Advanced diploma
   - □ Bachelor
   - □ Graduate certificate
   - □ Graduate diploma
   - □ Masters
   - □ PhD
   - □ Other, please specify_____

8. How long have you been working in your role?
   - □ Less than five years
   - □ Five to 10 years
   - □ 11 to 20 years
   - □ 21 to 30 years
   - □ More than 31 years

9. In which area do you work? If you work across a number of areas, please choose all that apply.
   - □ Acute facility—medical
   - □ Acute facility—surgical
   - □ Acute facility—critical care
   - □ Acute facility—perioperative
   - □ Acute facility—aged care
   - □ Paediatrics
   - □ Maternity
   - □ Child and family health
   - □ Community
   - □ Mental health
   - □ Drug health
   - □ Clinics
   - □ General practice
   - □ Whole of acute hospital
   - □ Aged care facility—low-care
   - □ Aged care facility—high-care
   - □ Other, please specify_____

10. Which term best describes where you work?
   - □ Metropolitan
   - □ Regional
   - □ Rural
   - □ Other, please specify_____

For those who ticked any of the enrolled nurse options in Question 5, include Questions 11 to 14

11. Which professional association(s) are you a member of? Choose all that apply.
   - □ Enrolled Nurse Professional Association NSW (i.e., ENPA)
   - □ National Enrolled Nurse Association of Australia (i.e., NENA)
   - □ Australian College of Nursing (i.e., ACN)
   - □ Other, please specify_____
   - □ Not a member of any professional association

12. Have you considered leaving your role as an enrolled nurse?
   - □ Yes (go to Question 12(a) and then Question 13)
   - □ No

12a. What were your reasons for considering leaving your role as an enrolled nurse? Choose all that apply.

- □ I had no intention of staying an enrolled nurse
- □ Workload issues
- □ Limited career progression as an enrolled nurse
- □ Finding there is increased responsibility as an enrolled nurse
- □ The role of the enrolled nurse is not valued
- □ The role of the enrolled nurse is not understood
- □ Retirement
- □ To become a registered nurse
- □ To become a registered midwife
- □ I have felt no job satisfaction as an enrolled nurse
- □ Financial reasons (not enough pay)
- □ Clinical judgement is not valued or considered
- □ Professional voice is not valued or considered
- □ Bullying and harassment within the workplace
- □ Other, please specify_____

13. What is keeping you in your role as an enrolled nurse? Choose all that apply.

- □ Opportunities for career progression as an enrolled nurse
- □ Clinical judgement is valued and considered
- □ Professional voice is valued and considered
- □ Improved teamwork
- □ Financial incentives
- □ Family/personal circumstances
- □ Other, please specify_____

14. Are you considering working towards a bachelor of nursing (registered nurse) or a bachelor of midwifery (registered midwife) within the next five years?

- □ I am currently enrolled in a bachelor of nursing (registered nurse)
- □ I am currently enrolled in a bachelor of midwifery (registered midwife)
- □ Yes, but not yet enrolled
- □ No
- □ Undecided

Section B: The role of the enrolled nurse

All participants from this point

15. Does the title 'enrolled nurse' reflect the role?
    - □ Yes (go to Question 17)
    - □ No (go to Question 16)
    - □ Unsure (go to Question 16)

16. Which title best reflects the role?
    - □ Enrolled nurse—notation on registration for those unable to administer medications
    - □ Endorsed enrolled nurse
    - □ Registered nurse (division 2)
    - □ Other, please specify_____

16(a). Why? _____

Using the scale below, please identify your response regarding the following statements.

	Strongly disagree	**Disagree**	**Agree**	**Strongly agree**
1. The enrolled nurse does everything except for the S8s, and they are allocated a workload as a registered nurse.				
2. The enrolled nurse does everything except for the S8s, and they are allocated a workload as a registered midwife.				
3. The enrolled nurse does everything except for the S8s and should be allocated a workload as a registered nurse.				
4. The enrolled nurse does everything except for the S8s and should be allocated a workload as a registered midwife.				

17. Is the enrolled nurses' clinical judgement valued and considered by other members of the multidisciplinary team?
    - □ Yes (go to Question 23)
    - □ No (go to Question 22)

18. If you answered 'No' to Question 21, should the enrolled nurses' clinical judgement be valued and considered by other members of the multidisciplinary team?
    - □ Yes—what needs to change to enable this?

      _____

    - □ No—why not?

      _____

19. For the purposes of this study, a professional voice is when thoughts, opinions and ideas are heard and respected in forums (e.g., in team meetings or through professional associations). Does the enrolled nurse have a professional voice?
    - □ Yes (go to Question 25)
    - □ No (go to Question 24)

20. If you answered 'No' to Question 23, should the enrolled nurse have a professional voice?
    - □ Yes—what needs to change to enable this?
      _____
    - □ No—why not?
      _____

21. Please describe what a nursing team means to you and how patient work is allocated in that nursing team.
    - □ Free text_____

22. How does the enrolled nurse work as part of the nursing team?
    - □ Nursing team—allocated to a number of patients and work together with a registered nurse/midwife
    - □ Nursing team—allocated to a group of patients but divide the patient load (e.g., allocated one side each, i.e., registered nurse/midwife takes patients 1 to 5 and the enrolled nurse 6 to 10) and come together for S8 medications only
    - □ Patient allocation—individually allocated patients
    - □ Allocation of tasks
    - □ Other, please specify_____

Using the scale below, please identify your response regarding the following statements.

	Strongly disagree	**Disagree**	**Agree**	**Strongly agree**
1. I feel enrolled nurses are not valued members of the multidisciplinary healthcare team.				
2. I feel enrolled nurses are not valued members of the nursing team.				
3. I would rather work with registered nurses only.				
4. I would rather work with registered midwives only.				

Using the scale below, please identify your response regarding the following statements.

	Never	Sometimes	Unsure	Mostly	Always
1. The enrolled nurse works under the *direct* supervision of a registered nurse/midwife (i.e., when the registered nurse/midwife is actually present and personally observes, works with, guides and delegates the enrolled nurse).					
2. The enrolled nurse works with *indirect* supervision from the registered nurse/midwife (i.e., when the registered nurse/midwife works in the same ward, facility or organisation but does not constantly observe the enrolled nurses' activities).					
3. The enrolled nurse works with no more or less supervision than a registered nurse/midwife.					
4. Registered nurses/midwives resent having to be responsible for somebody else's work (e.g., 'I can do my work, but I don't want to be responsible for someone else's work').					

23. Whose responsibility is it to know the enrolled nurse's scope of practice? Choose all that apply.
    - □ Assistants in nursing
    - □ Assistants in midwifery
    - □ Enrolled nurses
    - □ Registered nurses
    - □ Registered midwives
    - □ Other, please specify_____

Using the scale below, please identify your response regarding the following statements.

	Strongly disagree	Disagree	Agree	Strongly agree
1. I feel enrolled nurses have a clear understanding of their scope of practice.				
2. I feel enrolled nurses are supported to work within their scope of practice.				
3. I feel assistants in nursing have a clear understanding of the enrolled nurses' scope of practice.				
4. I feel registered nurses have a clear understanding of the enrolled nurses' scope of practice.				
5. I feel registered midwives have a clear understanding of the enrolled nurses' scope of practice.				

Using the scale below, please identify your response regarding the following statements.

	Never	Sometimes	Unsure	Mostly	Always
1. Enrolled nurses are being rostered in place of registered nurses/midwives because they are cheaper.					
2. Enrolled nurses' pay reflects the scope of practice of enrolled nurses.					
3. Greater financial incentives would keep enrolled nurses as enrolled nurses.					

24. Should you feel you have not been able to express your thoughts and ideas, or you would like to add additional information or any other comments, please do so.

_____

_____

_____

_____

_____

Thank you for your time in completing this questionnaire.

Appendix P: Focus group questioning route

Valuing Enrolled Nurses

Focus Group Questions

The focus groups will have a semi-structured approach. Questions will be asked around EN's scope of practice, professional development and career pathways for ENs, the professional voice of ENs and the value of their role.

The following questions will be presented for discussion at the respective focus groups. From the data received questionnaires will be developed.

Enrolled Nurse focus groups

- Why are you an enrolled nurse?
    - How do you feel about your role?
- Describe the role of the EN in the context of the nursing workforce
- I would like to explore your scope of practice. Do you feel there is a clear understanding by the other nursing staff of your scope of practice?
    - If yes, why?
    - If no, why not?
        i. What needs to change to create a clear delineation between the roles?
- Tell me a time when you felt valued/not valued.
- Does the role of the enrolled nurse have a professional voice?
    - If yes, why?
    - If no, why?
        i. If no what needs to change for the EN to have a professional voice?
- What professional development/career pathway opportunities do you see for enrolled nurses?

Other nursing & midwifery staff focus groups

- Describe the role of the EN in the context of the nursing workforce.
- I would like to explore your understanding of the EN's scope of practice. Do you have a clear understanding of the EN's scope of practice?
    - If yes, why?
    - If no, why not?
        i. What needs to change to create a clear delineation between the roles?

- Do you feel the role of the EN is valued?
    - If yes, why?
    - If no, why not?
        i. What needs to change for the role of the EN to be valued?
- Does the role of the enrolled nurse have a professional voice?
    - If yes, why?
    - If no, why?
        i. If no what needs to change for the EN to have a professional voice?
- What professional development/career pathway opportunities do you see for enrolled nurses?

Appendix Q: Integrated analysis—the role of the enrolled nurse

Table Q1.1: Integrated analysis —the role of the enrolled nurse

QUAL themes	Qual descriptors and findings	Integrated themes	quan categories	quan data
		The EN as an individual		
4.2.3 The EN as an Individual. Valued.	From the perspective of the EN, how they feel and are valued. 4.2.3.2 *So, that's the point when it comes to being valued. There is only a small group who actually see me as another nurse, not an EN or an EEN; they just see me as, well, 'you're a nurse like me*'. (EN FG5). 4.2.3.2 *I know the right answer, and they won't believe me. And that I find very humiliating*. (EN FG5).	Intrinsic and extrinsic motivator. EN understand their role and scope of practice. Push factor.	6.2.4 The EN as an individual. 6.2.5.6 Valued team members	6.2.4.2.2 Many ENs (53.5%, *n* = 77) had considered leaving their role – 29% citing not feeling valued 6.2.5.6 The EN cohort disagreed more strongly than the non-EN cohort ($p < .001$) to both statements. 'I feel ENs are not a valued member of the nursing team'. 'I feel ENs are not a valued member of the nursing team'. 6.2.5.9 The EN cohort did not believe their pay reflected their SOP, while the non-EN cohort believed it did ($p < .001$).
4.2.3 The EN as an Individual 4.2.3.1 Self-identity	Captures being a nurse. 4.2.3.1 *'being a nurse' (EN FG1; EN FG3; EN FG5).* 4.2.3.1 *'I've always wanted to be a nurse (EN FG5).*	Intrinsic motivator EN understand their role and scope of practice. Pull factor	6.2.4.The EN as an individual 6.2.4.2 Leaving or staying in their role 6.2.5.9 Financial implications	6.2.4.2.3 Some ENs believed their professional voice was valued and considered (21.6% *n* = 33*)* '*it's what I know and feedback is that I'm good at my work*' (EN)

QUAL themes	Qual descriptors and findings	Integrated themes	quan categories	quan data
				6.2.4.2.1 Many ENs (56.6%, *n* = 82) were not (or did not intend) to enrol in a bachelor of nursing or midwifery 6.2.5.9 *I do not work for the money I work for the satisfaction. As far as money keeping me as an EEN I see myself as a nurse first and I am comfortable with being a nurse' (EN).*
4.2.3 The EN as an Individual. 4.2.3.2 Trusted.	Honest, sincere, reliable. 4.2.3.1 *'I'm not allowed to hold the keys'* (EN FG3). 4.2.3.2 *'About trust [and] about people who've got your back*' (EN FG3). 4.2.4.2 '*Trust each other'* (EN FG4).	EN understand their role and scope of practice. Extrinsic motivators. Push and Pull factors.	6.2.5 The EN in the workplace and the profession. 6.2.5.3 Clinical judgement valued and considered.	6.2.5.3 ENs' clinical judgement is valued and considered by members of the multidisciplinary team. Yes (75.5%, *N* = 304) No 17.8% (*N* = 72). A one-way ANOVA revealed statistically significant differences based on the participants' education levels ($F(9,362) = [3.871]$, $p < .001$). The scores were higher for RNs with up to a Bachelor's degree (0.94 ±0.24) and RNs with a postgraduate degree (0.78 ±0.43) and lowest for ENs with an Advanced Diploma (0.62 ±0.50).

QUAL themes	Qual descriptors and findings	The EN in the working environment	quan categories	quan data
4.2.4 The EN in the workplace. 4.2.4.1 Confusion.	Inability to determine which role, predominately between the EN and RN roles. 4.2.3.1 *'There is not much difference between ENs and RNs, it's just a nurse*' (EN FG5). 4.2.3.1 *'Just a nurse*' (EN FG2). 4.2.4.1 '*No difference*' (non-EN RN FG2). 4.2.4.1 '*They do everything, and I think we see them as one of us*' (non-EN RN FG5) 4.2.3.1 '*There is no EN or RN…just the more experienced and senior nurses'* (EN FG1). 4.2.4.1 '*You kind of just expect them to do the same as us, and to know the same as us*' (non-EN RN FG3). 4.2.4.1 '*Expect[ed] them to do the same as us*' (non-EN RN FG3).	EN and RN understands the role and scope of the EN. RN understands their role when working with an EN. Extrinsic motivator. Push factors.	6.2.5 The EN in the workplace and profession. 6.2.5.2 Perceptions of allocated workloads.	6.2.5.2 The EN cohort had a significantly stronger agreement than the non-EN cohort ($p < .001$) with the statement, 'the EN does everything except for the S8s, and they are allocated workloads as a RN'. A one-way ANOVA revealed statistically significant differences based on the professional characteristics of education level ($F(9,362) = [6.442]$, $p < .001$) and length of time in role ($F(4,367) = [2.229]$, $p < .05$). ENs with an Advanced Diploma had a significantly higher mean score (2.80 ±0.77) compared to ENs with up to a Diploma (2.45 ±0.94), RNs with up to a Bachelor's degree (2.02 ±0.88) and RNs with a postgraduate degree (1.66 ±0.97).

	4.2.4.1 '*I am allowed to do an [indwelling catheter] and [in] some wards, I am not allowed to do an [indwelling catheter]. Some wards are allowed to do this, and some wards aren't allowed*' (EN FG5). 4.2.4.1 '*One minute, you're allowed; the next minute, you're not*' (EN FG2).			The results showed that those with 21 years and above (2.47 ±0.93) had stronger agreement with the statement followed by those with 11-20 years of experience (2.26 ±0.94), and then those with 0-10 years of experience (2.19 ±0.96). 6.2.5.2 *'We do S8s, we do pt [patient] pca [patient controlled analgesia], do cannulas, do piccs [peripherally inserted central catheter] [and] do wound infusions*' (EN). 6.2.5.2 '*I work in a facility where EENs actually administer S8 medications*' (non-EN).
4.2.4 The EN in the workplace. 4.2.4.2 Teamwork in practice.	How members of the nursing workforce and multidisciplinary team work together. 4.2.4.2 *'I work with a great bunch of RNs, and I have been for 15 years, and we equally trust each other'* (EN FG3). 4.2.4.2 *'We're very fortunate we've got a very good team here …everyone works to share the load'* (non-EN RN FG3).	EN and RN understands the role and scope of the EN. RN understands their role when working with an EN. Extrinsic motivator. Push and Pull factors.	6.2.5 The EN in the workplace. 6.2.5.5 Working as part of a nursing team.	6.2.5.5 Working together versus patient allocation, with 47.8% (*N* = 191) describing that they were allocated to a number of patients and worked together, in contrast to 41.0% (*N* = 164) having either a patient load or individual patient allocation. '*Working with their own patient load*' (non-EN). '*Allocated a patient load*' (EN).

	4.2.4.2 *'I will look after patients one to five, and she'll look after patients six to 10, and we'll meet in the middle*' (non-EN RN FG5). 4.2.4.2 '*I don't know that those conversations are actually being valued in the workplace about how … to best work with each other*' (non-EN RN FG5).			'*The voice of all team members is valuable and should be sought and heard*' (non-EN). '*Patient allocation is based on acuity*' (non-EN). 35.2% (*n* = 51) of the EN cohort identified that they worked as part of the nursing team, in contrast to 54.9% (*n* = 140) of the non-EN cohort. The reverse was found with the description of patient allocation, with 53.8% (*n* = 78) of the EN cohort indicating that they were allocated patients, in contrast with 33.8% (*n* = 86) of the non-EN cohort.
4.2.4 The EN in the workplace. 4.2.4.3 Supervision in practice.	The supervision of the EN by the RN. 4.2.4.3. '*Very, very loose word that, um, supervision … they only see them [the EN] at handover, and they are their supervisor. So, that's a very loose term*' (non-EN RN FG2). 4.2.4.3 '*If they are taking a patient load, the way that it happens in maternity, no one is overseeing anything*' (non-EN RM FG1).	EN and RN understands the role and scope of the EN. RN understands their role when working with an EN. Extrinsic motivator. Push and Pull factors.	6.2.5 The EN in the workplace. 6.2.5.7 Required supervision	6.2.5.7 The EN cohort had a significantly stronger disagreement than the non-EN cohort with the statement, 'the EN works with no more or less supervision than a RN/RM' ($F(9,307) = [3.907]$, $p < .001$). The open-ended responses from both cohorts indicated that the level of supervision was not related to the role but to the '*level of experience of the EN/RN*' (EN and non-EN)

	4.2.4.3 '*I know, ultimately, the RN's responsible at the end of the day*' (EN FG5).			
QUAL themes	**Qual descriptors and findings**	**The EN in the Australian midwifery workforce**	**quan categories**	**quan data**
4.2.4 The EN in the workplace. 4.2.4.1 Confusion.	If there were no ENs, everyone would know what they needed to do. 4.2.4.1 '*We register differently as nurses and midwives'* (non-EN RM FG1). 4.2.4.1 *'I still up to now do not understand what their role is, even when they are taking a patient load'* (non-EN RM FG1). 4.2.4.1 *'I try and ask them, and they also don't seem to know their own scope of practice and are themselves really struggling to work in the maternity field*' (non-EN RM FG1).	RM understand the role and scope of the EN, and their role when working with an EN Extrinsic motivator Push factor	6.2.5 The EN in the workplace 6.2.5.1 Perceptions of allocated work	6.2.5.2 The EN cohort had a significantly stronger agreement than the non-EN cohort ($p < .001$) with the statement, 'the EN does everything except for the S8s, and they are allocated workloads as a RM' '*I feel their role is often blurred and used as midwifery replacement*' (non-EN [RM]) '*They are not the same—this needs to be better understood*' (non-EN [RM]).

QUAL themes	Qual descriptors and findings	The EN in the nursing profession	quan categories	quan data
4.2.5 The EN in the profession. 4.2.5.1 Career pathway. 4.2.5.2 Lack of recognition.	Includes retirement, transitioning to the RN role. 4.2.5.1 *'I'm looking at retirement'* (EN FG4). 4.2.5.1 *'Seriously considering retirement'* (EN FG5). 4.2.5.1 *'[I am] seriously considering [the] retirement option as [I] have no job satisfaction as an EN and [my] professional voice is not valued*' (EN FG2). Education that is specific to the EN role. . 4.2.5.2 '*I have accreditation with everything; I just continue as an EN*' (EN FG1). 4.2.4.2 '*Stay educated, stay educated [because] things have changed*' (EN FG1). 4.2.5.2 '*We get extra money for it, but we can't use the skills that we learnt in it because the hospital won't let us*' (EN FG5).	The organisation provides opportunities for the EN and understands how the nursing team needs to work together to ensure all roles work within their respective scope and standards of practice. Extrinsic motivator. Push and pull factors.	6.2.4 The EN as an individual. 6.2.5 The EN in the workplace and the profession. 6.2.4.2.1 Consideration of enrolment in a bachelor of nursing or midwifery. 6.2.6.3 Career opportunities and limitations.	6.2.4.2.1 Many ENs (56.6%, *n* = 82) were not (or did not intend) to enrol in a bachelor of nursing or midwifery. 6.2.4.2.2 Many ENs (53.5%, *n* = 77). Had considered leaving their role – 27% citing limited career progression. 6.2.4.2.2 ENs considered retirement (6.2% *n* = 9) 6.2.4.2.3 ENs (41.8%, *n* = 64) intended to stay in their EN roles. They felt their professional voice and clinical judgement were both valued and considered 6.2.6.3 '*Add special grades of qualifications to ENs such as RNs can (CNS [clinical nurse educator], Educators etc.)*' (EN), and '*special grades should be remunerated properly and opened up more to reflect higher grades of duty/scope in practice*' (non-EN). 6.2.6.4 *As an EN I sometimes feel undervalued when workshops are advertised and RNs have top billing to attend* (EN).

The EN in the profession Title	The name of the role. '*What does the word "enrolled" actually mean (i.e., you are enrolled in a course?) … people still ask, what does it mean? The multitude of names indicates disunity within the profession, and is this professional?*' (EN FG 5).	Extrinsic motivator	6.2.5 The EN in the workplace	Wanted to change the title (71.4%, *N* = 167) *[It] doesn't matter what the title is, but differentiation [is] important so other staff know what an EN can be expected to do*. (EN).

Note. EN = enrolled nurse; RN = registered nurse; RM = registered midwife

Supplementary materials

Supplement A: Summary of key themes per decade

Table SA1.1: Summary of key themes per decade

Key themes	Pre-1949	1950–1959	1960–1969	1970–1979	1980–1989	1990–1999	2000–2009	2010–2019
Introduction of role	X, O (Brown, 1994; IHM & CCAAN, 1969; RPNAO, n.d.; Statement of Functions, 1957)	X (Dewdney, 1972)						
Formalised roll or licensing	X, O (IHM & CCAAN, 1969; RPNAO, n.d.; Statement of Functions, 1957)	X (Albani et al., 2006)						
Entry-level education, discussion, creation or change	O (RPNAO, n.d.; Statement of Functions, 1957)	X, O (Albani et al., 2006; National Association of LPNs, n.d.; RPNAO, n.d.)	X (Education of Nurses Inquiry, 1970)	X (Albani et al., 2006; Education of Nurses Inquiry, 1970)		O (Jacob et al., 2016; Nielsen, 1997; RPNAO, n.d.)	X (Chiarella, 2002; Department of Education, Science and Training, 2007; Heath, 2002; Ryan, 2009)	X (ANMAC, 2011, 2017)
Title creation or change	X, O (Albani et al., 2006; Macleod et al., 2017; National Association of LPNs, n.d.; RPNAO, n.d.)	O (RPNAO, n.d.)	X, O (Albani et al., 2006; RPNAO, n.d.)	X, O (ANMC, 2002; National Association of LPNs, n.d.; Nielsen, 1997)		O (RPNAO, n.d.)	X (Manwarring & Passlow, 2004)	X (NMBA, 2018a)
Changes at a national level	X, O (Albani et al., 2006; National Association of LPNs, n.d.; RPNAO, n.d.)		X (IHM & CCAAN, 1969; Education of Nurses Inquiry, 1970)			X (ANMC, 2002)	X (ANMC, 2002; Chiarella, 2002; Heath, 2002; Manwarring & Passlow, 2004; Senate Community Affairs References Committee Secretariat, 2002; Working Group on Aged Care Worker Qualifications of the National Aged Care Forum, 2001)	X (Australian Health Practitioner Regulation Agency, 2011; ANMAC, 2017; NMBA, 2016)

Key themes	Pre-1949	1950–1959	1960–1969	1970–1979	1980–1989	1990–1999	2000–2009	2010–2019
Professional EN association formed		O (RPNAO, n.d.)	O (Merton, 1962)			X (Enrolled Nurse Professional Association NSW, n.d.)		
Role confusion/ lack of role delineation with registered nurse role		O (Merton, 1962; Rasmussen, 1962; Statement of Functions, 1957)	O (Merton, 1962; Rasmussen, 1962)	X, O (Dewdney, 1972; Education of Nurses Inquiry, 1970; Pratt & Russell, 2002)	X, O (Jacob et al., 2016)	X, O (Chang & Twinn, 1995; Francis & Humphreys, 1999; Jacob et al., 2016)	X (Chaboyer et al., 2008; Duckett, 2000; Gibson & Heartfield, 2003, 2005; Heath, 2002; Kenny & Duckett, 2005; Milson-Hawke & Higgins, 2004; Pryor, 2007; White et al., 2008)	X, O (Armitage et al., 2015; Cusack et al., 2015; Dalton et al., 2016; Eagar et al., 2010; Endacott et al., 2018; Jacob et al., 2012, 2013, 2015; Lankshear et al., 2016; Lavander et al., 2017; Leon et al., 2019; MacKinnon et al., 2018)
Teamwork			O (Merton, 1962; Rasmussen, 1962)				X (Heartfield & Gibson, 2005; Heath, 2002)	O (Havaei et al., 2019; Huynh et al., 2011; Moore et al., 2019)
Discussions of EN scope of practice			X, O (IHM & CCAAN, 1969; Education of Nurses Inquiry, 1970)	O (Advice editor, 1980)	O (Chang & Twinn, 1995)		X, O (Blay & Donoghue, 2007; Chaboyer et al., 2008; Chiarella, 2002; Della & Fraser, 2006; Gibson & Heartfield, 2005; Heartfield & Gibson, 2005; Henderson & Wickett, 2010; Kenny & Duckett, 2005; Milson-Hawke & Higgins, 2004; Nankervis et al., 2008; Sweet, 2009; White et al., 2008)	X, O (Armitage et al., 2015; Brown et al., 2015; Cusack et al., 2015; Dalton et al., 2016; Eagar et al., 2010; Endacott et al., 2018; Henderson & Wickett, 2010; Hutchinson et al., 2011; Jacob et al., 2012, 2013, 2014a, 2014b, 2014c, 2015, 2017; Kerr et al., 2012; Leon et al., 2019; MacKinnon et al., 2018; MacLeod et al., 2017; McKenna et al., 2019; NMBA, 2018a, 2018b; Enrolled nursing industry reference committee, 2018; Whittingham, 2012)

Key themes	Pre-1949	1950–1959	1960–1969	1970–1979	1980–1989	1990–1999	2000–2009	2010–2019
EN to registered nurse career structure					O (Walker, 1989)	X, O (I. Allan & McLafferty, 1999; Brown, 1994; Hemsley-Brown & Humphreys, 1996; Webb, 1999)	X, O (A. Allan & McLafferty, 2001; Dearnley, 2006; Gibson & Heartfield, 2003, 2005; Greenwood, 2000; Hoodless & Bourke, 2009; Iley, 2004; Kenny & Duckett, 2005; Rochester & Kilstoff, 2004; Milson-Hawke & Higgins, 2004; Ralph et al., 2013; Rapley et al., 2006, 2008; Webb, 2001)	X, O (Birks et al., 2010; Jacob et al., 2012, 2013; Janzen et al., 2013; Leon et al., 2019; Melrose et al., 2012; Ralph et al., 2013)
Continuing professional development for the EN				X (Pratt & Russell, 2002)		X (Pratt & Russell, 2002; Witham, 1999)	X (Della & Fraser, 2006; Hoodless & Bourke, 2009)	X (Australian College of Nursing, 2019)
Medication administration				O (Shores, 1975)		O (RPNAO, n.d.)	X (Heath, 2002; Manwarring & Passlow, 2004; McEwan, 2008; Senate Community Affairs References Committee Secretariat, 2002; Working Group on Aged Care Worker Qualifications of the National Aged Care Forum, 2001)	
National competency standards							X, O (ANMAC, 2017; ANMC, 2002; Canadian Council for Practical Nurse Regulators, 2013; Manwarring & Passlow, 2004)	X, O (Canadian Council for Practical Nurse Regulators, 2019; NMBA, 2016; Singapore Nursing Board, 2018)
EN feeling devalued					X (Evans, 1994)	X (Blay & Donoghue, 2007; Gibson & Heartfield, 2005; Heartfield & Gibson, 2005; Hoodless & Bourke, 2009; Kenny & Duckett, 2005; Nankervis et al., 2008)	X (Jacob et al., 2013; Leon et al., 2019; Ralph et al., 2013)	

Key themes	Pre-1049	1950-1959	1960-1969	1970-1979	1980-1989	1990-1999	2000-2009	2010-2019
EN role questioned/ phased out		O (Merton, 1962)	O (Merton, 1962)		O (Glasper & Rushworth, 1998; UKCCNMV, 1987)	O (Glasper, 2016; UKCCNMV, 1987)	O (Arieli, 2007; Editor, 2009)	O (Enrolled nurses here to stay—finally, 2010)

Note. X = Australian Context; O = International Context; ANMAC = Australian Nursing & Midwifery Accreditation Council; ANMC = Australian Nursing & Midwifery Council; Education of Nurses Inquiry = New South Wales Committee of Inquiry Into the Education of Nurses; EN = enrolled nurse; IHM & CCAAN = Institute of Hospital Matrons of New South Wales & Australian Capital Territory Committee to Consider All Aspects of Nursing; LPNs = licensed practical nurses; NMBA = Nursing and Midwifery Board of Australia; RPNAO = Registered Practical Nurses Association of Ontario; Statement of Functions = Statement of Functions of the Licensed Practical Nurse; UKCCNMV = United Kingdom Central Council for Nursing, Midwifery & Health Visiting.

Supplement B: Question development—response to ‘relevance’

Partcipant	SL	DC	KV	JM	AG	TJ	SEN	RR	NumberinAgreement	ItemCVIRelevance
Question1Relevance	3	3	3	3	3	3	3	3	8	1.00
Question2Relevance	3	3	3	3	3	3	3	3	8	1.00
Question3Relevance	3	1	3	3	3	3	3	2	6	0.75
Question4Relevance	3	3	3	3	3	3	3	#NULL!	7	0.88
Question5Relevance	3	3	3	3	3	3	3	3	8	1.00
Question6Relevance	3	2	3	3	3	3	3	3	7	0.88
Question7Relevance	3	3	3	3	3	3	3	3	8	1.00
Question8Relevance	3	3	3	3	3	3	3	3	8	1.00
Question9Relevance	#NULL!	3	3	3	3	3	3	2	6	0.75
Question10Relevance	3	3	3	3	3	3	3	3	8	1.00
Question11Relevance	3	3	3	3	3	3	3	3	8	1.00
Question12Relevance	3	3	3	3	3	3	3	3	8	1.00
Question13Relevance	3	3	3	1	3	3	3	3	7	0.88
Question14Relevance	3	3	3	1	3	3	3	2	6	0.75
Question15Relevance	3	3	3	3	3	3	3	3	8	1.00
Question16Relevance	3	3	3	3	3	3	3	3	8	1.00
Question17Relevance	3	#NULL!	3	3	3	3	3	3	7	0.88
Question18Relevance	3	3	3	3	3	3	3	3	8	1.00
Question19Relevance	3	3	3	3	3	3	3	3	8	1.00
Question20Relevance	3	3	3	3	3	3	3	3	8	1.00
Question21Relevance	3	3	3	3	3	3	3	3	8	1.00
Question22Relevance	3	3	3	3	3	3	3	3	8	1.00
Question23Relevance	3	3	3	3	3	3	3	3	8	1.00
Question24Relevance	3	3	3	3	3	3	3	3	8	1.00
Question25Relevance	3	3	3	3	3	3	3	3	8	1.00
Question26Relevance	3	3	3	3	3	3	3	3	8	1.00
Question27Relevance	3	3	3	3	3	3	3	3	8	1.00
Question28Relevance	3	3	3	3	3	3	3	3	8	1.00
Question29Relevance	3	3	3	3	3	3	3	3	8	1.00
Question30Relevance	3	3	3	3	3	3	3	3	8	1.00
Question31Relevance	3	3	3	3	3	3	3	3	8	1.00
Question32Relevance	3	3	3	3	3	3	3	3	8	1.00
Question33Relevance	3	3	3	3	3	3	3	3	8	1.00
Question34Relevance	3	3	3	3	3	3	3	3	8	1.00
Question35Relevance	3	3	3	3	3	3	3	3	8	1.00
Question36Relevance	3	3	3	3	3	3	3	3	8	1.00
Question37Relevance	3	3	3	3	3	3	3	3	8	1.00
Question38Relevance	3	3	3	3	3	3	3	3	8	1.00
Question39Relevance	3	3	3	3	3	3	3	3	8	1.00
Question40Relevance	3	3	3	3	3	3	3	3	8	1.00

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
ItemCVIRelevance	40	0.75	1.00	0.97	0.07354
Valid N (listwise)	40				

Figure SB1.1: Question development—response to ‘relevance’

Supplement C: Question development—response to ‘clarity’

Partcipant	SL	DC	KV	JM	AG	TJ	SEN	RR	NumberinAgreement	ItemCVIClarity
Question1Clarity	3	3	2	3	3	3	3	3	7	0.88
Question2Clarity	3	3	3	3	3	3	3	3	8	1.00
Question3Clarity	2	3	3	3	3	3	3	3	7	0.88
Question4Clarity	2	1	2	1	1	3	3	#NULL!	2	0.25
Question5Clarity	2	3	3	3	3	3	3	3	7	0.88
Question6Clarity	2	1	3	3	3	3	3	3	6	0.75
Question7Clarity	2	3	3	3	3	3	3	3	7	0.88
Question8Clarity	3	3	3	3	3	3	3	3	8	1.00
Question9Clarity	1	3	3	3	3	3	2	3	6	0.75
Question10Clarity	2	3	3	3	3	3	2	3	6	0.75
Question11Clarity	3	3	2	3	3	3	3	3	7	0.88
Question12Clarity	3	3	3	3	3	3	3	3	8	1.00
Question13Clarity	2	3	3	1	3	3	3	3	6	0.75
Question14Clarity	2	3	3	1	3	3	3	3	6	0.75
Question15Clarity	3	1	3	3	3	3	1	3	6	0.75
Question16Clarity	3	1	3	3	3	3	1	3	6	0.75
Question17Clarity	3	#NULL!	2	3	3	3	1	3	5	0.63
Question18Clarity	3	3	3	3	3	3	3	3	8	1.00
Question19Clarity	2	3	3	3	3	3	3	3	7	0.88
Question20Clarity	3	1	3	3	3	3	3	3	7	0.88
Question21Clarity	3	3	3	3	3	3	3	3	8	1.00
Question22Clarity	3	3	3	3	3	3	3	3	8	1.00
Question23Clarity	3	3	3	3	3	3	3	3	8	1.00
Question24Clarity	3	3	3	3	3	3	3	3	8	1.00
Question25Clarity	3	3	3	3	3	3	3	3	8	1.00
Question26Clarity	3	3	3	3	3	3	3	3	8	1.00
Question27Clarity	3	3	3	3	3	3	1	3	7	0.88
Question28Clarity	3	3	3	3	3	3	3	3	8	1.00
Question29Clarity	3	2	3	3	3	3	3	3	7	0.88
Question30Clarity	3	3	3	3	3	3	3	3	8	1.00
Question31Clarity	3	3	3	3	3	3	3	3	8	1.00
Question32Clarity	3	3	3	3	3	3	3	3	8	1.00
Question33Clarity	3	3	3	3	3	3	3	3	8	1.00
Question34Clarity	3	3	3	3	3	3	3	3	8	1.00
Question35Clarity	3	3	3	3	3	3	3	3	8	1.00
Question36Clarity	3	3	3	3	3	3	3	3	8	1.00
Question37Clarity	3	3	3	3	3	3	3	3	8	1.00
Question38Clarity	3	3	3	3	3	3	3	3	8	1.00
Question39Clarity	3	3	3	3	3	3	3	3	8	1.00
Question40Clarity	2	3	3	3	3	3	3	3	7	0.88

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
ItemCVIClarity	40	0.25	1.00	0.8969	0.14948
Valid N (listwise)	40				

Figure SC1.1: Question development—response to ‘clarity’

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