NURSES' EXPERIENCES OF
FULL SCOPE LPN PRACTICE
IN ACUTE CARE

by

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Abstract

The practice of licensed practical nurses (LPNs) in acute care in British Columbia (BC) is undergoing a shift to incorporate the enhanced range of entry-level competencies introduced by the College of LPNs of British Columbia in 2000. The full range of new LPN competencies, which now constitute full scope, became a requirement for practical nurse licensure in BC in 2007 and are challenging LPNs and Registered Nurses (RNs) alike to reexamine and redefine the LPN role and LPN/RN relations in acute care. Research exploring the experiences of RNs and LPNs, in their own words, with full scope LPN practice in acute care staff mixes has not previously been conducted in BC.

This qualitative descriptive study explored the perceptions of 5 RNs and 4 LPNs working in RN/LPN skill mixes, in various Lower Mainland acute care settings where the LPNs work to full scope. Conventional qualitative content analysis was used to analyze the data from one in-depth interview and 8 short-answer surveys. Analysis of one in-depth interview with an LPN yielded 3 categories: professionalism, receptivity, and appropriateness. Analysis of the 8 survey responses from RNs and LPNs yielded 3 categories as well, namely: defining the role, determining the impact and determining the fit of the role. Findings in this study indicate that overall, both RNs and LPNs report that clear communication, LPN role clarity, experience working together over time, and a supportive work environment contribute to positive experiences of the RN/LPN skill mix.
Feelings of burden, inconsistent teamwork, lack of respect, concerns about patient acuity levels, and varied perceptions of the ability of LPNs and RNs to assume responsibility for patient care present areas of challenge in the workplace.
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CHAPTER I

Introduction

In this chapter I will present background information that not only stimulated my interest in pursuing this research but also provided me with a basis of understanding as I formed my research question. I will then provide a statement of the problem and the research question which I developed in response to it. Next, I will clarify two key terms that are utilized throughout this study, namely full scope and competencies. Finally I will end with a brief description of my assumptions as a researcher approaching this study. In the following chapter I will explore the relevant literature in more depth.

Background to the Problem

Health care service restructuring, a shortage of registered RNs in British Columbia (BC) and an ongoing interest in cost containment strategies in health care have resulted in an increasing number of LPNs being integrated/reintegrated into staff mixes in various health care delivery settings (e.g. acute care hospital and long term care facilities) (Greenlaw, 2003; Lantz, 2004; McPherson, 2004). At the same time, the scope of practice for LPNs has expanded with the introduction of an enhanced range of competencies introduced by the College of Licensed Practical Nurses of British Columbia (CLPNBC) in 2000 which has increased opportunities for LPN utilization in various practice settings (CLPNBC, 2000; Greenlaw). According to Catherine Overton, former Deputy Registrar for the CLPNBC, in 2004 a full 2/3 of LPN registrants worked in acute care settings (personal communication, August 23,
However, the move towards widespread utilization of LPNs to full scope in this setting is limited and inconsistent, despite the introduction of the expanded scope and new range of competencies in 2000.

The term ‘full scope’ of practice refers to far more than skills, and is not limited in application to the nursing practice of LPNs. In their discussion paper examining proposed implementation guidelines for deploying full scope LPNs (FSLPNs in this study) in Alberta’s health authority employment settings, the Health Authorities Health Professions Act Regulations Review Committee (HAHPRRC), defined full scope as “deploying health professionals to the full range of their roles, responsibilities and functions they are educated, competent and authorized to perform” (HAHPRRC, 2002, p.7). However, according to Donna Nicholson, RN, recent LPN facilitator for Vancouver Coastal Health, the term full scope is generally considered “an employer term” used by employers to differentiate between “traditional” LPNs and those prepared to function within their enhanced scope of practice (personal communication, January 12, 2005).

Currently, full scope practice for LPNs in BC includes expansion into 6 select competency areas outlined in 2000 by the CLPNBC: a) comprehensive assessment; b) medication administration including administration of range doses (e.g. including administration of range doses and taking and transcribing doctor’s orders); c) wound management; d) airway management; e) elimination management; and f) infusion management (e.g. non-medicated infusions) (CLPNBC, 2000; CLPNBC, 2004; Greenlaw, 2003). As of 2006, LPNs in British Columbia were required to demonstrate knowledge and practice capabilities that
cover the enhanced range of competencies constituting ‘full scope’ practice in order to register with the College of LPNs of BC (CLPNBC). However, the deadline for meeting the enhanced competencies within medication administration (e.g. pharmacology) was moved to January, 2007 (CLPNBC, 2004).

The introduction and utilization of full scope LPNs in BC has been inconsistent. For example, an LPN on one acute care unit may practice to full scope while another on a similar unit at another facility may be limited (e.g. unable to administer medications). On some units, LPNs might not be part of the skill mix at all and the unit might be staffed solely by RNs or RNs and care aides. On other units particularly in long term care, RN positions have been eliminated and replaced with LPNs (McPherson, 2004). Changed in staff mixes involving LPNs has, as a result, “been met with uncertainty, fear and in some instances hostility and resentment” from RNs (McPherson, p.3). Several barriers to LPN utilization to full scope have been identified. These barriers include: a) unclear definitions of acuity; b) misperceptions of LPN competencies; c) role confusion; d) issues of territoriality; e) lack of support and assistance for LPNs; and f) lack of resources for LPNs (e.g. educational funding) (Greenlaw, 2003; HAHPARRC, 2002). Despite potential impediments to the integration of FSLPNs, the trend is to deploy increasing numbers of these nurses into the workforce, not only in BC but across Canada. In their final report, the Canadian Nursing Advisory Committee noted that employment practices that limits nurses from practicing to the fullest of their capabilities, whether RN, LPN, or registered psychiatric nurse (RPN)
needs to cease, and that nurses should be supported in working to their fullest professional capabilities in all settings (CNAC, 2002). In addition, the College of Registered Nurses of British Columbia (CRNBC) position statement on nursing staff mix and appropriate care acknowledges the current trend towards re-engineering of nursing care delivery teams, and affirms the need for RNs to be utilized to their maximal capabilities (CRNBC, 2007).

Utilization of full scope LPNs in the acute care setting poses some unique challenges. Rising patient acuity, lower staffing levels, lack of sufficient support and education for nurses and inconsistent utilization of LPNs that is not always clearly defined has impacted both RNs and LPNs and left them with questions “about patient care and safety of their practice” (McPherson, 2004, p.3).

According to the CRNBC (2005), in situations when the breadth of patient health care needs increases (e.g. in acuity, complexity or variability), RNs and LPNs need to collaborate more closely, and the RN needs to be more involved in the provision of care. However, the defining criteria for increased breadth of patient care needs are not clearly outlined.

In a joint effort between the CLPNBC and the CRNBC (formerly RNABC), workshops were developed to address concerns and facilitate collaboration among RNs and full scope LPNs in BC. Two former nursing practice consultants (both active in practice at the inception of this inquiry and have since moved on to other positions), Pamela Ottem and Janice Joyce, employed by the RNABC and College of Licensed Practical Nurses of BC (CLPNBC) respectively have been active in supporting the integration of full scope LPN practice in BC.
**Problem Statement**

In this time of role reorganization and clarification, the LPN Current Utilization Advisory Committee recommended that reports be compiled that explored the experiences of nursing teams (Greenlaw, 2003). Rob Calnan (2003), former Canadian Nurses’ Association (CNA) president and a LPN, has commented that current restructuring of nursing care delivery teams poses a challenge to traditional roles and role boundaries in nursing. Due to a number of factors occurring in acute care contexts (e.g. increased patient acuity, less predictable patient outcomes, and variation among employer utilization of LPNs), LPNs working in these settings have not generally practiced at full scope.

**Purpose of the Study**

While full scope LPN utilization in acute care areas in BC is inconsistent at present, the trend appears to be towards increased integration of full scope LPNs into acute care nursing skill mixes (Greenlaw, 2003). In this study I explored the experiences of RNs and LPNs practicing in acute care settings where LPNs are practicing to full scope. Research participants included RNs and LPNs from different acute care units in the Lower Mainland.

The purpose of this qualitative description study was to gain an understanding of the perspectives of RNs and LPNs who are practicing alongside or as full scope LPNs in the acute care setting. This research is a step towards understanding the perspectives and experiences of both RNs and LPNs regarding this issue of full scope LPNs in acute care settings. The current trend
toward increased implementation of full scope LPNs in acute care practice
settings coupled with the lack of information regarding how nurses perceive
these shifts in staff mix and nursing practice support, in my opinion, the need for
this descriptive study. A study that considers the perspectives of RNs and LPNs
in an acute care setting when faced with a change in the staff mix (e.g. addition
of full scope LPNs) will contribute to a better understanding of the situation and
add to the nursing practice/health care literature. This thesis offers an informed
contribution based on a review of information gathered from nurses (e.g. LPNs
and RNs) in the Greater Vancouver area.

Research Question

Based on my understanding of the issue as I have presented it and the fact
that there is little available information on the perspectives of nurses pertaining to
full scope LPN practice in acute care, my research question was, “What is the
experience of registered nurses and licensed practical nurses working with or as
full scope LPNs in the acute care setting?”.

Definition of Terms

Full Scope

The term ‘full scope’ of practice refers to far more than skills, and is not limited
in application to the nursing practice of LPNs. In this study, I adopted the
definition of full scope practice as set out in a broad sense for all health care
providers by Alberta’s Health Authorities Health Professions Act Regulations
Review Committee. Therefore, full scope refers to LPN practice that utilizes “the
full range of their roles, responsibilities and functions they are educated, competent and authorized to perform" (HAHPRRC, 2002, p.7).

Competencies

For the purposes of this study, I have adopted the definition of competencies outlined in the joint document on practice expectations of RNs and LPNs produced by the CRNBC and CLPNBC, published by the CRNBC in 2005. LPN competencies are, therefore, “statements about the knowledge, skills, attitude, and judgment required” of the individual LPN in order to “perform safely and ethically” within an individual’s nursing practice or in a designated role or setting” (CRNBC, p.4).

Assumptions

The lens through which a qualitative researcher views their research (e.g. informed by personal agendas or biases) has the potential to influence and even invalidate the research process (Morse & Field, 1995). Therefore, it is important for researchers to develop, “a critical awareness of one’s self and one’s motives for maximal performance in the research arena” (p.15). In my nursing experience in several acute care environments (e.g. thoracic surgery and neonatal intensive care), direct patient care was provided exclusively by RNs. My more recent work as an LPN educator in both classroom and acute care clinical settings has heightened my awareness of differences and similarities in educational backgrounds and scopes of practice of RNs and LPNs in BC, particularly in acute care areas (e.g. acute medical and surgical units). As a
result of my personal experiences, I entered this research process with certain assumptions and beliefs regarding full scope LPN practice in acute care. The central assumptions I hold are:

1. The implementation of full scope LPN practice in acute care is meeting with skepticism and resistance from some RNs.
2. Some LPNs view the only notable differences between themselves and RNs in the acute care setting as: a) only RNs are able to administer IV medications and b) LPNs are paid less than RNs.
3. RN/LPN teams in acute care can be effective and deliver quality patient care.

Summary

In this chapter I have outlined my area of research interest, identified the purpose of the study and my research question, defined two important terms and clarified my own assumptions as a researcher. In the next chapter I will explore the relevant literature, with particular focus on the evolving role of the LPN in BC and full scope LPN practice and utilization in the acute care practice setting. In chapter 3, I outline my methodology and the details of my planned approach to data collection and analysis for this study. I also consider criteria for rigor. In chapter 4, I present a chronology of how my study unfolded and the analysis of data collected. Chapter 5 begins with a presentation of my research conclusions with additional, relevant literature touched upon.
Following a discussion of the rigor and strengths and limitations of the study I conclude with consideration of nursing implications and a final summary.
CHAPTER II
LITERATURE REVIEW

LPNs have been part of the Canadian nursing landscape since their introduction around the time of the First World War, with their original nursing assistant role evolving over the last twenty years into a more autonomous role (Villeneuve & McDonald, 2006). This chapter sets out to review relevant literature pertaining to the evolving role of LPNs in British Columbia. The literature surveyed here includes such topics as: a) the changing LPN role in BC; b) changes in LPN competencies; c) full scope practice; d) utilization and integration of full scope LPNs in BC; e) LPNs in acute care in BC; and f) RN/LPN Workshops. By no means is this literature review exhaustive. However, it does provide an overview of the state of LPN practice in BC.

The Changing LPN Role in BC

As mentioned in the previous chapter, several factors (i.e. shortage of RNs and cost containment concerns) have been associated with a growing number of LPNs being integrated/reintegrated into nursing teams in various health care delivery settings (e.g. acute care hospital and long term care facilities) (Greenlaw, 2003; Lantz, 2004; McPherson, 2004). In 2003, 4815 LPNs registered with the CLPNBC (4262 renewals and 553 initial registrations (CLPNBC, 2003). In 2005, the number of LPNs registered with the CLPNBC had increased to 5590 (CLPNBC, 2005). As the number of LPNs employed in BC continues to grow, so too does the number of LPNs working to their full scope of
practice that includes the introduction of an enhanced range of competencies introduced by the College of Licensed Practical Nurses of British Columbia (CLPNBC) in 2000. The result of the expanded competency areas, scope of practice, and approach to educational preparation was a shift in the role of the LPN from a predominantly assistant role to a role that could operate with more autonomy and/or collaborate more effectively with other members of the health care team (e.g. RNs) (CLPNBC, 2000). In the next section I will discuss the changes in LPN competencies in more depth.

**Changes in LPN Competencies**

The issue of LPN competencies can be confusing to nurses unfamiliar with LPN practice, as I was prior to becoming an LPN educator. In an effort to clarify the evolving role of the LPN in BC, the CLPBC published the document entitled, "Understanding the Role of the LPN: Entry to practice competencies for LPNs in BC" (CLPNBC, 2000). A second publication, "Beyond entry to practice competencies for the LPN in BC, more expert and specialized competencies for LPNs in BC." was published 4 months later and provided a comprehensive guide to the standards of practice and linked them with the 10 competency areas for LPNs in BC, with expectations for novice to expert LPNs outlined for each area in a case based manner.

The 10 competency areas for LPNs in BC as outlined by the CLPNBC include: 1) provides competent, professional care, 2) serves the public and the nursing profession, 3) performs and refines client assessments, 4) develops
client-focused plans of care, 5) intervenes: puts theory into action, 6) intervenes: communicates with clients, 7) intervenes: teaches client, verifies learning, 8) evaluates client progress, 9) organizes care delivery for self and team members, and 10) practices collaboratively in the health care system. These competency areas were validated in 1997 by the National Nursing Competency Project and later by the CLPNBC in 1998 (CLPNBC, 2000). In addition to the 10 competency areas, in November 2000, the CLPNBC revised the role of the LPN, emphasizing their role as care providers in the health care team and reflecting the move in LPN education in BC away from a skill based towards a competency based approach that included movement into the areas of health promotion and restoration.

However, in the LPN Current Utilization Study conducted in 2003, the competency areas selected and cited for investigation into the utilization of full scope LPNs were those added as entry-level competencies for LPNs in 2000. As mentioned in chapter 1, full scope practice for LPNs in BC now includes the following 6 select competencies: a) comprehensive assessment; b) medication administration (i.e. including administration of range doses and taking and transcribing doctor’s orders); c) wound management; d) airway management; e) elimination management; and f) infusion management (e.g. non-medicated infusions) (CLPNBC, 2000; CLPNBC, 2004; Greenlaw, 2003). Competencies are “statements about the knowledge, skills, attitude, and judgment required” of the individual LPN in order to “perform safely and ethically” within an individual’s nursing practice or in a designated role or setting” (CRNBC, 2005, p.4; CLPNBC,
As of January 2007, LPNs in British Columbia are now required to demonstrate knowledge and practice capabilities that cover the full range of enhanced entry level competencies constituting full scope practice in order to register with the College of LPNs of BC (CLPNBC, 2004). It is important to note that not all of these 6 entry level competencies are entirely new to BC LPNs. For example, medication administration has been included in their practice profile since 1984 (CLPNBC, 2004). However, since that time, this competency has been amended several times. Administration of subcutaneous injections was added to the BC LPN competency profile in 1996. Approximately 3.5 years later, in 1999/2000, administration of intramuscular injections was added. The range of competencies in this category was further expanded to its current state in 2002. This recent expansion of the medication administration competency included the addition of: a) non-medicated intravenous therapy infusion management, b) taking and transcribing doctor’s orders, and c) “administering initial dose medications” (CLPNBC, 2004, p. 2).

Please note that at the time of this writing, the CLPNBC was in the process of reexamining and redefining the entry-level competencies for LPNs in the province. No current publication has been released that details any changes to entry level competencies. Therefore, this study focuses on the notion of full scope practice as it incorporates the above mentioned 6 competencies introduced in 2002 and required for LPN licensure in BC as of 2006 (except for Medication Administration which had a deadline for completion extended to January 2007) (CLPNBC, 2004).
Full Scope Practice

As I mentioned in the previous chapter, the term ‘full scope’ of practice refers to the deployment of “health professionals to the full range of their roles, responsibilities and functions they are educated, competent and authorized to perform” (HAHPRRRC, 2002, p.7). Supporting nurses (e.g. RNs, RPNs, and LPNs) to work at their respective full scopes of practice is one of many recommendations put forth by the Canadian Nursing Advisory Committee (2002). However, full scope is generally a term reserved for discussions regarding LPNs and is used to differentiate between those LPNs who meet the enhanced range of competencies introduced in 2000 and those who do not. In light of the enhanced range of entry-level competencies that constituted full scope beginning in 2000, the LPN Current Utilization Study was conducted in an effort to better understand and clarify the role of the LPN in BC (Greenlaw, 2003). The LPN Current Utilization Study sampled representatives from managerial, educational, and upper level nursing administrative positions from all regional health authorities, including the Provincial Health Services Authority in BC. From the perspective of study participants, LPNs were “being supported to work their full scope of practice” in an increasing variety of care settings (Greenlaw, p. 20). Plans included LPN utilization into new practice areas included emergency rooms and operating rooms traditionally considered as specialty areas in acute care nursing requiring advanced nursing education and preparation.
Utilization and Integration of Full Scope LPNs in BC

As mentioned in the previous chapter, utilization of full scope LPNs in BC has been and continues to be inconsistent. The overall trend is to deploy an increasing number of LPN in various practice settings across the province. While the increasing addition of LPNs to the workforce could be determined a direct response to the nursing shortage, in some settings RN positions have been eliminated and replaced with LPNs (McPherson, 2004). The salary difference between RNs and LPNs is notable but not grossly significant (e.g. starting wage for LPN in 2007 was $22.81/hr and for an RN $26.91/hr) (BCNU, 2005; HEU, 2005). This wage difference could make the LPN role even more appealing in settings that employed RNs and where patients care needs are equally met by the LPN scope of practice.

Also mentioned in the previous chapter, increasing the numbers of LPNs in staff mixes has "been met with uncertainty, fear and in some instances hostility and resentment" from RNs (McPherson, 2004, p.3). In fact, several barriers to LPN utilization have been identified and noted in the previous chapter. Despite potential barriers to the utilization of full scope LPNs, the trend continues to increase numbers of these nurses in the workforce, not only in BC but across the country.

LPNs in Acute Care

According to Catherine Overton, former Deputy Registrar for the CLPNBC, in 2004 approximately two-thirds of the more than 4,000 registered practicing LPNs
in BC were employed in acute care (e.g. medical/surgical) settings (personal communication, August 23, 2004). High acuity levels and rapid turnover of patients in acute care, especially surgical areas, pose a challenge to utilization of full scope LPNs for two main reasons. First, the skills in nursing assessment, organization and management of patient care and teaching may well require the competencies of RNs (Pamela Ottem, personal communication, August 5, 2004). Second, LPNs provide care for clients with "...less complex care needs and acuity as well as to clients with predictable outcomes" (CRNBC, 2005). Therefore, the organization of patient assignments in practice environments where patient acuity is greater and patient status potentially more unstable may become a challenge.

A search in CINAHL yielded a sole article on appropriate skill mix of LPNs and RNs in acute care. Clark and Thurston (1994) noted that among LPNs there was considerable variability in their willingness to collaborate with and consult RNs in the provision of patient care. Whether or not RNs were reluctant to collaborate and work with LPNs in this setting was not discussed.

**RN/LPN Workshops**

As mentioned in the previous chapter, in an effort to clarify the scopes of practice and role expectations of RNs and LPNs, the CLPNBC and the CRNBC (formerly RNABC), has offered and continues to offer workshops to inform nurses and facilitate communication between them on practice issues. Pamela Ottem and Janice Joyce, employed by the RNABC and College of Licensed
Practical Nurses of BC (CLPNBC) respectively were active in their role as practice consultants and facilitators of these workshops.

Ottem and Joyce worked collaboratively, along with additional nursing practice consultants from both the RNABC and CLPNBC, to coordinate and facilitate RN/LPN workshops designed to bring RNs and LPNs together to clarify and discuss roles and responsibilities. Both of these practice consultants observed that their members were seeking direction and role clarity, especially as RN/LPN care delivery teams are being reinvented and full scope LPNs are being deployed in a variety of care settings (Pamela Ottem, personal communication, July 27, 2004; Janice Joyce, personal communication, August 6, 2004). Some LPNs have asked, "Why are LPNs replacing RNs?" (Janice Joyce, personal communication, July 27, 2004). Meanwhile, some RNs have wondered what the term full scope means as it applies to LPNs and what, if any, are the limitations of full scope LPN practice (Pamela Ottem, personal communication, August 6, 2004).

In an effort to address member concerns, the CLPNBC and RNABC have offered facilitated workshops for RNs and LPNs in order to enhance role clarity via mutual exploration and clarification of each other's roles and responsibilities (Greenlaw, 2003; Janice Joyce, personal communication, August 6, 2004; Pamela Ottem, personal communication, July 27, 2004; CRNBC, 2005). Workshops have been offered at various facilities around the province and have been generally very well received. However, the frequency of the workshops has been variable (Janice Joyce, personal communication, November 15, 2004).
Summary

In this chapter I have presented some additional background information that serves to frame this study in the context of LPN practice to full scope in BC with a focus on acute care settings. As a practical nursing instructor in the acute care setting I have often been asked, primarily by RNs, “What can they (LPNs) do?” which speaks to the ongoing confusion some RNs in acute care face when confronted with the concept of full scope LPN practice in their workplace.

To my knowledge, there is little research-based information about the experiences of RNs and LPNs faced with a change in staff mix involving introduction of full scope LPNs into acute care practice environments in BC. In the next chapter I will outline the methodology of my study and approaches to data collection and analysis.
CHAPTER III

METHODOLOGY

In this chapter I outline the following: a) the purpose of my research, b) the methodology used in my study (e.g. qualitative description), c) the procedures surrounding recruitment of participants, d) my initial plan for data collection and analysis, and e) considerations of rigor. Finally, I end this chapter with an introduction to the change I made to use surveys as the primary means of data collection following unsuccessful attempts at recruiting interview participants. The research question I developed sought to solicit the experiences of nurses with full scope LPN practice, in their own words. I decided to utilize a qualitative approach to my guide my inquiry because it fit well with my research question and desire to gain an understanding of the unique perspectives of nurses.

Qualitative research strategies are oriented to aid the researcher in seeking answers to “questions that stress how social experience is created and given meaning” (Denzin & Lincoln, 1994, p.4). In my view, therefore, qualitative research strategies can provide a richer, more in-depth understanding of nurses’ and full scope LPN practice than quantitative methods. I wanted to fully explore the experiences of RNs and LPNs, and this would have not been possible with a quantitative approach because in my opinion, a quantitative approach would not have allowed me the opportunity to respond to the data and explore emergent concepts fully, as is possible with a qualitative approach.
Purpose

"The question posed in this study is: "What is the experience of registered nurses and licensed practical nurses working with or as full scope LPNs in the acute care setting?", with a focus on BC. What follows is a description of what I originally proposed and set out to do to explore the experiences of RNs and LPNs. It will soon become evident that my study did not progress as planned and in fact required a major change in my approach to data collection. This does not detract from the thesis' rigor. Maxwell (1996) has indicated that subtle adjustments (or major adjustments, sometimes) are needed when undertaking qualitative research projects. Details of the changes made, rationales for change, and outcomes will be discussed further in chapter 4 as the circumstances surrounding the changes served to inform my inquiry.

Qualitative Description

In order to explore the experiences of RNs and LPNs, and following consultation with my supervisor, I decided to engage in a small scale, qualitative descriptive study. To my knowledge, nurses' experiences of full scope LPN practice in acute care in BC have yet to be documented in the literature. Qualitative description is one approach to qualitative research aimed at discovering a “straight descriptive summary” of a phenomenon of “special relevance to practitioners and policy makers” (Sandelowski, 2000, p.338, 337). In fact, it is considered by Sandelowski to be, “the method of choice when straight descriptions of phenomena are desired” (p. 339).
Other established qualitative approaches such as ethnography, phenomenology, and grounded theory can be used to address questions pertaining to experience. However, the degree of depth and interpretation generally required to conduct a comprehensive ethnography or phenomenological inquiry surpassed the scope and primary intent of my study. Phenomenology, ethnography, and grounded theory are generally more interpretive in nature than needed for an introductory inquiry into a relatively unstudied topic. Ethnographies typically involve more immersion into the field of study and culture of interest with the average number of participants ranging from 25 to 50 (Polit & Hungler, 1999). Also, ethnographic analyses are often aimed at describing cultural behaviours, revealing social patterns or observed conduct (Morse & Field, 1995; Polit & Beck, 2004). As I did not set out to identify patterns or observable patterns of conduct and given the general scale of a typical ethnography, I did not find that this methodology was best suited to my question.

Phenomenological inquiries involve a reductionist process aimed at isolating the essence and meaning of a lived experience and revealing critical truths about reality that are grounded in personal experiences (Morse & Field, 1995; Polit & Beck, 2004). Phenomenological inquiries can be descriptive or interpretive, but both aim to provide a rich description of the essence of a particular lived experience. Again, while my area of interest might be amenable to a phenomenological inquiry, the depth and breadth of such an inquiry surpasses both my overall aim at attaining an introductory understanding of nurses'
experiences and the limited time and resources available for my study (Morse & Field, 1995; Polit & Hungler, 1999)

The inductive nature of qualitative description can be useful in providing a description of a phenomenon in terms that are meaningful and relevant to those experiencing it (Sandelowski, 2000). Perhaps maligned by some researchers who view it as to simplistic, Sandelowski observes that many research studies undertaken under the guise of phenomenology, grounded theory, and ethnography in fact more accurately utilize qualitative description method albeit with undertones of the aforementioned methodologies. In discussing qualitative description, Sandelowski highlights the utility of the method as a basic, effective, and low inference approach to answering research questions seeking to find "a comprehensive summary of an event in the everyday terms of those events" (p. 336). Undertaking a study using qualitative description is akin to a fact-finding mission aimed at providing a "minimally theorized or otherwise transformed" rendering of data in terms that stem from the data themselves (p. 337). However, qualitative description does not simply end with a rendering of facts. The researcher has a key role in qualitative description in identifying key categories in response to a particular question and also recognizing and describing latent meaning attributed to the experiences.

In studies using qualitative description the researcher recognizes the significant role they play in determining the final nature of the product (i.e. an informed description of the subjective experiences of participants). In my case, my background as an RN and practical nurse educator in various acute care
settings provided a lens through which I examined the data and ultimately framed my final description.

Recruitment

Initially, I set out expecting to interview approximately 10 nurses (an equal mix of RNs and LPNs) who work in one of 4 acute care units in a large Lower Mainland hospital where the LPNs practice to full scope (as of March 2006). As it turned out I was able to engage 9 participants in total. Only one was confirmed to work in the original setting specified above. The 6 additional participants joined the study by responding to anonymous, mail-in surveys (Appendix VI). While I ended up with a mix of RNs and LPNs, I was unable to confirm the specific units or facilities where these nurses practiced. Details of the switch in data collection method will be discussed further in this chapter.

I completed the UBC Behavioural Research Ethics Board approval form in March of 2005 and obtained approval by May of 2005 (Appendix I). I then completed the research approval request form for Vancouver Coastal Health Research Institute in March of 2005 and obtained approval to proceed by May of the same year. Sandelowski (2000) suggests purposive sampling, especially “maximum variation sampling”, for qualitative descriptive studies (p.337). Initial recruitment efforts employed convenience sampling (i.e. whoever responded to the study notices) in order to gain an initial base of participants and data that would later guide my purposeful sampling as the study progressed. Purposeful sampling would have enabled me to obtain data from a variety of nurse participants, for example, if only young RN graduates with no previous work
experience with LPNs responded I might then try to recruit RNs with more extensive and longer practice histories that included past work with LPNs. The idea behind purposive sampling, in particular maximum variation sampling, is to gain a broad understanding of an event or topic from a variety of unique perspectives. Therefore, my initial recruitment approach seemed like a solid plan that would result in more than enough participants. Numerous nurse colleagues, students, former students and bedside nurses, to whom I mentioned my study topic in the months leading up to the actualization of my study, expressed a keen interest in either participating or supporting my research. I was encouraged by the interest and positive feedback I received and entered into the recruitment phase of my study with a good deal of confidence that I would receive more than enough interest in my study, so much so that I would in fact be able to conduct purposive sampling.

My initial recruitment efforts sought nurses who were employed on 4 surgical units at the selected acute care hospital facility where the LPNs had been practicing to full scope on their respective units for approximately 6 months. A total of 10 recruitment notices (Appendix II) were placed throughout the 4 units in June 2005 in various “high traffic areas” (e.g. staff bulletin boards, staff lounges, and staff washrooms). Following posting of the study notices only 3 study inquiries were received.

I also planned to introduce my study at staff meetings organized by unit managers. This latter approach to advertising/recruitment did not occur however as the meetings were repeatedly rescheduled or cancelled by the managers (e.g.
‘not a good time’, ‘too busy’, manager on vacation). After close to 2 months of unsuccessful attempts at rescheduling meetings (i.e. coordinating unit manager and staff availability and my own full time work schedule) and facing a particularly busy time at work, personally, no further attempts were made.

By October 2005, following a) a prolonged period of no responses to study notices; b) ongoing delays and rescheduling attempts with unit managers to speak at staff meetings on the units; c) a prophetic statement from my single interview participant that I was unlikely to receive any other interview participants; and d) following consultation with my supervisor, a decision was made to change the method of data collection. Anonymous, mail-in short answer surveys were constructed using 6 of the original 9 interview questions and coupled with the demographic form (Appendix V) utilized with the initial interview. Over the next 3 months batches of anonymous, mail-in surveys were distributed to unit managers and colleagues who requested and/or offered to distribute them to nurses they knew personally who either worked on the 4 units at the selected acute care facility or in other acute care facilities where the LPNs worked to full scope. In total 36 surveys were distributed and 8 were returned completed for a response rate of 22 percent. One survey was returned intact and completely blank and as such is not included in future discussions of the surveys. Since the surveys were distributed by hand, from acquaintance to acquaintance, I assumed that the response rate would have been considerably higher and was quite stunned to see once again that few nurses decided to participate. The notion of resistance to participation is discussed further in the next chapter.
Procedures

In this section I will describe my approach to data collection and analysis as I originally intended. I will also present my considerations of rigor for this study. I will then outline what constituted my audit trail for this study. Finally, I will present the circumstances and details surrounding a change to using short answer surveys as my main method of data collection.

Data Collection

I planned to collect data using approximately 10, single, one hour, semi-structured, open-ended interviews and a brief demographic form (designed primarily to facilitate purposive sampling) with each participant. Informed consent was to be obtained prior to beginning an interview (Appendix III). The interviews were to employ a short interview guide, consisting of 9 open ended questions that I developed to aid in focusing and standardizing my inquiry on the experiences of nurses (Appendix IV). My construction of the 9 interview guide questions was influenced by Charmaz’s (2002) suggestions for how to construct a qualitative interview guide. The questions were broad enough to solicit a wide range of participants’ experiences of full scope LPN practice in acute care, but also focused enough to keep data collection in tune with the objective of my inquiry. Questions were going to be modified as needed, on an ongoing basis, based on findings from data and preliminary analysis of each interview.

I also intended to draw upon collateral data sources where possible (e.g. personal communications with nursing practice consultants, unit managers,
discussions with nursing colleagues, and observations of the transition to full scope LPN practice in acute care settings where I have work experience as an LPN educator), to add additional richness to the context of the nurses’ experiences/statements. This collateral data helped to inform my discussion of my findings and I will discuss this further in chapter 5. Finally, I kept anecdotal and reflective notes throughout my process of recruitment, data collection, and data analysis as a means of laying out my own experiences and thought processes as I moved forward in the research process. This reflective process not only served to guide my later analysis of the data, but also helped to direct my changes in data collection approach and management (e.g. the shift to surveys).

The main, initial data collection techniques I selected (semi-structured interviews & use of collateral data sources) were selected following a review of Sandelowski’s (2000) article on qualitative description in which proposed techniques for data collection for the method were outlined. In the article, Sandelowski suggests data collection techniques that seek a “broad range of information”, such as, “minimally to moderately structured interviews and/or focus group interviews” (p. 338). In addition, other data gleaned from observations and review of print materials is proposed to be useful in studies employing qualitative description. Even the switch to short-answer questions in the survey later in the study was not, in my understanding, a massive departure from suggested data collection in qualitative description since it used the same open-ended, interview guide questions and included a question which encouraged participants to add
any additional information they felt was relevant, if not covered in previous questions. However, I will discuss the shift to surveys and the surveys themselves in more depth in chapter 4.

Data Analysis

My initial plan was to proceed with data analysis concurrently with data collection. As mentioned previously, I also planned to modify the interview guide as needed as I progressed with the interviews and analysis in order to better flesh out themes/categories identified in each previous interview or potentially identify new themes/categories. Content analysis would be used to analyze the interview data as recommended by Sandelowski (2000) in outlining qualitative description. Additionally, I kept anecdotal notes and a reflective journal to further facilitate my analysis.

All interviews were to be transcribed verbatim and then reviewed in depth. Demographic information was to be catalogued and used to facilitate purposive sampling as the study progressed. Ultimately, my aim was to discover a series of categories or themes that were directly reflected in the data and best captured and described the experiences of RNs and LPNs of full scope LPN practice in acute care. This was my plan. However, in the case of my study as with many things in life even the best of plans can sometimes require adjustments and this approach had to be modified as I have mentioned previously and will discuss further in this chapter and in the next.
Content analysis. Qualitative content analysis is the analysis strategy recommended by Sandelowski (2000) for qualitative descriptive studies. This approach is the "least interpretive of the qualitative analysis approaches" and is aimed at representing the data (i.e. both the explicit and implicit meaning of the data) in its own terms (Sandelowski, p.338). Sandelowski cites Altheide who discusses ethnographic content analysis and highlights the central position of the researcher in relation to the data. The process of qualitative content analysis is inherently "reflexive and interactive" (Sandelowski, p.338). Through a process of constant comparison and continual discovery the researcher employing qualitative content analysis visits and revisits the data, identifies categories and generates a straight, "narrative description" that includes both the explicit and latent content of the data (Sandelowski, p. 74). Since Altheide's discussion on ethnographic content analysis, general qualitative content analysis has been described in even greater depth. With the aim of facilitating the researcher's use of this analysis strategy with enhanced clarity of approach and purpose, Hsieh and Shannon (2005) outline 3 forms of qualitative content analysis (conventional, directed and summative).

Conventional qualitative content analysis is differentiated primarily from the other two types of qualitative content analysis in that the initial codes and categories are derived directly from the data rather than from existing research, theory and literature. For the purposes of my inquiry, therefore, conventional qualitative content analysis was selected as the analytic strategy to best answer my research question.
Criteria for Affirming Rigor

To ensure rigor in qualitative research is to ensure research is conducted in such a manner that errors are avoided and findings can be considered trustworthy and believable (Koch & Harrington, 1998; Lincoln & Guba, 1985. Lincoln and Guba outline four criteria for evaluating trustworthiness that are applicable to qualitative research, 1) credibility; 2) applicability; 3) auditability; and 4) confirmability. Using guidelines for rigor outlined by Sandelowski (1986) and Lincoln and Guba, several steps were taken during my research process to ensure issues of rigor, particularly auditability and credibility, were addressed.

Auditability

Trustworthiness in qualitative research is fundamentally concerned with making the research process visible and traceable (Sandelowski, 1993). Auditability is the term applied to the process or steps involved in delineating the research process and decision making process therein (Beck as cited by Koch & Harrington, 1998). Several steps were taken to address auditability in my study, from its initiation to conclusion, thereby making my decision making process visible and traceable. For example, details of the sampling process, specifically the initial approach taken and subsequent changes, are outlined in Chapter 4. Five main processes surrounding data collection and management I employed during the course of the study are also outlined. These 5 processes included: 1) use of a predetermined interview guide to help guide the single, semi-structured interview; 2) consistently applied analytic techniques (e.g. coding method, use of
marginal notes, and colour coding system) when reviewing the interview transcript and later survey responses; 3) ensuring working definitions of analytic terms (e.g. codes and categories) are provided; 4) checking in with my thesis supervisor at intervals to help ensure my decision making process remained visible and logic in the inductive reasoning process remained clear; and 5) keeping a reflective journal for the duration of the research process which served as a sounding board for my thought processes throughout the process of data collection and management, not only the ‘how’ but also the ‘why’ of my decision making processes.

Credibility

Credibility refers to the believability and relevance of the research conducted (Lincoln & Guba, 1985). Several steps were taken to ensure credibility in my research. In an ongoing fashion, I checked to ensure that my analysis was data driven by reviewing my codes and categories while reflecting back on the data as a whole. To facilitate this process I kept a journal where I noted my progress with category and code development, my impressions of the data and how reflective of the data, or not, the codes and categories seemed as subsequent surveys were received and reviewed. In this manner of ongoing reflection and taking time to step back from my coding to review the data as a whole, I was able to further develop and refine my categories.

I also discussed my developing categories with my thesis supervisor at intervals as I proceed with the analysis. In addition I challenged and refined my
conclusions by returning to the data and seeking both similarities and differences to ensure that my conclusions indeed made sense and remained relevant to the data. This process of challenging and refining my conclusions was aided by checking them with my thesis supervisor at intervals to ensure my inductive reasoning process remained logical and visible.

My Audit Trail Discussed. What follows is a description of the processes undertaken by me during my research. It is important to note that the single participant interview obtained and subsequent 8 surveys returned were treated as independent data initially and only in the latter stages of analysis did I look to compare and contrast categories from both sets. The process of shifting to surveys is an important part of my research which is discussed later in this chapter and further in Chapter 4.

The single interview was conducted with the use of my interview guide and was later transcribed verbatim. The transcript was then read while concurrently reviewing the original interview audiotape in order to ensure accuracy of the transcribed data. Following the first read, the transcript was read through in its entirety again, at which time I highlighted keywords and/or phrases using colored pencils and marginal notes. Initial codes identified constituted “primary categories”. These primary categories were numerous initially and were later refined and combined, as I continued to immerse and reimmerse myself in the data, in order to obtain a more concise and yet relevant summary of the participant’s responses.
Survey responses were transcribed verbatim onto my computer and collated into a single document. The survey data was reviewed and coded in a similar fashion as was the interview transcript, however, I did not seek to confirm or disconfirm categories found in the interview data as I sought to treat the survey and interview data as distinct in the preliminary phases of my analysis. Combining data sets and treating them as a single grouping would have been inappropriate as there was much difference in the manner of data collection and data received.

Categories identified in the interview and survey data and the substance and nature of subsequent revisions to categories were tracked by date and marginal notes and later, in my reflective journal. Also, collateral data obtained (e.g. my experience trying to organize unit information sessions for my study; my experiences with prospective participants on that unit; staff postings on an acute care unit implementing full scope LPN practice; anecdotal information from nursing colleagues; and information from articles) were recorded in a reflective journal as I proceeded.

Once I identified several key categories in each respective data set, I then looked for similarities and differences among/between interview and surveys, recognizing that I was dealing with two distinct data sets, speaking to a common topic. Ongoing reflection on the processes of analysis and my own biases in my reflective journal helped to keep my research process transparent. Keeping my reflective journal helped to provide me with a “critical gaze” on the analytic processes undertaken and to enhance their defensibility by providing an audit
trail of my research process (Koch & Harrington, 1998; Thorne, Reimer Kirkham, MacDonald-Emes, 1997). Meetings with my supervisor at intervals also helped to advance my research in a logical and transparent fashion that helped keep me accountable to the research process and true to the data.

The Shift to Surveys

In the 4 months following the initial interview no further study inquiries were received that resulted in an interview. The study unfolded radically different from what I had expected. Plans for data collection and analysis were no longer meeting the needs of the study. In effect, data collection had ground to a literal halt and the proverbial clock was ticking. As a result, and in consultation with my supervisor, I reworked my initial plan for the study (i.e. recruitment and data collection approaches). This decision to switch my focus from single interviews to anonymous, mail-in surveys using 7 of my original 9 interview guide questions as the main method of data collection was made for several reasons which will be detailed in Chapter 4. I submitted a proposal to the UBC Behavioural Research Ethics Board for approval of a change to surveys in October of 2005 and obtained approval by November of the same year.
CHAPTER IV

Data and Analysis

The nature of my question

My research question was, “What is the experience of registered nurses and licensed practical nurses working with or as full scope licensed practical nurses in the acute care setting?”. In essence, I wanted to know how nurses who are living this rather ‘new’ phenomenon first hand are experiencing it. The impetus for my question stems from my work as a registered nurse with an acute care/critical care background and more recently as a practical nurse educator. I am actively involved in the education of practical nurses in the acute care component of their education at the college where I teach and have been curious as to how both RNs and LPNs are experiencing the implementation of full scope LPN practice in the acute care setting.

My question was deliberately broad in nature because it is, to my knowledge, the first inquiry of its kind to focus exclusively on the experiences of nurses with full scope LPN practice in acute care in British Columbia. My question was well suited to qualitative description method as this method is, “especially amenable to obtaining straight and largely unadorned answers to questions of special relevance to practitioners and policy makers” (Sandelowski, 2000, p. 337).

What Happened: A Chronology

The time of the study coincided with a heavy time at work for me personally, therefore my research process which began in the spring of 2005 concluded in
winter 2007. Soon after I entered the recruitment phase of my study, it became obvious to me that there were significant impeding factors influencing my attempts at recruitment. I was surprised by the low response rate to my study notices. I considered the apparent reluctance to participate as data to consider in and of itself, particularly as the one interviewee predicted that no-one else would volunteer. What follows, is an account of how my research process unfolded for me beginning with the posting of study notices in June of 2005.

Initial recruitment efforts

Once I received approval to proceed with my study from the ethics board of the selected hospital site in March 2005, I approached the unit managers to introduce myself and proceeded to post a total of 10 study notices. Surprisingly, in the four months following the posting of study notices, I received only 3 queries regarding my study and only 1 resulted in an interview. This was entirely surprising for me, as many nurses with whom I discussed my research with in casual conversation, prior to initiating recruitment, all made comments to the effect that they thought this was a good and timely topic and that I was sure to have a lot of responses. In chapter 3 I outlined my subsequent change in recruitment and data collection techniques to anonymous, mail-in surveys delivered by hand to prospective participants by unit managers and personal work colleagues. Thirty-six surveys were distributed in total and each survey packets contained: a) a 3 page survey using 6 of the 9 original interview guide questions, b) a demographic form, and c) a stamped, self-addressed envelope.
Below, I provide summary information on the 9 nurses who ultimately participated in my study (e.g. 1 interviewee and 8 survey respondents).

Participants

In total, 9 nurses participated in my study (4 LPNs, 5 RNs). The single interviewee was an LPN. One person mailed in all survey documents blank and as such is not included as a participant. This submission of a blank survey was fascinating to me as it showed someone took the time to fold the survey and accompanying documentation, lick and seal the envelope and find a mailbox while providing no information whatsoever. This person's non-response response was unique, thankfully. To facilitate my discussion on the survey responses in this chapter, however, I will now only refer to those surveys that were submitted complete (002-009).

Completed surveys submitted were anonymous therefore the details of who, in particular, provided the respondents with a survey and what was said to the respondent about the study at the time they were given a survey are not known. However, I assume the respondents acquired their surveys directly from one of the managers or colleagues I provided batches of surveys to. Also, it is not known whether or not the survey respondents work at one of the 4 specific units initially the focus of my recruiting efforts since packets of surveys were distributed to some of my work colleagues as well as the unit managers of the 4 units at the selected acute care facility. All study participants were female and all but one received her nursing education in British Columbia.
The participants ranged in age and years for nursing experience. The LPN participants were generally older (i.e. >35yrs), however one LPN who responded did not state her age. The RN participants ranged in age from early twenties to mid-thirties. Years of nursing experience spanned a wide range among all participants (e.g. 1 – 25 yrs). However, overall the RN participants had less practice experience overall than the LPN participants. Only 1 survey participant failed to include her/his length of nursing practice. All but 2 participants acknowledged nursing experience in more than one type of practice setting (e.g. sub-acute medicine, long term/extended/intermediate care, hospice, clinics, and emergency). Two participants (1 RN and 1 LPN) had attended the joint CRNBC/CLPNBC RN/LPN workshops.

As I mentioned in the previous section, despite posting numerous study notices and hearing casual expressions of interest in my study from a number of nurses and colleagues, I only interviewed one nurse. What follows is a summary of the 3 expressions of interest I received from nurses regarding my study once I posted my study notices. Following that, I present my analysis of the interview data.

Three expressions of interest: one interview

The first query of interest in my study came from a RN who spoke with me while I was placing the study notices. This RN expressed a keen interest in participating in an interview with me, giving me her telephone number and inquiring if she could set up an appointment on the spot. She told me that the
presence of the LPNs on her unit has led to much stress for her and 75% of the other RNs. She added that working with an LPN causes her to be more scattered due, in part, to the frequent questions she receives regarding LPN patients from LPNs and physicians. Also, she stated that the LPN presence was “confusing for patients” since she would need to administer some medications (e.g. IV medications) for the LPN’s patients that the LPN could not deliver since the action falls beyond the LPN scope of practice. During our conversation, I also overheard some RNs joking with each other that there are a number of RNs leaving the unit “because they don’t want to work with LPNs” then the RN I was speaking with added, “just kidding”.

I casually mentioned that I used to teach RNs and now teach LPNs. She reacted with visible surprise and then offered to post study notices in the break room and bathroom. Conversation changed to social matters briefly until I asked her if she could explain how the nursing assignments were set up on her floor. She explained the assignment structure to me briefly and added that some LPNs are great and others are not. She said that working with some LPNs is better when she can delegate well. She added that RN workloads are often heavier when working with an LPN and “at the end of my shift I get home just exhausted”. Finally, she mentioned that the hospital nametags only use the title “nurse” and not “registered or licensed practical nurse” and that this lack of distinction was not welcome (e.g. by RNs and some patients). Apparently needing to get back to work, we set up an interview for the following week; however, she did not return a
planned confirmation call the morning of the scheduled interview and I did not hear from her again.

The second inquiry came from a nurse who later became participant #001. In fact, this nurse contacted me to see if my study was connected to some project or study the CLPNBC had called to invite her to participate in back in March 2005. She had not received any further information from the CLPNBC and hence decided to call my study contact number. I was confused when she contacted me initially, since I had not heard of (nor have heard of since) any proposed or active inquiries being conducted by the CLPNBC. I explained my study to her and I was invited to her home for an interview. This nurse was extremely forthcoming with her experiences as a LPN practicing to full scope on her unit at the acute care facility. This interview was transcribed verbatim and later analyzed; the analysis and results will be discussed later in this chapter. During the interview, this nurse did express that for a number of reasons (e.g. cultural background of a number of fellow FSLPNs at the hospital) I would probably not have many or any further interview participants, strangely enough, her words were prophetic.

The third and final inquiry into my study came in early September 2005 from a LPN who was not an employee on the study units, but was in fact considering employment there. She stated that she had seen my study notices and that the purpose of her call was to find out what I knew about the unit as she was considering applying for a casual position there. This nurse wanted to know whether or not I felt the unit(s) in question was/were a good place for LPNs to work and what I knew about the transition (e.g. to full scope). I was quite taken
aback by this. She sounded disappointed when I told her my research was for my thesis and was not a program evaluation. She stated that “the system (healthcare) is sick”, with too many experienced nurses retiring, too few RNs emerging from the 4 year programs, and too many LPNs coming out of the 12 month programs with fewer and fewer mentors.

She also stated that she finds that LPNs are often working beyond their scope of practice out of necessity and that she has hope for, but worries about the younger, newer nurses who don’t have experience to draw from. Finally, she stated that the transition to full scope practice in her current workplace was not without growing pains and that “I’ve already been through that…I don’t want to go through that again”. She was not interested in participating in the study and when she realized that my research was not a program evaluation for the unit promptly ended the telephone discussion.

As I mentioned earlier in this chapter, following the posting of my study notices only one expression of interest resulted in an interview. In the following section I present my analysis of the interview.

**Analysis of Interview with Participant 001**

The first and only interview participant in my study approached me in the spring of 2005. As an LPN working on one of the four units I posted study notices on, this participant was eager to speak with me and during my one hour interview with her she recounted numerous examples of her personal views and her experiences working to full scope in acute care. Following my initial reviews
of the interview transcript, and using the procedures for analysis described in Chapter 3, to address the research question, "What is the experience of registered nurses and licensed practical nurses working with or as full scope LPNs in the acute care setting?", I identified 8 categories.

These eight initial categories were: 1) critical thinking, 2) communication, 3) isolation, 4) survival, 5) receptivity, 6) recognition/respect, 7) identity, and 8) appropriateness. After a period of a few weeks, during which time I was working on other things, I returned to the interview and my eight categories to review them and the supportive quotes I had identified for each. Some categories required change while others still seemed appropriate to me. For example, the category entitled critical thinking seemed too narrow, especially in light of comments this participant made when discussing critical thinking and how this participant felt hers was being questioned by some RNs on the unit. What this participant seemed to be saying, when I looked at the context of her comments, was that she felt her professionalism or abilities as a nursing professional were being questioned. In later comments this participant provided specific examples that, in my view, asserted her professionalism, such as how she managed emergent patient care situations without support from her buddied RN and identified several RN medication errors. In light of this I changed the category title to professionalism. In my discussion of the category of professionalism I will provide examples further illustrate that professionalism is a more fitting category then solely critical thinking.
Further reflection on my modified category and remaining categories led me to believe that my analysis could be more concise. In other words, I could reduce the number of categories while still capturing the essence of what this participant was saying in her interview. After careful consideration and ongoing immersion in the data and my analysis, I reviewed and consolidated my 8 previous categories into 3 key categories that appeared to typify her experiences. These 3 categories are: 1) professionalism, 2) receptivity, and 3) appropriateness/fit. Each of the 3 categories is discussed below; supporting quotes are included that best exemplify each category.

**Professionalism**

The theme of professionalism stemmed from a number of comments made by this participant whereby she expressed feeling that her professionalism and even at times her professional identity were being challenged and/or undermined by RNs and unit management. She also made comments which seemed to affirm and assert her professionalism and professional identity. For the purpose of this analysis, therefore, professionalism refers to actions and characteristics of a professional. The initial categories of *critical thinking, identity, and* some aspects of *communication* all served to inform this category of *professionalism*. This category is presented in terms of professionalism challenged and professionalism asserted.
Professionalism challenged. This participant made a number of comments which in my view demonstrated that she perceived some RNs as challenging or questioning her professional capabilities and competencies as a nursing professional, in effect possibly viewing her as a lesser professional. One of the first observations she made was that not only some, but many RNs question the LPNs ability to think critically in the clinical area; "for some reason there’s a belief with a lot of the RNs that, um, that we are not trained as critical thinkers and that we shouldn’t be there because we couldn’t possibly think it out”.

In addition to making the comment that RNs questions LPNs ability to think critically, she gave a specific example of an incident where she felt a RN challenged her critical thinking and professionalism and directly undermined her to her patient.

Here she is referring to an incident where an RN directly questioned her professionalism (i.e. how she responded to a patient’s Foley catheter clamp coming loose and leaking urine onto the floor). The LPN stated that she stood in the doorway. Behind the RN when she heard the RN stating to the patient, “well she didn’t do a damn thing for you did she?”. The same RN then allegedly proceeded to report this participant to her manager with a story of improper nursing care that was not accurate, according to this participant. Unit RNs approaching unit management with allegedly unsupported complaints of her own and other unit LPNs’ practice, and unit management acting in favour of the RNs is a recurrent issue discussed by this participant; “and it is abuse, you’re not paid, anyone is not paid to take that in their job.”
Along with comments regarding how she feels LPNs’ abilities to think critically in practice is challenged by some RNs, she also stated that RN mistrust of LPNs (e.g. competencies and capabilities, including critical thinking ability) is directly to blame for lack of inclusion of LPNs in nursing teams in some acute care units in her facility.

I understand that they decided to take the full scope LPN out of there again even though they had just put them in. Now I don’t know the reasons exactly why but what I have heard is that some of the LPNs were doing a fantastic job and were trusted and some were not and that’s not a part of the reason, it was the reason they decided to take them out. Now I don’t know exactly if that’s true or not...

Here she was speaking about another acute care unit she was worked in, at full scope, a few years prior to joining her present unit. Along similar lines, during a conversation I had with one of the unit managers for one of the four units where I placed study notices, I was told about an incident on another acute unit in the hospital in which an LPN allegedly did not report a significant, physiological patient finding to her buddied RN until the end of her shift. Her manager used this as an example of how the LPNs were not necessarily reliable in reporting or perhaps even recognizing important, reportable patient findings in a timely manner.

Another example of how this participant felt that LPN professionalism in general is challenged or undermined was highlighted when she talked about the seemingly arbitrary distinctions regarding nursing skills/ tasks that are designated for RNs and LPNs in units where she has worked.

I worked there initially and it was all full scope many LPNs there actually, um, and we would give sliding, sliding scales insulin...and then it was decided oops, can’t do that, its too, its too, uh, patients are too acute but it
kind of made me laugh because in my experience in long term care many people's standard way of receiving insulin is sliding scale so it doesn't always necessarily mean that the patient, often too on surgical floors, I know on (specific unit) our surgeons as soon as they came in, they'd be taken off regular insulin and put on sliding scales until they had their surgery, until they were stable, so it's ironic that the powers that be have judged it as a duty that we can't do because it doesn't make sense.

She again commented on seemingly arbitrary distinctions between LPN and RN tasks when she stated the following.

It was very specific points that were, at which point does it become a patient that only the RN can look after... it was a very initial list I remember looking at it and it made actually no sense because what they do is they would still give us the patients with the sliding scales. We could take the glucometer, we'd just have to grab an RN to do that so if you're telling us the patient is too acute then the patient is too acute, you can't have it both ways and this is the kind of stuff that ... still is, it hasn't changed.

This observation on her part is similar to one that I had when I first took a student group to a sub-acute medical ward in the same hospital facility in 2003. There was a list of skills that excluded LPNs even though they fell within the scope of LPN practice as outlined by the CLPNBC. Now in retrospect, that unit had only recently started utilizing LPNs to full scope and this list was most likely to be reviewed once implementation was more established. However, it did seem like a rather arbitrary list on first reading and was a source of confusion for both myself and my students initially.

**Professionalism asserted.** Perhaps in response to her recounting experiences where she felt criticized by RNs, this participant proceeded to make statements that seemed to me to assert her professionalism in several ways.
First, she asserted her capacity to think critically by questioning the same ability in her RN critics (e.g. recent graduates who are younger and might still live at home).

we have our critical thinking and that, that’s a real thorn in my side is the critical thinking thing, my god, ...but for some reason there’s a belief with a lot of the RN’s that, um, that we are not trained as critical thinkers and that we shouldn’t be there because we couldn’t possibly think it out or, you know, and, and that’s something that doesn’t just come with education, that’s something that comes with training and it sort of comes with upbringing, um, and I think if you’re living out on your own through life, you become a critical thinker and I find that quite often the people that use that terminology were still living at home [laughter] and hadn’t worked before, hello, how critical has your thinking been?

Second, she reflected on her own broad range of previous experiences and the fact that she has been practicing to full scope for some time prior to her present position; “I am from (a location outside of BC) and they’ve upgraded some time ago and they still are, still are, you know, adding different areas but so I was initially hired in 2002 full scope”.

...I guess, at (this hospital) some people had to go back to school, well I didn’t have to do that because I had that in my course and because I’d gone back in (early 1990’s) and gotten a four month pharmacology so I was already up there, um, but what they did do is they increased my duties into the full scope.

Third, she commented on her experience catching/recognizing errors in practice made by RN colleagues; “But you know, the other night how many med errors I found on my shift, three all made by RN’s”, and “so while they’re running around pointing their fingers, picking and going on and on, their own practice is going to be affected too”.

Fourth, she gave a detailed example of how she managed an emergent patient situation (and assumed a leadership role) with little to no support from her
buddied RN on the unit or other unit RNs. In this experience she recounted, she spoke of how she was forced to manage the care of two patients who became critically ill during her shift. These 2 patients were no longer stable, their outcomes no longer predictable and therefore fell beyond her sanctioned scope of practice. However, when she attempted to change assignments with her buddied RN she was told to “f*** off” and how it “it must be f***ing nice for you LPNs to give up your patients the minute they get hard” (e.g. become acutely ill/unstable). She spoke of how she then collaborated with a float RN to coordinate and manage the care of these 2 patients until the end of her shift.

In addition to this participant giving examples which demonstrate her efforts to assert her own professionalism, she also spoke of her professional identity as an LPN and how RN attitudes towards LPNs need to change. She also expressed pride in her identity as a LPN.

RN’s need to get off their hoity toity throne and realize that LPNs are trained competent professionals just as they are and that, in fact, a lot of their behavior proves that four years university doesn’t mean shit because they’re not showing what they should show based on education, just on education alone, that’s all that matters to them, um, so having said those two things, they also have to learn to work with each other and to be less harsh on each other, they’re hard on each other particularly hard on us because they see us as lower end of the food chain and that has to change. I’ve had people say to me well aren’t you going to become a nurse and I’ll say, I’m a licensed practical nurse, I am a nurse I don’t want to be an RN, if I wanted to be an RN I would become an RN.

In summary, this participant offered several examples and personal reflections that in my view spoke to the notion of professionalism. In the next section I will discuss the category of receptivity.
Receptivity

The category of receptivity was generated upon further reflection on the interview transcript and reflection on the initial categories of: communication, isolation, survival, and recognition/respect. The experiences discussed by this participant that led to my generating the aforementioned 4 categories, upon further reflection, all seemed to speak to the larger point of receptivity. For example, the initial category of communication, included comments from this participant regarding how she felt some RNs were unwilling to include her in conversations regarding patient care and how she felt misunderstood by some RNs. Further reflection on the comments regarding communication with RNs I was struck by the idea that some RNs were not receptive to communication from this participant. The other initial categories (e.g. isolation, survival, respect, and recognition) all included comments that indicated this participant did not feel neither she, nor the other LPNs in some cases, were being welcomed, supported and/or included in the unit. Receptivity herein refers to the willingness to include and accept both the presence and professional contribution of this participant on the unit. The overwhelming sense I got from the interview with this participant is that, from her perspective, neither the facility nor staff (e.g. RNs and unit management) were very receptive to the arrival of full scope LPNs on the unit. As a result, this participant recounted feeling quite marginalized.

For the purposes of this discussion, I will expand on the category of receptivity by presenting examples that highlight this participant’s overriding thought that there is a lack of receptivity in her workplace towards not only her but to the
presence of other LPNs now practicing to full scope. I will also provide a couple of instances where she gave specific examples of particular individuals who, in her opinion, were more receptive to herself and other LPNs; however, there are very few examples. Finally, I will present her suggestions for how receptivity in her workplace could be enhanced and would in turn improve working conditions for herself and potentially other LPNs in her facility.

Receptivity: a lack thereof. This participant cited numerous examples and personal experiences which, in my opinion, can be interpreted as examples of a lack of receptivity for her and her LPN colleagues. In my review of the interview transcript I was struck by how this participant gave example after example of instances where RNs, and in some cases her unit manager, displayed not only a lack of receptivity but also both subtle and blatant resistance to her presence and participation on the unit’s nursing care team.

One of the comments this participant made that started my consideration of the category of receptivity regarded the impetus for the introduction and integration of full scope LPN practice in her facility. She commented that the move to incorporate LPNs in the select acute care units was a decision made by management that was then imposed on the units.

...this was not something that management or staff ... wanted, this was something that was implemented on them, imposed upon them so I think people need to know that because this is not what staff or managers wanted, they’ve had to deal with it but basically the LPN board and the powers that be decided well, we’ve got these LPNs that are trained, capable, cost less, more cost efficient, they just started putting them in and why are you making them upgrade to full scope and not giving them jobs, hello, you have to do it, so that’s why this is happening.
The above quote highlights that the inclusion of full scope LPNs was a change that was not necessarily desirable to unit staff or management and as a result was perhaps in part to blame for the negative receptions that she and apparently other LPNs faced. This comment that the change to include full scope LPN practice was forced or imposed from higher up was echoed in a discussion I had with one unit manager who told me in a separate conversation that the units were told that they would have to choose between adding patient care aides (PCAs), unregulated care providers, without specific assessment or nursing capabilities, or full scope LPNs. This particular manager said that faced with this choice, they chose LPNs because they can do more in terms of participating in patient care. Hearing this comment from the unit manager then focused my attention on this participant’s comment. I considered how it must feel to know that you are not necessarily wanted in an environment, but are rather being tolerated as the lesser of two rather undesirable choices.

This participant’s feeling that the unit, and in particular the RNs on the unit, were not particularly receptive to the introduction of full scope LPNs is something she supported with several examples, beginning with the frank statement that some RNs simply do not want LPNs on the unit.

..some that perceive it this way are older nurses that have been there for now fifteen, twenty years and just for some reason think its always been this way, we don’t need LPNs, they shouldn’t be here so they just don’t want them.

She mentioned that from the outset, the introduction of the LPNs on the unit was not a wholly positive experience. She commented that there was no
organized introduction of the LPNs on her unit, while there was a small luncheon in the staff room she noted that it was not well attended and did not include actual introductions of each of the LPNs. Later, she stated that the LPNs underwent a lengthy, 3 month orientation process that far exceeded the standard orientation of new RNs in both length and level of detail of individual competencies that were assessed (e.g. dressing changes); “Come on, they don’t give RNs that and new graduate RNs don’t get that and we were, uh, all working experienced LPNs”.

They treated us as if we were total imbeciles, just graduates, they assessed everything we did from the way that we dressed a hang nail to the way that we signed and dotted our i’s, they nit picked and nit picked and nit picked for three months.

For this participant, the orientation process and other LPNs hired was more like an extended evaluation that showed a clear lack of respect towards the experienced LPNs and did not recognize the more than a decade of work experience in this facility and the nursing expertise they brought with them to the unit. In addition, she noted and I later confirmed, that there is only one LPN on duty on each unit for any given 12 hour shift.

So basically there’s one on per shift at night, there’s on per shift during the day so you’re really very much alone, you don’t have another person of your capacity ever on, you see them at the end of the shift when you quit.

This participant expressed feelings of being isolated, professionally, as the only opportunity to collaborate with a peer would come at shift change or on her days off. She also commented that she felt the LPNs were/are basically “set up for disaster”; perhaps these feelings of professional isolation and hyper-scrutiny contribute to this.
Another example of how, in this participant’s view, she and the other LPNs were not readily received on the unit is less to do with the structural aspects mentioned above, but more so with informal interactions with RNs on the unit and with her manager. However, communication among nurses is a thread that is also pulled through with these examples. For example, this participant commented early on in our interview that she has a varied range of professional experiences in various settings and as such, felt she has the capacity to comment on issues of patient care on her unit. However, she noted that she rarely expresses her thoughts on the unit since the receptions those comments receive from (some) RNs are then misconstrued.

And I think that bothers a lot of the RN’s that I have a more (experience). I don’t have a super specialty but I have a wide variety so I can comment on stuff that I have done in a wider scope. It doesn’t make me a know it all one very subject, its just, its like a little slice of everything and they take it that way so its to a point now that I don’t even share my experiences or even bother to open my mouth because its misconstrued as “oh she’s blowing off again about all she’s done” or you know what I mean?

In effect, she silenced herself and withheld her contribution to the nursing team since she felt it was not being received in the manner or spirit it was being offered.

I mentioned earlier in the previous category, an example in which this participant gave a detailed account of an experience where she attempted to communicate and collaborate with her buddied RN and was met with very pointed and aggressive resistance. When she brought forward the incident to her charge nurse, the response she received seemed hardly receptive and apparently resulted in no supportive or other noted response whatsoever.
I even went to the charge nurse that day and I said, look, we're having problems here, I said we should be, um, changing our assignments here and she said well that's something that you need to work out with your RN and I said well I'm trying to work it out but she's telling me to fuck off, nothing was done, I was left to fight it out with her. So this is what I'm talking about, they set you up for disaster.

However, not all of this participant’s experiences of feeling unwelcome on her unit include such overt examples as the previous one. She recounted particular episodes where she felt she was the target of more subtle, passive, and indirect aggression and even shunning of her by RNs.

For example, this participant talked about how she was apparently being excluded from conversations in the breakroom.

...well there’s some bonds between people, there’s some clicks, I mean I’ve gone into the staff room and been totally ignored for the whole forty-five minutes I’ve sat there even when I’ve tried to talk but you know what, I’m a bigger person than that.

In a caring environment which this is completely not, I think people, I think we’ve gone for like nine weeks and people walk right by me like I’m not even there, they don’t speak to me unless I look at them and go, hello, how are you and that’s always gone on and particularly too to the LPNs they do not want us there, when it comes right down to it, this is implemented on them, they see it as something that will fail eventually, sooner or later we’ll be out there...

She also recounted an experience on a particular shift when she became physically ill, was in a great deal of pain, and apparently received no expressions of care or sympathy from the RNs on the unit that shift.

And oh, they just made me feel so guilty and so horrible, it was horrible. ...I call it schizophrenic, if you’re that retarded towards a staff member like they were that night...how in hell can you turn around and be compassionate to a patient, its almost schizophrenic.

In my experience, when a nurse colleague is visibly ill, they are sent home and as difficult as it is the rest of the team pulls together to cover the sick nurse’s
patients until a replacement can arrive. I found this particular experience difficult to listen to, due to the apparent lack of compassion from this participant's colleagues. The words used by this participant to describe the incident seemed to indicate that she was upset and even hurt by the lack of caring shown her by her colleagues. This lack of inclusion in breakroom conversations and apparent lack of caring behaviour towards this participant when she was physically ill on the unit seemed to show a lack of receptivity to this participant on a more personal even human level. The reception this participant and other LPNs on the unit received, primarily from some RNs on the unit, seemed to take its toll; "I'm just a single woman living in a basement suite trying to live, you know, and these people are out for blood half the time" and "everybody is just trying to survive this, I know some of them didn't make it".

...quite honestly everybody is just trying to survive and everybody is afraid to talk to each other that its going to be used somehow – which is why you haven't got a lot of response to your (research) ...um, yes from what I can see...

As I looked back over the numerous examples cited above, they seemed to me to speak to a lack of receptivity on the part of some RNs and her unit manager to both the presence of this participant and other LPNs. However, there were a couple of instances mentioned where this participant appeared to feel more positive about how she and the other LPNs were received; “and some, don't get me wrong, some of the staff are wonderful, they have treated me and others with the utmost respect but the majority don't”.

In the above quote, this participant was discussing what she felt distinguished "the good people" (e.g. some RNs) she works with on the unit.
But she then went on to note that even some nurses who seemed enthused at the prospect of her arrival and that of the other LPNs being hired on the unit soon turned unpleasant once the LPNs actually arrived: "they’ve worked with me, they’ve worked with other people, they’ve seen us......but then once we started full scope it was a different story because they see you as a threat as opposed to a co-worker".

This participant also reflected on her own perspective in terms of how she views the workplace (i.e. the people in it) and this gave me some insight into what attitudes or behaviours would contribute to a more receptive workplace, not only for her and other LPNs but also in more general terms. For example, she told me about her perspective on individuals and how she views each as a unique whole whom she treats with respect; each person that passes through life and each situation touches you and becomes part of you and it comes out in some kind of way and I don’t even think these people are aware of their own behavior sometimes”.

I see myself, I see all people as a whole, I don’t just see them as an RN or an LPN or a doctor, these are professions, these are training things that we’ve taken but there’s more to it than that because I know that, we judge that, I don’t see that happening.

I mean I don’t care, to me doctor, cleaner, I treat them all the same, they’re all a vital part of health care, not going anywhere so you’ve got to work with them and respect them, each person has their own place in the pyramid.

In the above quotes, this participant is highlighting what in her view seem to be important components in the workplace, namely that everyone is viewed from a holistic perspective and is treated with respect. The notions of viewing people
from a holistic perspective and with respect could be viewed as two ways to increase receptivity in the workplace, for example, to full scope LPNs such as this participant. In the next section I will discuss the final category identified in my analysis of this interview, appropriateness.

**Appropriateness**

The category stemmed from a reflection on a relatively few statements when compared to the other two categories. However, in my view it is important to make a distinct category that addresses the idea of appropriateness. For the purpose of this discussion appropriateness refers to suitability such as in the suitability of LPN patient assignments on the unit. While certainly this category may find some overlap with the other 2 categories I have identified thus far, in my opinion it warrants being distinguished as the question as to whether or not the acute care environment is appropriate for full scope LPN practice is one which I have at various times posed to myself, and one which I have heard mentioned in informal discussions with RN colleagues.

In the category of professionalism, this participant made several comments in which she seemed to me to be asserting her professionalism as a nurse and her participation on the nursing care team. However, at one point, if only briefly, she commented on the fact that arriving at suitable, or appropriate, patient assignment in her current work setting was challenging at times. The challenge was related to the fact that patient turnover on her unit is quite high. Also, her
example of how some RNs have resisted her attempt to establish appropriate patient assignments in fact placed her in a precarious position.

This participant commented on how, when faced with the inability to change her patient assignment, she managed to continue to provide patient care with the assistance of a float RN. What I did not hear mentioned was anything about the potential for professional liability for her in working with patients who fell beyond her scope of practice. While asserting her professionalism in the face of a difficult patient care situation compounded by a lack of receptivity on the part of her buddied RN and a lack of support from her unit manager, the fact remains that she was in a sense forced to care for patients that technically fell beyond her scope of practice (e.g. stable patients with predictable outcomes) and were hence inappropriate for her to care for. There seems to me, therefore, to be a potential risk to LPNs working in acute care that they may find themselves in a situation where they are required to provide care to patients who fall beyond their scope of practice.

**Transition to Surveys**

In the previous chapter I discussed my change to anonymous, mail-in surveys as my primary means of data collection. To recap, I distributed 36 surveys in batches to the unit managers for the units that were the original focus of my recruiting efforts and then also to several personal work colleagues. A total of 8 completed surveys were returned over a period of 6 months for a response rate
of 22 percent. In the next section I outline my approach to analyzing the survey data.

**Analysis of the Surveys**

My analysis involved reviewing each survey response for each question in the survey and using colored pencils to underline what seemed to me to be key comments and or recurrent themes. Key comments and/or recurrent themes identified were highlighted because they were either mentioned by several respondents or were unique to a particular respondent (e.g. only one LPN stated that in her acute care setting the patients were too acute or potentially inappropriate for her to work with). Over a process of a few months I reviewed the survey responses and my underlined portions and generated categories which reflected what I had identified in the survey responses. Following my initial reviews of the survey data I identified 7 preliminary categories. The preliminary categories I identified were: 1) expanded skills, 2) education/training, 3) communication, 4) teamwork, 5) appropriateness/fit, 6) burden, 7) acceptance, and 8) accountability/responsibility. The categories generated were often reflected in responses to more then one question, so I proceeded to collate my data into an excel spreadsheet which listed each category and supporting quotes which were identified by respondent ID and the question under which the response came. In this manner it became easier for me to visualize the categories as well as patterns in terms of who spoke to the different categories (i.e. LPNs and/or RNs).
Following further reflection on these categories coupled with additional reviews of the study data and reorienting myself back to my research question and the specific questions used in the surveys, I reorganized them into 3 broader categories: *defining the role*, *determining the impact*, *determining the fit of the role*. For example, from the responses to the question asking respondents what their understanding of full scope LPN practice meant I initially identified the categories of *expanded skills*, *education/training* and *accountability/responsibility*. However, upon further reflection I noticed that comments within both of the aforementioned categories actually stemmed from responses to questions about understanding and meaning of full scope LPN practice. Therefore, I created the broader more inclusive category of *defining the roll* (e.g. in the acute care setting). Also, elements of the initial categories of *teamwork*, *communication*, *burden and acceptance* together seemed to me to reflect how the respondents were experiencing and perceiving the impact of the addition of the full scope LPN role in their acute care work setting.

Each of the three categories will be discussed below, with supporting quotes from the data provided. Also, while I approached my analysis of the survey data as separate from that of the interview, some of the categories I identified in the interview also appeared in the survey responses. While I did not “look” for them in the survey responses, I did find some commonalities. Such is the case with the category of appropriateness/fit which I discuss later in this chapter.
Defining the Role

The category of 'defining the role' emerged as I reflected on the preliminary categories of expanded skills, education/training and accountability/responsibility. As mentioned in the preceding section, these 3 categories all serve to inform a larger, more overriding category which captured nurses' comments on the role of the full scope LPN and the defining features of that role as seen from the perspective of both RNs and LPNs surveyed. Therefore, what follows is my analysis of how I found both RNs and LPNs were defining the role of the full scope LPN.

Five of the 8 survey respondents commented on the topic of the education and preparation of full scope LPNs. Overall, the RNs and LPNs who responded seemed to have a mixed view on LPN education (i.e. curriculum and outcomes). One RN noted that LPNs will prepare themselves academically for their expanded role and accompanying responsibilities; “they will work to the full scope of their practice by taking the necessary courses and education in order to take more responsibility for patient care”.

However, most of the RN respondents commented on actual or potential limitations of the LPNs, even if noting that LPNs will take necessary courses to work to their full scope. Some of the RN respondents were quite critical of the education and training of the full scope LPNs, citing critical thinking skills as lacking or insufficient. One RN commented, “mostly I find that lack of knowledge / education and minimal critical thinking skills in some areas puts added stress on the partnered RN, as this directly affects trust in the partnership”. Another RN
noted that, “with good training they will be more confident and knowledgeable and contribute more, but may always be limited in certain “RN” situations”.

Finally, one other RN noted the following:

Some LPNs are obviously stronger than others but every time I follow them and examine their care I find things that have not been fully thought through. Despite a very long conversation they still miss many of the basics as these things are not included well in their curriculum. - pharmacology; - critical thinking skills.

As the above excerpt demonstrates, while only one RN criticized the LPN curriculum for lacking in some aspects of pharmacology, more than one RN brought into question the LPNs’ capacity for critical thinking.

The two LPNs who commented on the topic of education were clear in their assertion that the LPN role is expanding in step with their education. As one of these LPNs stated, “full scope LPN practice is the completed upgrading of pharmacology, physical assessment, taking & transcribing doctors’ orders, IV therapy as well as the PN curriculum of gerontology & acute med nursing”.

Another LPN respondent noted that since the introduction of her full scope role in her workplace, however, she is finding that her education level is “constantly being questioned”. She links this with ongoing resistance from RNs in her workplace to her being a member of the nursing team and that this contributes to a stressful and hurtful work environment.

While education was one aspect of full scope LPN practice that was noted by many of the respondents, both RN and LPN, expanded skill set was by far the most commented upon by all respondents. Both RNs and LPNs cited specific skills as defining features of what full scope LPN practice is, in their
understanding. One RN, a former LPN, commented that LPNs are, “are able to give oral/SC/IM medications, assessments, (dressing changes), and discharge. Under the guidance of an RN they can care for patients who are medically stable”. Another LPN noted that full scope LPNs, “…can practice full physical assessment, med administration (basic pharmacology & geropharmacology), taking and transcribing orders, IM/SC injections, meds by other routes except IV, IV therapy”.

Perhaps the emphasis on skills lists as defining features of full scope LPN practice is placed because the skills lists are a tangible distinction between RN and LPN. As I mentioned in chapter 2, in preparation for my study I spoke with an RN coordinator of a plan to implement full scope LPN practice and she commented that the term full scope was itself an employer generated term used to denote the extent of utilization of LPN skills and competencies as defined by the CLPNBC. No respondents commented on the role of their employer in defining the term full scope. Also, the role of their employers in the implementation of full scope LPN practice in their respective workplaces was not commented on either.

Beyond skills and education, all respondents commented on the accountability and responsibility associated with full scope LPN practice; as one RN, a former LPN, noted, “LPNs are accountable/responsible for their own practice”. One of the LPN respondents commented that full scope LPN practice, means to be able to be accountable, responsible, following the standards of
practice and competencies as well as the code of ethics as outlined by the College of Licensed Practical Nurses.

In addition to comments from RNs on the increase in accountability and responsibility for LPNs working to full scope in their acute care workplace, some RNs noted that their own level of responsibility increased when working alongside full scope LPNs. One RN noted that she feels the RN is responsible and therefore must care somewhat for the LPNs' patients. Another RN commented that as a result of the scope of practice limitations for LPNs the RNs need to carry their own patient load but also assist LPNs with certain RN tasks (e.g. IV medication administration), thereby increasing their work load and the number of patients they have a responsibility towards.

One LPN commented on an increase in responsibility for RNs since the introduction of full scope LPN practice, but from her perspective she implied that the increase was not due directly to involvement with LPN patients but rather due to RN reluctance to assume sole responsibility for personal care of their unstable clients. From reading the full survey of this LPN, I understand “total care” in this case to mean total personal care (e.g. toileting, hygiene, feeding). In the opinion of this LPN and from the perspective of some RNs, the introduction of full scope LPN practice brings with it a new or increased level of responsibility for some RNs with regard to performing personal care for their patients where they may have had assistance in the past (e.g. from LPNs or care aides). The differences in perceptions, here in the case of perceptions of increased RN responsibility
following the introduction of full scope LPN practice will be discussed further under the next category, defining the impact of the role.

As the LPN becomes more autonomous in the work setting it seems some RNs may be forced to reexamine and perhaps clarify their own roles in relation to full scope LPNs. The category of defining the role encompasses the survey responses that comment on defining features of full scope LPN practice for both RNs and LPNs. These defining features of full scope LPN practice include: education (i.e. to meet full range of entry-level competencies as outlined by the CLPNBC), an expanded skill set and scope, and increased level of accountability and responsibility.

Overall, LPNs and RNs were able to articulate a clear understanding of what constitutes full scope LPN practice and often used specific skills as indicators or defining features. Some RNs used notions of limitations and even cited specific, perceived deficiencies (e.g. lack of knowledge and critical thinking skills) and/or increase in RN responsibilities as defining features of the full scope LPN role. However, generally there was consensus on what defines the role of the full scope LPN (e.g. accountable and responsible for own patient load of stable patients with predictable outcomes with the ability to perform specific nursing interventions consistent with their scope as outlined by the CLPNBC). Thus it is logical to conclude that a major point of agreement between the two is what constitutes full scope LPN practice. However, there seems to be some difference in opinion between some RNs and LPNs as to the extent of knowledge
or educational preparation of full scope LPNs and their ability to apply this knowledge critically in practice; I elaborate on this notion in the next chapter.

Determining the Impact of the Role

This category emerged upon subsequent review of my preliminary categories that seemed to capture respondents' perspective regarding the impact of including the full scope LPN role in their acute care setting. The preliminary categories that informed this broader category include: burden, teamwork and communication. In addition, I also found upon subsequent reviews of the survey data, that some LPN responses fell outside these preliminary categories. For example, statements of personal and professional satisfaction did not readily 'fit' into the aforementioned categories of burden and teamwork. Therefore, creating the category determining the impact allowed me the freedom to include more descriptive statements that highlighted the broad and varied impact of full scope LPN practice on nurses. Responses from nurses who responded to my survey were varied, both among RN and LPN respondents and between them. What follows is my description of the impact of full scope LPN practice on the survey respondents. To facilitate my discussion of this category, I have divided my discussion of impact into 3 subcategories, namely: burden, teamwork and personal impact.

Burden. Of the RNs, 4 of 5 commented on the impact of full scope LPNs in the nursing skill mix on them in terms of additional burden. This sense of burden
also became apparent while I was examining the previous category and noted that some RNs were defining full scope LPN practice, in part, by the increase in responsibility for them. This increase in responsibility was, for some RNs, felt in terms of taking on heavier patients (i.e. greater acuity and/or complexity) and taking on "RN" tasks for LPN assigned patients.

Mostly I find that lack of knowledge/education and minimal critical thinking skills in some areas puts added stress on the partnered RN...the LPNs are having a lot of trouble coping (time management wise) and therefore aren’t much help to the RN buddied with them who has 3 much heavier pt’s then one normally would if they weren’t “teamed up” with an LPN.

Another RN commented on the impact of including full scope LPNs on her unit and related loss of a full time care aide position.

With the addition of full scope LPNs to our floor, we have lost a floating full-time care aid who helped with wastes, transfers, mobilizing and many other 2-person, time-consuming jobs. Now all the primary nurses do everything themselves or need to find another qualified RN or LPN who also have their own assignment, to help with heavy work, of which there is a lot. The LPN works in one modified team assignment with an RN. Each takes a pt. load, but the LPNs pts may have “RN tasks” for the RN in that team. Also, the LPN can’t do “RN tasks” for anyone else on the floor. So it sometimes means they don’t circulate their help when they have time to spare. Their role is also newer to them, so I feel this is partly the reason as they are filling up their day with their own patients and not looking beyond.”; “Overall, I feel that the LPNs have brought some great + positive, experiences to the floor with their own expertise, but that the overall workload has changed in a negative way for the RN’s on the floor. ”; “We still have care aids come in for the extra difficult days, but we have had a lot of back injuries and sick time lately in my perception, which I partly attribute to the ↑ workload since we started using FSLPNs and got rid of our full-time care aids. I also think it is not saving any money for this reason.

As mentioned in my discussion of the category, defining the role, it was not only RNs who acknowledged an increase in RN responsibility as a result of the introduction of full scope LPN practice. One LPN commented that in her
experience, "RN's are reluctant to take more responsibility regarding "total pt care" of unstable client". She went on to add that the introduction of full scope LPN practice into the acute care setting is resulting in a shift in responsibilities for patient care for both RNs and LPNs; "Many RNs have worked their careers without doing any pt care. The pts they are now expected to care for & assess were the ones previously done by the LPNs. They only dealt with the meds and IVs". What this comment seemed to indicate to me is that this LPN is acknowledging the impact of full scope LPN practice for RNs (e.g. resulting in an increase in responsibilities formerly delegated to LPNs and now being added back to the role of some RNs).

Another LPN acknowledged the sentiment among some RNs that their workload has increased since the introduction of full scope LPNs and also commented that assignments are divided and, depending on who she is working with, she is able to divvy up tasks to help balance the workloads.

  
  e.g. RN hangs my IV bag of KCL I will do their ins/outs or something that LPN is not able to do because (it is) not within their scope... If the pt assignment is 7 – LPN takes on the 4 – RN 3 pts – because RN has to do LPN's duties (Example given: RN has to hang TPN)

  
  Some survey respondents, however, did not comment on the notion of burden for either RN or LPN but rather focused on the idea of teamwork between RNs and LPNs. Perhaps the notion of burden and increased workload for some RNs was noted by some respondents and not others due to differences unit organization or leadership. For example, perhaps some RN respondents have experience working in environments where they have assumed total care of their patients and thus there is no impact in this area on them since the introduction of
full scope LPNs. Or perhaps, the introduction of full scope LPNs on some units was implemented in such a way or handled by the nurses in such a way as to ensure responsibilities were shared and therefore a notable burden was not perceived.

**Teamwork.** In my review of the survey responses to questions regarding experiences working with or as a full scope LPN, one of the recurrent topics I noticed was that of teamwork. Some nurses commented that RN/full scope LPNs were able to work effectively as a team. Some nurses noted some difficulties pertaining to teamwork among RNs and full scope LPNs. One RN, a former LPN, commented on specific characteristics of the LPN that facilitated teamwork.

As a current RN and a previous LPN full scope, I think that both professions can work together in harmony as long as it is clear what that scope of LPNs is. As well as the LPN vocalizes their limitations and seeks assistance when they need help. ... The LPNs I have worked with are knowledgeable about their limits, caring, very independent and strong in communication skills. This makes working in RN/LPN mix very easy.

As I mentioned, however, some respondents commented on problems with teamwork. Problems with teamwork that were noted differed between RNs and LPNs. For example, one RN observed that the LPNs ability to contribute to the team is limited by the fact that relative newness of the full scope role in the acute setting, the high acuity of the patients, and the limitations of their scope of practice results in the LPNs tending to focus on their own assignments and being limited in the contribution they can make towards the RN's patients.

The LPN works in one modified team assignment with an RN. Each takes a pt. load, but the LPN's pt's may have "RN tasks" for the RN in that team. Also, the LPN can't do "RN tasks" for anyone else on the floor. So it
sometimes means they don’t circulate their help when they have time to spare. Their role is also newer to them, so I feel this is partly the reason as they are filling up their day with their own patients and not looking beyond.

Yet another RN noted that one LPN had repeated personality conflicts with RNs that stemmed, in her view, from resentment for the presence and potential involvement of RNs with her patients. This RN felt that the LPN was offended when others pointed out she was not an RN and would require assistance with some things; “she would get verbal and defensive when it was pointed out she was an “LPN” not an “RN”, and she took offense to any suggestion that she needed to get help from an RN”.

However 3 of the LPN respondents commented on difficulties with teamwork and attributed them to the RNs. Three reasons for difficulties with teamwork were noted by LPN respondents. First, one LPN cited an inconsistent desire on the part of RNs to work in a team with LPNs; “depending on who I’m working with, some RN’s are able or enjoy as I do working in a team environment”. Second, on LPN commented on RN resistance to the presence of the full scope LPNs; “I as an LPN (am) meeting resistance, noncompliance as being respected as part of the team on most shifts. I find this extremely stressful & hurtful”. Third, one LPN noted a lack of focus on collaborative practice (e.g. with LPNs) in RN education programs; “RNs that are good are moving to other areas or retiring. The quality of the med/surg RN coming in is not the same standard. They are not taught to be team players in many areas”.

Overall, in reading the survey responses I got the sense that while an RN/LPN skill mix could be effective, the onus is largely placed on the LPN to
make it work. For example, if the LPN is clear on their scope and limitation and is able to articulate them among other things, working in an RN/LPN skill mix. One LPN commented that when she first was introduced to her unit she found it stressful due in part to the higher acuity of patients but also due in part to the hesitance of RNs in working with LPNs; “the RNs were very reluctant on having LPNs on the floor, but as time progressed and the LPNs were able to prove themselves the RNs (some of them) were able to accept it.”

The idea that, initially at least, the LPNs faced some hesitance, resistance or even mistrust from some RNs was also noted by an RN respondent who originally thought there would be an increase in patient safety issues arising from the introduction of full scope LPNs (i.e. since patients often present with multiple co-morbidities). However, this RN then went on to comment that she felt more comfortable with the idea of full scope LPN practice, “after working with the LPNs for awhile”.

Overall, in my review of the survey responses, I found that the introduction of the full scope LPN into the acute care setting impacts RNs and LPNs but in different ways. RNs commented on an increase burden of responsibility and workload. LPNs commented on the need to prove themselves, in a sense facing a burden to prove their role in the team. Another aspect of the impact of the introduction of full scope LPN practice is felt in terms of teamwork between RNs and LPN. While some respondents commented that they have worked effectively in a RN./LPN skill mix, there is clearly room for improvement. Some RNs note the limitations of LPN practice and a perceived imbalance of patient care delivery
that leaves some RNs to face a heavier, more acute patient load with less available assistance. While one LPN acknowledged that some RNs feel their workload is increased since the introduction of LPNs, other LPNs commented that they offer to help rebalance the workload as best they can but that it depends on the RN they work with. The willingness, or lack thereof, of nurses to work together in team oriented manner was something addressed by RN and LPN respondents and is, in my view, a significant factor when considering the notion of teamwork. If members of a team are not willing or able to work together as a team, then the function of that team and their common goal, in this case patient care, must undoubtedly suffer.

One RN gave an example of an LPN who resisted collaboration with RNs. One LPN noted that some newer RNs are not educated to have a team orientation, at least from her perspective as an LPN. As quoted earlier, another LPN commented on how the resistance she experienced from some RNs to her presence on the team caused her to feel stressed and hurt. In the next section I will discuss the personal impact on both RNs and LPNs of introducing full scope LPN practice into acute care.

**Personal impact.** In my review of the survey responses I became particularly interested in the personal impact of full scope LPN practice on the RNs and LPNs, their feelings surrounding the introduction of the full scope LPN role. While some nurses, both RN and LPN, expressed having positive experiences overall working with a RN/LPN skill mix, each group highlighted unique features
of this positive experience. Several LPNs expressed feeling happy or satisfied with finally being able to work to the fullness of their competencies and capabilities. For example on LPN noted that she was now, “happy to be able to use all skills. More fulfilled to be able to learn more and apply it to practice”.

One LPN cited feeling better received as a nurse now that she worked to full scope in the acute care setting, “I feel more accepted as a nurse for making contributions that I am capable of”. Yet another LPN expressed satisfaction in being able to provide continuity of care for her patients.

...rewarding for me because I have worked at other facilities in this capacity & loved it. I am able to practice what I learn. To be able to nurse from the beginning to the end is more satisfying in the sense that you are more in complete contact of your assignment & patients.

However, not all feelings expressed by LPN respondents were positive. Two LPNs commented on feeling stress as a result of RN resistance to their presence on their unit(s) as well as high patient acuity. Yes another LPN expressed feeling of annoyance and frustration; “annoyance that it has taken 20 years to accept this role, frustration that there is blurring of LPN/RCA duties and role expectations”.

This LPN’s feelings seemed not so much a result of specific experiences with RNs on her unit(s), but rather with what seems to be more broad reaching, systemic issues, such as others’ perceptions of role confusion between LPNs and care aids, and the length of time it has taken for the full scope LPN role in acute care to have come to fruition. These mixed feelings regarding the full scope LPN role in acute care were not limited to LPNs.
For example, several RN respondents cited positive experiences, overall, in working with full scope LPNs. Others expressed feeling stressed and perceiving an increase in RN injuries and sick time since the introduction of full scope LPNs and increase in workload for RNs.

Overall, I feel that the LPNs have brought some great positive experiences to the floor with their own expertise, but that the overall workload has changed in a negative way for the RNs on the floor. ... We have had a lot of back injuries and sick time lately in my perception, which I partly attribute to the increased workload.

One RN observed that working with LPNs who, in her view, lack knowledge and critical thinking skills is a source of stress and also impacts the RN's trust of the LPN.

My experience has been mostly positive. Working with a full scope LPN can be challenging if the person I'm working with is new or a float LPN that I don’t know. Blending styles of nursing and personalities can be challenging. Sometimes trust is an issue – I have good working relationships with the regular LPNs on our ward at this time.

Despite feeling stress, perhaps some mistrust, and a sense of burden as mentioned in a previous sections, some RNs commented on a bigger picture, beyond their individual experiences on their unit(s). In other words, they feel that a period of adjustment, working in the new skill mix, will ultimately facilitate their adaptation to the changes in skill mix. Also, one RN even expressed empathy for the LPNs as she reflected on the impact on both RNs and the LPNs. This RN acknowledged that the increase demands of their expanded scope and the acute setting could be a source of stress for the LPNs.

A bit of a difficult transition, mostly due to the acuity of patients. ...lack of knowledge/education and minimal critical thinking skills in some areas puts added stress on the partnered RN, as this directly affects trust in the
The patients are demanding given the complexity of their illnesses, and I can understand how stressful that would be.

Overall, I found that the respondents provided me with many insights into how the introduction of the role impacted them in terms of their workload (e.g. burden), work relationships (e.g. teamwork) and on a more personal level as well (e.g. increased job satisfaction and stress). In addition to commenting on the impact of the full scope LPN role in their workplace and on them personally, the nurses who responded to my survey also commented on the notion of the appropriateness of the full scope LPN role.

**Determining the fit of the role**

The third and final category I identified from my reviews of the survey data includes responses regarding the perceived fit of the full scope LPN role in acute care in the present, but also in some cases in the future. For the purpose of the discussion of the survey results, fit refers to the suitability of the full scope LPN role in the acute care setting. All respondents commented to varying degrees on this topic, however overall the RN respondents appeared to have more to say compared with the LPN respondents.

Some of the LPN respondents, as mentioned in the previous section, mentioned feeling more satisfied with being able to care more fully for their patients. While not explicitly stating it, in my view this implied a perception that these nurses felt their role was both appropriate and a fit for the acute environments where they worked. Only one LPN commented, and then in only a few words, that she did not feel her role was appropriate in the acute
environment, “patients aren’t appropriate for LPNs (too acute)”. This LPN was unique with this comment on a mismatch between role and patient environment.

While a couple of LPN respondents commented on some uncertainty regarding the fit or appropriateness of the full scope LPN role in the acute care setting, their comments were directed to the system in which they work. For example, one noted that the future of the LPN role in the acute setting is uncertain because there are few LPNs working in her work setting at present. Therefore, in my view, perhaps this LPN was uncertain about the future and fit of the full scope role largely in part because she did not have enough exposure to seeing the role implemented in her workplace.

Another LPN commented on animosity from RNs directed at the full scope LPNs and attributed this to a poorly implemented introduction of the role initially.

I think the introduction of the LPNs at full scope was poorly done. It has caused a lot of animosity between nursing groups. I think the public need to be more educated about LPNs and their role in the health care system.

This LPN also noted that public education of the LPN role is necessary. From my understanding of what this LPN stated, the perception of appropriateness of the full scope LPN role is largely in the eye of the beholder. In other words, how the role is introduced and how others understand the role of the full scope LPN could play a significant role in both the determination and perceptions of appropriateness or fit of the role.

Finally, another LPN noted that the full scope LPN is a “new level as the replacement of the diploma nurse” and that in the face of an ever increasing RN nursing shortage the LPN can help alleviate the shortage by applying their
capabilities where appropriate. This LPN noted that the LPN role is appropriate in the acute care environment, with patients who fall within their scope (i.e. patients with predictable outcomes); "even in acute setting, (which is where I work) there are always this cross section".

While all but one LPN appeared to feel that their role was appropriate in their respective acute care settings, several RNs did not feel the same. In fact a couple of RNs stated quite clearly that in their view the full scope LPN role was not appropriate in their work setting(s). These nurses cited high patient acuity and unpredictability as key reasons why the full scope LPN role did not fit.

Personally, I don't think (full scope) LPNs are appropriate on our ward (vascular). The pt's have multi-faceted & complex issues that are outside their limited ability to critically think. On this ward a full scope "workload" role would be more appropriate.

I believe it is inappropriate to have (full scope) LPN where I currently work. In a team setting as an assistant would be fine but as an independent nurse, it is not safe. We do not have a "stable population with predictable outcomes". We have very sick patients with multiple co-morbidities that often never become stable. It is not uncommon for our pts to suffer a CVA or MI or PE even day of discharge. I have seen LPNs both under and over react to situations, I have not yet seen the critical thinking skills required to work in our setting.

From the above quotes, it is clear that these RNs do not feel that the full scope LPN role, perhaps as it is currently being utilized, is appropriate to their work setting. In addition, and in response to the question regarding views for the future of the full scope LPN in acute care, one RN had a strong reaction.

Frightening. Based on a review by D&T done at our place we should be (approx) 23 LPN + 77% RN. Presently it is 10% 90% and it is already scary. The RNs watch + help and often have to change assignments through the shift. Increasing this ration I believe would result in deleterious events for patients.
However, this same RN later went on to comment that she believes there is a role for the LPN in acute care but as a “team worker with an RN”. She stated that LPNs are often great patient advocates and would be perhaps better suited to work in post-acute, long term and transitional care settings where they would practice with greater independence with a more stable patient population. Another RN reinforced this view of the importance of context in determining appropriateness of the full scope LPN role. Other RN respondents were more receptive to the incorporation of full scope LPNs in acute care, as long as the context (e.g. patient population) is appropriate for their scope of practice. As one RN noted, “LPNs in acute care will be moved to areas where they contribute the most” and that “with good training they will be more confident and knowledgeable and contribute more, but may always be limited in certain RN situations”.

One final factor that may play a role in how the appropriateness of the full scope LPN role in the acute care setting is determined is the personal characteristics of the LPN. In the view of some RNs: a) if the LPN is able to look beyond his/her own assignment and make an additional contribution to other patients on the team; b) if the LPN is strong in communication skills and well able to articulate their role; c) if the LPNs are knowledgeable (e.g. pharmacology); and d) if the LPN consistently asks for RN assistance when necessary, then the RN/full scope LPN skill mix in acute care can work. In the view then of some RNs, it may well be up to the LPNs to prove themselves in these ways in order to demonstrate appropriateness of their role in acute care. This is consistent with some LPN comments referring to how they feel the need to prove themselves.
The Interview and the Surveys

As I mentioned in the previous chapter, my analysis of the sole interview and 9 completed surveys were approached separately. My process of analysis itself (e.g. viewing and reviewing the data, reflecting back on my research question and questions asked, and identifying and then refining categories) was applied to both sets of data, individually. While I did not seek out differences and similarities between the interview and survey data during the analysis itself, once each analysis was completed I reflected back on the results of both to see if there were any points of comparison.

What I found in the interview was an overwhelming focus on challenges this LPN faced to practicing at full scope on her acute care unit. She expressed meeting resistance to her presence, in several forms, such as: having her professional competencies and capabilities challenged, and perceiving a lack of receptivity to her inclusion on the unit and to her contribution as a nurse. Some LPN survey respondents also expressed feeling that the introduction of their role in their acute care setting(s) has met with resistance from some RNs along similar lines to what the interview participant stated. In my analysis I also noted resistance from RNs to the introduction and/or ongoing presence of full scope LPNs in their respective acute care settings. This RN resistance was evident in comments such as those in which RNs noted that after some time working together they feel more comfortable with the LPNs and those where RNs stated frankly that LPNs are not appropriate in their setting.
Some RN survey respondents commented that the full scope LPN role is and can be effective in the acute care setting as long as patient assignments are appropriate and suggested a workload or less independent role. The LPN interviewed and LPN survey respondents did not comment on other possible way of utilizing LPNs to their full scope but rather asserted their capabilities to provide full care for patients (e.g. within their scope of practice) in acute care settings, save for select RN tasks.

Overall, in my review of the data and final categories I am left with the sense that both LPNs and RNs have mixed reactions to the introduction of the full scope LPN role in acute care. There are clearly challenges for both groups as they adjust to the changes. Some RNs are not receptive to the introduction of the full scope LPN role on their respective units, but these RNs were in a minority. Overall, the nurses appear to be facing the task of adjusting to change and determining how it is working/will work and what it means for them. Most survey respondents as well as the LPN interviewed see the role of the full scope LPN in acute care as viable and timely. How this role is introduced and supported once established is something for further consideration perhaps. The LPN interviewed observed that the manner in which the LPNs were introduced on her unit and an ongoing perception of lack of support for their presence from her unit manager both had a negative impact on her experience. The notions that the manner in which the role is introduced and the attitudes of others both have an impact on the full scope LPN was supported by some of the LPN survey respondents as well. This would suggest to me that an important factor in nurses' experiences
with full scope LPN practice could be working to establish and ensure a receptive work environment which is appropriate to the LPN role. In the next chapter I will discuss this further as well as propose some suggestions for possible future research in this area and possible implications for nursing education regarding the LPN role in acute care.
CHAPTER V

Discussion

In undertaking my qualitative description study I sought to gain an understanding of how nurses, both RNs and full scope LPNs, are experiencing and perceiving working in a RN/LPN skill mix in the acute care setting. Currently there is little formal literature soliciting the experiences of RNs and LPNs who are living the change in skill mix in recent years to include full scope LPN practice. As an RN and a practical nurse educator in the acute care semester of an established PN educational program in the Lower Mainland I have been involved in the preparation of LPNs for full scope practice in acute care. In my experience, I have often been asked questions by RNs about the meaning of full scope LPN practice in the acute care setting. I have also been privy to conversations among some LPNs who viewed little distinction between their practice and that of RNs (i.e. ability to administer IV meds being cited as a main distinction). The enhanced range of entry-level competencies included in the full scope of practice for BC LPNs in 2000 is continuing to expand and educators are attempting to keep in step with these changes to entry-level competencies. In my work as an LPN educator, I helped facilitate my students' socialization into RN/LPN skill mixes in various acute care settings where full scope LPN practice was not yet fully implemented. During this time I became increasingly curious about how RNs and LPNs would experience working in an RN/LPN skill mix in the acute care setting with LPNs practicing at full scope. Therefore, I undertook this study with the hopes of gaining a more informed understanding of the
experiences of RNs and LPNs working with or as full scope LPNs in the acute care setting.

In this chapter I will discuss the findings from my study with my conclusions. I then explore some related work and go on to discuss implications from my findings that help to inform and/or lend support to strategies for nursing practice, nursing education, nursing policy and future nursing research.

**Research Conclusions**

As I described in earlier chapters I interviewed one LPN and received short-answer mail-in surveys from 8 nurses (3 LPN and 5 RN). I used conventional content analysis as outlined by Hsieh and Shannon (2005) to guide my analysis of the interview and survey data. From my analysis of the single interview I identified 3 categories: a) professionalism, b) receptivity and c) appropriateness. **Professionalism** included participant comments that seemed to assert her own professional identity and role on the team as well as comments regarding perceived challenges to her professionalism (i.e. from some RNs and her manager). **Receptivity** captured the notion of how this LPN believed she and her LPN colleagues were received on her unit (e.g. by RNs and management). Also included in this category were comments that suggested factors that could positively influence how LPNs are received into a RN/LPN skill mix in acute care. **Appropriateness** was developed to include ideas around suitability of the acute care setting for the LPN (e.g. patient assignments). Seen together, my analysis of the interview with the LPN participant yielded a picture of a nurse who felt
competent and proud to be an LPN yet in practice faced many challenges and barriers to working and being part of the RN/LPN team in her acute setting. Feelings of having her professionalism and professional identity challenged and feeling poorly received personally and professionally seemed to dominate in her interview. The challenges she expressed did coincide with some of the barriers to increased LPN utilization identified by Greenlaw (2003), namely role conflict, lack of support and acceptance and possible “turf” protection (e.g. RNs protecting their “turf” (p. 13).

However, this participant did discuss some factors that she seemed to feel could make a positive impact on her work setting and experience. Such factors as ensuring all staff members adopt a holistic, open-minded approach towards one another (e.g. seeing past the job titles and recognizing the humanness of each person) and treat one another with respect (e.g. RNs being more respectful towards LPNs).

Following the sole interview, and faced with the realization that I was unable to recruit more individuals to face to face interviews, I distributed 36 short-answer surveys to unit managers from the selected units targeted by my initial recruitment efforts and also to 3 personal work colleagues. Eight of the 36 surveys were returned completed and subsequently analyzed using conventional content analysis.

From my analysis of the surveys I identified 3 categories, not wholly different from those identified in the analysis of the single interview. The 3 categories I identified from the survey data include: a) defining the role, b) determining the
impact and c) determining the fit of the role. *Defining the role* was developed from survey responses from RNs and LPNs that seemed to demonstrate their respective efforts at defining the role of the full scope LPN in the acute care setting. There was a notable emphasis on particular skills the full scope LPN is sanctioned to perform. Respondents also commented on the additional educational preparation of full scope LPNs. However, the extent of this preparation was questioned by some RN respondents (e.g., extent of education in pharmacology and critical thinking). Increases in LPN accountability, responsibility and accompanying autonomy in practice were also commented on as features of full scope LPN practice. Some RNs defined full scope LPN practice as it related to their own practice and some cited an increase in their own workload as a defining feature. For example, some RNs commented that full scope LPN practice meant they now had their own patient assignment and in addition were required to perform RN skills for some LPN patients such as IV medication administration. Finally, some nurses stressed the collaborative aspect of full scope LPN practice.

*Determining the impact* encompassed RN and LPN comments regarding how full scope LPN practice impacted them and their work experience. More specifically, some RNs felt burdened by an increase workload of providing care to patients with unpredictable and complex health challenges while also aiding LPNs in caring for their patients with tasks that fall outside the LPN full scope of practice. Overall, LPNs expressed a greater sense of satisfaction at being empowered to work to the fullness of their scope. However, one LPN noted that
patient acuity in her acute setting was too high. Some RNs noted that they have developed good working relationships with the LPNs on their team and that the teamwork is effective. Other RNs and some LPNs saw room for improvement in the area of teamwork as perhaps the introduction of the full scope LPN role can perhaps initially appear to polarize nurses as nurses focus on managing their own assignments (e.g. LPNs focusing too much on their patients and RNs being reluctant at times to collaborate with LPNs). Certain LPN characteristics (e.g. good communication skills and knowledge of own limitations) were cited that, from the perspective of some RNs, enhanced the RN/LPN working relationship. From the perspective of some LPNs, RN reluctance and critiquing of LPNs was a barrier to teamwork and was also a source of stress and even hurt feelings. Overall, there are some definite positive impacts of the full scope LPN role on both RNs and LPNs yet there remains room for improvement (e.g. in teamwork, with some LPNs stressing the attitude of some RNs as a barrier to teamwork.

Finally the final category, *determining the fit of the role* encompassed comments made by RNs and LPNs regarding the appropriateness of the full scope LPN role in their acute care setting. This category appeared to be dominated by the RN respondents, some of whom felt the inclusion of full scope LPN practice was inappropriate on their units. Other RNs suggested that the onus of LPN fit in their acute setting lay with the LPNs themselves to in effect prove their fit on the team. Some LPNs felt that their fit on their units improved once they had an opportunity to prove themselves (e.g. to the RNs) and when RNs were less resistant to their presence.
Related Work

There is limited available literature pertaining to full scope LPN practice in acute care. However, the Vancouver Island Health Authority (VIHA) began implementing a shift to implement full scope LPN practice in various facilities in 2002 with projections of 63% of LPNs working at full scope in acute care and rehab facilities by May, 2003 (Stein, 2003). They used this implementation project as an opportunity to conduct research into the impact and effectiveness of their full scope LPN implementation project. Phase one involved education aimed at broadening the range of functions for LPNs, towards full scope practice. In phase 2, research was conducted to solicit nurses’ perceptions of their work environments and the process of implementing full scope LPN practice with 6 themes identified. Twenty-four nurses (11 LPNs and 13 RNs) participated in the second phase evaluation, all considered senior level nurses from various sites with 20 or more years of practice experience and selected by their managers. While it is not clear what proportion of nurses worked in acute care settings, some of the findings from this study are reflected in findings from my study. For example, one of the six themes entitled “double edged sword” refers to the mixed responses of both RNs and LPNs. On one hand, nurses reported factors that resulted increased job satisfaction (e.g. RNs working as mentors and LPNs assuming more control and responsibility for patient care). However, on the other hand, both groups of nurses also reported factors that contributed to a negative effect on job satisfaction (e.g. increased job stress).
In my findings from the survey analysis, under the category of determining the impact, RNs and LPNs commented on the positive and negative impact of full scope LPN practice. Some LPNs reported an increase in job satisfaction relating to being able to work to full scope and provide greater continuity of care. Unlike in the VIHA study, no nurses I surveyed commented on the mentoring role of RNs. However, respondents from both groups of nurses commented to varying degrees on factors which increase job stress such as increase in perceived workload, high patient acuity and inconsistent teamwork.

Not all themes identified in the VIHA project evaluation were reflected in my findings. For example, one theme entitled gray area referred to confusion around the role of the LPN and how to best organize patient assignments and care. The nurses who responded to my survey seemed to be able to clearly articulate the role of the LPN, although often relying on skills lists for differentiation. Perhaps if I had surveyed more nurses and/or included a question that specifically asked about gray areas with regard to full scope LPN practice I might have a different result. Or, perhaps in 2005 nurses are more familiar with full scope LPN practice and what it means. Five of the 9 survey respondents had attended joint CRNBC/CLPNBC RN/LPN workshops at different times in the years leading up to my study and there was no recognizable difference in reported understandings of full scope LPN practice between respondents who attended the workshops and those that did not. Perhaps information regarding the LPN role was obtained by nurses who did not attend the workshops through articles in Nursing BC, publications from the CRNBC, unit managers, colleagues, or other sources.
Implications

Based on my findings from the study I have identified some implications from my study and strategies aimed at nursing practice, education, and research. As I considered the following implications I remained cognizant of the fact that the scale of my study was small and future research efforts on the issue of full scope LPN practice in acute care settings might be useful in strengthening my implications and proposed strategies.

Implications for Nursing Practice

The central importance of fostering effective teamwork in RN/LPN skill mixes emerged as an important implication from this study. One way to begin that process might be to put in place systematic plans detailing approaches to facilitating effective communication between RNs and LPNs. Such strategies might benefit both groups of nurses and the nursing team as a whole. From the findings of my study, I have identified several directions for improving communication and teamwork among RNs and LPNs; in effect improving nursing practice from the perspective of the environment in which RNs and full scope LPNs practice and the working relationships among them. In my analysis I identified a number of comments made by participants that highlighted challenges to RN/LPN practice in their acute care settings. For example, the sole interviewee spoke of a perceived lack of caring and respect (e.g. demonstrated by some RNs towards herself and other LPNs) and also impaired communication between RNs and LPNs (e.g. LPN input in patient care discussions not
welcomed). Some survey respondents commented teamwork is not always present or effective between LPNs and RNs. However, other respondents noted that after time spent working together, they felt that they worked more effectively together and relationships were strengthened. Finally, one RN, a former LPN noted that when LPNs are able to clearly articulate their role and communicate effectively with RNs, teamwork is improved.

Following my review of my analysis, I identified 3 potential strategies for improving nursing practice by fostering teamwork (e.g. via improving communication and collaboration) between RNs and LPNs. In my view, these strategies will contribute to improvements in the practice environment of RNs and LPNs as well as the working relationships among them. The first strategy is one which I observed in action on several acute care units at Richmond Hospital that have recently implemented full scope LPN practice. The second strategy stems from a comment from the LPN participant I interviewed who noted that there were no regular unit meetings to discuss patient and professional issues and how she felt communication among unit nurses had much room for improvement. The third and final strategy I present offers a potential means to foster communication and collaborative practice among RNs and LPNs while also providing role modeling examples that could be used by nurses in various units.

First, in order to facilitate and promote communication between RNs and LPNs working on acute care units, regular scheduled team meetings between these nurses (e.g. buddied RNs and LPNs) could occur each shift. In my recent experience as an LPN educator on two units at Richmond hospital I noted a
policy that was adopted at the time full scope LPN practice was implemented. Midway through each shift where LPNs and RNs worked together, LPN/RN pairs are required to meet and discuss their patients for a minimum of 15 minutes.

Second, in addition to mid-shift meetings between RN and LPN buddies, regular unit team meetings could be conducted (e.g. every month or two months). Unit meetings, facilitated by a consistent person (e.g. clinical nurse leader) who openly supports and encourages the RN/LPN skill mix, in which issues of patient care, concerns in practice, and also successes in teamwork are openly discussed could result in enhanced communication and willingness to view themselves as part of a team rather then two distinct groups of practitioners working alongside one another.

Third, in order to foster and strengthen collaborative practice among RNs and LPNs I suggest the CLPNBC and CRNBC produce joint publications, perhaps monthly, that promote examples of effective RN/LPN teamwork and collaborative practice. The colleges, in collaboration with employers, could put out an ongoing call for submissions of practice examples that highlight the work of LPNs and RNs. Each month, a single example could be selected and published and the unit where the example stemmed from could be rewarded with pens or pins that stated something like “Nurses Working Together”. Perhaps at the end of the year one unit could be selected for a profile/write-up highlighting how their RNs and LPNs are working effectively together and that unit could receive a lunch. By combining a small incentive program with a means to highlight effective practice and RN/LPN teamwork, nurses at the bedside might be motivated to seek out
positive examples of teamwork and collaborative practice and also learn from the experiences of nurses on other units (e.g. examples serve to model effective behaviours/practice). These publications might also be useful in nursing education programs (RN and LPN) in courses that deal with professional practice issues and aid students by providing models for effective teamwork.

The aforementioned strategies are presented as potential means of nurturing supportive, team oriented work environments for RNs and LPNs. In the next section I discuss some implications for nursing education with some strategies for promoting effective practice among RNs and LPNs, with a focus on the education of student nurses.

Implications for Nursing Education

As mentioned in chapter 4 and the discussion of findings in the previous section, the importance of role clarity, communication, willingness to collaborate and ability to function in a team environment are notable. Findings from this study lend support to initiatives that aim to foster all of the aforementioned in nurses, in particular in student nurses. For example, Villeneuve and MacDonald, (2006) propose that an effective strategy for approaching nursing education in the future in Canada would involve a unified, laddered program structure where all LPNs and RNs would share their initial education (e.g. the length of the LPN program). A shared educational experience would contribute, it is hoped, to enhanced collaborative practice because there would be a foundation of collaboration and understanding on which to base working relationships in
practice. This move towards a collaborative educational model has already been adopted by Vancouver Community College with the upcoming introduction of a BSN stream in their nursing program in 2008.

**Implications for Nursing Policy**

As mentioned in the discussion of findings in the previous section, the central importance of fostering effective teamwork in RN/LPN skill mixes emerged as an important implication from this study. Findings from my study lend support to two current policy initiatives in BC aimed at fostering collaborative practice. The first initiative is the Collaborative Nursing Practice initiative aimed at clarifying and enhancing collaborative nursing practice among RNs, Registered Psychiatric Nurses (RPNs), and LPNs in BC (Greenlaw, 2006). A central concept in collaborative nursing practice is increased understanding among nurses of their respective roles (e.g. similarities and differences) leads to increased respect and that respect is integral to effective collaboration. In my findings, some LPNs felt a lack of respect from some RNs and a need to prove themselves. The Collaborative Nursing Practice Steering Committee, a subcommittee formed from the Nursing Directorate of BC, produced a resource tool aimed at managers and educators which offered specific information and strategies for promoting communication, understanding, and teamwork among nurses. For example, the resource tool presents an exercise, using simulated patient cases, aimed at helping nurses identify appropriate RN and LPN patient assignments. The activity then suggests nurses go on to discuss patient details and produce appropriate priorities and plans of care. The findings from my study lend support to initiatives
like this one that are aimed at promoting communication and collaborative practice among all nurses.

The second initiative is the development of the Interprofessional Network of BC (in-BC) (in-BC, 2007). The in-BC initiative is a joint effort, developed by members of the University of Victoria, School of Nursing in conjunction with several educational institutions and health care agencies in BC. The goal of this network is to create sustainable partnerships between educational institutions and various health care agencies (e.g. BC Cancer Agency, BC Children’s Hospital, and Vancouver Acute) by promoting collaborative practice models and programs among health care providers form numerous disciplines (e.g. medicine, nursing, social work, rehabilitation sciences and pharmacy). The premise behind the initiative is that health care overall will improve when members of the health care team have a greater understanding of one another’s roles and are able to communicate and collaborate effectively. In their publication describing their interprofessional education project, several strategies are put forward to help them meet their goal. For example, overlapping student practicums to facilitate collaborative practice among disciplines and case based learning activities. These strategies could readily be applied more specifically to the education of student RNs and LPNs to foster collaborative relationships and would have an additional benefit of preparing them to develop collaborative relationships with other health care team members. For example, RN and LPN student groups already often share clinical placements but structure their times so that one group is off the unit prior to the other group’s arrival. On occasion I have been
able to encourage verbal reports between my LPN students and RN students. However, these occurrences have been rare and sporadic. Perhaps a more formalized approach to promoting communication between RN and LPN student groups where possible (e.g. verbal shift reports at shift change) could be one strategy to foster communication and collaborative practice among these nurse groups.

**Implications for Nursing Research**

The findings of this research study suggest additional avenues of inquiry on the topic of full scope LPN practice in acute care. In this section I suggest 2 possible directions for future research that would yield further information regarding full scope LPN practice in acute care. First, I suggest a larger scale study that could further explore the experiences and perceptions of nurses working in a RN/LPN skill mix. In the VIHA project evaluation I mentioned earlier in this section, the researchers utilized focus groups comprised of senior RNs and full scope LPNs to assess the impact and experience of the implementation of full scope LPN practice in acute and rehab settings. Perhaps a similar study, engaging groups of practicing nurses (senior and recent graduates) and/or groups of student nurses could help further an understanding of nurses' knowledge of each others scopes of practice and practice experiences working in RN/LPN skill mixes.

Several challenges to positive experiences of RN/LPN skill mix were identified in this study. In addition to these challenges, some respondents noted that after working together for awhile they felt more positive about working in an RN/LPN
skill mix. Building on the idea then that experience working together over time contributes to positive perceptions of the RN/LPN skill mix, a longitudinal study that involved revisiting participants after 6 months or one year following initial contact could yield more information about the evolution of RN/LPN working relationships over time and offer more detail about what forms the basis for a positive change in the experience of working in an RN/LPN skill mix in acute care.

Summary

LPNs represent a growing and valuable nursing resource in BC. Since the introduction of full scope LPN practice in 2000 that includes an expanded range of entry level competencies, LPNs are working in more settings with an increase in the level of autonomy in their practice. The RNs who were used to working with LPNs in more of a support and assistant role and RNs who are new to the RN/LPN skill mix are challenged to view the full scope LPN in the capacity of colleague with considerable overlap in scopes of practice, but also with distinct limitations. LPNs who are now working to full scope are working to establish themselves as active team members in their new role in some acute care settings. The findings of this qualitative study offer some insight into how RNs and LPNs perceive and experience full scope LPN practice in the acute care setting. I suggest the findings presented here contribute to our understanding of how RNs and LPNs are negotiating the new direction in nursing skill mix and how they can be supported in this endeavour by clarifying factors that support and factors that hinder RNs and LPNs working together effectively.
In summary, the findings of my study indicate that both RNs and LPNs seemed to have a good understanding of what constitutes full scope LPN practice. In the acute care setting, which is a high intensity work setting for nurses (e.g. high patient acuity, complexity of patient issues, and overall workload), RNs and LPNs are being challenged to collaborate in the provision of patient care. Some LPNs seemed to be faced with the need to prove themselves and establish themselves in their new role; “the RNs were very reluctant on having LPNs on the floor, but as time progressed and the LPNs were able to prove themselves the RNs (some of them) were able to accept” their presence on the unit. The need of some LPNs prove themselves and assert their position on the nursing team seemed to be spurred by some RNs who expressed concern regarding the competence and critical thinking skills of the full scope LPN in the context of the acute care setting.

Findings in this study also indicate the presence of some challenges faced by RNs and LPNs since the implementation of full scope LPN practice in the acute care setting. For example, some RNs and even one LPN did not feel that the full scope LPN role was appropriate to their acute setting (e.g. patients too acute and health needs too complex). Some RNs felt that the limitations of the LPN scope of practice can result in an increased workload burden for them due to the loss of care aide positions as LPN positions are increased. Teamwork was identified as an area of challenge identified in the findings also. For example, some LPNs felt the RNs were reluctant to collaborate with them or unsure of how to engage in teamwork; “they are not taught to be team players in many areas”. Some RNs felt
the LPNs were too focused on their own assignments and/or were perhaps not yet comfortable in their own role to branch out and contribute to the team as a whole.

Findings in this study indicate that overall, both RNs and LPNs report that clear communication, LPN role clarity, experience working together over time, and a supportive work environment contribute to positive experiences of the RN/LPN skill mix. Feelings of burden, inconsistent teamwork, lack of respect, concerns about patient acuity levels, and varied perceptions of the ability of LPNs and RNs to assume responsibility for patient care present areas of challenge in the workplace. In response to these findings, I proposed some strategies and presented some current initiatives designed to build upon those factors I identified that contribute to positive experiences of RN/LPN skill mix for nurses. For example, strategies to encourage and support collaborative practice (e.g. RN/LPN shift meetings and student RN and LPN workshops). The strategies presented were also selected in hopes of addressing some of the areas of challenge in the workplace for RNs and LPNs.

This is an exciting and challenging time for acute care nursing in BC. The introduction of full scope LPN practice into the nursing skill mix in an increasing number of acute care units presents challenges but also opportunities for RNs and LPNs to collaborate in new and effective ways. In summary this study offers a glimpse of the multifaceted impact of the introduction of the full scope LPN role into the acute care setting on nurses who are practicing on the front line of the change.
References

%202006%20and%20after.pdf


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tape recorded. All interviews will be transcribed by a professional transcriptionist. Access to transcripts will be restricted to the investigator, Elizabeth McTaggart, and project supervisor, Dr. Angela Henderson.

Risks and Benefits:

The only known risk to you or to others from participating in this project is breach of confidentiality. Steps to ensure that confidentiality is not breached are outlined in the next section.

Your participation will aid in furthering nursing’s understanding of the experiences of RNs and LPNs working together in the acute care setting.

Confidentiality:

Your participation in this project is confidential. Any information resulting from the interview(s) will be kept confidential. All audio tapes and subsequent documents will be identified by a code number and pseudonym that/which will be selected in consultation with you at the time of your interview. Only your pseudonym or study number will be used during the research process and/or in any reports. Direct quotations from your interview may be used in the final report, but only your designated pseudonym will be used as an identifier. Audiotapes and transcripts will be kept in a locked filing cabinet and computer records will be password secure.
Appendix IV

Initial Interview Guide

“Describe your experience of first hearing about FSLPNs in acute care?...about FSLPNs coming to your unit?”

“What is your understanding of FSLPN practice?”

“Can you tell me something about your experience working with or as a FSLPN”

“Tell me about your thoughts and feelings about the introduction of FSLPNs in your workplace.”

“Describe the effects, if any, of FSLPNs on your own practice.”

“What does FSLPN practice mean to you?”

“Tell me about your experience of working in an RN/FSLPN skill mix.”

“In your view, what does the future for FSLPNs in acute care look like?, and why do you think that? OR, on what do you base your view?”

“Is there anything else you would like to tell me about?”
Appendix V

Demographic Data

Age: _____  Sex: ☐ Female  ☐ Male

Type of Nurse: ☐ LPN  ☐ RN

Years of Nursing Practice: _____________

Type(s) of nursing practice settings where you’ve worked previously
  *e.g. acute care, long term care, critical care, hospice, other (please specify):

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

Did you receive you nursing education in BC? ☐ Yes  ☐ No

*If no, please specify where.

_________________________________________________________________________

Have you previously worked in a health care setting in a capacity other than the one you currently practice in as an RN or LPN? ☐ Yes  ☐ No

*If yes, please specify.  ______________________________________________________

_________________________________________________________________________

Have you attended one of the joint RNABC / CLPNBC “RN/LPN” workshops?

*If yes, please specify the date. ☐ Yes  _____ / ______  ☐ No

Month  Year
Title: NURSES' EXPERIENCES OF FULL SCOPE LPN PRACTICE IN ACUTE CARE.

Instructions: Please answer the following questions (point form is acceptable). Feel free to use additional paper as needed. Do not write your name on the survey. Please submit your survey using the self-addressed, stamped envelope provided. Thank you for your valuable contribution!

1. What is your understanding of Full Scope LPN practice?

2. Tell me about your thoughts and feelings about the introduction of full scope LPN practice into your current workplace.
3. What does FSLPN practice mean to you?

4. Tell me about your experience of working in an RN/full scope LPN skill mix in your current work setting.
5. In your view, what does the future for full scope LPNs in acute care look like?

6. Is there anything else you would like to tell me about?