

**THE SOCIAL ORGANIZATION OF REGISTERED NURSES AND LICENSED
PRACTICAL NURSES WORKING TOGETHER: AN INSTITUTIONAL
ETHNOGRAPHY**

by

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ABSTRACT

Across Canada, registered nurses (RNs) and licensed practical nurses (LPNs) work closely together to provide care to patients in many different healthcare settings. How they work together in some settings recently changed with a nursing care delivery reform initiative throughout one provincial health authority. In 2015, a new nursing care model, Organizing Nursing Team Resources for Accountability Collaboration and Communication (ONTRACC), was piloted on some hospital units. Through the ONTRACC model, RNs and LPNs worked more autonomously and to their full scopes of practice, with independent patient assignments.

This study, guided by institutional ethnography (IE), explicates how RNs and LPNs worked together, including the tensions they experienced, as they transitioned from working together as “buddies” to working more autonomously through the ONTRACC model. IE is a research approach that was developed by Canadian sociologist Dorothy Smith, which allows researchers to explore the social relations that organize people’s everyday lives. Through IE, the hidden practices and activities that large social institutions, such as health authorities, professional regulatory bodies, and unions, generate in their ruling become visible. Data was collected on two orthopedic units by first observing and interviewing frontline RNs and LPNs, then interviewing others with knowledge of the ONTRACC model and/or RNs and LPNs working together. Additionally, the texts that organize the RNs and LPNs’ work were collected and analyzed, including provincial nursing acts, job descriptions, and hospital policies.

Nursing care delivery reform is often done to reduce costs and improve patient outcomes. This thesis explicates how the ONTRACC model met some of these

institutional goals, but also subordinated the RNs and LPNs' previous knowledge of their work and scopes of practice.

Keywords: institutional ethnography, intraprofessional collaboration, interprofessional collaboration, interdisciplinary, nursing, nursing care, nursing practice, oppressor/oppressed, patient care, practical nurse, registered nurse

DEDICATION

I would like to dedicate this thesis to my parents and (late) grandparents who unwaveringly encouraged and supported me throughout my studies. Without their love, I would not be where I am today. I would also like to dedicate it to my wonderful husband who always “picks up the slack” at home and is without a doubt my best friend.

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List of Abbreviations

ANBLPN	Association of New Brunswick Licensed Practical Nurses
CNA	Canadian Nurses Association
HHN	Horizon Health Network
IE	Institutional Ethnography
LPN	Licensed Practical Nurse
NANB	Nurses Association of New Brunswick
NBNU	New Brunswick Nurses Union
ONTRACC	Organizing Nursing Team Resources for Accountability Collaboration and Communication
RN	Registered Nurse
SJRH	Saint John Regional Hospital
WHO	World Health Organization

Introduction

After graduating from Dalhousie University with my Bachelor of Science in Nursing (BScN) in 2009, I accepted a position as a registered nurse (RN) on a busy Intensive Care Unit (ICU) at the Saint John Regional Hospital (SJRH) in New Brunswick, Canada. As a new RN, I struggled to communicate with the licensed practical nurses (LPNs), with whom I worked. Our different credentialing and “scopes of practice” confused me, which was problematic because we often shared patient assignments. Collaboration was a buzzword I frequently heard - but did not fully understand. I wanted to “collaborate” effectively with my LPN colleagues but noticed I frequently repeated or duplicated care activities with my patients.

How RNs and LPNs work together in many healthcare settings in New Brunswick has changed since I began my nursing career at SJRH in 2009. In the mid 2010s, Horizon Health Network (HHN), one of New Brunswick’s two health authorities, began a plan to reform nursing care delivery through the “enhancement of the roles of all nursing team members,” with a new nursing care delivery model (HHN, 2018, p.9). This model, called the Organizing Nursing Team Resources for Accountability Collaboration and Communication (ONTRACC) model, changed (and is still changing) how RNs and LPNs work together and care for their patients (HHN, 2018). The ONTRACC model is being implemented over time, with some elements still in the development phase (HHN, 2018).

In 2014, the orthopedic unit at SJRH became one of several ‘pilot’ units and began implementing some elements of the ONTRACC model (HHN, 2018). The ONTRACC model required changes to many elements of the unit’s work environment,

including staffing levels/mix, patient assignments, and workload. For example, some RN positions were eliminated and some LPN positions were created.

Previously on the unit, RNs and LPNs worked together as “buddies” and were assigned to a shared group of patients, similar to my experiences working in the ICU. Each patient received care from both RN-LPN buddies, who divided their patients’ care needs into tasks to organize their work and ensure they met their patients’ needs. The RNs and LPNs completed these tasks mostly independently, updating each other throughout the day. For example, the LPNs assessed each patient, took vital signs, and completed graphic sheets, while the RNs administered medications.

In some ways, this approach was contrary to HHN’s philosophy of “holistic Patient and Family Centred Care,” which encourages “compassionate health care based on a partnership among practitioners, patients and family” (HHN, 2019). Over recent years, discourses of holistic and patient-centred care have been popular among policy makers in the promotion of neoliberal objectives to encourage patients to take greater individual responsibility in their health (Madden & Speed, 2017). Holistic patient and family centred care is widely discussed in nursing and healthcare literature and considered the gold standard for nursing care (Jasemi et al., 2018). According to Fazio et al. (2018), it is a philosophy of care built around the needs of the patient and their family and contingent upon good interpersonal relationships and collaboration between the patient, their family, and practitioners.

The World Health Organization argues that, “holistic and compassionate health care requires an effective partnership between people who need care and people who provide care” (WHO, 2007, p. 9). This is harder to achieve when the “people who

provide care's" (WHO, 2007, p.9) work routines are organized around tasks and completed by different people (Fazio et al., 2018). Although both buddies knew many things about each patient on their assignment, neither buddy knew everything all the time. This was problematic because there were care activities the LPNs did not do, which made it hard for them to develop a full "partnership" with their patients. For example, if a patient had pain and told the LPN, the LPN then had to ask the RN to administer pain medication. The RN usually needed to assess the patient first, often asking the same questions the LPN initially asked. This was frustrating for the patient, the LPN and the RN. The ONTRACC model "refocused" nursing care away from a team-based structure, towards RNs and PNs working to their "full scopes of practice" and independently caring for patients, with RNs assigned to "more complex" patients and LPNs assigned to "less acute, less complex" patients (HHN, 2018; NANB & ANBLPN, 2015, p. 12).

Adapting to Change

Most of the RNs and LPNs I know are committed to providing safe patient care. However, many of them routinely express concern about changes in their work routines which create stress and confusion and re-organize how they work with each other. The roll-out of the ONTRACC model was a big change for the RNs and LPNs. Coinciding with the launch of the ONTRACC model, the scope of practice for LPNs expanded. In the past, medication administration in acute care areas, like orthopedic units, was RNs' work (Association of New Brunswick Licensed Practical Nurses [ANBLPN], 2014). This changed in 2014, when medications administration in acute care areas became a basic competency for all LPNs (ANBLPN, 2014). I remember during this change, my colleagues, both RN and LPNs, expressed many emotions, some were excited, while

others were upset; but all had some concerns about what this would mean to their work and how they worked together.

This study, guided by institutional ethnography (IE), explicates RNs' and LPNs' experiences, including their assumptions and concerns about each other, through the implementation of the ONTRACC model. IE is a research approach developed by Canadian sociologist Dorothy Smith. In this study, it is used to explore RNs' and LPNs' actual experiences with providing patient care side-by-side. Institutional ethnographers aim to explicate how people's actual experiences come "to be dominated and shaped by forces outside of them and their purpose" (Campbell & Gregor, 2004, p.12). This is an appropriate approach because it will allow me to work from RNs' and LPNs' everyday experiences caring for patients, while focusing on the "textually mediated social organization" of nursing care (Smith, 1990). In this thesis, I uncover the "forces outside" of RNs and LPNs that organize their work and shape how they provide nursing care to patients.

An Epistemological and Ontological Shift

As I learned about IE, I began to change how I thought about both knowledge ("what is knowledge?"/"how do I gain knowledge?") and reality ("what is reality?"). Institutional ethnographers often talk about the distinctive epistemological and ontological "shifts" which distinguish IE from other qualitative approaches (Campbell & Gregor, 2004; Deveau, 2008). These shifts are related to how institutional ethnographers explore the disjuncture (or schism) between ideological knowledge and experts' authorized explanations and people's experiential knowledge in the context of their everyday lives (DeVault and McCoy, 2002; Deveau, 2008).

My epistemological and ontological shifts are apparent in this thesis, which I began writing before I had chosen or become familiar with IE. Before I learned about IE, I had already written the first two chapters. While I re-wrote parts of my first chapter, thinking more like an institutional ethnographer, I decided not to change my second chapter, which was written as a stand alone manuscript for publication. Institutional ethnographers begin their studies from a particular standpoint, which hooks them into their standpoint informants' experiential way knowing. This manuscript was a concept analysis and hooked me into what institutional ethnographers call "the ideological way of knowing something" (Deveau, 2008, p. 6). I decided to keep the manuscript because it was an important part of my 'journey,' but I wrote an introduction to explain its place in my thesis.

Epistemology "is a way of understanding and explaining how we know what we know" (Crotty, 1998, p. 3). IE committed me to a particular way of looking at knowledge. To make the epistemological shift, I needed to reject ideological ways of knowing and instead know the world as RNs and LPNs inhabit it. For example, I needed to see things like "collaboration" and "optimized scopes of practice" as concepts and material, text-based discourses made by humans to serve specific needs in the social organization of RNs' and LPNs' work. This way of knowing about "collaboration" and "optimized scopes of practice" reflects a more embodied and experiential way of knowing. It enabled me to see how the tensions the RNs and LPNs experienced were located withing 'the social' and did not reside within RNs and LPNs themselves (Deveau, 2008).

Ontology, according to Crotty (1998), “is concerned with what is, with the nature of existence, with the structure of reality” (p. 10). Institutional ethnographers make an “ontological shift” when they reject experts’ authorized explanations of what is happening and instead move towards what George Smith (1990) describes as the “sensuous world of people’s actual practices and activities” (p. 48). For example, many experts think that RNs and LPNs do not work together or to their full scopes of practice and argue that “collaboration” and “optimized scopes of practices” will improve the healthcare system. Thus “collaboration” and “optimized scopes of practice” have become authorized ways of explaining RNs’ and LPNs’ work. This is problematic because it transfers agency away from RNs and LPNs themselves. As I learned about IE, I needed to train myself to reject the authorized explanations I previously accepted without thought to discover more about frontline RNs’ and LPNs’ actual practices and activities. This shifted my focus from explaining why things happened on the units to discovering how they happened. Deveau (2008) argues that understanding how something works is empowering because this is “a pre-requisite to knowing how to change it” (p. 5)

Organization of Thesis

The organization of a paper-based thesis is similar in many ways to a traditional thesis. For example, paper-based theses and traditional theses often have similar sections, such as an introduction/background section to set the general tone of the thesis, and a concluding chapter to show how I fulfilled the goals of the thesis. Many of the chapters of a paper-based thesis, however, are written as stand-alone manuscripts for publication, which may be targeted to specific journals (Polit & Beck, 2010). Paper-based theses

facilitate the dissemination of findings and knowledge, by enabling the author to move directly from completing the thesis to journal submission (Polit & Beck, 2010).

My paper-based thesis is organized into four main sections: a background section, a method section, a finding section and a discussion section. These sections are then subdivided into chapters. Only some of chapters are stand-alone manuscripts which have the feel of a separate publication. The other chapters act as bridges between the stand-alone manuscripts. Institutional ethnographers generally write with a narrative style that guides readers through their informants' typical day-to-day routines. Thus, having some chapters act as bridges was important to maintain a 'flow' throughout the thesis.

Sections & Chapters

Background Section: Chapters 1 & 2

There are two chapters in my background section. Chapter 1 is not a stand-alone manuscript but sets the historical context of nursing in Canada. The historical context is important because it locates nursing within patriarchal, hierarchal institutions, such as universities and health authorities, that continue to influence it today (Mansell, 2004; Group & Roberts, 2001). Importantly, institutions are defined by Smith (2005) as "complexes embedded in the ruling relations that are organized around a distinctive function, such as education, healthcare, and so on" (p. 97).

In Chapter 1, I also present some definitions and existing models of "interprofessional/ intraprofessional education" and "interprofessional/intraprofessional collaboration." These models, created by experts, have been taken up by institutions, such as universities and health authorities, to organize the education and practice of RNs, LPNs and other healthcare providers across Canada. They are the accepted explanations

of how collaboration should be taught and practiced. These definitions and models often appear in the job descriptions, policy documents, and other texts that shape and organize RNs' and LPNs' daily work. They are also part of the neoliberal political and public discourses, particularly around "restructuring" and "reform," that impact frontline RNs' and LPNs' daily work. Restructuring and reform occur through government/public concerns over healthcare spending and the desire to cut costs and find more efficient ways to organize patient care. The ONTRACC model, for example, was designed to "[enhance] of the roles of all nursing team members" (Horizon Health Network, 2018, p.9).

Chapter 2 is a stand-alone manuscript for publication, entitled "Nursing Intraprofessional Collaboration: A Concept Analysis." I used Walker and Avant's (2010) concept analysis method to consider uses, definitions, and models of the concept "nursing intraprofessional collaboration" and to explore how this concept differs from other similar concepts.

Arguably, a concept analysis does not belong in an IE. According to Smith (1990), concepts such as "nursing intraprofessional collaboration," are generally given authorized meaning through institutions and are a type of ruling themselves. A guiding assumption of IE is that authorized concepts gain traction, becoming part of people's everyday vocabulary through texts, like policy documents. People then use words like collaboration even when their authorized meanings do not fit with their actual experiences. The process of writing this paper, however, increased my awareness of my own assumptions about "nursing intraprofessional collaboration" and the uses of terms like "collaboration" in the literature. It also helped me understand how concepts gain

their authorized meaning, so I felt it was important to include this paper, which will be submitted for publication to the “Journal of Interprofessional Care.”

Methodology Section: Chapters 3 & 4

There are two chapters in my methodology section. Chapter 3 is a stand-alone manuscript for publication entitled, “Observation and Institutional Ethnography: Helping us See Better?” This manuscript is introduced by a sub-chapter entitled, “Moving Forward.” I completed this manuscript when I was learning about IE and thinking about how it would guide my study. According to Smith (2001), “exploring how texts mediate, regulate and authorize people’s activities in modern societies expands the scope of ethnographic method beyond the limits of observation” (p. 159). Consequently, most researchers prioritize interviewing and the analysis of texts over other data collection methods. In this paper, I argue that observation is still an important data collection method in IE because it informs the analysis of texts and reveals how they are used at field sites. I plan to submit this paper for publication to the journal, “Qualitative Inquiry.”

Chapter 4 is not a stand-alone manuscript. In Chapter 4, I consider the theoretical foundations of IE and how I used this methodology to explicate how RNs and LPNs work together. Institutional ethnography commits researchers to a “particular way of looking” at things (Campbell & Gregor, 2004, p. 7). I explain some of Dorothy Smith’s methodological tools, including: standpoint and disjuncture, social relations, work, ruling relations, and texts, which were important to my study. These methodological tools guide institutional ethnographers in how they manage the technicalities of their studies, such as their data collection and analysis (Campbell & Gregor, 2004). The recruitment scripts,

observation and interview protocols, and documents are introduced in this chapter and appended at the end of the thesis.

Findings Section: Chapter 5

There is one chapter in my findings section. Chapter 5 is a stand-alone manuscript for publication entitled, “Registered Nurses and Practical Nurses Working Together: An Institutional Ethnography.” It presents the main findings of this study and will be submitted for publication to the journal “Qualitative Health Research.”

Discussion Section: Chapter 6

There is one chapter in my discussion section. Chapter 6 is not a stand-alone manuscript for publication. It presents an integrative discussion of the first five chapters and expands on my findings presented in Chapter 5.

Appendix A

I included one additional stand-alone manuscript for publication as an appendix (Appendix A). I prepared this manuscript early on, when I first became interested in RNs and LPNs working together. Although it is part of my journey, this manuscript entitled “Looking Back to Move Forwards: Understanding the History of How Intraprofessional Nurse Collaboration Can Inform Tomorrow’s Nurse Leaders,” is not congruent with IE’s theoretical underpinnings. Institutional ethnographers do not simply describe social institutions or the social relations (ways people interact with each other) embedded within them (Rankin, 2017a&b). Rather, institutional ethnographers explicate the connections among the local settings of everyday life, institutions, and translocal relations of ruling (Rankin, 2017a). Consequently, it is important to avoid generalized or theorized explanations that conceptualize what people are doing (Rankin, 2017a). In this paper, I

describe historical developments in nursing that may have contributed to challenges, that RNs and LPNs now face when they work together, such as intra and interprofessional hierarchies. I also present a model which generalizes how RNs and LPNs have worked together at different points in time. When I began the data collection for my study, I needed to be careful not to let this paper distract me from being able to describe what RNs and LPNs were actually doing on their units. This manuscript was published in the conference proceedings of the World Nursing Conference 2015, in Singapore.

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Chapter1: Setting the Context

Reading the Literature as an Institutional Ethnographer

Gerish and Lacey (2010) suggest that most doctoral research proposals begin with a review of existing literature on the topic. These authors emphasize that researchers' familiarity with research and publications about their topics is an important first step in the research process. As an institutional ethnographer, in my review of the literature, I positioned myself explicitly as a "discourse analyst" (Rankin, 2017), which allowed me to consider the larger context, particularly how the literature constructs or contributes to the social world around RNs and LPNs. This was different positioning than more conventional approaches to reviewing the literature, which usually focus on identifying gaps. Whilst I was interested in purported gaps, I paid attention to how these gaps became research priorities, which were built on particular worldviews. I was also mindful that when researchers then try to fill in gaps, they often take up the contexts and assumptions of the knowledge that has already been constructed about their topics.

Through institutional ethnography, my reading was explicitly to 'set the context' or to learn more about how knowledge about the topic is constructed and socially organized. As a discourse analyst, I paid attention to who was funding, writing and citing research. How was published work being used by employers and regulators? What grey literature existed? How was research designed and how did it import conceptual and theoretical frameworks? What were the formulations of rigour that were described in published findings? How were conventional approaches to research and knowledge development abstracted from the materiality of things happening? My scholarly interest was in how particular constructions of knowledge became the

dominant ways of knowing through which many topics became understood. Dorothy Smith (2005) suggests that these forms of authorized knowledge must be problematized by institutional ethnographers; examined for whether and how they subordinate people's actual experiences in real places.

With this in mind, institutional ethnographers do not review literature or use it as facts the way other researchers might (Benjamin & Rankin, 2014). Instead, institutional ethnographers examine prior research "from the inside out, like a shirt, so we can inspect the seams of construction" (Mueller, 1995, p. 106). Consequently, I considered the process of knowledge construction, including the activation and subordination of existing knowledge. For example, nursing knowledge may be subordinated when managerial decisions, which are made in a business-like way to make hospitals run more efficiently, result in nursing practice changes that work against the interests of RNs and/or LPNs and their patients (Rankin, 2004).

Institutional ethnography "is distinctive among sociologies in its commitment to uncovering 'how things are actually put together,' 'how things work'" (Campbell et al., 2006, p.1). When institutional ethnographers read the literature, they are particularly concerned with how authors' position themselves in relation to the topic or how the topic is situated within different social structures or institutions (Campbell & Gregor, 2004). Institutional ethnographers also attend to how knowledge becomes activated and practiced in people's work and how people's work is supported by knowledge (Benjamin & Rankin, 2014; Campbell & Gregor, 2004). Importantly, people may not always activate knowledge in their work. Nurse managers may want to make nursing practice "more efficient," so they develop some new policies. Their nursing staff may

reject the new efficiency mandate and may create “work arounds” to avoid changing how they do things.

I began reviewing the literature on RNs and LPNs working together before I considered my research methodology; and went through the literature trying to identify gaps. Most of the literature I found about collaboration was about “interprofessional collaboration” between physicians and other healthcare professionals, such as RNs, pharmacists, physiotherapists, and occupational therapists. Thus, the dominant approach to knowledge generation about collaboration is between health professions with more distinctly different scopes of practice, such as physicians and RNs, rather than those with overlapping scopes of practice, such as RNs and LPNs. When I reflected on the social contexts in which I worked as a RN, where I had more frequent interactions with LPNs than with physicians, and I became further convinced of the importance of inquiry into RNs and LPNs working together.

I found little literature about collaboration authored by LPNs. Physicians or other healthcare professional, who are prepared at a baccalaureate level or higher, authored most of the academic literature I read. Several LPN professional associations and regulatory bodies, including the Association of New Brunswick Licensed Practical Nurses (ANBLPN), authored professional publications, either independently or with the RN professional association/regulatory bodies, about working together. These professional publications target their members’ nursing practice needs, providing practical information to help them in their workplaces.

History of Nursing Education and Regulation

An understanding of the history of nursing and nursing education in Canada is necessary to provide context to some of the challenges nursing currently faces. Organized nursing and health care in Canada began with the early French colonists (both men and women) who immigrated to their colonies in North America (Mansell, 2004; Ross-Kerr, 2006). Like the Indigenous societies they met, these settlers often depended on traditional knowledge of disease and the human body and herbal remedies were the only medicines available (Ross-Kerr, 2006). The colonists also brought more formalized health care, but one that reflected the divisions and hierarchy of the healthcare professions in France (Johnston, 1984). In the mid-19th century, the British nurse, Florence Nightingale, started her movement to improve the standards of nursing care. Nightingale came to prominence during the Crimean war (1853-1856) for her dedicated care of wounded and sick British soldiers (Mansell, 2004).

Nightingale was upper class and well-educated, and implemented strategies, such as an improved awareness of hygiene, that drastically reduced the morbidity and mortality of patients (Mansell, 2004). She subsequently founded a school of nursing, the Nightingale Training School, in England, which became a model for nursing schools in Canada and around the world (Mansell, 2004). Mansell (2014) suggests that Florence Nightingale used her own image, as the “lady of the lamp,” to promote nursing as a respectable profession for women. She had gained this nickname from a phrase in a report from *The Times* newspaper in which she is described as “a ministering angel ... [whose] slender form glides quietly along each corridor... alone, with a little lamp in her hand, making her solitary rounds” (cited in Cook, 1913, p. 237). This came at a time

when there were few respectable vocations for women outside the home (Brooks & Rafferty, 2007).

During the early 20th century, nursing continued to evolve – especially following the formation of new professional nursing organizations, which addressed some of the challenges that nursing staff were experiencing (Mansell, 2004). The Canadian National Association for Trained Nurses, which was formed in 1908 and is now called the Canadian Nurses Association (CNA), promoted leadership within the nursing profession and encouraged its members to consider their role in healthcare beyond the bedside care of their patients (Elliott, Ruddy, & Villeneuve, 2008). Mansell (2004) describes how nursing leaders became concerned with the educational preparation of nursing staff and the working relationship between nursing staff and other care providers, especially physicians. Price, Doucet, and Hall (2014) argue these issues became more important as patient care became more acute with more complex treatments. For example, nursing staff began to work in areas that required greater specialization, such as pediatrics and orthopedics (Price et al., 2014).

Initially, few educational and professional standards existed for nursing staff (Mansell, 2004). Education programs varied in their lengths and their entry requirements. Many hospital-based training programs required students to work long hours and follow strict schedules (Mount Saint Vincent University [MSVU], 2005). Mansell (2004) describes how many nursing leaders wanted to standardize the nursing educational requirements, including setting admission standards, improving the availability of teaching equipment, and setting a nursing curriculum. In 1932, an important benchmark occurred with “The Survey of Nursing Education in Canada,” better known as the “Weir

Report.” This report advised that nursing schools should be used primarily to educate nursing staff and not to provide hospitals with a workforce of nursing students (Mansell, 2004). The Weir Report further recommended that nursing education should be included in the general education system – with the minimal requirements for nurses to be four years of high school followed by an additional three years of nursing training (Mansell, 2004). This report not only supported nursing leaders' visions for improved nursing education, but also recommended that the government allocate funds to support these improvements (Mansell, 2004). Mansell (2004) considers how not everyone agreed with the conclusions of the Weir report. She describes how some felt more educated, less disciplined women would not make good nursing staff; however, the demands of increasingly complex medical treatments required improved nursing education (Mansell, 2004).

Over time, nursing education became more formalized. In 1919, the University of British Columbia in Vancouver established the first university-based nursing school, which offered a basic nursing degree program (MSVU, 2005). Other universities also began offering courses to nursing staff who had already graduated from hospital-based programs (MSVU, 2005). Nursing staff who had received more formal education began to distinguish themselves from other nurses and receive recognition for their additional qualifications (Mansell, 2004). They began to call themselves “graduate nurses” (Mansell, 2004). Provinces eventually began to hold examination for the registration of nurses, thereby making an official distinction between nursing staff (MSVU, 2005). All graduates of recognized nursing programs who passed their provincial exams were then able to identify themselves as registered nurses or RNs (Mansell, 2004). The different

credentialing between RNs and other nursing staff created a hierarchy within the nursing profession, with RNs receiving better pay. Many RNs also worked closely with nurse's aids (who were female) or orderlies (who were male) (Lucas, 2019). Nurse's aids and orderlies usually completed short, hands-on training programs that focused more on physical care than on knowledge about medical processes (Lucas, 2019). Although personal care remained, and continues to remain, an important part of all nursing, RNs looked to provide greater medical attention to patients.

Throughout nursing's history, physicians and other experts subordinated the knowledge nursing professionals had about their work. For example, at the beginning of the 19th century, when nursing was formalizing as a profession, physicians - not nursing professionals - taught in nursing schools and published on nursing education and practice (Group & Robert, 2001). Group and Roberts (2001) argue that "the presumption that physicians could define another profession marks the development of nursing as a profession distinctly different from the 'emergence' of 'male' professional groups" (p. 120). Today, experts continue to subordinate the knowledge nursing professionals have about working on the frontlines with their patients through policy decisions/documents. For example, policy decisions/documents are often written by experts located in offices away from where nursing professionals care for their patients.

In the early 1930s, the CNA recognized practical nurses (PNs) who then numbered almost 4700 across the country (Lucas, 2019). Lucas (2019) considers how RNs appreciated the assistance PNs could provide in delivering patient care. These PNs were limited, however, in their role in patient care to providing more task-based activities, like bathing and toileting (Lucas, 2019). Rheaume (2003) describes how, like

RNs before them, PNs struggled to become recognized, self-regulating nursing professionals. The first legislative acts controlling the education, testing, licensing, and practice of practical nursing occurred during the 1940's (Lucas, 2019). In most provinces, licensing of PNs initially came under the provincial RNs' associations (Rheaume, 2003). Slowly, provincial PNs associations formed. Initially, Rheaume (2003) argues these associations simply provided support for PNs. Eventually, these associations gained responsibility for establishing the standards of education, practice, and licensing for their members (Rheaume, 2003). At different points, RNs have expressed concern over the advancement of practical nursing in Canada (Mansell, 2004). For example, in a briefing to the Royal Commission of Health Services in 1962, the CNA recommended that PN programs be discontinued (CNA, 1962).

Nursing Regulatory Bodies

There are no national RN or PN registrations or licenses in Canada. Nursing registration and licensure are the responsibilities of the provinces (10) and territories (2). In many provinces, PN associations have struggled to take responsibility for their members. For example, in New Brunswick, a PN association formed in 1965 – but licensing continued to be administered under the Nurses Association of New Brunswick (NANB), which was for RNs until 1977 (Rheaume, 2003). In that year, an Act of Incorporation by the New Brunswick Legislature enabled the Association of New Brunswick Registered Nursing Assistants to take responsibility for their own education, licensing, and disciplining (Rheaume, 2003). The Nurses' Association of New Brunswick and several other RN groups initially opposed this bid for an Act of Incorporation, but decided to support it when they "fac[ed] criticism from a number of outside groups for

attempting to maintain control over [practical nursing]” the way medicine had controlled them (Rheume, 2003, p. 439).

Interestingly, in Ontario, RNs and PNs are under the same regulatory body, some provinces with separate RN/PN regulatory bodies have expressed interest in merging to follow this model (CRNNS, 2017). For example, in 2015, the College of Registered Nurses of Nova Scotia (CRNNS) and the College of Licensed Practical Nurses of Nova Scotia (CLPNNS) began conversations around uniting as one nursing regulator for the province (CRNNS, 2017). On June 4th, 2019, the ‘new’ Nova Scotia College of Nursing (NSCN) received authority through changes to Nova Scotia’s Nursing Act to be the nursing regulator for the province. Nova Scotia’s nursing leaders hope this single regulatory body will enable all members “to work to their full scope of practice, facilitate red tape reduction, and epitomize the type of collaboration among health care professionals that is necessary for ... the future of health care” (NSCN, 2019).

Protected Titles

A key purpose of the regulation of RNs and LPNs is to protect the public – and one aspect of regulation is protecting titles and designations to ensure they are used appropriately. Initially, in New Brunswick, LPNs had the title of “Registered Nursing Assistant” or RNA. In 1987, RNAs tried to have the New Brunswick Legislature adopt changes to their Act, which would change the designation (of Registered Nursing Assistant) to “Licensed Practical Nurse.” This attempt (and another attempt in 2000) met resistance from RN leaders and was unsuccessful (Rheume, 2003). There was concern that “the name change would precede demands for greater responsibilities in relation to patient care and ultimately erode nursing functions” (Rheume, 2003, p. 439). Finally, in

2002, the Association succeeded in their attempt to have changes to the Act and the Association became the Association of New Brunswick Licensed Practical Nurses (ANBLPN) (Rheaume, 2003).

Today, the title Licensed Practical Nurse or LPN is used in most Canadian provinces, along with the title “infirmier(ère) auxiliaire” (in Quebec) and “registered practical nurse” or RPN (in Ontario) (Huynh et al., 2010). In New Brunswick, the title “nurse” is protected under the Nurses Act (1984, amended in 1997 & 2002) and is restricted to RNs, nurse practitioners (NPs) and nursing students in a program approved by the Nurses Association of New Brunswick (NANB). Thus, New Brunswick legislation has given RNs exclusive rights to the title “nurse” and action can be taken against LPNs who refer to themselves as “nurses” (ANBLPN, 2016). Additionally, The Code of Ethics for Registered Nurses (2017) states, “Nurses represent themselves clearly with respect to name, title and role” (p.16). In other Canadian provinces, RNs do not have exclusive rights to the title “nurse” and LPNs may introduce themselves as “nurses” to their patients.

In this thesis, I primarily use the titles “licensed practical nurse” (or LPN) and “registered nurse” (or RN) to identify my informants’ credentialing. I wanted to use the titles my informants used, themselves, in their interviews. These are also the titles used in New Brunswick and most other Canadian provinces. The only exceptions are in Chapters 2 and 5, which are stand-alone manuscripts for publication and intended for wide dissemination of my findings. In these chapters, I use the title “practical nurse” (or PN) because, in Ontario, the title “registered practical nurse” is preferred over the title “licensed practical nurse” and I wanted my topic to be clear to all my readers.

Today's Issues and Trends

By the late 1980's, a need to increase the efficiency and effectiveness of healthcare delivery in Canada became very apparent (Rheume, 2003). In 1997, M. E. Jeans (Executive Director) of the CNA mentioned that she felt the biggest threat to RNs was “[their] inability to work [with others], openly and with trust and understanding toward the common goal of a strengthened nursing profession” (cited in Mansell, 2004, p. 171). This statement implies threat perceptions influence how RNs and LPNs work with each other, which makes exploring RNs' and LPNs' actual experiences with working together even more important. In the literature, threats in the form of decreasing status and autonomy, uncertainty, and unfairness are shown to influence collaborative tendencies.

Many of the issues and trends faced by RNs also pertain to LPNs. LPNs typically learn the same nursing concepts as RNs (such as oxygenation, perfusion, patient-centred care, etc.), but have a shorter, less in-depth education program, do not initiate plans of care, and care for more stable patients (Huynh et al., 2010; Lucas, 2019). Canadian baccalaureate nursing (BN) and LPN education programs have higher entry requirements today than in the past (Lucas, 2019). They both require a minimum of a high school diploma – usually with high marks and several science courses (Lucas, 2019). According to Lucas (2019), RNs and LPNs experience similar challenges in their workplaces, resulting in the need for nurses to learn to work together to meet these challenges and advance nursing interests. Both RNs and LPNs are evolving with the Canadian health care system (Mansell, 2004).

Many authors argue “*inter/intraprofessional collaboration*” leads to more efficient patient care (Reeves et al., 2008; Lo, 2011). Jenkins (2013) argues a driving force behind the emphasis on achieving increased efficiency in the healthcare system has been the rising costs of healthcare. According to the Canadian Institute of Health Information (CIHI, 2019), health care spending accounted for 11.6% of the Canada's Gross Domestic Product in 2019. This puts Canada in line with many industrialized nations, such as Germany (11.5%) and Britain (9.6%), but noticeably behind the United States at 17.6% (World Health Organization, 2013). Examining the total cost of healthcare to the economy, however, minimizes the impact of these costs to the governments. In New Brunswick, approximately 40% of the provincial budget is directed towards healthcare, which has led some researchers to question the very sustainability of the system (Jenkins, 2013). Burgeoning health costs is a contemporary context through which the issue of working together in the nursing profession can be viewed.

In addition to the challenge of the rising costs of healthcare, there is perceived a nursing/healthcare worker shortage in Canada. Nursing/healthcare worker shortages occurs when the demand for nursing staff, such as RNs and LPNs, and other healthcare workers outpaces the supply (Sawaenqdee et al. 2016). Canada’s nursing/healthcare worker shortage, however, is not entirely due to a lack of qualified RNs and LPNs or those interested in pursuing nursing as a career, with other causes including: lack of potential educators, high turnover, and inequitable distribution of the workforce (Sawaenqdee et al., 2016). In some areas (mostly urban centres), there is a surplus of RNs and/or LPNs. Many nursing education programs report turning away qualified applicants.

The University of New Brunswick (UNB), for example, only accepts 40 percent of qualified applicants due to limited number of seats in the program (Steeves, 2018).

Globally, many healthcare organizations have been experimenting with different staffing mixes to respond to the perceived shortage of healthcare workers (MacPhee & Borra, 2012). The World Health Organization (WHO, 2008) recommends “task-shifting” as a way to create a “flexible” healthcare workforce. Task-shifting occurs when “specific tasks are moved, where appropriate, from highly qualified health care workers to health care workers with less training and fewer qualifications to make more efficient use for the available human resources” (WHO, 2008, p 2).

The roles of both RNs and LPNs have changed significantly over the years. For example, the New Brunswick government granted LPNs the authority to practice more independently within their scope of practice. Additional competencies were added to their scope, including administering intravenous and intramuscular medications and immunizations (with appropriate training). Such changes have meant that LPNs are now able to work in more practice settings and take on expanded roles that include full patient care. Butcher, MacKinnon, and Bruce (2018) consider how disciplinary knowledge intersects with the reassignment or sharing of various tasks between RNs and LPNs. They argue it may create ambiguity and confusion around scopes of practice and may negatively affect workplaces (Butcher et al., 2018).

Interprofessional Frameworks

Although the CNA considers “intraprofessional education and collaboration” between RNs and LPNs to be an important part of building effective healthcare teams and improving patient outcomes, little research has been conducted in this area (CNA, 2010).

As previously mentioned, “interprofessional collaboration,” or collaboration between healthcare providers from different professional backgrounds, such as collaboration between physicians and nurses, has received more attention from researchers (Virani, 2012). Several models and frameworks for interprofessional collaboration between healthcare providers currently exist, such as the Canadian Interprofessional Health Collaborative’s (CIHC,2010) “National Interprofessional Competency Framework,” WHO’s (2010) “Framework for Action on Interprofessional Education and Collaborative Practice,” and finally the University of Toronto’s (2009) “Framework for the Development of Interprofessional Education and Core Competencies.”

These frameworks consider the “competencies” related to “collaboration.” Before beginning to describe each of these frameworks individually, it is important to note that all healthcare professions use different competencies to describe and evaluate the knowledge, attitudes and skills needed by those in that profession to practice safely and responsibly. According to Verma, Paterson and Medves (2006), competencies help to “describe excellent performance in a particular [profession]” (p. 109). Competencies are, however, human constructs and do not necessarily depict the actual work that is done in a particular setting. They are also often written using institutional language, which may be used differently by different people. As an institutional ethnographer, I am interested in what is actually happening and how what is happening is being socially organized.

Canadian Interprofessional Health Collaborative Framework

The Canadian Interprofessional Health Collaborative (CIHC), which is composed of different health organizations, health educators, health providers, and students, developed their “National Interprofessional Competency Framework” in 2010 to describe

the competencies that are needed by healthcare providers to engage with each other in collaborative care (CIHC, 2010). They describe their framework as evidence-based; and focused on explaining ideal collaborative relationships and providing healthcare providers with direction for the establishment of such relationships (CIHC, 2010). This framework uses six overarching competency “domains” to identify key aspects of collaborative relationships, including: role clarification, team functioning, patient-centered care, collaborative leadership, interprofessional communication, and interprofessional conflict resolution (CIHC, 2010). The domains are purposefully very broad (CIHC, 2010). Each domain is further clarified with descriptors and explanations to help healthcare providers relate each domain to their individual situations across diverse settings (CIHC, 2010).

World Health Organization’s Framework

WHO’s (2010) “Framework for Action on Interprofessional Education and Collaborative Practice” also considers collaboration between healthcare providers. According to Gilbert, Yan and Hoffman (2010), it aims to identify both the characteristics of effective collaborative relationships and to provide strategies for policymakers to implement to develop and improve interprofessional education and collaboration in various patient-care contexts worldwide. They also argue WHO’s (2010) framework promotes the idea that healthcare providers need exposure to collaboration with others early in their education programs (Gilbert et al., 2010). According to WHO’s (2010) framework, employers and educators need to work together to develop and support interprofessional education initiatives and collaboration between healthcare providers in their workplaces (Gilbert, et al., 2010).

University of Toronto's Framework

Finally, the University of Toronto (2009) developed a framework for the development of interprofessional education for their health professional programs. This framework describes interprofessional education as a progression along a continuum of three stages: starting with exposure, followed by immersion, and ending with competence. At each stage, learners develop their knowledge of interprofessional collaboration through three constructs (or building blocks) of interprofessional education: collaboration, communication, and values and ethics. This framework requires assessment and evaluation at each stage of a learner's development by outlining the knowledge, skills/behaviors, and attitudes that learner should develop before progressing. This framework depicts the process of becoming a proficient collaborator as being step-wise in nature.

Each of these frameworks presents interprofessional collaboration to be a skill that develops over time; and its development requires the involvement and support of both educators and employers. These frameworks also associate interprofessional collaboration with certain competencies. The University of Toronto's Framework, in particular, emphasizes that individuals progress in their abilities to collaborate with others over a continuum and through their experiences. For example, RNs or LPNs working on an intensive care unit may collaborate well in this environment where their work is familiar, but struggle on a pediatric or orthopedic unit where things are different. These frameworks are themselves a component about how knowledge is socially organized. The competencies may appear in the job descriptions, scopes of practice documents, etc. that shape and organize RNs' and LPNs' daily work. It is important to remember, however,

that these competencies are abstracted and do not necessarily reflect what people are actually doing.

Interprofessional Versus Intraprofessional Education

The benefits of “*inter*” and “*intraprofessional* education” have been widely cited (WHO, 2010; Lucas, 2019), but how are they treated differently in the literature?

According to WHO (2010), “*Inter*professional education” occurs “when students from two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes” (p. 7). Oandasan and Reeves (2005) argue *inter*professional education provides learners from more than one profession with an opportunity to learn from each other and about each other’s roles in patient care. Leonard, Shuhaibar, and Chen (2010) assert that *intraprofessional* education takes place when collaborative learning occurs between those who share a common professional education, values, socialization, identity, and experience.

The terms *inter* and *intraprofessional* have both been used to describe collaborative learning experiences that involve RN and LPN learners. For example, Huynh, Alderson, Nadon and Kershaw-Rousseau (2011) consider RN-LPN collaboration to be interprofessional collaboration because RNs and LPNs are often not regulated by the same professional bodies. In contrast, the Canadian Nurses Association (CNA, 2010) uses the term “*intraprofessional*” nurse collaboration in its documents when referring to RN-LPN collaboration. The most dominant term used to describe RNs and LPNs working together is *intraprofession* collaboration, which is the term used by many provincial RN/LPN regulatory bodies, such as the Nurses Association of New Brunswick (NANB) and the Association of New Brunswick Licensed Practical Nurses (ANBLPN).

The use of both these terms in the literature is significant, however, and follows the assertion in the Health Professions Regulatory Advisory Council (HPTAC) report of June 1996, which states, “The distinction between nurses ... are not publicly understood, and they are not as great as distinction between [other medical] professions” (p.10).

This distinction continues to cause confusion today, particularly around scopes of practice. For example, many RN and LPN regulatory bodies, such as NANB and ANBLPN, have published professional literature for their members about how to work together (NANB & NBLPN, 2015). In NANB and NBLPN’s (2015) guide, it describes how “[q]uestions often arise about whether an activity is “within the scope” of practice of an RN or an LPN” (p. 7).

History of Collaborative Practice

In the past, nursing professionals and other healthcare professionals worked together in extremely hierarchical ways. Apker, Propp and Ford (2002) describe how healthcare professions that were more specialized or required more extensive education, such as medicine, were (and still are) considered to be more prestigious and better remunerated than others. Even within professional groups in health care (such as different types of physicians and different types of nursing professionals), specializations, expanded scopes of practice, and years of seniority create hierarchies and power imbalances that can negatively affect patient care (Apker et al., 2005). For example, Taran (2011) argues these hierarchies and power imbalances within hospitals hamper communication between healthcare professionals, such as between physicians and RNs or RNs and LPNs.

Mansell (2004) argues these shadows of the past lie particularly heavily on

nursing. For example, RNs receive higher pay, although their scope of practice overlaps that of LPNs, and RNs and LPNs often share tasks and patient assignments. Mansell (2004) describes how many RNs remain concerned about their roles in patient care and their replacement by LPNs and other healthcare workers, which may undermine their working with others.

Chapter 2: Manuscript #1

Manuscript #1 is a concept analysis of “Intraprofessional Nurse Collaboration.” A concept analysis is the systematic process by which an abstract concept is explored, defined, and differentiated from similar concepts to be used when communicating about it (Walker & Avant, 2010). Xyrichis and Ream (2008) have mentioned various approaches for concept analysis, including methods of Rogers (2000), Walker and Avant (2010), Morse (1995), and Meleis (2011), but Walker and Avant’s method is the most commonly used. Walker and Avant’s (2010) approach to concept analysis has eight steps: choosing a concept, determining the purpose of analysis, identifying all uses of the concept, defining attributes, identifying a model case, identifying borderline, related, and contrary cases, identifying antecedents and consequences, and defining empirical referents.

The title, “nurse,” is protected in New Brunswick, and only RNs and NPs can call themselves “nurses.” As I have previously mentioned, this is not the case in other provinces and countries, where RNs, NPs, and LPNs can all call themselves nurses. Throughout most of this thesis, I refrain from using the title, “nurse,” to avoid confusion. This is a manuscript, however, intended for publication in an international journal and I use the title “nurse” to refer to RNs, NPs, and LPNs, as this labelling would be expected by most of its readers.

I completed this manuscript early in my doctoral studies, before I had decided on my methodology. Arguably, it is not the best fit with institutional ethnography. The process of completing a concept analysis itself shows how knowledge is socially organized. Concepts are abstracted ideas; and thus, the process of systematically

exploring/defining/differentiating them to establish or apply authority to their meaning shows the ruling relations of the academe. For an institutional ethnographer, positioning a topic conceptually is avoided. Nonetheless, examining and familiarizing oneself with how the topic is conceptualized provides insight into how authorized ideas gain traction, become part of people's vocabulary and organize what people can know. Thus, institutional ethnographer pays attention to how people may use these concepts to describe their work, and to note when those concepts contradict with what they are actually doing. For example, a RN might say, "I collaborate" but this statement alone does not reveal what this RN is actually doing. This RN might have helped another nursing staff member reposition a patient. Alternately, this RN might simply view their relationships with the other nursing staff members positively.

Draper (2014) humorously criticizes the problem with analyzing concepts by completing a "mock" concept analysis of "chair." Through this mock concept analysis, Draper (2014) shows that it is pointless to clarify the concept of chair by analyzing it and developing a list of defining attributes as recommended by Walker and Avant (2010). He explains that it is what people mean when they say chair that is important; for example, are they pointing to a wheelchair or a recliner? (Draper, 2014). Draper's (2014) mock concept analysis emphasizes the importance of getting to the bottom of what people actually mean by conceptualized words like collaboration (Draper, 2014). Dorothy Smith herself is very interested in how people use words and how certain words gain traction in people's vocabularies (Campbell, 2003). Her efforts towards knowing take up Ludwig Wittgenstein's (1958) view that the meaning of a word is or develops on the basis of how it is used and understood (Campbell, 2003). Wittgenstein (1958) argued that people

should use descriptions to make the meaning of words, like “collaboration,” understood instead of using explanatory generalizations.

I chose to include Manuscript #1 because it was an important part of my doctoral journey and required me to reflect on what I think I know. The process of completing this concept analysis also made me reflect on how knowledge is socially organized.

Moreover, many of the “defining attributes” may appear in the job descriptions, scopes of practice documents, etc. the RNs and LPNs referred to in their interviews. My next step after completing this concept analysis was to detach myself from what I knew, so I could start thinking like an institutional ethnographer.

Concept Analysis of Intraprofessional Nurse Collaboration

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This manuscript will be submitted to the *Journal of Interprofessional Care*. It is presented in the formatting style of this journal. The title “practical nurse” (or PN) is used instead of “licensed practical nurse” (or LPN) for clarity. In Ontario, the title “registered practical nurse” is preferred over the title “licensed practical nurse.”

Abstract

Nursing professionals often work collaboratively with each other and with other healthcare professionals to deliver quality patient-centred care. The World Health Organization (2010) considers interprofessional collaboration, or collaboration amongst healthcare professionals who have *different* professional backgrounds, to be a way of improving healthcare worldwide. While there is a body of research focused on interprofessional collaboration, less is known about *intraprofessional* collaboration, or collaboration between healthcare professionals, such as nursing professionals, who *share* a professional background but may belong to different professional *categories* or *levels*. Thus, they may have *similar* - yet *distinct* – scopes of practice and roles in patient care. Currently, there is no widely accepted definition of *intraprofessional* collaboration between nursing professionals, which limits research and causes confusion for those interested in this topic.

We have used Walker and Avant's (2010) eight-step concept analysis model to develop an operational definition of the term nursing intraprofessional collaboration. We (1) selected a concept; (2) determined the purpose of the analysis; (3) identified uses of the concept; (4) determined the defining attributes; (5) identified the model case; (6) identified any borderline and contrary cases; (7) identified any antecedents and consequences; and (8) defined empirical referents. Our search included: dictionaries, thesauruses, and published, as well as grey literature sources.

Having a comprehensive operational definition will promote the sharing of knowledge to further advance the study and practice of intraprofessional nursing collaboration. There are many professional categories within nursing, which makes it

important to understand how they collaborate with each other. As governments seek to reduce healthcare costs, increasingly we will see different levels of healthcare professionals, such as registered nurses (RNs) and practical nurses (PNs), from the same professional background working together.

Keywords: concept analysis, intraprofessional collaboration, nursing, patient care, registered nurse, practical nurse,

Conceptual Analysis of Intraprofessional Nurse Collaboration

Background

Healthcare professionals around the world, including nursing professionals, need to ‘do more with less’ as most healthcare systems struggle to contain healthcare costs, while still maintaining their standards of healthcare services. Aging populations, rising public expectations, and the introduction of new technologies are examples of the challenges facing today’s healthcare professionals (Aiken et al., 2012). Although patients’ needs are increasing, there seem to be proportionally fewer resources, including human resources, available to care for them. Increasingly, healthcare professionals need to rely on their collaboration with others – both from *different* and *similar* – professional backgrounds to fill gaps in their services. The World Health Organization (WHO, 2010) recommends *interprofessional* collaboration, or collaboration amongst healthcare professionals who have *different* professional backgrounds, to improve healthcare services and delivery worldwide. While the term *interprofessional* collaboration appears frequently in nursing and other health literature and the WHO’s (2010) definition is widely accepted/used, the term *intraprofessional* collaboration appears less frequently and has no widely accepted/used definition. This is an oversight in the nursing and healthcare literature where different *categories* or *levels* of healthcare professionals who share a professional background often work together to provide patient care. For example, practical nurses (PNs), registered nurses (RNs), and nurse practitioners (NPs) work closely together in many healthcare settings.

The use of different *categories* or *levels* of healthcare professionals from the same professional background, such as PNs, RNs, and NPs, is a popular cost containment

strategy. This enables the use of task shifting, which is “a process whereby specific tasks are moved, where appropriate, to health workers with shorter training and fewer qualifications” (WHO, 2008, p. 7). This term has particular significance to the profession of nursing. Maier et al. (2016) found many countries have implemented task-shifting to maximize their health workforce capacity. Maier et al.’s (2016) study focused on task-shifting where nursing professionals advanced their practice to take up tasks from physicians. Task-shifting, however, also allows the less complex tasks like toileting and some dressing changes, which are in both RNs’ and PNs’ scopes of practice, to be done by PNs, which frees up RNs for more complex tasks like administering high alert intravenous medications. PNs are compensated at a lower rate than RNs, so using them appropriately means staffing mixes can be adjusted to contain costs, while still meeting patients’ needs.

As Butcher et al. (2015) note, there is little literature that discusses the intraprofessional experiences of an individual within the various healthcare professions. Moore and Prentice (2012) argue that nursing professionals spend more time collaborating with each other than they do with other types of healthcare professionals. Moreover, nursing professionals are the largest group of healthcare providers worldwide and how they work together and collaborate with each other significantly affects patient outcomes. Despite this, very little is known about intraprofessional collaboration among nursing professionals. Therefore, as a starting point, the purpose of this paper is to develop an operational definition of ‘intraprofessional nurse collaboration’ through performing a concept analysis of this term. MacKinnon, Butcher, and Bruce (2018) found RNs and LPNs frequently used the language of ‘skills’ to differentiate their roles in

patient care, which suggests some ambiguity surrounding their scopes of practice. A study from Eagar, Cowin, Gregory, and Firtko (2010) suggests that ambiguity and confusion surrounding scopes of practice negatively affect collaboration in the workplace, which could result in negative outcomes for both nursing professionals and their patients. It is our hope that this paper will clarify what is meant by the concept of/and practice of 'intraprofessional nurse collaboration' and better define the roles of nursing professionals when working together.

Method

Walker and Avant (2010) described an eight-step concept analysis model, which is frequently used to analyze terms in nursing. Their process was modified from Wilson's (1963) concept analysis process, which has 11 steps and is more complex. The following eight steps were used for the present concept analysis on intraprofessional nurse collaboration: (1) select a concept; (2) determine the purpose of the analysis; (3) identify the uses of the concept; (4) determine the defining attributes; (5) identify the model case; (6) identify any related, contrary, or invented cases; (7) identify any antecedents and consequences; and (8) define empirical referents.

Our search included dictionaries, thesauruses, and published, as well as grey literature sources. This provided a comprehensive review across professions and sources. We completed a literature search using the World Wide Web, Google Scholar, PubMed, MEDLINE, CINAHL and reference lists of related journal articles within a timeline of 1965 to 2019. We used combinations of the following terms 'nursing', 'nurse', 'practical nurse', 'licensed practical nurse', 'registered nurse', 'nurse practitioner', 'teamwork', 'collaboration', 'intraprofessional', 'interprofessional', 'leadership' and 'delegation' in

defining our searches. These terms evolved from informal conversations with experts on inter and intraprofessional collaboration. We did not include terms related to specific job positions, like ‘clinical nurse specialist,’ ‘intensive care nurse,’ ‘graduate nurse’ or ‘nurse manager.’ These terms usually refer to RNs whose different practice roles are determined through specializations and job descriptions rather than their level of education or category of license. Articles related to such specific job positions were retrieved from the more general terms (e.g. – ‘nurse’) of our search. We only included resources published in English or translated into English.

We focused our search on nursing and healthcare literature, despite the fact that intraprofessional collaboration also occurs in professions outside of the health professions. For example, teaching assistants collaborate with teachers and engineering assistants collaborate with engineers. Walker and Avant (2010) do suggest that consideration be given to all uses of a concept (across professionals and disciplines); however, Xyrichis and Ream (2007) caution that too full an exploration of a concept across too many different contexts may actually be unhelpful to completing a meaningful analysis. Therefore, this concept analysis focused primarily on nursing and healthcare literature because of the integral role patients play in such collaborations. When nursing professionals collaborate with each other, they are also collaborating with patients and their families, whose care needs and goals also influence the dynamic. Thus, the intensity of the interpersonal relationships between nursing professionals and their patients sets interprofessional nurse collaboration apart from intraprofessional collaboration in professions outside of the health professions.

Results

We described the first two steps of the concept analysis – the selection of the concept of interest and determination of the purpose of the analysis – in the introduction of this paper. While the steps are presented sequentially, the process was iterative, consistent with Walker and Avant’s (2011) approach, in that new information and ideas discovered in later steps affected earlier steps. For example, when we were completing steps 6 and 7, identifying the antecedents and consequences, we returned to step 3, reviewing the literature, to thoroughly explore the antecedents and consequences and provide greater clarity

Step 3: Uses of the Concept Nurse Intraprofessional Collaboration

Step 3 involved the identification of past uses or specific definitions of the concept ‘intraprofessional nurse collaboration.’ This was achieved through exploring relevant nursing and healthcare literature, as well as existing definitions, which are summarized in this section.

Intraprofessional collaboration in the nursing literature. Our literature search uncovered few uses or specific definitions of the concept ‘intraprofessional nurse collaboration.’ In the nursing literature, the concept of intraprofessional nurse collaboration is often discussed with interprofessional collaboration. Some researchers argue collaboration between many categories of nursing professionals (such as PNs and RNs) is actually interprofessional because there are sometimes different designations, licensing processes and organizations involved. We demonstrate throughout this paper that their shared professional origins and overlapping scopes of practice and roles in patient care make their collaboration intraprofessional rather than interprofessional.

Most research has focused on interprofessional relationships between RNs and other healthcare providers, such as physicians. Stefaniak (1998) explored the perceptions of collaboration among nursing professionals and found they define collaboration with each other as a “working together to solve a common problem or reach a common goal” (p. 10). She identified three occasions that encourage nursing professionals to collaborate with each other: knowledge/skills deficits, change and transitions, and communication gaps (Stefaniak, 1998).

Many of the articles retrieved from our search described the impact of effective (or ineffective) collaboration and/or teamwork on the health of nursing professionals as well as patients (Barrett & Yates, 2002; Cummings et al., 2008; Moore & Prentice, 2012). Bogaert et al. (2013) considered how RNs’ work environment affected their perceptions of their work and patients’ outcomes. They found that RNs who were encouraged to participate in decision-making; used/developed professional and personal skills; and shared others’ values felt better about their work and that their patients had better outcomes (Bogaert et al., 2013).

Other articles described different skill mixes (Havaei, Dahinten, & MacPhee, 2019) and nursing care delivery models which organize nursing professionals to work together in different ways (Butcher, MacKinnon, & Bruce, 2018; MacKinnon). Havaei et al. (2019) found RNs who worked in skill mixes with LPNs reported lower levels of exhaustion than those who worked in skill mixes without LPNs. Some articles were more ideological and described new nursing care delivery models or different ways of “optimizing scopes of practice” (Nelson et al., 2014; Oelke, Wilhelm, & Jackson, 2016).

There is also a body of literature that addresses intraprofessional education in nursing programs. Butcher et al. (2015) defined intra-professional education as, “various categories of students under one disciplinary umbrella, such as nursing (which would include RNs, licensed practical or vocational nurses [LPNs/LVNs] and registered psychiatric nurses (RPNs)) engaged in learning processes together in various educational contexts” (p. 2). Others maintained that intraprofessional education also occurred when students from differing years of the same program (such as a baccalaureate nursing program) were involved in learning together (Leonard, Shuhaibar, & Chen, 2010; West, Zidek, & Edwards, 2013). Bowers (2006) argued that intraprofessional education occurred on “occasions when one profession learns through collaboration from and about significant specializations to improve the quality of service” (p. 421). These definitions on intraprofessional education contribute to our understanding of the concept of nursing intraprofessional collaboration in two ways. They describe: 1) how collaboration is needed to improve patient outcomes, and 2) how mutual learning results when intraprofessional collaboration takes place. When nursing professionals collaborate with each other, they learn from each other about how to improve their patients’ outcomes and they also learn how to work better together.

Intraprofessional collaboration in the healthcare literature. There is also a body of literature that uses the concept intraprofessional collaboration outside of nursing, but within the healthcare literature. We considered this literature because there was little nursing specific literature and patients also play an integral in these collaborations. Bainbridge and Nasmith (2011) considered physician intraprofessional collaboration and identified several key components, including: 1) developing and maintaining

relationships that enable collaboration in patient care, 2) partnering with others during referrals and consultations to ensure patients receive timely treatments, and 3) partnering effectively with others to ensure patients' receive coordinated and timely care.

Intraprofessional collaboration may be different between nurses than between physicians. Garman, Leach, and Spector (2006) argued that, intraprofessionally, nursing is less hierarchal than medicine; and nursing professionals tend to support each other.

Definitions. During our literature search exploring the use of the concept intraprofessional nurse collaboration, we consulted dictionary definitions of the terms 'nurse,' 'intraprofessional,' and 'collaboration' independently from each other, as there was no definition for nursing intraprofessional collaboration.

According to Merriam-Webster's Online Dictionary (2018), the word 'nurse' derives from Middle English 'nourice,' 'norce,' 'nurse' and from the Anglo-French 'nurice.' First known uses of this term go back to the 13th century. Dictionary definitions conceive 'nurse' as:

- A person who "cares for the sick or infirm; specifically: a licensed health-care professional who practices independently or is supervised by a physician, surgeon, or dentist and who is skilled in promoting and maintaining patients' health" (Merriam-Webster's Online Dictionary, 2018).
- A person "trained to care for the sick or infirm, especially in a hospital" (Oxford Online Dictionary, 2018)

The International Council of Nurses (ICN, 2018) define 'nursing' activities to include: the promotion of health, prevention of illness, and the care of ill, disabled and dying people. They also describe advocacy; education; research; promotion of a safe

environment; and participation in shaping health policy and health systems management to be key nursing roles (ICN, 2018). These definitions identify how nursing professionals are skilled, licensed health professionals who often work with others and are responsible for many aspects of patient care.

We found few dictionary definitions of ‘intraprofessional’ during our literature search. The prefix ‘intra,’ meaning ‘within’ is frequently used to in the formation of compound words (Merriam-Webster’s Online Dictionary, 2018). The word ‘professional’ is defined as relating to a job that requires special education, training, or skills (Merriam-Webster’s Online Dictionary, 2015). The term ‘intraprofessional team’ is conceived in the Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health (2003) as a team of professionals who are from the same profession.

We found many dictionary definitions of ‘collaboration.’ According to Merriam-Webster’s Online Dictionary (2018), the noun ‘collaboration’ is conceived as:

- The act of process of working together, especially in a joint intellectual effort.
- The result of cooperating treasonably, as with an enemy occupation force in one’s country.

The McGraw-Hill Concise Dictionary of Modern Medicine (2018) defines collaboration between healthcare providers as the process of working together toward a common goal by various participants. These definitions emphasize how collaboration involves people working together to achieve a shared purpose. These people might have different backgrounds (or even be adversarial, as with the *enemy* definition) – but they are united by something that matters to them, such as meeting a patient’s needs.

Step 4: Defining Attributes

Step 4 required us to describe the defining attributes of the concept, intraprofessional nurse collaboration, or the things that must exist for this to occur (Walker & Avant, 2010). McKenna (1997) cautioned researchers against having too many attributes because some attributes may only be peripherally related to the concept. He recommended that researchers think about what attributes “really characterize the concept well” (McKenna, 1997, p. 62). We returned to our literature search and identified articles where researchers explored ‘collaboration’ or nursing professionals working together, and identified themes. From our analysis of these themes, we identify the following defining attributes for intraprofessional nurse collaboration:

- entering into a joint effort
- sharing in decision-making
- learning and benefiting from each other’s knowledge and expertise
- understanding and appreciating each other’s contributions

Related concepts. It becomes possible to identify related concepts, or those that are similar or associated with the one being analyzed, after the defining attributes have been described. ‘Intraprofessional nurse collaboration’ is often related to other types of similar interpersonal behavior, such as intraprofessional nurse cooperation or teamwork. The terms, ‘teamwork’ and ‘collaboration,’ are often used almost interchangeably, although some researchers argue that there are differences between them (Lawson, 2004; Xyrichis & Reem, 2008). Xyrichis and Reem (2008) proposed that the primary difference between teamwork and collaboration is that shared-leadership may be lacking in collaboration. They explain how a physician may ‘collaborate’ with other healthcare professionals and ask for recommendations when treating a patient - but the final decision

about the treatment rests with the physician (Xyrichis & Reem, 2008). We feel there is a notable hole in their argument because most teams similarly have leaders or captains with whom final decisions might rest. Henneman et al. (1995) actually used the words ‘team’ and ‘team approach’ in their concept analysis of collaboration. Our conclusion is that the concepts of teamwork and collaboration are very similar, but teamwork does not have all the defining attribute of collaboration. In teams, individuals often see themselves as an entity and work towards a common goal (Cohen & Bailey, 1997; Lemieux-Charles & McGuire, 2006; Salas et al., 2005; and Shortell et al., 2004). Nursing professionals are often organized in teams by external factors (such as similar work schedules or specialty areas) – and, as result, are required to participate in teamwork. For example, nursing care delivery models often organize RNs and LPNs into teams where they share patient assignments and divide patient care tasks. Although they participate in teamwork to care for their patients, this does not necessarily mean they *collaborate* with each other, as shown through the following constructed cases.

Steps 5 and 6: Constructed Cases

Steps 5 and 6 of a concept analysis involve the identification of constructed cases, which help to further increase the understanding of a concept (Walker & Avant, 2010). Specifically, we present a model case, a borderline case, and a contrary case. We use the same scenario, an interaction between a PN and a RN, to develop all the constructed cases. In the scenario, a PN (Kevin), on a busy medical unit, shares an assignment with a RN (Maryam). The PN helps a patient who is unsteady on her feet back into her bed. The patient asks the PN about when she will be discharged. It is the PN’s first day back to

work. The PN is unsure when the patient will be discharged and speaks with the RN about this patient's concern.

Model case. Model cases provide relatable, real-world examples of the concept that contain all its critical attributes (Walker & Avant, 2010). The following model case demonstrates nursing intraprofessional collaboration between a PN and a RN on an acute care hospital unit.

Practical Nurse: “Maryam, Mrs. Jones was very unsteady on her feet today when I helped her back into bed. She asked me when she will be going home. This is my first day caring for her and I am not sure what to tell her. I know you worked with her yesterday – what do you think about her unsteadiness? Did her physician mention anything to you about her discharge?”

Registered Nurse: “I helped her yesterday and she seemed steady then. Mrs. Jones’ physician mentioned in rounds that he is planning to discharge her tomorrow. Perhaps we should go speak with her and we can assess her together?”

Practical Nurse: “I think that would be helpful.”

In this example, Kevin and Maryam are jointly motivated to help Mrs. Jones. Kevin effectively communicates his concerns about their patient to Maryam. He knows Maryam cared for Mrs. Jones’ yesterday and (in her role as a RN) attended rounds with the physician. She likely has some knowledge about Mrs. Jones that he does not have. Together, Kevin and Maryam decide how they will both approach this situation. They recognize and appreciate the roles they both have in caring for their patients.

Borderline case. Borderline cases contain some, but not all the critical attributes of a concept and are used to emphasize the exactness of the model case in demonstrating a concept (Walker & Avant, 2010). To continue the scenario given above:

Practical Nurse: “Maryam, Mrs. Jones’ has some questions about when she will be discharged. I don’t know if she is ready.”

Registered Nurse: “Hmmm... Okay. I have to go in to give Mrs. Jones’ her morning medications anyway. I’ll talk to her now.”

Practical Nurse: “Okay.”

In this borderline case, Kevin and Maryam are both involved in Mrs. Jones’ care; however, neither nursing professional is motivated to work together. They use minimal communication to discuss Mrs. Jones or her potential discharge. Kevin does not clearly ask whether or not Maryam knows if Mrs. Jones will be discharged and Maryam does not provide any information. Kevin also does not explain why he does not think Mrs. Jones is ready to go home and Maryam does not ask for more information about her progress. Neither Kevin nor Maryam show any appreciation or recognition of the role the other has in Mrs. Jones’ care. Although Maryam will reassess Mrs. Jones’ situation, she will do so without the benefit of Kevin’s observations. No one has learned anything about each other’s knowledge and expertise or fully benefited from their interaction.

Contrary cases. Contrary cases have none of the critical attributes of a concept (Walker & Avant, 2010).

In a final modification of the above scenario:

Practical Nurse: “Maryam, Mrs. Jones...”

Registered Nurse: “Yes, yes – I am bringing Mrs. Jones her medications now. I suppose she is waiting for them. Why don’t you answer that call bell?”

In this contrary case, Maryam assumes Kevin is asking her about Mrs. Jones’ medications and he does not correct her. Kevin does not assert his role in Mrs. Jones’ care. He also does not seem to want to take responsibility for Mrs. Jones’ queries about her discharge. Maryam does not listen to Kevin and applies a hierarchal attitude towards him. She does not seem to value his input. Maryam will approach Mrs. Jones, but with the wrong consideration in mind, and the hierarchical nature of their encounter will probably limit future collaboration between the two nursing professionals. Maryam will likely repeat the questions Kevin already asked Mrs. Jones, thus duplicating care.

Step 7: Antecedents and Consequences

The seventh step in Walker and Avant’s (2010) model is describing the antecedents, the things that precede the occurrence of concept, and the consequences, the things that result from the occurrence of a concept. From our literature review, we found the antecedents of intraprofessional nurse collaboration included:

- Two or more categories of nurses (determined by staff mixes) that are motivated to help a patient maintain or improve a health goal
- They understand each others’ roles, scopes of practice, and contributions of patient care
- They communicate openly with each other
- They work through shared and individual processes

These antecedents are present in our model case and lacking in our contrary case. In our model case, Kevin and Maryam both want to respond to Mrs. Jones' questions about her discharge. They communicate openly with each other and understand how they both contribute to her care. In our contrary case, Kevin and Maryam do not seem interested in Mrs. Jones' situation and communicate minimally with each other. The defining attributes, antecedents and consequences are summarized in Figure 1.

When nursing professionals work together, they work through shared and individual processes, which can help or hinder their entering into a joint effort. Their shared process is the nursing process: assessment, diagnosis, planning, implementation and evaluation (Kozier et al. 2004). The nursing process is a "systematic, client-centered method for structuring the delivery of nursing care" (Kozier et al., 2004, p. 243). Working through each step of the nursing process helps all nursing professionals to select nursing actions and interventions that are appropriate for a given patient. Other shared processes include things like long-standing unit routines. These shared processes result from their shared professional background and workplace and distinguishes nursing intraprofessional collaboration from interprofessional collaboration. All people have their own individual processes, such as beliefs, feelings and expectations about themselves, which influences their behaviour (Stein 1995). In particular, individual nursing professionals have internal values and beliefs about their roles as nurses, and these influence their behaviour when they collaborate with others.

Initially we included education as an antecedent for intraprofessional nurse collaboration. After some discussion, we decided there was insufficient evidence to show intra/interprofessional education (IPE) activities *always* increases collaboration between

nursing professionals in their clinical practice (Lim & Noble-Jones, 2018). For example, Lim and Noble-Jones (2018) completed a qualitative synthesis of the literature and argue that there was currently insufficient evidence to recommend the inclusion of IPE activities in nursing curricula.

From our literature review, we found the consequences of intraprofessional nurse collaboration included:

Patients:

- Improved patient outcomes
- Improved integration of nursing care
- Greater satisfaction with nursing care

Nurses:

- Personal knowing and mutual reflection
- Increased job satisfaction and wellness
- Increased learning and professionalism

Step 8: Empirical Referents

To complete the final step of Walker and Avant's model, we must determine empirical referents for the concept. Empirical referents are used to describe the presence of the defining attributes, providing a way to observe the existence of the concept (Walker & Avant, 2010). Empirical referents are oftentimes the same as the defining attributes when the concept is not abstract, which is the case with the concept under study (Walker & Avant, 2010). The defining attributes: entering into a joint effort; sharing in decision-making; learning and benefiting from each other's knowledge and expertise; and understanding and appreciating each other's contributions are all phenomena that can be

verbalized/self-reported by nursing professionals or seen through observation. For example, a PN can say, “I appreciated the RN’s help in selecting the appropriate dressing for my patient’s wound” (entering into a joint effort, sharing in decision-making, appreciating each other’s contributions). Similarly, a researcher can observe a PN and a RN work together to complete a dressing change (entering into a joint effort). In the literature, there are instruments which assess some of these phenomena, including questionnaires and observer-based guides. For example, the Decision Support Analysis Tool (DSAT) (Guimond et al., 2003) is an observer-based, shared decision-making assessment tool.

Discussion

Based on our findings from the concept analysis, we propose that intraprofessional nurse collaboration happens when two or more categories of nursing professionals (e.g. PNs, RNs, NPs) work together jointly with each other and their patients to help their patients reach or maintain health goals. Different categories of nursing professionals contribute their different roles, scopes of practice, knowledge, and expertise to this joint effort, which results in learning from the collaboration. They are unified through their understanding of the nursing process, but may apply it differently based on internal (e.g. - values and beliefs) and external (e.g. – scopes of practice) factors. Consequently, good communication skills from everyone are important. To achieve intraprofessional collaboration, nursing professionals need to voluntarily share their knowledge and expertise with each other, understand and value each other’s contributions, and be equally motivated to meet their patient care needs.

Model of Intraprofessional Nurse Collaboration

Our concept of nurse intraprofessional collaboration is articulated through the Intraprofessional Nurse Collaboration Model outlined in Figure 2. The model emphasizes the relationship between: (1) patients' care needs (which create a need nursing professionals to collaborate), (2) antecedents (which influence decision-making about how nursing professionals will collaborate), (3) nursing professionals shared processes (which is 'the nursing process' and followed by all nursing professionals), (4) nursing professionals individual processes (which are influenced by the individual characteristics of each nursing professional), and (5) patient outcomes (which may change as a result of nursing professionals' collaboration and require nurses to re-evaluate what they are currently doing.) The model shows that multiple factors, both external and internal to nursing professionals, influence how they collaborate with each other. Some factors, such as scopes of practices, may change overtime, but are beyond the control of individual nursing professionals. Other factors, such as nursing professionals' personal habits, can change through personal knowing and reflexivity.

Personal knowing and mutual reflection. When nursing professionals collaborate to care for their patients, they share their professional skills, actions, knowledge and experiences with each other to meet the needs of their patients. Carper (1978) identified four fundamental patterns of knowledge in nursing: empirics (science of nursing), esthetics (art of nursing), personal knowing (knowledge of one's self), and ethics (moral knowledge of nursing). Nursing professionals share many patterns of knowledge, such as empirics, which is the science (or accepted facts and procedures) of nursing. For the purposes of intraprofessional nurse collaboration, personal knowing

appears particularly important. Carper (1978) considers personal knowing to be significant to how nursing professionals interpret and value their professional actions and experiences. Personal knowing enables nursing professionals to understand themselves and express empathy towards others, such as patients and colleagues.

Consequently, personal knowing enables nursing professionals to situate themselves within their shared experiences both professionally and individually. It helps them to appreciate and understand the *effects* of their collaboration on both their patients and each other. A reciprocal ethics exists between nursing professionals and delimits the nature of their activities and relationships with each other and patients (DeMarco, Horowitz, & McLeod, 2000). Reflectivity allows them to examine the overall helpfulness of their collaboration and identify needs and actions of change (DeMarco et al., 2000). Many of the challenges nursing professionals encounter when they collaborate with each other cannot be resolved through scientific knowledge and require nurses to use their personal knowledge and creativity to find solutions. Reciprocal ethics and reflexivity help nursing professionals to become better collaborators (DeMarco et al., 2000).

Implications

Having an operational definition of intraprofessional nurse collaboration enables researchers to construct statements and hypotheses that accurately capture this concept, as well as develop or modify existing research instruments and interview guides to ensure that they reflect the defining attributes of this concept (Walker & Avant, 2011). A clear understanding of intraprofessional nurse collaboration also has implications for nursing education and practice, as this concept is currently poorly understood in these contexts. For examples, having an operational definition for nursing intraprofessional collaboration

is valuable in nursing education so that nursing students are taught the defining attributes and antecedents that foster collaborative practice among nursing professionals.

Limitations

Nursing care delivery models organize how nursing care is provided to patients. This concept analysis assumes nursing care delivery models that support patient-centred care goals and allows differently credentialed nursing professionals to communicate with each other and participate shared decision-making. Additionally, while concept analyses are useful to operationalize concepts so that everyone is speaking about the same thing, the end product is tentative as our understanding of concepts change over time (Walker & Avant, 2011).

Conclusion

This concept analysis has implications both within and outside the profession of nursing. As governments seek to reduce healthcare costs, different levels of healthcare providers from the same professional background will increasingly work together to provide patient care. Many health care systems currently rely on PNs, RNs and NPs; physician assistants and physicians; occupational therapy assistants and therapists, etc., to meet patients' needs and it is likely this trend will continue into the future. A strong conceptual understanding of nursing intraprofessional collaboration will improve research into how nursing professionals work together. As noted previously, multiple external and internal factors, including scopes of practices, roles, responsibilities, assessments, planning, personal knowing, team norms, and habits all influence how nurses collaborate with each other. These factors are all driven by patients' care needs to encourage nursing intraprofessional collaboration, with the aim to achieve positive

patient outcomes. We hope that by conceptualizing these important aspects of healthcare we are contributing to a dialogue to improve nursing intraprofessional collaboration.

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Figure 1:
Walker and Avant's (2010) Concept Analysis Framework

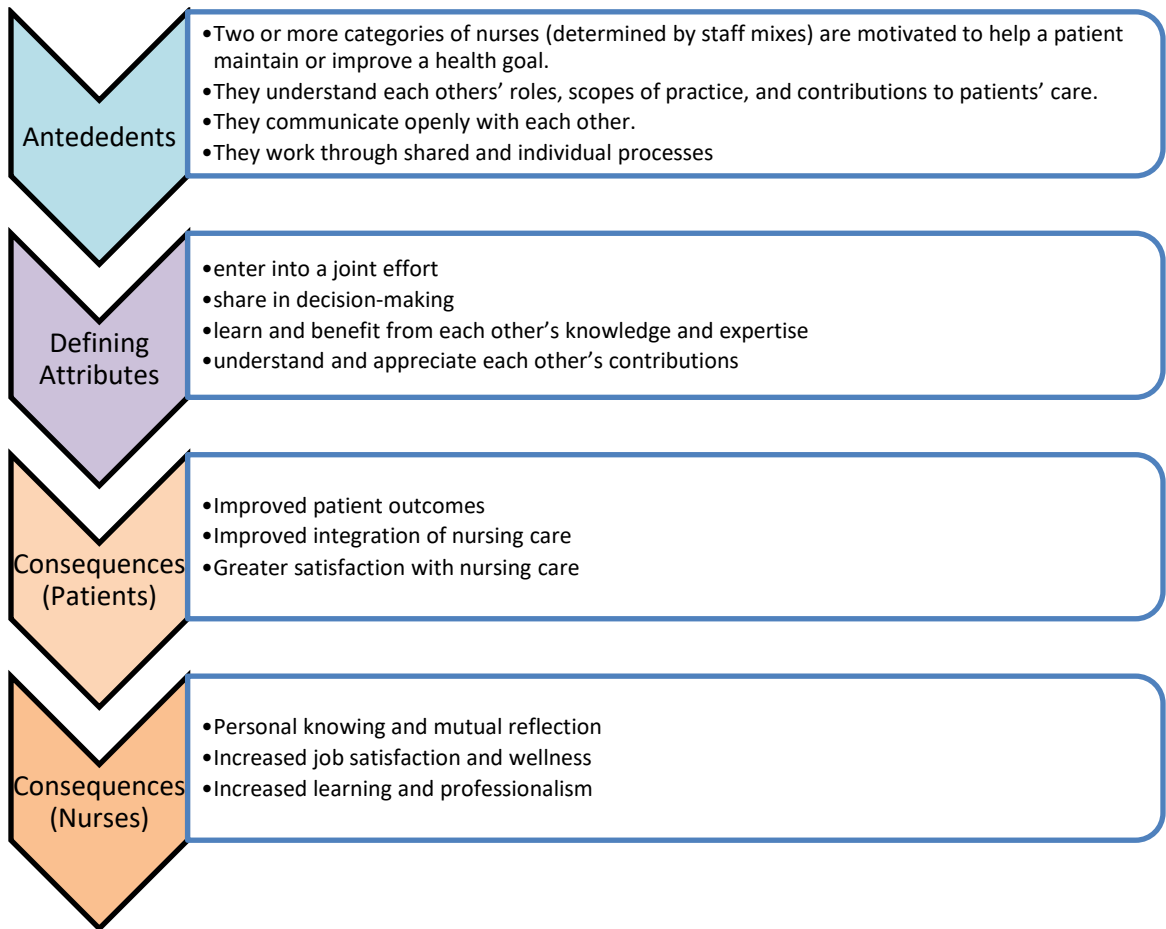
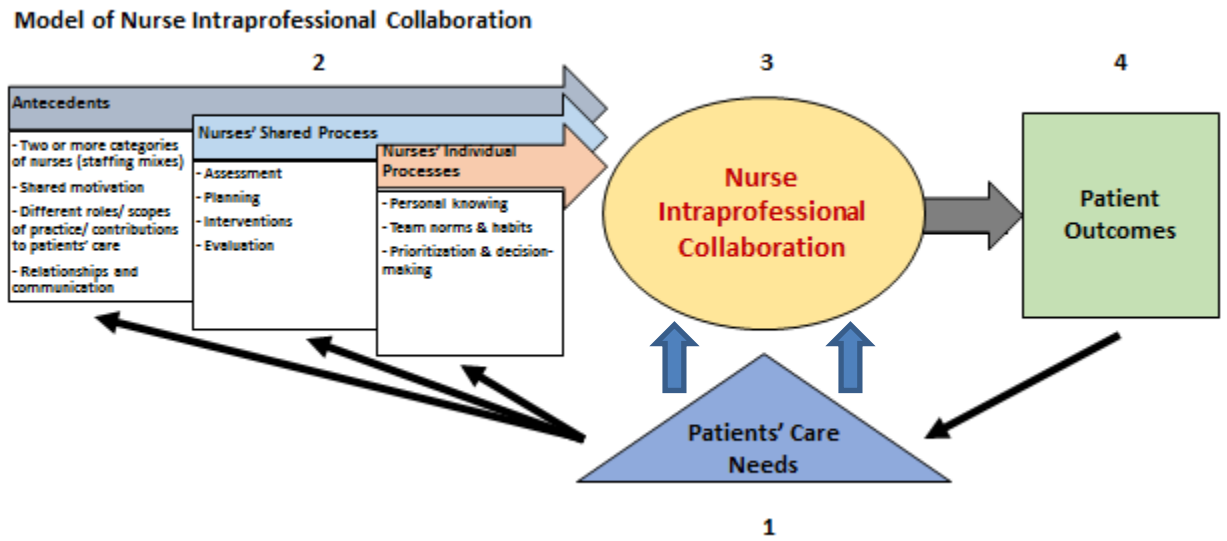


Figure 2
Model of Intraprofessional Nurse Collaboration



Chapter 3: Moving Forward and Manuscript # 2

Detaching Myself from What I “Know”

To begin thinking like an institutional ethnographer, I needed to detach myself from what I “knew” about RNs and LPNs working together. As a RN, I consciously and subconsciously had theories and explanations of “nursing intraprofessional collaboration.” These theories and explanations came from my own experiences working as a RN, listening to colleagues, participating in professional organizations, reading scholarly articles about “collaboration,” etc. I did not want to insert these theories and explanations into my study. My job was to stay closely connected to RNs’ and LPNs’ own descriptions of their work and my observations of what is really going on (Smith, 2005). I needed to reflect on my experiences as both a RN and a researcher to suspend these ideas to discover what actually happens.

Moving Forward

Thinking about the context of my topic and my concept analysis of “intraprofessional nurse collaboration” caused me to reflect on my own positioning in my inquiry, as a RN and as a researcher. As I began my research, I knew I needed to remember that what is known may potentially reinforce existing power dynamics and the ruling people experience in their daily lives (Campbell & Gregor, 2004). For example, many of the researchers interested in this topic are, like myself, RNs. As I have discussed, nursing has its own hierarchy. Registered nurses have a baccalaureate preparation and are receiving a higher remuneration for their work than LPNs. They are also more likely to be in positions where they are participants in the regimes of knowledge and power, for example - conducting research or managing nursing units. I

needed to be wary of dominant perspectives and attend to what frontline nursing professionals, both RNs and LPNs, experience in their everyday work.

The context of my topic and my concept analysis also caused me to consider what I needed to do to explicate my topic's social organization (Campbell & Gregor, 2004). Particularly, I needed to question the terminology I used. For example, differently located people, such as a nurse manager, a RN and a LPN, may all use the term "collaboration" but with different meanings. The knowledgeable practices of a nurse manager, who does not occupy the same location as the RN or LPN, will be organized differently and their perspective will be different (Rankin, 2017). The nurse manager might say, "my staff collaborated" and a RN might say, "I collaborated." The nurse manager might mean a RN and a LPN shared a patient assignment and the RN might mean she helped a LPN with a dressing change. Both the manager and RN use the term "collaboration" in place of an explanation of their own experience or the work that actually took place. Consequently, my first commitment as a novice institutional ethnographer was to remain grounded in the everyday world and what actually happens and notice how differently located people use institutional language differently.

Manuscript #2 Introduction

Institutional ethnography (Smith, 2006) was adopted as the methodological framework for the current study. The main assumption of IE is that people's everyday experiences are shaped and organized, often unknowingly, by factors that lie outside of their everyday experiences. In modern societies, this organization is most often mediated by texts or text-based materials, such as documents, posters, and photographs (Smith., 2005, 2006). One of the critical features of an IE project is that of a standpoint, which is

the entry point for the project, and a place for the researcher to begin his/her inquiry. For this study, I took the standpoint of both RNs and LPNs.

Manuscript #2, which constitutes Chapter 2 is entitled, “Observation and Institutional Ethnography: Helping Us See Better.” The purpose of this manuscript was to consider observation as a data collection method in IE. IE seeks to uncover how things actually happen – for this study, how institutional discourses shape RNs’ and LPNs’ practice(s) and how they work together to care for patients. I thought “seeing” firsthand how RNs and LPNs worked together, including what texts/text-based materials they activated during their shifts, would help me better understand what was really going on. Although I wanted to use observation as a data collection method, I was aware that observation is used differently in IEs than in traditional ethnographies. Consequently, the purpose of this manuscript was to consider how institutional ethnographers use observation differently than traditional ethnographers, and how they do not prioritize it as highly as a data collection method.

Writing this manuscript allowed me to consider the challenges with using observation as a data collection method and some strategies to overcome these challenges. This manuscript will be submitted for publication to the journal, “Qualitative Inquiry.”

Observation and Institutional Ethnography: Helping Us to See Better

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This manuscript will be submitted to *Qualitative Inquiry*. It is presented in the formatting style of this journal.

Abstract

Institutional ethnography is a research approach that originates from the work of Canadian sociologist, Dorothy Smith. It is not as well-known as traditional ethnography, which is one of the more conventional qualitative approaches. Although institutional and traditional ethnographers often use similar data collection methods, including observation, interviewing and textual analysis to complete their research; their intents for their research and data are different. This has implications for *how they use* and *prioritize* data collection methods.

Observation is often a beginning step for both institutional and traditional ethnographic studies; and it is, arguably, one of the most utilized data collection methods used by traditional ethnographers. Less is written about its use by institutional ethnographers. The purpose of this discussion paper is to consider observation as a data collection method for institutional ethnographies. I begin by explaining some of the differences between institutional ethnography and traditional ethnography. I then describe aspects of observation, including some of the issues associated with this data collection approach, as it relates to qualitative research in general, and then specifically to institutional ethnography. Finally, some examples from nursing and the broader healthcare literature are also used to show how observation can be beneficial and help institutional ethnographers *see better*.

Observation and Institutional Ethnography: Helping Us to See Better?

You can see a lot by just observing. – Yogi Berra

Introduction

Institutional and traditional ethnography are qualitative research approaches that share many similarities. Both institutional and traditional ethnographers go into the field and collect data to gain understanding about something that is happening. Often, they use similar data collection methods, including observation. Although there are many similarities between institutional and traditional ethnography, there are also many differences, particularly related to the theoretical underpinnings of these approaches and the purposes of their data analyses. These differences have implications for *how* institutional and traditional ethnographers *use* and *prioritize* observation, and other data collection methods. In this paper, I will describe institutional and traditional ethnography and discuss some of the differences between these two approaches. My purpose is to consider how institutional ethnographers use observation differently than traditional ethnographers, and how they do not prioritize it as highly as a data collection method. Instead, institutional ethnographers place a higher value on interviews and textual analysis. I also discuss some concerns that appear in the literature regarding the use of observation as a data collection method in general, and how these translate for institutional ethnographers. Some examples from nursing and the broader healthcare literature are used to show how observation can be beneficial and help institutional ethnographers “see better.”

Traditional Ethnography

Most people are more familiar with traditional ethnography, than institutional ethnography. Traditional ethnography is a well-known qualitative methods. When people think about ethnography, they often imagine a researcher who lives among and observes a particular cultural group to learn about aspects of their daily activities. Frank Hamilton Cushing is a well-known early traditional ethnographer (DeWalt & DeWalt, 2002). He spent four and a half years as a participant observer with the Zuni Pueblo people around 1879 in a study for the Smithsonian Institute's Bureau of Ethnology (DeWalt & DeWalt, 2002). O'Connell-Davidson and Layder (1994) argue that traditional ethnography "belongs to the tradition of "naturalism" which centralizes the importance of understanding the meaning and cultural practices of people from within the everyday settings in which they take place" (p. 165). It is; thus, understandable why traditional ethnographers often rely on observation because it allows them to see what a particular group in a particular setting is doing at a particular time (O'Connell-Davidson & Layder, 1994). Traditional ethnography is a somewhat flexible methodology and appeals to many modern researchers seeking to understand societal interactions and experiences, among other topics. Today, traditional ethnographies may focus on an aspect of a group's life, such as healthcare, or different levels of experiences among populations living in society.

Institutional Ethnography

Institutional ethnography is a research approach that was developed during the 1970's and 80's by Canadian sociologist, Dorothy Smith in her work to study women's experiences. She found much of the existing 'authoritative' knowledge of this period subordinated the knowledge women had about their own experiences. This 'authoritative'

knowledge was often the knowledge of male scholars and other ‘experts’; thus, it did not give authority of knowing to men and women equally. This was particularly problematic because women often used this ‘authorized’ knowledge to explain their experiences even when these explanations did not reflect their lived experiences Smith envisioned “an alternate sociology, a sociology that was not confined to a particular category of people” (Smith, 2005, p.1). She wanted a way to study people’s *actual* experiences, as they are for *them*; and validate the *knowledge* and *understanding* people have about their own lives. This is significant to healthcare contexts, where traditionally the male-dominated profession of medicine *authorized* healthcare knowledge, dominating over the female-dominated profession of nursing. Until the early 20th century, nursing professionals were taught by physicians, which was problematic because their *authorized* medical model did not always match nursing professionals’ experiences with their patients.

Smith drew from feminist, Marxist and other post-positivist theories and sought to develop a sociology that equally represented all people; a sociology in which anyone, regardless of their gender, could participate as a seeker of knowledge (Campbell & Gregor, 2002). Campbell and Gregor (2002) assert that “[t]he claim made for institutional ethnography is that it offers a knowledge resource for people who want to work towards a more equitable society” (p. 103). Institutional ethnography allows investigators to use peoples’ everyday experiences as their entry-points into uncovering how institutions organize and ‘rule’ their lives. It is an approach to social research where the aim is to collect data which explicates how people’s daily activities in a particular, local setting are ruled by larger social institutions located elsewhere. Recently, researchers have successfully used institutional ethnography to generate understanding of many healthcare

issues, such as patient-centred care, patient satisfaction, and the social organization of nurses' work (Rankin, & Campbell, 2006; Rankin, 2003; Townsend, Langille, & Ripely, 2003).

Similarities and Differences

There are many similarities between institutional and traditional ethnographic studies. For example, institutional and traditional ethnographers use similar data collection methods, including observation (Campbell & Gregor, 2004). However, the goals of traditional and institutional ethnographers are different; and this has implications for how data collection methods are used and how data is prioritized/analyzed between these two approaches.

As mentioned above, traditional ethnographers seek to *describe*, from an insider's understanding or perspective, the experiences of a social or cultural group or an aspect of social life *located within a particular setting* (Fetterman, 1989). They aim to reveal tacit knowledge of this particular group about their culture and/or social experiences (Loiselle & Profetto-McGrath, 2011). This is the knowledge that is so widely accepted by a group that its members do not talk about it and may not even be aware of (Loiselle & Profetto-McGrath, 2011). Traditional ethnographers also worry about misinterpreting their data; and usually triangulate data collected from different methods, for example observation and interviews, to increase the trustworthiness of their research (Marshall & Rossman, 2016). In triangulation, data collected by different methods are compared to "test the quality of the information to understand more completely the part an actor plays in the information to understand more completely the part an actor plays in the social drama, and ultimately to put the whole situation into perspective" (Fetterman, 1998, 89).

Institutional ethnographers also want to collect data that display insiders' knowledge (Campbell & Gregor, 2004). They have, however, a different intent for their data. The ultimate purpose of an institutional ethnography "is *not* to produce an account *of or from* those insiders' perspectives," but to explicate the often invisible social relations that rule people's everyday lives (Campbell & Gregor, 2004, 89-90). According to Quinlan (2009), "An institutional ethnographer's starting point is the actualities of people's everyday experience; their end point connects the actualities to the social organization that governs the local setting" (p. 628). Consequently, institutional ethnographers use their data to trace back and describe these social relations that exist beyond people's everyday experiences in their local setting, but connect them to distant ruling institutions. This has important implications for how institutional ethnographers prioritize different data collection methods. While traditional ethnographers may rely primarily on their observations of people's behavior in a local setting, institutional ethnographers cannot. Observations in local setting alone will not reveal to them how institutions exert their rule from afar.

Institutional ethnographers thus prioritize interviews and textual analysis over observation to gain information about distant ruling institutions. They consider 'texts' to be essential to both the existence and ruling of institutions (Smith, 2001). Texts are the material forms of words, including images and sounds, that are replicable (Smith, 2006; Turner, 2006). Books, radio announcements, photographs, and bus tokens are all examples of texts (Smith, 2006). When a person 'activates' a text in a particular setting, he/she becomes connected to other people and processes taking place and organized elsewhere (Smith, 2006; Turner, 2006). According to Smith (2006) "institutional

discourse is set in texts ... texts are of central importance to IE because they create this essential connection between the local of our (and others') bodily being and the translocal organization of the ruling relations" (p.118-119).

Institutional Ethnography and Observation

Smith (2001) writes, "exploring how texts mediate, regulate and authorize peoples' activities in modern societies expands the scope of ethnographic method beyond the limits of observation" (p. 159). Although, through this quote, Smith makes it clear that interviews and the analysis of texts are preferred method of data collection, observation does provide some data that may be different and useful. Observation makes it possible to confirm whether what people say they do and what they actually do match up. It is important to note that both accounts (what people perceive that they do and what they do) provide information, but the information is different. The following two examples demonstrate how observation can add to the data provided by interviews and textual analysis. These examples consider the experiences of two different nursing professionals: a registered nurse and a practical nurse. The first example shows how observation can reveal what a registered nurse actually does when he or she 'collaborates' with a team. The second example explains how observation reveals all the texts a practical nurse unconsciously activates during their daily work activities.

During interviews, people use language that can make their actual activities unclear. For example, a healthcare provider, such as a registered nurse, may say "I collaborated with a team," but the actualities of what he or she did are missing. What activities belong to the concept "collaboration"? What does "collaboration" mean to this registered nurse? What does it mean to his or her manager or in the hospital where he or

she works? What does it mean to his or her professional association? What does it mean to the other members of the “team”? Campbell and Gregor (2004) caution that professional and conceptual language often conceals what people really do. The term “collaboration” is conceptual and may be made even more vague by being part of an institution’s professional or rhetorical language. Consequently, it blankets or covers up what the healthcare provider’s actual activities are. Observation can help reveal the steps the healthcare provider took or the texts that were activated to make this collaboration happen. As Diamond (2006) argues, “observation enhances institutional ethnography’s goals of incorporating place, time, people’s activities, and the presence of larger social institutions within local settings” (p. 45).

Similarly, in interviews, people may not be able to explain how they, and those around them, activate texts in their workplaces. For example, in an interview, a practical nurse may say, “I don’t administer medications.” This does not mean that practical nurses do not administer medications. This practical nurse may not administer medications because he or she has not completed a particular certification or educational program. Other practical nurses on the unit, in the hospital, or at in another health care setting may administer medications. Many acute care hospital policies have further restrictions on the types of medications practical nurses can administer than those described in their professional organization’s or licensing body’s scopes of practice documents. Observations allow researchers to see what is happening (e.g., are any practical nurses administering medications?) and what texts are used in a particular setting (e.g., is there a medication administration policy?), which provides context for data gathered through interviews or textual analysis. Textual analysis allows institutional ethnographers to

understand the policies and protocols and scopes of practice documents, but observation lets them ‘see’ how people ‘activate’ these texts locally in their workplaces.

Observation as a Data Collection Method

As discussed above, observation allows institutional ethnographers to locate their research within a particular, local setting. To use it effectively, institutional ethnographers need to understand its general particulars as a data collection method. Observation is frequently used in qualitative approaches and is either structured or unstructured (Mulhull, 2003). Structured observation is most suitable for positivistic research and requires investigators to unobtrusively record their participants’ physical and verbal actions from afar (Mulhull, 2003). It is a useful data collection method when the research question and information needed are defined; and is frequently used in psychology (Mulhull, 2003). There are examples of structured observation in nursing research; for example, Duxbury et al. (2010) used structured observation to code nurse-patient behaviors/interactions during medication administration.

Unstructured observation is a data collection method frequently used in traditional ethnographies and is a good fit with interpretist or constructivist research (Mulhull, 2003). Researchers who use unstructured observation consider the spontaneous behaviors of people engaging in their daily activities. The ‘context’ of what is observed is important - as the constructivist research paradigm encourages the co-construction of knowledge between the observer and the ‘observee’ (Mulhull, 2003; Dymna, 2006). Observer-as-participant is a type of unstructured observation where the researcher identifies him or herself as a researcher but interacts with the people he or she is observing. Some uses of unstructured observation occur in nursing research; for example, Jackson, Hutchinson,

Luck, and Wilkes (2012) used unstructured observation to explore nurses' experiences with verbal abuse in their workplaces. Both Mulhull (2003) and Dympna (2006) argue that unstructured observation is an underused data collection method in nursing. Although Dympna (2006) reviewed uses of observation in nursing literature, it was oftentimes difficult to identify how it was actually used.

Several researchers note that unstructured observation is less favored as a data collection method in qualitative nursing research, than interviews (Mulhall, 2003; Dympna, 2006). This is surprising because nurses and other healthcare providers are trained to be 'good observers' and value observation as a data collection method because observation is essential for their practice. Nightingale (1860; 1969) recognized the importance of observation as a skill for nurses. In *Notes on Nursing*, she wrote:

The most important practical lesson that can be given to nurses is to teach them what to observe—how to observe—what symptoms indicate improvement—what the reverse—which are of importance—which are of none—which are evidence of neglect—and of what kind of neglect. All this is what ought to make part, and an essential part, of the training of every nurse (p. 105).

Nurses often observe their patients' verbal and non-verbal behaviors when they complete their physical assessments and use these observations to enhance their overall data collection. For example, observations can cue nurses to ask their patients particular questions. A nurse might ask about a long sternotomy scar and learn about a patient's bypass surgery and struggles to quit smoking. Observations can also be used to help interpret things that people verbally report or to further understand peoples' experiences. As Mulhall (2003) argues, it assists researchers in similar ways, such as by providing more context for people's actions or behaviors.

Challenges and Opportunities for Observation with Institutional Ethnography

There are many challenges, as well as opportunities, when using observation with IE (Dympna, 2006; Mulhall, 2003; Loiselle, Profetto-McGrath, Polit & Beck, 2013). The main challenges include the presence of the researcher, time commitment, field site access, selective reporting/ researcher biases, and informed consent/deception (Dympna, 2006; Mulhall, 2003; Loiselle et al., 2013). Each of these issues have been discussed and debated in nursing and other literature. They will only be discussed in this paper as they relate to the use of observation in institutional ethnography, which may be different from other research approaches. Opportunities related to each challenge are also discussed.

The Researcher's Presence

Researchers often worry about how their presence will affect peoples' activities at their field sites. Campbell and Gregor (2004) argue that traditionally "the researcher's presence" has been treated "as a problem that must be overcome" (p. 14). This is not the case with institutional ethnography (Campbell & Gregor, 2004). Traditional ethnographers worry about how their presence will change people's activities and often triangulate their observational data with other data, such as interviews, to verify their 'trueness' and give them evidential weight. Institutional ethnographers, however, are interested in how their observations in local settings occur; and are organized and connect back to ruling institutions. Thus, if an institutional ethnographer's presence creates changes in people's activities, this becomes part of the analysis. Institutional ethnographers often represent ruling institutions, such as universities, and through their research, their presence becomes another social relation that exists in people's local settings.

Time Commitment

Concerns have been raised that observational research can be too time consuming. Above, for example, I mention how Frank Hamilton Cushing spent four and a half years observing the Zuni Pueblo people (DeWalt & Dewalt, 2002). This amount of time and quantity of observational data is not needed for most institutional ethnography studies; in fact, observational data may not prolong time spent at a field site. In a discussion paper, Bisailon and Rankin (2012) discussed their experiences using institutional ethnography as a research method (working independently of each other and on separate projects). They both reflected on how their presence, just ‘waiting,’ at field sites for interviews with people provided them with impromptu opportunities to collect observational data; which helped support and better inform their interviews (Bisailon & Rankin, 2012). Bisailon and Rankin (2012) describe how the process of waiting often had them ‘sitting in the same chairs’ as the people they interviewed. Their observational data did not ‘add time’ to their research projects because they used time that needed to be spent at their field sites for interviews anyway.

Field Site Access

Oftentimes, researchers have difficulty gaining access to field sites, particularly hierarchal government-run institutions (Taber, 2010). For example, Taber’s (2010) research focused on the everyday experiences of women working in the military. She met with resistance when she tried to observe military women’s groups (Taber, 2010). She reflected afterwards that, although her experience was frustrating, it encouraged her to deepen her understanding of institutional ethnography so she could adapt her original approach (Taber, 2010). Her experiences with her application to observe the women’s

group also made her reflect on how inflexible the military's processes are. To avoid frustrating experiences, Bisailon and Rankin (2012) encourage researchers to reflect on their field sites and try to anticipate challenges, such as access, before they arise. They also recommend that researchers remain flexible and open to unexpected opportunities to collect data, such as those presented while 'waiting' (Bisailon & Rankin, 2012).

Bisailon and Rankin (2012) both needed to make re-applications for ethical approval from their respective universities to gain access to new field sites during their research. The work of ethics committees is itself text-based; and receiving ethical approval may be challenging for institutional ethnographers (Campbell & Gregor, 2003). Often institutional ethnographers do not know their interview schedules and other information required for an ethics review (Campbell & Gregor, 2003). This is a challenge for many qualitative researchers. Institutional ethnographers need to clearly explain the particulars of their research approach, so ethics review boards understand why they may need to make changes to their prospective plans as their research progresses (Campbell & Gregor, 2003).

Bias and Selective Reporting

With other qualitative approaches, such as traditional ethnography, observation is sometimes seen as an alternative to self-reports (Loiselle & Profetto-McGrath, 2011). Researchers who apply traditional ethnography often attempt to operate in the background as an objective bystander in order to develop an impartial understanding of their participants (Dharamsi, 2011). For institutional ethnographers, this aim of impartiality is not possible because it relies on one's ability to remain completely detached from the people one observes (Dharamsi, 2011). Institutional ethnographers are

aware that they commit themselves to a certain social relation with the people they are interested in when they begin their projects (Campbell & Gregor, 2004). As Campbell and Gregor (2004) reason, institutional ethnographers' past experiences and knowledge relate them to the people they are interested in and reveal/establish their location in relation to their collected data. Rather than treating the institutional ethnographer's location as a problem of bias, it becomes another way of exposing how knowledge is organized. Smith, herself, writes, "[t]he experiences that the data produces as data may be our own; it may be gained through participation in a workplace or it may be based entirely on interviews" (2005, 125).

Observation as a Starting Point

Institutional ethnographers use observation differently, depending on the purpose research study. Diamond (2006), a sociologist, discusses how observation can be like "a starting point on a map, a 'you are here' point" (p. 60). Many institutional ethnographers use it to help them realize a problematic for their studies. Smith describes the problematic as "a territory to be discovered" (Smith, p. 41) - generally in the early stages of fieldwork. Oftentimes, the problematic is 'discovered' when institutional ethnographers notice 'disjunctures' or contradictions between official explanations of what is going on and what actually appears to happen (Campbell & Gregor, 2005; Smith, D. E., 1990). Once institutional ethnographers have a problematic in mind, their goal is to find other data collection methods, such as interviews, the analysis of texts, or observations of other people, to explain it. The following two examples show how two researchers, Kathleen Benjamin (Benjamin & Rankin, 2014) and Timothy Diamond (2006) (both interested in

long-term care facilities) used their observations to ‘discover’ the problematics of their studies.

In the first example, Kathleen Benjamin, a registered nurse, used her observations of personal support workers working in a long-term care facility as an entry-point into her doctoral work (Benjamin & Rankin, 2014). She observed mealtimes were very rushed, stressful times in long-term care facilities where she was working and absorbed much of the personal support workers’ time (Benjamin & Rankin, 2014). She noted how the standards in place by the long-term care facilities to provide the residents with a pleasant dining experience actually did the opposite and reduced the time the personal support workers had to support the residents’ physical activity (Benjamin & Rankin, 2014). Benjamin’s problematic emerged from her observations of mealtimes and her next step was to look for more data that further explicated it (Benjamin & Rankin, 2014).

In the second example, Diamond (2006) reflected on how he completed an institutional ethnography in several long-term care facilities in America. He described how he was surprised to observe an expensive-looking fur coat in a resident’s closet (Diamond, 2006). Diamond (2006) knew this long-term care facility was subsidized and most of the residents came from underprivileged backgrounds. Observing the coat helped Diamond (2006) to see the social relations behind its presence in the resident’s closet. He questioned the resident and learned she once lived in a nice suburb and wore the coat to church with her husband (Diamond, 2006). According to Diamond, “the coat’s journey was a journey of policy in motion” (Diamond, 2006, p. 68). The resident went from her home in the suburbs, to a hospital, to a Medicare long-term care facility, and finally to subsidized facility after her personal resources were depleted (Diamond, 2006).

Discussion

This paper includes a discussion on how institutional ethnography differs from traditional ethnography; and how this has implications for how institutional ethnographers use and prioritize their data collections methods, particularly observation. Traditional ethnographic research is often concerned with describing and interpreting peoples' cultural behaviors (Loiselle & Profetto-McGrath, 2011). Traditional ethnographers engage in fieldwork and carefully observe the behaviors, artefacts, and speech/writings of the people in whom they are interested (Loiselle & Profetto-McGrath, 2011). Institutional ethnographers also strive to extend their understanding of peoples' daily activities and work, but they aim to go beyond descriptions of what is being observed or talked about in a local setting to understanding how people unconsciously sustain and support large social institutions through their activation of 'texts' (Turner, 2006). An institutional ethnographer's goal is not to understand people – but to map out the social and ruling relations that connect, organize and control them (Turner, 2006).

Consequently, an institutional ethnographer's data collection methods must expand beyond just what people do in a local setting; therefore, it is understandable that institutional ethnographers prioritize interviews and textual analysis over observation. It can be argued, however, that observation is still an important data collection method and can provide context to how and by whom texts are activated in local settings. In interviews, institutional ethnographers listen to people describe their actions, usually in past tense – but through observation, institutional ethnographers see peoples' actions, as they occur, in a particular setting. Observation also allows institutional ethnographers to see how people activate texts (and which texts) during their everyday and working lives.

Institutional ethnographers can use observation to reveal discrepancies between what people self-report and what actually occurs. Additionally, conceptual and professional language/rhetoric can conceal what people really do and only direct observation makes such discrepancies known.

Many qualitative approaches use observation as a data collection method, even though there are some issues with this approach, such as the researcher's presence/bias/selective reporting, time commitment, and accessibility to the field site (Dympna, 2006; Mulhall, 2003; Loiselle et al., 2013). Despite these issues, observations can create a fuller picture for researchers and can be a valuable and useful data collection method. Consequently, institutional ethnographers could consider how these issues pertain to their individual studies, and institutional ethnography as a research approach, before being deterred from using it. Researchers do need to consider how these issues relate differently to institutional ethnography than other ethnographic methods and, as a result, may not be of concern at all. Remaining concerns may be minimized through a steadfast commitment to transparency and adherence to ethical principles and guidelines.

Conclusion

In conclusion, there are aspects of peoples' lives that are ruled and organized by institutional guideline, principles, and regulations, which people or nursing professionals may not understand or be able to explain/describe. They may not even be aware how these rules and regulations influence their work or interventions. Including observations as a data collection method creates a contextual picture with interviews and documents/texts of a reality of institutional healthcare settings, collaborative approaches and nursing interventions in patient care. Observation can help institutional

ethnographers understand how peoples' lives are ruled by institutions in ways that they, themselves, may not understand or be able to explain/describe.

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Chapter 4: Methodology

Interdisciplinarity and Nursing Practice

The conceptual framework of IE positions interdisciplinarity somewhat differently than how other conceptual frameworks discuss it. Miller (1982) defines interdisciplinarity as, “the generic all-encompassing concept and includes all activities which juxtapose, apply, combine, synthesize, integrate or transcend parts of two or more disciplines” (p. 6). With IE, interdisciplinarity is taken up as a feature of the social organization of nursing work. The social ontology of institutional ethnography is focused on the materiality of RNs’ and LPNs’ efforts to “juxtapose, apply, combine, synthesize, integrate/transcend” with people from different disciplinary backgrounds (Miller, 1982, p. 6). Thus, the research focus is on *describing and explicating* these practices as important empirical features of nursing work.

Critical sociologists Goorman and Berg (1999) describe nursing work as interdependent on and linked to the work of others, including: physicians, social workers, etc. They argue that nursing professionals are “semi-independent” – by having their own tasks, but also relying on others (Goorman & Berg, 1999). They also consider how nursing professionals mediate and coordinate their work with the work of others, who follow different professional standards and are positioned differently within the social matrices of health professionals’ regulatory and employment relations (Goorman & Berg, 1999). Nursing professionals’ activities to coordinate and link their work with the work of other people (including patients and families) are core to the practicalities of nursing work.

This IE shows how nursing professionals work links together, but also how it is linked to “the flow of activity” (Goorman & Berg, 1999, p. 6) and work of the many others, whose different disciplinary backgrounds and practices enter and leave the nursing professionals’ purview. Following a core tenet of institutional ethnography, I entered into my inquiry from the standpoint of nursing professionals. Ontologically grounded in nursing work, I explicated the social processes and practices organizing nursing professionals’ everyday experiences. Nursing professionals are relied upon to establish the terrain where other people come and go. IE enabled me to make visible as social relations the complex practices that coordinated people’s interdisciplinary actions across separations of time and space, often without their conscious knowledge (Campbell & Gregor, 2004).

For an institutional ethnographer, a key interest is in the texts that link people from various disciplines across time and geography (Campbell & Gregor, 2004). Goorman and Berg (1999) focused their attention on the electronic health record and examined the interdisciplinarity embedded in nursing work that was activated through the communication capacities of a digitally stored collection of patient-health information, which included: laboratory data/results, physicians’ orders, scheduling information, etc. They emphasized how nursing works with electronic patient records linked to others’ work, such as medical work. This is fundamental to how nursing professionals produce and gather information. The texts, embedded in both digital and paper records, were one focus of my research attention as I worked to discover empirically how they, “juxtaposed, applied, combined, synthesized, [and] integrated” the information needs of nursing professionals with those of others, including: physicians, physiotherapists, pharmacists

and laboratory technologists. Although my topic focused on how nursing professionals work together, the work of others was a part of what I examined because the work of RNs and LPNs is socially organized within the broader field of healthcare work itself.

Purpose and Research Questions

IE is a method of inquiry that allows researchers to explore the social relations that structure people's everyday lives. The overall purpose of this study was to explicate the social organization of RNs' and LPNs' experiences working together in acute care settings in New Brunswick, Canada. To begin this study, I considered the following five research questions:

1. What was RNs' and LPNs' current knowledge about their work together and how it unfolded, including what was needed to provide their patients' care?
2. What language did RNs' and LPNs' use to describe their work? Particularly, how did they use the language of "collaboration", "roles and responsibilities," "scopes of practice," etc.?
3. What texts did RNs' and LPNs' activate during their work and how did these texts mediate their interactions with others'?
4. How did the texts RNs' and LPNs' used intersect with other institutional texts of regulatory associations, employers, unions, etc.?
5. What were the tensions and problems that arose within the ruling relations that were implicated in how the RNs' and LPNs' worked together to provide patient care?

Why Institutional Ethnography?

IE was the best methodology to guide my study, given my focus on how frontline RN and LPNs work together during the implementation of the ONTRACC model. As previously mentioned, IE is a research approach that aims to explicate, or produce descriptions, of how people's everyday experiences are socially organized within large institutions that extend well beyond where the everyday work of interest to the researcher is being carried out (Bisaillon, 2012). The ONTRACC model was implemented through, new policies and protocols, which were authored by people who are not directly involved in frontline patient care. IE allowed me to see how the RNs and LPNs, unconsciously and routinely perpetuate hospitals' institutional rule over them through their activation of these new policies and protocols during their daily work.

Dorothy Smith. During the 1970s, Canadian sociologist, Dorothy Smith, found that much existing authoritative knowledge subordinated women's knowledge about their own experiences (Campbell & Gregor, 2004). This was problematic because women often used this authoritative knowledge to explain their experiences, even when these explanations were not accurate (Campbell & Gregor, 2004). Smith, herself, identified an uncomfortable break between her mothering work, which involved feeding, bathing, and clothing her small children - or caring for their bodies; and her academic work (Smith, 2006; Campbell, 2003). She found the knowledge she used to complete her mothering work was not recognized or valued the way her academic knowledge was (Smith, 1987). Smith (1987) wrote about mothers' work at home in relation to her children's schooling – and made visible the everyday work of women, as well as how the organization of the educational system makes it “practically impossible and emotionally difficult for women

with small children to choose to lead their lives differently” (p. 203). IE has since been used to explicate many different socially organized experiences, including healthcare issues (Townsend, Langille, & Ripely, 2003; Rankin, & Campbell, 2006; & Rankin, 2003).

Smith’s experience of this uncomfortable break resonated with me and my experiences within nursing (Smith, 2006; Cambell, 2003). Nursing is a gendered, hierarchal profession (Rajacich et al, 2013). Although today both men and women have successful careers as nurses, nursing has traditionally been viewed as women’s work (Rajacich et al., 2013). Men remain underrepresented in nursing, accounting for only around 6% of Canadian nurses (Rajacich et al., 2013). Some authors argue that nursing, as women’s work, remains subordinate to other traditionally male-dominated health professions, such as medicine (Price, Doucet, & Hall, 2014).

In addition to possible subordination to other health professions, there is some degree of hierarchy within nursing itself. RNs are baccalaureate prepared and are better remunerated for their work than LPNs who complete a two-year college program. Although RNs and LPNs have overlapping scopes of practice in many settings, RNs typically do more care planning (or organizing caring actions) and LPNs do more personal care/toileting (or caring for patients’ bodies). In our society, organizing work is frequently perceived as more valuable than body work, even though it is no less important. This is similar to Smith’s own uncomfortable experience, where she found her academic work was considered more valuable than her mothering work or caring for her children’s bodies (Smith, 2006; Campbell, 2003).

Dorothy Smith describes IE as “an alternate sociology” and a way to look at the puzzles of everyday life (Smith, 2005, p. 1). She maintains IE is “not confined to a particular category of people” and is a way to study people’s actual experiences, as they are for them (Smith, 2005, p. 1). Institutional ethnographers begin from the standpoint of people, living their everyday lives, rather than from within established discourses which are aligned with society’s ruling institutions (Grahame, 1998). IE was an appropriate choice for my project because it allowed me to explore what actually happens, from the standpoint of frontline nursing professionals completing their daily work. IE allowed me to extend my research beyond established discourses and the historical/gendered/societal positioning of RNs and LPNs; and enabled me to identify and explicate issues from the perspective of both of these nursing professional groups. I was thus able to study their actual experiences, as they were for them; and validate the knowledge and understanding they had of their work.

Institutional Ethnography Methodological Tools

IE has methodological tools, which guided me in how I approached my inquiry into how frontline nursing professionals work together in acute care hospital settings. The methodological tools most relevant to my research included: standpoint, problematic/disjuncture, work, texts, social relations, ruling relations, and language.

Standpoint

Standpoint is an important methodological tool that provides a way for the researcher to “examine how knowledge works and whose knowledge counts.” (Rankin, 2017a, p. 2). Campbell (2004) argues, “[o]ne cannot know about [people’s] lives without their showing or telling it in one way” (p. 209). Standpoint is the social position from

which researchers begin their inquiry (Campbell & Gregor, 2004). I used the standpoint of nursing professionals, both RNs and LPNs, because they were the “expert knowers” of their daily experiences with each other (Rankin, 2017a, p. 2).”

This standpoint allowed me to explicate their working together from the perspective of both, together. Bisailon (2012) recommends starting with the standpoint of those oppressed or exploited to reveal the aspects of social relations that are mostly invisible. It is arguable that neither RNs nor LPNs are oppressed compared to others in the world. Both RNs and LPNs are educated, having a baccalaureate or college-level education, respectively, and employed in a skilled profession. However, using the standpoint of nursing professionals, RNs and LPNs together, minimized the historical/societal positioning that presupposes one group of nursing professionals is more important than the other. It also prevented RNs and/or LPNs from becoming “the objectified subjects” of this thesis (Smith, 2005, p. 228).

Problematic and Disjuncture

The problematic and disjuncture are methodological tools that support a coherent analysis (Rankin, 2017a). The problematic is neither the research question nor the problems that people are experiencing (Campbell & Gregor, 2004). Smith states that the problematic “is a territory to be discovered” in the early stages of entering the field (Smith, 1987, p. 41). The problematic often arises from the ‘disjuncture’ between the official versions of how things happen and what is happening. In IE, the term “disjuncture” describes the “split” or “schism” between people’s actual experiences and experts’ authorized explanations of those experiences (Smith, 1990, p.4). Smith (1999) describes how experts, like researchers and managers, start in a theorized world that

focuses on “nominalized social phenomena” or concepts such as collaboration and scopes of practice. Nominalized social phenomena come to represent people’s activities instead of representing the people who act (Smith, 1999). Thus, such concepts do not always accurately explain people’s actual experiences.

Work

Work is another methodological tool that supports a coherent analysis.

Institutional ethnographers follow work processes, verbally and visually mapping what is done and by whom (Ng et al. 2013). Smith (1987) considers her definition of work to be “generous” in that the work involved may be part of a paid job or it might fall into the broader field of unpaid or invisible work (Devault, 2006). This has implications for how researchers approach their data collection because work is everything “people know how to do and their daily lives require them to do” (Campbell & Gregor, 2004, p. 28). By Smith’s (1987) definition, nursing work includes all the activities engaged in by nursing professionals. Consequently, observation and shadowing were an important data collection strategy for my project because nursing “collaborative” work included more activities than those that are generally recognized and recorded through institutional texts, such as those described in scopes of practice documents (Rankin, 2004). For example, collaborative work included everything that went into organizing the “collaborative” activities the RNs and LPNs completed, such as verbal requests for help. It also included the thinking/knowing that sat behind what the RNs and LPNs did– what each RN or LPN knew (or thought he/she knew) about what the other was doing, how each RN or LPN knew about what the other was doing, and why it was relevant to everything else that was going on. This was all part of my data collection. The RNs and LPNs themselves often

did not consider these activities to be work because they were so frequent and repetitive throughout the day, but they became an important part of my analysis

Texts and Social Relations

In modern society, texts organize the activities of people. Texts are the material forms of words, including images and sounds that are replicable (Smith, 2006; Turner, 2006). Examples of texts include: books, photographs, television commercials, bus tickets, and sales receipts. Smith (2001) writes, “exploring how texts mediate, regulate and authorize peoples’ activities in modern societies expands the scope of the ethnographic method beyond the limitations of observation” (p. 159). Textual analysis was an important data collection method for my inquiry. Observations and interviews in the local setting (the orthopedic units) alone could not reveal how texts connect nursing professionals in their local setting to distant ruling institutions, like health authorities and regulatory bodies.

Within IE, texts play a central role in coordinating social relationships (Rudrum, 2016). People’s activities are purposefully coordinated and socially organized to happen as they do (Campbell & Gregor, 2004). Smith (2006) used the term “social relations” to describe how people’s seemingly independent activities actually contribute to larger social phenomena that organize other people’s lives. Nursing professionals may take for granted how their routine activities connect them to others. For example, during my standpoint informant interviews, many RNs and LPNs talked about documenting their work by charting and filling out graphics/flow sheets throughout their shifts. These graphics/flowsheets connected the RNs and LPNs to the other health professionals on the unit. These health professionals, including physiotherapists and physicians, used the data

that was charted by the RNs and LPNs to make decisions about patients' progress. Sometimes important information was lost because it did not fit into the graphics/flowsheets' categorizations of tasks. Additionally, when the RNs or LPNs got "tied up" with their patients and did not have time to complete the graphics/flowsheets (as per their routine), information was not available when others needed it.

Social relations had implications for how I approached my data analysis. Texts also allow happenings in one place to influence actions in another because of their "everywhereness" (Rudrum, 2016). For example, people who are not directly involved in frontline patient care are often the ones who write the policy and procedure documents all RNs and LPNs throughout the health authority follow. When I analyzed my data, I needed to think about the activities occurring across multiple different institutional locations. I started in the local settings - the orthopedic units where RNs and LPNs worked together - but then I needed to think translocally, or distant settings, such as the offices of health authorities, which were far from the units where the RNs and LPNs actually work. The decisions made translocally impact the RNs and LPNs' work locally.

Campbell and Jackson (1992) discuss the idea of nursing work being conceptualized through texts and written up in particular ways to make it and health care more manageable. HHN has a Charting By Exception (CBE) policy, which is a shorthand method of charting, through which RNs and LPNs document their work on graphics/flowsheets, and only follow-up with narrative charting for exceptions to what is usual for patients. HHN's graphic/flowsheets categorize RNs and LPNs work into tasks, which are mostly standardized across the health authority. Campbell and Gregor (2004) argue it is "convenient for management to understand nursing work as tasks that can be

defined and assigned to [different nursing professionals]” (p. 20). As a result, the RNs and LPNs often used the language of the graphics/flowsheets (or tasks) to describe their work. They also categorized their work to fit into the graphics/flowsheets, even when it did not always depict the work being done.

Ruling Relations and Language

Ruling relations and language are methodological tools that help researchers get from being aware of tensions to figure out what is going on. Ruling relations are types of social relations that involve the all of the various institutions that organize, manage, and essentially rule society (Smith, 1990). Ruling relations insert the interests of these institutions – interests that often do not match the interests of the standpoint informants (who work in the everyday world). Ruling does not happen outside the practices of people, who often activate ruling relations through texts.

Smith argues that institutions are “pervasively interconnected” because they are “textually-mediated” (Smith, 1999, p. 49). Texts organize and structure how RNs and LPNs work; they are commonplace, even though RNs and LPNs may not think about them during their shifts. Nursing licenses are an example of texts that rule RNs and LPNs’ activities and organize their social relations with others, including how they work with each other. Both RNs and LPNs must hold licenses to practice nursing, but there are differences in the roles, responsibilities and accountabilities associated with each category of nursing license.

Registered nurses and LPNs complete different requirements to obtain their respective licenses and these requirements are ruled by different institutions. Registered nurses in Canada, for example, must complete a baccalaureate degree from an accredited

nursing program and write the North Council Licensure Examination (NCLEX) to be eligible for licensure through a provincial/territorial nursing regulatory body.

Consequently, universities, the National Council of State Boards of Nursing (NCSBN), the provider of the NCLEX, and provincial/territorial nursing regulatory bodies are all institutions that rule the process RNs complete to obtain their licenses to practice with patients.

Institutions exert their rule in many ways. Institutions use the language of experts, such as researchers and managers, to form the concepts related to people's work. This leads to people adopting this same language to discuss their own experiences, even when this language does not always fit with what is actually happening. These ruling concepts begin to lead the discussions of people's experiences, which leads to the ruling organizations being able to control society (Adams & Sydie, p. 217). Many such concepts become buzzwords, such as "collaboration," that replace people's lived experiences and obscure or transform what is known (Bisaillon, 2012). A nurse manager might say, "my staff collaborate," but his/her use of the term "collaboration" obscures the actual work that took place. To that nurse manager, "collaboration" might mean the RNs and LPNs on his/her share patient assignments, or it might mean the RNs administer medications, while the LPNs do bedbaths. The word "collaboration" replaces descriptions of the work that is taking place between the RNs and LPNs.

Study Setting

I collected data on two orthopedic units in two hospitals, located in different cities, in New Brunswick, Canada, as practice settings. New Brunswick has two regional health authorities, Regional Health Authority A (or Vitalité Health Network), which

operates in French and Regional Health Authority B (or Horizon Health Network (HHN)) which operates in English (*Regional Health Authorities Act 2002* (NB) s.19). These two health authorities were established in 2008, from the dissolution and merger of the previous eight health authorities. The stated goal of this transition to two health authorities was to “cut costs,” standardize care and improve performance targets by ensuring services were delivered more uniformly and efficiently throughout the province (Government of New Brunswick, 2018).

The ONTRACC model is being implemented throughout Regional Health Authority B, or HHN. Horizon Health Network (HHN), the largest healthcare institution in Atlantic Canada, operates 12 hospitals and many clinics and other community-based healthcare services, such as community health care centres (HHN, 2017). By recruiting informants from two different hospitals, Saint John Regional Hospital (SJRH) and Dr. Everett Chalmers Regional Hospital (DECH) within the same province, I was better able to distinguish unit and hospital-specific nursing work processes from provincial and institutional-specific nursing work processes. While New Brunswick is Canada’s only bilingual province, these hospitals are in larger Anglophone urban areas (Pepin-Filion, 2014). Interviewing or “talking to people” is an important element of institutional ethnographic research (DeVault & McCoy, 2002, p.756). I am an Anglophone, so I conducted my research in the more Anglophone areas of the province to improve my understanding of what my informants say about their work processes and what is going on around them. Understanding the words of informants and those around them is important due to IE’s analytic attention to language and how ruling relations work in a particular setting (Smith, 2005).

Sample

I recruited two ‘types’ of informants for my study. First, within each hospital, I recruited RNs and LPNs (n = 14, with 8 RNs and 6 LPNs) who allowed me to shadow them as they completed their daily work (See Appendix A). These were my standpoint informants. They gave me a good understanding of the actual practices of RNs and LPNs working together and the interaction of those practices with material objects, particularly texts (Quinlan, 2009). Quinlan (2009) used a similar approach by shadowing three nurse practitioners to study how the “knowledge work” of interdisciplinary teams happened across different healthcare sites in Saskatchewan. To recruit these standpoint informants, I posted a recruitment letter on the bulletin boards of the orthopedic units of the two hospitals (Appendix B). The letter provided a description of the inclusion criteria and gave my contact information.

My inclusion criteria for prospective informants was RNs or LPNs with a minimum of two years of work experience on the orthopedic unit within their hospital. I believed such RNs and LPNs would be more familiar with their units and the texts they routinely activated through their work than those who were newly graduated or only recently hired to the unit or the hospital. Benner (1982) describes nursing professionals with two years’ experience as “competent” and familiar with their workplace routines.

To expand beyond the data I collected from these RNs and LPNs, I also recruited other informants who had different range of knowledge about how things work (see Appendix A). I contacted these informants by phone (see Appendix B). The selection of these informants was based upon the analysis of the standpoint informant data (purposive sampling). These other informants had different knowledge about how RNs and LPNs are

hired, rostered, paid and so forth. Many of them were responsible for monitoring, reporting, or evaluating the care practices of RNs, LPNs, or both. They included a patient, other employees of HHN, and representatives from different nursing organizations outside of HHN, such as the nursing regulatory bodies. These interviews helped me to map the ruling relations that are organizing how RNs' and LPNs' work and interactions with each other are institutionally coordinated (see Appendix C). This sampling strategy is consistent with an institutional ethnographic approach.

Data Collection

In this section, I explain how I collected and analysed my data. My data collection occurred over a four month period. I used three data collection methods: shadowing/observation, interviews, and document collection/analysis. Throughout my data collection, I remained flexible so I could respond to the emerging findings of my study. I kept a reflective research journal as an audit trail and recorded all my decisions throughout my study.

Observation

First, I shadowed the RNs and LPNs I recruited as standpoint informants for my research. Shadowing is an observational method, which involves the researcher closely following the informant over a period of time to gain an understanding of his or her everyday work (Ng et al., 2013; Quinlan, 2008). The observations I made while I was shadowing my standpoint informants allowed me to discover the realities of their work during their shifts. This knowledge enabled me to uncover their empirical knowledge and discover challenges and tensions they experienced during their shifts. For example, I saw

firsthand, how the RNs and LPNs negotiated their breaks, who did which tasks for which patients and how shift report worked.

I recorded my observations through a fieldnotes template (Appendix E). When I was with the RNs and LPNs, I focused on making descriptive notes of their activities and the chronology of events on the unit (the unit routine). These notes were rough and I needed to flesh them after I completed each shadow shift. When I fleshed out my descriptive notes, I often added missing reflective comments, for example – my thoughts/questions about the RNs and LPNs' work. I always shadowed the RNs and LPNs before I completed my interviews with them, so I could use what I observed to inform my interviews.

Interviewing

After shadowing my standpoint informants, I arranged individual, audiorecorded interviews with them, either in a private area at the hospital or another location of their choosing. During these interviews, we talked about what I observed in regard to their work with their nursing colleagues. I also asked them about their experiences of LPNs and RNs working together (see Appendix F for interview script for standpoint informants). Through these interviews, I was most interested in revealing the RNs' and LPNs' empirical knowledge of their work, so I focused on their stories and descriptions of what happens. I was also interested in contrasting the RNs' and LPNs' descriptions of their work with my observations of what they actually did. This revealed how their own views of their work were institutionally organized.

Following preliminary analysis of my observations and interviews with my standpoint informants, I generated my list of other informants to interview. These other

informants were purposely chosen based on my ongoing data collection and analysis process. The questions I asked these informants were focused more on identifying the trans-local relations and institutional processes that organized the standpoint informants' work (see Appendix G for interview script for other informants).

All my interviews were one-on-one and lasted approximately one hour. With the permission of the participants, all interviews were audio-recorded and transcribed (see Appendices G, H, I, & J for invitational letters and consent forms). Milne and Oberle (2005) suggest using a flexible interviewing approach, with open-ended questions to allow participants to tell their stories in their own words (again, see Appendices D & H for interview scripts). Devault and McCoy (2006) consider the purposefulness of IE interviews in getting to empirical descriptions of what is happening and avoiding feelings, opinions, and interpretations. Consequently, I used semi-structured interview questions (such as, "Can you describe what sorts of things make your day run smoothly? Can you tell me about the daily frustrations and challenges that happen in your work?"). There were also more specific questions included to cover demographic background (education, years of experience as an RN or LPN, clinical areas of practice).

Document Collection

Institutional ethnographers consider texts to be essential to both the existence and ruling of institutions (Smith, 2001). According to Smith (2001), "Exploring how texts mediate, regulate and authorize people's activities beyond the limits of observation (p.159)." It is through texts and their "everywhereness" that researchers can explicate the connections between the local and the translocal, thereby making visible the working of institutions in people's everyday lives. I collected key documents throughout my study,

which included: assignment sheets, rosters, workforce planning documents, hospital policies/protocols, job descriptions, standards of practice, and scopes of practice guides. In IE, a chain of texts and work processes emerge through attending to the connections that informants reveal through their interviews or their work (Ng et al., 2013). Consequently, I gathered a great many text and used them as part of my analytical process – which actually pointed to more texts and more interviews.

Data Analysis

My analysis was not motivated to criticize my informants' nursing practice, but to explicate how the RNs and LPNs worked together during the implementation of the ONTRACC model. In IE, data analysis actually begins in the planning stages of the study and takes place throughout the entire study. Consequently, there is “no ‘one way’ to conduct an IE investigation” (DeVault & McCoy, 2002, p. 755) and institutional ethnographers do not know in advance exactly which steps they will take. (DeVault & McCoy, 2002). As DeVault and McCoy (2002) explain, the process of conducting an IE study is “rather like grabbing a ball of string, finding a thread and then pulling it out” (p. 755). As a novice researcher, I found not having a step-by-step written out plan stressful at times. Although I knew what topic I was interested in (RNs and LPNs working together), I did not know in advance who I needed to interview or what texts I needed to examine. I decided on each step in my study based on the last step (or what I had already discovered), with the hope I would keep pushing forward in the process of figuring out more on the social organization of RNs' and LPNs' experiences of working together in an acute care setting.

Discovering the Research Problematic

Although there is “no ‘one way’” to conduct an IE study, most institutional ethnographers begin by discovering a puzzle that is “latent in the actualities of the everyday world” (Smith, 1987, p. 91). This puzzle becomes the research problematic (Stooke, 2010). Rankin (2017) describes the research problematic as “key to a coherent analysis in IE” and recommends using the problematic to “[open] up the scaffold though which to analyze disparate goings on that, at first do not seem to be connected.” I started my data collection with the accounts of the frontline RNs and LPNs who were my standpoint informants. While I was observing/shadowing and interviewing these RNs and LPNs, I kept asking myself questions like, “what work are they doing?” and “how is this work organized?” I noted any frustrations or tensions I observed or heard about on the unit. I collected any texts these RNs and LPNs activated (e.g. graphics/flowsheets they completed, practice guidelines they referred to) through their shifts. From my observations/shadowing and interviews with these RNs and LPNs, I made a list of other people, such as nursing leaders, these RNs and LPNs thought I should talk to. I then setup interviews with some of these informants. While I was setting up these interviews, I began reading and re-reading the transcripts of the interviews for differences between “knowing something from a ruling versus an experiential perspective” (Campbell & Gregor, 2004, p. 48). Once I discovered the research problematic, I “[opened] up the scaffold though which to analyze disparate goings on that, at first [did] not seem to be connected.” (Rankin, 2017).

Two Types of Data

Institutional ethnographers need to collect data at two different levels (Dalmer, Stooke, & MacKenzie, 2017). First, I collected entry-level data from the RNs and LPNs on their units (local data). From this data I learned about the RNs and LPNs everyday, local experiences, including tensions and frustrations. Then, from this entry-level data, I learned where to look for data positioned outside the local setting (or translocal data). For example, I interviewed people located elsewhere (nursing leaders) whose work organized the RNs and LPNs work on the units. According to Campbell and Gregor (2004), it is this translocal data that enables institutional ethnographers to see “how people’s everyday lives may be organized without their explicit awareness but still with their active involvement” (Campbell & Gregor, 2004, p. 17). Consequently, when I read and re-read the interviews with these other people (my other informants), I started “push[ing] beyond the local settings of people’s everyday experience” (Smith, 2005, p.49). Although my study began with the actualities of RNs’ and LPNs’ work, and their knowledge of their work, on their units, I was able to uncover the mechanisms by which it was being organized by the ruling relations. I continued with my data collection until I had exposed a network of links between my locally and translocally generated data.

Strategies for Data Analysis

Whenever I interviewed any of my informants, I kept in mind that each informant participates – either knowingly or unknowingly – in the ruling relations that shape their experiences. From the beginning of my study, I took “notice” of informants’ uses of “authorizing language” or language and concepts that were imported from other texts and discourses (Rankin, 2017). I found this helped me tease out the ways their descriptions of

their experiences were embedded in the ruling relations. I read and re-read my informants' transcribed interviews, which I imported into NVivo (Commercially available software used for the organizing and analyzing of qualitative data). I highlighted uses of authorizing language and used NVivo's notes and query functions to add comments.

Rankin (2017) describes several strategies institutional ethnographers use to begin managing and working with their data. Of Rankin's strategies (2017), I found "indexing" and "mapping" particularly helpful. I used "indexing" early in my data collection and analysis to create a "cross-reference" for linked work processes and texts (Rankin, 2017). To index my data, I noted topics that were frequently discussed in my informants' interviews (both standpoint and other). I then created folders for each of these topics in which I placed written descriptions of all the work processes that were associated with them. I also included any texts that were activated during any of the work processes. After I discovered my research problematic, I found myself reaching for certain folders more frequently than others. What was inside these folders became the ends of the analytic threads I followed to explicate how the RNs' and LPNs' work was organized beyond their units.

Indexing helped me to manage my data early on and prepared me for my mapping work. Mapping helped me to track ruling relations from the work of people locally into the work of other people translocally. According to Rankin (2017), the goal of mapping is to lay out a display of what is happening (a map), either in words or diagrams, that describes the features of the social practices and their respective material forms and relationships. My mapping work included written descriptions and a diagram that plotted

out the various texts that organized the RNs and LPNs daily lives. I used “indexing” and “mapping” to trace these topics and work processes beyond the local setting to reveal the ruling relations at play. This allowed me to ‘see beyond the local’ by depicting the interconnectedness of ruling relations which operate translocally.

NVivo

As mentioned above, NVivo was used to manage the transcribed interviews. Some of the features of NVivo, such as the annotations, notes and query functions, were used to “converse with the data” and highlight practices that were puzzling (Rankin, 2017, p. 1). As Smith (1987) points out, actors describing their everyday worlds might not be able to articulate or be aware of the social relations linking their work across many locations; it is these generally taken-for-granted or unexamined aspects of nursing work that were embedded in the data, that guided the analytical process.

Reflexivity

Throughout this study, I reflected not only on my own experiences, assumptions, values and beliefs around RNs and LPNs working together, but also on my understanding of IE. Reflexivity, specifically a reflexive journal, is one way in which I purposefully thought about what I, as a novice institutional ethnographer, brought to this research. Rankin (2017a) describes common errors researchers make when using IE. Several of these pitfalls resonated with me. For example, Rankin (2017a) cautions researchers not to become “captured” by institutional discourses, which can harness researchers to the ruling relations and impede good analysis. As I was accustomed to using institutional language, like “collaboration” or “scopes of practice,” which do not provide descriptive accounts of what is actually going on, I needed to train myself out of this habit. I needed

to remember my standpoint informants were the expert knowers and I needed to learn from them about their experiences. Thus, when my standpoint informants used this language during their interviews, I needed to ‘dig deeper’ and ask them to provide descriptive accounts as well.

Ethics Approval

I obtained ethical approval from the Research Ethics Boards (REBs) at both the UNB and HHN prior to my recruitment and data collection (again, see Appendices H, I, J, & K for invitational letters and consent forms). I recruited my standpoint informants through posters on hospital message boards and word of mouth. My recruitment of my other informants proceeded in an iterative fashion, primarily by word of mouth. I provided all informants with a letter of information and a detailed verbal description of the study and obtained signed consent before any shadowing or interviews. Although I did not anticipate these interviews causing distress to any of my informants, I needed to be prepared in case they did trigger painful memories. I informed all my informants that they had the right to stop the interview at any time and I also ensure debrief was available from a local mental health professional through a crisis helpline (Chimo HelpLine).

As mentioned above, I made detailed ethnographic fieldnotes to record my observations. Ng. et al. (2013) recommend making field notes not only about the informant’s work processes, but also about the contexts in which his or her work occurs. This sometimes involved observing/listening to RNs and LPNs with patients or other HHN employees. To respect the RN/LPN-patient relationships and patients’ privacy, when I was shadowing the RNs and LPNs, I did not follow them behind pulled curtains or closed doors. Consequently, observations only occurred with the consent of my

standpoint informants and patients, and as outlined in protocol that was approved by UNB and HHN's REBs. On the orthopedic units, I wore a name tag that said "Researcher" to identify myself to patients and other staff members.

During this research, I did find myself to be in a position of dual agency with some of my informants (Ferguson, Myrick, & Yonge, 2006). I am a RN and I have worked across New Brunswick as both a nurse and a nurse educator. To address this, I made an effort to recruit informants who did not know me as a co-worker or nurse educator. In the end, both a former colleague and a former student participated in my study. I worried both my former colleague and my former student would feel uncomfortable or assume I was evaluating them and their professionalism. I discussed my concerns openly with them, but they both assured me they really wanted to participate and share their experiences with me. There were no issues with their participation in the study.

Chapter 5: Manuscript #3

Chapter 5 is a manuscript entitled “Registered Nurses and Practical Nurses Working Together: An Institutional Ethnography.” This manuscript presents the main findings of my research, and will be submitted to the journal, *Qualitative Health Research*.

Registered Nurses and Practical Nurses Working Together:

An Institutional Ethnography

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This manuscript will be submitted for publication to the journal, *Qualitative Health Research*. It is presented in the formatting style of this journal. The title “practical nurse” (or PN) is used instead of “licensed practical nurse” (or LPN) for clarity. In Ontario, the title “registered practical nurse” is preferred over the title “licensed practical nurse.”

Abstract

Background: In Canada, two categories of nursing professionals, registered nurses (RNs) and practical nurses (PNs), provide nursing care to patients. Recently, a health authority in a Canadian province implemented a new nursing care delivery model to “optimize” nursing, patient, and hospital outcomes. This new model shifts nursing care from being delivered by RN-PN teams, who worked together as “buddies” to care for an assignment of patients, to RNs or PNs working independently to care for a smaller assignment of patients.

Purpose: The purpose of this study is to explicate how RNs and PNs worked together during the implementation of the new model and how their work together is socially organized to happen as it does.

Methods: Dorothy Smith’s (1987) Institutional Ethnography (IE) guided this study. IE allows researchers to enter into their studies through the standpoint of ordinary people, like RNs and PNs, and explicate how their experiences are socially organized through texts and textually mediated discourses. To address this study’s purpose, eight RNs and six PNs were recruited as standpoint informants. These RNs and PNs were observed during shadow-shifts and interviewed. Twelve other informants with special knowledge of the new model, such as nurse managers, were also interviewed. Textual analysis of relevant documents, including regulatory, union, and health authority documents, was also completed.

Findings and Significance: The new model challenged the RNs and PNs’ knowledge of working together. This research is significant because RNs and PNs typically work with each other more than they work with other health professionals, such as physicians; and

understanding how they work together can lead to changes that can improve patient and health system outcomes.

Registered Nurses and Practical Nurses Working Together:

An Institutional Ethnography

In Canada, two groups of nursing professionals, registered nurses (RNs) and practical nurses (PNs), work together to provide care to patients. Nursing care delivery models organize how these RNs and PNs work together, including mixes of credentialed staff, or the ratios and numbers of each nursing professional group (Harris & McGillis Hall, 2012). Harris and McGillis Hall (2012) argue the decisions around how these models are organized are often driven by a combination of “patient, provider and organizational factors” (p. 2). A health authority in a Canadian province (New Brunswick) recently implemented a new nursing care delivery model; the Organizing Nursing Team Resources for Accountability, Collaboration, and Communication (ONTRACC) model, to improve patient and health system outcomes (HHN, 2018). The ONTRACC model shifts nursing care from being delivered by RN-PN teams, who worked as “buddies” and cared for an assignment of patients together, to RNs or PNs who work independently and care for a smaller assignment of patients. To prepare for the ONTRACC model, some PNs needed to meet mandatory upgrade requirements, such as a medication administration course, through either their regulatory body or approved post-secondary education programs (ANBLPN, 2014).

The ONTRACC model was developed to address a forecasted nursing shortage and decrease provincial healthcare spending by “optimizing” the roles and activities of RNs and PNs on acute care units, such as orthopedics (HHN, 2018). Canada-wide, the sustainability of healthcare services is a concern. The Canadian Nurses Association (CNA, 2014) forecasts Canada will be short almost 60,000 full-time RNs in 2022. New

Brunswick's provincial healthcare budget increases annually and is 9.8% higher in 2019-2020 than in 2014-2015 (Government of New Brunswick, 2018). In 2009, a provincial government report argued that "optimizing the role of [PNs] so as to maximize their scope of practice (consistent with training)" would improve nursing care delivery (Crescent Management Consulting, 2009, p. 44). The purpose of this study is to explicate how RNs' and PNs' worked together during this transition and the social organization of their work to help inform future changes to the ONTRACC model. This study was guided by institutional ethnography (IE), a methodology that uncovers how people's everyday experiences are coordinated by the work done with texts in institutions.

Background: What do RNs and PNs do?

In Canada, RNs and PNs are both self-regulated professionals. Being "self-regulated" means that the provincial governments have, through legislation, delegated the regulatory responsibility and accountability of RNs and PNs to provincial nursing regulatory bodies. These regulatory bodies, often nursing colleges or associations, establish entry-to-practice competencies, or the "knowledge, skills and judgement required ... to provide safe [and] competent" nursing care, approve nursing educational programs, and complete professional conduct reviews (Nurses Association of New Brunswick [NANB], 2013, p. 4). Although RNs' and PNs' entry-to-practice competencies are negotiated by these regulatory bodies, what RNs and PNs actually do in their daily work often depends on their "scopes of practice," or their roles and what they are permitted to do by their regulatory bodies, their employers, and their practice environment (NANB, 2015). For example, RNs and PNs who work in certain specialty areas, such as orthopedic units, may do certain activities, such as the set-up and care of

traction to stabilize and realign bone fractures, or the set-up and care of vacuum-assisted closure (V.A.C.) and suction dressings to promote wound healing, which RNs and PNs working in other settings would not do. These RNs and PNs may need to acquire additional specialized knowledge to do such care activities safely and their employers may need to develop policies to guide the RNs' and PNs' practice. RNs or PNs who float, or are not routinely assigned, to such areas may need help from the permanent nursing staff to do these specialized activities. Consequently, RNs' and PNs' roles, specific activities and routines can vary significantly from one practice environment to another. The number of shared or overlapping RN-PN activities/routines can also vary from one practice environment to another, further the blurring lines practice for these nursing professionals.

Nursing Care Delivery Models and Re-organization

Across Canada, with the legacy of neoliberal policies and ongoing transfer of public services to private ownership, there is concern about the financial sustainability of the publicly insured health care system; and a great deal of scrutiny is being placed on all healthcare spending. Healthcare staff's salaries account for around 60% of most Canadian hospitals' overall budgets; and historically, decision-makers have seen reductions in the number of healthcare staff to be a way to contain costs (Canadian Institute for Health Information [CIHI], 2011). When decision-makers examine the healthcare workforce, they must balance cost containment pressures against maintaining a sufficient staffing quota to care for patients and to meet certain quality and patient outcomes. Major Canadian hospitals go through accreditation processes, where their services are evaluated against a series of standards specific to service areas, such as medication management

(Health Standards Organization, 2019). These standards consider both “[h]aving the right people” and certain quality patient outcomes (Health Standards Organization, 2019).

Recently, some decision-makers are focusing more on changing the mix of credentialed staff, such as nursing staff, rather than reducing overall staffing quotas (Burke, Ng, & Wolpin, 2016). Changing the mix of nursing staff often means decreasing the number of RNs while increasing the number of PNs in a particular setting. Some researchers note that nursing staff, particularly the RNs and PNs who provide most direct professional nursing care, are often “seen ... as a source of savings” (Born, Dhalla, & Ferguson-Paré, 2013, p.1). RNs have higher salaries than PNs and health authorities may hire fewer RNs to reduce costs (Born, Dhalla, & Ferguson-Paré, 2013).

In some cases, RN-positions have been replaced by PN-positions (Born, Dhalla, & Ferguson-Paré, 2013), despite the differences in levels of education. For example, RNs complete longer, more extensive educational programs, which typically take three to four years of study at a university, although there are some shorter second-degree entry programs. The skills and knowledge RNs require to perform complex, critical health-care tasks are most effectively taught at a baccalaureate level (CNA, 2020). These baccalaureate nursing (BN) programs focus more on the knowledge and skills needed to develop and implement multi-faceted plans for managing chronic disease, treating complex health conditions, and assisting in the transition from hospital to the community (Canadian Nurses Association, 2020). PN programs are at the college level and are typically two years in length.

RNs’ and PNs’ different educational backgrounds mean they have different “scopes of practice.” Consequently, decision-makers may experiment with new nursing

care delivery models to respond to the changing mixes of nursing staff available on each shift to ensure patient care is delivered by the nursing professional who has exactly the right education and skill to do the job. These new nursing care delivery models are often described in scholarly and grey literature as, “workforce optimization.” Decision-makers often argue that - not only do the new delivery models optimize nursing scopes of practice - but they are also improving the quality of care and patient outcomes (Burke, Ng, & Wolpin, 2016).

Many of the emerging models to organize nursing care are focused on team-based structures, or teams of RNs and PNs where each team member completes specific activities for a group of patients. Some researchers argue these team-based structures support “collaborative practice” (Ritter-Teitel, 2002) or the notion that health workers improve their capacity to “work together with patients, families, caregivers, and communities to deliver the highest quality of care” (WHO, 2010, p. 4). The World Health Organization (2010) argues that the new emphasis on the concept of “collaborative practice” is the best way to “maximize the strengths and skills of health workers enabling them to function at the highest capacity” (WHO, 2010, p. 15). Some research suggests that the outcomes for team-based models are not as positive as the dominant reports. These researchers are more cautious about team-based structures (MacKinnon, Butcher, & Bruce, 2018). A recent critical report from MacKinnon et al. (2018) suggested the new team-based nursing care delivery model led to fragmented, task-oriented, divisions of patient care between the RNs and the PNs (MacKinnon et al., 2018). Their research used ethnographic methods to examine what was actually happening in a team-based nursing care delivery model in two hospitals in British Columbia (MacKinnon et al., 2018).

Other quantitative research has pointed to less favorable outcomes related to the efforts to contain costs and the impact of changes in nursing staffing mixes and new nursing care delivery models on certain quality for patient outcomes. Some studies have shown that changes to nursing staff ratios, in particular the reduced number of RNs to the number of PNs, has a negative impact on patient ratings of their hospital care (Aiken et al., 2012; Opper & Young, 20017; Tsai, Orav, & Jha, 2015). Reduced overall number of RNs to patients (i.e., RN-to-patient ratios) have been shown to have a negative impact on measurable patient outcomes (Lankshear, Shelodon, & Maynard, 2005; Olley et al., 2018), such as patient death rates (Aiken et al., 2002), lengths of stay (Thornblade et al., 2018), and complications (Falk & Wallin, 2018). Indeed, several studies have linked care delivery models that include only RNs, which eliminate PNs and unregulated care assistants, to better patient outcomes (Aiken et al., 2014; North et al, 2013; Thornblade et al., 2018). Although these studies suggest higher levels of RN staffing mean better care for patients, these studies only consider certain categories of select patient outcomes or they are based on patients' own perceptions (Aiken et al., 2012) that do not easily accommodate aspects beyond interpersonal relationships and a patient's experience of receiving care (see for example Rankin & Campbell, 2006).

There are several gaps in the current approaches to evaluating the success of new models of care. Many studies use in hospital deaths as an outcome. There are, however, many other outcomes that are less tangible or are harder to monitor and measure, for example situations when RNs or PNs do not recognize when patients' health statuses change. Some researchers have examined "failure to rescue" or the inability to prevent patients' deaths after the development of complications (Tourangeau, Cranley, & Jeffs,

2006). For example, Tourangeau et al. (2006) noticed increased “failure to rescue” rates on units with fewer RNs in their staffing mix. This study relied on categories of “determinants of mortality,” however, which do not represent everything there is to know about what is going on in nursing and in-patient care (Tourangeau et al., 2006). Few studies explore what actually happens when RNs and PNs work together, for example, what decision-making about patient acuity actually looks like. There also is a general bias to RN-focused studies, which greatly outnumber PN-focused studies. This is likely because these studies are usually authored by doctoral-level prepared RNs conducting the research. Thus, there seems to be an inherent slant towards the interests of RNs.

Purpose

The purpose of this institutional ethnography (IE) study (Smith, 1987) is to explicate how RNs’ and PNs’ worked together during the transition to the ONTRACC model and how their work together is socially organized to happen as it does. In IE, the standpoint establishes the knowledge and practices of the people located there (Rankin, 2017). Institutional ethnographers aim to make visible and trace the knowledge and practices of those people “locally” to the work of other people elsewhere or “translocally” within the institutional matrix (Rankin, 2017). For example, RNs’ and PNs’ entry-to-practice competencies are directed by their regulatory bodies and their scopes of practice are negotiated between their regulatory bodies, educational programs and their employers. Both nurse managers and frontline RNs and PNs involved in the transition to the ONTRACC model informally talked to the first author about the new model prior to this study. The frontline RNs and PNs expressed a mix of emotions about their changing work relationships. For example, some PNs were anxious about having an

independent assignment or their own group of patients to care for, while others were excited. These informal conversations guided the development of the following five research questions:

1. What was RNs' and PNs' current knowledge about their work together and how it unfolded, including what was needed to provide their patients' care?
2. What language did RNs' and PNs' use to describe their work? Particularly, how did they use the language of "collaboration", "roles and responsibilities," "scopes of practice," etc.?
3. What "texts" did RNs' and PNs' activate during their work and how did these "texts" mediate their interactions with others'?
4. How did the texts RNs' and PNs' used intersect with other institutional texts of regulatory associations, employers, unions, etc.?
5. What were the tensions and problems that arose within the "ruling relations" that were implicated in how the RNs' and PNs' worked together to provide patient care?

Methodology

Research Design

Institutional ethnography (IE) (Smith, 1987) was used to address the research questions. Smith's (1987) IE approach begins "locally," from the standpoint of everyday people, then maps out "translocally" to consider the work of other people elsewhere (Campbell & Gregor, 2002). Smith (1987) recognizes how society is text-based and the activation of texts, including government, regulatory, union and health authority

documents, and text-based discourses, mediate people's work and influence people's understandings of their experiences. RNs and PNs activate texts and textually mediated discourses frequently throughout their work with each other and with their patients. For example, RNs and PNs activate texts when they use vital documents, such as clinical pathways, checklists, flowsheets, and graphics, to guide their care activities for patients who are recovering from certain procedures. They also adopt, sometimes unconsciously, the terms used in these documents to talk about their patients. For example, the RNs and PNs routinely say things like, "the patient has pain around five," referring to the zero to 10 numerical rating scale used on the graphics to measure pain intensity. Similarly, other healthcare professionals activate these same documents to guide their care of these same patients and also adopt these same terms. For example, the physiotherapists use the same zero to 10 numerical rating scale used on the graphics to talk about patients' pain. These departmental documents are often developed by other people and/or institutions with other practical goals and priorities in mind, like standardization across a health authority. Arguably, these departmental documents are "textual realities" and are "normal, integral, and indeed essential features of the relations and apparatuses of ruling" (Smith, 1990, p. 83). As such, they organize, manage, and sequence the care patients are to receive from a variety of health professionals.

Context and Setting

In 2014, changes to nursing staffing mixes were implemented in some New Brunswick hospitals within one of the two provincial health authorities, Horizon Health Network (HHN), including the Dr. Everett Chalmers Regional Hospital (DECH) and Saint John Regional Hospital (SJRH). Some RN positions were eliminated and some PN

positions were created. The following year, a group of nursing leaders within HHN proposed the ONTRACC model to “implement strategies and processes to refocus care delivery on the key foundations of nursing practice: accountability, collaboration, communication, and patient-centeredness” (HHN, 2018, p. 9). The ONTRACC model “refocused” nursing care away from a team-based structure, towards RNs and PNs working to their “full scopes of practice” and independently caring for patients, with RNs assigned to “more complex” patients and PNs assigned to “less acute, less complex” patients (HHN, 2018; NANB & ANBLPN, 2015, p. 12).

Data was collected on orthopedics units at both the DECH and SJRH over three months. Although these hospitals were located within similarly sized cities, with populations between 58,000 to 68,000, one hospital (DECH) is designated as a level-three trauma center, while the other hospital (SJRH) is designated as the level-one trauma center for the province. These orthopedics units were at different stages of implementing the ONTRACC model during data collection. One of the orthopedic units (DECH) was beginning to implement independent assignments, while the other orthopedic unit (SJRH) had already implemented independent assignments for most nursing staff members. This allowed the researchers to collect data that reflected the RNs’ and PNs’ knowledge and experiences at two different stages of the implementation process – when the RNs and PNs were transitioning from working in buddied assignments to independent assignments, and when they worked in independent assignments.

Informants

Informants who either worked at one of the two acute care hospitals, either directly with patients or in managerial/leadership roles or had special knowledge of RNs

and PNs working together or the ONTRACC model, such as nursing practice advisors, were recruited through posters, invitational emails, or phone calls. Tables 1 and 2 summarize the informants' (n=24) demographic information. Eight frontline RNs and six frontline PNs were recruited as standpoint informants. Ten other informants were also interviewed and came from a variety of backgrounds, including nurse managers, nursing educators, nursing practice advisors, other allied health professionals, and a patient.

Data Collection

Data collection methods included: a) observing/shadowing standpoint informants, b) making field notes, c) conducting interviews, and d) identifying the texts activated through the standpoint informants' work (Creswell & Porth, 2018).

Observation and field notes. As an observation method, the researcher shadowed each standpoint informant (the RNs and PNs) for a minimum of one, eight-hour shift, then completed an individual, semi-structured interview with each of them. Shadowing is an observational method, which involves the researcher closely following the informant over a period of time to gain an understanding of his or her everyday work (Ng et al., 2013; Quinlan, 2008). The observations made during these shadow shifts enabled the researcher to see the realities of the RNs and PNs work - both together and with their patients. Most of these shadow-shifts were conducted on day shifts, with only one conducted on a night shift. The shadow-shifts were done on both weekdays and weekends, dependent on the standpoint informants' schedules.

The researcher kept the research questions in mind throughout shadow shifts – and paid particular attention to things like the challenges and tensions the RNs and PNs experienced during their shifts. Due to the private nature of some nursing work,

observations were limited to common spaces, such as the nursing station, storage areas, medication room, and did not include observing any care that was private, like bathing or toileting. The observations were recorded using a field notes template developed by the researcher, which focused on the chronology of events on the unit (the unit routine) and included descriptive notes of the RNs and PNs' activities. The researcher read and re-read these notes after each shift for completeness and added further details when necessary to ensure nothing was missed.

Interviewing. After each shadow-shift, the researcher interviewed each standpoint informant (the RNs and PNs). Examples of interview questions included: (a) Can you tell me about a typical day at work?; (b) Can you tell me what makes your day run smoothly?; (c) Can you tell me about the challenges you experience in your work?; and (d) When you shared patients' care with other nursing professionals, how do you decide who does what? The researcher also asked questions related to things she observed during the shadow shifts, such as, "I saw you doing this today, can you tell me what was going on?" Probes were used to encourage the standpoint informants to further share their stories and descriptions of their everyday experiences, or their empirical knowledge of their work.

A list of 'other' informants was then generated following a preliminary analysis of both the observation/shadowing and interview data from the standpoint informants. These other informants were nursing professionals who did not work the frontlines, such as nursing leaders and nurse managers, other allied health professionals and a patient. They were purposely chosen based on the ongoing data collection and analysis process. They were asked questions that focused more on identifying the translocal relations and

institutional processes that organized the standpoint informants' work. All the interviews lasted approximately 30 to 60 minutes. With the permission of the informants, all the interviews were audio-recorded and transcribed.

Identification of texts. Institutional ethnographers consider texts to be essential to both the existence and ruling of institutions (Smith, 2001). The researcher paid attention to any texts that were used during the observations/shadowing usually health authority documents, or mentioned during the interviews, usually health authority, regulatory or union documents. Eventually, a “chain” of texts and work processes (Ng et al., 2013) emerged through attending to the connections that both the standpoint informants and other informants revealed through their interviews or their work. Nursing is heavily regulated by textual practices – and many of the collected texts are shown in Figure 1.

Analysis

IE, as Rankin (2017) explains, has a “distinctive ontological shift” from other qualitative methodologies. Institutional ethnographers must resist looking for categories, patterns or themes in their data, which she describes as “misstep.” DeVault and McCoy (2002) explain, the process of conducting an IE study is “rather like grabbing a ball of string, finding a thread and then pulling it out” (p. 755). Data analysis begins in the planning stages of the study and takes place throughout the entire study. Consequently, institutional ethnographer often decided on each step in their studies based on the last step (or what they have already discovered).

Discovering the Research Problematic

Although there is “no ‘one way’” to conduct an IE study, most institutional ethnographers begin by discovering the research problematic (Stooke, 2010). The research problematic “is a territory to be discovered” in the early stages of entering the field; and it arises from disjunctures between people’s actual experiences and authorized explanations of their experiences (Smith, 1990, p.4). Rankin (2017) describes the research problematic as “key to a coherent analysis in IE” and recommends using the problematic to “[open] up the scaffold though which to analyze disparate goings on that, at first do not seem to be connected.” The researcher discovered the problematic by reading and re-reading the transcripts of the interviews for differences between “knowing something from a ruling versus an experiential perspective” (Campbell & Gregor, 2004, p. 48).” The research problematic helped the research choose among the threads and to handle the emerging data.

Two Types of Data

Institutional ethnographers go between data collected at two different levels (Dalmer, Stooke, & MacKenzie, 2017). The researcher started by collecting entry-level data from the RNs and LPNs on their units (the local setting). From the preliminary analysis of this data, the researcher learned where to look for data positioned outside the local setting (the translocal setting). Analysis of both the locally and translocally generated data enables institutional ethnographers to see “how people’s everyday lives may be organized without their explicit awareness but still with their active involvement” (Campbell & Gregor, 2004, p. 17).

Strategies for Data Analysis

The researcher kept in mind that each informant participates – either knowingly or unknowingly – in the ruling relations that shape their experiences. The researcher took “notice” of informants’ uses of “authorizing language” or language and concepts that were imported from other texts and discourses (Rankin, 2017). This helped the researcher tease out the ways the informants’ descriptions of their experiences were embedded in ruling relations. The researcher read and re-read her informants’ transcribed interviews, which she imported into NVivo. She used NVivo’s notes and query functions to highlight uses of “authorizing language” and add comments.

Rankin (2017) describes several strategies institutional ethnographers use to begin managing and working with their data, including “indexing” and “mapping.” The researcher used “indexing” early in her data collection and analysis to create a “cross-reference” for linked work processes and texts (Rankin, 2017). The researcher noted topics that were frequently discussed by the informants and created folders for each of these topics. The researcher “indexed” all data (written descriptions of work processes and texts) related to these topics in the folders. The research problematic guided the researcher towards certain folders; and what was inside these folders became the ends of the analytic threads the researcher traced to untangle how the RNs’ and PNs’ work was organized beyond their units. The researcher used mapping midway through her data collection to track ruling relations. According to Rankin (2017), the goal of mapping is to lay out a display of what is happening (a map), either in words or diagrams, that describes the features of the social practices and their respective material forms and relationships.

The researchers' mapping work included a diagram that plotted out the various texts that organized the RNs and PNs daily lives.

Ethical Considerations and Funding

Ethics approval for this study was obtained from both the University of New Brunswick (UNB) and the local health authority (HHN). Informed consent was obtained from all informants and they were reminded that they were free to withdraw from the study at any time. This study was partially funded through a grant from the New Brunswick Health Research Foundation (NBHRF).

Findings

In this section of the paper, the author explores the research problematic and three specific analytic threads which emerged from the data: 1) RNs' and PNs' previous knowledge, 2) independent patient assignments, and 3) the work of the resource/charge nurse.

Problematic

It was not uncommon for the RNs and PNs to make comments like, "What we are doing works, why change?" or "Why do we have to do things differently?" Although these comments were light-hearted, they indicated frustrations and tensions, which revealed the disjunctures that eventually set the research problematic of the study. The RNs and PNs easily use authorized language, including words like "collaboration," "competencies" and "scopes of practice," to express their frustrations and to describe their everyday work. For example, some of the RNs and PNs talked about changes to their "scopes of practice" and how the ONTRACC model would make "collaboration" more difficult. As a problematic, there was a break between how these RNs and PNs

knew how to work together as “buddies” and how the ONTRACC model organized things differently. The disjuncture they experienced was about how the ONTRACC model challenged their current knowledge of their work, including their “scopes of practice,” “collaboration” and their patients.

The story the first author saw unfold was *how did the RNs and PNs transition to the ONTRACC model, and integrate the required changes into their practice?* As a problematic, this story contained the rupture between how the RNs and PNs knew how to work together to care for a shared assignment of patients as buddies, where they both participated in components of their assigned patients’ nursing care, and how the ONTRACC model organized things differently. When the RNs and PNs worked as buddies, their assigned patients were of varying levels of acuity; and the RNs and PNs worked interdependently. For example, the PNs checked patients’ blood glucose levels and reported the results to the RNs who then administered insulin.

The implementation of the ONTRACC model changed how the RNs and PNs worked together, and how they “knew” their patients. The RNs and PNs now had their own assignments of patients, who were now identified by the charge (SJRH) or resource (DECH) nurse as “more complex” or “less acute, less complex” to be assigned to the suitably qualified nursing professional (RN or PN). Although the ONTRACC model was supposed to make things run more efficiently, the RNs and PNs experienced it as a “shake-up” of their knowledge of their shared work processes. This was knowledge they had developed over time to ensure their patients’ needs were met and to “keep things running smoothly.”

Analytic Thread 1: RNs' and PNs' Previous Knowledge

Unit routines. The RNs and PNs had invisible or tacit knowledge, which they used to sequence and prioritize their nursing interventions. For example, in their interviews, the RNs and PNs often talked about things like how the hospital ran and when meal trays arrived. Many of the RNs and PNs used the term “unit routines” to describe this knowledge which kept things running smoothly. As one PN (DECH) explained,

I try to get as many people washed up before breakfast as possible. I find that that's a huge, 'cause I want them up in the chair for their meals, if I can get them up. The odd time, you know, sometimes you don't get to them and you don't get them up in a chair for breakfast but you know I try 'cause then x-ray comes and gets them for recheck x-rays and then physio comes and gets them up and there's always somebody in there half the time.

This PN knew their work, helping patients “up in the chair for their meals,” linked to the work of the dietary staff, the x-ray technicians, and the physiotherapists. They wanted to complete certain interventions before breakfast because they knew after breakfast the physiotherapists would need time with the patients. Figures 2 and 3 summarize the RNs' and PNs' descriptions of certain events, such as the arrival of meal trays, which often created the contours of the structure of their shifts. Their descriptions aligned with what the researcher observed in how typical shifts unfolded on the two units, and these figures give a sense of key nursing work processes on the units.

The RNs' and PNs' valued this tacit knowledge, which “wasn't written down in any one place.” As one PN (DECH) explained,

The [PN] that was orientating me was awesome, she left since but she was great and she had the same routine, so like it was good to learn from that because when you have a schedule you can fit other things in there. It was really helpful that they laid that out for me because then it kind of gave me a good flow of the unit or a flow of the day.

Several of the RNs and PNs previously worked on other units or ‘floated’ (i.e. sometimes worked on different units). Their descriptions about how things differed from unit-to-unit

emphasized how a deep familiarity with things like the timing of physiotherapy, the arrival of meal trays, or “who does what” is critical knowledge. For example, one RN talked about the inconsistencies between units in the timing of meal tray delivery, which made it challenging to monitor blood glucose, administer medications, and feed patients in a coordinated manner.

When the RNs and PNs worked together as “buddies,” before the implementation of the ONTRACC model, they shared in many nursing work processes. For example, PNs who completed assessments would check patients’ blood glucose levels, then report their findings to RNs. The RNs, who administered all the patients’ medications, administered insulin as ordered. The author was surprised by how frequently the “buddied” RNs and PNs talked about their organizing work. These RNs and PNs had a central, but relatively invisible, role in their organizing work which was considered routine by many, even though it required problem-solving and knowledge. As one PN (DECH) explained,

Normally it starts out with getting report together and, and then going out on the floor and doing vitals assessments, getting people up for breakfast, and getting blood sugars. And, then, after they’re all done eating, then going on, and - you know - doing bed baths, and any other sort of tasks like dressings or things like that. Then, in the afternoon, you’d have ins and outs, other vitals that we might have, you know, for rechecking or just like TID [three times daily] vitals or anything of that sort. And then, that would normally be when post-ops and admissions start showing up because that, I mean OR times in the morning will get out in the afternoon.

This “what happens when” knowledge had developed between them overtime, to accommodate their breaks and ensure they got everything done by the end of their shifts.

Although the ONTRACC model was promoted through a managerial discourse of “optimization” and “efficiency” its implementation disrupted the RNs and PNs established, shared nursing work processes. For example, the PNs no longer reported their patients’ blood glucoses to their buddy RNs and instead had to administer ordered

insulin to their patients' themselves, along with all their other medications. The PNs needed to learn some of the RNs' work knowledge and work processes, such as how to get a missed or lost medication dose from the hospital pharmacy. Although preparation for the ONTRACC model happened over several years, for example many PNs completed medication administration education in 2015, it was implemented over several months and the PNs needed to adapt quickly.

Unexpected Situations. After the implementation of the ONTRACC model, the RNs and PNs needed to reinterpret their own professional judgment about what should be done for their patients' care. When unexpected situations would arise, such as when the RN or PN needed to attend to unexpected or emergency patient needs, like severe pain, or when equipment was unavailable or not working, they no longer had an assigned "buddy" to attend to other patients or "get things back on track." One PN (SJRH) noted,

[Sometimes] I'm just off my game or whatever and my time management is not the greatest or sometimes... there is more care to this patient, and I don't get everything I want to get done before trays breakfast trays come. Then I fell behind.

Several of the RNs and PNs talked about how "feeling behind" made them feel "frazzled" or "overwhelmed."

The RNs and PNs knew each patient and knew what they needed to manage unexpected situations. One RN (DECH) explained,

We have to prioritize, you know, if somebody's having trouble breathing, somebody's having pain, somebody's nauseated, then we'll change things that way. I'll let [the PN] do the vitals assessments, then I'll give the medications based off [these] vitals and the assessments and the complaints or the concerns of the patients.

For example, when a PN told this RN a patient was in pain, this RN knew the PN could give the patient an ice pack, but he needed to administer any medication. This RN also knew he could ask the PN to complete certain work activities, like a dressing change on

another patient, so they would not get behind. The author noted in her observations that the RNs and PNs who had not yet fully transitioned to the ONTRACC model frequently checked-in with each other and adjusted their care activities regularly in consultations with one another throughout their shifts.

Competence. Other things, such as judgements about each other's competence, also influenced how the buddied RNs and PNs worked together. As a nursing leader, who is a director, explained,

RNs still walk around with you know at times talking about well I'm responsible for all that work that all those people do, or I've got 12 patients on my assignment even though there is a [PN] carrying half of that assignment... Some of its drama, but some of it is a pure lack of understanding around peoples' roles, responsibilities and accountabilities.

The buddied RNs and PNs, however, understood each other's "roles, responsibilities and accountabilities" in the context of their "organizing work." Instead, they talked about how each others' competence, which seemed almost as important as unit routines or professional title (or scope of practice) in determining "who does what." As a RN (DECH) explained,

Like, sometimes I might go and do the assessments and vitals myself or even go after to kind of recheck just to kind of have my own baseline. It does depend on who I'm paired up too, today I was paired up with "X" and I trust [this PN] a hundred percent, [they are] super diligent, I worked with [them] many times. So today, I won't need to do that because I trust[their] assessments completely, [their] a great professional.

This RN's judgement about their buddy PN's competence was grounded in the PN's everyday behaviors, such as showing up on time and being "super diligent," as well as professional competence. This RN later explained how they trusted this PN to recognized emergency patient needs, such as altered levels of consciousness, and responded quickly – keeping the RN "up to speed." This RN knew what they needed to practice differently

depending on who they were buddied with, what they knew about the patients and what was actually happening.

The RNs and the PNs experienced tensions when they were “buddied” with someone who was not competent, meaning they needed to assume more patient care responsibilities. For example, if this RN did not think their ‘buddy’ was competent to complete the patients’ assessment, she would re-do them during the shift. The RNs’ workload increased, and nursing care was duplicated.

The implementation of the ONTRACC model coincided with recent rotation changes. As one RN (SJRH) noted,

Yeah. So you probably, like noticed, I haven’t really interacted much with the [PNs]... I’m not really close with them [the PNs who are working today] at all, like the [PNs] that I [regularly] work with, like for all my shifts, like I’d be more inclined to go, like ask them for help just cause I’m closer with them, know them more – if that makes sense.

This RN was not working with the PNs they knew and did not interact with many of the other RNs or PNs. This raised questions for the author about recent rotation changes which meant the RNs and PNs (on both units) were no longer working with the same people. Previously, most of the RNs and PNs often worked with the same group of nursing staff, who either followed or partially followed the same rotating shift schedules.

Now, as one RN (SJRH) explained,

So our rotation, before you would do like two days two nights or three days one night and you would have your, your full partner and you would have half partners with you, but now we’ve changed that you’re not going to have a full partner, so you do like you could do two days two nights, you could have three days one night, you may have four off you may have five off. So you’re going to be working with everyone.

These rotation changes were implemented, separately from the ONTRACC model, with the institutional goal of providing improved “nursing coverage.” A nurse manager explained,

The goal of the ‘Kronos Optimization Scheduling,’ which is a separate project that has been ongoing for two or three years now ... was to start to combine vacant part-time positions to create full-time positions to be able to offer new grad nurses or nurses returning from other provinces full-time positions or even international recruitment. I mean, nobody is going to come to Canada for a part-time position.

These changes may have had an opposite effect. As one RN noted,

It’s the people that keep you at work and I think people are going to lose that family feel and then they’re going to be like you know if I’ve had a bad set or something, well then I’m going to look elsewhere, I’m not going to stay here, I’m going to go, nothing’s keeping me here so you know what I mean, I think that’s, it could be damaging in a sense.

Without “that family feel,” nursing staff may feel less committed, to the extent that they are less likely to stay in their jobs and keep working under pressured circumstances.

Shaking things up. The implementation of the ONTRACC model “shook-up” their unit routines and, in doing so, changed their relationships with each other and subverted their knowledge of their work. For the RNs and PNs, previous unit routines and buddied assignments provided some predictability, comfort, and stability. Some of the RNs and PNs found the ONTRACC model was actually organized in a way that prevented them from working together – or to work more in isolation (through independent assignments). As one RN (DECH), explained,

They also keep telling us we’re going to learn work collaboratively which I think you saw today, we do pretty good here on our unit, so we’re kind of like what...so the suggestions that they’re giving to us or the examples they’re giving to us of what is going to change, in our view, is not collaborative, that’s separating us, right?

This RN’s (DECH) experiential knowledge of “working collaboratively” was tied up in type of assignment (buddied) she worked in. The ONTRACC model challenged this knowledge, and although authorized explanations of the ONTRACC model emphasized how it would “enhance and improve the process of collaboration and effective decision-making in clinical settings” (HHN, 2018, p. 13), this RN (DECH) knew that it was

disrupting her ideas about collaboration – as the term was moved into its conceptual home within the institutional discourse and embedded into the new model of care.

The analytic thread of the RNs' and PNs' previous knowledge led to numerous clues to the other two analytical threads, which focus on the RNs and PNs' experiences after the implementation of the ONTRACC Model. These threads included independent patient assignments, and the work of the resource (DECH) and charge nurses (SJRH).

Analytic Thread 2: Independent Patient Assignments

One nursing leader (RN), a project coordinator, noted the purpose of the ONTRACC model was to, “[look] at patient care through a new lens and [to see] how autonomy and working to the full scope of practice would be beneficial both, you know, for patients, your organization and employees.” The ONTRACC model organized the RNs and PNs to work more isolation, with independent patient assignments. When the RNs' and PNs' talked about these independent patient assignments, their understanding was embedded in the rhetoric of “scopes of practice” and “who they were allowed to care for.”

When the author asked the RNs and PNs about their independent assignments, the RNs and PNs used the language of chronicity and acuity to describe the differences between their patient assignments. For example, one PN (SJRH) explained PN-patient assignments,

So a lot of our patients, as [PNs], they're chronics, so they're stable... [During shifts,] they usually sleep, were incontinent, went to the bathroom... that kind of thing. Maybe they're medicated for pain, that usually seems to be the norm, usually sometimes they're fine, they sleep, they're good. A lot of the, sometimes there's other issues, but if there is a lot of other issues ... then sometimes that person will end up going to an RN anyway.

This PN (SJRH) used the “authorizing language” of “chronics” and “stable” to describe these patients. This language was imported from practice guides and policies to categorize RN-patients and PN-patients. For example, a practice guide co-written by NANB and ANBLPN (2015) stated “RNs, because of their greater depth and breadth of foundational knowledge, care for patients with more complex care needs and less predictable outcomes”(p. 7); and a health authority policy, stated “[f]or patients who are less predictable and more complex, more RN intervention will be needed, for patients who are more predictable and less complex, PNs may practice more independently.” (Horizon Health, 2018, p.13).

Complex or predictable. Patient categories of “complex” and “predictable” created tensions and frustrations when the authorizing explanations of “more predictable, less complex” were at odds with their RNs’ and PNs’ experiential knowledge. Some PNs were frustrated with how certain patients were “complex,” and always assigned to RNs; particularly with their previous knowledge of caring for all patients in buddied assignments. For example, post-operative (post-op) patients were nearly always assigned to the RNs when before the PNs worked with the RNs to care for these patients. One PN (SJRH) described how they “miss[ed]” being involved in the care of “complex” patients.

But I miss the, the, receiving the patient from the OR - you know doing that kind of stuff, working with the IVs and like you know accepting them as up to the floor with the RN... But other than that there’s really, I’m pretty much working to my full scope, I feel like that’s the only thing I really miss is just kind of working with that fresh, like the fresh post-op patient.

They explained how they were sometimes assigned to care for patients prior to minor, same day procedures, such as a kidney stone removal, but these patients were usually re-assigned to a RN when they returned to the unit.

The PNs (SJRH) understood “the line needs to be drawn somewhere,” but found it challenging when they could do many of the activities required to care for post-operative patients and had previously been involved in their care. A RN noted,

[The PNs] don't feel competent enough at times anymore because, when you were buddied, you would have, they would be with you with the post-op, so you may do like the initial assessment but then they would go and do the hourly checks on them 'cause you would be busy doing something else, right. Where now they never get a post-op, and I think that, they don't like that, just in the fact they don't feel like they're being treated as if they're not competent when they're more than competent enough to do it. It's just that's how it's been, like the RN's, that's just, we were told that's how it's going to be, and you know what I mean.

Most of the post-operative patients were recovering from scheduled hip or knee replacement surgeries and were usually discharged a few days later. The care activities of these patients were arguably considered “routine” by the RNs and were guided by standardized “care paths” forms. These forms coordinated the care of these patients, with checklists of sequenced “desired outcomes,” such as “up in chair” the day of surgery and “ambulate three times” on post-op day two (Horizon Health Network, 2018). A nursing leader, who is a program coordinator, perceived “the role for the RN is going to be the care planning and getting back to you know from the time of admission start you know taking a look at where the patient wants to go, with the patient and family input as well, so that, that's huge.” The care path forms standardized care planning for these patients recovering from hip or knee replacement surgeries. As one RN noted,

Like it's a lot, we do a lot of post-ops right, so everyone's real goal is I want to be pain-free and I want to be able to move right, where before at home they were in a lot of pain, they were in like that acute chronic pain and they weren't able to mobilize that they would want to.

The first few hours after the patients returned from the OR, their care was fairly routinized.

The RNs and PNs experience less tension when patients more clearly fell into the category of “complex.” For example, a PN “wasn’t allowed” to do the monitoring and medication checks required for patient-controlled analgesia (PCA). Consequently, these patients were assigned to RNs. A PN (SJRH) described what happened when she realized she was assigned a patient with a PCA.

But as soon as I started looking up that patient, I saw that they had a PCA. I said, they have a PCA, and then they go like, ‘oh so then they changed the assignment’ and then they swapped it out with [another patient], and the RN took the one with the PCA and I took the one that the RN had that was stable.

This PN experienced less frustrations when she knew she could not complete the patients’ care activities.

Although the PNs’ (SJRH) patients were “Less complex, more predictable, low risk for negative outcomes” (NANB & ANBLPN, 2015, p.15), they frequently had “heavy” care needs such as the “nursing home patients.” The PN’s patients were often time consuming and physically demanding to care for because they often required more assistance with toileting, bathing, and dressing. These categories meant that the PNs dealt more with the “heavy” nursing work, such as toileting, which potentially undermined collegial relations between RNs and PNs. As one PN explained,

It's nice when a RN has somebody that we always have ‘cause we’re ... so used to doing all that total care type stuff with them, so it's kind of nice to know that you know regardless of what your title is you can still have that patient.

This PN explained how it is nice to know that RNs are not above or absolved from this type of work. These patients often had multiple medical diagnoses, such as diabetes, heart failure, Alzheimer’s disease, and dementia; and their care was not guided by standardized “care paths.” They were often admitted for longer stays and had challenging psychosocial needs. These patients were ones who would benefit from the “enhance[ed] RN role and

... the elevat[ed] expectation around leading care teams, coordinating patient care and developing nursing care plans.”

Analytic Thread 3: Work of the Resource or Charge Nurse

Many of the practice and policy documents, such as the practice guide co-written by NANB and ANBLPN, defined the terms “complex” and “predictable” with variability of interpretation to fit with different practice settings/contexts. One nursing leader noted, “there’s a lot of people that would feel very comfortable if they had a list that they could check off of as it relates to scope of practice.” This variability of interpretation meant decision-making about “complex” and “predictable” often fell to the units’ charge (SJRH) or resource (DECH) nurses’ interpretation of “complex” and “predictable,” as they were responsible for making the patient assignments. One nursing leader, a director, explained how patient assignments were now,

“... a more complicated conversation - ‘cause it's not so black and white, and it’s starting to challenge even our resource nurses and charge nurses around how they do assignments, who gets assigned to who. So lots of work for us to do in terms of dialogue and understanding some of the nuances of the various units, but this is a big piece of it.

Previously, when patient assignments had been created for RN and PN ‘buddies,’ the ‘buddies’ were usually assigned to several rooms in close proximity with each other. According to this nurse leader, an educator, “You can’t just assign ‘the back wall’ anymore. If the assignment isn’t good, it isn’t going to work. It needs to be the right patient for the right [nursing professional], you know?”

Good patient assignments. “Good” assignments, where patients did not need to be re-assigned, became more important after the implementation of the ONTRACC model; and bad assignments were a source of frustration and tension among the RNs and PNs. As one PN who worked in an independent (SJRH) assignment explained,

But if someone's not doing well – then they should be with an RN. Often what they'll do is they'll ... swap out a patient, because my patient kind of went down the tubes, so we need to switch it up. But sometimes if that will even happen like at 3:30. At 3:30, there's a new assignment right. So if a patient wasn't doing well throughout the day, at 3:30 the charge nurse will put that patient with a RN.

With independent assignments, when the assignments were “good” and the right nursing professional was assigned to care for the right patient, they did not need to re-assign patients later. If a PN's assignment was not “good,” if their patient deteriorated, then that patient would be re-assigned to a RN. The RN would then need to quickly “get up to speed” on a patient they do not yet know while attending to the patient's urgent needs. The RN's increased workload also likely impacted care of their other assigned patients, some of which would be re-assigned to the PN.

The RNs and PNs sometimes experienced frustrations and tensions when the assignments were not good. The patient assignments were no longer geographically clustered, presenting some problems as the RNs and PNs moved from one end of the unit to the other, which was observed when shadowing the RNs and PNs. As one RN (DECH) explained,

I go into the room [a four bed room] and I don't have very much time 'cause I know I have like so many other things I need to do. So, ... like I always feel like I'm in a rush and you know apologizing, like I'm sorry like I have to go, or like I'll be right back, and then when patients like get frustrated about you know the wait or something and like you can, you get where they're coming from.

This RN also described how they were only looking after one patient in a four bed room, but they could not “ignore” the other 3 patients or tell them “sorry, you are not my patient today.” Often when they entered the four bed, they ended up doing things like getting glasses of water for the other patients in the room.

Organizing work. The organizing work that used to happen between an RN and PN assigned to a group of patients have also been changed. The resource

nurses (DECH) and charge nurses (SJRH) were much more heavily implicated, as both the RNs and PNs relied more on the charge and resource nurses, or clinical nurse specialists (CNS), for advice or to answer questions about specific patients' care needs. As one PN (SJRH) explained,

I always go to the charge nurse if I think that there can be a change of some sort.... She knows all the patients. So, you know, [the charge nurse] knows what is going on with everyone's patients. I always go to the charge nurse or [the orthopedic CNS] if, 'cause there's both of them there, usually, so if it's an ortho patient sometimes I'll just go to [the orthopedic CNS] instead of the charge nurse, because they talk.

It made sense to this PN to go straight to the charge nurse, who had some "knowledge" their patients rather than explain the scenario from scratch to another nursing colleague (RN or PN). The charge/resource nurses received full "shift reports" on all the patients. As a holder of some knowledge on every patient, the charge or resource nurse knew from reports, charts, and other records what was going on with each patient. A charge/resource nurse explained,

Yeah, I'm more or less putting out small fires, if something's going on, then I'm the one calling the doctor to say, this is going on, what, what do you want me to do about this... so if anything's going on you're going in to assess the patient and then you're calling the doctor to find out what they want done or if they need to come up and see them.

Importantly, the charge (SJRH) or resource (DECH) nurses were not directly involved in the patients' assessments or care; and their "knowledge" was a different type of knowledge than the more intimate knowledge the RN-PN buddies had with their shared patients.

Working together. The RNs' and PNs' talk was infused with terms like "collaborative practice," which carried institutional traces; and, in doing so, they activated certain texts. For example, a RN job posting listed the "ability to work within a collaborative practice with other nursing personnel" as a required qualification for the

position (HHN, 2019). Most of their “collaborative practice with other nursing personnel,” for example consultations about deteriorating patients, now happened with the charge nurse.

Although the RNs and PNs were still visible to each other on the units, they were not assigned to the same patients. The RNs and PNs did “help each other out,” for example getting other patients glasses of water, answering call bells, but they did not frequently update each other or discuss their patients. As one RN (SJRH) explained,

You have to speak up and say I need help, I need you, can you do this while I do that, or I'll hang this for you if you go do a set of vitals for me on this person, that's kind of the, the key is to know when to ask for help.

The RNs and PNs did not know each other's patients, so they needed to “speak up” more when they needed help. The RNs and PNs sometimes discussed patients who stayed on the unit for a long time. Oftentimes, all the RNs and PNs had been assigned to care for these patients at some point, were familiar with their backgrounds and developed relationships with them and their families.

Conclusion

Nursing care delivery models, like the ONTRACC model, organize how RNs and PNs work together to care for their patients. This study was guided by IE; and explicated how RNs' and PNs' worked together during the implementation of the ONTRACC model on two orthopedic units. Institutional ethnographers begin from the standpoint of people, living their everyday lives, rather than from within established discourses which are aligned with society's ruling institutions (Grahame, 1998). Different people in a situation will have different experiences of it and there are different versions of every story; and every story holds traces of its social organization (Campbell & Gregor, 2004). Taking the

standpoint of RNs and PNs exposed a problematic (Smith, 1987) that became visible through the tensions experienced by RNs and PNs, revealed in the observational data and interviews.

The story the author saw unfold was more than a story about RNs and PNs unhappy about changes on their units. As a problematic, there was a rupture between the RNs and PNs previous knowledge of working together as “buddies,” which had developed over time and “[kept] things running smoothly,” and how the ONTRACC model organized things differently. Although authorized explanations of the ONTRACC model emphasized how it would “enhance and improve the process of collaboration,” some RNs and PNs found the ONTRACC model actually organized them so they worked more in isolation (through independent assignments) (HHN, 2018, p. 13).

With independent assignments, it became more important for the charge/resource nurse to make “good” assignments or to assign the right nursing professionals to the right patient. If a PN’s assignment was not “good,” or a patient became “complex,” then that patient would be re-assigned to a RN, which caused frustration. Fortunately, this did not happen frequently. Future related studies on units where unexpected or emergency care needs arise frequently should be considered. Although both orthopedic units were fast paced, the nursing care of many of the “complex” patients was predicted and guided by clinical pathway documents and many of the “stable” patients were waiting for nursing home placement. The implementation of the ONTRACC model may look very different on units where unexpected or emergency patient needs arise frequently, making it harder for the charge and resource nurses to make “good assignments.” On units where unexpected/emergency patient needs arise frequently, there are likely frequent re-

assignments of patients. Frequent re-assignments would likely subordinate holistic standards of nursing care.

MacKinnon et al. (2018) argue readers of IEs need to consider the context of studies to determine the transferability of the findings themselves. The RNs and PNs standpoint informants worked in a specific context and their experiences may not be representative of other RNs and PNs. The data was also collected during a time of transition and captures the RNs and PNs adjustment to the ONTRACC model.

Importantly, however, many of the texts are beyond the RNs and PNs' units (the orthopedic units) and may have relevance to other contexts. Consequently, this research has implications for how nursing leaders continue to implement the ONTRACC model throughout the province or how other, similar nursing care delivery models are implemented in other settings.

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Figure 1

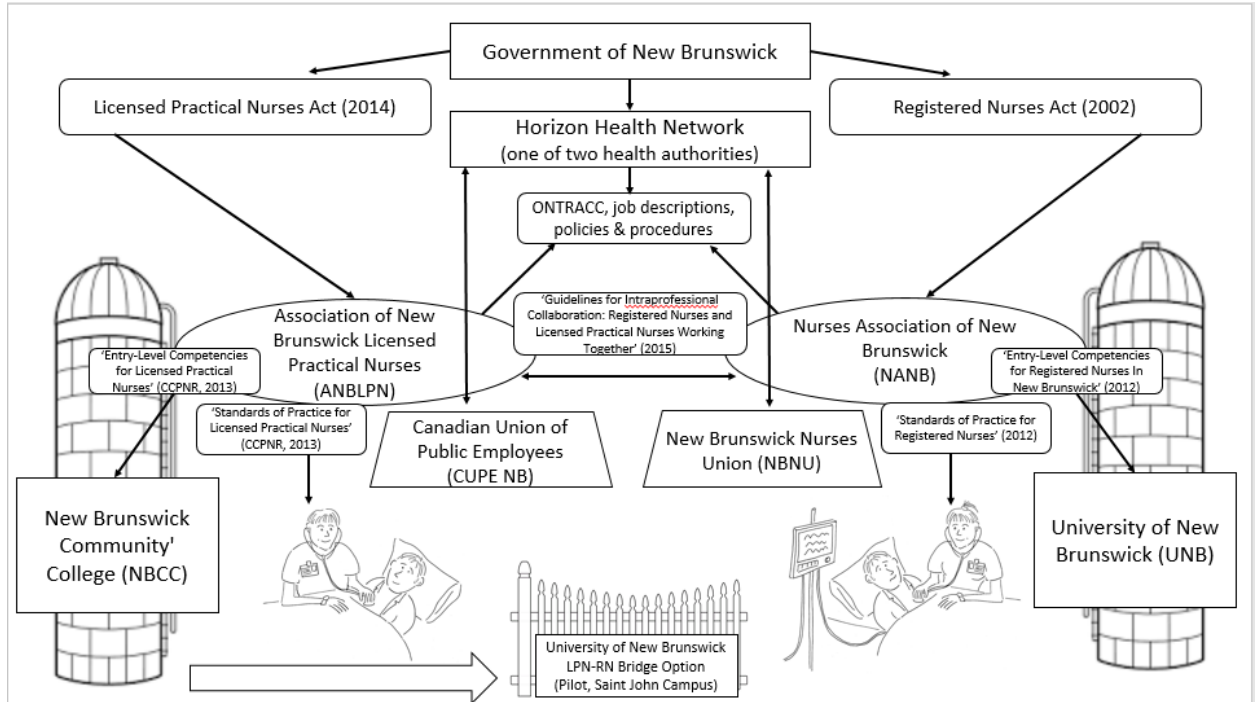


Figure 1. Institutions and texts that organize nursing work in New Brunswick. Many different institutions, including: the provincial government, regulatory/accrediting bodies, health authorities/other employers, labour unions, universities/colleges, organize the work of frontline RNs and PNs in New Brunswick. These institutions are linked together through a chain of different ‘texts,’ including: legislative acts, mission/vision statements, and policy/guidelines documents.

The Government of New Brunswick, under the Nurses Act (2002), gives NANB the authority to establish, maintain and promote the ‘entry level competencies’ and ‘standards of practice’ for RNs and NPs in the province. In addition to setting licensure requirements, NANB accredits all baccalaureate nursing (BN) programs offered in the province (through UNB and Université de Moncton) to ensure graduates meet these ‘entry-level competencies.’ Similarly, the Government of New Brunswick, under the LPN Act (2014), gives ANBLPN the authority to regulate practical nursing by setting/maintaining licensure and education requirements (NBCC and Oulton College). The Government of New Brunswick has two health authorities to manage and deliver hospital and other healthcare services within the province. Two different unions (NBNU for RNs and CUPE NB for PNs) engage in a collective bargaining process with these health authorities to negotiate wages, working conditions, hours of work and job security.

Tables 1 & 2

Table 1

Standpoint informants (frontline nursing professionals, n = 14)

Site	Informants	# years employed as RN/PN	# years working at current site	# years on current unit
Site A: DECH	RN (4)	< 5 years (1)	< 5 years (2)	< 5 years (2)
		5-10 years (3)	5-10 years (2)	5-10 years (2)
	PN (4)	< 5 years (4)	< 5 years (4)	< 5 years (4)
Site B: SJRH	RN (4)	< 5 years (1)	< 5 years (2)	< 5 years (2)
		5-10 years (2)	5-10 years (1)	5-10 years (1)
		11-15 years (1)	11-15 years (1)	11-15 years (1)
	PN (2)	5-10 years (1) 15-20 years (1)	5-10 years (2)	5-10 years (2)

Table 2

'Other' informants (nursing leaders, n = 8, other, n = 2)

Role	Other informants	# years employed as RN/PN	# years in current role
Nursing leaders	RN (6)	< 5 years (1)	< 5 years (4)
		15-20 years (1)	5-10 years (4)
		20-25 years (1)	11-15 years (1)
		> 25 years (5)	
	PN (2)	10-15 years (1)	< 5 years (1)
		> 25 years (1)	5-10 years (1)
Other	Other (2)	N/A	< years (1) 5-10 years (1)

* RN who previously worked as an PN included in RN group

Figures 2 & 3

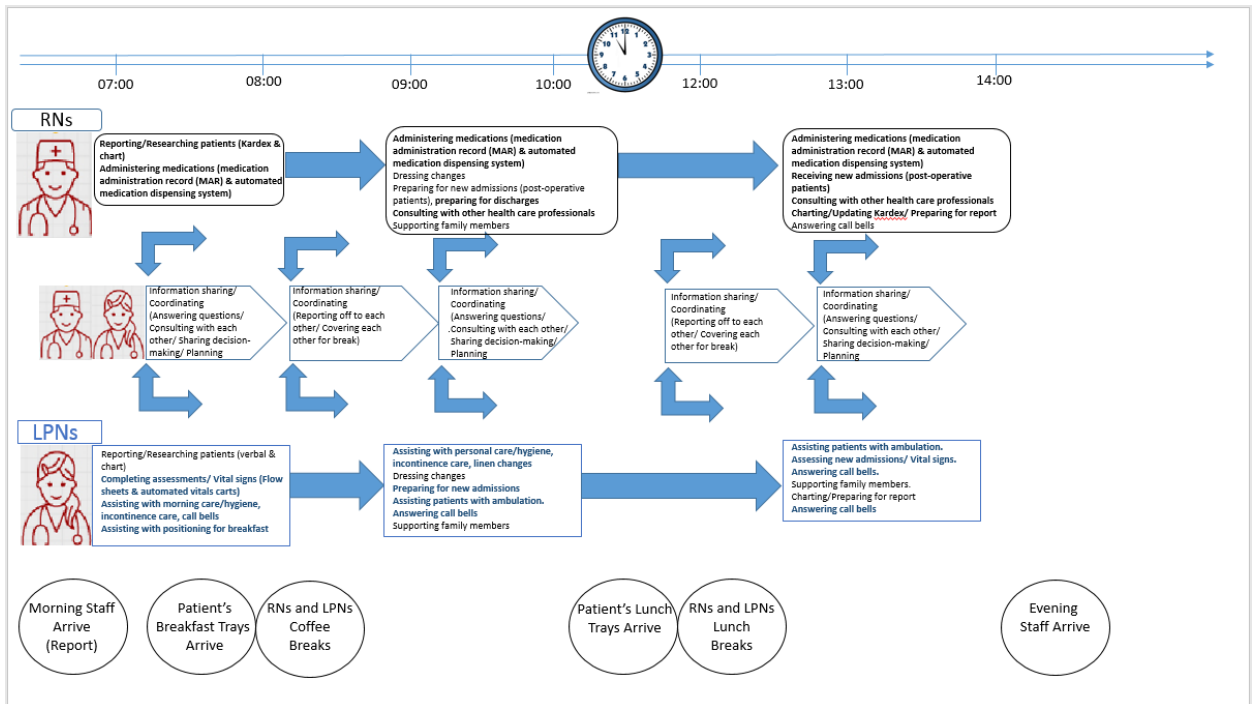
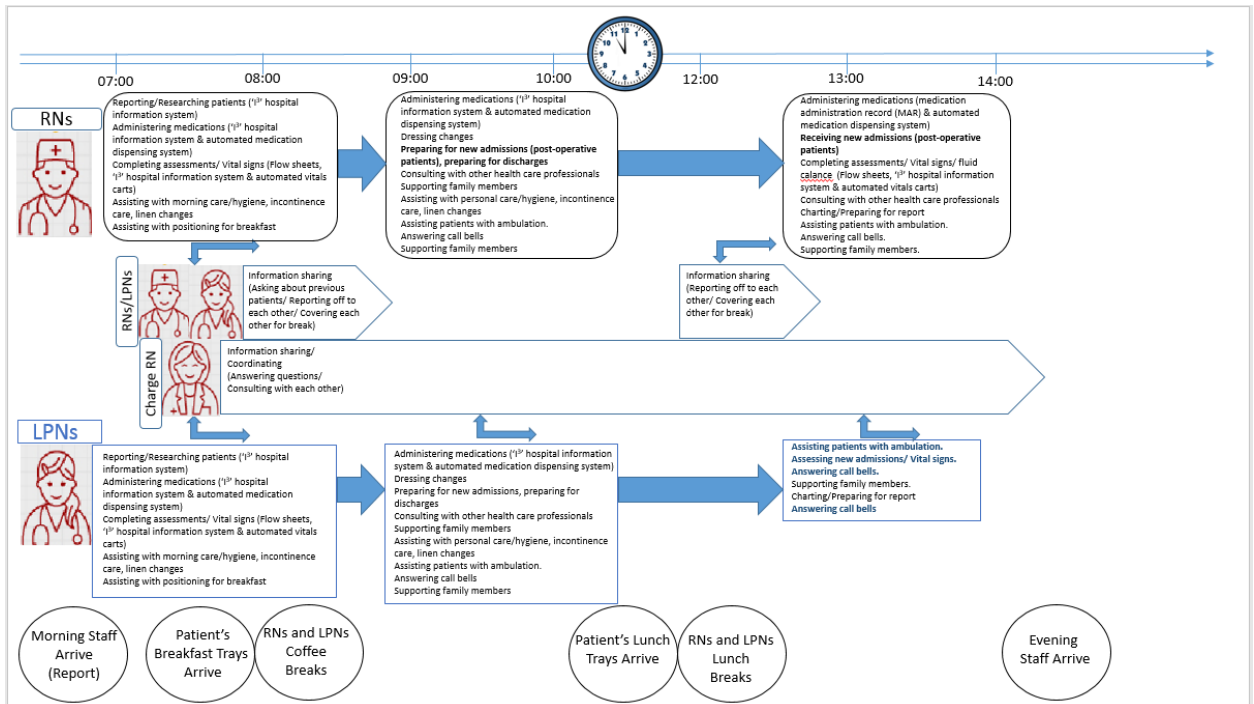


Figure 2. Unit “routine” of RNs and PN working in a shared assignment. Although there were some variations in the descriptions/observations of the unit routine, this figure gives a sense the recurrent tasks, like completing assessments, shown in the square boxes, which the majority of the RNs and PNs described during their interviews or were observed on the unit. Most of the RNs and PNs described their work both in terms of the tasks they completed (square boxes), or events, like the arrival of breakfast trays, shown in the circles. Often these tasks/events related the RNs and PNs activities to the activities of other healthcare professionals and hospital staff. For example, the arrival of the breakfast trays integrated the RNs’ and PNs’ activities with the activities of the dietary staff. In a sense, such events often created informal deadlines for the RNs and PNs. For example, the PNs often talked about how they wanted to complete their patients’ assessments before the breakfast trays arrived.

The RNs’ tasks and PNs’ tasks followed unit norms rather than the recently extended/expanded nursing ‘scopes of practice.’ For example, the RNs administered all the patients’ medications and the PNs completed vital signs and did more personal care/hygiene and incontinence care. Although the RNs and PNs completed many tasks independently, these tasks were often integrated, and the RNs and PNs needed to share information and coordinate their activities with each other. For example, the RN would ask the PN about a patient’s blood pressure prior to administering cardiac medications, or the PN would ask the RN to administer opioid (narcotic) pain medication, if requested by a patient, prior to personal care/hygiene.



Note: I3 is the clinical information system used at SJRH. All healthcare professionals (including nursing staff) use the I3 system to enter/view orders, alerts and test results

Figure 3. Unit routine of RNs and PNs working in independent assignments. The RNs and PNs worked more autonomously in their independent assignments and followed their extended/expanded ‘scopes of practice.’ Most of the RNs and PNs still described their work both in terms of the tasks they completed (square boxes), or events, like the arrival of breakfast trays, shown in the circles. However, they also talked about ‘types’ of patients, like ‘post-ops’ and ‘chronics’ – or ‘RN patients’ and ‘PN patients.’ The RNs and PNs worked more closely with the charge/resource nurse to address any concerns than with each other. The charge/resource nurse often negotiated and liaised with the surgeons, and made suggestions about patient situations.

Chapter 6: Integrated Discussion and Conclusion

This chapter is a discussion of further insights from the study findings, which were reported in Chapter 5. To set the context, I summarize the findings from Chapter 5 and consider other emerging threads or accounts from my data not previously presented. Finally, I discuss the limitations of this study, study rigor and trustworthiness, and implications for nursing practice and future research.

Study Findings

In chapter 5, which was written as a manuscript for publication, I described the social organization of RNs and LPNs work with each other to care for their patients. According to authorized views, the intent of the ONTRACC model was to “optimize” both the roles of RNs and LPNs, “enhance and improve” collaboration, and support holistic standards of nursing care (HHN, 2018, p. 13). How the implementation of the ONTRACC model actually “happened,” however, was contradictory to these views. The implementation the ONTRACC model did not “optimize” the RNs and LPNs roles, instead it “shook-up” the RNs’ and LPNs’ their knowledge of how/when things happen on their units (their “unit routine”) which was what kept things running smoothly. The RNs and LPNs did not find they were organized to work more collaboratively, but instead found they were organized to work more in isolation. They no longer shared patient assignments, so they no longer regularly discussed their patients or updated each other throughout their shifts. Finally, in some ways the categorization of patients of either “complex” (assigned to RNs) or “predictable” (assigned to LPNs) actually subordinated holistic standards of nursing care. When the patients of LPNs were not “predictable” and

deteriorated, they needed to be re-assigned to RNs. The RNs, then needed to quickly “get up to speed” to attend to the urgent needs of patients they did not know.

Unexplored Threads and Future Research

There were several other threads or accounts that came out during my fieldwork that I did not explore in depth. This is common for an IE study because it is impossible to explore all the threads within the time constraints of a study. These unexplored threads may be areas for future research. They are described below and include: nursing hierarchies, nursing workload, and patient-centred care.

Analytic Thread 1: Nursing Hierarchies

There has been considerable discussion about social hierarchies within and between different health professions within scholarly and professional discourses. For example, Feng et al. (2017) found, around the world, both the prestige and income of nursing professionals are far lower than those of other healthcare professionals, such as physicians and pharmacists. Within nursing itself, there seems to be consensus that RNs are positioned above LPNs. Although many factors have been identified as contributing to this social hierarchy within nursing (for example, social capital variables [Brown & Jones, 2004], professional socialization [Nisrabadi, Lipson, & Emami, 2004] and scope of practice [Nelson et al., 2014]), my discussion here focuses specifically on things that emerged from the IE study findings. These factors include: (a) seniority and (b) the collective bargaining process.

Seniority. In both scholarly and professional discourses, nursing seniority has been associated with positioning within the nursing hierarchy (Brown & Jones, 2004); and tensions related to seniority have been conceptualized as “intraprofessional conflict,”

“lateral violence,” and “workplace bullying/incivility” (Bambi et al. 2018; Bennet, 2015; Boateng & Adams, 2016). Within New Brunswick, RNs and LPNs are represented by different labour unions and have different collective agreements with the two provincial health authorities (Canadian Union of Public Employees and Treasury Board, 2017; NANB and Board of Management, 2015). Both RNs and LPNs accrue “seniority” that is based on the length of time they are employed with either of the provincial health authorities; and through both collective agreements, seniority provides specific rights for those who have more years of service. For example, there are provisions in both the RNs’ collective agreement and the LPN’s collective agreement (seniority language) that give senior RNs or LPNs more preference when requesting things such as time off or a change in position (Canadian Union of Public Employees and Treasury Board, 2017; NBNU and Board of Management, 2015). Although seniority rewards employees for their loyalty and years of service, it also contributes to a social hierarchy or “pecking order” where some nursing staff enjoy better remuneration or benefits than others who have the same title, job description and responsibilities.

In my interviews, some of my standpoint RNs and LPNs described how seniority caused workplace tensions/conflict. According to one RN, “seniority is everything.” Seniority can be problematic because it can devalue the specialty education and personal merits of some of the newer RNs and LPNs, and the experience of RNs and LPNs who worked in non-unionized positions. For example, a focus on seniority may mean senior nursing staff feel they have authority over newer RNs or LPNs. One RN explained how they found more senior RNs and LPNs sometimes expected newer nurses to “prove themselves.” They described how more senior RNs and LPNs, “want to know you’ve

gotten your feet wet and spent some time in the trenches. They want to know you know what you're about." This RN expressed how they found this frustrating because, although they were new to the orthopedic unit, they had, "floated and ... seen a lot in a short time." Alternately, senior nursing staff may also feel wary of newer RNs or LPNs who completed their educational programs more recently. For example, newly graduated LPNs completed a medication administration course as part of their educational program while other LPNs needed to take a course to upgrade. One LPN described how a senior LPN mocked their interest in medication administration and excitement about independent assignments calling them a "wannabe RN."

Collective bargaining. The RNs and LPNs also talked about how the process of collective bargaining also contributes to workplace tensions and conflict. Some of the RNs expressed concern over issues like job security and were alarmed by the expanded and extended scopes of practice among the LPNs. One RN talked about how it was, "kinda scary how much LPNs can do." For example, the timing of two recent NBNU (2013) campaigns, "I am a Registered Nurse" and "There is no Substitute for a Registered Nurse" coincided with RN-layoffs and expanded or extended scopes of practice among the LPNs. These campaigns were about both "leadership and taking back the pride in being a registered nurse" and "job security" (NBNU, 2013, p. 1). Some perceived these campaigns, particularly the "There is no Substitute for a Registered Nurse" campaign, as disrespectful to LPNs.

Every few years, bargaining units from NBNU and CUPE separately negotiate new collective agreements with the provincial health authorities. During my interviews, the standpoint RNs and LPNs shared many of the same concerns, including workplace

safety, heavy workloads, stagnant wages and job security. The goal of collective bargaining is to win something that is controlled by another, usually the employer. When employees, who want the same things (improved working conditions, wage/benefit increases, and job security), are represented by different unions, this can lead to an “us versus them” mentality. Even when a desired contract is achieved, long-lasting adversarial relationships may develop with the employer or with the members of other unions.

Future research on seniority and the collective bargaining processes in New Brunswick may be beneficial, now that the ONTRACC model has been implemented throughout HHN. RNs’ and LPNs’ experiences of seniority may not fit with how seniority is laid out in collective agreements (for example, employees’ date of hire). A newly graduated LPN may not feel like their specialty education in medication administration is valued. A RN who worked outside of New Brunswick for many years may feel upset to have the same seniority as a newly graduated nurse. Such scenarios are not uncommon and may create workplace tension.

A study guided by IE could explicate what “seniority” means to RNs and LPNs. IE encourages researchers not to treat concepts like seniority as “already given” (Smith 1987, 156). Such a study could also explicate the ruling relations that organize the collective bargaining process. Knowing how the ruling relations currently reach into this process may provide insight into how to support a more collective nursing voice. As the boundaries between nursing roles become more blurred and not as easily differentiated as they once were, it may be beneficial for both RNs and LPNs to work together to promote

the interests of all nursing staff and advocate for better working conditions and opportunities for everyone.

Analytic Thread 2: Nursing Workloads

There is consensus within scholarly and professional discourses that workloads in acute care settings are heavy (Singer et al., 2016; Berry & Curry, 2016). Inadequate staffing levels have been reported as one of the contributing factors for such heavy nursing workloads. Some countries, including Australia, Japan, and California in the United States, have mandated staffing ratios as a way of addressing nursing workloads (Singer et al., 2016). Some researchers have found an association between mandated nurse-patient ratios with improved patient outcomes and financial savings to the health system by decreasing lengths of stay, adverse events and employee turnover (Berry & Curry, 2016). Other researchers and experts, however, argue mandated ratios offer a simplistic formula that does not take into account the numerous factors that impact the level of staff a patient should receive (Needleman et al., 2011).

In New Brunswick, there are no mandatory minimum staffing ratios for RNs and LPNs. New Brunswick hospitals do sometimes close units “because of overcrowding and understaffing” when it is “so bad health care in the hospital has been compromised” (Brown, 2019). Both NANB and NBNU drew attention to the issue of minimum staffing ratios during the 2018 provincial election, where they recommended these minimum ratios to party candidates (NANB & NBNU, 2018). No action to mandate minimum staffing ratios was taken, however, by the elected conservative government.

According to a Canada-wide study conducted by Singer et al. (2016), the nursing units in hospitals with the highest nursing staff-to-patient ratios are intensive care units,

with an average of one patient per nursing staff member. The nursing units in hospitals with the lowest nursing staff-to-patient ratios are long-term care units, with an average of six patients per nursing staff member (Singer et al., 2016). Surgical units are in the middle with an average of three patients per nursing staff member (Singer et al., 2016). In Canada, health care is a provincial responsibility, care levels and regulations vary across the country (Berry & Curry, 2016). In the current study, most RNs and PNs were assigned four patients each on both orthopedic units. According to one RN, being assigned three patients was a “very, very good day.”

In this study, the RNs and PNs talked about there never being “enough hands.” When the RNs and LPNs talked about their workloads they frequently described both their tasks and the limited time they had to complete them. They regularly explained how they were “busy” and needed to “keep moving;” and that just a few disruptions could make their days run poorly. Being busy influenced how the RNs and LPNs completed their work together. For example, one LPN described how they felt frustrated when they asks someone for help and they forget.

So, then I have to kind of go to them again and be like, are you going to do that or I can get somebody else to do it, and then they’ll be like, ‘oh I was going to, I just was doing this’ and then we just you know, so that can kind of get a little frustrating if you try to ask somebody else for a set of hands and then they forget which is perfectly fine ‘cause I’ve done it before too.

The RNs and LPNs heavy workloads reduced the time they had to communicate with or help each other.

The CNA’s (2017) “Code of Ethics” encourages RNs and LPNs to “advocate,” and use their voices to impact the nursing profession. RNs and LPNs, however, often accepted their heavy workloads. As one RN explained,

We've been short for a while. It's frustrating when we're short and you're feeling, you're being pulled in a million directions and your head is spinning, like your patients need you. You need to hang antibiotics for an LPN, you have a patient whose getting blood, so you have to do vitals every half hour on them. Then, you have patients who need to be discharged and they need to be discharged now, so then a DOSA (day of surgery admission) can come up from surgery, and then you're assessing them, and doing hourly vitals on them. That can be challenging and difficult to get a handle on it, and then you don't even have time to sit and chart. That's really challenging where you're, you're literally pulled in a hundred directions and time management is crucial in that. That's what I find the most challenging really is, are those things, that's, that's what bothers me the most on our floor I would think. How do I handle it? I just do.

This RN seems to accept that this is “the way things are” and makes personal sacrifices, like missing breaks, to handle it.

Personal sacrifices. The RNs and LPNs on both units often made personal sacrifices to compensate for their heavy workloads. In their interviews, they frequently described the personal sacrifices they routinely made for their jobs, such as missing their breaks and staying after their shifts had ended without additional financial compensation. The charge nurse assigned the RNs' and LPNs' to either the “first” or “second” breaks and the RNs and LPNs had little flexibility in changing these times. With their heavy workloads, the RNs and LPNs faced the dilemma of missing their breaks or failing to provide their patients with the care they require them to provide. Many of the RNs and LPNs talked about missing first break because the timing of the break disrupted their morning care activities with their patients, such as personal care and activities of daily living. One RN explained that she felt “guilty” if her patients were not “washed up” before she went to her break,

I find a lot of times especially if I'm on first break I don't go, a lot of times my second day shift I have the same assignment, its better, like you just have the routine more down pat and you know the patients, yeah, I just find the second day is always tends to be easier.

The RNs and LPNs were not paid for their breaks and had to complete a form which needed to then be approved by the unit manager to get paid for any missed breaks. Many of the RNs and LPNs felt “it’s not worth the effort” to complete the form and went unpaid.

RNs and LPNs are accountable to practice standards, professional codes of ethics, and hospital policies which prioritize patients’ needs. For example, one RN described,

I missed my break, which I never mind. I don’t mind, that’s the nature of the job, some days I can take breaks, some days I can’t - whatever. Like it’s human life here, like we’re not, nobody cares if I can go and sit and have a coffee, like somebody might be bleeding out... so I make the choice [not to take a break] and I’m comfortable with it.

Although this RN is entitled to breaks, the importance/unpredictableness of nursing work (i.e. – the possibility somebody “might be bleeding out”) and the heaviness of her nursing workload meant that they regularly missed their breaks.

Other RNs and LPNs described how they often arrived early or stayed past the end of their shifts to finish their work without receiving any financial compensation.

Health and wellness. The RNs’ and LPNs’ heavy workload affected their health and wellness. For example, several RNs and LPNs reported the nonstop pace of their work exhausted them both physically and mentally. Although HHN has several health and wellness programs for RNs and LPNs, including onsite fitness facilities, online employee wellness services, and employee recognition programs (e.g. – the online “Bravos” program), the RNs and LPNs’ heavy workloads made it difficult for them to engage in self-care. For example, many of the RNs and LPNs worked 12-hour shifts, and several talked about lack of time to use the onsite fitness facilities due to long working hours and being overtired from work. Another RN talked about how she had not had time to learn about the employee recognition program (“Bravos”). She described,

I think they were trying to curb like some of the, like I think people we're saying the morale was going down and stuff like that, so they're trying to give [recognition]. Like I said, I don't even know how to put a 'Bravo' in and I really should look into it. Because, most of the time what I really try to do is like, say thanks for really helping me out today. I like go to people and be like, you know, thanks for the help on that or whatever, but yeah [the 'Bravos'] are kind of like thank you's, or like great job on whatever kind of recognition, yeah.

Many of the HHN-organized health and wellness programs, were unknown to the nursing staff or "one size fits all" and did not account for nursing staff's many needs, which were quite variable.

The RNs' and LPNs' considered their personal sacrifices, which led to physical and mental exhaustion, to be normal, and felt within the context of the HHN, these experiences were invisible. Once the ONTRACC model has been fully implemented, it may be helpful to complete another study to explicate the RNs and LPNs workloads. A study guided by institutional ethnography could uncover the reality of the RNs' and LPNs' workloads, which may be different than managerial descriptions of them (such as those in job postings) or "official" measures of workload (such as annual performance review forms or processes). Interview questions could focus on how nursing work is recognized. This would reveal RNs' and LPNs' lived reality of personal sacrifices and how their experiences fit within the ruling relation's boundaries of nursing work.

Analytic Thread 3: Person-Centred Care.

There were other changes introduced with the ONTRACC model, including bedside whiteboards, which were specifically implemented to support HHN's philosophy of "holistic Patient and Family Centred Care." Much like "collaboration," "person-centred care" is a buzzword (rhetoric) frequently used in scholarly and professional discourses. The WHO (2018) defines people-centred care as "healthcare services tailored

to people's needs and are provided in partnership with them rather than simply given to them." This WHO definition frequently influences the conceptualization of people-centred care in scholarly and professional literature. HHN's philosophy of "holistic and Patient and Family Centred Care" is congruent with the WHO definition of person-centred care and includes the following conceptualization: "compassionate health care [is] based on a partnership among practitioners, patients and family (as explained by the patient)" (HHN, 2019).

Although the RNs and LPNs talked about using the whiteboards in their interviews, the use of the whiteboards was not discussed in Chapter 5 because these whiteboards were intended to organize the RNs and LPNs relationships with their patients, not each other. The RNs and LPNs were supposed to use the bedside whiteboards to develop their daily goals and deepen their "partnership" with their patients. The whiteboards, however, were perceived as a "make work" project by the RNs and LPNs. As one RN stated,

I'm bad at doing [that] - [asking,] 'well what is your goal for today,' because I feel, like it's a lot. We do a lot of post-ops right? So, everyone's real goal is 'I want to be pain free' and 'I want to be able to move right,' where before at home they were in a lot of pain, they were in like that acute chronic pain and they weren't able to mobilize that they would want to. So, yeah, it's just to me - it's just one added step to do when I have, my mind is already full of everything I have to do (chuckle).

The RNs and LPNs often wrote their names and the date on the whiteboards, but did not use them to develop goals with their patients. The RNs and LPNs did do other things to partner with their patients. For example, in the current study, the RNs and LPNs described special moments that they sometimes experienced with their patients and their families. These moments often included giving their patients choices, for example, walking in the hallway now or later. The RNs and LPNs; however, often felt constrained

by their professional responsibilities and other things happening on the unit to have the time needed to provide true patient-centred care. As some RNs and LPNs stated, writing goals was not practical because the RNs and LPNs could not guarantee they would be able to help their patients meet them.

Clinical pathways. On the orthopedic units, much of what the RNs and LPNs did with their patients is guided by the clinical pathways they use to make decisions about their patients' care. Official explanations of these clinical pathways are that they are "evidence-based" or "proven best practice." They are also a way to standardize the quality and efficiency of nursing care across different healthcare settings; and thus, the basis for the growing belief among the public that hospitals must be run more uniformly, effectively and efficiently (Matthews & Closson, 2009). The RNs and LPNs know the need for following these clinical pathways to keep their patients "on track" for a timely discharge, but they also want to provide care based on their patients' individual needs. They reported sometimes finding it difficult to "customize" these pathways to meet particular patients' requests.

According to the clinical pathways, the RNs and LPNs begin teaching out-of-bed and chair transfers to patients recovering from hip replacements shortly after their surgeries. As a RN described,

But for the most part we know exactly what's going to happen, a hip comes in, we're going to get them up at the side of the bed on the first night. They might pivot to a commode chair to go to the bathroom the first night, mostly women, men they get the fancy urinal, we don't have that option. And then, but we know that four days after surgery again unless something like outside of the surgery happens, they go home.

If a patient does not want to get out of bed when the RN knows they are supposed to, the RN's ability to customize the pathway depends on everything else that is happening on

the unit. Does the RN have something else to do at that time? When is the surgeon doing rounds? Will someone be able to help the RN mobilize the patient later? These clinical pathways are structured interprofessional care plans which sequenced the RNs and LPNs care activities with their patients with those of other healthcare professionals, such as physiotherapists. Consequently, customizing care can disrupt other people's days.

Although this study focused on how RNs and LPNs work together, many of the nursing 'practice standards' and regulatory documents I came across focused on the RN/LPN-patient relationship. Consequently, it would be beneficial to explicate how RNs and LPNs work together to engage with their patients and involve them in their care. Townsend's (1998) IE of occupational therapists, for example, found disjuncture between occupational therapists' person-centred intentions and practice. Townsend (1998) revealed how many institutional processes disempowered patients. For example, treatment teams did not consider patients to be part of the team; and the patients were prevented from taking reasonable risks.

Limitations to Analysis

There were some limitations to this study related to data collection, which may have led to some underdeveloped or missed threads (accounts). For example, to respect the RN/LPN-patient relationships and patients' privacy, when I was observing/shadowing the RNs and LPNs, I did not follow them behind pulled curtains or closed doors. I also did not listen to any sensitive or confidential patient conversations. My interviews and observational data revealed that personal care work, such as helping patients with bathing, toileting, moving, and feeding patients took a lot of time. As a result, I may have missed some insights into RNs and LPNs work with each other at the patients' bedsides.

The implementation of the ONTRACC model significantly changed how personal care work was organized. Previously, only the RNs administered medications, so the LPNs' took more responsibility for the patients' personal care work. In the morning, the RNs went to the medication room to prepare the patients' medications and the LPNs went to the patients' bedsides to take their vital signs and help them out of bed for breakfast. In my interviews, some of the LPNs described how the previous division of tasks (with LPNs more responsible for these unglamorous tasks) served to reinforce to the LPNs that their work was of a lesser worth. One LPN, for example, said this had made her feel like a 'butt wiper.' Although these tasks are unglamorous, they are an essential part of patient care and foundational to nursing practice. They are also 'heavy' tasks and the RNs and LPNs helped each other complete them. Given that I was not present for patients' personal care work, I was not able to observe how the RNs and LPNs negotiated their roles when they helped each other with these tasks, which would have been valuable. For example, when an immobile patient uses a bedpan or becomes incontinent, who rolls the patient? and who cleans the patient's perineal area (does peri-care)?

On both orthopedics units, there were many other healthcare professionals and hospital staff involved in the units' routines and patients' care who I did not interview. Oftentimes, their work intersected with the RNs and LPNs work, and hearing about their experiences may have been beneficial. For example, the ward clerks completed many administrative tasks and kept the units running smoothly. On days when a ward clerk was absent, their administrative tasks (answering the phone, updating both patients' records, etc.) became the RNs and LPNs' work, which decreased their nursing-care time with patients. As one RN described, "[h]aving a ward clerk makes things way easier ... it just

kind of like those paperwork tasks get kind of put off on everyone else so it makes things more hectic.” Similarly, according to Bamford-Wade et al. (2012), RNs and other healthcare professionals have reported that a lack of clerical support results in more of their time taken up by administrative tasks. Unfortunately, due to recruitment and time constraints, I was unable to interview any of the ward clerks. Thus, their perspective was not available for my analysis.

I may also have missed some insights into RNs’ and LPNs’ work with each other by limiting my data collection to the two orthopedic units. For example, I interviewed a surgeon who talked about spending more time working with the other members of the surgical team, which included the operating room RNs and LPNs. The surgeon explained,

Yeah, gosh I don’t know for sure. I don’t know what the level of training that our scrub people are, I would think they’re LPNs but I don’t know. And then there’s also at least one RN in the room and I don’t know what the mix of the rest of them are.

While the RN or LPN title does not change, RNs and LPNs experience variations in their work (for example, their tasks) depending on where they work. The surgeon described how, in the OR,

I feel like the roles are, are clouding to some extent which is probably good for some, for some efficiencies and I don’t know if that presents any problems you know ‘cause it gets people into trouble, but I think, I think what makes them well together is what makes any teamwork work well together, and as soon as you know there might be a different level of training and expertise and the person who has less training needs to respect that, but the person who has more training probably doesn’t want to have it and you don’t want to be the one responsible all the time right.

In the OR, there is one patient and everyone (the surgeon, the anesthesiologist, the RNs, the LPNs, etc.) is caring for them. Consequently, nursing care cannot be organized by level of “complexity” in the same way that it is organized on the orthopedic unit, and ‘complexity’ cannot be conceptualized into types of patients

(e.g. – DOSA). A future study may consider the social structure (e.g. - hierarchy) and the social organization of RNs and LPNs work together in the OR.

Study Rigor and Trustworthiness

Readers of research expect qualitative studies to be carefully conducted because there is a risk of subjectivity or biases influencing the results (Cypress, 2017).

Consequently, these studies are judged by certain criteria to evaluate their rigor or trustworthiness (Cypress, 2017). The rigor of a study refers to the exactness with which the study was conducted to enhance its quality of its findings (LoBiondo-Wood, Haber, & Singh, 2013). Cypress (2017) argues the term qualitative rigor is an oxymoron, considering that qualitative research is a journey of explanation and discovery that does not happen within ridged boundaries. Lincoln and Guba's (1985) criteria are frequently referenced and suggest that the trustworthiness of a study can be established by evaluating the study's credibility, transferability, dependability, and confirmability. Additionally, the trustworthiness also takes into consideration strength of the research design and the appropriateness of the method to answer the research question (Cypress, 2017).

According to Smith (2005), rigor in IE is closely linked to the “ontological shift” that requires institutional ethnographers to stay firmly focused on “things happening” rather than theorizing explanations of how things happen (p. 4). Institutional ethnographers begin in “an embodied standpoint in the social” and seek to map how peoples' practices and activities are organized (Kearney et al., 2019). Hence, IE researchers use a somewhat different approach than other qualitative researchers to build rigor into their studies (Benjamin, 2011). Rigor in IE is achieved “not from technique –

such as sampling or thematic analysis – but from the corrigibility of the developing map of social relations” (Smith, 2006, p. 33). As such, I began my study by shadowing and interviewing the RNs and LPNs who were my standpoint informants. They were the “expert knowers” of their everyday work (Smith, 2005). During my shadowing, I took detailed field notes of everything I observed so I could see what was actually happening on the units. I also interviewed other people who were knowledgeable about the ONTRACC model and nursing practice to gain a deeper understanding of what was going on.

My nursing background was a potential threat to the rigor of this study. Although IE does not prohibit researchers from relying on their existing knowledge to deepen their understanding, researchers’ knowledge can influence observations and findings (Benjamin, 2011). My own nursing knowledge may have influenced how I interpreted certain situations. I needed to train myself not to take things at face value or assume they were similar to my own experiences as a RN. For example, when the RNs and LPNs talked about things like report, I needed to ask them to explain what they meant. I constantly reminded myself that, even though I am a RN, this word might mean something different to me than it does to them. Similarly, I reminded myself these things were likely different between the two orthopedic units on which I was collecting my data. Benjamin (2011) explains the importance of thinking about everything as “fundamentally mysterious” as a way to avoid the trap of taking things at face value (p. 101). She describes how things there are many things which are common, “taken-for-granted,” or accepted, like heavy workloads. When such topics surface in interviews, however, the researcher’s job is to follow them by asking probing questions.

My position as a nurse educator in a baccalaureate nursing (BN) program may have influenced how my informants behaved while I was shadowing them and how they responded to my questions afterwards. The concept of position refers to how the researcher's life experience can facilitate or inhibit the study of specific types of problems. Given that certain positions are linked to power, the researcher has to question themselves at the onset of their work, concerning their own positions and those of their informant. For example, does the informant speak from a position of power or subordination? As an 'expert' in nursing practice, my informants may have felt in a subordinate position. They might, for example, have felt like I was evaluating their nursing practice. As a result, they may have been more collegial than normal because they knew I was watching them.

I purposely shadowed the RNs and LPNs for full, eight-hour shifts to try and overcome this. It is generally assumed that the presence of the researcher gradually becomes less intrusive and people revert back to their "normal" behavior over time (Wall, 2008). Shadowing my informants for eight hours also allowed me to establish rapport with them. Some of my participants were quite candid. One LPN for example confessed, "I'll go work at Costco than go back to buddied assignments." Even if my presence did influence the RNs and LPNs' behavior, an ontological assumption of ruling relations is that they are constituted outside (external) of people's daily experiences (Benjamin, 2011; Smith, 2005). Even if the RNs and LPNs were more collegial than normal, this study's findings would still provide insight into the ruling relations that shape and organize their work.

Contributions of the Study to the Development of New Knowledge

This study contributes to the development of new knowledge in several ways. To my knowledge, it is the only study guided by IE that explicates the social organization of RNs and LPNs working together in New Brunswick and one of the very few in Canada. My analysis shows how RN-LPN “collaboration” does not happen in a bubble, separate from other translocal and local forces. In fact, examining people’s actions beyond the local setting distinguishes IE from more conventional ethnographic research approaches. The ONTRACC model itself originated translocally (from provincial budget cuts, and HHN nursing leadership decisions).

This study adds new knowledge by telling the story how the implementation of the ONTACC model unfolded through the day-to-day work of RNs and LPNs with their patients. Through my observations locally (on the two orthopedic units), I could see how parts of the model were interpreted differently than intended by the RNs and LPNs. For example, the RNs and LPNs interpreted the bedside whiteboards as ‘add-ons,’ rather than valuable ways to engage with their patients.

Although other authors have explored how RNs and LPNs work together, these studies were not situated in New Brunswick. For example, MacKinnon, Butcher and Bruce (2018) used IE to explore RNs and LPNs’ work together, they collected their data in British Columbia. As MacKinnon et al. (2018) note, the generalizability of their findings is limited by their study’s context and needs to be determined by the readers of their research. Unlike other qualitative methods, IE rejects over-arching generalizations and theoretical constructs (Timmons, 2017). Although nursing practice is arguably similar across Canada, some of the texts (e.g. regulatory documents) which organize and

coordinate their practice are different – sometimes quite different. Butcher and MacKinnon (2015) reviewed RN and LPN regulatory documents across Canada and found much variation in how RN's and LPN's respective roles are conceptualized. Not surprisingly, how Mackinnon et al.'s (2018) informants' worked was different from how the informants' worked in this study.

Transferability

The findings of this study cannot be generalized, as the informants worked in a specific context. This research began with what RNs and LPNs knew and experienced on two orthopedic units in New Brunswick, Canada. These RNs and LPNs, the standpoint informants, self-selected to participate in this research, and their experiences may not be representative of other RNs and LPNs. MacKinnon et al. (2018) argue readers of IEs need to consider the context of studies to determine the transferability of the findings themselves. IE helps uncover how the everyday experiences of people in a particular local setting are organized by and linked to the work of others elsewhere. Some of the texts go beyond the local setting of the RNs and LPNs' units (the orthopedic units) may have relevance to other contexts within the province. The data, however, was collected during a time of transition, and captures the RNs and LPNs adjustment to the ONTRACC model. This research still has implications for how nursing leaders continue to implement the ONTRACC model throughout the province. The goal of the research - to produce knowledge that is useful to people and help address the concerns and issues the informants have shared - was achieved.

Leadership and Education Implications

Several of the LPNs talked about being “limited” as an LPN because most nursing leadership and management positions are only accessible to RNs. Consequently, RNs were in the position to make most of the decisions, which impacted the LPNs’ daily lives. RNs and LPNs may advance their careers through seniority or by completing specialty certifications; however, salary banding establishes the pay range and roles for each type of nursing professional. One recommendation would be to increase support for LPNs who want to become “leaders” either informally or informally within their practice setting.

The image of two silos and a gate (see Figure A) illustrates the authorizing discourses about levels in nursing, which begin with educational programs. The two educational programs are largely ‘siloes’ and opportunities for career growth for LPNs are limited (as shown in Figure A by the gate). LPNs who are interested in more advanced career opportunities can enroll in a BN program or a bridge program, shown in Figure A, to become RNs. The UNB LPN-RN bridge option, a pilot program which was recently renewed, allows working LPNs to advance their education more quickly by taking into account their previous education and work experience. This program reduces the time that it takes to earn a BN degree from four years to just two. Graduates from this program can continue to advance their careers by enrolling in Master’s in Nursing or PhD in Nursing programs or move into advanced practice registered nursing roles. Unfortunately, seats in the bridge program are limited and it is currently only offered through UNB’s Saint John campus. Increased flexibility with this program, such as online delivery would increase opportunities LPNs to advance in their careers.

Future Research Implications

This study exploring RNs and LPNs' daily experiences working together to provide patient care has generated the terrain for other IE studies. In the future, I would like to explore how nursing ratios (at the organizational level) and staffing decisions (at unit level) are made. How nursing work is linked to organizational decision-making about nursing staffing quotas was only glimpsed at in the data I collected for my research. One of my 'other' informants, a surgeon, shared,

“Several years ago we got benchmarked to the Fredericton orthopedics floor and then all of a sudden we got - our numbers dropped down to their numbers, which is ridiculous because we're a level one trauma centre. Our patients are sicker, we're doing bigger operations, we're doing spine, we're doing much more revision arthroplasty, it was a foolish thing to do, but those, that team sucked it up and did it.

Benchmarking is the term used to describe the comparison and measurement of a healthcare organization's services against other provincial or national healthcare organizations (HHN, 2018). Through benchmarking, decision-makers use performance indicators and other tools to compare their organization to other healthcare organizations (HHN, 2018). As my other informant noted, however,

Benchmarking always moves people down to a lower common denominator, we rarely benchmark and move people up right... We never benchmark and say, oh we should have as many nurses and LPNs and they have in Saint John, let's give Fredericton four more right. Nobody ever does that, benchmarking is usually done as a cost-saving measure, so yeah it's a great question, who drives it, and unfortunately its usually economically driven.

Consequently, it would be beneficial to know what 'performance indicators' and tools are used determine patients' needs and workload to justify decisions about staffing quotas. RNs and LPNs may, for example, have a different views of performance indicators than nurse managers. For RNs and LPNs a low score is not necessarily representative of poor

quality care. I would like to examine how benchmarking enters the text-work-text sequence and how this sequence results in funding decisions.

Acute care units are fast moving and physically, mentally, and psychologically demanding work places. In this study, the RNs and the LPNs frequently talked about nursing leaders' (nurse managers, charge nurses, etc.) roles in how unit staffing decisions were made. Although I interviewed several nursing leaders for this study, and they talked about staffing work, they were not my standpoint informants and the social organization of this work was not the focus of this study. It would, however, be useful better understand how patient assignment decisions are made and what factors shape and organize this work

Conclusions

In New Brunswick, Canada, nursing care is provided by two categories of nursing professionals, RNs and LPNs. While they have different titles and regulatory bodies, it is important to recognize that both RNs and LPNs fall under the umbrella of nursing. Currently, a new nursing care delivery model, the Organizing Nursing Team Resources for Accountability, Collaboration and Communication (ONTRACC) model, is being phased-in on two orthopedic units, at two different hospitals, within the province of New Brunswick. The ONTRACC model was developed within the context of both fiscal thinking and improved patient care, with the goal of 'optimizing' the roles and activities of RNs and LPNs in acute care, such as on orthopedic units. It shifts nursing care from being delivered by RN-LPN teams, who work as 'buddies' and care for assignment of patients together, to RNs or LPNs who work independently and care for a smaller assignment of patients.

The purpose of this study was to consider how RNs' and LPNs' work together within the context nursing care delivery reform. My goal was to see what was really going on in terms of everyday work frontline RNs and LPNs were doing to care for their patients. The ONTRACC model included changes to staffing mixes and how RNs and LPNs worked both together and with their patients. The RNs and LPNs experienced different authorizing discourses from the different organizations that regulate and direct the practice of nursing within the province, including regulatory associations, employers, and unions. Sometimes these discourses overlapped and sometimes they conflicted with each other. The changes the implementation of the ONTRACC model required the RNs and LPNs' to make in their practice challenged their knowledge of "collaboration" (or their work together, including their "unit routines"/"scopes of practice"). The story that unfolded was, how did the RNs and LPNs transition to a new nursing care delivery model (the ONTRACC model), and integrate the required changes into their nursing practice?

This study will inform future IE studies focused on the work of RNs and LPNs. For example, going forward I would like to explore how nursing ratios (at the organizational level) and staffing decisions (at unit level) are made. Some of my 'other' informants talked about 'benchmarking' and how decision-makers use 'performance indicators' and other tools to compare their organization to other healthcare organizations (HHN, 2018). This peaked my interest and I think it would be beneficial to know what 'performance indicators' and tools are used determine patients' needs and workload to justify decisions about staffing quotas. There may be a disjuncture between official definitions of 'performance indicators' and frontline RNs' and LPNs' views of quality patient care. This study is significant because nursing professionals work with each other

more than they work with other health professionals, such as physicians. It is important to look at how nursing care is delivered, and what that means from the perspective of RNs and LPNs, as well as the experience of patients and families. This is how we will be able to identify solutions that will improve the overall delivery system.

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Appendix A: Tables 1 & 2

Table 1

Standpoint informants (nursing professionals, n = 14)

Site	Informants	# years employed as RN/LPN	# years working at current site	# years on current unit
Site A:	RN (4)	< 5 years (1)	< 5 years (2)	< 5 years (2)
		5-10 years (3)	5-10 years (2)	5-10 years (2)
	LPN (4)	< 5 years (4)	< 5 years (4)	< 5 years (4)
Site B:	RN (4)	< 5 years (1)	< 5 years (2)	< 5 years (2)
		5-10 years (2)	5-10 years (1)	5-10 years (1)
		11 – 15 years (1)	11 – 15 years (1)	11 – 15 years (1)
	LPN (2)	5-10 years (1)	5-10 years (2)	5-10 years (2)
		15 – 20 years (1)		

Table 2

'Other' informants (nursing leaders, n = 8; other, n = 2)

Role	Other informants	RN/LPN	# years employed as	# years in current role
Nursing leaders	RN (6)		< 5 years (1)	< 5 years (4)
			15-20 years (1)	5-10 years (4)
			20-25 years (1)	11-15 years (1)
			> 25 years (5)	
	LPN (2)		10-15 years (1)	< 5 years (1)
			> 25 years (1)	5-10 years (1)
Other	Other (2)	N/A		< years (1)

* RN who previously worked as an LPN included in RN group

Appendix B: Recruitment Poster – Standpoint Informants

Volunteers Needed for a Study on Nurses Working Together

Title: The Social Organization of Nurses Working Together: An Institutional Ethnography

Sarah Balcom, PhD student in Interdisciplinary Studies, University of New Brunswick, is exploring how nurses work with each other is organized in acute care settings. Findings of this study will help inform future nursing practice and institutional policies and procedures related to nurses' work with each other as they care for patients.

Who is needed?

- Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) who have two years of experience working on an acute care unit and are able to speak and understand English.

What do you need to do?

- The researcher will shadow you during one of your shifts on an acute care unit, looking at your interactions with your nurse colleagues. The researcher will make notes about what happens, but will not interrupt your work and will leave at any time, for any reason upon request. Next, the researcher will interview you to learn more about what she observed.

For further information or to volunteer to be in the study, please contact Sarah Balcom at XX or email XX

Appendix C: Recruitment Telephone Script – Other Informants

Hello _____ (name).

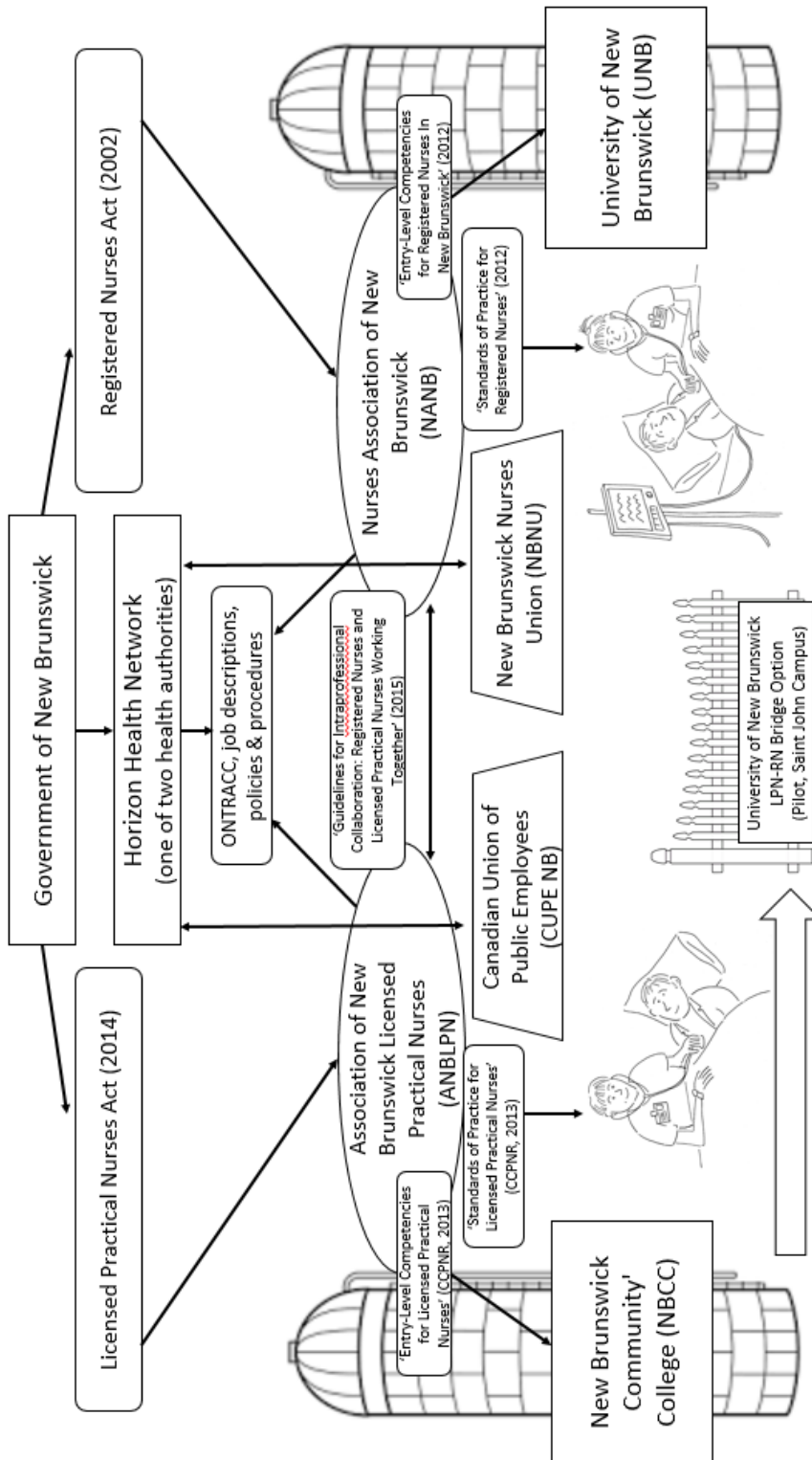
My name is Sarah Balcom, and I am a doctoral student in Interdisciplinary Studies at the University of New Brunswick.

Is this a good time to speak to you? Yes _____ → proceed No _____ → call back later

- I am doing a research study as part of my doctoral program that looks at the social and organizational factors that influence how differentially credentialed nurses (Registered Nurses (RNs) and Licensed Practical Nurses (LPNs)) work together to care for patients in acute care settings in New Brunswick.
- You have been identified as someone who has knowledge about this topic and I would like to interview you for my study.
- If you are agreeable, I would like to interview you, either face-to-face or over the phone. It will involve questions regarding the social and organizational factors that influence RNs and LPNs work together to care for patients. The interview will be about 45 minutes long and will be audiotaped.
- Anything you tell me will be strictly confidential and your participation is voluntary. You can also withdraw from the study at any time.
- Are you interested in participating? If No _____ → Thank you for your time. Goodbye. If Yes _____ → Proceed to schedule interview.
- I would like to send you an invitational letter and a consent form prior to the interview. Could I have your email address _____.

- Do you have any questions? Yes _____ No _____ Thank you.

Appendix D: Map of ‘Ruling Relations’



Appendix E: Fieldnotes Template

Pseudonym: _____
Facility/unit: _____
_____ hrs

ID number: _____
Date: _____ Duration of observation:

Key Observations	Timeline	Informant's Work
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07:00

08:00

09:00

10:00

11:00

12:00

13:00

14:00

15:00

16:00

17:00

18:00

19:00

1. What work do RNs and LPNs do together to care for patients?

2. How do RNs and LPNs decide to do what they do together?

3. What challenges did RNs and LPNs encounter in their work together?

4. What made the RNs and LPNs day go smoothly in the context of working together?

5. What text(s) (e.g. policies, 'job aids') do RNs and PNs interact with or create during their typical day as they work together?

6. What potential texts do I need to obtain?

7. What was the language used, tone, context of the conversations between RNs and LPNs?

8. Who else do RNs and LPNs interact with related to their work together? (e.g. physicians, physios)?

9. Summary of information obtained. Things that were unclear?

10. Potential questions arising from the observations?

Appendix F: Interview Script – Standpoint Informants

Introduction

- Introduce self and explain the purpose of the interview.

“Good morning/afternoon/evening.

Thank-you for allowing me to shadow you and for agreeing to participate in this interview. I would like to start by reviewing the purpose of this research to be sure that you understand why you are here. The purpose of this research is to explore how differently credentialed nurses (registered nurses (RNs) and licensed practical nurses (PNs)) work together to care for patients and how their work together is socially organized. Today, I will be asking you to describe your work as a RN/LPN and how you work with other nurses to care for your patients.

Your participation in this interview is entirely voluntary. You can choose not to answer any question or to leave at any time. Anything you say is confidential. Although the interview will be audio-recorded, it will be stored securely on a password protected computer.”

Consent

- Distribute pre-prepared consent form.

“Please review the following consent form – it was sent to you as an electronic document prior to this interview. If you do not have any questions about the consent form, please sign it and return it to me.”

- Have informant sign the consent form.

Interview

- Facilitate discussion around the following question.

1. “Can you describe your typical work day? What activities do you do from the start to the end of your shift?”

2. “Can you describe what sorts of things make your day run smoothly? Can you tell me about the daily frustrations and challenges that happen in your work?”

a. *Possible probing questions*, “Tell me about your best day at work.” “So what made it a good day?” “Tell me more about that.”

3. “I noticed that you often shared patients’ care with other nurses, how do you decide who does what?”

a. *Explore further as needed to get details*, “What do you *do* to share patients’ care with other nurses?” “How do you *know* what you need to do?” “Tell me more about that.”

4. I noticed that you and other nurses on your unit document your work throughout your day? Can you tell me about the different documents you complete?

a. *Explore further as needed to get details*, “When you share patients’ care, how do you decide who documents what?”

5. Can you suggest other people that I should speak to or other documents that I should be looking at?

a. *Explore further to get at who these other people are as well as the work they do*, “What work does XXXX do?”

Wrap-up

“Thank-you for participating in this interview. Is there anything I have not asked you about that you would like to add or feel it is important for me to know?”

Appendix G: Interview Script – Other Informants

Introduction

- Introduce self and explain the purpose of the interview.

“Good morning/afternoon/evening.

Thank-you for allowing agreeing to participate in this interview. I would like to start by reviewing the purpose of this research to be sure that you understand why you are here. The purpose of this research is to explore how differently credentialed nurses (registered nurses (RNs) and licensed practical nurses (PNs)) work together to care for patients and how their work together is socially organized. Today, I will be asking you to describe your knowledge/experiences with this topic.

Your participation in this interview is entirely voluntary. You can choose not to answer any question or to leave at any time. Anything you say is confidential. Although the interview will be audio-recorded, it will be stored securely on a password protected computer.”

Consent

- Distribute pre-prepared consent form.

“Please review the following consent form – it was sent to you as an electronic document prior to this interview. If you do not have any questions about the consent form, please sign it and return it to me.”

- Have informant sign the consent form.

Interview

- Facilitate discussion around the following question.

1. Can you describe your knowledge about (or your work with/experiences with) differently credentialed nurses working together?

****Probing questions****

2. Can you suggest other people that I should speak to or other documents that I should be looking at?

a. *Explore further to get at who these other people are as well as the work they do*, “How do you know XXXX?” “What work does XXXX do?”

Wrap-up

“Thank-you for participating in this interview. Is there anything I have not asked you about that you would like to add or feel it is important for me to know?”

Appendix H: Invitational Letter – Standpoint Informants

Project title: The Social Organization of Nurses Working Together: An Institutional Ethnography

My name is Sarah Balcom and I am a doctoral student at the University of New Brunswick. I am completing research on how differently credentialed nurses work together as part of my PhD studies. Dr. Shelley Doucet from the Nursing Department, Faculty of Science, Applied Science and Engineering in Saint John is supervising my work.

What is this research about?

In Canada, registered nurses (RNs) and licensed practical nurses (LPNs) work closely together to provide care to patients in many different healthcare settings. There is, however, little published research about the actual ‘collaborative’ work that exists between these two groups of differently credentialed nurses. The purpose of my research is to understand how registered nurses (RNs) and licensed practical nurses (LPNs) in New Brunswick work together to care for their patients and how this is socially organized. This study is guided by the theory and methodology of institutional ethnography, which proposes that people’s everyday lives are socially organized by large social institutions. To complete this research, I will collect data through observations and interviews with people both inside (such as RNs, LPNs, patients, and unit managers) and outside of acute care units of Saint John Regional Hospital and the Dr. Everett Chalmers Hospital (such as Nurses Association of New Brunswick (NANB) practice consultants and union representatives).

What does this mean for me?

I need to recruit RNs, LPNs, and others with knowledge about this topic to participate in this research. I would like to observe you as you go about your typical day – paying attention to how you work with other nurses to provide patient care. Based on the findings of my observations, I will interview you individually to learn more about your activities and experiences working with other nurses. Others with knowledge about this topic will also be invited to be interviewed. Each interview will last ~ 45 minutes and will occur at a mutually agreed upon location. Your participation is voluntary and you can withdraw from the study at any time. I do request that you agree to participate in both the observations and the interviews.

How will the research benefit/harm me?

During the observations, you may feel self-conscious. You may ask to me to leave your work area at any time and for any reason. I will not observe any of your interactions with patients that are private in nature, such as when bed-bathing.

During the interviews, I will ask you questions about you work with other nurses. You may at times feel uncomfortable disclosing your thoughts. Your comfort is important to me and you can choose not to answer questions. Although you may not personally benefit from this study, its findings will help inform institutional policies and procedures, and could lead to improvements in nursing practice.

Is this confidential?

This information you provide or any health information that I see/hear during my observations will be kept confidential. I will assign you an ID number and will use the ID number to organize my files of your data. Only your ID number or a pseudonym will

appear on my field notes or in any publications that result from this study. Paper data, such as my field notes, will be stored in a locked filing cabinet in the researcher's office. Your audio-recorded interview, will be stored on a password protected computer located in the researcher's locked office. The paper and digital data will be destroyed ten years after the completion of the thesis (deleted/shredded). If you decide at any point to withdraw from the study, I will ask you for permission before I use any of your data.

What if I have more questions? Who can I contact?

You may contact me, Sarah Balcom at XX or email XX. You may also contact my supervisor, Dr. Shelley Doucet at XX or email XX. For ethical concerns you may contact the Chair of the Horizon Health Research Ethics Board at XX or the Chair of the University of New Brunswick Research Ethics Board at XX.

Appendix I: Invitational Letter – Other Informants

Project title: The Social Organization of Nurses Working Together: An Institutional Ethnography

My name is Sarah Balcom and I am a doctoral student at the University of New Brunswick. I am completing research on how differently credentialed nurses work together as part of my PhD studies. Dr. Shelley Doucet from the Nursing Department, Faculty of Science, Applied Science and Engineering in Saint John is supervising my work.

What is this research about?

In Canada, registered nurses (RNs) and licensed practical nurses (LPNs) work closely together to provide care to patients in many different healthcare settings. There is, however, little published research about the actual ‘collaborative’ work that exists between these two groups of differently credentialed nurses. The purpose of my research is to understand how registered nurses (RNs) and licensed practical nurses (LPNs) in New Brunswick work together to care for their patients and how this is socially organized. This study is guided by the theory and methodology of institutional ethnography, which proposes that people’s everyday lives are socially organized by large social institutions. To complete this research, I will collect data through observations and interviews with people both inside (such as RNs, LPNs, patients, and unit managers) and outside of acute care units of Saint John Regional Hospital and the Dr. Everett Chalmers Hospital (such as Nurses Association of New Brunswick (NANB) practice consultants and union representatives).

What does this mean for me?

I would like to individually interview about your knowledge about this topic. The interview will last 45- 60 minutes and will occur either over the phone or at a mutually agreed upon location. The interview will be audiotaped. Your participation is voluntary and you can withdraw from the study at any time.

How will the research benefit/harm me?

I will ask you questions about your knowledge with this topic. You may at times feel uncomfortable disclosing your thoughts. Your comfort is important to me and you can choose not to answer questions. Although you may not personally benefit from this study, its findings will help inform institutional policies and procedures, and could lead to improvements in nursing practice.

Is this confidential?

This information you provide will be kept confidential. I will assign you an ID number and will use the ID number to organize my files of your data. Only your ID number or a pseudonym will appear on my field notes or in any publications that result from this study. Paper data, such as my field notes, will be stored in a locked filing cabinet in the researcher's office. Your audio-recorded interview, will be stored on a password protected computer located in the researcher's locked office. The paper and digital data will be destroyed ten years after the completion of the thesis (deleted/shredded). If you decide at any point to withdraw from the study, I will ask you for permission before I use any of your data.

What if I have more questions? Who can I contact?

You may contact me, Sarah Balcom at XX or email XX. You may also contact my supervisor, Dr. Shelley Doucet at XX or email XX. For ethical concerns you may contact the Chair of the Horizon Health Research Ethics Board at XX or the Chair of the University of New Brunswick Research Ethics Board at XX.

Appendix J: Informed Consent Form – Standpoint Informants

Project title: The Social Organization of Nurses Working Together: An Institutional Ethnography

Researcher: Sarah Balcom (Doctoral Student, University of New Brunswick)

Supervisor: Dr. Shelley Doucet (Associate Professor, University of New Brunswick)

Research Description:

In Canada, registered nurses (RNs) and licensed practical nurses (LPNs) work closely together to provide care to patients in many different healthcare settings. There is, however, little published research about the actual ‘collaborative’ work that exists between these two groups of differently credentialed nurses. The purpose of this research is to explore how RNs and LPNs work together in acute care setting in New Brunswick, and how this work is socially organized. The results of this research will be used to provide insight into nursing practice in New Brunswick and inform changes to institutional policies and procedures.

The researcher will use observations, interviews, and document analysis to explore RNs and LPNs work with each other. Should you agree to participate, the researcher will shadow you during one of your regularly scheduled shifts, then interview you about your experiences.

The interviews will be audiotaped and notes may be taken during both the shadowing and the interviews. The researcher will review all information and all personal information will be removed prior to data storage and analysis.

All data collected is confidential and will only be used as described in the attached Invitational Letter and this consent form. All data collected will be securely stored. Access to data will only be granted to the researchers listed above. No personally identifiable information will be given out at any time or included any publications or scholarly materials that result from this research..

Participants may choose to withdraw from this research at any time.

Informed Consent

I _____ have been informed of the purpose of this research and agree to participate in this study.

If you have any questions that have not been answered satisfactorily by the researcher or her supervisor (named above), please contact the Chair of the Horizon Health Research Ethics Board XX or the Chair of the University of New Brunswick Research Ethics Board at XX.

Appendix K: Informed Consent Form – Other Informants

Project title: The Social Organization of Nurses Working Together: An Institutional Ethnography

Researcher: Sarah Balcom (Doctoral Student, University of New Brunswick)

Supervisor: Dr. Shelley Doucet (Associate Professor, University of New Brunswick)

Research Description:

In Canada, registered nurses (RNs) and licensed practical nurses (LPNs) work closely together to provide care to patients in many different healthcare settings. There is, however, little published research about the actual ‘collaborative’ work that exists between these two groups of differently credentialed nurses. The purpose of this research is to explore how RNs and LPNs work together in acute care setting in New Brunswick, and how this work is socially organized. The results of this research will be used to provide insight into nursing practice in New Brunswick and inform changes to institutional policies and procedures.

The researcher will use observations, interviews, and document analysis to explore RNs and LPNs work with each other. Should you agree to participate, the researcher will interview you about your knowledge and experiences with this topic. The interviews will be audiotaped and notes may be taken during. The researcher will review all information and all personal information will be removed prior to data storage and analysis.

All data collected is confidential and will only be used as described in the attached

Invitational Letter and this consent form. All data collected will be securely stored on a

password protected computer located in the researcher's locked office. The paper and digital data will be destroyed ten years after the completion of the thesis (deleted/shredded).

Access to data will only be granted to the researchers listed above. No personally identifiable information will be given out at any time or included any publications or scholarly materials that result from this research.

Participants may choose to withdraw from this research at any time.

Informed Consent

I _____ have been informed of the purpose of this research and agree to participate in this study.

If you have any questions that have not been answered satisfactorily by the researcher or her supervisor (named above), please contact the Chair of the Horizon Health Research Ethics Board XX or the Chair of the University of New Brunswick Research Ethics Board at XX.

Appendix L: Manuscript #4 – Looking back to move forward

Looking Back to Move Forward:

How Understanding the History of Intraprofessional Nurse Collaboration
Can Inform Tomorrow's Nurse Leaders

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Abstract— Today, registered nurses and practical nurses work together in teams with other healthcare professionals to meet patients' needs. This team approach requires effective collaboration to ensure patients benefit from the knowledge, expertise and skills of each team member and to avoid duplication of care. The need for registered nurses and practical nurses to collaborate intraprofessionally is a fairly recent development in nursing. Unfortunately, shadows of the past lie heavily on nursing and historical intraprofessional hierarchies and rivalries continue to influence the profession today. Registered nurses and practical nurses have largely overlapping scopes of practice in patient care, but registered nurses can practice with more independence, develop nursing care plans, and may assume more supervisory roles. Unfortunately, their similar scopes of practice can result in feelings of competition rather than those of collaboration. In this paper, we discuss how historical developments in nursing have contributed to the challenges, such as intra and interprofessional hierarchies, that registered and practical nurses now face when they try to work together collaboratively in various healthcare settings. We also present a model to explain how registered nurses and practical nurses have, throughout their shared history, continued to become more adept at meeting these challenges, and accomplish their goals collaboratively. Finally, we present the

implications for nurse leaders working in administrative, teaching, and practice settings and suggest strategies to overcome the historical challenges to intraprofessional collaboration so that the past is not repeated in the future.

Keywords- *intraprofessional collaboration; history;nursing*

I. Introduction

Today, RNs and PNs work in increasingly complex and interprofessional settings. Patients' needs are becoming more complicated and, as a result, healthcare professionals must respond to new challenges in their workplaces, such as increased patient acuity and the use of increasingly complex technologies [1]. To meet these challenges, RNs, PN, and other healthcare professionals must engage in collaborative patient-centred care [1]. Collaborative care occurs when healthcare professionals from both different and similar professional backgrounds work together to provide their patients with high quality care [2]. The traditional hierarchies in health care actively discourage this necessary collaboration [3]. The history of nursing has contributed to the internal hierarchies within the profession, which need to be understood by those entering the profession or those currently in practice so that they can be prepared to address barriers to collaboration existing within their workplaces. In this paper, we present a model to explain how RNs and PNs have throughout their shared history

become more adept at meeting challenges, and accomplish their collaborative goals. Finally, we discuss the implications of barriers to collaboration for nursing leaders working in administrative, teaching, and practice settings and suggest strategies to overcome the historical challenges to intraprofessional collaboration.

II. Background and purpose

Historically, RNs, PNs, and other healthcare professionals have worked together in extremely hierarchical ways. Healthcare professions that were more specialized or required more extensive education were often, and often still are, considered to be more prestigious and better remunerated [4]. Even within professional groups of nursing, differences in specializations, advanced practice roles, expanded scopes of practice, remuneration, and years of seniority create barriers and power imbalances [4]. Such hierarchies and power imbalances can create feelings of competition rather than collaboration.

Today's RNs and PNs are professionals working collaboratively with patients, each other and other healthcare professionals to provide care in a variety of settings [5]. RNs and PNs share their leadership, advocacy, research, and critical thinking skills with each other and other healthcare professionals to promote health and safety and to prevent disability and disease within their practice settings [5]. Thus, RNs and PNs must understand their scopes of practices and roles in patients care and work collaboratively amongst themselves to overcome divisive hierarchies within the healthcare system.

In this paper, we provide a historical overview of how registered and practical nursing emerged from a shared professional background; and how this shared background provides a context through which their current relationship with each other and in patient care can be better understood. Although history shows RNs and PNs have over time become more adept at meeting challenges, and accomplish their goals together, they need to continue to adapt to changes in the healthcare system and patient care together. Our intent is to provide nursing leaders with insight from this historical overview that can be used to develop strategies to enhance collaboration between RNs and PNs in the future.

III. Methods

A literature review of the history of organized nursing in Canada from colonial times to present day provided the basis for this paper. A search of several electronic databases, including: CINAHL, Google Scholar, PubMed, and Medline identified primary relevant literature. Broad subject terms such as 'registered/practical/licenced practical nurse,' 'RN/LPN' 'nurs*,' 'hierarchies,' 'history,' 'collaboration,' and 'intra/interprofessional' ensured a comprehensive search inclusive of all types of organized nursing. The titles, abstracts, and articles returned from this search were then screened for relevance and applicability. The reference lists of these returned articles identified additional articles for retrieval. Further information was obtained through select and reputable internet sites, including those published by national and provincial nursing organizations.

IV. Emergent themes

Four themes emerged on the history of RN and PN collaboration. These included: 1) distinguishing and differentiating; 2) opposing and organizing; 3) cooperating and collaborating; and 4) appreciating and adjusting. These themes were translated into the model shown in Figure 1, and relate to the widely known phases of group and team development outlined in Tuckman's 'forming-norming-storming-performing' model [6].

A. Distinguishing and Differentiating

The theme, 'distinguishing and differentiating' considers how RNs and PNs evolved together during the formalization of educational and professional standards. It relates to the 'forming' of Tuckman's model, where individuals begin learning about each other as they begin to collaborate [6]. For RNs and PNs to collaborate effectively, they must be able to 'distinguish' and 'differentiate' their roles in patient care. Consequently, nurse leaders must understand how their roles evolved in order to promote collaboration in their workplaces today.

In Canada, nursing was initially not formalized and most nurses provided care to patients under the supervision of a physician who determined the role of nursing in patient care. Beginning in the late 19th century, nurse leaders struggled to establish educational and

professional standards for nursing, which resulted in emergence of different and more formalized nursing roles [6]. Nursing professional organizations, such the Canadian National Association for Trained Nurses (formed in 1908 and now called the Canadian Nurses Association), promoted leadership within the nursing profession and sought standardized nursing educational requirements and establish a nursing curricula [6]. Nursing staff, who had received more formal training began to want to distinguish themselves from others and receive recognition for their additional qualifications [6]. When provinces began to hold provincial examinations for the registration of nurses in the 1920's, there became an 'official' distinction between nursing staff [7]. All graduates of recognized nursing programs who completed their provincial exams distinguished themselves as 'Registered Nurses' [7]. This created a hierarchy within nursing, as graduates of recognized nursing programs received greater recognition and improved employment opportunities.

As early as the 1930s, the Canadian Nurses Association (CNA) recognized PNs, who then numbered almost 4700 across the country [1]. These PNs were restricted in patient care, however, to more task-based activities, like bathing and toileting [1]. Like RNs before them, PNs struggled to become recognized, self-regulating nursing professionals [9]. The first legislative acts controlling the education, testing, and practice of PNs occurred during the 1940's [1]. In most provinces, PNs initially came under the provincial RN associations [9]. Slowly, provincial PN associations formed. Initially, these associations simply provided support for PNs and over time they gained responsibility for establishing the standards of education, practice, and licensing for their members [9].

B. Opposing and Organizing

The theme, 'opposing and organizing' examines how the growing self-governance of PNs has led to rivalries between RNs and PNs. It relates to the 'storming' of Tuckman's model, where individuals challenge each other and question their previously held assumptions [6]. As previously identified, the differences in education between RNs and PNs helped create a hierarchy within nursing. Since the early 20th century, RNs have expressed concern over the advancement of

practical nursing in Canada. In 1962, in a briefing to the Royal Commission of Health Services, the CNA even recommended that practical nursing programs be discontinued [10].

As PNs formalized their roles, RNs began to feel uncertainty about their own position in the healthcare system and even threatened [9]. In the 1940's and 1950's, working conditions, including long hours and increasing needs of their patients, concerned many nurses, but perceived threats to the profession encouraged caution when advocating for system change in fear of being replaced [7]. In 1945 for example, the CNA president cautioned RNs in an editorial of the *Canadian Nurse* that "There are others who will supersede us ..." [11]. Mansell argues that many nursing leaders of the 1940's and 1950's encouraged nurses to maintain their image of service rather than pursue better working conditions [7]. RNs were more worried about losing their position in the healthcare system than working collaboratively with others, such as PNs, to improve it.

C. Cooperating and Collaborating

The theme, 'cooperating and collaborating' recognizes the importance of collaboration between RNs and PNs and how they are increasingly learning how to work more collaboratively. It relates to the 'norming' of Tuckman's model, where individuals focus on working collaboratively towards their mutual goals [6]. Recently, innovative intraprofessional learning activities have been proposed to help both pre-licensure and post-licensure nursing staff develop and improve their collaboration skills. The World Health Organization (WHO) considers inter and intraprofessional education to be an effective way to prepare healthcare students for collaborative practice in the workforce [2]. Interprofessional education provides learners from more than one profession with an opportunity to learn about, from, and with each other to improve health outcomes [2]. Intraprofessional education occurs when collaborative learning occurs between those who share a common professional education, values, socialization, identity, and experience [12].

The CNA recently suggested that "[r]espectful intraprofessional nurse collaboration among RNs [and other nursing personnel] should be a main feature of nursing education" (p. 3) [13]. The

CNA's commitment to intraprofessional collaboration and education among RNs and PNs was reflected in the Canadian Registered Nurse Exam (CRNE), where 14-24% of the questions on CRNE included professional practice competencies, such as leadership and intraprofessional communication and collaboration [14]. This commitment continues to be shown through the National Council Licensure Examination (NCLEX), which is replacing the CRNE, as the measure of competency of Canadian nurses. About 20% of the questions on the NCLEX exam address collaborative competencies [15].

D. Appreciating and Adjusting

Finally, the theme, 'appreciating and adjusting' identifies how both RNs and PNs are adjusting their practice to work collaboratively by appreciating each other's contributions to patient care. This theme relates to the 'performing' phase of Tuckman's model, where individuals value the contributions of all team members and are

motivated to continue in their collaboration [6]. Unfortunately RNs and PNs often work in high-stress environments and burnout and nursing staff dissatisfaction are common problems in many workplaces [16]. Larrabee et al. identified that there is an important relationship between RNs and PNs' collaboration and feelings of cohesiveness and their overall satisfaction with their jobs [16]. Many nursing leaders are starting to appreciate this relationship and are interested in empowering both RNs and PNs and looking at new models of care so RNs and PNs can perform better in their jobs.

In 1997, M. E. Jeans, the Executive Director of the Canadian Nurses' Association, claimed that the biggest threat to RNs was "[their] inability to work [with others], openly and with trust and understanding toward the common goal of a strengthened nursing profession" (p. 171) [7]. Many of the issues and trends faced by RNs also pertain to PNs and RN and PN professional organizations have started to work together to collaboratively meet these challenges.

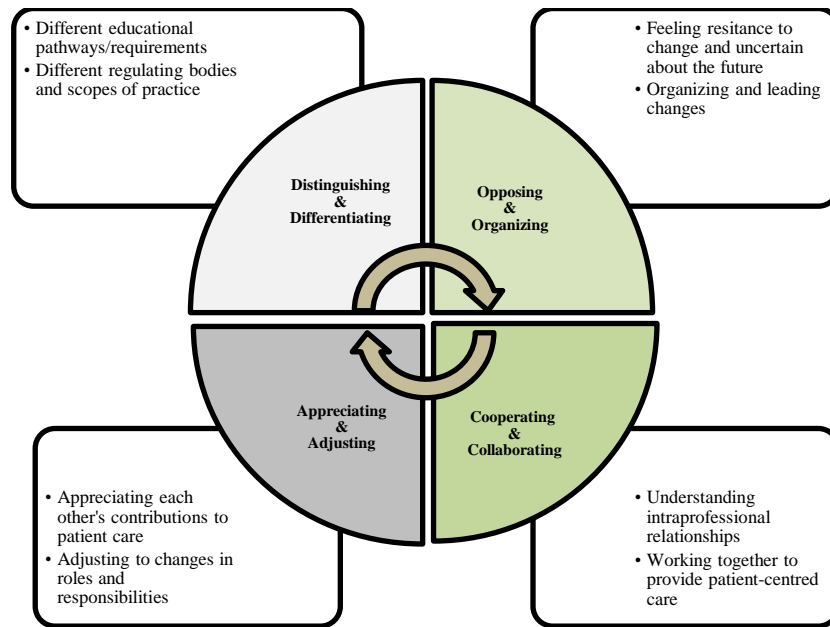


Figure 1: Historical Themes of RN and PN Collaboration

V. Implications for nursing leadership

The history of nursing shows that collaboration between RNs and PNs has improved over time and progressed through the stages Tuckman outlined in his model of team development [6]. Although management literature consistently demonstrates that teams and groups progress through phases of group development, the literature also indicates they may not progress sequentially and they may return to early phases between later phases [17]. Consequently, in order to advance RN and PN collaboration, continued leadership and support is required for nursing staff administratively, educationally, and through their practice. Table 1 provides an overview of how nursing administrators, educators, and clinicians can support RNs and PNs to practice collaboratively.

Nurse Administrators

Gersick found that the development of groups and teams is influenced by members' awareness of limited resources and other stressors [17]. The history of RN and PN collaboration shows that similar to Gersick's findings, more effective collaboration occurs when workplaces are stable, adequately staffed, and employing graduates from both RN and PN programs [17]. Effective collaboration also occurs when RNs and PNs feel like they are 'in it together,' such as during the Second World War. Nursing administrators are in a unique position to help overcome many of the barriers to collaboration between RNs and PNs by promoting collaborative work environments. Table 1 outlines suggestions for nursing administrators to play a leadership role in promoting intraprofessional collaboration.

Nurse Educators

Intra and interprofessional education are effective ways to introduce RNs and PNs to collaboration at both the pre and post-licensure stage. Recently, the University of Toronto considered specifically how different health professionals learn to work together as teams and created a framework for the development of interprofessional education for their health professional programs [18]. This framework considers interprofessional education to progress along a continuum of three stages: starting with exposure, then immersion, and finally competence [18]. At each stage, learners develop their knowledge through three constructs

(or building blocks) of interprofessional education: collaboration, communication, and values and ethics [18]. This framework emphasizes the knowledge skills/behaviors, and attitudes that learners need for effective teamwork and highlights the step-wise nature of becoming a proficient collaborator [18]. Professional programs have a responsibility to purposefully integrate intra and interprofessional learning activities across their curriculums so students have opportunities to continuously develop their skills.

Nurses in Clinical Practice

RNs and PNs must be flexible in their approaches to working collaboratively to meet the changing needs of the healthcare system. Studies show that a major barrier to the success of interprofessional education and collaboration has been the lack of understanding of shared scopes of practice [19]. Given that RNs and PNs have considerable overlap in their scopes of practice, it is critical that they thoroughly understand each other's boundaries, scopes, and roles in patient care across different healthcare settings. Consequently, nursing professionals (representing both streams of the profession) need to take a leadership role and advocate that regulatory documents clearly explain the full range of each of these roles and how they complement each other. Such documents are especially important given the changing/expanding roles of both RNs and PNs in many healthcare settings and new healthcare technologies. Table 1 outlines specific suggestions for nurse clinicians to promote intraprofessional collaboration.

Conclusion

It is clear that the history of intra and interprofessional hierarchies have impacted RN and PN collaboration. Although the profession of nursing continues to advance, many RNs and PNs still feel like they are fighting against long-standing hierarchies and power imbalances within the profession. It is critical that the issues created through nursing's history be understood to address today's professional issues. Our proposed model suggests that RNs and PNs have become more adept at collaborating together over time. The history of nursing shows that change is required to meet current times and needs, but also that change is possible. Consequently, nursing

professionals need continued leadership and support administratively, educationally, and in

their practice to promote collaboration between RNs and PNs into the future.

TABLE I. IMPLICATIONS FOR NURSE LEADERS

<i>Goals</i>	<i>Activities</i>
<p>Nurse Administrators →</p> <ul style="list-style-type: none"> - overcome organizational barriers to collaboration - promote collaborative work environments 	<ul style="list-style-type: none"> - encourage RNs and PNs to jointly participate decision-making and coordination of patient care - clarify differences in scopes of practice between RNs and PNs - implement strategies to enable RNs and PNs to work to their full scopes of practice - encourage RNs and PNs to develop their collaboration skills through workshops, meetings, or education - ensure that workplaces are stable, adequately staffed, and employing graduates from both RN and PN programs
<p>Nurse Educators →</p> <ul style="list-style-type: none"> - introduce pre- and post-licensure nurses to the knowledge, skills/behaviors, and attitudes that are required for effective collaboration 	<ul style="list-style-type: none"> - provide opportunities for baccalaureate and practical nursing students to practice collaboratively during clinical experiences - clarify questions about differences in RN and PN scopes of practice - provide practicing RNs and PNs with opportunities for intraprofessional education
<p>Nurses in Clinical Practice →</p> <ul style="list-style-type: none"> - use a flexible approach to working collaboratively in a changing healthcare system 	<ul style="list-style-type: none"> - read and understand ‘Scopes of Practice’ documents - role model collaboration for colleagues entering the profession

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Curriculum Vitae

Candidate's full name:

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Universities attended (with dates and degrees obtained):

September 2014 to Present	University of New Brunswick, Fredericton, NB, Canada Ph.D. in Interdisciplinary Studies, expected in Spring, 2020. Supervisor: Dr. Shelley Doucet
September 2012 to May 2014	University of New Brunswick, Fredericton, NB, Canada Masters of Nursing (Nurse Educator Stream) Supervisor: Dr. Kathy Wilson
September 2005 to May 2009	Dalhousie University, Halifax, NS, Canada Bachelor of Science in Nursing
September 2001 to May 2005	Dalhousie University, Halifax, NS, Canada Bachelor of Arts in English Literature

Publications:

2016	Balcom, S. (2016). Surviving and thriving in intensive care: Preparing new nurses. <i>International Journal of Health and Medical Sciences</i> , 1(3), 48-50. Principal author.
2016	Liu, C., Balcom, S. , Carrigan, S., Malloy, M., & Mamma, V. (2016). Gerontology across the professions and the Atlantic: Students' reflective views and voices. <i>Gerontology & Geriatrics Education</i> , 1-26. Equal contribution.

Conference Presentations:

- 2019 **Canadian Orthopaedic Nurses Association Annual Conference, Saint John, NB, Canada.**
Balcom, S. & Doucet, S. (2019). Changing tracks: RNs and LPNs working together on two orthopedic units in New Brunswick.
 Abstract published and oral presentation given.
- 2019 **31st Annual Ethnographic & Qualitative Research Conference (EQRC), Las Vegas, NV, United States.**
Balcom, S., & Doucet, S. (2019). The Social Organization of Nurses Working Together: An Institutional Ethnography.
 Abstract published and oral presentation given.
- 2018 **Qualitatives 2018, Fredericton, New Brunswick, Canada**
Balcom, S., & Doucet, S. (2018). Observation and Institutional Ethnography: Helping Us to See Better?
 Abstract published.
- 2018 **30th Annual Ethnographic & Qualitative Research Conference (EQRC), Las Vegas, NV, United States.**
Balcom, S., & Doucet, S. (2018). Observation and institutional ethnography.
 Abstract published and oral presentation given.
- 2016 **Canadian Association of Gerontology (CAG) 2016: Fostering Innovation on Research on Aging, Montreal, QC, Canada.**
 Cotton, B., **Balcom, S.,** & Svendsbo, E. (2016). What is Elder Care Like Elsewhere? An International Comparison of Canada, the United States, and Norway's Healthcare Systems.
 Abstract published and poster presentation given.
- 2016 **2016 Canadian Health Workforce Conference, Ottawa, ON, Canada**
Balcom, S., & Doucet, S. (2016). Intraprofessional collaboration: A concept analysis.
 Abstract published and poster presentation given.
- 2016 **7th International Conference on Medical, Medicine and Health Sciences, Denpasar, Indonesia**

- Balcom, S.** (2016). Surviving and thriving in the ICU: Preparing new nurses. Full paper published and oral presentation given.
- 2015 **First Middle East Conference in Interprofessional Education, Doha, Qatar**
Balcom, S., & Doucet, S. (2015). Intraprofessional collaboration: A concept analysis.
 Abstract published and poster presentation given.
- 2015 **Atlantic Region Canadian Association of Schools of Nursing Annual Conference, Saint John, Canada**
Balcom, S., & Doucet, S. (2015). All together now: Intraprofessional collaboration between RNs and LPNs.
 Abstract published and poster presentation given
- 2015 **Canadian Student Health Research Forum, Winnipeg, Canada**
Balcom, S. (2015). Intraprofessional nurse collaboration: An exploration of professionalism and collegiality among registered nurses and practical nurses.
 Abstract published and poster presentation given.
- 2015 **Annual Worldwide Nursing Conference, Singapore, Singapore**
Balcom, S., & Doucet, S. (2015). Looking back to move forward: How understanding the history of intraprofessional nurse collaboration can inform tomorrow's nurse leaders.
 Full paper published and oral presentation given.
- 2014 **Canadian Nursing Education Conference, Halifax, Canada**
Balcom, S. (2014). In cahoots: Intraprofessional RN and LPN collaboration.
 Abstract published and oral presentation given.
- 2014 **Interprofessional Health Research Day, Saint John, Canada**
Balcom, S. (2014). Improving intraprofessional collaboration among nursing students.
 Abstract published and poster presentation given.

2013

University of New Brunswick's MN Day.

Balcom, S., Farrell, T., & Wile, A. (2013). Breast-self-examination: A touchy subject.

Abstract published and oral presentation given.