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Enhancing Role Clarity for the Practical Nurse

A Leadership Imperative

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OBJECTIVE: The aim of this study was to determine factors contributing to practical nurse (PN) role confusion and the impact on nursing intraprofessional team collaboration.
BACKGROUND: There is limited literature describing the intraprofessional relationship of the RN and PN in areas such as role conflict, scope of practice, and team collaboration.
METHODS: A mixed-methods design was used targeting Ontario RNs and PNs, including an online survey and focus groups.
RESULTS: Results (N = 1101) revealed varying levels of knowledge regarding the distinct and overlapping scope of practice for each role, with shared opinions regarding areas such as respect, teamwork, and the role of leadership.
CONCLUSIONS: Nurses' roles will continue to evolve in response to changes in patient populations and healthcare systems. As such, role clarity is essential to support optimal use of nursing knowledge for safe patient care. Leadership is key to establishing parameters for professional practice and creating a culture of collaboration and respect.

In many countries, nursing is a distinct profession with multiple designations, most commonly that of RNs and practical nurses (PNs). Reported percentages of PNs in the profession range from 19% in Australia,[1] 21% in the United States,[2] to 33% in Canada.[3]

Although some form of the PN role has been in existence for decades, there is a paucity of current literature describing the role and relationship with their RN colleagues about overlapping practices, role harmony or conflict, and intraprofessional team collaboration. The aim of the study was to learn the factors contributing to confusion regarding the PN and RN roles, the distinct and overlapping scope of practice, and the impact on nursing team collaboration.

Background

Within Canada, the Ontario registered PN (RPN) role is synonymous with the licensed PN role in other provinces and the United States and the enrolled nurse role in Australia. For this report, PN is used throughout.

Nursing, in Ontario, is a self-regulated, autonomous profession with 3 designations: RN/extended class (known as the nurse practitioner) and RPN, all of which are accountable to 1 regulatory body, the College of Nurses of Ontario. In this article, RPN will be referred to as PN. Revisions to the Nursing Act 1991[4] allowed a broader range of role functioning (eg, initiation of controlled acts) and regulatory changes to the basic entry to practice competencies. In 2002, the educational requirement for PN was changed from a certificate program (ie, 12-18 months

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of study) to that of a 2-year diploma program offered through an accredited college. This was followed in 2005, with changes to RN educational requirement stipulating the baccalaureate degree in nursing for RNs. Practical nurses and RNs study from a similar body of nursing knowledge, yet their foundational knowledge bases differ in their respective entry-level competencies. In Canada, PNs study for 2 years, whereas RNs study for 4 years to achieve a greater breadth and depth of knowledge, clinical decision making, critical thinking, research utilization, leadership, care delivery systems, and resource management.[5] These changes have resulted in varying degrees of role ambiguity regarding the PN role and, in some instances, role conflict within the intraprofessional team.[6]

Existing studies of nursing models of care, which include RNs, PNs, and aide roles, provide some initial evidence of the benefits of optimizing scope of practice and effective team collaboration such as increased nurse satisfaction and enhanced patient outcomes.[7-10]

Role Ambiguity Leads to Role Conflict

Because of the inconsistent use of terms such as role conflict, ambiguity, tension, and extension, role theory provides a useful framework for understanding these complex phenomena. Role theory has been described by Biddle[11] as consisting of actors (people) performing parts (roles) with written scripts (expectations) that are appreciated by others. The degree of role clarity is determined by the level of agreement among the actors regarding the behavioral role expectations. Role ambiguity results from inconsistent information about the expected role behaviors originating from organizational or individual sources (eg, multiple lines of authority).

For nursing, role extension is the inclusion of skills or practices not previously associated with the role and role expansion as additional skills and areas of practice within a specialist role, involving greater degrees of accountability and autonomy.[12] Although role extension tends to include practices from another profession (eg, medicine), the PN role can be viewed as role extension, given the new areas of practice and skills, previously the sole domain of the RN. The same can be said for the RN role, which now includes areas of practice and skills, previously the sole domain of medicine. Nursing role extension intended to meet the changing needs of patient populations and provide continuity of care. Besner et al[13] identified the challenge for nurses to differentiate between the notion of full scope of practice and the numerous tasks performed as part of the patient care delivery process. This focus on tasks becomes problematic as roles continue to evolve and expand, with individuals then being concerned about the distinct nature of their role in care delivery.

Within complex organizations, the pressure to conform to role expectations can be exerted by individuals with greater sources of power or authority.[14] Because of the inherent hierarchy within nursing teams, reconciliation of the contribution of each nurse, regardless of professional designation, is vital to nurse satisfaction and the quality of care provided.[15]

Methods

Design and Sample

A mixed-methods approach was used, including an online survey, for 11 months (February-December 2013), and guided by an expert panel of PNs and RNs from direct care and administrative roles within all sectors and nursing faculty from PN and RN programs. The targeted sample included PNs and RNs across Ontario.

Data Collection

Targeted stakeholder groups were recruited for the survey through social media strategies such as Facebook and Twitter and snowball sampling via personal and professional networks, membership listing, and e-mail forwarding. Recruitment via social networking can be time and cost efficient while still maintaining confidentiality.[16-18] Ten focus groups were held with leaders of nursing teams. The focus group participants (n = 47) were all RNs representing various geographical regions and care settings across Ontario.

Design of the Registered Practical Nurse Role Clarity Questionnaire

The literature revealed no existing, relevant instruments; therefore, the Registered Practical Nurse Role Clarity Questionnaire (RPN-RCQ) was constructed (see Document, Supplemental Digital Content 1, http://links.lww.com/JONA/A466). Items were generated from the literature review, input from the expert panel, legislation, and professional standards.[6]

The questionnaire items had 4 options for the respondents' level of agreement with the statement ("strongly disagree," "disagree," "agree," and "strongly agree"). Also added was an "I don't know" (IDK) option as role clarity or ambiguity may be a function of knowledge and was therefore deemed relevant. Space was provided for commentary in several sections so that qualitative analysis could complement the quantitative findings. The draft questionnaire was piloted by 21 representative PNs and RNs for item validity (eg, relevance) and clarity (eg, readability, understanding of instructions). Post hoc psychometric testing of the RPN-RCQ was conducted to evaluate internal consistency, resulting in a Cronbach's α coefficient of .855. The complete description of the

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psychometric testing and analysis of the RPN-RCQ are beyond the scope of this article and will be described in a future publication.

Data Analysis

Statistical analysis was conducted using SPSS for Windows 17.0 (SPSS Inc, Chicago, Illinois). To enhance clarity of findings, the 4 response options were recoded into dichotomous variables of disagreement versus agreement (ie, strongly disagree plus disagree and strongly agree plus agree, respectively), with the responses of IDK maintained as a distinct category. Results are presented as frequency/percentage distributions for each classification of respondent ("Admin," PN, and RN). χ^2 Tests of independence were calculated for the demographic variables to determine whether the differences in responses were statistically significant.

Qualitative data from the online questionnaire and focus groups were analyzed using conventional content analysis[19] for the coding and identification of common themes. Relevant exemplars have been selected to complement the quantitative findings.

Ethical Considerations

All communications regarding the online questionnaire and focus groups included information regarding the purpose, voluntary participation, and assurance of confidentiality. No personal identifiers were requested or collected. This project was undertaken by the professional association (Registered Practical Nurses Association of Ontario [RPNAO]) in direct response to members' feedback regarding role confusion and practice frustration. The data and resulting "lessons learned" were intended for the development of resources for use by RPNAO and its members. As such, this study fell within the realm of quality improvement (Article 2.5, Tri-Council Policy Statement), and institutional review board approval was not required.[20]

Results

In total, 1101 questionnaires were received, representing participants from all sectors (hospital, long-term care, community and public health, and primary care) and domains of practice (direct care, administration [Admin], clinical education, and research). Because of the provincial engagement approach for recruitment, an overall denominator for a response "rate" was not possible.

Demographics: Questionnaire Respondents

Sixty percent (n = 661) of the sample were PNs, and the remaining 29% (n = 317) were RNs. Most (75%, n = 722) were direct care staff, with 25% (n = 235) in Admin (ie, managers, directors, and clinical educators). The Admin category consisted of both PNs (n = 77, 33%) and RNs (n = 158, 67%).

Just more than half of the respondents (51%) worked in a hospital, followed by long-term care (18%), community (9%), public health (5%), and primary care (5%). Sixty-one percent of the PNs were educated at the diploma level, and 39% were educated at the certificate level. Forty-four percent of the RNs had a baccalaureate degree, followed by diploma level (28%) and graduate level (28%). Late-career nurses (PNs and RNs with >15 years of experience) represented 45% of the respondents, with 28% each at midcareer (6-15 years) and early career (≤5 years). Table 1 presents background data. Missing data ranged from 11% to 14% and account for totals that may not sum to 100% in the detailed, descriptive tables.

A χ^2 analysis of the various demographic variables revealed no significant differences in responses among clinical manager, Admin/director, and clinical educator participants; therefore, these 3 roles were recoded as "Admin." This would allow comparison between direct care roles (PN and RN) and non–direct care roles (Admin).

Table 1. Respondent Demographics: General Survey

	Frequency	%
Professional designation		
RN	317	28.8
PN	661	60.0
Total	978	88.8
Missing[a]	123	11.0
Educational preparation		
PN diploma	386	35.1
PN certificate	247	22.4
RN diploma	99	9.0
Baccalaureate	155	14.1
Graduate	97	8.8
Total	984	89.4
Missing[a]	117	11
Role		
Direct care staff	722	65.6
Clinical manager	78	7.1
Admin/director/executive	91	8.3
Clinical educator	66	6.0
Total	957	86.9
Missing[a]	144	13
Practice setting		
Hospital	565	51.3
LTC	195	17.7
Community	103	9.4
Primary care	49	4.5
Public health	50	4.5
Total	974	88.5
Missing[a]	127	11

[a]Missing: data not entered by the participant.

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Although there were no statistically significant differences in the responses of the PNs and RNs, their results were maintained distinct. Similarly, there were also no relevant comparative differences in responses based on demographic variables such as educational preparation and length of practice.

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Survey Results and Qualitative Findings

Variations in Knowledge

For the item "The PN role is clear," the 3 categories of respondents were in general agreement, ranging from 53% (Admin) to 46% (PNs) and 48% (RNs). As to their awareness of the legislated, controlled acts for nursing, lower levels of agreement were identified in the item "PNs can perform the same controlled acts as the RN," with responses ranging from 30.4% (RNs) to 35.8% (PNs) and 37% (Admin). These agreement levels are important as this statement is "true" (ie, according to Ontario legislation) and indicates lack of knowledge within the scope of practice. The variation was also uncovered in the responses to items regarding the degree to which PNs and RNs are knowledgeable about the role and scope of practice in each other's role. Generally, there was higher agreement across all 3 categories that PNs are knowledgeable about the RN role and scope, with agreement ranging from 65% to 76%, but there was much lower agreement regarding RN knowledge about the PN (eg, 23%-37%) (Table 2).

Respect and Teamwork

The 3 categories of respondents' agreement were at the moderate to high level regarding the degree of teamwork and respect required between nurses in direct care roles. Furthermore, there were similar levels of agreement that PNs are viewed as being an equally contributing members of the team, used within teams for clinical decision making. Similar high levels of agreement were found regarding the items describing that PNs and RNs show mutual consideration, respect, and trust in the expertise and that there is generally harmony in the nursing team (Table 3).

An interesting observation was seen when comparing the quantitative findings with the qualitative commentary that depicted many examples of disharmony. Examples include the following:

> I once had a nurse manager tell me I was too intelligent to be a PN; I was RN material. I found this really insulting because to me it suggested PNs were stupid. (PN)

> PN stigma has skewed many managers' knowledge of the PN role, which in turn disallows PNs to work to their full potential. (Manager)

The Leadership Imperative

Across all categories of respondents, the agreement was strong, ranging from 58% to 73%, that nursing leaders, such as chief nursing officers, directors, and managers, have an understanding of the meaning of scope of practice and how this differs between the 2 direct care roles. Consensus was observed through the high levels of agreement (>70% for all items) that the role of leadership enables PN and RN team functioning (Table 4). Consistently, nursing leaders were seen as pivotal in ensuring good relationships, contributing to the climate, defining behavioral expectations,

Table 2. *Variations in Knowledge*

	Strongly Disagree/ Disagree, %	IDK, %	Strongly Agree/Agree, %	n
The role of the PN is clear.				
Admin	38	9	53	234
RN	43.6	8.5	47.9	188
PN	44	10.2	45.8	519
The PN can perform the same controlled acts as the RN.				
Admin	51.8	11.2	37	233
RN	64.4	5.3	30.3	188
PN	54.3	9.9	35.8	525
PNs are knowledgeable about the role of the RN.				
Admin	15.6	8.7	75.8	231
RN	17.4	9.2	73.4	184
PN	14.9	15.2	69.9	521
RNs are knowledgeable about the role of the PN.				
Admin	46.7	16.3	36.9	233
RN	58	10.2	31.7	186
PN	51.2	18.4	30.5	522

Rounding in the data tables as presented may result in totals not precisely at 100%.

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Table 3. Teamwork and Respect

	Strongly Disagree/ Disagree, %	IDK, %	Strongly Agree/ Agree, %	n
The PN is regarded as an equally contributing member of the healthcare team.				
Admin	18.9	5.6	75.6	233
RN	22	3.7	74.4	187
PN	26.4	5.0	68.7	520
PNs and RNs show consideration and respect for each other.				
Admin	23.7	15.8	65	234
RN	21.7	9.2	69.2	185
PN	21.6	13	65.2	523
PNs and RNs trust in the expertise of one another.				
Admin	23.5	20.1	56.4	234
RN	30.7	14.5	54.8	186
PN	26.1	16.7	57.2	521
PNs are sought out by members of the healthcare team for help with problems.				
Admin	21	15.4	63.6	234
RN	21.7	14.7	63.6	184
PN	18	14.2	67.7	521

and ensuring assignments appropriate to competency and patient complexity.

> It is up to the leadership to inform themselves and their teams about the PN role and how it is to be fully utilized on individual units. If the leaders are not clear, the units will most certainly not be clear. (Manager)

Organizational Practices

There were agreement levels (58%-83%) that organizational issues, such as restructuring and job insecurity, have had a negative impact on PN/RN teamwork. Although there were moderate to high levels of agreement (eg, 50%-66%) that scope of practice and models of care are seen as priority issues, a low level of agreement (<30%) responded that integrating the role of the PN with its broadened scope of practice had been a smooth transition. This was similarly identified in the high agreement levels (>80% for all categories) that there was wide variation on PN role enactment by specific units or departments or within their local region. The respondents noted that the specific model

Table 4. The Role of Leadership

	Strongly Disagree/ Disagree, %	IDK, %	Strongly Agree/ Agree, %	n
Those in leadership positions (eg, unit manager, chief nursing officer, program directors) have a good understanding of nursing scope of practice.				
Admin	18.1	18.1	63.8	232
RN	20.9	17.2	61.9	186
PN	26.1	16.1	57.8	521
Those in leadership positions have a good understanding of the difference between PNs and RNs.				
Admin	17.3	17.6	63.1	233
RN	20.5	9.9	59.6	186
PN	25.5	20.9	54.5	521
Clinical educators have a good understanding of what is meant by nursing scope of practice.				
Admin	9.9	16.8	73.3	232
RN	8	22	69.9	186
PN	8.5	20.2	71.3	519
Clinical educators are able to explain the difference between PNs and RNs.				
Admin	13.1	23.3	61.6	232
RN	12.4	26.9	60.8	186
PN	13.5	24.7	61.9	519

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of nursing care delivery can influence the respective scopes of practice. Along with this notion were lower points of agreement (33%-44%) about whether the PNs can fully use their competencies learned in their educational programs (Table 5). This can be a barrier to full scope of practice.

> They want to work to full scope of practice, but the organization limits them. (RN)

> The scope of practice for PNs in the hospital where I work is excellent. I have avoided applying for positions in hospitals where I know that I cannot utilize my full scope of practice. (PN)

The IDK Response Option

The IDK responses with the highest levels of ambiguity were in the organizational practice component, with 7 of the 10 items having IDK responses in proportions from 17% to 33%. Responses by category of respondent were approximately equal for the organizational items with high IDK responses.

Discussion

Changes to legislation, regulation, and education have highlighted the blurring or overlap in nursing roles. Nurses in direct care and leadership positions remain uncertain and struggle with the subsequent ambiguity to the point of frustration and team conflict. Those in Admin roles provide leadership in healthcare delivery systems and define processes and policies for role descriptions, performance appraisals, models of care, and nursing procedures. The proportion of IDK responses from this cohort about items relative to scope of practice, regulatory, and educational elements was concerning. Role ambiguity needs to be addressed in a formal manner with creative approaches for basic and clinical education, information, communication, and "change" initiatives for those providing leadership to nursing teams.

The results of this study highlight the vital role of nursing leadership in navigating this complex issue. Leaders must have the requisite knowledge of the

Table 5. *Organizational Practices*

	Strongly Disagree/ Disagree, %	IDK, %	Strongly Agree/ Agree, %	n
PNs are allowed to function to their full scope of practice (eg, no old polices or restricting scope).				
Admin	33	16.3	50.6	233
RN	38.6	15.2	46.2	184
PN	37.9	13.3	49.4	517
Scope of practice and models of care are viewed as a priority in our organization.				
Admin	20.9	18.4	60.7	234
RN	20.6	23.8	65.7	185
PN	24.6	25.8	49.6	520
Integrating the "new" role (eg, increased scope of practice) of the PN has been smooth.				
Admin	45.9	25.8	28.4	233
RN	47.8	29	23.1	186
PN	49.7	22.6	27.4	521
The knowledge and experience gained in PN educational programs are fully used in the practice setting.				
Admin	37.4	21.9	40.7	233
RN	31.3	33	35.7	185
PN	34.2	22.3	43.5	520
There is wide variability in how the full scope of the role of the PN is enacted (eg, unit to unit; regionally, by program).				
Admin	8.2	8.6	83.3	233
RN	9	6.9	84.2	189
PN	8.8	7.7	82.6	521
Organizational factors (eg, reorganization and job uncertainty) have had a negative impact on the way PNs and RNs work together.				
Admin	23.2	21.9	54.9	233
RN	17.3	22.6	60.1	186
PN	22.4	19	58.7	522
The nursing care delivery model in place (eg, total patient care, primary nursing, team nursing) plays a role in determining the scope of practice for the RN and the PN.				
Admin	21.4	18.5	62.1	233
RN	25.2	23.1	51.6	186
PN	23.3	20.9	47.7	522

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legislation, regulation, and entry-level competencies basic to nursing roles. As scope of practice continues to evolve and pressures to deliver quality care with the most efficient resources continue, navigating, mitigating, and resolving issues regarding role ambiguity have become a core leadership competency. The potential implications for not focusing on the role clarity/ambiguity issues of PN practice in a formal manner may hold the potential for negative impact at levels of the patient (eg, patient safety), nurse (eg, role satisfaction), and the health system (eg, availability of the right provider, providing the right care).

Suggested practices based on the key messages drawn from the findings and supported by existing literature include (1) optimizing the role of leaders in setting expectations regarding scope of practice, collaboration, and respect within the practice setting for PNs and others[6,8,15,21] and (2) creating nursing care delivery models based on principles of collaboration and partnership for optimal teamwork, respect, and knowledge sharing.[6,8,10,15,22,23]

Limitations

This is the 1st project of its kind to explore the PN role clarity issues in Ontario. The authors recognize the limitation of volunteer, self-report, and sampling biases given the dependence on respondents to forward the online survey to whom they considered might be interested in involvement. The provincial engagement included using a new instrument, the RPN-RCQ, and although initial psychometric testing revealed acceptable levels of internal consistency, further testing of the RPN-RCQ instrument is required. The authors also recognize that scope of practice and/or credentialing standards for different levels of nursing roles may be more differentiated in other countries or practice settings.

Conclusions

Scopes of practice will continue to evolve over time to meet the evolving needs of patient populations, technology, complexity, and the healthcare system. Increased clarity regarding roles and responsibilities is imperative to support decision making and optimal utilization of nursing resources.[6,24] The changes to legislation, scope of practice, entry-level practice competencies, and intraprofessional/interprofessional models of care have created the necessity to explore the value and functionality of each role within nursing formally and comprehensively. Consideration for further research of this topic in other countries and practice settings would contribute to our individual and collective understanding of this very complex issue that is present in practice settings globally.

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