EXPLORING WHAT QUALITY MEANS TO LICENSED PRACTICAL NURSES
AND IMPLICATIONS FOR PROFESSIONAL PRACTICE

By

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Abstract

Licensed Practical Nurses (LPNs) have a significant role to play in British Columbia’s rapidly changing health care system. The intention of this action research project was to engage LPNs registered with the College of Licensed Practical Nurses of British Columbia (CLPNBC) through individual interviews and an online survey to identify what quality nursing practice looked like and how they felt when they saw it or were part of it. The findings indicated LPNs placed considerable importance on the acquisition of competence, were sensitive to how their colleagues perceived their value as part of the nursing team, and expressed confusion as to how CLPNBC should advocate for quality practice among registrants. Based on these findings, recommendations were made that would facilitate opportunities for LPNs to demonstrate ongoing quality nursing practice. This organizational action research project was designed and conducted in full compliance with Royal Roads University’s (2007) Research Ethics Policy.
Acknowledgements

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I have genuinely learned to believe in myself and to trust the process. I look forward to the personal and professional journeys yet to come!
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Chapter One - Focus and Framing

The College of Licensed Practical Nurses of British Columbia (CLPNBC) was established under the Health Professions Act, RSBC 1996, c 183, with the mandate to regulate the profession of licensed practical nursing in BC. The organization has experienced a variety of challenges in developing a quality assurance program that will promote high practice standards amongst its registrants and as a result, this inquiry was prompted by those challenges. As expressed by one author, “The work of developing the science of regulation cannot be conducted in isolation . . . Regulation, education, practice and research share overlapping concerns” (Alexander, 2010, p. 3).

Located in Burnaby, B.C., the College of Licensed Practical Nurses of British Columbia (CLPNBC) is a health regulatory organization established in 1996, under section 12(1) of the Health Professions Act, RSBC 1996, c 183 (the “Act”). As one of 22 Health Regulatory Organizations (HROs) in B.C., CLPNBC (the “College) is mandated through this legislation to regulate the profession of licensed practical nursing in the public interest. As a non-profit organization fully funded through application and registrant fees, CLPNBC regulates approximately 12,000 registrants throughout the province. Section 16(2)(e) of the Act mandates CLPNBC to “establish and maintain a continuing competency program to promote high practice standards amongst registrants”. Unfortunately, the section of the Act that speaks to specifics of a continuing competency program, also referred to in the legislation as a quality assurance (QA) program, is not yet in force owing to other Ministerial priorities. As such there is nothing in the Act to dictate what a QA program should look like nor a description of the components it should contain. Protection of the public is a key objective of self-regulating professions, and “programs which ensure the competence of practitioners and the quality of their services are one of the core
responsibilities of the regulatory body” (Logan, 2003, p. 8). CLPNBC works closely with the provincial government and a variety of stakeholders, including employers and individual LPNs, to clearly define LPN practice, to make nursing practice safe and to ensure public protection.

As a nursing policy consultant with CLPNBC, I research and develop program policy and process. Glesne (2011) stated “action research has as its essence the intent to change something, to solve some sort of problem, to take action” (p. 15). In the past, CLPNBC has taken a broad approach to adopting QA principles having established a committee to oversee development of a QA program. The inquiry question this project explored was: What does quality mean to registrants and what implications does quality have on professional practice when it is or is not present? The sub-questions addressed to answer this overarching question were as follows:

1. What does quality nursing practice look like to the registrant?
2. What activities are LPNs currently engaging in to facilitate, support and maintain quality in their practice?
3. What indicators are registrants currently using and what others may be used to identify and measure quality nursing practice among registrants?
4. What implications do these findings have for those responsible for leading registrant-focused quality assurance program development within other health regulatory organizations?

Significance of the Inquiry

The struggle my organization faces to develop a quality assurance (QA) program that will provide valid, credible and reliable information on the practice of the profession, comes primarily in two areas: 1) determining how best to measure quality in registrants’ nursing practice; and, 2) identifying relevant indicators, activities, and tools that measure quality in registrants’ practice, and incorporating them into a formalized QA program. The overall change
this inquiry was meant to support is the development of a fulsome and relevant approach to identifying quality in the practice of registrants. This began with an exploration into what quality meant to registrants, and the impact quality had on professional practice when it was or was not present.

The first benefit was anticipated to come to registrants as an opportunity to take ownership for accountability in their professional practice, on their own terms, and within collaboratively defined parameters set by CLPNBC based on direct input from registrants themselves. Klatt, Murphy and Irvine (2007) concluded that “accountability is a promise and an obligation, to both yourself and to the people around you, to deliver specific, defined results” (p. 8, italics in original). The second benefit was expected to come to the organization in a streamlined process for identifying registrants who are struggling to maintain quality in their nursing practice so that they can be better supported by CLPNBC and their employer to get “back on track”, before they end up in an inquiry and discipline process with the College. Shared accountability exists for both CLPNBC in its commitment to protecting the public through the enhancement of registrants’ professional practice, and for registrants in taking advantage of the opportunity to identify gaps in their own practice. This perspective was and continues to be a significant driver for finding ways to improve the quality measurement process from its current state when this inquiry was launched. Ultimately, the public who receive care from CLPNBC registrants were anticipated to be the primary beneficiary to an improved quality assurance program.

It was recognized when this inquiry began that if CLPNBC did not meet its legislated mandate and the public were put at risk, controls and assurances on quality practice were not exercised, or a significant lack of clarity about professional obligation and what it meant for the
profession continued without correction, government would have the authority to deny the profession the continued privilege of self-regulation. Further, government could assume control and oversight of the profession by creating legislation that effectively absorbed the regulatory function of the regulatory body on an interim basis, dissolved the CLPNBC completely (Teachers Act [SBC 2011 c. 19]) or consolidated regulation of like-professions under a single College structure (Ministry of Health- Dentistry, 2012b, para. 1).

**Organizational Context**

The College of Licensed Practical Nurses of BC is made up of two separate yet interdependent entities: a College staff of 29, and the Board of Directors. Comprised of four public members appointed by the provincial government through an order in council, and eight elected LPN members, the Board is responsible for establishing the organization’s strategic plan. In regard to the College itself, three overarching programs are identified to carry out the CLPNBC’s work: the Executive Office, which includes Finance, Information Technology and Corporate Services, the Policy and Practice Department, where this quality measurement process inquiry would reside, and the Regulatory Services Department which administers credential assessment, registration renewal, and inquiry and disciplinary processes (CLPNBC, 2012a, p. 1).

In November 2010, I attended a meeting in which representatives from the Health Human Resource Planning and Legislative Branches of the provincial Ministry of Health (the “Ministry”) met with leaders from each of the 22 BC HROs for a forum discussion about legislated requirements related to quality assurance program development. Several topics were addressed resulting in a commitment that HROs could continue to develop QA programs as was appropriate for their professions. It was also stated that within the following 18 to 24 months, the timeframe Ministry representatives declared for enacting sections of legislation related to QA,
the Ministry would not sanction or revoke HROs’ existing programs and prescribe a ‘cookie cutter’ approach to QA program development. Since that meeting, CLPNBC has engaged in various data collection exercises related to registrant roles, employment, and professional development activities, calling these a quality assurance program. However, at the time this inquiry began, no analysis of the data had been undertaken to paint a true picture of the quality that existed in a registrant’s practice relevant to the variety of contexts and circumstances they found themselves in on a daily basis.

CLPNBC is authorized through provincial legislation (Health Professions Act, RSBC 1996, c 183, to set a variety of standards of practice for the LPN profession in BC. These include professional standards, practice standards, scope standards and ethical standards. Professional standards set out the expectations for how registrants are to behave while carrying out their nursing practice whereas practice standards assist registrants to apply professional standards to a specific aspect of practice such as medication administration or documentation. Scope standards identify the boundaries of nursing practice through limits; what LPNs are not permitted to do, and conditions; the circumstances under which registrants may carry out a particular nursing activity. Lastly, ethical standards outline the ethical obligations registrants have to the profession, the employer and the client. While not utilized by CLPNBC as a QA program tool per se, these documents have been used for registration purposes and the professional standards and practice standards were identified in a QA declaration (CLPNBC, 2012h, para. 3) that new registrants were required to complete as part of the initial registration application process with CLPNBC. These different types of standards documents are used by our practice support staff to support quality practice by those registrants experiencing practice difficulties. These are internal
QA processes, but were not the focus of this inquiry regarding the development and support of a registrant focused QA program.

The goal of such a program is to “promote high practice standards amongst registrants” (Health Professions Act, RSBC 1996, c 183), and as a rule is not designed to catch “bad practitioners”. Standards of practice have been utilized as an evaluation tool in CLPNBC’s internal registration, practice support, and inquiry and discipline processes. Significantly, specific sections of the BC Health Professions Act require both external registrant focused QA, and internal Inquiry/Discipline policies and processes be severed from each other, and a higher degree of confidentiality, greater than that of the BC Protection of Privacy Act, be applied to any information gained about or from a registrant through such a program or process. Therefore, information gathered through these external QA program activities would not be shared with other departments, although those departments have been permitted to share information they gather, with QA staff. As the organization moves forward, it will continue to clarify and emphasize this, acknowledging the importance of keeping the processes and associated activities separate to ensure confidentiality and adherence to the legislated requirements for conducting an external QA program, and to ensure voluntary participation and protection from legal sanction for practitioners disclosing practice errors.

Organizationally, the College’s Policy & Practice Department Operational Plan (CLPNBC, 2012g) outlines strategic priorities related to the development of a QA program. Relevant activities that would be engaged to meet the priorities include the creation of a quality assurance framework, a review of relevant literature to determine potential models that may be employed to assess registrants’ professional practice, development of policies and procedures, as well as measurement tools and evaluation processes (CLPNBC, 2012g, p. 3). This will also
include revision of the QA Committee terms of reference by incorporating a change from overseeing “the establishment, implementation, and evaluation of outcomes associated with the collection and analysis of registrant . . . nursing-related employment activities” (CLPNBC, 2011, p. 1), to an intra-professional focus on registrant professionalism and quality practice through internal data gathering, information analysis, and process development activities as set out in the department’s operational plan (CLPNBC, 2012g, p. 3). Staff from the Regulatory Services and Policy and Practice departments will be engaged in collaborative work through the sharing of information gathered during both registration renewal and practice support activities. Staff has been generally open to new learning to facilitate their work, but with several concurrent initiatives ongoing, there was the potential for becoming overwhelmed with information and struggling to see how it all fit together within the context of professional regulation.

As such, and with the opportunity to support an action research project that aimed to improve, if not redevelop CLPNBC’s external process for measuring the quality of registrants’ practice by gaining a better understanding of what quality means to registrants, I began this inquiry focused on meeting the organization’s Mission: “The CLPNBC is responsible for regulating the profession of Licensed Practical Nurses (LPNs) in the public interest” (CLPNBC, 2012f, para. 1) as it endeavoured to develop and improve its external quality assurance process. In an effort to be recognized as a leader in professional nursing regulation on the provincial, national and international stage, CLPNBC collaborates with other nursing regulatory and licensing bodies sharing information and learning about best practices related to quality assurance and quality measurement. This aligns with the College’s Vision: “Building excellence in licensed practical nurse regulation” (CLPNBC, 2012f, para. 2).
Finally, the essence of the organization’s work lies in its values. “CLPNBC is committed to being: transparent; accountable; relevant; collaborative; respectful; and fair” (CLPNBC, 2012f, para. 3). Interestingly, all of the values that guide CLPNBC’s work mirror expectations held for registrants’ professional practice, including ethics demonstrated “to adhere to moral norms of conduct and to assume an ethical and professional commitment primarily to the health and well-being of clients and families, but also to colleagues, employers and themselves” (CLPNBC, 2004, p. 4). Continuing competence is a non-negotiable aspect of being a professional and integral to demonstrating quality in one’s practice. Adaptability and collaboration are at the heart of achieving positive patient outcomes in an unpredictable and fast-paced health care system; this is what allows professionals to accomplish what they do on a daily basis. This lies in concert with what Kouzes and Posner (2007) offered “the clearer we are about our values, the easier it is to stay on the path we’ve chosen . . . it’s crucial that we have some signposts to tell us where we are” (p. 52).

According to the Canadian Institute for Health Information (CIHI) 8,501 LPNs reported working as a licensed practical nurse in British Columbia in 2011 (CIHI, 2012a, p. 49). From 2007 to 2011 the number of LPNs registered and working in BC rose from 5,791 to 8,501; a 46.8% increase (CIHI, 2012c).

LPNs work in a variety of clinical practice settings throughout BC. In 2011, the distribution of practice settings where BC LPNs reported working included: acute care hospitals (43.6%); community health agencies (6.1%); long-term care facilities (42.4%); and other places of work (7.8%) (CIHI, 2012a, p. 49). LPNs also work in non-clinical nursing domains, including administration, education and research. The gender distribution of males to females amongst BC LPNs in 2011 was 8.9% to 91.1% (p. 49). The age distribution of LPNs employed in BC in 2011
ranged from 45.1% under the age of 40, to 48.7% between the ages of 40 and 60, while 6.2% were over the age of 60 (p. 49). The average age of BC LPNs in 2011 was 41.6 years (p. 49). Just over 6,000 (6,048) of LPNs registered and working in BC in 2011 had graduated from their nursing programs in the previous 10 years (CIHI, 2012b).

Prior to June 30, 2012 all BC practical nursing students entered into a certificate nursing program of 49 weeks in length (BC Campus, 2012, p. 11). Beginning July 1, 2012, all CLPNBC recognized practical nursing programs began offering exclusively, a provincial practical nursing curriculum of 16-18 months duration for nursing educational preparation at the diploma level (BC Campus, 2012, p. 11, para. 3). While the educational preparation and resulting credential has changed, all graduate practical nursing students are still required to successfully complete the Canadian Practical Nurse Registration Examination (CPNRE) in order to be eligible to register with CLPNBC (CLPNBC, 2012d, para. 7).

Specific sections of the Health Professions Act, RSBC 1996, c 183, such as section 19(1), permit the CLPNBC Board of Directors to “make bylaws, consistent with the duties and objects of a college under section 16, that it considers necessary or advisable, including bylaws to do the following: (n) establish requirements for continuing education and for continuing competence for registrants”. CLPNBC bylaw 53(1) states “To be eligible for a renewal of registration, a... registrant must: (e) provide proof of having met the continuing competence requirement of the College as requested” (CLPNBC, 1998, pp. 22-23). Continuing competence requirements are identified further in the CLPNBC bylaws (1998) where “A registrant must complete all requirements of the continuing competence program as approved and required by the Board” (s. 55(1) and “Registrants must undergo a full competency review at least one every five years unless otherwise directed by the Board (s. 55(2). Finally, “registrants are obligated to evaluate
their own practice and identify gaps in their own practice on an ongoing basis” (CLPNBC, 2009, p. 7) according to the baseline competencies for licensed practical nurses, established by CLPNBC. “The continuing competence requirement is the method by which CLPNBC ensures public protection through the delivery of safe, competent and ethical care on the part of licensed practical nurses” (CLPNBC, 2012h, p. 2). As of March, 2014 CLPNBC does not have any mandatory continuing competence requirements in place, however CLPNBC has been collecting registrant self-reported practice hours during the past three annual registration renewal periods with a view to implementing a mandatory practice hour requirement beginning with the 2015 renewal period (CLPNBC, 2012i, para. 3).

Complaints received have been reviewed and sorted into relevant categories of fitness to practise, professional misconduct, incompetence, and unprofessional conduct (CLPNBC, 2012c, para. 6) with subsequent investigations focused on gathering evidence to support case decision-making by the CLPNBC Inquiry Committee. The numbers of complaints received by CLPNBC have fluctuated since CLPNBC was established under the Health Professions Act in 1996, but with the introduction of Duty to Report legislation under sections 32.2, 32.3, and 32.4 of the Health Professions Act, RSBC 1996, c 183, the number of complaints and subsequent investigations into registrants’ competence increased between 2007 to 2011 from a low of 29 in 2009 to a high of 72 in 2011 (CLPNBC, 2012b, para. 6). It is expected that this trend will continue upward for the foreseeable future.

**Systems Analysis of the Inquiry**

CLPNBC has been constantly tasked with finding better ways to regulate nursing practice in order to protect the public. However, because of ongoing systemic change the organization has often been perceived by its registrants as doing something for the public at their expense,
because of their confusion as to the actual purpose of the regulatory body. Bolman and Deal (2008) explained “from a political perspective, conflict is natural. It is best managed through processes of negotiation and bargaining, where settlements and agreements can be hammered out” (p. 386). Situations such as this require greater clarity through the provision of information to differentiate the roles of the regulatory college, the professional association and the union; all of which provide services to LPNs in BC in one capacity or another (CLPNBC, 2012j, para. 1). “It seems that there is confusion and concern as to the College’s involvement . . . the College is not associated in any way with any website or newsletter produced by associations or other organizations related to Licensed Practical Nursing” (CLPNBC, 2007, p. 8). Formally seen as an organization created through legislation that governed based on regulation, CLPNBC represents but a layer within the BC health care system and shares responsibility for the provision of quality health care services by LPNs in BC.

**Shared responsibility for controls on nursing practice.** “A system is composed of parts, but we cannot understand a system by looking only at its parts. We need to work with the whole of a system” (Wheatley, 2006, p. 139). There are four levels of control on nursing practice in British Columbia: the provincial Government; the regulatory body; the employer; and the individual LPN (as shown in Figure 1 below).
Improving Quality Measurement Processes

Figure 1. Controls on LPN practice- A shared responsibility.

Each level successively narrows practice by more clearly defining what is expected of an LPN, and the criteria under which their nursing practice must be carried out. CLPNBC collaborates with each of the other levels to make nursing practice safe and to protect the public. The first and broadest level of control is government that creates legislation and regulation which includes information to guide the development of quality assurance programs, policies and processes. The Regulation is written very broadly with the expectation that the regulatory body (CLPNBC), at this next level, will develop bylaws, programs, policies, standards, limits, and conditions to place boundaries on LPN practice and the performance of activities that are higher risk, or are new to LPNs in B.C. This is one way that external quality assurance mechanisms work to define expectations for quality and ongoing competence in registrants’ practice. In turn, employers develop policy to support practice and evaluation processes that explain what an LPN is expected do in their workplace. An employer may also choose to provide educational supports and resources to ensure ongoing quality of service to the public. Finally, the individual LPN is
responsible for ensuring that she or he is competent to carry out an activity and to identify gaps in their own competence. The LPN is also required to seek out activities to ensure maintenance of competency and quality in their practice as a professional nurse.

**Accountability.** CLPNBC has multiple accountabilities to various external stakeholder groups within the province related to QA (see Figure 2 below).

*Figure 2. Systemic accountabilities for ensuring quality in registrant practice and care provision.*
The general public. The largest of these groups is the general public who receive care services. While stakeholder accountability for various care provision and quality assurance activities may be perceived to be reciprocal within the system; when it comes to being accountable to the public for the services these entities provide, accountabilities related to ensuring the public of quality are to some degree one-sided for CLPNBC, the Ministry, the professional association (LPNABC), employers, and registrants. For example, CLPNBC’s overall mandate is public protection, but the public does not have any accountability to CLPNBC to ensure quality in the practice of a registrant who is providing care to them. The public holds CLPNBC accountable for adhering to its legislated mandate, but CLPNBC does not hold the public accountable for its involvement in ensuring quality care is provided to them. In addition, regulated health care professionals are bound by duty-to-report legislation whereas members of the public are not, although the public is strongly encouraged to bring poor quality practice to the attention of the regulatory body wherever possible.

Provincial government: Ministry of Health. Government is elected by the public, and the public expects government will create legislation and regulation that result in “creating better health outcomes for British Columbians through a more efficient, sustainable health system” (Government of British Columbia- Ministry of Health, 2012a, p. 2). Reciprocal accountability within the system exists here in that the Ministry of Health, through legislation, requires CLPNBC to develop a QA program, and holds CLPNBC accountable for measuring and reporting in general terms on the quality of practice for the profession as a whole. Reciprocally, CLPNBC requires the Ministry to develop guiding legislation and regulation so that CLPNBC has some parameters within which to work as it develops its program policies, processes, and requirements relevant to QA and quality measurement. CLPNBC’s work to clarify appropriate
QA program components, once legislative changes come into effect, will require ongoing communication with Ministry staff and stakeholder groups to gather information and eventually discuss findings from the consultation.

**Licensed Practical Nurses Association of BC (LPNABC).** The LPNABC (the “Association”) is a professional association that advocates for LPNs in BC. “LPNABC promotes professional excellence and lifelong learning with strength through a unified voice representing the Licensed Practical Nurses of British Columbia” (LPNABC, 2012, p. 1). The Association may impact political aspects of the system by lobbying government for increased wages, added job classifications and benchmarks, or for expanded credentialing, utilization and opportunities within the healthcare system for LPNs in BC. Their advocacy work would be the result of CLPNBC QA requirements for increased registrant accountability in seeking educational supports to maintain quality practice. “The political prism puts more emphasis on strategy and tactics than on resolution of conflict” (Bolman & Deal, 2008, p. 206). Therefore, at this time CLPNBC cannot predict what will happen in the system related to the Association’s efforts.

**Practical nurse (PN) educators.** Responsibility for the preparation of nursing students for entry into the profession lies with practical nurse educators working in post-secondary institutions across the province. While CLPNBC is authorized to “establish . . . standards of academic or technical achievement” (Health Professions Act, RSBC 1996, c 183), required to become registered with CLPNBC, it is limited to only being permitted to “recognize” PN programs that offer the Provincial PN curriculum such that the program will adequately prepare students to write the Canadian Practical Nurse Registration Examination (CLPNBC, 2012d, para. 1). Entry-level nursing programs are available through both public and private educational institutions and a significant component of the practical nurse curriculum includes facilitating
increased awareness and understanding of the LPN’s professional obligations once they become a CLPNBC registrant (BC Campus, 2012, p. 23). Educating students about their future professional standards and QA requirements is the role of PN educators and not CLPNBC (CLPNBC, 2012d, para. 2). In addition to the importance of adhering to professional standards and a code of ethics for the provision of safe, competent and ethical care, students are taught that LPNs must meet any quality assurance and continuing competence requirements imposed on them by CLPNBC (BC Campus, 2012, p. 41). While CLPNBCs legislated mandate does not permit it to impose QA requirements on non-registrants nor can it dictate QA related curriculum content to the schools that teach the PN program in BC, CLPNBC is only permitted to evaluate an LPN’s understanding and adherence to QA requirements once they have graduated from their program and become registered with CLPNBC (CLPNBC, 2012g, para. 1).

**Private and public employers.** A significant majority of LPNs in BC are employed by either a private or public employer (CIHI, 2012a, p. 49). Employers create policies and other resources and supports to facilitate quality health care provision in and by their organizations. While individual LPNs have the expectation they will be able to meet their professional standards and any quality assurance requirements placed on them by CLPNBC in their workplaces, they need to work with their employers to access those supports and resources. Historically, CLPNBC has kept its QA efforts separate from those of employers, and employers have declined to become involved in CLPNBC QA programs and processes, choosing instead to focus in their own internal QA program evaluation and risk-management activities. However, through collaboration at both the regulatory and employer levels within the health care system, there may be opportunity to create quality measurement processes and standards applicable to both the individual nurse as registrant, and to their practice within the context of their
employment setting. This in turn may create a more fulsome picture of quality professional practice among LPNs in BC in the future. Broader legislative and regulatory revision may be required to accommodate issues experienced by both private and public sector employers as they try to develop education, supports and resources to facilitate quality practice in their workplaces. Nonetheless, CLPNBC must ensure that its “systems and processes should be flexible enough to support the information needs required to meet changes in strategies, markets and competition” (Commonwealth of Australia, 2000, p. 6) so that stakeholders will be able to identify CLPNBC as meeting its public protection mandate through its QA program and processes.

**Chapter Summary**

The College of Licensed Practical Nurses of British Columbia regulates professional practice by setting a variety of standards of practice for the LPN profession. In addition to setting standards, CLPNBC is mandated under the Health Professions Act to “establish and maintain a continuing competency program to promote high practice standards amongst registrants” (Health Professions Act, RSBC 1996, c 183). Although the goal of such a program is to “promote high practice standards amongst registrants”, it is important to note that it is not designed to catch “bad practitioners”.

QA is more than a set of tools and methods. It is a spirit, where clients become demanding and express their expectations, where health providers question their own performance, and where managers make client oriented decisions, based on data, to redesign and improve a system continuously. It does not happen overnight. (Bouchet, Francisco & Ovretveit, 2002, p. 95)

This inquiry focused on supporting the organization’s endeavours to develop and improve its external quality assurance process thereby meeting its Mission: “The CLPNBC is responsible for regulating the profession of Licensed Practical Nurses (LPNs) in the public interest” (CLPNBC, 2012f, para. 1).
Chapter Two: Literature Review

This review of literature is intended to gain an understanding into the inquiry question: What does quality mean to registrants and what implications does quality have on professional practice when it is or is not present? Willis, Evans, Stoelwinder and Cameron (2007) declared that it is not enough for a health care provider to simply say that they provide quality care or that quality exists in their practice as a self-regulating professional (p. 276). Validation of such statements requires the identification, measurement, and evaluation of the quality of care that is being or has been provided by the health care provider.

This literature review will begin with a focus on identifying and measuring quality and then move to a discussion on its measurement in nursing practice through the use of clear and relevant quality indicators to facilitate quality improvement. That will be followed with an exploration of quality assurance by nurses as it relates to the concepts of self-regulation, self-assessment and reflection. The final aspect of this review will focus on the importance of consistent and supportive leadership in the face of transformational change and the impact culture and resistance to change can have on an organization when moving forward in support of quality improvement.

Identifying Quality and its Measurement in Nursing Practice

“To measure quality, our concepts of what quality consists in must be translated to more concrete representations that are capable of some degree of qualification” (Donabedian, 1988, p. 1147).

Obligations of professional regulatory bodies to measure quality in the practice of its registrants.

A major problem confronting health care today is the perception that by simply collecting data, performance and/or quality will improve. Some regulatory bodies believe that data
collection in and of itself will lead to quality improvement. The assumption is that simply paying attention to something (i.e. data collection) will uncover issues and drive staff to make changes. (Kosel, Gelinas & Paxson, 2007, p. 97S)

Bolman and Deal (2008) explained “A standard is a benchmark to ensure that goods and services maintain a specified level of quality” (p. 55). Mainz (2003) further explained that monitoring health care quality is impossible without the use of quality indicators (QIs); they create the basis for quality improvement and prioritization in the health care system (p. 523). QIs are meant to facilitate rapid, actionable change and should be used as a focus for feedback and learning, leading to improvement rather than blame (Freeman, 2002; Willis et al., 2007). In the realm of professional regulation, the object of creating QIs to be used for QA purposes is to create a “no blame” culture where issues can be addressed and poor practice remediated before an adverse event occurs. Quality, at best can be protected and enhanced but not assured. “Quality itself is a social construct and without personal commitment to quality in our work and pride in accomplishing it, no amount of organizational planning will be enough to safeguard it” (Koch, 1992, p. 785).

**Defining quality.** Van Berkel and Wolfhagen (2002) proposed that much has been written on the meaning of quality and many definitions have been suggested (p. 337). For example, Needleman, Kurtzman and Kizer (2007) implied that nurse training and competencies reflect the skills individual nurses bring to the hospital and the bedside (p. 15S). Van Berkel and Wolfhagen (2002) explained that Harvey and Green (1993) tried to classify definitions into five discrete but interrelated ways of thinking about quality: “1) quality as exceptional, 2) quality as perfection of consistency, 3) quality as fitness for purpose, 4) quality as value for money, and 5) quality as transformation” (p. 337). They concluded that it is not possible to talk about quality as a unitary concept; quality must be defined in terms of a range of qualities (p. 337). Donabedian
(1988) said that when specifying what quality is and before attempting to assess the quality of care, either in general terms, or in any particular site or situation, “it is necessary to come to an agreement on what the elements that constitute it are. To proceed to measurement without a firm foundation of prior agreement on what quality consists in is to court disaster” (p. 1743).

**Quality in the context of nursing practice.** Interestingly, the literature reviewed provided a variety of differing views on quality among the various health care professions. While foundational education prepares health care professionals to take on the responsibility for carrying out activities seen to be representative of quality practice, nursing is seen by some as unique in the way it prepares practitioners to provide quality care: “nursing knowledge arises from the intertwining of nursing education, nursing practice and nursing research. It is manifested in nursing activities and behaviours . . . the presence or absence of these activities determines the degree of the quality of nursing care” (Gunther & Alligood, 2002, p. 355). Vuori (2007) raised some concerns with this “uniqueness” and stated “unfortunately though, it is their training and socialisation into the profession that may contribute to a negative attitude toward quality assurance . . . education emphasises independent judgement . . . practice is characterised by narrow specialisation” (p. 11). Pelkonen (1994) further explained that quality assurance in nursing is a way to demonstrate explicit accountability to patients, an aspect forgotten by those who see professionalism as only safeguarding its own benefits (p. 26).

**Indicators in nursing.** Idvall, Rooke and Hamrin (1997) identified that while indicators are selected and developed from important aspects of care or key functions in nursing care, there is little discussion in the literature about indicators that are “strategic, professional and of particular importance for the quality of nursing care” (p. 12). Similarly, Shwartz, Burgess and Berlowitz (2009) suggested there is a trend in health services to add indicators that broaden the
definition of quality and reflect on its many aspects, rather than adding measures that are consistent with existing measures (p. 235). While nurses cited the ability to act in the best interest of the patient as the prime indicator of quality practice (Coulon, Mok, Krause & Anderson, 1996; Gunther & Alligood 2002; Lynn & Moore, 1997; Williams, 1998), adverse events, along with traditional volume indicators (such as length of stay), "have little in common with either patients' or nurses' perceptions of quality care” (Gunther & Alligood, 2002, p. 355).

**Behaviour.** When one thinks about facilitating quality practice, the question of what quality looks like comes to the forefront. One suggestion found in the literature reviewed was that the behaviour of the practitioner is demonstrated in a way that appears to be consistent with expected outcomes of quality care. Several authors spoke about behaviour and behaviour change as a measure of quality: Adelson, Hepburn and Vanloy (1997) focused on three stages in the change in behaviour; awareness, competence, and performance (p. 70). Awareness, for example, includes elements of knowledge acquisition, recognition that innovation exists, and a preliminary evaluation of significance to the practitioner (i.e. “this could apply to me”). An array of sources can trigger this awareness including “journal articles, publications, news releases, continuing education (CE) programs, professional meetings, and interaction with colleagues” (p. 70). Gunther and Alligood (2002) posited that by defining quality from the nursing profession's frame of reference, one focuses on evaluating services provided; that is, nursing actions and behaviours linked to the use of nursing knowledge (p. 353).

**Competence.** Gunther and Alligood (2002) warned that while high quality nursing equates with competence in the cognitive, affective and psychomotor domains, “unfortunately, only cognitive, and psychomotor competencies dominate nursing education and nursing practice” (p. 357). Therefore the suggestion arises that competence, and subsequently, behaviour
may be negatively impacted if the affective domain is not properly addressed through nursing education. Adelson et al. (1997) further defined competence as “the capacity to perform the desired behaviour. Practitioners must acquire the appropriate knowledge, skills, and, in some cases, attitudes that are necessary to incorporate the proposed behaviour into their clinical repertoire” (p. 70).

**Performance.** Donabedian (1988) identified two elements in practitioners’ performance; one technical, the other interpersonal. He explained that technical performance was dependent on the knowledge and judgment used in arriving at the appropriate strategies of care and on skill in implementing those strategies, whereas successful interpersonal performance “is the vehicle by which technical performance is implemented and on which its success depends” (p. 1743).

Ritzer (1993) and Riehle, Hanold, Sprenger and Loeb (2007) agreed on the perspective that in today’s healthcare system, the employee is not required to think but merely to follow instructions. This causes significant concern and potential danger in a profession where the public relies on safe care from a provider who is competent; possessing the knowledge, skill, judgment and ability to carry out relevant care activities safely and ethically. This is where indicators are used as a focus for feedback and learning, leading to improvement.

**Internal quality improvement versus external registrant-focused quality assurance.** Freeman (2002) observed that indicators for external accountability are of little use in understanding how interventions or implementation processes have influenced internal results, and are not capable of showing why particular results are obtained, as is required to inform policy and programme amendments (p. 129).

**Importance of clarity of purpose when developing indicators.** For a quality assurance program to be valid and credible, careful attention must be paid to the selection of clear and well-
defined measures, data collection, quality and verification, and the way in which the data quality are reported (Farquhar, Kurtzman & Thomas, 2010, p. 252; Klaus, Boyle & Simon, 2009, p. 12; Koch, 1992, p. 789; Riehle et al., 2007, p. 78S). Any attempt at measuring quality must first establish purpose and from whose perspective the measurement is occurring. Stakeholders must discuss and agree on which indicators to include (Kosel et al., 2007, p. 101S; Mainz, 2003, p. 524; Willis et al., 2007, p. 277). The purpose for developing quality indicators is predicated on identifying what the indicator will be used to measure; structure, process or outcome, as well as who will be using the indicator; leadership and management, or frontline workers (Donabedian, 1998, p. 1746; Kosel et al., 2007, p. 87S; Mainz, 2003, p. 523; Tarr, 1996, pp. 80). “Each measurement should be traceable, and the system must focus on measurement as information, not measurement as control; measurement systems must be constantly re-evaluated” (Tarr, 1996, p. 80).

**Frameworks and indicators.** Gunther and Alligood (2002) stated “nursing frameworks contain epistemological questions that revolve around the ways the nurse knows and the structure of knowledge” (p. 355) and recommended a framework for defining quality of care based in nursing’s unique body of knowledge through identification of nursing actions associated with high quality care. Needleman et al. (2007) expanded on this by stating that “a fully functional system of nursing-sensitive performance measurement requires the development of measures that address all the domains of nursing that should be monitored” (p. 28S).

**Planning for measurement.** Riehle et al. (2007) offered that when beginning development of a measurement framework, a review of the literature specific to performance measurement must be completed to establish the key questions, identify the evidence base, and find preliminary measures. Several authors also stressed that it is necessary to establish this
relationship before any particular component of structure, process or outcome can be used to assess quality (Donabedian, 1998; Needleman et al.; Redfern & Norman, 1990).

This allows the weakness in one approach to be bolstered by strength in another; it helps one interpret the findings; and if the findings do not seem to make sense, it leads to reassessment of study design and a questioning of the accuracy of the data themselves. (Donabedian, 1998)

**Keeping it simple.** The key to understanding successful measurement methodologies is to make them conceptually sound, simple to follow, and realistic. Multiple authors (Freeman, 2002; Kosel et al., 2007; Mainz, 2003; Willis et al., 2007) argued the need for measurement methodologies that are uniform in nature and simple for participants to apply, while also admitting that QI development is not easy. Kosel et al. (2007) concluded “understanding what to measure and how to select appropriate measures is one key reason measurement isn’t simple” (p. 87S). Therefore, it is critically important that stakeholders share a common understanding of the intended use of any proposed indicators.

**Strategies underlying indicator development.** Berwick (1996) explained that to make improvements one must be clear about what the organization is trying to accomplish and how they will know that a change has led to improvement. “Measurement helps to know whether innovations should be kept, changed, or rejected to understand causes and to clarify aims” (p. 619). Several authors identified that development of indicators may take either a “top-down” or a “bottom-up” approach (Fitzsimmons, 1992; Hamilton 1992; Harvey 1991; Idvall et al. 1997; Kitson, 1989; Redfern & Norman 1990; Smeltzer, 1987). Idvall et al. (1997) explained that a “bottom up” model means that indicators are set, monitored and evaluated by staff at the local level, while a “top-down” model means that the indicators are developed by key people at the top of an organization or outside the organization (p. 10). Adelson et al. (1997) cited the importance
of practitioners being predisposed to change and having the appropriate knowledge and skills to implement change. It is also important that structures within the organization enable and maintain new behaviours (p. 69).

**Considerations.** Idvall et al. (1997, pp. 9-12), McCance, Telford, Wilson, MacLeod and Dowd (2011, p. 1149), and Needleman et al. (2007, p. 12S) agreed that certain things need to be considered when developing performance indicators: the selection of indicators is an important part of the quality assurance process; specific information is needed when identifying indicators, and before they can be used in quality assurance; the need for indicators to be reflective of standards; the need to develop methodologies that can produce evidence to illustrate performance; and clinical indicators are not a direct measure of quality— it merely flags a deviation from the desired norm.

McCance et al. (2011) further suggested that although the task of identifying indicators that are sensitive to nursing and midwifery care is a challenge, the use of appropriate and relevant performance indicators provides an opportunity to demonstrate the unique contribution of nurses and midwives in delivering outcomes for patients and clients (p. 1146).

**Using quality indicators to measure structure, process and outcomes.** Several authors (Kosel et al., 2007; Mainz, 2003; Willis et al., 2007) have discussed the purpose of developing structure, process and outcome related QIs, and the use of these different measures to identify quality; “the key to developing performance measures is to first understand the nature and scope of the issue you are faced with and then to define what success (the desired outcome) will look like” (Kosel et al, 2007, p. 86S). Mainz (2003) explained that “the assessment of structure is a judgement on whether care is being provided under conditions that are either conducive or contrary to the provision of good care” (p. 525). Redfern and Norman (1990) and Willis et al.
(2007) also described structural indicators as related to the structure of the setting in which care occurs, outlining attributes such as material resources, human resources, and organizational structures that impact the quality of care provided in those settings. These same authors, along with Mainz (2003) proposed that process indicators denote what is actually done in giving and receiving care, i.e. the practitioner’s activities in making a diagnosis, recommending or implementing treatment, and providing immediate information. Outcome indicators are states of health or events that follow care and may be affected by health care. They may require a longer time frame to develop and can therefore be more difficult to collect data on.

**Measurement against standards.** Redfern and Norman (1990) proffered that quality and standards are closely related but are distinguishable in that quality is something we constantly strive for and which we may never achieve, whereas standards are attainable if set at a realistic level (p. 1261). One of the purposes of performance measurement is to perform to a certain standard or goal. “If the performance measurement is an indirect measure of the goal, the measure often becomes a substitute for the goal itself” (Tarr, 1996, p. 82). Koch (1992) advocated "to effectively evaluate care, one must first define what constitutes nursing systems, function, staff performance and patient care. Standards provide the basis for criteria development, the compliance and effectiveness of the standards” (p. 787).

**Validity of the measurement process in nursing practice.** Willis et al. (2007) defined validity as something that refers to the ability of the indicator to accurately measure the area of quality it intends to measure (p. 279). This subjectivity means that the reliability and validity of the instruments, as measured by conventional quantitative techniques, is likely to be low, “although this may be lessened with extensive validity testing in relation to the concepts of quality that they purport to measure” (Redfern & Norman, 1990, p. 1268). Adelson et al.
proposed that “validity concerns the perceived technical or scientific merit of the proposed innovation or change”, and suggested that one question whether practitioners believe it to be effective in an attempt to answer the question of validity (1997, p. 71). Klaus et al. (2009) offered that for validity to be present, an instrument must be an authentic measure of the event it claims to measure. “Nurse leaders need to interpret the reported statistics correctly and know the strengths and limitations of each statistic” (p. 13). “One cannot assume that an instrument developed for another population will include all dimensions that their population views as components of good nursing care” (Larrabee & Bolden, 2001, p. 49).

In summary, it is incumbent that regulatory bodies understand data collection does not equate to performance improvement. While developing assessment methods that ensure all practitioners of a health profession are competent remains a significant challenge, the process needs to balance public safety while maintaining the expectation for self-regulation by the health care professional (Austin, Croteau, Marini, Violato & Dan, 2003, p. 2). Defining what quality is and what it looks like can also be challenging, but most often the researchers and authors reviewed defined quality as “fitness of purpose” which varies among different health care professions. “This definition allows for variability in institutions, rather than forcing them to be clones of one another” (Van Berkel & Wolfhagen, 2002, p. 337).

Quality indicators that focus on structure, process and outcome are used for feedback and learning that leads to practice improvement in the areas of professional behaviour, competence and performance. They provide nurses an opportunity to demonstrate the unique contributions they make to client care. It is also important to note that before indicators can be developed, all participants, beginning with frontline staff right up to the leadership of an organization, need to define their goals, agree on the use of the data to be collected and design systems to achieve the
task of data collection (Willis et al., 2007, p. 278). The intention of quality measurement therefore, is to help professionals understand what constitutes best practice, and to help improve patient outcomes accordingly.

While regulatory bodies and employing organizations take responsibility for setting the expectations (standards) and requirements (indicators) for quality that a practitioner must meet, it falls solely to the regulated nursing professional to determine how they will meet the requirement in their own practice. The next topic explores nurses’ obligations for quality professional practice.

**Quality Assurance by Self Regulating Professionals in Nursing**

**Why self-regulation.** Sinclair (1997) posited simply that “self-regulation is of course not a new phenomenon” (p. 530). Evetts (2002) expanded further on this and stated “professional workers have been characterized as having autonomy both in respect to their professional judgments and decision-making, and in respect of their immunity from regulation or evaluation by others” (p. 341). “Discretion is the most important aspect of professional judgment and is what makes the distinction between self-regulation and external forms of regulation” (p. 341). Pelkonen (1994) added “the idea of self-regulation has also clearly fostered the belief in the nurses’ own possibilities and abilities” (p. 26), thus, the behavior is valued and is perceived as being chosen by oneself (Pelletier, Fortier, Vallerand & Briere, 2001, p. 281). Regehr and Eva (2006) summarized these other authors’ thoughts and clarified “part of the expectation of being a professional is a demonstrated willingness to engage in personal, individualized efforts to maintain a minimum level of competence” (p. 34). The importance of the individual practitioner taking responsibility for engaging in quality practice is stressed by many authors (Gunther & Alligood, 2002; Handfield-Jones, Mann, Challis, Hobma, Klass, McManus, Paget, Parboosingh,
Wade & Wilkinson, 2002; Pelkonen, 1994; Vuori, 2007). However, the focus on individual practitioner responsibility for quality practice has only occurred more recently.

Handfield-Jones et al. (2002, p. 952) and Regehr and Eva (2006, pp. 34-35) explained that the self-regulating model of daily practice involves the professional following a set of continuously enacted steps: (1) reflection on daily practice to self-assesses daily performance; (2) identification of certain areas of personal knowledge or skills that seem to have dropped below professional (or personal) standards of practice; (3) recognition that leads to a decision to seek opportunities to improve in these areas; (4) engaging in appropriate learning opportunities to learn (or relearn) the knowledge or skills to perform well (at or above the minimum professional or personal standard); (5) the new knowledge or skills are put into action; (6) performance is reassessed to ensure achievement of (at least) the minimum standard of practice in this area of performance; and (7) the process is repeated as needed where needed. This cycle of behaviour is where the opportunity to discover the personal and professional meanings of quality lies, and to align those discoveries so that the client’s best interests are served above all else (Evetts, 2002; Gunther & Alligood, 2002). This lies in congruence with Schunk and Zimmerman’s (1998) statement that accurate self-perceptions, coupled with incremental beliefs about the possibility of change, “are much more propaedeutic for learning than overly optimistic and general feelings of self-esteem, which can actually be misleading and ultimately detrimental to learning” (p. 71).

Self-regulation and professionalism. Regehr and Eva (2006) explained that professional self-regulation has two equally important actions. The first requires regulatory authorities to respond to problematic members of their community by assessing the individual’s situation. The second involves taking responsibility to determine sanctions, place limitations on practice, and/or provide support for re-education as necessary (p. 34). From a regulatory perspective these
actions facilitate ensuring a minimum standard of performance among the profession’s members while ensuring public safety. However, this model also depends on the regulator to act when practice is poor, and does not address the employer’s responsibility to act since the regulator has no role in employee supervision. Further, it does not address the concept of self-regulation requiring the professional to take responsibility for identifying the limit of their skills, and remediating gaps to lead to improved performance in practice (Duffy & Holmboe, 2006; Eva & Regehr, 2011). The traditional model of self-regulated professional development “presumes that an individual will select ongoing learning activities that fill professional gaps, but this assumes that the professional can effectively self-assess” (Regehr & Eva, 2005, p. S46). In fact, Davis, Mazmanian, Fordis, Van Harrison, Thorpe and Perrier (2006) identified that health care professionals were poorer at performing accurate self-assessment than most other professionals (p. 1094). This raises doubts about the capacity of individuals to effectively self-assess personal or professional areas of relative strength and weakness (Davis et al., 2006, p. 1095). Therefore, when learning takes place in a self-regulating profession, that profession’s regulatory authority must be more attentive in ensuring the activity does take place rather than relying only on the professional’s personal drive to do so.

**Self-assessment capacity.**

There is a complementary set of functions served by the ability to accurately self-assess one’s strengths. The right path is not always smooth even if it is right, and early abandonment of an appropriate plan of action is as costly as selecting an inappropriate plan in the first place. (Eva & Regehr, 2005, p. S46)

The belief that professionals have the capacity to self-assess appropriately in a variety of contexts related to quality measurement practices is highly disputed. In addition, whether or not the professional will self-assess, and then know how and what to do to remediate deficiencies or gaps in their practice also remains an area of dispute among researchers. Parker, Alford and
Passmore (2004) stated “self-assessment skills are generalized skills that operate similarly across a variety of tasks and contexts and are directly related to competence in the subject area” (p. 705), whereas Regehr and Eva (2005) suggested self-assessment requires the involvement of learners in judging whether or not learner-identified standards have been met. They stated “effective self-assessment is vital for setting realistic expectations of one self, to avoid setting oneself up for failure” (p. S46). Eva and Regehr added to their research in 2011 and further offered that “the goal of focusing upon self-assessment should be to develop an understanding of what self-assessment is and how to use it as a means to improving practice” (2011, p. 327).

Several studies found that high achievers tend to underestimate their performance relative to the expected standard, and underachievers tend to overestimate their performance relative to the expected standard (Davis et al., 2006; Parker et al., 2004; Regehr & Eva, 2006; Ward, Gruppen & Regehr, 2002). “While each of us has areas of competence that may be below our own personal standard, we believe with certainty we are not below the minimum acceptable standard” (Regehr & Eva, 2006, p. 38). However, as Regehr and Eva further suggested, “It is important to remember for any given skill, 25% of us are in the bottom quarter of performance” (p. 38). One reason practitioners may not be good at recognizing gaps in their practice is that “they often confuse confidence with competence” (Duffy & Holmboe, 2006, p. 1137).

**Linking reflection in action to reflection on action.** Regehr and Eva (2005) maintained that the emphasis of reflection-on-action has become more important than reflection-in-action in the self-assessment literature (p. S51). However, Wilson (2008) identified the importance of engaging in both reflection-in-action and reflection-on-action. He stated that by limiting oneself in the way they reflect on and assess their own practice,

There is . . . a reduced opportunity to learn from the things we do well and to correct the things which we do less well” . . . By consciously reflecting on past actions there is the
opportunity to appraise and evaluate what has happened and to identify possible areas for improved performance. (pp. 178-179)

Reflection, in and of itself, involves on the spot surfacing, criticizing, restructuring and testing of one’s instinctive understanding of an experience, and is central both to the practitioner’s ability to successfully complete projects and to their professional development (Hatton & Smith, 1995; Riehle et al., 2007; Schon, 1983; Wilson, 2008). By engaging in reflection-in-action, it implies that the professional has reached a stage of competence where they are able to think consciously about what is taking place and modify their actions almost instantaneously (Riehle et al., 2007, p. 64S) and distinguishes “professional from non-professional practice” (Hatton & Smith, 1995, p. 34). Just as reflection-in-action provides material for reflection-on-action (p. 40), using process indicators to measure quality not only provides information needed to develop and revise outcome indicators, (Willis et al., 2007, p. 277) it also facilitates improved quality of practice. By its nature reflection-on-action takes place after the decisions and events being reflected upon (Hatton & Smith, 1995; Regehr & Eva, 2005). Therefore, reflection-on-action may be more congruent to an outcome indicator wherein it would capture the effect of care procedures on the condition of patient populations (Mainz, 2003, p. 525).

Reflection on the future. In addition to discussing the implications of both reflection-in-action and reflection-on-action on self-assessment and performance improvement, Wilson (2008) identified that “when practitioners do not reflect on the future by evaluating where they are and what they still need to do, they lose the opportunity to identify possible areas for improved performance” (p. 178). Wilson further explained that “through discussion and examination of future possibilities a consensus can be developed . . . . Unlike the past which cannot be changed . . . it is possible to have a variety of futures. There is not . . . only one future, but there are many
possible alternatives” (2008, p. 180). This view corresponds well with Duffy and Holmboe (2006) when they stated that “the role of the self-assessment . . . becomes an extremely important area for future work in continuous professional development” (p. 1138).

**Nurses’ obligations to participate in QA.** When suggesting that nurses have to be taught about quality measurement prior to entering practice, it is notable the fundamental message from the literature is that nurses make a significant difference to outcomes of care (Ball, 2004; Clarke & Aiken, 2008; McCance et al., 2011; Rafferty & Clarke, 2009). Farquhar et al. (2010) stated “Without nurses driving and actively participating in quality improvement, real and sustained achievements in performance are unlikely” (p. 253). Matthes, Cheng, Ogunbo, Reilly, Wilbon and Wood (2010) explained that nurses are responsible for identifying performance improvement opportunities as well as collecting and disseminating data, and are the heart of hospitals' continuous quality improvement activities (p. 127). “The challenge for any performance measurement system is to provide timely, meaningful, transparent and detailed comparisons . . . that will enable them [nurses] to understand and evaluate their current levels of performance” (p. 128). As was noted earlier, Harvey (1991) stated that in particular frontline nurses seemed to have been inadequately involved in the development and direct participation in quality assurance programmes in the past resulting in resistance to the idea of ongoing practice assessments (p. 281). Sinclair (1997) further rationalized any quality assurance program that obligates practitioners to participate must have an emphasis upon “gaining a moral commitment from participants, and upon using information, education, technology sharing, and perhaps peer group pressure, as means to achieve this end” (p. 534). Gunther and Alligood (2002) added “nurses remain morally responsible and legally liable for its quality with the attendant responsibility and right to specify what represents professional practice” (p. 353).
Accountability for quality professional practice. Koch (1992) described the primary argument presented to nurses: that by participating in quality assurance activities, one fulfills their obligation and collective responsibility for professional nursing practice and evaluation of nursing care. More importantly, nurses are warned that if they do not establish their own criteria for quality, other professionals will impose them on nursing practice (p. 791). Redfern and Norman (1990) went on to state such approaches acknowledge that “change and improvement in clinical practice must come from the hearts and minds of the practitioners themselves” (p. 1268). It involves professional growth as it “requires reflective practice in that individual clinical nurses must ask themselves if and how they could do better” (Fitzsimmons, 1992, p. 16). These approaches demand that clinical nurses are highly valued and encouraged to take their rightful place at the centre of the quality assurance cycle (Gunther & Alligood, 2002, p. 354; Harvey, 1991, p. 278).

In summary, self-regulation is not a new concept, although the way people interpret the term in the context of their own professional practice varies; sometimes with good results, but more often than not, the results are left wanting. For many nurses, autonomy has meant exercising their professional judgment and being immune to others’ evaluation of their practice (Evetts, 2002; Regehr & Eva, 2006). It is this professional judgment or “discretion” that distinguishes self-regulation from external forms of regulation. Self-regulation gives rise to possibilities and abilities among nurses and the willingness to maintain a minimum level of competence by taking responsibility for quality in one’s own practice. The self-regulating model of daily practice involves an ongoing cycle of actions that the nurse engages in, including reflection on and in their practice as well as reflecting on the future (Handfield-Jones et al., 2002; Regehr & Eva, 2006; Wilson, 2008). Those who self-regulate identify where something has not
gone to plan, and revise the plan to result in a better or more preferred outcome. This revision may include engaging in professional development activities. However, it appears from the literature that nurses are among the poorest self-assessors of all professional groups (Regehr & Eva, 2005; Schunk & Zimmerman, 1998).

Nurses have a professional obligation to participate in QA activities however, nurses do not take the initiative or are often not involved in the development of the tools and systems being designed to assess and evaluate the quality in their practice (Harvey, 1991). If this pattern continues, nurses run the risk of having QA processes and standards forced on them, rather than establishing them as is a foundational part of self-regulation. It is however, important to note that quality assurance is only but one facet of professional accountability (Koch 1992). It takes an involved leader to bring the organization forward and to involve frontline nurses in the programs and projects where quality measurement indicators and tools are developed and piloted. The next topic discusses how organizational culture impacts the measurement and facilitation of quality improvement and the role of leadership in making change happen in order to support quality improvement.

**Leading Change in Organizational Culture to Support Quality Improvement**

Kotter and Schlesinger (2008) suggested that because of the many different ways in which individuals and groups can react to change, correct assessments are often not intuitively obvious and require careful thought (p. 132). “Regardless of how well change might be planned in terms of the more formal organizational characteristics, it is the hidden informal aspects of organizational life which will act to help or hinder it” (Idvall et al., 1997, p. 12). Heifetz and Laurie (2001) questioned “whose values, beliefs, attitudes, or behaviours would have to change in order for progress to take place? What shifts in priorities, resources, and power are necessary?
What sacrifices would have to be made and by whom?” (p. 134). These questions give rise to the fact that culture has a significant impact on whether practice change results in practice improvement. Naylor, Lustig, Kelley, Volpe, Melichar and Pauly (2013) submitted that in developing a measurement framework for nursing, leaders identified three major assumptions: 1) the nursing workforce has the skills to influence patient care quality, and research will demonstrate this positive link; 2) science is enhanced by the collaboration of interdisciplinary teams; and 3) stakeholders will use evidence to guide decision making (p. S2). Needleman et al. (2007) further cautioned when designing a nursing performance system, one must decide how willing they are to accept such measures as indicative of nursing performance (p. 16S).

Organizational culture. Senior (2002) identified that culture and politics of many organizations limit the amount of change and transformation in which they can successfully engage, even though such change may be highly desirable for meeting the challenges and demands of a broader environment (p. 12). R. Pope, Garrett and Graham (2000) spoke of this in terms of the nursing profession: “The history of change in nursing can be viewed as a continual process of rethinking the role of the professional nurse- from kindly presence at one extreme, to formally trained, highly skilled, clinically adept professional at the other” (p. 342). In subsequent years, the process of professionalization has experienced a significant increase, and the language of quality assurance is now firmly a part of nursing practice (Marr & Giebing, 1994; R. Pope et al., 2000). Kotter and Schlesinger (2008) indicated that until changes sink deeply into an organization’s culture, a process that can take five to ten years, new approaches are fragile and subject to regression (p. 130). Senior (2002) rationalized that permanent organizational change will only be brought about by first changing peoples’ attitudes and values (p. 17). “Without credible communication, and a lot of it, the hearts and minds of the troops are never captured”
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(Kotter & Schlesinger, 2006, p. 128). Several authors further agreed the locus of responsibility for problem solving, when faced with an adaptive challenge, must shift from an organization to its people; however, if internal support is not in place, adoption of an evidence-based practice change remains a challenge (Clement-O’Brien, Polit & Fitzpatrick, 2011, p. 437; Heifetz & Laurie, 2001, p. 132). “The pursuit of excellence in nursing care requires the creation of organizational cultures that shape and mould the motivation of clinical nurses and mobilize their creative capacities” (Redfern & Norman, 1990, p. 1269).

Assessing for resistance. New managers quickly learn that they will have to "overcome resistance" from individuals, groups and departments if they seek to initiate organizational change (Hallinger & Bridges, 2007, p. 177; Kotter & Schlesinger, 2008, p. 134). To predict what form staff resistance might take managers need to be aware of the four most common reasons people resist change: 1) a desire not to lose something of value, 2) a misunderstanding of the change and it implications, 3) a belief that change does not make sense to the organization, and 4) a low tolerance for change (Kotter & Schlesinger, 2006, p. 132). However, Schunk and Zimmerman (1998) explained that resistance is contrary to the idea of self-regulation; “To engage in self-regulation requires that learners possess a level of willingness to learn, often over lengthy periods” (p. 229). Handfield-Jones et al. (2002) further supported this position stating resistance from nurses was because of “a lack of participation and involvement . . . was associated with more negative feelings towards the assessment of their practice” (p. 949) and if left unchecked and unmotivated, “unless something positive influences the practitioner . . . practice tends to get worse over time” (p. 951). These authors further suggested “few managers take time before an organizational change to assess systematically who might resist the change initiative and for what reasons” (p. 132). Therefore, it is incumbent on CLPNBC to work with
LPNs, their employers and practical nurse educators to plan, implement and evaluate a user-friendly and relevant QA program that will support LPNs to engage in and learn from these activities resulting in practice improvement.

**Motivation to change.** A fundamental principle of motivation for change is to underscore the discrepancy between where one finds oneself at the present time, and where one wishes to be once they achieve their goal (Ferlie & Shortell, 2001, p. 291; Skinner, 2001, p. 6). Kotter and Schlesinger further rationalized that without proper motivation, people won't help, and the change effort goes nowhere (2006, p. 125). Adelson et al. (1997) reconciled this by explaining that attention to issues of team building and communication has had a positive impact on nurses’ motivation at the performance stage. These include “enhanced collaboration between physicians and nurses, enhanced communication and team functioning and improved services to clients, and job satisfaction, role explicitness, greater use of skills, communication among staff, and greater goal clarity and attainability” (p. 74). Clement-O’Brien et al. (2011, p. 432) and Sinek (2009, p. 117) identified that history shows success by early adopters is often enough to move the masses to near total agreement. Individuals, managers, and policymakers need to look within themselves and decide whether, when, and how they want to "step up to the plate" to meet the difficult challenges of changing how things are done (Ferlie & Shortell, 2001, p. 291). Farquhar et al. (2010) stated “Nurses, as the most trusted and single largest group of health care professionals, are ideally suited and well positioned to inspire confidence in the health care industry” (p. 253).

**The leader’s role in leading change.** Tuecke (2003) described Senge’s view of leadership as “the capacity of a human community to shape its future and, specifically, to sustain the significant processes of change required to do so” (p. 83). Fitzsimmons (1992) aligned this perspective on leadership with nurses’ ability to sustain change by retaining “ownership of the
standard which they have set” (p. 16). Smith (2013) provided further integration of this idea with the role of the regulator, “central to its methodology is the need for regulators to assure safety and conformity to standards” (p. 214). If it is perceived that the leader does not value the change or does not share the same desire for the goal, nurses are less likely to be willing to accept the change (Berwick, 1996; Clement-O’Brien et al., 2011; Litaker, Ruhe & Flocke, 2008).

Leaders as change agents therefore become more important for their characteristics and ability to make sense of change dynamics already underway. Their personal characteristics have a significant effect on others’ adoption of innovation (O’Connor & Walker, 2003, p. 291). Leaders recognize, clarify and reframe adaptive emergent changes, and explain where they are heading, what they will have produced by way of a redesign, and how further intentional changes can be made (Clement-O’Brien et al., 2011, p. 437; Greenwood & Hinings, 1996, p. 1038; Weick & Quinn, 1999, p. 381). Clement-O’Brien et al. (2011) further placed this into a nursing context: “the nurse leader needs to prepare the environment, educate the staff, involve staff in the change process and communicate the value of the innovation” (p. 436).

The visible leader. Cox (1999) advised on the importance of leadership visibility and involvement, “it is important that all levels of the organization regularly see management and top leaders involved in every aspect of the organization, including quality improvement” (p. 61). Pelkonen (1994) related this philosophy to the nursing profession; “positive and visible leadership by the head nurse and director of nursing services has been crucial for the success of quality assurance efforts in healthcare organizations” (p. 24). However, because most practitioners lack sufficient time, resources, managerial support and information systems to address behaviour change, another key shift is the empowerment of every employee to fix problems “on the spot” (Leggitt, Potrepka & Kukolja, 2003, p. 321; Skinner, 2001, p. 4). Naylor
et al. (2013) summarized that to achieve better care and outcomes while ensuring the efficient use of finite resources, it is essential to advance our understanding of the causal linkages between nurses and the care they deliver (p. S2).

**Working through change.** Kotter and Schlesinger (2006) said that change, by its definition, requires creating a new system (p. 125). Change occurs through cognitive restructuring via a three phased process people go through as they internalize and come to terms with the details of the new situation that the change brings about. The first phase is letting go-how people deal with their losses. The second is the neutral zone- when the old is gone and the new is not fully operational. The third is the new beginning- psychological realignments have taken place- and people develop a new identity, experience new energy and purpose, and make change begin to happen (Denny, 2005, p. 1; Weick & Quinn, 1999, p. 372). Ultimately, it is a process to be managed through a complex journey where the [nurse] takes a dynamic approach, not only in treating patients and in working with colleagues, but also in initiating and enhancing their experience with the change process (Handfield-Jones et al., 2002, p. 952).

In summary, for strategy to succeed and to reinforce change that has been made, nurses, nursing leaders, and regulatory bodies need to understand themselves, their people and their organization, and potential sources of conflict. They must be consistent in their engagement of change to ensure quick successes, and celebrate the successes that are achieved when they are achieved (Denny, 2005, pp. 2-3; Heifetz & Laurie, 2001, p. 134). Real transformation takes time, and a renewal effort risks losing momentum if there are no short-term goals to meet and to celebrate.

Without short-term wins, too many people give up or actively join the ranks of those people who have been resisting change. Commitments to produce short-term wins help keep the urgency level up and force detailed analytical thinking that can clarify or revise visions. (Kotter & Schlesinger, 2006, pp. 129-130)
A second, very general lesson is that “critical mistakes in any of the phases [of change] can have a devastating impact, slowing momentum and negating hard-won gains” (Kotter & Schlesinger, 2006, p. 125). Idvall et al. (1997) further linked this to nursing and suggested in order to avoid negative outcomes, “It is important to identify thresholds for good quality of care which are realistic and achievable, even if the ambition is to become excellent” (p. 12). Berwick (1996) summarized it well when he stated “we must be clear about the distinction between stressing the current system (relying on more of the same) and introducing a truly new system” (p. 620).

**Chapter Summary**

The intention of this chapter was to provide a review of literature relevant to the research question: What does quality mean to registrants and what implications does quality have on professional practice when it is or is not present? As discussed throughout the chapter; literature on how quality is identified and measured, the engagement of nurses as self-regulating professionals in QA, and leading organizational change to support quality improvement provides valuable information for laying the foundations to answer this research question.

The major reason for introducing quality assurance and incorporating the findings into daily nursing practice is to ensure that the nursing profession is continuously evaluating and improving nursing practice, although a significant limitation for quality assessment is that the research methods utilized tend to lead to a narrow count of nursing activities rather than an emphasis on quality of care (Donabedian 1988; Koch, 1992; Redfern & Norman, 1990; Schroeder & Malbush, 1984). Gunther and Alligood (2002) added that uncertainty in the perception of quality itself has kept the work of quality measurement on the conceptual rather than the practice level (p 354). Certainly the regulatory body (CLPNBC) has an obligation to
measure quality in the practice of its registrants, but it is the LPNs themselves who must take the initiative to reflect on their practice and determine the best way to become “better” in their practice, and as a result improve their behavior, their competence and their performance. If LPNs fail to do so, standards and expectations about what quality should look like in the context of nursing practice may be forced upon them and strategies prescribed as to how they must go about ensuring quality nursing practice. As a result, the response to an identified gap or deficiency may not automatically be a rush to fill it (Regehr & Eva, 2006, p. 36). Nevertheless, it is important to note that nurses remain morally responsible and legally liable for quality of the care they provide (Glen 1998; Gunther & Alligood, 2002) with the “attendant responsibility and right to specify what represents professional practice” (Gunther & Alligood, 2002, p. 353).

Lastly, when explaining the importance of consistent and supportive leadership in the face of transformational change and cultural impact, Fernandez and Rainey (2006, pp. 169-173) and Kotter and Schlesinger (2006, p. 126) recommended change leaders and change participants pay attention to several factors to effectively plan for and deal with potentially detrimental issues, and to celebrate short-term wins as they occur. Anderson and Ackerman Anderson (2001) suggested that an organization's existing culture must be assessed for its fit with the desired future state's requirements as they are discovered (p. 45). Ensuring this is done as a partnership will greatly increase the chance of success. Heifetz and Laurie (2001) concluded leaders must work with their colleagues at all levels to ensure sustained change; “solutions to challenges reside not in the executive suite but in the collective intelligence of employees and stakeholders at all levels, who need to use one another as resources … and learn their way to solutions” (p. 132).
Chapter Three: Inquiry Approach and Methodology

In this chapter, the chosen methodology and over-arching framework are defined in addition to the rationale for how this inquiry approach was a fit for the sponsoring organization, the College of Licensed Practical Nurses of British Columbia (CLPNBC) and would enable the following question to be addressed: What does quality mean to registrants and what implications does quality have on professional practice when it is or is not present? The criteria and rationale for the chosen participants and methods are outlined along with details of how the study was conducted. Requirements for establishing rigor, to ensure trustworthiness and authenticity, are provided as is the acknowledgement of ethical issues.

Inquiry Approach

This project used an action research (AR) methodology as its overall approach. The value of an AR methodology is that it connects diverse groups of people to create awareness, gain knowledge, solve problems, and foster change by collaboratively developing potential solutions to the practical concerns of participants (Coghlan & Brannick, 2010, pp. 3-9; Rapoport, 1970, p. 499; Reason & Bradbury, 2008, p. 4; Stringer, 2007, p. 21).

Rigorous inquiry, data collection, data analysis, reflection on findings, and action and implementation was built into the research methodology through a series of “look, think, act” cycles (Stringer, 2007, p. 9). The collaborative and cyclical nature of AR facilitated a process by which a diverse group of registrants were able to work with CLPNBC as it endeavours to improve its QA program. By using an AR approach, the project brought stakeholders, particularly registrant licensed practical nurses, together in what Reason and Bradbury (2008) described as a participatory and democratic process (p. 4), with the primary goal of engaging registrants in a joint exploration of quality as part of LPNs’ professional practice. This approach
was in alignment with the organization’s values of accountability and collaboration. “The research process is collaborative and inclusive of all major stakeholders with the researcher acting as a facilitator who keeps the research cycles moving” (Glesne, 2011, p. 23). The key reason for approaching this project through AR was not only to accommodate the needs of stakeholders participating in the project by using a collaborative research model, but in doing so, to adapt CLPNBC’s QA program development and research processes as well. The project also included a component of quantitative research.

This does not mean that quantitative information is necessarily excluded from a study, because it often provides significant information that is part of the body of knowledge that needs to be incorporated into the study. This information can be included in the processes of meaning making that are essential to action research, but it does not form the central core of the processes of investigation. (Stringer, 2007, pp. 19-20)

Qualitative data collection focused on gathering subjective information from registrants as a way to promote the humanistic perspective evident in AR, and in this project. Glesne (2011) stated that qualitative data collection focuses on words and observations that are difficult to quantify and must be interpreted or deconstructed (p. 283). It was important for participants to come with a perspective based on their own experiences and, as a way to keep them focused on their own practice, I asked participants to talk about the quality that was already existent in what they do, and how that contributed to a QA measurement process relevant to them.

I used questions influenced by an appreciative approach to seek out a series of statements and reflections to describe where registrants “want to be, based on the high moments of where they have been” (Hammond, 1996, p. 7). “Because statements are grounded in real experience and history, people know how to repeat their success” (p. 7).

Although qualitative research has quite properly become a prominent strategy in sociology and some other areas of the social sciences, it is by no means as persuasive as quantitative research, and in any case many writers recognize that there is much to be gained from a fusion of the two research traditions. (Bryman & Cramer, 2005, p. 2)
Project Participants

The stakeholders invited to participate in this project were limited to CLPNBC registrants.

**Full licensure practical nurse interview participants.** Open invitation and random sampling were used to offer CLPNBC registrants who hold “FULL” licensure, practising in the clinical, administrative, educational, and research/policy nursing domains, an opportunity to participate in a focus group as part of this inquiry. “By its definition, the random sampling method accords every person of a population an equal chance to be included in a sample and as such, become a respondent” (Papantoniou, 1992, p. 265). To accomplish random sampling, the organization’s registrant list was broken into five alphabetical sections to identify registrants whose last names began with A-E; F-J; K-O; P-T; and U-Z. One of my advisory team members then pulled the names of 1500 registrants (300 from each section) who met the participant criteria. From that number, every fifth name was identified and an invitation to participate in a focus group was sent via blinded email to that registrant (see Appendix A). Respondents replied to one of my advisory team members identified in the invitation either via email or telephone to confirm their participation and a list was kept by that team member. Of the potential respondents, every fifth name was to be selected to arrive at a maximum of 60 focus group participants. However, due to very poor response, only eight licensed practical nurses from different locations around the province agreed to participate. Therefore, individual interviews became the chosen data gathering method. Each of these registrants was contacted by my advisory team member to ask if they would be interested in participating in individual interviews rather than in a focus group; the reason as to why was discussed with each of them. Fortunately, each of these registrants agreed to participate in an interview and a consent form for participation in an
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Interview was sent via email (see Appendix B). Each was asked to read and sign the consent and return it to my advisory team member prior to the interview date arranged with them. These registrants represented a homogeneous sampling that, as described by Patton (2003), “focuses, reduces variation, simplifies analysis, and facilitates . . . interviewing” (p. 5).

**Full licensure practical nurse online survey participants.** The same random sampling technique was used to engage 1300 (11.6%) of the 11,150 of CLPNBC registrants holding “FULL” licensure (CLPNBC, 2012b). The organization’s registrant list was again broken into five alphabetical sections and one of my advisory team members pulled the names of 1300 registrants (260 from each section) who met the participant criteria. I did not do any further random sampling to reduce the number of potential respondents to the survey. An invitation to participate in an online survey was sent via blinded email to the entire group of registrants (see Appendix C). Each of the 1300 participants selected had the unrestricted opportunity to choose whether they wished to participate in the survey or not. Response to the survey was anonymous; completion and submission of the survey also indicated that informed consent had been given by the participant.

Registrants holding “INTERIM” licensure were excluded as they are not able to practice in BC until they have passed the national registration exam and achieved “FULL” licensure with CLPNBC. Registrants involved in a professional conduct review process with CLPNBC were also excluded so as not to put undue pressure on them to participate in discussions about quality practice when they may already be under scrutiny for poor quality practice.

**Research advisory team.** I recruited, through purposive sampling, a research advisory team from among colleagues who worked at CLPNBC. The team consisted of an administrative support person and four experts on practical nursing practice. These colleagues assisted me with
logistical planning, and in the identification of relevant research methods, questions, and participants. I asked them to pilot research questions, assist in data gathering, and to review my data analysis. All research advisory team members were required to sign a Letter of Agreement (see Appendix D).

Inquiry Methods

Data collection tools. I had originally planned to use focus groups and an online survey to gather my research data, however very few registrants responded to the invitation to participate in a focus group. Therefore it was decided, in collaboration with my sponsor, to conduct individual interviews and a subsequent online survey to gather data that may aid the organization in developing a QA program relevant to registrants and their practice.

Interviews and surveys are the methods most commonly used by my sponsoring organization to engage registrants and stakeholders, and solicit their opinions regarding the organization’s programs and initiatives. These methods were chosen primarily to adhere to the principles of qualitative research: in particular, participative action research (AR). “AR is democratic and participatory because it involves stakeholders in defining problems, implementing solutions and evaluating them” (Williamson & Prosser, 2002, p. 587). Although the primary purpose for selecting interviews and a survey to collect data was to support the principles of qualitative research, there was also some quantitative data elicited through the survey as well.

Most likely . . . think of research as a process that uses an instrument such as a survey, involves a large number of people, and is analyzed by reducing data to numbers. Quantitative and qualitative researchers, however, use similar elements in their work and their methods should be viewed as more on a continuum than as a dichotomy. (Glesne, 2011, p. 4)
Eight LPNs were invited to participate in individual interviews as part of this project, while 1300 LPNs were invited to participate in the online survey. These tools and methods were finalized in consultation with my research advisory team and my sponsor. The random sampling procedures and selection processes utilized for both the individual interviews and the survey, and all of the resulting correspondence, were managed on my behalf by one member of my advisory team. Potential LPN interview participants were emailed a separate letter of invitation. After participants confirmed their participation through email or via telephone to a designated contact person, a consent form was sent to them (see Appendix B). Participants completed the consent form and returned it via email or fax prior to participating in an individual interview.

**Interviews.** By using an individual interview method for data collection, the researcher can ask meaningful questions based on the key inquiry question that prompted discussion. “Questions work when they contribute to the purpose and objectives of a process” (Strachan, 2007, p. 3). The facilitator can also seek clarification to ensure trustworthiness of each participant’s responses and can prompt and direct conversation. Witzel (2000) explained Kvale’s definition of the qualitative research interview as "an interview, whose purpose is to gather descriptions of the life-world of the interviewee with respect to interpretation of the meaning of the described phenomena" (p. 1). I utilized a semi-structured interview protocol that included prompts to focus each of the primary questions asked of participants. Supplemental questions were also asked for the purpose of probing participant’s responses further and to encourage expansion on the responses provided (see Appendix E).

Given that the purpose of this research project was to gather data that will inform the development of a quality assurance program, it was fitting to utilize a qualitative interview method. “If the communication process is focused reasonably and acceptably on the
reconstruction of orientations and actions, the interviewees respond with trust and thus open up; they feel that they are being taken seriously” (Witzel, 2000, p. 3). Witzel further suggested it is this trust relationship that promotes the respondent's capability to remember and motivates self-reflection (p. 3).

Because of the geographic dispersion of the interviewees, all but one of the interviews was conducted by telephone. Although an interviewer can still speak with people who are not easy to access, one of the disadvantages of communication by telephone is the reduction of social cues. The interviewer does not see the interviewee, so body language, for example, cannot be used as a source of extra information. However, social cues such as voice and intonation are still available (Opdenakker, 2006, p. 4) and were carefully attended to in this inquiry. Finally, interviews permit the interviewee’s previous knowledge to be disclosed and “serves in the data collection phase as a heuristic-analytical framework for ideas for questions during the dialogue between the interviewer and respondent” (p. 4). At the same time, this principle of disclosure is evident in that through discussion what the interviewee determines to be relevant is stimulated (Witzel, 2000, p. 2).

The research advisory team assisted in the development and pilot testing of data gathering questions for the individual interviews. To prepare for the interview process itself, I conducted a mock interview with one of the advisory team members so that I would be comfortable in facilitating the conduct of the interview session, and so that recording methods and equipment could be fully tested prior to use in data collection. The protocol and questions for the interviews can be found in Appendix E. The data gathered during the individual interviews subsequently informed the questions that were developed and asked in the online survey (see Appendix F for the questions used on the survey).
Online survey. “Surveys are of limited utility in the first phases of an action research process, because they provide very limited information and are likely to reflect the perspective, interests and agendas of the researcher(s)” (Stringer, 2007, p. 78). The main strength of a survey is the ability to collect unambiguous and easy to count answers. Online surveys are economical and large samples of people can be included. Fortunately, CLPNBC had moved exclusively to electronic correspondence with its registrants; with all registrants required to have an active email address on file, it made an online survey the best option for contacting a geographically diverse pool of participants. Consequently, the online survey was chosen as the preferred method for gathering data from the larger group of participants involved in the second data gathering phase of this project.

Gray (2004) described two types of survey approaches, analytical and descriptive. “Analytical surveys attempt to test a theory in a field, their main purpose being to explore and test associations between variables” (p. 102). “Analytical surveys take many of the features of experimental, deductive research and so place an emphasis on reliability of data and statistical control of variables, sample size, etc.” (p. 99). In contrast, descriptive surveys tend to use open-ended questions to explore perspectives.

Descriptive surveys are designed to measure the characteristics of a particular population, either at a fixed point in time, or comparatively over time. They are designed to measure what occurred, rather than why . . . descriptive surveys can be the source and stimulus for policy changes and social action. (Gray, 2004, p. 100)

It is for the reason of asking questions about positive experiences that have occurred in registrants’ practice that a survey format was chosen. Because 1300 CLPNBC registrants who hold a FULL registration were invited to participate in the survey, the survey was primarily quantitative in nature. It included both multiple choice and closed ended questions with response options developed, in part, based upon the results of the individual interviews. The survey was
further supplemented with a limited number of short answer questions. Questions for both methods were pilot-tested and revised as necessary prior to moving forward with participant engagement in the data-gathering phase of the project.

There are advantages and disadvantages to using open-ended and close-ended questions on a survey. Open-ended questions have the potential for rich responses, some of which may not have been anticipated (Gray, 2004, p. 194). However, “the downside of open questions is that while they are easy to answer they are also difficult to analyse” (p. 195). Close-ended questions make it easier to compare the views of one group to another and to analyze the resulting data. They may provide clues about answers which they may not have thought of themselves however, they may also restrict the richness of alternative responses (p. 195). Together these items focused on generating descriptive quantitative and qualitative data which aligns with the view that “qualitative and quantitative methodologies are not antithetic or divergent, rather they focus on the different dimensions of the same phenomenon” (Amaratunga, Baldry, Sarshar & Newton, 2002, para. 29).

It is also important to note this project utilized a Canadian-based survey platform- Fluid Surveys- so as to avoid any concerns people may have had about their survey information being housed on an American-based server, such as that of Survey Monkey. This particular survey platform was chosen because it is able to collate and theme the survey results as well as provide a breakdown of the quantitative and qualitative data collected. Survey results are tabulated in real time and can be viewed in both aggregate and individual response format (Fluid Surveys, 2013, para. 1).

**Study conduct.** Prior to conducting my research, I undertook a pilot with my advisory team to explore the interview and survey processes I wished to follow, and to validate the
relevance of the questions I planned to ask. All but one of the team members were licensed practical nurses who hold FULL registration with CLPNBC, and who worked as Nursing Practice Advisors for the organization. The fifth team member was an administrative assistant responsible to coordinating the interview activities and for placing the survey onto the online platform, as well as responding to any questions or concerns participants had.

Conduct of individual interviews. Each interview took place either in person or via telephone dependent on their geographic location within the province relative to where I was conducting the interviews. Planning was facilitated by the administrative support person on my research advisory team, under my guidance as the researcher. Particular attention was paid to selecting interview times that met each participant’s needs and took place sufficiently apart from the regular work location and hours to maintain as confidential the involvement of the participant from regular co-workers, and free from distraction and interruptions during the session.

Each interview was conducted following the protocol found in Appendix E. Verbal consent was reviewed at the beginning of each interview and participant agreement was obtained to ensure each was comfortable with the process and that confidentiality and the anonymity of their comments would be maintained at all times. If my presence had created a situation where participants felt it was not safe to engage in open and honest discussion, the invitation administrator was prepared to offer participants the opportunity to be interviewed by someone other than myself who was external to the organization. Luckily, this was not an issue of concern for any of the interview participants and I was able to conduct each interview and review the resulting tapes.

It was possible that different advisory team members would be required to act as the note-taker in the series of interviews, therefore templates created to guide note-taking were used
to complement the use of an electronic recording device during each interview, and to arrive at a comprehensive transcript. Team members were oriented to the interview process during the development and piloting for the interview conduct. They were also asked to participate in training that included a mock interview so that they could become comfortable with the events that would take place during the interview. This advisory team member was introduced to interview participants at the start of the discussion, and their purpose for being in attendance was explained.

Member checking procedures followed the interview where each participant was sent the session transcript to review and to provide any edits that would enhance the accuracy and completeness of the information. Participant transcripts were identified by the initials of their first and last names, and given that these volunteers were drawn from a population of over 11,000 it was felt that this coding would not lead to the potential for others to inadvertently identify these individuals.

Names were not included as part of the data analysis and all raw data and transcribed materials were kept in a locked cabinet in my office. All electronic data was kept on a password protected USB and computer accessible only by me. The key was kept in my possession at all times. Themes and categories of information identified from each interview formed the basis for finalizing the survey questions.

**Survey conduct.** An anonymous online survey was created using Fluid Surveys. To introduce the survey, randomly sampled participants were sent an electronic invitation letter (see Appendix C) which included the electronic link to the survey. The beginning of the survey included an anonymous consent declaration. Subsequent reminders notifying participants of the opening and closing of the survey were sent electronically one week after the survey opened. The
survey remained open for ten days from October 15 to October 25, 2013, and all correspondence included an administrative contact name, number and email so that participants could call with questions about the survey or receive technical support. Participants’ identifying information was not recorded unless the respondent agreed to provide their name and a contact email in response to the final question on the survey, for the purposes of future program planning. The types of questions respondents asked, as well as the comments they provided, were themed in general terms.

Following conclusion of the survey, results were analysed and discussed with the advisory team before arriving at an initial set of recommendations. These were provided to the project sponsor and upon this final meeting, my academic research ended and a transition into follow up action by the organization began. In discussion with my sponsor, the organization’s work will begin with an activity taken to a small group that includes staff and Quality Assurance Committee members. An exercise involving force field analysis, “a technique created by Kurt Lewin for problem solving and managing change” (Coghlan & Brannick, 2010, p. 140), will be facilitated by my Director and project sponsor for this group to arrive at two to three priority recommendations. Force field analysis is “based on the assumptions that in every situation there are forces driving change and forces restraining change, and that an emphasis on reducing restraining forces is more effective than increasing driving forces” (p. 140). This activity will provide an opportunity for ownership of the recommendations by those responsible for administering and overseeing their integration into the organization’s QA program. From there, the organization’s quality assurance committee will revise the existing QA framework as needed— one component of which includes the measurement of quality in registrants’ professional practice. I was clear in articulating that the force field activity was beyond the scope of my thesis
research data collection, and was the process by which I transitioned the project’s follow up to the organization.

**Authenticity and trustworthiness, reliability and validity.** I used a range of sources to triangulate the data gathering process that included engaging a variety of participants from across the province in interview and survey data collection methods, literature review and a review of other organizational documents and resources. Stringer (2007) suggested “The credibility of a study is enhanced when multiple sources of information are incorporated” (p. 58). I understood the importance of recognizing that I may make mistakes in my interpretations and would have to rely on triangulation to bring about confirmation of what the data was actually telling me and to generate a richer set of explanations of my data (Gibbs, 2007, p. 94).

“Rigor in action research is based on checks to ensure that the outcomes of research are trustworthy- that they do not merely reflect the particular perspectives, biases, or worldview of the researcher” (Stringer, 2007, p. 57). To ensure trustworthiness, notes taken during the individual interviews and all data were included in the analyses. Additionally, questions were carefully crafted to remove any bias, probative questions were used to ensure interviewees had the opportunity to expand upon or clarify their answers, and all interviewees were given the opportunity to review their transcripts and to provide any changes or additional information that would enhance the accuracy and completeness of their comments. Coghlan and Brannick (2010) further stated “Avoiding issues, closing your eyes to reality, turning a blind eye, burying your head in the sand, refusing to inquire into some matter and so on, diminish your authenticity” (p. 23). It was imperative that I address the issue of authenticity in my research by being attentive to the data, being reasonable in making judgements about the data, and being responsible in making decisions and taking action on the research findings. This required me to rephrase my interview
questions to confirm responses so that I could record data correctly and that accurate data were analyzed throughout the data gathering process. Care was also taken to construct survey questions based on the themes that emerged from the interview data and then to pilot test these questions and the survey platform before its use to ensure clarity. Providing survey respondents with an opportunity to contact an administrator with questions or problems was also put in place to optimize the reliability of this tool and the validity of the information it collected.

Conflicts of interest. My role as a Nursing Policy Consultant within the organization involves supporting safe, competent and ethical LPN practice through policy, program and resource development. I am not involved in reviewing complaints cases nor am I involved in any kind of investigation activities. Instead I am involved in the professional practice and quality assurance areas of professional regulation. Therefore, I have no connection to any processes that would have created a negative atmosphere for my interactions with participants prior to our meeting for an interview, and I do not believe any undue influence existed as I proceeded to engage each participant in the project.

It was made clear to all participants that I was conducting this research on behalf of CLPNBC as an RRU graduate student, and that I was not present as a CLPNBC registrant or as an employee of the organization. Every effort was made to ensure participants were informed of “the purpose. . . and likely consequences of the study” (Stringer, 2007, p. 55), and I confirmed with them their understanding of the concept of informed consent and the fact that it would endure throughout their participation in the project.

Data analysis. To uncover themes and patterns relevant to the key inquiry question for the project, I moved through Stringer’s (2007) action research cycles of “look-think-act”. The data were broadly extracted and then focused in their significant features by categorizing and
coding, identifying themes and analyzing key experiences (Miles & Huberman, 1994, p. 10; Stringer, 2007, pp. 98-103). A text analysis was conducted allowing open-ended responses to be quantified. In addition, I created filters based on multiple conditions to break down the results and uncover essential information (Fluid Surveys, 2013, para. 7). Finally, I was able to create cross-tabs, charts and graphs to display findings as required (para. 4-5). Reports were also downloaded into Word and Excel formats (para. 9).

**Analysis of qualitative data.** Sofaer (2002) explained that “the use of rigorous qualitative research methods can enhance the development of quality measures, the development and dissemination of comparative quality reports, as well as quality improvement efforts” (p. 329). Sofaer further suggested “it is especially critical that the analysis and interpretation process be deliberate and thorough to avoid the use of initial impressions rather than detailed examination of raw data” (p. 329).

C. Pope, Ziebland and Mays (2000) proposed five stages of data analysis in their article on analyzing qualitative data (p. 116). These stages outline the activities that I engaged in to analyze the qualitative data collected in my project from both the interviews and the survey’s open-ended questions.

- **Familiarization**—immersion in the raw data by listening to tapes, reading transcripts, and studying notes. Editing of all transcripts and notes to reflect the feedback from participants and blinding the transcripts to remove any participant identifiers
- **Identifying a thematic framework**—identifying all the key issues, concepts, and themes by which the data can be examined and referenced, drawing on assumed issues and questions derived from the goals and objectives of the study as well as issues raised by respondents themselves. The end product of this stage is a detailed index of the data
• **Indexing**—applying the framework and/or index systematically to all the data in textual form, sorting data into preliminary themes through color coding or other cutting/sorting processes

• **Charting**—rearranging the data according to the applicable part of the thematic framework and forming charts that would contain clean summaries of views and experiences

• **Mapping and interpretation**—using the charts to define concepts, map the range and nature of phenomena, create typologies and find associations between themes with a view to providing explanations for the findings. The process of mapping and interpretation is influenced by the original research objectives as well as by the themes that have emerged from the data themselves

The survey platform that I used had the capability to capture the information provided in participants’ open-ended responses. I was able to separate and review these comments in context to identify themes, etc. and I relied on that platform to support these kinds of activities as part of my greater data analysis work. I recognized that I must review all of the data and information collected and therefore, did not depend wholly on the programs or the survey platform to do this work for me.

To keep up with how the data received may change the context of my research, I kept in mind what Glesne (2011) stated:

Data analysis done simultaneously with data collection enables you to focus and shape the study as it proceeds. If you consistently reflect on your data . . . your study will be more relevant and possibly more profound than if . . . done after data collection. (p. 188)

These data led to the initial identification of research findings that I discussed with my research advisory team and my sponsor. By consulting with my advisory team throughout the data analysis process, and asking them to bring “fresh eyes” to what I had done in my initial sorts, it was helpful to identify if they saw these findings as well represented within the data, or if
alternative sorts were required to suggest additional findings. Based on the final research findings, I formulated recommendations about what quality practice looks like and how it may be possible to measure or evaluate it on an individual registrant basis, using customizable tools and activities to promote high practice standards amongst registrants.

**Analysis of quantitative data.** Once the survey responses were returned, I assigned a unique numbered code to each survey, and also to each demographic category within the survey. I then calculated the number and percent of respondents who chose each response option to each close-ended question, and also determined the mean and standard deviation for the responses to each Likert type question. Finally, I undertook some sub-group analyses based on demographic variables such as age grouping, years as an LPN, area of responsibility, position, and place of work. In this way, the coded responses to demographic questions were used to enable comparison of trends among the resulting sub-groups.

To understand the demographic composition of interviewees, I also used a limited number of short-answer, open-ended questions, found in Appendix E, to establish the interviewee’s length of time as an LPN, the position that they currently hold with their employer, the area of responsibility they hold, and the type of practice setting in which they work.

**Ethical Issues**

For this project, I adhered to the guidelines outlined in the Royal Roads University *Research Ethics Policy* (16 February, 2011). In addition, I observed the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (TCPS 2, 2010) policy guidelines based on the Tri-Council’s three core principles: respect for persons, concern for welfare, and justice (p. 8).
**Respect for persons.** “Respect for human dignity requires that research involving humans be conducted in a manner that is sensitive to the inherent worth of all human beings and the respect and consideration that they are due” (TCPS 2, 2010, p. 8). Every effort was made to ensure that participants understood that they had the right to give free and informed consent to participate or not and, if they did volunteer, they were free to withdraw at any point without prejudice. I also explained that I would share my research findings with participants so as to facilitate their ownership of the research as much as my own (Coghlan & Brannick, 2010, p. 134). Lastly, I provided interviewees with the opportunity to review their own transcripts so as to identify any concerns or inaccuracies that may have arisen during the interview itself, and to correct them as required.

In order to “close the loop” with participants and my advisory team members at the conclusion of my project when the “hand-off” of findings to the organization took place, I provided participants and the advisory team with a copy of the research findings and an acknowledgement of their contributions to the study outcomes. Correspondence with participants was carried out anonymously through one of my advisory team members. However, once authorized, sharing information about the study and the research findings with the general registrant base, as well as with stakeholders, was done through the organization’s monthly electronic newsletter. These activities are in alignment with the organization’s values of transparency, relevance, respect and fairness (CLPNBC, 2012f, para. 3).

**Concern for welfare.** Researchers and Research Ethics Boards should “aim to protect the welfare of participants, and, in some circumstances, to promote that welfare in view of any foreseeable risks associated with the research” (TCPS 2, 2010, p. 10). I was able to ensure that participants’ rights to privacy were maintained from the onset of initial issuing of invitations to
participate in the interviews and the subsequent consent process for each individual interview, for participation in the survey, right through their participation, refusal to participate, or their withdrawal from an interview or completion of the survey. This also extended throughout the data analysis process, including member-checking activities that led to verification of the findings and ultimately, anonymous reporting out on the study outcomes. I asked a member of my research advisory team to make initial and ongoing contact with all potential and selected participants on my behalf, as a way to reduce potential risk or harm due to political, social or personal implications that may arise from participants’ participation, or non-participation, in the project.

If my presence, in anyone’s mind, had created a situation where candid discussion was perceived by them as not safe, I would have removed myself from the interview process and asked one of my advisory team members to facilitate the interview on my behalf. Fortunately, this did not occur as my advisory team member administering the interview invitation process offered interviewees the opportunity to be interviewed by someone else if they did not feel comfortable with me. All stated they felt comfortable speaking with me.

Reducing vulnerability and maintaining confidentiality was imperative to fostering a trusting relationship between the participants, the team and myself. I was aware that I could lead interview participants into reaching certain assumptions or conclusions about an idea out of fear of going against my opinions as the facilitator, or even out of the fear of disappointing me. I also realized that as a researcher and facilitator I could greatly impact the outcome of an interview/discussion. I had to maintain awareness that I could unintentionally or inadvertently inject my personal biases into the participants' expression of ideas. Therefore, in clarification of
researcher bias, I continually reflected upon my own subjectivity and “how I will use and monitor it in my research” (Glesne, 2011, p. 49).

Kvale (1996) stated, “Confidentiality in research implies that private data identifying the subjects will not be reported” (p. 114). To maintain confidentiality and anonymity, I ensured that participants’ responses would not provide any identifying information in the final research report. This was done through the use of initials to identify each interview participant, the anonymizing of transcripts, and the assurance that the survey was being returned anonymously. I also strived to ensure the protection from access by others to that information through the appropriate storage of paper and electronic data, etc. Finally, concern for the welfare of participants was impacted by the confidentiality agreements I received from my advisory team members to not discuss the identity of any fellow participants with anyone outside of the project, or any information shared within the interview process itself.

**Justice.** TCPS 2 (2010) defined justice as “treating people fairly and equitably” (p. 10). The random sampling procedures and selection processes utilized in the study, and all of the resulting correspondence for the project, was managed on my behalf by one of my advisory team members who are not in a position of power within the organization or who could potentially influence someone from participating or not. As a researcher inside my own organization, I was not privy to who was invited, nor to who accepted or declined to participate in the project. The larger number of LPNs invited to participate in the survey allowed for people to decline to participate, but still allowed for sufficient data to make the activity and the subsequent data worthy of inclusion in the study. It was made clear that all participants were given an equal opportunity to participate, to decline to respond to questions, or to withdraw altogether without any negative impact on their relationship with me or with CLPNBC (see Appendices B & C).
Chapter Four: Findings and Conclusions

This cycle of action research permitted me to investigate and understand how LPNs think about and perceive quality nursing practice. Specifically: What does quality mean to registrants and what implications does quality have on professional practice when it is or is not present? The sub-questions related to the overarching questions were: (1) What does quality nursing practice look like to the registrant? (2) What activities are LPNs currently engaging in to facilitate, support and maintain quality in their practice? (3) What indicators are registrants currently using and what others may be used to identify and measure quality nursing practice among registrants? and (4) What implications do these findings have for those responsible for leading registrant-focused quality assurance program development within other health regulatory organizations?

Included in this chapter are a summary of response rates, qualitative and quantitative data reporting notations, thematic analyses of the findings and study conclusions. Finally, the scope and limitations of the research are described at the end of the chapter.

Inquiry Findings

Qualitative and quantitative data gathered from interviews and an online survey will be presented in a consolidated manner to assist in determining findings and conclusions and will be followed by recommendations offered in Chapter Five. A summary of the results for all survey questions can be found in Appendix G and the analysis below will be referenced to themes and relevant questions. Responses from both the qualitative and quantitative methodologies have been kept anonymous so that no data can be directly attributed to any individual participant. However, verbatim quotes from interviewees are identified as (I1) through (I8) and those from open ended questions on the survey as (S1) through (S107).
**Individual interviewees.** The eight interviewees, each living in different areas of the province, included one male, reflective of their proportionality provincially and nationally (CIHI, 2012a, p. 49) as shown in Table 1.

Table 1

**Interview Response Rates by Gender**

<table>
<thead>
<tr>
<th>Interviewee Gender (n=8)</th>
<th>*Percent of Respondents</th>
<th>Percent of LPNs in BC</th>
<th>Percent of LPNs in Canada</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>12</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>Female</td>
<td>88</td>
<td>91</td>
<td>92</td>
</tr>
</tbody>
</table>

*percentages have been rounded to a whole number

While interviewees from the hospital sector were significantly underrepresented when compared to provincial and national groups (see Table 2), they were significantly overrepresented in the “other place of work” category (CIHI, 2014b).

Table 2

**Interview Response Rates by Place of Work**

<table>
<thead>
<tr>
<th>Place of Work (n=8)</th>
<th>*Percent of Respondents</th>
<th>Percent of BC LPNs’ Place of Work</th>
<th>Percent of Canadian LPNs’ Place of Work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital¹</td>
<td>12</td>
<td>43.1</td>
<td>44.8</td>
</tr>
<tr>
<td>Community Health²</td>
<td>12</td>
<td>7.5</td>
<td>12.0</td>
</tr>
<tr>
<td>Nursing Home/Long Term Care³</td>
<td>37</td>
<td>42.9</td>
<td>36.7</td>
</tr>
<tr>
<td>Other Place of Work⁴</td>
<td>37</td>
<td>6.5</td>
<td>6.5</td>
</tr>
</tbody>
</table>

*percentages have been rounded to a whole number

¹includes data from hospital (general, maternal, pediatric, psychiatric), mental health centre and rehabilitation/convalescent centre.
²includes data from community health centre, home care agency, nursing station (outpost or clinic) and public health department/unit.
³includes data from nursing home/long-term care facility
⁴includes data from business/industry/occupational health office, private nursing agency/private duty, self-employed, physician’s office/family practice unit, educational institution, association/government and other

As can be seen from Table 3, interviewees in their first 10 years of practice made up 63% of participants, slightly less than the provincial rate, but more than the national statistic (CIHI,
2014d). Interviewees with more than 31 years as an LPN accounted for 25% of participants, much greater than both the provincial and national rates.

Table 3

*Interview Respondents by Length of Time as an LPN*

<table>
<thead>
<tr>
<th>Length of time as an LPN (n=8)</th>
<th><em>Percent of Respondents</em></th>
<th>Percent of BC LPNs Length of time as an LPN</th>
<th>Percent of Canadian LPNs’ length of time as an LPN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than one year</td>
<td>0</td>
<td>74.1</td>
<td>54.5</td>
</tr>
<tr>
<td>1-5 years</td>
<td>38</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6-10 years</td>
<td>25</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11-15 years</td>
<td>0</td>
<td>9.6</td>
<td>16.4</td>
</tr>
<tr>
<td>16-20 years</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21-25 years</td>
<td>0</td>
<td>6.1</td>
<td>13.0</td>
</tr>
<tr>
<td>26-30 years</td>
<td>13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31-35 years</td>
<td>25</td>
<td>10.2</td>
<td>16.0</td>
</tr>
<tr>
<td>36-40 years</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>46-50 years</td>
<td>0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*percentages have been rounded to a whole number

In summary, interviewees were predominantly female, in the first 10 years or had 26 or more years of experience in their LPN career, and were evenly split between working in a long-term care setting or a non-traditional “other” type of practice setting.

**Survey respondents.** Of 1300 invitees, only 107 (8.2%) LPNs began the survey, and only 90 (6.9%) completed it. Information about survey respondents’ age groupings and length of time as an LPN can be found in Tables 4 and 5 respectively. As can be seen from Table 4, respondents represented a wide range of ages with those in the 30-34 year age grouping under-represented when compared to BC and national numbers. Conversely those in the under 30, 35-39, 45-49 and 55-59 age groupings were over-represented when these comparisons are made.
Table 4

Survey Response Rates by Age Grouping

<table>
<thead>
<tr>
<th>Age Group (n=102)</th>
<th>*Percent of Survey Respondents</th>
<th>Percent of BC LPNs in Age Group</th>
<th>Percent of Canadian LPNs in Age Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>21-25 years</td>
<td>6</td>
<td>18.7</td>
<td>17.5</td>
</tr>
<tr>
<td>26-30 years</td>
<td>15</td>
<td>14.4</td>
<td>12.6</td>
</tr>
<tr>
<td>30-34 years</td>
<td>6</td>
<td>13.0</td>
<td>12.1</td>
</tr>
<tr>
<td>35-39 years</td>
<td>17</td>
<td>13.4</td>
<td>13.0</td>
</tr>
<tr>
<td>40-44 years</td>
<td>13</td>
<td>12.4</td>
<td>12.9</td>
</tr>
<tr>
<td>45-49 years</td>
<td>17</td>
<td>12.2</td>
<td>12.9</td>
</tr>
<tr>
<td>50-54 years</td>
<td>11</td>
<td>9.8</td>
<td>10.7</td>
</tr>
<tr>
<td>55-59 years</td>
<td>13</td>
<td>4.5</td>
<td>5.9</td>
</tr>
<tr>
<td>60-64 years</td>
<td>3</td>
<td>1.3</td>
<td>2.0</td>
</tr>
</tbody>
</table>

*percentages have been rounded to a whole number

As seen in Table 5, respondents with ten or less years of experience as an LPN made up almost three-quarters of survey respondents (71%) and were significantly over-represented when compared to the national statistic. Conversely, respondents identifying themselves as having more than 31 years as an LPN (5%) were greatly underrepresented when compared to the national rate.

Table 5

Survey Response Rates by Length of Time as an LPN

<table>
<thead>
<tr>
<th>Length of time as an LPN (n=103)</th>
<th>*Percent of Respondents</th>
<th>Percent of BC LPNs’ Length of Time as an LPN</th>
<th>Percent of Canadian LPNs’ Length of Time as an LPN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than one year</td>
<td>5</td>
<td>74.1</td>
<td>54.5</td>
</tr>
<tr>
<td>1-5 years</td>
<td>43</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6-10 years</td>
<td>23</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11-15 years</td>
<td>11</td>
<td>9.6</td>
<td>16.4</td>
</tr>
<tr>
<td>16-20 years</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21-25 years</td>
<td>1</td>
<td>6.1</td>
<td>13.0</td>
</tr>
<tr>
<td>26-30 years</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31-35 years</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>36-40 years</td>
<td>4</td>
<td>10.2</td>
<td>16.0</td>
</tr>
<tr>
<td>41-45 years</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>46-50 years</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*percentages have been rounded to a whole number
Survey respondents reported holding a variety of positions, as reported in Table 6 below; however the most common position grouping, LPN Staff Nurse/Community Health Nurse, was underrepresented among survey respondents when compared with provincial and national statistics (CIHI, 2014c). Survey respondents who reported themselves in the other four position groupings were overrepresented by more than two times when compared to provincial and national figure.

Table 6

<table>
<thead>
<tr>
<th>Survey Respondents by Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q 3- Respondent Subgroup by Position (n=107)</td>
</tr>
<tr>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>LPN/Staff Nurse/Community Health Nurse</td>
</tr>
<tr>
<td>Instructor/Educator/Professor</td>
</tr>
<tr>
<td>LPN Specialty</td>
</tr>
<tr>
<td>Coordinator/Care Manager</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

*percentages have been rounded to a whole number

Survey respondents were almost equally split between working in a hospital setting and in a nursing home/long term care setting, as seen in Table 7. Similarly, respondents reported working in community health as often as they reported working in settings not captured by the other three categories (CIHI, 2014b).

Table 7

<table>
<thead>
<tr>
<th>Survey Response Rates by Place of Work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Place of Work (n=107)</td>
</tr>
<tr>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Hospital</td>
</tr>
<tr>
<td>Community Health</td>
</tr>
<tr>
<td>Nursing Home/Long Term Care</td>
</tr>
<tr>
<td>Other Place of Work</td>
</tr>
</tbody>
</table>
Respondents who reported working full time were overrepresented when compared to provincial statistics, but were underrepresented in comparison to national rates (CIHI, 2014a). Those reporting a casual status accounted for almost twice that of the national rate (see Table 8).

Table 8

<table>
<thead>
<tr>
<th>Q 6- Respondent Subgroup by Employment Status (n=107)</th>
<th>*Percent of Respondents</th>
<th>Percent of BC LPNs by Employment Status</th>
<th>Percent of Canadian LPNs by Employment Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full time</td>
<td>42</td>
<td>37.7</td>
<td>49.8</td>
</tr>
<tr>
<td>Part time</td>
<td>32</td>
<td>33.0</td>
<td>35.4</td>
</tr>
<tr>
<td>Casual</td>
<td>26</td>
<td>29.3</td>
<td>14.8</td>
</tr>
</tbody>
</table>

In summary, survey respondents were more likely to be between 35 and 49 years of age, in the first 10 years of their career as an LPN and most often reported holding a full time LPN position in either a hospital or in a long-term care setting.

**Thematic analyses.** There were five main themes that emerged during the data analysis. These included:

1. LPNs associated quality nursing practice with a variety of indicators and readily identified important supports and resources that they believed facilitated quality practice.

2. The choices LPNs make about their own education, including how they access educational opportunities and the importance they place on engaging in educational activities, are closely linked to how they see its benefit to their current role and career path.

3. Maintaining and enhancing quality in one’s own practice is predicated on understanding the concept of public protection as it relates to client-centred care.
4. Self-concept among LPNs is tied to their learning, how they and others perceive their competence and the validation by others of them as professional nurses.

5. LPNs had little else to offer, beyond a focus on mentorship and collaborative relationships, when asked how they identify and measure quality nursing practice.

**Theme One. LPNs utilize a variety of different indicators and activities to describe quality nursing practice.** Respondents identified that quality means different things to different people: “quality practice sometimes means rules or it means just having something to follow so you don’t have to worry about going outside the lines” (I3); and “quality is the dedication to improve, the dedication to educate our fellow colleagues, and to mentor rookies and newcomers” (I2). As such, I have divided this theme into two subthemes: a) the importance of identifying and describing quality and b) tracking and reflecting on one’s own practice to facilitate quality nursing practice.

**Information, resources and supports for quality practice.** LPNs depend on and seek out a variety of resources and supports developed by their employers and CLPNBC. They do this to gain a better understanding of what is expected of them and to identify and describe what quality looks like in their own and others’ practice. Two survey questions asked respondents about quality nursing practice. Table 9 sets out their selections in response to each of these questions. For a full list of terms used in the item and the response rates (see Appendix G).
Table 9

| Survey Respondent Selected Descriptors of Quality in Licensed Practical Nursing Practice |
|-----------------------------------------------|-------------------------------|-------------------------------|
| Q-10: What do you think of when you hear the term “quality” used to describe nursing practice? | *Percent of Respondents Selecting Descriptor (n=101) | Q-13: Which of the following words or phrases best describes what quality nursing practice looks like to you? | Percent of Respondents Selecting Descriptor (n=100) |
| Best practice                               | 81                             | Knowledgeable                 | 75                           |
| Competence                                   | 81                             | Competence                    | 73                           |
| Respect                                     | 73                             | Skilled                       | 64                           |
| Ethical                                     | 71                             | Empathetic                    | 63                           |
| Teamwork                                     | 71                             | Striving for excellence       | 63                           |
| Trust                                        | 63                             | Being proactive               | 62                           |
| Collaboration                                | 62                             | Learning culture              | 61                           |
| Confidence                                   | 61                             | Resourceful                   | 61                           |

*percentages have been rounded to whole numbers

Respondents most often identified “best practice” as a descriptor for what they thought of when the term “quality” was used to describe nursing practice. This coincided well with the most often selected descriptor for what quality nursing practice looked like to respondents: “knowledgeable” and described by a survey respondent: “It is your responsibility to your license and your client that your practice stays up to date and relevant to ensure best practice and care for the client” (S89).

A substantial number of respondents identified the terms “teamwork” and “collaboration” as descriptors for quality nursing practice, with almost three-quarters (71%) selecting “teamwork” and 62% selecting “collaboration” respectively. In addition, several interviewees expressed their belief in the importance of teamwork and collaboration among all care providers: “Going into nursing was about how I could make a difference in the lives of others by working as [part of] a collaborative team. When I think of quality practice I think of the collaboration and teamwork” (I4). In short, LPNs identified quality through both the intrinsic and extrinsic actions
of themselves and others. They held certain beliefs about what quality is when trying to describe it to others, and what quality looks like as demonstrated by others.

Survey respondents were further asked about the type of impact clear, LPN relevant employer policies, and ease of access to practice support information, resources and services from CLPNBC had on their nursing practice and ability to maintain high practice standards. Table 10 presents their responses.

Agreement among respondents was not consistent for either experience. Fewer than half (44%) indicated employer policies had a positive impact on their practice as confirmed by one survey respondent: “When I need to know more, I refer to in-facility policy and procedure manuals, the on-site DOC and my Director of Care RN” (S24), while more than half (53%) reported ease of access to practice support, information, resources and services from CLPNBC had an overall positive impact; “I always speak with my advisor at CLPNBC. I thought it would be scary to call them, but they were great. They don’t tell you you’re wrong they provide you with information to make good decisions about your practice” (S72).

Table 10

*percentages have been rounded to a whole number

Scale: 1 = Very negative impact, 2 = Slightly negative impact 3 = Neutral impact, 4 = Slightly positive impact, 5 = Very positive impact.

<table>
<thead>
<tr>
<th>Based on your own practice experiences, please rate the impact that each one of the following has had on the quality of your nursing practice, and on your ability to maintain high practice standards</th>
<th>*Percent of Responses</th>
<th>Mean</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>22</td>
<td>Clear employer policies that are relevant to LPNs (n=98)</td>
<td>9</td>
<td>14</td>
</tr>
<tr>
<td>26</td>
<td>Ease of access to practice support information, resources and services from CLPNBC (n=98)</td>
<td>5</td>
<td>10</td>
</tr>
</tbody>
</table>
Improving Quality Measurement Processes

Understanding that a variety of circumstances can also influence how a participant may respond to a question, the research looked further at respondents’ experiences with clear relevant employer policy and the impact it had on their practice relative to their place of work (see Table 11). There was a lack of consistent agreement about the impact the experience had based on place of work among all subgroups. Half of the respondents (50%) working in an “other place of work” and 48% of the individuals working in a nursing home/long term care indicated the positive impact of clear employer policies on their practice. One interviewee indicated the importance of being involved in the development of employer policy: “On the management side, I like affecting policies of change and the outcome for the patient. That’s really what I’m looking at right now” (I4). Conversely, one interviewee described their experience with a lack of clear employer policies: “When anything bad happened it was a blame game, not a learning opportunity. Management automatically blames staff – pointing fingers. We need to work on that” (I2).

Table 11

Survey Respondents Indicating the Type of Impact Clear Employer Policies Relevant to LPNs had on the Quality of Their Nursing Practice and Their Ability to Maintain High Practice Standards, Based on Place of Work

<table>
<thead>
<tr>
<th>Q- 22 Respondent Subgroup by Place of Work</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Mean</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital (n=41)</td>
<td>10</td>
<td>12</td>
<td>34</td>
<td>29</td>
<td>15</td>
<td>3.3</td>
<td>1.16</td>
</tr>
<tr>
<td>Community Health (n=5)</td>
<td>0</td>
<td>40</td>
<td>60</td>
<td>0</td>
<td>0</td>
<td>2.6</td>
<td>0.62</td>
</tr>
<tr>
<td>Nursing Home/Long Term Care (n=40)</td>
<td>5</td>
<td>15</td>
<td>33</td>
<td>23</td>
<td>25</td>
<td>3.5</td>
<td>1.16</td>
</tr>
<tr>
<td>Other Place of Work (n=12)</td>
<td>25</td>
<td>8</td>
<td>17</td>
<td>33</td>
<td>17</td>
<td>3.1</td>
<td>1.45</td>
</tr>
</tbody>
</table>

*percentages have been rounded to a whole number

Scale: 1 = Very negative impact, 2 = Slightly negative impact 3 = Neutral impact, 4 = Slightly positive impact, 5 = Very positive impact.

In summary, respondents relied on access to information, resources and supports to know how best to fulfil what is expected of them by their regulatory body and their employer. They
also identified inconsistencies in the clarity and relevance of employer policies to support quality in their practice.

*Tracking and reflecting on the quality in one’s own practice.* Respondents identified a variety of ways in which they tracked and recorded reflections on their nursing practice; Table 12 identifies the options selected most often by respondents. Respondents appeared to prefer the development of a professional portfolio to store information (47%) on their practice; however, it is important to note that the contents of a professional portfolio could also include a learning plan; the next most often selected option at 34%. One respondent indicated the value of a professional portfolio stating: “anything I get, I put all my certificates/pamphlets for courses I do in there [portfolio]” (I3).

Table 12

*One-Hundred Respondents’ Selections of Descriptors for how They Keep Track of Their Reflections on Their Nursing Practice*

<table>
<thead>
<tr>
<th>Respondent Selections</th>
<th>Q 14- *Percent of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Portfolio</td>
<td>47</td>
</tr>
<tr>
<td>Learning Plan</td>
<td>34</td>
</tr>
<tr>
<td>Self-reflective activities (art/music)</td>
<td>34</td>
</tr>
<tr>
<td>Written personal diary</td>
<td>31</td>
</tr>
<tr>
<td>Written professional journal</td>
<td>9</td>
</tr>
<tr>
<td>Recorded (voice/video) professional journal</td>
<td>1</td>
</tr>
<tr>
<td>Recorded (voice/video) personal diary</td>
<td>0</td>
</tr>
</tbody>
</table>

*percentages have been rounded to a whole number

While some respondents thought diaries and journals to be of value; “I do journal. Typically my journaling will happen when I am sort of up to a dilemma or ethically not sure what to do. I’ll journal for a little while and then I’ll stop again for a while” (I4), others did not: “I don’t record my reflections, does anyone?” (S23). One respondent rationalized their reluctance to record their reflections: “Journals are not for me. I plan my day in my head so I don’t need to
write it down” (I1), while another summarized the dangers in not engaging in regular reflection about their own nursing practice:

I . . . have the deepest respect and honour for all people . . . but if you’re a person who can’t reflect while you’re doing something and you don’t take a moment to understand why you’re participating and where you’re going with it, then how can you help people? (I5).

Table 13 looks further at the percent of respondents who identified their use of a professional portfolio based on their age grouping. While approximately half of respondents in the majority of age groups (40-49 years, 50-59 years and 20-29 years) reported using a professional portfolio, caution must be taken when interpreting the responses in the 60-69 year age grouping with only four respondents in that category.

Table 13

<table>
<thead>
<tr>
<th>Respondent Subgroup using a Professional Portfolio by Age Grouping</th>
<th>*Percent of Sub-group</th>
<th>Sub-Group Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-29 years</td>
<td>52</td>
<td>11 of 21</td>
</tr>
<tr>
<td>30-39 years</td>
<td>30</td>
<td>7 of 23</td>
</tr>
<tr>
<td>40-49 years</td>
<td>47</td>
<td>14 of 30</td>
</tr>
<tr>
<td>50-59 years</td>
<td>50</td>
<td>12 of 24</td>
</tr>
<tr>
<td>60-69 years</td>
<td>75</td>
<td>3 of 4</td>
</tr>
</tbody>
</table>

*percentages have been rounded to whole numbers

In summary, respondents identified the variety of ways they track and reflect on their nursing practice. Overall, approximately half of respondents utilize a professional portfolio or components that may sit within a professional portfolio (learning plan, journal or diary) as their preferred tools. However, several respondents did state they instead favoured engaging in self-reflective, cognitive based activities.

**Theme one summary.** Respondents were able to identify what quality practice is when they see it; they described it, reflected on it, and approximately one half of them recorded it in a
variety of ways relevant to their own preferences. When asked, respondents were fairly consistent in their selection of a small group of terms to describe what quality nursing practice looked like to them. In addition, they selected a variety of terms as descriptors for what they thought of when the term “quality” was used to describe nursing practice. Agreement about the impact clear and relevant employer policies had on their practice was not consistent among the total respondent group, however more respondents indicated a positive impact than they did negative. While some respondents saw the collection of their reflections and achievements using a professional portfolio as tangible proof of quality in their practice, there were others who explained they didn’t see the value in reflecting on their practice, suggesting that it was not important to them to do so.

Theme Two. The choices LPNs make about their own education, including how they access educational opportunities and the importance they place on engaging in educational activities, are closely linked to how they see its benefit to their current role and career path. Respondents overwhelmingly identified they were invested in lifelong learning as part of their professional growth and placed significant importance on engaging in educational activities. However, they did tend to gravitate to employer offered opportunities that would assist them in their day to day activities rather than focusing on activities that may expand their career path (see Table 15). I have separated this theme into the following sub-themes: (a) the importance of engaging in learning activities, and (b) looking at fit with role and career path when accessing educational opportunities.

The importance of engaging in learning activities. Contained in the theme of education, the importance of engaging in learning activities came up in several interview and survey responses. Comments such as, “for me, if something scares me, I don’t know very much about
something, it’s usually a sign that I need to learn about it and get it under way” (I5) and “no one knows everything, none of us do. Nursing never stops expanding, so out [sic] minds shouldn’t stop either [sic]” (S7) were provided. Each of these comments brings one back to the idea that deciding to engage in learning starts with the individual and is shaped by situations encountered by the LPN as part of their work-life based on the availability of opportunities around them. One survey respondent remarked “nursing is an ever evolving and changing landscape. Best practices change; we need to change and learn as we go” (S37). It can be seen in Table 14 that survey respondents demonstrated a difference in agreement about the impact each experience had on their nursing practice. Forty-seven percent of respondents indicated ease of access to educational opportunities that are relevant and LPN focused had a “slightly positive” or “very positive” impact. One interviewee observed “there should be no barriers to what LPNs can access; [it] pushes knowledge higher and [creates a] bigger challenge. If the challenge is there, I think they [LPNs] should be up for it” (I8).

Table 14

Survey Results for Questions Related to LPNs’ Perspective on the Importance of Engaging in Learning Activities

<table>
<thead>
<tr>
<th>Based on your own practice experiences, please rate the impact that each of the following has had on the quality of your nursing practice, and on your ability to maintain high practice standards</th>
<th>*Percent of Responses</th>
<th>Mean</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>Ease of access to educational opportunities relevant to LPNs and LPN practice (n=98)</td>
<td>8 16 29 21 26</td>
<td>3.4</td>
</tr>
<tr>
<td>24</td>
<td>Personal commitment to lifelong learning (n=98)</td>
<td>1 3 12 24 59</td>
<td>4.4</td>
</tr>
</tbody>
</table>

*percentages have been rounded to a whole number

Scale: 1 = Very negative impact, 2 = Slightly negative impact 3 = Neutral impact, 4 = Slightly positive impact, 5 = Very positive impact.

Several respondents indicated that having a personal commitment to lifelong learning could override any negative stereotypes their professional designation might imply about the
value LPNs bring to the health care system. One respondent remarked, “being an LPN doesn’t mean one doesn’t have thirst for knowledge; isn’t it up to challenge to learn” (I8) while another offered advice about the importance of engaging in learning activities: “keep learning to keep up with advances in nursing practice and the roles of LPNs as part of the healthcare team” (S26).

Table 15 shows respondents’ experiences with ease of access to educational opportunities based on place of work and position. Regardless of work location and position type, approximately half of all respondents reported a positive impact resulting from access to relevant education. Exceptions were found in the data for the small group of four individuals working in Community Health where only one reported the impact to be positive, and the even smaller group of two Coordinator/Care Managers for whom the impact had been neutral or negative.

Table 15

*percentages have been rounded to a whole number
Scale: 1 = Very negative impact, 2 = Slightly negative impact 3 = Neutral impact, 4 = Slightly positive impact, 5 = Very positive impact.

While one survey respondent suggested that the negative impact they experienced was because “there needs to be more learning opportuntiy [sic] for LPNs as there is for RNs within
the same employer” (S56), another interviewee indicated that regardless of the challenges LPNs may encounter trying to find educational opportunities, it shouldn’t stop them from learning: “I would say that any LPN anywhere could find some kind of educational activity whether formal or informal. If they looked they could find something, absolutely” (I6).

Question 30 on the survey (see Appendix G) asked respondents “Have you ever participated in a CLPNBC quality assurance program?” It was striking that 90 (97%) of the 93 respondents to this question indicated “No”. Of those whom responded in the affirmative, one explained “I provided certificates and documentation to the college” (S45), while another stated “[I] noted the in-services I have attended” (S52). It is rather surprising that respondents identify the importance of engaging in educational activities to maintain quality in their practice, yet don’t identify these activities as relevant to a quality assurance program.

Looking at fit with role and career path when accessing educational opportunities. Survey respondents were asked to identify the kinds of activities they had engaged in to maintain or grow quality in their practice over the previous five years. They were provided with a range of options that included both formal and informal educational activities as well as several alternative options. Table 16 outlines the options selected most often by respondents.

Table 16

<table>
<thead>
<tr>
<th>Respondent Selections (Top Five)</th>
<th>Q 15- Percent of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer offered in-service/workshop</td>
<td>90</td>
</tr>
<tr>
<td>Reading nursing articles</td>
<td>71</td>
</tr>
<tr>
<td>Online self-study modules</td>
<td>62</td>
</tr>
<tr>
<td>Employer offered course/program</td>
<td>57</td>
</tr>
<tr>
<td>Colleague to colleague mentoring</td>
<td>48</td>
</tr>
</tbody>
</table>

*Five Options Most Often Selected by 100 Respondents about Engaging in Educational Activities over the Past Five Years to Maintain or Grow Quality in Their Nursing Practice*
Ninety percent of all respondents indicated they had participated in employer offered in-services/workshops, with more than half (57%) identifying their participation in an employer offered course/program. It is also noteworthy that a majority of respondents engaged in self-directed professional development by reading nursing articles (71%) and using online self-study modules (62%), further demonstrating their commitment to lifelong learning. Colleague to colleague mentoring was also popular with almost half of respondents choosing this option. One interview participant explained the value in being mentored and in mentoring others:

Co-workers would often take my lead on the care I was doing and it’s really great because then you get the chance to mentor them; you give them education. For myself, when I am working with a strong nurse, I take learnings from them . . . seeing an approach that works really well with a family or patient, you take those learnings and can keep bringing them forward to your own practice. (I4)

Another so eloquently explained the ultimate downfall in not engaging in learning activities: “I don’t have time to learn’ is actually equivalent to ‘I don’t have time to improve’. This is poison to both our professional development and to our own fulfillment as individuals” (I8).

Theme two summary. When speaking about professional development, respondents validated the importance of having a personal commitment to lifelong learning by engaging in and seeking out learning activities and educational opportunities that fit with their role and career path. Convenience in accessing opportunities offered by their employer or that were readily available appeared to figure heavily into the kinds of activities respondents engaged in. Respondents also spoke of the value in reciprocal learning through mentoring or being mentored by their colleagues. Nonetheless, respondents were quick to identify the need for ongoing professional development in order to keep up with the ever-present changes in health care today.

Theme Three. The purpose for maintaining and enhancing quality in one’s own practice is built on the philosophy of patient/client centred care and an understanding of one’s
individual responsibility to meet regulatory requirements and obligations to practice safely, competently and ethically. The most frequently selected option chosen by survey respondents answering question 11 which asked them to choose words or phrases that best described the impact of their work on colleagues, was “patient/client centered” (see Appendix G). As expressed by one interviewee, “Because CLPNBC’s mandate is protection of the public, you want to make sure that the LPNs are practising at their best quality of nursing skills in order to be able to protect the public” (I6). Given this information, I have broken this theme into two sub-themes: a) a patient/client-centric care focus in practice, and b) the importance of clarity about LPN scope of practice.

Practice that is patient/client-focused. The ability to provide high quality client-centered care is based on having access to information about the client whenever and wherever needed. Respondents were asked to identify the type of impact “ease of access to information about a patient when I need it” had on the quality of their nursing practice and their ability to maintain high practice standards. Seventy-three percent indicated this experience had a positive impact on their practice; more than 12 times the percentage of respondents who indicated the experience had a negative impact on their practice (6%). Table 17 illustrates these findings. A survey respondent supported this with: “Quality practice depends on how much information you obtain. As an LPN the more updated information you get, the better the quality of your practice” (S80).

Table 17

Survey Results for Questions Related to LPNs’ Perspectives on Avenues they can Access to Maintain and Enhance Quality, Client-Centered Nursing Practice

<table>
<thead>
<tr>
<th>Based on your own practice experiences, please rate the impact that each of the following has had on the quality of your nursing practice, and on your ability to maintain high practice standards</th>
<th>*Percent of Responses</th>
<th>Mean</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ease of access to information about a patient when I need it (n=98)</td>
<td>2 4 21 29 44</td>
<td>4.1</td>
<td>1.00</td>
</tr>
</tbody>
</table>
When asked about the impact “ease of access to physical and material resources when I have questions about best practices/policies” had on their practice, a significant majority of respondents (61%) indicated a positive or very positive impact. One respondent suggested “be open minded when information is shared and don’t assume that you know as much as you will ever know. Sometimes the best learning opportunities are not formal or in a classroom” (S31).

In response to the question about “ease of access to information about a patient when I need it” an interview participant indicated the importance of seeking more information about a client: “[be] considerate of many different facets of a client’s problem and know it’s not necessarily about a particular conclusion but about assessment and the gathering of information so that a reasonable goal can be reached” (I5). Another identified the need for new information on an ongoing basis:

As healthcare is always changing and policies continually change, it is important to keep up with the standards/best practices. It is also important to keep learning new things, new ways of doing things to be able to provide the best possible care to our patients and clients (S76).

*The importance of clear information about LPN scope of practice.* When asked how clarity about LPN scope of practice from CLPNBC had impacted their practice, levels of agreement among the entire group of respondents were fairly consistent in response to this question with a small majority (56%) reporting a positive impact (see Table 18).

Table 18

<table>
<thead>
<tr>
<th>Ease of access to physical and material resources when I have questions about best practices/policies (n=98)</th>
<th>2</th>
<th>8</th>
<th>30</th>
<th>28</th>
<th>33</th>
<th>3.8</th>
<th>0.98</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>percentages have been rounded to a whole number</em></td>
<td>Scale: 1 = Very negative impact, 2 = Slightly negative impact 3 = Neutral impact, 4 = Slightly positive impact, 5 = Very positive impact.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Survey Results Related to Clarity about LPN Scope of Practice and the Type of Impact it has had on the Quality of Respondents’ Practice and Their Ability to Maintain High Practice Standards

*Percent of Responses*
Based on your own practice experiences, please rate the impact that each of the following has had on the quality of your nursing practice, and on your ability to maintain high practice standards

<table>
<thead>
<tr>
<th>Clarity about LPN scope of practice from CLPNBC (n=98)</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Mean</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clarity about LPN scope of practice from CLPNBC</td>
<td>6</td>
<td>4</td>
<td>34</td>
<td>21</td>
<td>35</td>
<td>3.8</td>
<td>1.16</td>
</tr>
</tbody>
</table>

*percentages have been rounded to a whole number
Scale: 1 = Very negative impact, 2 = Slightly negative impact, 3 = Neutral impact, 4 = Slightly positive impact, 5 = Very positive impact.

It was disappointing that only 35% of respondents found this information to have a very positive impact on their practice with a further 21% reporting a slightly positive impact. An interview participant likened gathering information to building a tool box, “I believe it [seeking out information] helps you just put more tools in that toolbox. (I6). Of equal consideration is that a further 10% felt it had a negative impact. One survey respondent explained: “My experience with private homecare [sic] agencies is some companies [sic] are not aware or do not care about the LPN scope” (S45).

*The importance of having easy access to resources and services from CLPNBC.* When asked about the impact having access to supports from CLPNBC had on their practice, it was surprising and disappointing that almost half of respondents (46%) indicated a neutral or negative impact (see Table 19).

Table 19

Survey Results Related to Ease of Access to Practice Support Information, Resources and Services from CLPNBC and the Type of Impact it has had on the Quality of Respondents’ Practice and Their Ability to Maintain High Practice Standards

<table>
<thead>
<tr>
<th>Based on your own practice experiences, please rate the impact that each of the following has had on the quality of your nursing practice, and on your ability to maintain high practice standards</th>
<th><em>Percent of Responses</em></th>
<th><em>Mean</em></th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ease of access to practice support information, resources and services from CLPNBC (n=98)</td>
<td>5</td>
<td>10</td>
<td>31</td>
</tr>
</tbody>
</table>

*percentages have been rounded to a whole number
Scale: 1 = Very negative impact, 2 = Slightly negative impact, 3 = Neutral impact, 4 = Slightly positive impact, 5 = Very positive impact.
Often LPNs are unclear about CLPNBC’s mandate and have difficulty seeing how what it does impacts on their practice, especially when what they would like CLPNBC to do for them is clearly outside the Regulator’s mandate of public protection. Respondents’ comments to question 28 (see Appendix G) appear to confirm this. When asked “What are some of the things that CLPNBC could do to assist you to improve your nursing practice?” respondents commented: “Making access to updating skills etc. easier” (S71), and “Advocating for our practice development [sic] and ensuring we all work to our full potential in accordance with the education requirements from the various schools” (S106). Both of these requests best fit with the mandate of the Licensed Practical Nurses Association of BC to advocate for the advancement and recognition of LPNs in BC and improve the educational and professional status of LPNs in BC (LPNABC, 2015, para. 3), and not that of CLPNBC.

The final question asked of respondents relevant to their ability to maintain and enhance quality in their practice by meeting the obligation to practice safely, competently and ethically was “what are some of the things that CLPNBC could do to assist you to improve your nursing practice?” Table 20 lays out the three most and least often chosen options in response to this question.

Table 20

<table>
<thead>
<tr>
<th>Respondent Selections (Top Three)</th>
<th>Q 28- *Percent of Respondents</th>
<th>Respondent Selections (Bottom Three)</th>
<th>Q 28- *Percent of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Online educational offerings</td>
<td>76</td>
<td>Evaluating LPN practice on a regular basis</td>
<td>27</td>
</tr>
<tr>
<td>Education days/conferences</td>
<td>69</td>
<td>More information about non-clinical domains of LPN practice</td>
<td>44</td>
</tr>
<tr>
<td>Clearer practice support documents</td>
<td>63</td>
<td>Easier access to practice support services</td>
<td>45</td>
</tr>
</tbody>
</table>

*percentages have been rounded to a whole number
While interactive and engaging activities such as online educational offerings were chosen by 76% of respondents, followed by education days/conferences (69%), the less interactive option of clear practice support documents still received support by the majority (63%). One interviewee suggested “I’ve been to the CLPNBC annual meeting where they’ve put education on. They have a lot of different in-services they put on through their meeting time” (I4). Least preferred overall, respondents did not appear to favour CLPNBC “evaluating LPN practice on a regular basis” (27%), although the nature of a quality assurance program that reviews LPN practice and registrants’ ability to maintain high practice standards is identified in College by-laws. Interestingly and suggesting a self-assessment approach is preferred as a counter point to this low rating for CLPNBC evaluations, one respondent suggested “keep on learning, find more resources in nursing practices and do a full assessment on professional growth every five years” (S43).

Theme three summary. Respondents readily identified the connection between having access to updated and timely information and their ability to provide quality client-centred care. Exploration of this particular topic was the only one where a majority of respondents agreed the impact on their practice was positive. The role of CLPNBC and ongoing accessibility to the information and services it delivers was one of the factors respondents identified as impacting the quality of their practice, although only one-third indicated a positive impact. More often, though, respondents indicated a neutral or negative impact on their practice arising from accessing these resources and supports from CLPNBC making this an issue that warrants further examination. In addition, while interactive and engaging activities appealed to respondents the most, they also liked being able to access resources such as practice support documents to review
on their own. This is well-aligned with respondents’ preference for self-assessment of their practice rather than submitting to an evaluation by their regulatory body.

**Theme Four. LPNs’ self-concept is tied to their learning success, how they and others perceive their competence and validation by others of them as professional nurses.** Because self-concept was found to be at the root of how LPNs see themselves as professional nurses, I will separate this theme into two sub-themes: (a) competence and the implications it has for being perceived as a professional and (b) validation of competence by both the LPN and those the LPN works with.

**Competence and its implications for the perception of professionalism.** Table 21 highlights the survey results related to how LPNs viewed their competence when patient acuity or complexity increased. Almost half of respondents (44%) agreed that this circumstance had either a “slightly positive” or “very positive” impact on their nursing practice and ability to maintain high practice standards. In contrast, 24% agreed that the experience had either a “slightly negative” or “very negative” impact on their practice.

Table 21

<table>
<thead>
<tr>
<th>Percent of Responses*</th>
<th>Mean</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>20 Increasing patient acuity/complexity (n=98)</td>
<td>5</td>
<td>19</td>
</tr>
</tbody>
</table>

*percentages have been rounded to a whole number

Scale: 1 = Very negative impact, 2 = Slightly negative impact 3 = Neutral impact, 4 = Slightly positive impact, 5 = Very positive impact.

The qualitative data also revealed that respondents identified the importance of acquiring competence in the face of an ever-changing healthcare system:
Educate yourself and keep on learning; health care is ever evolving around us. You are ethically bound to provide competent care which can only be upheld by maintaining your knowledge of what skilled nursing practice is at any given moment in time. (S31)

Another summed up the negative consequences of not keeping up with requirements for developing competence to address these changes: “Complacency is a deterrent [sic] to the profession . . .” (S8). When talking further about quality in nursing practice and the perception that competence may look different based solely on one’s professional nursing designation, one interviewee summed it up nicely when they said “maybe RNs don’t realize a lot of LPNs are competent and do a really good job. Quality is quality for all nurses” (I1).

When asked to identify what the term “quality” made them think of and how they would describe the positive impact their work has had on their colleagues, the words “competence” and “competent” were the terms chosen most often by participants in response to survey questions 10 and 11 (see Appendix G). Table 22 breaks these responses down by length of time as an LPN.

Table 22

<table>
<thead>
<tr>
<th>Respondent Subgroup by Length of Time as an LPN</th>
<th>Q 10- *Percent of Sub-Group</th>
<th>Q 10- Sub-Group Count</th>
<th>Q 11- *Percent of Sub-Group</th>
<th>Q 11- Sub-Group Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 year to 10 years</td>
<td>80</td>
<td>57 of 71</td>
<td>54</td>
<td>38 of 71</td>
</tr>
<tr>
<td>11-20 years</td>
<td>86</td>
<td>12 of 14</td>
<td>71</td>
<td>10 of 14</td>
</tr>
<tr>
<td>21-30 years</td>
<td>86</td>
<td>6 of 7</td>
<td>43</td>
<td>3 of 7</td>
</tr>
<tr>
<td>31-50 years</td>
<td>78</td>
<td>7 of 9</td>
<td>89</td>
<td>8 of 9</td>
</tr>
</tbody>
</table>

*percentages have been rounded to whole numbers

Respondents who chose the word “competence” to describe what they thought about when they heard the term “quality” used to describe nursing practice were very well-represented in all respondents groups ranging from 78% to 86%. Noteworthy is that 89% of respondents in
the most experienced group chose the term “competent” to describe the positive impact their work had on their colleagues; more often than did respondents in any other respondent group.

In summary, respondents identified the opportunity to show their competence when patient/client acuity increased as having an overall positive impact on their practice. “Competence” was strongly associated with early and mid-career respondents’ thoughts about quality in nursing practice, whereas being “competent” was something the most experienced respondents felt well described their work and its positive impact on their colleagues.

Validation of competence and learning by LPNs and their colleagues. The second subsection in the theme of self-concept is respondents’ views on the importance of validation by their colleagues of the LPN’s competence and learning. One interview participant supported this with “I am proud of my practice when I can be a resource to my colleagues and they trust my knowledge and experience” (I8). Half of the interview participants indicated working as part of a team delivering care to clients alongside registered nurses (RNs) and identified the difficulties they had experienced in having these colleagues accept them as a professional nurse and value them as a team member. One participant explained “Within practice, I feel as an LPN that I have something to prove to an RN. Maybe RNs don’t realize a lot of LPNs are competent and do a really good job” (I1). This leads one to query whether LPNs’ colleagues may underestimate the competence and abilities of the LPN.

Table 23 indicates respondents’ perspectives on the ease of accessing support from colleagues, as well as how employers’ understanding of LPN role expectations in the workplace have impacted LPNs’ ability to demonstrate quality nursing practice and maintain high practice standards.
Survey Results for Questions Related to LPNs’ Perspective on the Importance of Validation of Their Competence and Learning by Their Colleagues

<table>
<thead>
<tr>
<th>Based on your own practice experiences, please rate the impact that each of the following has had on the quality of your nursing practice, and on your ability to maintain high practice standards</th>
<th>*Percent of Responses</th>
<th>Mean</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>Ease of access to support from colleagues when I need assistance with a patient/client’s care requirements (n=98)</td>
<td>0 7 15 34 44</td>
<td>4.1</td>
</tr>
<tr>
<td>23</td>
<td>Clarity about LPN role expectations at the employer level (n=98)</td>
<td>6 14 32 22 26</td>
<td>3.5</td>
</tr>
</tbody>
</table>

*percentages have been rounded to a whole number
Scale: 1 = Very negative impact, 2 = Slightly negative impact 3 = Neutral impact, 4 = Slightly positive impact, 5 = Very positive impact.

Respondents appeared to have a considerable level of agreement about their experiences when accessing support from their colleagues; with more than three quarters (78%) of respondents indicating the impact was either “slightly positive” or “very positive”. One survey respondent observed “We are given the opportunity to grow and learn in the art of nursing practice. Having peers that bring experience and information sharing [sic] is a great way to learn” (S8). Conversely, only 7% indicated a slightly negative impact when accessing support from peers. As expressed by one interviewee “You always feel like you have to prove something to them. Some RNs make you feel like they don’t think you are up to snuff; you have to work harder to prove that to them” (I1).

When it came to clarity about the LPN’s role and employer expectations, there appeared to be less consistent agreement among respondents about this experience and its impact on their nursing practice than there had been for question 17. Forty-eight percent of survey respondents indicated a “slightly positive” or “very positive” impact associated with having this clarity. One interviewee provided a possible reason for the diversity in respondent perspectives:

“It guided us on the best ways to do things and policies to put in place so we clearly know what’s right and wrong. But this is difficult in home care, in a rural area because some standards are grey and it’s hard to follow rules when dealing with a remote and culturally different area.” (I3)
Theme four summary. Participants identified maintaining competence and acquiring new competencies in the face of an ever-changing healthcare system as an integral part of their professionalism. However they also felt they always had to prove themselves because their RN colleagues did not understand LPN practice or what was expected from LPNs in the workplace. Respondents also regarded validation of their competence and the quality of their nursing practice by colleagues as essential to their self-concept, emphasizing that quality is quality for all nurses regardless of their professional designation.

Theme Five. LPNs had little else to offer, beyond a focus on mentorship and collaborative relationships, when asked how they identify and measure quality nursing practice. Although this particular theme was not singularly prominent in the data, information provided by participants on the importance they gave to mentorship and role models, teamwork and collaborative relationships, as a factor that influences quality in nursing practice, was threaded throughout. Survey participants expressed a variety of perspectives on what indicated quality and identified these concepts as sub-themes in several questions. Unfortunately, this particular group of respondents had very little to offer about what they believe quality is and looks like beyond what was provided to them for comment in the survey.

Interviewees, however, did expand a great deal on seeing quality demonstrated in their colleagues’ practice and wanting to seek them out for information, guidance, advice and mentorship so they could grow the quality in their own practice: “They (work colleagues) all have the highest regard for everything whether it’s confidentiality or ethical practice. They model that; practice what they preach . . . I can only hope to be like that in my own professional life”. (16)
Qualities of a mentor/role model. While several authors cautioned conflating the terms mentor/role model/coach, etc., and suggested that defining mentoring has been difficult due to the use of interchanging terms such as coach, preceptor, and teacher (Bally, 2007, p. 144; Butterworth, Faugier & Barnard, 1998; Milton, 2004), others have managed to arrive at agreement on what mentoring in nursing is; a voluntary process of teaching and learning that takes place within a long-term professional, reciprocal relationship between two nurses positioned on different levels, with different ages, personalities, and credentials (Bally, 2007, p. 144; Canadian Nurses Association, 2004, p. 24; Smith, McAllister & Crawford, 2001, pp. 101-102; Stewart & Kreuger, 1996, p. 311). However, the intent of this theme is to simply present and discuss participants’ perspectives on the mentors and role models they’ve encountered in their own nursing practice.

A variety of options were provided to respondents in survey question 13: “which of the following words or phrases best describes what quality nursing practice looks like to you?” (see Appendix G). Selections made by this group were well-aligned with comments from interviewees who openly shared their experiences interacting with a mentor, or in acting as a mentor to their colleagues. They cited specific behaviours and characteristics indicative to them of quality practice: “I am proud of my practice when I can be a resource to my colleagues and they trust my knowledge and experience” (I8). Coincidentally, seventy-five percent of survey respondents to this question identified being knowledgeable as a descriptor of what quality practice looked like to them. Another interviewee suggested that there are certain expectations put on nurses who choose to guide others: “I think for nurses . . . we’re expected to mentor and be role models” (I5). This perspective is consistent among study participants in that almost half (43%) of survey respondents selected role model as a descriptor for quality nursing practice.
Sixty-one percent of survey respondents also selected being in a learning culture as an indicator for quality in nursing practice in survey question 13 (see Appendix G). Respondents saw value in learning, however, most of the interviewees’ comments focused on their learning in the context of guiding nursing students in the practice setting. “I preceptored some new grads in their final practicums . . . I saw lots of weaker areas that I may not have seen at that stage myself, but you really want to take that on and mentor those people” (I4). While varied, respondents’ input also moved from a focus on mentorship and being a mentor, to engaging in mentoring activities themselves.

Engaging in mentoring activities. In survey question 15: “What kinds of activities have you engaged in, over the past 5 years, to maintain and grow the quality of your nursing practice?” (see Table 16). Almost half of survey respondents (48%) selected colleague to colleague mentoring, with a further 12% choosing professional coaching as activities they’ve engaged in over the past five years to maintain or grow quality in their nursing practice. One interviewee was adamant about having a nurse-mentor, “absolutely, I have a mentor . . . that person is a nurse” (I5), while another spoke about the importance of having a connection with a mentor or group of mentors: “I linked myself with really strong nurses, joined nursing practice councils and linked myself to people that were there for the right reasons. Having them as role models . . . for the learning I could gain from them” (I4). Yet another interviewee articulated this same expectation when speaking about one of her mentors’ credibility with students: “She really pulled us in and made us part of the team. We became those junior mentors really early” (I6). This interviewee spoke fondly of her many years as a mentor, after having had a very good experience with her own mentor while in nursing school.
Participant responses to survey question 31, “What advice would you give to a colleague about the importance of lifelong learning to maintain and grow quality in their nursing practice?” (see Appendix G) also provided some insights into the fact that a mentorship dynamic is not limited to interactions with nursing colleagues: “All the staff you work with can teach if you give them opportunity; RCA's, ECG techs, lab techs, other nursing staff . . . If you can't learn from those willing to teach, you will struggle in this profession” (S106). One interviewee even identified that a specific colleague who was not a nurse who had influenced her practice: “I’ve learned from him (the regional pharmacist) how he deals with people – he’s a real professional and a role model. He can change the way you practice and it makes your life easier every day” (I3). And still another explained “I talk to my colleagues; gleaning from others. That probably is the most significant is just by watching by others’ examples; especially those that I value” (I8).

Accessing and utilizing mentor resources to support quality practice. In survey question 29 participants were asked, “If you were having practice difficulties, what kinds of resources would you access, and utilize, to support safe, quality practice?” (see Appendix G). Table 24 shows the kinds of resources identified- with almost half (49%) choosing practice advice and consultation.

<table>
<thead>
<tr>
<th>Respondent Selections (Top Five)</th>
<th>Q 29- Percent of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional standards of practice</td>
<td>78</td>
</tr>
<tr>
<td>Practice guidelines</td>
<td>75</td>
</tr>
<tr>
<td>Practice standards</td>
<td>72</td>
</tr>
<tr>
<td>Code of ethics</td>
<td>60</td>
</tr>
<tr>
<td>Practice advice/consultation</td>
<td>49</td>
</tr>
</tbody>
</table>

Additional qualitative data was gathered in response to this question and, although minimal, was consistent regarding access to colleagues for support: “colleagues” (S27), “cne
(clinical nurse educator) support at our facility” (S44), “co-workers’ experienced advice” (S32). When acting as that resource, one interviewee explained “They ask for tips and what should I do; what should they do if a situation comes. Sometimes they can ask me for advice” (I2). Another interviewee explained the need to have immediate access to a knowledgeable resource: “Looking to our nurse educator and involving her because I recognize that those are my shortcomings and I can’t keep up to date on everything. Making sure to use the resources appropriately by guiding and mentoring people appropriately” (I4). A secondary component to this theme was respondents’ perspectives on collaboration and teamwork, and the perceived impact these concepts had on the quality of their nursing practice.

Collaboration and teamwork as an indicator of quality. Although the terms “teamwork” and “collaboration” were used synonymously by many study participants, they differentiated between the two terms when responding to survey question 10, “What do you think of when you hear the term “quality” used to describe practice?” (see Appendix G). Table 25 indicates the subtle difference seen by participants.

Table 25

<table>
<thead>
<tr>
<th>Respondent Selections (Top Five)</th>
<th>Q 10- Percent of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Best practice &amp; Competence (tie)</td>
<td>81</td>
</tr>
<tr>
<td>Respect</td>
<td>73</td>
</tr>
<tr>
<td>Ethical &amp; Teamwork (tie)</td>
<td>71</td>
</tr>
<tr>
<td>Trust</td>
<td>63</td>
</tr>
<tr>
<td>Collaboration</td>
<td>62</td>
</tr>
</tbody>
</table>

One interviewee explained what being part of a team meant to her: “I guess being relational and able to be part of a team with your colleagues and also being able to connect with your patients, being an all-around personable, team player type of person and being responsible
to know your stuff” (I1). Another interviewee suggested that collaboration is, “that willingness to learn in order to get it right and not being afraid to say “I don’t know”. That was a really big part of what I admire” (I4). Once the data was reviewed, it became evident participants understood that teamwork and collaboration had an impact on their colleagues as well.

*The impact of collaboration and teamwork on colleagues.* Survey question 11 asked, “If you had to pick 5 words/phrases that best describe the positive impact your work has on your colleagues, what would those words/phrases be?” (see Appendix G). As seen in table 26, respondents identified collaboration as one of their top five choices for a descriptor of the positive impact their work has on their colleagues.
Table 26

*Five Options most Often Selected by 101 Respondents when Describing the Positive Impact Their Work has had on Their Colleagues*

<table>
<thead>
<tr>
<th>Respondent Selections (Top Five)</th>
<th>Q 11- Percent of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient/client centred</td>
<td>59</td>
</tr>
<tr>
<td>Competent</td>
<td>58</td>
</tr>
<tr>
<td>Collaboration</td>
<td>53</td>
</tr>
<tr>
<td>Trusted</td>
<td>51</td>
</tr>
<tr>
<td>Reliable</td>
<td>49</td>
</tr>
</tbody>
</table>

One interviewee spoke of the nature of collaboration, describing the dynamic: “together we can collaborate about changes that need to happen or why something has happened this way, so could we have done something differently or not at all” (I8). The social aspects of the collaborative experience and one’s ability to reflect and develop deeper problem-solving skills are representative in the comment made by an interviewee:

I think when I started going into the educational realm and being able to teach those young minds – imparting my knowledge on them – when you see them out there and you work beside them in the field and they’re doing a great job, it’s such an extensive feeling of accomplishment in that way. I was able to teach them my standards or what I believe in and you see them using that out in the field (I6).

In addition to asking respondents about the impact their work has had on their colleagues, a second survey question, question 12 asked about the positive impact LPNs’ work has had on the clients and families they work with. “If you had to pick 5 words/phrases that best describe the positive impact your work has on the patients/clients and families you encounter, what would those words/phrases be?” (see Appendix G).

Interestingly, only 18% or respondents chose collaboration as a way to describe the positive impact their work has had on the patients/clients and families they encounter. While very few survey respondents chose this option, interviewees commented rather consistently on the benefit to clients when nurses collaborate with each other. “She was someone that I really
looked up to in that facility that I worked in. It was never about her and her nurses it was always about the patient” (I5). Another interviewee agreed: “going into nursing really was first about how I could make a difference in the lives of others and then it was about working as a collaborative team” (I4).

Theme five summary. While several authors have attempted to identify what mentorship in nursing looks like, respondents easily identified the qualities of a mentor with some explaining that what had been important to them in their own mentor/mentee relationship, either as a student or a new nurse, was something they carried with them as they assumed a mentor role during their career. Engaging in mentoring activities and accessing and utilizing mentors and role models was seen by participants as important for growing and supporting the quality of their nursing practice. Mentoring relationships were seen by respondents as especially inspirational and influential to the kind of nurse they want to be “Role modeling and leadership is important [sic] for inspiring others that we work alongside of” (S9). Respondents further explained that mentoring others led to a sense of collaboration and teamwork with their colleagues, “When I think of quality practice I think of being a mentor and the collaboration and teamwork that is most important” (I4). However, respondents were not as clear about the impact the kinds of mentorship related activities they see as indicative of quality had or how they extended beyond a colleague-to-colleague relationship and on to clients and their families.

Summary of findings. This action research-based inquiry set out to explore what quality practice looked and felt like to licensed practical nurses registered with CLPNBC and the implications that may exist for LPNs’ professional practice if quality is or is not present. A number of conclusions have been reached and are focused on participant perspectives resulting from the activities, information, resources and other supports they engaged with in order to
Improving Quality Measurement Processes

maintain and/or grow quality in their practice. As indicated earlier in the data analyses, there was wide ranging perception among LPNs as to what quality is (Table 9, question 10) and what it looks like (Table 9, question 13), as well as the kinds of activities they felt were most appropriate to engage in to achieve and support quality in their practice. LPNs did appear to understand that the obligation for maintaining and enhancing the quality of their professional practice lay solely with themselves. Although, a majority of participants also depended heavily on their employers, unions, professional associations and regulatory body to provide or facilitate access to educational opportunities (see Table 16) rather than seeking offerings on their own outside the confines of the employer/employee relationship. Moreover, LPNs expressed hope that their colleagues and the people to whom they provided nursing care saw value in who they were and what they brought to the health care system, based on their learning successes, opportunities to demonstrate their acquired competence to others and not be seen as less competent simply because of their professional designation. With the amount of data gathered on the idea of mentorship and role models, collaboration and teamwork within the health care team, it leaves one to wonder if LPNs see these concepts as applicable or impactful only inside the colleague-to-colleague dynamic and not necessarily transferred to the nurse/client relationship.

Study Conclusions

The goal of this study was to identify what quality means to LPNs and the implications the presence of quality has on an LPN’s professional practice. The following conclusions were drawn from the analysis of data obtained through participant interviews and the online survey. Each conclusion is detailed below and is further supported by academic literature that was reviewed.
1. Quality to LPNs meant seeking out best practices, acquiring competence, and gaining respect from others for their demonstrated readiness to continually learn. LPN’s were clear in accepting responsibility for maintaining this quality in their practice.

2. LPNs had discovered the value in reciprocal learning through colleague-to-colleague mentoring activities.

3. An integral part of LPNs’ self-concept and how they view their value in the health care system goes beyond simply “feeling” competent and lies instead in their ability to acquire competence and being perceived by others as a competent nurse.

4. LPNs identified their responsibility for establishing quality in their own practice, and that CLPNBC should advocate for quality practice among its registrants, but were confused about the reasons why CLPNBC would do so.

Conclusion One. Quality to LPNs meant seeking out best practices, acquiring competence, and gaining respect from others for their demonstrated readiness to continually learn. LPN's were clear in accepting responsibility for maintaining this quality in their practice. This conclusion identifies the priority LPNs gave to learning in the development of one’s career as a nursing professional, as well as the importance they placed on having access to resources and information that are engaging, clear and relevant to their needs. In turn, LPNs believed that by engaging in these practices and demonstrating their competence, they would be seen by the health care team as a value-added member.

There was more consistent agreement among respondents about the kind of impact a personal commitment to lifelong learning had on the quality of their practice, than for ease of access to educational opportunities relevant to LPNs and LPN practice. One survey participant explained the value ongoing learning had to them as a professional nurse: “Achveing [sic]
quality in your nursing is all about lifelong learning. Never stop learning because if you do, you stop growing” (S13). Others described learning in the context of what quality meant to them: “quality is based on your understanding and confidence in your everyday practice. This I do personally by researching and collaborating with team members” (S79), and “quality practice depends on how much knowledge you’ve obtained. As an LPN, the more updated information you get, the better quality grows in your practice” (S80). These observations lie in agreement with Gunther and Alligood’s (2002) suggestion that “professional accountability or quality of care is directly linked to the use of nursing knowledge” (p. 354), and added that nursing knowledge “arises from the intertwining of nursing education, nursing practice and nursing research. It is manifested in nursing activities and behaviours . . . the presence or absence of these activities determines the degree of the quality of nursing care” (p. 355).

Most survey participants and interviewees identified taking part in some kind of learning activity or educational opportunity in the five years preceding this study. They spoke about a belief in its value to their role as an LPN and ultimately the benefit it had for their ongoing ability to care for their clients: “to continue to grow as an LPN one must always be updated with gurrent [sic] practices which have proved to be more efficient and beneficial to [the] nurse and the patient” (S46).

LPNs wanted to be able to review, absorb and utilize these supports in a way that provided the most benefit to them and to their clients. A majority of survey respondents and interviewees identified that ease of access had a positive impact on their practice. They also indicated the significance of being proactive when seeking out information and other supports for their practice: “I advise colleagues there is always more to learn and improve on. Stay interested; always ask questions and look for those answers yourself” (S44).
Taking ownership. LPNs did appear to understand that the obligation for maintaining and enhancing the quality of their professional practice was their responsibility. Kouzes and Posner (2007, p. 252) and Baruch (2004, p. 62) wrote about the sense of ownership people experienced when they are given the tools and support they need to carry out their tasks (p. 252). In addition, a number of studies also suggested that individuals with high levels of self-efficacy are more likely to choose to participate in challenging assignments and take responsibility for personal development than individuals with low levels of self-efficacy (Bandura, 1982; Bandura & Schunk, 1981; Baruch, 2004; Noe & Wilk, 1993).

Interview participants working for private employers commented about the barriers they’ve experienced when trying to access education, with one interviewee sharing their experience: “Sadly, our facility doesn’t help us with that [education], we do it on our own. I continue on and take anything available” (I2). Another interviewee further explained, “I’m trying to take anything through [the health authority] to update my training which is not being provided at my facility” (I1). Although these comments highlight the inconsistencies LPNs experienced in finding relevant educational opportunities and having to resort to their own initiative to find appropriate and interesting offerings, they are validated in Kumra and Vinnicombe’s (2008) findings that “the career development process . . . requires individuals to be proactive . . . and self-motivated” (p. S71).

The value of learning. Consistent messages among several authors reviewed included: wanting individuals to know when they don’t know, to know how to problem solve, to foster a learning environment and a culture of competency as well as it being important to enhance nurses' knowledge and skills to help them succeed (Alexander, 2012; Walker, Olson & Tytler, 2013). However, Weinberg, Cooney-Miner and Perloff (2012) cautioned having a highly
educated nursing workforce does not necessarily provide direct support for the association between that and patient outcomes (p. 9) and commented “ostensibly, if education directly affects patient outcomes, it does so by influencing nurses’ practice or nurses’ interactions with patients and care providers” (p. 4). Weinberg et al’s. findings also suggested that an explanation for the relationship between nurses' education and care quality does not point specifically to the value of higher formalized education, but rather as Mark, Salyer, and Wan (2003) found, to the importance of the work environment (p. 224). These authors’ perspective is endorsed very well with one interviewee’s summation of what quality practice is, and is representative of participants’ efforts to seek, demonstrate and maintain quality in their nursing practice: “I think that quality practice is . . . working together to the best of your ability; using all of your hands-on practice and doing the best you can with the art of it in client care, empathy, and teamwork” (I1).

In summary, LPNs were already engaging in activities to maintain the quality of their practice, however the ability to access opportunities that are convenient to them, such as those offered by their employer or that were readily available from an external source, had a significant impact on the kinds of activities LPNs engaged in. Some have suggested achieving quality practice may be as simple as supporting nurses “to be able to recognize the value of each nursing role, share the workload equitably and work together to optimize patient care” (Walker, et al, 2013, p. 25) or preparing teams for upcoming changes in practice through education, planning and discussions about the effects on nurses (Bateman as cited in Cavanaugh, 2013, p. 26). While these perspectives and practices bode well for LPNs who may not have workplace support, or time to fully explore options for formal learning, opportunities may exist to more actively support the commitment to lifelong learning identified by LPNs. These will be addressed further in Chapter Five.
Conclusion Two. LPNs had discovered the value in reciprocal learning through colleague-to-colleague mentoring activities. This conclusion is based on the theme of mentorship and collaborative relationships that, while not individually prominent in the study, was woven throughout the data. Nearly half of online survey respondents and all of the interviewees were united in their belief in the importance and value of having access to colleagues to guide them through their day-to-day activities and to role-model quality professional practice.

I think a good mentor has to be honest. They have to listen. They don’t have to know the answers; they just have to help you find the answers within yourself. It’s about being able to question. But mostly it’s to be listened to and to be honest (I7).

Learning through mentorship opportunities. Rye and Boone (2009) believed that mentorship provides and inspires learning and influences role socialization (p. 869), while Walker et al., (2013) added that it can also “facilitate, model and sustain collaboration” (p. 27). Historically, non-formal learning has been fairly systematic and pre-planned involving some type of guidance from a third party such as a mentor, experienced co-worker or manager. However, emerging models have begun to provide structure to these kinds of approaches specifically through on-the-job training and mentoring (Griffin & Keen, 2013; Mok, 2011). Moving this into a nursing context, communities of practice have emerged with the main objective of connecting people who have a commonality of practice, creating ongoing opportunities for inter-professional shared learning and improved performance (Bateman, 2011; D'Amour, Goulet, Labadie, SanMartin-Rodriguez & Pineault, 2008; Phelan, Barlow & Iverson, 2006; Rye & Boone, 2009).

Impact on nursing practice. Bateman (2011) articulated the value of mentorship declaring “professionals must be given a chance to share their experience and expertise with each other” (p. 71). Unfortunately, as Neary (2000) explained, there appeared to be some variation in
the personal definition one holds of being a mentor, based on their position and role within an organization. “Although there was some overlap of the practitioner’s definition of their responsibility as a mentor and as a supervisor, there was clear evidence that staff acting as supervisors did not see themselves as teachers, role models or facilitators” (p. 467). Huynh, Alderson, Nadon and Kershaw-Rousseau (2011) concurred that incompatibility between RNs and LPNs often takes root in role ambiguity, confusion related to the day-to-day application of their unique roles, and differential social status within the organizational hierarchy (p. 3).

With a link established between a successful mentor/mentee relationship and quality patient care (Luparell, 2011, p. 92; Rye & Boone, 2009, p. 868; Tiberius & Flak, 1999, p. 7) it may be assumed that a poor experience for either party can negatively impact patient care by impacting the quality of the nurse's practice. Miller and Kontos (2013) surmised that RNs and LPNs could form a collegial and cohesive community of caring professionals, based on their professional identity and intergroup dynamics (p. 1798). Walker et al. (2013) confirmed this with their finding that “a high level of employee engagement [in peer-to-peer support] transforms a traditional hierarchical nursing structure into an environment where RNs and LPNs collaboratively care for sets of patients and make team-based decisions (p. 24). Bally (2007) further suggested that “focusing on the positive outcomes of mentoring, such as individual growth, collaboration, staff retention, and satisfaction, and, ultimately, enhanced patient care, are surely goals with which all [nurses] can identify and strive to attain” (p. 146).

In summary, study participants identified the positive impact of mentorship and collaborative relationships on both the quality of their nursing practice, and to a lesser degree on patient outcomes, as indicated earlier in theme five. LPNs believed that having access to colleagues to guide them through their regular routines and to role model quality professional
practice was important. In the past, collegial relationships were accepted as primarily unstructured and simply a part of the workplace, however in recent times more structure has been introduced into mentorship models to facilitate connecting people who share a common practice and ongoing learning. Nursing especially has adopted this practice, but still has work to do to overcome differences in the personal definitions and interpretations nurses have of their responsibilities as a mentor. Role clarity and transparent expectations for one another when engaged in a mentor/mentee relationship has been shown to result in better quality patient care (Luparell, 2011; Rye & Boone, 2009). “Mentoring . . . fosters an open and trusting relationship between mentor and mentee and eliminates the fear of repercussions . . . These activities facilitate the sharing of best practices between new workers and veterans through these learning opportunities” (Griffin & Keen, 2013, p. 10).

**Conclusion Three.** An integral part of LPNs’ self-concept and how they view their value in the health care system goes beyond simply “feeling” competent and lies instead in their ability to acquire competence and being perceived by others as a competent nurse. This conclusion is based on the comments expressed by several study participants about the pride they felt in their role as an LPN, as well as their ability to collaborate with and be seen by others as an equal partner on the healthcare team and within the healthcare system: “I was really proud of the fact I had taken on a challenge . . . typically they had only offered to RNs. It was like a little extra pat on the back” (I4). “I have been thinking about that [quality practice] and it makes me feel proud . . . to be an LPN means that we’re upholding the highest regard for everything that we do” (I6).

**Nursing identity.** Perceiving oneself to hold a unique personal and/or professional identity can have both positive and negative implications. Miller and Kontos (2013) suggested
that “nursing identity is associated with feelings of group belonging and solidarity” (p. 1798) originating from the collective position nurses occupy as subordinates in their healthcare system. However, these feelings may, in turn, negatively affect how they engage as a group with others (Briskin 2011; Miller, Reeves, Zwarenstein, Beales, Kenaszchuk, & Conn, 2008). Nursing ideologies within health care teams today have developed over many years to influence how practitioners feel about other categories of nurses, as well as their own place in nursing. Regrettably, this history has created a nursing culture that often negatively influences the way teams communicate and work together (Atwal & Caldwell, 2005, p. 272; Bateman, 2011, p. 9).

Several studies have scrutinized intra-professional interactions and verified antagonistic relations between groups of nursing professionals and a cohesive feeling of pride fostered through a 'siege mentality' by nurses holding negative stereotypes of others (McKenna, Smith, Poole, & Cloverdale, 2003; Miller et al., 2008; Miller & Kontos, 2013). To put this into an RN/LPN dynamic, Stein-Parbury and Liaschenko (2007) found that RNs felt devalued in their relationships with physicians at times (p. 476), just as LPNs felt the same in their relationships with RNs (Bateman, 2011, p. 33). Bateman further warned that making assumptions of individual competence based on credential could place nurses in situations they may not be competent to manage (p. 32). Thus, the presumed relationship between strong professional identity and poor identification as a member of an inter-professional team may require re-thinking (Miller et al., 2008; Miller & Kontos, 2013; Sands, Stafford & McClelland, 1990).

**Trust and respect.** The majority of survey participants utilized both of these terms to describe what they thought about when they heard the phrase “quality practice” (Table 9, question 10). Huynh et al. (2011) identified that trust and respect have consistently emerged in the literature as the emotional factors most influencing the nature of the interactions between
nurses and nursing support staff. “Mutual trust within the nursing team is considered to be the cornerstone of intra-professional collaborations. Based on this RNs and LPNs feel empowered to actively seek out and provide constructive feedback to each other” (p. 4). These authors further observed that both professionals must manage their emotions (i.e., trust or distrust towards each other) while balancing respect for their colleagues' professional role against an individualized trust for the professional as a person (p. 3). These findings were consistent with those of both Walker et al. (2013) who explained “collaborative nursing practice shines a light on performance strengths and deficiencies of individuals and teams” (p. 27) and of Weinberg et al. (2012) who posited that better patient outcomes are a product of work environments, enhanced communication with patients and other care providers, and professional empowerment (p. 5).

Nevertheless, Huynh et al. (2011) also cautioned one should be aware that prescribed organizational policies aimed at maximal productivity and the hectic pace of day-to-day nursing care do not lend themselves to the fostering of the positive emotions critical for intra-professional collaboration: trust and respect (p. 5).

In summary, the way LPNs perceive others’ views of them as nursing professionals will have to evolve from the current negative stereotypes to ones that have a positive influence on the way nursing teams communicate and work together. “The working relationship between RNs and LPNs will be a decisive factor in nursing care, one that significantly influences the quality of care” (Huynh et al., 2011, p. 1). This will become a very important focus as the complexity of nursing care continues to increase along with the acuity of patients' medical conditions. “If nurses hold shared values, they themselves form a powerful group who can start to influence the thinking about and attitudes towards the nursing profession by policy makers and governments” (Horton, Tschudin, & Forget, 2007, p. 726). But herein lies the challenge for the family of
nurses; “to challenge our own hierarchies, turf issues and negative behaviours, and commit to work together finding common ground toward creating a health care system that is truly focused on the patient” (Bateman, 2011, p. 68).

**Conclusion Four.** LPNs identified their responsibility for establishing quality in their own practice and that CLPNBC should advocate for quality practice among its registrants, but were confused about the reasons why CLPNBC would do so. This conclusion is based on the findings in several of the preceding themes related to participants’ perceptions of the role of CLPNBC in assuring and supporting quality nursing practice, and to the specific obligation LPNs have to maintain and grow quality in their own practice.

Interestingly, LPNs were inconsistent in their knowledge about how CLPNBC would carry out those activities within its legislated mandate of public protection. For example, one interviewee expressed a clear and correct understanding about CLPNBC’s mandate and its role in assuring quality in LPNs’ nursing practice: “the College is regulated by the Health Professions Act which dictates that it is to protect and serve the public” (I4). However, another survey respondent demonstrated a lack of understanding about the fact that CLPNBC’s mandate is focused on public protection and not on advocacy for LPNs: “CLPNBC advocating for the advancement of the profession would assist changing others’ view of LPNs as a “less professional nurse” (S106); this particular activity aligning with the role of the professional association, as mentioned earlier in theme three.

While all study participants identified that the College had a distinct role in providing guidance for LPNs’ decision-making, “the CLPNBC annual conference was interesting because it guided us on the best ways to do things and policies to put in place so we know clearly know what’s right and wrong” (I3), slightly more than half of survey respondents indicated that clarity
from CLPNBC on the LPN scope of practice (56%) and ease of access to practice support information, resources and supports (53%) had a positive impact on their practice (see tables 17 & 18, respectively).

The last part of this conclusion involves participants’ suggestion that quality begins with the individual LPN: “Instead of starting at the College level, it [ensuring quality practice] should start with the LPN. It should be about the individual practice as the biggest part” (I6). This idea was reflected in themes one and five where participants spoke about taking time to reflect on their practice “[I] think at the end of each working day, what did I do right, and what did I do wrong; what could I have done better” (S40), and seeking out tools and resources to help them act on those observations: “I use the Helen Randall Library (at the College of Registered Nurses of BC) for learning tools” (S2); “[LPNs] should already know guidelines and practice, seek help from nurse clinician / manager for education [sic]” (S60).

The role of the regulator. Austin et al. (2003) explained that among major changes introduced in the regulation of health professionals was the notion that “a self-regulating profession must develop a quality assurance mechanism to ensure the effectiveness . . . of its members” (p. 3). Consequently, the process of professionalization has experienced a significant increase, and the language of quality assurance is now firmly a part of nursing practice (Marr & Giebing, 1994; R. Pope et al., 2000).

Several authors have written about the variety of ways to achieve quality and agree that the major reason for introducing quality assurance, and incorporating the findings into daily nursing practice, is to ensure that the nursing profession is continuously evaluating and improving on its practice (Donabedian 1988; Koch, 1992; Schroeder & Malbush, 1984). Needleman et al. (2007) posited ideally, outcome measures used to evaluate nursing care would
be clearly evident, documented, captured by existing data systems, and linked by evidence to nursing processes (p. 17S), but Idvall et al. (1997) also identified the limitations of indicators “nursing is very complex, contextual and beyond measurement. There are domains that are difficult to reach and make measureable, such as the professional intuition to assess the patients, interpersonal relationships and nursing advocacy” (p. 12).

Providing guidance for LPNs’ decision-making. Standards of Practice developed by CLPNBC reflect the minimum expectations for LPNs’ professional practice (CLPNBC 2014). This particular document, along with a variety of other resources and tools, is designed to support the development of what Koch (1992) described as “skills and expertise required by nurses to develop, test, monitor and record quality assurance data” (p. 789). Redfern and Norman (1990) proffered that quality and standards are closely related but are distinguishable in that quality is something nurses constantly strive for and which may never be achieved, whereas standards are attainable if set at a realistic level (p. 1261). Adelson et al. (1997) cited the importance of having structures within the organization that enable and maintain new practitioner behaviours after being predisposed to change and having the appropriate knowledge and skills to implement change (p. 69).

Smith (2013) submitted “in many respects, health care professionals (italics in original) require the same sort of information as patients in order to assure that they are performing in line with accepted practice, and to promote improvement” (p. 214). Austin et al. (2003) further suggested the intention with this is to help professionals understand what constitutes best practice, and to help them improve accordingly. “The College facilitates this process by providing documentation tools and information, but does not prescribe the type or quantity of continuing education required” (p. 4). “All . . . are provided with a list of available resource
materials to assist them in their continuing professional development activities” (p. 5). These observations also align with the processes CLPNBC has developed to support LPNs’ quality nursing practice.

**Quality starts with the LPN.** Farquhar et al. (2010) stated, “nurses, as the most trusted and single largest group of health care professionals, are ideally suited and well positioned to inspire confidence in the health care industry” (p. 253). Additionally, quality improvement is dependent on nurses' talents and expertise and a collaborative approach to care: “without nurses driving and actively participating in quality improvement, real and sustained achievements in performance are unlikely” (p. 253). Adelson et al. (1997) stated “practitioners must acquire the appropriate knowledge, skills, and, in some cases, attitudes that are necessary to incorporate the proposed behaviour into their clinical repertoire” (p. 70). These views are consistent with that of CLPNBC (2009) where competence is defined as “the ability of a nurse to integrate the professional attributes required to perform in a given role, situation or practice setting.

Professional attributes include, but are not limited to: knowledge, skills, judgment, attitude, values and beliefs” (p. 22).

**Ownership.** Gunther and Alligood (2002) recognized that nurses remain morally responsible and legally liable for the quality of their nursing practice with the attendant responsibility and right to specify what represents professional practice (p. 353), while Adelson et al. suggested that practitioners adopt new practices “not because of their technical advantages but because they conform to the norms in the prevailing environment” (1997, p. 71). Koch (1992) described the primary argument presented to nurses: that by participating in quality assurance activities, one fulfills their obligation and collective responsibility for professional nursing practice and evaluation of nursing care. More importantly, nurses are warned that if they
do not establish their own criteria for quality, other professionals will impose them on nursing practice (p. 791).

In summary, although there needs to be greater clarity on the role of CLPNBC in assuring and supporting LPNs’ quality practice, LPNs also need to take responsibility for establishing quality in their own practice. Smith (2013) suggested “a regulator may be more interested in identifying those practitioners who pose a threat to patients, however the data and analytic requirements for such safety purposes are quite distinct from those needed for professional improvement” (p. 214). Austin et al. (2003) agreed in that “such requirements may have little benefit on professional practice and do not provide assurances that the practitioner has the knowledge and skills necessary to provide safe and effective patient care” (p. 2). Redfern and Norman (1990) reasoned a regulatory framework must support the creativity of professionals in solving their own safety and quality problems in their own organizations; “quality assurance in nursing thus requires that nurses have the ability to measure their care, to define standards and to change their professional practice” (p. 1261). Austin et al. (2003) added “evaluating the effectiveness of continuous professional development is a vital role for self-regulating professions” (p. 4). Farquhar et al. (2010) offered that although many nurses have limited understanding of the very policies that drive these quality assurance activities (p. 253), Matthes et al. (2010) felt that nurses are at the crux of hospitals’ continuous quality improvement activities (p. 127). “The challenge for any performance measurement system is to provide timely, meaningful, transparent and detailed information that will enable nurses to understand and evaluate their current levels of performance” (p. 128).
Scope and Limitations of the Inquiry

“Human inquiry, like any other human activity, is both complex and always incomplete” (Stringer, 2007, p. 179). This inquiry sought to gain a better understanding of what quality looks and feels like to LPNs practicing in British Columbia, and while the scope of this research was limited to data obtained from 107 survey respondents and in-depth interviews with eight participants, as a group they were in many ways demographically reflective of their counterparts across BC and nationally. At the same time, given that response rates for both data gathering methods were small in comparison to the numbers invited to participate in the study, this places limitations on the generalizability of the themes and conclusions.

Of particular note is that while I had hoped to hold focus groups around the province, an insufficient number of participants responded which would have resulted in only one focus group. Because of the geographic dispersal of participants, a single focus group was not possible leading to a lost opportunity for participants to interact and build on each other’s comments. However, individual interviews did permit me to get into deeper discussion with a participant than a focus group would have allowed for and was helpful when triangulating themes and analyzing the overall context of the discussions.

The acute care perspective was also missing from the interview participant group. Therefore, the qualitative data obtained from the interviews under-represented the inpatient focus which will make it difficult to generalize the themes and conclusions to the entire profession given that 43% of the registrant base of CLPNBC reported working in an acute care/hospital setting. This study was further limited to only those LPNs with a current FULL practicing CLPNBC registration. There was no inclusion of, or discussion with, employers or other health professionals who work with LPNs.
Similarly, the possibility also existed that as a result of the small sample size, only those who were interested in the topic participated in the research and that the findings were biased as a result of this interest. “Response Bias is one of the most common phenomena observed during data collection” (Singh, 2007, p. 84). By combining revealing interview data and rich surveys, along with literature, this provided relevance and authenticity to the data collected and instilled confidence that the findings are reflective of current feelings among practitioners about the impact quality has on their professional nursing practice. However, caution should be exercised if generalizing these findings to future LPNs as different educational and practice experiences might reveal unique contexts that may not have been present at the time of this research study.

**Chapter Summary**

This chapter detailed themes and conclusions based on the responses and perspectives provided by participants in answer to the inquiry question: What does quality mean to registrants and what implications does quality have on professional practice when it is or is not present? The intention of this action research project was to engage licensed practical nurses working in practice settings representative of the overall CLPNBC registrant demographic to assist in identifying what quality nursing practice looks like and how it makes them feel when they see it or are part of it. The variety of factors that impact or influence one’s ability to recognize and integrate quality into their nursing practice are a reminder of the need for ongoing dialogue and consultation with all stakeholders in order to create easily accessible, timely and relevant resources and supports that LPNs can access and utilize to facilitate quality practice and positive patient outcomes. By combining academic research and qualitative and quantitative data, along with the literature reviewed, this has resulted in the recommendations that follow in Chapter Five.
Chapter Five: Inquiry Implications

Vaill (1996) used the term “permanent white water” to describe the complex, churning, and ever-changing environment in which most people find themselves, both personally and professionally. He explained that such conditions take us out of our comfort zones and ask things of us we never imagined would be required (p. 10). Vaill’s perspective has significant meaning moving forward, because it is anticipated that as CLPNBC, its system partners and LPNs engage in change that arises from the following recommendations, there will be more than enough “white water” to contend with and manage.

Chapter Five proposes recommended changes for CLPNBC, resulting from the integrated qualitative and quantitative data presented in Chapter Four. This section consists of three parts: a) study recommendations that are based on research findings, study conclusions and relevant literature; b) organizational implications which describe and analyze each recommendation in terms of organizational change and implications of not implementing the recommendations; and c) implications for future inquiry and research.

The qualitative and quantitative study findings presented earlier addressed the research question “What does quality mean to registrants and what implications does quality have on professional practice when it is or is not present?” The following sub-questions were also addressed:

1. What does quality nursing practice look like to the registrant?
2. What activities are LPNs currently engaging in to facilitate, support and maintain quality in their practice?
3. What indicators are registrants currently using and what others may be used to identify and measure quality nursing practice among registrants?
4. What implications do these findings have for those responsible for leading registrant-focused quality assurance program development within other health regulatory organizations?

The following recommendations are focused primarily around the work of CLPNBC and are presented with an emphasis on strategies to support LPNs’ ongoing identification, understanding, application, and confirmation of quality in their nursing practice, as well as clarifying and reinforcing the role of CLPNBC to positively impact the practice of LPNs through the promotion of high practice standards. LPNs’ input and perspectives have informed the recommendations which provide the foundation for supporting quality in LPN practice. It is also suggested that these recommendations would apply to LPNs and would be inclusive and involve them.

**Study Recommendations**

This research study confirmed the subjectivity that underlies one’s ability to identify what quality looks and feels like, and the factors that make it more difficult to integrate quality into both collegial and nurse-client relationships. It also confirmed that licensed practical nursing is a rapidly evolving profession and CLPNBC is an organization making great strides towards promoting high practice standards among registrants through the provision of information, supports and resources. There were positive experiences where LPNs commented on successful identification and application of quality to their nursing practice. These were marked by relationships built on trust, inter-professional collaboration, and effective communication. However, it was also clear that LPNs remained inconsistent in their interest and involvement in making changes that positively impacted their practice and that while there were LPNs willing to
motivate their colleagues by engaging in ongoing education, mentorship and role modeling, they required support that emphasized inclusion and collaboration in order to do so.

Vision must permeate through the entire [profession] as a vital influence on the behavior of all [LPNs]. And we would feel genuinely threatened by incongruous acts because we would understand their disintegrating effects on what we dream to accomplish. [CLPNBC] would become an organization of integrity, where our words would be seen and not just heard. (Wheatley, 2006, p. 56)

The four recommendations arising from this inquiry are:

1. It is recommended that over the next six months, CLPNBC Policy & Practice department staff collaborate with subject matter expert LPNs to plan an ongoing initiative to create easily accessible, user-friendly, relevant tools and resources that support LPNs to demonstrate and validate their commitment to lifelong learning.

2. It is recommended that over the next year CLPNBC Policy & Practice department staff initiate an ongoing project to evaluate current practice support and information dissemination activities, and explore new ways to create a perception among LPNs that CLPNBC is positively impacting (influencing) the quality of their nursing practice.

3. It is recommended that over the next eighteen months CLPNBC Policy & Practice staff, in collaboration with staff from the College of Registered Nurses of BC (CRNBC) and the College of Registered Psychiatric Nurses of BC (CRPNBC), come together to undertake planning for a joint initiative to support their registrants in understanding how to work with other nurses in BC based on a commonality of practice, rather than on differences in professional designation.

4. It is recommended that over the next two years, CLPNBC collaborate with employers and other BC Nursing Regulators (CRNBC & CRPNBC) to plan for a program to support all nurses to learn about the mentor/mentee relationship and to embrace
reciprocal learning, irrespective of nursing designation, to meet their professional standards of practice.

**Recommendation one.** It is recommended that over the next six months, CLPNBC Policy & Practice department staff collaborate with subject matter expert LPNs to plan an ongoing initiative to create easily accessible, user-friendly, relevant tools and resources that support LPNs to demonstrate and validate their commitment to lifelong learning.

Fernandez and Rainey stated, “Successful [practice] change usually requires sufficient resources to support the process” (2006, p. 172). Adelson et al. (1997) observed “practitioners acknowledge the existence of a problem or opportunity for change and assess its seriousness or importance” before choosing how to remediate the issue and implement the change (p. 71). The findings and conclusions presented in Chapter Four related to indicators LPNs were using to identify and measure quality in their nursing practice, provided comments from both interviewees and survey participants regarding their use of tools such as professional portfolios, journals, learning plans and other resources to reflect on their practice, and to track and subsequently confirm to themselves and others their readiness to continually learn. These activities align well with Koch’s (1992) suggestion that “nurses using qualitative approaches seek understanding and use methods such as personal documents . . . yielding descriptive data . . . as another way of knowing” (p. 792).

Study participants approached the issue of maintaining and growing quality in their nursing practice in a variety of ways. Some explained they did not see value or have any idea of how they could track their activities or where to access resources that would support them to do so. Others were quite clear as to their preference for engaging in self-reflective, cognitive based activities and the kinds of tools and resources they utilized. Many respondents, when asked if
they tracked their thoughts about their own practice, preferred to engage in cognitive reflection as a “reassurance” they were on track. “Reflection-on-action may be used by some as a quality measurement tool similar to an outcome indicator . . . used to support activities aimed at performance improvement” (Willis et al., 2007, p. 278).

I recommend that over the next six months, CLPNBC Policy & Practice department staff engages with subject matter expert LPNs to develop a variety of user-friendly, relevant template tools and resources, such as professional portfolios, learning plans and/or checklists that will provide a guide for LPNs to track and cognitively reflect on their professional practice and development.

Kosel et al. (2007) suggested that for a vast majority of health care practitioners the most successful qualitative tools are user-friendly, incorporate simple strategies for getting help, and ensure that only relevant data is entered. Designing tools and resources with these principles in mind will “improve the efficiency and effectiveness of the tools and will enhance the quality of the information collected” relative to identifying quality in one’s nursing practice (p. 90S). Sinclair (1997) further concluded that professionals will be interested and able to meet their obligations to engage in quality assurance activities if conditions are right and they feel they are supported by a system designed to accommodate differences in personal values and attributes, practice environments and contexts of practice (p. 546). However, Willis et al. (2007) cautioned “it is not enough for a health care provider to simply say that they provide quality care. Validation . . . requires measurement and assessment of the quality of the care . . . provided by the health care provider” (p. 276). This is where it will be especially important for CLPNBC to determine how and if the data tracked by LPNs about their professional practice might be required by the regulatory body should the quality of an LPN’s practice ever come into question.
Recommendation two. It is recommended that over the next year CLPNBC Policy & Practice department staff initiate an ongoing project to evaluate current practice support and information dissemination activities, and explore new ways to create a perception among LPNs that CLPNBC is positively impacting (influencing) the quality of their nursing practice. Senge (2006) said “organizations learn only through individuals who learn” (p. 129), thus “developing the competence and confidence of their constituents (so that they might be more qualified, more capable, more effective leaders in their own right) is a personal and hands-on affair” (Kouzes & Posner, 2007, p. 261). The study findings indicated that while a majority of participants were utilizing a variety of CLPNBC-based resources to support their practice, almost three-quarters of survey participants preferred to review and absorb the information on their own, rather than speaking with a CLPNBC staff member for support. This same proportion selected online education offerings, reading nursing articles and engaging in self-study modules to improve their nursing practice. It was not surprising, then, that slightly less than half of survey respondents reported that CLPNBC and the information it provided was not positively impactful on their practice.

There appears to be a disconnect between the information and resources that LPNs are accessing from CLPNBC, and their perception of the value those supports have on the quality of their nursing practice. Therefore, I recommend that CLPNBC evaluate its current practice support and information dissemination activities, and explore new ways to create a perception among LPNs that CLPNBC is positively impacting (influencing) the quality of their nursing practice. Kouzes and Posner (2007) advised, “Leaders must have the confidence to let go of control, expose vulnerabilities, and show trust in others” (p. 227). As indicated earlier in this paper, practical nursing students are taught that LPNs must meet any quality assurance and
continuing competence requirements “imposed” on them by CLPNBC (BC Campus, 2012, p. 41). Koch (1992) further suggested that nurses are warned that if they do not establish their own criteria for quality, other professionals will impose them on nursing practice (p. 791). This may explain why LPNs gravitate towards self-centric professional activities, because they feel that CLPNBC is acting as “Big Brother” watching over them to make sure they integrate quality into their own practice, and why LPNs may have difficulty identifying any positive impact CLPNBC has on their practice.

CLPNBC has to be careful that in moving forward it is not perceived as employing a command and control or “top-down” approach to information dissemination and practice support, as it may run the risk of establishing a quality control system despised, and strongly resisted by those whose activities are being controlled, rather than creating a quality assurance system supported by everybody (Sinclair, 1997, p. 537; Vuori, 2007, p. 13). Bolman and Deal (2008) concurred that “involvement and training will not ensure success unless existing roles and relationships are realigned to fit the new initiative” (p. 382). The concept of self-regulation may become less threatening as CLPNBC demonstrates that the results of practice support can, be used positively and confidentially; guidelines that identify the expectations for appropriate practice must be created in a way that employs an inclusive approach (Gunther & Alligood, 2002; Pelkonen, 1994; Sinclair, 1997). The reasons for such differences in minimum personal acceptable levels of quality and those expected by the regulatory body at a professional level may include practitioners’ personalities, knowledge, attitudes and experiences, the effects of co-workers, and the influence of professional guidelines and standards. (Handfield-Jones et al., 2002, p. 956).
While CLPNBC and its staff are committed to maintaining the organization’s values of fairness, accountability, collaboration, transparency, relevance and respect in their work, there is much to be done to facilitate a paradigm shift among LPNs so that they feel CLPNBC is having a positive impact on the quality of their nursing practice: “Leaders take every opportunity to show others by their own example that they’re deeply committed to the values and aspirations they espouse” (Kouzes & Posner, 2007, p. 75).

**Recommendation three.** It is recommended that over the next eighteen months CLPNBC Policy & Practice staff, in collaboration with staff from the College of Registered Nurses of BC (CRNBC) and the College of Registered Psychiatric Nurses of BC (CRPNBC), come together to undertake planning for a joint initiative to support their registrants in understanding how to work with other nurses in BC based on a commonality of practice, rather than on differences in professional designation.

It must be realized that there is nothing more difficult to plan, more uncertain of success, or more dangerous to manage than the establishment of a new order; for he who introduces [change] makes enemies of all those who derived advantage from the old order. (Machiavelli as cited in Bolman & Deal, 2008, p. 387)

As indicated earlier in the findings and conclusions, study participants had many personal insights to share about their working relationships with their colleagues and the perception that professional hierarchies still exist in nursing. It was evident from study participants’ comments that the concept of “nurses eat their young” has played itself out across the nursing profession affecting all nurses regardless of the type of nursing designation (LPN, RN, RPN) one holds. Interviewees in particular were very vocal about their disappointment when faced with having to “prove” themselves to be competent, quality practitioners and worthy of the role they played on the health care team. Skinner (2001) identified that too often, changes [in the composition of the health care team] are implemented without sufficient attention to building an understanding and
commitment to the improvement process throughout different levels of the [profession]” (p. 5). Therefore, I recommend that CLPNBC collaborate with CRNBC and CRPNBC to plan how to support their registrants to develop an understanding about how to work with each other based on a commonality of practice, rather than on differences in professional designation.

Historically, licensed practical nursing in BC was viewed as a vocation rather than as a profession and although LPNs are now regulated as professional nurses, the health care system has been inconsistent in supporting utilization of nurses based on shared scope and competence. Many employers have instead opted to recognize professional designation as the first criterion for determining staffing models. Some nurses have blindly adopted this philosophy as well because they themselves have “deeply held internal images of how the world works, images that limit [them] to [new] ways of thinking and acting” (Senge, 2006, p. 163). Ferlie and Shortell (2001) offered reasons why resistance to change often occurs: “in almost all cases, an overly hierarchical culture emphasizing rules, regulations, and reporting relationships is negatively associated with implementation of quality improvement and related practices” (p. 294).

Caramanica, Cousino and Petersen (2003) added their nursing perspective on how to change this belief stating collaboration requires members of the team to have “an underlying respect and value for what each discipline brings to the care of the patient. There is a high level of trust among the disciplines . . . with a solid understanding of the individual discipline's scope of practice” (p. 339).

Collaboration at the regulator level “requires listening, understanding, and accepting” (Bolman & Deal, 2008, p. 404), just as it does in settings where nurses work together. Role modeling working together at the regulator level translates well at the unit level as both observe essential core principles of successful quality improvement approaches that have been identified
in the literature: leadership at all levels; organizational learning requires leadership from executives, line (middle) managers, and informal network leaders throughout organizations (Caramanica et al., 2003, p. 339; Carroll & Edmondson, 2002, p. 51), a pervasive culture that supports learning throughout the change process (Argyris & Schon, 1978; Burhans, Chastain and George 2012; Dekker, 2007; Marx, 2001); health care regulators, employers and practitioners can improve quality and other outcomes by enhancing their capabilities for organizational learning (Anderson & Ackerman Anderson, 2001; Carroll & Edmondson, 2002; Ferlie & Shortell, 2001, p. 282). By facilitating ongoing education, planning, consultation and discussion among the nursing regulators and with nurses about the effects the current environment has in the workplace, these activities may encourage LPNs, and possibly all nurses, to discard current negative mindsets and positively influence the way nursing teams communicate and work together. Through an emphasis on the development of effective teams, the importance and effectiveness of using interdisciplinary teams to achieve quality/safe patient care cannot be overemphasized, (Caramanica et al, 2003, p. 339; Ferlie & Shortell, 2001, p. 282). Weisbord (2012) summarised it well: “By getting [nurses] together in the workplace, [involving] people in the control of their own lives, work, and destinies . . . [there is] no higher form of leadership” (p. 371).

Recommendation four. It is recommended that over the next two years, CLPNBC collaborate with employers and other BC Nursing Regulators (CRNBC & CRPNBC) to plan for a program to support all nurses to learn about the mentor/mentee relationship and to embrace reciprocal learning, irrespective of nursing designation, to meet their professional standards of practice. Mills, Francis and Bonner (2008) suggested that “mentoring is often proposed as a solution to the problem of nursing workforce shortages” (p.
23) and confirmed Stewart and Kruger’s (1996) definition of nurse mentoring, making an amendment to include clinicians as potential mentees:

Mentoring in nursing is a teaching-learning process acquired through personal experience within a one-to-one, reciprocal, career development relationship between two individuals diverse in age, personality, life cycle, professional status, and/or credentials. The nurse dyad relies on the relationship in large measure for a period of several years for professional outcomes, such as research and scholarship; an expanded knowledge and practice base; affirmative action; and/or career progression. Mentoring nurses tend to repeat the process with other nurses for the socialization of [clinicians], scholars and scientists into the professional community and for the proliferation of a body of nursing knowledge. (p. 315)

The findings and conclusions presented in Chapter Four included several comments from study participants related to their experiences as both a mentor and mentee. More than half of survey respondents indicated they had engaged in mentorship and coaching activities to maintain or grow quality in their nursing practice. Several interviewees identified the qualities they appreciated most in a mentor, speaking fondly about their experiences as a mentee and of bringing the best of what they learned in that relationship to their subsequent role as a mentor. Rye and Boone (2009) believed that mentorship can “provide . . . and inspire [nurses’] learning, influence their role socialization and reinforce their competence” (p. 869); Farquhar, Kurtzman and Thomas (2010) agreed stating: “nurses, as the most trusted and single largest group of health care professionals, are ideally suited and well positioned to inspire confidence in the health care industry” (p. 253).

A small number of participants reflected on their role as a new nurse being mentored into the profession, while many others specifically addressed the collegial support they received while pursuing ongoing career development as suggested in Mills et al’s (2008) amended definition of nurse mentoring mentioned above. It is this focus on ongoing collegial support, rather than a new nurse’s transition to practice, that underlies my final recommendation to
CLPNBC to collaborate with employers and other BC Nursing Regulators to support all nurses to learn about the mentor/mentee relationship and to embrace reciprocal learning, irrespective of the nursing designation they hold, to meet their professional standards of practice. Each professional nursing group in BC has a set of professional standards established by their respective regulatory bodies that outline the minimum expectations for practitioners’ professional practice. There are three concepts consistent across all groups: guides others; seeks guidance; and shares nursing knowledge (CLPNBC, 2014; CRNBC, 2012; CRPNBC, 2012). Each of these articulates well with the premise of mentorship as a way for nurses to support each other to meet their professional standards of practice.

Study participants consistently identified the positive impact mentorship and collaborative relationships had on the quality of their nursing practice, and the importance they placed on having access to colleagues to guide and role model quality professional practice for them. Bolman and Deal (2008) explained how much of the work in large organizations of every sort is now done in groups or teams. “When these units work well, they elevate the performance of ordinary individuals to extraordinary heights” (p. 101). Schunk and Zimmerman (1998) moved this into the nursing context and advised simply that “[nurses] who know when, how, and from whom to seek help should be more likely to be successful than those who do not seek help appropriately” (p. 69). The Mills et al., (2008) rural nurse mentoring project has lessons that are extremely positive for all nursing environments: “identifying experienced nurses who mentor one another . . . affirming them and supporting them. Mentoring . . . shapes how they frame their nursing perspectives of self to aspire . . . over time, creating a future culture of support (p. 33). When you understand a challenge from a new perspective or viewpoint and perhaps even consider abandoning previously learned principles or approaches, you have a better chance to
figure out new ways to respond (Eoyang, 2013, p. 6; Handfield-Jones et al., 2002, p. 951).

Therefore, I agree with Block, Claffey, Korow, and McCaffrey (2005) that “educating mentors to their roles is beneficial and should be instituted before mentorship programs are adopted” (p. 137) and that keeping this in mind in the context of supporting nurses to meet their professional standards of practice provides support for this recommendation.

Organizational Implications

Regardless of the outcomes of this action research project, the requirement for LPNs to establish, maintain and grow quality in their nursing practice will continue to be the primary criterion against which CLPNBC evaluates LPNs in their role as a professional nurse (Health Professions Act, RSBC 1996, c 183.). Providing LPNs the opportunity to share their reflections, successes, challenges and suggestions about what quality looks and feels like and the impact quality has had on their professional practice was a process that proved to be very informative. Heifetz and Laurie (2001) concluded that “solutions to challenges reside not in the executive suite but in the collective intelligence of employees and stakeholders at all levels, who need to use one another as resources … and learn their way to solutions” (p. 132). Finding ways to engage all LPNs in an inclusive change process that supports them in their ability to appreciate their professional obligations, and to understand the impact these obligations have on their professional practice promises to be fascinating. To implement the recommended changes, it is important to consider potential implications. “There may be a number of reasons why individuals or groups can react very differently to change- from passively resisting it, to aggressively trying to undermine it, to sincerely embracing it” (Kotter & Schlesinger, 2006, p. 132). The following section discusses organizational implications for CLPNBC and proposes an implementation process to realize the study recommendations.
Implications for creating tools and resources that support LPNs to validate their commitment to lifelong learning. The research findings identified that LPNs like to learn. For the most part, they keep track of what they learned and when, and they like to be able to show others their achievements as a way of validating their contribution to and place within the healthcare team. However, participants were inconsistent in how or if they recorded their accomplishments. Some did not know what they should document while others were unable to articulate the professional value in doing so. Larrabee and Bolden (2001) rationalized this with the observation that different [nursing groups] stress some dimensions of nursing [education] less than others. (p. 49). In looking at issues related to the development of standardized quality assurance tools, Koch (1992) suggested there are common problems applicable to the development of any instrument (p. 789). “There are positives and negatives associated with such an activity and that a balance must be maintained between [practitioner] and [regulatory] perspectives” (p. 789). O’Connor and Walker (2003) explained that the applicability of strategies and tools into the practice setting is the goal of any leadership program (p. 292), but cautioned looking for an "ideal" tool to align with the culture of a [profession] will be frustrating. “What is deemed appropriate will depend on how we want to define "culture". . . the intended use of the results, and the availability of resources” (Scott, Mannion, Davies & Marshall, 2003, p. 929).

Kosel et al. (2007) explained it is important to ask what kind of tool or resource is required as it may be one that LPNs are already familiar with. “What is chosen must always be built with the primary end-user needs first and foremost in mind” (p. 89S); in this case primarily LPNs, but secondarily, CLPNBC should it require evidence to support the nurse’s claim of quality practice. “The first step in designing a . . . tool involves understanding the capabilities of the audience and the scope of the project the tool is intended to support” (p. 89S).
CLPNBC staff involvement, along with that of subject matter expert LPNs, will be integral to the development of tools and resources that will support LPNs to document and record their efforts related to a professional commitment to lifelong learning. This process would begin with a face-to-face discussion about the recommendation at a meeting with my organizational sponsor. Support from the Director, Policy and Practice would be beneficial to promote the recommendation and its potential benefits to the Leadership Team and to Policy and Practice department staff, who are also LPNs, and who would be instrumental in developing, designing and articulating the value of such resources to LPNs. The latter idea of having LPNs involved in development of these tools and resources fits well with what Smith (2013) offered, “there is a widespread belief that data for professional improvement are best designed, collected and disseminated by the professionals themselves, and fed back to practitioners in a constructive unthreatening manner” (p. 214). Therefore, as leaders, it is our goal to engage registrants in order to minimize barriers and work through them together.

Engaging registrant LPNs in the work of the College has proven more difficult for CLPNBC in the past as indicated in the findings and conclusions presented in Chapter Four. For some, the perception is that CLPNBC is rule-bound and disciplinary in its work. “The college needs to engage registrants to both better understand the current state and to seek input into how it can be more effective in the eyes of registrants” (Bayne, 2012, p. 17). In seeking registrant involvement in the development of these resources, several authors wrote about end-users taking ownership not only for the way they use the tool or resource, but for development of something that has relevance to them and their practice. “When they believe they’re able to mobilize the resources and support necessary to complete a task, then they persist in their efforts to achieve” (Harvey, 1991, p. 277; Kouzes & Posner, 2007, p. 252).
If CLPNBC fails to engage LPN registrants in development of the types of resources they requested in the study findings, Harvey (1991) warned that, implemented in a top-down way the tools will be less well accepted by nurses. “[Nurses] characteristically described feeling less involved and less well prepared . . . and were more likely to experience feelings of threat and anxiety and to question the . . . credibility of [the resource]” (p. 284). Redfern and Norman (1990) countered with “bottom-up approaches seem to emphasize the development of quality as a process that “stems from growth and change in the hearts and minds of practitioners themselves” (p. 1268).

Austin et al. (2003) summarized the benefit to both the regulatory body and registrants in that these tools provide the College with useful information regarding [registrants] lifelong learning activities:

As such, it is an important source of data for program planners, but more importantly provides an opportunity for [registrants] to identify their own learning and demonstrate [to others] how they are maintaining competency through their use of tools and resources by which learning objectives can be established and self-monitored. (p. 4)

**Implications for evaluating practice support and information dissemination activities, and exploring new ways to create a perception among LPNs that CLPNBC is positively impacting (influencing) the quality of their nursing practice.** Systems theory holds that one cannot understand disparities in practice and organizational weaknesses in isolation. One must recognize the reciprocity of dependence and impact of the parts on the whole and understand the whole within the context of the larger environment (Goeschel, 2011; Reason & Bradbury, 2008; Vincent, 2004; Wieck & Sutcliffe, 2006). These relationships, in the context of LPN regulation and practice in BC, were illustrated in Chapter One (see Figure 2.). CLPNBC has done a great deal of work to support and promote quality nursing practice among LPNs. Yet, as
indicated in the findings and conclusions presented in Chapter Four, LPNs struggle to identify the positive impact CLPNBC’s work has had on their nursing practice.

This research study was related to identifying quality in LPNs’ nursing practice—something that the findings confirmed was forefront in all participants’ minds. However, the LPN profession in BC has been subject to several years of ongoing pledges to make significant legislative changes that would result in an expanded scope of practice for LPNs. These changes will only amplify the need for revision to CLPNBC’s practice support resources (CLPNBC, 2015), as well as a rethink about the way it disseminates practice support related information. The general sentiment of many study respondents was that CLPNBC’s role, relative to LPN practice, had very little to do with them other than the requirement to hold a current registration to practice. If CLPNBC chooses not to take a proactive role in helping LPNs move beyond the task of completing their annual quality assurance requirements and into a better understanding of the impact their regulatory body has on their practice, the concept of professional self-regulation will continue to lose its significance for LPNs. “Without credible communication, and a lot of it, the hearts and minds of the troops are never captured” (Kotter & Schlesinger, 2006, p. 128).

Anderson and Ackerman Anderson (2001) explained that for a comprehensive transformational change strategy to be successful, it has to include three equally important components: content, people and process (p. 43). Launching this recommendation requires that CLPNBC engage LPNs for their feedback on what is and is not helpful. The channels for feedback must be easily accessible and a variety of media should be considered in addition to face-to-face meetings. These could include blogs and message boards, on-line chats, and video-conferencing with live-feed webinars and podcasts. CLPNBC staff at all levels must be encouraged to keep trying these strategies even if the initial response continues to be low. While
the findings did show that LPNs prefer communication and learning options that did not promote dialogue, email could also be considered a safer vehicle for providing feedback. Since communication is complex in organizations, it is reasoned that effective communication would utilize a variety of approaches and would be customized to the audience and the situation. Communication should also be planned so that important messages can be delivered repetitively in a variety of formats; “give people information, and do it again and again” (Bridges, 1991, p. 27). Several authors confirmed that leaders should take this risk as communication is one of the most important elements in the change process; it helps reduce resistance, minimize uncertainty and increase stakeholder involvement and commitment (Adelson et al., 1997; Carter, 2008; Kotter, 1996). As a result, LPNs may better understand the critical role played by CLPNBC; “they need to view the College as a key resource in ensuring the quality and safety of nursing practice, in reinforcing the distinction between a vocation and a profession, and helping them to protect the integrity of the professional brand” (Bayne, 2012, p. 17).

Implications for supporting LPNs to develop an understanding about how to work with other nurses based on a commonality of practice. Lahey and Currie (2005) stated “Since the premise of interprofessional practice is shared and even overlapping competencies, a different notion of clarity is inherent. Boundaries between the various professions and their respective scopes of practice are to be adjusted, made fluid, or perhaps blurred” (p. 210). Porter-O’Grady (as cited in Bayne) concurred, suggesting that “we need to think in terms of interfaces rather than the boundaries between professions. We need more dialogue and less opportunity for maintaining arbitrary and capricious differences between professions” (2012, p. 13). These authors’ perspectives and the fact that study participants commented a great deal on the negative nature of interactions with their registered nursing colleagues, based solely on differences in their
professional designations and a lack of understanding about what an LPN can do, form the foundation for the next recommendation.

Given that LPNs “work collaboratively with colleagues in the health care system to assess, plan, deliver and evaluate quality nursing services” (CLPNBC, 2014), there is an expectation that nurses should “know” how to work together. However, that may not be the case, as evidenced in the findings and conclusions provided in Chapter Four. Goeschel (2011) confirmed this with “none of us—nurses, physicians nor administrators—learned our craft working in collaborative teams, but today the public, policymakers and payers expect us to practice a synchronized whole” (p. 30). Addressing this recommendation is timely given government’s impending revisions to a common regulatory framework for all nurses, delineated by the amount of practice oversight required, not solely by a professional’s nursing designation. Helping LPNs to understand what working together means may be best achieved through collaboration with the other BC nursing regulatory bodies to create shared resources that can be used to support nurses to learn about the commonality of nursing practice they share, regardless of nursing designation. While each group within the nursing family has its own professional regulation, they do have shared competencies and a shared scope of practice; the latter providing a framework that fits well with reinforcing the objective of nurses working together in practice settings in a way that draws on nurses’ individual and complementary expertise and professionalism to provide quality client care. “This is key to ensuring a complementary, consistent, comprehensive, efficient, and effective integration of roles and functions. It is essential to ensuring the wealth of knowledge that resides with each regulator effectively informs . . . decision-making” (Bayne, 2012, p. 16).

Implementing this recommendation will require policy and practice department staff at each of the three nursing regulators to identify and agree on the need for such a resource, request
permission from their respective Directors to embark on this work and any collateral education vehicles required, and develop them through a common policy development process. Presenting the content may be carried out independently or in a dual or triumvirate fashion by the regulators, but it is important to understand that given study participants’ comments, it will be critical for regulators to create safe opportunities for open dialogue and supportive problem-solving. The implications of delaying or denying the development of these kinds of resources and opportunities are continued change efforts that do not fully realize CLPNBC’s goals for supporting informed quality nursing practice by LPNs. Multiple intervention strategies, such as education and communication, participation and involvement, negotiation and agreement to deal with potential barriers to change, are more likely to be more effective than a single intervention (Clement-O’Brien et al., 2011, p. 432; Kotter & Schlesinger, 2006, pp. 134-137). This leadership perspective enables organizations to produce continuous change by means of repeated interactions among individuals and teams resulting in the creation of tools and resources that fit purposes at hand (Weick & Quinn, 1999, p. 377).

Implications for collaborating with employers and other BC Nursing Regulators to support nurses to learn about the mentor/mentee relationship and to embrace reciprocal learning to meet their professional standards of practice. Quinn et al. (1996) stated “many professionals have little respect for those outside their field, even when all parties are supposedly seeking the same goal” (p. 75). This research study confirmed these authors’ perspective and revealed that nursing professionals do not always respect and acknowledge their colleagues’ credentials or their experience, even though they are often providing care to the same client or group of clients. The findings and conclusions in Chapter Four presented study participants’ experiences with being a mentee and/or a mentor. Many found themselves working with nurses
who had more foundational nursing education, but with far less professional experience than the LPN. This resulted in LPNs taking on what participants identified as a mentor role; however their efforts were not always welcomed simply because they were an LPN.

In order to implement this recommendation, which builds on the concept of nurses working together and addresses the provision of ongoing collegial support through mentorship activities, CLPNBC must recognize that employers have a significant role to play related to recognizing and supporting LPNs as mentors. CLPNBC could meet with employers to better understand their existing mentorship programs and to what degree the information and supports provided articulate with professional standards of practice. This recommendation may also prove beneficial during the implementation of a comprehensive pilot project that encompasses all nursing designations, through the creation of valuable ‘how to’ resources used to support the introduction of a successful mentoring program. While some of the content developed and provided by CLPNBC and other nurse regulators could be used to reinforce the value of mentorship in meeting nurses’ professional standards, CLPNBC has no control over how many LPNs could participate in such employer offered programs. Although LPNs’ participation may be limited due to external constraints related to the availability of fiscal, physical and material resources, Bolman and Deal (2008) advised to be aware that innovation can create issues; for example, individuals’ ability to feel effective, valued and in control. “Without support, training, and a chance to participate in the process, people become powerful anchors, embedded in the past, that block forward motion” (p. 396). Therefore, formal support and recognition for mentors should not be reserved only for nurses with a professional designation congruent with degree-level education as to do so could stall efforts at ongoing collegial support between diverse groups of nurses. Carroll and Edmondson (2002) warned that depending solely on professional
designation to identify a potential mentor can be a "competency trap" in which complacency and commitments to the skills that made individuals and organizations successful prevent growth and change (p. 53). “These can be categorized into several themes, one of which is the perceived status quo: "We've always done it this way". Such practices, often steeped in tradition rather than best practice, have been referred to as "sacred cows" (Makic, Martin, Burns, Philbrick & Rauen, 2013, p. 29). With an identified connection between positive mentor/mentee relationships and quality patient care (Clark, Farnsworth & Springer, 2008; Luparell, 2011), it follows that a poor mentorship experience for either party can negatively impact client care, interfere with learning, cause loss of motivation and withdrawal, and lead to negative feelings and even physical ails (Clark, 2008, Marchiondo, Marchiondo & Lasiter, 2010; Rye & Boone, 2009; Tiberius & Flak, 1999). Identifying the negative aspects of nursing collegialism makes an important contribution to understanding mentoring and other aspects of professional development. (Miller & Kontos, 2013, p. 1804).

It may also be important in following up on this particular recommendation to work with other provincial nursing organizations such as LPNABC and the unions that represent nurses in BC, to support nurses to learn about mentorship and the value of reciprocal learning in the context of establishing, maintaining and growing quality nursing practice. Mentorship has inherent in it, “a staggering potential for collaborative learning . . . collectively, we can be more insightful, more intelligent than we can possibly be individually” (Senge, 2006, p. 221). Kouzes and Posner (2007) suggested “leaders know that part of their job is to set up conditions that enable each and every team member to feel a sense of ownership for the whole job” (p. 258). Heifetz, Grashow, and Linsky (2009) concluded that individuals experience a sense of shared responsibility when they understand what those in other parts of the organization do all day, “to
see what kinds of challenges they are dealing with, and to identify practices and norms that could help them in their own part of the company” (p. 169). In aligning this further with the nursing profession O’Connor and Walker (2003) offered:

In its work of building a wisdom community, the Nurse Leader operates on the premise that wisdom springs from within each individual; each individual is responsible and accountable for his or her own learning. In an environment that fosters discovery as a result of the synergy created, individual wisdom emerges. (p. 293)

Taking the time to plan properly and put organizational resources and supports in place to facilitate participation and engagement in mentorship programs will not only enhance learning opportunities and nurses’ role satisfaction, but ultimately, client care outcomes will be positively impacted. Clarity of roles and the definition of what mentoring is and its place in the organization will also assist nurses to better support one another and to respect each other and what each brings to today’s health care system.

**Implications for Future Inquiry**

The intent of this research study was to learn what participants’ believed quality in nursing practice looked and felt like, as well as the types of activities they were engaging in to support and maintain quality in their own nursing practice. The research findings presented in this paper provided an overview of their experiences and revealed a variety of opportunities for future inquiry. However, due to the limited size of the respondent group involved with this study, it is hoped that future research projects, especially those related to the development, implementation and evaluation of CLPNBC’s quality assurance program, are successful in engaging a larger number of LPNs.

Eva and Regehr (2005) suggested that for many health care professionals, engagement in reflection-in-action has taken precedence over reflection-on-action (p. 143). Outcomes of this study revealed that participants were inconsistent in the way they approached and applied
reflection to their own nursing practice. Future research about how LPNs reflect on their practice, whether they are able to link these concepts through application, as well as the impact these types of reflective activities have on the quality of their practice and on client outcomes, will expand on this research study. It is an area of inquiry that connects well to the topics discussed in the literature reviewed in Chapter Two. The conclusion Redfern and Norman (1990) came to, “thus, there is a recognition that any improvement in nursing care requires the development of "reflective practice", in that . . . nurses ask themselves if and how they could do better” (p. 1268) supports this suggestion.

CLPNBC has an important role to play in ensuring the information and services it delivers to LPNs are easily accessible, applicable and relevant to their needs. Almost half of this study’s survey respondents indicated a neutral or negative impact on their practice arising from their experiences trying to access and integrate these resources and supports into their nursing practice. A review by Davis et al (1995; 1999) suggested that learning based on interactive forms of support may be more effective than traditional activities and that information about which methods were most effective and in which settings was not at all clear. This observation, when combined with the research findings, makes this an issue that warrants further examination relative to LPNs. “There are indeed very interesting new educational approaches within the field of self-regulatory professional development, but we need further evaluations of their impact, cost and possibilities for implementation” (Grol, 2001, p. 2581).

A final topic I suggest for future inquiry would be to research the effectiveness of CLPNBC’s current quality assurance program and its impact on LPNs’ professional practice. In reflecting back on the statement Willis et al. (2007) made that it is no longer sufficient for professionals to say they provide quality care; as regulators we must validate that claim (p. 276),
there still remains a tremendous amount of work to be done to create something that is engaging, relevant and easy for LPNs to apply to their nursing practice. As Bayne (2012) suggested, “the need for ongoing assessment of performance to assure quality and safety implies a role for regulatory bodies that may be more extensive than it has been historically” (p. 15). Cox (1999) suggested that with step-by-step management, instilling quality into the culture of a profession will be an ongoing activity (p. 58). This aligns well with the position Kouzes and Posner (2007) took, reminding us that when embarking on change, “the most effective change processes are incremental, not one giant leap” (p. 193).

Chapter Summary

This inquiry, through a review of the literature and presentation of research findings and conclusions, answered the question, What does quality mean to registrants and what implications does quality have on professional practice when it is or is not present? It has the potential to inform the College of Licensed Practical Nurses of BC (CLPNBC) with options for consideration of how best to develop one or more components of its QA program and to position the College as a leader in the promotion of high practice standards amongst registrants.

There is also the possibility that this inquiry could inform a larger group of health care regulators and/or employers in BC and across Canada which may result in opportunities for groups of healthcare professionals, their employers and their regulatory bodies to work together to better define, identify and measure quality in a practitioner’s professional practice. Adapting to the challenges embedded in change “can only be addressed through changes in people’s priorities, beliefs, habits, and loyalties. Making progress requires going beyond any authoritative expertise to mobilize discovery, shedding certain entrenched ways, tolerating losses, and generating the new capacity to thrive anew” (Heifetz, Grashow, & Linsky, 2009, p. 19).
Report Summary

“Action research involves a collaborative change management . . . relationship between researcher and client aimed at both solving a problem and generating new knowledge” (Coghlan & Brannick, 2010, p. 44).

Following review and discussion of the study findings and conclusions, the recommendations offered in this chapter were developed and refined in consultation with my organizational sponsor for the project. As the Director of Policy and Practice at CLPNBC, she acknowledged that the outcomes presented in this thesis provided the organization with the information it needed to identify whether it was doing its work well, and areas that need to be focused on moving forward. During our final meeting as student and sponsor, she confirmed that this study had resulted in “ideas, concepts and literature that will carry the work of the organization forward” (W. Winslow, personal communication, March 19, 2015).

The study findings, conclusions and recommendations were also shared with the Policy and Practice Team through a presentation and discussion about the general and specific implications for CLPNBC resulting from my research. This was done in consideration of their anticipated involvement in the planning and implementation of each recommendation. Although I have not formally shared the study data with other CLPNBC staff members, Leadership will engage their own departments in discussion about the recommendations where they are relevant to their work. Planning is also underway to build on my inquiry through a colleague’s organization-sponsored research project related to CLPNBC’s newest quality assurance initiative.

The biggest barrier to adopting each of the recommendations in a timely manner may be related to the priority that must be given to work resulting from upcoming revisions to the
legislation governing the LPN profession in BC. Those changes and the demands they may have on already strained resources have the potential to impact how the recommendations are planned for and the timelines for implementing them. It is positive, however, that CLPNBC is presently addressing part of recommendation one through the ongoing use of a variety of resources designed to support LPNs’ professional practice. New resources are being developed and will fit well with the purposes of the recommendation.

CLPNBC is also in the process of launching an information dissemination project related to the newest component of its external quality assurance program. The survey data presented in this study identified a large segment of LPNs who were unable to convey the kind of impact CLPNBC’s work has had on their practice. The goal in implementing recommendation two is to raise LPNs’ awareness and/or move that group into being able to articulate the positive impact the College’s practice support services have had on them and their ability to establish, maintain and grow quality in their nursing practice.

CLPNBC already engages regularly with the other BC nursing regulators through policy discussions and collaborative initiatives; however with the upcoming changes to all three nursing regulations in BC, closer collaboration about what these changes mean and the impact they will have on how nurses work together will be the primary focus moving forward. Having time to absorb the revised regulation and the impact those changes have on nurses’ practice, will give the regulators time to determine which aspects of collaboration need to be addressed first.

The final recommendation may not be possible to begin planning for until some of the work related to educating nurses about how to work together as described in recommendation three has been implemented and evaluated. Nonetheless, CLPNBC is committed to facilitating quality wherever possible and is interested in carrying out all of the recommendations as
workloads, available resources, timing, and priorities permit. “Constituents want leaders who remain passionate despite obstacles and setbacks. In uncertain times leaders with a positive, confident, can-do approach to life and business are desperately needed” (Bolman & Deal, 2008 p. 349).
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Improving Quality Measurement Processes


Farquhar, M., Kurtzman, E. T., & Thomas, K. A. (2010). What do nurses need to know about the quality enterprise? *The Journal of Continuing Education in Nursing* 41(6), 246-256


Improving Quality Measurement Processes


Improving Quality Measurement Processes


Appendix A: Letter of Invitation to LPNs for Participation in a Focus Group

[Date]

Dear [participant name],

I would like to invite you to be part of a research project that I am conducting for the College of Licensed Practical Nurses of British Columbia (CLPNBC). This project is part of the requirement for a Master’s Degree in Leadership (Health), at Royal Roads University. My name is Janice Harvey and my credentials with Royal Roads University can be established by contacting Dr. Brigitte Harris, Program Head, MA Leadership (Health) at [email address].

The objective of my research project is to explore what quality means to registrants and the implications quality has on professional practice when it is or is not present, as part of a larger quality assurance (QA) program. In addition to submitting my final report to Royal Roads University in partial fulfillment for a Master of Arts in Leadership (Health) Degree, I will also be sharing my research findings with CLPNBC. The project findings may be presented at provincial and/or national regulatory conferences. As this research will also be published, a copy of this thesis will reside in the RRU library as well as in Library and Archives Canada, accessed through the Thesis Canada Portal, and the ProQuest/ UMI database.

The research data will be put towards developing one component of a much larger quality assurance program. It may also form the basis for a variety of journal articles related to the responsibilities of a health regulatory organization in developing a quality assurance program to meet its legislated mandate to establish and maintain a continuing competency program to promote high practice standards amongst registrants.

My research will utilize open-ended questions in a focus group activity and is foreseen to last approximately 90 minutes. The foreseen questions will include such things as: “tell me about a time when you felt really proud of your nursing practice and what you had accomplished on a shift”; and “tell me about one accomplishment you are particularly proud of that helped you to grow as a professional nurse”. Your name was randomly chosen as a prospective participant from among all individuals who hold a current FULL registration with CLPNBC in good standing. You will have an opportunity to verify the data collected during the focus group. The data will then be used, in part, to formulate survey questions for the next cycle of research for the project.

Information will be recorded in both electronic and hand-written formats and, where appropriate summarized, in anonymous format, in the body of the final report. In order to maximize trustworthiness of the data collected, digital recording will be utilized however you can request that the recorder be turned off at any time for a few minutes during the session. At no time will any specific comments be attributed to any individual unless your specific agreement has been obtained beforehand. Each member of the focus group will be expected to treat as confidential both the identity of all other participants and all of comments made during the focus group. You are asked to not disclose or discuss this information with anyone who was not part of the group.
All documentation will be reviewed with my research advisory team, and will be kept strictly confidential and without personal identifiers. Participants’ names and any other personal identifiers will not be included as part of the data analysis, and all raw data and transcribed materials will be kept in a locked cabinet in my office. The key will be kept on my person at all times. Compiled research data will be retained for a period of one (1) year without personal identifiers and all raw data will be destroyed at the conclusion of the research through confidential shredding. Data and information pertaining to an individual who has chosen to withdraw at any time during the research process will not be retained and will be destroyed through confidential shredding provided that their withdrawal is received prior to the analyses of these data. Once the data have been analyzed, best efforts will be made to remove any quotations contributed by the withdrawn participant.

A potential conflict of interest could arise from sharing information about challenging experiences in maintaining high practice standards in your nursing practice. Confidentiality and free and informed consent will be maintained at all times throughout the research project. You are free as a participant to share only information that you feel comfortable sharing in a small group and to decline to answer any questions that might be posed.

You are not compelled to participate in this research project. If you do choose to participate, you are free to withdraw at any time without prejudice. Similarly, if you choose not to participate in this research project, this information will also be maintained in confidence.

Please feel free to contact me at any time should you have additional questions regarding the project and its outcomes. Research findings and recommendations will be shared with participants at the conclusion of the project. The CLPNBC will also provide information about the research project findings and recommendations to its registrants and stakeholders through articles published in its College Connection newsletter.

If you would like to participate in my research project, please contact my research advisory team member at:

Name: [name]
Email: [email address]
Telephone: [telephone number]

Sincerely,

Janice Harvey
Appendix B: Informed Consent for LPN Participation in a Research Project Interview

My name is Janice Harvey, and this research project is part of the requirement for a Master of Arts in Leadership (Health) Degree at Royal Roads University. My credentials with Royal Roads University can be established by contacting Dr. Brigitte Harris, Program Head, MA Leadership (Health) at [email address].

This document constitutes an agreement to participate in my research project, the objective of which is to explore what quality means to registrants and the implications quality has on professional practice when it is or is not present.

The research will utilize open-ended questions and is foreseen to last approximately 45 minutes. The questions I will ask refer to times in your career when you felt really proud of your nursing practice and what you had accomplished on a shift, as well as any accomplishments you feel have helped you to grow as a professional nurse. In addition to submitting my final report to Royal Roads University in partial fulfillment for a Master of Arts in Leadership (Health) Degree, I will also be sharing my research findings with CLPNBC. As this research will also be published, a copy of this thesis will reside in the RRU library as well as in Library and Archives Canada, accessed through the Thesis Canada Portal, and the ProQuest/UMI database.

The research data may be utilized to develop one component of a much larger quality assurance program. The project findings may be presented at provincial and/or national regulatory conferences. They may also form the basis for a variety of journal articles related to the responsibilities of a health regulatory organization in developing a quality assurance program to meet its legislated mandate to establish and maintain a continuing competency program to promote high practice standards amongst registrants. Research findings and recommendations will be shared with participants at the conclusion of the project.

Information will be recorded in both electronic and hand-written formats and, where appropriate, summarized, in anonymous format, in the body of the final report. In order to maximize trustworthiness of the data collected, electronic recording will be utilized however you can request that the recorder be turned off at any time for a few minutes during the session. At no time will any specific comments be attributed to an individual unless specific agreement has been obtained beforehand. Each participant will be expected to treat as confidential both the identity of all other project participants, and all of comments made during the interview. You are asked to not disclose or discuss this information with anyone who was not part of the research project.

All documentation will be reviewed with my research advisory team, however will be kept strictly confidential and without personal identifiers. Participants’ names and any other personal identifiers will not be included as part of the data analysis, and all raw data and transcribed materials will be kept in a locked cabinet in my office. The key will be kept in my possession at all times. Compiled research data will be retained for a period of one (1) year and all raw data will be destroyed at the conclusion of the research through confidential shredding. Data and information pertaining to an individual who has chosen to withdraw at any time during the research process will not be retained and will be destroyed through confidential shredding.
provided that their withdrawal is received prior to the analyses of these data. Once the data have been analyzed, best efforts will be made to remove any quotations contributed by the withdrawn participant.

A potential conflict of interest could arise from sharing information about challenging experiences in maintaining high practice standards in your nursing practice. Confidentiality and free and informed consent will be maintained at all times throughout the research project. You are free as a participant to share only information that you feel comfortable sharing.

You are not compelled to participate in this research project. If you do choose to participate, you are free to withdraw at any time without prejudice. Similarly, if you choose not to participate in this research project, this information will also be maintained in confidence.

By signing this letter, you give free and informed consent to participate in this project.

Name: (Please Print): __________________________________________________

Signed: _____________________________________________________________

Date: _______________________________________________________________
Appendix C: Letter of Invitation to LPNs for Online Survey Participation

[Date]

Dear [participant name],

I would like to invite you to be part of a research project that I am conducting for the College of Licensed Practical Nurses of British Columbia (CLPNBC). This project is part of the requirement for a Master’s Degree in Leadership (Health), at Royal Roads University. My name is Janice Harvey and my credentials with Royal Roads University can be established by contacting Dr. Brigitte Harris, Program Head, MA Leadership (Health) at [email address].

The objective of my research project is to explore what quality means to registrants and the implications quality has on professional practice when it is or is not present, as part of a larger quality assurance (QA) program. In addition to submitting my final report to Royal Roads University in partial fulfillment for a Master of Arts in Leadership (Health) Degree, I will also be sharing my research findings with CLPNBC. The project findings may be presented at provincial and/or national regulatory conferences. As this research will also be published, a copy of this thesis will reside in the RRU library as well as in Library and Archives Canada, accessed through the Thesis Canada Portal, and the ProQuest/UMI database.

The research data will be put towards developing one component of a much larger quality assurance program. It may also form the basis for a variety of journal articles related to the responsibilities of a health regulatory organization in developing a quality assurance program to meet its legislated mandate to establish and maintain a continuing competency program to promote high practice standards amongst registrants.

One major component of my research project is an online survey and is foreseen to take approximately 30 minutes to complete. The survey will include demographical questions to establish age groupings of participants, the length of time the participant has been an LPN, and the context of participants’ practice settings. There will also be a series of close-ended (yes/no, agree/disagree) questions, as well as some open-ended questions that ask you to provide comments or information about one of your previous answers to a close-ended question. Your name was randomly chosen as a prospective participant from among all individuals who hold a current FULL registration with CLPNBC in good standing. The data obtained will be used to formulate recommendations that will be provided to CLPNBC as it develops a fulsome quality assurance program to promote high practice standards amongst registrants. The survey and respondents’ feedback will be kept on a Canadian-based survey platform, Fluid Surveys, to ensure Canadian standards for privacy and security are met.

All survey responses will be reviewed with my research advisory team, and will be kept strictly confidential. All data and associated materials will be password protected and kept in a locked cabinet in my office. The key will be kept on my person at all times. Compiled research data will be retained for a period of one (1) year and all raw data will be destroyed at the conclusion of the research through confidential shredding. Data and information pertaining to an
individual who has chosen to withdraw at any time during the research process will not be
retained and will be destroyed through confidential shredding.

This survey asks for your personal opinions about a variety of issues related to quality
and about your professional nursing practice. You are encouraged to answer as honestly as
possible, guided by your first impressions as you read the question. If you feel uncomfortable or
unable to answer any question, simply skip it and go on to the next one.

You are not compelled to participate in this research project by completing and
submitting this survey. If you do choose to participate, then simply click on the survey link
below and follow the instructions. Your submission of the completed survey will be accepted as
your indication of giving your informed consent. If you do choose to participate, you are free to
withdraw at any time without prejudice.

[Survey link inserted here]

*Please complete and submit the survey no later than 6:00 pm PST, Friday, October 25,
2013.

Please feel free to contact me anytime at [telephone number] or [email address] should
you have additional questions regarding the project and its outcomes. Research findings and
recommendations will be shared with participants at the conclusion of the project. The CLPNBC
will also provide information about the research project findings and recommendations to its
registrants and stakeholders through articles published in its College Connection newsletter.

Sincerely,

Janice Harvey
Appendix D: Letter of Agreement for Research Advisory Team Member

In partial fulfillment of the requirement for a Master of Arts in Leadership (Health) Degree at Royal Roads University, Janice Harvey (the Student) will be conducting an inquiry research study on behalf of the College of Licensed Practical Nurses of British Columbia (CLPNBC) to explore what quality means to registrants and the implications quality has on professional practice when it is or is not present, as part of a larger quality assurance (QA) program.

The Student’s credentials with Royal Roads University can be established by contacting Dr. Brigitte Harris, Program Head, MA Leadership (Health) at [email address]

Research Advisory Team Member Role Description

As a volunteer Research Advisory Team Member assisting the Student with this project, your role may include one or more of the following: providing advice on the relevance and wording of questions and letters of invitation, supporting the logistics of the data-gathering methods, including observing, assisting, or facilitating an interview or focus group, taking notes, transcribing, or analyzing data, to assist the Student and the CLPNBC organizational change process. In the course of this activity, you may be privy to confidential inquiry data.

Confidentiality of Inquiry Data

In compliance with the Royal Roads University Research Ethics Policy, under which this inquiry project is being conducted, all personal identifiers and any other confidential information generated or accessed by the research advisory team advisor will only be used in the performance of the functions of this project, and must not be disclosed to anyone other than persons authorized to receive it, both during the inquiry period and beyond it. Recorded information in all formats is covered by this agreement. Personal identifiers include participant names, contact information, personally identifying turns of phrase or comments, and any other personally identifying information.

Bridging Student’s Potential or Actual Ethical Conflict

In situations where potential participants report directly to the Student or have concern about the implications for their professional relationship with the Student by participating or choosing not to participate in the research study, you, as a neutral third party with no supervisory relationship with either the Student or potential participants, may be asked to work closely with the Student to bridge this potential or actual conflict of interest in this study. Such requests may include asking the Research Advisory Team Member to: send out the letter of invitation to potential focus group and survey participants, receive calls/emails of interest in participation from potential participants, independently make a selection of received participant requests based on criteria you and the Student will have discussed previously, arrange and confirm the logistics for the data-gathering method, including contacting the participants about the time and location of the focus group and any options for participation via other means if available, conduct the focus group (usually no more than one) with the selected participants (without the Student’s presence or knowledge of which participants were chosen) using the protocol and questions
worked out previously with the Student, and producing written transcripts of the focus groups where you may attend as note-taker/transcriptionist with all personal identifiers removed before the transcripts are brought back to the Student for the data analysis phase of the study. You will not be asked to both facilitate and transcribe a focus group session.

This strategy means that potential participants as per above will be assured they can confidentially turn down the participation request from the Research Advisory Team Member, as this process conceals from the Student which potential participants chose not to participate or simply were not selected by you, the third party, because they were out of the selection criteria range (they might have been a participant request coming after the number of participants sought, for example, a focus group request number 10 when up to 9 participants would be selected for a focus group). Research Advisory Team members asked to take on such 3rd party duties in this study will be under the direction of the Student and will be fully briefed by the Student as to how this process will work, including specific expectations, and the methods to be employed in conducting the elements of the inquiry with the Student’s oversight, and will be given every support possible by the Student, except where such support would reveal the identities of the actual participants.

Personal information will be collected, recorded, corrected, accessed, altered, used, disclosed, retained, secured and destroyed as directed by the Student, under direction of the Royal Roads Academic Supervisor.

Research Advisory Team members who are uncertain whether any information they may wish to share about the project they are working on is personal or confidential will verify this with Janice Harvey, the Student.

Statement of Informed Consent:

I have read and understand this agreement.

__________________________  ____________________________  ____________
Name (Please Print)        Signature               Date
Appendix E: LPN Individual Interview Protocol and Questions

45 Minute Session

1. Welcome
2. Facilitator introduction (RRU student doing a thesis project, assisting CLPNBC with research)
3. Note-taker/transcriptionist introductions (1 research advisory team member)
4. Purpose of interview (goal of research project, interviews as a data gathering method to further inform subsequent survey questions)
5. Review of consent (at any time free to leave/withdraw, decline to answer, etc. without prejudice. Sign and provide to note-taker if not already received via email prior to session)
6. Questions from participant
7. Ground rules (confidentiality, respect)
8. Opening discussion (interviewer)
9. Questions
10. Interviewer- Participants can email further questions to note-taker- will blind them and pass them to me for response to participant back through note-taker
11. Closing (thank-you) and next steps (Sharing of interview transcript through note-taker to participants for member-checking and validation of content- emphasize very short turnaround time).

Demographic Questions:

- How long have you been an LPN?
- Do you hold an LPN position at your place of employment?
- What area of responsibility do you have in your role as an LPN?
- What kind of setting do you practice in?

Interview Questions:

- What do you think about/how does it make you feel when you hear the term “quality practice”? (prompt: in the nursing professions)
- Why do you think CLPNBC would want to assure quality in LPNs’ practice? (prompt: legislation requires it, the College just decides it is a nice-to-do)
- Tell me about a time when you felt really proud of your practice and what you had accomplished on a shift (prompt: think of a time when you left a shift feeling like you had made a real difference to either your colleagues or the patients/families you encountered that day)
- Tell me about one accomplishment (educational/professional development) you are particularly proud of that helped you to grow as a professional nurse (prompt: how important is lifelong learning for nurses/ what would you suggest to a colleague if they were to ask you how they could find learning opportunities)
- What does quality nursing practice look like to you- have you seen quality demonstrated (role modelled) in some of the things your colleagues do? (prompt: what
is something that someone did that impressed you, or left you with a really good feeling about their professionalism as a nurse)

- What kinds of things do you do to improve or grow your nursing practice? (educational opportunities, professional development opportunities) (prompt: what kinds of opportunities are available to you through your employer, union, colleagues, professional associations)

- Are there colleagues or others who you may go to for support to maintain quality in your practice? (prompt: do you have a mentor or a trusted person to whom you can go for advice/support)

- How do you personally keep track of your practice and your reflections on your nursing practice? (prompt: diary, professional journal, self-assessment activities)

- Is there anything that you would like to add to today’s conversation? (prompt: something that is important for me to know)
Appendix F: LPN Online Survey Preamble and Questions

You are being invited to participate in a survey that asks LPNs who currently hold a FULL registration with CLPNBC to tell us about their professional nursing practice and what they are doing to ensure quality in their practice. The purpose of this survey is to gather information from LPNs that will help CLPNBC develop a new quality assurance program for LPNs in BC. We hope to hear about the challenges and the successes LPNs have had in achieving quality practice, and what quality means to you and your professional practice. We would also like your opinion on where you think more support or opportunity is needed so that you can engage in the kinds of activities that will assist you in your professional practice, and facilitate the provision of safe, competent and ethical care.

This survey is being made available to a group of randomly selected LPNs from across BC working in a variety of nursing domains and practice settings. We hope that this research activity will result in the development of an improved quality assurance program that will promote high practice standards among registrants and provide you with opportunities to identify when quality practice happens and what led to it happening. As well we hope to learn more about why poor quality practice may occur and the barriers and challenges that contribute to difficulties in maintaining high practice standards. Finally, we’d like to find out about the kinds of supports and resources LPNs feel would be helpful in avoiding and/or correcting poor quality practice.

If you agree to participate we ask that you complete a web-based survey that will take about 30 minutes to finish (details below). This survey and all respondent feedback will be kept on a Canadian-based survey platform, Fluid Surveys, to ensure Canadian standards for privacy and security are met. Your answers will be kept confidential and once the data are returned to [Name], all identifying information such as your name and email address will be removed before any responses are seen by me and before any further analyses are conducted. All data and associated materials will be password protected and kept in a locked cabinet in my office. The key will be kept on my person at all times.

Participation in this study is voluntary. You may refuse to participate, refuse to answer any questions or withdraw at any time. If you do not wish to respond to particular questions, please skip over them. Completion of the survey indicates your consent to participate in this research. There are no known risks to participating in this research and any information provided by you will not have any effect on your registration or relationship with CLPNBC.

If you would like more information about the survey or how the data will be used, please contact [email address]. If you need technical support, please contact [email address]. This survey will be available for your input until 6:00 pm PST, Friday, October 25, 2013.

A note on privacy:

This survey is anonymous. The record kept of your survey responses does not contain any identifying information about you unless a specific question in the survey has asked for this.

Sincerely, Janice Harvey- Royal Roads Master of Leadership (Health) Student
Survey Questions

Demographics

1. Do you hold a current FULL (2013) registration with CLPNBC? (y/n)
2. What area of responsibility do you work in? If you work in more than one setting, choose the one where you spend the most time. (Drop down list as per CIHI data dictionary- coincides with registration data CLPNBC collects annually)
3. What type of position do you hold? If you work in more than one position, choose the position that you work in most often. (Drop down list as per CIHI data dictionary- coincides with registration data CLPNBC collects annually)
4. What is your place of work? If you work in more than one setting, choose the position that you work in most. (Drop down list as per CIHI data dictionary- coincides with registration data CLPNBC collects annually)
5. Does the position you currently hold require you to be an LPN?
6. What is your employment status?
7. Which BC health authority do you work in? If you work in more than one, choose the one you work in the most (Drop down list of each BC health authority with option for “not employed by a health authority)
8. How long have you been an LPN? (Drop down list as per CIHI data dictionary- coincides with registration data CLPNBC collects annually)
9. What age group do you belong to? (Drop down list as per CIHI data dictionary- coincides with registration data CLPNBC collects annually)

The following section asks you for your observations and impressions about what quality is and what it looks like in nursing practice.

10. What do you think of when you hear the term “quality” used to describe nursing practice? (List of possible responses as informed by interviewee responses plus “other- please explain”)
11. If you had to pick 5 words/phrases that describe the positive impact your work has on your colleagues, what would those words be? (List of possible responses as informed by interviewee responses plus “other- please explain”)
12. If you had to pick 5 words/phrases that describe the positive impact your work has on the patients/clients and families you encounter, what would those words be? (List of possible responses as informed by interviewee responses)
13. Which of the following words or phrases best describes what quality nursing practice looks like to you? (List of possible responses as informed by interviewee responses plus “other- please specify”)
14. How do you keep track of reflections on your own nursing practice? (List of possible responses as informed by interviewee responses plus “other- please specify”)
15. What kinds of activities have you engaged in, over the past 5 years, to maintain or grow the quality of your nursing practice? (List of possible responses as informed by interviewee responses plus “employer intranet resources- please specify”; Internet resources- please specify”; and “other- please specify”)
16. How do you keep track of your own professional development? (List of possible responses as informed by interviewee responses plus “other- please specify”)

For the following questions you are asked to reflect on your own practice experiences. Based on those experiences, please rate the impact that each of the following issues has had on the quality of your nursing practice and your ability to maintain high practice standards.

The scale you will be using to rate each item is: 1- A very negative impact, 2- A slightly negative impact, 3- No impact, 4- A slightly positive impact, 5- A very positive impact

17. Ease of access to support from colleagues when I need assistance with a patient/client’s care requirements (select 1-5)
18. Ease of access to information about a patient when I need it (select 1-5)
19. Ease of access to physical and material resources when I have questions about best practices/policies (select 1-5)
20. Increasing patient acuity/complexity (select 1-5)
21. Ease of access to educational opportunities relevant to LPNs and LPN practice (select 1-5)
22. Clear employer policies that are relevant to LPNs (select 1-5)
23. Clarity about LPN role expectations at the employer level (select 1-5)
24. Personal commitment to lifelong learning (select 1-5)
25. Clarity about LPN scope of practice from CLPNBC (select 1-5)
26. Ease of access to practice support information, resources and services from CLPNBC (select 1-5)

The following section asks you to identify the kinds of things you feel CLPNBC is, or should be responsible for, when it comes to quality assurance.

27. Why do you think CLPNBC would want to assure quality in LPNs’ practice? (List of possible responses as informed by interviewee responses plus “other- please specify”)
28. What are some of the things that CLPNBC could do to assist you to improve your nursing practice? (List of possible responses as informed by interviewee responses plus “employer supports- please specify”; and “other- please specify”)
29. If you were having practice difficulties, what resources would you access, and utilize, to support safe, quality practice? (List of possible responses as informed by interviewee responses plus “employer supports- please specify”; and “other- please specify”)
30. Have you ever participated in a CLPNBC quality assurance program? (yes- please explain/no)
31. What advice would you give to a colleague about the importance of lifelong learning to maintain and grow quality in their nursing practice? (Field for qualitative data)
32. Confidentiality is of utmost importance to CLPNBC in this data gathering activity. Would you give your permission for CLPNBC to contact you as it moves forward with the development of a quality assurance program? (yes- field for qualitative data/no)

Congratulations, you’re finished the survey! Please click on the “submit” button at the bottom of this page to complete your survey. Thank you for your participation in this important CLPNBC research project.
### Appendix G: Responses from online survey—All Respondents

**Demographics**

<table>
<thead>
<tr>
<th>Respondents by Registration Status</th>
<th>All Respondents</th>
<th>Percentage Yes</th>
<th>Percentage No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1- Do you hold a current (2013) FULL registration with CLPNBC?</td>
<td>107</td>
<td>97</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q2- Respondent Subgroup by Area of Responsibility</th>
<th>*Percent of Respondents</th>
<th>Subgroup Count in Respondent Pool (n= 107)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital (acute care)</td>
<td>35</td>
<td>37</td>
</tr>
<tr>
<td>Rehabilitation/Convalescent Care</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Extended Care</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Long Term Care/Nursing Home</td>
<td>37</td>
<td>40</td>
</tr>
<tr>
<td>Mental Health Centre</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Home Care Agency</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Community Health Agency/Health Centre</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Education Institution</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Association/Government</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Physician’s Office/Family Practice Unit</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Self-employed/Private Practice</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Private Nursing Agency/Private Duty</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Totals</td>
<td>100</td>
<td>107</td>
</tr>
</tbody>
</table>

*percentages have been rounded to whole numbers

<table>
<thead>
<tr>
<th>Q 3- Respondent Subgroup by Position</th>
<th>*Percent of Respondents</th>
<th>Subgroup Count in Respondent Pool (n= 107)</th>
</tr>
</thead>
<tbody>
<tr>
<td>LPN/Staff Nurse/Community Health Nurse</td>
<td>82</td>
<td>88</td>
</tr>
<tr>
<td>Instructor/Educator/Professor</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>LPN Specialty</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Coordinator/Care Manager</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Totals</td>
<td>100</td>
<td>107</td>
</tr>
</tbody>
</table>

*percentages have been rounded to whole numbers
### Q 4- Respondent Subgroup by Place of Work

<table>
<thead>
<tr>
<th>Subgroup</th>
<th>Percent of Respondents</th>
<th>Subgroup Count in Respondent Pool (n= 107)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>42</td>
<td>45</td>
</tr>
<tr>
<td>Community Health</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Nursing Home/Long Term Care</td>
<td>38</td>
<td>41</td>
</tr>
<tr>
<td>Assisted Living</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Private Nursing Agency/Private Duty</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Self-employed</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Physician’s Office/Family Practice Unit</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Educational Institution</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Association/Government</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>100</strong></td>
<td><strong>107</strong></td>
</tr>
</tbody>
</table>

*percentages have been rounded to whole numbers

### Q 5- Respondent Subgroup by Requirement to be an LPN for Current Role

<table>
<thead>
<tr>
<th>Subgroup</th>
<th>Percent of Respondents</th>
<th>Subgroup Count in Respondent Pool (n= 103)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>96</td>
<td>99</td>
</tr>
<tr>
<td>No</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>100</strong></td>
<td><strong>103</strong></td>
</tr>
</tbody>
</table>

*percentages have been rounded to whole numbers

### Q 6- Respondent Subgroup by Employment Status

<table>
<thead>
<tr>
<th>Subgroup</th>
<th>Percent of Respondents</th>
<th>Subgroup Count in Respondent Pool (n= 107)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full time</td>
<td>42</td>
<td>45</td>
</tr>
<tr>
<td>Part time</td>
<td>32</td>
<td>34</td>
</tr>
<tr>
<td>Casual</td>
<td>26</td>
<td>28</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>100</strong></td>
<td><strong>107</strong></td>
</tr>
</tbody>
</table>

*percentages have been rounded to whole numbers
### Q 7 - Respondent Subgroup by BC Health Authority Worked in

<table>
<thead>
<tr>
<th>Health Authority Worked in</th>
<th>*Percent of Respondents</th>
<th>Subgroup Count in Respondent Pool (n= 103)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fraser</td>
<td>22</td>
<td>23</td>
</tr>
<tr>
<td>Interior</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>Vancouver Island</td>
<td>21</td>
<td>22</td>
</tr>
<tr>
<td>Northern</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Providence Health Care</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Provincial Health Services</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Vancouver Coastal</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>Not employed by a health authority</td>
<td>17</td>
<td>18</td>
</tr>
<tr>
<td>Totals</td>
<td>100</td>
<td>103</td>
</tr>
</tbody>
</table>

*percentages have been rounded to whole numbers

### Q 8 - Respondent Subgroup by Length of time as an LPN

<table>
<thead>
<tr>
<th>Length of time as an LPN</th>
<th>*Percent of Respondents</th>
<th>Subgroup Count in Respondent Pool (n= 103)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than one year</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>1-5 years</td>
<td>43</td>
<td>44</td>
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<tr>
<td>6-10 years</td>
<td>23</td>
<td>24</td>
</tr>
<tr>
<td>11-15 years</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>16-20 years</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>21-25 years</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>26-30 years</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>31-35 years</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>36-40 years</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>46-50 years</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Totals</td>
<td>100</td>
<td>103</td>
</tr>
</tbody>
</table>

*percentages have been rounded to whole numbers

### Q 9 - Respondent Subgroup by Age Group

<table>
<thead>
<tr>
<th>Age Group</th>
<th>*Percent of Respondents</th>
<th>Subgroup Count in Respondent Pool (n= 102)</th>
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</thead>
<tbody>
<tr>
<td>21-25 years</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>26-30 years</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>30-34 years</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>35-39 years</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>40-44 years</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>45-49 years</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>50-54 years</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>55-59 years</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>60-64 years</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>65-69 years</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Totals</td>
<td>100</td>
<td>102</td>
</tr>
</tbody>
</table>

*percentages have been rounded to whole number
Q10 | What do you think of when you hear the term “quality” used to describe nursing practice?

<table>
<thead>
<tr>
<th></th>
<th>*Percent of Respondents</th>
<th>Count in Respondent Pool (n= 101)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Art</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>Empathy</td>
<td>57</td>
<td>58</td>
</tr>
<tr>
<td>Teamwork</td>
<td>71</td>
<td>72</td>
</tr>
<tr>
<td>Collaboration</td>
<td>62</td>
<td>63</td>
</tr>
<tr>
<td>Pride</td>
<td>37</td>
<td>37</td>
</tr>
<tr>
<td>Best practice</td>
<td>81</td>
<td>82</td>
</tr>
<tr>
<td>Clarity of right/wrong</td>
<td>49</td>
<td>49</td>
</tr>
<tr>
<td>Competence</td>
<td>81</td>
<td>82</td>
</tr>
<tr>
<td>Ethical</td>
<td>71</td>
<td>72</td>
</tr>
<tr>
<td>Confidence</td>
<td>61</td>
<td>62</td>
</tr>
<tr>
<td>Standardization</td>
<td>53</td>
<td>54</td>
</tr>
<tr>
<td>Respect</td>
<td>73</td>
<td>74</td>
</tr>
<tr>
<td>Excellence</td>
<td>59</td>
<td>60</td>
</tr>
<tr>
<td>Trust</td>
<td>63</td>
<td>64</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>

*percentages have been rounded to whole numbers

Q11 | If you had to pick 5 words/phrases that best describe the positive impact your work has on your colleagues, what would those words/phrases be?

<table>
<thead>
<tr>
<th></th>
<th>*Percent of Respondents</th>
<th>Count in Respondent Pool (n= 101)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empathy</td>
<td>24</td>
<td>24</td>
</tr>
<tr>
<td>Collaboration</td>
<td>53</td>
<td>54</td>
</tr>
<tr>
<td>Pride</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Best practice</td>
<td>35</td>
<td>35</td>
</tr>
<tr>
<td>Competent</td>
<td>58</td>
<td>59</td>
</tr>
<tr>
<td>Ethical</td>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td>Confident</td>
<td>27</td>
<td>27</td>
</tr>
<tr>
<td>Excellence</td>
<td>19</td>
<td>19</td>
</tr>
<tr>
<td>Trusted</td>
<td>51</td>
<td>52</td>
</tr>
<tr>
<td>Patient/client centered</td>
<td>59</td>
<td>60</td>
</tr>
<tr>
<td>Reliable</td>
<td>49</td>
<td>49</td>
</tr>
<tr>
<td>Efficient</td>
<td>26</td>
<td>26</td>
</tr>
<tr>
<td>Motivational</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Dedicated</td>
<td>32</td>
<td>32</td>
</tr>
<tr>
<td>Satisfied</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Respected</td>
<td>36</td>
<td>36</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

*percentages have been rounded to whole numbers
If you had to pick 5 words/phrases that best describe the positive impact your work has on the patients/clients and families you encounter, what would those words/phrases be?

<table>
<thead>
<tr>
<th>Word</th>
<th>*Percent of Respondents</th>
<th>Count in Respondent Pool (n= 101)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empathy</td>
<td>65</td>
<td>66</td>
</tr>
<tr>
<td>Collaboration</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td>Pride</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Best practice</td>
<td>31</td>
<td>31</td>
</tr>
<tr>
<td>Competent</td>
<td>55</td>
<td>56</td>
</tr>
<tr>
<td>Ethical</td>
<td>31</td>
<td>31</td>
</tr>
<tr>
<td>Confident</td>
<td>28</td>
<td>28</td>
</tr>
<tr>
<td>Excellence</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>Trusted</td>
<td>58</td>
<td>59</td>
</tr>
<tr>
<td>Patient/client centered</td>
<td>75</td>
<td>76</td>
</tr>
<tr>
<td>Reliable</td>
<td>34</td>
<td>34</td>
</tr>
<tr>
<td>Efficient</td>
<td>26</td>
<td>26</td>
</tr>
<tr>
<td>Motivational</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>Dedicated</td>
<td>23</td>
<td>23</td>
</tr>
<tr>
<td>Satisfied</td>
<td>7</td>
<td>7</td>
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<tr>
<td>Respected</td>
<td>27</td>
<td>27</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

*percentages have been rounded to whole numbers
Q13 | Which of the following words or phrases best describes what quality nursing practice looks like to you?

<table>
<thead>
<tr>
<th></th>
<th>*Percent of Respondents</th>
<th>Count in Respondent Pool (n= 100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being proactive</td>
<td>62</td>
<td>62</td>
</tr>
<tr>
<td>Not accepting the status quo</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Solution focused</td>
<td>45</td>
<td>45</td>
</tr>
<tr>
<td>No-blame culture</td>
<td>39</td>
<td>39</td>
</tr>
<tr>
<td>Learning culture</td>
<td>61</td>
<td>61</td>
</tr>
<tr>
<td>Striving for excellence</td>
<td>63</td>
<td>63</td>
</tr>
<tr>
<td>Practice what you preach</td>
<td>32</td>
<td>32</td>
</tr>
<tr>
<td>Self-assured</td>
<td>23</td>
<td>23</td>
</tr>
<tr>
<td>Resourceful</td>
<td>61</td>
<td>61</td>
</tr>
<tr>
<td>Experienced</td>
<td>45</td>
<td>45</td>
</tr>
<tr>
<td>Dedication</td>
<td>59</td>
<td>59</td>
</tr>
<tr>
<td>Competence</td>
<td>73</td>
<td>73</td>
</tr>
<tr>
<td>Role model</td>
<td>43</td>
<td>43</td>
</tr>
<tr>
<td>Considerate</td>
<td>51</td>
<td>51</td>
</tr>
<tr>
<td>Information seeking</td>
<td>42</td>
<td>42</td>
</tr>
<tr>
<td>Skilled</td>
<td>64</td>
<td>64</td>
</tr>
<tr>
<td>Committed</td>
<td>51</td>
<td>51</td>
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<tr>
<td>Knowledgeable</td>
<td>75</td>
<td>75</td>
</tr>
<tr>
<td>Empathetic</td>
<td>63</td>
<td>63</td>
</tr>
<tr>
<td>Sincere</td>
<td>51</td>
<td>51</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

*percentages have been rounded to whole numbers
Q14 | How do you keep track of your reflections on your own nursing practice?

<table>
<thead>
<tr>
<th>Method</th>
<th>*Percent of Respondents</th>
<th>Count in Respondent Pool (n= 100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Written personal diary</td>
<td>31</td>
<td>31</td>
</tr>
<tr>
<td>Recorded (voice/video) personal diary</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Written professional journal</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Recorded (voice/video) professional journal</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Professional portfolio</td>
<td>46</td>
<td>46</td>
</tr>
<tr>
<td>Learning plan</td>
<td>34</td>
<td>34</td>
</tr>
<tr>
<td>Self-reflective activities (art/music)</td>
<td>34</td>
<td>34</td>
</tr>
<tr>
<td>Other</td>
<td>17</td>
<td>17</td>
</tr>
</tbody>
</table>

*percentages have been rounded to whole numbers

Q15 | What kinds of activities have you engaged in, over the past 5 years, to maintain and grow the quality of your nursing practice?

<table>
<thead>
<tr>
<th>Activity</th>
<th>*Percent of Respondents</th>
<th>Count in Respondent Pool (n= 100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer offered in-service/workshop</td>
<td>86</td>
<td>86</td>
</tr>
<tr>
<td>Employer offered course/program</td>
<td>57</td>
<td>57</td>
</tr>
<tr>
<td>Formal post-basic education through a college or university (online)</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Formal post-basic education through a college or university (classroom)</td>
<td>23</td>
<td>23</td>
</tr>
<tr>
<td>Online self-study modules</td>
<td>59</td>
<td>59</td>
</tr>
<tr>
<td>Regular review of course materials</td>
<td>48</td>
<td>48</td>
</tr>
<tr>
<td>Colleague-to-colleague mentoring</td>
<td>48</td>
<td>48</td>
</tr>
<tr>
<td>Professional coaching</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Reading professional journals</td>
<td>41</td>
<td>41</td>
</tr>
<tr>
<td>Reading nursing articles</td>
<td>70</td>
<td>70</td>
</tr>
<tr>
<td>Joining a professional committee</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Joining a professional association</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Employer intranet resources</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td>Internet resources</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

*percentages have been rounded to whole numbers
<table>
<thead>
<tr>
<th>Q16</th>
<th>How do you keep track of your own professional development?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>*Percent of Respondents</td>
</tr>
<tr>
<td>Written personal diary</td>
<td>21</td>
</tr>
<tr>
<td>Recorded (voice/video) personal diary</td>
<td>1</td>
</tr>
<tr>
<td>Written professional journal</td>
<td>10</td>
</tr>
<tr>
<td>Recorded (voice/video) professional journal</td>
<td>0</td>
</tr>
<tr>
<td>Professional portfolio</td>
<td>51</td>
</tr>
<tr>
<td>Learning plan</td>
<td>27</td>
</tr>
<tr>
<td>Review course materials</td>
<td>39</td>
</tr>
<tr>
<td>Certificates</td>
<td>61</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
</tr>
</tbody>
</table>

*percentages have been rounded to whole numbers
For the following questions you are asked to reflect on your own practice experiences. Based on those experiences, please rate the impact that each of the following issues has had on the quality of your nursing practice and your ability to maintain high practice standards.

Number of Respondents n=98

<table>
<thead>
<tr>
<th><em>Theme</em></th>
<th><strong>Percent of Responses</strong></th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Very Negative Impact (1)</td>
<td>Slightly Negative Impact (2)</td>
<td>Neutral Impact (3)</td>
</tr>
<tr>
<td>Ease of access to support from colleagues when I need assistance with a patient/client’s care requirements</td>
<td>SC</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Ease of access to information about a patient when I need it</td>
<td>MEQ</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Ease of access to physical and material resources when I have questions about best practices/policies</td>
<td>MEQ</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Increasing patient acuity/complexity</td>
<td>SC</td>
<td>5</td>
<td>19</td>
</tr>
<tr>
<td>Ease of access to educational opportunities relevant to LPNs and LPN practice</td>
<td>E</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>Clear employer policies that are relevant to LPNs</td>
<td>ISR</td>
<td>9</td>
<td>14</td>
</tr>
<tr>
<td>Clarity about LPN role expectations at the employer level</td>
<td>SC</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td>Personal commitment to lifelong learning</td>
<td>E</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Clarity about LPN scope of practice from CLPNBC</td>
<td>MEQ</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Ease of access to practice support information, resources and services from CLPNBC</td>
<td>ISR/MEQ</td>
<td>5</td>
<td>10</td>
</tr>
</tbody>
</table>

*ISR= Indicators, Supports and Resources; E= Education; MEQ= Maintaining and Enhancing Quality; SC= Self Concept; MCR= Mentorship and Collaborative Relationships

1 Percentages have been rounded to whole numbers
**Q27** Why do you think CLPNBC would want to assure quality in LPNs’ practice?

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percent of Respondents</th>
<th>Count in Respondent Pool (n= 93)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLPNBC is interested in LPNs’ practice</td>
<td>47</td>
<td>44</td>
</tr>
<tr>
<td>Legislation requires it</td>
<td>56</td>
<td>52</td>
</tr>
<tr>
<td>Employers don’t do a good job of it, somebody has to</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>To uphold CLPNBC’s reputation</td>
<td>39</td>
<td>36</td>
</tr>
<tr>
<td>The public must be protected from poor practitioners</td>
<td>67</td>
<td>62</td>
</tr>
<tr>
<td>Poor LPN practice reflects on CLPNBC</td>
<td>22</td>
<td>20</td>
</tr>
<tr>
<td>Poor LPN practice reflects on the whole profession</td>
<td>51</td>
<td>47</td>
</tr>
<tr>
<td>Holding LPNs accountable for meeting standards</td>
<td>65</td>
<td>60</td>
</tr>
<tr>
<td>CLPNBC must set the rules for getting and keeping a license to practice</td>
<td>48</td>
<td>45</td>
</tr>
<tr>
<td>LPNs are responsible for ensuring quality in LPNs’ practice</td>
<td>57</td>
<td>53</td>
</tr>
<tr>
<td>CLPNBC is responsible for ensuring quality in LPNs’ practice</td>
<td>52</td>
<td>48</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

*percentages have been rounded to whole numbers

**Q28** What are some of the things that CLPNBC could do to assist you to improve your nursing practice?

<table>
<thead>
<tr>
<th>Assistance</th>
<th>Percent of Respondents</th>
<th>Count in Respondent Pool (n= 93)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Easier access to information and resources on the CLPNBC website</td>
<td>51</td>
<td>47</td>
</tr>
<tr>
<td>Clearer practice support documents</td>
<td>62</td>
<td>58</td>
</tr>
<tr>
<td>More information about non-clinical domains of LPN practice</td>
<td>44</td>
<td>41</td>
</tr>
<tr>
<td>Easier access to practice supports services</td>
<td>45</td>
<td>42</td>
</tr>
<tr>
<td>Online educational offerings</td>
<td>76</td>
<td>71</td>
</tr>
<tr>
<td>Education days/conferences</td>
<td>69</td>
<td>64</td>
</tr>
<tr>
<td>Evaluating LPN practice on a regular basis</td>
<td>27</td>
<td>25</td>
</tr>
<tr>
<td>Joint presentations with other health professions</td>
<td>52</td>
<td>48</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

*percentages have been rounded to whole numbers
Q29 | If you were having practice difficulties, what kinds of resources would you access and utilize, to support safe quality practice?

<table>
<thead>
<tr>
<th>Resource</th>
<th>Percent of Respondents</th>
<th>Count in Respondent Pool (n= 93)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional standards of practice</td>
<td>78</td>
<td>73</td>
</tr>
<tr>
<td>Code of ethics</td>
<td>60</td>
<td>56</td>
</tr>
<tr>
<td>Practice guidelines</td>
<td>75</td>
<td>70</td>
</tr>
<tr>
<td>Practice standards</td>
<td>72</td>
<td>67</td>
</tr>
<tr>
<td>Guidelines for developing learning plans</td>
<td>29</td>
<td>27</td>
</tr>
<tr>
<td>Practice advice/consultation</td>
<td>48</td>
<td>45</td>
</tr>
<tr>
<td>Baseline (entry-level) competencies</td>
<td>38</td>
<td>35</td>
</tr>
<tr>
<td>Self-assessment tools</td>
<td>46</td>
<td>43</td>
</tr>
<tr>
<td>Competency validation tools</td>
<td>31</td>
<td>29</td>
</tr>
<tr>
<td>Employer supports</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>

*percentages have been rounded to whole numbers

Q30 | Have you ever participated in a CLPNBC quality assurance program?

<table>
<thead>
<tr>
<th>Participated</th>
<th>Percent of Respondents</th>
<th>Count in Respondent Pool (n= 93)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>No</td>
<td>97</td>
<td>90</td>
</tr>
</tbody>
</table>

*percentages have been rounded to whole numbers

Q31 | What advice would you give to a colleague about the importance of lifelong learning to maintain and grow quality in their nursing practice?

Open-Ended Responses (n= 90)

Q32 | Confidentiality is of utmost importance in this data gathering activity. Would you give permission for CLPNBC to contact you as it moves forward with the development of a quality assurance program?

<table>
<thead>
<tr>
<th>Permission</th>
<th>Percentage of Respondents</th>
<th>Count in Respondent Pool (n= 90)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes (please provide contact information)</td>
<td>47</td>
<td>42</td>
</tr>
<tr>
<td>No</td>
<td>53</td>
<td>48</td>
</tr>
</tbody>
</table>

*percentages have been rounded to whole numbers