Developing Effective Strategies to Strengthen Collaborative Practice Between Registered Nurses and Registered Practical Nurses Through Action Research

by

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Abstract

Collaborative practice in health care is essential as it strengthens the relationship among teams and enhances an integrative work platform. Registered Nurses (RNs) and Registered Practical Nurses (RPNs) work together across different care settings in a supportive role that enhances patient outcomes, job satisfaction, and retention. Nursing stands as the largest healthcare profession in the nation, boasting nearly 4.2 million nurse's nationwide (Statistics Canada, 2022). In Canada, nurses constitute the largest segment of regulated health professionals, comprising approximately half of the total health workforce. However, globally, there has been a shortage of nurses attributed to burnout, physical injuries, and job dissatisfaction (Statistics Canada, 2022). To address the nursing shortage, several healthcare services have adopted the nursing skilled-mix model, facilitating collaboration between RNs and RPNs. At NHU, over the last six years, this practice model has been utilized to adequately staff nurses on Specialized Acute Care (SAC) units. Nonetheless, no formal study has been conducted to explore the experience of RNs and RPNs regarding collaborative practice. Qualitative action research was conducted to comprehend challenges and pinpoint effective strategies for strengthening collaborative practice among RNs and RPNs. Cycle 1 findings from participating RNs and RPNs revealed the necessity for broader discussions involving nursing leadership staff in Cycle 2. There were clear indications of knowledge gaps regarding scope of practice, disparities in assignments and professional development opportunities for RPNs resulted in ethical dilemmas, power imbalance between RNs, and RPNs regarding autonomy and the need for organizational leadership to take accountability to devise effective collaborative strategies were some of the major barriers to collaborative practice.

Keywords: collaborative practice*,* scope of practice, knowledge gap, nursing skilled-mix, power imbalance, silos, equity in clinical practice, leadership accountability, evidence-based framework

Dedication

To my cherished mother, whose unwavering presence and encouragement have never faltered, thank you for continually inspiring me and instilling the belief that no challenge is insurmountable when approached with determination and faith. You are the wind beneath my wings.

To my son and sole offspring, Evon Junior, affectionately known as Blessing, you have been an inspiration of blessings in my life, igniting the drive that propels me towards excellence. My love for you knows no bounds.

To those who have consistently supported me in various ways throughout my doctoral journey, you embody the essence of true partnership and the guiding force that holds me accountable. Thank you!

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In a plot twist worthy of a sitcom finale, I am thrilled to announce that I have once again defied the odds, conquered the challenges, and emerged victorious in completing this dissertation. I proudly declare, "I did it!"

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Section One: Introduction

The purpose of this action research was to identify effective strategies to strengthen collaborative practice between registered nurses (RNs) and registered practical nurses (RPNs) on Specialized Acute Care (SAC) units in one Toronto Hospital (pseudonym - NHU). Collaboration in healthcare is defined as integrative work among healthcare professionals through communication and decision-making that seeks to enhance and achieve goals that will improve patient wellness and address illness needs (Henneman et al., 1995). SAC units, located within tertiary care hospitals, provide specialized care for patients facing sudden instability necessitating intensive monitoring, as seen in Emergency Rooms (ERs), Cardiology, and Medical-Surgical units. Collaborative nursing practice is essential in healthcare facilities to guarantee the provision of high-quality patient care. The primary nurse categories rotating in the clinical space are RNs and RPNs, who work together on a platform called the nursing skilled-mix model. The nursing skilled-mixed model is defined as an important staff element that involves the mixing of nursing staff, primarily, RNs and RPNs (Jacob et al., 2015). Effective collaboration between RNs and RPNs is crucial for successful partnership in delivering patient care, as demonstrated by Negley et al. (2009). Their research highlights that collaborative practice among nurses leads to positive outcomes, including improved patient health and increased job satisfaction (Negley et al., 2009). This is achieved through the sharing of knowledge, skills, and resources.

The methodology utilized in this study is Qualitative Action Research (AR). This methodology stands out for its collaborative nature, facilitating active involvement from researchers, participants, stakeholders, and collaborators in devising sustainable actions to address the identified issue. The study's objective was to delve into the results obtained from Cycle 1 interviews, aiming to explore various strategies that could bolster collaborative practice. This was achieved through the engagement of RNs, RPNs, and nursing leadership staff in co-creating solutions during focus group discussions. The

ultimate goals were to strengthen an integrative platform between RNs and RPNs on SAC units and enhance patient health outcomes through these collaborative efforts.

The report begins (Section One) with an introduction related to RNs and RPNs experience of collaborative practice while working on SAC units at NHU and the strategies needed to strengthen teamwork to enhance safe patient care. This encompasses an overview of the practice problem, the research purpose and question, a depiction of the research setting and participants, along with a succinct summary of the research design. Section Two delineates the research findings, detailing participants' experiences and perspectives regarding barriers to collaborative practice, while Section Three offers an extensive literature review, analyzing and evaluating existing perspectives from scholarly works on the subject. In addition, the contextualization section contrasts and reflects upon the diverse viewpoints presented in both the results and the literature review. Lastly, the appendices provide additional information about the study.

Problem Statement

The proposed problem of practice concerns the historical isolation and compartmentalized approach to work between RNs and RPNs, and the impact it has had on their collaborative and integrated working relationship. Collaborative practice in health care enhances a cohesive work platform and is essential as it strengthens the relationship among teams. As an Advanced Practice Nurse Educator (APNE), it was observed that RNs and RPNs work side-by-side, but as distinct entities, where the two nursing groups function independent of each other (Boblin et al., 2008). Normally, RNs and RPNs are tasked with their individual primary care assignments, which further increase isolated practice. These distinct entities could be thought of as ‘silos’ where there is a disconnect during the administration of patient care that has often resulted in poor patient outcomes. Improving collaborative nursing practice between RNs and RPNs involves eliminating the tendency for isolated practices within each nursing group.

Professional associations, nurse scholars, and practicing nurses have emphasized the importance of intraprofessional collaborative nursing practice in providing optimal patient care across diverse settings (Moore et al., 2019). Nonetheless, there is limited evidence available describing the process and outcomes of this practice (Prentice et al., 2020). There is a perception in healthcare that once you have worked alongside a member of the interprofessional team, you automatically understand each other's roles (Jacob et al., 2015). Even though major changes have occurred in the practice-base model for RNs and RPNs, there has been conflicting understanding of what roles each category of nurses play, increasing the lack of collaboration seen in clinical practice on SAC units. Even though guidelines to enhance collaborative practice between RNs and RPNs have been designed, they have not been effectively instilled in hospital settings; hence, silo practice continues to exist in healthcare organizations (Prentice et al., 2020). One main concern is that the framework developed to enhance collaborative practice is not evidence-based, which makes it significant to delve deeper into ways to address collaborative practice between RNs and RPNs (Prentice et al., 2020). Since patient safety and satisfaction and other patient positive outcomes are dependent upon collaboration, it is important to explore the determinants that encourage intra professional nursing collaboration through breaking down separation in nursing practice (McInnes et al., 2017).

Purpose of Research

The aim of this study was to explore how collaborative practice works in this context using AR design to discover what helps and hinders collaboration between RNs and RPNs as they work on SAC units. With the ongoing nursing shortages at NHU, the nursing skilled-mix model was introduced to SAC units in an effort to alleviate the burden of care on RNs and to ensure that patients receive optimal nursing care. The nursing skilled-mix model was designed so that both RNs and RPNs would work together on SAC units, which were once predominantly staffed by RNs and which are now staffed by a mix of RNs and RPNs. This shift in nursing practice has created challenges that have affected both groups

of nurses' practice, which has led to poor patient's outcomes and job-satisfaction. There is a need to understand what collaborative practice means to RNs and RPNs and how co-creating with stakeholders could help strengthen teamwork among RNs and RPNs on SAC units. Furthermore, it is useful to understand the effects of the nursing skilled-mix model on nursing practice as a new concept to SAC units.

Research Questions

The aim of the research is to contribute to the current literature and understanding of issues concerning collaborative practice at NHU between RNs and RPNs by examining their lived experience in order to develop strategies that can be used to strengthen how RNs and RPNs work together. Qualitative descriptive data in the form of personal semi-structured interviews and focus group discussions were completed in two Cycles to answer the following research questions:

Cycle 1:

Research Question 1 (RQ1) - To what extent is collaboration practiced between RNs and RPNs on SAC units?

Research Question 2 (RQ2) - What are the barriers to collaborative practice between RNs and RPNs?

Research Question 3 (RQ3) - What are the enablers to collaborative practice between RNs and RPNs?

Cycle 2:

Research Question 4 (RQ4) - How can RNs, RPNs and staff co-create together to develop strategies that can be used to strengthen collaborative practice between RNs and RPNs on SAC units?

Context

NHU is known as Canada's largest research and teaching hospital located in downtown Toronto. It is composed of twelve medical programs spread across ten hospital sites. Of these, are three main acute care sites, encompassing critical care, oncology, transplant, surgical and medical units, outpatient clinics as well as, multiple operating rooms. Furthermore, NHU prides itself on being 'first' in numerous innovative programs, such as the Invivo-lung, a process wherein a human lung is maintained on a breathing machine until the time of transplantation. NHU also has its own medical educational institution where a number of the employees earn their certification. Given its extensive clinical involvement, NHU typically has 108,569 emergency patient visits per year.

Approximately fourteen thousand clinical and non-clinical staff, 1,400 physicians, 3,400 students and 1,800 volunteers are employed at NHU, of which 4,565 are nurses. Since prior to and particularly during the COVID-19 pandemic, there has been a decline in the number of nurses available for SAC units, posing challenges to adequately staffing these areas. As a result, the nursing skilled-mix model was implemented to enable RNs and RPNs to collaborate in addressing the rising demand for nursing care on SAC units. The primary nurse categories that rotate and provide patient care on a 24-hour cycle are RNs and RPNs. In Toronto, the College of Nurses of Ontario (CNO) has expanded the range of responsibilities for RPNs, allowing them to safely work on SAC units including the Emergency Room (ER), Multi-organ Transplant (MOT), General Internal Medicine (GIM), Cardiology, Thoracic, Nephrology, and Neurology departments. Over the past six years, the nursing skilled mix model has been implemented on SAC units, however, there has not been a formal review conducted to assess its effectiveness, hence, the initiation of this research study.

Research Participants/Collaborator/Stakeholders

The research study encompassed participants, collaborators, and stakeholders, classified as either internal or external, with potential impacts at the micro, macro, and community levels. At the

macro level, it involves establishing intentional relationships with primary, secondary, and community stakeholders to foster collaboration that impacts all aspects of the study pathway (Stringer & Aragón, 2020). At the micro level, RNs and RPNs who participated in semi-structured interviews during Cycle 1 are among the primary participants. It was crucial for the researcher to adopt an open mindset, in order to fully grasp the essence of their narratives.

The macro level impacts happen when methods are used to build an organization in ways that cause people to come together to achieve collective goals on things that are of common concern (Stringer & Aragón, 2020). At the macro level, internal stakeholders included collaborators such as Nurse Managers (NM), APNEs, Patient Care Coordinators (PCCs), Nurse Practitioners (NPs) and Nurse Coordinators (NCs), with whom the researcher established networks, such as to secure access to their clinical units for participant recruitment, whereas, others participated in semi-structured focus group discussions in Cycle 2. Social mapping visually represents social data to identify patterns, connections, and assets within an organization, which helps to understand its dynamics, inequalities, and available resources (Aragón, 2020). Engaging in social mapping is also a key method to facilitate the acquisition of diversity in participants who are affected by the issues at hand and who would be able to provide a comprehensive review, as well as to identify other internal stakeholders who may have similar experiences (Stringer & Aragón, 2020).

Inclusion, connection, equitability and cooperation are some of the qualities that build supportive organizational structures at the macro level. For these qualities to be maintained, it requires integration of principles and processes that engage stakeholders at the community level (Stringer & Aragón, 2020). Stakeholders who sit at the lower level often have valuable experience that enriches the study, although they require the support of those who are at higher levels. In the context of this study, the Chief Nursing Executive, Director of Education, Clinical Research Manager and other external supporters acted within the capacity at the community level who would influence change at the senior

leadership level in nursing practice, policies, and guidelines. In the context of AR, “community is not a place, but it is a state of mind” (Stringer & Aragón, p. 279, 2020). Advocacy is a community impact that describes the ability to act on someone else’s behalf, whether providing professional, legal, medical, or other resources (Kalaitzidis & Jewell, 2020). Each participant/collaborator/stakeholder role is an example of advocacy in which they co-create and iterate together. The research process will generate results that can be used to enhance how RNs and RPNs work together in the clinical settings. AR aim is to bring about a transformation in both individual and collective practices and without adequate comprehension and support, the outcome may prove ineffective (Kemmis, 2010).

Positionality

Throughout the years, I embraced the role of a change agent, initially before finishing my undergraduate studies, and particularly during my tenure in the Intensive Care Unit (ICU). Frequently, my colleagues and managers would approach me, entrusting me with leading various initiatives. One notable project involved creating a peer-to-peer bedside educational model aimed at strengthening the confidence of both new and seasoned nurses in executing seldom used and complex procedures. Upon finishing my master's degree in nursing and taking on the position of an APNE, I eagerly seized the opportunity to educate both RNs and RPNs. My interactions with both groups of nurses validated my knowledge that RPNs frequently experience feelings of inferiority compared to RNs, and that both RNs and RPNs have limited awareness of their respective scopes of practice. Furthermore, as RPNs expressed their sense of being regarded as 'inferior' to RNs, I gained an insider perspective into the fragmented relationship that commonly exists between RNs and RPNs on SAC units. Conversely, my status as an outsider stems from the fact that I am not an RPN and therefore cannot personally testify to their lived experiences. My speculations stem entirely from observations and the narratives shared by RPNs throughout my time as an APNE in clinical settings over the years.

My racial identity constitutes a vital aspect of my positionality. Moreover, my status as a woman of color exacerbates the challenges I encounter, mirroring the common experience of discrimination often endured by racialized black women. It is imperative that I ensure my prior and ongoing experiences with racial disparities in the nursing field do not impact the outcomes or decisions made during the study. Most importantly, I need to remain open-minded and understand that not everyone may find my issue of concern engaging, as both RNs and RPNs might interpret it as directed towards them.

Engaging in reflective practice in research involves recognizing my positionality and scrutinizing my inherent biases as both a nurse and a doctoral student delving into research. After instructing both RNs and RPNs, I must guarantee that past experiences and observations in the clinical setting involving both groups of nurses do not interfere with my research focus on the study. It is crucial that my intentions solely revolve around collecting data on the lived experiences of RNs and RPNs concerning collaborative and integrative practice. Briscoe (2005) discussed various types of positionalities, among which is demographic positionality. Demographic positionality entails the assumptions and biases researchers adopt when attempting to comprehend the lived experiences of others, despite not having experienced those experiences themselves. It is not realistic to presume a comprehensive understanding of the lived experiences of RPNs solely because I am an RN. Therefore, the utilization of AR would be beneficial in evaluating barriers to collaborative practice between RNs and RPNs. In healthcare, there is a common perception that merely working alongside a member of the interprofessional team automatically leads to an understanding of each other's roles (D'Amour, 2012). It is crucial to be mindful of my immersion in the study to prevent being unduly influenced by participants and stakeholders' sentiments regarding the topic or swayed by their personal opinions. However, it is equally important to establish a comfortable environment where individuals feel encouraged to express their opinions openly, respectfully, and without judgment. (Stringer & Aragón, 2020).

Synopsis of Research Design

The research methodology employed in this study is known as Action Research (AR), a form of qualitative research with roots dating back to the 1950s, pioneered by Kurt Lewin and other psychologists. The essence of understanding qualitative research lies in recognizing that individuals construct meaning through social interaction within their environment (McDonald, 2021). AR would be most suitable for this study since it aims to explore the benefits and barriers of collaborative practice among RNs and RPNs at NHU, addressing my problem of practice. RNs and RPNs undergo varying levels of training. Despite both providing hands-on patient care and working closely with patients, they often function as separate entities. The feelings of inferiority expressed by RPNs in comparison to RNs have led to RPNs resigning from their positions (Tuckett et al., 2015). As a result, staffing levels have been strained, job satisfaction has been impacted, and burnout has increased. Moreover, the COVID-19 pandemic has seen a vast amount of nurses leaving the profession (Statistics Canada, 2022).

Approximately six years ago, the scope and practice of RPNs was expanded (CNO, 2021), granting them autonomy to provide more advanced care and operate in SAC settings. This has provided RPNs with the chance to work in areas that were previously predominantly staffed by RNs only. RNs harbored doubts about the viability of this nursing skilled-mix, as they struggled to comprehend how RPNs would handle the care of acutely ill patients. It was evident that RNs lacked an understanding of the scope of practice of RPNs, as their assumptions were rooted in past experiences where RPNs were primarily assigned menial tasks. This attests to the need for clear understanding of scope of practice needed to delineate RNs and RPNs.

Data retrieval was done in two parts, which was Cycles 1 and 2. In Cycle 1, RNs and RPNs shared their lived experience of collaborative practice on SAC units. Findings were coded and categorized and main themes were retrieved, which identified barriers that RNs and RPNs experienced. These data findings further inform Cycle 2 activities and evaluation steps. Amendment was made to the previous

proposal for Cycle 2 through the Research Ethics Board (REB) at the clinical site. Cycle 2 consisted of semi-structured focus group discussions with RNs, RPNs and staff who co-created together to discuss findings from Cycle 1 to develop strategies to be used to strengthen collaborative practice between RNs and RPNs on SAC units. Data were analyzed and coded using theoretical and descriptive processes with the aim to develop a standardized framework to be used to strengthen collaborative practice between RNs and RPNs. Appendix A describes the research design in more detail.

Section Two: Results

In Cycle 1 of the research process, eight RNs and eight RPNs were interviewed about their experience of collaborative practice on SAC units. Findings from the interviews were analyzed and used to inform Cycle 2 action and evaluation steps. Cycle 1 will be discussed with more details of participant selection, data collection, and analysis.

Participants

The recruitment of participants for Cycle 1 used purposive sampling, as the researcher's intention was to specifically select RNs and RPNs who actively work on SAC units. This approach was undertaken to gain insights into their viewpoints regarding collaborative practice. According to Etikan et al. (2016), purposive sampling, alternatively known as judgmental sampling, involves a deliberate selection of participants based on their specific qualities relevant to the research problem at hand. In conjunction with purposive sampling, the researcher employed snowball sampling as a method to enlist participants. Snowball sampling entails encouraging initial participants to nominate other nurses from their units to partake in the research. The inclusion/exclusion criteria were as follows:

- Participants must be an employee at NHU
- Participants must work on one of the following units at the General site: Cardiology, Thoracic, General Internal Medicine (GIM), Nursing Resource Team (NRT) or the Emergency Room (ER)
- Participants must hold an RN or RPN designation

Exclusion Criteria included:

- RNs and RPNs at all other NHU sites, excluding the General site

Demographic Data

Fifty-percent of the sample were RNs (n=8) and fifty-percent were RPNs (n=8). All participants worked in SAC units on either thoracic (n=1), ER (n=6), cardiology (n=2), GIM (n=2), and the NRT (n=5). Most participants worked in the ER (n=6) and the NRT (n=5) and the least number of participants

worked on thoracic (n=1). Eighty-one percent of the participants had (0-5 years) experience, followed by 13% (6-10 years) experience and 6% (greater than 10 years) experience. The RNs were comprised of seven females (n=7) and one male (n=1), while the RPNs were comprised of four females (n=4) and four males (n=4), for an overall total of 11 females (68.75%) and five males (31.25%) participants. Table 1 represents participants' background data.

Table 1

Participant Demographics: SAC Unit

Characteristic		Frequency	%
Professional designation	Registered Nurse (RN)	8	50
	Registered Practical Nurse (RPN)	8	50
Years of experience	0-5	13	81
	6-10	2	13
	>10	1	6
Clinical practice unit	Emergency room	6	38
	Nursing resource team	5	32
	General internal medicine	2	12
	Cardiology	2	12
	Thoracic	1	6
Gender	Males	4	31.25
	Females	12	68.75

Procedure

Prior to entering Cycle 1, the Institutional Research Board (IRB) application was submitted and amended prior to receiving approval from Northeastern University. Immediately after, the Research Ethics Board (REB) application was submitted for the research site approval to gain access to staff on SAC units, which included Cardiology, GIM, Thoracic, NRT, and the ER. This process was rigorous and lasted approximately three months. IRB dictates that any research that includes human subjects must be approved in advance to comply with institutional and government mandated guidelines for ethical research (Blee & Currier, 2011). In discussion with Nurse Managers (NM), Patient Care Coordinators

(PCC) and APNEs, recruitment was initiated, and consultations incorporated full disclosure to gain permission to conduct the study on their units. Afterwards, details regarding the study were emailed to all RNs and RPNs on the units identified for the study, which included the contact information for the researcher for participants who were interested. As the site chosen for the interview is the institution where the researcher works, all correspondence initiated with participants had to be done via the institution communication platform such as email, phone number and Microsoft Team for interviews as mandated by the sites' REB guidelines. Recruitment also involves providing study briefings during staff safety huddles. All participants provided informed consent, which included sharing the aims, purpose, use of results, and potential consequences of the study, as well as obtaining written acknowledgment of their willingness to participate (Stringer & Aragón, 2020). Data collection was continuous, with the primary focus on gathering insights from both RNs and RPNs, who typically work twelve-hour shifts encompassing both day and night rotations. This approach aimed to capture diverse perspectives, crucial for the study's findings. Semi-structured interviews were conducted virtually using Microsoft Teams, ensuring a secure virtual platform. The researcher scheduled interviews during participants' days off to avoid disrupting patient care. Interview questions were formulated based on theoretical concepts derived from literature and pilot interviews conducted earlier during the R2 phase.

Data Analysis

Throughout the interviews, field notes were taken and documented. Subsequently, in vivo, a theoretical coding process was employed for data analysis, identifying common themes, which were then categorized into emergent groups (Saldana, 2021). Before commencing in vivo coding, the field notes were thoroughly reviewed multiple times. Process coding was implemented to structure the data into primary headings, which were further developed into descriptive themes. Themes were used to produce the research findings. Sixteen interviews were completed from participants from SAC units who 1) worked in acute care prior to the initiation of the nursing skilled-mix model, 2) were hired during the

initiation of the nursing skilled-mix model or 3) were hired post initiation of the nursing skilled-mix model. The following categories and themes were dominant within the data collection and will be discussed below. Table 2 illustrates the data gathering and analysis process.

Table 2

Data Gathering and Analysis Process

Data Gathering	Data Analysis
	Phase 1
Interviews	Active listening, observing, rephrasing, detecting patterns, interpreting
In vivo and process coding	Read and reread field notes, code, synthesize, detected patterns, identified themes and categories, interpreted and described
Validation/Reliability	Members Check-in
	Phase 2
Focus Group Discussion	Active listening, Observing, rephrasing, detecting patterns, interpreting
In vivo and process coding	Read and reread field notes, code, synthesize, detected patterns, identified themes and categories, interpreted and described
Validation/Reliability	Members Check-in

Variation in Knowledge of Scope of Practice

Of the sixteen participants who underwent interviews, 94% of RNs and RPNs indicated that they lacked a comprehensive understanding of each other's scope of practice. Similarly, when asked about their comprehension of their individual scope of practice, all participants replied, “no”.
They attributed this to two distinct factors: 1) lack of clear instruction on scope of practice during nursing school, and 2) uncertainty regarding limitations for RPNs, as both RNs and RPNs were

completing similar tasks at the same level. One RPN explained, 'I am worried of being at risk of losing my license as I am practicing outside of my scope, but I am too afraid to speak up as I am a novice nurse and I was told to just do it.' Another RPN stated, 'There was a lack of knowledge as to what an RN can do versus what an RPN could do and that some nurses, especially the senior RNs, would limit RPNs to what they can do.' RNs and RPNs reiterated that they needed more education on the description of the roles and responsibilities of both categories of nurses as they are asked to work to full scope but there was no explanation or guidance of what this really is.

Competency

The implementation of the nursing skilled-mix model resulted in the recruitment of RPNs to SAC units. Some RPNs possessed prior experience in acute care, while others were recent graduates entering the field. Eighty percent (80%) of RPNs expressed concerns about working beyond their scope and risk jeopardizing their license to practice. Several RPNs experienced the need to consistently demonstrate their capabilities to RNs, as there was a perceived lack of trust in their ability to perform tasks safely. Some RPNs expressed feeling constrained by excessive limitations when certain tasks were taken away from them. Additionally, some RPNs mentioned feeling reluctant to ask questions, as it was implied that they should already possess the necessary nursing skills upon accepting the job. This led to differing levels of frustration, as one RPN expressed, 'It was challenging at the onset to constantly face criticism due to my limited skills and practice.' Some RNs have suggested that an extended training period with the APNE would be beneficial as RPNs were unfamiliar with many of their skills.

Disrespect and Inferiority

While some participants recalled experiencing collaborative practice between RNs and RPNs during their student days, the majority reported its absence once they transitioned to independent practicing nurses. The majority (87.5%) of RPNs stated that they encountered verbal hostility, leading to feelings of humiliation and a desire to resign. These behaviors were most often displayed by senior RNs.

One RPN stated that 'frequently, RNs would ask me why don't I go back to school and train to become an RN because the pay that I get is garbage.' When asked "how did this make you feel?", the RPN responded, 'It makes me feel humiliated.' When RPNs overheard senior RNs expressing reluctance to work with nurses who underwent two years of schooling and appeared uncertain in their tasks, it made them feel diminished as nurses and unwelcome within the team. At times, RPNs were referred to as 'half-nurses,' an experience they described as working in a hostile environment. In an interview with John, he asked the student researcher, 'Who am I?' He recounted that when his nurse educator instructed him to direct any question to a nurse (referring to RNs), it prompted him to question himself, 'Am I not a nurse?' For a brief moment, he bowed his head and with tears welling in his eyes, he looked at the researcher and asked for permission to swear, stating, 'I am angry.'

Job-satisfaction

The reception of RPNs in acute care settings was unfavorable, potentially due to a systemic cultural norm that they can only do menial tasks. In the past, RPNs primarily worked in long-term care and rehabilitation units, as SAC units such as ER were considered too critical for RPNs to be employed. The exacerbation of the nursing shortage, particularly evident during the COVID pandemic, has resulted in an increase in RNs opting for early retirement or transitioning into non-clinical roles. The expanded scope of practice by the CNO for RPNs has opened the opportunity for them to work in SAC units.

Upon the implementation of the nursing skilled-mix model on SAC units, RNs perceived that RPNs would provide direct support to RN's allocated assignments instead of RPNs being assigned their own independent patient care tasks. This notion came about due to RNs consistently feeling burnout due to the nursing shortage. Moreover, NMs encountered a limited number of applications for RN vacancies, leading to the initiation of the nursing skilled-mix model and recruitment of RPNs on SAC units. Furthermore, findings from an Acuity Based Staffing (ABS) analysis demonstrated that RPNs could safely care for 70% of patients on SAC units. While some RPNs were grateful for the chance to enhance

their skill proficiency on SAC units, many experienced a sense of feeling unwelcome, while others decided to resign their positions. Results from the Cycle 1 semi-structured interviews revealed that seventy-five percent of RPNs felt rejected, uninvited and treated less than a nurse. Table A13 in Appendix A captures the data findings. One RN participant recounted her past experience as an RPN, noting numerous rejections that left her feeling inferior. She went on to express that whenever she

Table 3

In Vivo, Process, and Theoretical Coding

RNs/RPNs Clinical Experience	Exemplar Quotes	Theme
Job-dissatisfaction	It felt like they do not really trust us as nurses to be taking care of new incoming patients. I found it unfair, because that was why | transferred to this unit to expand my critical thinking.	Feeling inferior Lack of trust
Poor Retention	Some days it was so overwhelming that I just wanted to quit. I have seen other RPNs quit.	Feeling overwhelmed
Fear and Frustration	Like if you ask them a question, they are like; you should know that already in a condescending way. You may have questions that you just want to be sure about and they are not very approachable and that is what rubs me off the wrong way, then you do not want to talk or approach them anymore.	Intimidating Condescending
Scope of Practice	I do not think that I am that knowledgeable about the scope of practice. We need more education on the description of the roles and responsibilities on the RN and RPN. We are asked to work to full scope but there is no explanation, no guidance of what this is.	Role confusion Lacking knowledge
Competency	I have asked for assistance because I did not know how to do a particular task and I was just left to figure it out myself.	Poor teamwork Lack of support

identified herself as an RPN, recruiters promptly informed her that they were solely pursuing RNs. When she inquired about the reasons behind the discrimination, she was informed that RPNs can only do menial tasks. However, after transitioning to an RN role, she noted a stark contrast in her experience, feeling constantly welcomed and valued at work. She frequently advocated for RPNs, taking the time to educate her RN colleagues about their capabilities and contributions. She elaborated that she frequently witnesses RPNs resigning due to the hospital's culture failing to recognize them as valuable team members. The in vivo, process, and theoretical coding are depicted in Table 3.

Summary

Cycle 1 semi-structured participant interviews revealed that the platform used to establish, introduce, and to oversee the implementation of the nursing skilled-mix model was ineffective. No formal reviews were conducted since its inception, and RNs and RPNs expressed uncertainty regarding their roles. As the nursing skilled-mix model was a recent addition to SAC units, RPNs experienced a persistent need to validate their abilities to RNs, reflecting a lack of trust in their capabilities to perform tasks safely. While nurses are accountable for adhering to their scope of practice, nursing leadership, particularly NMs, have the responsibility to design structures that can support RNs and RPNs adaptation to new care models where roles are similar yet diverse. The literature indicated that NMs frequently face challenges stemming from unclear job descriptions and shifts in scope of practice. These issues led to ambiguity and job dissatisfaction among the nursing team. Establishing strategies that can be used to develop standardized frameworks for nurses is crucial in streamlining roles and responsibilities, especially considering the overlapping tasks performed by RNs and RPNs. Confidence in their roles would eliminate confusion and foster teamwork among nurses (McInnis, 2017). Healthcare organizations should endeavor to institute structures that are profitable to building a collaborative culture for practitioners, thus, a review of how the nursing skilled-mix model was utilized on SAC units would be beneficial in strengthening collaborative practice between RNs and RPNs.

Cycle 2 Action Steps

This section provides an overview of focus group discussions that were implemented as an action research plan for RNs and RPNs collaborative practice on SAC units. It will focus on delineating the goals, objectives, activities, and the evaluation of these focus group discussions conducted during the winter of 2024.

Action Step Goals and Objectives

The purpose of this Cycle 2 action research study was to identify strategies that can strengthen collaborative practice between RNs and RPNs on SAC units. This was inspired by the interview results in Cycle 1 where participants described their experience of what collaborative practice means to them, and underscored the necessity for organizational leadership to actively engage in crafting and implementing policies aimed at strengthening collaborative practice at NHU.

Participants expressed difficulties in collaborating effectively due to a lack of understanding of their own and each other's scope of practice, resulting in role confusion and job dissatisfaction. Moreover, there has been a rise in feelings of mistrust, inferiority, and humiliation.

The main activities for Cycle 2 are a series of focus group discussions. Focus group discussions are frequently utilized as a qualitative method to delve deeply into social issues and gather data from a purposive sample of individuals, rather than from a statistically representative sample of a larger population (Nyumba et al., 2018). The most effective approach to tackle the problem of practice and devised appropriate strategies was best managed by bringing participants and key stakeholders together who are impacted by the issue. This includes RNs, RPNs and nursing leadership staff who are directly involved in overseeing nursing practice.

The aim of Cycle 2 action steps was to enhance collaborative practice between RNs and RPNs on SAC units at NHU. The purpose of the action steps was to conduct focus group discussions involving RNs and RPNs from SAC units, along with nursing leadership staff who directly impact nursing practice to co-

create. Participants were encouraged to share their perspectives on how structural teamwork could be enhanced at NHU to strengthen collaborative practice between RNs and RPNs on SAC units. Identifying and addressing obstacles to collaborative practice can enhance teamwork between RNs and RPNs, leading to increased nurse retention and attract new staff to NHU, where a culture of collaboration is emphasized. Just as nurses came together as a collaborative team during the COVID-19 pandemic to care for those in need, the aim of the focus group discussions were to engage nurses at all levels to collaborate on strategies to address barriers that jeopardize teamwork. This endeavor aims to rebuild a hospital environment that recognizes and values the contribution of both RNs and RPNs to patient care. Even though the CNO provided guidelines for nurse's practice, the insights delineated from the data in Cycle 1 motivated the researcher to employ a platform that facilitated dialogue between nurses and nursing leadership staff where they co-create together to better understand gaps to collaborative practice. Furthermore, this enables stakeholders and collaborators in positions of influence to directly understand the challenges encountered by RNs and RPNs when engaging in collaborative practice on SAC units.

The aim of the focus group discussion is to provide nurses with a platform to express their views on the nursing skill mix initiative, exploring both its advantages and challenges, and assessing its impact on patient care. It was necessary to discuss what strategies could be implemented to strengthen collaborative practice between RNs and RPNs and furthermore, it was imperative for the organization to acknowledge that neglecting to address the collaboration between RNs and RPNs might lead to incidents that could pose liabilities to the organization. Additionally, the organization holds a position of authority capable of influencing other entities, including various unions that also play a role in shaping how different groups of nurses collaborate and perceive their roles within the broader healthcare system.

Action Step Activities

This section will outline the activities that were rolled out throughout the implementation process of the focus group discussion. These action steps are divided into the following phases 1) Laying the groundwork, 2) Initiative development and 3) Assessing the outcome.

Laying the Groundwork

First, an amendment was needed from the research site in order to implement Cycle 2 activities. The amendment took four months (August to November 2023) to be approved. During this time stakeholders were kept abreast of the study progress through emails, presentations and meetings. The main activities for Cycle 2 were done in the form of focus group discussions. Following consultations with key stakeholders including the Chief Nursing Executive, Director of Education, and the Project Manager in Collaborative Academic Practice, it was decided that focus group discussions would be best divided into two segments: 1) with RNs and RPNs and 2) with nursing leadership staff. This decision was driven by the historical data that RNs and RPNs often choose to remain silent when in the presence of leadership, possibly due to feeling psychologically unsafe (Alingh et al., 2019). Therefore, the decision to conduct separate focus group discussions with RNs and RPNs was aimed at fostering an environment of openness and transparency. This approach intended to ensure that the shared data would be genuine, unbiased, and free from fear of repercussions.

To maintain the confidentiality and privacy of all participants, the Institutional Review Board (IRB) mandated the assignment of pseudonyms to each participant, and it required that all cameras remain switched off during the virtual sessions conducted on Microsoft Teams™. The researcher sought support from the study site digital team to ensure facial recognition and name privacy, but in a trial session, it became apparent that names were easily identifiable. Assistance was further requested from the communication platform at the research site, but no substantial support was provided. To ensure participant privacy, the researcher explored practical measures and found that participants could sign

into Microsoft Teams platform using their personal devices where they could create their pseudonym. Identifying participants by pseudonym was vital for the researcher, as it would be essential during data analysis to understand the perspectives from each nursing specialty regarding collaborative practice between RNs and RPNs.

In January 2024, the recruitment process for participants began with the distribution of mass email communications. The approved recruitment letter was sent to every nursing group within NHU, including RNs and RPNs working across SAC units, as well as long-term care units, outpatient clinics, and various departments within nursing leadership. This recruitment targeted over four thousand potential participants. The objective was to ensure that all nursing staff who had collaborated with RNs and RPNs in a setting that utilized the nursing skilled-mix model had a fair chance to participate. The number of participants required for the research study ranges from two to three RNs, two to three RPNs and eight to ten nursing leadership staff. At the outset, 21 participants expressed interest in participating in the focus group discussions, but ultimately, nine followed through to engage in consent (composed of three RPNs, one RN, and five nursing leadership staff). To recruit the required number of participants to initiate Cycle 2, the researcher employed snowball sampling, a widely used method in qualitative research (Parker et al., 2019). Two PCC, an APNE, a NC, and an RN were directly emailed the recruitment letter to gauge their interest in participating, and they all provided consent. These participants were thoughtfully chosen because they would have been involved in the skilled mix initiative, whether as frontline RNs, educators, or in managing scheduling and assignments alongside nurses. Despite obtaining consent from 14 participants, only 13 ultimately completed the focus group discussion, as one RPN withdrew consent due to a family emergency. The overall participants held diverse titles with a summation of three PCCs, two NMs, two APNEs, one NP, one NC, two RNs, and two RPNs. Table 4 displays the participants in Cycle 2 and their level of interaction with stakeholders.

Table 4

List of Participants: Participant's Roles, Goals, and Linkage to Stakeholders

Participants Role in Organization	The Participant's goals	Linkages with other stakeholders
Unit Manager (NM) (Internal Stakeholders)	To understand the change in roles for RN and RPNs and engage nurses in collaborative practice	Work alongside Advance Practice Nurse Educators, Patient Care Coordinators, Chief Nurse Executive, Director of Education, Nurse Practitioners and RNs and RPNs.
Patient Care Coordinator (PCC) (Internal Stakeholders)	To allocate shift schedule to RNs/RPNs that enhances collaborative work between RNs and RPNs	Work alongside In-charge Nurses, Advanced Practice Nurse Educators, Unit Managers, Nurse Practitioners, RNs and RPNs
Registered Nurse (RN) (Internal Stakeholders)	Work alongside RPNs on specialized acute care units	Work alongside Nurse Practitioners, In-charge Nurses, Advanced Practice Nurse Educators, Nurse Managers, Patient Care Coordinators and RPNs
Registered Practical Nurse (RPN) (Internal Stakeholders)	Work alongside RNs on specialized acute care units	Work alongside Nurse Practitioner, In-charge Nurse, Advanced Practice Nurse Educators, Unit Managers, Patient care Coordinators and RNs
Advanced Practice Nurse Educator (APNE) (Internal Stakeholder)	Provide education to RNs and RPNs	Work alongside Patient Care Coordinator, RNs and RPNs, Director of Education and Nurse Managers
Nurses Practitioner (NP) (Internal Stakeholder	Delegate tasks to RNs and RPNs	Work alongside Nurse Managers, Patient Care Coordinators, Advanced Practice Nurses Education, RNs and RPNs
Nurse Coordinator (NC) (Internal Stakeholder)	Collaborate with RNs and RPNs to ensure effective patient care	Work alongside Nurse Managers, NPs, Advance Practice Nurse Educator, Patient Care Coordinator, RNs and RPNs

Initiative Development

Prior to the beginning of the focus group discussions, all participants were provided with pseudonyms and reminded to keep their cameras off upon logging into the Microsoft Teams platform. The researcher emphasized that no identifiers would be allowed during the discussions to maintain privacy and confidentiality. Five focus group discussion sessions were conducted due to the inability of all participants to attend at once. Three sessions involving nursing leadership were held from February

8th to 12th, 2024, while two sessions with RNs and RPNs took place on February 13th and 15th, 2024. The session commenced with a presentation detailing the historical context of the nursing workforce, the persistent nursing shortage, the importance of the nursing skilled-mix model, and the integration of expanded roles for RPNs in launching the nursing skilled-mix program on SAC units. A concise summary was provided about Cycle 1 to help participants understand the inspiration behind the researcher's undertaking of this study. Prior to the ending of the presentation, the researcher engaged in sharing anonymous verbatim data from Cycle 1 regarding participants' firsthand experiences of collaborative practice on SAC units.

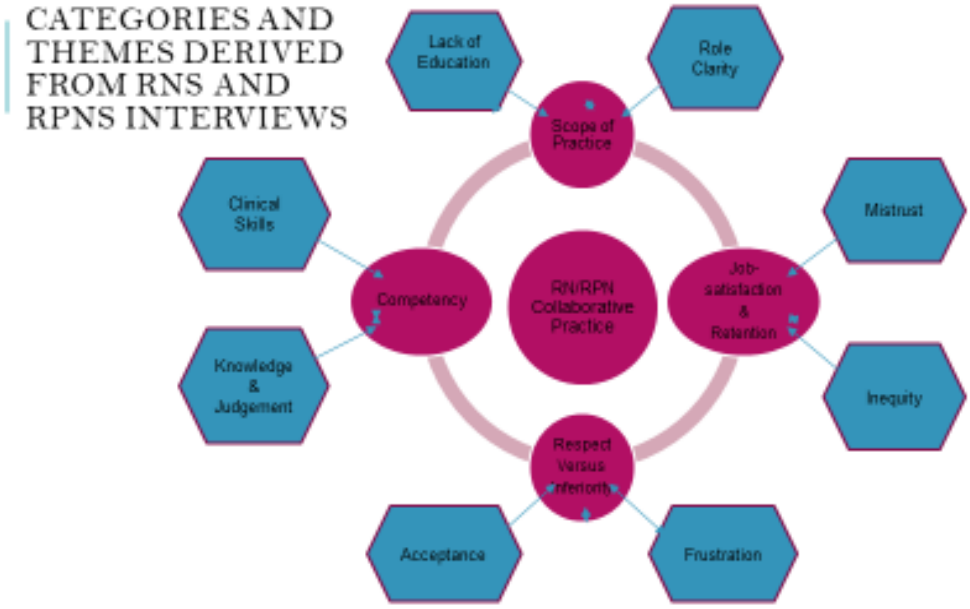
From the analyzed data of Cycle 1, four primary themes and eight categories were identified using in vivo via theoretical coding until saturation of data was achieved (Saldana, 2021). The key themes were as follows: 1) Scope of practice, 2) Competency, 3) Respect versus Inferiority, and 4) Job satisfaction and retention. Regarding the scope of practice, participants discussed issues such as inadequate education and role ambiguity. For competency, participants discussed possessing the requisite knowledge, judgment, and clinical skills necessary to fulfill nursing responsibilities. In terms of respect and inferiority, they expressed frustration and a desire for acceptance among their colleagues. Lastly, when discussing job satisfaction and retention, they described feelings of inequity and mistrust. This sentiment underscored a critical aspect of the workplace environment, where the lack of fairness and trust not only diminished their job satisfaction but also ignited a strong desire to leave their roles in search of a more supportive and equitable working environment.

In Appendix A, Table A13 presents the key findings from the data collected during Cycle 1 of the study. Additionally, Figure 1 below outlines the main themes and categories identified through the analysis of interviews with participants in Cycle 1, which played a pivotal role in shaping the subsequent phase of the research. This initial set of data proved to be of paramount importance as it guided the formulation of discussion questions for Cycle 2. These discussions revealed key insights into how the

hospital's organization and practices could be improved to greatly enhance teamwork between RNs and RPNs at NHU. Through this systematic process, the research gradually expanded on these insights, leading to a deeper examination of ways to create a more unified and collaborative work environment.

Figure 1

Themes and Categories of RNs and RPNs Collaborative Practice



Program in Action

Twenty-one participants initially responded to the recruitment email, but only nine engaged in the consenting process. Five additional participants were recruited by utilizing purposive sampling and were consented, however one participant withdrew. The remaining 13 participants were scheduled to attend one of five sessions based on their availability during week 5 and 6 of the winter term. The sessions took place virtually via Microsoft Teams. In the standard focus group discussion session, there was a 15-minute presentation providing historical and statistical context on the healthcare workforce, emphasizing the pivotal role of nurses and the inception of the nursing skilled-mix model on SAC units at NHU. The presentation then provided a brief summary of the implementation of Cycle 1 activities and

the collection of data, followed by the sharing of participants' anonymous lived experiences regarding their perceptions of collaborative practice.

All participants were asked the same open-ended questions to initiate discussions on strategies for improving collaborative practice. These questions, starting with either "how" or "what," were designed to stimulate dialogue and were based on themes identified in the data from Cycle 1. Questions were centered on the following themes: 1) exploring the benefits and challenges of collaborative practice, 2) identifying factors that influence collaboration, 3) distinguishing between role clarity and ambiguity, 4) discussing strategies that improve work environment, and 5) assessing the advantages of adopting a standardized framework to strengthen collaborative practice. These questions deliberately addressed barriers that hindered collaborative practice between RNs and RPNs, offering participants an opportunity to recognize gaps in teamwork while sharing their perspectives on strategies to enhance collaboration. Figure A3 and A4 show the questions that were asked during the focus group discussions. To enhance participants' comfort level, the researcher reassured them of the anonymity of their identities. Additionally, participants were reminded that the anonymous data shared with them might provoke feelings of anxiety, and if they felt uncomfortable, they could request to leave the session and withdraw from the research.

Action research frequently aims to empower marginalized populations. In the focus group discussions, RPNs shared their experiences of feeling disregarded, while RNs demonstrated empathy by acknowledging that differences in years of study and professional titles created barriers to collaborative practice. They emphasized the necessity of shifting power dynamics to foster a supportive community where there is a collective ability to effect change, as advocated by Apgar (2022). The diverse roles of the participants encompassed the primary nursing leadership categories at NHU, with the exception of the professional practice division. The involvement of the professional practice division is crucial for nurses' professional development, so their participation would have been invaluable. Their engagement

would provide insights from a professional practice perspective on potential strategies to enhance collaborative practice. The researcher attempted multiple recruitment strategies to involve nursing leadership from professional practice, but was unsuccessful. A notable discovery was that hosting multiple focus group sessions yielded a substantial amount of data drawing from multiple perspectives. The smaller group size also fostered an intimate atmosphere conducive to transparency.

Participant/Collaborator/Stakeholder Experience

The audience of this action research project include frontline RNs, RPNs and staff. The primary research participants were RNs, RPNs and staff who worked at all NHU sites who have experience working with RNs and RPNs in the nursing skilled-mix. Therefore, the inclusion and exclusion criteria varied slightly as participants could be recruited from any of the NHU sites. Prior to recruiting participants, assistance was solicited from the Director of Education who supplied the researcher with all group emails for every category of nurses employed at NHU, subsequently, enabling engagement with a wider demographic to potential participants. A sample of 21 participants responded and only two RNs, 2RPNs and 5 nursing leadership staff were initially consented for the focus group discussion. Four nursing leadership staff and one RN was recruited via purposive sampling and one RPN withdrew consent due to family emergency. During each focus group session, an external research assistant volunteered as scribe to assist with collating field notes. In addition, the researcher also took field notes during these sessions.

To enhance the preparation for the focus group discussion, collaborators such as the Chief Nursing Executive and the Project Manager for nursing research in collaborative academic practice at the research site met with the researcher and provided useful strategies on conducting successful focus group discussions. Additionally, they offered insights to enhance the focus group presentation based on feedback from Cycle 1, ensuring that participants would receive relevant information before the discussions section following the presentation. The research Information Technology (IT) team was also

contacted to provide guidance on maintaining participant name confidentiality during the Microsoft Team invite and throughout the active discussion. The provided instructions proved ineffective, prompting the engagement of external support from Toronto Metropolitan University (TMU), whose guidance successfully ensured participant privacy and confidentiality.

Internal stakeholders were the Chief Nursing executive, Director of Education, Project Manager for nursing research, RNs, RPNs, PCCs, APNEs, NMs, NP, and NC. External stakeholders encompassed the nurse scientist from TMU, who provided guidance to the researcher on preserving participant privacy when utilizing virtual platforms, and the RN who volunteered as the scribe to record field notes. The roles and professional status of the participants are essential to the research data and dissemination of study findings, as they symbolically contributed to the next steps in the process (Saldana, 2021). The role of participants, stakeholders, collaborators, and other critical reference groups is fundamental as they share important information about the problem of practice. The utilization of social mapping was key to facilitating the acquisition of diversity in participants who are affected by challenges that affect how RNs and RPNs engage in collaborative practice (Stringer & Aragón, 2020).

Cycle 2 Evaluation

The implementation of the focus group discussions gave participants a sense of relief as they felt that a vital concern was being addressed. Through this platform RNs, RPNs and nursing leadership felt that they had an opportunity to share their perspectives of what has been a long-standing issue. Throughout the focus group discussions, participants expressed recognition of the significance for NHU organizational leadership to dedicate time to comprehending barriers to collaboration in clinical practice, which extend beyond nurses to include other members of the interprofessional team. The anonymous data shared from Cycle 1 interviews allowed participants in Cycle 2 to be connected to the lived experience where empathy, equity, trust, respect and role clarity were some of the core themes that were derived from the data. Another vital proposed strategy voiced by participants was focused on

the role senior leadership and management teams should take in owning their responsibility to actively participate in developing standardized frameworks. These frameworks would help streamline how RNs and RPNs engage in collaborative practice on SAC units.

The next step in the research process is to present the anonymous Cycle 2 data to stakeholders of the senior leadership and management team where they would co-create with the researcher to propose the following phase in how the results would be disseminated and materialized. One such step that has already taken place is the utilization of this research finding to inform a study proposal at the research site on how to address complexity in nursing care between RNs and RPNs. The Principal Investigator valued the data from this study on nurse-to-nurse collaboration and how strengthening teamwork between RNs and RPNs would help decrease the level of complexity in nursing care.

Cycle 2 Results/Findings

The objective of the action research was to pinpoint obstacles impacting collaborative practice between RNs and RPNs, as well as to propose strategies to strengthen teamwork. Findings from Cycle 1 indicated that RPNs perceived a lack of appreciation as essential team members when collaborating with RNs. This sentiment arises from several factors: firstly, a deficiency in understanding their scope of practice, which fosters role ambiguity and confusion; secondly, the presence of power differentials between RNs and RPNs, leading to feelings of frustration and inadequacy; and thirdly, issues of mistrust and inequity contributing to job dissatisfaction and retention challenges faced by RPNs on SAC units. Moreover, RNs and RPNs expressed that these barriers stem from reduced management presence on the units, their lack of understanding regarding scope of practice for RNs and RPNs and the skilled-mix model, and a deficiency in team-building opportunities for both groups of nurses.

When evaluating the efficacy of Cycle 1 findings, Cycle 2 results affirm the presence of barriers to collaborative practice between RNs and RPNs, highlighting the necessity of a systemic approach to enhance teamwork within SAC units. Five primary strategies emerged from the focus group discussions

as pivotal actions to bolster collaborative practice between RNs and RPNs. These strategies encompass: 1) Clarifying scope of practice, 2) Emphasizing organizational accountability to collaborative practice, 3) Enhancing capacity via team-building events, 4) Fostering equity and inclusion, and 5) Promoting respect and civility. Participants also contributed tangible and valuable helpful resources they deemed essential to enhancement of collaborative practice between RNs and RPNs. Figure A2 visual and graphics in Appendix A captured the themes of findings.

Clarifying Scope of Practice

Scope of practice is the fundamental principles by which a nurse practices, as the CNO sets practice standards that govern how RNs and RPNs administer nursing care. These standards serve as the cornerstone of nursing professionalism, delineating the boundaries of responsibility, competence, and ethical conduct within the profession (CNO, 2021). As guardians of public safety and advocates for patient well-being, nurses adhere steadfastly to these guidelines, ensuring that every action taken in the course of care delivery is rooted in best practices and aligned with the highest standards of quality and integrity (CNO, 2021). Consensus was reached among all participants that establishing role clarity constitutes the initial fundamental step necessary to attain collaborative practice between RNs and RPNs. The focus group discussions and reflections unveiled that insufficient education regarding scope of practice leads to errors in medical and patient care, resulting in liabilities for the nurse and hospital organization.

Participants described that the knowledge gap concerning scope of practice, stemming from the absence of clear practice guidelines, accounts for the lack of teamwork observed between RNs and RPNs. They emphasized the necessity for an ongoing process, commencing during the orientation of new hires, to ensure consistency, particularly given the high turnover rate in nursing. RNs discovered that certain RPNs exhibited expertise in their practice, repeatedly surpassing novice RNs. However, the lack of comprehensive understanding regarding their scope of practice led to confusion in teamwork

dynamics. Consequently, this situation escalated job-dissatisfaction among nurses and contributed to increased resignations from their positions.

Participants highlighted not only the need to address the lack of awareness regarding the scope of practice for RNs and RPNs but also emphasized the importance of holding management teams accountable for ensuring their comprehension of upskilling in the RPN scope of practice and expanded roles. This understanding is vital for implementing strategies aimed at guaranteeing RNs and RPNs are cognizant of their differences and overlapping duties. Furthermore, participants asserted that the development of a standardized framework necessitates the involvement of key stakeholders at the discussion table. Abigail (pseudonym) an RN of over 10 years expressed that we need to put other members around the table to talk about scope of practice and the difference in education so that people understand this is why RPNs cannot administer certain types of medications instead of making them feel like they are not enough. Adam, an RPN who was completing his Bachelor of Science Degree to become an RN, further emphasized that:

> How RPNs are introduced to the units is significant as they should be made to feel a part of the nursing team. He further stated that role clarity should be done on an ongoing and repetitive basis such as in staff meetings where RNs and RPNs can discuss ways to collaborate while they work alongside each other as this is about the patient's positive outcomes.

The strategies articulated by the participants illustrated a favorable outcome of the focus group discussion, enhancing participant comprehension regarding the barriers stemming from a lack of knowledge about scope of practice among RNs and RPNs. This understanding extends to how it influences collaboration and shapes perceptions of each other's roles, potentially leading to underestimation of their collective capabilities when they collaborate.

Nursing leadership participants noted a significant disparity in educational opportunities between RNs and RPNs, which poses a hindrance to collaborative practice. Nya (pseudonym), a NP of over 10 years, conveyed:

> Education and training differences can be barriers where RNs have more opportunities than RPNs. Upskilling RPNs within the framework of their broadened scope of practice would help us to utilize them to their full capabilities within their limitations so that they feel worthwhile.

It was discussed that the intraprofessional team are often unable to differentiate between RNs and RPNs, as they are unaware of the difference. Paul, a PCC, who have prior experience in other nursing leadership roles for over 10 years, highlighted:

> Across educational institutions, I see movements about integrating interprofessional education within collaborative academic practice that include other healthcare providers than just RNs and RPNs. Bringing all these professions together in education would allow them to have role clarity as they get a chance to mingle with each other and learn the value of each other's roles, as everyone has distinct expertise.

The anonymous data from Cycle 2, shared with participants during the focus group discussion, evoked expressions of empathy with some individuals expressing frustration upon realizing that these barriers to collaboration continue to persist. Nya stated, “I really felt sad to hear that RPNs are feeling unhappy about their own education, as everyone who is licensed to practice has merit-based education and competency and are helping humanity.” Participants emphasized the urgency for leadership within the hospital organization to establish measures aimed at strengthening collaborative practice before further losses occur within the nursing profession.

Emphasizing Organizational Accountability

The focus group discussion also presented potential strategies to improve collaborative practice between RNs and RPNs from an organizational standpoint. Drawing from the discussions, which

included considerations of organizational perceptions. Participants noted that nurses' views on leadership at both micro and macro levels affect how RNs and RPNs work together. When policies and guidelines about practice standards are not enforced in ways that encourage engagement in collaborative practice, it strains the relationship between RNs and RPNs. Several participants emphasized that senior leadership holds a critical role in influencing nursing practice, and continual enhancements to improve patient care start with investments aimed at optimizing effective teamwork between RNs and RPNs. Sue, (pseudonym) an RN of over 20 years, who also works as a researcher at the Toronto Metropolitan University, asked:

> What does administrative and senior leadership prioritize to their workers regarding collaborative practice? What type of training, support and resources do they offer to frontline staff to be able to do this?

Sue further questioned that the current healthcare environment has been affected by COVID-19 pandemic and Ontario Bill 124 wage suppression legislation and asked if anyone has tapped in to find out about how nurses are feeling about their profession.

Recent statistics indicate that nurses are remaining in the profession for a maximum of one year as they seek alternative opportunities (Zangiabadi & Ali-Hassan, 2023). Nearly one in four nurses (24.4%) expressed intentions to leave their current position or pursue job changes within the next three years, a rate surpassing that of other occupation groups (Zangiabadi & Ali-Hassan, 2023). When questioned about what would incentivize them to remain in nursing, participants outlined enhancements in compensation, safe staffing, work-life balance, workplace culture, physical and psychological safety, and avenues for career progression (Barrowclough et al., 2023). Sue, a RN-researcher, emphasized:

> Today we have the largest international nurses entering the workforce due to expedited processes by the CNO to combat the nursing shortage, therefore, with all these changes, how do

> we make the working environment be such that RNs and RPNs feel a part of the team? This would be more effective by hearing from them, such as what is being done through this study to find out what are those factors and issues that are preventing collaboration from taking place.

Participants delved further into concerns regarding the division caused by various nursing unions and advocated for senior leadership to assume the responsibility in addressing these gaps. At NHU, there is one union representing RNs and two representing RPNs. As the scope of practice for RPNs expanded and they became capable of working on SAC units, they were viewed as potential threats to RNs' job positions. In an attempt to preserve RNs' jobs, participants expressed that the union representing RNs frequently fostered division between RNs and RPNs. Ashley, an RPN of over 30 years, expressed:

> A lot of this also came from representatives of the Ontario Nurses Association (ONA) who will go to the public and say RNs are better as they do not kill patients, but RPNs do. I have heard this said many times in my 30-years nursing career. RPNs are not stupid people! For collaborative practice to be effective between RNs and RPNs, it cannot just come from lower management, it has to start with the Chief Executive Officer (CEO) and the Chief of Nursing to recognize RPNs as nurses and not glorified carriers.

> Benjamin a PCC on SAC units conveyed: Unions create segregation between RNs and RPNs as observed during Nursing Week occurring every May, where only RNs are acknowledged and RPNs are celebrated for only one day in the summer. RPNs are disgruntled and wonder why they are not celebrated during nursing week and furthermore, the unions representing RNs and RPNs do not collaborate in any way, leaving RPNs feeling unsupported.

In light of the insights gleaned from the experience of RNs and RPNs regarding collaborative practice, during the focus group discussion, participants emphasized the importance of senior leadership in establishing equitable structures that discourage favoritism among nurses. It was asserted that to

strengthen collaborative practice between RNs and RPNs, senior leadership needs to lead the change, as unit managers might not have the resources to implement these significant changes. Nya, a NP, expressed that for the change to be successful; it requires sufficient time to become ingrained in the culture:

> The hospital organization needs to look at how campaigns can drive change and it cannot be an overnight fix, or flavor of the month, it has to be a long term investment to address broken teams. We need to dedicate at least 18 months into it for it to become the norm and culture of the organization.

When Nya and other participants highlighted the necessity for meticulous planning, consideration, and evaluation to successfully strengthen collaborative practice on SAC units, it accentuated the insightful deliberations emerging from focus group discussions. Furthermore, participants contended that senior leadership should broaden its focus on collaborative practice to encompass both inter- and intraprofessional teams, thereby making collaborative practice an expectation for all healthcare practitioners. This, in turn, enhances the patient care experience and yields positive outcomes.

Enhancing Capacity Through Team Building Events

Capacity building, enhancement, and sustainability in clinical practice represent the foundational solution to addressing staff engagement challenges, ultimately contributing to the improvement of patients' health outcomes (Nurdin & Baharuddin, 2023). Global health and sustainable development initiatives have particular goals when formulating roadmaps and budgets to mobilize resources aimed at enhancing capacity in teamwork among healthcare providers including nurses who deliver ongoing patient care (Nurdin & Baharuddin, 2023). Participants in the focus group discussion emphasized the significance of team-building events as a crucial component in capacity building and dismantling hierarchies between RNs and RPNs, thereby facilitating stronger collaboration between the two nursing groups. Over the years, power struggles have persisted between RNs and RPNs, shaping a

culture of superiority among RNs and inferiority among RPNs, ultimately leading to breakdowns in their collaborative efforts. Participants highlighted that creating a collaborative environment starts with promoting teamwork at the start of each shift such as during morning huddles, which provide an overview of activities and anticipated challenges. This guarantees that all nurses understand how they can assist their coworkers. Connectivity within the workplace is crucial, and participants also emphasized the value of relationships cultivated outside of work as important strategies for improving collaborative practice among RNs and RPNs. Abigail, an RN with over 10 years experience, is of the belief that small intentional activities aimed at team building have a significant impact when it comes to developing collaborative teams. Abigail remarked:

> Even after work, we would go and get sushi. We are happy to be out talking about work and this makes you meet people that you work with but have not spoken to and now I get back to the work environment feeling like you understand and trust them more, and you now see them more than just an RN or RPN but as a person. It really brings people together and the collaboration is palpable.

Likewise, Adam, an RPN currently pursuing his RN degree, expressed that team-building events often revolve around not just grand gestures, but also the small, personal acts and their impact on individuals' emotions. He conveyed:

> Getting to know your team by acknowledging birthdays, going for coffee, dinner etc., is good for especially new hires to help engraft them into a collaborative workforce and teach them how we value the culture of teamwork. This would definitely build better relationships and trust.

Building capacity within a group is a fundamental aspect of team building. Participants acknowledged that RPNs felt disenfranchised by the unequal distribution of opportunities accessible to RNs compared to RPNs. When RNs and RPNs are taught how to appreciate each other's expertise and acknowledge the interconnectedness of their roles, it promotes mutual support and respect, reducing

obstacles to collaboration. Moreover, educating RNs about the breadth of RPNs' scope of practice and their capabilities would empower RPNs to work in an environment that promotes job satisfaction. Nya, a NP, shared:

> One of the things that could help build collaboration is to encourage the articulation of capacity and strength. There is a sense of pride that needs to be infused to make sure that RNs and RPNs equally feel proud to have chosen a healthcare profession. There should be campaigns to showcase who nurses are as a team and what they possess as an RN or RPN to patient care, as collectively we are here to enhance patient care.

Paul (pseudonym), a PCC, discussed the significance of inclusion in building capacity through team-building activities that promote collaboration among RNs and RPNs. He recounted a positive experience regarding the integration of RN and RPN roles, noting:

> Team building activities can help with collaboration between RNs and RPNs like organizing workshops so that there are group activities and simulation scenarios that can help inform teamwork and collaboration between the RNs and RPNs. For example, charge nurse education workshops are held for bought RNs and RPNs, as some RPNs work on units that are predominantly staffed with RPNs. This gave the RPNs an opportunity to be included in the charge nurse workshops and they are treated the same way as RNs. Both RNs and RPNs work alongside each other in the simulation activities and the feedback showed that they had clarity with their roles, which enhanced collaboration. It also helped to break down the feeling of hierarchy.

Sophia (pseudonym), a NC, articulated that the provision of additional opportunities for RPNs to feel valued as integral team members is crucial for fostering a collaborative environment between RNs and RPNs. She further explained that inadequate management of complex workload, insufficient support

from leadership, and a lack of recognition and appreciation for employees' contributions are among reasons RPNs feel excluded. She expressed:

> Management could recognize seasoned RPNs expertise by allowing them to support education and teaching to new nurses and students nurses in a supportive role to the nurse educator, as too often APNEs are in meetings and not able to offer immediate educational support when needed.

Timothy (pseudonym), a PCC, expressed the belief that initiatives aimed at developing nursing practice are futile if they do not include RPNs. He stated:

> How can we talk about nursing practice without having RPNs involved? In addition, when we have nursing council meetings, there should be RPNs from each unit to participate so that they feel a part of the team. We cannot be talking about nursing practice but then we do not have RPNs at the table. Furthermore, RPNs should also be a part of the executive body. Making them feel a part of the team will definitely strengthen collaborative practice.

Emphasizing the strengths of individuals and teams and leveraging these strengths to provide optimal care are essential methods for fostering collaborative practice between RNs and RPNs. Participants stress the importance of maintaining consistency in practice to facilitate change. The focus group discussion unveiled that organizational leadership needs to formulate an effective approach towards strong cultivation of collaborative practice between RNs and RPNs.

Fostering Equity and Inclusion

In the clinical area, fostering equity and inclusion between RNs and RPNs is paramount. Both groups play integral roles in patient care delivery, and creating an environment where each member feels valued and respected is essential for optimal outcomes. By promoting equity and inclusion, healthcare organizations can harness the full potential of their nursing workforce and cultivate a culture of collaboration and mutual respect (Hassmiller & Wakefield, 2022). RNs and RPNs embracing each

other as integral members of the healthcare team is crucial for fostering a cohesive and effective working environment. The absence of equity and inclusion in the healthcare setting can lead to feelings of marginalization, frustration, and diminished morale among both RNs and RPNs, hindering effective teamwork and patient care outcomes. Certain participants in Cycle 2 became notably vocal about the frustrations experienced by RPNs when they do not receive equal opportunities compared to RNs. For example, Ashley (pseudonym), an RPN with over 30 year's experience, expressed her concerns regarding the underpayment of RPNs despite their comparable patient care duties to RNs. She stated:

> As an RPN, it took me 30 years to get a $15 increase and that is really sad. Pay difference is a common theme that I heard discussed all the time and RNs would continuously ask me why don't I just go and further my education to become an RN.

Discussions such as these have led RPNs to feel disrespected and stir up contention between RNs and RPNs. Sue, who works as a frontline nurse and researcher, expressed that:

> The skill mix was supposed to help RNs and RPNs collaborate as nurses, but when people feel devalued and treated like 'garbage,' what ends up happening is that they leave the profession and proper patient care suffers. Clearer understanding of what each other's roles are and fair assignments, will cause less confusion, decrease contention and one group of nurses would not feel like they are more indispensable.

Equity and selflessness are fundamental principles in nursing practice, essential for providing high quality and compassionate care to patients, so engrafting a culture of inclusion where RNs and RPNs feel treated fairly and respected is essential for collaborative practice. Sue continues to explain:

> We have to first start by looking at the human behind the profession. She further stated that not everyone is fortunate in our society to afford a four year degree program, especially if they are single parents, immigrants or refugees, as that affects their decision around their education.

Participants believed that promoting equality between RNs and RPNs in clinical practice involves a commitment to mutual respect, good communication, teamwork, support, equal opportunities, and acknowledging their contributions to patient care. By promoting these principles, healthcare organizations can create a positive work environment where all members of the team can thrive and deliver high-quality care to patients. Abigail, an RN of over 10 years expressed the impact the focus group discussion would have on her nursing practice. She stated:

> So, as an RN, I can now understand why RPNs feel disrespected and judged as they are highly skilled and doing their best and not even getting paid as well as RNs. I will be leaving this discussion with adjusting the way that I work with and view RPNs as they are an important addition to the nursing team. I do not want to contribute to RPNs feeling inadequate and frustrated about their role as nurses.

Equity and inclusion are interconnected concepts that reinforce each other in the pursuit of social justice and community well-being. By promoting equity through selfless actions, RNs and RPNs can contribute to creating a more equitable and compassionate healthcare system for practitioners to work. NM and senior leadership are accountable to provide nurses with tools that can foster equity and inclusion in clinical practice to enhance quality patient care.

Promoting Respect and Civility

In the ever-evolving realm of healthcare, nurturing an atmosphere of mutual respect and civility among RNs and RPNs is not merely essential but also fundamental for providing the highest standard of patient care (Stephens & Clark, 2024). In the complex landscape of clinical practice, the collaboration and synergy between RNs and RPNs stand as pillars, ensuring the smooth coordination of healthcare for patients. Grounded in mutual respect and civility, this collaborative relationship goes beyond professional designations, bringing together both groups of nurses in a shared commitment to excellence and empathy in nursing care (King et al., 2021). Nursing is known for its caring attributes.

Within the nursing profession where teamwork and collaboration are crucial, instances of bullying can erode trust and camaraderie among colleagues. Nurses, who are tasked with providing comfort and support to patients during their most vulnerable moments, may ironically find themselves on the receiving end of incivility from their own peers. This creates discord between the nurturing image of nursing and the harsh realities faced by those within the profession. Sara (pseudonym), an APNE, expressed her efforts to create inclusive educational sessions aimed at fostering positive relationships. She elaborated on the historical challenges within nurse-to-nurse relationships that have spanned centuries. She stated, “Nurses are known to eat their young but they also eat their RPNs. It is only going to make it difficult for us to work as nurses when we do not respect other members of the team, including RPNs.” Alexis (Pseudonym), a NM on SAC units further emphasized that we have unrealistic expectations when we do not provide the right resources but expect positive outcomes. She verbalized the following: “There are relationship barriers and nurses are also offended and hurt, so how do we help them overcome their views when we ask them to collaborate, be trustful and be friendly?” Ongoing tension and stress for employees can result from conflicts with colleagues, supervisors, or a hostile work environment. In healthcare settings, displaying uncivil behavior can hinder effective cooperation, diminish employee satisfaction, and jeopardize patient safety. Naomi (pseudonym), an APNE, stressed the importance of standardizing expectations for RNs and RPNs to foster collaborative practice. She emphasized:

> A collaborative framework should be a part of on-boarding and annual e-learnings. We have to remember that whatever affects the relationship between nurses also affects patients. We have to think about how the end users are affected by our collaborative or non-collaborative relationship.

She further emphasized that the key to successful behavioral change lies in consistency, stating:

> Also evaluation and re-evaluation of the process is important as not because we implement something means that we are done. We may need to use a staggered approach where one unit starts first and then learn from the mistakes of that unit experience.

Abigail, an experienced RN with over a decade of service, believes that trust forms the foundation for promoting respectful and civil behavior. She emphasized that her foremost duty at work is to guarantee the safety of her patients. Abigail underscores the importance of being able to trust her colleagues to provide vigilant care for her patients in her absence. She explained:

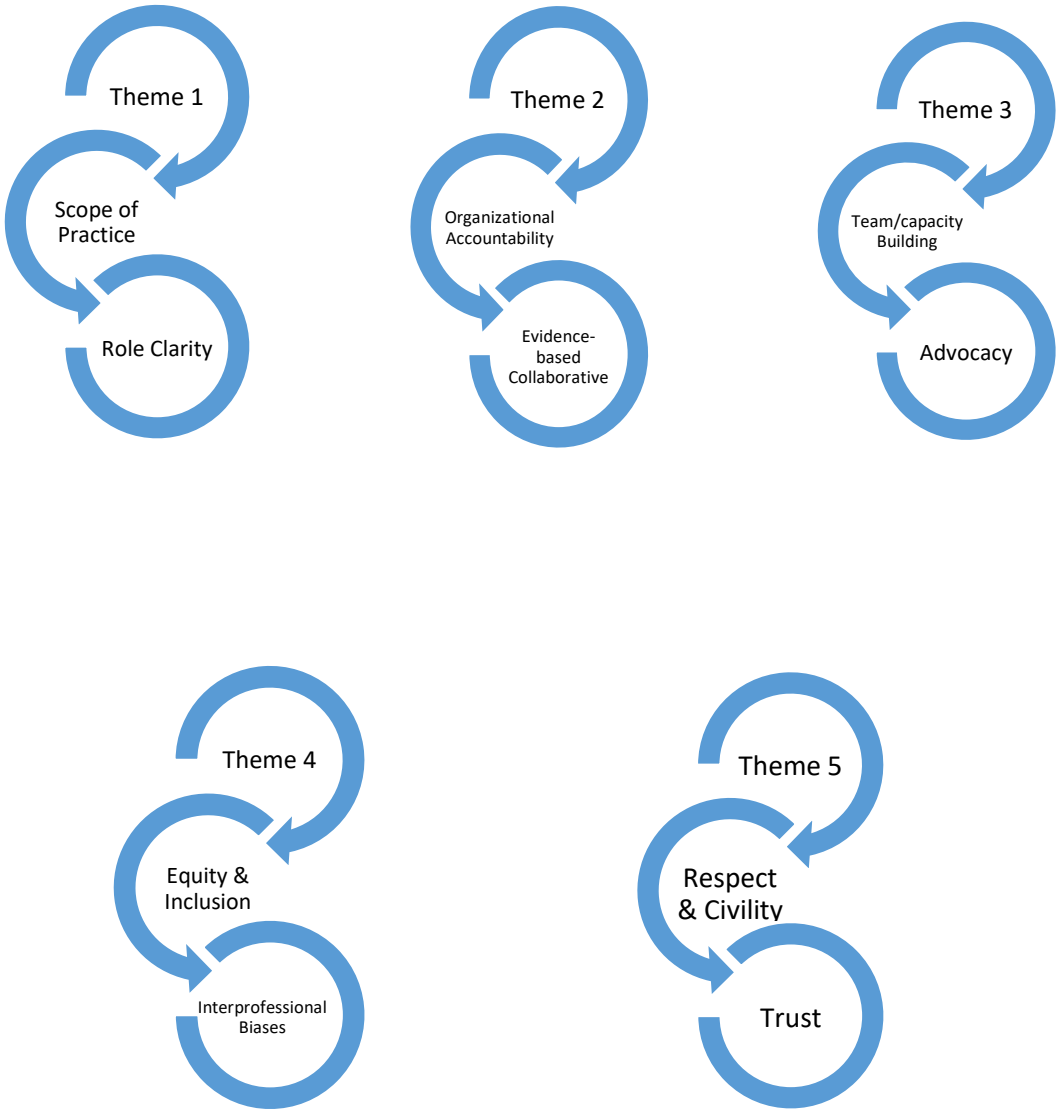
> In nursing trust is a big factor, for example, when we go on breaks, we want to trust that our colleagues are keeping our patient safe. We trust that in a code blue situation that each member of the team knows his or her roles. When trust is broken, does it affect patient care?

The focus group discussion allowed participants to share ideas on how respectful and adaptable reactions to each other in the clinical settings is important to building a collaborative workforce. It requires participating in constructive conversations, campaigning for organizational improvements, demonstrating moral fortitude, collaboratively shaping cultural standards, and enabling both internal and external stakeholders to influence systemic change (Geiderman et al., 2022). Figure 2 shows a graphical presentation of Cycle 2 Themes and Categories.

Figure 2

Cycle 2 Findings Visual Graphics

Focus Group Discussion Potential Strategies to Strengthen Collaborative Practice on SAC Units



Helpful Resources

In enhancing collaborative practice between RNs and RPNs, accessing helpful resources is paramount. These resources not only offer valuable guidance but also serve as catalysts for fostering effective teamwork and communication within healthcare settings. From training programs to educational materials and professional networks, a myriad of resources should exist to support RNs and RPNs to build and sustain collaborative practice initiatives. The focus group discussions facilitate participants in exchanging beneficial resources they deem valuable for enhancing collaborative practice. NHU can review these suggestions as potential strategies to consider and determine the most effective

approach for integration into organizational culture. When assessing education and competency, Adam (pseudonym), an RPN currently pursuing his RN degree, shared:

> We could improve competency by having educational resource binders that are accessible to help define roles and scope of practice so that nurses, charge nurses and NM could use as reference. Orientation should be seen as a form of clinical practice where a passport/checklist should be developed so that new hires can show what skills have been accomplished during the orientation period. This would allow RNs and RPNs to be aware of each other's level of competency and have realistic expectations.

To practice positive affirmation at work, Adam continued to share:

> Having posters that trigger positivity for example, a quote saying, we are all colleagues' or we are here for each other. We should talk about empathy in reflective practice and understand perspectives.

Minimizing conflicts within nursing practice is crucial for promoting collaborative practice between RNs and RPNs. Participants contributed their ideas on strategies they believe can assist in attaining this objective:

> It is important to bring the right people around the table who will be able to have the right interpretations and applications that will help us to move forward.
>
> Abigail RN: Provide time within scheduled shifts for RNs and RPNs to engage in interactions, communication and discussions. (Ashley, RPN).

Sue, an RN-researcher observed:

> Engage RNs and RPNs in activities that encourage them to get to know each other starting first with who they are as a person, just as how we train them to understand the person behind the illness, so we should get them to understand the nurse behind the profession. This will help to eliminate how they view titles over respecting each other as professionals.

Establishing a sustainable relationship between RNs and RPNs in clinical practice is essential for fostering a collaborative and effective healthcare team. Participants relay thoughts they found to be helpful solutions such as:

> Start by utilizing research that is done on relationship development to strengthen collaboration between RNs and RPNs. Use success stories from other units who have done well, even in Long-Term Care (LTC) where the nursing skilled-mix initiative started. We should ask "how did they figure it out?" Look at how well collaborative practice has worked in other parts of the world, even though scope of practice may differ. Look at relational practice and inquiry to understand what is happening within nursing practice. (Sue, RN-researcher).

Frances, a NM, noted: "We have to start to enact changes through this study by listening to peoples lived experience and then implement ways to continue to leverage those stories?" Sue, an RN-researcher, stated:

> We could use art-based inquiry, as there are many things that can be said through art. What are things that people are not telling us that they are feeling that they could express through art? The question I have is can we replicate this study on all units that have the skill mix nursing? What does this look like in other hospitals such as urban versus rural hospitals? It would have been helpful for RNs and RPNs to hear success stories of how nurses adapted to the skill mix.

Naomi, an APNE, reflected the following:

> Being inclusive with how the changes are brought to frontline nurses and staff in general. Most nurses felt that they were taken off guard by the change, as they were not included in the decisions when introducing the nursing skilled mix initiative. Town halls, workshops, in-services where staff are given an opportunity to ask questions are ways to be inclusive and would provide the psychological support RNs and RPNs needed to adjust to the change.

Through reflection, clinicians can learn from both successes and challenges encountered in clinical practice. They explore the reasons behind their actions, consider alternative approaches, and identify areas for improvement. Participants were able to spend time in the focus group discussions to reflect on what other approaches could be taken in making the launch of the nursing skilled-mix initiative successful in ways where RNs and RPNs work effectively as a team. These are some thoughts shared during this discussion as strategies: “Evaluating the process as not because we implement something means that we are done” (Alexis, NM) and Sue (RN-researcher) (below):

> Research, engaging in reflective practice by asking who I am as a nurse, and looking within oneself-first is where we should start. Furthermore, asking questions such as what does collaboration means to me, why do I value collaboration, why is it important, what am I seeking for and what can I offer? These questions should be asked to/by both RNs and RPNs to help them look within themselves and develop strategies. (Sue, RN).

Prioritizing job satisfaction and career fulfillment is crucial, especially in light of the urgent necessity to retain our nursing staff, however, addressing areas such as communication obstacles and ethical dilemmas are significant issues, which mirrors the frustrations expressed by nurses. Cultivating relationships and recognizing the value of individuals, their professions, and expertise are essential for enhancing collaborative practice.

Conclusion

The culmination of Cycle 2 highlights the significance of focus group discussions involving frontline RNs, RPNs, and nursing leadership staff. These sessions provided a platform for participants to delve into the anonymous data from Cycle 1, gaining insights into the lived experiences and perspectives of RNs and RPNs regarding collaborative practice. Moreover, these discussions offered an opportunity for further analysis of the data and the formulation of helpful resources aimed at fostering sustainable activities to enhance collaboration between RNs and RPNs working on SAC units.

Summary

The objective of this action research is to pinpoint and comprehend obstacles hindering collaborative practice, while establishing strategies to strengthen teamwork and collaboration between RNs and RPNs on SAC units. Cycle 1 data collection uncovered issues such as a lack of clarity regarding scope of practice, competency, role confusion, frustration, humiliation, inferiority, and job dissatisfaction, all impacting nurse retention at NHU. Collaborating with stakeholders and drawing from collected data and literature, it was determined that hosting focus group discussions could illuminate strategies to fortify collaborative practice between RNs and RPNs.

The assessment of Cycle 2 confirmed that participants in both cycles shared similar experiences, underscoring the urgency to address these barriers. Data indicated five key areas for enhancement: clarifying scope of practice, promoting organizational accountability, enhancing capacity through team-building events, fostering equity and inclusion, and promoting respect and civility. Participants at NHU proposed actionable ideas to bolster collaborative practice between RNs and RPNs on units where the nursing skilled-mix model exists.

Section Three: Literature Review

The purpose of this literature review was to understand challenges to collaborative practice that RNs and RPNs experience on SAC units and develop strategies that can be used to strengthen teamwork between these groups of nurses. To gain deeper insights into the significance of this study and to assist organizational leadership in devising strategies, this section offers a comprehensive literature review that delves into the experiences of RNs and RPNs as they engaged in collaborative practice. This section initially examined the importance of delineating scope of practice to guarantee competency and clarity of roles. Subsequently, it delved into the significance of enhancing team capacity within an equitable framework to cultivate a trusting environment. Lastly, it discusses how stability in collaborative practice necessitates the implementation of evidence-based frameworks and organizational accountability within nursing practices.

Scope of Practice

Scope of practice delineates and details the patient care tasks that nurses are authorized to execute. Despite variances between the scope of practice for RNs and RPNs, there exist areas of similarities in the nursing activities undertaken by both groups (Moore et al., 2017; Rizany et al., 2018). Understanding scope of practice within the healthcare field is paramount for ensuring safe and effective patient care. Scope of practice delineates the boundaries and responsibilities of healthcare professionals based on their education, training, and licensure. It defines what tasks and procedures each professional is authorized to perform, as well as under what circumstances they may need to collaborate or refer to other members of the healthcare team. For instance, when a patient's condition becomes unstable, it is common practice for RPNs to transfer care to either RNs or physicians (North and South Dakota State Board of Nursing, 2021). These delineations not only protect patients but also empower healthcare providers to work collaboratively within their areas of expertise. Understanding and adhering to the

scope of practice guidelines set forth by regulatory bodies is essential for maintaining the highest standards of patient care and professionalism in healthcare settings.

Ineffective nursing care can stem from various factors, including a lack of understanding regarding scope of practice for RNs and RPNs and their interconnectedness. Research indicates that RPNs may not always fully utilize their capabilities and may avoid certain activities within their scope of practice, and instead, defer them to RNs (Endacott et al., 2018). This practice can hinder the achievement of optimal collaborative practices between these nursing groups, impacting patient care outcomes (Jeffs et al., 2020). Enhanced understanding and acknowledgment of each other's scope of practice among RNs and RPNs could serve as a catalyst for optimizing the utilization of RPNs, especially on SAC units. According to Walker et al. (2013), when healthcare professionals have a clear comprehension of the roles and capabilities of their colleagues, they can allocate tasks more effectively, leading to improved efficiency in healthcare delivery. Scope of practice for RNs and RPNs is significant to identify levels of competency and clarity to how safe nursing care is administered (Pijnacker, 2018). In essence, fostering enhanced understanding and acknowledgment of each other's scope of practice empower healthcare teams to leverage the full potential of RPNs in SAC units. This collaborative approach not only optimizes workflow and resource utilization but also contributes to the delivery of high quality, patient-centered care, ultimately improving patient outcomes in healthcare settings.

Competency

Nursing competency serves as the cornerstone of quality patient care, encompassing the knowledge, skills, judgement, and abilities required for safe and effective practice in the healthcare profession. A competent nurse is not only proficient in clinical skills but also demonstrates critical thinking, communication, and teamwork abilities essential for navigating the complexities of modern healthcare environments. As emphasized by Dr. Patricia Benner's seminal work on novice to expert theory, competency in nursing is a dynamic and evolving process that evolves over time through

education, experience, and reflection (Benner, 1984). Furthermore, nursing competency is intricately linked to patients' outcomes, with research consistently demonstrating the impact of competent nursing care on improving clinical outcomes, enhancing patient satisfaction, and reducing adverse events (Kramer et al., 2013; Cho et al., 2019). Thus, understanding and fostering nursing competency are essential imperatives for ensuring the delivery of safe, efficient, and patient-centered care in healthcare settings.

Over recent years, there has been a notable expansion in the scope of practice for RPNs, granting them certification to undertake a broader range of advanced patient care tasks (CNO, 2021). This evolution reflects both the evolving healthcare landscape and the growing recognition of RPNs' capabilities in meeting the complex needs of patients. However, this expanded scope has also led to a blurring of lines between the responsibilities of RNs and RPNs, creating confusion regarding task differentiation. As a result, nurses from both categories often find themselves uncertain about which tasks overlap and who holds the primary responsibility, particularly in settings with high patient acuity and an aging population. The confluence of these factors have led to instances where RPNs may find themselves providing care that stretches beyond the boundaries of their designated scope of practice (Lankshear et al., 2016). This phenomenon can occur due to various reasons, including staffing shortages, time constraints, or a lack of clarity regarding professional roles and responsibilities. In environments characterized by increased patient acuity and complex care needs, RPNs may feel compelled to step into roles traditionally reserved for RNs to ensure timely and comprehensive care delivery. However, the ramifications of RPNs administering care outside their scope of practice are multifaceted. While it may address immediate care needs, it also raises concerns about patient safety, legal implications, and professional accountability. The changing healthcare environment requires clearly defining the roles and duties of both RNs and RPNs to improve patient outcomes and reduce possible risks. Addressing these challenges requires a multi-layered approach encompassing education,

policy development, and interprofessional collaboration. Clarifying the scope of practice for RPNs through comprehensive guidelines and continuing education programs can enhance nurses' understanding of their roles and responsibilities. Additionally, fostering effective communication and collaboration between RNs and RPNs is essential for promoting cohesive teamwork and ensuring that care delivery aligns with professional standards and regulatory requirements.

NMs face significant challenges stemming from unclear job descriptions and the evolving scope of practice for RPNs. Research conducted by Lankshear et al. (2016) underscores this issue, revealing that 37% of nursing leaders agree that RPNs can undertake tasks identical to those performed by RNs. This statistic highlights a pervasive lack of understanding regarding the delineation of roles within the nursing team and the CNO scope of practice. The implications of such confusion are profound and multifaceted. NMs must navigate the complexities of assigning responsibilities and delegating tasks effectively while ensuring compliance with regulatory guidelines and professional standards. Unclear job descriptions and misconceptions about the capabilities of RPNs can lead to role ambiguity and potential conflicts within the nursing team (Cho et al., 2019).). Moreover, they may inadvertently contribute to suboptimal patient care outcomes and compromise patient safety. Addressing these challenges require proactive measures aimed at promoting clarity, transparency, and collaboration within the nursing workforce. NMs play a pivotal role in fostering a supportive work environment where all team members understand their roles, responsibilities, and limitations. This entails providing clear guidance on job expectations, facilitating ongoing education and training initiatives, and promoting open communication channels to address any concerns or misunderstandings (Lu et al., 2019). Furthermore, enhancing nurse NMs' awareness of the evolving scope of practice for RPNs is essential for promoting effective workforce planning and resource allocation. By equipping NMs with the knowledge and tools necessary to make informed decisions,

healthcare organizations can optimize staffing levels, improve workflow efficiency, and ultimately enhance the quality of patient care delivery.

Importance of Role Clarity

Role clarity and role ambiguity/confusion are critical concepts that profoundly impact the effectiveness and efficiency of nursing practice. Role clarity refers to the degree to which both RNs and RPNs possess a clear understanding of their respective tasks, responsibilities, and processes within the workplace. This comprehension extends beyond one's own roles to encompass an understanding of the roles of their colleagues as well (Pijnacker, 2019). On the other hand, role ambiguity or confusion describes the lack of clarity, certainty, and predictability that RNs and RPNs experience in performing their jobs due to ambiguous job descriptions and practice guidelines (Pijnacker, 2019). This uncertainty can arise from various factors, including changes in scope of practice, evolving healthcare policies, and inadequate communication channels within the healthcare team. The consequences of role ambiguity can be far-reaching, impacting both individual nurses and the overall quality of patient care. When nurses are unsure of their roles or responsibilities, it can lead to decreased job satisfaction, increased stress levels, and reduced confidence in decision-making. Moreover, role ambiguity can hinder effective teamwork and collaboration, as nurses may hesitate to delegate tasks or seek assistance from colleagues due to uncertainty about each other's capabilities (Lu et al., 2019). Addressing role ambiguity requires proactive measures aimed at promoting clarity, transparency, and communication within the nursing workforce. Clear job descriptions, well-defined scope of practice guidelines, and ongoing education and training initiatives are essential for ensuring that nurses understand their roles and responsibilities. Additionally, fostering open communication channels and encouraging collaboration among healthcare team members can help clarify expectations and reduce ambiguity in nursing practice.

Over the past decade, there has been a growing emphasis on delineating the roles of RNs and RPNs within the nursing workforce, particularly in response to challenges such as nursing shortages, quality of patient care outcomes, and job dissatisfaction (Kushemererwa et al., 2020). This increased focus highlights the importance of improving the nursing skill mix by strategically assigning RNs and RPNs according to their specific skills and abilities to improve healthcare delivery overall. In Canada, where nursing shortages and evolving healthcare needs are prominent, understanding and examining the distinctions between RNs and RPNs have become imperative for nursing leadership. As highlighted by Martin and Weeres (2016), healthcare organizations are increasingly recognizing the need to redesign care delivery models to ensure the provision of high-quality patient care. This involves not only clarifying the roles and responsibilities of RNs and RPNs but also leveraging their respective strengths to maximize the efficiency and effectiveness of healthcare delivery.

When nurses possess clear and precise information regarding their tasks, functions, and responsibilities, as well as understanding the expected duties to deliver nursing care, they tend to evaluate their work more positively and experience greater satisfaction in their workplace (Orgambídez & Almeida, 2020). This clarity and understanding contribute to a sense of confidence and empowerment among nurses, enabling them to perform their roles more effectively and efficiently. Furthermore, research suggests that role clarity is closely associated with job satisfaction and overall organizational commitment among nurses (Gardner et al., 2016). Nurses who have a clear understanding of their roles are more likely to experience greater job satisfaction, as they can confidently fulfill their responsibilities and contribute to positive patient outcomes. Moreover, when nurses feel valued and supported in their roles, they are more likely to be engaged and committed to their organization's mission and goals. Conversely, a lack of role clarity can lead to feelings of uncertainty, frustration, and dissatisfaction among nurses (Orgambídez & Almeida, 2020). When nurses are unsure about their responsibilities or the expectations placed upon them, it can result in stress, burnout, and decreased job satisfaction.

Moreover, role ambiguity can lead to inefficiencies in workflow, miscommunication, and conflicts within the nursing team, ultimately impacting the quality of patient care delivery.

In conclusion, as the scope of practice for RPNs continues to expand, it is imperative to address the challenges arising from task differentiation and ensure that nurses practice within their designated scope. By fostering clarity, promoting collaboration, and providing ongoing support and education, healthcare organizations can empower RNs and RPNs to deliver safe, effective, and patient-centered care in today's complex healthcare landscape. The challenges posed by unclear job descriptions and changes in the scope of practice for RPNs underscore the need for proactive measures to promote role clarity and mitigate role confusion within nursing teams. By fostering a culture of clarity, collaboration, and continuous learning, NMs can empower their teams to deliver safe, effective, and patient-centered care in today's dynamic healthcare environment.

Building Capacity

Capacity building among nurses is an essential endeavor that underpins the delivery of high-quality healthcare services and the attainment of positive patient outcomes. Capacity building refers to the process of enhancing the knowledge, skills, competencies, and resources available to nurses to effectively address the evolving challenges and demands within the healthcare system. By investing in continuous professional development, training programs, and supportive learning environments, healthcare organizations can empower nurses to adapt to changes in clinical practice, embrace innovation, and provide evidence-based care (World Health Organization [WHO], 2021). Moreover, capacity building fosters a culture of lifelong learning and professional growth among nurses, enabling them to stay abreast of emerging healthcare trends, technologies, and best practices (Sherman & Bishop, 2020). This proactive approach not only strengthens individual nurse capabilities but also enhances the resilience and adaptability of the nursing workforce as a whole, ultimately contributing to improved patient outcomes and the advancement of healthcare delivery (Reeves et al., 2017).

Team building among nurses is a vital component of fostering effective collaboration, communication, and cohesion within healthcare settings. As frontline caregivers, nurses rely on strong teamwork to deliver safe, efficient, and patient-centered care. By investing in team building initiatives, healthcare organizations can cultivate a supportive work environment where nurses feel valued, respected, and empowered to work together towards common goals. Research suggests that effective team building among nurses leads to improved patient outcomes, enhanced job satisfaction, and reduced burnout rates (Cimiotti et al., 2012). When nurses feel supported by their colleagues and have strong relationships built on trust and mutual respect, they are better equipped to navigate the complexities of patient care and overcome challenges collaboratively. Team building initiatives can take various forms, including interdisciplinary training sessions, communication workshops, and team-building exercises. These activities provide opportunities for nurses to enhance their communication skills, develop a shared understanding of roles and responsibilities, and foster a sense of camaraderie and belonging within the team (Kozlowski & Ilgen, 2006). Moreover, team building fosters a culture of collaboration and continuous improvement, where nurses feel comfortable sharing ideas, seeking feedback, and working together to identify solutions to common challenges (Sherman & Bishop, 2020). By promoting open communication and constructive dialogue, team-building initiatives help break down silos and promote a more cohesive and united nursing workforce.

The absence of team building or capacity building initiatives among RNs and RPNs can have significant negative consequences on both the nursing workforce and patient care outcomes. Without effective collaboration and ongoing professional development, nurses may experience various challenges that hinder their ability to deliver high-quality care. Some challenges are reduced communication and collaboration. Without team building efforts, communication breakdowns and siloed working environments may occur, leading to fragmented care delivery. RNs and RPNs may struggle to effectively coordinate patient care, share critical information, or collaborate on treatment

plans, resulting in inefficiencies and potentially compromising patient safety (Sherman & Bishop, 2020). Another negative feedback is how it can affect role ambiguity leading to conflict between RNs and RPNs. In the absence of clear guidelines and understanding, tensions may arise over task delegation, decision-making authority, and scope of practice, undermining teamwork and morale within the nursing team (Kushemererwa et al., 2020). Furthermore, lack of team building among RNs and RPNs can lead to decreased job satisfaction and burnout. The lack of skill development, professional growth, and recognition can leave nurses feeling undervalued and disengaged, leading to decreased motivation and increased turnover rates (Cimiotti et al., 2012). Ultimately, the negative effects of insufficient team building and capacity building initiatives can impact patient care outcomes. When nurses are not adequately supported or empowered to perform their roles effectively, there is a higher risk of medical errors, adverse events, and suboptimal patient outcomes (WHO, 2021).

Trust in Teams

Trust within nursing teams plays a crucial role in building capacity and fostering effective teamwork. When nurses trust one another, they feel confident in their colleagues' abilities, judgment, and intentions, which promotes collaboration, communication, and mutual support (Kramer et al., 2013). This trust creates a positive work environment where nurses are empowered to share knowledge, seek assistance, and work together towards common goals, ultimately enhancing the capacity of the nursing team to deliver high-quality care (Wong et al., 2013). Research has shown that trust among nursing team members is associated with improved job satisfaction, decreased burnout rates, and enhanced patient outcomes (Kramer et al., 2013). When nurses trust their colleagues, they experience greater psychological safety and job engagement, leading to increased morale and overall well-being. Moreover, trust facilitates effective communication and information sharing, enabling nurses to collaborate more seamlessly and make informed decisions regarding patient care. Furthermore, building trust within nursing teams requires ongoing effort and investment in relationship-building

initiatives that should be consistent. Team-building exercises, interdisciplinary training sessions, and regular meetings provide opportunities for nurses to develop rapport, establish common goals, and build mutual respect (Sherman & Bishop, 2020). Moreover, leaders are important in building trust by demonstrating transparency, integrity, and accountability when interacting with team members (Cummings, 2018). Furthermore, trust is closely linked to psychological empowerment, which refers to the belief that one has the autonomy, competence, and impact to influence one's work environment (Laschinger et al., 2014a). When nurses feel empowered, they are more likely to take initiative, innovate, and contribute to the continuous improvement of patient care. Trusting relationships within the nursing team facilitate psychological empowerment by creating a supportive climate where nurses feel valued, respected, and empowered to make meaningful contributions (Tsai, 2019).

When trust is broken among RNs and RPNs, it can have profound negative effects on team building and capacity within nursing units. Trust is the foundation of effective teamwork, communication, and collaboration in healthcare settings, and its absence can lead to a breakdown in relationships and diminish the overall effectiveness of the nursing team (Laschinger et al., 2014b). Lack of trust among nurses accounts for impaired communication. When nurses mistrust their colleagues, they may hesitate to share information, seek assistance, or engage in open dialogue, leading to misunderstandings and miscommunication (Lee & Kim, 2015). This lack of communication can hinder the flow of critical information, compromise patient safety, and impede the team's ability to coordinate care effectively (Kramer et al., 2013). Trust is also essential for fostering collaboration and teamwork among nurses. When trust is broken, nurses may be reluctant to work together, share responsibilities, or support one another, leading to a fragmented and disjointed approach to patient care. This lack of collaboration can result in inefficiencies, missed opportunities for innovation, and ultimately, suboptimal patient outcomes (Sherman & Bishop, 2020). Trust is vital for creating a supportive environment where nurses feel comfortable expressing ideas, sharing concerns, and engaging in problem-solving activities.

When nurses feel unsupported or undervalued by their colleagues, they may experience feelings of frustration, isolation, and emotional exhaustion. This can lead to decreased job satisfaction, diminished morale, and ultimately, higher turnover rates within the nursing workforce (Kramer et al., 2013).

Equity in Practice

Equity between RNs and RPNs in nursing practice is crucial for fostering a fair and inclusive healthcare environment where all members of the nursing team can contribute effectively to patient care. Achieving equity requires recognizing and addressing disparities in opportunities, resources, and recognition between RNs and RPNs (Cho et al., 2019). Equity in nursing practice entails ensuring that both RNs and RPNs have access to equitable education and training opportunities to develop their skills and advance their careers. This includes providing support for RPNs to pursue further education and training programs, such as bridging programs or continuing education courses, to enhance their knowledge and competencies (Connelly et al., 2023). Equity also involves ensuring that both RNs and RPNs are able to practice to the full extent of their scope of practice, as defined by regulatory bodies and professional standards. This requires clear delineation of roles and responsibilities, as well as opportunities for collaboration and interdisciplinary teamwork to leverage the strengths of each role (CNO, 2019). Equity in practice also necessitates recognizing and valuing the contributions of both RNs and RPNs within the healthcare system. This includes acknowledging the unique skills, expertise, and experiences that each role brings to the nursing team, as well as providing opportunities for professional growth, leadership development, and career advancement for both groups (Martin & Weeres, 2016). Equity also entails ensuring that both RNs and RPNs have access to the support, resources, and opportunities needed to thrive in their roles. This may include access to mentorship programs, professional development opportunities, and support networks to enhance job satisfaction, retention, and overall well-being (Kushemererwa et al., 2020).

When equity is absent among RNs and RPNs in nursing practice, it can lead to various negative consequences for both the nursing workforce and patient care outcomes. The absence of equity may result in disparities in opportunities for professional development, career advancement, and access to resources between RNs and RPNs (Laschinger et al., 2014a). This can create feelings of inequality, frustration, and demotivation among nursing staff, leading to decreased job satisfaction and morale (Kushemererwa et al., 2020). Without equity, there may be ambiguity and conflict regarding roles and responsibilities within the nursing team. RNs and RPNs may feel uncertain about their scope of practice, leading to misunderstandings, tension, and conflict over task delegation, decision-making authority, and professional boundaries (CNO, 2019). The absence of equity can erode trust and collaboration among nursing team members. When RNs and RPNs perceive inequities in treatment or opportunities, it can lead to feelings of resentment, mistrust, and disengagement, hindering effective communication, teamwork, and collaboration essential for delivering quality patient care (Sherman & Bishop, 2020). Ultimately, the lack of equity among RNs and RPNs can negatively impact patient care quality and outcomes. Disparities in opportunities and resources may result in suboptimal staffing levels, inadequate training, and decreased job satisfaction among nursing staff, compromising the overall quality and safety of patient care delivery (Connelly et al., 2023). Addressing the absence of equity among RNs and RPNs requires proactive efforts from healthcare organizations, regulatory bodies, and nursing leaders. By promoting clear roles and responsibilities, providing equitable access to education and training, and fostering a culture of respect, recognition, and inclusivity, healthcare organizations can create a supportive work environment where all nursing staff feel valued, empowered, and able to contribute effectively to patient care (Rodwell et al., 2013).

In conclusion, team building among nurses is essential for promoting effective collaboration, communication, and cohesion within healthcare settings. By investing in team building initiatives, healthcare organizations can create a supportive work environment where nurses thrive, ultimately

leading to improved patient outcomes and a more resilient nursing workforce. The absence of team building and capacity building initiatives among RNs and RPNs can have detrimental effects on both the nursing workforce and patient care. Healthcare organizations must prioritize investment in these initiatives to promote effective collaboration, professional development, and ultimately, the delivery of safe and high-quality patient care. When team building is eroded, it results in broken trust among RNs and RPNs that is detrimental to team building and capacity within nursing units. Furthermore, achieving equity between RNs and RPNs in nursing practice requires addressing disparities in opportunities, resources, and recognition to create a fair and inclusive healthcare environment. By promoting clear roles and responsibilities, providing equitable access to education and training, and recognizing the unique contributions of each role, healthcare organizations can support the professional growth and development of both RNs and RPNs, ultimately leading to improved patient outcomes and a more resilient nursing workforce.

Fostering a Collaborative Environment

Fostering a collaborative environment in nursing is essential for optimizing patient care delivery, promoting professional growth, and enhancing overall job satisfaction among healthcare providers. Collaboration among nurses involves working together as a cohesive team, leveraging each other's strengths, expertise, and perspectives to achieve common goals and deliver high-quality care to patients. This collaborative approach not only enhances patient outcomes but also creates a supportive and inclusive work culture where nurses feel valued, respected, and empowered to contribute to the advancement of healthcare practices. Research underscores the significance of collaborative practices in nursing, highlighting their positive impact on patient safety, satisfaction, and overall healthcare quality (D'Amour et al., 2012; Tsai, 2019). Establishing a collaborative environment requires fostering open communication, mutual respect, and trust among nursing team members (Sherman & Bishop, 2020; Lee & Kim, 2015). This involves creating opportunities for interdisciplinary teamwork, encouraging

knowledge sharing, and promoting a culture of continuous learning and improvement. By embracing collaboration, nurses can leverage their collective expertise to address complex patient needs, innovate care delivery models, and navigate healthcare challenges more effectively, ultimately leading to improved patient outcomes and a more resilient nursing workforce (Zhang et al., 2019).

To cultivate a collaborative environment, healthcare organizations must prioritize strategies that facilitate open communication, mutual respect, and interdisciplinary teamwork among nursing staff (Sherman & Bishop, 2020). This includes establishing clear channels for communication, such as regular team meetings, huddles, and interdisciplinary rounds, where nurses can share information, discuss patient care plans, and address concerns collaboratively (Choi & Kuruzovich, 2019; Maxson et al., 2011). Moreover, fostering a culture of collaboration requires promoting a shared vision and sense of purpose among nursing team members (Häyrinen et al., 2019). Nurses should be encouraged to work towards common goals, aligned with the organization's mission and values, to enhance teamwork and cohesion. Leadership plays a pivotal role in fostering collaboration by providing support, recognition, and opportunities for professional growth and development among nursing staff (Laschinger et al., 2014a). By fostering a collaborative environment in nursing, healthcare organizations can enhance patient care delivery, promote job satisfaction, and foster a culture of continuous learning and improvement among nursing staff. Embracing collaborative practices not only benefits patients but also contributes to the overall resilience and effectiveness of the nursing workforce.

When a collaborative environment is absent between RNs and RPNs, it can lead to various challenges that impact patient care and the overall effectiveness of the nursing team. Without effective collaboration, the potential for miscommunication, inefficiencies, and gaps in care delivery increases, which can negatively affect patient outcomes (Kramer et al., 2013). The absence of a collaborative environment can result in communication breakdowns between RNs and RPNs. Without effective channels for communication, vital information may not be adequately conveyed or shared, leading to

misunderstandings, errors, and delays in patient care. This can compromise the continuity and quality of care delivery (Sherman & Bishop, 2020). The absence of collaboration can exacerbate role ambiguity and conflict between RNs and RPNs. Without clear delineation of roles and responsibilities, misunderstandings and tensions may arise over task delegation, decision-making authority, and professional boundaries. This can create a strained work environment, hinder teamwork, and impede the delivery of coordinated care (Kushemererwa et al., 2020). Ineffective collaboration may result in suboptimal resource utilization within the nursing team. Skills and expertise may be underutilized or overlooked, leading to inefficiencies in workflow and missed opportunities for leveraging the strengths of each role. Suboptimal resource utilization can compromise productivity, effectiveness, and overall outcomes within the healthcare setting (Martin & Weeres, 2016).

Strengthening collaboration and integration between RNs and RPNs is essential for optimizing patient care outcomes and promoting a cohesive healthcare team. Several strategies can be implemented to enhance collaboration and integration between these two nursing roles, drawing on their respective strengths and expertise. Clearly defining the roles and scope of practice for both RNs and RPNs is fundamental to fostering collaboration. This includes delineating specific responsibilities, tasks, and competencies for each role, as well as identifying areas of overlap and opportunities for collaboration (CNO, 2019). Establishing clear role boundaries can help mitigate role ambiguity and conflicts, allowing nurses to work together more effectively as a cohesive team. Implementing team-based care models that leverage the strengths of both RNs and RPNs can enhance collaboration and integration within nursing teams. This may involve adopting collaborative care planning processes, interdisciplinary rounds, and case conferences where nurses collaborate with other healthcare professionals to develop comprehensive care plans and coordinate services (Sherman & Bishop, 2020). Team-based approaches facilitate information sharing, continuity of care, and shared accountability for patient outcomes. Creating a supportive work environment that values and respects the contributions of

both RNs and RPNs is crucial for fostering collaboration and integration. This includes promoting a culture of mutual trust, open communication, and professional autonomy, where nurses feel empowered to collaborate, innovate, and advocate for their patients (Laschinger et al., 2014a). Recognizing and celebrating the unique strengths and expertise of each role can foster a sense of belonging and collective purpose within the nursing team.

Evidence-based Collaborative Framework

A collaborative framework in nursing practice is a structured approach that emphasizes teamwork, communication, and coordination among healthcare professionals to deliver comprehensive and patient-centered care. This framework recognizes the value of interdisciplinary collaboration, where nurses work alongside physicians, therapists, pharmacists, and other healthcare providers to address the complex needs of patients (Reeves et al., 2017). An evidence-based collaborative framework for RNs and RPNs is important in modern healthcare settings. Such a framework not only enhances patient care outcomes but also fosters a supportive and cohesive work environment among healthcare professionals. Collaborative frameworks based on evidence-based practices ensure that patients receive comprehensive and coordinated care from both RNs and RPNs. This collaboration allows for a holistic approach to patient care, addressing both medical and non-medical needs effectively. Research has shown that interdisciplinary collaboration among healthcare professionals leads to improved patient outcomes, including reduced hospital readmissions, lower mortality rates, and increased patient satisfaction (Mitchell et al., 2018; Reeves et al., 2017).

An evidence-based collaborative framework encourages the integration of the latest research findings and best practices into clinical decision-making processes. By working together, RNs and RPNs can critically appraise evidence, adapt guidelines to suit specific patient populations, and ensure the delivery of high-quality, patient-centered care (Stetler et al., 2018). Furthermore, collaborative practice allows for the dissemination of evidence-based knowledge throughout the healthcare team, promoting

a culture of continuous quality improvement and innovation (Mitchell et al., 2018). By leveraging the expertise and skills of both RNs and RPNs within a collaborative framework, healthcare organizations can optimize resource utilization. This includes better deployment of staff according to their competencies, reducing unnecessary workload burdens, and improving overall efficiency in healthcare delivery (Aiken et al., 2014). Research indicates that participation in collaborative care models fosters a culture of learning and innovation among healthcare professionals, leading to improved job satisfaction and retention rates (O'Keeffe et al., 2019).

A collaborative framework specific to RNs and RPNs nursing care is crucial to delineate the distinct roles and scopes of practice while emphasizing the importance of collaboration and teamwork. By understanding their respective scopes of practice, RNs and RPNs can collaborate effectively, delegate tasks appropriately, and leverage each other's strengths to meet patient care needs (CNO, 2019). Interprofessional education and training initiatives play a vital role in fostering collaboration between RNs and RPNs. Joint educational programs, workshops, and simulations provide opportunities for nurses to learn together, develop mutual respect, and enhance communication skills (Reeves et al., 2017). These initiatives promote a shared understanding of roles and responsibilities, facilitating seamless collaboration in clinical practice. Implementing team-based care models that leverage the expertise of both RNs and RPNs is essential for optimizing patient care outcomes. Collaborative care planning, interdisciplinary rounds, and case conferences enable RNs and RPNs to work together to develop comprehensive care plans and coordinate services (Sherman & Bishop, 2020). By embracing a team-based approach, nurses can ensure continuity of care and address the diverse needs of patients effectively. Effective communication and shared decision-making are critical components of the collaborative framework for RNs and RPNs. Nurses must engage in open dialogue, exchange information, and collaborate on care decisions to provide patient-centered care (Laschinger et al., 2014b). Utilizing standardized communication tools, such as electronic health records and

interprofessional care plans, can facilitate communication and information exchange between RNs and RPNs, promoting seamless collaboration in nursing practice (Dykes, 2020).

The absence of a collaborative framework for RNs and RPNs in nursing care can have several negative consequences that impact both patient outcomes and the overall effectiveness of the healthcare team. Without a structured approach to collaboration, there is a heightened risk of miscommunication, inefficiencies, and fragmented care delivery. A lack of collaboration between RNs and RPNs can lead to communication breakdowns, where important information may not be effectively conveyed or shared between team members. This can result in misunderstandings, errors, and delays in patient care, compromising patient safety and quality of care (Sherman & Bishop, 2020). Without clear guidelines and processes for collaboration, there is a higher likelihood of role ambiguity and conflict between RNs and RPNs. Unclear role boundaries and overlapping responsibilities can lead to misunderstandings and tensions within the healthcare team, hindering effective teamwork and coordination of care (Kushemererwa et al., 2020). In the absence of a collaborative framework, care delivery may become fragmented, with tasks and responsibilities being disjointed or duplicated. This can result in inconsistencies in patient care plans, gaps in monitoring, and suboptimal outcomes for patients (Laschinger et al., 2014b). Addressing these challenges requires the establishment of a collaborative framework that promotes effective communication, clarifies roles and responsibilities, and fosters mutual respect and trust among RNs and RPNs. By implementing structured approaches to collaboration, healthcare organizations can enhance care coordination, improve patient outcomes, and create a supportive work environment that empowers nursing staff to deliver high quality, patient-centered care.

Organizational Accountability

Hospital organizations have a significant responsibility to provide clear and comprehensive collaborative guidelines for RNs and RPNs to ensure effective teamwork, communication, and

coordination of care. Collaborative guidelines serve as a framework that outlines the roles, responsibilities, and expectations of RNs and RPNs in delivering patient care within the healthcare setting. These guidelines should be developed collaboratively with input from nursing leadership, frontline staff, and other healthcare professionals to ensure they reflect the unique needs and dynamics of the organization (Sherman & Bishop, 2020). Primarily, collaborative guidelines should clarify the respective scopes of practice for RNs and RPNs, delineating the specific tasks and responsibilities that each role is authorized to perform. This helps mitigate role ambiguity and ensures that nursing staff understand their roles within the healthcare team (CNO, 2019). Additionally, the guidelines should establish protocols for communication and information sharing between RNs and RPNs, including procedures for handoffs, consultations, and care coordination. Standardized communication tools, such as electronic health records and interprofessional care plans, can facilitate seamless information exchange and promote continuity of care (Laschinger et al., 2014b). Furthermore, collaborative guidelines should outline processes for shared decision-making and conflict resolution, emphasizing the importance of mutual respect, trust, and open communication among nursing staff. This fosters a culture of collaboration and teamwork, where RNs and RPNs work together effectively to address patient needs and achieve common goals (Kushemererwa et al., 2020). Moreover, the guidelines should include mechanisms for ongoing education and training to ensure that nursing staff remain competent and up-to-date in their practice. Hospital organizations must prioritize the development, implementation, and regular review of collaborative guidelines to support RNs and RPNs in delivering safe, high-quality care to patients (Thiel, 2017). By providing clear expectations and support structures, organizations can enhance collaboration, improve patient outcomes, and create a positive work environment for nursing staff.

When hospital organizational leadership fails to take accountability for ensuring or supporting a collaborative environment and framework between RNs and RPNs, several negative outcomes can

occur, affecting both patient care and the overall effectiveness of the healthcare team. Without clear guidance and support from organizational leadership, there is a risk of communication breakdowns between RNs and RPNs. This can lead to misunderstandings, errors, and delays in patient care, compromising patient safety and quality of care (Sherman & Bishop, 2020). Lack of accountability from hospital leadership may contribute to role ambiguity and conflict between RNs and RPNs. Unclear role boundaries and overlapping responsibilities can lead to tensions within the healthcare team, hindering effective collaboration and coordination of care (Kushemererwa et al., 2020). When organizational leadership does not prioritize collaboration, care delivery may become fragmented, with tasks and responsibilities being disjointed or repeated. This can result in inconsistencies in patient care plans, gaps in monitoring, and suboptimal outcomes for patients (Laschinger et al., 2014b). In the absence of support for collaboration, there is a risk of suboptimal resource utilization within the nursing team. Skills and expertise may be underutilized, leading to inefficiencies in workflow and missed opportunities for leveraging the strengths of each role. This can ultimately impact productivity, effectiveness, and job satisfaction among nursing staff (Martin & Weeres, 2016). A lack of accountability for fostering collaboration can contribute to a negative organizational culture characterized by mistrust, disengagement, and dissatisfaction among nursing staff. This can lead to higher turnover rates, reduced staff morale, and ultimately, poorer patient outcomes (Sherman & Bishop, 2020). Addressing these challenges requires strong leadership commitment and accountability for promoting a collaborative environment and framework within healthcare organizations. By prioritizing collaboration, providing clear guidance and support, and fostering a culture of mutual respect and teamwork, hospital leadership can enhance care delivery, improve patient outcomes, and create a positive work environment for nursing staff.

In conclusion, an evidence-based collaborative framework for RNs and RPNs is essential for improving patient outcomes, optimizing resource utilization, fostering professional development, and

promoting evidence-based practice in healthcare settings. The absence of a collaborative environment between RNs and RPNs can have detrimental effects on patient care outcomes and the overall functioning of the nursing team. It is essential for healthcare organizations to prioritize efforts to foster collaboration, promote open communication, and establish clear expectations and roles for nursing staff to optimize care delivery and enhance patient outcomes. Strengthening collaboration and integration between RNs and RPNs requires a multifaceted approach that encompasses clear role definition, interprofessional education, team-based care models, and a supportive work environment. By implementing these strategies, healthcare organizations can optimize patient care delivery, enhance job satisfaction among nursing staff, and ultimately improve healthcare outcomes. Collaborative framework in nursing practice is essential for optimizing patient care outcomes and promoting a positive work environment. A framework tailored to RNs and RPNs nursing care encompasses clear role definition, interprofessional education, team-based care models, effective communication, and professional development initiatives. By embracing collaboration and teamwork, RNs and RPNs can optimize patient care outcomes, promote efficiency in healthcare delivery, and ensure the delivery of high quality, patient-centered care.

Summary

A collaborative environment between RNs and RPNs is crucial for effective patient care delivery. Hospital organizational leadership plays a vital role in developing frameworks that support cohesive teamwork and clarify roles and competencies. These frameworks outline clear guidelines for collaboration, including communication channels, shared decision-making processes, and delineation of responsibilities. By prioritizing collaboration and providing necessary resources and support, hospital leadership fosters role clarity and competency among nursing staff. Interprofessional education, training programs, and standardized protocols further enhance mutual understanding and respect between RNs and RPNs. Ultimately, a collaborative environment facilitated by strong leadership ensures optimized

patient outcomes, improved job satisfaction, and a positive organizational culture focused on patient-centered care.

Section Four: Contextualization

The purpose of the study was first to explore RNs' and RPNs' lived experience of collaborative practice on SAC units and then to identify effective strategies that can be used to strengthen teamwork among these categories of nurses. This study addressed research questions in two phases: Cycle 1 looked at what extent is collaboration practiced between RNs and RPNs on SAC units, what are the barriers to collaborative practice between RNs and RPNs and what are the enablers to collaborative practice between RNs and RPNs. Cycle 2 asked how RNs, RPNs and staff can co-create together to develop strategies that can be used to strengthen collaborative practice between RNs and RPNs on SAC units.

Cycle 1 findings illuminated existing barriers to collaborative practice between RNs and RPNs on SAC units. RPNs expressed feelings of disparity in assignments and limited career development opportunities, leading to moral distress, diminished trust, and a desire to leave the work environment. Both RNs and RPNs identified a fundamental lack of comprehension regarding each other's scope of practice and competency levels as a key contributor to the deficiency in collaborative practice. Additionally, they perceived nurse managers as lacking the knowledge and skills necessary to cultivate an effective collaborative atmosphere, particularly in understanding the scope of practice for both RNs and RPNs. In order to address Cycle 1 findings, focus group discussions were held to enable RNs, RPNs and nursing leadership staff to co-create to develop strategies that could be used to strengthen collaborative practice between RNs and RPNs on SAC units. Cycle 2 analysis revealed that issues concerning collaborative practice between RNs and RPNs at NHU have been long-standing and require immediate attention to prevent nurses from leaving the profession. They underscore that to facilitate a change in the collaboration between RNs and RPNs, the engagement of organizational leadership is essential. This section provides an analysis of RNs and RPNs' practice standards, elucidates how the

findings from Cycle 1 and Cycle 2 align with existing literature, and delineates implications to strengthened professional practice and organizational accountability.

Context Analysis

The action research took place at NHU located in Toronto, which is the largest research and teaching hospital network in Canada. The organization is inclusive of three acute care sites, one Long-term Care (LTC), three Rehabilitation (Rehab) units, and an educational institution. NHU is a major employer of RNs and RPNs in Ontario, as 4,565 work across the network accounting for 32% of the total employees. While it is typical for RNs and RPNs in LTC and Rehab settings to operate within a nursing skilled-mix environment, this work structure was introduced to SAC units in 2018 in response to nursing shortages, necessitating a shift in care provision in accordance with the standards set by the CNO. NHU mandated each SAC unit to conduct an ABS study, and the analysis of the gathered data revealed that RPNs could effectively and safely manage the care of up to 70% of patients on these units.

Before joining NHU as an employee, I gained experience working at a mid-range hospital on a critical care unit that exclusively employed RNs. Concurrently; I served as a clinical instructor for RPNs, delivering theoretical and practical instruction across several hospitals in Toronto. This firsthand experience not only allowed me to familiarize myself with their scope of practice but also played a pivotal role in fostering the development of their critical thinking abilities. During this period, I also participated in a study focused on observing the collaborative practice of RN and RPN students during their clinical rotations. This study highlighted distinct differences in teamwork between the two groups of student nurses.

Following the completion of my Master's degree, my introduction to leadership roles commenced at NHU. Here, I actively contributed to the ABS study using a test-retest design. As an APNE within one of the SAC units, my responsibilities included training newly hired RPNs assigned to my unit, as well as educating RNs about the scope of practice for RPNs and introducing them to the new nursing

skilled-mix model initiative. Throughout this period, RNs posed several questions, including concerns about whether RPNs could effectively manage the care of acutely ill patients and if recruiting RPNs to SAC units would threaten their job security. Following the training of the initial cohort of RPNs, they shared their experiences with me, expressing feelings of inequity in patient's assignments, perceptions of being treated as inferior, and being tasked with responsibilities they believed were beyond their scope of practice. In one scenario, an RPN opted to transition to permanent night shift, perceiving this as a means to minimize negative interactions with RNs, as well as, to attend to her mental wellbeing. In another instance, a different RPN chose to return to her previous province to work, as she expressed feeling undervalued as a member of the team. The introduction of the nursing skilled-mix model brought about considerable uncertainty where both RNs and RPNs expressed apprehension about how to collaborate effectively.

This firsthand experience allowed me to interact with both nursing groups, listening carefully to understand their perspectives on the nursing skill mix model in SAC units. Analysis of these discussions revealed prevalent feelings of disparities among RPNs, which, if not addressed, could potentially result in RPNs resigning from their positions within SAC units. One of the primary concerns raised was the potential impact on collaborative practice between RNs and RPNs, and its effects on patients' positive outcomes. Three years later, I transitioned into a managerial role within a unit that had a scarcity of RPNs. With my comprehensive grasp of the scope of practice for RPNs, I swiftly recognized the opportunity for increased RPN staffing in this area. However, my proposal was met with various apprehensions, primarily stemming from concerns about the perceived incompetence of RPNs. This reinforced the realization that a lack of comprehension regarding the scope of practice for RPNs was prevalent across multiple units within NHU.

Following six years since the implementation of the nursing skilled-mix model, there has been no formal examination conducted to explore the firsthand experiences of nurses working on the SAC

unit. Recognizing this gap, I deemed it essential to conduct an in-depth investigation into this phenomenon, thus initiating this study as part of a dissertation in practice. In order to identify effective strategies to strengthen collaborative practice between RNs and RPNs, I first gathered their lived experience utilizing semi-structured interviews. Cycle 1 data collection confirmed findings from previous studies that understanding scope of practice would eliminate confusion about the differences and similarities in role, as unclear guidelines have led to instances where RPNs may find themselves providing care that stretches beyond the boundaries of their designated scope of practice (Lankshear et al., 2016). This created an ethical dilemma within the team and resulted in frustration, job-dissatisfaction, distrust; feeling devalued and further widened the gap in silo practice.

Cycle 2 research indicated that focus group discussion with RNs, RPNs and nursing leadership staff would provide the opportunity for co-creation to develop strategies that can be used to strengthen collaborative practice. Data collection supported the findings that an evidence-based collaborative framework could establish clear guidelines for collaboration, including communication methods, shared decision-making, and defining responsibilities. In the absence of well-defined guidelines and established collaboration processes, the probability of encountering role ambiguity, conflict, issues with trust, inequity and RPNs feeling inferior to RNs would continue to increase between RNs and RPNs (Kushemererwa et al., 2020; Reeves et al., 2017). Early establishment of a framework that can be used to educate and transform behaviours would help bridge the gap to isolated practices observed between RNs and RPNs and for this to be effective, it would require the engagement of micro and macro level organizational support.

Bridging the Silo Gap

Numerous studies have documented the prevalence and negative consequences of silo practice in healthcare settings. For instance, research by Sidani et al. (2017) found that siloed approaches to care delivery hindered effective teamwork and communication among healthcare providers, resulting in

fragmented care and increased risk of medical errors. Similarly, a study by Cranley et al. (2018) highlighted how siloed practices among nursing staff led to role ambiguity, conflicting priorities, and reduced job satisfaction. RPNs experience silos both internally (working alongside RNs) and externally (when discriminated against by RN unions). RPNs often feel that they are not celebrated because their level of qualification is considered menial. This concept has prevented RPNs from being utilized to their full capabilities. The silo gap can also be attributed to lack of understanding of scope of practice that has resulted in role ambiguity.

Nurses Eat Their RPNs

Historically, it is said that nurses eat their young (Johnson et al., 2015). Participants in Cycle 2 alluded to the concept that nurses are also known to eat their RPNs, which refers to the feelings of belittlement, undermining, exclusion, and intimidation experienced by RPNs that can have detrimental effects on the professional and personal well-being of RPNs. During Cycle 1, participants who were RPNs encountered instances where they hesitated to seek support from RNs, fearing they might be perceived as burdensome. Additionally, some RPNs reported feeling constantly belittled for their career choice to pursue RPN rather than RN status (Smith et al., 2017; Peters et al., 2018). Research studies have highlighted the prevalence and impact of horizontal violence, or lateral hostility within nursing where one study found that up to 85% of nurses reported experiencing or witnessing horizontal violence in the workplace (Curtis et al., 2011). Another study revealed that nurses who experienced lateral violence reported higher levels of job dissatisfaction, burnout, and turnover intentions (Johnson et al., 2015).

Superior Versus Inferior

The dynamic between superior and inferior roles within nursing, particularly between RNs and RPNs, is a complex and multifaceted issue that has garnered attention in the literature. Research has shown that hierarchical structures within healthcare settings can perpetuate a sense of superiority among RNs, who may view themselves as having greater knowledge, skills, and authority compared to

RPNs (Tonges & Ray, 2019). This perceived superiority could lead to a power differential that affects the working relationships between RNs and RPNs, contributing to feelings of inferiority among RPNs (Cummings et al., 2018). RPN participants have expressed that this experience has prompted them to consider resigning from their positions. Studies have also highlighted various factors that contributed to the perception of superiority among RNs; include differences in educational preparation, scope of practice, and professional status as RNs typically undergo more extensive education and training, obtaining a Bachelor of Science in Nursing (BSN) degree, while RPNs complete diploma programs that are shorter in duration (Drennan et al., 2019). Nursing leadership participants thought that addressing the issue of superiority versus inferiority within nursing requires a concerted effort from organizational leadership to promote equity, respect, and collaboration among all members of the healthcare team. This would include fostering a culture of mutual respect and appreciation for the unique contributions of both RNs and RPNs, providing opportunities for professional development and advancement for RPNs, and promoting interdisciplinary teamwork and communication (Foronda et al., 2016; Laschinger et al., 2014a).

Craving Psychological Safety

Psychological safety, particularly among RNs and RPNs, is a critical aspect of creating a supportive and collaborative work environment within healthcare settings. Psychological safety refers to the shared belief among team members that they can express themselves, share ideas, and take risks without fear of negative consequences such as ridicule or punishment (Edmondson, 1999). When RPN participants experienced apprehension about seeking clarification from RNs regarding patient care activities, it not only impeded the professional development of RPNs but also had a direct impact on the quality of care delivered to patients. Research has shown that psychological safety is positively associated with various desirable outcomes in healthcare teams, including improved communication, increased innovation, enhanced teamwork, and better patient outcomes (Edmondson, 2019). When RNs

and RPNs feel psychologically safe in their work environment, they are more likely to speak up about concerns, share knowledge and expertise, and collaborate effectively to deliver high-quality patient care (Kornadt et al., 2021). Nursing leadership participants felt that promoting psychological safety among RNs and RPNs would require the intentional efforts to create a culture of respect, trust, and openness within healthcare organizations and that this would require extensive involvement of organizational leadership planning and execution over a period of time.

Eliminating Labelling

Eliminating labeling among RNs and RPNs is essential for fostering a culture of respect, collaboration, and mutual support within healthcare teams. Labeling refers to the tendency to categorize individuals based on their professional designation, which can lead to stereotyping, prejudice, and discrimination (Chao et al., 2019). Research has shown that labeling and stereotyping of nurses based on their educational background (i.e., RN or RPN) can contribute to tensions and hierarchies within nursing teams, undermining communication, teamwork, and patient care (Cummings et al., 2018). This can result in RNs being perceived as superior and RPNs as inferior, creating power differentials and barriers to collaboration (Tonges & Ray, 2019). When RPNs collaborate with RNs in an environment where everyone is referred to simply as "nurse," they reported experiencing a greater sense of collegiality among colleagues. Additionally, they perceived that patients experience less confusion regarding the roles of different nursing professionals. However, participants emphasized the importance of both RNs and RPNs maintaining awareness of their respective accountabilities and limitations within their scopes of practice.

The Person Behind the Position

"The person behind the position" refers to recognizing the individual behind the professional designation of RPN. It emphasizes acknowledging the unique skills, experiences, and motivations that lead individuals to choose the RPN career path and the importance of valuing RPNs for their

contributions within the healthcare team. In Cycle 2, participants highlighted that nurses are frequently instructed to consider the individual beyond their illness when interacting with patients and that this same phenomena should be applied to RPNs, emphasizing the importance of recognizing the person behind the professional nursing designation. They elaborated that societal factors, such as financial constraints, family responsibilities, immigration or refugee status can significantly influence individuals' decisions regarding their education and pursuit of a career as an RPN. Valuing RPNs as integral members of the healthcare team involves creating a work environment that fosters collaboration, respect, and professional development for all nursing professionals (Peters et al., 2018). While RPNs may have different educational backgrounds and scopes of practice compared to RNs, their expertise in areas such as patient assessment, medication administration, and health promotion should be recognized and respected (Smith et al., 2017). By recognizing 'The person behind the Position' and valuing RPNs for their unique skills, experiences, and contributions, healthcare organizations can create a supportive and empowering environment where all nursing professionals can thrive and deliver exceptional care to patients.

Personalized Biases

Personalized biases regarding RPNs being perceived as inferior to RNs can stem from various sources including societal norms, professional hierarchies, educational backgrounds, and personal experiences. Biases against RPNs may have historical roots embedded in the evolution of nursing as a profession. These biases can manifest in different ways and may have significant implications for healthcare delivery, interprofessional relationships, and patient outcomes (CNO, 2020). Traditionally, RNs have been associated with training that is more comprehensive, higher academic qualifications, and greater autonomy compared to RPNs, who were initially trained for more basic nursing tasks. RPN participants felt that they were limited to what they could do, as RNs and NMs felt that they did not possess the capabilities to engage in some advanced care. This bias subtly or overtly implies that RNs

possess greater knowledge and skills compared to RPNs. It is a form of personalized bias that is strengthened by confirmation bias, where individuals tend to notice and remember information that confirms their existing beliefs. Additionally, biases stemming from media portrayals often highlight the role of RNs, potentially exacerbating prejudices against RPNs. The limited representation of RPNs in these depictions may lead to the perception that their contributions are less significant or noteworthy. In focus group discussions, RPN participants expressed concerns that RN unions sometimes depict them negatively in the media, suggesting that RPNs harm patients during care. This portrayal not only creates a negative impression but also diminishes the value of the contributions RPNs make to patient care. Participants noted that all of us have our own assumptions that we unintentionally show and this could prevent integration of RNs and RPNs working collaboratively. Addressing personalized biases against RPNs requires a multifaceted approach involving education, awareness campaigns, interprofessional collaboration, and policy changes. Promoting a culture of respect, recognition, and equality within healthcare settings is essential for fostering collaboration and optimizing patient care.

Engaging in Advocacy

Engaging in advocacy for RPNs in clinical practice involves actively promoting their rights, recognition, and professional contributions within healthcare settings. Advocacy efforts aim to address disparities, challenge biases, and create an environment that values the unique skills and expertise of RPNs. Encouraging teamwork and collaboration among healthcare professionals is essential for recognizing the contributions of RPNs (Reeves et al., 2017). Nursing leadership participants stressed the importance of having joint sessions such as simulations, workshops etc. that would create opportunities for RNs, RPNs, and other members of the healthcare team to work together to foster mutual respect and appreciation for each other's expertise. Participants encourage respect for RPNs position in healthcare noting that everyone who is licensed to practice has merit-based education and competency and are helping humanity. Providing mentorship opportunities and supporting professional

development initiatives for RPNs can empower them to expand their skills and take on leadership roles (Buchan & Dal, 2002). Mentoring programs, continuing education opportunities, and career advancement pathways can contribute to the retention and advancement of RPNs within the healthcare workforce (Nowrouzi et al., 2012). Participants highlighted that experienced RPNs often make effective charge nurses when compared to novice RNs. They believe that more opportunities should be given to RPNs to work alongside APNEs to support novice RPNs. Engaging RPNs in research endeavors and promoting evidence-based practice would enhance their credibility and influence within the healthcare community.

Educate to Collaborate

Educating nurses, particularly RNs and RPNs, on collaboration within hospital organizations involves equipping them with the necessary skills and strategies to effectively communicate and advocate for collaborative practices. Encouraging nurses to speak up about collaboration requires creating a culture of openness, mutual respect, and shared decision-making. Developing comprehensive communication skills training such as active listening, assertive communication and constructive feedback techniques to both RNs and RPNs can empower them to express their thoughts, concerns, and ideas effectively. Nurses generally feel silence by the notion of respecting a patient's wishes and carrying out physician's orders, so teaching them how to engage in reasoning with each other would help foster a collaborative environment. Moreover, participating in assertive and constructive conversation would help create a psychologically safe environment where nurses feel comfortable to speak up without fear of retribution is essential for promoting collaboration. Participants noticed that there is a need for creative ways in communication style to engage nurses to participate in conversations about collaboration such as using tools like storytelling, visual arts or reflective practice. Establishing feedback mechanisms, such as regular team debriefings, peer evaluations, and anonymous suggestion systems, allows nurses to provide input on collaboration and teamwork processes (Edrees & Paine, 2013).

Hospital organizations can foster psychological safety by encouraging open dialogue, valuing diverse perspectives, and emphasizing a blame-free approach to error reporting and learning (Edmondson, 2019). Participants suggested that the foundation of collaboration begins during interviews and orientation of new hires where they are taught unit culture and the sacred practice of collaboration. Educate to collaborate lies in the ability to be inclusive and see both RNs and RPNs as equal. Participants underscore the significance that engaging RPNs at nursing council sessions where nursing practice is being discussed is important as they play important roles in patient care. Inclusivity goes beyond just inviting RPNs to meetings but more so, electing them to be on the executive and planning committees where they could actively collaborate in decision-making.

Early Sensitization to Collaboration and Teamwork

The study supports the existing literature that early sensitization of collaboration between RNs and RPNs was needed to help break down the barriers that prevent effective teamwork and is crucial for fostering a cohesive and efficient healthcare team. Research suggests that early exposure to interprofessional and collaborative practice during nursing education can significantly impact attitudes and behaviors towards teamwork (Reeves et al., 2010). Cycle 2 data illustrated that incorporating collaborative learning experiences into nursing learning activities, such as workshops and orientation sessions, would allow RNs and RPNs to develop an understanding of each other's roles, responsibilities, and contributions to patient care, thereby promoting mutual respect and trust between RNs and RPNs. Furthermore, ongoing professional development opportunities were found to reinforce the importance of collaboration and teamwork throughout the nursing career trajectory. Continuing education programs that focus on communication skills, conflict resolution, and team dynamics can help RNs and RPNs enhance their collaborative abilities and navigate complex healthcare environments (Loveridge et al., 2019). Early sensitization also takes into consideration how collaborative practice was introduced to

new RNs and RPNs. Participants stressed the need to ensure that this practice commenced during hospital wide and unit-based orientation.

Interprofessional Alliances

Building an alliance for the defense of RPNs in practice by other healthcare practitioners is crucial for ensuring the fair treatment, recognition, and professional support of RPNs within the healthcare system. Such alliances strengthen solidarity among healthcare professionals, promote advocacy for RPNs' rights and contributions, and foster a culture of respect and collaboration. RPNs often fear humiliation and disheartened words said by RNs about them when they are being described as half nurses and that their pay is garbage. Participants from the nursing leadership group expressed how it was disheartening to know the different feedback from RPNs when people are not enthused when they hear about RPNs. It made them feel sad to hear of RPNs feeling unhappy about their own education. Furthermore, they believe that clearer understanding of what each of their roles would cause less confusion, decrease contention and one group of nurses would not feel like they are more indispensable. Healthcare practitioners can advocate for the elimination of bias and stigma against RPNs within the healthcare system. Challenging stereotypes, promoting cultural competence, and fostering a culture of inclusivity and respect help create a supportive environment where RPNs feel valued and empowered to contribute to patient care (Kelly & Ahern, 2009). Participants believe that one of things that could help build alliance is to encourage the articulation of capacity and strength among RNs and RPNs where a sense of pride is infused in ways that make RNs and RPNs feel equally proud to have chosen a healthcare profession. There should be campaigns to showcase nurses to show who they are as a team and what they possess as an RN or RPN as healthcare professionals. Advocating for policies that recognize the valuable contributions of RPNs, ensure equitable access to resources and opportunities, and protect against discrimination would help create a supportive regulatory environment for RPNs in practice. Participants highlighted that developing strengths within the nursing

team and using those strengths to deliver the best patient care along with consistent practice would drive positive change.

Oath of Service

The concept of an oath of service for RNs and RPNs underscores their commitment to providing high-quality care, upholding ethical standards, and working collaboratively within interprofessional healthcare teams. While specific oaths may vary, they typically encompass principles of professionalism, compassion, integrity, and teamwork. An oath of service for RNs and RPNs emphasizes the importance of professionalism and ethical conduct in nursing practice. It serves as a reminder of their duty to act in the best interests of patients, adhere to professional standards, and maintain integrity in their interactions with colleagues and patients (ANA, 2015). Participants noted that this starts at the bedside with role clarity as without this, there will be friction between RNs and RPNs impacting patient safety, increase in incidences, prolong length of hospital stay, and budgetary constants. Many oaths of service emphasize the significance of interprofessional collaboration and teamwork in delivering optimal patient care. RNs and RPNs pledge to work collaboratively with other healthcare professionals, including physicians, pharmacists, and allied health professionals, to promote patient safety and positive healthcare outcomes (WHO, 2010). Many oaths of service include a commitment to advocacy and social justice, reflecting nurses' role as advocates for vulnerable populations and agents of change within the healthcare system. RNs and RPNs pledge to address health disparities, promote health equity, and advocate for policies that advance the well-being of individuals and communities (Purnell, 2013). Participants in Cycle 2 referred to organizational leadership doing better at developing clear guidelines and clarifications to ensure that both nurses follow their scope of practice in the clinical areas. They emphasize that we need to bring it back to the patient's positive outcomes and its reliance on RNs and RPNs collaboration. By embracing an oath of service that emphasizes professionalism, patient-centered care, interprofessional collaboration, continuous learning, and advocacy, RNs and RPNs demonstrate

their dedication to ethical nursing practice and their role as integral members of the healthcare team. Such oaths serve as guiding principles that shape nurses' behaviors, decisions, and interactions in their daily practice.

Conclusion

In summary, the findings of this study shed light on the barriers hindering collaborative practice between RNs and RPNs on SAC units. Several factors were identified as contributing to these barriers, with a key factor being the segregation of RNs and RPNs in clinical settings. This segregation fosters biases and perceptions of inferiority, ultimately leading to feelings of psychological unsafety among RNs and RPNs. Addressing these challenges requires the implementation of strategies aimed at strengthening collaborative practice between RNs and RPNs. Such strategies include fostering interprofessional alliances, providing education and training opportunities, advocating for equitable treatment and social justice, and upholding ethical standards. By cultivating a culture where collaboration is prioritized and celebrated as the cornerstone of nursing practice, healthcare organizations can overcome barriers and promote a more cohesive and effective interdisciplinary approach to patient care.

Implications for Organization

This study sheds light on the barriers to collaborative practice encountered by RNs and RPNs on SAC units, emphasizing the necessity to devise strategies aimed at strengthening teamwork between these nursing groups. While Cycle I and II findings identified some areas of successful collaboration, the predominant data underscore the urgent need to address how nurses collaborate on SAC units to bolster teamwork and improve patient’s outcomes. Without organizational commitment to employing evidence-based collaborative frameworks for RNs and RPNs, the prevailing levels of frustration, job dissatisfaction, and resignations among nurses at NHU on SAC units are likely to persist. It is increasingly

imperative to ensure that RNs and RPNs feel psychologically secure in their work environment, where inclusion, equity, and trust serve as foundational elements.

Systemic Change

Collaborative practice among healthcare professionals, particularly nurses, has been a longstanding challenge in the healthcare landscape. Several studies and literature have pointed out cases of horizontal violence happening not just between RNs and RPNs, but also among nurses of the same designation (Duchscher & Cowin, 2004). Moreover, historical practices, such as assigning RPNs primarily to LTC and Rehab settings, have perpetuated inherent biases regarding their suitability for roles on SAC units. Despite advancements in the scope of practice for RPNs, which have included advanced training in skills and critical thinking, organizational efforts to increase awareness of their capabilities have been limited. This lack of awareness has left RNs with inadequate knowledge of RPNs' competencies, leading to misconceptions and feelings of insecurity among RNs who may perceive RPNs as potential replacements. Establishing clear systems outlining roles and responsibilities would not only enable RNs to appreciate the contributions of RPNs but also foster a collaborative environment conducive to both groups of nurses (Duchscher & Cowin, 2004). Given that this systemic culture is deeply ingrained within NHU, it necessitates the active involvement and accountability of organizational leadership in spearheading the reformation of collaborative practice between RNs and RPNs within SAC units.

Social Justice

Hospital organizations play a pivotal role in promoting social justice, particularly in addressing disparities in patient care. However, there has been a noticeable lack of attention to social justice in healthcare settings regarding the treatment of healthcare practitioners themselves. Nurses, guided by standards set by regulatory bodies like the CNO and hospital protocols, primarily focus on task-oriented patient care derived from theoretical frameworks. Unfortunately, this approach often lacks emphasis on

fostering collaboration among healthcare providers in the delivery of care. Consequently, nurses tend to operate within silos rather than engaging in team-based nursing practices. The inclusion of RPNs in SAC units exacerbates this siloed practice, creating a further divide between RNs and RPNs. This divide can lead to feelings of distrust, exclusion, and disunity among nursing staff.

Accepting the division between RNs and RPNs within SAC units as the status quo perpetuates a continuous breakdown of collaborative practice between these nursing groups. This breakdown inevitably leads to a ripple effect on patient safety, as interruptions in effective patient care become more prevalent. It is morally unacceptable to condone the unfair treatment experienced by RPNs as acceptable, especially considering the detrimental impact on patients, nurses, and the entire interprofessional healthcare team. By shining a spotlight on the barriers hindering collaborative practice between RNs and RPNs, researchers, along with influential stakeholders capable of driving change, can become agents of social justice in collaboration reformation between RNs and RPNs. As someone who has witnessed firsthand the disparities in treatment experienced by RPNs while working as an RN, it became apparent during my doctoral study that addressing this issue and advocating for change was imperative. Utilizing this platform to highlight the issue and continue the work towards fostering a culture of inclusivity and equity in healthcare settings becomes not only a professional responsibility but also a moral obligation.

Further Research

Action research is a systematic approach to problem solving and improvement that involves cycles of planning, acting, observing, and reflecting. While action research is valuable for addressing immediate issues and making iterative improvements, the need for ongoing research is essential for sustaining change, adapting to evolving contexts, promoting continuous learning, engaging stakeholders, and ensuring long-term success in collaborative practice initiatives. The following are five

recommendations for organizational leadership to continue the work initiated by this study on collaborative practice between RNs and RPNs:

Promote a Culture of Inclusivity and Respect

Leaders should foster a culture of inclusivity and respect within the organization, where all members of the healthcare team feel valued and empowered to contribute to patient care. This involves addressing biases and stereotypes, promoting diversity and cultural competence, and recognizing the unique contributions of RNs and RPNs to the healthcare team. Further research is needed to deepen our understanding of how to foster a culture of inclusivity and respect within healthcare organizations. By continuing to explore the impact of organizational culture, assess the effectiveness of diversity and inclusion initiatives, identifying strategies for addressing biases and stereotypes, examining the role of leadership, and understanding the unique contributions of RNs and RPNs, the researcher along with stakeholders can continue the work to promote a positive and empowering workplace culture where all members of the healthcare team feel valued (Hofstede, 2011).

Standardized Protocols and Guidelines

Developing standardized protocols and guidelines for collaborative practice can clarify roles, responsibilities, and expectations for RNs and RPNs working together. Clear communication channels and decision-making processes can streamline care delivery and enhance teamwork. Further research in these areas can provide valuable insights into the development, implementation, and impact of standardized protocols and guidelines for collaborative practice between RNs and RPNs. By clarifying roles, responsibilities, and expectations, improving communication channels, and streamlining care delivery processes, standardized protocols have the potential to enhance teamwork and optimize patient care outcomes (Cassidy et al., 2021). Research should also investigate the long-term sustainability of standardized protocols and guidelines for collaborative practice. I will engage with

stakeholders to assess factors that influence ongoing adherence to protocols, as well as identifying strategies for continuous improvement and adaptation as this research continues to evolve.

Quality Improvement Initiatives

Implementing quality improvement initiatives focused on enhancing collaborative practice can drive organizational change and improve patient outcomes. The findings in Cycle 1 and 2 can be used for further study using the quality initiative process to include a wider population of RNs, RPNs and participants to gather extensive data for deeper understanding of the problem of practice and implement impactful strategies to strengthen collaborative practice between RNs and RPNs. Monitoring collaboration metrics, soliciting feedback from nursing staff, and implementing evidence-based interventions can identify areas for improvement and promote a culture of collaboration (Gurses et al., 2009). The researcher intends to work alongside organizational leadership to develop quality initiatives that foster a culture of collaboration and identify best practices that will create a collaborative work environment. One significant way is to examine the role of continuous quality improvement processes in integrating evidence-based guidelines into collaborative care delivery.

Expand Research to Other NHU Sites

Expanding research efforts to include multiple hospital sites can provide a more comprehensive understanding of collaborative practice interventions and their impact across diverse healthcare settings. By conducting studies in various hospital settings internally and externally to NHU, researchers can capture a broader range of perspectives, practices, and contextual factors that may influence the effectiveness and implementation of collaborative care models (Harrison et al., 2019). By comparing experiences across different hospitals, researchers can identify recurring challenges and success factors that influence the adoption and sustainability of collaborative care models (Borkowski, 2020). Expanding research efforts to include multiple hospital sites offers numerous benefits, including capturing contextual variations, enhancing generalizability, identifying best practices, understanding common

barriers and facilitators, and informing scalability and sustainability considerations. Collaborative multi-site research can ultimately contribute to the advancement of evidence-based collaborative practice interventions and the improvement of patient outcomes across diverse healthcare settings. The researcher intends to participate in multiple conferences and webinars locally and globally to share the findings of the study in order to sensitize healthcare organizations of the impending need and importance of collaborative practice in areas where RNs and RPNs work alongside each other.

Research and Evaluation

Conducting research studies and evaluations to assess the impact of collaborative practice interventions on patient outcomes, nursing satisfaction, and healthcare costs can provide valuable insights for future initiatives. Evidence-based practice guidelines can inform decision-making and drive continuous improvement in collaborative practice (Melnyk & Fineout-Overholt, 2019). Future studies can provide valuable insights into the effectiveness, implementation, and sustainability of collaborative practice interventions on SAC units (Borkowski, N. (2020). Evidence-based practice guidelines can serve as a foundation for guiding research efforts and informing decision-making processes aimed at driving continuous improvement in collaborative practice. Research can examine how collaborative approaches to patient care, such as interdisciplinary teamwork and coordinated care delivery, influence patient outcomes across different healthcare settings and populations. Furthermore, studies can also examine the role of organizational culture, leadership support, and interprofessional education in successful implementation efforts. Developing an evidence-based framework to guide the work to be done on strengthened collaborative practice between RNs and RPNs at NHU is significant to accomplishing this goal.

By focusing on these areas, healthcare organizations can foster a culture of collaboration, respect, and mutual support among RNs and RPNs, ultimately enhancing patient care delivery and promoting professional development and satisfaction among nursing staff.

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Appendix A: Research Design

The aim of this research appendix is to demonstrate my understanding as the researcher of the research design, providing a detailed account of the applied research methodology employed in this project. Specifically, the emphasis lies on comprehending the concept of collaborative practice for RNs and RPNs working on SAC units. This appendix will present a comprehensive overview of qualitative action research, examined through the lenses of convergent care and system theory to ascertain the most appropriate methodology for this study. Additionally, it will explore the process of Cycle 2 data collection and related activities. Lastly, ethical considerations, trustworthiness, and study limitations will be comprehensively examined.

Qualitative Research Approach

The study was informed by both convergent care and systems theory approaches. Convergent Care methodology involves implementing enhancements in nursing and healthcare practices comprising four key concepts: comprehensive organizational care, collaborative care among healthcare professionals, individualized precision care, and self-care for both patients and healthcare providers (Wei, 2022). According to Wei (2022) achieving convergent care is a collaborative process that involves all stakeholders working together including six major facilitators, which are competence, compassion, accountability, trust, sharing, and engagement. Similarly, the systems theory approach to health employs scientific insights to comprehend factors affecting health outcomes, clarifies the relationships among these factors, and adapts designs, processes, or policies based on acquired knowledge to improve health outcomes (Mele et al., 2010). The integration of convergent care with systems theory not only highlights participants' voices and lived experiences but also empowers them to co-create solutions concerning challenges faced by RNs and RPNs regarding collaborative practice on SAC units. Convergent care research drives actions toward improvement by immersing and expanding, while

systems theory formulate strategies to enhance outcomes, enabling a collaborative approach to establishing systemic cultural changes.

Research design is an essential component of a study as it aids in formulating the scientific approach in which the research process will unfold. In this study, the researcher examined the barriers that prevented RNs and RPNs from engaging in collaborative practice. Since this would largely depend on the lived experiences shared by participants, the researcher found qualitative research to be a suitable approach. The aim of qualitative research is to achieve a comprehensive understanding of a particular event, phenomenon, or population by exploring multiple perspectives (Jencik, 2011). Qualitative research is multifaceted in focus as it seeks to study things in their natural settings to explain routines or problematic moments or meanings of a problem (Rosskam, 2018). The key to understanding qualitative research lies in the idea that meaning is socially constructed by individuals as they interact within their world and that reality is not fixed or singular as believed by the positivist approach, but instead comprises multiple dimensions of reality that change over time (Merriam, 2002). In qualitative studies, researchers bring their own worldview, paradigm, and beliefs to the research project, and this helps to determine the interpretation of findings (Creswell & Poth, 2016).

Action Research Methodology

The research design employed in this study is AR, a qualitative research approach with origins dating back to the 1940s, pioneered by Kurt Lewin and other psychologists. AR, as conceptualized by Kurt Lewin, is a participatory approach to research aimed at fostering social changes and improvement in real-world settings (Lewin, 1946). Kurt Lewin introduced the concept of AR in the 1940s, emphasizing the importance of collaboration between researchers and practitioners in addressing practical problems and effecting change (Reason & Bradbury, 2008). Lewin's work laid the foundation for action research, which involves cycles of planning, action, observation, and reflection to generate knowledge and drive positive change within a specific context (McNiff & Whitehead, 2011). This approach emphasizes the

active involvement of stakeholders and the integration of theory and practice to address complex social issues.

The key to understanding qualitative research lies with the idea that meaning is socially constructed by individuals as they interact within their environment (McDonald, 2021). This entails practitioners conducting a systematic inquiry within their own context to improve practices and collectively tackle real-world issues. This method often emphasizes the involvement, empowerment, and active engagement of participants throughout the research process. AR would best support this research study as the problem of practice seeks to understand the benefits and barriers when RNs and RPNs in one Toronto hospital engage in collaborative practice. RNs and RPNs have different levels of training, and although both provide hands-on care to patients and work side-by-side with patients, they often operate as distinct silos. AR would help to examine why this practice exists and use the active engagement of RNs and RPNs to develop actions that could strengthen collaborative practice. The key difference that distinguishes action research from other qualitative research methods lies in its systematic approach to inquiry and its emphasis on collaborative efforts within the community to instigate change through actionable steps. This approach is grounded in the belief that research should not only aim to understand the complexities of a given issue but also actively engage with participants and stakeholders to address these challenges and effect meaningful change (Reason & Bradbury, 2008).

Understanding the lived experience of RNs and RPNs within collaborative and integrative practice requires the researcher's epistemological stance, immersing into the study to analyze and interpret its significance. AR employs methodological designs like interviews, discussions, and surveys to facilitate participation, reflection, and empowerment, yielding valuable data that provides substantial insights into practice issues (Lewin, 1946). Unlike traditional qualitative research methods, which may prioritize the generation of knowledge for academic purposes, AR prioritizes practical outcomes and real-world impact. It involves researchers working closely with stakeholders, including community

members, practitioners, and policymakers, to identify areas for improvement and collaboratively develop and implement strategies to address these issues (McNiff & Whitehead, 2011). Furthermore, AR is characterized by its cyclical nature, involving iterative processes. This iterative process allows for continuous learning and adaptation, enabling researchers and stakeholders to refine their approaches based on ongoing feedback and evaluation (Kemmis & McTaggart, 2000). In summary, the systematic approach to inquiry and the emphasis on collaborative action distinguish AR as a method uniquely suited to driving meaningful change within communities and organizations. It is not only about understanding the problem but also actively engaging with stakeholders to co-create solutions and bring about tangible improvements in practice (Stringer, 2014).

Data Collection and Analysis: Cycle 1

The gathering and analysis of data are crucial steps in the research process. In Cycle 1, eight RNs and eight RPNs were interviewed about their experience of collaborative practice on SAC units. Findings from the interviews were analyzed and used to inform Cycle 2 action and evaluation steps. A more thorough discussion on Cycle 1 will further delve into the methods employed for selecting participants, the strategies implemented for gathering data, and the analytical techniques used to distill meaningful conclusions from the collected information. This comprehensive approach ensures a deep understanding of the intricacies of collaborative practice from the viewpoints of those directly involved, thereby enriching the research with practical insights and guiding subsequent phases with informed strategies.

Participants

The recruitment of participants for Cycle 1 employed purposive sampling, with a deliberate focus on selecting RNs and RPNs actively engaged in SAC units. This strategic approach aimed to capture firsthand insights into their perspectives on collaborative practice dynamics. As outlined by Etikan et al. (2016), purposive sampling, also referred to as judgmental sampling, involves the intentional selection

of participants based on specific attributes pertinent to the research inquiry. Additionally, the researcher utilized snowball sampling as a complementary method to expand participant recruitment. Snowball sampling involves leveraging initial participants to nominate other nurses from their respective units to participate in the study, thereby broadening the pool of potential contributors. The inclusion criteria for participant selection encompassed several key factors:

- Participants must be an employee at NHU
- Participants must work on one of the following units: Cardiology, Thoracic, General Internal Medicine, Nursing Resource Team (NRT) or the Emergency Room
- Participants must hold a designation of RN or RPN

Exclusion Criteria included:

- RNs and RPNs employed at all other NHU site excluding the General site

Demographic data

Fifty percent of the sample consisted of RNs (n=8), and fifty percent were RPNs (n=8). All participants worked in SAC units, with one on thoracic (n=1), six in emergency (n=6), two in cardiology (n=2), two in general internal medicine (n=2), and five in the nursing resource team (n=5). The majority of participants worked in the emergency room (n=6) and nursing resource team (n=5), while the fewest worked in thoracic (n=1). Eighty-one percent of the participants had 0-5 years of experience, followed by 13% with 6-10 years of experience and 6% with more than 10 years of experience. The RNs consisted of seven females (n=7) and one male (n=1), while the RPNs consisted of four females (n=4) and four males (n=4), totaling 11 females (68.75%) and 5 males (31.25%) overall. Table A1 depicts the background data.

Table A1

Cycle 1 Participants: Participants' Demographic Information

Participant (pseudonym)	Clinical Unit	Gender	Years of Experience
Kelly	Emergency Room	Female	2
Peter	Emergency Room	Male	3
Helen	Nursing Resource Team	Female	5
Susan	Nursing Resource Team	Female	10
Deborah	Cardiology	Female	3
Raymond	General Internal Medicine	Male	2.5
Nick	Cardiology	Male	1.5
Lisa	Emergency Room	Female	2
Frances	Nursing Resource Team	Female	2.5
Princess	General Internal Medicine	Female	5
Jasmin	Nursing Resource Team	Female	0.5
Kate	Thoracic	Female	10
Rick	Emergency Room	Male	2
Angela	Emergency Room	Female	5
Marjorie	Emergency Room	Female	2.5
Blessing	Emergency Room	Male	4

Procedure

Prior to entering Cycle 1, the Institutional Research Board (IRB) application was submitted and amended before receiving approval from Northeastern University. Subsequently, the Research Ethics Board (REB) application was submitted for approval from the research site to gain access to staff on SAC units, which included Cardiology, General Internal Medicine, Thoracic, Nursing Resource Team (NRT), and the Emergency Room. This process was rigorous and lasted approximately three months. IRB dictates that any research involving human subjects must be approved in advance to comply with institutional and government-mandated guidelines for ethical research (Blee & Currier, 2011). After discussions with Unit Managers, Patient Care Coordinators (PCCs), and Advanced Practice Nursing Educators (APNEs), recruitment was initiated, and consultations incorporated full disclosure to gain permission to conduct the study on their units. Subsequently, details regarding the study were emailed to all RNs and RPNs on the identified units, which included the contact information for the researcher

for interested participants. As the chosen interview site is where the researcher works, all correspondence initiated with participants had to be done via the institution's communication platform, such as email, phone number, and Microsoft Teams for interviews, as mandated by the site's REB guidelines. Recruitment also involved providing study briefings during staff safety huddles. All participants provided informed consent, which included sharing the aims, purpose, use of results, and potential consequences of the study, as well as obtaining written acknowledgment of their willingness to participate (Stringer & Aragón, 2020). Data collection was continuous, with the primary focus on gathering insights from both RNs and RPNs, who typically work twelve-hour shifts encompassing both day and night rotations. This approach aimed to capture diverse perspectives, crucial for the study's findings. Semi-structured interviews were conducted virtually using Microsoft Teams, ensuring a secure virtual platform. The researcher scheduled interviews during participants' days off to avoid disrupting patient care. Interview questions were formulated based on theoretical concepts derived from the literature and pilot interviews conducted earlier during the R2 phase.

Data Analysis

Throughout the interviews, field notes were taken and documented. Subsequently, in vivo, a theoretical coding process was employed for data analysis, identifying common themes which were then categorized into emergent groups (Saldana, 2021). Before commencing in vivo coding, the field notes were thoroughly reviewed multiple times. Process coding was implemented to structure the data into primary headings, which were further developed into descriptive themes. These themes were utilized to derive the research findings. Sixteen interviews were conducted with participants from SAC units who either 1) worked in acute care prior to the initiation of the nursing skilled-mix model, 2) were hired during the initiation of the nursing skilled-mix model, or 3) were hired post-initiation of the nursing skilled-mix model. The following categories and themes emerged prominently within the data collection and will be discussed further below.

Variation in Knowledge of Scope of Practice

Of the sixteen participants who underwent interviews, 94% of both RNs and RPNs indicated that they lacked a comprehensive understanding of each other's scope of practice. Similarly, when asked about their comprehension of their individual scope of practice, all participants replied, “no”. They attributed this to two distinct factors: 1) a lack of clear instruction on the scope of practice during nursing school, and 2) uncertainty regarding the limitations for RPNs, as both RNs and RPNs were carrying out similar tasks at the same level. One RPN explained that I am worried about being at risk of losing my license as I am practicing outside of my scope, but I am too afraid to speak up as I am a novice nurse and I was told to just do it. Another RPN stated that there was a lack of knowledge as to what an RPN can do versus what an RN could do and that some nurses, especially the senior experienced RNs, would limit RPNs to what they can do. Both RNs and RPNs reiterated that they need more education on the description of the roles and responsibilities of both categories of nurses as they are asked to work to full scope but there were no explanation or guidance of what this really is.

Competency

The implementation of the nursing skilled-mix model resulted in the recruitment of RPNs to SAC units and their training in advanced patient care tasks. Some RPNs possessed prior experience in acute care, while others were recent graduates entering the field. Eighty percent of RPNs expressed concerns about working beyond their scope of practice and jeopardizing their license to practice. Several RPNs experienced the need to consistently demonstrate their capabilities to RNs, as there was a perceived lack of trust in their ability to carry out tasks accurately. Some RPNs expressed feeling constrained by excessive limitations, with certain tasks taken away from them. Additionally, some RPNs mentioned feeling reluctant to ask questions, as it was implied that they should already possess the necessary nursing skills upon accepting the job. This led to differing levels of frustration, as one RPN expressed, it was challenging at the outset to constantly face criticism due to my limited skills and practice. Some RNs

have suggested that an extended training period with the Advance Practice Nurse Educator (APNE) would be beneficial, as RPNs were unfamiliar with many of their skills.

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Disrespect and Inferiority

While some participants recalled experiencing collaborative practice between RNs and RPNs during their student days, the majority reported its absence once they transitioned to independent practice. Eighty-seven point five percent of RPNs stated that they encountered verbal hostility, leading to feelings of humiliation and a desire to resign. These behaviors were most often displayed by senior RNs. One RPN stated that frequently, RNs would ask me why don't I go back to school and train to become an RN because the pay that I get is garbage. When asked how this made you feel, the RPN responded, it makes me feel humiliated. When RPNs overheard senior RNs expressing reluctance to work with nurses who underwent two years of schooling and appeared uncertain in their tasks, it made them feel diminished as nurses and unwelcome within the team. At times, RPNs were referred to as

'half-nurses,' an experience they described as working in a hostile environment. In one interview, an RPN posed the question to the student researcher, 'Who am I?' He recounted that when his nurse educator instructed him to direct any questions to a nurse (referring to RNs); it prompted him to question himself, am I not a nurse? For a brief moment, he bowed his head and with tears welling in his eyes, he asked the researcher for permission to express his frustration, stating, 'I am angry.'

Job-Dissatisfaction

The reception of RPNs in acute care settings was not readily acceptable, potentially due to systemic cultural norms. In the past, RPNs primarily worked on long-term care units, as acute care settings like the Emergency Room were considered too critical for RPNs to withstand. The exacerbation of the nursing shortage, particularly evident during the COVID pandemic, has resulted in an increase in RNs opting for early retirement or transitioning into non-clinical roles. The expanded scope of practice for RPNs, especially during the pandemic, has facilitated their ability to work in SAC units. Upon the implementation of the nursing skilled mix model on SAC units, RNs perceived RPNs as RN assistants, particularly due to burnout resulting from inadequate nursing staffing levels. In some instances, Nurse Managers encountered a limited number of applicants for RN vacant positions, leading to recruitment of RPNs. Furthermore, the findings of the Acuity Base Study (ABS) carried at NHU on all SAC units, demonstrated that RPNs could safely care for 70% of patients on SAC units.

While RPNs were grateful for the chance to enhance their skill proficiency in SAC settings, many experienced a sense of being unwelcome and ultimately decided to resign from their positions. Results from the interviews revealed that seventy-five percent of RPNs felt rejected, unwelcomed, and did not feel treated like a nurse. One RN participant recounted her experience as an RPN, noting numerous rejections that left her feeling inferior. She went on to express that whenever she identified herself as an RPN, recruiters promptly informed her that they were solely seeking RNs. When she inquired about the reasons behind this discrimination, she was informed that RPNs were perceived as having limited

Table A2

Cycle 1: In Vivo, Process, and Theoretical Coding

RNs/RPNs Clinical Experience/Category	Exemplar Quote	Theme
Job-dissatisfaction	It felt like they do not really trust us as nurses to be taking care of new incoming patients. I found it unfair, because that was why | transferred to this unit to expand my critical thinking.	Feeling inferior Lack of trust
Poor Retention	Some days it was so overwhelming that I just wanted to quit. I have seen other RPNs quit.	Feeling overwhelmed
Fear and Frustration	Like if you ask them a question, they are like, 'you should know that already in a condescending way. You may have questions that you just want to be sure about and they are not very approachable and that is what rubs me off the wrong way, then you do not want to talk or approach them anymore.	Intimidating and condescending
Scope of Practice	I do not think that I am that knowledgeable about the scope of practice. We need more education on the description of the roles and responsibilities on the RN and RPN. We are asked to work to full scope but there is no explanation, no guidance of what this is.	Role confusion Lack of knowledge
Competency	I have asked for assistance because I did not know how to do a particular task and I was just left to figure it out myself.	Poor teamwork Lack of support

capabilities. However, after transitioning to an RN role, she noted a stark contrast in her experience, feeling consistently welcomed and valued at work. She frequently advocates for RPNs, taking the time to educate her RN colleagues about their capabilities and contributions. She elaborated that she frequently witnesses RPNs resigning due to the hospital's culture failing to recognize them as

valuable members of the healthcare team. The in vivo, process, and theoretical coding are illustrated in Table A2.

Summary

The participant interviews revealed that the structure established to introduce and oversee the implementation of the nursing skilled-mix model was ineffective. No formal review was conducted since its inception, and both RNs and RPNs expressed uncertainty regarding their roles, as the nursing skilled-mix model was a recent addition to SAC units. RPNs experienced a persistent need to validate their abilities to RNs, reflecting a lack of trust in their capacity to perform tasks accurately. While nurses are accountable for adhering to their scope of practice, nursing leadership, particularly nurse managers, bears the responsibility of guiding nurses as they adapt to a new model of patient care. The literature review indicated that nurse managers frequently face challenges stemming from unclear job descriptions and shifts in the scope of practice for RNs and RPNs. These issues led to ambiguity and job dissatisfaction among the nursing team. Establishing a standardized framework for nurses is crucial in streamlining roles and responsibilities, especially considering the overlapping tasks performed by RNs and RPNs. Confidence in their roles eliminates confusion and fosters teamwork among nurses.

Educating RNs and RPNs about their collaborative roles would eradicate ambiguity and cultivate an integrated work environment. Collaboration should engage stakeholders across institutions where activities and policies are aimed at fostering a culture where all nurses feel accepted and welcomed. Healthcare organizations should endeavor to institute structures that are profitable for building a collaborative culture for practitioners; thus, a review and analysis of the nursing skilled-mix model and barriers experienced by RNs and RPNs on SAC units was warranted. Cycle 1 results engaged stakeholders who co-created together to examine gaps and develop strategies that can be utilized to strengthen RNs' and RPNs' collaborative practice.

Data Collection and Analysis: Cycle 2

The insights gathered from the data collected during Cycle 1 sparked the decision to utilize focus group discussions as a collaborative approach. These discussions were designed to empower participants to co-create strategies aimed at formalizing a framework to strengthen collaborative practice between RNs and RPNs. This section will delineate the execution of action steps and data analysis, highlighting the effectiveness of the focus group discussions.

Participants

The primary research participants were RNs, RPNs, and staff who worked at various sites of NHU on SAC units where the nursing skilled-mix model exists. Therefore, the inclusion and exclusion criteria varied slightly, as participants were not exclusively from one site of NHU. Prior to recruiting participants, assistance was solicited from the Director of Education, who provided the researcher with all group emails for every category of nurses employed at NHU, thereby facilitating outreach to a broader population. After applying the inclusion and exclusion criteria, a sample of 21 participants responded, and initially, two RNs, two RPNs, and five nursing leadership staff were consented for the focus group discussion. Four nursing leadership staff and one RN were recruited via purposive sampling, while one RPN withdrew consent on the day of the focus group session due to a family emergency. During each focus group session, an external research assistant volunteered as the scribe, documenting data throughout the discussions. Additionally, the researcher took field notes during these sessions.

Thirty-five percent of the sample consisted of nurses, including RNs (n=2) and RPNs (n=2). Among them, there were three females and one male. Sixty-five percent of the participants were composed of nursing leadership staff, which included PCCs (n=3), NMs (n=2), APNEs (n=2), NPs (n=1), and NCs (n=1). Among the nursing leadership staff, there were three males and six females. The roles and professional statuses of the participants are crucial to the research and the dissemination of the study findings, as they symbolically contribute to the process by sharing vital information about the

problem of practice (Saldana, 2021). The utilization of social mapping was instrumental in facilitating the acquisition of a diverse range of participants who are directly and indirectly affected by barriers affecting RNs and RPNs collaborative practice (Stringer & Aragón, 2020). Table A3 displays the demographic data of the participants.

Table A3

Participants' Demographics: Focus group Discussion

Characteristic		Frequency	%
Professional designation	Registered nurse (RN)	2	15
	Registered Practical Nurse (RPN)	2	15
	Nurse Practitioner	1	8
	Nurse Coordinator	1	8
	Nurse Manager	2	15
	Advanced Nurse Educator	2	15
	Patient Care Coordinator	3	23
Gender	Male	5	38
	Female	8	62
Clinical practice unit	General internal medicine	4	31
	General surgery	5	38
	Outpatient services	4	31

Procedure

The aim of this Cycle 2 action research study was to identify strategies that can strengthen collaborative practice between RNs and RPNs on SAC units. This was inspired by the interview results in Cycle 1 where participants described their experience of what collaborative practice means to them, and underscored the necessity for organizational leadership to actively engage in constructing and implementing policies aimed at strengthening collaborative practice at NHU.

The planning phase to initiate focus group discussions with eligible participants began immediately after REB approval from the research site. The REB dictated that any research involving human subjects must be approved to comply with institutional and government-mandated guidelines

for ethical research (Blee & Currier, 2011). The main activities for Cycle 2 are a series of focus group discussions: 1) with RNs and RPNs and 2) with staff. Focus group discussions are frequently utilized as a qualitative method to delve deeply into social issues and gather data from a purposive sample of individuals, rather than from a statistically representative sample of a larger population (Nyumba et al., 2018). The most effective way to address the problem of practice and develop suitable strategies was by convening participants and key stakeholders directly affected by the issue. This includes RNs, RPNs, and staff who are directly involved in overseeing nursing practice.

The goal of Cycle 2 action steps was to have participants co-create together in ways where they could discuss data shared from Cycle 1 participants and offer their perspectives on how organizational teamwork could be enhanced at NHU. Learning and understanding barriers to collaborative practice will not only assist in identifying ways to strengthen collaboration between RNs and RPNs, but it would also improve nurse retention and attract other nurses to join the staff at NHU, where teamwork would be prioritized. Just as nurses came together as a collaborative team during the COVID-19 pandemic to care for those in need, the aim of the focus group discussion is to engage nurses at all levels in collaborating on strategies to address barriers that jeopardize teamwork. This endeavor seeks to rebuild a hospital environment that recognizes and values the contribution of both RNs and RPNs to patient care.

The purpose of the focus group discussion was to offer nurses an opportunity to have an outlet to speak about the nursing skilled mix initiative to examine the benefits and barriers and how it affects patient care. It was necessary to know what strategies could be implemented to strengthen RNs and RPNs collaborative practice and furthermore, it was imperative that the organization recognized that without addressing how RNs and RPNs work together, might result in incidents that could result in liabilities to the organization. Furthermore, the organization stands in a position of power who can influence other entities such as the various unions who also impact how different groups of nurses work

together and see themselves in the wider healthcare system. Semi-structured interviews were conducted virtually using Microsoft Teams™, ensuring a secure virtual platform.

Data Analysis Technique

The purpose of Cycle 2 was to determine if focus group discussions were an effective method to formulate strategies that can be used to strengthen collaborative practice between RNs and RPNs. Multiple tools were employed for their effectiveness, including semi-structured interviews and focus group discussions, along with the use of field notes, analytic memos, in vivo coding, and member check-ins. The analysis was performed using in vivo, a coding technique for processing. Data obtained from the initial workshop with RNs and RPNs were manually coded using a descriptive coding method and organized into themes. Subsequently, the analysis of the second cycle data was carried out; identifying themes that specifically addressed barriers and provided resourceful strategies. Member check-ins were conducted to ensure data accuracy and validity, providing participants with the opportunity to offer feedback and clarification where necessary. In Cycle 2, Lime Survey© was utilized for member check-ins, and one participant provided additional feedback, whereas, others had no further adjustment. A comparable method involved multiple readings of the data, grouping and categorizing related terms, and employing a multimodal graphical display to present the five major themes derived from the participants' data. These themes are 1) clarifying scope of practice, 2) organizational accountability, 3) enhancing capacity via team-building events, 4) fostering equity and inclusion, and 5) promoting respect and civility.

The focus group discussion facilitated participants in co-creating resources aimed at developing a standardized framework to guide collaborative nursing practice on SAC units. AR involves collaborating with those impacted by the issue, thus engaging both internal and external stakeholders. This collaboration has not only fostered a sense of camaraderie and mutual respect among nursing staff but

has also been instrumental in identifying practical, effective strategies aimed at bolstering collaborative

Table A4

Cycle 2: In Vivo, Process, and Theoretical Coding

Focus Group Discussions	Exemplar Quotes	Theme
Scope of Practice	Education and training differences can be barriers where RNs have more opportunities than RPNs. Upskilling RPNs within the framework of their broadened scope of practice would help us to utilize them to their full capabilities within their limitations so that they feel worthwhile.	Understanding different roles Effective utilization Building confidence
Organizational Accountability	The hospital organization needs to look at how campaigns can drive change and it cannot be an overnight fix, or flavor of the month, it has to be a long-term investment to address broken teams. We need to dedicate at least 18 months into it for it to become the norm and culture of the organization.	Importance of involvement Need for cultural change Long-term investment
Capacity and Team-building	One of the things that could help build collaboration is to encourage the articulation of capacity and strength. There is a sense of pride that needs to be infused to make sure that RNs and RPNs equally feel proud to have chosen a healthcare profession.	Instilling professional values Recognizing individual values Distinguishing team values
Equity and Inclusion	We have to first start by looking at the human behind the profession. Not everyone is fortunate in our society to afford a four year degree program, especially if they are single parents, immigrants or refugees, as that affects their decision around their education.	Acceptance of each other Practicing empathy
Respect and Civility	Nurses are known to eat their young but they also eat their RPNs. It is only going to make it difficult for us to work as nurses when we do not respect other members of the team, including RPNs.	Improving teamwork Building trust

practice. Through this dynamic exchange, leadership and frontline nurses together have been able to pinpoint areas for improvement, devise innovative solutions to address gaps, and work towards a more integrated, cohesive working environment that enhances patient care and nursing satisfaction. The in vivo, process, and theoretical coding are illustrated in Table A4.

Ethical Considerations

Ethical considerations in AR may pose challenges for both researchers and participants, as they often encounter aspects of exposure not typically found in other research methodologies, such as quantitative research. This can be particularly consequential for researchers conducting studies within their own workplace, necessitating frequent reflection and reflexivity to uphold ethical boundaries and ensure the integrity of the research process (Williamson & Prosser, 2002). Participating as an insider in this research also raises ethical challenges, as this role has the potential to compromise certain aspects of objectivity (Coghlan & Cassey, 2001). Moreover, as a Registered Nurse, inherent bias towards RNs may exist, and there could also be sympathetic bias towards RPNs. Therefore, continual self-reflection was imperative throughout the course of this study.

Ethics approvals were obtained from both Northeastern University and the research site. Throughout the recruitment process, full disclosure regarding the study and its objectives was provided. Participants who expressed interest in joining the study via email were required to provide informed consent. If participants have any questions about this study, they may contact the researcher via a secure platform as mandated by the research site. For inquiries regarding participant rights in this research, they may reach out to the Research Ethics Board (REB) at NHU via email at REB@nhuresearch.ca (pseudonym).

As the research took place at NHU, the researcher intentionally selected specialized units to recruit participants where they had no prior experience working. Participants were invited to join the virtual semi-structured interviews via Microsoft Teams™. They were encouraged to join from a suitable

setting that enabled them to participate without distraction. Additionally, the researcher secured a private room onsite at NHU for participant interviews. The semi-structured interviews were recorded, all participants were given fictitious names, and the data were treated with confidentiality. Anonymity was maintained in all records and publications. The recorded sessions have been stored on a password-protected storage device for a period of ten years. After this time, they will be securely destroyed. There were no direct benefits for participating in the study. The research findings were utilized to inform RN/RPN collaborative practice on SAC units at NHU, aiming to enhance collaborative practice between RNs and RPNs. The data in this study will continue to be treated confidentially. The reports and publications derived from this study will utilize only group data and will not identify individual participants as being involved in the research. The decision to participate in this research project was entirely voluntary for each participant. They were informed that participation was optional, and they had the right to refuse to answer any questions. Additionally, participants were made aware that they could withdraw from the study at any time, even after it had commenced.

Trustworthiness

Trustworthiness or rigor of a study pertains to the level of confidence in the data, interpretation, and methods employed to ensure the quality of the study (Pilot & Beck, 2014). In qualitative research, trustworthiness is assessed to ensure validity and reliability of the study through four distinct areas: credibility, dependability, confirmability, and transferability. Credibility commonly pertains to both internal and external validity, ensuring that there is corroborating evidence that aligns with the study's intentions (Lincoln & Guba, 2005). In this research study, internal validity was secured by fostering trust among participants through the establishment of a privacy and confidentiality environment. Extensive data were collected using open-ended questions, allowing participants to articulate their lived experiences freely. External validity was ensured by including a diverse range of SAC units in the study, such as medical, surgical, in-patient, and outpatient units, thus providing comprehensive coverage

across various clinical areas. Moreover, incorporating nurses from NRT allows the researcher to collect comprehensive data concerning collaborative practices between RNs and RPNs. NRT nurses rotate across various SAC units, exposing them to diverse experiences in teamwork between RNs and RPNs.

Dependability plays a critical role in qualitative research, ensuring the reliability and consistency of both findings and interpretation of the data. It refers to the researcher's ability to clarify the study process with comprehensive details, thereby ensuring the reproducibility of the work (Stringer & Aragón, 2020). This was achieved by employing data triangulation, as evidenced when participants in Cycle 2 focus group discussions echoed similar experiences as those shared by participants in the Cycle 1 interviews, following the comparison and amalgamation of results.

Confirmability assesses the researcher's capacity to authenticate and communicate that the results are grounded in the information provided by participants, devoid of the researcher's interpretations or biases (Stringer & Aragón, 2020). The ability to take detailed field notes and utilize in vivo for theoretical coding, which involves multiple re-reads, offered an opportunity to authenticate the data. In addition, the use of direct quotes from participants provided greater understanding and validation of the information retrieved from participants in Cycle 1 and 2. Furthermore, conducting member check-ins using Lime Survey also contributed to substantiating the data and supported confirmation bias.

Lastly, transferability occurs when the researcher provides contextual information that assesses the applicability of the results to the research's intended aim or similar situations (Lincoln and Guba, 2005). This was observed when participants on various SAC units were able to describe similar experiences, indicating that the findings could be relevant and applicable to SAC units within NHU and potentially to similar healthcare settings with the nursing skilled-mix practice.

Limitations

The study identified some solid ways in which trustworthiness has been established; however, there are a few limitations that were recognized. Initially, despite the lively engagement during interviews and focus group discussions, it is noteworthy that only one RN interview took place in person, while all other participants opted for virtual interactions. Additionally, the IRB approval from the research site mandated that focus group discussions be conducted virtually, with cameras turned off to safeguard participant privacy and confidentiality. Increased opportunities for in-person interactions may have facilitated even deeper engagement.

Secondly, the participant demographic data in Table A1 revealed a notable presence of nurses who commenced working on SAC units after the implementation of the nursing skilled-mix model. Exploring participants' perceptions of the preparation process before integrating RNs and RPNs on SAC units could have provided valuable insights. This aspect is crucial, as preparation significantly influences individuals' acceptance of change. Additionally, having more participants with over ten years of experience would have offered a deeper understanding of the historical context of RNs' perceptions of the RPN role and its evolution over time, including uncertainties surrounding RPNs working in acute care settings.

Thirdly, it is important to recognize the context in which this study took place, specifically the ongoing challenges brought by the coronavirus pandemic. Nurses, along with healthcare professionals worldwide, have been thrust into a relentless battle against COVID-19, grappling with unprecedented levels of physical, psychological, and emotional strain. The pandemic has imposed profound stressors on nursing staff, from the persistent demands of caring for critically ill patients to the fear of contracting the virus themselves and transmitting it to their loved ones. These extraordinary circumstances undoubtedly cast a shadow over the data collection process, potentially influencing the perspectives and experiences shared by participants. Unlike the hypothetical scenario of collecting data prior to the

pandemic's onset, when the focus might have been predominantly on the structural implementation of the nursing skilled-mix initiative, the pandemic context likely prompted discussions on additional challenges, such as heightened infection control measures, increased workload, and the strain on interprofessional collaboration. Thus, it is imperative to recognize the pandemic's impact as a significant contextual factor shaping the data and interpretations gleaned from this study.

Finally, at NHU, the skilled-mix model was implemented across various departments, including Rehabilitation units, where both RNs and RPNs are present. However, it is essential to recognize that these units differ significantly from SAC units examined in this study. Unlike SAC units, Rehabilitation units typically accommodate patients with lower acuity levels and focus on long-term recovery and therapy. Consequently, replicating the study's methodology and findings in Rehabilitation units may not yield comparable results due to the disparities in patient populations and acuity levels. Therefore, future research endeavors aiming to explore collaborative practice between RNs and RPNs should carefully consider the unique characteristics and dynamics of each clinical setting to ensure the relevance and applicability of their findings.

Table A5

Participant Demographics: SAC Unit

Characteristic		Frequency	%
Professional designation	Registered Nurse (RN)	8	50
	Registered Practical Nurse (RPN)	8	50
Years of experience	0-5	13	81
	6-10	2	13
	>10	1	6
Clinical practice unit	Emergency room	6	38
	Nursing resource team	5	32
	General internal medicine	2	12
	Cardiology	2	12
	Thoracic	1	6
Gender	Males	4	31.25
	Females	12	68.75

Table A6

Data Gathering and Analysis Process

Data Gathering	Data Analysis
	Phase 1
Interviews	Active listening, observing, rephrasing, detecting patterns, interpreting
In vivo and process coding	Read and reread field notes, code, synthesize, detected patterns, identified themes and categories, interpreted and described
Validation/Reliability	Members Check-in
	Phase 2
Focus Group Discussion	Active listening, Observing, rephrasing, detecting patterns, interpreting
In vivo and process coding	Read and reread field notes, code, synthesize, detected patterns, identified themes and categories, interpreted and described
Validation/Reliability	Members Check-in

Table A7

In Vivo, Process, and Theoretical Coding

RNs/RPNs Clinical Experience	Exemplar Quotes	Theme
Job-dissatisfaction	It felt like they do not really trust us as nurses to be taking care of new incoming patients. I found it unfair, because that was why | transferred to this unit to expand my critical thinking.	Feeling inferior Lack of trust
Poor Retention	Some days it was so overwhelming that I just wanted to quit. I have seen other RPNs quit.	Feeling overwhelmed
Fear and Frustration	Like if you ask them a question, they are like, you should know that already in a condescending way. You may have questions that you just want to be sure about and they are not very approachable and that is what rubs me off the wrong way, then you do not want to talk or approach them anymore.	Intimidating Condescending
Scope of Practice	I do not think that I am that knowledgeable about the scope of practice. We need more education on the description of the roles and responsibilities on the RN and RPN. We are asked to work to full scope but there is no explanation, no guidance of what this is.	Role confusion Lacking knowledge
Competency	I have asked for assistance because I did not know how to do a particular task and I was just left to figure it out myself.	Poor teamwork Lack of support

Table A8

List of Participants: Participant's Roles, Goals, and Linkage to Stakeholders

Participants' Role in Organization	Participants' goals	Linkages with other stakeholders
Unit Manager (NM) (Internal Stakeholders)	To understand the change in roles for RN and RPNs and engage nurses in collaborative practice	Work alongside Advance Practice Nurse Educators, Patient Care Coordinators, Chief Nurse Executive, Director of Education, Nurse Practitioners and RNs and RPNs.
Patient Care Coordinator (PCC) (Internal Stakeholders)	To allocate shift schedule to RNs/RPNs that enhances collaborative work between RNs and RPNs	Work alongside In-charge Nurses, Advanced Practice Nurse Educators, Unit Managers, Nurse Practitioners, RNs and RPNs
Registered Nurse (RN) (Internal Stakeholders)	Work alongside RPNs on specialized acute care units	Work alongside Nurse Practitioners, In-charge Nurses, Advanced Practice Nurse Educators, Nurse Managers, Patient Care Coordinators and RPNs
Registered Practical Nurse (RPN) (Internal Stakeholders)	Work alongside RNs on specialized acute care units	Work alongside Nurse Practitioner, In-charge Nurse, Advanced Practice Nurse Educators, Unit Managers, Patient care Coordinators and RNs
Advanced Practice Nurse Educator (APNE) (Internal Stakeholder)	Provide education to RNs and RPNs	Work alongside Patient Care Coordinator, RNs and RPNs, Director of Education and Nurse Managers
Nurses Practitioner (NP) (Internal Stakeholder	Delegate tasks to RNs and RPNs	Work alongside Nurse Managers, Patient Care Coordinators, Advanced Practice Nurses Education, RNs and RPNs
Nurse Coordinator (NC) (Internal Stakeholder)	Collaborate with RNs and RPNs to ensure effective patient care	Work alongside Nurse Managers, NPs, Advance Practice Nurse Educator, Patient Care Coordinator, RNs and RPNs

Figure A1

Themes and Categories of RNs and RPNs Collaborative Practice

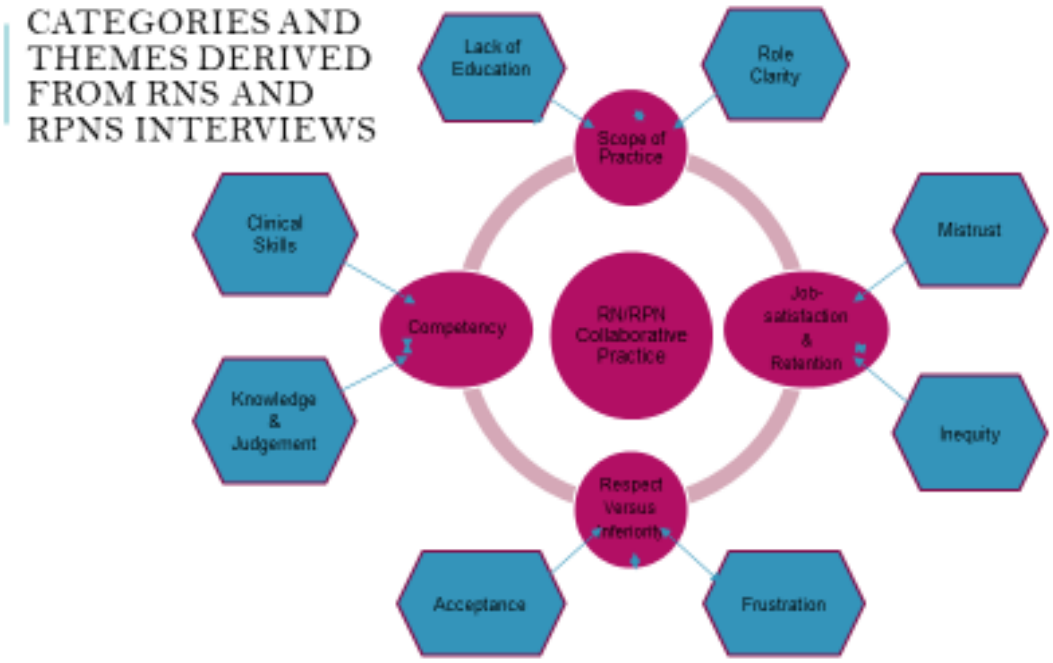

Figure A2

Cycle 2 Findings: Focus Group Discussion of Strategies to Strengthen Collaborative Practice on SAC Units

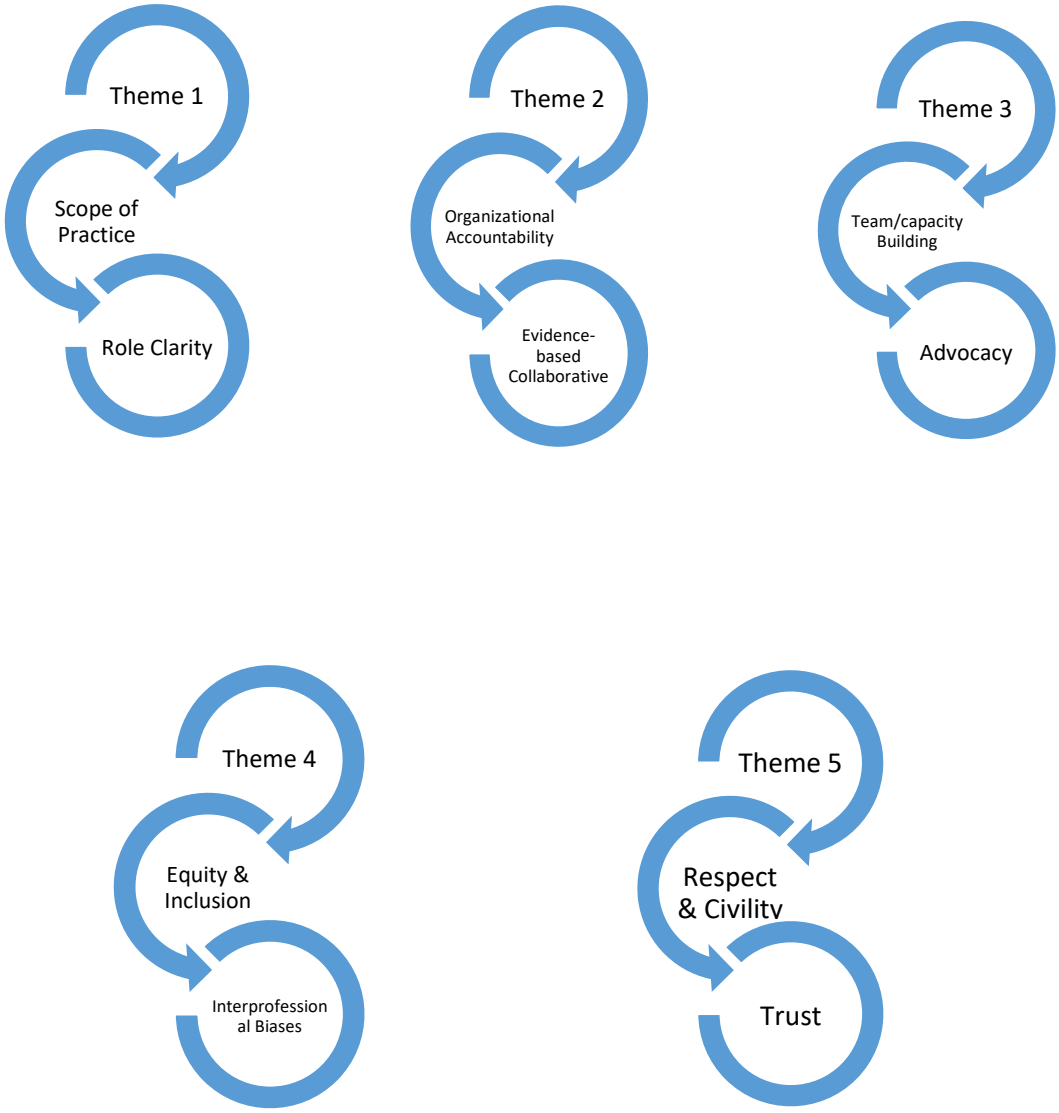

Figure A3

Cycle 2 Focus Group Discussion Questions

Figure A4

Cycle 2 Focus Group Discussion Questions on Potential Strategies

Table A9

Cycle 1 Participants' Demographic Information

Participant (pseudonym)	Clinical Unit	Gender	Years of Experience
Kelly	Emergency Room	Female	2
Peter	Emergency Room	Male	3
Helen	Nursing Resource Team	Female	5
Susan	Nursing Resource Team	Female	10
Deborah	Cardiology	Female	3
Raymond	General Internal Medicine	Male	2.5
Nick	Cardiology	Male	1.5
Lisa	Emergency Room	Female	2
Juliet	Nursing Resource Team	Female	2.5
Princess	General Internal Medicine	Female	5
Jasmin	Nursing Resource Team	Female	0.5
Kate	Thoracic	Female	10
Rick	Emergency Room	Male	2
Angela	Emergency Room	Female	5
Marjorie	Emergency Room	Female	2.5
Blessing	Emergency Room	Male	4

Table A10

In Vivo, Process, and Theoretical Coding

RNs/RPNs Clinical Experience	Exemplar Quotes	Theme
Job-dissatisfaction	It felt like they do not really trust us as nurses to be taking care of new incoming patients. I found it unfair, because that was why | transferred to this unit to expand my critical thinking.	Feeling inferior Lack of trust
Poor Retention	Some days it was so overwhelming that I just wanted to quit. I have seen other RPNs quit.	Feeling overwhelmed
Fear and Frustration	Like if you ask them a question, they are like, 'you should know that already in a condescending way. You may have questions that you just want to be sure about and they are not very approachable and that is what rubs me off the wrong way, then you do not want to talk or approach them anymore.	Intimidating and condescending
Scope of Practice	I do not think that I am that knowledgeable about the scope of practice. We need more education on the description of the roles and responsibilities on the RN and RPN. We are asked to work to full scope but there is no explanation, no guidance of what this is.	Role confusion Lack of knowledge
Competency	I have asked for assistance because I did not know how to do a particular task and I was just left to figure it out myself.	Poor teamwork Lack of support

Table A11

Participants' Demographics: Focus group Discussion

Characteristic		Frequency	%
Professional designation	Registered nurse (RN)	2	15
	Registered Practical Nurse (RPN)	2	15
	Nurse Practitioner	1	8
	Nurse Coordinator	1	8
	Nurse Manager	2	15
	Advanced Nurse Educator	2	15
	Patient Care Coordinator	3	23
Gender	Male	5	38
	Female	8	62
Clinical practice unit	General internal medicine	4	31
	General surgery	5	38
	Outpatient services	4	31

Table A12

In Vivo, Process, and Theoretical Coding

Focus Group Discussions	Exemplar Quotes	Theme
Scope of Practice	Education and training differences can be barriers where RNs have more opportunities than RPNs. Upskilling RPNs within the framework of their broadened scope of practice would help us to utilize them to their full capabilities within their limitations so that they feel worthwhile.	Understanding different roles Effective utilization Building confidence
Organizational Accountability	The hospital organization needs to look at how campaigns can drive change and it cannot be an overnight fix, or flavor of the month, it has to be a long-term investment to address broken teams. We need to dedicate at least 18 months into it for it to become the norm and culture of the organization.	Importance of involvement Need for cultural change Long-term investment
Capacity and Team-building	One of the things that could help build collaboration is to encourage the articulation of capacity and strength. There is a sense of pride that needs to be infused to make sure that RNs and RPNs equally feel proud to have chosen a healthcare profession.	Instilling professional values Recognizing individual values Distinguishing team values
Equity and Inclusion	We have to first start by looking at the human behind the profession. Not everyone is fortunate in our society to afford a four year degree program, especially if they are single parents, immigrants or refugees, as that affects their decision around their education.	Acceptance of each other Practicing empathy
Respect and Civility	Nurses are known to eat their young but they also eat their RPNs. It is only going to make it difficult for us to work as nurses when we do not respect other members of the team, including RPNs.	Improving teamwork Building trust

Table A13

Cycle 1 Semi-Structured Interview Main Findings

Core Themes	Who Are Affected	Data/Findings
Scope of Practice	RNs and RPNs	94% of RNs and RPNs do not fully understand theirs or each other scope of practice
Competency	RPNs	80% felt that they were working outside of their scope of practice
Inferiority/Frustration	RPNs	87.5% experienced verbal hostility and humiliation
Job-dissatisfaction	RPNs	75% felt rejected and unwelcomed

Table A14

Cycle 2 Participants' *Demographic Information*

Participant (pseudonym)	Nursing Position	Gender	Clinical Unit
Naomi	Advanced Practice Nurse Educator	Female	Out-patient
Alexis	Nurse Manager	Female	Medical
Nya	Nurse Practitioner	Female	Surgical
Timothy	Patient Care Coordinator	Male	Out-patient
Benjamin	Patient Care Coordinator	Male	Out-patent
Frances	Nurse Manager	Female	Medical
Sara	Advanced Practice Nurse Educator	Female	Surgical
Sophia	Nurse Coordinator	Female	Surgical
Paul	Patient Care Coordinator	Male	Out-patient
Adam	Registered Practical Nurse	Male	Surgical
Sue	Registered Nurse	Female	Medical
Ashley	Registered Practical Nurse	Female	Medical
Abigail	Registered Nurse	Female	Surgical

Table A15

Complete Schedule of Cycle 2 Events and Activities

Date/Time	Time	Event	Number of Attendees
Thursday, February 08, 2024 @ 11:30 am	2-APNEs 2-NMs 1-PCC	Focus Group Discussion # 1 via Microsoft Teams	5
Saturday, February 10, 2024 @ 2:30pm	1-PCC 1-NC	Focus Group Discussion #2 via Microsoft Teams	2
Monday, February 12, 2024 @ 12pm	1-NP 1-PCC	Focus Group Discussion #3 via Microsoft Teams	2
Tuesday, February 13, 2024 @ 11:30am	1-RN 2-RPNs	Focus Group Discussion #4 via Microsoft Teams	3
Thursday, February 15, 2024 @ 2:30pm	1-RN	Focus Group Discussion #5 via Microsoft teams	1

RN & RPN COLLABORATIVE PRACTICE

Hello:

Are you a Registered Nurse (RN) or Registered Practical Nurse (RPN) who works in an acute care unit at NHU?

Are you interested in taking part in a study about how RNs and RPNs can support each other in the clinical settings?

In order to participate, you will need to meet the following eligible criteria:

- You must be an employee at HGT (pseudonym)
- You must work on one of the following units: Cardiology, Thoracic, General Internal Medicine, Nursing Resource Team (NRT) or Emergency
- You must be a RN or RPN

What is required?

- You will attend an interview for 30-45 minutes
- Interviews will be conducted via Microsoft Teams, interview Rooms at HGT, or a suitable area off site that is close to the participant

Participant enrolment:

- You can email Alicia Jones at Alicia.Jones@nhu.ca or call 437-225-6489

Participant Recruitment:

- A consent form will be provided for you to read and you can ask clarifying questions at anytime

Participant Withdrawal:

- You can voluntarily decide at any time during the study to change your mind and withdraw from being a participant. Withdrawal from the study will not affect you in any way

Reimbursement

- You will be reimbursed a token of a $10 Starbucks or Tim Hortons Gift Card for participating

Risk:

- You may feel a little anxious about answering the questions, however, there is no known risk in participating in this study

Benefits:

- Information from this study may help to inform how RNs and RPNs work collaboratively at NHU.

Thank You!

Focus Group Discussion about Barriers Affecting RN & RPN Collaborative Practice

Hello:

Are you a Registered Nurse **(RN)**, Registered Practical Nurse **(RPN**) or a staff in Nursing Leadership role at NHU?

Are you interested in being a part of a focus group discussion about barriers that are affecting RNs and RPNs collaborative practice in the clinical settings and how we can strengthen teamwork among RNs and RPNs?

In order to participate, you will need to meet the following **eligible criteria**:

- You must be an employee at University Health Network NHU
- You must work on an acute care unit (e.g. Transplant, Thoracic, Surgery, Emergency, NRT etc.)
- You must be in a nursing leadership role that involves regulation and enhancement of RNs and RPNs clinical practice, or
- You must be an RN or RPN

What is required?

- You will attend a focus group discussion for 1 to 1 ½ hr.
- Two focus group discussions will be conducted **virtually via Microsoft Teams**, 1) with nurses only and 2) for nursing leadership staff only. Participants will be given an anonymous ID.

Participant enrolment:

- You can email Alicia Jones at Alicia.Jones@nhu.ca or call 437-225-6489.

Participant Recruitment:

- A consent form will be provided for you to read and you can ask clarifying questions at any time.

Participant Withdrawal:

- You can voluntarily decide at any time during the focus group discussion to change your mind and withdraw from being a participant. Withdrawal from the study will not affect you in any way.

Reimbursement

- You will be reimbursed a token of a $10 Starbucks or Tim Hortons Gift Card for participating.

Risk:

- There are no known risks in participating in this study

Benefits:

- Information from this study will be used to help inform how RNs and RPNs work together as a team at NHU (pseudonym).

Thank You!

Appendix B: Dissemination Plan

Presentation Manuscript

Abstract

Collaborative practice in health care is essential as it strengthens the relationship among teams and enhances an integrative work platform. Registered Nurses (RNs) and Registered Practical Nurses (RPNs) work together across different care settings in a supportive role that enhances patient outcomes, job satisfaction, and retention. Nursing stands as the largest healthcare profession in the nation, boasting nearly 4.2 million nurse's nationwide (Statistics Canada, 2022). In Canada, nurses constitute the largest segment of regulated health professionals, comprising approximately half of the total health workforce. However, globally, there has been a shortage of nurses attributed to burnout, physical injuries, and job dissatisfaction (Statistics Canada, 2022). To address the nursing shortage, several healthcare services have adopted the nursing skilled-mix model, facilitating collaboration between RNs and RPNs. At NHU, over the last six years, this practice model has been utilized to adequately staff nurses on Specialized Acute Care (SAC) units. Nonetheless, no formal study has been conducted to explore the experience of RNs and RPNs regarding collaborative practice. Qualitative action research was conducted to comprehend challenges and pinpoint effective strategies for strengthening collaborative practice among RNs and RPNs. Cycle 1 findings from participating RNs and RPNs revealed the necessity for broader discussions involving nursing leadership staff in Cycle 2. There were clear indications of knowledge gaps regarding scope of practice, disparities in assignments and professional development opportunities for RPNs resulted in ethical dilemmas, power imbalance between RNs, and RPNs regarding autonomy and the need for organizational leadership to take accountability to devise effective collaborative strategies were some of the major barriers to collaborative practice.

Keywords: collaborative practice*,* scope of practice, knowledge gap, nursing skilled-mix, power imbalance, silos, equity in clinical practice, leadership accountability, evidence-based framework

Problem of Practice, Purpose and Research Questions

The core challenge examined in this study centers on the entrenched division and compartmentalization inherent in the historical roles of RNs and RPNs. This division has significantly hindered their ability to collaborate and function cohesively. The primary aim of this research is to provide a comprehensive understanding of the collaborative practices experienced by RNs and RPNs on SAC units. By delving into their lived experiences, the study aims to unearth complexities regarding collaborative practice and to devise strategies aimed at enhancing collaboration. Through the application of qualitative descriptive data collection methods, including personal semi-structured interviews and focused group discussions conducted across two distinct cycles, the research seeks to address the following key inquiries:

Cycle 1:

Research Question 1 (RQ1) - To what extent is collaboration practiced between RNs and RPNs on SAC units.

Research Question 2 (RQ2) - What are the barriers to collaborative practice between RNs and RPNs.

Research Question 3 (RQ3) - What are the enablers to collaborative practice between RNs and RPNs.

Cycle 2:

Research Question 4 (RQ4) - How can RNs, RPNs and staff co-create together to develop strategies that can be used to strengthen collaborative practice between RNs and RPNs on SAC units.

Background and Context

The action research was conducted at NHU, situated in Toronto, which stands as the largest research and teaching hospital network in Canada. This organization encompasses three acute care

sites, one LTC facility, three Rehab units, and an educational institution. NHU serves as a significant employer of RNs and RPNs in Ontario, with 4,565 nurses employed across the network, constituting 32% of the overall workforce. While the operational model of skilled-mix environments for RNs and RPNs is customary in LTC and Rehab settings, this framework was extended to SAC units in 2018 due to nursing shortages, necessitating an adjustment in care delivery aligned with the standards established by the CNO. NHU mandated each in-patient SAC unit to conduct an ABS study, and subsequent analysis of the collected data revealed that RPNs could effectively and safely oversee the care of 70% of patients on SAC units.

Research Design and Methodology

The methodology adopted for this study is AR, a qualitative research approach rooted in the understanding that individuals derive meaning through social interactions within their surroundings (McDonald, 2021). This research design aligns well with the study's objectives, which center on examining both the benefits and hurdles of collaborative practice between RNs and RPNs at NHU, thereby tackling the identified problem statement. AR is deemed suitable due to its inherent focus on investigating real-world issues within specific contexts, making it particularly apt for delving into the complexities of collaborative nursing practice in this healthcare setting.

This methodology emphasizes the necessity of participant involvement, empowerment, and active engagement at every stage of the research process. Employing AR would be particularly conducive to supporting this study, given its focus on exploring the challenges and advantages encountered when RNs and RPNs within a specific Toronto hospital engage in collaborative practice. Despite both nursing groups being directly involved in patient care and having close interactions with patients, they often operate within distinct spheres. AR methodology offers a robust framework for delving into the underlying factors contributing to this separation and harnessing the active involvement of RNs and RPNs to devise strategies aimed at fortifying collaborative practice. Through a combination

of interviews and focused group discussions, AR enables a comprehensive examination of the dynamics shaping collaborative nursing practice, paving the way for informed interventions tailored to address specific barriers and enhance teamwork within the healthcare setting.

Participants

Numerous participants contributed valuable insights at various stages of this study. During Cycle 0 (baseline), RNs and RPNs from LTC and Rehab units affiliated with NHU participated, allowing the researcher to pilot the interview questions intended for Cycle 1. For Cycle 1, RNs and RPNs from the primary sites of NHU, housing SAC units, were recruited. Table B1 illustrates the participants in Cycle 2.

Table B1

Cycle 2 Participants' Demographic Information

Participant (pseudonym)	Nursing Position	Gender	Clinical Unit
Naomi	Advanced Practice Nurse Educator	Female	Out-patient
Alexis	Nurse Manager	Female	Medical
Nya	Nurse Practitioner	Female	Surgical
Timothy	Patient Care Coordinator	Male	Out-patient
Benjamin	Patient Care Coordinator	Male	Out-patent
Frances	Nurse Manager	Female	Medical
Sara	Advanced Practice Nurse Educator	Female	Surgical
Sophia	Nurse Coordinator	Female	Surgical
Paul	Patient Care Coordinator	Male	Out-patient
Adam	Registered Practical Nurse	Male	Surgical
Sue	Registered Nurse	Female	Medical
Ashley	Registered Practical Nurse	Female	Medical
Abigail	Registered Nurse	Female	Surgical

Selection criteria were tailored to units that were newly implemented into the nursing skilled-mix model following the ABS survey. In Cycle 2, participants included a mix of RNs, RPNs, and nursing leadership staff. Recruitment was expanded to encompass all NHU sites where individuals had experience with nurses in a skilled-mix model, engaging them in a series of focused group discussions.

Procedure

Based on the findings from Cycle 1 data analysis, it became apparent that significant barriers were impeding collaborative practice between RNs and RPNs. In response, the decision was made to convene focus group discussions, providing an avenue for RNs, RPNs, and nursing leadership to collectively explore potential strategies for strengthening collaborative practice. The objective of Cycle 2 was to foster participant collaboration, enabling them to delve into the insights gleaned from Cycle 1 data and offer their perspectives on how organizational teamwork could be enhanced at NHU. Through these collaborative efforts, the aim was to identify actionable steps towards improving collaboration and teamwork among nursing staff.

In the winter of 2024, a series of focus group discussions took place over five sessions, with three sessions involving nursing leadership staff exclusively, and two sessions including both RNs and RPNs. Each session began with a twenty-minute presentation, followed by a thirty-minute group discussion. The primary objective of these focus group discussions was to foster engagement among nurses across all levels of the organization, encouraging them to collaborate in developing strategies to overcome barriers and reconstruct an environment that recognizes and appreciates the valuable contributions of both RNs and RPNs to patient care. Through these discussions, participants had the opportunity to share insights, exchange ideas, and collectively explore solutions to enhance collaboration and teamwork within the healthcare setting. The schedule of the discussions is presented below in Table A17.

Data Collection

In the initial phase of data collection, Cycle 1 involved conducting semi-structured interviews with both RNs and RPNs to gain insights into their perspectives on collaborative practice and its significance within the healthcare context. Building upon the insights gleaned from Cycle 1, the

subsequent phase, Cycle 2, employed semi-structured focus group discussions involving RNs, RPNs, and nursing leadership staff. These sessions served as collaborative platforms for participants to collectively

Table B2

Complete Schedule of Cycle 2 Events and Activities

Date/Time	Time	Event	Number of Attendees
Thursday, February 08, 2024 @ 11:00- 12:30 pm	2-APNEs 2-NMs 1-PCC	Focus Group Discussion # 1 via Microsoft Teams	5
Saturday, February 10, 2024 @ 2:30- 4:00 pm	1-PCC 1-NC	Focus Group Discussion #2 via Microsoft Teams	2
Monday, February 12, 2024 @ 11:30-1:00 pm	1-NP 1-PCC	Focus Group Discussion #3 via Microsoft Teams	2
Tuesday, February 13, 2024 @ 11:00-12:30 pm	1-RN 2-RPNs	Focus Group Discussion #4 via Microsoft Teams	3
Thursday, February 15, 2024 @ 3:30-5:00 pm	1-RN	Focus Group Discussion #5 via Microsoft Teams™	1

brainstorm and devise actionable strategies aimed at enhancing collaborative practice specifically within the SAC units at NHU. Furthermore, to enrich the depth of data collected and analysis, various tools and techniques were utilized, including the meticulous documentation of field notes and observations, the formulation of analytic memos, the systematic in vivo coding process, the development of a comprehensive coding dictionary, and the utilization of audio recordings. These methodological approaches facilitated a thorough exploration and interpretation of the data findings, ensuring a robust

and comprehensive analysis of the factors influencing collaborative practice among RNs and RPNs within the healthcare setting.

Results/Findings

The objective of this action research is to delve into the barriers hindering collaborative practice among RNs and RPNs in SAC units, while formulating strategies to bolster teamwork and cooperation. Insights gleaned from Cycle 1 data illuminated a spectrum of issues, ranging from uncertainty surrounding scope of practice and competencies to role ambiguity, alongside emotions of frustration, humiliation, and a pervasive sense of job dissatisfaction. These factors collectively contribute to the challenge of retaining nursing staff at NHU. Collaborative efforts with stakeholders, coupled with thorough analysis of data and existing literature, led to the decision to facilitate focus group discussions. This avenue was deemed instrumental in unearthing actionable strategies aimed at fortifying collaborative practice within the RN and RPN cohorts.

Upon reviewing Cycle 2, it became evident that participants in both cycles echoed similar sentiments, underscoring the urgency to address existing barriers. The analysis revealed five primary areas ripe for enhancement: delineating the scope of practice, enforcing accountability among organizational leaders, enhancing team capacity through collaborative endeavors, fostering equity and inclusivity, and nurturing a culture grounded in respect and civility. Notably, participants at NHU offered tangible recommendations to fortify collaborative practice between RNs and RPNs within units operating under the nursing skilled-mix model.

Recommendations

Future research endeavors should prioritize the proactive involvement of organizational leadership in all facets of evidence-based framework development, implementation, and utilization. Overcoming the hurdles associated with collaborative practice between RNs and RPNs demands a comprehensive approach, beginning with senior leadership's active engagement in the standardization

of frameworks. By taking a top-down approach, senior leadership can ensure that these frameworks are meticulously crafted and effectively integrated into the organizational culture, fostering a positive environment for nursing collaboration. Moreover, this concerted effort should extend beyond nursing to encompass all members of the healthcare team, thereby promoting a culture of interdisciplinary collaboration and mutual respect.

Secondly, it is imperative to provide nurse managers with robust support mechanisms, including their involvement in educational initiatives such as workshops, webinars, and presentations. These educational sessions should focus on deepening their comprehension of the nuanced differences and similarities in the scopes of practice between RNs and RPNs. Clear guidelines are essential to mitigate role confusion and uncertainty regarding nursing responsibilities, which commonly arise in the absence of established protocols. Moreover, nurse managers often encounter obstacles in implementing changes due to resource constraints, underscoring the critical role of senior leadership support in facilitating effective change management. Thus, senior leadership must allocate adequate time and resources to nurse managers, empowering them to cultivate a positive organizational culture where RNs and RPNs can collaborate seamlessly in an environment conducive to teamwork and mutual support.

Thirdly, it is essential to integrate evidence-based frameworks as a mandatory tool for all nurses. This entails providing comprehensive training on the framework to every newly hired nurse and making its utilization an expectation in daily practice. For nurses already employed at NHU, scheduled training sessions should be arranged, enabling them to engage in simulations alongside both RNs and RPNs to facilitate the development of a collaborative environment. This practice should be consistently reinforced in daily operations to ensure its integration into the organizational culture, promoting a standard approach to collaborative practice among all nursing staff.

Finally, it is crucial to integrate the utilization of the framework into daily practice routines. NHU should embed collaborative practice principles into various aspects of work life, such as safety huddles,

staff meetings, debriefing sessions, and signage throughout the facility. Additionally, the development of e-learning modules and annual competency review sessions should be implemented, requiring participation from all RNs and RPNs. These modules would serve as opportunities for continuous education and reinforcement of collaborative practice expectations, ensuring that all nursing staff members remain proficient and aligned with the established framework.

Conclusion

In summary, improving collaborative practice among RNs and RPNs demands a comprehensive strategy involving organizational leaders, nurse managers, and frontline staff. This approach encompasses the implementation of evidence-based frameworks, the provision of support and education to nurse managers, and the integration of collaborative principles into everyday routines. Through these concerted efforts, healthcare institutions can cultivate an environment characterized by teamwork and mutual respect. Moving forward, ongoing research should delve deeper into the efficacy of these interventions, while also engaging organizational leadership more extensively in fostering positive cultural shifts. By collectively addressing barriers and championing collaboration, healthcare teams can elevate patient care outcomes and establish a workplace that is both supportive and inclusive for all members.