

REGISTERED NURSES' LIVED EXPERIENCE WORKING TO SCOPE OF PRACTICE IN
PEDIATRIC AMBULATORY MEDICAL CARE CLINICS

by

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ABSTRACT

In today's financial climate, the entire health care system, including nurses, has to ensure that care delivered is evidenced based, has positive outcomes, and is provided in the most fiscally responsible way possible. The literature highlights the fact that nurses, in general, are not working to the full scope of what they are authorized and educated to provide. A qualitative methodology grounded in interpretative phenomenology (Hermeneutic) was used to uncover how pediatric ambulatory care nurses live out their role, scope of practice, and the meaning they give to the experience of working to full scope of nursing practice in pediatric ambulatory medical care. Eight pediatric ambulatory medical care nurses from an Atlantic Canadian healthcare facility took part in focus groups to share their experiences about working to full scope of practice in their ambulatory nursing roles.

Interpretation of focus group session transcripts identified an over-arching central theme of "we are the mothers of our clinic areas" that reflected the lived experiences of this ambulatory nursing group. Three other sub-themes wove through the main theme; (a) What we do on a daily basis is our full scope of practice, (b) Ambulatory nursing: a different sort of busyness; and (c) Feeling under the gun: lack of resources and time. These nurses saw themselves as the "mothers" of their ambulatory clinic areas. They not only supported their patients and provided for their needs, but they also supported and coordinated their multidisciplinary team members to ensuring best possible care. Pieces of their work utilized their specialized nursing knowledge and skills, but they were also spending enormous amounts of time on tasks that did not make use of this. The nurses saw all of this work, both nursing and non-nursing, as work that fell within their scope of practice. What was also uncovered was the extensive knowledge and skill these registered nurses possess. Yet, using this knowledge to provide meaningful nursing interventions often came second to the nurses' perceived role as clinic "mother", where ensuring all team members had what they needed took priority. Nurses took on this work, as there was often no one else available or willing to do it. Disturbingly, this seemed to be the expectation of their colleagues and their administrators.

This study highlights the fact that there is much work to be done by both administrators and nurses to improve this situation and allow the pediatric ambulatory medical care nursing group to work to full scope of practice and deliver best nursing care to the families they serve. This work provides administrators with a starting point to address identified barriers and facilitators to create an environment where registered nurses are empowered to provide nursing care that best meets the needs of the patients and families they serve. This will involve clearly defining a role that fully utilizes their knowledge and skills to positively influence health care outcomes.

LIST OF ABBREVIATIONS USED

LPN	Licensed	Practical Nurse
RN	Registered	Nurse
RPN	Registered	Psychiatric Nurse

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CHAPTER I

Introduction

The business of health care is ever changing. The past decades have been witness to unimaginable advances in the medical sciences and supporting technology (Baranek, 2005). People are living longer, and living with more complex and chronic medical conditions (National Expert Commission, 2012; Romanow, 2002). These changes come with high financial costs that tax the resources of the system. The increasing demand for fiscal restraint, coupled with an identified national nursing shortage (Canadian Nursing Advisory Committee, 2002) highlight the fact that we cannot continue to provide health care in the same manner.

The entire health care system, including nurses, has to ensure that care delivered is evidenced based, has positive outcomes, and is provided in the most fiscally responsible way possible. Health care leaders and decision makers have repeatedly identified the importance of being able to clearly define the scope of practice for all members of the health care team, including the registered nurse (Baranek, 2005; Canadian Nurses Association, 1993; Canadian Nurses Association, 2003). The ability to establish the value that each discipline and/or care group brings to patient care is crucial when attempting to design the most cost effective and efficient models of care in challenging financial times (Canadian Nurses Association, 2003). This has been an ongoing challenge for nurses, who have long functioned as a jack-of-all-trades in their day-to-day work. This is particularly true for ambulatory nurses. This group historically worked in physician driven clinics where much of their time was involved in following a physician dictated plan of care and providing many clerical and organizational functions

that enabled medical care to proceed. With the ongoing shift of healthcare out of the inpatient settings and into communities and ambulatory care areas, the needs of the ambulatory patient and family have become much more complex and nursing care provided has had to follow suit (American Academy of Ambulatory Care Nursing, 2012). Many ambulatory care clients require the advanced nursing knowledge that comes with a registered nursing education. This is exemplified by the ever-growing body of research to support that nursing interventions are providing positive outcomes in health care, often times at reduced costs (Brown, Birch, & Thabane, 2012). Yet, the literature and personal experience would support the fact that nurses, in general, are not working to the full scope of what they are authorized and educated to provide (Besner et al., 2005; Lillibridge et al., 2000; Oelke et al., 2008; White et al., 2008).

I graduated from a baccalaureate-level nursing program and obtained my Registered Nursing license 20 years ago. My career has predominantly been in the area of pediatric medical care at the IWK Health Centre in Halifax, Nova Scotia. For the past eighteen years, I have been directly involved in ambulatory medical care. The field has been exciting and ever changing. In my time, I've witnessed the shift of health care away from inpatient units and toward ambulatory care areas. With this change, the skills and competencies required to care for a more medically complex population have become part of the role of the ambulatory care nurse. The early days of my career generally involved pediatrician led patient visits. I provided basic nursing care (vital signs, heights, weights, basic teaching) to a relatively stable population of children. These were generally short visits, with the plan of care being almost completely in the hands of the physician. As more and more children with complicated chronic illnesses were surviving

and being cared for outside of the inpatient units, the look of the ambulatory visit changed. These children and families did not just need the expertise of the physician, but their multitude of needs required ongoing care and planning by various members of the multidisciplinary health care team. I recognized the need for a different kind of nursing care for these families. They required not only advanced technical care and the team coordination that the nurse would bring, but the care required the knowledge base that came with the training of the registered nurse; the knowledge to assess and evaluate how the specific medical concerns were impacting the child individually, and work with the child and their entire family to build the strengths and skills they would require to provide ongoing care for their child.

This type of nursing care is time intensive. More of this intensive care was being called for with no decrease in the more straightforward, traditional general pediatrician visits that continued to be seen in my clinical area. I recognized that some of the more routine, skill-based care that was being provided might not require the training of a registered nurse (RN). I felt that my knowledge and skill could be better utilized in the care of the more medically complex clientele. With the support of my manager, we recruited the first Licensed Practical Nurse (LPN) to work in the pediatric ambulatory medical care clinic at the IWK at a time when nursing care in the pediatric ambulatory medical clinics was provided exclusively by an RN staff. The move came with challenges, but we were both very proud of the advances we saw to the scope of the RN practice in that specific area. I was able to provide the more complex nursing care to the children and families who required it, and the LPN was effectively providing the more routine care to the more stable and predictable patient group that came into our area.

What I observed next led me toward the focus for this thesis. The registered nurses in many of the other ambulatory medical clinics at my health centre were noticing similar shifts in the complexity of their patient populations and the nursing care those patients required. I was hearing comments that I had not considered when we initiated the changes in responsibilities in our clinic. Many nurses felt strongly that part of their role should continue to be the “physician driven” tasks that had, historically, been the standard of nursing care in their ambulatory areas. Any idea of delegating that work to another staff person was generally frowned upon on the premise it was part of the full registered nurse’s assessment, and gave them insight into the family dynamic, and the coping skills of the child and family. RNs were concerned that not being present at all clinic visits (regardless of complexity) would lead to errors and omissions in medical follow-up. Ironically, when presented with the challenges of providing more advanced technical care like the heparanizations of central venous access lines or teaching families the skills related to nasogastric tube placement and feeding, RNs argued that they were too busy with their current tasks and had not performed that sort of specialized care for such a long time that they did not feel competent to provide it, nor had they much interest in learning. They were anxious to send more complex tasks to other areas. The nurses had the overwhelming feeling that their workload had increased to the point they require more nursing staff in most of the clinics, but they seemed opposed to the idea of looking at LPN or non-licensed assistants providing any care to their patient population. Some also resisted any attempts at being re-educated to be able to provide some of the technical nursing tasks an expanded nursing scope of practice would require.

To attempt to understand lived experience of this group of nurses, it is important to be aware of the recent provincial and health centre strategies impacting them. The government of Nova Scotia has long recognized the struggles of providing health care to a population with high rates of chronic illness, an increasing elderly population, health care staff shortages, and fiscal challenges (Province of Nova Scotia Health Transformation: A Partnership of the Department of Health, District Health Authorities, and the IWK Health Centre, 2008). In an effort to search for a solution to these issues, a provincial committee was struck. The group proposed a new Collaborative Care Model be implemented throughout the province (Province of Nova Scotia Health Transformation: A Partnership of the Department of Health, District Health Authorities, 2008). This focused on four key areas in which transformation was to occur. People, process, technology, and information were named the four pillars (Province of Nova Scotia Health Transformation, 2008). Within this process, one of the key outcomes included the optimization of the role of the registered nurse (Province of Nova Scotia Health Transformation, 2008). The IWK Health Centre rapidly applied this new provincially developed Collaborative Care Model and set out to implement it within the health centre. The IWK (Simmons, 2010) maintained that the Models of Care initiative:

Encompasses the creation of a practice environment, in which the interprofessional team can optimize their respective scopes of practice/scope of employment using effective and efficient processes, information and technology to provide patient-centred, high quality, safe, and cost effective care. The Models of Care Initiative is focused on optimizing the utilization of the knowledge and skills of the health care workforce to ensure patients have access to the right providers at the right time,

and are critical to overcoming the current and future workforce shortages and improving quality of care (p. 2).

Over the past 4 years, the IWK has worked to apply this model to many settings though out the health centre. Active working committees of management and front line care providers spent much time assessing current practices, recommending practice changes, and implementing these changes. These changes were many and varied. In some areas, the results included the initiation of Licensed Practical Nurses and Care Team Assistant roles to support patient care in areas that were previously fully Registered Nurse staff. Although, most of these changes did not result in job loss, there were a few examples where positions were cut and staff were displaced to different work areas. For the most part, the changes in roles were accommodated by vacancies related to retirements and turnover in staff unrelated to this process. Although the intent of this process was not to cut staff (or even necessarily cut costs in the short term), there was a palpable fear of the process among many staff.

As of yet, the Models of Care process has not had any direct impacts to human resources in the Ambulatory Medical Care Clinic areas at the IWK. One of the teams did go through the assessment process, but upon reflection of the centre's senior executive, none of the recommended changes were implemented. This background is important in understanding the context of the Health Centre at the time of the study.

In the fall of 2013, the IWK Children's Health program announced the initiation of a devoted review of all ambulatory services. Although the term "Models of Care" had not been corresponded to the staff as a pillar of this review, it was recognized that the principles would be used in the evaluation. When looking at the day-to-day work

environment of the ambulatory nurses, it was essential to keep this in mind. There was an undercurrent of fear as to what an ambulatory review would bring, especially in light of the models of care changes that impacted the nursing care IWK patients received and associated job changes.

Almost two years ago, I took on the role of Manager of the Children's Ambulatory Medical team at the IWK Health Centre. My areas of responsibility include the majority of the pediatric ambulatory medical care areas in the health centre. I am a huge advocate of nurses working to full scope of practice and champion the positive outcomes a nurse working to full scope of practice can provide in the care of patients and families. I was very interested to know how nurses of the Children's Ambulatory Medical team at the IWK Health Centre understood "full scope of practice" and if they felt that is what they are enacting on a daily basis. If they felt they were, I wanted to know what structures and supports they felt facilitated this full scope of practice, and if not, I wanted to know what nurses felt were the barriers preventing them working to full scope. This was especially important in light of the models of care work and ambulatory review work that was proceeding in the health centre.

Purpose

This research project was intended to explore the experience of registered nurses in working to full scope of practice in ambulatory medical care clinics at the Izaak Walton Killam (IWK) Health Centre. This was done in an attempt to provide a starting point for discussion of these issues in the area of pediatric ambulatory medical care nursing by looking at the lived experience of nurses working in these areas.

The research questions were:

- What are nurses' understandings of working to full scope of nursing practice in pediatric ambulatory medical care clinics at the IWK Health Centre.
- What are nurses' understandings of the barriers and facilitators to maximizing scope of practice in ambulatory medical care clinics at the IWK Health Centre.

Significance of the Research

It was anticipated that by gaining a deeper appreciation of registered nurses understanding of working to full scope of practice in ambulatory medical care clinics at the IWK Health Centre, ambulatory managers would be better informed to initiate care model reviews, identify of education gaps, and inform policy decisions around the care of the centre's ambulatory care patients. On a broader level, it was hoped this work would help to build a knowledge base around the scope of nursing practice within ambulatory care, an area given minimal attention in the published literature to date. The primary researcher believes that this was accomplished. The following chapters will provide a detailed review of the related literature, the methods and methodology used in this study, the study results, and finally a detailed discussion of what was learned and the recommendations that came out of this work.

CHAPTER II

Literature Review

The following chapter will provide a review of the available literature relating to nursing scope of practice in pediatric ambulatory care areas and other related publications. The discussion is divided into the subheadings of; What is Scope of Practice?, Underutilization of Health Human Resources, Staff Mix, The Ambulatory Care Nurse, and Resistance to Change

What is Scope of Practice?

What is the work of the registered nurse? At first read, this seems a very simple question, but nurses have long had difficulty defining their role. They often function as a jack-of-all-trades and feel that it is almost impossible to describe a typical workday (Rondinelli, Omery, Crawford, & Johnson, 2014). But, a well-defined scope of practice is essential to policy makers, educational institutions, employers, and consumers. It is the basis for the preparation of standards of practice, the development of educational curricula, human resource management and determination of who is best qualified to deliver specific health care services (Baranek, 2005; Canadian Nurses Association, 1993; Canadian Nurses Association, 2003). In these times of fiscal tightening, vague is not adequate. In a climate where funding is tied to evidence based outcomes, nurses are being challenged to explicitly define their role and demonstrate the benefits of their service to the health care system.

Provincial and national governing bodies attempt to define the practice. In Nova Scotia, the Registered Nurses Act (Registered Nurses Act, 2006) defines the professional practice of the registered nurse in Nova Scotia:

"practice of nursing" means the application of specialized and evidence-based knowledge of nursing theory, health and human sciences, inclusive of principles of primary health care, in the provision of professional services to a broad array of clients ranging from stable or predictable to unstable or unpredictable, and includes;

- (i) assessing the client to establish the client's state of health and wellness,
- (ii) identifying the nursing diagnosis based on the client assessment and analysis of all relevant data and information,
- (iii) developing and implementing the nursing component of the client's plan of care,
- (iv) co-coordinating client care in collaboration with other health care disciplines,
- (v) monitoring and adjusting the plan of care based on client responses,
- (vi) evaluating the client's outcomes,
- (vii) such other roles, functions and accountabilities within the scope of practice of the profession that support client safety and quality care, in order to
 - (A) promote, maintain or restore health,
 - (B) prevent illness and disease,
 - (C) manage acute illness,
 - (D) manage chronic disease,
 - (E) provide palliative care,
 - (F) provide rehabilitative care,
 - (G) provide guidance and counseling, and
 - (H) make referrals to other health care providers and community resources,

and also includes research, education, consultation, management, administration, regulation, policy or system development relevant to subclauses (i) to (vii).

This definition is reflected in the Standards of Practice for Registered Nurses (College of Registered Nurses of Nova Scotia, 2011) and the Code of Ethics for Registered Nurses (Canadian Nurses Association, 2008). The Registered Nurses Act (2006) identifies those activities that can only be performed by Registered Nurses. In other words, if others without the essential skills, knowledge, or judgment of the professional nurse attempt to perform them, the recipients would be put at risk (College of Registered Nurses of Nova Scotia & College of Licensed Practical Nurses of Nova Scotia, 2012). The standard for nursing practice is defined as the “minimal professional practice expectations for any registered nurse in any setting or role, approved by Council or otherwise inherent in the nursing profession” (Registered Nurses Act, 2006). As can be imagined, the acts and standards are very broad and vague.

Scope is broadly defined as the “activities nurses are educated and authorized to perform, as established through legislated definitions of nursing practice complemented by standards, guidelines and policy positions issued by professional nursing bodies” (Canadian Nurses Association, 1993, p.15). The definition of scope is partially based on the interpretation of provincial and national legislation by regulatory bodies that produce policy papers, principles and standards (Oelke et al., 2008). Scope has flexible boundaries so as not to threaten the ability of the profession to grow and develop (College of Registered Nurses of Nova Scotia & College of Licensed Practical Nurses of Nova Scotia, 2012; Lillibridge, Axford, and Rowley, 2000). Authority (as given by the RN Act (2006)), education, and experience can constrain the RNs scope of practice (College of

Registered Nurses of Nova Scotia & College of Licensed Practical Nurses of Nova Scotia, 2012). The nurse's individual scope is also influenced by practice settings, employer requirements and the needs of the clients (Baranek, 2005; Canadian Nurses Association, 1993). It is always narrower than the scope of the profession as a whole (Canadian Nurses Association, 2000) and will expand with experience, on a novice to expert continuum (Registered Nurses Association of the Northwest Territories and Nunavut, 2010).

The current job description for the staff nurse at the IWK Health Centre is attached (Appendix A). This exemplifies the broad nature of these sorts of documents and the variation of work that can and does occur, within the scope of this document.

Again, the nature and variation of the work of nurses make establishing scope a challenging feat, particularly when consideration is given to the multitude of practice areas within the health care system and the factors that each nurse brings to any given role.

Are nurses working to full scope of practice?

The general consensus in the very limited published literature is that not all registered nurses are working to full scope of practice. Besner et al. (2005), Oelke et al. (2008), and White et al. (2008) examined the scope of practice enactment of nurses (RNs, Registered Psychiatric Nurses (RPNs), and LPNs) at 14 different acute care patient care units in Calgary and Saskatoon. The research team used a descriptive-comparative exploratory designed cross-sectional research study to obtain 167 interviews of RNs, LPNs, RPNs, patient care managers and assistant managers, and various nurses in specialized roles and 53 interviews with other members of the interdisciplinary health care team and a few patients. The group found substantial differences in what nurses

were educated to do (full scope of practice) and what they perceived they were allowed to do in the actual practice setting (role enactment). Of the RN group, only 50% perceived they worked to scope. Their managers and educators generally felt that most were not, citing that the registered nurses were too task focused and therefore not working to their full capacity.

Lillibridge, Axford, and Rowley (2000) used a naturalistic inquiry approach to interview 24 critical care nurses from five clinical agencies in Australia in an attempt to understand the scope of practice of nurses. This study suggested that nurses negotiate and adjust their professional boundaries on a case-by-case and individual basis to meet the circumstance of the situation. This varied from limiting scope to stepping over the line and crossing into medical practice. The study identified that nurses often limited their scope to maintain a comfort zone. This was done in numerous ways, including adhering to traditional practices, and blindly supporting the physician in command. The authors concluded that this behavior tended to maintain the status quo and contribute to nursing practice becoming stagnant and task oriented. Alternatively, they found that nurses would “step over the line” at times, and cross into medical practice, often by acting in the medical domain but not through previously approved channels. An example of this was an ICU nurse advancing a Swan-Ganz catheter if the patient was having ectopy, a procedure contradicted by hospital policy and not within the nurses’ domain. The authors stressed the need for nurses to define their scope of practice and in doing so, stabilize their professional boundaries.

These two studies focus on acute care and critical care nurse and were published over five years ago. To date, there is no available published research able to address if ambulatory pediatric nurses are working to full scope of practice.

What are the barriers and facilitators in practicing to scope?

There is an equal dearth of research around the actual barriers and facilitators of nurses working to full scope of practice. Besner et al (2005) authored one of the few studies that looked at these questions with acute care nurses (Oelke et al, 2008). This study identified barriers related to interprofessional relationships (feeling of lack of confidence and/or respect between team members), work environment (time, workload and patient acuity), and the challenges in providing continuing education in the workplace (Besner et al., 2005; Oelke et al., 2008). Facilitators were: working as a team, management and leadership support and support for continuing education (Besner et al., 2005; Oelke et al., 2008).

A limited amount of nursing literature has touched on factors that nurses perceive as facilitators and barriers to their abilities to carry out their practice of nursing. Interestingly, this work mirrors much of the Besner et al. (2005) findings looking at scope of practice. Facilitators have been identified as; adequate training and opportunities for professional development (United Kingdom Central Council for Nursing, Midwifery and Health Visiting, 2000), organizational support (United Kingdom Central Council for Nursing, 2000), adequate guidance and support (Jackson, 2004), mutual respect, collaboration, and trust within the health team (Crosby et al., 2000; United Kingdom Central Council for Nursing, Midwifery and Health Visiting, 2000), good skill mix in the workplace (United Kingdom Central Council for Nursing, Midwifery and Health

Visiting, 2000), and practitioner motivation, intuition, education, experience and supervision (United Kingdom Central Council for Nursing, Midwifery and Health Visiting, 2000).

Some barriers were identified as: lack of resources including staffing resources (Crosby et al., 2000; United Kingdom Central Council for Nursing, Midwifery and Health Visiting, 2000) and clarity of roles and boundaries among various providers (Pearson, 2003).

One study identified barriers specific to ambulatory nurses fulfilling their roles. Hackbarth, Haas, Kavanagh, and Vlasses (1995) surveyed ambulatory care nurses in the United States and found that they reported lack of time, lack of support staff, excessive paper work, administrative blocks to clinical practice, excessive numbers of patients and lack of monetary resources as barriers to their clinical practice.

Blurring of scopes in health care

When discussing scope, it is important to note that although there is uniqueness to the role of all health care disciplines, the various scopes can, and will often, overlap (Tomblin Murphy & O'Brien-Pallis, 2002). Some registered nurses feel their role is being eroded by what they consider the absorption of many aspects of their role by other health care providers or, in some cases, passed on to family members in the community (College of Registered Nurses of Nova Scotia, 2009). This is further complicated by recognition that there remains a lack of consensus around the scope of responsibilities of licensed and unlicensed health care workers. This further confuses the definition of scope of practice for these various health care workers. This can lead to nurses pressured

to practice below or above their scope (American Academy of Ambulatory Care Nursing, 2012).

Nurses' interpretation of scope of practice

Another noteworthy point is the tendency of registered nurses to define their scope of practice in terms of the tasks they perform (for example: intravenous line starts, patient education, medication administration). This does not take into account the knowledge that registered nurses bring to their role. Nursing care is not merely a collection of tasks (Besner et al., 2005). Dorothy Pringle, professor emeritus at the University of Toronto, recently commented that “nursing is a profession in transition, moving from a task oriented workforce (doing) to one where there will be more requirements to be thinkers and planners – knowledge workers” (College of Registered Nurses of Nova Scotia and Nova Scotia Health Research Foundation, 2012, p. 7). This new way of looking at the work of the registered nurse is a complete paradigm shift from the way in which most nurses defined their work for many years. The advanced academic rigor of the baccalaureate programs, now considered an entry level requirement into the profession, coupled with the fiscal realities of the health care system and subsequent need to streamline care and demonstrate positive outcomes, likely contribute to this shift in thinking.

Underutilization of Health Human Resources

The reality of our current health care system is that nurses are working longer and harder. Budget cuts have resulted in fewer nurses available to do more nursing work and, at the same time, there is an expectation that they pick up the non-nursing tasks left behind from the shortage of support staff (Advisory Committee on Health Human

Resources, 2002). RNs are verbalizing their frustration at the abundance of these time consuming clerical and non-nursing duties which are consistently taking away from their ability to provide the high level of patient care they would like to provide (Canadian Nursing Advisory Committee, 2002). These non-nursing tasks have been found to reduce job satisfaction and decrease self-esteem, as nurses believe administrators do not value their important intellectual contribution to patient care (Baumann et al., 2001). Not having time for the patient care they are trained for leads nurses to feel a decrease in motivation and pride (Druker, 1993), which lends to a decrease in productivity and effectiveness (Canadian Nursing Advisory Committee, 2002).

Health care leaders and policy makers are well aware of this underutilization of registered nurses. The Advisory Committee on Health Human Resources (2002) made reference to the alarming underutilization of our educated and well-paid nursing staff for these non-nursing tasks. The Canadian Senate report on the healthcare system reports that “nurses are an expensive and shrinking resource and we cannot afford to be using them to carry out those non-nursing tasks” (Standing Senate Committee on Social Affairs, Science and Technology, 2002, p. 117). In ongoing attempts to optimize the utilization of health human resources, it is essential that registered nurses are working to their full scope of practice (College of Registered Nurses of Nova Scotia, 2009).

Staff Mix

Prevailing concern over a national nursing shortage coupled with the costs control initiatives endemic to our health care system, has resulted in attempts to review and change the skill mix in nursing care. This often involves a combination of RN, LPN, and non-licensed staff providing patient care. Policy makers are ever cognizant of the

potential impact of any such change in the quality of care (Lankshear, Sheldon, & Maynard, 2005). These attempts to adjust the skill mix have been met with mixed reviews. Feelings that such attempts attack the value of nursing and dilute nursing skills are counterbalanced with the feeling that these measures could potentially increase the professionalism of nurses and free up their time to perform activities requiring their higher level of skill and knowledge (Currie, Harvey, West, McKenna, & Keeney, 2005).

What does the research say?

The literature has many examples that cite the benefits of an RN workforce in acute hospital care. Needleman, Buerhaus, Mattke, Stewart, and Zelevinsky (2002) found that a higher proportion of RNs in the staff mix was associated with a shorter length of stay, lower rates of urinary tract infection, and lower rates of upper gastrointestinal bleeding, lower rates of pneumonia, shock or cardiac arrest and “failure to rescue” in acute care adult medical patients.

An Ontario study of 46, 941 patient admissions to 75 acute care hospitals (with most responsible diagnosis of acute myocardial infarction, stroke, pneumonia, or septicemia), demonstrated that there is a relationship between a lower 30-day mortality and a richer registered nurse skill mix (Tourangeau, Giovannetti, Tu, & Wood, 2002).

A 2002 study used administrative data from over 6,000,000 hospital discharges of adult medical and surgical patients from 799 hospitals in 11 American states to look for a relationship between the amount of care provide by nurses in the hospital and 14 possible adverse outcomes. They concluded that a greater proportion of hours of nursing care provided by registered nurses was associated with better care (Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2002).

Making any valid recommendations in regard to replacing a proportion of registered nurses with licensed practical nurses, licensed vocational nurses, or nursing assistants is difficult (Crossman & Ferguson, 2005; Currie et al., 2005; Estabrooks, Cummings, Squires, Giblin, & Simpson, 2009; McKenna, 1995; Butler et al., 2011; Spilsbury & Meyer, 2001). Numerous published systematic reviews of the literature detail these issues. Lankshear, Sheldon, and Maynard (2005) carried out a systematic review of the research on nurse staffing and healthcare outcomes in the acute care sector. They suggested that a richer skill mix (more registered nurses) was associated with improved patient outcomes, but only up to a certain point. They noticed a curvilinear relationship between increasing nursing levels and improved outcomes in two separate studies (Mark, Harless, McCue, & Xu, 2004; Blegen & Vaughn, 1998). The effect seemed to tail off at higher RN levels. The authors suggested that perhaps at higher RN levels, these staff had to carry out work that could be done effectively by other staff (Lankshear, Sheldon, & Maynard, 2005). A recent Cochrane Review systematically reviewed publications around nursing staff models and patient and staff-related outcomes (Butler, et al., 2011). The outcomes of replacing the proportion of registered nurses with licensed practical nurses, licensed vocational nurses, or nursing assistants was reviewed. It was concluded that no valid recommendations could be made due to small numbers of studies and an overall lack of rigor in many of those published (Butler, et al., 2011). Crossman and Ferguson (2005) explored the research to date on skill mix in nursing. They concluded that much of the available research was dated and lacked the necessary rigor to provide meaningful interpretation. But, they did conclude that there is minimal evidence to support the potential for the redistribution of certain tasks in nursing (based

on sound evidence and not merely on staff availability, service demand or apparent costs) (Crossman & Ferguson, 2005).

To complicate the issue of skill mix even further, there is emerging evidence that nursing care outcomes may be improved when care is provided by baccalaureate-prepared versus non-baccalaureate-prepared nurses. Studies of community home care nurses have demonstrated that care by baccalaureate-prepared RNs is associated with the need for fewer visits (O'Brien-Pallas et al., 2001) and improved knowledge and behavior scores in clients related to their health condition (O'Brien-Pallas et al., 2002). Another 2005 study showed surgical patients in hospitals experience lower mortality and failure-to-rescue rates when cared for in hospitals with higher proportions of nurses educated at the baccalaureate level, or higher, (Aiken, Clarke, Cheung, Sloane, & Silber, 2003).

What is certain is that there is a glaring dearth in the research literature dealing with appropriate skill mix in both acute and ambulatory care settings.

The Ambulatory Care Nurse

The 1980s and 1990s brought about vast changes in our health care system. Huge technological advances coupled with fiscal tightening of health care budgets changed the face of our nation's health care delivery. These factors worked together to stimulate a shift in the focus of health care from inpatient to ambulatory settings (American Academy of Ambulatory Care Nursing, 2012). With this shift, an increasingly complex and diverse patient profile emerged in ambulatory care. As the complexity of patients increased, the demand for professional caregivers with the knowledge, skill, and ability to deliver care increased as well (American Academy of Ambulatory Care Nursing, 2012). The old physician-driven system (where doctors provided medical assessment, prescribed

medication, and provided some simple medical treatments) has evolved into a patient-focused system where multiple health care professionals provide leadership and care in health care settings (American Academy of Ambulatory Care Nursing, 2012). The complexity of the patients being followed in many of these ambulatory areas requires the services of a registered nurse to ensure safe, quality care (American Academy of Ambulatory Care Nursing, 2012).

The role of the ambulatory care nurse

Over the years, authors have attempted to define the work of ambulatory care nurses. One of the early attempts was made by Verran (1981), who defined the domains of ambulatory care nursing. This study used the Delphi technique to refine and validate a list of nursing care activities and areas of responsibilities as derived from the nursing literature of the time. The model involved a taxonomy, which included seven responsibility areas of nursing care (patient counseling, health care maintenance, primary care, patient education, therapeutic care, normative care, and non-client centered care) and 41 activities under these domains (Verran, 1981).

Hastings and Muir-Nash (1989) built on Verran's (1981) work and validated a refined conceptual framework used to define and describe ambulatory nursing care. The application of the nursing process, and Orem's (1980) Self-Care Deficit Theory were paramount in the refinement process. The new taxonomy has nine responsibility areas (health status assessment, planning, patient counseling and support, patient education, therapeutic care, communication, documentation, normative care, and non-patient centered care) and 61 nursing activities.

Many years later, Hackbarth, Haas, Kavanagh, and Vlasses (Hackbarth, et al., 1995; Haas & Hackbarth, 1995a; Haas & Hackbarth, 1995b; Haas, Hackbarth, Kavanagh, & Vlasses, 1995c) published a landmark set of four articles dealing with the dimensions of the staff nurse role in ambulatory care. The articles were based on a descriptive, cross-sectional survey of 606 ambulatory nurses across the United States (Hackbarth, et al., 1995). A mailed questionnaire, returned anonymously, was utilized. It included 91 Likert-type questions to determine dimensions of the current staff nurse role. Demographic questionnaires and open-ended questions were also utilized. The respondents were asked how often they performed each of the identified activities, how important they considered the activity to be to the role of the ambulatory nurse in the future, and finally, if they were to keep or delegate an activity, what level of provider should the responsibility of the activity be delegated to.

The study identified eight core dimensions of staff nurse roles in ambulatory care (enabling operations, technical procedures, nursing process, telephone communications, advocacy, teaching, care coordination, expert practice within setting), and three core dimensions of quality improvement/research roles in nursing (quality improvement, research, continuing education) (Hackbarth et al., 1995). Their data suggested that a significant component of ambulatory nursing practice (enabling operations and technical procedures) were lower-level functions such as setting up rooms, transporting clients, and collecting specimens. Other components such as teaching, advocacy, nursing process, and telephone communication were higher-level professional activities that were performed at more moderate frequencies. More complex and sophisticated nursing activities such as care coordination and expert practice (functioning as advanced nursing resource or

student preceptor) were infrequently performed. A similar pattern emerged from studies exploring the quality/research role of the ambulatory nurse. Nurses were more likely to be engaged in continuing education activities as opposed to research activities (Hackbarth et al., 1995). This is likely related to the prominence of diploma and associate degree prepared nurses who responded to this American study. These programs typically emphasized skill in technical procedures and have limited content in research and leadership (Hackbarth et al., 1995). Given the increasing complexity of care in ambulatory settings, coupled with the obvious financial impacts of having higher paid providers doing low-level tasks, the realization that nurses were infrequently performing functions that required disciplinary knowledge and critical thinking, while frequently performing lower-level tasks was identified as a concern (Hackbarth et al., 1995).

Interestingly, this was not the first time this had been identified. Fulbrook and Caws (1999) studied the work of nurses employed at a pediatric outpatient clinic in Britain. They concluded that the nursing work done in this clinic was predominantly driven around the work of the physicians. In fact, 60% of their time was spent on non-nursing activities.

When Haas et al. (1995) analyzed the practice of ambulatory nurses, it was found that there was a difference in nurses' work when contrasted in terms of different ambulatory settings and different models of care delivery. Nurses who considered themselves to be working under a medical or functional model of care were more likely to be more frequently performing lower and mid-level core dimensions of care (work not generally requiring a registered nurses designation to provide). Nurses who self-reported as practicing under a primary nursing, case management, or community nursing model

were more likely to be associated with more frequent performance of higher level dimensions of nursing care (Haas et al., 1995).

Research out of the Children's Hospital of Eastern Ontario by MacDonald and Thibault (1996) used the Hastings and Muir-Nash (1989) framework to create profiles of the nursing role in their various ambulatory clinics and services. The hospital had previously identified two categories of ambulatory nurses. The service nurse, who provided care across the complete health care delivery continuum (contact with their patients in inpatient, ambulatory and community areas) and the clinic nurse, who provided nursing support to specific medical/surgical clinics. As a whole, the scope of practice of the ambulatory nurses at their health centre was broad and covered virtually all of the nursing activities defined by the Hastings and Muir-Nash (1989) framework. There were quantifiable differences in the nursing role between clinic and service nurses. Service nurses performed more activities under the planning, patient counseling and support, and patient education areas of responsibility. The clinic nurses performed more activities under the health status assessment, therapeutic care, documentation and normative care areas of responsibility (MacDonald & Thibault, 1996).

Haas and Hackbarth (1995) asked ambulatory nurses which of their role dimensions they would be willing to delegate in the future. They reported that enabling operations functions (such as setting up rooms, taking vital signs, and transporting clients) and some technical activities (such as assisting with procedures, informing clients about procedures, and collecting specimens) could be delegated to an LPN, nurse's aide, technician, and/or clerk. On the other hand, nurses were more hesitant to delegate higher-level dimensions of nursing process, high-tech procedures, care coordination and expert

practice/community outreach. They also felt that quality improvement and research dimensions of the nurses' role were almost entirely within the scope of the professional nurse and should not be delegated.

Rondinelli et al. (2014) used a descriptive self-report survey of 187 ambulatory nurses practicing in various different clinic areas in a health care organization in Southern California to determine what activities ambulatory nurses performed the most frequently. The top five activities were reported as; assessment of the patient's health history, chief complaint/subjective history, nurse advice during message management, assessing laboratory test results, and triage/access.

The value of ambulatory nursing care

The need for ambulatory nurses to demonstrate that they have significant impact on the process and outcomes of care delivery has been identified for many years (Hackbarth et al, 1995; Haas et al., 1995; Haas & Hackbarth, 1995a, Haas & Hackbarth, 1995b).

Nurses' perception

Conway-Phillips (2006) surveyed the members of the American Academy of Ambulatory Care Nursing to explore the value that these nurses felt they brought to the workplace. The 248 nurse respondents described; patient/family education, telephone/clinic triage, patient care and coordination of care, leadership/management, collaboration with medical staff, patient advocacy, staff education, compliance with regulatory/accrediting standards, financial benefits (for example, by preventing hospital admissions and inappropriate use of emergency departments), continuity of care, access to care, quality initiatives, and research as the areas they felt they provided value. When

the same questions were asked to a convenience sample of ambulatory care registered nurses employed in adult and pediatric primary care and specialty clinics in at a medical centre in South Carolina in 2010 (Matutina, Hamner, & Battaglia, 2010), their responses fell into 12 categories: nursing process, experience/education, coordination of care, leadership, collaboration, health teaching/health promotion, resource utilization, performance improvement, ethics, professional practice, environment/safety, and research. The two studies revealed similar themes but there was a difference in the weight of the responses. For example, the latter study showed a decrease in the respondents who felt the patient/family education added value to their role. Interestingly, the number one response of the latter study was nursing process, followed closely by their experience and education. With an increased emphasis on the whole process, including an evaluation component, the authors felt that this shift in perceived value may be related to a greater emphasis on outcome measurements in health care and the need to evaluate the outcome of care to determine if patient goals are being met (Matutina, Hamner, & Battaglia, 2010).

Rondinelli et al. (2014) used a descriptive self-report survey of 187 ambulatory nurses practicing in various different clinic areas in a health care organization in Southern California to determine what value ambulatory nurses felt they brought to their workplace. They reported; patient satisfaction, normal laboratory values, prevention of complications, correct level of medical treatment, and decreased anxiety levels.

Evidence based outcomes

Over the past ten years, there has been an increase in literature demonstrating the benefit of nurse-provided service in ambulatory health care (American Academy of

Ambulatory Care Nursing, 2012). These have included improved patient health outcomes and improved patient satisfaction (Buchholz, Wilbur, Miskovich, & Gerard, 2011; Casey & Ormrod, 2003; Dewar, Craig, Muir, & Cole, 2003; DiScenza, Nies, & Jordan, 1996; Lee, 2005; Philis-Tsimikas & Walker, 2001; Philis-Tsimikas, et al., 2004; Quirk, 1998; Shimabukuro, Kramer, & McGuire, 2004; Wolosin, 2003; Wong & Chung, 2006); reduced readmission, reduced secondary complications, reduced mortality, and reduced cost of service (Hamner, 2005; Leenerts, Koehler, & Neil, 1996; Peter, Chaney, Zappia, Van Veldhuisen, Pereira, & Santamaria, 2011; Raftery, Yao, Murchie, Campbell, & Richie, 2005; Schadewaldt & Schultz, 2010; Schroeder, Trehearne, & Ward, 2000; Uppal, Jose, Banks, MacKay, & Coatesworth, 2004); and positive impacts of nurse telephone/triage services on patient satisfaction, improved access to healthcare, reduced emergency department visits, hospitalizations, and improved compliance with care (Adams, 1997; Chang, Mayo, & Omery, 2002; Gulanick, Green, Crutchfield, Myers, & Marren, 1996; Hamner, 2006; Little, Saul, Testa, & Gaziano, 2002; Moscato, et al., 2007; Muender, Moore, Chen, & Sevick, 2000; O'Connell, Stanley, & Malakar, 2001; O'Connell, Towles, Yin, & Malakar, 2002; Piette, Weinberger, & McPhee, 2000; Tschirch, Walker, & Calvacca, 2006; Valanis, et al., 2007; Viscon, McCallum, Thornlow, & Champagne, 2011; Wetta-Hall, Berg-Copas, & Dismuke, 2005; Wilson & Hubert, 2002; Wong, Wong, & Chan, 2005; Young & Ireson, 2003; Williams, Warren, McKim, & Janzen, 2012). This provides evidence to support the fact that registered nurses in ambulatory care can and do have the skills and ability to improve patient and health system outcomes.

Resistance to Change

Over the past few decades, numerous reasons have been identified highlighting a need to redesign current nursing models (Hayman, Wilkes, & Cioffi, 2008). These include: the ability and capacity to accommodate increased patient to nurse ratios, increased patient acuity, and new technology; responding to staff shortages (RN shortage) through skill mix; and more effective utilization of existing staff as a result of fiscal restraints (Christensen & Bender, 1994; McCulloch, 1995; Robinson, 1991; Roch, 1992).

As with any change, a level of reaction is to be expected (Bruning, 1993).

Although there is little literature available on nurses' reactions to potential change in nursing care models, articles focused on the common reactions to organizational change exist within the extant literature. This section will investigate potential reasons for resistance to change, and is based on both health care and organizational management literature. It is not possible to be aware of all sources of resistance to change (Torbin, 2011), but being aware of some of the more common reasons may enhance an understanding of the perceptions and beliefs nurses have which may explain some of the resistance to changing their model of nursing care delivery.

Many basic human factors have been proposed to explain resistance to change. These include general avoidance to change and maintenance of equilibrium (Marquis & Huston, 2008; Watson, 1971). Perhaps, a general fear of the unknown (uncertainty) may be underlying resistance to change (Amos, Jones, Hines, Skov, & Kloosterman, 2012; Torbin, 2011). A fear that change could be intrusive and disruptive (Beer, Eisenstat, & Spector, 1990; Shin, Taylor, & Seo, 2012; Strebel, 1996), may be rooted in prior negative experiences (Kanter, 2012), which may increase anxiety about potential implications

associated with change. Many people tend to value familiarity, working within their comfort zone, habit, and maintenance of the status quo (Amos et al., 2012; Maurer, 1996; McPhail, 1997; Muchinsky, 2008; Rumelt, 1995; Torbin, 2011; Watson, 1971).

Certainly, change could have a detrimental impact on these values. Any sense of loss of control can lead to resistance to change (Amos et al., 2012; Kanter, 2012; Muchinsky, 2008; Steptoe, Fieldman, Evans, & Perry, 1993). There are also people with a general level of cynicism (Rumelt, 1995) and even a theory that there may be a “resistance to change” personality trait (McCrae & Costa, 2008; Oreg, 2003).

When thinking about a specific change, employees may have a distorted perception of what the change is (Esler & Nipp, 2001; Rumelt, 1995), or may not understand the need for change (Torbin, 2011). They may have a general level of insecurity (Watson, 1971) and not feel competent to work in a changed environment (Kanter, 2012; Torbin, 2011). Interestingly, if an individual has high self-efficacy (belief that they have the skill, ability, and knowledge to perform certain tasks) they are more likely to respond positively to change (Crouch, Sinclair, & Hintz, 1992).

One of the most common reasons for change resistance, and difficulty with the change process in organizations, is a lack of trust in management (Albrecht, 2010; Oreg, 2006; Rousseau & Tijoriwala, 1999; Torbin, 2011). Resistance will occur if people do not trust the intentions behind the change (Curtis & White, 2002; Daft, 2010) or if they feel a change is being imposed on them (Hayman, Wilkes, & Cioffi, 2008). The employee may fear that a change could bring more work (Kanter, 2012; Pollard, 2001). They may fear that their job could change into one that is less interesting, less autonomous or less challenging (Oreg, 2006). They may feel that the change could have

an impact on their power and prestige, their job security, or the intrinsic rewards they obtain from their job (Oreg, 2006). There is also a suggestion that a change may cause an employee to perceive a loss of face, where they take some personal responsibility for the previous system not being appropriate (Kanter, 2012). A work change could challenge the employee's sense of worth and belonging in the organizations (Hultman, 1998). All of these factors could produce resistance to organizational change.

Lastly, in these times of fast and furious change within healthcare, sheer exhaustion, saturation with the pace of change, excessive change, and a sense that everything seems different have been attributed to a sense of change resistance in employees (Kanter, 2012; Torbin, 2011).

Any resistance to change must be taken seriously by managers and leaders. Often, a resistance to change may be a true sign that something is not right, and the perceived threat may be real (Kanter, 2012). Change is not always beneficial, and resistance to change may be a positive response (del Val & Fuentes, 2003). Managers should be reminded that certain aspects of a change might not have been fully considered (Waddell & Schol, 1998) and they may need to take the time to reevaluate the proposed change.

Conclusion

Health care leaders and decision makers have repeatedly identified the importance of being able to clearly define the scope of practice for all members of the health care team, including the registered nurse (Baranek, 2005; Canadian Nurses Association, 1993; Canadian Nurses Association, 2003). The ability to establish the value that each discipline and/or care group brings to patient care is crucial when attempting to design

the most cost effective and efficient models of care in challenging financial times (Canadian Nurses Association, 2003; Prior, 2012). This has been an ongoing challenge for nurses, who have long functioned as a jack-of-all-trades in their day-to-day work. This is particularly true for ambulatory nurses. This group historically worked in physician-driven clinics where much of their time was involved in following a physician dictated plan of care and providing many clerical and organizational functions that enabled medical care to proceed. With the ongoing shift of healthcare out of the inpatient settings and into communities and ambulatory care areas, the needs of the ambulatory patient and family have become much more complex and nursing care provided has had to follow suit (American Academy of Ambulatory Care Nursing, 2012). Many ambulatory care clients require the advanced nursing knowledge that comes with a registered nursing education. This is exemplified by the ever-growing body of research to support that nursing interventions are providing positive outcomes in health care, often times at reduced costs (Brown, Birch, & Thabane, 2012). Yet, the literature and personal experience would support the fact that nurses, in general, are not working to the full scope of what they are authorized and educated to provide (Besner, et al., 2005; Lillibridge, et al., 2000; Oelke, et al., 2008; White, et al., 2008). Reasons cited as barriers to working to full scope in acute care areas include: heavy workload, high patient acuity, lack of time, poor communication, and ineffective teamwork (Besner, et al., 2005; Fry, 2013; Oelke, et al., 2008). Little work has been done in the ambulatory care areas. The literature review clearly shows the dearth in recent literature around the scope of practice of the ambulatory nurse and exemplifies the need to gain a better understanding of the modern day experiences of nurses in these clinical areas.

CHAPTER III

Research Design

Methodology

This project focuses on uncovering how pediatric ambulatory care nurses live out their role, scope of practice, and the meaning they give to that experience. The dearth of research on this subject is startling given the ongoing discussions.

An objective, scientific research model would be inadequate to provide the detailed exploration and complex understanding that the primary researcher sought to find in this work. For this reason, a qualitative design using an interpretative phenomenological (Hermeneutic) methodology was used. This chapter will detail the reasons for this choice and provide a detailed description of the study methodology and methods.

Qualitative Paradigm

The decision to use a qualitative methodology was multifaceted. First, when an issue or problem has to be explored and little is understood about the phenomenon of interest, situating the study within a qualitative approach is appropriate (Creswell, 2013). Secondly, this study was not looking to answer measurable questions; rather, to explore experiences of ambulatory nurses working in the pediatric setting. Quantitative measures and statistical analysis would not provide these outcomes (Creswell, 2013). The final reason is that the qualitative approach is grounded in a belief that there are multiple realities and an understanding that the researcher, the research subjects and the readers of the study embrace different realities (Creswell, 2013). No two people are going to experience the same phenomenon the same way. There is a belief that reality is socially

constructed and context dependant (the meaning is defined by circumstance and environment), and as such, provides no absolute truths or generalizations. In light of the existing challenges identified within the research literature, it was believed that undertaking an approach that encompassed how ambulatory care pediatric nursing is lived would enhance our understanding and provided a foundation for effective change. For these reasons, a qualitative methodology was chosen.

Phenomenology

Phenomenology is a methodology within the qualitative paradigm which examines how and in what way humans exist within their world (“being in the world”). It does not attempt to provide theories or generalizations (Crist & Tanner, 2003); rather, its goal is to describe lived experience (Barroso, 2010, Creswell, 2013; Speziale & Carpenter, 2007). Phenomenology has its roots in philosophy (Baker, Wuest, & Stern, 1992). It was originally conceptualized by the German philosopher, Edmund Husserl (1859-1938) (Baker, Wuest, & Stern, 1992). Husserl was critical of the positivist focus of an observed external reality (Baker, Wuest, & Stern, 1992). He introduced the concept of life world or lived experience (Koch, 1995). His phenomenological approach involved the study of phenomena as they appear through the human consciousness (Koch, 1995) by seeking to uncover the nature of meaning of the human lived experience (Koch, 1995). Husserl claimed that this could be done when the researcher bracketed out his world/preconceptions and described the experience of the phenomena using the actual words of the person who had the experience (Koch, 1995).

Interpretative (Hermeneutic) Phenomenology

The ideas behind phenomenology have not remained static, but have been modified by scholars through the years (Lopez & Willis, 2004). Martin Heidegger, a student of Husserl's moved beyond the descriptive nature to include a deeper understanding of meaning through interpretation (Leonard, 1994). He argued that all description is already interpretative as every form of human awareness is interpretative (Leonard, 1994). The process acknowledges that the researcher, research subjects and interpretative team are inextricably situated in their worlds and bring their own preconceptions and theories to their interpretation of the world, including the research questions, processes and results (Crist & Tanner, 2003).

Husserl and Heidegger also clashed in their epistemological/ontological views. Heidegger suggested that we move beyond the epistemological debate and move toward considering the problems of ontology; that is, what is it to be a human being and how the world is intelligible to all of us (Leonard, 1994). With this knowledge, he proposed that we would be better able to answer the questions of how we know the world (Leonard, 1994). "Heideggerian phenomenologists, propose that there is no privileged position for "objective" knowing and that all knowledge emanates from persons who are already in the world" (Leonard, 1994, p.53).

Hermeneutics is the science of interpretation. Its origins can be traced back to the 17th century and even earlier, when the Greeks were engaged in interpreting texts of Homer. The 19th century saw the development of a theory of hermeneutics by German philosopher Wilhelm Dilthey. Heidegger was one of the 20th century philosophers who further refined the underlying philosophical theory (Fjelland & Gjengedal, 1994). A

phenomenological-hermeneutic approach “is essentially a philosophy of the nature of understanding a particular phenomenon and the scientific interpretation of phenomena appearing in text or written word” (Speziale & Carpenter, 2007, p. 88; Heidegger, 1962). Hermeneutic phenomenology unveils otherwise concealed meanings in the phenomenon of interest (Speziale & Carpenter, 2007).

Several assumptions can be found within Heideggerian phenomenology that inform the philosophical underpinnings of this methodology:

- The world is *a priori*, it is a given in our culture. “World is a meaningful set of relationships, practices, and language that we have by virtue of being born into a culture” (Leonard, 1994, p.46). This *a priori* existence of the world gives meaning to the taken-for-granted skills and practices (Leonard, 1994).
- Being a person involves giving significance and value to things. This *Dasein* (being in the world), as termed by Heidegger, motivates what we peruse and what we care for, and in turn, the activities we pursue and the things we care for (Heidegger, 1975).
- Heidegger believes that the person is self-interpreting. These interpretations “are given in our linguistic and cultural traditions and make sense only against a background of significance” (Leonard, 1994, p.52). This is contrary to the Husserlian claim that these “interpretations are a product of individual consciousness” (Leonard, 1994, p.52).
- The Cartesian premise of mind-body dualism implies that the body is an object of possession, “a machine driven by mechanical causality... extrinsic to the essential self” (Leder, 1984, p.30). The phenomenological notion of person refutes this by

believing the person is embodied, rather than just having a body. “Our bodies provide the possibility for the concrete action of self in the world. It is the body that first grasps the world and moves with intention in that meaningful world” (Leonard 1994, p. 52).

- Heidegger refutes the idea of linear times, described as “endless succession of nows” (Leonard, 1994, p.52) and describes the idea of person in time by the concept of the Temporality, where time is both directional and relational (Leonard, 1994). “Because all human beings are constituted by temporality, all knowledge, in this view, is temporal. Atemporal, ahistoric transcendent knowledge of human behavior is impossible” (Leonard, 1994, p. 55).

Essentially, there are four existential life worlds that interconnect to become the key components of interpretative phenomenology: corporeality (embodiment), relationality (our connection with the self, others, and the world within which we exist), temporality (not to be equated with linear or clock time) and spaciality/situatedness (how individuals situate the self within their world) (Munhall, 2007).

Interpretative Phenomenology in Nursing

The practice of nursing encourages a holistic approach where the nurse cares for the mind, body, and spirit of humans (Speziale & Carpenter, 2007). Caring for just one part of the client is inconsistent with nursing practice, just as breaking humans down into parts would be inconsistent with nursing research (Speziale & Carpenter, 2007). Benner (1994) introduced a science of caring for nurses using interpretative phenomenology based primarily on the philosophies of Heidegger (1962). Her ideas have been further articulated in subsequent works (Chan, Brykczynski, Malone, & Benner, 2010).

Benner's (1994) integration of interpretative phenomenology into nursing research is cited throughout this project's methodology and her ideas played an integral part in the project's development.

Through this work, this researcher was able to uncover commonalities and differences in meanings, skills, practices, and embodied experiences. This was done by uncovering exemplars or paradigm cases that embodied the meanings of the everyday practices; in a way that they were not destroyed, distorted, decontextualized, trivialized, or sentimentalized (Benner, 1994).

Social Ecological Theory

In working toward an understanding of the lived experience of the registered nurse, the appreciation that factors that influence the individual nurse's life experience will in turn be influenced by all of the interrelated systems that impact that individual nurse's life. Bronfenbrenner's (1979) social ecological theory provides a basis for this understanding. With this perspective, the individual is inextricably linked to a complex system of interconnected rings of influence (Hess & Schulz, 2008). These systems are; microsystems (institutions and groups with which the individual has direct contact and as such have immediate and direct impact such as familial, academic, and employment settings); mesosystems (the synergy among the individual's various microsystems); exosystems (those systems that the individual does not directly participate in but because of others in their microsystem, impacts their lives, for example, the impact of a child's school system on their parents); macrosystems (the general cultural patterns in a society, for example, the impact of a capitalist society on the life of an individual); and

chronosystems (the dimension of time on the development of the individual including factors such as technological advances, shifts in ideas about truth and reality over time).

The understanding that the individuals' interpretations are nested in many overlapping and converging systems of interrelated physical and interpersonal contacts meshes nicely with the philosophical underpinnings of the interpretative phenomenological methodology. It strengthens the appreciation that factors such as individual, group and other systems, both inside and outside the walls of the IWK Health Centre impact understanding.

Locating Myself in the Research

One of the assumptions of interpretative phenomenology is that “the researcher has a preliminary understanding of the human action being studied. It is by virtue of our world that we, as researchers, have the questions we have and that we see the possibilities we see. Thus we approach our interpretive project with some pre-understanding, or as Heidegger called it, a fore-structure of understanding, into which by virtue of the structure of being (care), we are thrust or projected” (Leonard, 1994, p. 57). The primary researcher became an instrument of the research. This primary researcher's pre-understanding and context to the proposed work is detailed in the introduction section of this thesis. This also serves to identify the researcher's beliefs and pre-conceptions around the phenomenon of the registered nurse working to full scope of practice in a pediatric ambulatory care area.

Methods

The following section will detail the methods used in conducting this research study. A discussion of setting, sampling, and data collection methods will follow.

Setting

Participants were recruited from the IWK Health Center in Halifax, NS. This is a university affiliated medical centre that provides tertiary care services to the women, children, and youth of the maritime provinces and beyond. The entire health centre has 270 inpatient beds and has approximately 204,769 ambulatory care visits per year (IWK Health Centre, 2012). At the time of recruitment, there were 25 registered nurses employed in full-time, part-time, or casual positions within the ambulatory pediatric medical care portfolio who had been working in the role for over two months. This included clinical areas of neurology, endocrinology/diabetes, nephrology, respiratory, cystic fibrosis, general pediatrics, gastroenterology, immunology, infectious disease, rheumatology, and allergy. There had been two retirements from these areas in the past five years.

Purposeful Sampling

Qualitative research methodologies utilize the concept of purposeful sampling (Creswell, 2013). Individuals and sites are selected based on their capacity to inform an understanding of the research problem and phenomenon of study (Creswell, 2013). In accordance with interpretative phenomenology methods, a convenience sample targeting participants who have experience with the phenomenon of interest was used (Baker, Wuest, & Stern, 1992; VanManen, 1990). To be included in this study, participants had to be currently employed in a staff nurse position in an Ambulatory Pediatric Medical clinic at the IWK Health Centre who had been in their ambulatory pediatric nursing position for over two months. It was felt that those working for less than two months

would still be in the orientation phase of their new positions and not yet be practicing fully independently in their clinic areas.

In hermeneutic interpretative phenomenology, sample size is considered adequate when the interpretations are visible and clear and new informants fail to reveal new findings and meanings (Benner, 1994; Crist & Tanner, 2003). This is termed saturation (Morse, 1995; Sandelowski, 1995). Creswell (2013) notes that as a general rule of thumb with qualitative research, one should study only a few individuals but collect extensive detail on each individual studied. Typical sample sizes for phenomenological studies range from 1 to 10 people (Starks & Brown-Trinidad, 2007). Prior to recruitment, there was anticipation of recruiting one-third to one half of the potential pool for this research design. This would have consisted of 9-12 nurses. As recruitment progressed, it was evident that recruitment of nine nurses would not be possible. Many did not express interest and others stated they were unable to take the time out of their busy schedules. Over a two month period, eight nurses were recruited and took part in this study.

Grounded in the interpretative tradition of phenomenological hermeneutics, several methods of data collection were employed to tell the stories of registered nurses working in pediatric ambulatory medical clinics at the IWK Health Centre.

Pilot – Semi-structured Interview Guide

There had been two retirements from the Ambulatory Medical Care areas in the five years previous to this study. These nurses retired prior to the primary researcher taking on the role of manager in their areas. The semi-structured interview guide (Appendix B) was piloted with these two nurses in a single focus group session. The recently retired nurses were recruited for this session by the primary researcher who also

facilitated the session. This was done in an effort to identify any deficiencies and gaps in the interview guide. Because this session stimulated the desired conversations, no changes were made to the interview guide after the pilot session. This session was also audio taped verbatim (with the permission of the participants) and transcribed. This data was not part of the study data and not part of the final analysis. The principal researcher for the study contacted the retired nurses by telephone and e-mailed a letter (Appendix C) explaining the study and rationale for the pilot. The principal researcher arranged for a convenient time and place (private home) for a quiet and comfortable 90-minute pilot focus group.

Of note, there was some thought that by using the term “scope of practice” in this study and using that terminology in interviewing nurses, it may increase fear and cloud results. Nurses may not feel comfortable in talking freely about their work lives for fear identifying areas of their work that could be done by other licensed/unlicensed nursing support staff. Given that the Ambulatory Review was proceeding, there probably was some underlying fear of change with this group of nurses. It was decided to acknowledge this and proceed. It was also decided to leave the “scope of practice” terminology in the correspondence to study participants and in the interview guide (Appendix B). This is a term that has been used for many years within the College of Registered Nurses of Nova Scotia, Canadian Nurses Association, and the administration of the IWK. It may bring both positive and negative feelings, but it is common language. For nurses to provide the discussion around their scope of practice, it was necessary to use the words, as they are accustomed to hearing.

Focus Group

Due to the ethical concerns implicit in the power position of the manager/employee relationship, it would have been inadvisable for the primary researcher (and in this case, manager) to actively recruit and interview her staff. The power relationship between a manager and her staff created an obvious concern for fairness and special attention to avoid any suggestion of coercion. It is acknowledged that by the researcher using herself as the research instrument, a deeper understanding of the phenomenon can be developed and would be the ideal situation (Gadamer, 1976; Fleming, 2002; van Manen, 1984). Because this case made it impossible, and the benefit of hearing the lived experience of the currently practicing nurses was key to truly understanding the lived experience of this group of nurses, ways to work around this less than ideal situation had to be found.

All participation was voluntary and this was made clear in the recruitment letters (Appendix D). Participation, or lack thereof, in no way affected the employment of the staff nurses that were on the recruitment list for this study. An assistant who held no authority or power position over the staff nurses did the recruitment (circulated information about study and managed informed consent explanations and letters) for the currently employed staff nurses.

A research assistant presented the study to the currently employed nurses during a meeting scheduled at the IWK Health Centre when most ambulatory nurses were scheduled to work. All eligible nurses received an invitation to the meeting (from the Administrative Assistant for the Manager of the Children's Ambulatory Medical Care team), but attendance was purely voluntary. A few days before and a few weeks after the

meeting, the Administrative Assistant for the Manager of the Children's Ambulatory Medical Care team e-mailed current employees a letter explaining the study. Any questions about the study were referred to Dr. Brenda Sabo. Those wishing to participate in the study were given dates and times for focus group session that were arranged by the research assistant. The three focus group sessions occurred outside of regular clinic hours in a comfortable and private room at the IWK Health Centre. All nurses were asked to complete short demographic questionnaires prior to the focus group discussion to gain insight into nurses' age, education level, and years of nursing practice (Appendix E). All focus group sessions were audio taped and transcribed verbatim to ensure accuracy and integrity of the participants' narratives. Verbatim transcription is important in phenomenology as the closeness between the researcher and the text is critical to the research design (Halcomb & Davidson, 2006). The verbatim transcription facilitated data analysis by bringing the researcher closer to the data (Halcomb & Davidson, 2006). There was a second research assistant present in all focus groups. The role of this assistant was to observe interactions and non-verbal communications in the sessions and document observations. This documentation aided in the primary researcher's analysis of the transcribed data.

The primary researcher also interviewed both primary and secondary research assistants at the conclusion of the focus group sessions. This provided an opportunity for the researcher to delve into the research assistants' experiences facilitating and being present in the focus group sessions and develop a deeper understanding of the interpretative process. It must be understood, that the focus group facilitator and assistant cannot be thought of as a functionally objective roles. Their context (especially the

facilitator) influenced interpretation of and interaction with the focus group participants. They became part of the understanding process. They were participants in this process, coming with their own fore-structure of knowing nursing, pediatrics, ambulatory care, and the context of the health centre environment. In reviewing text, the researcher remained cognizant of this and reflected on it as the texts were read and re-read during the hermeneutic circle of understanding process. The interviews started with the open-ended question; “tell me about your experience facilitating and being present in the focus groups for this study.” The interviews were audio taped and transcribed verbatim.

It is understood that it is not common practice for a research assistant to be used in a graduate level research project. Due to the ethical considerations described earlier, in this case, we felt strongly that this was the most prudent way to glean the key information and perspective that these nurses could provide (in discussion with supervisory committee, Dalhousie Research Ethics, and Graduate Studies December 2012).

The interview is considered to be the main method of data collection in phenomenological research as it creates the situation where participants’ descriptions can be explored, illuminated and probed (Wimpenny & Gass, 2000). The objective of the interview in a phenomenological study is to elicit the participant’s story (Stark & Trinidad, 2007) and requires “the use of reflection, clarification, requests for examples and description and the conveyance of interest through listening techniques” (Jasper, 1994, p. 311). Although the use of focus groups in interpretative phenomenology is not commonplace, there are arguments to justify and encourage their use (Bradbury-Jones, Sambrook, & Irvine, 2009; Palmer, Larkin, DeVisser, & Fadden, 2010). Focus group

data were utilized in this project as the primary researcher felt that it could be justified given the research question was congruent with its use.

The key argument against the use of focus groups in phenomenological research is that the multiple voices of a focus group increase the complexity of the context, the interactional complexity of the discussion and the difficulty in inferring and developing personal, phenomenological, accounts (Palmer, Larkin, DeVisser, & Fadden, 2010). By remaining cognizant of this, and taking it into account during the hermeneutic circle of interpretation, the researcher can effectively interpret the human experience and also enrich the study findings by the use of the focus group texts (Palmer, Larkin, DeVisser, & Fadden, 2010).

Heideggerian phenomenology is not concerned with “uncontaminated” participant accounts, and is in fact concerned with researcher and participant interpretation (Bradbury-Jones, Sambrook, & Irvine, 2009). The hermeneutic circle involves a continual reciprocal interpretation with participants (Bradbury-Jones, Sambrook, & Irvine, 2009). This is consistent with a focus group method. Focus groups can also add to the understanding of the experience and contextual factors that interpret the phenomenon (Palmer, Larkin, DeVisser, & Fadden, 2010). Focus groups can be useful for cross-checking and clarification, particularly when findings appear contradictory (Bradbury-Jones, Sambrook, & Irvine, 2009). The interaction of participants in focus groups can actually enrich data by allowing participants to hear each other’s stories and add their own perspectives and insights as the story unfolds (Bradbury-Jones, Sambrook, & Irvine, 2009). It is important to note, that this method was not used to check validity

or arrive at the truth, because this is clearly contrary to the interpretative phenomenology grounding this project (Bradbury-Jones, Sambrook, & Irvine, 2009).

With the underpinnings of the social ecological theory, an appreciation of the multiple systems that must be considered when attempting to interpret understanding is critical. With an underlying belief that nurses practice both individually and communally, and their understanding as such are both individual and communal, there is credence given to the method of focus group data collection in this project.

Small group interviews (focus groups) can encourage the creation of a “natural communicative context” where nurses can talk to each other in the way they would in their work environments and not attempt to translate their stories for the benefit of the researcher (Benner, 1994). Talking with coworkers also helps to simulate the work environment, which will encourage thought and discussion about work situations (Benner, 1994). The participants in a focus group co-created experience and meaning. It is this researcher’s hope that for all of the reasons stated, using this approach strengthened the study. It is also important to note that data may have looked differently if individual interviews were used.

The focus groups were facilitated based on the attached guide (see Appendix B). The focus groups were made up of eight nurses in three separate groups (three in two of the groups and two in one of the groups). The active discussion portion of the focus group sessions lasted between 45 and 70 minutes. It was important that the groups were small enough that each nurse could “tell their narrative as a self-contained story with minimal interruptions and then other members of the group can add valuable perspectives as the story unfolds, probing for more information and adding their own insights to

shared meanings” (Bradbury-Jones, Sambrook, & Irvine, 2009, p.668-669). It was also essential that each member of the group had an opportunity for their story to be heard. To ensure this, the focus group facilitator was adept in ensuring the quieter participants’ voices were heard and the more dominant voices were tactfully managed (Bradbury-Jones, Sambrook, & Irvine, 2009). These small focus groups were sufficient to elicit the robust narratives essential for this interpretative phenomenological methodology. It was understood that saturation would not be clear until the focus groups proceeded and the interpretation process began. Recurrent themes were clear and evident by the end of the third focus group.

Reflective Journaling

Self-reflexivity is an integral part of hermeneutic research. This involves “ongoing conversation about the experience while simultaneously living in the moment, actively constructing interpretations of the experience and questioning how those interpretations came about” (Laverty, 2003, p.22). The use of a reflexive journal is a way to engage in the hermeneutic circle and move back and forth between the parts and the whole of the text (Laverty 2003). Throughout the study process, the primary researcher journaled understandings, thoughts, successes, and challenges that were beneficial in the ongoing hermeneutic process of understanding.

Data Analysis

In interpretative phenomenology, the analysis process includes the significance of the existing world and its meanings for the researcher (Crist & Tanner, 2003). There is an innate understanding that people are inextricably situated in their worlds (Merleau-Ponty, 1962). The researcher must be aware and recognize any assumptions that could

influence her conduct during the interview or interpretation of interviews. The act of recognizing these interpretations has been described as the forward arc or the “hermeneutic circle” and the interpretation is termed the return arc (Crist & Tanner, 2003), or the “movement of uncovering” of the circle (Packer & Addison, 1998, p. 275). The circular process of the “hermeneutic circle” allows for narratives to be “examined simultaneously with the emerging interpretations, never losing sight of each informant’s particular story and context” (Crist & Tanner, 2003, p. 203). The researcher continues to interview and observe informants during this process. These processes can and will overlap as the process of hermeneutic interpretative phenomenology is not linear (Crist & Tanner, 2003).

Crist and Tanner (2003) have proposed a method of analysis, or “interpretative process” to be used with hermeneutic interpretative phenomenology. This process provided a framework for data analysis in this work, with an understanding that the analysis process could not be completely prescribed. As Benner (1994) pointed out, interpretative phenomenology is a circular and non-linear process.

“Early focus and lines of inquiry” begin the process (Crist & Tanner, 2013). The researcher reviews and critically evaluates the first few informants’ narratives (Crist & Tanner, 2013). Missing or unclear pieces are identified. The lines of inquiry that are revealed through this initial interpretation, provide guidance for subsequent interviews and provide a richer understanding of the phenomenon (Crist & Tanner, 2003). As interviews, focus groups and ongoing interpretation continue, “central concerns, exemplars and paradigm cases” will begin to present themselves (Crist & Tanner, 2013). The researcher will begin to identify central concerns, and important themes and

meanings that are evolving for specific informants (Crist & Tanner, 2003). Relationships between past and current experiences are explored (Crist & Tanner, 2003). The researcher will write a summary of key concerns and excerpts from each narrative. As new interpretations emerge, through this writing process, the text summary is re-written and revised. As this process progresses, exemplars and paradigm cases emerge (Crist & Tanner, 2003). Exemplars are defined as “salient excerpts that characterize specific common themes or meanings across informants” (Crist & Tanner, 2003, p. 204). Paradigm cases are “strong instances of concern or ways of being in the world, doing a practice, or taking up a project” (Benner, 1994, p.113). As the process continues, the central concerns of the informants start to come clear and “shared meanings” can be interpreted (Crist & Tanner, 2003, p. 204). The final interviews and observations will address any identified needs for inquiry and finally, the process ends with a phase of “dissemination of the interpretation” (Crist & Tanner, 2003, p. 204). This is an iterative process between narratives, field notes, and researcher interpretation. It is essential to remember that the interpretation actually develops through the entire research process. It is an unending process that leaves the final interpretation to the report’s readers (Crist & Tanner, 2003). This framework was followed during the data analysis phase.

NVivo software, version 10 (QSR International, Melbourne, Australia) was used to facilitate data analysis. NVivo is a data management package that provided a tool for organization of emerging categories and eventual themes and subthemes from the focus group narratives.

Rigour

The prominence of philosophy in the methodology and methods of interpretative phenomenology render the use of generic, qualitative criteria for rigour (Guba & Lincoln, 1994, Sandelowski, 1986) problematic. Lincoln and Guba (1985) define four criteria to validate a qualitative study and naturalistic axioms (Creswell, 2013). These four criteria are: credibility, transferability, dependability, and conformability and their adherence were evidenced in the work (Lincoln & Guba, 1985).

1. Credibility involves a true and faithful interpretation of the human experience (Sandelowski, 1986). “A study is credible when other people (other researchers or readers) can recognize the experience when confronted with it after having only read about it in a study” (Sandelowski, 1986, p. 30). Koch (1994) states that credibility this is strengthened when researchers describe and interpret their research experiences. This was achieved through the use of phenomenological writing and reflective journaling and reinforced by a process of member checking. The results were presented to the ambulatory medical care nurses working at the IWK. This provided an opportunity to ensure resonance and concreteness of the results with those whose experience were being interpreted.
2. Transferability, or fittingness, as described by Sandelowski (1986, p. 32) refers to a study whose “findings can “fit” into contexts outside the study situation and when its audience views its findings as meaningful and applicable in terms of their own experiences.” This was achieved by providing a detailed description of the context (nurses working in pediatric ambulatory medical care clinics) to enable the reader to make similar judgments.

3. Dependability, or auditability, as described by Sandelowski (1986, p. 33) refers to the ability of “another researcher can clearly follow the “decision trail” used by the investigator in the study.” Verbatim transcripts helped ensure rigour in a data trail for accurate auditing (if needed) by research team, supervisor, or an independent person (Halcomb & Davidson, 2006). NVivo software, version 10 (QSR International, Melbourne, Australia) served to reflect a data trail enhancing study rigor by capturing, not only the emergent themes but the primary researcher’s thoughts within memos as the data were analyzed. Review could help identify any issues that may have arisen with review and analysis of focus group transcribed records. A detailed decision trail, encompassing the researchers decisions around theoretical, methodological, and analytic choices throughout the study (Koch, 1994) was evident in the thesis.
4. Confirmability is established when credibility, transferability and dependability are achieved and involves the primary researcher showing how interpretations were determined (Koch, 1994). Through all of the processes described to ensure credibility, transferability, and dependability the primary researcher is confident that confirmability has been achieved in this thesis.

Ethical Considerations

Research ethics board approval was sought and attained from the IWK Health Centre Research Ethics Board.

The Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans provides groundwork for ensuring ethical practice in research (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of

Canada, and Social Sciences and Humanities Research Council of Canada, 2010). The core principles outlined by the Tri-Council Policy Statement are respect for person, concern for welfare, and justice (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada, 2010).

Respect for person was addressed by ensuring that all participants were fully informed of the purpose and methods involved in the research. Informed consent forms (Appendix F & G) were reviewed and signed by all participants of the focus group sessions.

Concern for welfare was also addressed. Although there were no anticipated risks or injuries with the study, there was an understanding that during the focus group process, feelings may be revealed that could be emotionally charged and difficult to discuss. The focus group facilitator was prepared for such circumstance. The focus group facilitator was prepared to provide the number of the IWK's Employee Assistance Program for additional support if required. The facilitator was also prepared to suggest participants visit their family doctors if the interviews distressed or upset them. Participants were also informed from the onset that they were free to withdraw at any time with no adverse consequences.

The concerns for justice are prevalent in this project. The power relationship between a manager and her staff created an obvious concern for fairness and special attention to avoid any suggestion of coercion. All participation was voluntary and this was made clear in the recruitment letters (see Appendix C & D). Participation or lack thereof in no way effected the employment of the staff nurses that were on the

recruitment list for this study. An assistant who held no authority or power position over the staff nurses did the recruitment (circulated information about study and managed informed consent explanations and letters) for the currently employed staff nurses. The researcher was never made aware of the nurses' participation or refusal to participate in the study. All signed consents were given directly to the research project supervisor (Brenda Sabo) and the primary researcher was never given access. The research assistant forwarded the focus group audiotapes directly to a transcriptionist (with a copy to the project supervisor). The transcriptionist and research assistant were briefed on the concerns regarding participant confidentiality and asked to pay special attention to this. If there were questionable comments made in the sessions, the research assistant was advised to connect with Dr. Sabo to determine the best method to ensure confidentiality was maintained (i.e. remove comment, black out identifying words, etc.). Only the transcribed records (with actual names and potential identifiers removed by the project supervisor) were given to the primary researcher. This was to help to prevent any chance of actual or potential negative or positive implications by participating or refusing participation in the study.

Participant confidentiality was strictly maintained in accordance with the Tri-Council Policy Statements (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada, 2010). A pseudonym was chosen for each participant and used in focus groups. These names appeared in all transcriptions and were again modified prior to final thesis submission to reflect gender neutral names to further ensure anonymity. Participants were informed (in recruitment letter (see Appendix C) and in letters of

consent) that quotes from their stories might be used in reports and publications but their names would be removed to ensure privacy. All tapes and transcripts will be held in a locked cabinet for five years and then destroyed.

Conclusion

An interpretative phenomenological (Hermeneutic) methodology was used to uncover how pediatric ambulatory care nurses live out their role, scope of practice, and the meaning they give to that experience. Since this was a search for the meanings of this phenomenon with a purpose of understanding the lived experience of these nurses, the interpretative (Hermeneutic) phenomenological methodology was an excellent choice.

CHAPTER IV

Findings

Using an interpretative phenomenological methodology, this study explored the lived experience of registered nurses in working to full scope of practice in ambulatory medical care clinics at the IWK Health Centre. The research enabled insight into the research questions:

- What are nurses' understandings of working to full scope of nursing practice in pediatric ambulatory medical care clinics at the IWK Health Centre?
- What are nurses' understandings of the barriers and facilitators to maximizing scope of practice in ambulatory medical care clinics at the IWK Health Centre?

The comments and conversations of the participants in the focus group sessions identified an over-arching central theme of "We are the mothers of our clinic areas". Three other sub-themes wove through the main theme; (a) What we do on a daily basis is our full scope of practice, (b) Ambulatory nursing: a different sort of busyness; and (c) Feeling under the gun: lack of resources and time. This chapter is devoted to a discussion of these themes and how they integrate and address the initial research questions.

Study Participants

Eight nurses participated in the study. Details of the individual demographic breakdown of the participants are not included in these findings. This was intentionally omitted as it was felt that this level of detail could potentially identify these nurses. It should be noted that the gender of the nurses was intentionally excluded from the demographic questionnaire for the same reasons. With this in mind, the demographics of this group are only described in broad terms. In a further attempt to ensure

confidentiality, the alias names each nurse used in their focus group sessions were changed in this report to ensure gender neutrality. Reporting on specialty certification and continuing education of participants was also excluded.

The participants ranged in age from 29 years to 57 years (one experienced nurse would not state her age). The average age was 45.9 years old (not including the nurse who refused to state her age). Their number of years practicing nursing ranged from 5 to 40+ with an average of 23.2 years. Their number of years working in Pediatric Ambulatory Medical Care Clinics ranged from 2.5 years to 26 years, with an average of 13.3 years. Seven of the eight participants listed BScN/RN as the highest level of education achieved. One respondent listed RN.

These nurses took part in one of three focus group sessions where a semi-structured interview guide (see Appendix B) was used to encourage reflection on their lived experiences working to scope of practice in Pediatric Ambulatory Medical Care Clinics. The comments from the nurses have been edited for readability; however, every attempt has been made to preserve their accuracy and meaning. An example of this would be the addition of a subject in place of a “the” to reflect the meaning of the sentence without having to quote an entire paragraph to define the subject. In addition, some identifying information has been removed to maintain confidentiality and ensure anonymity of the participants.

Central Theme: We Are The Mother’s Of Our Clinic Areas

Nurses who took part in this study talked about having a strong devotion to the children and families they cared for in their clinic areas. They consistently went above and beyond to ensure their needs were met and that they were receiving the best and most

coordinated care. To provide this type of service, the nurses were missing breaks, not having down time, and regularly feeling rushed and unable to keep up with the demands. Interestingly, they felt a similar devotion to all members of their interdisciplinary teams. They talked of being the “go to” person for all members of the team. If any member needed support, had questions, or was unable to provide full service to their clients, the nurses felt they were expected to step in and meet these needs. Again, this often took nurses away from other nursing care, break times, or their ability to leave work at the end of the day in a timely way. Pat¹ described this work as being “the mother of the clinic”. The responsibility never really ends: “I often feel like we're the mothers. You know, we're picking up everything at the end of the day and walking out of there”. This comparison, of ambulatory nurse to mother struck a chord with the primary researcher, who worked for many years in these clinical areas. This belief, although not always put into those words, was woven into the study participants’ stories of their day-to-day work, their understanding of scope of nursing practice, and barriers and facilitators to delivering the care they strived to provide. Interestingly, when the results were presented to the entire group of Pediatric Ambulatory Medical Care Nurses at the IWK Health Centre, there was a palpable reaction when this concept was discussed. The nurses came to life and shared more stories of how this concept applied to their lived experiences. The remainder of this chapter will provide discussion of the three subthemes, including how they are woven together within the “mother of the clinic area” main theme to provide the reader with an interpretation of nurses’ lived experience in working to full scope of practice in the pediatric ambulatory medical care areas at the IWK Health Centre.

¹ Names have been changed to protect the identity of all study participants

What we do on a daily basis is our full scope of practice.

Nurses who took part in this study predominantly defined full scope of practice as all that they did in their day-to-day work. They identified that they do many things that would not always be considered to be the work of a registered nurse, such as faxing, photocopying, and room cleaning. They also explained that they often didn't have the time in their day to provide everything they would have liked for all of the children and families who were seen in their clinic areas. But, all of those things they did on a daily basis would constitute their full scope of practice.

Pat, described full scope of nursing practice in terms of the outcomes seen with her patients and families:

I would say that working to the full potential, is having our patients and families understand their plan of care, and carry that out. And that involves a lot of care coordination, education and just liaising with external and internal resources to make that happen.

The nurses noted that the actual work for the clinic nurse varied day-to-day and clinic-to-clinic. Terry put it simply, “*No two days of the week are the same*”.

There were definite consistencies and similarities about the work described by the participants in the three focus groups. The described work, which was often task-based, included both work requiring registered nursing knowledge and skill and work considered to be “non-nursing work”.

Nursing Work.

The nurses talked about work that they routinely did in their clinic areas that was mutually accepted to be “nursing” work: This included telephone-facilitated nursing

care, coordination, assessment, education, procedures, and beyond entry level competencies.

Telephone facilitated nursing care.

All nurses discussed work that occurred over the telephone. An enormous amount of time was spent on the telephone in the provision of telephone-facilitated care. An unidentified participant from the first focus group commented, “50% of our care is probably over the phone”.

The nurses believed that this work utilized registered nursing knowledge to assess a situation over the phone, and make an intervention plan. Chris explained “*We have to gather information over the phone often and make judgement calls based on what we can assess over the phone*”.

This was felt to be very important work by all. It underpinned effectiveness in supporting families to care for their children at home and often helped to avoid an unnecessary trip to the health centre. As Kim noted:

Often, families, through just telephone care, work through their issue and are just able to come for follow-ups and not have to come to the hospital and go to emerg and feel like they have no control over their situation.

Nurses identified a large amount of post-clinic visit follow up work done over the phone. This involved coordination and consultation between various team members, but often it was the nurse who was providing the telephone support to the families. Carol described “*a huge amount of telephone calls to follow up and then relay messages on to the physician, and then relaying the messages back and arranging follow-up on bloodwork and changes in medication*”.

A few of the nurses talked about providing on-call nursing consultation service facilitated by a paging system. This involved families paging an “on call” registered nurse when in need of nursing guidance or advice. Jess explained; *“on our call, we are talking to families. We're not talking to physicians. We're talking to... The families are actually calling us directly. And so we do a lot of care through that way as well”*.

Telephone facilitated care with this group was done for a myriad of different reasons, but all felt that it was work they did on a daily basis that fostered positive outcomes for the patient population they served.

Coordination.

Care coordination was also consistently described as being within the scope of practice. This, like telephone facilitated care, varied in its intent, but was always a consistent part of the day-to-day ambulatory nurse role.

Providing coordination of visits for families’ who had clinic appointments was one form of this. Sam described the work as *“...talking to a booking clerk about booking issues and trying to coordinate, you know, that the siblings get seen together, those issues are important. Or coordinating with other clinics so that they don't come twice in two days”*.

Kim explained;

If they're coming from Miramichi, they don't have to make 6 trips in a month, to coordinate all of their care together so that they're seen all on one day or two days, and to make sure that their care is comprehensive instead of missing 3 appointments and having families have to come back down is an extra part of that.

The coordination work could also take the form of supporting a family to coordinate their care while in the health centre. Pat explained “*we sort of help coordinate them throughout the day. You know, where they need to go and if they need to have blood work or see the next team member*”.

The nurses discussed how they facilitate care coordination for children and their families with external health care providers and communities. Pat commented on how important this was for nurses working at a tertiary care centre:

Here at the IWK, our teams look after such a wide variety of like area. We look after the Maritime Provinces; patients from NB and PEI and even Cape Breton and Yarmouth; they don't want to have to come all the way back to the IWK to learn how to do that. So we tend to reach out to those community partners and really try to say, well, okay, where can we send you to make this happen so that you don't have to come back?

The coordination of care for the children and families planning a visit, at a visit, or between/in follow up to a visit was common work that fell within the full scope of these nurses’ work. This work was discussed in all focus groups as being registered nurses’ work that enhanced patient care and contributed to clinic flow. The nurses recognized that they were well positioned to take a lead role in this important work and do so on a daily basis.

Assessment.

Most of the nurses described some basic nursing assessment that takes place when the children and families are in the clinic area for a visit. Sam explained what this could look like;

We do a height and weight. For diagnostic testing, we do a set of vitals as well. Then we take them in and do a quick assessment, a physical assessment, medication history, and then get the physician.

A common theme among the nurses was that they were unable to do as thorough an assessment as they would like, as time was always a factor. Kim explained:

There are limits as to how much you can do with just a nursing assessment because you know you have 10 minutes to get a height, weight, blood pressure and then to start with a history or a physical is just you don't have time.

The nurses attempted to triage patient needs on initial assessment to ensure the child and family received the care they needed in that visit. Sam stated:

If there's obviously a patient that needs a lot more one-on-one time then I would speak to the physician or I would spend that time with them and let the physician know that I'm going to be a little bit behind because this patient really needs some medication delivery review because they're very uncomfortable.

Nursing assessment is considered to be an integral part of the nursing process. This is the information that nurses use to inform their plan of care for any patient and family. Time pressures are a reality in today's health care system. This is not just an "excuse" but a reality of clinic work. As will be touched on later in this chapter, there is limited space and many patients scheduled to see a physician in short time periods. This time pressure not only made these nurses feel that they weren't delivering the best care, but appeared to impact their ability to develop and enact what they felt would be the best nursing care plan for their patients and families.

Education.

Assessing learning needs of the patient and family and providing subsequent education was common work in most clinic areas. Terry stated, “*you may end up doing teaching post or an assessment post the physician visit. There is a lot of incidental teaching and setting up plans for further teaching*”.

Sam provided a little more detail, stating:

If the physician wants medication administration technique assessed or if it's a new medical diagnosis or a new patient that we're seeing, we'll assess what their knowledge level is like. We'll always assess technique at the first visit, and do education as necessary.

More complex and group teaching was described as being a frequent occurrence in many of the clinic areas. Jess explained an example of what this could look like when preparing children and families to use unfamiliar medical device:

They're there for a much longer period of time. So that's a different type of teaching. It's different from new diagnosis, different from your incidental teaching for your follow-up patients. But it's still another type of teaching that takes a lot of time and preparation and planning. And that sort of isn't only the day of, it's a class beforehand and it's talking to the family in advance of that and making sure everything is in place for that.

These descriptions of the various types of education that nurses were providing to their patients were, in many cases, due to the varying patient care needs in the different clinic areas. Teaching was generally able to be done in a short time period and understanding was often reassessed at subsequent visits. Other areas would provide

education to prepare families to use more complex and invasive medical devices. These education sessions often required scheduled time for teaching sessions and often required frequent follow up with the families until they were comfortable with the care. This spoke to the diversity of nursing care occurring in the ambulatory areas.

Procedures.

Interestingly, only a few of the nurses mentioned nursing procedures as being a part of their day-to-day work and scope of practice. Historically, ambulatory patients were not medically complex and the role of the nurse was often to follow the physician-led plan and ensure the patient and family were comfortable and content. It is important to point out how infrequently this sort of work was cited by the registered nurses in this study. Although not discussed in the focus group sessions, there are an increasing number of children with complex medical conditions requiring more procedural nursing care (such as enteral feeding, central line care, tracheostomy care) being seen in the clinic areas. There is an associated push by many ambulatory nurses to refer these procedural needs to other nurses (inpatient, day patient areas). Interestingly, the nurses who discussed doing procedures as part of their daily work were the younger nurses and not those with many years of experience in the ambulatory areas. It would make sense that those not used to this sort of work (more experienced ambulatory nurses) would not identify it as being within their scope. It also follows that younger nurses, who generally have had recent in-patient experience, and have an associated proficiency in this sort of procedural care, would have no reason to think that this was not an expectation of their ambulatory nursing role.

Beyond entry-level competencies.

Nurses in a few of the clinics described competencies beyond entry level that they were able to provide in their clinic area and envisioned more autonomy around these sorts of delegated medical functions. Direct quotes are intentionally excluded as they would be felt to present a risk to anonymity of the participants.

Granted, these types of delegated medical functions are “tasks” that registered nurses have been specially educated and authorized to do, it is interesting that this does not seem to be seen within the context of the full registered nursing scope and exemplifies only a discrete piece of the work that full nursing scope would aim to provide.

Non-Nursing Work.

Routine work being done, but not considered by the registered nurses in this study as being “nursing work”, included clerical activities, preparation of rooms and areas, administrative activities, work in the scope of other allied health professions and procedures. While some would suggest this work to be clerical, the participants understood this work as being within their scope. In keeping with the goal of describing the lived experience of the participants, this work will be discussed in this section.

Clerical activities.

In all focus groups, there was conversation about the clerical work done by registered nurses, as there were not sufficient supports to do this in the clinic areas. Jo stated:

There's a lot of things that I think could be clerical. Like at the end of the day, we don't have a ward clerk. So we're taking charts apart and filing them and photocopying them, and things like that. That takes a lot of time.

This is just the tip of the iceberg in terms of the conversations that took place about the clerical work done by the registered nurse on a daily basis. It was interesting that this was a main theme with all of the nurses, but seemed to be justifiable by some as being necessary to keep the ambulatory clinics going. Sam stated:

And some of that non-nursing work is important in the ambulatory setting, like things that we wouldn't think of necessarily as nursing work. But I think in a clinic setting, it's a little different. Just, you know, follow-up with patients around bloodwork or talking to a booking clerk about booking issues and trying to coordinate, you know, that the siblings get seen together, those issues are important. Or coordinating with other clinics so that they don't come twice in two days.

Some other examples of “clerical” roles were: coordinating patient appointments, calling health care professionals to see patients, faxing, photocopying, calling the health centre lab or external centers, searching health records for lab data, calling health records departments and tracking down missing records, cleaning rooms, searching for addresses and mailing out information/prescriptions to families, ensuring supplies are not outdated, and stocking rooms with supplies when needed. All of the focus groups gave a multitude of examples of how this impacted them daily. Jo stated:

A big part of that is the clerical part and the parts like pulling charts or taking charts apart at the end of the shift, and things like that, filing things, stuff like that. I wish we had more clerical staff to do more...some of the paperwork.

Kim commented on those non-nursing things that took up a lot of time in her clinic area: *“Administrative things and tracking down growth charts or going through charts and calling Health Records. Or making photocopies. Cleaning clinic rooms. Moving patients around”*.

Terry noted that this has been an issue in the clinic area for many years:

It's been an issue for years that nursing is doing secretarial work because you have to have it done and there's nobody else to do it. So in order to do your task, what you need to do, the lack of secretarial is a haunting task. So you spend so much time doing that prep.

They felt that this is, for the most part, was work within their scope of practice. Because these nurses spend such a great amount of time doing these sorts of tasks, and always have, they may consider this as within scope of the ambulatory nurse's role. Interestingly, when asked to discuss barriers to working to full scope of practice, the acknowledgement of the abundance of clerical work they were doing was quickly identified as something that someone in a support role could provide. What can be concluded is that the nurses are doing this because they consider them necessary tasks.

Prepare rooms and area.

Common work discussed in all focus groups was the “prep” work that all nurses spent time doing to ensure their clinics ran smoothly. Pat stated:

If we're going to have clinic that day, we do a lot of getting ready, organizing, making sure we're ready to roll with clinic. You know, that might mean cleaning up the room or, you know, just those little things there.

Devon explained:

That's getting the equipment, the IVs set up, the room set up. Any isolation patients. Chart and paperwork, make sure that we've gotten all of the charts. So there's a lot of clerical stuff around there. And making sure that it's set up for each patient if they have appointments, and that their plan for their day is set up.

There are also “maintenance” type activities that go on all through the day. For example, Chris stated:

You know, a patient has left a room but nobody has been in there to clean it. Their sheet is still left on the examining room...you know. And you're going in to use it so you tidy it up. So there's always those things.

How frustrating this must be for the registered nurses who described in great detail the busyness of their days and an inability to find time to provide the nursing and emotional support to patients and families that they feel they should, yet are left in situations where they had to clean rooms and search for equipment.

Work in scope of other allied health professions

The nurses identified work that they did that may be perceived as a better fit within the scope of other allied health providers, but fell on them because those resources were not always available. There were numerous discussions around lack of social work support. Jo noted “*that's a lot of stuff that isn't necessarily nursing. Maybe a social worker could do it. But we do all of that*”. Sam also mentioned lack of social work

support: *“We don't have a social worker with our service at all. And often the biggest issues are affordability of medications”*. As Sam mentioned, the type of support the nurses refer to generally involved attaining financial resources to provide for medication or other care the child and family may have required. Assisting families in finding and securing financial resources to care for their children has historically fallen within the domain of the social workers at the IWK. With the movement of care out of the inpatient areas and into ambulatory and community settings, there has been an increase in prescriptions and treatments not covered by the publicly funded Medicare system. Families often require support to navigate other government programs, private donors and insurance companies to attain the financial supports necessary to care for their child. This is not a traditional role for IWK nurses but one that has fallen to them, as there has been no increase in social work resources devoted to the ambulatory areas. It must be mentioned that this sort of role is mentioned in the job description for a registered nurse at the IWK Health Centre (Appendix A).

Devon mentioned the lack of pharmacist support in her clinic area: *“We have no pharmacists that helps us with stuff. There are no pharmacists applied to our area.”*

With an increase in very complex medications being prescribed and at times, administered, in many pediatric ambulatory care clinics, the nurses are justified in requesting the education and support that is provided by a pharmacist in other areas of the health centre. The nurses have been tasked with doing their own research and liaising with pharmaceutical companies to meet their educational needs. This would not be an expectation for nurses on inpatient units or within other outpatient areas such as hematology, oncology or nephrology. Up to fifteen years ago, IWK pharmacists had very

little association with the ambulatory areas. Pharmacist positions directly supporting clinical areas is a relatively new phenomena. There would have been little need, in the past, given standard, non-complex medications historically required by the ambulatory patients. This has changed over time. The specialized knowledge and skill of a pharmacist is a gap in these areas that is being felt by the nurses who are asked to deliver and educate families about these complex medications.

Administrative duties.

The nurses identified many administrative duties that they were responsible for, as they did not routinely have a supervisor or manager physically in their clinic areas. Jo noted “*the nurses who work in those clinics are responsible for, you know, reporting something that's broken or... You can't just pass it on to the manager... somebody's got to be following up on all those other things*”.

Sam stated;

One other role that we have or that I have and lots of nurses in the Unit is as chairs of the different Morbidity and Mortality (MOM) committees. So I'm the chair of our clinic's MOM. So any adverse events that happen related to our clinic come to me and I have to do the follow-up, and then work with the quality improvement coordinator to implement improvements or monitor situations and things like that.

Jo commented on the difference between the administrative responsibilities that fell on the clinic nurse that would not necessarily have been the expectation of the staff nurse on the inpatient units.

We do a lot of the things for accreditation or reports that maybe we wouldn't have to do as a general staff nurse. But that's what we're categorized as, as a staff nurse. And on a unit where there are 20 or 30 or 40 or 50 nurses, they don't necessarily have to participate in that.

Sam described the role as chair of the MOM Committee as being acceptable, yet Jo seems troubled by the work that would fall out of these sessions and work involved in accreditation. Is it possible that the “task” work of chairing a committee is somehow perceived as different to the “thinking” work involved in taking information and translating it to improve care delivery, and in turn, practice?

What we would love to do if we had time.

As previously mentioned, there were a number of nursing practice elements that the nurses felt they were not able to provide as consistently and thoroughly as they would have liked due to time constraints. It is important to note these areas, as this was part of the conversations of what could constitute ambulatory nurses broadening their scope of practice.

One of the focus groups talked of some medical tasks they felt they had the skill and ability to do, but as of now, these things fell within the medical domain. They felt tasks such as ordering lab and diagnostic tests and prescribing and dosing medications should and could fit within their scope of practice. Chris reports:

After you've been in an area for a certain period of time, things do become routine to a certain aspect after a while. And you know what the routine is, you know what needs to be done, you know what referrals need to be made, you know what x-rays need to be done, what blood work needs to be done, what

prescriptions need to be given. You know, certainly within our scope, I think it could be expanded.

Jess also talked about things that could benefit her patient population and would fit within her scope of nursing practice, but she just didn't have time to do them.

I think doing some...having the time to do some support groups would be... You know, lead support groups for people dealing with the same thing, and different age groups. And I don't think we always have the time to dedicate to preparing it and organizing it, and doing it.

There is an interesting disparity between wishes to take on physician (or nurse practitioner) duties (such as ordering test, and prescribing medications) and wishes to facilitate support groups for families. The more task oriented duties of prescribing and ordering are interesting propositions. Could this be considered another "task" that nurses' feel could be added to their scope? Could this be the nurses' desire to move to a more medical focus?

The ambulatory nurses who participated in this study described their work as multifaceted and ever changing. The work was a combination of what they would consider nursing activities and non-nursing activities. The work was predominantly described as those tasks that kept the clinic running to ensure patient flow and care were maintained. The combination of tasks was what the pediatric ambulatory care nurses understood as being their full scope of nursing practice. Missing from this understanding was discussion of the knowledge work that would go into the registered nurse overall care for the patient. Central to this was the need to ensure patients and team members had what they needed in the moment often at the expense of the nurse's ability to devote

the time and nursing resource they felt the patient care needs demanded. This would certainly be a trait often associated with a “mother”... putting the needs of everyone else ahead of their own, often at the expense of meeting their own needs.

Ambulatory nursing: a different sort of busyness

A second consistent theme across the three focus groups was the idea that the reality of ambulatory nursing is not what everyone thinks it is. This could be the perception of coworkers or administration. The nurses verbalized that not everyone understood their work. Jess stated:

I think the impression of ambulatory nurses is that it's an easy job. You've got Monday to Friday. You've got it great. It's nice and easy. But it's busier in a different way than the ward. I'm not saying the wards aren't busy. They are very busy. But I think we have a different busy.

The differences between the work of an inpatient nurse and the ambulatory care nurse were discussed. Inpatient nurses focused on the patient and family in hospital and in front of them, while ambulatory nurses dealt with children and families both at the health centre and out in the communities. This created a different sort of busyness and responsibility. Chris stated:

Sometimes there's follow-up and sometimes there's coordination, and sometimes you're on the phone with other areas to coordinate things. You know, whether it be a child going into a school with a new diagnosis. You know, sometimes we're going into that school or coordinating somebody else to go into that school. You know, so there is a lot more than just having the actual patient there in front of you.

Terry stated:

With ambulatory care, it's more than just the time that the family is actually in the building. So it may have pre-clinic preparation, the clinic nursing history or procedures that need to be done, the post-clinic coordination, and the telephone phone calls between each visit or in trying to lead up. It's not just when the patient is actually in front of you. It's that whole gamut.

These ambulatory nurses are often the primary health care contact for patients and families over many years to many decades. They are involved with supporting families to care for their children in homes and communities and in health centres, in well times and in times of acute illness. This is not the kind of work that is completed at the end of the day. In contrast, the work of the inpatient nurse generally involves meeting the immediate care needs of the patient and family who are in front of them. Once discharged, the nurses may never see the patient and family again. Once the shift is over, there is another nurse coming in to provide care. The reality of ambulatory nursing is best described as grounded in the long-standing relationships between ambulatory nurses and families' which, in turn, leads to the strong commitment ambulatory nurses feel to their clinic areas and their clinic patients. At the same time, it should be acknowledged that inpatient nurses perceive their practice as relational in nature, however the longevity of the relationship differs from that of ambulatory care. Jess stated:

I think that we are very dedicated to the patient population that we serve because we're the ones that serve them and there's nobody coming at the end of the day to take them over. So if we don't complete it, we're the ones that are staying late to complete it. We're the ones that are coming in early to make sure it's done. We're

the ones that are doing this kind of thing because they're our patient population and we're their contact. And there's nobody taking over for us.

The nurses felt ownership and a responsibility to meet everyone's needs, from patients and families to coworkers. As Pat stated: *"any problem-solving situation, people come and get the nurse because they can't seem to know what to do. They need direction"*. Terry gave an example of a common situation with an upset family: *"any parent that's a tiny bit upset or irritable or crying or nasty or angry, or pick any adjective you want. "I will get you the nurse"*. Terry talked about the constant questions and interruptions from other health care providers: *"and it's not just those type of people that interrupt but the physician that can't find something, the dietician that can't find something, anybody who can't find something, 'Ask the nurse'"*.

Devon felt that many things fell on the shoulders of the nurse. It seemed to be the expectation of the nurse, the health care team and the health centre management, that the nurse was the team member to pick up all of the pieces.

But there's some things that still have to be done. And the expectation, it's not just our expectations that we put on ourselves, it's the expectation of the team and the management that, well, it has to be done so you will have to do it.

Nurses are seen as the go-to people for not only patients but for the entire health care team. Looking at the history of ambulatory care nursing, this was the expectation. It is clear from the nurses' stories that this expectation persists. It is also clear that the nurses accepted this responsibility and oblige most requests, even if they don't feel the request falls within their role. Having the registered nurses called away from patient care to continually support other health care professions to carry out their work does not seem

optimal. It would seem inappropriate to pull a physician out of an examination room to ask where the Band-Aids are kept, but this is a daily reality of in the life of the ambulatory nurse.

The nurses recognized that these demands had a big impact on their ability to do their own work in a timely way. Terry stated:

I could be in my office needing half an hour to do a project or 15 minutes to do something, and I literally will leave my office unfortunately because the printer is outside my office, and by the time I get the piece of paper out of the printer, I've been inundated by 5 people and forgot what I was trying to do in the first place. Because then I'm like pulled in all different... So then forget about the project. Once you come out of your office, you're like a free for all.

Devon pointed out her concerns over the consequence of nurses doing everything for everyone at the expense of themselves. She found it interesting that other professions seemed more effective at saying no to things and recognizing that others can take on some of the work.

We'd like to be able to do our nursing job and not everyone else's job. I think we're the only profession that can't say no, that isn't allowed to say no to something. Almost all the people that work around us say no, I'm not going to do that. Even though it's whatever type of job it is and would be their job, they can say no. And it falls back on nursing. I just find amazing that that is allowed to happen. That it just falls... Everything falls back on nursing, whatever it is.

Devon also notes that she feels that saying no is difficult for nurses as a profession.

I think it's difficult for nurses to feel comfortable with not getting something done for a family that they feel is important. I think that's a challenge. And it's a challenge for us to let that go or delegate it to someone else. It is a bit of a challenge. And learning to say no, as I said. Because I had this conversation already today, that, you know, just look at the things that are expected of you and you have to say no to the thing that are non-urgent, non-nursing, even though they may be important, you know. And I hesitate because it's a challenge for nursing to say no to some things.

The main theme of ambulatory nurses as “mothers” of the clinic can be clearly seen here. Mothers are known to be organizers, peacekeepers, knowers, and most importantly, the one person you can always go to take care of problems. The mother is often the last to bed, as she is tidying up from the events of the day. She rarely says no when her children have a need. This is reflective of the way nurses felt they were seen by patients and staff. There was an expectation that they would take care of any problems and make sure everything was in order at the end of the day. They did this. They found it hard to say no. They felt like this was an expectation. They weren't really sure why this continued to fall to the registered nurse.

It can't be disputed that the work of ambulatory nurses looks differently than the work of inpatient nurses. What can be disputed is that ambulatory care nurses have easy jobs. They often become experts in nursing care in their specialized areas. They become content experts for the entire health center and beyond. They develop strong and lasting professional relationships with the children and families they serve. They become the first person these families call when health care needs arise or support is needed. When

they are not in the office, these calls wait for their return. There is no one to take over when they go home at night. The work, questions and concerns are ever present. They are the people all team members go-to to solve problems or ask questions. They are the “mother” to all. Ambulatory nurses take this on with grace and professionalism. They embrace their roles and are committed to meeting the needs of their patients and families.

Feeling under the gun: lack of resources and time

The third major theme identified in the three focus group sessions was that nurses felt they did not have enough time or resources to provide optimal nursing care to the children and families they served. They would like to have more time to provide the nursing services they felt would benefit their patient population the most. When asked for one wish to improve the practice of ambulatory nursing, Sam stated:

It would be enough time to see patients and do all the required procedures, follow-up, education with each visit.

Terry stated that she would wish for:

Enough resources to handle the patients that we have, whether clerical, nursing, space, time. That you weren't constantly feeling you were under the gun, under space, that you could do your proper nursing and you're not trying to do everything else.

Jess pointed out that other factors, like not enough staff or too many patients, also contribute to the constant feeling of too much to do:

I think most times we strive to work to our scope of practice but sometimes there's just not time to get everything that you wanted to do done, whether it's staffing or the number of patients or other things interfering that you have to pick up and do.

Sam stated: *“In an ideal world, we'd see less patients at a time or there would be more nurses”*.

There was a definite sense of frustration among the nurses who felt these time and resource pressures on a daily basis. Devon described her frustration when she was unable to provide the families the nursing care she felt would best support them:

Nurses always want to help the families and support them. I mean that's their main thing, is to make sure that the family is getting the most and the best and the latest and the... you know, you really want that for your families. And if you can't do that, it's very frustrating. If you can't offer that or if you can't channel a family into an avenue that can offer that, then it's very frustrating. But yet it's very rewarding on the other side, that when you can. That you know that you've really supported a family, it's very rewarding.

The ambulatory nurses clearly felt a constant sense of busyness and inability to spend sufficient time to provide the level of nursing care they felt their patients and families deserved. The nurses attributed this busyness to the great amount of non-nursing work they were required to do and other hindrances related to human resources, space and clinic flow. The next section more clearly describes the factors nurses considered barriers to providing the nursing care they desired. These barriers included time, non-nursing tasks, administrative work, space, management, and physician issues. The section will end with a few factors nurses felt could be put in place to facilitate optimal nursing care in their ambulatory areas. Primarily, these addressed remedying the identified barriers, but also education and a supportive team were thought to facilitate working to full scope of registered nursing practice.

Barriers to working to full scope of nursing practice.

Time.

A lack of time was by far the biggest barrier that nurses felt prevented them from working to full scope of practice and providing the nursing care they felt would be the ideal. Nurses' talked of trying to juggle the many responsibilities of their day, such as responding to numerous telephone calls while seeing patients in a busy clinic. They also talked of the constant multitasking and the constant disturbances that were the norm in their days.

Devon stated:

You often feel frustrated because you don't have time to do anything besides the basic. Like I've got to put an IV in and start an infusion. I've got to do that. And you know there's issues with that family that they're wanting to talk to you about but you really don't have time.

Chris talked about the need to routinely prioritize what would be done each day in order to ensure the most urgent needs were met. These assessments impacted the timeliness of care the child/family received:

So at times you have to prioritize what you get done. And some phone messages may have to wait until the next day or an email might have to wait until the next day. We do our best to try to get everything done. The teaching may be done a little more condensed or quicker.

A number of nurses discussed how time constraints routinely limited their ability to do their nursing work. For example, Sam talked about how time constraints impacted the ability to provide thorough teaching to the children and families seen in the clinic.

When we have a busy clinic, and you have to teach someone how to deal with certain situations, maybe teach them how to give a medication in an emergency, and you know that there's a line-up outside waiting, you start to feel a little bit stressed. And that gets a little bit frustrating because you feel like you're rushing them. And you know, if you have a language barrier, that part can get a bit frustrating. So sometimes you just... You know, they leave and you think, oh god, I hope they got it all. I mean you would be calling them again. But if it's something that is unscheduled and it comes up in a clinic then sometimes you feel a bit strapped for time. I do anyway sometimes. You feel like you're rushing a little bit. Or you might have interruptions or distractions.

Nurses never really felt like they were able to meet patients' nursing care needs. There was a sense of being barely able to survive each day and always feeling like they wanted to do more. One can only imagine how this would negatively impact the sense of job satisfaction these nurses felt at the end of these workdays. Not to mention, the impact of this continually happening over time.

Non-nursing tasks.

All of the focus groups discussed the vast amount of “non-nursing” work they were doing on a daily basis. This ranged from clerical and housekeeping duties to duties they felt fit better within the professional scope of administrators or other health care providers. There was a sense that if there were more appropriate resources available to take on some of this work, ambulatory nurses would be better able to focus on nursing work. This was fully discussed in the section “What we do on a daily basis is our full scope of practice.”

Devon stated:

It's to be able to focus on the nursing and have the non-nursing tasks taken away like clerical, cleaning. You know, there's a lot of stuff that nurses do that really takes away from actually what they were hired to do. And to be able to actually go into a family and not run in, do something quickly and leave. Like to go in and actually have a few minutes to say, you know, "How have you been since you were here last?" You don't even have time to do some basic assessments when you're doing it in the height and weight room, you know, because you have no time and you have no space. You know, like just to have the time and the stuff taken away that's non-nursing.

This was further reinforced by Pat who stated:

I think that providing more emotional support would be good. And I think having people just to take away that non-nursing stuff that we do so that we can focus on the nursing part. Which would be education and emotional support and just I think helping people understand what they're supposed to do.

Administrative Roles

Ambulatory medical care nurses felt they often had to take on administrative roles as they were working in areas with no supervisor or manager directly in their work areas. Unlike the inpatient areas, ambulatory nurses felt responsible to deal with issues as they arose in the clinic area. They had a responsibility to report and follow up on problems and issues that arose in their areas. They felt they were expected to take active roles in accreditation work and were responsible for report writing; things that staff nurses in inpatient areas were not responsible for. Pat stated:

Unfortunately there's a lot of administrative stuff that we end up doing. And maybe that will come up later. But you know, we don't really have a lot of support so the nurse ends up doing a lot of that stuff. Because we can't do the higher level scope without the other stuff being done.

The appropriateness of this work falling to the registered nurse was discussed under the “What we do on a Daily Basis is our Full Scope of Practice” portion of the findings discussion. It can be argued that much of this work reasonably falls within full scope of nursing practice as it involves the specialized knowledge and problem solving skills the registered nurse brings to the clinical area. But, it was clear from the respondents that they felt the time needed to complete this work, took away from valuable time needed to provide direct nursing care to the patient and family.

Space.

Insufficient space in the ambulatory clinic areas was felt to be another barrier to providing the desired registered nursing care. This was multifaceted. Space limitations resulted in difficulties coordinating patient care and an inability to access tools/room needed to provide care.

Limited ambulatory clinic space led to situations where treatments had to be done at different centres as they were unable to be accommodated at the tertiary health center. This was not felt to be ideal for the families who had to come to the tertiary care centre for physician and team assessments, yet have treatments at other facilities. This was felt to prohibit best patient care. Terry stated:

You don't have space to do their infusion but you have to see them. So then you're inconveniencing the family, that you're bringing them for a visit to assess them.

But then the family has to go somewhere else to get the infusion. So you can't... Although you want to coordinate their care, your space and/or staffing is preventing you from doing that.

Limited space also led to a slowdown in the pace of clinics. Health care professionals (including nurses) were forced to wait on available rooms to see their patients. Nurses often had to wait for seats, telephones, and computers to do their work. This put the clinic behind and limited the time available for nurses to spend with their patients. Kim reported:

There can sometimes be... Between each side of the hall, here could be 2 physicians on one side and 2 physicians on the other with 3 rooms for 2 physicians with 12 patients all at different times. And sometimes, especially with the multidisciplinary clinics, you just run out of rooms. And you have patients waiting. So it again cuts into your time.

Pat pointed out the space and resource limiting effect of the numerous medical students who are generally in the clinic areas.

Because this is a teaching hospital and we do have an awful lot of medical students, which is wonderful, however they're always on our... You know, they're using our computer, that we can't get at it. And they perhaps are using our room, which we would have used to make, you know, the nurse room or whatever. So I think resources and space, as Devon had indicated, also comes through because when you have more bodies, like medical students... Some days we have 2 or 3. And that takes a huge drain. And there's no seats for us or there's no... You know, they're dictating and we can't use the phone. So that's a bit of an issue too, I think.

That you say, oh, I'll make that call later. You know, you're trying to do your phone calls in between patients, and it doesn't happen.

These space concerns cannot be disputed. The unpredicted growth in patient visits to these ambulatory care areas has been astounding. Not only are there more clinic visits each year, but many new treatments/procedures are being done on an outpatient basis with a much more medically complex population. This is a reality in the clinic areas today. Could this be related to nurses enacting the “mothering” role and putting the needs of others first? Could this be related to members of the health care team not fully understanding the role of a registered nurse working to full scope of practice and the benefit of this work reflected in positive health care outcomes?

Management.

A few nurses felt that management did not understand their work and for that reason did not allow for the schedule flexibility that would facilitate better nursing care provision (for example, enforced clinic closure periods twice a year). Some felt that management did not understand how devoted they were to their patients and felt that this was reflected in the lack of autonomy and flexibility they were given with their work schedules and time off. Kim commented that she believed there should be more autonomy in the ambulatory nurses' work hours and vacation schedule:

And I find there is a lot more autonomy in clinical roles, especially in clinical coordinator roles, I find, than on the floor. But I think along with that autonomy, you need to have some...there has to be some give back. If you're going to give more, the organization needs to give you something back in return.

She pointed out: *“I really don't think that they know how hard the nurses in clinic work and how dedicated they are to their families. And I'm not sure that the people that are making the rules really know that”*.

Sam noted that ambulatory nurses did not receive the support they should from management to ensure clinics and nursing work were scheduled in such a way to allow for regular scheduled breaks for the ambulatory nurses. This nurse noted: *“less support from clinical leaders or management about, you know, the need for scheduled lunch break or scheduled breaks because that interferes with clinic”*.

Many of the nurses who took part in the focus groups commented on the fact that there was not always another nurse assigned to the clinic area when one of the nurses was sick or on vacation. This practice was felt to have a huge impact on the remaining nurses' ability to provide the nursing care they would wish to provide. Jess reported:

In ambulatory, there is no coverage. So if somebody is sick or somebody is on vacation, there is no casual staff. So you are always working short when there's somebody sick or somebody is on vacation. It's just the way it is. And we have to work around it.

Pat stated:

We often don't get replaced when someone is on vacation or someone is ill. So it's challenging because it's difficult to do the job when you're full staff is there but when your complement is decreased, you just do the best you can. But the no replacement of staff is difficult.

Nurses are clearly feeling that their managers do not understand their work and as such, do not provide appropriate flexibility or replacement/coverage support. Because of

the specialized clinical knowledge these nurses bring to their specific areas, it would be challenging to provide registered nurse replacement staff who would have the knowledge and skill to provide the required care. What these nurses may be looking for is someone to ensure clinic flow is maintained, telephones are answered, paperwork is filed, and follow-up appointments are made in their absence. Would this not be non-nursing work? Could the true “registered nursing work”, such as care coordination, wait until the registered nurse returns given the non-urgent nature of the services? Is it in fact more clerical type support that is being called for?

Physician issues.

Nurses felt that physician needs rather than those of the patient and family drove their ambulatory clinics. The ambulatory physicians have competing academic, research and clinical aspects to their work. This has led to pressure to see many patients in short periods of time. Sam explained:

The way clinics are scheduled definitely interferes with or can impact the ability to spend the necessary time with the patients. I never seem to have enough time for education. But even, you know, children that we see for follow-up, there's supposed to be a medication administration review with each initial assessment. And often that's not totally doable because there's too many other patients waiting or it's just too busy.

The nurses felt that they couldn't always provide all of the support and education necessary to ensure best care for these families, as time was so limited when the families were in clinic. Spreading some of this work out over more clinic time would have been the nurses' choice.

Physicians often “squeezed” extra patients in late in the day and these patients often had education and support needs. This created a pressure for the nurses to remain beyond their regular work hours to provide the necessary nursing care to these families.

Terry stated:

The physician decides that, you know, they've gotten phone calls that Johnny has to be seen because he's not doing well. So they put it on at the end of their schedule. But the problem is... the rest of the allied health are gone, you know. So the family gets the doctor's appointment but all the rest of it is left in emails, phone calls, and everybody else is picking up and doing their visit over the next few days over some route to provide this care, what they need. Which is not the ideal. You mention it to the physicians. Sometimes they listen, sometimes they don't. Or sometimes they forget when it happens again, and they do it again a month's time or two weeks' time. But, "Well, Johnny is sick. I have to see him. This is my only spot. I can stay tonight.

And, as Pat described, this can cause some rushing around at the end of the day, which she felt may not be necessary:

Like that family comes in at 2:30 or 3:00, and the lab closes at 4:30. You know, if that patient needs blood work or x-rays or... I mean how many times have we run down trying to get them at least to get that done? I mean... But sometimes you look at that and you say, wow, did that really have to be like that? It's just really not fair to anyone.

It must be recognized that these physicians are doing their best to meet the needs of ever-growing patient demands in light of their other professional obligations. The

majority of the physicians in these areas are funded by alternate funding plans that involve expectations to maintain a certain level of clinical care but also, research, education, and often, administrative mandates. What these physicians are not seeing is the impact this is having on families, registered nurses and other health care team members. Could this come from a lack of understanding of what the registered nurse provides for these families? Is there a true understanding of the positive outcomes that can come from the nurses' work, or do physicians still perceive the primary role of the nurse as following through with their medical agenda and ensuring their orders are received and followed through?

A few of the nurses commented that they feel physician's scheduling of appointments is not conducive to providing the best care to families. As Pat mentioned: *"It is difficult with the scheduling of appointments because I do feel it's out of our control. And I don't know how to make that better"*. These areas continue to operate under the assumption that physicians lead and direct the care in their clinic areas. This culture would not be conducive to nurses working to expand their role to fully utilize nursing knowledge and not simply follow physician directives. Nurses feeling unable to change this practice is a testament to this.

Some nurses commented on the benefit of doing face-to-face assessments versus not meeting the family and having to do assessment and teaching over the telephone. Because of the busyness of clinics, physicians will often see patients and send them home before the nurses have a chance to meet with them. This can also happen when patients are seen in "travelling clinics" where there is no nurse present. Families tend to call after they are seen by the physicians in travelling clinics and are confused and in need of

guidance and support from the nurse. It takes the nurse a lot of time to sort out the issues over the phone and support the family to care for their child.

If you know the family, you build a rapport. Well, if you don't know the family, it takes an awfully long time to build a rapport over the phone. But at least if you've had... You know, sometimes I say 5 minutes in the clinic, don't let them go out the door if you're starting them on a treatment. Just give me 5 minutes. I can do more in that 5 minutes in person that's going to take me a half an hour over the phone. Because you know, you can kind of look at them and they can understand it. So you know, sometimes it's, "Oh, I don't want to bother you." But it's going to take me longer to clean up, I hate to use the word mess, but to fix this if I haven't met them. Because then you're going in blindsided. You don't know this family. You don't know their idiosyncrasies. You don't know the relationship with the children with the parents. You're assuming things. But if you can actually see them, you can make a much better assessment.

Could this reflect a poor understanding by physicians as to the full benefit and scope of the registered nurses role? This coupled with the historical belief that the doctor dictates the plan of care and the nurse follows, could lead to this disregard of the needs of the registered nurse.

Facilitators to working to full scope of nursing practice.

Nurses discussed means by which they would be better able to provide optimal nursing care to the families they served. The majority of this discussion revolved around remedies to the identified barriers of lack of resource and time. But, they also discussed

supports such as education and a supportive team that would enable them to work to full scope of nursing practice.

Enough resources.

Having enough resources including clerical, nursing, space and time are felt to be key to having the ability to work to full scope of nursing practice. Terry stated:

Enough resources to handle the patients that we have, whether clerical, nursing, space, time. That you weren't constantly feeling you were under the gun, under space, that you could do your proper nursing and you're not trying to do everything else.

When asked how she felt this could happen, Terry stated that the province would win the lottery so appropriate resources could be provided:

How do I think it could happen? Yeah, the province win a lottery. You know, it's financial. We cover the Maritimes. We have a very large encompassing... Our families have complex chronic illnesses. Many of them cannot get resources of the same, unless they got to Toronto or west. So you know, you'd have to come up with the resources. You know, we want to give the best care possible but sometimes we're short changing the resources. So you're giving them adequate care with the most resources you can, and hoping everything goes fine. But you're constantly feeling you're pressed for time, you're pressed for resources, you're doing the best you can.

Interestingly, the solution was felt to be more money to provide more resources. There was no discussion about ways to do things differently.

Education.

The nurses identified that they were considered experts in their very specialized clinical areas. They routinely responded to calls from families and other health care professionals from across the district. Yet, often, they were not offered the financial support to attend the specialized conferences and learning opportunities that allowed them to keep current in their specialty areas. In-house education opportunities are generally very generic and do not address their educational needs. As Devon stated:

I just think that would be my wish, is that there was a fund that could be shared amongst the nurses for education to help support and advance their knowledge. That's always been a dream in my whole career actually, you know.

One nurse commented on the expertise that is expected of the ambulatory clinic areas:

I think in order to work to full scope, you really have to understand. Like having the expertise and being able to share it with people. I mean we don't always know the answer but I think people look to us in the whole Atlantic Canada there. You know, if they have somebody specific, they'll call us and say, "Well, how do I do this?" Because we often have physicians and pediatricians phoning our nurse lines looking for, you know, "You've asked me to give this injection. How do I do this? And what am I supposed to be looking for?" And it's interesting because here we are, you know, nurses, but we have...those people are trying to tap into our expertise.

When Chris was asked what helped her work to full scope of nursing practice she stated quite simply *"the education that I received"*.

Recognizing the specialized nursing work these nurses provide and knowing that proper education is necessary to provide this specialized care, it is disturbing that there is little resource available to these nurses to maintain or build their knowledge.

Supportive team.

Working with a supportive team of physicians and other health care professionals was felt to support nurses to work to full scope of their practice. One nurse mentioned the benefit of having physicians and more senior nurses in their areas who could support and mentor when they took on new ambulatory roles. Chris also noted this when asked what supported her to work to full scope of nursing practice: *“Usually there is a physician for back-up. So knowing that they're there to ask questions to. And then the other senior coworkers that are there”*. The benefit of a cohesive and supportive care team working together to provide best patient care is integral to successful health care outcomes. It is not surprising these study participants have identified this.

In Summary

The nurses who took part in this project discussed their lived experiences in pediatric ambulatory medical care clinics. They provided real and honest accounts of their work and detailed how they cared for the children and families in their clinic areas. They discussed how they worked within their teams and organization. The main theme woven through all of their accounts was idea that they were viewed as “the mothers” of their clinic areas. They described all of the work they did on a day-to-day basis, both nursing and non-nursing tasks, as their full scope of practice. They eloquently described multitasking and constant prioritizing that took place every day in an attempt to provide for clinic patients and other health care team members. This was felt to lead to a different

sort of busyness not understood by most. They described the intense pressure that this puts them under. Not enough time, not enough space, not enough support staff, and physician dictated care were included in the barriers that nurses felt prevented them from providing the registered nursing care they desired. The nurses felt strongly that more resources infused into the system would better position them to do the registered nursing work that would provide improved patient outcomes. They also identified the benefit of ample education and the support of their interdisciplinary teams as facilitators to providing the nursing care they desired. The following chapter will build on these results by bringing literature into the discussion to help ground and interpret the findings.

CHAPTER V

Discussion

This study explored the experience of registered nurses in working scope of practice in ambulatory medical care clinics at a tertiary pediatric center in Atlantic Canada by addressing the questions:

- What are nurses' understandings of working to full scope of nursing practice in pediatric ambulatory medical care clinics at the IWK Health Centre.
- What are nurses' understandings of the barriers and facilitators to maximizing scope of practice in ambulatory medical care clinics at the IWK Health Centre.

An interpretative phenomenological methodology enabled reflection on the lived experience of nurses currently working in this area. Three subthemes emerged; (a) what we do on a daily basis is our full scope of practice, (b) ambulatory nursing: a different sort of busyness, and (c) feeling under the gun: lack of resources and time. These subthemes meshed together to provide an overarching theme given to this experience; “we are the mothers of our clinic areas.” Through these themes and subthemes, a new insight into pediatric ambulatory nurses' understanding of working to full scope of practice and the barriers and facilitators to maximizing this scope was depicted. This chapter will discuss these newly uncovered insights and compare and contrast them to current literature and practice.

We Are The Mothers of our Clinic Areas

There is a stereotype in Western Culture of what it is to be a mother. Jessica Lange, an American actress has said, “The natural state of motherhood is unselfishness. When you become a mother, you are no longer the center of your own universe. You

relinquish that position to your children” (Lange, J., u.d.). Tenneva Jordan, a mother and author, is widely known for her quote “A mother is a person who seeing there are only four pieces of pie for five people, promptly announces she never did care for pie.” (Jordan, T., 2014). This connotation of “motherhood” involves selflessness, putting the needs of children and family before their own, being present, being a leader, and being an educator. The ambulatory nurses who participated in this study clearly saw these qualities reflected in their experience as registered nurses in their ambulatory areas.

There has been much discussion in the literature about female gender traits and their association with the work of the nurse (McLaughlin, Muldoon, & Moutray, 2010; McDonald, 2013), but interestingly, nothing was found likening motherhood to nursing. To put this discussion in context, it is important to look at the gender issues and stereotypes that stem from the history of the nursing profession. Prior to Florence Nightingale, nurses were predominantly (a) home-based women who cared for family members and neighbors, (b) members of religious orders who had taken vows to care and serve, and (c) uneducated lay attendants who chose nursing as a last resort to provide for themselves (Anthony, 2004). The work of Florence Nightingale served to organize and legitimize the practice of nursing enabling it to be an option for married Victorian women who wished to work outside of the home (Anthony, 2004). Support for Nightingale’s work, including her nursing training program, further strengthened opinion that nursing was a respectable career option for unmarried women but reinforced a view that this was women’s’ work (Anthony, 2004). This belief was further strengthened by European religious sisterhoods who provided another model for nursing training programs (Anthony, 2004). Within all of this, the role of the nurse was viewed as subservient to

the physician who both directed care and administered the hospital (Anderson, 2004). Even the training environment of the time mimicked the cloistered environment of the religious sisterhood that aimed to protect and preserve the virtue of young women (Anderson, 2004). The vision/stereotype of nursing was born. Nurses were considered to be kindly, caring females (Anderson, 2004) who were “subordinate, nurturing, domestic, humble, and self sacrificing” (Meadus, 2000, p. 8). This was perpetuated by the dynamics of the historical medical model of care. In this paternalistic model, physicians were dominant members of the relationship (Fagin, 1992). Nurses were given a voice in the 1980’s with the advent of primary nursing and the nursing process (Lyon, 1993). Nurses were then able to openly challenge medical control by articulating nursing decisions based on their nursing process (Lyon, 1993). In Nova Scotia today, there is a move toward strong collaborative care models (Province of Nova Scotia Health Transformation: A Partnership of the Department of Health, District Health Authorities, 2008) where all team members are recognized for the strengths and knowledge they bring to the care team and their knowledge and skill are used appropriately. This provides a platform for nurses to move away from the stereotypical subservient handmaiden role for good. But this shift comes with ongoing challenges. The old stereotypes are difficult to break. There has also been speculation that not only those external to the profession will be challenged. Salvage (1983) suggests that nurses struggle to give up what they sometimes consider the positive connotations that come from the image of dedication and self-sacrifice even though this hinders their ability exert confidence and act as equal members of a health care team (Buresh & Gordon, 2006).

It is also important to reflect on the many strong and positive traits associated with motherhood. Mothers are leaders in their families and have enormous knowledge and wisdom. These are also traits the nurses described as their lived experience.

The following sections will further discuss this concept and how it weaves into nurses understanding of their scope of practice, the uniqueness of their roles, and routinely working with insufficient time and resources.

What We Do on a Daily Basis is Our Full Scope of Practice

The nurses in this study described working to full scope of nursing practice as the tasks and activities they did on a day-to-day basis, in their clinic areas. Their work varied from day to day and was multifaceted. Nurses identified some components of their work as “nursing” work. This included a vast amount of telephone-facilitated care, some care coordination, assessment and education, and occasionally some nursing procedures and delegated medical functions (e.g. medication dose adjustments). Nurses identified many other components of their work as “non-nursing” work. This included clerical activities, housekeeping activities, administrative activities, and filling in to do the work in scope of other health care professionals. These findings prompt discussion at various levels. To begin, the study participants’ understanding of the definition of “scope of nursing practice” will be debated and contrasted to the generally accepted definition. Further discussion around why this discrepancy exists will follow. This section will end with a discussion of the various components of non-nursing and nursing work and reveal how this all fits within nurses’ understanding that they are “the mothers of their clinic areas.”

The definition of scope of nursing practice as described by the nurses who participated in this study is not consistent with the broadly accepted definition seen in

nursing literature. When asked to discuss what full scope of nursing practice was for them, they consistently described all of the tasks they do on a day-to-day basis. This would describe role enactment, as opposed to role scope. Nursing scope of practice is defined as “predefined expectations of the role that all nurses are educated and legislated to perform at entry to practice” (Oelke et al., 2008, p.59) and role enactment as “actual performance of tasks and activities associated with nurses’ roles as delimited by legislation, employer policies, experiences, context of practice, competencies, etc.” (Oelke et al., 2008, p. 59). Full scope of nursing practice focuses on the role that is reflected in the knowledge base of the profession, not necessarily how it is enacted (Besner et al., 2005). Of note, this confusion around definition was also seen in Besner et al.’s (2005) descriptive-comparative exploratory study looking at scope of practice of acute care nurses in three health centers in western Canada.

This was a surprising finding to the primary researcher. When contemplating the full scope of practice of pediatric ambulatory care nurses, one considers full extent of what the nurses’ education, experience, patient population, provincial nursing act and provincial RN standards, and comfort level would allow. The idea that cleaning rooms, photocopying, faxing forms, and filing would be considered as full scope of RN practice was surprising. They did this work because no one else did. Nurses felt that they functioned as “the mothers” of the clinic and needed to ensure that everyone (patients and health care team members) had what they needed. It is understandable the nurses would consider all of the tasks that they do to keep the clinic running as work that falls within their scope of practice. This response could also be attributed to the specific question the nurses were asked: “I am interested in the scope of practice of the registered nurse in

ambulatory pediatric medical care area. Please tell me about your understanding of nursing scope of practice” followed by “tell me about your day-to-day experiences when you worked as a nurse in your practice area”. The primary researcher hoped to glean responses about work that aligned with “optimal” scope of practice as opposed to the “full” duties and tasks that were provided by nurses during their workday. This is recognized as a limitation to the study results and could partly explain the nurses’ responses.

Nurses’ describing their work in terms of “tasks” is a point worthy of further discussion. The nurses in this study consistently described their work as a series of tasks; phone calls, coordinating appointments with families, coordinating appointments with booking clerks, heights, weights, blood pressures, medication teaching, diagnostic testing, faxing, photocopying, cleaning rooms, and the list could go. There was no discussion about the knowledge work that went into the tasks they performed. An example of this would be how a nurse’s understanding of a family coping with a chronically ill child would provide the basis for the individual family assessment they would facilitate, the questions they would ask, the health centre and community connections they would facilitate, and the coordination, education and support necessary on a long term basis. Little of this can be captured as a “task” yet it is how the nurses perceive their own work and how other team members and administrations have described this work. Describing nursing work as a series of tasks is deep seeded and pervasive in the nursing profession.

Nursing bodies have historically tried to interpret the work of nursing in broad definitions by listing tasks and procedures performed by the registered nurse (CRNNS,

2009). What is being seen in these ambulatory clinic areas is reflective of a larger nursing issue. This interpretation is concerning and serves to propagate the idea that nursing work is a series of tasks, rather than the complex role that registered nursing is. Findings of a discussion paper from the College of Registered Nurses of Nova Scotia (2009) suggests nursing practice can no longer be determined by simply listing tasks as the role is far too complex (CRNNS, 2009). Registered nurses, health care administrators, and legislators must address these issues so a true understanding of the scope of registered nursing work can be established. With a heightened understanding of the “thinking work” performed by the registered nurse, perhaps nurses, health care team members, clients, and administrators could better support registered nurses doing registered nursing work in the ambulatory areas and beyond.

Given that the nurses in this study are describing their work in terms of tasks, and many of these tasks are described as non-nursing in nature, it leads to the question; does this group of nurses truly understand what working to full scope of nursing practice could mean? Can they identify work that would utilize the knowledge, skill, and ability that they have by virtue of their registered nursing education and experience? To use terminology from Hackbarth et al.’s (1995) research into the work of ambulatory nurses in the United States, the question becomes, are these nurses aware of the “high level” and “complex” nursing activities they could be providing and the positive patient outcomes that these nursing interventions generate? Nurses in this study were very proud of the “nursing” work they felt they were doing. Care coordination and telephone facilitated care were identified as being substantial aspects of their nursing work. Hackbarth et al. (1995) define nursing coordination as a complex nursing skill, using the unique and

strong knowledge and skill that come with a registered nurse's education. Care coordination is consistently cited as being within the scope of the registered nurse in ambulatory care areas (Verran, 1981; Hastings & Muir-Nash, 1989; Hackbarth et al., 1995; MacDonald & Thibault, 1996; Rondinelli et al, 2014). This work is complex and time consuming but is central to the care of children with complex health care needs (Committee on Children with Disabilities, 1999; Peter et al, 2011). Research has also shown that RN coordination is linked with a decrease in emergency visits and inpatient days (Peter et at, 2011). The study participants verbalized these sorts of positive outcomes. They are indeed aware.

Telephone facilitated nursing care would also be described as a higher level nursing function (Hackbarth et al., 1995). This is work that is very common to most ambulatory nursing practice (Hackbarth et al, 1995; Conway & Phillips, 2006; American Academy of Ambulatory Care Nursing, 2012b; Matutina, Hamner, & Battaglia, 2012). The nurses' report that in providing telephone consults, they are able to keep children out of the health centre by providing support and advising families how to care for their children at home before a crisis occurs that would lead them to the Health Centre. This is consistent with the many examples cited in the literature of how telephone facilitated care being done by ambulatory care nurses is contributing to positive patient outcomes (Little et al., 2002; Moscato et al., 2007; Walker & Calvacca, 2006; Valanis et al., 2007; Viscon, McCallum, Thornlow, & Champagne, 2011; Williams, Warren, McKim, & Janzen, 2012). This is yet another example of how these nurses were able to identify how higher level registered nursing functions were making a difference in the health outcomes of the patients and families they serve.

This leads to another questioning? Do the physicians and administrators understand this work and its associated benefit to the patient? Nurses in this research do not feel they do, nor does the primary researcher.

The nurses in this study talked about the barriers to their practice that were of direct consequence to the “physician centeredness” of the clinic bookings. Ambulatory Clinics were generally booked around the priorities of the attending physicians. This often translated into many children being booked for clinic appointments when the physicians’ schedules permitted. There was little concern given to the nursing care these families may require or the availability of nursing staff when the children were booked to be seen. Would this happen if physicians truly understood the positive outcomes that come from registered nursing interventions. Lived experience would suggest that this is not nearly as much of an issue when it comes to scheduling allied health team appointments (social work, physiotherapy, clinical nutritionist) with families. There seems to be a better understanding of the roles and the desired outcomes expected from the allied health team members.

There is probably some truth to the belief that administrators do not have a full understanding of the nursing role either. This confusion is not unique to the clinics. It has also been identified by the American Academy of Ambulatory Care Nurses (2012) as a hindrance to fully utilizing registered nurses in ambulatory care areas. This researcher believes that the concerns the nurses had about inadequate space illustrated this point. The nurses pointed out that children and families were often not able to be seen in a timely way or there were too many children booked at one time with not enough space for all members of their health care team to see them in a timely way. There was often a

pressure to get families in and out so others could utilize the clinic rooms. The ambulatory nurses reported that space concerns were presenting an increasing barrier to practicing to full scope of registered nursing practice. The nurses also discussed the abundance of learners who take over chairs, desks, and phones in the clinic area, making it difficult for the nurses to do their work. It seems as though little consideration is given to what sort of time and accommodations are needed to provide appropriate registered nursing care in these areas. It also would seem that the needs of the physicians, and even learners, are trumping that of the registered nurse. Any discussion about space issues at the health centre has revolved around difficulties meeting physician wait time standards. Never have the needs of nurses been discussed. It should be noted here that this is another example of nurses putting the needs of others first, just as a mother would with her children.

These sorts of space concerns have been previously noted in the literature. Hackbarth et al. (1995) pointed out that insufficient space is a barrier to ambulatory nurses' practice. They suggest that space must be configured to support nursing. If this is not done, nurses will "forever float from room to room, patient to patient, or task to task" (p.97) and not move toward an expanded scope of practice, maximizing more advanced nursing roles such as care coordination and teaching. A change in booking practice where ambulatory nurses visits are identified in the schedule and appropriate time booked, just as it is for other team members, might resolve this issue.

The nurses in this study reported that they spent a lot of time doing non-nursing tasks. It is important that this does not get overlooked when conveying their lived experience. There was a definite duality in the description of these tasks by the study

participants. On one hand, they described them as part of their scope of practice, yet on the other hand, they felt the enormous amount of time they spent doing them was taking from the time they would like to spend providing the nursing care they felt their patients deserved.

The ambulatory nurses who participated in this study described their work as multifaceted and ever changing. The work was a combination of what they would consider nursing activities and non-nursing activities. This work was predominantly described as those tasks that kept the clinic running to ensure patient flow and care were maintained. This combination of tasks was what the pediatric ambulatory care nurses understood as being their full scope of nursing practice. Central to this was the need to ensure patients and team members had what they needed in the moment often at the expense of the nurse's ability to devote the time and nursing resource they felt the patient care needs demanded. This would certainly be a trait often associated with a "mother"... putting the needs of everyone else ahead of their own, often at the expense of meeting their own needs. There was also evidence that physicians and administrators may be not have a clear understanding of the "optimal scope" of nursing practice and as such, encouraged this sort of assistive work.

Ambulatory Nursing: A Different Sort of Busyness

The nurses in this study did not feel that their work was well understood by other nurses, other health care team members, nor their health centre administrators. They believed that others felt they had easy jobs because they did not work nights and weekends. They were of the opinion that others did have an understanding of all that

they did in the run of a day, including how busy they were and the responsibility they held for their patient population.

The multitasking and diversity of the ambulatory nurse practice has been noted in numerous studies that have attempted to define the role (Verran, 1981; Hastings & Muir-Nash, 1989; Hackbarth et al., 1995; MacDonald & Thibault, 1996; Rondinelli et al., 2014). This work can range from supportive tasks (ushering patients between departments), to direct patient care (education and clinical procedures), to more advanced nursing roles (research). There is no question that ambulatory care nurses are asked to continuously and simultaneously manage multiple and varied clinical activities in the same time frame (Rondinelli et al., 2014). But, is this not true for most nurses who care for inpatients? Two significant differences in the ambulatory and inpatient nursing practices that might explain why nurses felt that their busyness is different. The nurses involved in this study would often be providing care for well over 20 patients and families each day. This could be in their clinic area, in an inpatient area, by telephone, or by electronic mail. An inpatient nurse would be responsible for a much smaller number of patients on any given shift. This, in itself, could explain a perceived increased need for constant multitasking. The other big difference is that the nurses in this study were generally the only nurse (or one of two or three) in their clinic areas. As they verbalized, their responsibility to their clinics and their patients could never be passed on to someone else, as the inpatient nurse could do at the end of shift. This contributed to the enormous responsibility these nurses felt to their patients. It also contributed to their feeling of being more autonomous in their practice than their inpatient colleagues.

Interestingly, this autonomy in nursing practice was also noted in MacDonald and Thibault's (1996) study of pediatric ambulatory nurses at the Children's Hospital of Eastern Ontario. These ambulatory nurses became the nursing experts for the patient care requirements of their specialty areas. Members of their immediate multidisciplinary teams, health centre partners, and community partners recognized this knowledge and expertise and called on these nurses for advice and guidance on a regular basis. Inpatient nurses can also be considered experts in their areas, but generally, they are not the only registered nurse with such specialized knowledge and skill in their care areas. As well, clinical educators and clinical leaders generally support them. Up until recently, these nurse leader roles did not exist in the ambulatory areas. The ambulatory nurses were the main experts in their specialized areas and were frequently called on by patients, health care providers, community groups, and administrators to consult and advise about all that effected their patient populations. The primary researcher would agree that this constitutes a different level of autonomy and responsibility that the inpatient nursing roles.

These ambulatory nurses felt that their managers and hospital administrators did not fully understand or appreciate their work. They believed that inadequate replacement coverage and rigidness, in terms of scheduling work hours, was a result of this lack of understanding and appreciation. They also felt that this was a barrier preventing them from providing the registered nursing care they desired. Interestingly, management is frequently cited as a barrier to nurses working to full scope of practice in the literature (Besner et al., 2005; Hackbarth et al., 1995). This would appear to be a poor understanding of nurses scope of practice on the part of the health centre administrators,

but would argue that staff scheduling has less to do with poor understanding of the roles and more to do with conserving health care dollars to maintain registered nursing staff in a climate of fiscal cutbacks. Administrators have had to make the difficult choice to limit nursing sick time/vacation time replacement and enforce ambulatory shutdown periods to save money to avoid the possibility of layoffs.

Administrators have displayed a poor understanding of the specialized knowledge held by these nurses and the responsibility placed on this group, as evidenced by the lack of educational opportunities supported by the health centre. The ambulatory nurses in this study described continuing education as a key facilitator to working to full scope of nursing practice in the pediatric ambulatory care areas. This was also noted in Besner et al.'s (2005) research around scope of nursing practice in the acute care areas. Besner et al. (2005) noted difficulty in providing nurses time away from their clinical duties to take part in in-house workshops and education opportunities. The concern was verbalized a little differently in this study. Nurses considered themselves as experts in the nursing care of their very specialized patient populations. Having access to the latest evidence in their areas was critical to being able to provide their care. This could be in the form of health centre based education programs, journal article reading, etc. But, what was deemed to be the most important was support for attendance at national and international conferences dealing with their very specific patient populations. It was recognized that with ongoing funding cuts in health care, these funding opportunities are becoming more difficult to access every year. There are limited resources for in-house education opportunities in the ambulatory areas and time is very limited to do any literature searches and reading during work hours. Haas and Hackbarth (1995b) cited that

continuing education programs for ambulatory care nurses can no longer be reactive (designed to meet regulatory requirements) but must be proactive to meet the increasing internal and external expectations that are placed on this group of nurses. This is an issue that demands attention.

The pediatric ambulatory care nurses in this study were justified in believing their role was not well understood. They possess great knowledge, hold great responsibility, and are continuously pulled in numerous directions trying to meet the many varied needs of their patients. On top of all of this, they are looked upon as the “mothers” of their clinic areas. They are the “go-to” people when questions or problems arise. Not only are they called on for health care related issues, but often they are the photocopiers, faxers and way finders as well. This is demanding work that is little understood by most.

Feeling Under The Gun: Lack of Resources and Time

The focus groups participants talked at length about the barriers they faced in working to full scope of nursing practice, or more precisely, the barriers to providing the nursing care they would like. Time was certainly the biggest and most overwhelming factor that nurses felt prevented them from doing the job the way they felt it should be done. The same concerns are echoed in the acute care areas as well (Besner et al.'s, 2005). With increased financial pressures on our Canadian health care system and a constant pressure to do more with less, it is not at all surprising that nurses feel they are under constant time pressure to get everything done. This is causing an enormous amount of stress among ambulatory care nurses. They had concern that families who would benefit from more nursing care in the ambulatory setting, were not able to receive it because of constant pressures on their time. Not having time for the patient care they are

trained for leads nurses to feel a decrease in motivation and pride (Druker, 1993), which lends to a decrease in productivity and effectiveness (Canadian Nursing Advisory Committee, 2002). This section will delve further into these concerns that have potential to have substantial negative impact on both patient care and nursing human resource.

Nurses in this study expressed concerns about the large amount of non-nursing work they were doing each day and cited this as a barrier to being able to provide the nursing care they desire. This work included: clerical work, housekeeping tasks, work falling in the scope of other health care professionals, and administrative work. Some of this could clearly fall to support staff. Why do the registered nurses in the study feel that they should not own this work? What would their Registered Nurse position description suggest? What would the literature suggest?

Many of the clerical and housekeeping tasks described as being performed by the participants, are clearly activities that could safely and effectively be done by support staff. While the nurses' reflected that they often felt they needed to be engaged in pieces of the work (for example, helping booking clerks coordinate numerous patient appointments with different services when a family comes to the health centre), they clearly stated that much of this work could be handed over to clerical support if there was more capacity in that area. The literature on the work of the ambulatory nurse would reflect this common finding in ambulatory clinics (Fulbrook & Caws, 1995, Hastings & Muir-Nash, 1989; Hackbarth & Haas, 1995). A significant component of ambulatory nursing practice are these sorts of "enabling operations" which are classified as "lower-level" nursing functions (Hackbarth et al., 1995). Given the increasing complexity of care in ambulatory settings, coupled with the obvious financial impacts of having higher

paid providers doing low-level tasks, the realization that nurses are infrequently performing functions that required disciplinary knowledge and critical thinking, while frequently performing lower-level tasks (Hackbarth et al., 1995) is concerning.

There are a number of reasons for this. History plays a big part. As previously identified, ambulatory care clinics of the past were predominantly physician driven with a relatively well patient population (Fulbrook & Caws, 1995). The role of the nurse in these clinics was looked on as being a handmaiden to the physician (Pinkney-Atkinson & Robertson, 1993). As the complexity of ambulatory patient care has increased, and best practice would suggest a movement toward a multidisciplinary approach to patient care, nurses have found it challenging to move away from the role as handmaiden and solidify their role in these multidisciplinary health care teams. Health care managers have not been facilitating nurses to change this historical view. A poor understanding of the actual full scope of the registered nurses practice coupled with administrators' decisions to mitigate clerical and support positions with the intention of maintaining registered nursing jobs in tight financial times (AAACN, 2011), have acted to potentiate this poor utilization of the registered nurse in ambulatory care areas. Another contributing factor is the strong commitment these nurses feel to the children and families they serve. They described consistently going above and beyond to ensure that their patients received the best care possible. They realized that the clerical and cleaning functions must be done to ensure their clinic areas ran smoothly and patients were cared for. As the largest single group within the health care work force, nurses have long been available and willing to take on tasks, when "no other provisions have been made", and hence, these tasks have been accepted as nurses work (Crouch, 1992; Crossan & Ferguson, 2005). As the

“mothers” of the clinic area, they picked up where there was work to be done, even if it meant they were struggling to find the time to do their nursing work.

Nurses in this study also described doing work that they considered in the scope of other allied health professions, often stating that access to these professionals was insufficient in their areas. When discussing work in the realm of the social work discipline, nurses generally talked about the work involved in helping families secure financial resources to meet their child’s health care needs. The provision of emotional support and guidance with socially and mentally complex patients and families is deemed, by this group of nurses, to be work that would be better served by a social worker. However, one might challenge this notion. It is interesting to look at this through the lens of the IWK Registered Nurse position description (Appendix A). The position description is broken down by the components of the nursing process (assessment, planning, implementation, and evaluation), care coordination, professional practice and patient safety. The “assessment” section references many of the factors the nurses referred to as being within the scope of practice of the social work discipline. A few examples of the many examples of this include assessment of expectations/potential for living in the community and identifying and incorporating data relevant to the determinants of health for the patient and situations.

Similar reference is seen in the description of the “planning” role. This involves the broad planning of care based on the nursing assessment and with consideration of such factors as strengths, risk factors, options, consequences of actions, health promotion, and learning. When reviewing to the “intervention” roles, there is no direct mention of nurses providing intervention for anything in this social/spiritual/financial realm. This

could be fit into the broad statement “Through the critical analysis of theory as it applies to the practice setting, patient population and individual patient’s health status, provides care appropriate to the patient’s situation and in accordance with IWK Health Centre policies and procedures, best practice and established standards of care”, but it is not explicit in the document. Interestingly, the actual reference to these support and facilitation interventions are not explicitly mentioned in the job description. The implementation of these nursing strategies such as emotional support and support to access other services should fall within the scope of the registered nurse. This is another example where nursing leaders and administrators are failing to identify and facilitate nursing interventions with their positive outcomes. If this group is not identifying the work that the nurses in this study are in fact doing on a daily basis, it is understandable that the nurse would not consider it a priority.

To add yet another dimension, it must be acknowledged that this work definitely falls within the scope of social work practice. This is reflective of the role overlap and ambiguity among disciplines found in Besner et al.’s (2005) study of acute care health care centers in the Canadian West. In the majority of the pediatric ambulatory medical care clinics at the IWK Health Centre, there are both nurses and social workers assigned to the clinical areas. The primary researcher would argue that there is confusion between team members as to who is in the best position to provide these sorts of interventions. A lack of role clarity among all team members has been seen to result in duplication and omission of service. Is the fact that the nurses in this study feel that social workers are better suited to take on this work a symptom of their busyness and attempt to identify tasks that can be served by others? Is this in fact their attempt to manage their scope and

their day-to-day work? Are these feelings reflective of this group of nurses attempting to manage their scope and set clearer boundaries? Lillibridge, Axford and Rowley (2000) comment that providing clarity to this is essential for the profession to determine the boundaries of nursing practice. The overlapping scopes of practice in health care today are well documented and a potential hindrance to efficient and cost effective health care (Baranek, 2005; Canadian Nurses Association, 1993; Canadian Nurses Association, 2003). Improved communication between members of interdisciplinary care teams in conjunction with institutional support through clear and supported policies/position descriptions is suggested to address this issue that is so widespread throughout our health care system.

The ambulatory nurses also verbalized concern over the amount of time they were spending doing administrative type activities that they feel would not be the responsibility of the staff nurse in an inpatient setting. This work varied from ensuring equipment is appropriate and in working condition to chairing quality practice committees. They felt these responsibilities were taking away valuable time that could be spent on more patient-focused nursing work. The primary researcher would challenge this assessment by the nurses in this study. Interestingly, this type of work has been described as full scope of practice in the literature (Hackbarth et al., 1995), yet has been construed by these nurses as being work more appropriately in the scope of a unit manager. There is literature to support that the education and experience that the registered nurse brings to our health care systems positions them well to do this sort of work and was in fact was part of what ambulatory nurses defined as their ideal practice in the Haas and Hackbarth (1995b) study. It is interesting that this group of nurses did not

consider this work to be their priority and often felt management or other leadership roles, like clinical leaders, should look after it. Could this be a symptom of the “taken for granted” knowledge that nurses bring to the job? Could this be considered a simple task by the nurses who don’t see the knowledge and experience that would enable this work to occur? For example, understanding the use of equipment with their specific patient population would be essential in negotiating repair timelines, or deciding on appropriate purchases. Similarly, discussing adverse events in a health care setting would involve an understanding of the patient population and care systems involved in their care. With their consistent presence in the clinic areas and their role as coordinators of patient care, these ambulatory registered nurses are ideally situated to take essential and active roles in these sorts of quality initiatives.

The roots of nursing as a profession have enabled a stereotype of nurses to be female, kindly, caring, subordinate, nurturing, domestic, humble, and self-sacrificing (Anderson, 2004; Meadus, 2000). The role of the ambulatory care nurse had its beginnings physician-driven clinics where much of their time was involved in following a physician dictated plan of care and providing many clerical and organizational functions that enabled medical care to proceed (Hackbarth & Haas, 1995). These have been difficult stereotypes ambulatory nurses to move away from. As the “mothers” of the clinic area, they picked up where there was work to be done, even if it means, as it often does, that they are struggling to find the time to do work that they would consider to be “optimal” nursing work that would have great benefit for their patients.

In Summary

This study looked at a very specific group of pediatric ambulatory medical care nurses and aimed to uncover an understanding of how they understood working to scope of nursing practice and what barriers and facilitators would influence this. As was the case in other studies (Besner et al., 2005; Lillibridge et al., 2000; Oelke et al., 2008; White et al., 2008), it was found that these nurses, in general, are not working to the full scope of what they are authorized and educated to provide. The barriers identified by these pediatric ambulatory care nurses were similar to those cited in other studies of ambulatory care nurses (Hackbarth et al., 1995), and included lack of time, lack of support staff, excessive paper work, administrative blocks to clinical practice, excessive numbers of patients and lack of monetary resources.

By interpreting these nurse stories, this study provided some insight as to why this may be the case in this particular ambulatory area. These nurses see themselves as the “mothers” of their ambulatory clinic areas. They not only support their patients and provide for their needs, but they also support and coordinate their multidisciplinary team members in ensuring best possible care. Their work included work that utilized their specialized nursing knowledge and skills, but also included a lot of tasks that didn’t. Interestingly, the nurses understood all of this work as falling within their individual scope of practice. What was also uncovered was the extensive knowledge and skill these registered nurses possess. Yet, using this knowledge to provide meaningful interventions that improve patient outcomes often came second to the nurses’ perceived role as clinic “mother”, where ensuring all team members had what they needed took priority. Nurses took on this work, as there was often no one else available or willing to do it.

Disturbingly, this seemed to be the expectation of their colleagues and their administrators.

This highlights the fact that there is much work to be done by both administrators and nurses to improve this situation and allow the pediatric ambulatory medical care nursing group to work to full scope of practice and deliver best nursing care to the families they serve. Recommendation for change will be addressed in the following chapter.

CHAPTER VI

Recommendations

This study was successful in uncovering a new understanding of how registered nurses working in pediatric ambulatory medical care departments experience working to full scope of nursing practice. An overarching theme of “We are the mothers of our clinic areas” was central to this understanding. Three strong sub-themes were conveyed giving further meaning to the overarching “clinic mother” concept: (1) What we do on a daily basis is our full scope of practice, (2) Ambulatory nursing: A different sort of busyness, and (3) Feeling under the gun: Lack of resources and time. Registered nurses are so busy that they don’t have time to provide the nursing care to their individual patients that they feel would benefit them the most. The question becomes, what happens next? What can be done to ensure this research provides benefit to ambulatory nurses, patient care, and the health care system in general? This chapter will focus on addressing these questions by providing recommendations for nursing practice, nursing education, nursing research, and nursing administration. An explanation of how this will fit within Nova Scotia’s Collaborative Care Model (Province of Nova Scotia Health Transformation: A partnership of the Department of Health, District Health Authorities, and the IWK Health Centre, 2008) will follow. The chapter will conclude with a short discussion on knowledge translation principles important in moving the results of this project forward.

Nursing Practice

As identified by the provincial committee (Province of Nova Scotia Health Transformation: A Partnership of the Department of Health, District Health Authorities,

and the IWK Health Centre, 2008), nurses are spending far too much time performing tasks that can be done by staff in assistive and supportive roles. This study indicated that this was the case in pediatric ambulatory care clinics at the IWK Health Centre. This phenomenon has historical and financial roots (American Academy of Ambulatory Care Nursing, 2011; American Academy of Ambulatory Care Nursing, 2012) but it is clear that it shouldn't continue. This researcher feels it is essential that supports be put in place to allow registered nurses to work to full scope of practice and in turn, provide best possible patient care. Registered nurses must be fully engaged in the decisions and implementation of these sorts of roles in their clinic areas. Interestingly, this study showed that nurses identify much of what they do as being clerical in nature and fully support the implementation of non-nursing resource to perform these sorts of tasks. As Haas and Hackbarth (1995a) identify, the professional nurse is the most appropriate provider to decide what part of the current nursing role can be delegated safely and should be fully engaged in making these decisions (Haas & Hackbarth, 1995a).

The next steps will involve dramatic change in the nursing practice that has occurred in ambulatory care for many years. As with all change, bumps in the road will be expected. First, nurses must let go of many of the clerical and supportive tasks they have always done. It is expected that this will be a difficult transition and will require education, support, and time. Many registered nurses are not comfortable with delegation and do not possess the communication skills necessary to implement a team nursing approach in their health centres (Dobson, Adamson, & Drexler (2007). It is also known that many nurses believe that if they do not provide care themselves, it will not be done well (Haas & Hackbarth, 1995a). Supports will have to be put in place by health centre

administrators to ensure change is able to happen in a planned, informed and effective way.

Nurses will be expected to spend greater time on “higher level” nursing practices and fully utilize their specialized knowledge, skills, and abilities to improve patient care. This too will be a big change in practice. Nurses will have to be reminded that, by virtue of their registered nursing education and vast experience in their clinical settings, they possess the extensive knowledge base to take this on. Work will have to be done to hone these skills to allow these nurses to actively engage in developing a system where their skills and knowledge can fully utilized. The ambulatory nurses are perfectly positioned to determine their patient population needs and desired outcomes. From here, they can work with their teams and administrators to determine what full scope of practice could be in their clinical areas. As the College of Registered Nurses of Nova Scotia & Nova Scotia Health Research Foundation (2012) point out, “Registered Nurses are well positioned to use their knowledge and expertise to help create a better healthcare system” (p.1). Once these functions are determined, a commitment to devote resource and time to build knowledge and skills around care planning, goal setting with clients and families, telephone facilitated care, care coordination, and some nursing procedures (central line care, enteral feeding care) will be necessary. This new work will not be as task oriented as the current state, but will require skill in critical thinking and communicating. By changing their focus from tasks to the knowledge base used to provide care, nurses will be in a better position to define the specialized care they truly provide (CRNNS, 2005; Canadian Nurses Association, 1993). This will assist in the ever-important ability to

define nurses' specialized scope and move toward evaluating outcomes of their interventions.

Nursing Education

Nurses in this study identified a lack of resource available through their workplace (time and financial support) to keep current on best practice in their specialized clinical areas and in nursing practice in general. These nurses also identified appropriate continuing education opportunities as being a facilitator to ambulatory nurses working to full scope of practice. Haas and Hackbarth (1995, IV) noted the importance of nursing staff having the opportunity to attend both on and off-site educational opportunities. They feel this is for two reasons; (1) to be kept up to date with rapid changes in their areas and have exposure to both presenting experts and others in their field dealing with similar issues and (2) to be rewarded for good performance. A recommendation coming out of this work would be an acknowledgement of this gap by health center administrators and support being put in place to ensure our ambulatory care nurses get the education and support they require to provide best nursing care.

A recommendation from this study is that support staff be put in place to provide “non-nursing” supportive services (clerical work, cleaning services), so registered nursing staff can enhance their nursing work and in turn provide “higher level” nursing service to their clients. This could include skills that were not previously performed by the ambulatory nurse (examples could be; central line care, complex patient education, and nursing research). Education is essential during the change involved in any sort of redesign (Hayman, Wilkes, & Coiffi, 2008). The obvious training involved in providing services never before provided by these nurses is just the tip of the education iceberg.

The entire ambulatory medical care system will be affected. Change management strategies must focus on all stakeholders in these areas. Registered nurses are perfectly situated to lead these sorts of changes. This leadership will require education around, and enhancement of, change management skills. Implementation of this change will involve a need to strengthen skills in communication coupled with an understanding of what full RN scope can be, and the benefit that their work brings to the patient population cared for.

Nursing Research

As the health centre embarks on the process of implementing supportive roles and expanding the nursing work that registered nurses are providing in the clinic area, it will be necessary to measure the outcomes of these changes. Initially, this could include measures of job satisfaction of the registered nurses and new support staff, perception of the impact of the change on physicians, other members of the health care team, and patients, and tracking of financial impacts of the changes.

Movement toward a collaborative model of care will further encourage a shift away from the belief that the physicians is sole authority and towards a new understanding of interdisciplinary team members as equal and collaborative members of patient focused care team. Support for nurses to communicate and evaluate (a) their unique knowledge and (b) the improved patient outcomes that their care provides, and (c) deliver care in a way consistent with nursing process and nursing values will display the nurses' unique role. These changes should slowly change the stereotype of nurses from nurse as subservient handmaidens to nurses as knowledgeable and equal partners in health care delivery (Anderson, 2004, Fletcher, 2007; Province of Nova Scotia Health

Transformation, 2008). Repeating this sort of “nurses’ lived experience” study after full implementation would be advised. The primary researcher would anticipate a change in the results. Perhaps the stronger traits of leadership and educator that go along with motherhood will overshadow some of the traits that would potentiate a sense of subservience (go-to, putting needs last). Another research avenue could be an exploration of perception the work of the nurse by colleagues, administrators and patients both before and after recommendation are enacted.

Future research by this group of nurses should be encouraged and supported. This work should be directed at the outcomes of those pieces of their nursing work they feel provided the greatest benefit to their patients, such as coordination of care, telephone facilitated care, and emotional support. This will help ensure best care is being provided and strengthen the status of the registered nurse within the pediatric ambulatory medical health care team.

Nursing Administration

Nurses in ambulatory areas are spending far too much time performing tasks that can be done by staff in supportive roles and not enough time on nursing functions that fully utilize their nursing skills and knowledge. Efforts to be fiscally responsible and conserve nursing services, compounded with a poor understanding of the different nursing roles, may leave hospital administrators partly to blame for this phenomenon (American Academy of Ambulatory Care Nursing, 2011). This researcher believes that it is time for nursing and health care administrators to become more educated on the scope of the registered nursing role and how it fits with other supportive nursing, allied health, and medical scopes. Armed with this knowledge, administrators will be better

positioned to implement appropriate supportive and health care roles in the ambulatory area. Administrators must be aware that this work will be challenging. Although the literature shows that care in ambulatory areas is evolving toward team relationships, including models where licensed professionals and unlicensed professionals are utilized (American Academy of Ambulatory Care Nursing, 2012); it also shows that there are no clear solutions. There is a lack of consensus regarding the appropriate scope of responsibility for licensed and unlicensed care professionals in the new ambulatory environments and this is compounded by an unclear understanding about the appropriate utilization of RNs and other health care professionals in these areas (American Academy of Ambulatory Care Nursing, 2012).

This study also uncovered that Ambulatory Nurses often feel that they are taking on work better fitting with the scope of other health care professionals within the Health Centre. This is a concern. Baranek (2005) reported that this overlap in roles leads to “role confusion, competition among providers, workplace tension, a lack of trust across professionals, a diminishing of professional identity, and both the under- and over-utilization of professionals” (p. 2). Work must be done within this ambulatory care area to clarify roles, ensure the best mix of health professionals whose areas of expertise compliment as opposed to duplicate each other, and most importantly, ensure all health care professionals, including nurses have a clear understanding of their scope and that of the other team members. Administrators must be prepared to address issues of role clarity and expectations and enact appropriate staff mix changes using effective change management strategies when introducing new models of care (Besner et al, 2005). All of this is key to maximize a collaborative practice model (Spilsbury & Meyer, 2001;

Pearson, 2003; White, et al., 2008); the model felt to be necessary to ensure a sustainable Canadian health care system (Baranek, 2005).

When looking at changing the dimensions of the staff nurse role in ambulatory care, it is essential that administrators consider a few things first. The mission and philosophy of the health centre, the internal environment of the health centre (including union status, fiscal and space constraints), and finally external factors (including the wants of the customer and governmental expectations, population health needs, and available human resources in the area) must be taken into account (Haas & Hackbarth, 1995a). When it comes to skill and grade mix in health care areas, administrators must be aware of the decade old concerns that managers are only interested in cost and not quality and professionals are only interested in quality and not cost (McKenna, 1995). Administrators and professionals must use evidence and research to support decisions and support high quality outcomes (McKenna, 1995). It is also essential that nurses' opinions are asked when organizations move forward with changes. Not being asked or having their opinions discounted leads to nurses feeling marginalized (CRNNS, 2005). Managers must involve nurses in any redesign process and adopt a collaborative approach involving participatory decision making (Hayman, Wilkes, & Cioffi, 2008; Roussel et al, 2012).

Nova Scotia's Collaborative Care Model

As discussed in the introduction chapter, the government of Nova Scotia struck a committee to search for a solution to the issues of providing health care to a population with high rates of chronic illness, an increasing elderly population, health care staff shortages, and fiscal challenges. The group proposed a new Collaborative Care Model to

be implemented throughout the province (Province of Nova Scotia Health Transformation: A Partnership of the Department of Health, District Health Authorities, 2008). This focused on four key areas in which transformation was to occur. People, process, technology, and information were named the four pillars (Province of Nova Scotia Health Transformation, 2008). Within this process, one of the key outcomes included the optimization of the role of the registered nurse (Province of Nova Scotia Health Transformation, 2008). The results and recommendations that come out this thesis work fit nicely into this provincial model for change.

The “people” pillar of the model is most in line with the results of this study. There must be work done to ensure the most appropriate care team member is doing the work required to meet the needs of the patient and family. This will involve not only optimizing the roles of nurses and allied health providers and putting a renewed focus on interdisciplinary collaboration, but also by implementing more support staff to ensure this work can happen in an efficient and cost effective way (Province of Nova Scotia Health Transformation: A Partnership of the Department of Health, District Health Authorities, and the IWK Health Centre, 2008). It should also be noted that nurses are ideally situated to facilitate the care coordination of their complex pediatric medical care patients and this will be maximized.

The second pillar is “process.” There are numerous process pieces that should be further developed in the ambulatory areas: (a) Comprehensive care plans that identify both patient needs, but also most appropriate care provider; (b) Processes to link and coordinate care along the continuum; (c) Empowerment of the interdisciplinary teams to work together effectively in these collaborative care models is essential and will require

education, guidance, and support. Nurses will play a lead role in both providing, developing, and leading these initiatives.

“Information” is the third pillar. Recommendation to ensure ambulatory nurses are given access to the most up-to-date information and education would certainly fit. Investment must be made to ensure this becomes a reality. The fourth pillar is “technology”. Support in this area is essential, and involves using technology to support communication, process, and flow.

Knowledge Translation

The findings in this study support existing literature that identifies; a general underutilization of registered nurses knowledge and skills (Besner et al., 2005; Oelke et al., 2008; White et al., 2008) and a large piece of ambulatory nurses’ work being “lower level” in nature and subsequently not fully utilizing their knowledge and skill (Hackbarth et al., 1995). This evidence would support the need to make changes to the current ambulatory nursing practice. The new role would involve less supportive, clerical, and housekeeping tasks and more work that fully and effectively utilizes registered nursing knowledge and skill level to provide best patient outcomes. The introduction of support roles and subsequent expansion of the practice of the registered nurse in the pediatric ambulatory areas are clear recommendations coming out of this study. As discussed in this chapter, this includes recommendations for nursing practice, nursing education, and nursing administration. But, for these recommendations to move forward, an effective change management strategy must be planned and utilized.

PARIHS framework.

Translating research knowledge into practice is frequently identified as complex and often not undertaken in an effective way (Helfich et al., 2010). There is much to consider as the findings and recommendations of this work are moved forward in the ambulatory areas. The Promoting Action on Research Implementation in Health Services framework, or PARIHS framework (Rycroft-Malone, 2004) is a conceptual framework that defines key elements that interact to successfully implement evidence based practices (Helfich et al., 2010). These key elements are evidence, context and facilitation (Rycroft-Malone, 2004). For successful implementation to occur, all stakeholders, including nurses, must be clear on the evidence presented, the quality of the context, and the type of facilitation needed to ensure a successful change to practice (Rycroft-Malone, 2004). Although it is not within the scope of this paper to undertake a full discussion on knowledge translation, some broad recommendations for next steps can be derived using these concepts.

Evidence.

Evidence must include different sources of knowledge. A clear understanding of the literature presented in this paper is important, but just as important is the experience that comes from working in these pediatric ambulatory care roles. An integration of the research findings and the knowledge coming from the lived experience of staff in these areas is essential for successful change to occur. The primary researcher can lead this initiative by presenting the findings of this study to both registered nurses, interdisciplinary ambulatory team members, and health centre administrators. Initially, this will be done by verbal presentations at staff meetings and administrative committee

meetings. Translation of this knowledge can be moved even further, by the publication of results in local, national, and international journals. This will support discussion and has the potential to effect positive changes in the field of ambulatory nurses in a broader context.

Context.

The concept of context includes culture, leadership, and evaluation (Rycroft-Malone, 2004). A culture of decentralized decision making with strong relationships between managers and staff and a facilitative management style improve the likelihood of effective change in practice. A leader who can stimulate a shared vision in staff will be much more successful in creating a culture where informed change can occur, than those who use command and control tactics. Building leadership skills in registered nurses will also facilitate moving this sort of change forward. A process of evaluation that allows for determination of appropriate, efficient, and effective change is also important to ensure success.

Facilitation.

The final key element to consider is facilitation. This involves the processes of enabling the implementation of evidence into practice. Rycroft-Malone (2004) recommends facilitators be “individuals with the appropriate roles, skills, and knowledge to help individuals, teams, and organizations apply evidence into practice” (p. 300). The purpose of facilitation in this situation would encompass both providing support to ensure competence in a new and expanded scope, but also to be instrumental in moving the entire ambulatory team to change attitudes, behaviors, and ways of working, to achieve a new model of ambulatory care. This requires a facilitator with the skills and attributes to

adjust their role and style at the different phases of the implementation process. The role of the facilitator is “concerned with enabling the development of reflective learning by helping to identify learner needs, guide group processes, encourage critical thinking, and assess the achievement of learning goals” (p. 300). The primary researcher would see this as being a masters prepared nurse who possess both experience in the pediatric ambulatory medical area and demonstrated skill and ability in the above listed attributes to move forward and is excited to announce that the IWK Health Centre has recently announced funding to put such a position in place. This will be a reality by 2015.

Reflecting on these study recommendations through a PARIHS framework lens will foster a better chance of successful implementation of these study results into meaningful practice change in the pediatric ambulatory medical care environment.

CHAPTER VII

Conclusions

I began this journey with the intention of gaining a better understanding of the scope of nursing practice of pediatric ambulatory medical care nurses at the IWK Health Centre. I came into this project with nearly twenty years experience providing front line registered nursing care in these ambulatory areas, and had recently taken on the role of manager of Pediatric Ambulatory Medical Care. This new role provided me not only a different lens, but a new motivation to explore the scope of practice of this group of nurses. I wanted to ensure I was facilitating the full use of the breadth and depth of knowledge and skill I knew this group of nurse brought to their care areas. An initial literature search identified little by way of research into the scope of the pediatric ambulatory medical care nurse, but it did provide some valuable insights into challenges faced by the nursing profession and ambulatory nursing in general. These were similar challenges to what I was seeing in our ambulatory areas. Nurses were generally not working to the full scope of what their education and experience would allow (Besner et al., 2005; Oelke et al., 2008; White et al., 2008). Ambulatory nurses were spending a substantial amount of time performing “lower level” functions such as clerical work and cleaning (Fulbrook & Caws, 1995, Hastings & Muir-Nash, 1989; Hackbarth & Haas, 1995) and were infrequently performing “high level” nursing work, work that would fully utilize their registered nursing knowledge and skill (Hackbarth et al., 1995). Given the increasing complexity of care in ambulatory settings, coupled with the obvious financial impacts of having higher paid providers doing low-level tasks; the realization that nurses were infrequently performing functions that required disciplinary knowledge and critical

thinking, while frequently performing lower-level tasks (Hackbarth et al., 1995) was concerning, both to the profession, the health care system at large, and to me, an ambulatory health services manager. An interpretative phenomenological methodology allowed me to incorporate my understanding about this work with that of the currently practicing nurses to gain a deeper appreciation of this scope of nursing practice.

What emerged was a new understanding of the lived experience of working to scope of practice in pediatric ambulatory medical care clinics. An overarching main theme of “we are the mothers of our clinic areas” gave meaning to the work these nurses did on a day-to-day basis. Three subthemes meshed together to provide a more complete understanding of what it meant to be an pediatric ambulatory medical care nurse; (a) what we do on a daily basis is our full scope of practice, (b) ambulatory nursing: a different sort of busyness, and (c) feeling under the gun: lack of resources and time. These nurses saw themselves as the “mothers” of their ambulatory clinic areas. They not only supported their patients and provided for their needs, but they also supported and coordinated their multidisciplinary team members to ensure best possible care. Pieces of their work utilized their specialized nursing knowledge and skills, but much of it did not. Interestingly, the nurses understood all of this work as falling within their individual scope of practice. What was also uncovered was the extensive knowledge and skill these registered nurses possessed. Yet, using this knowledge to provide meaningful interventions that improve patient outcomes often came second to the nurses’ perceived role as clinic “mother”, where ensuring all team members had what they needed took priority. Nurses took on this work, as there was often no one else available or willing to

do it. Disturbingly, this seemed to be the expectation of their colleagues and their administrators.

It is important to recognize the limitation of these results. A convenience sample of nurses from one tertiary care health centre was recruited to participate in this qualitative study. These results cannot be applied to all pediatric ambulatory nurses in all health care centres. But, the findings do add to an understanding of the lived experience of pediatric ambulatory care nurses and may provide the groundwork for similar studies in other pediatric centres.

The understanding of the work of ambulatory care nurses in this specific setting coupled with the knowledge that similar findings have been noted in the minimal available related literature, position both nurses and health centre administrators in a more informed place to expand, define and evaluate the work of the registered nurse in pediatric ambulatory medical care clinics. Administrators have been given a starting point to address identified barriers and facilitators to create an environment where registered nurses are empowered to provide nursing care that best meets the needs of the patients and families they serve. This will involve clearly defining a role that fully utilizes their knowledge and skills to positively influences health care outcomes. There is much exciting work on the horizon. Next steps should involve models of care changes, identification and provision for education needs, and in turn, policy change as initial steps to enhance nursing and health provided utilization resources at the IWK Health Centre.

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Appendix A

IWK Health Centre – Registered Nurse Job Description

Registered Nurse Job Description
February 1, 2010



Registered Nurse *Job Description*

The **Registered Nurse (RN)** is a member of an interdisciplinary care team, providing holistic, comprehensive care to meet the needs of individuals, families and/or communities. The Registered Nurse provides leadership in nursing assessment, planning, implementation and evaluation for the purpose of promoting, maintaining or restoring health, preventing illness, injury, and disability or supporting a peaceful death. The RN provides care in collaboration with the patient and family, other nurses and health team members throughout all stages of health and complexities of illness. The RN develops professional relationships for the purpose of providing care in collaboration with the patient and family, other nurses and health team members throughout all stages of health and complexities of illness. The RN independently provides safe, competent, compassionate ethical nursing care to stable, predictable and unpredictable populations. The RN ensures the goals and needs of the patients and families are prioritized and individualized, using nursing knowledge, critical thinking and clinical judgement. The RN engages in independent, interdependent and dependent functions to provide healthcare focusing on comprehensive assessment, patient/family education, and coordination of care. These functions may be self-determined, or assigned by physician, nurse practitioner or other RN's.

Definitions:

Team - there is a fundamental base that a team moves beyond just a "group" of people. At its fundamental level a team is an integrated, directed group of individuals who share a common goal and vision. Team development is not static and linear, but is evolutionary

Inter-professional – A fully integrated practice by a team of professionals from a diverse background of disciplines. Each member of the team has an integrated knowledge of the other team members' roles, and all work from an equally valued team mandate. When two or more professions purposely interact in order to learn with, from and about each other ... to improve effectiveness and the quality of care

Collaboration – An effort to consult and co-operate as a group or team in developing a shared direction or vision. Each member still maintains a separate functional identity. A collaborative practice is an active, often ongoing practice partnership between professionals, teams or organizations.

Reports to: Manager

Qualifications: (Minimum Requirements)

Formal Education:

- Graduate from an approved Registered Nurse program (BN or BScN Preferred).
- Licensed or eligible for licensure by the College of Registered Nurses of Nova Scotia.
- Current successful completion of a BCLS program is required.

Experience:

- Previous experience is an asset.
- Previous experience in a similar practice setting may be required in certain practice setting.

Knowledge, Skills, Abilities:

- Ability to work as a member of an interdisciplinary team.
- Demonstrates critical thinking skills, including clinical judgment, problem solving skills and strong decision making ability.
- Demonstrates:
 - Professional and mature manner.
 - Effective interpersonal and communication skills.
 - Initiative.
 - Effective time management and organizational skills.
 - Required assessment and teaching skills.

RN Job Description

Care and Passion

- Taking pride in providing safe, high quality care to the populations we serve
- Building successful relationships with patients and families as partners in decision-making and care
- Making a positive difference in people's lives
- Contributing to a culture of inclusion and diversity

ASSESSMENT

- ❖ Performs initial and ongoing biopsychosocial assessment specific to the setting and target population, which may include, but is not limited to:
 - physical status,
 - psychological status,
 - social/family interactions,
 - spiritual status,
 - financial resources that impact on health status,
 - roles and responsibilities of the individuals/families/communities/client and caregivers,
 - learning capabilities and education needs,
 - self-care capabilities,
 - health risks,
 - cultural influences,
 - environment and
 - expectations/potential for living in the community.
- ❖ Identifies and incorporates data relevant to the determinants of health for the patient and situations (e.g., income, education, employment status, work conditions).
- ❖ Utilizing the therapeutic relationship, assesses the unique health care needs/strengths of individuals/families/communities including:
 - Coping with acute or chronic illness,
 - Support after discharge,
 - Relationships and developmental stages.
- ❖ Recognizes potentially critical situations and takes appropriate action.
- ❖ Documents and communicates pertinent information in a timely manner.
- ❖ Monitors, through assessment data, the ongoing health status of the individual/family/community.

- ❖ Recognizes deviations in health care needs and adjusts the care plan accordingly.
- ❖ Collaborates with members of the healthcare team and individuals/families/communities to collect, validate and expand assessment data.

PLANNING

- ❖ Analyzes assessment data to identify the individuals/families/communities' needs and strengths and thought negotiates and communicates
- ❖ Mutually establishes priorities for optimal independence, in partnership with individuals/ families/ community and members of healthcare team, initiates planning, short and long term goals and expected outcomes, including transitioning.
- ❖ Develops the plan of care based on the assessment including consideration of strengths, risk factors, options, consequences of actions, health promotion, learning, comfort, safety, privacy, dignity and integrity.
- ❖ Applies knowledge of pertinent nursing and related healthcare research and evidence to care planning; uses current knowledge to justify plan of care.
- ❖ Integrates inter professional and multiagency factors into the care plan.
- ❖ Negotiates with the individual, family, community, health care team, and service providers when there is a difference between the care plan and the wants, needs and strengths of the individuals / families / communities.

IMPLEMENTATION

- ❖ Collaborates and communicates effectively with individuals, families, communities, team member(s) and internal/external resources to implement and coordinate plan of care/services.
- ❖ Through the critical analysis of theory as it applies to the practice setting, patient population and individual patient's health status, provides care appropriate to the patient's situation and in accordance with IWK Health Centre policies and procedures, best practice and established standards of care.
- ❖ Administers treatments and medications and performs procedures as defined by IWK policies and procedures.
- ❖ Performs Beyond Entry Level Competencies, Medical Directives and Delegated Medical Functions as approved for practice setting, as outlined in the health centre policy.
- ❖ Provides consistent, current, factual information to children, youth, women and families
- ❖ Offers culturally safe and competence nursing care
- ❖ Teaches and coaches patients and families in a flexible and creative manner using accurate and consistent information.
- ❖ Implements and evaluates teaching of individuals/ families/communities, and assists in developing education materials.
- ❖ Articulates rationale for decisions that are based on current theory and research

EVALUATION

- ❖ Evaluates, reports, and documents expected and unexpected responses to care, in partnership with individuals/families/communities.
- ❖ Reviews and revises the plan of care based on reassessment of changing status and progress.
- ❖ Evaluates total patient progress and evaluation of patient outcomes by initiating and maintaining the integrated patient care plan from admission to discharge.
- ❖ Recognizes patterns of health care needs within the population served, including health promotion and prevention, (such as infection rates, early discharge outcomes) and assesses the effectiveness of interventions over time.
- ❖ Discusses observations with and makes recommendations to interdisciplinary team and leaders to influence program development/evaluation.
- ❖ Interacts with patients and families in a respectful manner facilitating their growth and adaptation to their health care experience.
- ❖ Maintains an accurate account of care given through clear, concise, written and verbal communication and evaluates, communicates and documents patient/client response to care.
- ❖ Continuously evaluates plan of care and makes revisions to plan as necessary in consultation and collaboration with other members of the health care team and client/family in the development and revision of the plan of care
- ❖ Protects individual and family confidentiality, privacy and creates an overall environment that is safe and secure

CARE COORDINATION FOR A GROUP OF PATIENTS:

The RN serves as the coordinator of care within the bedside care delivery team. The members of this team vary depending on the needs of the patient population. In this role he/she will:

- ❖ Provide leadership at the bedside team level for ensuring that an integrated inter-disciplinary plan of care is created as early as possible in the patient experience for scheduled and unscheduled patients;
- ❖ Focus on ensuring that the patient care experience is coordinated and integrated within an inter professional model of care, both within acute care and across the continuum of care.
- ❖ Assume responsibility for assessing, planning, implementing, directing, supervising, evaluating direct and indirect care, and evaluation of patient outcomes in collaboration with the inter professional team.
- ❖ Assign care to licensed practical nurses according to their scope of practice and the IWK Policies and Procedures
- ❖ Provide guidance or direction to a licensed practical nurse when working collaboratively to care for a patient considered to be unstable with unpredictable outcomes.
- ❖ Assign care to unregulated health care team members according to their scope of employment and the DHA/facility Policies and Procedures
- ❖ Supervise assigned care of unregulated health care providers.
- ❖ Serve as a key resource to the family and patient

- ❖ Organize patient and family conferences as required to ensure active involvement in the development of the plan of care as well as the ongoing management and monitoring of progress
- ❖ Facilitate decision making through renewed processes of communication including scheduled rounds as well as ad hoc meetings to ensure timely flow and progression of the ongoing stay and discharge
- ❖ Identify barriers to smooth flow and timely progression of the ongoing stay and review with the team to rectify issues at the earliest possible moment.
- ❖ Facilitate and coordinate referrals based on needs
- ❖ Ensures patient/family education by an appropriate person
- ❖ Participate in direct patient care delivery as per their defined scope of practice

• **Excellence and Leadership**

- Building our reputation for excellence in the Maritime community and beyond
- Contributing to a sustainable health care system through formal and informal partnerships
- Pursuing excellence in care, teaching and research through a spirit of discovery and innovation
- Leveraging our reputation and influence to advocate for the health of the population
- Being accountable for our relationships, decisions and actions

- ❖ Takes the position of team leader and assumes the responsibilities outlined in unit specific profile.
- ❖ Advocates for the rights of the patient and family and for provision of their unique care requirements.
- ❖ Identifies system (environmental/unit) limitations and offers recommendations of change.
- ❖ Provides input into the development of IWK Health Centre policies/procedures and practices.
- ❖ Participates in and supports the development and implementation of the plans, goals and objectives of the workplace.
- ❖ Maintains commitment through active participation in meetings and committees, and carries out responsibilities.
- ❖ Demonstrates a commitment to the values of the Health Centre and the profession of nursing and acts in congruence with the vision, value, and mission.
- ❖ Leads initiative to constructively challenging the status quo, questioning assumptions, taking action and resolving conflicts.
- ❖ Uses human and material resources effectively and efficiently.
- ❖ Records workload accurately and in a timely manner.
- ❖ Fosters the development and maintenance of shared leadership through personal contribution and by supporting the contribution of colleagues in decision-making processes.
- ❖ Maintains an acute awareness of the changes within the health care system that may affect the practice of registered nurses in Nova Scotia through education.
- ❖ Functions as a change agent by thinking reflectively, questioning assumptions, assessing alternatives, and supporting change
- ❖ Advocates for the nursing profession by contributing to an environment that supports and acknowledges other's contributions and successes.
- ❖ Provides guidance and support in a preceptor role to students, colleagues, and other personnel as appropriate, to assist in their orientation to work routines, roles and expectations.

- ❖ Mentors colleagues in areas of expertise and seeks mentorship to achieve full potential in professional development.
- ❖ Demonstrates a spirit of inquiry by examining current practice and uses research findings to improve outcomes of nursing care and shares in the dissemination of research findings.
- ❖ Ensures that work time is managed to meet the needs of patient and family and the unit overall.

PROFESSIONAL PRACTICE

- ❖ Assumes responsibility for clinical competence in designated area of practice consistent with current knowledge
- ❖ Demonstrates accountability for own nursing practice by complying with Canadian Nurses Association (CNA) Code of Ethics, College of Registered Nurses of Nova Scotia (CRNNS) standards for nursing practice, the IWK Health Centre standards and policies and procedures.
- ❖ Demonstrates accountability for practice using strategies such as providing rationale for decisions and actions, acknowledging errors, taking corrective action, recognizing own limitations and consulting with others as necessary
- ❖ Maintains certification in mandatory programs; CPR, Delegated Medical Functions, Medical Directives and Beyond Entry Level Competencies and others, as required by the Health Centre and practice area.
- ❖ Understands and complies with:
 - Legal requirements of licensure
 - Registered Nurses Act – including continuing competence
 - IWK Health Centre Policies and Procedures
 - Freedom of Information and Protection of Privacy Act (FOIPPA)
 - Other relevant legislation
- ❖ Maintains awareness of own values and ethical priorities and how they may impact on their own practice.
- ❖ Develops therapeutic relationships with individuals/families/communities, displaying appropriate use of communication skills, respect, empathy and an understanding of the unique values of each individual/family.
- ❖ Displays a collaborative attitude of mutual respect and valuing of others in interactions with individuals/families/communities and members of the interdisciplinary healthcare team.
- ❖ Appropriately advocates on behalf of the individuals/families/communities including:
 - Providing access to information in consultation and collaboration with other team members.
 - Consultation regarding ongoing consent for care
 - Promoting comfort and safety
 - Facilitating participation in decisions affecting care
 - Intervening effectively in situations where safety or well-being may be compromised; while respecting individual rights and diversity.
- ❖ Recognizes and examines processes to correct unsafe practice issues or inappropriate professional conduct.
- ❖ Identifies, achieves, and maintains own professional development needs and competencies, seeks appropriate learning opportunities and evaluates own learning.

Appendix B

Interview Guide

1. I am interested in the scope of practice of the registered nurse in ambulatory pediatric medical care areas. Please tell me your understanding of nursing scope of practice
2. Tell me about your day-to-day experiences when you worked as a nurse in your practice area?
3. Describe for me a particular experience where you felt you were working to full scope of practice? What supported your ability to work to full scope of practice in this situation? How did this experience influence your nursing practice?
4. What factors interfered with your ability to work to full scope of practice?
5. Describe for me a particular experience when your felt you were unable to work to full scope of practice. If you were to be in this situation today, what would you do differently?
6. If you could have one wish fulfilled for nursing in your practice area today, what would that be? How do you think this could happen?
7. Describe, for me, what you perceive to be the ideal pediatric ambulatory nurse practice? What makes this ideal for you?

Probes and Prompts for Each Question

1. Tell me more about that.
2. Please elaborate on what that means to you.
3. What about that situation stands out for you?
4. What was the most difficult part of that situation for you?

5. What was the most satisfying part of that situation for you?
6. Give me examples of this?

Appendix C

Letter for Recruitment of Participants (Pilot Group)

You are invited to participate in a research study exploring the scope of practice of registered nurses working in Pediatric Ambulatory Medical Care areas being conducted by a Master of Nursing student. You have been selected to participate because you have recently retired from your position as a registered nurse in a Pediatric Ambulatory Medical Clinic at the IWK Health Centre. I would like the opportunity to discuss your experiences in that role. The findings of this session will not be used as data to inform study conclusions. This group will act as a pilot session to give opportunity for the principal investigator to trial semi-structured questions developed to explore and discuss perceptions and experience related to working to scope of practice in your previous ambulatory nursing position. Your responses, conversation and feedback about these questions will aid in formalizing questions to be asked to the currently practicing nurses in the Ambulatory Medical Care Clinics at the IWK Health Centre. The anticipated length of the focus group is 90 minutes. The session will be audiotaped and transcribed. All information will be kept confidential and your identity will be protected. All data collected will be securely stored with only the primary researcher and her thesis supervisor having access. Participation in this study is voluntary. Should you wish to discontinue your involvement in this study you may do so at any time. There is no formal remuneration for participating in this study although all participants will receive a \$25.00 Chapters Gift Certificate in gratitude for their contributions and time. All information will be kept confidential and your identity will be protected. All data collected will be securely stored with only the principal investigator and thesis supervisor

having access to data. The results of the study will be made available to you upon its completion and at your request. The insights gained from this research may be used at a later date to develop staff education and policy initiatives in the Pediatric Ambulatory Clinical Areas. If interested, you will be asked to sign a more formal consent form with further information related to the study.

Appendix D

Letter for Recruitment of Participants (Focus Group)

You are invited to participate in a research study exploring the scope of practice of registered nurses working in Pediatric Ambulatory Medical Care areas which is being conducted by a Master of Nursing student. You have been selected to participate because you are a registered nurse currently working in a Pediatric Ambulatory Medical Clinic at the IWK Health Centre. I would like the opportunity to discuss your experiences in that role. You will be invited to focus group session, facilitated by a research assistant, to explore and discuss your perceptions and experience related to working to scope of practice in your ambulatory nursing position. The anticipated length of the focus group session is 90 minutes. The insights gained from this research may be used at a later date to develop staff education and policy initiatives in the IWK Pediatric Ambulatory Clinical Areas.

Participation in this study is voluntary. Choosing not to participate will have no impact on your employment at the IWK Health Centre. Should you wish to discontinue your involvement in this study you may do so at any time. There is no formal remuneration for participating in this study although all participants will receive a \$25.00 Chapters Gift Certificate in gratitude for their contributions and time. All information will be kept confidential and your identity will be protected. All data collected will be securely stored with only the thesis supervisor having access to all data. The principal investigator will not be advised of your participation or decision to decline to participate. She will not have access to the audiotaped focus group sessions, and will only be given access to the transcribed records from the sessions. No given names will be included in

these transcribed records. Reporting of data is collective. If direct quotes are used, pseudonyms of your choice will be used to protect your identity. The results of the study will be made available to you upon its completion and at your request. Data analysis will be shared with all those interested at the end of the study in a staff meeting to enhance nurses understanding of working to full scope of practice in the ambulatory pediatric medical nursing environment. If you are interested in participating, you will be asked to sign a more formal consent form with further information related to the study. Please contact Dr. Brenda Sabo, Associate Professor, Nursing, Dalhousie University School of Nursing (phone: 494-3121; e-mail: Brenda.Sabo@dal.ca).

Appendix E

Demographic Questionnaire

1. Name (alias)
2. Age
3. Number of years practiced/practicing nursing
4. How long have/had you worked in a pediatric ambulatory medical clinic?
5. What is the highest level of nursing education you have achieved?
RN _____
BScN/BN _____
MN _____
PhD _____
Other _____
6. What continuing education have you taken?

Appendix F
Consent Form (Pilot Group)



IWK Health Centre

5850/5980 University Avenue

PO Box 9700

Halifax, NS B3K

6R8

Canada

Tel:

902.470.8888

[www.iwk.nshealth](http://www.iwk.nshealth.ca)

h.ca

Information and Consent Form

Study title: Registered Nurses Lived Experience Working to Scope of Practice in Pediatric Ambulatory Medical Care Clinics (Abbreviated Title: Nursing Practice in Ambulatory Clinics).

Investigators:

Karen Carter, BScN RN, Manager Children's Ambulatory Medical Care.

Barb Stonehouse, MN, RN, Director, Children's Ambulatory Medical Care.

This research is being completed as partial requirement for a Master of Nursing Degree at Dalhousie University. This project is being supervised by Dr. Brenda Sabo, Associate Professor, School of Nursing, Dalhousie University.

Funding Source: Nursing Research and Development Fund. Dalhousie University.

Introduction and Purpose: This is a voluntary research study intended to explore the scope of practice of registered nurses working in pediatric ambulatory medical care clinics at the IWK Health Centre. There is very little published literature that

investigates the work and scope of pediatric ambulatory care nursing in general.

This study hopes to answer the questions;

1. What do nurses perceive as working to full scope of nursing practice within the pediatric ambulatory medical care clinics at the IWK Health Centre?
2. What values and beliefs do they hold about scope of practice?
3. What qualities/factors do nurses identify as facilitators to support working to full scope of practice?
4. What qualities/factors do nurses identify as barriers in working to full scope of practice?

The study responses may be used at a later date to develop staff education and policy initiatives in the IWK pediatric ambulatory clinical areas.

How will the researchers do the study? This study will follow a qualitative phenomenological research design that will use focus group sessions as a means to collect data. Each session will include 3 to 4 nurses. Each participant will be invited to attend one of the 3 to 4 available sessions. The sessions will be facilitated by research assistants and audiotaped. The tapes will be transcribed and the documents will be examined. In reviewing and reflecting on the transcripts of the focus group sessions, the primary researcher hopes to gain a better understanding of the practice of registered nurses working in Ambulatory Medical Care Clinics at the IWK Health Centre. This is a single centre study.

What will I be asked to do? You will be asked to take part in one 90-minute focus group session that will occur at the IWK Health Centre or the residence of yourself or another retired ambulatory care nurse who may also take part in this focus group. It is hoped there will be two participants in this session. Karen Carter, the principal researcher, will lead a conversation about your experiences working as a registered nurse in the ambulatory medical care area. You will also be asked to complete a short, 5 minute, questionnaire asking about your age, education, and nursing experience.

You have been selected to participate because you have recently retired from your position as a registered nurse in a Pediatric Ambulatory Medical Clinic at the IWK Health Centre. I would like the opportunity to discuss your experiences in that role. The findings of this session will not be used as data to inform study conclusions. This group will act as a pilot session to give opportunity for the principal investigator to trial semi-structured questions developed to explore and discuss perceptions and experience related to working to scope of practice in your previous ambulatory nursing position. Your responses, conversation and feedback about these questions will aid in formalizing questions to be asked of the nurses currently practicing in the Ambulatory Medical Care Clinics at the IWK Health Centre.

Potential Harms and Burdens. There is a chance that talking about your work experience may bring about happy or upsetting feelings.

Potential Benefits. Taking part in this study may provide no direct benefit, but we hope what we learn in this study may help IWK decision makers gain a better understanding of the scope of practice and barriers and facilitators to achieving the full scope. With this information, gaps in care can be identified and policy decisions can be made with a better understanding of the day to day realities of the front line ambulatory care nurse.

Ongoing Nature of Consent. The primary researcher has a responsibility to inform you, as a participant, of any changes in the research project that may affect you. Any changes to study design or change in potential risks or benefits of this study will be disclosed to you. You may withdraw from this study at any time.

Can I withdraw from the study? You may withdrawal from this study at any time.

Costs and reimbursements. There will be no cost to you except the time involved in taking part. In appreciation for your time, all participants will receive a \$25.00 gift certificate to Chapters.

How will my privacy be protected? All study records will be kept in a locked area for 5 years following publication of the results. Only study staff, excluding Ms. Carter, and the IWK REB Audit Committee will have access to these records. After that time, all study records (including questionnaires, tapes, transcriptions and consents) will be destroyed. After that time, all records will be destroyed.

What if I have study questions or problems? All questions or concerns about the study can be addressed by Karen Carter (phone: 423-6061; e-mail: kcarter@dal.ca)

What are my Research Rights? Signing and returning this letter of consent and taking part in the focus group sessions indicate that you have agreed to take part in this research and for your responses to be used. In no way does this waive your legal rights nor release the investigators, sponsor, or involved institution for their legal and professional responsibilities. If you have any questions at any time during or after the study about the research in general you may contact the Research Office of the IWK Health Centre at 470-8520, Monday to Friday, between 8:00am and 4:00pm.

How will I be informed of the study results? Within a year of the focus group sessions, the grouped results of the study will be available. Upon request, Karen Carter will forward a summary of the results to you.

Signature Page

Study title: Nursing Practice in Ambulatory Clinics

Participant Consent

I have read or had read to me this information and consent form and have had the chance to ask questions which have been answered to my satisfaction before signing my name. I understand the nature of the study and I understand the potential risks. I understand that I have the right to withdraw from the study at any time. I have received a copy of the Information and Consent Form for future reference. I freely agree to participate in this research study.

Name of Participant: (Print)

Participant Signature:

Date: _____ Time:

STATEMENT BY PERSON PROVIDING INFORMATION ON STUDY

I have explained the nature and demands of the research study and judge that the participant named above understands the nature and demands of the study.

Name: (Print)

Signature: _____ Position:

Date: _____ Time:

STATEMENT BY PERSON OBTAINING CONSENT

I have explained the nature of the consent process to the participant and judge that they understand that participation is voluntary and that they may withdraw at any time from participating

Name (Print)

Signature: _____ Position:

Date: _____ Time:

Appendix G
Consent Form (Focus Group)



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PO Box 9700
Halifax, NS B3K
6R8
Canada
Tel:
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Information and Consent Form

Study title: Registered Nurses Lived Experience Working to Scope of Practice in Pediatric Ambulatory Medical Care Clinics (Abbreviated Title: Nursing Practice in Ambulatory Clinics).

Investigators:

Karen Carter, BScN RN, Manager Children's Ambulatory Medical Care.

Barb Stonehouse, MN, RN, Director, Children's Ambulatory Medical Care.

This research is being completed as partial requirement for a Master of Nursing Degree at Dalhousie University. This project is being supervised by Dr. Brenda Sabo, Associate Professor, School of Nursing, Dalhousie University.

Funding Source: Nursing Research and Development Fund. Dalhousie University.

Introduction and Purpose: This is a voluntary research study intended to explore the scope of practice of registered nurses working in pediatric ambulatory medical care clinics at the IWK Health Centre. There is very little published literature that

investigates the work and scope of pediatric ambulatory care nursing in general.

This study hopes to answer the questions;

1. What do nurses perceive as working to full scope of nursing practice within the pediatric ambulatory medical care clinics at the IWK Health Centre?
2. What values and beliefs do they hold about scope of practice?
3. What qualities/factors do nurses identify as facilitators to support working to full scope of practice?
4. What qualities/factors do nurses identify as barriers in working to full scope of practice?

The study responses may be used at a later date to develop staff education and policy initiatives in the IWK pediatric ambulatory clinical areas.

How will the researchers do the study? This study will follow a qualitative phenomenological research design that will use focus group sessions as a means to collect data. Each session will include 3 to 4 nurses. Each participant will be invited to attend one of the 3 to 4 available sessions. The sessions will be facilitated by research assistants and audiotaped. The tapes will be transcribed and the documents will be examined. In reviewing and reflecting on the transcripts of the focus group sessions, the primary researcher hopes to gain a better understanding of the practice of registered nurses working in Ambulatory Medical Care Clinics at the IWK Health Centre. This is a single centre study.

What will I be asked to do? You will be asked to take part in one 90-minute focus group session that will occur at the IWK Health Centre. A research assistant will lead a conversation about your experiences working as a registered nurse in the ambulatory medical care area. You will also be asked to complete a short, 5 minute, questionnaire asking about your age, education, and nursing experience.

Potential Harms and Burdens. There is a chance that talking about your work experience may bring about happy or upsetting feelings.

Despite all precautions taken to ensure your identity is protected, there will be a chance that your comments and/or provided demographic information may be recognizable by Ms. Carter. This will in no way effect your employment at the Health Centre, but you must be aware of this risk. Participants will be reminded and encouraged to respect the confidentiality of all participants, but there is a risk that this ask may not be respected. If this was to occur, your participation in the focus group may be discussed, despite best efforts to prevent this. Again, this will in no way effect your employment at the Health Centre but you must be aware of this risk.

Potential Benefits

Taking part in this study may provide no direct benefit, but we hope what we learn in this study may help IWK decision makers gain a better understanding of the scope of practice and barriers and facilitators to achieving the full scope. With this information, gaps in care can be identified and policy decisions can be made with a better understanding of the day to day realities of the front line ambulatory care nurse.

Ongoing Nature of Consent. The primary researcher has a responsibility to inform you, as a participant, of any changes in the research project that may affect you. Any changes to study design or change in potential risks or benefits of this study will be disclosed to you. You may withdraw from this study at any time.

Can I withdraw from the study? You may withdrawal from this study at any time. Your decision to withdrawal will not affect your employment at the IWK in any way. If you withdraw from the study after completion of the focus group session, it may be impossible to exclude your comments from the transcripts of the focus group as all efforts to de-identify you will be made in the study process.

Costs and reimbursements. There will be no cost to you except the time involved in taking part. In appreciation for your time, all participants will receive a \$25.00 gift certificate to Chapters.

Conflict of Interest. The primary investigator of this study is your manager, Karen Carter. The research team acknowledges that there may be a perceived conflict of interest with this study due to the power position Ms. Carter holds with the participants. The following section describes the steps that will be taken to ensure privacy and minimize the perceived conflict.

How will my privacy be protected? Ms. Carter will not be made aware of who accepts or declines the invitation to participate in this study. If you chose to participate, you will be asked to choose a pseudonym (false name) and use this on your demographic questionnaire and in focus group discussions. Ms. Carter will not take part in the focus group sessions or be given access to the audiotapes from the sessions. The research assistant will deliver the audiotapes to Dr. Sabo who will send them to a transcriptionist. The transcriptionist will take special care to remove any identifying names, words and comments from the transcripts. Ms. Carter will only be given access to the de-identified transcribed records.

The participant list and signed consents will only be accessed by the Research Assistant and Brenda Sabo (Thesis Supervisor). This is all done to lessen the concern that nurses may feel pressure to take part in the study or not speak freely in focus group sessions, if they feel their manager will be aware and it may have a negative or positive impact on their employment.

Your choice to take part in this study, or not, will be kept confidential, and your identity will not be connected to the information you provide during the study. Whether you choose to take part in the study or not will have not affect on your employment at the IWK.

The results of this study will be reported and likely presented and published. Quotes from your stories may be used, but names will be removed and your information not be identifiable.

All study records will be kept in a locked area for 5 years following publication of the results. Only study staff, excluding Ms. Carter, and the IWK REB Audit Committee will have access to these records. After that time, all study records (including questionnaires, tapes, transcriptions and consents) will be destroyed. After that time, all records will be destroyed.

What if I have study questions or problems? All questions or concerns about the study can be addressed by Karen Carter's thesis supervisor, Dr. Brenda Sabo, Associate Professor, Nursing, Dalhousie University School of Nursing (phone: 494-3121; e-mail: Brenda.Sabo@dal.ca)

What are my Research Rights? Signing and returning this letter of consent and taking part in the focus group sessions indicate that you have agreed to take part in this research and for your responses to be used. In no way does this waive your legal rights nor release the investigators, sponsor, or involved institution for their legal and professional responsibilities. If you have any questions at any time during or after the study about the research in general you may contact the Research Office of the IWK Health Centre at 470-8520, Monday to Friday, between 8:00am and 4:00pm.

How will I be informed of the study results? Within a year of the focus group sessions, the grouped results of the study will be available. Karen Carter will present the results at a regularly scheduled IWK Ambulatory Nurse Group Meeting and forward a summary of this presentation to all staff nurses invited to participate in the study.

Signature Page

Study title: Nursing Practice in Ambulatory Clinics

Participant Consent

I have read or had read to me this information and consent form and have had the chance to ask questions which have been answered to my satisfaction before signing my name. I understand the nature of the study and I understand the potential risks. I understand that I have the right to withdraw from the study at any time without affecting my employment in any way. I have received a copy of the Information and Consent Form for future reference. I freely agree to participate in this research study.

Name of Participant: (Print)

Participant Signature:

Date: _____ Time:

STATEMENT BY PERSON PROVIDING INFORMATION ON STUDY

I have explained the nature and demands of the research study and judge that the participant named above understands the nature and demands of the study.

Name: (Print)

Signature: _____ Position:

Date: _____ Time:

STATEMENT BY PERSON OBTAINING CONSENT

I have explained the nature of the consent process to the participant and judge that they understand that participation is voluntary and that they may withdraw at any time from participating

Name (Print)

Signature: _____ Position:

Date: _____ Time: