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A Search for Role Clarity: A Critical Discourse Analysis of the RN and RPN Entry-to-Practice Competencies That Shape Nursing Curriculum in Ontario, Canada

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Abstract

There is confusion regarding the practice expectations of Registered Nurses (RN) and Registered Practical Nurses (RPN) for employers, educators, nurses, nursing students, and the public, in Ontario, Canada. As the entry-to-practice competencies (ETPC) serve as a guide to the curricular content of nursing programs, a critical discourse analysis of the entry-to-practice documents available to the public was performed to: 1) attempt to understand the meaning and intent of the ETPC, 2) answer the question of what are the differences in practice expectations for RN versus RPN graduates, and 3) determine how can role clarity be improved through this process. Critical discourse analysis affords the opportunity to understand these documents, not just through the words on the page, but understand the social, cultural, political, and contextual forces and processes that led to their creation by the nursing regulators in Canada. However, there are competency interpretation documents available only to nursing educators embarking on the College of Nurses of Ontario (CNO) program approval process, which are not made readily available to nurses, the public or employers. These interpretation documents provide a clearer picture of the key differences and similarities between RN and RPN practice expectations. Despite this increased clarity, some language use and sentence construction confound even a seasoned educator as these words have different meanings depending on the context and common understanding of the meaning. As a useful tool for nursing practice, a table of comparison was created to guide nursing educators, employers, nurses, nursing students, and the public to make visible these differences and similarities in both the competencies and the interpretation documents. This analysis also suggests that the College of Nurses of Ontario make the interpretation documents available to a wider audience to support the link between nursing practice and nursing education to create a living curriculum that can be responsive to the ever-changing needs of the profession.

Keywords

nursing curriculum, nursing education, entry-to-practice competency, role confusion, role ambiguity, role clarity, registered nurse, registered practical nurse, critical discourse analysis, critical social theory, feminist poststructuralist theory

Summary for Lay Audience

There are different types of nurses that practice in Ontario, Canada. There is confusion about the roles and practice expectations of Registered Nurses (RN) and Registered Practical Nurses (RPN) for patients, employers, the public, and nurse educators. To provide an approved nursing education program, all schools must ensure that they teach a list of elements, called entry-to-practice competencies, which Nursing Regulators in Canada determine what students must learn. There are two separate lists for RNs and RPNs; however, even these have similarities to each other, which creates more confusion. This research project compared both documents, the meaning behind the listed competencies, and the social and political forces that influenced their creation, in an attempt to more clearly understand the differences. As well, there was an analysis of interpretation documents, created by the College of Nurses of Ontario (CNO) that help the nurse educator to understand the meaning of each of the competencies listed. However, these are not available to employers or others that may be interested in the differences between RN and RPN roles. Despite the interpretations provided, some words used and sentence construction increased confusion, even for a veteran nurse educator, as the words have different meanings depending on the situation and understanding of the word. As a helpful tool for nursing practice, a summary table of the findings illustrates the differences and similarities serves as a guide to aid role clarity for educators, employers, nurses, nursing students and the public. This work also suggests that the College of Nurses of Ontario, who writes these interpretations, make the documents available to the various groups mentioned to improve client safety and protect the public. Nursing professionals need to have a greater understanding of how the competencies undergo routine revision and how the interpretation documents, and the intent behind these interpretations, are created; so, effective nursing programs can adapt to the ever-changing needs of the health care system and nursing practice.

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To the future nurse educators who may read my work – strive for excellence and make the students the focus of your endeavours. They are the future of our profession and worth the extra mile!

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Chapter 1

1 Role Confusion in Entry-to-Practice Nursing Education and Role Performance

Imagine, if you will, reading a document, an important document for your professional practice. You believe you understand the words and the meaning and use it to frame curriculum work then, after working with it for a period, you are given an additional document that has an interpretation to the meaning and understanding of the words in the first document. You are now confused and confounded because what you interpreted as the meaning behind the original document does not match with the interpretation document from the professional body, and you must go back and redo work you thought was well done. Such has been my experience over the last 2 years with the Registered Nurse (RN) and Registered Practical Nurse (RPN) Entry-to-Practice Competencies (ETPC) and interpretation documents created by the College of Nurses of Ontario (CNO) in 2019 (CNO, 2019a; 2019b; 2019c; 2019d). My journey in attempting to understand the difference in roles began long before these new sets of competencies were published, as changes in professional practice models (a realignment of RN to RPN staffing ratios) in Hamilton, Windsor, and Sarnia hospital units were occurring in early 2016 due in large part to financial exigencies experienced by these health care agencies (Draghici, 2016; Kula, 2016; Leslie, 2016). These news releases prompted an informal discussion with my social media connections on Facebook about the feelings of both RNs and RPNs working amidst these professional practice model changes. There were posts about resentment and role confusion between the RN and RPN with both categories of nurse wondering why the changes were happening. Thus began my fixation on understanding the difference, other than title and entry-to-practice education, between these two roles. The problem is that the new models of care being

implemented pre-pandemic saw a growing number of RPN positions and a lesser number of RN positions in hospitals (Draghici, 2016; Kula, 2016; Leslie, 2016).

Why, you may ask, does this matter? As we dwell in 2022/2023, and are two years into a global pandemic, the nursing shortage in Ontario is at a crisis level with 42% of older nurses intending to retire in the next 5 years and up to 50% of nurses under the age of 30 intending to leave the profession in that same timeframe (Registered Nurses Association of Ontario [RNAO], 2022). According to Statistics Canada (2022), one in four registered nurses (24.4%) intend to leave their jobs in the next three years compounded by nearly 23,000 nursing positions vacant across Canada at the end of 2021. These are startling statistics that give credence to the assertion that the health care system was pushed to the brink of collapse during the Covid 19 pandemic. The new practice models pre-pandemic and the current nursing shortage matter because, to counteract this great exodus, nursing programs are being asked to increase the intake of the number of students, to offer additional intakes at different times of the year, and to develop nursing degree programs in the College system in Ontario. However, the blurred lines between RN and RPN practice in Ontario made it challenging for prospective students, who attended open houses in one Ontario college, to decide which role to pursue. They did not understand the difference in the roles and without a CNO website to direct them to that would clearly explain the difference, some struggled to understand the difference other than money. Additionally, there is an increased interest, across the province, in developing programs to bridge the RPN to the RN role (S. MacDonald, personal communication, June 13, 2022), as the pandemic revealed issues in nursing practice, staffing, and care complexity (J. Mathews, personal communication, March 19, 2021).

The confusion that exists in practice and with the public regarding the difference in RN and RPN roles make me feel like I have been here before; a sense of déjà vu, if

you will. I am feeling uncertain about how different one nurse is from another in practice compared to the requirements to enter practice. I am a registered nurse (RN) who graduated from a two-year (six semester) college diploma program at a time when the discourse that RNs should have a degree as entry to practice was becoming entrenched as a goal (Canadian Nurses Association, 1982). Back in the late 1980's, many universities had 4-year entry-to-practice nursing degree programs. From my experience at the time, graduates of these degree programs worked in all areas of nursing, but moved primarily into public health and leadership as they were considered more skilled for these advanced-practice positions. There were few nurse practitioners (NP), as their practice was not regulated by the CNO until 1998 (Nurse Practitioner's Association of Ontario [NPAO], 2013). The RN had a 'helper' who was then called the registered nursing assistant (RNA). More than thirty years later, RNs are solely degree-prepared as entry to practice in Ontario, all other provinces, and territories in Canada except for Quebec (Canadian Nurses Association, 2015). NPs are primary-care givers, functioning in many different roles in cities and rural areas across the country (NPAO, 2013). RNAs have transformed into registered practical nurses (RPN) and require a two-year college diploma (4 or 5 semesters) for entry to practice (The Registered Practical Nurses Association [We RPN], n.d.) From my practice experience, the role that the RNA once performed is now the role of the personal support worker (PSW) who requires completion of a one-year certificate program, which must follow established Ministry of Colleges and Universities vocational standards. There are no formal registration requirements for PSWs, although registration and regulation have been under consideration at the provincial level (R. Roberts, personal communication, November 2, 2021). There has been significant change over the course of the last 30 years in the nursing profession; therefore, it is important to understand the professional designations that exist in Canada today.

1.1 Professional Designations in Nursing Practice

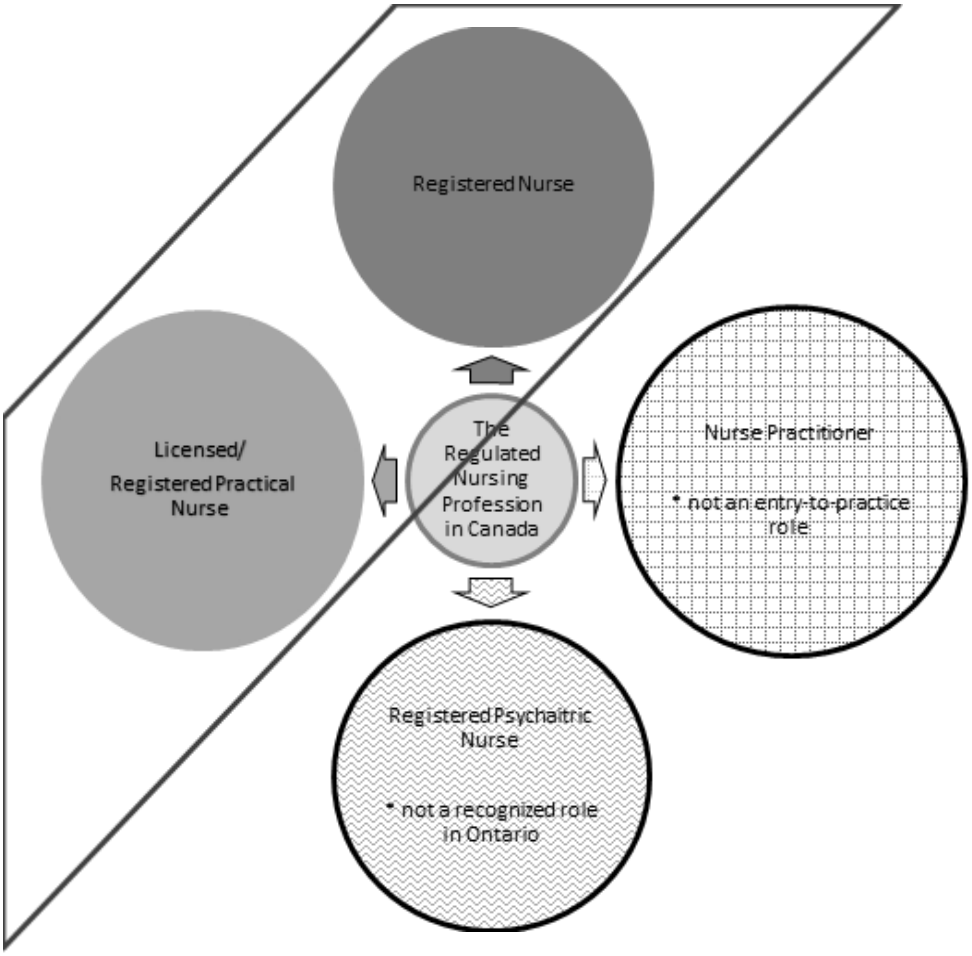
In Canada, there are four regulated categories of professional nurse. There is the RN who requires a four-year baccalaureate as entry to practice; the Licensed Practical Nurse (LPN, called the RPN in Ontario) with a two-year college diploma to enter practice; the Nurse Practitioner (NP) which requires one to be a practicing registered nurse to enter the program and requires a Master's degree to practice, and the Registered Psychiatric Nurse (also with the acronym of RPN). The registered psychiatric nurse role exists in many provinces with varying educational requirements to enter practice with or without basic nursing education; however, Ontario does not support this professional distinction (CNO, 2019e). Since my research focuses on entry-to-practice nursing curriculum and education in Ontario, this thesis will not address the registered psychiatric nurse nor the nurse practitioner roles (see Figure 1.1).

All regulated health professions are required to have regulatory colleges according to the Ontario Regulated Health Professions Act (1991/2022). These regulatory colleges guide the mandate and scope of practice of the profession, and in the case of nursing in Ontario, it is the College of Nurses of Ontario (CNO). In Ontario, the regulatory college for nursing practice is the same for all RNs, RPNs, and NPs; whereas, for many years all other Canadian jurisdictions had separate regulatory colleges for the different roles in nursing (Canadian Council of Practical Nurse Regulators, [CCPNR], 2016). However, as of 2020 British Columbia and Nova Scotia have combined registered nursing and licensed practical nursing regulators into one organization, modelling the CNO's long-standing framework (Prentice et al., 2020). The regulator councils (Canadian Council of Registered Nurse Regulators [CCRNR] and CCPNR) are made up of representatives from each province's and territory's regulatory

bodies, and work together to determine entry-to-practice competencies which guide practice of nursing and as a result, the curriculum of nursing education programs.

Figure 1.1

Graphic of Registered Nursing Roles in Canada and Focus of Study



In 2017, the Canadian Council of Registered Nurse Regulators initiated the revisions of the Entry-Level Competencies of Registered Nurses in Canada. This initiative was led by a working group comprised of 11 jurisdictions representing registered nurse regulators in Canada. A total of 101 competencies are grouped

thematically under nine roles. Integration of all nine roles enables the entry-level registered nurse to provide safe, competent, ethical, compassionate, and evidence-informed nursing care in any practice setting (Almost, 2021, p. 67).

These nationally developed competencies are then adjusted to fit with the language of each province. In Ontario, the CNO, being the regulating body that completes this process, changed the terminology from Entry-Level Competencies to Entry-to-Practice Competencies (CNO, 2019b), which must be met in order to be eligible to write the registration examination (NCLEX-RN). In addition, "six provinces (British Columbia, Alberta, Ontario, New Brunswick, Nova Scotia, and Prince Edward Island) also require the successful completion of a jurisprudence examination or module" (Almost, 2021, p. 68) for registration. A jurisprudence exam "assesses an applicant's knowledge and understanding of the laws, regulations, by-laws, practice standards and guidelines that govern the nursing profession" (CNO, 2020a). The process is much the same for practical nurses (CCPNR, 2019). This collaboration creates a distinctly Canadian approach to health and nursing, making it unique from the United States where the National Council of State Boards of Nursing (NCSBN) develop competencies from the practice analysis of newly registered nurses, the Knowledge, Skill, and Abilities (KSA) survey results, and the Integrated Processes from the NCLEX- RN test plan (NCSBN, n.d.).

> Unlike the NCSBN Practice Analyses, KSA statements, and NCLEX Integrated Processes, that are developed solely to direct the development of the respective NCLEX examination for the primary purpose of assessing the minimal competencies needed to for safe and competent entry-level nursing care, the Ontario competency documents appear to have multiple purposes. The Ontario competency documents appear to have a threefold purpose, namely to direct regulatory body expectations of nursing competence, direct nursing education

> program content, and guide development of minimal competency measurements related to the practice environment (NCSBN, n.d., p.8).

The difference in nursing education systems between Canada and the United States is significant. In the United States, there are LPNs who have one to one and a half years of education, in addition to differing levels of RN. There are four-year baccalaureate, three-year diploma, and two-year associate degree registered nurses (Benner et al., 2010). Globally, there is no one model for what constitutes the education and scope of practice of nurses, regardless of their professional designation (Barrett et al., 2021; Freeman, 2018). This creates tremendous confusion when comparing nursing roles and professional designations across various countries; therefore, limiting the examination to the Canadian context will provide a clear direction for the research work of nursing entry-to-practice education. To appreciate the current context, it is important to examine the origins of the issue and how role confusion and ambiguity became troublesome in the 21st century.

1.2 Role Ambiguity in Nursing in Ontario, Canada

Despite studies concluding that patients have better health outcomes with baccalaureate prepared registered nurses (RNs) providing care (Aiken et al., 2012; Needleman et al., 2011; Person et al., 2004; Tourangeau et al., 2007), beginning in 2016 in Ontario, RNs were increasingly being replaced with registered practical nurses (RPNs) in hospitals and other health care settings (Leslie, 2016). This is one perspective, but there is another perspective to this situation: bringing RPNs up to their full scope of practice after the changes to the Ontario Nursing Act (1991/2021) came into effect in 2014. Hospitals, the largest employer of nurses, (Ontario Hospital Association, 2020) faced near zero percent increases in funding over Premier Wynne's government's term (2013-2018), yet continued to be under ever-increasing pressure to balance

burgeoning budgets while ensuring patient care remained at a satisfactory standard. On the surface, the difference between the RN and RPN in Ontario appeared minimal as their technical skill sets appeared identical (Ontario Nursing Act, 1991/2021); however, RNs have two years of further education and must meet a separate list of entry-to-practice competencies to obtain licensure with the CNO (2019a). In my nursing practice, I have heard patients ask questions like “Are you a real nurse or one of those practical ones?” and “I do not know how to tell the difference between one nurse and the next, you all seem to do the same thing here”. I also had a staff member say to me, “We do the exact same work, but you get paid a lot more than we (RPNs) do. It doesn’t seem fair. I have less schooling but am expected to do all the same skills as you.” It was becoming challenging before for many, both within and outside the profession, to comprehend what the tangible differences were between these two nursing groups, and the implementation of new models of care only served to fuel the confusion.

Shortly after the changing models of care were announced in Sarnia, Hamilton, and Windsor, We RPN (formerly known as the Registered Practical Nurses Association of Ontario [RPNAO]) issued a report called *It’s All about Synergies: Understanding the Role of the Registered Practical Nurse in Ontario’s Health Care System* (Lankshear & Rush, 2014), in an attempt to provide an overview of the role of the RPN. However, this shift from RN to RPN positions triggered the development of position papers such as *RN/RPN Scope of Practice: Synopsis of Supportive Research* (Ontario Nurses Association [ONA], 2014), and *Mind the Safety Gap in Health System Transformation: Reclaiming the Role of the RN* (Registered Nurses Association of Ontario [RNAO], 2017) as attempts to restore RN positions. The research studies cited in both documents that support the advantages of the baccalaureate RN staffing, were out of date with the last and current versions of the entry-to-practice competencies of the RN and RPN (CNO, 2019a, 2019b). In addition, the document made recommendations to augment the RN

role and transform the health system in Ontario. The RNAO was encouraging the government and regulator (CNO) to allow RNs to prescribe some basic medications (RNAO, 2016).

After ONA and RNAO issued their documents, the CEO of We RPN, Dianne Martin, posted an online video entitled, *The Real Issues Facing Nursing in Ontario,* supporting the capabilities and role of the RPN (RPNAO, 2016) and partnerships with RNs in the evolving Ontario health care system.

Nursing is a constantly evolving profession as health, health care, treatment modalities, and human beings are everchanging. Not only have these elements evolved, but so have the roles of registered nurses and registered practical nurses. The most profound changes have occurred within the last two to eight years with changes to the scope of practice for RNs and RPNs in 2014 where RNs could initiate controlled acts and RPNs could implement them, and in 2017, some RNs could order specific medications (Ontario Nursing Act, 1991/2021). The RNAO posited that independent prescribing of medications would increase RN autonomy and give them the freedom to decide and prescribe rather than follow a medical directive (Punch, 2015). In May 2017, the Ontario government passed revisions to the Ontario Nursing Act (1991/2021) and the College of Nurses of Ontario (CNO, 2017a) announced that RNs now could prescribe some medications. The agreed upon medications proposed for RNs to prescribe were those that have existed primarily under medical directives - immunizations, contraception, travel health, smoking cessation, and topical medications for wound care. Medical directives are doctor's or nurse practitioner's orders, written in anticipation of clients' needs, where the nurse could implement them if the proper conditions were met according to the directive (CNO, 2018a). The CNO (2018a) added that a nurse uses their professional knowledge, judgment, and critical thinking skills to determine whether the client needs the medication or treatment and uses the directive to

administer the medication, without the need for contacting the primary care provider. This autonomy would be given to the experienced nurse, most likely working in a wellness setting (public health and community-based nurses) (CNO, 2017a). However, this change did little to differentiate the role of most RNs as over 60% of nurses work in hospitals (RNAO, 2019a) where prescribing is not permitted (CNO, 2017b), resulting in continued ambiguity between the roles of RNs and RPNs in this setting.

To attempt to address role ambiguity, Martin and Weeres (2016) examined role clarity and found that RNs had less understanding of the RPN scope of practice than RPNs had of the RN scope of practice. This lack of clarity led We RPN (of which Martin is the Chief Executive Officer) to deliver workshops on role clarity in the spring of 2017 throughout the province of Ontario (We RPN, 2017). Despite attempts at clarity, nursing organizations (ONA, 2016; RNAO, 2017) were troubled by the shift in scope of practice and nursing positions.

In 2020, the Ford government, in consultation with the CNO, requested further expansion of the RPN scope of practice to include greater ability to critically think through and initiate those controlled acts designated to RNs, other than prescribing the medications mentioned above (CNO, 2019b). The world was in the middle of a pandemic and the need for this increased scope was evident as the need for healthcare practitioners exploded. Up until this point, the RPN could perform these skills but could not initiate them independently. Therefore, the only clear distinction between RN and RPN roles remained prescribing medications for selected issues by select RNs. The murkiness continued.

To aid in understanding how this ambiguity came to be, it would help to review a brief history of the roles of RNs and RPNs to understand why there is a need to search for role clarity in nursing.

1.3 A Brief History of Registered Nursing and Nursing Education

Numerous books and articles convey the history of nursing in Canada by examining different issues of gender, military service, nursing specialties, and locations of nursing practice, as well as biographic works of influential nurses. Authors such as Bates et al., (2005), Gibbon and Mathewson (1947), Maggs (1987), Mansell (1996), McPherson (1989), Moran (1989), and Strong-Boag (1991), explored various issues of Canadian nursing history through a feminist lens covering a historical period from the 18th century to post World War II. Two researchers, Allemang (1974) and Kirkwood (1988) examined the history of nursing education specifically. Margaret Allemang, a pioneer in nursing historical studies, examined nursing education from 1880 to 1950. During those years, the term nurse only referred to the registered nurse (RN), since the formal registered nursing assistant (RNA) or registered practical nurse designation (RPN) did not exist. When Allemang (1974) wrote her doctoral dissertation, she described the registered nurse role in Canada and the United States, and developed themes regarding the history of nursing education. She viewed nursing education "in relation to its ideological tradition, to a changing society, and to the work that gives it meaning" (p. 269). Kirkwood (1988) used the case study method to examine nursing programs at the University of Toronto and McGill in Montreal in the 1980's. Through her feminist lens, Kirkwood (1988) highlighted the inequities and marginalization of nursing programs in the university environment. However, neither study discussed the RN and RNA/RPN roles during that time.

The history of nursing goes back centuries. This extensive consideration is not relevant to this study, so the review of nursing history will begin in the 20th century during World War I.

1.3.1 World War I

Despite the tragedies of war and the life-altering injuries that many soldiers returned home with, nurses gained a major victory during the war. Upon entering the war, nurses were workers in the armed services and little else. However, the status of nurses changed significantly when the rank of officer was given to those who served overseas. Nurses became lieutenants, majors, and colonels depending on their responsibilities in the field (Gibbon & Mathewson, 1947). This was a significant step in the professionalization of nursing, but it would take decades to occur. First, there were other hurdles to overcome.

1.3.2 Pre-World War II (1919 to 1939)

While many answered the call for nurses during World War I (WWI), there was a significant shift in this post-war era. The roaring twenties, an age of decadence after WWI and the global Spanish Flu pandemic, gave rise to labour shortages in nursing, fueled by the increasing demand for hospital services (Gibbon & Mathewson, 1947). Yet at the same time, nurses could not find permanent employment upon graduation due to the excessive use of hospital-trained nursing students as unpaid hospital workers. During this era, on-the-job training (an apprenticeship) was the model of education, where the curriculum was developed and delivered by an exploding number of nursing schools (Kirkwood, 2005). Students were poorly paid, but were given housing and uniforms. Nursing students were to abide by strict rules in hospital-based programs (Bates et al., 2005). Students were to be single or widowed between the ages of 18 and 35, have achieved a grade 11 or 12 education, and were able to speak English or French fluently. The language barrier kept many first-generation immigrants from entering programs. In addition, “regardless of their education achievement or language skills no African-Canadian or First Nations applicant was admitted to a Canadian nursing school before the 1940s” (Bates et al., 2005, p. 83). Nursing schools used these

barriers to promote nursing as “an occupation of relative privilege” (Bates et al., 2005, p. 83).

Upon graduation, most nurses worked as private duty nurses in people’s homes or as nurses who provided one-on-one care in the hospital for significantly ill patients – the term, still used (infrequently) today, for this type of work is the nurse ‘specialed’ a patient. This service was generally reserved for those who could afford it as universal health care was not in place across Canada until the 1960s (Government of Canada, 2019). Graduate nurses (registration would come later in the 20th century) were leaving the profession in droves due to the lack of work and dissatisfaction with work (low pay, long hours) when offered (Weir, 1932).

Education of nurses during this time focused on hospital training. In 1919, under the direction of Ethel Johns, the University of British Columbia (UBC) established the first 5-year baccalaureate nursing degree program in Canada (Gibbon & Mathewson, 1947). This first school led to the creation of five key degree nursing programs by the end of the 1920s at universities across Canada. The UBC program, designed to create leaders, teachers, and public health nurses was a significant event in nursing education, as it established that nursing was indeed in need of specialized education. However, there was much criticism over these degree programs as only the first and fourth years were delivered at the university. Years two and three saw students integrated into hospital training programs which created difficulties for ensuring quality educational practices. It was not until the 1940s when the first fully integrated nursing degree was offered at the University of Toronto (Davidson-Dick & Cragg, 2005).

During this time, The Canadian Medical Association (CMA) and the Canadian Nurses Association (CNA) commissioned George Weir, in 1927, to undertake a comprehensive report of the status of nursing and nursing education. In 1932, he completed the *Survey of Nursing Education in Canada* which highlighted the need for

advanced education for all nurses. His recommendation for baccalaureate-level nursing education as entry-to-practice did not materialize for 75 years and others remain unimplemented to this day, but his training school recommendations were supported by many in the field (Gibbon & Mathewson, 1947).

Weir (1932) recommended that hospital training schools meet certain criteria. A training hospital should have at least 75 beds and have a daily average of 50 patients. The report also recommended that hospitals establish nursing supervisors in different areas of the hospital to monitor the nurses-in-training, have five doctors capable of teaching the students the sciences, and enroll students capable of grasping the learning and responsibilities of a nurse (Weir, 1932). He further suggested that there was a growing need for psychiatric nursing courses to address this escalating health issue. After the Weir Report's release, the Canadian Nurses Association (CNA) assembled a group of nurse educators from across the country to implement some of the recommendations, particularly the one about standardization of nursing education, and developed a national nursing curriculum. In 1936, *A Proposed Curriculum for Schools of Nursing in Canada* was released. The CNA created a comprehensive guide to nursing education, administration, student rights and responsibilities, as well as detailed outline of the depth and breadth of learning required for each subject in the program, (i.e., a standardized curriculum). It was released as a tentative document that acknowledged its defects and omissions but hoped it would be a starting point from which to progress (CNA, 1936). Its introductory statement acknowledges the Weir recommendations and tempers them with the reality of nursing at the time, yet acknowledges that an undergraduate education was the best proposal, as put forth by Weir (1932).

> In view of the fact that the establishment of nursing education on an independent financial basis, and on a fully recognized professional level, can not [*sic*] be

> secured by revolutionary measures but must come about gradually, the construction of a curriculum in this transition period should first provide for those immediate adjustments which are recommended in the Survey Report (CNA, 1936, p. 6).

Another element in the document is the list of the “general functions” of a nurse. This was a list of eight statements that highlighted what nurses should be able to do upon graduation. They were:

1. To be able to observe, to reorganize and to interpret intelligently the physical, mental and emotional manifestations of health and illness.
2. To be able to give expert bedside nursing care in all types of illness.
3. To be able to adjust to home situations and to maintain so far as possible a healthful environment for the patient.
4. To be able to apply the principles of mental hygiene in the care of the sick, and to develop in the patient the mental attitudes that will favour recovery.
5. To be able to give instruction in the principles and practices of health as applied to the restoration, conservation and promotion of physical and mental health.
6. To be able to co-operate with doctors and other professional workers, to maintain good relationships and to participate in a community programme for the care of the sick, the prevention of disease, and the promotion of health.
7. To be able to co-operate with hospital, public health departments, public health nursing organizations and social agencies in the use of their facilities, and to assist in maintaining their standards of service for the welfare of the patient, the family and the community.

8. To be able at all times to invite confidence, to manifest a real interest in human problems, and to render the kind of assistance which typifies the spirit and practice of an indispensable professional service. (CNA, 1936, pp. 9-10)

These core competencies have persevered over time and, although stated in different ways and with more detail as we will later see, remain a foundation of nursing entry-to-practice competencies for 2020.

In addition, the CNA surpassed Weir's recommendations and suggested that training hospitals should have at least 100 beds and be able to provide experiences for adults, maternal and newborns, children, psychiatry, and wherever possible a community public health experience (CNA, 1936). These recommendations were not to come to fruition fully as the advent of World War II would transform a graduate nursing surplus into a shortage.

1.3.3 World War II

World War II ushered in many significant changes for nursing practice and education. The glut of registered nurses quickly became a dearth of nurses available to care for the sick and dying soldiers on the many fronts of the war. Nurses needed help with some of the basic care of the sick and the role of the nurse's aide was born (RPNAO, 2013).

The Chicago School of Nursing was far reaching and sent booklets about the care of patients so potential nurse's aides could learn at home through mail-order education. Much of my awareness about this Chicago school of nursing came from a box with an enamel combo urinal/bedpan and several of these booklets discovered in the attic of our first home. There were booklets about bathing, dressing, bedmaking, bowel and bladder care, and, lifting and transferring. I had never heard of mail-order nurse's aides, so the information fascinated me. When we moved from that home, I did

not realize the historical significance of these documents, so I discarded them. I kept the bedpan as a token memory. In searching for the documents for this work, I discovered that this school no longer exists, and as such, the documents are lost to history.

During WWII, a nursing shortage became most apparent, especially with the need to have nurses in the field hospitals overseas in Europe. There were no longer enough nurses to care for the patients at home in Canada. The Registered Nurses Associations of Ontario (RNAO) worked with the Ontario Department of Health to create eight centres delivering a 6-month course for nursing assistants (RPNAO, 2013). At the time, it was designed for those who wanted to be a nurse but had only a Grade 8 level of education (Russell, 1970). This was to be a five-year project designed to end after the war.

1.3.4 Post War Era

The shortage of nurses persisted after the war was over, and an inquiry was established to determine the education and needs for licensing of nursing assistants. The inquiry determined that three schools in Toronto, Hamilton, and Kingston should deliver a 9-month training program for nursing assistants (Russell, 1970). In 1947, the Nurses Act was amended to include the designation of certified nursing assistant, and in 1953, the program was lengthened to 10 months (Russell, 1970). In 1951, the Nurses Registration Act became law in Ontario, granting the RNAO the responsibility for the curriculum of schools of nursing and the registration of nurses in the province (RNAO, 1953). In 1953, the RNAO published a 32-page booklet entitled *Curriculum and Information for Schools of Nursing in Ontario* (RNAO, 1953). The graduate nurse was now the registered nurse and the certified nursing assistant became the registered nursing assistant (RPNAO, 2013). “The Nurses’ Act is proclaimed in January 1963, establishing the College of Nurses of Ontario (CNO). With this change in

legislation, registration becomes the responsibility of the college rather than RNAO" (RNAO, 2015, p. 1).

1.3.5 The End of Hospital Trained Nurses and the Birth of the Community College

In 1960, the Canadian Nurses Association published the *Spotlight on Nursing Education* under the direction of Helen Mussallem. The report summarized a comprehensive examination of nursing education with a view to assessing the readiness for training hospitals to pursue accreditation of their programs. It found that there was considerable variability in the education provided to nurses with an overemphasis on working on the nursing units rather than spending time in theoretical instruction, as over 50% of the total number of hours of instruction were taught in the first year of the programs, and there was "considerable fragmentation of major courses" (Mussallem, 1960, p. 84).

In 1961, the Canadian government established the Hall Commission of Health Services (Government of Canada, 2005). Its report, published in 1964, provided an unfavourable review of nursing education programs. The commission was highly critical of the hospital-based, apprenticeship model noting that 75% of hospital schools and 56% of university programs lacked faculty with proper educational qualifications. As well, Hall noted that the first year of the program provided the basic education and that 2 more years was spent in an apprenticeship that seemed overly long and possibly serving to lower the cost of care through unpaid work. Further, Hall suggested that nursing programs be shortened to 2 years. The commission suggested:

> "…two categories of nurse are required…the graduate of a four- or five-year integrated basic university programme…It is estimated that about 25 per cent [*sic*] of positions for nurses require this type and range of preparation… The

> graduate of a new type of two-year diploma program who would function as a clinical or bedside nurse." (Hall, 1964, p. 63)

Both categories would be called registered nurses. Hall (1964) indicated that "it was of utmost importance that these schools [University Schools of Nursing] be expanded rapidly in number to enable to prepare approximately one-fourth of the total recruits to the nursing force" (p. 67). The recommendation of diploma nursing education moving to the community college system was suggested in the report and in 1969 Humber College in Toronto, Ontario, offered the first college-based nursing program (Baker et al., 2012). By the mid 1970s, all Ontario diploma RN programs moved to the colleges from the hospital settings and were called *Schools of Nursing* (Bates, et al., 2005).

Despite the move to a more traditional and standardized education, the two-year registered nursing school programs did not last long. Educators realized two important things regarding the advantages of hospital-based programs (Davidson-Dick & Cragg, 2005). The first was that there was a lot of valuable learning that occurred during the working time on the units; it did not occur only in a classroom. The second was that students needed the ability to have time to transition to 'real world practice' so they could 'hit the ground running' (Davidson-Dick & Cragg, 2005). As a result, nursing schools were pushing for a longer program to allow for a consolidated practicum so that graduates were better prepared to handle the realities of nursing practice (Davidson-Dick & Cragg, 2005). Further, these authors noted that some schools opted to extend the school year and offer a 22-month course delivered over 24 months. However, with the growing acuity in clinical areas, community colleges offered the last 22-month program in 1987. I know this because I attended one of the colleges that offered that last two-year program in 1987 for my nursing diploma. Community college nursing diplomas were now three academic years in length with a 600-hour consolidation

practicum in their final semester of education. Returning to the Hall Commission report of 1964, it further recommended the continued use of nursing assistants to augment the capacity of the RN in providing care.

During this same period, the nursing assistant role was growing steadily across Canada and schools were offering programs that varied in length from nine to eighteen months (Russell, 1970). Russell (1970) also noted during this time that some schools "were being asked to teach nursing procedures that had not been approved as coming within the scope of the nursing assistant" (p. 139). The Canadian Nurses Association (CNA) was concerned about this increase in teaching and felt that it would lead to role confusion and, ultimately "difficulty in maintaining satisfactory standards of care" (Russell, 1970, p. 139). Therefore, the CNA recommended that the nursing assistant curriculum remain steady until the Hall Commission was concluded and appropriate policies could be determined (CNA, 1981). After the Hall Commission (1964) recommended that registered nursing programs be two years, the nursing assistant program length was shortened, from a maximum of 18 months to one year, to complement the RN programs' length of education (RPNAO, 2013). However, even more change would come in the ensuing decades.

1.3.6 The 1970's to 2000 – A Time of Transformation in Nursing Practice

In the 1970s, the first mention of a bachelor's degree as entry to practice by 1995 was discussed in the Alberta Task Force on Nursing Education (Government of Alberta, 1976) and was supported by the members of the Alberta Association of Registered Nurses but was subsequently rejected by the Alberta government stating it did "not agree with making the baccalaureate degree a mandatory requirement for practice" (Government of Alberta, 1977, p.6). However, this movement gained momentum and the discussions continued until the CNA biennial convention in 1980 where a resolution was passed to examine entry-to-practice education for registered nurses (CNA, n.d. a). In

1982, the CNA adopted the position that a university baccalaureate degree be entry-to-practice by the year 2000 and developed a task force to support this goal; however, it was not to be in Ontario. The CNO did not make a recommendation to the government until 1998 that baccalaureate education be entry to practice by 2005 (Wood, 2011). In 2000, the Ontario government agreed to the educational requirement change, and a rapid move to create collaborations between colleges (who could no longer offer a degree) and universities (degree granting institutions) began in Ontario (Wood, 2011). As well as entry-to-practice education, nursing practice and healthcare were undergoing significant changes in Ontario during the 1990s. Role professionalization and standardization of the health disciplines would lead to a major shift in how health-care professionals were regulated.

The need to overhaul the Health Disciplines Act gained momentum in the 1980s as the number of health-related professions grew. The Ontario Health Disciplines Act (1974/1980) transformed into the Ontario Regulated Health Professions Act [RHPA] (1991/2022) which established rules and regulations to which health professionals must comply. This piece of legislation has gone through multiple revisions through the years (41 in total as noted on the Government of Ontario e-laws website as of July 8, 2022) to expand the number of health professions and their scopes of practice. In 1993, the Act was finalized and enacted into law, thus it ushered in a new era of nursing practice. It was the initial version of this document that laid the foundation for the transformation of the RNA into the RPN role. Prior to enactment, RNAs could not practice independently. The RN was accountable for the skills and tasks that the RNA performed in the practice setting and supervised their practice. Now, the RN and RPN were responsible for themselves (Ontario RHPA, 1991/2022), with both able to oversee unregulated health care providers such as health care aides (now known as personal support workers) (Ontario Nursing Act 1991/2021).

> Entry-Level RPN practice will focus on the care of stable clients. However, the RPN's career path is a continuum of growth and evolution. Through a combination of experience and continuing education, the RPN's role can accommodate clinical situations of a more complex nature in a variety of areas of practice (CNO, 2004, p. 3)

If a client's condition changed or became unstable and the RPN no longer had the skills and knowledge required to care for the client, then they were to turn over care to the RN.

> The complexity of a client's condition influences the nursing knowledge required to provide the level of care the client needs. A more complex client situation and less stable environment create an increased need for consultation and/or the need for an RN to provide the full range of care requirements. (CNO, 2018b, p. 4)

In my personal experience there was confusion over what stable meant and its interpretation. I remember discussions in practice around whether the client was stable when they were dying as the outcome was predictable; however, the care could be complex at the same time. Thus, began my issues of role confusion.

1.3.7 Nursing in the 21st Century

On the heels of reform in RPN status and practice independence of the 1990s, came the transition from diploma prepared RNs to degree prepared RNs and certificate prepared RPNs to diploma prepared RPNs in 2005 (RPNAO, 2013). I began my teaching career in nursing programs during the first intake of the collaborative nursing degree and the last intake of the diploma RN in a community college in Ontario. It was a confusing time for me. With the shift to baccalaureate education, colleges in Ontario could no longer offer RN education independently and had to be affiliated with a university (RNAO, n.d.). One college, Humber in Toronto, to be able to deliver a nursing

program partnered with the University of New Brunswick to deliver their nursing degree (University of New Brunswick, n.d.). The College of Nurses of Ontario was also moving with the changes and the establishment of essential learning competencies.

> In the summer of 2004, the Executive Directors of registered nursing regulatory bodies across Canada initiated the formation of a national working group to the revise the entry-level competencies for Registered Nurses (RNs) …[and] aimed to enhance jurisdictional consistencies in entry-level competencies, serve as a guide for public and employer awareness of practice expectations of entry-level RNs, and provide evidence of educational requirements and curriculum development. The revised competencies reflect baccalaureate education. (CNO, 2007, p. 3)

However, the CNO decided on a different name for the competencies and labelled them as entry-to-practice competencies (ETPC) as they had done with their previous provincially-based competencies written in 1999 in preparation for the 2005 degree-prepared graduates (CNO, 2014a). In 2007, the RN competencies underwent revision (CNO, 2007) and again in 2014 (CNO 2014a). Then, in 2017, the Canadian Council of Registered Nurse Regulators [CCRNR] (2019) began work on another revision which was published in 2019, set to come into effect in September 2020 (CNO, 2019a). These are the current competencies at the time of this writing.

At the same time the RPN ETPC were experiencing their own metamorphosis. Their first version was developed in 1999 then revised in 2004, 2009, and 2011 (CNO 2004; 2009; 2011). Then in 2014, the RPN ETPC (CNO, 2014b) went through another revision as RPNs now had the ability to *perform* the controlled acts for nursing (Ontario Nursing Act, 1991/2021). Controlled acts “are considered potentially harmful if performed by someone who isn’t qualified” (CNO, 2020c, p. 2). RNs have been able to *initiate* controlled acts since 2014 (Ontario RHPA, 1991/2022). This means

that a nurse can perform the controlled acts without a primary care provider order (CNO, 2020b). There is a total of 14 controlled acts that can be performed by health professions in Ontario. Below is a list of those that can be performed by a nurse (RN or RPN). They are numbered as in the Act:

2. Performing a procedure on tissue below the dermis, below the surface of a mucous membrane [only part of this controlled act].
5. Administering a substance by injection or inhalation.
6. Putting an instrument, hand or finger,
   i. beyond the external ear canal,
   ii. beyond the point in the nasal passages where they normally narrow,
   iii. beyond the larynx,
   iv. beyond the opening of the urethra,
   v. beyond the labia majora,
   vi. beyond the anal verge, or
   vii. into an artificial opening into the body.
8. Dispensing a drug [only part of this controlled act].
14. Treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning. 1991, c. 18, s. 27 (2); 2007, c. 10, Sched. L, s. 32; 2007, c. 10, Sched. R, s. 19 (1). (Ontario RHPA, 1991/2022, Section 27)

In 2020, the CNO adopted the national level of practical nursing ETPC developed by the Canadian Council of Practical Nurse Regulators (CCPNR, 2019; CNO 2019b).

With the additional competencies and controlled acts added to RPN practice in 2014, issues of role confusion and a need for clarity were becoming apparent

(Lankshear & Martin 2019; Nowrouzi-Kia et al., 2022). This need for clarity was mainly fueled by the changed language of the RPN ETPC, moving away from the stable versus unstable to adopting the three-factor framework of the client, the nurse, and the environment to determine the level of nurse required for safe patient care. (CNO, 2018b). Client factors for a nurse to consider were complexity, predictability, and the risk of negative outcomes. Nurse factors included the client, a direct practice assessment, direct practice decision-making, direct practice planning, direct practice care coordination, direct practice implementation, direct practice evaluation, direct practice consultation, leadership, resource management, and research with many decision points in each element to determine which nurse would be appropriate to provide care. Environment factors included practice supports, consultation resources, and stability and predictability of the environment (CNO, 2018b). In my experience, this expanded RPN scope of practice created stress amongst some nursing colleagues who perceived the 3-factor framework to be based solely on knowledge, skill, and ability of an RPN to perform a skill, paving the way for differing models of care to be implemented.

Different models of care were explored in an Ontario hospital. As mentioned earlier, the Wynne government had frozen funding and in 2016, hospitals were looking to cut costs as an RN made anywhere from $31.45 to $52.10 per hour in a hospital setting (ONA, 2016, p. 1), and an RPN at a different Ontario hospital made $27.69 to $29.15 per hour. (Service Employees International Union, 2013, p. 94). For example, in my practice in a particular hospital in 2016, the model of care change switched out the second RN on a day shift to one RN and four RPNs on an acute medical unit. My RN colleagues reported experiencing burnout as they were given the sickest five patients on the unit, and had to assist or assume care if the condition of a patient, assigned to an RPN, deteriorated, and now required RN level care. There was no error or faulty care provided by the RPN, the patient was just too sick and unstable. Within a year, the unit

reverted to the two RNs with three RPNs model as staff were leaving the unit and patient acuity was ever-increasing.

It was during this time that the professional associations (RNAO and RPNAO) in Ontario each began asserting their position of importance. In 2016, the RNAO released a document entitled *Mind the Safety Gap in Health Care Transformation: Reclaiming the Role of the RN* in which the RNAO presented their concerns and provided suggestions that placed the RN at the centre of the solution.

> Replacement of RNs with less-qualified providers is short-sighted and inconsistent with government plans to evolve the health care system. Failure to ensure RN care is provided in hospitals threatens health system transformation goals, and compromises patient safety and health outcomes. The research is conclusive: fewer RNs means a heightened risk for patients and risks desired outcomes by increasing mortality and morbidity (Aiken et al., 2011; Ehsani et al., 2013; Estabrooks, Midodzi, Cummings, Ricker, & Giovannetti, 2005; Frith, Anderson, Fan & Fong, 2012; Glance et al., 2012; Hugonnet, Uckay & Pittet, 2007; Kane et al., 2007; Patrician et al., 2011; Rothschild et al., 2009; Tourangeau et al., 2007; Tubbs-Cooley et al., 2013; Twigg et al., 2012). (RNAO, 2016, p. 30)

In addressing the assertions made by the RNAO, the RPNAO (2016) released a video on YouTube discussing how:

> We are seeing conversations in the press and other places that devalues the contribution of RPNs and questions the contribution of RPNs and it is terribly upsetting to see that…[and implies that] the RPN is second best or the people you use only when you have a financial crisis…and [the use of] demeaning language towards the RPNs being hired [at Windsor Regional Hospital]… But the real problem in Ontario is that hospitals have not had a real increase in funding

> for years…[and] both categories of nurse are being eliminated… It is time to stop making this an RN-RPN issue and start making this about patients and the quality care they deserve. (RPNAO, 2016, 0:40, 1.21; 2:00; 2:53; 3:08; 5:20)

In 2017, the RNAO published a scoping review of articles demonstrating 70 years of RN effectiveness in the health care system, to "be used for evidence-informed decision making by policy-makers, researchers, and health care administrators" (p. 2). However, of the list of 626 articles, only a relative few articles: Aiken, et al., 2012; Aiken et al., 2014; Blegen, et al., 2013; Cheung & Aiken 2006; Fogarty, 1980; Ferguson & Jinks, 1994; Kutney-Lee et al., 2013; Long & Bernier; 2004; Ridley, 2008; Yakusheva et al., 2013, discussed the educational difference between diploma RNs and degree-prepared RNs as a factor, with none being in the Canadian or Ontario context. Most of these articles were conducted in the American context. To find if there was relevance to the Canadian context, an article by Lankshear et al. (2016), stated "Within Canada, the Ontario registered PN (RPN) role is synonymous with the licensed PN role in other Provinces and the United States and the enrolled nurse role in Australia" (p. 300). I contend that the scope of technical skills may be similar but the education between the US and Canada is not equivalent so the comparison is not a valid one. During an NCLEX item writing experience that I had in Chicago in 2015, it became clear when asking about PN education with my US colleagues, that the curriculum of the RPN education in Ontario was more equivalent to an Associate Degree nurse rather than a practical nurse. For example, in Ohio, a state that borders Canada, it clearly states that being a licensed practical nurse:

> means providing to individuals and groups nursing care requiring the application of basic knowledge of the biological, physical, behavioral, social, and nursing sciences *at the direction* [italics added] of a registered nurse or any of the following who is authorized to practice in this state: a physician, physician

> assistant, dentist, podiatrist, optometrist, or chiropractor." (Ohio Nurse Practice Act, 2017)

Likewise, in New Mexico:

> Licensed practical nursing means the practice of a directed scope of nursing requiring basic knowledge of the biological, physical, social and behavioral sciences and nursing procedures, which practice is *at the direction of* [italics added] a registered nurse, physician or dentist licensed to practice in this state" (New Mexico Nursing Practice Act, 2022).

In Ohio, the LPN diploma program is 12-18 months in length and 2 years for an associate degree (Nursing Process, 2022) and in New Mexico the LPN program is 1 to 2 years and "depends on the type of program schedule the student chooses" (Practical Nursing, 2022). Meanwhile in Ontario, RPNs, are accountable for their own practice and do not require an RN to direct it (Ontario RHPA, 1991/2022). Since 2005, the RPN program length is 2 years (either 4 or 5 semesters) (RNAO, n.d.).

In 2018, in a joint RNAO and ONA backgrounder document, it stated that "Ontario had the lowest RN to population ratio in the country" (RNAO & ONA, 2018, p.2), and "it is imperative that Ontario reverse the damaging trends which have caused the RN-to-population ratio to substantively drop…Patient safety and health outcomes are at risk and compromised if adequate numbers of RNs are unavailable" (RNAO & ONA, 2018, p.3).

In 2020, the Deputy Ministry of Health, Helen Angus, requested the CNO to augment the practice role of the RPN to be able to initiate more controlled acts (something that RNs can do since 2014) with no mention of increasing the scope of RN practice (CNO, 2020c). RNAO was quick to respond to the CNO and "sound the alarm on RPN scope expansion that will render the RPN and RN scope virtually identical, despite the vast differences in academic preparation." (RNAO & ONA, 2020). From my

personal experience in teaching both Bachelor of Science in Nursing (BScN) and RPN nursing students, the diploma RPN learns just as much depth and breadth of knowledge that I did in my diploma RN program, if not more, which, in my opinion, indicates that the RPN is adequately prepared to initiate controlled acts as there are still diploma-prepared RNs in practice settings. Despite the differing opinions, the COVID-19 pandemic would challenge nursing practice.

1.3.8 Nursing in the Pandemic World

I would be remiss not to mention the impact of COVID-19 on the world, and most particularly on the health care systems of a multitude of countries (Organisation for Economic Co-operation and Development [OECD], n.d.). As I write this in August of 2022, Ontario has lifted most restrictions and mandates, and COVID numbers are no longer reported daily in the news (Canadian Broadcasting Corporation [CBC], 2022). People remain hospitalized and ill with the latest COVID-19 variant and Ontario is in the seventh wave (Global News, 2022). However, a lack of staffing resources and patients who have delayed treatment and, are therefore more acutely ill, are forcing hospitals to reduce services or close departments (CBC, 2022). This pandemic has been an incredible challenge for nurses around the world as it has pushed them to the brink of their capacity. It has shed a light on the depth and breadth of problems within the health care system, one of which has transformed a pre-pandemic global nursing shortage (5.9 million) into a nursing staffing crisis (27.9 million in 2020-2021) (Buchan et al., 2022).

In April 2020 in Ontario, the early stages of the pandemic saw military forces brought in to assist in care provision in long-term care homes. Too many sick individuals and not enough staff to cope with the demands highlighted the issues of long-term care provision and a lack of staffing. The military personnel were so concerned they wrote a report to the government, and in May of 2021, the results were announced to the public via the media. This was a scathing report of “horrifying conditions” in two Toronto

nursing homes (Ontario's Long-Term Care COVID-19 Commission, 2021). This report highlighted issues of long-standing understaffing and underfunding which led to apparent neglect of residents; however, from my perspective, what the report fails to discuss is the impact on care due to staff illness related to COVID-19 and it failed to place accountability beyond that of the nursing staff and home operators. These situations pushed many nurses who were contemplating retirement to choose retirement or take breaks from nursing practice due to the working conditions that existed (Buchan et al., 2022). As a result, there is now an experience-practice gap occurring in some hospitals and agencies where the most senior nurse on a nursing unit may have less than five years of nursing practice experience (S. Landry, personal communication, November 2, 2021). In July of 2022, the Ontario government announced that is was adding a new Chief of Nursing and Professional Practice [CNPP], Dr. Karima Velji, to work with the Minster of Health and Deputy Minister of Health, beginning on August 2, 2022, to address the health care system's "urgent and ongoing challenges" (Bloomberg School of Nursing, 2022, para 2).

A recent survey report (RNAO, 2022) found that, of the 5200 Canadian nurses responding to the survey, an overall average (for all age groups) of nurses who indicated they intended to leave their current position in the next 12 months was 28.9%, compared to 16.7% of respondents in Australia, and 22% of international respondents. Further, the RNAO (2022) study found that 45-50% of nurses under the age of 25 intended to leave their current position within 12 months of the time of the survey. In comparison to pre-pandemic levels, according to Sandler (2018), "18% to 30% of new graduates will leave their current position for a different practice environment or the profession all together in the first year and up to 37%–57% will leave in their second year of practice" (p.23). The reports of less nurses available to work and the staffing shortages reported on social networking sites (Twitter, LinkedIn, Facebook) are staggering to me. One Facebook

post had a nurse posting a sign stating that they routinely work five nurses short of a full complement for safe patient care on a shift. I am concerned as to how anyone could maintain minimum safe practice standards with that level of staffing shortage. It is not only registered staff that are feeling overwhelmed. There is a severe shortage of personal support workers (PSW) as well in Ontario. "Job postings for personal support workers have more than quadrupled (+443%) since 2017, with over 5,000 postings in 2021" (Government of Ontario, 2022). So much so, that for the past 2 years, the provincial government has funded fast track (accelerated) programs offering paid clinical placements to entice people to join the program and workforce (Government of Ontario, 2022). In addition, the government announced increased funding for seats in BScN and practical nursing education (Government of Ontario, 2021) prompting at least one community college to offer a second intake of practical nursing students in January 2022, but having them work through the summer so they can graduate with their colleagues that started in September 2021 (personal communication, L. Charron, May 25, 2022). From this historical and current view of nursing practice and education it becomes clear that nursing education is influenced by multiple factors that intersect government, regulation, education, and practice.

1.4 Research Questions and Study Organization

This brief view of the history of RN and RPN practice in Ontario and Canada provides us with a snapshot of how and when role confusion came to be an issue, but there are key questions that remain unanswered. Who is driving the changes to nursing practice and entry-to-practice competencies which ultimately culminates in the curriculum delivered to nursing students? What are the key differences between RN and RPN nursing practice and scope? Why do we need role clarity and why is it important to nursing education and curriculum? Where is the research situated that would clarify this murkiness of roles and responsibilities? How can I contribute to creating clarity for

others and support greater collegiality amongst not only practicing nurses, nursing students, and nursing educators, but nursing regulators as well? From these general questions, I have refined them down to the following questions for the study.

1. What similarities and differences exist in the discourse contained within the two entry-to-practice documents?
2. How do the entry-to-practice competencies of the RN and RPN and their interpretations create distinction between the two nursing roles?
3. How does this discourse impact nursing educators and employers?

To position these questions, in chapter two I review the literature involved with role confusion, nursing practice, and nursing education. In chapter three, I provide an overview of Critical Social Theory (CST) and Feminist Poststructuralist Theory (FPT) and how they work with Critical Discourse Analysis (CDA) to examine discourse associated with the RN and RPN entry-to-practice competency documents. In chapter four, I use a critical social lens, informed by Habermas and the work of the Frankfurt School, to perform a critical discourse analysis, using Fairclough's 3D CDA Framework, of the four documents examining the internal and external factors (discursive and social factors) that impact the development and dissemination of these documents. I present an overall map comparing the RN and RPN competencies and provide an example of textual analysis of the documents. Given that there are four documents to review, a deep textual analysis of every word is a monumental undertaking and more than can be accomplished in this dissertation and, as such, is a limitation of this study. To conclude this study, I provide impressions, limitations, and possibilities for the future development of these documents using an FPT lens. My analysis intends to serve two processes: one, to enhance understanding and clarity, and two, to create an instrumental tool to support others. Additionally, infused in each chapter are experiences from my practice which are meant to enrich understanding of this work by providing examples of how the

roles that I have had in my career can provide context for the literature review, theories used, and approach to the work as well as, clarity for the analysis as they contribute in rendering my meaning making visible to the reader.

Before I begin, however, I feel that my insider status as a registered nurse, nurse educator, curriculum developer, and scholar situate me in a distinct way in the discourse, and the bias that I may knowingly and unknowingly have towards this research.

1.5 Positioning the Researcher in the Study

Before I delve any further into this study, I believe it is important to locate myself within this research project. My experiences as a nurse, colleague, educator, and curriculum developer influence how I view the documents that will reveal the similarities and differences in entry-to-practice competencies that inform nursing curriculum in Ontario, and the dissertation itself. I am a nurse who graduated in a time when the RPN was an RNA with significantly less responsibility and skill than today. In fact, my first nursing job had me signing the payroll sheet as a “Grad” where my RNA colleagues signed “Aide”. When the RNA transitioned into the RPN, I was a preceptor for RNAs learning medication administration and other skills acquisition to transition their practice. Later, I moved into nursing education beginning my career teaching the first BScN entry-to-practice cohort and the last diploma RN cohort in the same year. Change and transformation have been an integral part of my experience as a nurse. I carry this knowledge, and lived experience, with me as I enter the discourse of nursing curriculum evolution. I am not a bystander in this. Having been a nurse educator for over 20 years, I have experienced the process at the program, and most recently, at the school level where I led the development of a stand-alone, 4-year honours nursing baccalaureate degree for my employer. It was through this process that my passion for my dissertation work was reignited. I have spent the last 12 months immersed in ETPC, their interpretations, and examining processes by which a bridging program could be

developed to fully recognize the transition in practice from RPN to RN. My work with developing the curriculum for a new BScN degree and mapping the RN competencies to demonstrate that the curriculum meets all the competencies has had a significant impact on how I view the competencies. As I embark on the next phase of my work, developing a program of study that bridges the RPN to a BScN degree, this work has a significant impact on how I develop this program. My perceptions and thoughts about nursing will inherently get "mixed in" to the melee of interpretation. I do not believe this to be a hindrance to this study, but a way to enrich the analysis with a lived experience perspective from the grassroots. I also need to be aware of the personal bias I carry with regards to the issue of role confusion in nursing. I am an RN. I have worked and felt privileged to work with many RPNs in my career. Some may perceive that I am doing this work to be protective of the RN role. Although I believe I am not being protectionist, I acknowledge that I wonder if the heath care system has put too much work, stress, and responsibility on the RPN without giving them the education and tools to cope with the increased scope of practice. There is a need for role clarity to enhance and ensure the safety of clients receiving nursing care.

1.6 Limitations

This study is limited in its textual analysis of each competency and interpretation in the four documents. In completing this work, the data was too copious to include the analysis of every comparator competency, therefore an example will be given of the in-depth analysis of one or two RN entry to practice competencies and the RPN comparators will be provided in the text with an interpretation analysis provided in an appendix. As is inherent with my position of being involved in developing curriculum from these competencies, my bias cannot be underestimated or ignored.

Chapter 2

2 Literature Review

After reviewing the history of nursing education in the 20th and 21st centuries and laying the foundation for how the two nursing roles (RN and RPN) evolved over time in Ontario and Canada, I then turned to the literature to examine the issues of role clarity, the education of nurses, and the development of nursing curricula to ground and support the work of examining the entry-to-practice competencies for nurses. A comprehensive search of the Western University library databases, Google Scholar, and Canadian nursing associations and regulators websites revealed several sources discussing nursing staff mix focused on patient outcomes and job satisfaction (Anonymous, 2009; Hall & Doran, 2004; Hall et al., 2006; McGillis-Hall, 1999, 2003). However, a review of these sources failed to discuss RN and RPN role ambiguity in Canada. Part of the challenge may be that these publications predated the latest RPN entry to, and scope of, practice update (CNO, 2019b). Hence, a further search using the terms 'role creep' and 'role clarity' 'role confusion', 'collaboration', 'scope of practice', and 'care models' with RNs and RPNs in Canada within the last ten years ensued.

2.1 Role Clarity, Confusion and Collaboration

In searching RN and RPN collaboration and scope of practice as terms, there was limited information. Prentice et al. (2020) looked at the regulatory documents that assisted nurses to determine who was the appropriate care provider for clients. Of the ten documents they examined, the CNA document provided the clearest guidelines for staffing and intraprofessional practice; however, it was written before the latest iterations of entry-to-practice competencies. Baumann et al. (2014) examined effective RN and RPN collaboration and found that part of an effectively functioning team was knowing each other's roles. Further, they found that there was ambiguity between these

roles. Dahlke and Baumbush (2015), Lankshear et al. (2016), and Moore et al. (2017) supported these findings in their studies and noted that RNs did not understand the role of the practical nurse. Moreover, Moore et al. noted that some discrepancies in roles were due to an unwillingness of older staff to upgrade their skills (the setting where the study took place did not require all to do so) and led to practice issues.

Some sources discussed practice issues with RNs and RPNs (Duckett et al., 2012; Duncan et al., 2014; Harvey & Priddy, 2011; LoPresti et al., 2020; MacNaughton et al., 2013; Roch et al., 2014; Wells et al., 2011). These studies focused mainly on maximizing scopes of practice, interdisciplinary health care teams, models of care, and staffing levels. Anecdotally, Roch et al. (2014) commented in their data analysis, "Respondents had difficulty defining RNs' proper role in specific nursing practices involving interactions with patients" (p. 236). Harvey and Priddy (2011) acknowledged that there was role confusion with RNs, RPNs, and personal care attendants, but focused primarily on the cost savings of the changes which, Duncan, et al. (2014) noted, "reflects the growing replacement of RNs by nurses with less educational background" (p. 626) and thus, a need for role clarity.

In recent years in Canada, there has been a growing discussion of the need for role clarity and collaboration between RN and LPN/RPN roles. MacKinnon et al. (2018) discussed working to full scope in British Columbia by examining the social organization and experience of registered nurses and licenced practical nurses working together in a "team-based, functional nursing care delivery model" (p. 1). Only one study (MacNaughton et al., 2013) mentioned role confusion in Ontario; however, this study focused primarily on nurse practitioners' interactions (a role not addressed in this study) with other health care professionals, some of which included RNs and RPNs. It appears the most recent literature did not directly address RN and RPN role ambiguity in practice except in a commentary manner, indicating a need for research. Ganann et al. (2019),

conducted a scoping review of home care nurses' skill mix and found that role clarity was a key factor in the optimization of nurses in the community, but offered no solutions as to how to achieve this. Lankshear et al. (2016) posited that enhancing the role clarity of the practical nurse was a leadership imperative, for which they developed a Registered Practical Nurse Role Clarity Questionnaire and administered it to RNs, RPNs and administrators. Statements such as "the role of the PN is clear" resulted in less than 50% of practicing nurses and only 53% of administrators in agreement, indicating that there is a significant amount of role confusion, and therefore, a need for work in this area. MacKinnon et al. (2018) examined the care delivery model redesign at two Canadian hospitals where RN numbers were decreased and RPN numbers were increased in the staffing mix. This resulted in RPNs working to full scope of practice and RNs taking over care of unstable clients and coordinating the care of the unit including discharge planning, client transfers, and bed management. The authors concluded that the new model increased fragmentation of care, but acknowledged the complexity of looking at this single issue in the face of the multiple discourses occurring in nursing practice. Martin & Weeres (2016) reviewed the evolution of the practical nurse role since its inception in World War II and presented the case for nursing practice to return to its roots of nursing process to assist in clarifying the roles and appropriate use of RNs and RPNs in the clinical setting. They added that, "Research shows that the problem of LPN role ambiguity remains widespread, despite the availability of good resources intended to enhance LPN practice, facilitate nursing skill mix in decision-making, and ultimately improve patient care and patient outcomes" (p. 110). It is important to note that the research cited by Martin and Weeres predates the latest and previous version of the RPN entry-to-practice competencies; as well as the Nursing Act legislative changes request in 2020 by the Ontario government, yet to be implemented by the CNO (2020b), expanding the RPN role to be able to initiate certain controlled acts. Moore et al. (2019)

examined the factors influencing collaboration among RNs and RPNs and suggested that one strategy to improve collaboration would be to have joint education programs for RNs and RPNs. Nonetheless, the challenge remained that all but one of these publications predated the latest RN and RPN entry-to-practice competency updates (CNO, 2019a; 2019b). In addition, they addressed the existence of the problem, but did not provide a means as to how to increase the clarity between roles. These articles were primarily practice-focused in nature, so a search specifically focusing on nursing education literature was undertaken.

2.2 Nursing Education

The nursing education literature revealed few sources discussing role confusion, creep, collaboration, and clarity between RNs and RPNs in Canada. Martin-Saarinen (2008), in her master's thesis, traced the history of practical nursing education in Canada and suggested that nursing education needs to find ways to create opportunities for RNs and RPNs to study together to enhance collaboration and nursing knowledge. Butcher and MacKinnon (2015) conducted a case study analysis of practical nursing education in Canada with the purpose of beginning a dialogue about "conceptualizing nursing as one or more profession(s) and how this may impact the relationship of PN education to the discipline of nursing" (p. 238). They concluded that more research should examine the recent changes in nursing and how this new landscape may affect patients and the staff mix caring for them.

Limoges and Jagos (2015), examined how nursing education influenced RN and RPN intraprofessional relations in student practice. Their study, conducted at a community college in Ontario, Canada employed discourse analysis of nursing student's reflective journals and interviews of RN and RPN nursing students. The study found that students used historical perspectives of nursing hierarchy to differentiate their roles, exemplified by students' use of terms, such as "moving up to the BScN program" or

"moving down to the PN program" (Limoges & Jagos, 2015, p. 1026). In addition, students reported that the segregation of their schooling led to a lack of understanding of the other's roles until they entered the practice environment as a nursing graduate. Students noted that they had difficulty figuring this out during their clinical placements as they felt uncomfortable asking these questions of staff and teachers. Limoges and Jagos (2015) claim that their research is "the first to consider the power relations and ruling discourses housed within intraprofessional nursing education," (p. 1027). As a follow-up to this research, they examined an opportunity for joint education of RNs and RPNs in 2016. A key conclusion to their work noted that "joint education enhances collaboration between nursing designations by placing a focus on the actual knowledge, skill, and judgment rather than on the hierarchies established through credentialing" (Limoges & Jagos, 2016, p. 623). Despite these important findings, their studies failed to address the entry-to-practice documents and practice regulations that assist to differentiate nursing practice in Ontario, leaving one to question: How do students, graduates, and employers understand the unique role of the RN as compared to the RPN within the context of the prescribed curriculum and practice regulation? Limoges et al. (2018) conducted a qualitative study interviewing nursing faculty on their understanding of role clarity and collaboration between RN and RPN roles. They found that the power relations and hierarchy of having a university collaboration for RN education questioned the legitimacy of the college program (Limoges et al., 2018). In addition, they found that faculty themselves struggled to understand the differences between the two professional roles.

After an extensive search of published literature, it appears that there is a significant lack in examining the difference between RN and RPN entry-to-practice expectations and role clarity. It appears that this stems from a failure to address this issue in nursing education. Therefore, professional role clarity, from the standpoint of

the regulatory requirements and distinctions, that underpin curriculum development, needs researching.

2.3 Nursing Curriculum

The development of nursing curriculum in Ontario is achieved using the entry-to-practice competency documents as a framework to ensure that the educational program meets the minimum requirements for approval. The College of Nurses of Ontario (CNO) oversees this process and grants approval to programs that then must maintain a standard throughout its existence. The current state of curriculum and content development are interwoven into the understanding of the competencies, and therefore, will be discussed in greater depth in Chapter 4. However, I felt it was important to trace how nursing education and curriculum has developed over time to influence the present situation.

2.3.1 The Curriculum Revolution of the 1980s

In the mid-1970s, nursing educators in the United States began to feel discouraged by the Tylerian approach to curriculum delivery in nursing schools (Ironside & Valiga, 2007). Tyler's Rationale (1949) structured the function of curriculum based on four questions:

1) What educational purposes should the school seek to attain?
2) How can learning experiences be selected which are likely to be useful in attaining these objectives?
3) How can learning experiences be organized for effective instruction?
4) How can the effectiveness of learning experiences be evaluated? (Tyler, 1949, p. 1)

Tyler (1949) posited that, as well as examining the purpose of a curriculum and learning, it was important to study the learners themselves. "A study of learners themselves would seek to identify *needed changes in behaviour patterns* [italics added]

of the students which the educational institution should seek to produce" (p. 6). However, these were viewed as being prescriptive in nature and linear in approach with the evaluation of learning objectives (changes in behaviour) being perceived as the forefront of the Tyler Rationale (Kliebard, 1970). This was the type of approach to learning that I experienced when I went to nursing school. I found it to be very prescriptive and based on conforming to regimented behaviours that were deemed to be the only way to be "professional" and to pass the clinical courses. I was encouraged to think critically about what was happening with the health of my patient, but was discouraged to think of possibilities other than what was the usual way of doing nursing practice. As a creative thinker, this was a great source of frustration for me and caused me to contemplate quitting the program on several occasions. I felt trapped in a rule-driven, unidirectional way of doing and thinking. As a young adult, if it were not for my parents pushing me to finish, I would have quit. This would have been my greatest mistake. I would have missed the realities of nursing practice and the need for creative thinking in care provision, teaching, and curriculum development. My experience must not have been unusual, for there was a turn in nursing curriculum on the horizon.

The National League of Nursing (NLN) in the United States was instrumental in initiating the conferences to discuss how to change the curriculum to better meet the needs of students. At the time, the NLN felt there was felt a need to move away from objectives-based education and look to new approaches to educate nurses (Ironside & Vaglia, 2007). The discussion and revolution reached a fever pitch in the late 1980s (during the time that I was attending community college to obtain my nursing diploma). Several scholars developed new pedagogies based on critical social theory, caring, phenomenology, and feminism (Allen, 1990; Bevis, 1982; Bevis & Watson, 1989; Chinn, 1989; Diekelmann, 1988). These researchers felt a need to move away from the training model where the student did what they were told and independence was considered a

negative characteristic of a student, to look at nursing and patient care from a more holistic perspective.

Diekelmann (1988) felt that the revolution was possible only when nursing education could transform the accreditation process and look at the curricular as well as at the instructional level. She felt that the accreditation process was impeding the process of transformation for nursing education. At that time, a successful accreditation review meant that you had clear learning objectives and evaluation methods that addressed the content delivered, which was very much in line with Tyler's (1949) curriculum model (Tanner et al., 1988). Instead, Diekelmann called for a flexible accreditation process that would permit curricula to allow for a process orientation to learning and frequent change if necessary. She felt that clinical nursing would be an excellent learning space to incorporate phenomenological models where the student can discover what it means to be human, and how others enact this in the world. She believed that meaning-making should be an integral part of becoming a nurse and the lived experience should be examined and celebrated. Additionally, Diekelmann posited that a critical model should be coupled with the phenomenological model to understand the power imbalances in the student-teacher and nurse-patient dynamic, as these also contribute to how one exists in the world. Diekelmann proposed *Curriculum as Dialogue and Meaning* where nursing education teaches conceptually; and students need not move from unit to unit and specialty to specialty to gain vast experience, but suggested that immersion into the nursing culture may provide greater learning and experience by which to enter the nursing profession. However, this was not the only view expressed in the curriculum revolution.

Allen (1990) suggested that nursing education needs a critical social theory (CST) lens by which to view how we educate nurses and how we teach them to look at the world in which we practice and live. CST recognizes and appreciates the unique

world view of each individual and how they perceive, and are perceived by, others. Allen felt that this element was missing in nursing education as it socialized students into being other than themselves. In turn, educators also had to hide or limit showing of self to reach an ideal of being a nurse. Power imbalances between student and teacher, teacher and employer, and nurse and patient needed to be recognized and acknowledged as affecting these relationships. Allen called for a less rational form of education and an end to creating a product, otherwise known as a nursing student. However, with the critical social theory approach, the power dynamic in CST did not address the feminine dominance of the nursing profession.

Peggy Chinn (1989) asserted that feminist pedagogy should be incorporated into nursing education due to the dominance of women in the profession. At the heart of feminist pedagogy is the concept of reflection and an understanding of power in relationships. Chinn stated that it was important for a profession dominated by women to accept and embrace the unique position and perspectives that are inherent in nursing. Chinn and her colleague Charlene Wheeler conceptualized several powers related to teaching and learning. These included the power of process, the power of letting go, the power of the whole, the power of collectivity, the power of unity, the power of sharing, the power of integration, the power of nurturing, the power of intuition, the power of consciousness, the power of diversity, and the power of responsibility (Chinn, 2018). Using these elements, she presented a practical course outline and overview of how these powers could be explored in a nursing course. Despite these suggestions, in my personal nursing experience, many of the powers have yet to be incorporated fully into nursing curriculum.

Em Bevis (1982) along with her colleague Jean Watson (Bevis & Watson, 1989) worked tirelessly on the caring curriculum. This model, developed in such detail, at first looks as if it is a grand theory of nursing. However, on closer inspection and

understanding, it framed a way for a curriculum to explore how a nurse should approach the systems involved in client care and how to examine possible solutions that can be generated by nursing. It was this overarching theme of nursing's capacity to care and consider multiple elements of a client's life spaces and life ways that would allow the nurse to care for the patient holistically (Bevis and Watson, 1989). Caring was central to understanding the patient's experience, as it was caring that led the nurse to explore with the client the multiple facets that were intertwined in one's life that could be influencing health and well-being. She considered caring to be the "moral imperative of nursing education" (Bevis, 1989, p. 84). In 1988, Bevis suggested that nursing needed a new direction for the coming age and that there had been many turns in nursing curriculum. She suggested that the first turn in nursing education dated back to the 17th century religious orders, and the last being in 1987 where the emphasis was teaching in a practice discipline. Since then, I suggest that we have been through an additional turn in nursing education, with a focus on concepts and a move away from a medical model basis for content (Benner, 2011).

2.3.2 The New Millennium

"The purpose of nursing programs is to graduate nurses who can practice competently in a changing healthcare environment" (Iwasiw & Goldenberg, 2015, p. 80). The education of nurses, therefore must reflect the needs of individuals, families, communities, and populations in health and illness. Nursing curriculum involves learning complex content in the cognitive, affective, and psychomotor domain (Bloom, et al., 1956; Anderson & Krathwohl, 2001). Tyler (1949) had previously stated that it was important to provide appropriate educational experiences: "Students must have experiences that give him [*sic*] an opportunity to practice" (p. 65). In nursing, this encompasses clinical practice. In the program in which I teach, each week students enter the clinical setting to provide holistic care to clients. For example, in the first

semester in some schools, students do not go into a clinical setting, but learn the behaviours expected of them for clinical practice, such as professional demeanor, communication skills, basic hygiene skills, and physical assessments. Giddens and Brady (2007) declared, “Nursing programs have traditionally offered content-laden and highly structured curricula with an emphasis on behavioural outcomes fostering linear thinking,” (p. 67). This linear thinking left graduate nurses with a lack of critical thinking and clinical judgment abilities upon graduation. With the changes to registered nursing education from diploma to degree preparation, the minimum number of hours of clinical practice to complete before graduating was eliminated. Prior to this change, the registered nursing student was required to complete 1600 hours of practice prior to graduation. In Ontario, the government in conjunction with the Registered Nursing Association of Ontario (RNAO) created a program in 2008, the *Nurse Graduate Guarantee* [NGG] (Health Force Ontario [HFO], 2015) to cope with the lack of clinical preparation of new graduate nurses. This program allowed new graduate nurses to apply for time-limited positions in participating health care organizations. In the NGG, new graduates were to function as extra staff, over and above the normal staffing ratio for a period of 12 to 26 weeks. After 12 weeks, students could accept a permanent part-time or full-time position in the organization, if offered (HFO, 2015). This was a fantastic opportunity for some new graduates to gain valuable nursing experience not obtained during their formal education; however, the question became one of sustainability and the program was discontinued in 2015. This program addressed the shortcomings of a nurse’s formal education, but I questioned whether that belonged as the responsibility of the taxpayers or whether educational institutions should be accountable for the gap from theory to practice. Iwasiw and Goldenberg (2015) stated, “A compelling single situation, or a combination of circumstances, can result in the view that the existing curriculum is no longer working as effectively as desired, is outmoded in some way, or is not as

responsive to the context as it should be" (pp. 80-81). Recently in Ontario because of the staffing issues attributed to the pandemic, there was a revivification of the new graduate guarantee (Ontario Ministry of Health, 2022). However, I question whether this will solve the issues that nursing education is facing in the 21st century.

Benner (2011) provided a multi-pronged approach to dealing with the issues facing nursing education in the 21st century. She posited that all graduate studies in nursing should contain a component of education. Many nursing educators do not have a formal teaching training program to become faculty; they are often clinical experts recruited for their knowledge of a topic, not their ability to teach (Giddens & Brady, 2007). Benner (2011) further adds that curriculum needs to move to building deeper learning of key scientific concepts in a clinical framework and away from a "superficial gloss over a lot of topics" (2:13) found in the rational-technical model. With the volume of content covered in a course, nursing professors tend to fill the pails of students and then ask them to connect the dots on their own (Eisner, 2002) leading to what one colleague calls 'bulimic learning' (D. R., personal communication, June 6, 2022). Ndawo (2015) agrees: "With this type of instructivist teaching, learner nurses experience frustration, they are overwhelmed with this excessive content that they must learn, there is excessive reading assignments, content processing and memorization" (p.104). In retrospect, my personal experience tells me that nursing faculty assume that they must teach information for students to cope in the clinical environment, rather than students exploring and learning for themselves as the need arises.

Giddens and Brady (2007) felt that it was time for a change in nursing education. However, those trying to revise curriculum found that "... none of the core knowledge and competencies identified could be eliminated … [and] changes have made it difficult to determine essential knowledge and skills. [In addition] faculty members protect content associated with their own clinical expertise; thus, such

attempts usually result in nothing more than a rearrangement of content" (Giddens & Brady, 2007, p. 65). The student perspective provided me with tremendous insights into the content-based curriculum and supported the statements in the literature. One former student noted:

> A lot of students just memorize the steps instead of actually knowing what you are doing. … In nursing school, you don't have that confidence because you have been given so much stuff to remember and you can't…there too much in certain areas. (S. D., personal communication, November 7, 2015)

A second student, supported her colleague's view.

> [We need] more clinical based stuff. Less theory. I don't know if that can happen. Minimize the theory and everything in first year then introduce a clinical based course to get us prepped for second year would probably be fantastic… [and then] patient situations in year three. (A. S., personal communication, November 7, 2015)

Without knowing it, the two newer graduates at the time of the discussion identified the desired teaching and learning style of concept-based curriculum. "An organizational shift from a medical or practice model to a conceptual approach requires a complex curriculum design and is a "quantum leap" for faculty working within the structures mentioned above" (Giddens & Brady, 2007, p. 67). Concept-based curriculum has garnered much research and reporting in the literature (Anderson & Tollefson, 2016; Giddens et al., 2012; Goodman, 2014; Hardin & Richardson, 2012; Lewis, 2014; Murray et al., 2015; Patterson et al., 2016). More than ten years after its introduction, some nursing schools have integrated this curricular approach while others have not embraced this move, and yet others are in process of changing their curriculum structure (Deane, 2017).

Regardless of curriculum delivery method, when looking at the entry-to-practice competencies, it is difficult for lay people, or even nursing professionals, to discern the difference between the RN and the RPN expectations of practice. The language is similar in many cases although set up in a different manner (CNO, 2019a: 2019b). Furthermore, some textbooks available for both programs are identical. For example, the nursing fundamentals textbook used in one community college is the same for both RN and RPN practice. One publisher, in its most recent edition, added a chapter on practical nurse practice at the end of the book, in what appeared to be an afterthought (Potter et al., 2019). Despite knowing the basics of how the entry-to-practice competencies are determined, I had many questions as to why there are overlaps in the competencies, and by *de facto* the curriculum of RN and RPN education.

2.4 The Research Study

As is evident, no one has compared or analyzed the documents that guide and shape RN and RPN entry-to-practice or nursing education, and therefore, its curriculum. Researchers have discussed ways from a practice perspective and intradisciplinary educational opportunities to assist nurses and nursing students to better understand each other's roles but no one has undertaken the task to do an in-depth analysis of the competencies themselves. It is this endeavor that I believe will provide the greatest clarity for all and provide a substantive and tangible outcome to guide nurses in Ontario. Yet, I recognize that this dissertation work will have a limited shelf life because this interpretation is based on current documents and cannot address further revisions and updates. I am also aware that I am biased by my insider status as a nurse educator and several years in the profession. My interpretation may be blinded by taken-for-granted assumptions, yet this also provides me with a unique understanding of the situation that those outside of nursing education and practice cannot provide. This is

the reason I chose to use Critical Discourse Analysis as a methodology and Critical Social Theory and Feminist Poststructuralist Theory to underpin the analysis.

Chapter 3

3 Methodology and Theoretical Frameworks

Critical Discourse Analysis (CDA) was chosen as the best fit for the questions I had about the discourse of RN and RPN ETPC documents. Ontologically and epistemologically, CDA aligned in its analysis of not only the linguistics of the documents but also the formation and social context that shape their creation. In looking at CDA, there were significant ties to both Critical Social Theory (CST) and Feminist Poststructuralist Theory (FPT). Each of these theoretical lenses mentioned, served to view the analysis of the discourse (CST) and the recommendations (FPT) that arose from this work. To determine the theorist's perspectives that best fit my work, I undertook a survey of the literature of each and walk you through my process of discovery in this chapter.

3.1 The Roots of Critical Discourse Analysis

Critical discourse analysis (CDA) arose out of the work of Teun Van Dijk, Ruth Wodak, and Norman Fairclough after meeting at a critical linguistics symposium in Amsterdam in 1991 (Wodak, 2001). CDA was influenced by the work of Jürgen Habermas (a German philosopher and critical social theorist) and his critical views of language (Wodak, 2001). In determining the approach that I wanted to employ, I examined each of their ideas and approaches to CDA.

3.1.1 Teun Van Dijk

Van Dijk (2001) asserted that CDA is discourse analysis that "combines what perhaps somewhat pompously used to be called 'solidarity with the oppressed' with an attitude of opposition and dissent against those who abuse text and talk in order to establish, confirm or legitimate their abuse of power" (p. 96). Further, Van Dijk

suggested that CDA work is biased as it looks to reveal the power structures in place that keep dominant voices dominant. Therefore, there is a responsibility of the CDA researcher to be mindful that a process for CDA is followed and is, most importantly, relevant to the concerns of the dominated that clearly and explicitly states findings without obfuscating the evidence through jargon and esoteric language (Van Dijk, 2001). He considered his way of conducting CDA work was "that of 'socio-cognitive' discourse analysis" (van Dijk, 2001, p. 97).

Van Dijk divided his view of CDA into three levels of examination. The macro, or topical, or socio-cultural level was what he suggested to address first in an analysis of text. "It provides a first, overall, idea of what a discourse or corpus of texts is all about, and controls many other aspects of discourse and its analysis" (Van Dijk, 2001, p. 102). He proposed creating a list of the 'macropositions' of a text to accomplish this. Macropositions were power, inequity, and position in society and these affected the credibility and potential for uptake of the discourse by the greater society. The next level of the discourse that Van Dijk (2001) examined was the structural functional level, also called the local level. He looked at the process of discourse, the connotation of words, the coherence and themes of words, and most particularly, the modalities in which discourse was performed (Van Dijk, 2001).

> Thus, if we want to study – as would be typical in CDA – the ways some speakers or writers exercise power in or by their discourse, it only makes sense to study those properties that can vary as a function of social power. Thus, stress and intonation, work order, lexical style, coherence, local semantic moves (such as disclaimers), topic choice, speech acts, schematic organization, rhetorical figures and most forms of interaction are in principle susceptible to speaker control. But other structures, such as the form of words and many structures of sentences are grammatically obligatory and contextually invariant

> and hence usually not subject to speaker control, and hence irrelevant for a study of social power. (Van Dijk, 2001, p. 99)

The macro and local level discourse were often a strategy that positioned the creator of the discourse in a positive light and the intended audience in the negative. In examining these levels, it was important to look at the context and event models in each of these levels. It is this that Van Dijk (2001) was primarily focused on the meso, or the socio-cognitive level. "Local context is usually defined in terms of properties of the immediate, interactional situation in which a communicative event takes place" (Van Dijk, 2001, p. 109). Context models were crucial in Van Dijk's view as they reconciled the mental knowledge of the event and the meaning of the discourse. "In a rough sense, we may say that context models control the 'pragmatic' part of discourse and the event models the 'semantic' part (p. 112). In these mental models were social representations of knowledge, attitudes, and ideologies.

Van Dijk (2001) asserted that people had three types of knowledge: personal, group and cultural knowledge. Personal knowledge was represented in the mental model discussed above. Group knowledge was that shared by professional organizations, businesses, and specific social movements. The knowledge of groups was considered biased and may have been known to other groups as ideations or beliefs (Van Dijk, 2001). Group knowledge could be highly specialized as in the case of the nursing profession. Cultural knowledge was viewed as the social norms and practices of all members of the society or culture (Van Dijk, 2001). Attitudes were socially shared opinions and ideologies, and as mentioned above, were the knowledge of groups (Van Dijk, 2001). From these types of knowledge there were the concepts of social situations, action, actors, and societal structures that were central to understanding the nature of discourse (Van Dijk, 2001). Social situations described the settings in which discourse would occur, but one must have the cognitive capacity to see

the settings as relevant to the discourse. Action was the consequence of discourse that was derived from the analysis of social and political factors. Actors were the various types of speakers, writers, and producers of discourse as well as the recipients of said discourse. Societal structures defined the roles that actors embody in the uptake of the discourse and the social acts are the processes that situate the discourse (Van Dijk, 2001). After reviewing Van Dijk's (2001) basic components of this approach to CDA, I do not believe it fits with my goal for this project. The multimodality in which the discourse is presented, and the macro, meso, and local levels do not seem to fit with the way the entry-to-practice competencies are disseminated and taken up. Therefore, I turned to the work of Ruth Wodak.

3.1.2 Ruth Wodak

Ruth Wodak clearly defined the role of being critical in research. Gavin Kendall interviewed Ruth Wodak for an article in 2007 and she discussed how she got started and continued doing critical discourse analysis. In their discussion, she emphasized that criticality meant "not taking things for granted, opening up complexity, challenging reductionism, dogmatism and dichotomies, being self-reflective in [her] research and through these processes making opaque structures of power relations and ideologies manifest" (Wodak, 2007, para 17). Further, she stated that her contribution to CDA was the focus on interdisciplinary work and using a "discourse-historical approach" to CDA (Wodak, 2007). Wodak also indicated that she focused on the argumentation and rhetorical theory of texts rather than on functional linguistics and grammar. As well, she felt that in her approach there needed to be a person who understood the contextuality first-hand, an insider if you will, to make evaluations that were specific to the context or situation as someone from the outside would not be able to see the subtleties that exist. She viewed triangulation as a strategy to reduce the bias that may come from this insider view (Wodak, 2001). Triangulation used multiple methods in obtaining data to

increase the “confidence in the findings” (Heale & Forbes, 2013). Patton (2015) described four types of triangulation that could enhance a study’s credibility: 1) consistency of data sources within the same method, 2) using mixed methods - qualitative and quantitative, 3) using more than one person to analyze the data, and 4) using multiple theories to investigate the data.

Wodak’s (2001) discourse-historical approach to CDA was to look at discourse more as informing a set of symptoms rather than searching for the causes of the discourse. She felt that this was a pragmatic way of looking at discourse. The early critical theorists from the Frankfurt School had directed their efforts to debate the existence of multiple truths in society and approaches to reveal them, whereas Wodak was seeing CDA as a utilitarian effort to seek clarity for the specific problems in the discourse being investigated. She viewed the discourse-historical approach as looking at three types of critique: text or discourse immanent critique, socio-diagnostic critique, and prognostic critique (Wodak, 2001). Text or immanent critique examined inconsistencies and contradictions in the “text-internal or discourse internal structures” (Wodak, 2001, p. 65). Socio-diagnostic critique examined the manipulative or persuasive characteristics of a text or discourse. This was where the insider knowledge was useful by being able to view the discursive event in a broader social and political lens. The last form of critique, prognostic, looked at how language could be changed to be more accessible and less sexist or biased (Wodak, 2001). These three types of critique shaped the way the researcher examined the discourse. Wodak was clear that there is a difference between discourse and texts.

> ‘Discourse’ can thus be understood as a complex bundle of simultaneous and sequential interrelated linguistic acts, which manifest themselves within and across the social fields of action as thematically interrelated semiotic, oral or written tokens, very often as ‘texts’ that belong to specific semiotic types, that is

> genres…the most salient feature ... is the macro-topic, like unemployment … [whereas] ‘texts’ can be conceived as materially durable products of linguistic actions. (Wodak, 2001 p. 66)

Wodak also stressed that there were several important characteristics of her approach to CDA. These included:

1. The approach is interdisciplinary.
2. Interdisciplinarity is located on several levels: in theory, in the work itself, in teams, and in practice.
3. The approach is problem oriented, not focused on specific linguistic items.
4. The theory as well as methodology is eclectic; that is theories and methods are integrated which are helpful in understanding and explaining the object under investigation.
5. The study always incorporates fieldwork and ethnography to explore the object under investigation (study from the inside) as a precondition for any further analysis and theorizing.
6. The approach is abductive: a constant movement back and forth between theory and empirical data is necessary.
7. Multiple genres and multiple public spaces are studied, and intertextual and interdiscursive relationships are investigated. Recontextualization is the most important process in connecting these genres as well as topics and arguments (topoi).
8. The historical context is always analyzed and integrated into the interpretation of discourses and texts.
9. The categories and tools for the analysis are defined according to all these steps and procedures as well as to the specific problem under investigation.

10. Grand theories serve as a foundation (see above). In the specific analysis, middle range theories serve the analytical aims better.
11. Practice is the target. The results should be available to experts in different fields and, as a second step, be applied with the goal of changing certain discursive and social practices. (Wodak, 2001, pp. 66-67)

In addition to these 11 principles there were five discursive strategies used to examine the discourse. They were:

1. Referential/nomination (the use of metaphors to depersonalize or categorize in- and out-groups),
2. Predication (labelling social actors as either positive or negative in the discourse),
3. Argumentation ("topoi used to justify political inclusion or exclusion, discrimination or preferential treatment"),
4. Perspectivation (framing or discourse representation and speaker's point of view), and
5. Intensification or mitigation ("intensifying or mitigating the illocutionary force of (discriminatory) utterances"). (Wodak, 2001, p.73)

Wodak's work at first intrigued me as she used a historical approach to discourse analysis, and I believe that history serves as a starting point or perspective to begin an analysis of discourse. However, as she began to discuss the argumentative approach, I found it did not fit with the aims and goals of this research project. I turned to the work of Norman Fairclough.

3.1.3 Norman Fairclough

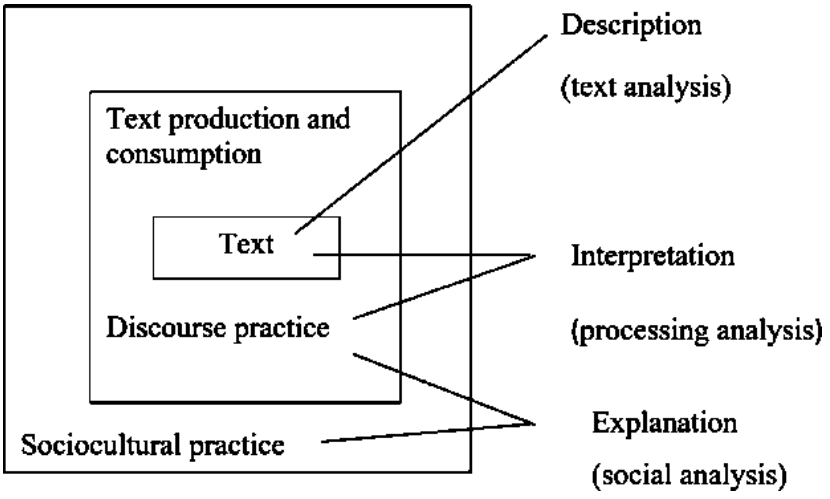
Much of what Wodak and Van Dijk wrote was based on the work of Fairclough (1992) who advocated for the analysis of the words and language of written and spoken texts, not in isolation, but to consider the political and social context in which they were

created, disseminated, and taken up by consumers of the texts. It is for this reason that I chose to use Fairclough's (1992) 3D model of Critical Discourse Analysis as he saw the term 'discourse'…as a form of social practice, rather than a purely individual activity…[implying] that discourse is a mode of action" (p. 63). Furthermore, "Discourse is a practice not just representing the world, but of signifying the world, constituting and constructing the world in meaning." (Fairclough, 1992, p. 64). Fairclough (1992) proposed that within discourse there are three functions of language: identity, relational, and ideational. Identity refers to how social identities are constructed in discourse. Relational refers to "how social relationships between discourse participants are enacted and negotiated" (p. 64). Finally, ideational refers to how the text expresses the world and the processes, relationships, and structures contained within it.

The 3D model of CDA looks at the text and its analysis as the first or core level (See figure 3.1).

Figure 3.1

Fairclough's 3D Model of Discourse Analysis (Fairclough, 1995, p.98)



In text analysis, Fairclough (1992) proposed that there are four main approaches in which to perform the analysis: vocabulary, grammar, cohesion, and text structure. Vocabulary was not merely the dictionary definition of words but more about the wording, meaning, and metaphor in terms of the context in which they occur (Fairclough, 1992). Grammar was concerned with the clause of a sentence rather than the finite points of grammar. Each clause's creation was a representation of "social identities, social relationships, and knowledge and belief" (p.76). Cohesion was based on how clauses linked to form sentences and how these form texts. Linkage was achieved by using vocabulary related to a specific field of study, the use of repeating words, synonyms, and grammatical devices such as pronouns and conjunctions, and thereby formed the architecture or structure of the text. However, Fairclough posited that it was difficult to analyze the text without talking about the discursive practices that underpin the production of the text (the second level).

In discursive practices, force (speech acts), coherence, and intertextuality were the three approaches to consider. Force was the active component of text, in terms of what speech acts that Austin (1975/1955) called locutionary (order), illocutionary (intention or suggestion) and perlocutionary (emotional suggestion). Coherence referred to the making sense of a document. Fairclough (1992) indicated, "that a text only makes sense to someone who makes sense of it, someone who is able to infer the meaningful relations in the absence of explicit markers" (p. 84). In other words, could the consumer of the text understand how sentences were woven together to make sense of the whole even though they may not be explicitly linked to each other? Intertextuality was the reference, either explicit or inferred, to other texts that existed and may have informed the current text under consideration. "The concept of intertextuality sees texts historically as transforming the past – existing conventions and prior texts – into the present" (Fairclough, 1992, p. 85).

Fairclough (1992) identified intertextuality as a foundational concept of performing CDA. All writing was influenced by other texts and all utterances were composed whether overtly or covertly of other written work, thus referring in one form or another to history – a manifest intertextuality. Fairclough (1992) further distinguished that history was related to hegemony and arose from the previous texts' influence, which could control the production of current and future texts. However, the way elements were written created ambiguity in the intertextuality of a text. If written in third person and passive opinion was presented, did it reflect the actual words of the person or was there interpretation occurring? For example, if I said that nursing students say that their schoolwork is overwhelming, are the students really saying this or would I be inferring this from comments made? By using this type of verbiage, the intertextuality of the document was not clear. Did the students really say this or did the writer interpret their words? Fairclough (1992) viewed this as a form of discourse representation in manifest intertextuality.

A second feature of manifest intertextuality was presupposition. In texts, the writer proposed certain 'givens' in the way that they created sentences. Fairclough (1992) used the example of the word 'that', which he indicated was an action that had taken place for a specified purpose. Another example he provided was if one were to examine a text and presuppose that there was no intertextuality, then a sentence on its own could contradict itself; as he exemplified "the Soviet threat is a myth" (p. 120). Without intertextuality this sentence presupposed that there was a soviet threat and then contradicted itself in saying it is a myth; however, if one used intertextuality and understood that someone has commented before that there was a Soviet threat then the idea that it was a myth could be understood as having historical context, and therefore, intertextuality (Fairclough, 1992).

A third feature of manifest intertextuality was negation (Fairclough, 1992). Negative clauses in sentences set the stage for disputes or controversies to be implied and discussed. It created a specific and potentially argumentative stance from the writer challenging the beliefs and stance of others on an issue.

A fourth feature of manifest intertextuality was metadiscourse. Fairclough (1992) asserted that there were three ways that a producer of texts could signal metadiscourse, or stepping outside and above the discourse. One was the use of hedging where the writer did not make a declaration but 'sort of' or 'kind of' eluded to the possibility that something may be a fact. Another was the use of metaphors or expressions to indicate that a part of the discourse belonged to another source. The last way that Fairclough indicated metadiscourse was the use of paraphrasing to explain another person's discourse. This last way was a very common method of metadiscourse used in scholarly writing as someone tried to explain what the original author was saying, but in their own words. As you can see, this has been used extensively in this document.

Irony was the last form of manifest intertextuality; however, in Fairclough's (1992) work, it was more than just saying something and meaning the opposite or something different. Irony was more than this simplistic view. One of the functions of irony was sarcasm or anger but was dependent upon the utterances of others before. Fairclough (1992) suggested that irony was the negative attitude towards a previous utterance. For example, your friend suggests that it would be a "great day to go for a car ride" during the car ride you get into an accident and you say with a different tone and inflection, "Yah, it was a great day for a car ride." This sarcasm reflected a negative attitude towards the first utterance. In Alanis Morrissette's (1995) hit song *Ironic,* she provided multiple examples of irony. In the line "It's a free ride when you already paid" there was a presupposition that someone told her that she had to pay for her ride, but when she gets to the ride, it says it is free. She provided examples of irony but was not using

sarcasm by repeating the words that someone else spoke verbatim. This element and example lead to the next concept of intertextuality, interdiscursivity.

Interdiscursivity (constitutive intertextuality) related to the genre of the discourse and how the style of writing or speaking may be associated with the audience for which it was intended, and the mode of delivery whether it was debate, exposition, or persuasion (Fairclough, 1992). In other words, the order in which a discourse was presented may be purposeful to engage persons taking up the discourse. Fairclough indicated that the "view of genre that I am adopting here is that it allows us to give due weight to both the way in which social practice is constrained by conventions, and the potentiality for change and creativity" (p. 126). He further indicated that "genre tends to be associated with a particular style [and that styles varied] along three main parameters, according to the 'tenor', 'mode' and 'rhetorical mode' of the text…" (p. 127). Tenor referred to the way in which participants communicated in an interaction, whether it be formal, as in a meeting with a superior at work about a concerning issue, or official as in an announcement by the government about new laws or potential legislation. Mode referred to how the discourse was communicated: written, spoken, or variations between the two. Rhetorical mode referred to the idea that if you were trying to persuade someone to buy something, it was a far different rhetorical mode of discourse than that, say, of a novel or a report.

The last element of intertextuality was that of transformations. Transformations, as its name indicated, was how discourse was transmitted or distributed and how it changed during its creation and dissemination. Fairclough (1992) provided examples to best explain this concept. One was that of medical consultations being transformed into medical records. Intertwined in transformation were the "transformational chains" (p. 130) that linked how the consultation morphed into the medical record. These chains were "sequential or syntagmatic" (p. 130). From my knowledge of the health care

system, in this example the transformational chain may include links such as interviewing and examining the patient, collating thoughts through verbal dictation into a device, converting the verbal recording into a written document by a transcriptionist, review of the written document by the care provider, corrections by the transcriptionist, and then placing it into the patient's medical record where it may be examined and taken up by other health professionals within the circle of care. Adding further to this example was the concept of coherence.

Coherence was a "property which interpreters impose upon texts, with different interpreters (including the producer of the text) possibly generating different coherent readings of the same text" (Fairclough, 1992, p. 134). Coherence was related to the presuppositions that the interpreters of the text brought with them before reading a text. "Texts postulate, and implicitly set up interpretive positions for, interpreting subjects who are 'capable' of using assumptions from their prior experience to make connections across the intertextually diverse elements of a text, and to generate coherent interpretations (Fairclough, 1992, p. 135). In other words, the consumer/reader of the text comes with previous knowledge and experiences that inform how they take up the text and make sense of it. Fairclough (1992) asserted that it was the analysis of these discursive practices that linked the text to the social practice.

Discourse as a social practice examined the ability of discourse to convey both ideology and power (or hegemony). Fairclough (1992) had three claims about ideology:

> First, the claim that it has a material existence in the practices of institutions, which opens up the way to investigating discursive practices as material forms of ideology. Second, the claim that ideology 'interpellates subjects', which leads to the view that one of the more significant 'ideological effects' … is the constitution of subjects. Third, the claim that 'ideological state apparatuses' (institutions such as education or the media) are both sites of and stakes in class struggle, which

> points to struggle in and over discourse as a focus for an ideologically-oriented discourse analysis… [and goes on further to indicate] I shall understand ideologies to be significations/constructions of reality (the physical world, social relations, social identities), which are built into various dimensions of the forms/meanings of discursive practices, and which contribute to the production, reproduction or transformation of relations of domination. (p. 87)

In describing hegemony, Fairclough (1992) asserted that it was "the power over society" (p. 92) that wanted to create a disequilibrium by creating treaties and persuading the subordinate classes into not only submission to the elite's views but into adopting them as their own. "Hegemonic struggle takes place on a broad front, which includes the institutions of civil society (education, trade unions, family), with possible unevenness between different levels and domains" (p. 92). It was but one form of power as there remained the more traditional view of imposing rules and order on others. Regardless of type, power served to aid in the analysis of texts to reveal how documents may be constructed and distributed. Fairclough (2003) explained that:

> My approach to discourse analysis (a version of 'critical discourse analysis') is based upon the assumption that language is an irreducible part of social life, dialectically interconnected with other elements of social life, so that social analysis and research always has to take account of language. (p. 2)

For every document created by an organization or agency, there were forces behind its construction, language use and intent that shaped its meaning, context, importance, and impact (Fairclough, 1992). Fairclough's approach to CDA was one that looked to situate the texts in the sociocultural landscape by examining it on three levels. For this project, the three levels roughly translate to: tracing the development and evolution of the entry-to-practice documents – the sociocultural practice; determining how the documents were created and produced – the discourse practice; and comparing the texts themselves –

the text analysis. Text analysis could be performed by examining the language and syntax used in documents and/or at the thematic level. However, Fairclough (2003) saw less absolutes in relation to CDA:

> I see discourse analysis as 'oscillating' between a focus on specific texts and a focus on what I call the 'order of discourse', the relatively durable social structuring of language which is itself one element of the relatively durable structuring and networking of social practices. Critical discourse analysis is concerned with continuity and change at this more abstract, more structural, level, as well as with what happens in particular texts. (p. 3)

Fairclough (2003), when analyzing texts, indicated that he employed Systemic Functional Linguistics (SFL) which was primarily focused on the "relationship between language and other elements and aspects of social life…oriented to the social character of texts" (p. 5). Fairclough based his work on Halliday's (2005) work in SFL:

> Systematic analysis and explanation at all levels—phonetics and phonology, lexicogrammar, discourse semantics, context and register/genre—does turn out to be relevant to many situations in institutionalized teaching and learning. If systemic functional linguistics has a role in this enterprise, this is at least in part, I think, because the theory has tended to evolve in response to problems faced and questions raised outside of language itself. (p. 133)

There were elements of SFL that were integral to Fairclough's work when analyzing the text. One was *transitivity*, which referred to the way in which verbs were constructed to represent reality and who was depicted as the agent and the affected (Fairclough, 1992). For me, this also suggested the possibility that passive verbs may also delete agency of power by deferring it objectively. In a similar fashion, the *theme* of the work could be interpreted through the positioning of clauses in a sentence (Fairclough, 1992). In complex sentences with multiple clauses, the question became one of position of

importance. In my experience with writing, the first clause of a sentence either set the stage for the remainder or determined the agency of the 'person' - first, second or third. Another element of transitivity is *nominalization.* Nominalization was the implicit action by a group of words that acted as a noun in a sentence without mentioning the verb tense or modality of the action. Fairclough noted that this was common in medical and technical texts where some features were implicitly understood by the consumer of the text. Another feature of text examination, using SFL, was the *mood* of the sentence, clause, or overall passage. The mood was reflected in, what I would term, the tone of the sentence. A sentence could declare something, tell you to do something immediately or ask you a question. This also involved the use of vocabulary. Was the sentence or passage short, precise, and to the point; or, was it verbose, winding in a convoluted manner to get to the point. Fairclough asserted word choice, euphemisms, and metaphors worked to construct the ideology that foregrounded the written work.

Fairclough (1992) identified that one of the concerns of CDA was "ideological effects – the effects of texts in inculcating and sustaining or changing ideologies" (p. 9). Fairclough suggested that textual analysis must be considered in terms of social analysis and its impact on power relations. He expanded further stating that "the social effects of texts are mediated by meaning-making, or indeed that it is meanings that have social effects rather than texts as such. But one resource that is necessary for any account of meaning-making is the capacity to analyze texts in order to clarify their contribution to processes of meaning-making" (p. 11). However, Fairclough found challenges in meaning-making. "It is very difficult to be precise about the processes involved in meaning-making for the obvious reason that they are mainly going on in people's heads, and there are no direct ways of accessing them" (p. 11). This conceptualization then turned to one of authorship. For example, a document completed by an organization may have multiple authors, and these individuals may not have been

given credit for their work; so, the person who conducted the study would never know who truly wrote the document. Additionally, an identified author may have had input from others during the writing process, and these individuals were not known to the person conducting CDA. These external influences may serve to transform discourses over time.

Democratization, commodification, and technologization were major tendencies in the evolution of discourse practices. As Fairclough (1992) indicated, “the first two relate to substantive changes in discourse practices, whereas the third suggests the conscious intervention in discourse practices is an increasingly important factor in bringing change about” (p. 200). Fairclough indicated that democratization involved greater access to discourses through the changing formality of language. Formal written language was giving way to a more casual or spoken form contained in written work. In addition, overt power dynamics were eliminated by the use of less imposing language even though the power exerted by the dominant group remained intact. This was a sort of softening of the tone and language used to give those who were subjugated a sense of power and control, even though it really did not exist. For example, I think of this in terms of phrases such as “thou shalt” softening to “it is highly suggested”. Further, Fairclough specified that there was greater access to prestigious discourse types – more people have access to prestigious positions (law, professoriate) where the normative dialects of language, English in particular, were more widely accepted. A person with an accent could communicate without having to learn the standard or normative way of speaking English as was expected in the past (think of news broadcasters). A final feature of democratization was gender-based discourse practices (Fairclough, 1992). The use of the pronouns he or she formerly indicated not just the person but also implied the position in society. A doctor or lawyer were always referred to as ‘he’ and a secretary or nurse were ‘she’. This has changed significantly in the 21st century with the

increased and accepted use of the pronoun “they” to indicate a person whether singular or plural. Has the gender power dynamic shifted accordingly? This may be relative to the pre-existing sociopolitical structures in place. As an example, the United States of America, as of 2022, has never elected a female president, whereas Great Britain has had three female Prime Ministers. One might ask if those individuals in countries that have elected female leaders were motivated to vote by talent and skill or were they seeing a female leader as a commodity to potentially gain influence, by being progressive, on the world stage?

Commodification is the use of language that reduces people and processes as a way to produce a product (Fairclough, 1992). We have seen this in nursing as we used to refer to the people we care for as patients, which had its own issues with subjugation, but this has transformed in written material to ‘clients’. Education still has ‘students’ as its common nomenclature for those that are the learners, however, some materials refer to ‘clients’ or ‘consumers’ of learning. Education is now an industry, particularly post-secondary education, where profitability is built into the funding models. Colleges Ontario’s (2021) strategic mandate agreements specifically indicate that for the cycle of 2020-2025, a greater portion of funding will be tied to performance. They stated:

> This new funding model:
>
> - Ensures students and graduates are set up to succeed in rewarding careers
> - Encourages institutions to be more efficient, specialized and focused on what they do best
> - Promotes greater accountability and transparency by ensuring that the funding postsecondary institutions receive results in positive economic outcomes. (Colleges Ontario, 2021, p. 1)

According to Fairclough (1992), students were constructed dichotomously – consumers on one hand and products on the other. Students could choose the program in which to

enroll at a particular school and even select some of their courses (consumer); however, once they got there, there were required courses, skills, or competencies to acquire in order to successfully complete the program and attain a credential, which employers were seeking in potential employees (product). Additionally, Fairclough explained that "educational discourse is not just a matter of vocabulary; it is also a matter of genre… being colonized by the advertising genre" (p. 210). For example, the marketing department at a particular school in Ontario was looking for language in its promotional materials to make sure "the program stands out from the competitors" from across the province in an attempt to attract students to attend their school (D. Forbes, personal communication, August 31, 2022).

The third major tendency in discourse was technologization. Fairclough (1992) posited that "interviewing, teaching, counselling, and advertising" were types of discourse technologies (p. 214). These technologies were tools by which an individual could acquire or perform a vast number of strategies in multiple contexts; however, Fairclough cautioned that these technologies interconnected "knowledge about language and discourse and power" (p. 216) and were becoming highly specialized and compartmentalized in educational institutions. Making these technologies into specialties further marginalized those without the knowledge of the discourse, and therefore, were less powerful in these contexts.

These three tendencies interacted in a complex system of increasing and/or decreasing perceived power in discourse. While democratization may have provided the consumer of the discourse with a greater sense of power and control, commodification reduced the sense of power in discourse to becoming the target of advertising, a consumer choosing between perceived alternatives. Technologization may have marginalized those, without the skill set, to be able to interact in social and discursive processes. All three of these tendencies could be interacting in the same text to create

fragmentation or confusion for the reader or analyst. It was the role of CDA to sort through these tendencies and reveal the taken-for-granted knowledge and power contained within a given discourse (Fairclough, 1992).

An element of Fairclough's approach to CDA that resonated with me was the position that he took about reality. He identified that there were potential and actual realities – "what is possible because of the nature (constraints and allowances) of social structures and practices, as opposed to what actually happens" (p. 14). He asserted reality was not merely what an individual knows. There was much about reality that cannot be known by a single person. Therefore, the analysis of a text could never truly be complete or the definitive version of its reality, as the person or person analyzing the text chose the questions, whether consciously or unconsciously, to ask about the text. There would inherently be some subjectivity in text analysis, and objectivity is truly not achievable in CDA work (Fairclough, 2003). He then discussed the elements of doing CDA.

The work of Fairclough resonated with what I wanted to achieve in the analysis of the RN and RPN ETPC; therefore, it was his work, particularly his 1992 book, that shaped my methodological approach. As well as examining the elements of the theory, I wanted to understand the features of CDA.

3.2 Features of Critical Discourse Analysis

In employing CDA, I felt it was important to examine the underlying assumptions, limitations, and contributions of CDA to nursing and the research to provide a fulsome examination of the methodology.

3.2.1 Underlying Assumptions of CDA

In summarizing the features of CDA, the underlying assumptions of the methodology could be viewed as an interdisciplinary method to analyze problems at work (Amoussou & Allagbe, 2018; Fairclough, 1992; Wodak, 2009; Van Dijk,

2001). There were “salient principles which are constitutive of all approaches in CDA” (Wodak, 2009, p. 1) which “focuses on social problems, and especially on the role of discourse in the production and reproduction of power abuse or domination” [in society] (Van Dijk, 2001, 96). In being critical, Fairclough (1992) referred to the work of Habermas and Foucault, both known for their work in Critical Social Theory, which was where the explicitly *critical* element of discourse analysis was based. The goal of criticality was to make the hidden visible, or to make the consumer of the text aware of what background and power structures, or hegemony, went into the creation of the text. Fairclough (1992) indicated that there were underlying assumptions embedded in CDA. Moreover, these assumptions were value laden and ideologically driven and the successful application of power in a text is ideologically based.

> What is distinctive about CDA compared with other approaches to research is that without compromising its social scientific objectivity and rigour, it openly and explicitly positions itself on the side of dominated and oppressed groups and against dominating groups. (Fairclough et al., 2011, p. 358)

In considering the value of doing CDA work, and the assumptions of performing the analysis, methodological rigor and interpretive rigor were important components for they could, not only validate the study; they could also be limitations.

3.2.2 Limitations of CDA

Like all research methodologies, there are limitations to what can be known and surmised through CDA. Scholars have pointed out some of these limitations. Liasidou (2008) characterized CDA as “merely an ideological interpretation and not an analysis” (p. 493) suggesting it was biased and selective in its interpretation. Blommaert (2005) indicated that “less than careful CDA may thus result, not in an empowered subject speaking with a more audible voice, but a stentorian analyst voice” (p. 33). However, Fairclough (1992) indicated that CDA was, by nature, subject to many interpretations. It

was these multiple realities that were the foundation of CDA's purpose of being critical, implying that reality was "constantly structured and restructured, articulated and rearticulated, in the process of ideological struggle" (Fairclough 1999, p. 76). In relation to the work of this study, Bowe et al. (1992) claimed that "practitioners do not confront policy texts as passive readers, they come with histories, with experience, with values and purposes of their own, they have vested interested in the meaning of policy" (p. 22).

Widdowson's (1995) critique of CDA panned both CDA and Fairclough's work directly. Widdowson regarded CDA as one of the latest trends in research at the time, and considered it "vogue" and that discourse was a challenging and unclear concept that privileged one view over another. Moreover, Widdowson saw CDA as a "contradiction in terms" (p. 159) as he could not reconcile the notion of an interpretation of a text with the idea of analysis as suggested in CDA's name. Widdowson further argued the phrases and letters could not truly be discourse or even text (Fairclough called these nominals), and considered text socially intentional. It was in this argument where his claims founder, as Fairclough acknowledged these issues, and asserted that one of the tenets of CDA was that text and discourse were socially constructed (Fairclough, 1992). Widdowson expressed concern about misinterpretation between the creator of the text and the reader of the text. He provided an example of a sign on an escalator, "Dogs must be carried" where an individual refused to ride because they did not want to be required to carry a dog. I argue that this is exactly what Fairclough meant by meanings being socially constructed and contextually based. The person refusing to carry a dog may have had a different first language, visual processing problem, or just not have had their mind in the same contextual space when reading the sign. I can think of a few times in my life whereupon reading something the first time I was confused, but after pausing and thinking about context, it made sense to me. Another element that

Widdowson criticized was how, depending on context, something may be offensive because the current context does not support that view. In considering American television programs from the 1960s and 1970s, some characters used, in their everyday language and discourse, elements that today would be considered offensive for people of different ethnic or racial backgrounds. This is an example of how society evolves over time, and therefore so do ideology and context. Fairclough had clearly indicated that this was possible in CDA. What I saw as fundamentally flawed in Widdowson's critique is that he was missing the idea that CDA was not looking to provide a single answer, but to examine possibilities and different ways of interpreting discourse. His work garnered a written response from Fairclough (1996) in a subsequent edition of the same journal where he asserts his position and approach to CDA (noted earlier) and the misinterpretation of his work by Widdowson.

In addressing the limitations of CDA, methodological and interpretive rigor were important to consider as ways to mitigate bias and increase the validity of the study. Crowe (2005) provided a succinct list of considerations for methodological and interpretive rigor:

Methodological Rigour

- Does the research question 'fit' discourse analysis?
- Do the texts under analysis 'fit' the research question?
- Have sufficient resources been sampled, e.g. historical, political, clinical?
- Are the data gathering and analysis congruent with the interpretive paradigm?
- Is there a detailed description of the data gathering and analytical processes?
- Is the description of the methods detailed enough to enable readers to follow and understand context?

Interpretive Rigour

- Have the linkages between the discourse and findings been adequately described?
- Is there adequate inclusion of verbatim text to support the findings?
- Are the linkages between the discourse and the interpretation plausible?
- Have these linkages been described and supported adequately?
- How are the findings related to existing knowledge on the subject? (p. 61-62)

The answers to these questions will be embedded in the findings of Chapter Four and the discussion in Chapter Five. Crowe's (2005) work on making sense of the methodological and interpretive rigor in CDA aided in understanding CDA's place in nursing research. She concluded that CDA "can make a contribution to the development of nursing knowledge by providing a research strategy to examine dominant discourses that influence nursing practice" (p. 55). The CNO ETP competencies are an enduring example of how policy and curriculum are intertwined in the fabric of nursing education and practice.

3.2.3 CDA Contributions to nursing, education policy, and the research study

Several authors in recent years have employed CDA in their studies describing either policy or education in nursing (Adam et al, 2023; Cooper et al., 2022; Dickman & Chicas, 2021; Evans-Agnew et al., 2016; Munro & Beck, 2021; Stjernswärd & Glasdam, 2022; Valderama-Wallace, 2017) indicating that this methodology was useful and appropriate for nursing research work.

In the mid 2000s, there were three authors that examined CDA and its usefulness for nursing research (Crowe, 2005; Smith, 2007; Traynor, 2006). Crowe (2005) and Smith (2007) specifically examined the methodology itself; however, Crowe and Traynor seemingly used the term discourse analysis and critical discourse analysis

as synonymous, but it was clear that Crowe was implying CDA when she stated “It places the social and historical context, rather than either the researcher’s hypothesis or the individual’s experience as central to the inquiry process… [and] context … is central to the research process” (p. 56). In addition, she indicated that the exemplar text was examined using Fairclough’s work. Traynor focused more on all types of discourse analysis, including CDA, during his meta-analysis of critical discourse articles in a specific nursing journal. He suggested that “possible strategies for future improvement could include more careful attention… to methodology and to the key features that differentiate the various approaches to DA” (Traynor, 2006, p. 71) as the different methodologies, proposed by different theorists had significant implications for the type of interpretations found in the text.

Both Crowe (2005) and Smith (2006) agreed that CDA explored the texts as social practices and that the language used was complex in that it not only communicates thoughts but was, in and of itself, a socially constructed reality. For example, the discourse or texts in a particular discipline may use common words or acronyms to describe a particular phenomenon in the field, but those words or acronyms may mean something else entirely to another discipline e.g., CDA may mean Critical Discourse Analysis to qualitative researchers; Canadian Dental Association to oral care practitioners and those who use toothpaste; and Canadian Dance Assembly to professional dancers, as well as possibly represent the initials of elements of a profession or other agencies within Canada and around the world. Therefore, in my opinion, it only makes sense that context is a vital part of understanding language use, whether in nursing or other fields. Smith proposed that CDA would allow nursing researchers to investigate a nursing-related issue as it afforded the ability to examine how “language functions in order to shape public perceptions of health and system issues and the policy debates that surround them” (p. 60).

Crowe (2005) provides a succinct synthesis of the steps involved when using CDA in nursing. These steps provide a process that I will use to analyze the texts. They are as follows:

1. Choose the text – the research question guides the selection of the text.
2. What is the purpose of the text and what authority does it have – what is the reason this text has been produced, who produced it, and where does its authority lie in relation to other discourses and society?
3. Process used for claiming the linkages to other discourses – what are the social, cultural, and political discourses linked to this document, and is there more than one internal discourse contained within the text.
4. Construction of the major concepts contained in the documents – how are the major concepts of the document presented, and are there any contradictions between concepts?
5. Process of naming and categorizing – "identifying the values and assumptions that underpin how things are categorized by the discourse and the value attributed to some characteristics and not others" (Crowe, 2005, p. 60).
6. Construction of reality and social relations between people – the construction of reality is greatly influenced by one's internalization of social structures of the culture i.e., what is best, most true, most accurate, and what special interest group may the discourse represent.
7. Implications for the practice of nursing – how will this impact nursing practice and influence the knowledge, values, and beliefs of nurses.

Smith (2007) indicated in her review of the development of CDA that: "the theoretical underpinnings of CDA bring together a wide variety of critical social theories …[and] thus works to mediate between pure linguistic analysis such as that of conversation analysis on one side, and post-structuralist studies of discourse on the other" (p. 61). Critical

social theory seemed an excellent fit as a framework to analyze the results of employing CDA as a methodology.

3.3 The Roots of Critical Social Theory

For this study, I chose to use Critical Social Theory (CST) as a framework as it dovetailed with the methodology of CDA and seemed a natural fit given its theoretical underpinnings for CDA. Critical Social Theory challenged the taken-for-granted assumptions of everyday life and asked us to examine issues through a lens that encouraged emancipation from the capitalist society. A capitalist society promoted domination and oppression of those not enacting the ideals of a free-market economy, where corporations were focused on profits over people. CST afforded me the ability to see how the development and enactment of the EPTC in nursing practice in Ontario were shaped by the constructs associated with capitalist notions, despite being in a socialistic system of universal health care. The critical elements of Fairclough's 3D model allowed me to examine not only the documents themselves but the sociopolitical forces and factors that underpinned their creation. Fundamentally, CST aligned with my view of the world and how I see that power structures were at play in every action and interaction that occurs. It provided a method to examine the ETPC documents critically, not just focusing on the words, but acknowledging the forces behind their creation and how they influenced nursing curriculum. Additionally, it allowed me to acknowledge my positionality when examining the content for comparison between the RN and RPN roles and scope of practice.

Critical Social Theory was born out of the Frankfurt Institute for Social Research, also know as the Frankfurt School, which formed in the 1920s (Browne, 2000; Mooney & Nolan, 2006; Wellmer, 2014: Wilson-Thomas, 2005) to examine issues of power and hierarchy that occur in social structures (Anyon, 2009). It was during this time in Germany that the rise of the National Socialist German Workers' (Nazi) Party came to

power. Its far-right political leanings and pervasive dripping of these ideals to the German populous forced the Frankfurt School to close in Germany in 1933, and its Jewish members, to relocate the School to the United States (Wellmer, 2014). Much of the writings of these early theorists were influenced by the holocaust and the rise and fall of Adolf Hitler and the Nazi party, as the presence of power imbalances and the need to reveal them, was a major factor in the development of CST. Some key critical theorists (Horkheimer, Adorno, Marcuse, and later Habermas) began their work at the Frankfurt School to facilitate an objective viewing of social phenomena. The school's work was inspired by Marx's *Critique of Political Economy* with a goal of transforming this critique into a critical social theory (Wellmer, 2014). For me to determine which theorist fit best with my ontology and epistemology, I examined some key figures of CST.

3.3.1 Max Horkheimer

Max Horkheimer became the director of the school in 1930 and, in 1937, authored an essay reflecting on *Traditional and Critical Theory* (Horkheimer, 1937/1972) in which he presented his foundational ideas for critical theory:

> Thus [,] the critical theory of society begins with the idea of the simple exchange of commodities and defines the idea with the help of relatively universal concepts. It then moves further, using all knowledge available and taking suitable material from the research of others as well as from specialized research. (p. 226)

Horkheimer (1937/1972) furthered the notion that to be critical, a theory functioned as a framework of judgment (or critique) of, and personal reflection on, society with a view to being explanatory, practical, and normative. In expounding on these, Horkheimer indicated that the theory must explain what is wrong in the current social situation (or reality); it must identify the people and forces that can change the situation; and, it must provide a way to criticize the suggested achievable and practical objectives for social

transformation. In other words, it searched for equity and social justice (Horkheimer, 1937/1972). Further, Horkheimer's view of the technical-rational approach in society was that it led to a reductionist view of the human. In appraising Horkheimer's work for this project, there were some elements of approach to CST that I agreed with, and others that I did not.

I agreed with Horkheimer that there needed to be an interdisciplinary mode of thinking which used sociology, history, philosophy, and economics to contextualize what it meant to be human (Horkheimer 1937/1972). Further, he indicated that when examining conditions or concepts using objective reasoning, we are more focused on the ends, whereas when using subjective reasoning, we are more focused on the means (Horkheimer, 1937/1972). This resonated with me and what I have practiced regarding health care ethics. A teleological approach (subjective reasoning) "would hold, the ends justify the means" (Purtillo, 1993, p. 9) and a deontological approach (objective reasoning) would hold that the means justify the ends. Horkheimer's (1937/1972) belief that it was important to use objective reasoning did not discount the notion that a person's emotional side would be tempted to use subjective reasoning to get what they desired, and use other humans in the process. Deontology or objective reasoning was most closely associated with Immanuel Kant, on whom Horkheimer based much of his work. Kant's work asserted that every human should be free, worthy of dignity and respect, and not used by another person to attain greater wealth, position, or advantage; an altruistic view of human actions. "*So act that you use humanity, whether in your own person or in the person of any other, always at the same time as an end, never merely as a means*" (Kant, 1797/1998, p. 38 [italics original]). I can see that Kant's view, for its time in the 18th century, was complex and innovative and has been interwoven into the fabric of human morality and now seems, in my opinion, fundamental to being a decent human being. Horkheimer wanted to further Kant's work and examine the tenets of

morality and dissect them to understand the complexity of human existence (Horkheimer (1937/1972). I agreed with Horkheimer's proposition that critical theory examines human activity in a society, where a person can struggle with internal conflict and alienation as they work through balancing their purpose with their emotional selves.

Despite agreeing with these elements, I disagreed with his assertion that as we pursue enlightenment with the technical, we become less focused on the human; that we are reduced to a product of society and are dehumanized in the process. I would argue that the pursuit of technology was focused on the human as far as making life easier to live. I could understand how Horkheimer thought that dehumanization may occur. I think that there was an element of dehumanization in the replacement of human labour for that of a machine, but I assert this has not necessarily been the goal or focus of technology. I also disagreed with Horkheimer's (1937/1972) assertion that science was merely searching for a universal way to explain the world and the people within it. His mechanistic worldview and failure to acknowledge the embeddedness of history and sociology in science, conflicts with my worldview that science is messy and complex and cannot be catalogued in a library index, as he shared in an example of his work (Horkheimer, 1937/1972). I was conflicted by this conception of CST by Horkheimer, so I then turned to Horkheimer and Adorno's work to see if Horkheimer's view had evolved over the 10 years that transpired between writings.

3.3.2 Horkheimer and Theodor Adorno

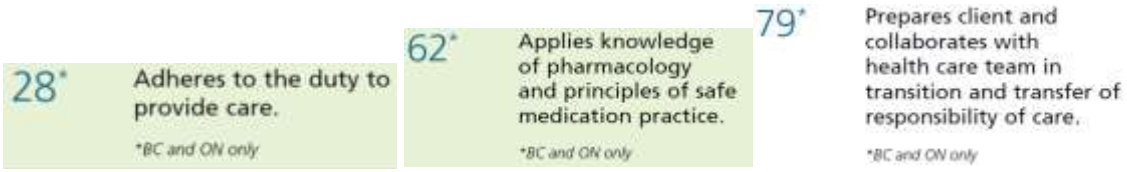
In 1942, Horkheimer partnered with Theodor Adorno to begin to write the *Dialectic of Enlightenment* (1947/2002). In the preface to the Italian edition of the book, the authors noted, "It is self-evident that, with regard to terminology and the scope of questions investigated, the book is shaped by the social conditions in which it was written" (Horkheimer & Adorno, 1947/2002, xiii). They asserted that enlightenment in its broadest sense was the ability of the average person to be the owner of their own

destiny, yet enlightenment was a myth of sorts as the social structure in place in the 20th century was a perpetuation of the division of labour and those in power. The structure of power entrenched in capitalism could not allow people to be truly free. "The oppression of society always bears the features of oppression by a collective… [and that] language itself endowed what it expressed, the conditions of domination, with the universality it had acquired as the means of intercourse in civil society." (Horkheimer & Adorno, 1947/2002, p. 16). They argued that the domination of the power by the sectors of industry failed to allow people the ability to see the world objectively and rationally, but rather, through the lens of the subjectivity of the leaders of industry. We are shaped not by our own thoughts and perceptions, but by those imposed on us through the loudest voices at the table dominating ideas or creating demands of those developing ETPC, while suppressing alternative views (Lau & Akkaraju, 2019).

This can be seen in the RPN ETPC where British Columbia and Ontario demanded additional competencies beyond those of the other provinces and territories (Figure 3.2). This knowledge is only available in the interpretation document and not in the publicly available competency document and seems to contradict the concept of enlightenment.

Figure 3.2

RPN Competencies that are exclusive to BC and Ontario (CNO, 2019d, p. 8, 15, 18)



The concept of enlightenment is very similar to how I, as a nursing professor, worked diligently during the first semester of the nursing program to enculturate new

students into the professional rules and regulations that guide nursing practice. During each class I introduced another element of practice, be it ethics, a code of conduct, or how to communicate with patients, I was hand-feeding the students to behave a certain way as ascribed by the historical aspects of the profession and the regulatory body (CNO, 2019a, 2020a). In addition, I recognize that some of the old traditions that I was taught many years ago seeped through: 'Make sure your uniform is free of pet hair debris and doesn't look like you slept in it.' I have often pondered in the grand scheme of things whether pet hair and wrinkled clothes really matter, but it has been so engrained into my way of being that it is difficult to separate that from the technical learning that is to take place. I ashamedly acknowledge that I have passed judgment in thinking that if the student does not care about their own appearance, will they care about the patients and their well-being? I wondered if this feeling was universal for the profession. I turned to the nursing literature for any possible evidence. I found that in 2014, Porr et al., conducted a qualitative study in Newfoundland that found adult patients' (over the age of 45) perceptions of an all white, clean, and tidy uniform, regardless of age and gender, scored significantly higher than patterned or coloured tops (or combinations of these) on competence, attentiveness, efficiency, approachability, caring, reliability, cooperation, and empathy. However, another study by Albert et al. (2008) found that age of the patient had a significant impact on perception of attire as paediatric and young adult patients showed less concern for the colour or pattern of the nurse's uniform in relationship to their ability to provide nursing care. This was contradictory to an objective and rational approach to the world that Horkheimer and Adorno ascribed. There was a duality in my mind that struggled with some of the elements of this iteration of CST, so I then turned to Herbert Marcuse.

3.3.3 Herbert Marcuse

Another member of the Frankfurt School was Herbert Marcuse. His seminal work *One-Dimensional Man* (1964/1991) laid the foundation for the "New Left Movement" of the 1960s. Marcuse asserted that the norms of society were the exact things which constrained a "free society". Further, the taken-for-granted nature in society that the political, economic, and intellectual liberties were fundamentally true and real would only be questioned if they could be negated from the norm. For example, political freedom was not what exists in society but was the opposite of this. Our sense of political freedom could only come from looking at the world when it was 'free from' politics over which individuals have no real or impactful control (Marcuse, 1964/1991). Therefore, freedom was not truly freedom but what the controlling members of society wanted the lower classes to believe is freedom. According to Marcuse (1964/1991) another distortion that accompanied the guise of freedom was that of need.

> Whether or not the possibility of doing or leaving, enjoying or destroying, possessing or rejecting something is seized as a *need* depends on whether or not it can be seen as desirable and necessary for the prevailing societal institutions and interests. (p. 4).
>
> The distinguishing feature of advanced industrial society is its effective suffocation of those needs which demand liberation-liberation also from that which is tolerable and rewarding and comfortable-while it sustains and absolves the destructive power and repressive function of the affluent society. (p. 7)

As a result, need was not truly need, but rather that which drove the political and economic machine in capitalist society and was shaped by what the corporate leaders want the lower classes to believe is a need (Marcuse, 1964/1991).

What Marcuse (1964/1991) was suggesting is that the structure of society is being constantly redesigned to have us believe that we need, for example, a cell phone.

I know many people who consider a cell phone a necessity of life in the 2020's. I admit that I would be lost without one. When I visit other cities and drive on major highways, pay telephones are rare compared to what existed the 1980's and 1990's. As well, in the early 2000s, I have seen the media present many stories of people being harmed by trying to assist others during an automotive breakdown on the side of the road. I have been led to believe that everyone, whom I could potentially help, may hurt me. As well, the media have led me to believe that everyone has a cell phone, so they can make their own calls for help. I too have the idea that I have the freedom to contact anyone at any time. However, it is the example that I have just given that exemplifies the idea of being drip-fed the notion of needs and freedoms that were purposely designed to increase my consumerism and conformity. I also argue that, because of cell phones, cars, and other devices that have computerization and global positioning system (GPS) tracking capabilities, it is impossible to 'disappear' from society. I believe we could have our every movement tracked if someone wanted to do so. To me, this really speaks to the skewed concept of need.

I agreed with Marcuse and his view of freedom and the skewed concept of need. In Marcuse's sense of freedom, I see the College of Nurses of Ontario (CNO) as a gatekeeper for safe practice in nursing and their policy documents as a method to control the behaviour of those in the profession, not purely out of self-interest, but to protect the public from harm. The CNO ETPC informs nursing education programs in Ontario what is needed for students to graduate and become competent practitioners; so, nursing programs conform to meet these competencies to be able to deliver a nursing curriculum. If this conformity is not achieved, a program risks being cancelled by the CNO and can no longer be delivered by the educational institution. There was nothing I disagreed with in Marcuse's view of criticality however, I felt that the idea of language and text as being a powerful element of society, and particularly education,

was missing in his assertions and was therefore not a good fit for my project. I then turned to examine Habermas and his ideas about CST.

3.3.4 Jürgen Habermas

Jürgen Habermas' work was the primary influence to use CST as a conceptual framework in this dissertation. His work, approach, and in particular, his philosophy of language spoke to my epistemological and ontological views. In examining Habermas' work, I learned that he came to the Frankfurt School as a research assistant of Adorno in 1956. By this time, the Frankfurt School had returned to Germany after its tenure in the United States (Edgar, 2006).

Habermas (1971/1968) posited that criticality was grounded in three domains: labour, communication (interaction), and power. These were the resources for human action and knowledge. Labour was how human beings (those not in power) were able to manipulate the world. By working and earning a living, individuals could change their lifeworld and circumstance. The world was controlled by the powerful elite, and social systems were governed by instrumental rationality where the rules of the 'system' looked to realize specific objectives by distributing power and money (Edgar, 2006). The powerful wanted human beings to see their version of reality (subjectively), but it was important for humans to see this manipulation and look at the world objectively or, reflect on and see beyond the subjective reality, and question the status quo (Habermas, 1971/1968). Communicative rationality was the "process of problem solving and conflict resolution through open discussion" (Edgar, 2006, xvi). The lifeworld was the other form of the social world and was created and maintained through the taken-for-granted knowledge and social skills of its individual members, one of which was an individual's ability to self-reflect. Habermas cautioned that the system could colonize the lifeworld thereby overpowering the communicative rationality and create a system where individuals could be manipulated to stop thinking critically and blindly follow the rules that

would govern their actions (Edgar, 2006). Intertwined in the system, lifeworld, and labour was the concept of power and the need for individuals to see how power was used and the sources of it. Furthering his thoughts on these notions, Habermas later developed the *Theory of Communicative Action and Universal Pragmatics*. Here Habermas (1981/1984) asserted that:

> The phenomenologist… simply begin[s] with the ontological presupposition of an objective world… [and] makes this a problem by inquiring into the conditions under which the unity of an objective world is constituted for the members of a community. The world gains objectivity only through counting as one and the same world for a community and speaking and acting subjects. The abstract concept of the world is a necessary condition if communicatively acting subjects are to reach understanding among themselves about what takes place in the world or is to be effected [*sic*] in it. Through this communicative practice they assure themselves at the same time of the common life-relations, of an intersubjectively shared lifeworld. The lifeworld is bounded by the totality of interpretations presupposed by the members as background knowledge. To elucidate the concept of rationality, the phenomenologist must them examine the communicatively achieved consensus; he must analyze what Melvin Pollner calls, with reference to Alfred Schutz, "mundane reasoning." (pp. 12-13)

Habermas (1981/1984) suggested here that humans were fundamentally communicative beings. There was a common ground that must be understood between the sender and receiver to be able to interpret meaning and challenge the communication. He used the term *communicative reason* to indicate the strength of a decision being based on a free and open discussion that generates a superior argument; however, the decision is not based on any form of coercion (Habermas, 1981/1984). Delving further into communication, Habermas, although opposed to positivism, was more sympathetic than

his predecessors about positivism (Edgar, 2006). Habermas posited that science cannot be pure or value-free and that those who study society are, in truth, also subjects in the studies. He was open to the positivist ideas within analytic philosophy, particularly the work of J. L. Austin whose *Theory of Speech Acts* informed Habermas' Universal Pragmatics Theory (Edgar, 2006).

Austin (1975/1955) proposed that communication and in turn sentences that described an action or an imperative by the speaker were *performative utterances.* I argue that by extension, any policies, laws, or expectations are performative utterances because they are indicating either an action or an imperative. Austin (1975/1955) further elucidated that there were three types of performative utterances: locutionary, illocutionary, and perlocutionary. Locutionary utterances could best be described as a direct order, i.e., "Do it". Illocutionary utterances were meant to suggest or even question an order, i.e., "I advise you to do it". Perlocutionary utterances were designed to evoke emotions with the "design, intention, or purpose of producing them" (Austin, 1975/1955, p. 101) in the receiver, i.e., "She encouraged me to do it". In looking at language and utterances, Habermas (1981/1984) made clear that *communicative reason* alone was not sufficient for the task and must be supplemented by critical theory to penetrate systematic "distortions, representations and politics embedded in our knowledge and speech" (Nickerson, 2022, para 5). Habermas (1981/1984) argued that there were no general rules of meaning, as meaning was entirely dependent on context, and that critical reflection was an important aspect in being able to see both sides of a situation. This idea is relevant to this study as any writing may have words that may have multiple meanings and it is the reader who makes the interpretation in context to what they know and what they have experienced. Therefore, the analysis of any written work could be interpreted differently by different individuals. In his earlier writing, which was greatly influenced by the political unrest at college campuses in the 1960's, Habermas

(1968/1971) first asserted that it was important to see both sides of the situation. He sympathized with the students and their protests calling for social change, yet realized that the militant factions of students calling for social transformation were "self-delusory and pernicious." Habermas' work spoke to me and my view of the world.

Habermas and his approach to CST fit with my way of thinking about words and language and with the conception of different types of utterances conveying different meanings, making it ideal for the project. In observing the language contained within the RN and RPN ETPC documents, I wanted to examine the language for commands versus suggestions in the discourse and consider the context in which meeting some of the competencies were to be achieved, which also was in keeping with Habermas' idea that there was no meaning without context. However, I wondered how this aligned with education, so I turned to Paulo Freire and his view of curriculum in education and power.

3.3.5 Paulo Freire

Although Paulo Freire was not a member of the Frankfurt school, his critical work about education was important in understanding curriculum and nursing education in this study. He looked at language and communication in the context of education in his landmark book, *Pedagogy of the Oppressed* (1970/2000). Freire posited that oppression was dehumanizing and the oppressed and the oppressor must be emancipated to experience true humanity.

> One of the basic elements of the relationship between the oppressor and oppressed is *prescription* [italics original]. Every prescription represents the imposition of one's individual choices upon another. Transforming of the consciousness of the person prescribed into one that conforms with the prescriber's consciousness. Thus, the behaviour of the oppressed is a

> prescribed behaviour, following as it does the guidelines of the oppressor. (Freire, 1970/2000, pp. 46-47)

Freire (1970/2000) suggested that the only way to free the oppressed and the oppressor was through a liberating education. However, he acknowledged that education was suffering from "narration sickness," meaning that students were the passive recipients of knowledge, and the teacher was the all-knowing sage on the stage narrating what must be learned. Further, Freire conceptualized this as banking of education where knowledge was deposited to students to withdraw it when called upon for evaluation of learning and led to the teacher-student contradiction. This resulted in the suppression of the critical consciousness of students and, therefore, their ability to transform the world. An element of the teacher-student contradiction that resonated with me and this project was "(h) the teacher chooses the program content, and the students (who were not consulted) adapt to it" (Freire, 1970/2000, p. 73). In nursing education, the curriculum in Ontario is prescribed by the CNO, which was prescribed by the CCRNR and the CCPNR. Students have little to no say in what they learn. Teachers have some say in what they teach and some control over how the students learn, but as we will see in the findings, the CNO often prescribes how the learning is to occur. Freire asserted that banking education serves to indoctrinate students to adapt to the world of the oppressed and that they are given a fragmented view of reality. Freire suggested that the solution rested with both the teacher and the students as both must be actively engaged in teaching and learning to move past merely adapting to the oppressors.

As has been revealed, the roots of critical social theory have multiple key theorists which began the movement to enlightenment, consciousness, and humanity. This is not the end of critical theorizing, but merely the beginning for students to explore critical social theory more deeply and understand newer views of criticality.

3.3.6 Newer Views of Critical Social Theory

The newer critical social theorists built upon the works of those before them and were, in my opinion, reiterating what was said by Habermas and Freire but in the context of a more recent past. These newer theorists asserted that CST was not intending to lay blame for power imbalances, but to reveal the realities of oppression and the forces that created the circumstances. Anyon posited, "We produce power and are produced by it" (p. 7). Others discussed the importance of power as embedded in every element of society (Anyon, 2009; Heslop, 1996; Wilson-Thomas, 2005). Further, CST exposed the way in which unequal power relations oppressed groups through inequitable policies and political dogma, and revealed ways to emancipate those that experience oppression (Browne, 2000; Freeman & Vasconcelos, 2010; Leonardo, 2004). It was this exposure that revealed that many elements of social and political order were taken for granted and normalized, yet were fundamentally unjust.

Critical Social Theory recognized that inherent in all systems is the individuals' taken-for-granted knowledge (Thompson, 1987) realized by unjust practices becoming culturally embedded over time (Freeman & Vasconcelos, 2010). These practices or knowledges became a dominant way of thinking or what Dant (2003) called "instrumental reason" (p. 160) and others described as *false consciousness* (Freeman & Vasconcelos, 2010; Mooney & Nolan, 2006). Critical Social Theory worked to raise the consciousness (Thompson, 1987) of participants and systems under examination by exposing the hidden knowledges and ideas of everyday practices to transform meaning and purpose (Freeman & Vasconcelos, 2010), so that individuals could have a "balanced participation in social interaction" (Wilson-Thomas, 1995, p. 572). To expose taken-for-granted knowledge, it was essential that all involved in the process be reflective (Freeman & Vasconcelos, 2010; Heslop, 1996; Mooney & Nolan, 2006; Thompson, 1987) and reflexive (Sayer, 2009) during the process. Through reflective

and reflexive practices, CST served to enhance individual autonomy and responsibility (Wilson-Thomas, 1995) thus providing an opportunity for the emancipation of the oppressed (Anyon, 2009; Browne, 2000; Freeman & Vasconcelos, 2010; Heslop, 1996; Leonardo, 2004; Mooney & Nolan, 2006; Thompson 1987; Wilson-Thomas, 1995). I wanted to understand some more of the features of CST.

3.4 Features of CST

After examining these many theorists and their work, and resonating with many of them, I wanted to employ an eclectic approach to the use of work of the individuals discussed above. To do this, I felt it was important to examine the underlying assumptions, limitations, and contributions of CST to nursing and the research to be able to collate my thoughts and to be able to analyze the findings effectively.

3.4.1 Underlying Assumptions of CST.

There were several fundamental assumptions that underpin CST's view of the world. Freeman and Vasconcelos (2010) articulated:

> Advocates… believe that society can be improved through education [but] are constrained as well as supported by local contexts, knowledge, interests, and needs [which] include diverse perspectives and interests… [The authors] emphasize [that] the process of inquiry is just as important as the result, … [that researchers] are self-critical and self-reflective, … [that they] assert that local values determining merit and worth need to be accounted for, … [and] locate the validity of the inquiry is [*sic*] the ability to effect change. (p. 11)

Browne (2000) also asserted several tenets and assumptions of CST, which held to the ideals that no knowledge is value neutral, that all knowledge was reconciled by social or historical power relations, that all societies implicated power or oppression in their very construction, and that "for oppression to exist there must be an imbalance of power" (Mooney & Nolan, 2005, p. 241). Further, facts cannot be separate from the values that

shape their creation, and that scrutinizing the social order could lead to emancipation and social transformation. Moreover, language was vital to create and understand knowledge, as mainstream research discourse continued to perpetuate the hegemonic forces inherent in the status quo. Lastly, new, critically oriented knowledge should serve to challenge and attempt to shift away from the status quo (Browne, 2000). Leonardo (2004) proclaimed that this shift can create a "discourse of hope" (p. 16) for the oppressed. However, what were the limitations of critical social theory?

3.4.2 Limitations of CST

Several authors found that CST imposed limits and constraints in the research of social issues (Anderson, 1989; Browne 2000; Ellsworth, 1989; Freeman and Vasconcelos, 2010; Lather, 1986; Sayer, 2009). Critical Social Theory contained a hidden assumption that people lived in only one reality and that everyone's reality was the same (Browne, 2000). "The focus of CST on unification, consensus, and the collective tends to erase or homogenize multiple subject-identities and diverse forms of experience and knowledge held by individual members of a community or society," (Browne 2000, p. 47). Additionally, Browne (2000) suggested that CST was deterministic in its approach and pushed towards a predetermined outcome that relied too heavily on the willingness and interest of people to reflect and dialogue about their own practices. Lather's (1991) concern was that using CST created a researcher that did not look at all aspects of the structure, but rather one that saw and valued what was important to them instead of being representative of the voices of the participants as they sorted out their understanding of their world. Further, Browne (2000) worried that the idea of a false consciousness implied that, universally, individuals were ignorant of the hegemony present in common sense notions of the world and may remain unaddressed and undervalued. Others express concerns that CST was too theoretical

and distant from real people (Lather, 1986), that it was too rhetorical rather than action-oriented (Anderson, 1989) and was too disempowering (Ellsworth, 1989).

Sayer (2009) had much to contribute as being problematic in CST. He suggested that there was too much emphasis on reflexivity and that CST served more to unsettle academic ideas rather than provide critiques of social practices. He was concerned that critique evaluates rather than instructs or moves actions forward. Sayer (2009) implicated that the researcher's and participant's judgments of good and bad were variable when looking at a system, and therefore may not have been representative of a unified truth. Despite the limitations mentioned, others felt that CST could contribute to nursing research.

3.4.3 Contributions to nursing and the research study

Thompson (1987) believed that CST was useful in nursing practice as it challenged institutional power and domination in nursing. In previous studies, CST addressed issues of horizontal violence, the feminine dominance of nursing, and the critical evaluation of nursing science, knowledge, and theory development (Thompson, 1987). Thompson (1987) further asserted that CST could "critique the conservative ideology in nursing education" (p. 28) while Browne (2000) saw CST as "critiquing the fundamental ideologies upon which nursing knowledge is developed" (p. 35). Critical Social Theory assisted nursing practice to reject the schism between theory and practice, and viewed it as two sides of the same coin (Leonardo, 2004). As well, CST influenced nursing in its capacity to assist in shifting knowledge from straightforward facts and routine practices to useful practical knowledge that could move the nursing profession towards greater social justice. This refocused the attention to the socio-political and historical context of health and health care, and provided the critical realism that could leverage nursing's positionality as vital to the health care system (Browne, 2000).

In examining role confusion between the RN and RPN and attempting to provide clarity through the examination and comparison of the ETPC, CST can provide a foundation that will aid in revealing the power relations that have shaped and transformed nursing roles, entry-to-practice expectations, and the resulting transformation of nursing education over time. Anyon (2009) suggested that CST could provide holistic solutions to many problems, and that to do so, it was important to engage in the "process of 'kneading the theory/research/data mix" (p.13) to understand how the working together of these elements has the capacity to transform societal structures. An analysis of the prescriptive curriculum, determined by the entry-to-practice competency documents, (CNO, 2019a, 2019b) will assist in discovering the essential differences between RN and RPN practice expectations, foundational education requirements, and program curriculum, thereby revealing the key differences in practice expectations for educators, employers, and nursing professionals in Ontario.

Given that nursing is a female dominated profession, an element CST that appeared silent to me was the patriarchal society in which nursing functions. There needed to be a feminist lens to make recommendations. Feminist Poststructuralist Theory seemed a good fit with the research.

3.5 The Roots of Poststructuralist Theory and a Feminist Lens

For me to understand the social and gendered curriculum development of entry-to-practice nursing education, feminist poststructuralist theory (FPT) provided an additional theoretical lens. Feminist Poststructuralist Theory arose out of the poststructuralist movement of the 1960s and 1970s. In my examination of poststructuralism and feminist poststructuralist theorists, I surveyed several and focused in on those who wrote about language, text, and interpretation, which resonated with my thinking about how to examine the implications of the analysis of the RN and RPN ETPC. I identified three key figures in poststructuralism, Michel Foucault (1969/1972),

Jacques Derrida (1974/1967) and Michael Apple (2013) and their work in poststructuralist theory. Then, I focused in on application of a feminist lens to poststructuralism, given that nursing continues to be a female dominated profession, and examined the work of three authors: Judith Butler (2011; 2015), bell hooks (1984; 2018), and Chris Weedon (1997). I then examined the assumptions, limitations, and potential contributions to the nursing profession and to the proposed study. These views of FPT were used as a lens to make recommendations for future steps in differentiating between the RN and RPN roles.

Poststructuralist discourses rejected the idea that science could lead to truth and proposed that there was no singular truth but multiple perspectives of what constitutes truths. Those selected here informed my knowledge and understanding of poststructuralism and the feminist approach in the analysis of discourse.

3.5.1 Michel Foucault

Foucault (1969/1972) was a key figure in poststructuralism who focused on the agency of power and discourse. He posited that power and knowledge were intrinsically linked concepts. He identified the acquisition of power as being directly related to one's ability to access and use knowledge. Knowledge was employed via discursive practices to regulate people's conduct (Foucault, 1969/1972). He asserted that power was discursively produced and moved through the body politic, not by a hierarchical method, but by diffused discourses for, to him, nothing existed outside of a discourse (Foucault, 1969/1972). For example, a flower had no meaning outside of the way it was perceived as a *sign,* as there were many features that underlie the concept of a flower and its meaning, which could only come through discourse. Further, all social practices (what one says and does) were discursive and evolved over time using language (Foucault, 1969/1972).

The function of language was to shape statements that build the dominant discourses (Foucault, 1969/1972). According to Foucault (1969/1972), the language in discourse played a substantial role in the analysis of social orders, power, and individual consciousness. Language was fundamental to discourse; however, language, and by extension, discourse were temporal as words had different meanings over time. This resulted in a need to understand the context of the discourse. Foucault's *Archeology of Knowledge* (1969/1972) also focused on the importance of examining the historical aspects that brought an institution to its current configuration by tracing the hegemonic forces that maintained the status quo and resisted future change. By breaking down or deconstructing these institutional forces, they could become visible and open to a critical view. Social organization, or as Foucault (1969/1972) called it, the discursive *field* (p. 29) referred to the multiple, and often, competing ways of meaning-making that institutions used to organize and structure processes. Inherent in the concept of discursive fields was the notion that some fields had more power than others, and therefore, leveraged more influence in the world order. These dominant and prevailing discourses were tied up with institutional practices that organized, regulated, and administered social life, and could become so entrenched that they were viewed as common sense. Even within systems such as medicine or nursing, there could be opposing or different "schools of thought" or discursive fields that could create conflict and power struggles. For power perceived as negative, an opportunity to bring about change through counter-discourses was possible by exploring of hidden or suppressed knowledge. This hidden knowledge was known as *bruised* knowledge to Foucault (1969/1972) and needed to be exposed to upset these dominant discourses. However, not all power was controlling or insidious in discourse as it could produce reality, like in the example of the flower above.

In the analysis of discourse, and by virtue its power, when examining documents "scholars have asked not only what these documents meant, but also whether they were telling the truth, and by what right they could claim to be doing so, whether they were sincere or deliberately misleading, well informed or ignorant, authentic or tampered with" (Foucault, 1969/72, p. 7).

3.5.2 Jacques Derrida

Jacques Derrida studied under Foucault in France; however, he departed from Foucault's (1967/1976) thinking and questioned the concept of language and, particularly, the relationship of verbal and written communication. Derrida argued that spoken words were created and lived in the present whereas written words were more complicated as they can be in the past. There was immediacy in speech, but writing was inherently in the past by the fact it was consumed after the creator had thoughts and then documented them. Derrida (1967/1976) asserted that the written text could hold different meanings than could speech of the same words, because the elements of intonation, inflection, and volume could not be interpreted correctly merely through reading. He famously described how a tree was not a "thing" but a concept that was *signified*; for, in speaking or writing when using the word 'tree' (the *signifier)*, Derrida indicated that the tree was a different conception to different people within the same conversation or through their reading of texts. The signifier points to the signified as the shared human idea of a tree. When a person thought of the word tree, they created a mental image of the word tree, but one person may have thought of a sequoia, whereas another person may create a mental image of a maple tree (Derrida, 1967/1976). He posited that there was no truth because language is not the same for each person. Describing words could be problematic as we use other words to explain them; and, through this exercise it became circuitous as the words used to describe the initial word

were eventually described by the initial word for which you were seeking the explanation.

He described the concept of *difference*, which asserted there could be no fixed concepts or written images as they constantly shifted in meaning, and in relation to each other, through a process of *deferral* (Derrida, 1967/1976). Deferral referred to the temporality of meaning. Today, this can be seen in everyday taken-for-granted changes of the meaning of words and terms that evolve and change over time. For example, the word 'queer', which once held a derogatory meaning for a person that was homosexual, now has been re-oriented to describe a person that does not identify exclusively as straight or homosexual. This demonstrated the subjectivity of language and the importance of understanding the context and time in which discourses were created.

Another feature of seeking meaning that Derrida discussed was the idea of *trace*. Derrida (1967/1976) argued that the present was always complicated by the past and what was anticipated in the future. *Signs,* enduring structures in society, e.g., law and order, were what Derrida said needed to be deconstructed to critique them and thus bring about change (Derrida, 1967/1976). There was a need to do this deconstruction as texts can contain secrets that need to be exposed. An element of secrets was the idea that there was always a binary implied within the text, e.g., the understanding of law and order truly implies that it carries the trace of its opposite – crime and chaos, or unlawful and disorderly. These examples represented the imperfectness of language which was a human creation, and therefore was flawed. It was for this reason that Derrida felt we should return our attention to text itself rather than the creator of it.

3.5.3 Michael Apple

Michael Apple (2013) employed poststructuralist ideation to shine a light on and focus in on education. His work was based on the work of poststructuralist theorists that came before him. He relied on the work of Foucault, Gramsci, Wexler, and others to

shape his, as he addressed the political and economic forces at work in education. Apple (2013) asserted that the social, political, and economic agendas of a region or country were embedded in the curriculum and structures of education.

> Social and economic values, hence, are already embedded in the design of the institutions we work in, in the "formal corpus of school knowledge" we preserve in our curricula, in our modes of teaching, and in our principles, standards, and forms of evaluation. (Apple, 2013, p. 25)

It was the hegemonic forces in society that reinforced an education system in which the educator was perceived as a neutral agent when, in fact, they were far from it. The liberal idea that education brought about social change was false (Apple, 2013). Educators perpetuated the marginalizing features of society within the school system and in the individual classrooms. He posited that unless viewing this through a critical lens, these elements remained tacit to many educators (Apple, 2013). Apple (2013) asserted that a critically reflective mode was important in that:

> First, curriculists help establish and maintain institutions that affect students and others in a myriad of ways…Second, it is important to argue that the very activity of rational investigation requires a critical style. The curriculum filed has been much too accepting of forms of thought that do not do justice to the complexity of inquiry and thus it has not really changed its basic perspective for decades…This is strongly mirrored in the behavioral movement in the quest for taxonomies which codify "cognitive," "affective," and "psychomotor" behavior. (Apple, 2013, p. 44)

The school system afforded the view that curriculum and the guiding principles of education served to reflect and perpetuate the homogenous structure and organization of society (Apple, 2013). In this, Apple (2013) contended that as educators we tend to often put students into categories and ignore the uniqueness of each student, and in this

way conform to the norms established by society. The “normal” or “average” student remained anonymous to the educator, and those labelled as “deviant” or “different” remain as originally labelled and were thus marginalized. This carried over as these students transitioned to other educational institutions or into the general society as the labelling often limited them in their ability to contribute to society (Apple, 2013).

Apple’s work was extensive and went far beyond these elements mentioned here; however, these were the elements of his work that contributed to the study when examining the social and economic construct of the nurse educator, nursing student, nursing curriculum, and nursing practice. Furthermore, nursing remains a female dominated profession with approximately 10% male as of 2019 (CNA, n.d. b). Given this, I determined that poststructuralism needed a feminist lens, so I turned to three philosophers to lends their thoughts to the discussion.

3.5.4 Judith Butler

In 2015, on the 25th anniversary of the release of their book *Gender Trouble,* Judith Butler presented at a conference in Lisbon, Spain, and indicated that a result of the book, the beginning of queer theory was born, yet that was not their intention. It was to reveal the taken-for-granted assumptions of the categories imposed on men and women, but more particularly women (Butler, 2015). Butler (2015) indicated that for generations, society (dominated by men) defined gender by a body’s reproductive ability. However, even within these binary functions, there were genetic and hormonal variations that were never acknowledged in historical discourses. Gender was both cultural and political in meaning, and was prompted by an obligatory binary norm created by power structures designed by men (Butler, 2015). Further, Butler described the achievement of equality as requiring the existence of a just and equitable world. They asserted that a body required others for support, existing in a network of relations, and that gender performativity was traditionally an either/or and that those that did not fit this binary were

marginalized by society (Butler, 2015). Despite advancements in some sectors of society accepting the "other" – women, racialized, and LGBTQ2AII individuals, there remains issues with pay equity, equal access to opportunities, and, in the United States with the recent Supreme Court overturning of Roe v. Wade, a woman's right to control her body. This places those on the margins in precarious positions and at risk for continuing to be left out of the conversations, and therefore, the decisions that impact them the greatest. It is this appreciation and articulation of women living in the margins that resonated with me in Butler's work. Despite some women becoming C-level officers (corporate executives) in organizations, in my opinion, it was only through the adoption of the "male way" of thinking about business. In nursing, a female dominated profession, it may not be visible to most that there is a male domination in society, however when looking at the practice level of nursing, the male-dominated physician group asserts it power by influencing governments who determine and direct the scope of practice of nurses. We saw this in the early development of the extended scope of practice with nurse practitioners (NP), with the Ontario Medical Association concerned about the scope of NP practice and skills (Kaasalainen et al., 2010).

3.5.5 bell hooks

The work of bell hooks challenged me to look beyond myself and the narrow view of feminism that I understood as a youth and much of my adulthood, and to view feminism from a different lens.

Growing up I had heard of the book *The Feminine Mystique* by Betty Friedan and the need for women to break out of the role of housewife to 'bring home the bacon and fry it up in a pan', yet due to my being white and from an upper lower-class home I did not comprehend that this was a privilege reserved for women that had spouses to provide for them. This was what bell hooks termed as the elitist view of feminism (hooks, 1984).

Her experience as a black woman growing up on the margins, made me realize that I did have greater white privilege than I had ever realized. Being from a black, Latina, or poor family, the mother/woman had to work and often it was as a form of servitude as a nanny or maid (hooks, 1984). It was not a choice. Without this income, families would not be able to meet the basic needs of food and shelter. One quote from hook's work *Feminist Theory from Margin to Center* resonated this point, but also posited another key element of feminism, which was the problem of male supremacy.

> Male supremist ideology encourages women to believe we are valueless and obtain value only by relating or bonding with men. We are taught that our relationships with one another diminish rather than enrich our experience. We are taught that women are "natural" enemies, that solidarity will never exist between us because we cannot, should not and do not bond with one another. We learned that lesson well. (hooks, 1984, p. 43)

She added that to follow the male supremacist ideology, women needed to believe they were victims and needed the feminist movement to fix the wrongs; however, women did not need this sense of victimhood to support or believe in feminism. In fact, hooks (1984) asserted that abandoning victimhood was the key to true feminine bonding, for the ability to stand strong in the face of sexism was to find meaningful ways to bond with other women through common ideas and goals. It was these comments that had me wondering if the stereotypical view of women not being able to get along at work was directly related to the fact of the male supremist history of society. Did the males create this dynamic of competition to keep women down? For if women knew the incredible power of working together, they could overtake the male supremist society and the entire culture of the world.

Out of these enlightened moments, hooks coined the term "… 'white supremacist capitalist patriarchy' was a way to define the interlocking systems of domination that

define our reality" (hooks, 2018, 0:20). Further she explained that the elements in this phrase did not act alone but were at work together at all times and shaped the reality of all those that did not fit within the boundaries of the term. hooks (2018) explained the preference of white supremacist over the use of racism as "the term racism keeps white people at the center of the discussion" (1:42).

The reading of bell hooks work brought back many stories I heard growing up and many memories. In the mid 1950s, my mother had a fruitful office manager career and was a semi-pro baseball pitcher who married at age 29, and gave up both to stay home with the children, as that was what white women were to do at the time and what my father, after arriving in Canada in 1952, viewed as a status symbol of success. A woman only worked if she was single, widowed, or was a new immigrant to the country, as was the case of both of my grandmothers; one was widowed and one was a new immigrant who came with very little to Canada.

During my childhood, my mother often talked of missing and wanting to go to work, but in the 1970's she discovered that women over 40 were not welcomed into the workplace as she was told a few times that she was too old. I remember her sense of devastation at this news. My mother realized that she was permanently at a disadvantage to have to depend on my father for money, clothing, etc. As a result, she instilled in me the value of "always make your own money, then you never have to rely on anyone else for it." As a result, a career was a significant personal goal. I wanted to work whether I had children or not. I wanted to have the independence my mother spoke of during those formative years. The feminist view was instilled in my life at an early age, even though I did not appreciate its significance at the time.

Reading and watching bell hooks discuss her view of feminism sharpened my understanding of why a feminist lens was necessary to discern how a white supremacist capitalist patriarchy perpetuated the shape and context of nursing practice, and is

implicated in all recommendations for role clarity in the RN and RPN entry-to-practice competencies.

3.5.6 Chris Weedon

Chris Weedon (1987) articulately explained Feminist Poststructuralist Theory (FPT) as, “By feminist critical practice I mean ways of understanding social and cultural practices which throw light on how gender power relations are constituted, reproduced and contested” (p. vii). Weedon proposed that FPT could provide a lens to examine the intersection of “language, subjectivity, social organization and power” (p. 12) while paying attention to the subjugation of women and the feminine in organizational structures. To understand FPT, it is essential to review the elements that intersect and shape the theory. Weedon (1997) asserted, “Once language is understood in terms of competing discourses…then language becomes an important site of political struggle” (p. 23). Language assumed no universal meaning but was contextual and could vary from culture to culture and profession to profession.

Weedon (1997) followed the work of Foucault in framing her view of poststructuralism which made her view of FPT a good fit for this study. The role of poststructuralism was not to separate and deconstruct how texts were created. Weedon added that “deconstruction theorizes the discursive context as the relationship of difference between written texts [and] does not spell out the social and power relations within which texts are located… [whereas] poststructuralism must pay full attention to the social and institutional context (p. 25). Weedon contended that FPT looked to examine the issue of the plurality of meaning and looked beyond Ferdinand de Saussure’s (1853-1913) assertion of the *sign* suggesting that signs were produced within language rather than reflected by language. The revealing of language in nursing and the meanings of what may seem like common terms, but hold significance or a different connotation when examining it from the nursing lens, is an example of this assertion. FPT

considered the societal and political milieu in which the discourses were created. Discourse gave importance to the discourse of the economy, class structures, and the fundamental connection of theory and practice, all of which related to the profession of nursing and the education of its members, as well as provided the locus for the construction of subjectivity (Weedon, 1997).

Subjectivity was another key concept of poststructuralism. It referred to the conscious and unconscious thoughts and emotions to understand and make sense of an individual's world (Weedon, 1997). FPT, "insist[s] that the individual is always the site of conflicting forms of subjectivity" (Weedon, 1997, p. 32). Subjectivity was not static and could change as a person engaged in different discourses; however, some people may have resisted the contradictions that arose and chose to ignore this expanded knowledge as a form of what I consider 'willful ignorance'. For, in my opinion, the aim of being critical is to recognize these differences, contradictions, and complexities that exist in life and how they came to be, then reflect on these to gain an enriched understanding of the world we live in, and identify opportunities for change.

Performativity was another construct in FPT that involved the study of the intersection of language and gender (Weedon, 1997). Performative utterances reflected the power of action in language, where the words became the effect of the action that it named (Austin, 1975).

> For feminists, the attempt to understand power in all its forms is of central importance. The failure to understand the multiplicity of power relations focused in sexuality will render the analysis blind to the range of points of resistance inherent of the network of power relations …" (Weedon, 1997, p. 124)

Performativity could derive from historical tropes, such as male domination of society, and could be perpetuated in an unconscious manner; therefore, it was important to also look historically at issues to understand how they had evolved or remained the same

over time (Weedon, 1997). For this study, I believed that it was important to recognize the embedded structures in nursing education and how they assisted in unpacking how this this performativity has affected curriculum and pedagogical approaches. However, it is important to note that this theoretical lens implies a subjectivity to the study making it unreproducible and shaped by my existence as a female, my educational experiences both as a learner and educator, and my personal history of nursing practice as well as the language and word usage embedded in the nursing profession. Subsequently, others may take a different view of the findings of this study. In addition, with nursing being female dominated, Weedon (1997) suggested that hegemonic forces "still assumed [females] to be naturally fitted for particular types of work" (p. 83). In addition, Weedon asserted that "…in patriarchal societies we cannot escape the implications of femininity. Everything we do signifies compliance or resistance to dominant norms of what it is to be a woman" (p. 87). I understand this to be that there is a contradiction in what it means to be a woman, or as Weedon suggested, that women were always in some way or another reacting to the situation and changing our mode of womanhood to adapt to patriarchal society.

3.6 Features of Feminist Poststructuralist Theory

To employ FPT, I needed to understand the underlying assumptions, limitations, and contributions to nursing and the research study. These were important to understand as I sought to make recommendations for change and further research into the issues of role confusion and the entry-to-practice documents.

3.6.1 Underlying assumptions of FPT

The poststructuralist or "linguistic turn in theory," (Carter, 2013) proposed a major shift "from the objects of knowledge to the processes of knowledge" (p. 583). With this shift came two critical assumptions: Language constructs reality, and the shifting meaning of language then shifts reality and the shift of language could come from

relationships (Carter, 2013; Francis, 2000; Weedon 1987). Feminist poststructuralism examined structural processes and explained, “How paying attention to the specific experiences and situated perspectives of human beings [can] become a *tool* [italics original] for knowledge building and rich understanding” (Brooks & Hesse-Biber, 2007).

Carter (2013) added that FPT valued the causes, effects, and cultural and historical production of objects. Aranda (2006) promoted that there were different versions of poststructuralism that remained compatible with feminist theory. She furthered this assumption by stating that instead of the absence of truth “there is an acknowledgement that all theory is provisional representing a perspective that needs to be exposed and its construction understood” (p. 137). Francis (2000) revealed a dichotomy in FPT as it aimed for deconstruction while retaining the feminist need to explain the socioeconomic reality of gender difference or what Weedon (1997) considered the feminist grand narrative. Poststructuralism alone could not reconstruct, only deconstruct; therefore, the addition of the feminist lens allows for the applicability in nursing research and the retention of a grand narrative that grounds the research in the realities of a feminine dominated profession.

In FPT there were multiple versions of the truth and thus does not attempt to pin down a researcher to look for absolute answers, instead it questioned the grand narrative and shed light onto the multiple possibilities of the meaning of a discourse (Frost & Elichaoff, 2014; Heslop, 1996) while revealing the structures that may serve to oppress the feminine.

3.6.2 Limitations of FPT

Heslop (1996) contended that there was a disconnect between the use of CST and FPT in research studies for nursing. She stated that “language, in poststructuralist theory, is viewed as the articulation of various discourses that pre-exist and transcend the individual exposed to them… [and serves as] relations of power… seen to lack

emancipatory intent" (p. 51). Bevir (2011) further posited that the words used in language created meanings that were not derived from the actions of the agents using these words but from the "reified languages based on the difference among semantic units" (p. 11) leading to what Francis (2000) described as "a problematic relationship with movements for social change" (p. 22). She stated that FPT can reveal the dominant discourses around a topic, but its function is not to attempt to alter them, rather to make them visible so others can see potential needs for change. Further, Weedon (1987) suggested that de Saussure's work on poststructuralism did not account for changes in the meaning of words over time, nor account for the different meanings based on the social and political structures being examined. Weedon asserted that "experience has no inherent essential meaning [but] may be given meaning in language" (p. 34). However, this could prove problematic as different experiences of the same event could serve conflicting interests. Therefore, it was understood that experiences may not fully legitimate the analysis of the discourse and may contribute to the analysis; yet, it cannot be undone or removed from my analysis of the discourse around RN and RPN ETPC.

3.6.3 Contributions to Nursing and the Research Study

Heslop (1996) examined the relationship between critical social theory and poststructuralism and its usefulness to use both when examining the concept of power and how it constructs knowledge and demonstrates the interrelationship of knowledge and truth. Heslop (1996) further asserted that poststructuralism could expose the "limits of critical social theory approaches and its need to be reflexive" (p. 52). Grant and Giddings (2002) agreed with Heslop's view of power and subjectivity but added that power was complex, a network if you will, between people and that we were all subjects in the study as all views are valuable and important. The researcher is enmeshed as a subject as well as in creating the knowledge which can cause the researcher to become

bogged down in an endless cycle of re-searching for answers exploring the nuances that comes with an attempt to analyze discourse. To illustrate this dominance of ideology, I reflected on my own lived experience in nursing education, and I understand how I have been cultured into a profession that perpetuates a certain world view. There is a world of nursing with certain expectations of how its knowledge and culture are created and legitimized overtly and covertly. I live this every day in my work as a nursing educator. Like culturally and ethnically diverse students in elementary and secondary education, nursing students are asked to assimilate to the curriculum and thus profession (system) and acculturate from their previous life and ways of being. Therefore, nursing education is not a neutral enterprise. Core courses in nursing curriculum address professionalism and how to behave in certain circumstances. Barratt (2018) saw this as problematic where nurses are on one hand to manage emotions and non-verbal communication, “while showing empathy and compassion whilst keep strong reactions that may arise from these under control” (p. 3). She further explored this dissonance and looked to build resilience in nurses. As an educator, I am encouraged to continue to preserve the notion that the world of nursing has an archetype of what it means to be a professional; perpetuating a “complex, stratified and unequal society” (Apple, 1979, p. 21).

Looking at the documents that inform entry-to-practice nursing education and therefore practice, FST can provide me with a lens to view the event and decisions that led to the current issue of RN and RPN role confusion and hopefully shed light on role clarity. It is important to note that feminist poststructuralist discourse analysis is a methodology in and of itself, however, this study does not use it as a methodology, rather it is used to illuminate the tension of power and subjectivity in a profession dominated by those who identify as female and who, until within approximately the last

60 years, have been dominated by a male world view in North America and in other places around the world.

Chapter 4

4 Findings of the Research

As noted in Chapter One, the research study aimed to answer three key questions:

1. What similarities and differences exist in the discourse contained within the two entry-to-practice documents?
2. How do the entry-to-practice competencies of the RN and RPN and their interpretations create distinction between the two nursing roles?
3. How does this discourse impact nursing educators and employers?

The analysis of the documents and the process that I took to explore the questions, follows. The chapter summary draws together the data to provide answers to the research questions.

I feel it is essential to acknowledge again that the results in the analysis were filtered through my experiential lens of professional nursing practice, and education. It is possible that others may view the ETPC differently or take a different approach to the analysis. My goal in this study was to unapologetically provide a succinct guide for nursing educators, practitioners, and employers to make visible the key differences and similarities between RN and RPN entry-to-practice education and practice expectations. In this way, clients receiving care have the most appropriate care provider for their needs, and the protection of the public is ensured. I understand that this may seem contradictory to the theoretical lens that I employ in the study, and this guide is to serve as a starting point for conversation as these documents undergo routine revision and my findings will be time limited in their applicability.

4.1 The Level of Sociocultural Practice

Fairclough (1992) considered sociocultural practice to be comprised of several elements that influenced text creation: target audience, and the nature of the relationship of the creator of the text to the consumer of the text. To review, there were two main elements of sociocultural practice – ideology and hegemony. Ideology is concerned with assessing a text by examining the institutions involved in its creation and how these influence the construction of reality. Hegemony looks at the position of the producer of the text in relation to their position in society, and the influence they can have in creating the constructed reality. The sociocultural practices involved in the creation of the RN and RPN Entry-to-Practice Competencies is multilayered and multifaceted.

To understand the creation of the ETPC, one must first understand how a registered nursing professional in Ontario has been defined by legislation created by multiple governments over time. As the world progresses and changes, so too do laws progress and change. The Nursing Act (1991/2021) and the Regulated Health Professions Act [RHPA] (1991/2022) underpin the role and function of a nurse in Ontario and the requirement of having a professional college to regulate the members and ensure the safety of the public. These two laws have been amended several times since their original creation, with the Nursing Act having undergone a significant change in 2021 and the RHPA being revised in 2022. These most recent versions are not included in the analysis of the RN and RPN ETPC, as they occurred after the latest versions of the ETPC.

The Government of Ontario has expanded the practice of nursing over the last 30 years with the most significant changes in practice occurring with RPNs and the creation of the formalized Nurse Practitioner role. The 1991 version of the Nursing Act (1991/2021) set the stage for the transformation of the Registered Nursing Assistant into the Registered Practical Nurse. In 2000, its revision signified that by 2005 an RN must

have a 4-year bachelor's degree (BScN – Bachelor of Science - Nursing, BSN – Bachelor of Science in Nursing, or BN – Bachelor of Nursing), and an RPN must have a 2-year college diploma rather than a certificate to enter practice. In 2014, the RPN became able to perform the controlled acts (RHPA, 1991) of nursing practice and then in 2018, they could perform these independently given that the situation met the College of Nurses of Ontario three-factor framework for the client, the nurse, and the environment. How these changes came about is an intricate dance between the Ministries of Health, Long-Term Care, and Colleges and Universities, the Registered Nurses Association of Ontario (RNAO), the Registered Practical Nurses Association of Ontario (WeRPN), the College of Nurses of Ontario (CNO), the Ontario Hospitals Association (OHA), the Ontario Medical Association (OMA), the College of Physicians and Surgeons of Ontario, and the Canadian Nurses Association (CNA).

One may wonder why so many players engaged in the creation of the scope of practice in nurses. The answer is not simple, nor does it occur in a linear fashion. It cannot be described as a spider web, for there is organization and a process to its creation. I would describe it as a ball of yarn that a kitten has batted at and unravelled around all the furniture (the power brokers) in a room. There is a start and a pause (with potential for more unravelling) in the process, but in-between it is chaotic, takes multiple turns, and depends on the size and agility of the kitten as to where the yarn can go. Thus, it becomes challenging to describe in written form without sounding like I am running around in circles; however, I shall attempt it here.

The penultimate authority of the scope of practice of nurses is the CNO. It is their board that decides whether it can approve the changes proposed to practice. The board is made up of nursing professionals as well as members of the public with the primary purpose being to ensure the safety of all clients cared for by a nurse. Sometimes the impetus for change evolves from the CNO as a function of

keeping up with the advancing practices in other provinces, which the CNA suggests based on input from the other provinces and international changes in health and wellness. The COVID-19 pandemic is the most recent example of a world health issue impacting nursing practice and entry-to-practice education. As well, there are times when RNAO or WeRPN advocate for changes in scope of practice. One such lobbying effort by RNAO in 2017 was for the RN to be able to prescribe some basic medications in response to the announcement that RPN practice expanded to include initiation of the controlled acts of nursing. The prescribing of medication was traditionally done by physicians, dentists, and in the last 15-20 years by nurse practitioners. RNAO wanted to create greater distinction between the RN and RPN. The medications listed were related to those services offered in public and community health environments – immunization, travel prevention and treatment, contraception, smoking cessation, topical wound care, and over-the-counter medications. Nurses working in a public hospital would not be permitted to prescribe. In response, the CNO determined that this would not be a part of entry-to-practice education, but is meant for practicing nurses with experience and clinical judgment skills. These nurses will be required to obtain additional education and will have it noted on their license. The Wynne government had approved this legislation in principle and asked the CNO to engage stakeholders regarding prescribing medications. The OMA and College of Physicians and Surgeons were interested parties as this could potentially impact the work of a physician, so there was a lot of debate about this proposed change in scope. The transition to the Ford government in 2018, and the global pandemic in 2020 until the present, moved this initiative onto the back burner.

The final decision-maker for any change to scope of practice or other practice-related changes rests with the provincial government. The pandemic shifted focus to the massive nursing shortage and having nurses out and working faster after graduation and

making it easier for retired and non-practicing nurses to reinstate their license. Prior to the pandemic, the new graduate nurse needed to obtain a temporary licence to work as a nurse before their registration was finalized. This required a job offer and paying a fee for the temporary licence. Now, they must prove they have completed the program and have a confirmed date to write the NCLEX or REx-PN exam. Nurses who had let their licence expire, retired, or resigned and wanted to work as a nurse again had to demonstrate several steps to have their licence reinstated. The Ontario Ministries of Health and Long-Term Care identified a need for a shift in priority related to nursing practice, and they raised alarm bells at the dearth of nurses in the province available to provide care.

In another example, in 2019 to early 2020, Ontario colleges were actively seeking stand-alone nursing degrees offered at community colleges. From 2000 until that time, colleges could offer a degree only if they had a university collaborative partner. Colleges Ontario lobbied for this opportunity to the Ministry of Colleges and Universities. In turn, the ministry lobbied the CNO and government to allow for this change. Both the government and the CNO must have agreement for a change such as this legislation to pass, as another function of the CNO is to approve the curriculum and overall function of nursing programs in Ontario.

4.2 Nursing Curriculum

The development of nursing curriculum is a multifaceted process. To understand the development of curriculum at a school level, it was important to understand the institutional curriculum that shapes nursing programs. Institutional curriculum in nursing sits at the intersection of nursing professional bodies, society, and schooling (Deng, 2009). Nationally, the Canadian Nurses Association (CNA) meets with world nursing associations to discuss a broad range of nursing issues around the world. From these discussions, the CNA meets with provincial and territorial nursing regulators to

determine core national competencies required for RN nursing graduates to be prepared for nursing practice. “The competencies also serve as a guide for curriculum development and for public and employer awareness of the practice expectations of entry-level registered nurses” (Canadian Council of Registered Nurse Regulators [CCRNR], 2012, p. 5).

In 2017, during a collaborative program team workshop, a colleague discussed their role in working with the CNO to begin to develop new RN entry-to-practice competencies. Nursing faculty members in the room, identified a need for greater clarity of the meaning of the current competencies, as they were repetitive open to interpretation. All faculty in the room were encouraged to see that educators were going to have input into competency development and not solely the representatives of the regulatory bodies. Why, may you ask? Nursing practice had been changing significantly in the previous few years. Clients were becoming much more complex to care for in clinical settings; not just from a disease burden perspective, but the social and psychological complexities were also increasing. Addiction, mental health issues, poverty, and homelessness were far more visible in the clinical setting than in previous years, and students required competence in these areas upon entering nursing practice.

Competence or competency as a construct has multiple layers of meaning. Merriam-Webster (2023a) defines competence as “the quality or state of having sufficient knowledge, judgment, skill, or strength (as for a particular duty or in a particular respect)” (p. 1). Lingard (2009) discussed the implications of competence as a ‘god term’. Lingard asserted that this word supersedes all others in importance and takes on a life of its own. She further noted that healthcare is full of god terms that define and frame a health profession’s education. If a health care professional is competent, then it was assumed that they were competent in all areas of practice and

would remain so until something untoward occurred to question that competence. However, this becomes problematic in that it also implies a clearly individualistic lens. Lingard posits that knowledge and skill acquisition is a collective endeavour as we do not learn in isolation, but with others. Competence in an individual is the goal, but unfortunately it becomes an all-encompassing term that fails to illustrate degrees, fluctuation, or collectiveness in the construct of competence in health professions that cannot perform competently without the collective efforts of all the health professions involved in client care. There is an interdependence inherent in competency that fails to be reflected adequately to health education learners (Lingard, 2009).

Another factor impacting nursing education was the changing nursing student entering the profession. Having educators partake in the discussions would bring the realities of the changing student profile to light. As an example, from my experiences, since I began teaching nursing programs in 2001, the student had changed because society had changed. The elementary and secondary school system had changed. The accountability of the student was altered by policies that supported the late submission of assignments with little to no penalty. The term “helicopter parenting” had entered the lexicon. This has been defined in the literature as:

> overprotective, or oversolicitous [*sic*] parenting... a form of parenting that includes intrusive and unnecessary micro-management of a child’s independent activities, [and] that attempts at control are linked to negative child outcomes... (parent–child closeness and child self-worth, and the highest levels of child depression, anxiety, and impulsivity) ... in emerging adulthood. (Padilla-Walker & Nelson, 2012, pp. 1178–1179)

More recently, the results of snowplow parenting have become a phenomenon seen in young adults “Snowplow parenting, also called lawnmower parenting or bulldozer

parenting, is a parenting style that seeks to remove all obstacles from a child's path, so they don't experience pain, failure, or discomfort" (WebMD, 2021, p. 1). It has been my and many colleagues experience that students who entered nursing programs directly from high school did not have the communication skills to advocate for themselves, let alone others, as their parents intervened to advocate for their children. Communication is a fundamental role of the RN and embedded in many RPN ETPC and an essential skill for nurses. Through the years, I have had experiences with several first and second year students who could communicate their needs, but not in a productive or constructive way. They would become defensive when they did not get the grade that they had hoped for, and as was typical, would blame me for their lack of success. This has been a standard mode of operation for decades with students. The difference now is that mom and dad were brought into the conversation to support their child's perspective. Years ago, as a provider of adult education, it was foundational that you worked with the student alone, but now there is another layer of dealing with parents. Another lifestyle factor that has changed communication for everyone, but particularly youth, is the cell phone and texting preferences. In and around 2011, I did a little experiment with my first-year students when we were discussing therapeutic verbal communication. I asked the students to not use their cell phones for texting for a week and then write a reflective journal about the experience. More than three-quarters of the students could not complete the activity, some for very valid reasons like the need to be able to be contacted in the event of an emergency with their children. Others just said that they could not cope without texting on their phone. Those that did complete the activity found it very challenging and did not like the experience. They found that calling people on the telephone was intimidating. This was to demonstrate to the students what they will not have access to when working as a nurse. The nursing student must develop effective and therapeutic communication skills. They are fundamental to

nursing practice. As a result of these two fundamental changes, there is more learning and support that must be given to nursing students so that they cannot only advocate for themselves but advocate for others as well. Consequently, there was a need to ensure that the competencies were clearer about accountability, independent thinking, and communication.

In 2018, I attended a presentation/webinar by the CCRNR regarding the update on the process of revising the entry-level competencies for RNs. The presentation explained the change in format of the competencies and how the old competency document (that was categorized in a different way) correlated to the new role-based competence of RN entry to practice. The presentation summarized the changes and the rationale for them. At that time, they had not completed their work, as they identified 85 competencies and 8 roles, whereas the completed document resulted in 101 competencies and 9 roles. It became clear to me that this new approach was very important to the CNO as they presented their work before it was finished. They also provided a link for nursing educators to review the competencies and provide further suggestions for change.

The Canadian Council of Practical Nurse Regulators [CCPNR] (2016) determine the core national competencies for RPN entry to practice. The latest iteration of these competencies was completed in 2019. In speaking with the RPN program approval lead at the CNO, the RPN competencies were developed into new practice roles by the CCPNR national working group in 2019. At the same time, RN competencies were being developed by the CCRNR national working group. RPN competencies were developed quickly to ensure that they were available to create the exam blueprint for the new REx-PN exam. Future considerations to merge the two competency frameworks would require interest and collaboration between CCRNR and CCPNR for that to be considered for the next iteration of competency development expected to start in 2024

(D. Rawlin, personal communication, March 24, 2021). Some provinces and territories adopt the national competencies as written, while the CNO further nuance these into Ontario specific entry-to-practice competency interpretations. As far as the RPN competencies are concerned, British Columbia and Ontario added 3 additional competencies due to the different nature of the RPN role in their provinces (as noted in chapter 2). Every five years, these competencies undergo review with the latest revision occurring in 2019. See Figure 4.1 for the overlap of agencies involved in the development of nursing competencies and how they inform curriculum in nursing education. See Table 4.2 for a comparison of the new role-based RN ETPC and the old categories of RN ETPC.

Another layer added to the nursing curriculum is generated through the accreditation of schools of nursing. The Canadian Association of Schools of Nursing [CASN] (CASN, n.d.) oversees accreditation of degree nursing programs in Canada. Until 2020, when the most recent ETPC came in effect, the CASN accreditation process served as the CNO RN program approval process, but that has changed. Now, in Ontario, accreditation refers to a quality assurance process of the school, faculty, program, and services.

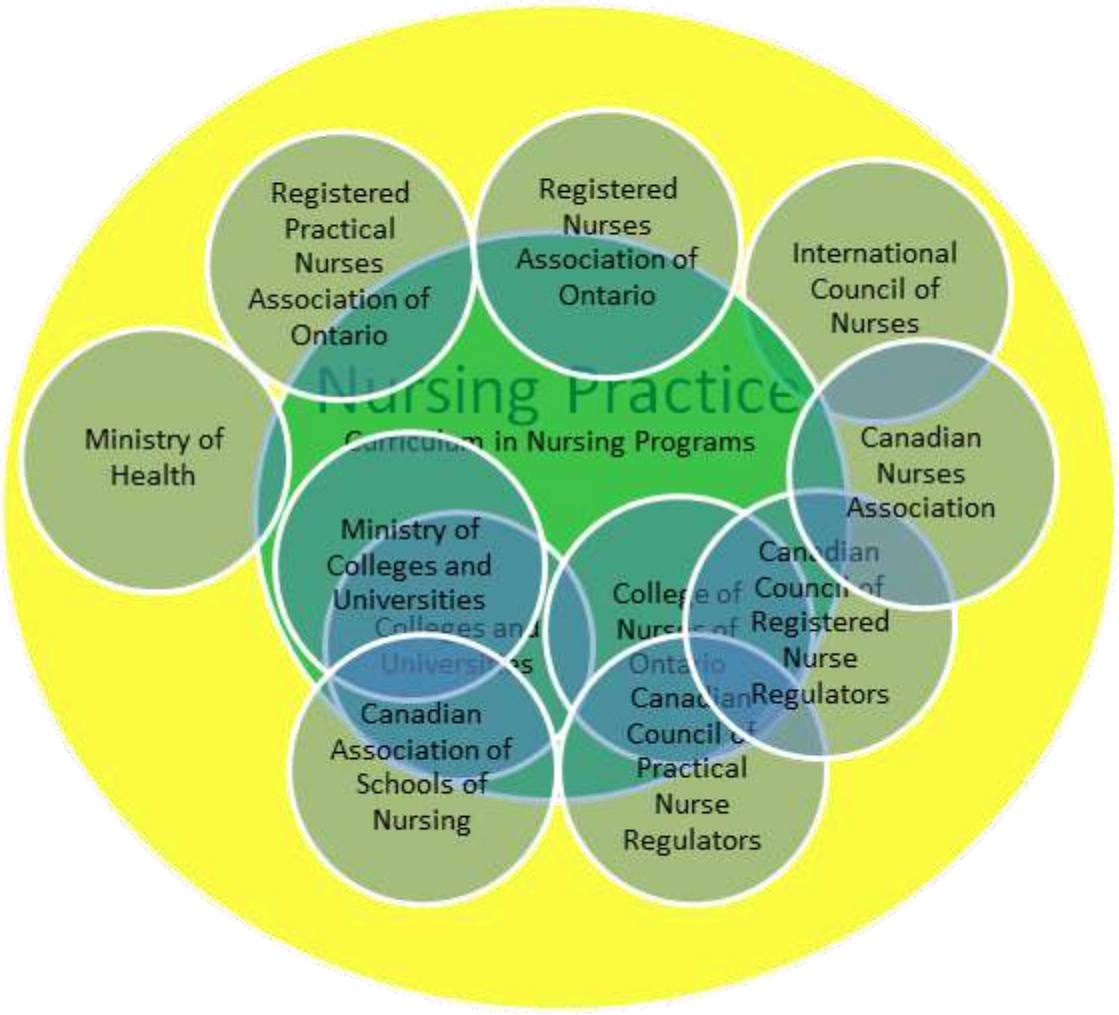
> [CASN] Accreditation identifies strengths and opportunities for improvement that can guide decision making. The process provides administrators and faculty with information regarding areas that require development, modification and/or resources. The program of accreditation sets forth overarching quality dimensions, standards, descriptors, and key elements against which nursing programs and their institutional units are assessed while also incorporating flexibility regarding the organizational structure and curriculum. This flexibility enables programs to be autonomous in their academic perspectives and

responsive to their particular regional, social, professional, and institutional contexts. (CASN, n.d., para 1-2)

As mentioned earlier, the diagram below depicts the agencies involved in the creation of the entry to practice competencies and the overlapping relationships between them.

Figure 4.1

A Graphical Resepresentation of the Organizations Involved in Nursing Practice and Curriculum Development in Ontario, Canada



These organizations live within the *political* milieu of nursing practice which may change with new governments and/or with *economic* turns through time. The overlap illustrates the interwoven nature of these organizations' impact on nursing practice.

The CNO program approval encompasses many of these elements as well as ensuring public safety and assesses the curricular content of the program to meet the needs of a newly graduated nurse ready to practice in Ontario.

> [Program approval is] a monitoring process for approving all entry-level nursing education programs (Practical Nursing, Baccalaureate Nursing and Nurse Practitioner) in Ontario... Program approval ensures graduates are prepared to practise nursing safely, competently and ethically for the nursing category and/or class for which they want to register.
>
> CNO's registration regulation requires that all applicants have graduated from a program approved by CNO's Council. Making sure this regulatory accountability is consistently and effectively applied to all nursing education programs is fundamental to protecting the public. (CNO, 15 March, 2022)

With the introduction of the newest set of competencies in late 2019, established programs for both BScN and PN were required to demonstrate how never-before-discussed competencies were woven into their curriculum and students who were currently in programs would meet these new ETPC upon graduation. This had not happened before, and it signaled a new level of accountability for nursing programs to the College of Nurses (CNO).

The CNO approves both RN and RPN schools of nursing in Ontario. In view of this structure, "the outcomes of schooling [are] not thought of as the cultivation of unique talents, but the achievement of standardized goals" (Eisner, 2002, p. 71). Tyler (2013) notes, "These educational objectives become the criteria by which materials are selected, content is outlined, instructional procedures are developed, and tests and

examinations prepared" (p. 60). Guided by these professional objectives, each university or college creates a school-based or programmatic nursing curriculum (subjects, courses, and materials) (Deng, 2009; Kennedy, 2010). In Ontario, each school of nursing can determine its own school-based curriculum, but presently, must pass the program approval process and ensure that it provides students with the opportunity to achieve all the CNO entry-to-practice competencies by graduation (CNO, 2019a, 2019b). These competencies become the "ends" of the institutional curriculum with the "means" being the school-based or programmatic curriculum that is developed (Tyler, 1949). Institutional curriculum was defined as the interaction of culture, society, and public policies on education. Programmatic curriculum attended to the schools' program's content, courses, and pedagogical approach to teaching and learning. School-based curriculum involved the individual schools and their policies which aid in the design of a quality program of study (Doyle, 1992; Tyler, 1949). Tyler (2013) later asserts a position on higher education.

As Tyler (2013) notes for higher education programs, "courses of study prepared by … subject specialists … represent their conception of objectives that the school should attempt to attain" (p. 64). Therefore, meeting the entry-to-practice competencies is the overarching goal of the curriculum of all nursing programs. This became evident to me during the program development process when there were times that creative and innovative ideas were constrained by the need for a certain percentage of elective courses, a more generic curriculum where specialized nursing fields were reduced from featured courses to survey courses, financial viability, and the need to make transparent the language of the CNO ETPC and their interpretations in course outcomes, objectives, and teaching materials.

4.3 Discourse Practice

The 2019 Registered Nurse Entry-to-Practice Competencies [RN ETPC] (CNO, 2019a) mark a significant departure from the previous version of 2014 (CNO, 2014a). Table 4.1 illustrates these various categories (numbering of competencies). Each major category of competency has a descriptor and the descriptors in each category of this version were taken from the National Competencies in the context of entry-level Registered Nurse practice, 2009, yet in the 2019 version of competencies, there is no mention of this document or an updated version. I find it curious that the descriptors were RN-based, but when understanding the addition of controlled acts (as defined by the Regulated Health Professions Act, 1991) to RPN practice, this was new and needed to be explained through the lens of an established set of practices. However, one could also view it as "professional creep": something that happens when intersecting roles are not clearly defined.

Table 4.1

New Role-Based ETPC Categories and the 2014 ETPC Categories (number of competencies within)

2019 Role-Based RN ETPC	2014 RN ETPC
Clinician (1.1-127) Professional (2.1-2.14) Communicator (3.1-3.8) Collaborator (4.1-4.5) Coordinator (5.1-5.9) Leader (6.1-6.11) Advocate (7.1-7.14)	Professional Responsibility and Accountability (1-23) Specialized Body of Knowledge (24-35) Application of Knowledge i) Ongoing Comprehensive Assessment (36-44) ii) Collaborating with Clients to Develop Health Care Plans (45-53) iii) Providing registered nursing care (54-69)

2019 Role-Based RN ETPC	2014 RN ETPC
Educator (8.1-8.5) Scholar (9.1-9.8)	iv) Ongoing Evaluation Client Care (70-74) Ethical Practice (75-86) Service to Public (87-94) Self-Regulation (95-100)

The current RN ETP competencies (CNO, 2019) marked not only a significant departure in structure but also provided the opportunity for educators to provide feedback before the final draft was crafted. A discussion in an annual nursing education program meeting reported that the goal of this new set of competencies was to make it clearer for nurses, educators, employers, and the public to understand the different areas of nursing practice. The categories of nursing practice were gone, replaced by roles of the RN with varying numbers of competencies in each category and increasing its total number of competencies for a grand total of 101.

The RPN ETPC were published in the same years as the RN ETPC with this parallel work being conducted by the CCPNR. Table 4-2 illustrates the difference in competency development from the 2014 to 2019 categories (number of competencies). In addition, there were significant changes to the 2019 version of the RPN EPTC, namely going from 121 in number to 79 as well as a change in approach for categorizing the competencies. Ontario and British Columbia (BC) have 79 while there are 76 for the remainder of provinces and territories. The three additional competencies,

numbered 28, 62, and 79, were demanded by those two provinces and so were included in the document and labelled as such.

Table 4.2

RPN ETPC Categories List from 2019 and 2014

2019 Practice Roles-Based RPN ETPC	2014 RPN Areas of Practice/Nursing Process-Based ETPC
Profession Practice (1-19) Ethical Practice (20-28) Legal Practice (29-36) Foundations of Practice (37-62) Collaborative Practice (63-79)	Professional Responsibility and Accountability Assessment (1-15) Planning (16-30) Implementation (31-50) Evaluation (51-62) Ethical Practice Assessment (63-68) Planning (69-72) Implementation (73-81) Evaluation (82-83) Service to the Public Assessment (84-87) Planning (88-90) Implementation (91-98) Evaluation (99-102) Self-Regulation Assessment (103-110) Implementation (111- 118) Evaluation (119-121)

“Each province and territory’s practical nurse regulatory body validates and approves the entry to-practice competencies that apply within its jurisdiction” (CNO, 2019b, p. 4.) When questioning as to why there were 3 extra competencies for Ontario and BC, these provincial jurisdictions, “made the decision to specifically identify these three additional ETP competencies as part of their adapted framework. They are reflected on the REx-PN exam blueprint and incorporated into CNO’s Program Approval Comprehensive

Review - Curriculum Assessment for PN programs." (D. Rawlin., personal communication, June 8, 2022). These two provinces opted to pursue a US-based testing platform for licensure beginning in 2023 (REx-PN by the National Council for State Boards of Nursing based in Chicago, Illinois), whereas the other provinces remain with the Canadian-based exam platform. This new testing method is the reason for these additional competencies.

The ETPC competencies for both the RN and RPN presented the materials in a unique way, changing the dynamic from their previous iterations. In Ontario, the CNO reviewed these competencies and then created interpretation statements to aid educators to determine what elements need to be included in the curriculum. The Program Approval team at the CNO, stated that they worked together (RN and RPN team members) to create the interpretation statements, and that was why there were some significant similarities in wording of the interpretation statements.

4.3.1 Analysis of the Texts of RN and RPN Entry-to-Practice Competencies

In creating a practical method to begin my comparison of these two documents, I examined the "front matter" which sets the stage for the list of competencies. Here I found identical wording as well as key differences in this portion of the document. In my professional experience as a Nurse Educator engaged in working with these documents, I noticed that when my colleagues and I would read the competencies, the front matter was often excluded in favour of getting to the 'meat and potatoes' of the actual competency statements. Yet, there is some key information presented in that front matter that can aid in understanding.

4.3.1.1 Front Matter Similarities and Differences. In the front matter of the competency document, there are significant similarities in not only structure and

appearance but wording, which is verbatim in several instances. Figures 4.2, 4.3, and 4.4 demonstrate these similarities and differences.

The table of contents outlines the different approach to the creation of the competencies. The RPN document on the left shows the assumptions underlying the document creation, whereas the RN document shows overarching principles. In addition, the RN document on the right shows the competency framework with the 9 roles of the nurse, whereas just the competency statements are in the RPN document as there is no framework. Both acknowledge the contributions of the respective council of nurse regulators as highlighted in Figure 4.2.

In Figure 4.3, as highlighted in each document, there is a substantive formatting difference as noted in the introduction. The RPN document uses bullets to list the "variety of regulatory activities" whereas the RN test lists them as part of the paragraph. The words are identical but the use of the bullets in the RPN document on the left provides greater emphasis and clarity as I read it. Bullets add emphasis to the list as well, supported in the principles of bullet use within Microsoft Word. In the RPN document, there is a paragraph under the purpose of the document that is absent in the RN document. The RPN paragraph provides a summary of the table of contents where the RN document does not include it. The rationale for the inclusion and exclusion of the summary paragraph is unclear. Given that the creation of the RN document occurred earlier than the RPN document, there is the possibility that clarifying the purpose was lacking in the RN document. Conversations with those at the CNO yielded no insight into this difference. Another slight difference is the font used for the subtitles under the purpose of the RPN document section. This takes up greater space and lengthens each subsection by a part or whole line of type. As shown, a key difference between the front matter of the two documents in Figure 4-3 is introduced at the bottom of this page on the RN document which is the overarching principles.

Figure 4.4 is where we see the departure of similar construction and wording of the document. In the RPN document on the right you see that there are “Assumptions” applying to the practice of practical nursing in Canada. All elements are bulleted with sub-set bullets used in the first point. As mentioned for Figure 4.3, the RN document numbers and bullets the “Guiding Principles” and provides a diagram of the conceptual framework for organizing competencies. There are 11 assumptions of practical nursing practice and seven guiding principles of RN practice. Table 4.3 summarizes the content of each and highlights by colour the similarities noted.

Figure 4.2

Page 2 of Table of Contents and Acknowledgements from the RN ETPC (CNO, 2019a) and RPN ETPC (CNO 2019b) documents

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Acknowledgments

The College of Nurses of Ontario (CNO) would like to thank CNO members who participated in the review and revision of this document. CNO also recognizes and thanks the Canadian Council of Registered Nurse Regulators' Revision of Entry-Level Competencies Project Working Group for the foundational work on entry-level competencies.

First Published March 1998 as Entry to Practice Competencies for Ontario Registered Nurses as of January 1, 2005; Updated June 2005; Revised February 2007; Revised June 2008 from the Jurisdictional Competency Project: Entry-level Registered Nurses; Revised February 2009 as National Competencies in the context of entry-level Registered Nurse practice. Adopted for Ontario Registered Nurses' Entry-to-Practice Competencies (ISBN 978-1-77116-009-8). Updated June 2018 for title change: Entry to Practice Competencies for Registered Nurses. Revised 2019.

Additional copies of this booklet may be obtained by contacting CNO's Customer Service Centre at 416 928-0900 or toll-free in Canada at 1 800 387-5526.

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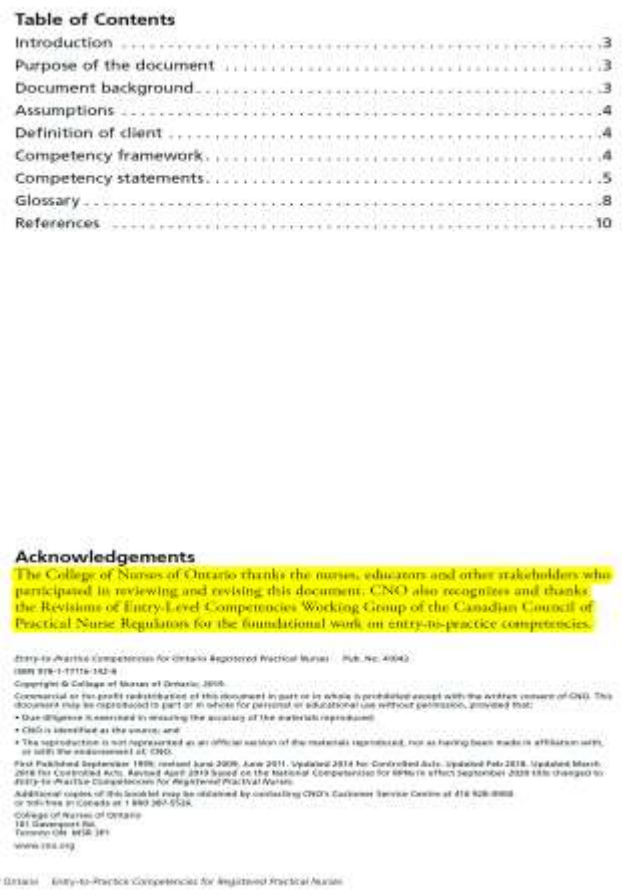

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Acknowledgements

The College of Nurses of Ontario thanks the nurses, educators and other stakeholders who participated in reviewing and revising this document. CNO also recognizes and thanks the Revisions of Entry-Level Competencies Working Group of the Canadian Council of Practical Nurse Regulators for the foundational work on entry-to-practice competencies.

First Published September 1999; revised June 2009, June 2011. Updated 2014 for Controlled Acts. Updated Feb 2018. Updated March 2018 for Controlled Acts. Revised April 2019 based on the National Competencies for RPNs in effect September 2018 title changed to 2019 Entry-to-Practice Competencies for Registered Practical Nurses.

Additional copies of this booklet may be obtained by contacting CNO's Customer Service Centre at 416 928-0900 or toll-free in Canada at 1 800 387-5526.

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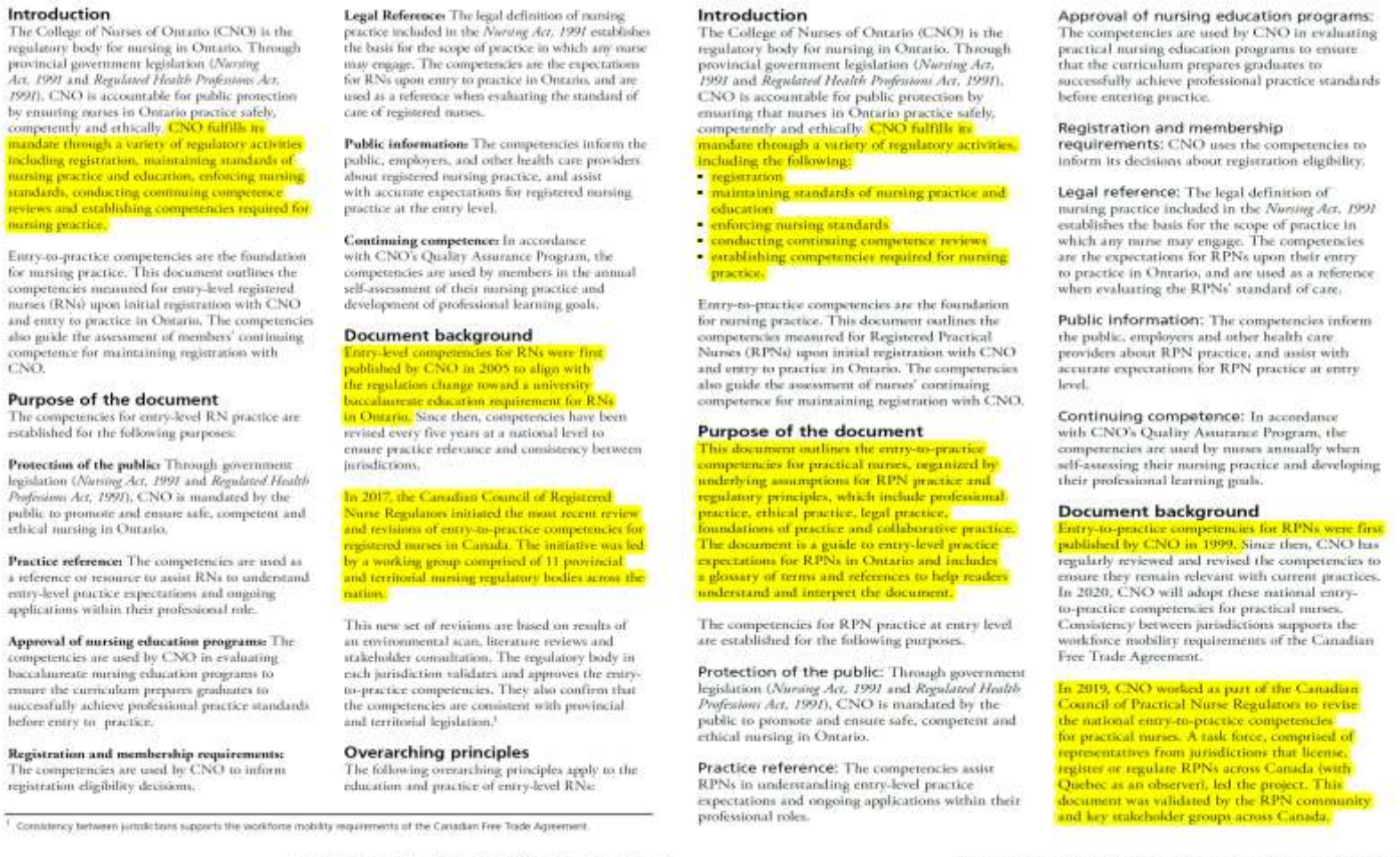
Figure 4.3

Page 3 of Front Matter from CNO RN (2019a) and RPN (2019B) ETPC Documents



Introduction

The College of Nurses of Ontario (CNO) is the regulatory body for nursing in Ontario. Through provincial government legislation (*Nursing Act, 1991* and *Regulated Health Professions Act, 1991*), CNO is accountable for public protection by ensuring nurses in Ontario practice safely, competently and ethically. CNO fulfills its mandate through a variety of regulatory activities including registration, maintaining standards of nursing practice and education, enforcing nursing standards, conducting continuing competence reviews and establishing competencies required for nursing practice.

Entry-to-practice competencies are the foundation for nursing practice. This document outlines the competencies measured for entry-level registered nurses (RNs) upon initial registration with CNO and entry to practice in Ontario. The competencies also guide the assessment of members' continuing competence for maintaining registration with CNO.

Purpose of the document

The competencies for entry-level RN practice are established for the following purposes:

Protection of the public: Through government legislation (*Nursing Act, 1991* and *Regulated Health Professions Act, 1991*), CNO is mandated by the public to promote and ensure safe, competent and ethical nursing in Ontario.

Practice reference: The competencies are used as a reference or resource to assist RNs to understand entry-level practice expectations and ongoing applications within their professional role.

Approval of nursing education programs: The competencies are used by CNO in evaluating baccalaureate nursing education programs to ensure the curriculum prepares graduates to successfully achieve professional practice standards before entry to practice.

Registration and membership requirements: The competencies are used by CNO to inform registration eligibility decisions.

Legal Reference: The legal definition of nursing practice included in the *Nursing Act, 1991* establishes the basis for the scope of practice in which any nurse may engage. The competencies are the expectations for RNs upon entry to practice in Ontario, and are used as a reference when evaluating the standard of care of registered nurses.

Public information: The competencies inform the public, employers, and other health care providers about registered nursing practice, and assist with accurate expectations for registered nursing practice at the entry level.

Continuing competence: In accordance with CNO's Quality Assurance Program, the competencies are used by members in the annual self-assessment of their nursing practice and development of professional learning goals.

Document background

Entry-level competencies for RNs were first published by CNO in 2005 to align with the regulation change toward a university baccalaureate education requirement for RNs in Ontario. Since then, competencies have been revised every five years at a national level to ensure practice relevance and consistency between jurisdictions.

In 2017, the Canadian Council of Registered Nurse Regulators initiated the most recent review and revisions of entry-to-practice competencies for registered nurses in Canada. The initiative was led by a working group comprised of 11 provincial and territorial nursing regulatory bodies across the nation.

This new set of revisions are based on results of an environmental scan, literature reviews and stakeholder consultation. The regulatory body in each jurisdiction validates and approves the entry-to-practice competencies. They also confirm that the competencies are consistent with provincial and territorial legislation.[1]

Overarching principles

The following overarching principles apply to the education and practice of entry-level RNs:

[1] Consistency between jurisdictions supports the workforce mobility requirements of the Canadian Free Trade Agreement.

Introduction

The College of Nurses of Ontario (CNO) is the regulatory body for nursing in Ontario. Through provincial government legislation (*Nursing Act, 1991* and *Regulated Health Professions Act, 1991*), CNO is accountable for public protection by ensuring that nurses in Ontario practice safely, competently and ethically. CNO fulfills its mandate through a variety of regulatory activities, including the following:

- registration
- maintaining standards of nursing practice and education
- enforcing nursing standards
- conducting continuing competence reviews
- establishing competencies required for nursing practice.

Entry-to-practice competencies are the foundation for nursing practice. This document outlines the competencies measured for Registered Practical Nurses (RPNs) upon initial registration with CNO and entry to practice in Ontario. The competencies also guide the assessment of nurses' continuing competence for maintaining registration with CNO.

Purpose of the document

This document outlines the entry-to-practice competencies for practical nurses, organized by underlying assumptions for RPN practice and regulatory principles, which include professional practice, ethical practice, legal practice, foundations of practice and collaborative practice. The document is a guide to entry-level practice expectations for RPNs in Ontario and includes a glossary of terms and references to help readers understand and interpret the document.

The competencies for RPN practice at entry level are established for the following purposes.

Protection of the public: Through government legislation (*Nursing Act, 1991* and *Regulated Health Professions Act, 1991*), CNO is mandated by the public to promote and ensure safe, competent and ethical nursing in Ontario.

Practice reference: The competencies assist RPNs in understanding entry-level practice expectations and ongoing applications within their professional roles.

Approval of nursing education programs: The competencies are used by CNO in evaluating practical nursing education programs to ensure that the curriculum prepares graduates to successfully achieve professional practice standards before entering practice.

Registration and membership requirements: CNO uses the competencies to inform its decisions about registration eligibility.

Legal reference: The legal definition of nursing practice included in the *Nursing Act, 1991* establishes the basis for the scope of practice in which any nurse may engage. The competencies are the expectations for RPNs upon their entry to practice in Ontario, and are used as a reference when evaluating the RPNs' standard of care.

Public information: The competencies inform the public, employers and other health care providers about RPN practice, and assist with accurate expectations for RPN practice at entry level.

Continuing competence: In accordance with CNO's Quality Assurance Program, the competencies are used by nurses annually when self-assessing their nursing practice and developing their professional learning goals.

Document background

Entry-to-practice competencies for RPNs were first published by CNO in 1999. Since then, CNO has regularly reviewed and revised the competencies to ensure they remain relevant with current practices. In 2020, CNO will adopt these national entry-to-practice competencies for practical nurses. Consistency between jurisdictions supports the workforce mobility requirements of the Canadian Free Trade Agreement.

In 2019, CNO worked as part of the Canadian Council of Practical Nurse Regulators to revise the national entry-to-practice competencies for practical nurses. A task force, comprised of representatives from jurisdictions that license, register or regulate RPNs across Canada (with Quebec as an observer), led the project. This document was validated by the RPN community and key stakeholder groups across Canada.

Figure 4.4

Page 4 of Front Matter in CNO RN (2019a) and RPN (2019b) ETPC - RPN Assumptions and RN Guiding Principles

1. Entry-level RNs are beginning practitioners. It is unrealistic to expect an entry-level RN to function at the level of practice of an experienced RN
2. Entry-level RNs work within the registered nursing scope of practice, and appropriately seek guidance when they encounter situations outside of their ability
3. Entry-level RNs must have the requisite skills and abilities to attain the entry-level competencies
4. Entry-level RNs are prepared as generalists to practice safely, competently, compassionately, and ethically:
   - in situations of health and illness
   - with all people across the lifespan
   - with all recipients of care: individuals, families, groups, communities and populations
   - across diverse practice settings
   - using evidence-informed practice
5. Entry-level RNs have a strong foundation in nursing theory, concepts and knowledge, health and sciences, humanities, research and ethics from education at the baccalaureate level
6. Entry-level RNs practice autonomously within legislation, practice standards, ethics and scope of practice in their jurisdiction
7. Entry-level RNs apply the critical thinking process throughout all aspects of practice.

Definition of client

The client is the central focus of registered nursing practice. In the context of this document, "client" refers to a person who receives services from a registered nurse. In most circumstances, the client is an individual, but the client can also include family members or substitute decision-makers. A client can also be a group, community or population.

Competency framework

There is a total of 101 competencies organized thematically under nine roles:

1. Clinician
2. Professional
3. Communicator
4. Collaborator
5. Coordinator
6. Leader
7. Advocate
8. Educator
9. Scholar

Figure 1: Conceptual framework for organizing competencies[1]

[1] Copyright © 2015 The Royal College of Physicians and Surgeons of Canada. Retrieved from http://www.royalcollege.ca/rcsite/canmeds/canmeds-framework-e. Adapted with permission.

The revised competencies are based on results of an environmental scan, literature review and stakeholder consultation.

Each province's and territory's practical nurse regulatory body validates and approves the entry-to-practice competencies that apply within its jurisdiction. Each regulatory body also confirms that the competencies are consistent with provincial and territorial legislation.

CNO practice documents, including *Professional Standards*, *Ethics* and the *Code of Conduct* are expected to be used in entry-level practice.

Assumptions

The following assumptions apply to the practice of practical nursing in Canada and to the entry-to-practice competencies included later in this document:

- The foundation of practical nursing is defined by:
  - entry-to-practice competencies
  - professional nursing standards of practice of the regulatory authority
  - nursing code(s) of ethics and ethical standards
  - scope of nursing practice applicable in the jurisdiction
  - provincial, territorial and federal legislation and regulations that direct practice
- RPN practice is built upon the four concepts of person, environment, health and nursing, and is grounded within the context of the current Canadian health care system, primary health care and emerging health trends
- RPNs possess competencies that are transferable across all areas of responsibility (for example, direct care, administration, education and research)
- RPNs are active participants in health promotion, illness prevention and harm reduction activities
- RPNs practice in any setting or circumstance where health care is delivered
- Requisite skills and abilities are required to attain the RPN entry-to-practice competencies
- RPNs practice autonomously, safely, competently and ethically along the continuum of care in situations of health and illness across a client's lifespan
- RPNs practice in situations of varying complexity and work collaboratively with the health care team to maximize client outcomes
- RPNs demonstrate leadership by fostering continued self-growth to meet the challenges of an evolving health care system
- RPNs follow a systematic approach to deliver safe, competent and ethical care by using the nursing process
- RPNs advocate for the implementation and use of evidence-informed practice.

Definition of client

The client is the central focus of practical nursing practice. In the context of this document, "client" refers to a person who receives health care services from a nurse. In most circumstances, the client is an individual, but the client can include family members or substitute decision-makers. A client also can be a group, community or population.

Competency framework

The 79 entry-level competencies are organized in five categories:

1. professional practice
2. legal practice
3. ethical practice
4. foundations of practice
5. collaborative practice.

The order of the categories and competencies is no an indication of priority or importance.

Bolded terms are defined in the Glossary.

Table 4.3

RN Guiding Principles and RPN Assumptions with Similarities Highlighted by Colour

Entry-Level RN Guiding Principles	Entry-Level RPN Assumptions
Practice expectations of a new graduate and not to expect an experienced RN	The elements of the foundation of practical nursing practice – ETPC, Standards, code of ethics and ethical standards, scope in jurisdiction, legislation that guides practice
Work within the RN scope of practice and seek guidance when something is outside their ability	Metaparadigm concepts of nursing and the context of the health care system and emerging trends
Must have requisite skills and abilities	Transferability of competencies to different areas of responsibility
Prepared as generalists for care in health and illness across the lifespan for families, groups, communities, and populations.	Active participants in health promotion, prevention, and harm reduction
Strong theoretical foundation to practice in many areas of nursing and other related disciplines	Practice in any setting where healthcare is delivered
Practice autonomously within legislation, standards, ethics, and scope in their jurisdiction	Must have requisite skills and abilities
	Practice autonomously, safely, competently, and ethically along the continuum of care, in health and illness across the lifespan
	Practice in situations of varying complexity and work collaboratively with the health care team.
	Demonstrate leadership by fostering continued self growth
	Follow a systematic approach to care delivery using the nursing process
	Advocate for the implementation and use of evidence-informed practice.

The RPN practice statements provide context for their nursing practice. I question whether “assumptions” is the correct term for this section as the content is describing the elements of RPN practice and not necessarily assumptions that would guide how one would read the competencies that follow. Some of these RPN assumptions are embedded into the RN competency interpretation statements for clinician and professional roles. These assumptions were reviewed in depth in the

Competency Interpretation Comparison Table and will be addressed directly in that section of the chapter. The guiding principles in the RN document frame how to view the capabilities of the entry-level RN.

The definitions of client in the RPN and RN document in Figure 4.4 are virtually identical with one significant word difference and one stylistic difference. The RN definition uses the term “registered” nurse when explaining the person who receives health care services; however, the RPN definition refers to the term as “nurse”. This may seem insignificant to those outside of the profession, but it creates a hierarchical stance in that the RN is providing services to those who need the level of assistance of a registered nurse, and the RPN is serving those who need a nurse. To fully understand this difference, the Competency Comparison Tables, located in this document and appendices, will illuminate the difference for those circumstances that require the scope of practice of an RN. The stylistic difference is the use of the word “also” in the RN document when identifying who clients may be, “…but the client can also include family members…” (CNO, 2019a, p. 4). It was omitted in this sentence phrase in the RPN document.

The competency framework for the RN document provides a diagram on page 4 and an explanation of the framework on page 5. One feature of this explanation is an overarching principle when reading the competency statements. “For the sake of clarity, and to avoid unnecessary repetition, certain key concepts (for example client-centred) are mentioned once and applied to all competencies” (CNO, 2019a, p. 5). I find this statement to be underemphasized considering its importance in the interpretation of competencies. It is not bolded, italicized, or highlighted, yet it is an important principle to keep in mind when examining and interpreting the competencies. Both documents mention a glossary, so a comparison of terms and definitions ensued.

4.3.1.2 Glossary. Before analyzing this section of the document, I thought that there may be some differences in terms that were considered important to be put into a glossary, but the definitions of similar terms would be similar if not identical. This was not the case. In fact, the commonalities were far fewer than the differences. Appendix A lists the glossary terms, identifies where the terms are the same or have the same underlying meaning in both documents, and provides a comparison of the definitions for similarity of wording and source. Bolding identifies similarities and Italics identify differences. Blank boxes in the table provide for alphabetization and alignment of similar terms for comparison.

From the data in Appendix A, it became easy to visualize the common terms and whether the definitions were similar or different; however, I questioned whether the glossary terms of one document were found in the other nurse's documents, so I then constructed a document search of the RN ETPC statements only (not the front or post matter) to see if the RPN glossary terms were contained within but just not highlighted. I then did the opposite for the RPN ETPC statements for the RN glossary terms. Appendix B illustrates whether each document's glossary terms were present in the other. Of the 35 terms that were unique to the RN ETPC document only 11 were found somewhere in the RPN document as words used in a sentence and not as part of a glossary or highlighted as a key term. In the RPN ETPC document there were nine words that were in the glossary that were not in the RN list. Of these, two could be found in the RN document; one of which was "advocate" which appeared in five places, as it was one of the roles of the registered nurse, and therefore, the action words for some of the competency statements within that role. The other term present in the RPN glossary and in the RN ETPC document was "duty to report" which was found in identically worded competency statements in each document. The glossary provided insight into the similarities and differences between RN and RPN entry-to-practice.

The insight gleaned from the glossary was that the registered nurse was expected to engage in far more theoretical constructs and emerging elements of nursing practice, whereas the registered practical nurse was expected to follow the legal, ethical, and moral guidance provided by the CNO. I see parallels between these two lists of words and different curricular theories. The RN ETPC and the multiple theoretical elements that reflect a social justice framework, align well with Vygotsky's (1978) sociocultural theory. As I read the list of terms in the RPN ETPC glossary, words like adverse event, duty to report, informed consent, near miss, and professional misconduct brought to my mind the experiences of the rule-driven nursing education that I received, and then my mind went straight to Tyler (2013) and his rule-driven and behavioural approach to curriculum. This signalled to me a clear distinction between the priorities of the RN and RPN ETPC, and therefore, a distinct set of practice expectations and approach to curriculum that underpinned each program's development. In addition, this also signalled to me the essential difference of two-plus years of RPN programming versus a four-year degree for BScN education. As an experienced nursing educator who recently led the development of a new BScN curriculum, I am acutely aware of the challenges in addressing the need to include basic knowledge and skills, research skills, critical thinking, clinical reasoning, and the RN ETPC in a four-year program; so, it is not difficult to understand that the practical nursing program development needs laser focus on what the learners need to know while ensuring meeting all the RPN ETPC.

4.3.1.3 ETPC Competency Statements. After looking at the glossary term comparisons, I began to question myself as to why I, and many others assume that the RN and RPN roles in care provision are considered so close when clearly the key terms absent from each other's ETPC documents clearly indicate that there is a difference in practice. Despite this, I wondered if the glossary terms themselves were only an issue of word usage but were possibly described in a different way other than the glossary

terms in the document. Therefore, I began by reviewing and analyzing the statements about each of the roles or areas of practice. Appendix C provides the definitions of each RN role and RPN area of practice.

Despite no similar areas of practice related to roles 3, 5, 6, 7, 8, and 9 in the descriptions of the areas of PN practice, there had to be some mention in the competency statements themselves about fulfilling the role of communicator, leader, advocate, and educator, as I have personally witnessed RPNs in practice performing these types of activities. The roles of scholar and coordinator were roles I had seen infrequently through my 30 plus years of nursing practice, so I am unsure as to whether there would be something to indicate the need to fulfill these in their entry-to-practice requirements. These statements alone were not going to give me the answers I sought regarding comparable practice. I had to delve deeply into the individual competency statements.

I conducted a comparison and analysis of the ETPC statements themselves. Figures 4.5 and 4.6 illustrate the work in process and the final wall of comparisons. Table 4.4 provides a sample of the results of a process of comparing the two sets of ETPC competency statements, not by a search and find function from a computer system, but by using my nursing and teaching knowledge and expertise to evaluate the similarities and differences.

Figure 4.5

Competency Comparison in Process

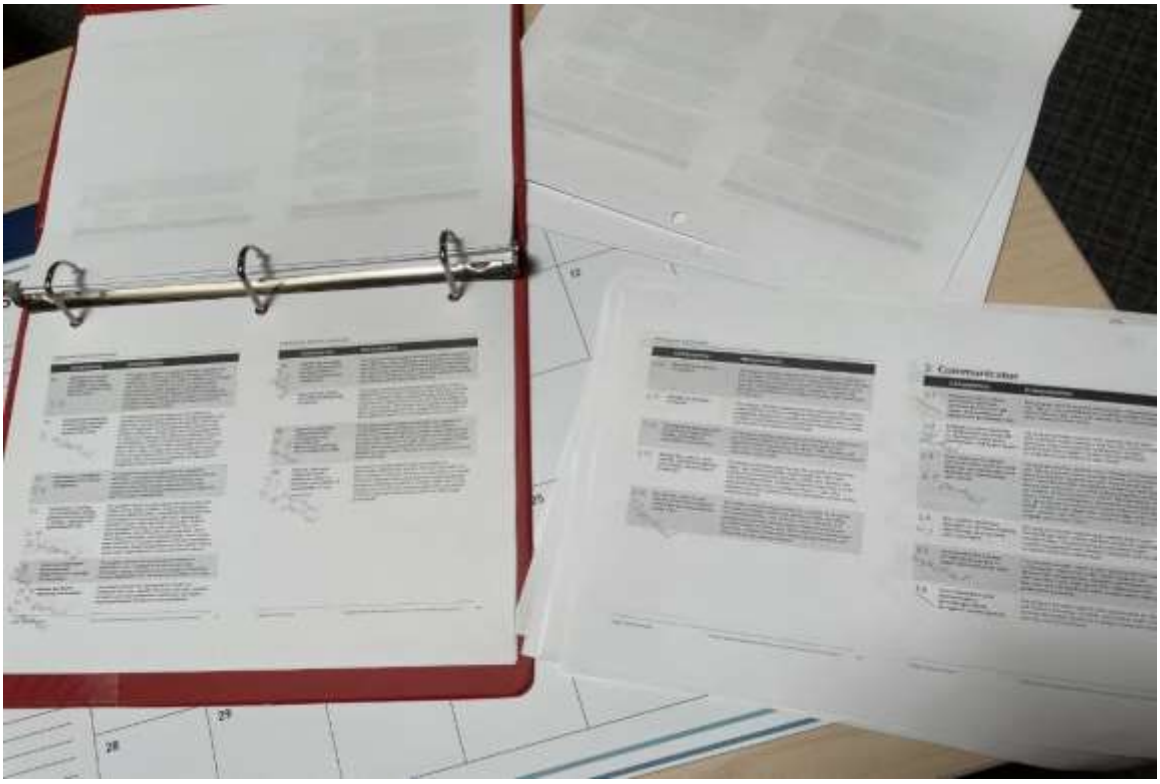


Figure 4.6

Wall of Competency Analysis

Table 4.4

Sample of the Comparison of RN and RPN Entry-to-Practice Competency Wording

(Commonalities Bolded; Differences Italicized)

RN ETPC	RPN ETPC	Notes
1.1 *Provide* **safe, ethical, competent,** compassionate, client-centred, and **evidence-informed** *nursing care* across the lifespan *in response to* **client needs**	**5. (PARTIAL)** Practises within own level of **competen*ce*.** **25. (INFERRED)** Preserves the dignity of clients in all personal and professional contexts. **29. (PARTIAL)** Practises according to legislation, practice standards, **ethics,** and organizational policies. **40. (PARTIAL)** *Engages in* **evidence-informed** *practice* by considering a variety of relevant sources of information. **42. (PARTIAL)** Formulates clinical decisions *consistent with* **client needs** and priorities. **51. (PARTIAL)** Applies principles of client **safet*y***.	5 RPN ETPC partially aligns with this RN ETPC There are similar words in each RPN statement that fit partially. In understanding client-centred care one of the principles is to preserve the dignity of the client; therefore, this is inferred as part of this element of the RPN statement. As noted in the glossary of terms comparisons in Appendix A and B, client-centred care does not appear in the RPN ETPC document.
1.2 *Conducts* a *holistic* nursing **assessment** to collect **comprehensive** information on client health status	**37.** *Completes* **comprehensive health assessments** of clients *across the lifespan*.	When looking at Bloom's Taxonomy, conducts is at a higher level of the psychomotor domain – complex overt response, whereas completes is at the level of mechanism. According to the definition of the different levels, complex overt response is considered at an expert level, whereas mechanism implies basic proficiency (Arkansas State University (n.d.)
1.3 Uses principles of trauma-informed care which places priority on trauma survivors' safety, choice, and control.	**No Equivalent**	There is no use of the term trauma-informed care in the RPN document.
1.4 *Analyzes* and *interprets* data obtained in client **assessment** to	**41. (PARTIAL)** *Comprehends, responds to and reports* **assessment** findings.	The RPN ETPC are partial to the RN as they are expected to be performed at a lower cognitive level of Bloom's taxonomy. Analyze (analysis) and interpret

RN ETPC	RPN ETPC	Notes
inform ongoing decision-making about client health status.	**42. (PARTIAL)** *Formulates* clinical decisions consistent with client needs and priorities. **43. (INFERRED)** *Identifies* nursing diagnoses.	(evaluating) versus comprehends (understanding) formulates (Affective domain - organization) and identifies (remembering)
1.9 Recognizes and responds immediately when client condition is deteriorating.	**60. (*Virtually* IDENTICAL)** Recognizes and responds immediately when a client's condition is deteriorating.	The only difference is the use of "a" indicating a singular versus what could be interpreted as singular or plural due to the absence of the article "a". However, I questioned if the responses were to be at the same level. This is when I realized that the interpretation document must be analyzed as well to achieve greater clarity of the difference in the roles.

Appendix D provides the complete table of comparisons of RPN competency statements where there was partial equivalence, inferred equivalence, no equivalent, and identical to the RN statements. A partial equivalence meant that there were some words that were identical between the statements but did not provide a complete interpretation of the competency. An inferred equivalence meant that, based on my nursing knowledge and educator lens, I saw that they could be interpreted as having a commonality of purpose or intent, but the wording was not alike enough to draw a partial comparison. No equivalent meant that there were no RPN ETPC statements that matched the intent or wording to the RN ETPC. Verbatim identical statements meant just that, the statements were verbatim between the two documents even though their numbering and categorization were not the same. Virtually identical indicated that there was a grammatical device difference such as the use of articles or phrasing. Almost identical indicated that there was a word that was different between the RN and RPN competencies, but otherwise the statement was identical. Sometimes the wording difference was an adjective, and sometimes the wording difference was a different level

of verb. The nature of the sameness or difference of the identical statements warranted further investigation to determine the differences.

4.3.1.3.1 ***Identical Competencies.*** Table 4.5 illustrates the identical competencies (all types) and provides deeper analysis into the semantics of the RN and RPN ETPC statements. The document text analysis column describes the analysis of the differences in words or grammar that may be in some statements. In addition, the interpretation of those were examined to see if the underlying responsibilities and intent could provide greater clarity for understanding of whether they were truly identical or whether there were actual differences required to achieve the competency.

Table 4.5

Sample of Identical Competencies Wording with Interpretation Comparison

RN ETPC and Interpretation Statement	RPN ETPC and Interpretation Statement	Document Text Analysis
1.9 Recognizes and responds immediately when client's condition is deteriorating.	**60. (Virtually IDENTICAL)** Recognizes and responds immediately when *a* client's condition is deteriorating.	**ETPC:** The article "a" is the only difference in wording. Is this grammatical intention to differentiate between specifics of one client for the RPN?
Interpretation: **The program will provide opportunities for students to recognize and seek immediate assistance**, or **help other in rapidly changing client** conditions **affecting** *client* **health or safety**.	**Interpretation:** The program will provide opportunities for students to recognize and seek immediate assistance *and/or* help others in *a* rapidly changing client condition affecting health or *patient* safety.	**Interpretation:** There are 4 grammatical or wording differences in these two statements, some of which implies a lesser capacity of the RPN to act. • The use of “or” versus “and/or.” The difference makes it seem like the RPN can do both whereas the RN does one or the other. • The use of “a” situation for the RPN versus non-article language implying more than one client for the RN • Pleural conditions in the RN version. This indicates that the RN could handle many issues with many clients experiencing deterioration, whereas the RPN is only dealing with one client at a time. This is contradictory to standard patient assignments as both RNs and RPNs can have 5 or more clients assigned during a shift, or could it be that the writers of the RPN interpretation statement recognized that an individual can truly only deal with one crisis at a time. The CNO RN program

RN ETPC and Interpretation Statement	RPN ETPC and Interpretation Statement	Document Text Analysis
		approval team, indicated that the interpretation statements were created in collaboration across departments within the CNO (I. Wu-Lau, Personal Communication, January 9, 2023). • Use of “client health or safety” versus “health or patient safety”. Patient safety has been a common term to describe safety issues in all areas of care, however the use of client and then patient safety is a bit confusing. Why use both in the same sentence. It would indicate that there is a difference between client safety and patient safety, and yet there fundamentally is no difference in the implementation and practice of each.

4.3.1.3.2 ***No Equivalent Competencies.*** With the RN ETPC competencies that had no equivalent, I was a bit confused as I have seen many RPNs perform these skills through the years and have heard my educator colleagues discussing these elements of curriculum in their Practical Nursing (PN) program they deliver. As well, several years ago, I taught in the PN program and remember discussing these areas of competence in theory and clinical courses. Is my knowledge still accurate today? As a result, I turned to the course outlines and weekly topics documents (Lambton College, 2021-2022) for the practical nursing program to search if and where these “no equivalent” competencies were discussed in the program. Table 4.6 illustrates the presence of these competencies in the RPN program curriculum.

Table 4.6

RN "No Equivalent" Competencies Compared to PN Curriculum Delivery

RN Competency	Courses in PN Program Where Competency was Taught
1.3	Discussed those who experience trauma in OB/Peds and Mental Health but not explicitly the principles of trauma informed care
1.7	Taught in all med-surg and nursing fundamentals courses as part of anticipating and planning care needs of clients
1.10	Taught in med-surg and nursing fundamentals courses and skills labs
1.12	Taught in med-surg, pharmacology and health assessment courses
1.14	Taught in palliative care course
1.15	Taught in palliative care course
1.16	Discussed in mental health course regarding what exists as harm reduction strategies but not explicitly for substance use other than safe injection sites
1.17	Not found in any course outlines
1.18	Briefly mentioned in mental health course but do not discuss recovery-oriented nursing care specifically just more about the mental health and addictions and people who are in recovery
1.19	Taught in mental health course
1.20	Taught in mental health and gerontology courses
1.25	Taught over many courses but did not see evidence of nursing or educational theory behind each of the elements in the interpretation statement.
3.1	Taught day one in the program, and is a basic level of practice expectation.
3.5	Unsure as they teach therapeutic nurse-client relationship but did not see the incorporation the theory of relational practice explicitly.
3.6	Taught in fundamentals course and practiced in all labs and clinicals
5.6	No mention of navigate services but are taught to provide clients with information during discharge teaching.
6.3	Discussed at a basic level (staff mix) in leadership course
6.8	Taught in skills labs and practiced in all clinicals

RN Competency	Courses in PN Program Where Competency was Taught
6.10	Discussed in multiple courses in the program
7.5	Discussed in multiple courses in the program regarding the wise use of supplies
7.8	Taught in community course but do not discuss the concept of social justice in depth
7.9	Taught in professionalism course that the client must be able to provide consent and understand what is happening for their care
7.11	Discussed in community and other second year courses but do not discuss primary health care or population health in depth.
7.14	Discussed in multiple courses in the program
9.6	Global health is not mentioned anywhere in the program

The program contains a palliative care course as part of their curriculum, yet I could not find any reference to palliative care, end of life, or terms like that in the RPN ETPC document. From my experience as a clinician and educator, many RPNs work in this nursing specialty. It is not just specialized palliative care units or hospice facilities, but long-term care homes and many hospital units that also experience death of clients. As a former long-term care and complex care nurse, I am aware that there are fewer RNs in long-term care; therefore, it is the RPN who provides the registered staff level of direct care and needs these skills as they enter practice. Was this possibly an oversight of the CCPNR team to include this area of competence? Whether it was an oversight or not, this should be included in the next iteration of the RPN ETPC. Regardless, there were absences of content or objectives related to the RN competencies.

I could not identify if there was teaching related to several health sciences topics - theoretical “ologies” listed in RN ETPC 1.21 - incorporated into PN courses. In the next

moment, my mind went to, “If RPNs are not taught the theory behind it, do they really understand why they do things for the patient?” Throughout my career in nursing education, it has been mentioned on many occasions during nursing team meetings that PN students are taught the rationale but not the theoretical basis for the rationale. This brought me back to my own diploma RN education where that was very much my experience and in turn provided greater clarity for me to understand the difference in approach to program delivery. Another competency that aligned closely with 1.21 was 1.17, which discussed the use of epidemiological principles in care. Having not found any reference to epidemiology in the PN program documents, this was one of the “ologies” that was not discussed. However, some remained ambiguous as to whether they were present in the PN program.

An RN competency that had me questioning whether it was discussed or not in a PN program was 3.5, “Incorporating the process of relation practice to adapt communication skills” (2019a, p. 6). I clearly saw in the course outlines discussion of the therapeutic nurse-client relationship (TNCR), but I could not find the term “relational practice.” Relational practice is a much deeper connection than the TNCR and involves a reflexive process of viewing the client as a person first and a health care recipient second (Hartick-Doane & Varcoe, 2007). I hoped that when I analyzed the interpretation statements that I would achieve more clarity, and this will be discussed in that section. One of the no equivalent RN ETPC that was not mentioned in the PN program documents was Competency 9.6, “Uses knowledge about current and emerging community and global health care issues and trends to optimize client health outcomes.” I thought that they would have discussed it in the program, but I thought the idea may be buried in competency interpretation language. The PN community course discussed global health issues such as the pandemic, disaster planning, and the opioid crisis. The course did not discuss emerging issues of housing, food insecurity, or supply chain

issues that can impact the health and well-being of individuals. My confusion came from the definition of client. Even though the definitions of client created by the CNO for the RN and RPN were virtually identical, the interpretation of community nursing in the PN program inferred that it was focused on caring for a client within a community setting rather than entire communities or populations as the definition of client indicated. Do RPNs care for populations or not? Therefore, I decided to do a term search using the Find function to see if the RPN competency and interpretation statements mentioned population anywhere. The search provided three instances of the word being mentioned:

> **26.** Advocates for equitable access, treatment, and allocation of resources, particularly for vulnerable and/or diverse clients and ***populations.***
>
> **Interpretation:** The program provides students the opportunity to identify the health disparities and inequities of vulnerable **populations** and the importance of advocacy. They will understand the varied ways to advocate for equitable access for clients, from escalating the issue to the team leader to involvement in system change. Students need opportunities to apply this knowledge by working with clients who access health and other community resources to maximize health outcomes. (CNO, 2019d, p. 8)
>
> **37.** Completes comprehensive health assessments of clients across the lifespan.
>
> **Interpretation:** The program teaches students about the importance of collaborating with the client and, as necessary, the health care team when performing assessments across the health spectrum and all client ***populations.*** Students learn the importance of engaging with clients to gather relevant information through health history and to identify the clients' health needs. For example, using a holistic approach with interview techniques that

> ensure clients are part of the development of their care plan. Students should be taught to perform physical assessments which include inspection, palpation, auscultation, and percussion, within their scope of practice. They should also be taught that a comprehensive assessment includes physiological, psychological, social, and spiritual assessments. (CNO, 2019d, p. 11)

In analyzing the use of population(s) in the statements above, I noted that in Appendix D ETPC 26 is almost identical to RN ETPC 7.4. In both the RN and RPN ETPC there is a distinction between client and population. However, if the definition of client according to the CNO includes populations, why have that distinction? There could be a couple of reasons for that. One was that the ETPC competencies were created at a national level by the CCPNR. There were other distinctions between provinces for listed RPN ETPC – British Columbia and Ontario have three more than the rest of the country as mentioned earlier. The definition of client for the practical nurse could be different between provinces. To verify the definitions of client were similar between provinces, I went to the College of Licenced Practical Nurses of Manitoba [CLPNM] (2022) Entry-Level Competencies document. There the term client is defined as, "…Client" may refer to an individual, family, group/aggregate, community or population…" (p. 7). When examining the document, I noted that their ETPC statements were different than Ontario and categorized differently, yet the CLPNM participated in the CCPNR, which created the 2019 competencies. I then noted that the CLPNM updated their competencies in 2022. Regardless, both RPN ETPC 26 and RN ETPC 7.4 distinguish between client and population.

When examining the interpretation of ETPC 26, the term "vulnerable populations" was mentioned. This term is defined by the National Collaborating Centre for Determinants of Health (2023) in Nova Scotia as "vulnerable populations are groups and communities at a higher risk for poor health as a result of the barriers they experience to

social, economic, political and environmental resources, as well as limitations due to illness or disability" (p. 1). This is a national definition, so it means the same to an RN as to an RPN. RPNs are meant to practice with populations and in the case of ETPC 26, advocate for their health and well-being.

In the RPN ETPC 37, the term populations did not appear in the competency itself but in the interpretation statement. The use of populations in this instance is to provide detail to the variety of types of clients for whom an RPN can perform assessments. The partial match RN ETPC 1.2 does not mention the term populations in either the competency or interpretation statement. I was left wondering what the difference was in practice between an RN and RPN when working with populations. To be able to make this distinction, I searched the RN ETPC and Interpretations for the term population. It appeared in several instances in the document. Table 4.7 is the result of the search.

Based on this term search alone, there were more areas of RN entry to practice that engages with populations. Therefore, it was evident that there is a difference in the level of expectation when working with populations between RN and RPN entry to practice.

Table 4.7

Instances of the Use of the Word Population in RN ETPC Competency and Interpretation Statements

Role and Competency Number	Competency and/or Interpretation
Clinician 1.17	*Interpretation* "… in specified populations (community and individuals viewed collectively)"
Leader 6.3	*Interpretation* "… nursing care to clients and the broader population…"

Role and Competency Number	Competency and/or Interpretation
Advocate 7.4	*Competency* "… for vulnerable and/or diverse clients and populations." *Interpretation* "… identify health equity issues across population… vulnerable and/or marginalized populations…"
Advocate 7.11	*Competency* "Uses knowledge of population health…" *Interpretation* "… significance for population health … health promotion strategies across different populations…"
Advocate 7.14	*Interpretation* "… incorporate knowledge of health disparities and inequities of vulnerable populations…"
Scholar 9.6	*Interpretation* "… emerging community, population and global health issues and research…"

4.3.1.3.3 ***Interpretation Statements.*** The interpretation statements presented a different level of power represented by the CNO in their creation. In the RN interpretation statements, the standard opening phrase is "The program will provide…" with all secondary sentences beginning with "Students will ..." gave me a "thou shalt" mental impression. When working with the interpretation documents for a recent work project of developing a BScN program curriculum and mapping out the competencies for CNO preliminary program approval, I felt a deep-seated need to ensure that all elements of the interpretation were included in the curriculum and that wording in course outcomes and objectives mirrored what was in the statements. However, when reviewing the RPN interpretation statements for development of an RPN bridging curriculum, I somehow felt less pressure as the standard opening phrase was "The program provides…" with secondary sentences having much greater variability with

phrases like “Students should … Students are required...Students must... or students need …" with explanatory sentences that elaborated on the meaning of the competency statement and were not command sentences. This was a short-lived sense of less pressure as team meetings around this work revealed that the RPN program faculty must provide the same level of wording and element inclusion in their program approval process. Given the fact that the RN competencies and interpretations were created before the RPN, I wondered whether the language change was intentional or not. This was but one question I was left with after comparing the interpretation statements.

The interpretation statement analysis (an abridged version is found in Appendix E) provided greater clarity as to the equivalence of competencies. Some RPN competencies that were thought to have some form of equivalence to the RN competencies did not when comparing their interpretation statements. Others, not thought to have some form of equivalence, revealed that there was, indeed, a measure of equivalence. Additional RPN competencies and interpretation statements that were not identified in my initial analysis were found when employing the Find Function and searching for phrases in the RPN ETPC and interpretation statements that were found in the RN interpretation statement and are identified in Appendix E and the differences are summarized in Appendix F.

Another issue that, as a technical writer, I struggled with was the use of the same terms in the interpretation statement as in the competency. I thought that I may have been overthinking that the word interpretation meant another way of saying something, so I went to the dictionary and the definition of interpretation was “the act or result of interpreting: EXPLANATION” (Merriam-Webster, 2023b). Then I searched the definition of the word explanation, “the act of explaining” (Merriam-Webster, 2023c) which led me to explain which was defined as, “to make known...to make plain or understandable...to give reason for or cause of...to show the logical development or relationships of”

(Merriam-Webster, 2023d). If the interpretation statements are meant to explain the competency, then why do they repeat the words of the competency? I can understand that the interpretation document is not meant for the public but for educators, who have extensive knowledge in the meaning of the terms, but from my experiences working with teammates on the new BScN program, even we had differences in how we understood the interpretation statements. Such is a limitation of this study as my work is but a layer of interpretation, informed by the CNO team's interpretation of the intent of the writers of the competency statements. Should the interpretation statements then be created by the original writers of the competency statement? It is hoped that the dissemination of these findings will have an impact on the issues identified.

4.4 Summary of Findings

The findings presented do answer the questions posed in this study. The summary of the similarities and differences of equivalence, after being adjusted for the interpretation analysis, between the RN and RPN ETPC and interpretation statements is contained in Appendix F. First, the critical discourse analysis reveals the distinction between the two nursing roles. The use of theory and framing of social justice issues underpinning RN practice as well as a decreased performance expectation for the implementation of some nursing knowledge and skills (e.g., assessment depth, care of those experiencing addiction, end of life, information literacy, and global health) provides evidence that there is a difference in capacity between the RN and RPN at entry to practice.

Second, the samples provided in this chapter indicated that the discourse between the RN ETPC and Interpretations and RPN ETPC and Interpretations are different in several ways. The front matter contains many similarities and some key differences. The foundational information is virtually identical yet the framework for the creation and role-based RN versus areas of practice based RPN ETPC provide a

different approach to practice. The addition of nurse educator consultation for the RN ETPC may have contributed to the creation of the role categories, which provides both the student and educator with the critical functions of an RN and to ensure that the complexity of the role is acknowledged; whereas, the areas of practice provide a more general approach to RPN entry to practice. As noted by the CNO, these competencies did not have the time and attention in their creation that the RN competencies did.

The glossary is another area where there is a departure in RN and RPN practice. Key terms for practice that were similar often used the same sources for the definition; however, there were many terms in the RN document that were not evident in the RPN document. Current and emerging issues in health care that were defined in the RN glossary were cultural humility, cultural safety, global health, recovery-oriented nursing care and relational practice. These were terms that were not found in the PN program documents nor in the glossary, and therefore, are not a part of the RPN entry-to-practice expectations at this time.

The comparison undertaken to understand the difference between roles and areas of practice showed some similarities and many differences in the discourse. Several of the RN roles had no match for the RPN areas of practice. However, the areas of practice had many concepts contained within. This was not a clear or concrete way to compare nursing practices. Only a comparison of the competency statements and interpretation statements could provide greater clarity.

The greatest clarity in role difference came from the comparison and analysis of the competency statements and the interpretation statements together. The comparisons yielded many RPN ETPC inferred and partially equivalent statements, identically equivalent statements, and no equivalent statements to the RN ETPC. There were some that yielded a difference of equivalence between the ETPC and the

interpretation statements. For the 101 RN ETPC and RN Interpretation statements (RNI), there were:

- There were15 instances where RPN ETPC and RPN Interpretation (RPNI) statements had identical equivalence to RN ETPC and their corresponding RNI statements
- There were 12 instances where RPN ETPC or RPNI had identical equivalence to an RN ETPC or its corresponding RNI statement, but not both, and the corresponding RPN ETPC or RPNI statement was partially equivalent, inferred or not equivalent to the other
- There were 38 instances where RPN ETPC and RPNI statements had partial equivalence to RN ETPC and their corresponding RNI statements,
- There were 20 instances where RPN ETPC or RPNI statements had partial equivalence to an ETPC or its corresponding RNI statement, but not both, and the corresponding RPN ETPC or RPNI statement was inferred or not equivalent to the other.
- There were 40 instances where RPN ETPC and RPNI statements had inferred equivalence to RN ETPC and its corresponding RNI statement.
- There were 5 instances where RPN ETPC or RPNI statements had inferred equivalence to an ETPC or its corresponding RNI statement, but not both, and the corresponding RPN ETPC or RPNI statement was not equivalent to the other.
- There were 27 RN ETPC and RNI statements that had no equivalent RPN ETPC or RPNI statement.

If you are good at math, you will know that this adds up to more than 79 RPN competencies and this is because there is overlap of the RPN ETPC and RPNI

statements with more than one RN ETPC and RNI statement. However, it is important to note that with the revised mapping, not all 79 RPN competencies aligned with the RN ETPC or RNI statements. With my experienced nursing educator lens, I thought that I must have made a mistake in my work, so I investigated this further. My understanding was that the RN would have had the same and more competencies to meet than the RPN, as they have two more years of education. RPN ETPC 75 and 77 did not map to any RN ETPC or RNI statement that would indicate a minimum of inferred equivalence when looking at the competency and interpretation statement together. RPN ETPC 75 focuses on mentoring relationships, which are not evident in the RN ETPC or RNI statements. Despite this, I know that mentorship is part of leadership, so could be inferred in some RN ETPC, but this was not evident to me. It was the same situation with RPN ETPC 77 that addresses the need to demonstrate formal and informal leadership in practice. With the RN having 11 ETPC related to leadership, this must have been inferred somewhere, but again this was not evident to me. However, there were two RN competencies that had no equivalent RPN competencies, but the analysis indicated that they were basic foundational actions of a nurse. Therefore, I interpreted that the RPN regulators may have felt that they were inferred in many of the RPN competencies already, as they were so fundamental, and therefore, did not need to be mentioned. This may be the case for the two RPN ETPC that were not equivalent to any RN ETPC. The inclusion of the interpretation statements changed many findings of the original competency-to-competency comparison, therefore, the importance of the interpretation statements in clarifying the expectations of the entry-to-practice competencies cannot be underestimated.

There were key differences in the discourse contained within identical statements. Linguistic style and grammatical differences were noted but the differences in practice were made most clear by the analysis of the verbiage using Bloom's

taxonomy. Different levels of expectation of practice were noted. As in the example provided earlier, there was a higher level of the psychomotor domain evident in RN practice, indicating that the RN has a different expectation for entry to practice. In one instance noted in Appendix E for RPN ETPC 24 and RN ETPC 6.1, the statements were very similar, nearly identical, and yet there was greater action implied for the RPN. The RPN "obtains knowledge and responds" to the TRC Calls to Action, yet the RN was only required to "acquire knowledge". What created confusion for me was that the interpretation statements were verbatim. The search for answers and the ability to distill the discourse between the practice documents were challenging at times.

With 79 competencies for the RPN, there appeared to be a significant amount of overlap, and about one-third of practice that appeared was different. However, having taught in the RPN program previously, I was confused as to what was happening as I was certain many of these concepts were taught. I reviewed PN program documents to learn if the "no equivalent" competencies were taught, and if so, to what depth. It was evident that there were elements in the PN program reviewed, but the results were not transferable to other schools, and therefore, in general to all RPN education programs.

The final question was more challenging to answer from the critical discourse analysis for it is the dissemination of these findings that will provide the greatest impact to educators and employers. There needs to be a succinct tool created that would provide transparency and understanding for educators and employers alike. The employers do not get the interpretation document information which would have a tremendous impact on understanding the key differences between RN and RPN entry-to-practice capabilities and expectations. I wanted to create a tool that provided clarity and could be easily understood by employers, educators, nurses, and the public. Appendix F illustrates my efforts to pull together such a document. However, there is much that could be done beyond the work here to aid in role clarity. I wish to

present this analysis and initiate a dialogue with the key stakeholders as recommendations for practice, employers, and most notably curriculum development in nursing programs. Chapter five will discuss these recommendations.

Chapter 5

5 Study Implications and Discussion

Events in the last decade, including the most recent global pandemic, have highlighted the need for clarity in the RN and RPN ETP expectations. Financial cuts in the mid 2010's left hospitals in certain regions in Ontario experiencing fiscal constraints that redefined their nursing practice model (Draghici, 2016; Kula, 2016; Leslie, 2016). To many, both inside and outside of the profession, this redefinition was viewed by some as a strategy to replace more costly RNs with more cost-efficient RPNs. The severe nursing staffing shortages we experienced during the COVID-19 pandemic has led to working in conditions where units are short several nursing staff during a shift – ensuring the demands on the nursing profession remain at the forefront of demands for attention to a strained health care system (Registered Nurses Association of Ontario [RNAO], 2022). To provide the safest, most appropriate, and cost-effective care, there needs to be clarity in the difference in role expectations of both category of registered nursing professional in Ontario, Canada.

Using a qualitative approach employing critical discourse analysis and framed by critical social theory and feminist post-structuralist theories, this study sought to answer three questions: how the RN and RPN ETPC created distinction between the two nursing roles; what the similarities and the differences in the discourse of the documents are; and how does the discourse impact nursing educator and employers. This chapter will review the key findings, provide some interpretation of the data, discuss the implications, acknowledge the study's limitations, and provide suggestions for how this data can inform nursing regulators, educators, and employers.

5.1 Key Findings

The critical discourse analysis methodology employed in this study revealed much about the sociocultural and discourse practices used in the creation of the ETPC documents for RNs and RPNs. There are provincial government ministries, agencies, and laws that prescribe what nurses can perform in relation to the controlled acts and whether they can perform or initiate these acts (CNO, 2020d). Additionally, the provincial government can request the regulator (CNO) to change practice or expand educational programming (CNO, 2023). With nursing practice being integral to a publicly funded health care system, its evolution, devolution, or transformation is most often in the hands of politicians looking for opportunities to trim health care budgets and make the best use of resources (CNO, 2023). The hegemony of provincial governments may not have a direct effect on the creation of the RN and RPN ETPC, but they can inform and modify the practices allowed for nurses within each jurisdiction.

The Canadian Nurses Association spearheads the updating of competencies and provides information regarding an international level of nursing practice (CNA, 2015). There are national nursing councils (CCRNR and CCPNR) that collaborate to develop national level ETPC, known as entry-level competencies in other provinces, for both the RN and RPN/LPN in Canada. These councils are made up of members from each provincial and territorial regulatory college for each designation of nurse (CCRNR, 2019; CCPNR, 2019). They function as separate entities. At the time of the creation of this version of the competencies, only one province, Ontario, had a joint regulatory college for RNs and RPNs. Since this most recent iteration other provinces have moved towards this model (Prentice et al., 2020). The competency documents published by the CNO have stayed relatively static in their presentation since 2009. This follows the same formatting as all CNO standards and documents which are all consistent with branding of the CNO.

The key findings of this research indicate that there are similarities and differences in RN and RPN practice. There are identical expectations of practice related to regulatory requirements contained within the ETPC documents. There are no equivalent competencies in RPN practice for new and evolving nursing and health care issues such as trauma-informed care, recovery-oriented care, person-centred care, global health, or the incorporation of research into practice. However, some areas of RN practice that are not mentioned in RPN ETPC are covered in at least one school's RPN program. Namely, medical assistance in dying (MAiD), palliative care, pain management, health promotion, suicide prevention, information and communication technologies, and knowledge of the health care system; with the caveat of the faculty of the program acknowledging that the theoretical elements that underpin these practices are not covered to any depth. One RN competency (3.1) that had no equivalent in the RPN competencies and required no verification with the RPN faculty was regarding introducing oneself by name and designation. This naming tradition has been a part of the first week of classes for both programs in my experience, for decades. I wondered why the RN competencies included this as a competency and the RPN competencies did not despite such a simple requirement being part of the most basic element of nursing education for both programs. Did the CCPNR team think it was too basic to mention? Did the CCRNR team have information that this was an issue that needed to be addressed? It is certainly a question that needs addressing at the next round of ETPC updates. Despite these clear, but at times baffling issues of ETPC lack of equivalence, multiple RPN competencies have some degree of overlap to RN competencies.

The major differences between the two documents come from Bloom's revised leveling (Anderson & Karthwohl, 2001) used extensively in the interpretation documents. This is key to the notion of understanding the theoretical rationale that underpins

practice described earlier. Bloom's Taxonomy is a hierarchical framework of learning objectives that distinguishes between level of complexity and domains (cognitive, affective, and psychomotor). For interpretation purposes, the Arkansas State University (n.d.) list of verbs was used in the analysis, but many exist on the internet and in the literature.

5.2 Interpretation of Data

It was only when I examined the RN and RPN interpretation statements that I could find some clarity in the differences between RN and RPN ETP expectations. What appeared to be overlap in competencies, sometimes demonstrated that the competency interpretations were very similar in wording and intent and other times there was a clear difference in practice expectation. For example, as noted in Appendix E there were competencies that I analyzed as being partially equivalent (I saw the same intention in the two statements despite obvious differences). One such situation concerned RN ETPC 3.8 and RPN ETPC 35. Both competencies are about documentation. The RN ETPC used many more adjectives to describe the quality of documentation whereas the RPN ETPC discussed the professional accountabilities associated with documentation. Both competency interpretation statements have a different focus as well. The RN interpretation discussed documenting assessment data and ongoing evaluation data, yet the RPN interpretations focused on documenting client care in general. Both interpretations refer to the CNO Documentation Standard, however the RN applies the standard when documenting and the RPN should be aware of the standard. This caused me to pause as I could not understand why the RPN should be aware and not apply it like the RN. The RPN has the same level of accountability for their documentation in a court of law. Conversely, the RPN had to document according to legislative, practice standards, ethical requirements, and organizational policies but the RN interpretation is silent on this. During my decades of practice and in my role as

an educator are that both elements – following legal requirements and good quality documentation – are fundamental to any nurse's practice, regardless of being an RPN or RN and thus have implications for nursing practice.

5.3 Implications

The results of this study provide insights into the issues of RN and RPN role confusion and provides some clarity for nurses, educators, employers, the public, and even prospective students in nursing. Appendix E documents the differences and similarities and further clarifies the distinct differences in entry-to-practice expectations. Illustrating the differences and similarities in practice, this study expands the work of many. Baumann et al. (2014) found that there was ambiguity between RN and RPN roles. Dahlke and Baumbush (2015), Moore et al. (2017), and Lankshear et al. (2017) supported these findings in their studies and noted that RNs did not understand the role of the practical nurse as well as the RPN understood the role of the RN. And why is it important for everyone working in intersecting care to understand these differences?

At the heart of role confusion is the issue of the controlled acts that RNs and RPNs can perform in Ontario. I do not believe it was a coincidence that, when in 2014, RPN practice allowed for the implementation of the controlled acts with a health care provider's order, like an RN, that some regional agencies chose to balance budgets by replacing RNs with RPNs. From a legislative perspective their practices encompassed the same activities. However, as I was completing the dissertation work, the CNO (2023) published in their online journal *The Standard,* that:

> The Ontario government is reviewing proposed changes under the *Nursing Act, 1991* to expand the scope of practice for RPNs...If the government approves the regulation, RPNs who have the relevant competence will be able to independently initiate specific controlled acts without an order in certain practice

> settings...In 2017, CNO started work to expand RPN scope of practice at the Minister of Health's request. (p. 1)

After reading the last phrase of this quote through a feminist lens, I was curious as to why these changes are requested by the government and not initiated by the profession. It seems to me that the profession of nursing is at the mercy of a patriarchial society that, in my opinion, continues to see nurses as more malleable than physicians. In my search to see if physicians have had requested practice changes by the government, I found that the Medicine Act (1991/ 2021) has undergone five changes since its 1991 creation with the last change to include physician assistants and psychologists into the act (the College of Psychologists and Behaviour Analysts remains separate and distinct) and other amendments adding osteopaths, restricting alternative medical practices, defining professional misconduct and its associated discipline, and changing committee compositions, whereas the Nursing Act (1991/2021) has undergone seven changes, with changes focusing on the addition and refinements of the NP role, the advancement of the RPN role, and the RN's ability to initiate controlled acts and provide psychological counselling. In my opinion, there is a strong indication that there is inequity regarding the imposition of changes between the two professions (male dominated and female dominated).

Returning to the proposed legislation for nurses, if this legislation is passed, the differences between the RN and RPN may become muddier; however, the CNO ETPC and Interpretation statements, in their current iteration, will continue to demonstrate the differences in practice expectations and level of knowledge required for the role.

Even though this is true, from a regulatory perspective, the results of this study clarified that the level of expected practice is different. For example, the assessment of clients is expected to be at a mastery level (using the right tools and techniques at the appropriate time) by the time an RN graduate enters practice, whereas the RPN must be

able to complete an assessment of clients by engaging with clients through good interview techniques (CNO, 2019c; CNO 2019d). It is the heart of the difference between legislative and regulatory expectations that defines RN and RPN practice as unique. The importance of both categories of nurse being present in the healthcare system cannot be underestimated. Each role contributes to the effective functioning of the nursing team. However, it was only through the analysis of the interpretation documents that the differences became clear. If an employer, practising nurse, or the public do not have access to understand the differences in practice, role confusion will continue. Educators in the province need to advocate for the sharing of this information with employers and practising nurses as they in turn could inform the curriculum of all nursing programs.

Educators in Ontario that are going through the Program Approval process with the CNO have access to these interpretation documents, yet there remains confusion and the potential for continued confusion. Only the members of faculty that are engaging in the process can get the ETPC interpretation documents and only for the program in which they are employed. This becomes problematic as universities do not teach RPN programs and colleges that have both RN and RPN programs may have faculty assigned to only one program. As a Nurse Educator developing the curriculum for a college-based BScN program, I had to ask permission from the CNO to get a copy of the RPN ETPC interpretation document to complete this study. I would welcome the chance to share my data with the CNO teams to provide an explanatory document to the public to help clear the role confusion and increase collegiality in RN and RPN students and practising nurses.

After completing my analysis of the RN and RPN ETPC and their interpretations, I think that the nursing organizations in Ontario, and even extending to other jurisdictions, would benefit from a summary of the results. The competitive nature that

was evident in documents created by the RNAO, and to a lesser extent by the RPNAO (WeRPN), following the changing models of practice announcements in 2015, set up an "us and them" dynamic in a female-dominated profession that has experienced a level of oppression since its earliest recorded days in North America. These two organizations need to be working together to advocate for this role clarity and to improve the working conditions of all registered nursing staff, as these challenges were made crystal clear during the pandemic. Again, a feminist perspective made me curious to know if there are as many organizations advocating (and possibly competing) for the medical profession. In a search for professional medical organizations, I found one – the Ontario Medical Association [OMA]. It advocates for the profession's interests including practice, political, and financial. (OMA, n.d.). There are the and the professional colleges (for the different areas of medical practice e.g., family physicians, surgeons, etc.) and the OMA. In nursing we have the RNAO, We RPN, NPAO, the Ontario Nurses Association and other unions representing nurses, and the CNO performing the same function. Do nursing organizations need to examine the effectiveness of the OMA at advocating for its members and profession and consider following their lead or would nursing be playing into the patriarchal society? Nursing needs to be strategic in how it asserts itself more effectively into the healthcare landscape, particularly considering that it encompasses the greatest number of health-care practitioners in the system (RNAO, n.d.). I believe there is an opportunity here for the profession of nursing.

Undertaking a critical discourse analysis of the RN and RPN ETPC documents and interpretations has revealed an opportunity for clarity and greater collaboration at the provincial and national levels of nursing organizations. This study could have far-reaching implications, not just in the education and practice of nursing in Ontario and Canada, but with other professionals as well. The peer reviewed literature has many examples of issues in role clarity in business and management studies (Aparna &

Sahney, 2022; Cäker & Siverbo, 2018; Cassidy & Stanley, 2019; Kauppila, 2014; Vullinghs et al., 2020), education (Brandmo et al., 2019; Lejonberg & Christophersen, 2015; Lieberman, 2004; Shepherd et al., 2016), and other health professions (Chen et al., 2022; Fukui et al., 2021; Lee et al., 2015; Saxe et al., 2017; Wynarczuk et al., 2019). However, despite the possibility of providing clarity, there are limitations to the findings of this study.

5.4 Limitations

Being a discourse analysis conducted by one experienced nurse educator, the main limitation of this study is that it is a singular view of the issue. My transactional reading (Rosenblatt, 1969) of the interpretations constructed new meaning that may have extended the intent of the original authors as they wrote the competencies. But transactional reading articulates that this happens whenever a reader engages with a text, as they bring their own knowledge, experience, and understanding to what they are reading. It may be a layer of variation in application that the authors of the competencies and interpretation documents did not consider. Despite this, the results indicate that there are different expectations in RN and RPN nursing practice. It is only through the inclusion of the interpretation document information, and the use of CDA, that this clearly becomes visible.

The theoretical frameworks used to aid in understanding (critical social theory and feminist poststructuralist theory) were chosen as a reflection of my mindset as I went through the process of critical discourse analysis. I incorporated the work of several contributors to the development of these theories as no one author could provide the depth of comprehension to reflect the complexity and nature of oppression reflected in my view of the world. Vulnerable people are addressed specifically in the competencies as they reflect issues with the key determinants of health for Canadians (Government of Canada, 2022). Since nurses work with this population, a critical lens is

vital to understand the underpinnings of the ETPC statements. Feminist poststructuralist theory provided me with the lens to look at the discourse analysis and see it in a way that acknowledged that nursing, as a female-dominated profession, has historically and continues to be subjugated to the male-dominated medical profession. This is left hanging for me. How does this relate to the role differentiation within the profession?

Another concerning limitation of this study is that these results will become obsolete when the next update to entry-to-practice competency statements and interpretations is undertaken. However, I do feel that sharing this information, and my recommendations, with the nursing regulators across the country will help to inform the next update.

5.5 Recommendations

This study has left me with several thoughts that may advance our profession as we continue the cyclical and ongoing initiative-driven changes to the way we define and implement new changes. I have several recommendations for enhancing the process of creating and interpreting the RN and RPN ETPC. However, first there is a fundamental need to replicate this work with a larger number and more diverse group of nursing professionals to provide more than my interpretation of the data. After this is completed, only then should the following recommendations be addressed.

One recommendation is that the CCRNR and CCPNR work together to create the next generation of competencies. It is my belief that only through transparency and cooperation that the competencies themselves can be levelled to clarify the roles, if these organizations can cooperate to clarify the level of practice expectation (and not just through the competency interpretations information). I further suggest that the CCPNR adopt a roles-based structure to their competencies so that the public, educators, employers, and nurses themselves have a comparable and easy to interpret reference to understand the difference in entry-to-practice expectations.

Another suggestion is that the competency interpretations be made available to more than just educators going through the program approval process. It is important for employers to have this information to provide clarity in the role expectations of the entry-to-practice for RNs and RPNs and to understand the capacity of each role. The interpretations should be included in the published competency document. For example, in RN competency 1.2 and its equivalent RPN competency 37 regarding health assessment data, the statements themselves provide evidence of the difference in comprehensive versus holistic, but it is the interpretation statements that provide the clarity about the level of capacity to perform the assessment using the terminology situated in the psychomotor domain of Bloom's Taxonomy. Providing the interpretations and the version of Bloom's taxonomy used to illustrate the differences would provide greater understanding for all involved. Further, I believe that it would behoove the nursing associations to examine how other health professions in Canada compose their competencies and even look to other countries with similar health care system structures to garner best practices for this endeavour.

A third recommendation is to add an appendix to each ETPC document that provides the data that I collated in this study regarding the equivalence of the competencies and their interpretation. The process undertaken during this study has provided me with a high level of clarity between the two roles. As an educator, I see when new textbooks are published, the publisher provides a document to indicate where the data from the old edition is contained in the new one; where there is brand new information; and when topics are no longer discussed. This type of work done in the comparison of not only updated versions, but between RN and RPN ETPC could provide many stakeholders with incredibly valuable information about the nature of the two roles in regulated nursing, and how they have changed. Making this information transparent through collaborative dialogue between the various constituent groups when designing

new documents is likely to decrease the existing silos between nurses and professional associations. As a profession that has been severely taxed during a global pandemic, this move would allow us to stand united in articulating the value and importance of nursing to the health care system.

A fourth recommendation comes from a model used in another province. When viewing the Manitoba PN regulator's website, I noted that there was a document that clarified the difference between entry-to-practice and ongoing practice expectations. I too, believe that this level of clarity is needed across the country to aid all stakeholders in understanding how a nurse's practice should evolve from the novice graduate to the expert nurse. The expectations of a novice nurse are much different than those of a seasoned nurse, and this is not articulated clearly for Ontario in either RN or RPN practice. The reason I suggest this is that the seasoned registered nursing professional can, and in my opinion, should, exceed the level of entry-to-practice expectations and not just from a regulatory perspective but a practice perspective. I have borne witness to seasoned RPNs having a greater capacity to critically think and problem-solve than a newly graduated RN, but nowhere is this acknowledged or captured to reflect the professional growth and development across the lifespan of a career. I acknowledge that this can be difficult to accomplish as specialty areas have key practice expectations, but this could be done with the input of the various nurse specialty interest groups that exist across the country. We need to change our thinking about credentials from an initial professional preparation as an endpoint and re-consider how to assess for the acquisition of expanded competencies gained through experience and growth in professional knowledge.

You may be wondering why I undertook a project like this. As an educator, in 2007, I created a proposal to streamline nursing education and deliver a hybrid program that would allow students to flexibly re-enter their education at various times in the

program and see those updates officially recognized. At the time, there was little interest by our university partner in this endeavour. RN education was directed by universities and RPN education was directed by colleges in Ontario and “nary the twain shall meet” was the message that I received. Now in the 2020s colleges can offer their own BScN degree and continue to have RPN programs in their purview. I have not lost sight of that original vision. My vision is that one day we may see a streamlined education of nurses that allows for an integrated RPN and RN educational program, which provides opportunities for students to determine which role of nurse they would like to pursue, not before they enter education but in a way that allows them to experience the separate roles and then decide which avenue is best for them. In doing so, this would also have the additional effect of increasing intraprofessional collaboration, and each would gain a new respect for the role of the other as well as providing clarity for the role they choose. A further benefit would be that it enables flexibility for nursing students to exit at a point in the program that still credits them with what they have achieved along a pathway in nursing.

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Appendix A

Comparison of Glossary Terminology and Definitions of Similar Terms with Notations (Similarities in Bold; Differences in Italics)

RPN ETPC Document	RN ETPC Document
Accountability **The obligation to answer for the professional, ethical, and legal responsibilities of one's activities and duties,** *including high standards for individual practice and responsibility for exemplary client care. (Davis, C. 2017)* Taken from Nursing Made Incredibly Easy – words not verbatim but a summary of paragraphs	Accountability The obligation to answer for the professional, ethical, and legal responsibilities of one's activities and duties *(Ellis & Hartley, 2009)* Quote taken from textbook by Ellis and Hartley – original authors?
Adverse event, Advocate, Autonomous practice	Assessment, Assign
Client **A person with whom the nurse is engaged in a therapeutic relationship. In most circumstances, the client is an individual but the client** *may* **include family members** or **substitute decision-makers**. The client *also can* be a **group** (*for example,* **therapy**), **community** (*for example,* **public health**) **or population** (*for example* **children with diabetes**). (Canadian Patient Safety Institute. 2019) Virtually identical wording but different authors sourced.	Client *A client is* a person with whom the nurse is engaged in a therapeutic relationship. In most circumstances, the client is an individual but the client may *also* include family members and/ or substitute decision-makers. The client *can also* be a group (*e.g.,* therapy), community (*e.g.,* public health) or population (*e.g.,* children with diabetes). (College of Nurses of Ontario, 2002)
	Client centre, Compassion, Competency, Competent
Client safety **The pursuit of the reduction and mitigation of unsafe acts within the health care system,** and **the use of best practices shown to lead to optimal patient outcomes.** (Canadian Patient Safety Institute, 2017). Identical authors but linking conjunction is different.	Safety The pursuit of the reduction and mitigation of unsafe acts within the healthcare system, *as well as* the use of best practices shown to lead to optimal patient outcomes (Canadian Patient Safety Institute, 2017)
Conflict resolution **The various ways individuals or institutions address conflict (for example, interpersonal, work) to move toward positive change and growth.** (College of Registered Nurses of Nova Scotia. (2012) Identical wording. Identical source.	Conflict resolution The various ways individuals or institutions address conflict (for example, interpersonal, work) to move toward positive change and growth (College of Registered Nurses of Nova Scotia, 2012)

RPN ETPC Document	RN ETPC Document
Quality improvement A systematic, formal approach to the analysis of practice performance and efforts to improve performance. (Canadian Patient Safety Institute. 2015) The RPN version is very generic while the RN version lays out the elements of the approach and it is inferred there that opportunities to improve are iterative.	Continuous quality improvement *A continuous cycle of planning, implementing, and evaluating the effectiveness of strategies, and reflecting to see what further improvements can be made* (College and Association of Registered Nurses of Alberta, 2014)
Critical inquiry **A process of purposive thinking and reflective reasoning through which practitioners examine ideas, assumptions, principles, conclusions, beliefs, and actions within a particular context.** (van Graan, A. C., Williams, M. J. S., & Koen, M. P. (2016) (Brunt, B. A. (2005) Identical wording. The RPN version uses a secondary source for the citation	Critical inquiry A process of purposive thinking and reflective reasoning through which practitioners examine ideas, assumptions, principles, conclusions, beliefs, and actions within a particular context. (Brunt, 2005)
Diversity, Duty to report	Cultural humility, Cultural safety, Determinants of health, Environmentally responsible practice
Evidence-informed practice **How nursing decisions are made with clients, using an ongoing process that incorporates research, clinical expertise, client preferences and other available resources. (Canadian Nurses Association. 2010**) Identical wording. Identical source.	Evidence informed How nursing decisions are made with clients, using an ongoing process that incorporates research, clinical expertise, client preferences and other available resources. Canadian Nurses Association, 2010)
Fitness to practice **Freedom from any cognitive, physical, psychological, or emotional condition or dependence on alcohol or drugs that impairs ability to provide nursing care.** (College of Nurses of Ontario. 2019) Identical wording. RPN document uses a later reference.	Fitness to practice Freedom from any cognitive, physical, psychological, or emotional condition or dependence on alcohol or drugs that impairs ability to provide nursing care (Canadian Nurses Association, 2017a)
	Global health, Harm reduction, Harmful incident
Health care team **A number of health care providers from different disciplines (often including both regulated professionals and unregulated workers) working together to provide care for and with persons, families, groups, communities or populations. (Canadian Nurses Association, 2017a)**	Health care team A number of health care providers from different disciplines (often including both regulated professionals and unregulated workers) working together to provide care for and with persons, families, groups, communities or populations. (Canadian Nurses Association, 2017a)

RPN ETPC Document	RN ETPC Document
Identical wording. Identical source.	
	Health disparities, health inequities
Health literacy **The ability to access, comprehend, evaluate and communicate information as a way to promote, maintain and improve health in a variety of settings across the life-course. (Rootman, I. & Gordon-El-Bihbrety, D. 2008)** Identical wording. Identical source.	Health literacy The ability to access, comprehend, evaluate and communicate information as a way to promote, maintain and improve health in a variety of settings across the life-course (Rootman, & Gordon-El-Bihbrety, 2008)
	Health promotion, Holistic, Information and communication technologies (ICTs)
Interprofessional team collaboration The process of developing and maintaining effective working relationships with learners, practitioners, patients/clients/families and communities to enable optimal health outcomes. (Canadian Interprofessional Health Collaborative. 2010) Although initially thought to be the same concept, the RPN version describes the action and the RN version describes the meaning of the term.	Interprofessional *Members from different healthcare disciplines working together towards common goals to meet the client's health care needs (Canadian Health Services Research Foundation, 2012)*
	Medical assistance in dying (MAiD)
Near miss **A client's safety incident that did not reach the client and therefore resulted in no harm. (Canadian Patient Safety Institute. 2015)** Identical wording. Identical source.	Near miss A client's safety incident that did not reach the client and therefore resulted in no harm (Canadian Patient Safety Institute, 2009)
Nursing diagnosis	No harm incident, Nursing informatics, Organizational Culture, Palliative care, Plan of care, Population health, Positional power, Primary health care
Professional boundaries **The point at which the relationship changes from professional and therapeutic to unprofessional and personal; the limits of the professional role. Crossing a boundary means that the care provider is misusing the relationship's power to meet personal needs, rather than the client's needs, or are behaving in an unprofessional manner with the client. The misuse of power does not have to be intentional to be considered a boundary crossing. (College of Nurses of Ontario. 2006) (Registered Nurses Association of Ontario. 2006)**	Professional boundaries The point at which the relationship changes from professional and therapeutic to unprofessional and personal. It defines the limits of the professional role. Crossing a boundary means that the care provider is misusing the power in the relationship to meet personal needs, rather than the needs of the client, or behaving in an unprofessional manner with the client. The misuse of power does not have to be intentional to be considered a boundary crossing (CNO, 2006, RNAO, 2006)

RPN ETPC Document	RN ETPC Document
Identical wording. Identical source. The only difference is the use of acronyms in the RN citation.	
Professional misconduct	Professional presence, Recovery-oriented nursing care, Relational practice
Research A systematic inquiry using scientific methods to advance knowledge, establish facts, answer questions or solve problems. Conducting research involves identifying a research question, using an appropriate methodology to answer the question and disseminating the results. A nurse who collects data as part of a project, may be "participating" in research, but not "conducting" research. (Loiselle, C. G., Profetto-McGrath, J., Polit, D. F., & Beck, C. T. 2011) The RPN definition describes the word and is sourced, whereas the RN definition is about the skill of critical appraisal and is not sourced.	Research skills *The ability to critically appraise the various aspects of a scientific research study.*
Scope of practice The expectations and limitations of duties and responsibilities of Registered Practical Nurses who **are legislated, educated, and authorized to perform** *roles, responsibilities and functions*, **as defined in Section 3 of the *Nursing Act, 1991*: "The practice of nursing is the promotion of health and assessment of, the provision of, care for, and the treatment of, health conditions by supportive, preventive, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function."** (College of Nurses of Ontario. (2018) The RPN definition uses the words expectations and limitations and uses the word responsibilities instead of accountabilities. The use of responsibilities implies a task orientation whereas accountability implies a results orientation to practice.	Scope of practice *Roles, functions, and accountabilities that registered nurses* are legislated, educated, and authorized to perform, as defined in Section 3 of the Nursing Act, 1991: "The practice of nursing is the promotion of health and assessment of, the provision of, care for, and the treatment of, health conditions by supportive, preventive, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function."
	Social justice
Social media **Software applications (web-based and mobile) allowing creation, engagement and sharing of new or existing content, through messaging or video chat, texting, blogging and other social media platforms. (Bodell, S., & Hook, A. 2014)**	Social media Software applications (web-based and mobile) allowing creation, engagement and sharing of new or existing content, through messaging or video chat, texting, blogging and other social media platforms (Bodell, & Hook, 2014)

RPN ETPC Document	RN ETPC Document
Identical wording. Identical source.	
Team dynamics	Therapeutic nursing intervention
Therapeutic nurse-client relationship **A connection a nurse establishes and maintains with a client, through the use of professional knowledge, skills and attitudes, to provide nursing care expected to contribute to the client's well-being. (Canadian Nurses Association. (2017a)** Identical wording. Identical source. The title of the definition varies by the use of the descriptor nurse-client but is inferred in the RN definition of therapeutic relationship.	Therapeutic relationship A relationship a nurse establishes and maintains with a client, through the use of professional knowledge, skills and attitudes, to provide nursing care expected to contribute to the client's wellbeing (Canadian Nurses Association, 2017a)
Unregulated health worker	Trauma informed care

Appendix B

Presence of Non-Similar Glossary Words in Opposite ETPC Statements

RPN ETPC Document Glossary Words	Location in RN ETPC Statements	RN ETPC Document Glossary Words	Location in RPN ETPC Statements
Adverse event	N/A	Assessment	ETPC 37, 41, 45
Advocate	It is the title of number 7 RN role and is part of the description of the advocate role. It appears as an action verb in ETPC 7.3, 7.4, 7.6, and 7.10	Assign	ETPC 78
Autonomous practice	N/A	Client centre	N/A
Diversity	N/A	Compassion	N/A
Duty to report	ETPC 2.11	Competency	N/A Found in front matter
Nursing diagnosis	N/A	Competent	N/A Found in front matter
Professional misconduct	N/A	Cultural humility	N/A
Team dynamics	N/A	Cultural safety	N/A
Unregulated health worker	N/A	Determinants of health	N/A
		Environmentally responsible practice	N/A
		Global health	N/A
		Harm reduction	N/A Found in front matter
		Harmful incident	N/A
		Health disparities	N/A
		Health inequities	N/A
		Health promotion	N/A Found in front matter
		Holistic	N/A
		Information and communication technologies (ICTs)	ETPC 38, 57
		Medical assistance in dying (MAiD)	N/A
		No harm incident	N/A
		Nursing informatics	N/A
		Organizational Culture	N/A
		Palliative care	N/A
		Plan of care	ETPC 54
		Population health	N/A
		Positional power	N/A

RPN ETPC Document Glossary Words	Location in RN ETPC Statements	RN ETPC Document Glossary Words	Location in RPN ETPC Statements
		Primary health care	N/A In front matter
		Professional presence	ETPC 14
		Recovery-oriented nursing care	N/A
		Relational practice	N/A
		Social justice	N/A
		Therapeutic nursing intervention	Therapeutic not included with term but found in ETPC 45, 53
		Trauma informed care	N/A

Appendix C

Descriptor of Each Role of RN Practice and Area of Practice of the RPN

RN Role Descriptions	RPN Areas of Practice Descriptions Aligned to RN Roles
1. Clinician Registered nurses are clinicians who provide safe, **competent**, ethical, **compassionate**, and **evidence-informed** care across the lifespan in response to **client** needs. Registered nurses integrate knowledge, skills, judgment, and professional values from nursing and other diverse sources into their practice.	**4. Foundations of Practice** RPNs use critical thinking, reflection, and evidence integration to assess clients, plan care, implement interventions, and evaluate outcomes and processes. Foundational knowledge includes: nursing theory, health sciences, humanities, pharmacology, and ethics.
2. Professional Registered nurses are professionals who are committed to the health and well-being of clients. Registered nurses uphold the profession's practice standards and ethics and are accountable to the public and the profession.	**1. Professional Practice** Registered Practical Nurses (RPNs) adhere to practice standards. They are responsible and accountable for safe, competent, and ethical nursing practice. They are expected to demonstrate professional conduct as reflected through personal attitudes, beliefs, opinions, and actions. RPNs focus on personal and professional growth. RPNs are expected to use knowledge, critical thinking, **critical inquiry,** and **research** to build an **evidence-informed practice**. *– this statement in this description aligns better with role of the RN's Clinician's role description.* **2. Ethical Practice** RPNs use ethical frameworks (e.g. Code of Ethics, ethical standards) when making professional judgments and practice decisions. They engage in critical thinking and critical inquiry to inform decision-making and use self-reflection to understand the impact of personal values, beliefs, and assumptions in the provision of care. **3. Legal Practice** RPNs adhere to applicable provincial/territorial and federal legislation and regulations, professional standards, and employer policies that direct practice. They engage in professional regulation by enhancing their competence, promoting safe practice, and maintaining their fitness to practise. RPNs recognize that safe nursing practice includes knowledge of relevant laws and legal boundaries within which RPNs must practise.
3. Communicator	

RN Role Descriptions	RPN Areas of Practice Descriptions Aligned to RN Roles
Registered nurses are communicators who use a variety of strategies and relevant technologies to create and maintain professional relationships, share information, and foster therapeutic environments.	
4. Collaborator Registered nurses are collaborators who play an integral role in the health care team partnership.	**5. Collaborative Practice** RPNs work collaboratively with clients and other members of the health care team. They recognize that collaborative practice is guided by shared values and accountability, a common purpose or care outcome, mutual respect, and effective communication.
5. Coordinator Registered nurses coordinate point-of-care health service delivery with clients, the health care team, and other sectors to ensure continuous, safe care.	
6. Leader Registered nurses are leaders who influence and inspire others to achieve optimal health outcomes for all.	
7. Advocate Registered nurses are advocates who support clients to voice their needs to achieve optimal health outcomes. Registered nurses also support clients who cannot advocate for themselves.	
8. Educator Registered nurses are educators who identify learning needs with clients and apply a broad range of educational strategies towards achieving optimal health outcomes.	
9. Scholar Registered nurses are scholars who demonstrate a lifelong commitment to excellence in practice through critical inquiry, continuous learning, application of evidence to practice, and support of research activities.	

Appendix D

Comparison of RN ETPC Statements to RPN ETPC Statements

RPN Areas of Practice Overview Statements

Used to provide an overarching explanation regarding those statements contained within each area of practice.

1. Professional Practice
Registered Practical Nurses (RPNs) adhere to practice standards. They are responsible and accountable for safe, competent and ethical nursing practice. They are expected to demonstrate professional conduct as reflected through personal attitudes, beliefs, opinions and actions. RPNs focus on personal and professional growth. RPNs are expected to use knowledge, critical thinking, **critical inquiry** and **research** to build an **evidence-informed practice**.

2. Ethical Practice
RPNs use ethical frameworks (e.g. Code of Ethics, ethical standards) when making professional judgments and practice decisions. They engage in critical thinking and critical inquiry to inform decision-making and use self-reflection to understand the impact of personal values, beliefs and assumptions in the provision of care.

3. Legal Practice
RPNs adhere to applicable provincial/territorial and federal legislation and regulations, professional standards and employer policies that direct practice. They engage in professional regulation by enhancing their competence, promoting safe practice and maintaining their fitness to practise. RPNs recognize that safe nursing practice includes knowledge of relevant laws and legal boundaries within which RPNs must practise.

4. Foundations of Practice
RPNs use critical thinking, reflection and evidence integration to assess clients, plan care, implement interventions, and evaluate outcomes and processes. Foundational knowledge includes: nursing theory, health sciences, humanities, pharmacology and ethics.

5. Collaborative Practice
RPNs work collaboratively with clients and other members of the health care team. They recognize that collaborative practice is guided by shared values and accountability, a common purpose or care outcome, mutual respect, and effective communication.

RN Role Overview Statements

Used to provide an overarching explanation regarding those statements contained within each practice role. (bolding original from CNO)

1. Clinician
Registered nurses are clinicians who provide safe, **competent**, ethical, **compassionate**, and **evidence-informed** care across the lifespan in response to **client** needs. Registered nurses integrate knowledge, skills, judgment and professional values from nursing and other diverse sources into their practice.

2. Professional
Registered nurses are professionals who are committed to the health and well-being of clients. Registered nurses uphold the profession's practice standards and ethics and are accountable to the public and the profession.

3. Communicator

Registered nurses are communicators who use a variety of strategies and relevant technologies to create and maintain professional relationships, share information, and foster therapeutic environments.

4. Collaborator
Registered nurses are collaborators who play an integral role in the health care team partnership.

5. Coordinator
Registered nurses coordinate point-of-care health service delivery with clients, the health care team, and other sectors to ensure continuous, safe care.

6. Leader
Registered nurses are leaders who influence and inspire others to achieve optimal health outcomes for all.

7. Advocate
Registered nurses are advocates who support clients to voice their needs to achieve optimal health outcomes. Registered nurses also support clients who cannot advocate for themselves.

8. Educator
Registered nurses are educators who identify learning needs with clients and apply a broad range of educational strategies towards achieving optimal health outcomes.

9. Scholar
Registered nurses are scholars who demonstrate a lifelong commitment to excellence in practice through critical inquiry, continuous learning, application of evidence to practice, and support of research activities.

RN ETPC	RPN ETPC (Level of Comparability) and Practice Category
Role of CLINICIAN	
1.1 Provides safe, ethical, competent, compassionate, **client-centred** and evidence-informed nursing care across the lifespan in response to client needs.	**5. (Partial)** Professional Practice Practises within own level of competence. **25. (Partial)** Ethical Practice Preserves the dignity of clients in all personal and professional contexts. **29. (Partial)** Legal Practice Practices according to legislation, practice standards, ethics and organizational policies. **40. (Partial)** Foundations of Practice Engages in evidence-informed practice by considering a variety of relevant sources of information. **42. (Partial)** Foundations of Practice Formulates clinical decisions consistent with client needs and priorities. **51. (Partial)** Foundations of Practice Applies principles of client safety.
1.2 Conducts a **holistic** nursing **assessment** to collect comprehensive information on client health status.	**37. (Partial)** Foundations of Practice Completes comprehensive health assessments of clients across the lifespan.
1.3	**No Equivalent**

RN ETPC	RPN ETPC (Level of Comparability) and Practice Category
Uses principles of **trauma-informed care** which places priority on trauma survivors' **safety**, choice, and control.	
1.4 Analyses and interprets data obtained in client assessment to inform ongoing decision-making about client health status.	**41. (Partial)** Foundations of Practice Comprehends, responds to and reports assessment findings. **42. (Partial)** Foundations of Practice Formulates clinical decisions consistent with client needs and priorities. **43. (Partial)** Foundations of Practice Identifies **nursing diagnoses**.
1.5 Develops plans of care using **critical inquiry** to support professional judgment and reasoned decision-making.	**44. (Partial)** Foundations of Practice Develops the care plan with the client, health care team and others. **55. (Partial)** Foundations of Practice Assesses implications of own decisions. **56. (Partial)** Foundations of Practice Uses critical thinking, critical inquiry and clinical judgment for decision-making.
1.6 Evaluates effectiveness of **plan of care** and modifies accordingly.	**45. (Inferred)** Foundations of Practice Implements nursing interventions based on assessment findings, client preferences and desired outcomes. **53. (Partial)** Foundations of Practice Evaluates the effectiveness of nursing interventions by comparing actual outcomes to expected outcomes. **54. (Partial)** Foundations of Practice Reviews and revises the plan of care and communicates accordingly. **55. (Partial)** Foundations of Practice Assesses implications of own decisions.
1.7 Anticipates actual and potential health risks and possible unintended outcomes.	**No Equivalent**
1.8 Recognizes and responds immediately when client safety is affected.	**58. (Inferred)** Foundations of Practice Recognizes high-risk practices and integrates mitigation strategies that promote safe care.
1.9 Recognizes and responds immediately when client's condition is deteriorating.	**60. (Verbatim Identical)** Foundations of Practice Recognizes and responds immediately when a client's condition is deteriorating.
1.10 Prepares clients for and performs procedures, treatments, and follow up care.	**No Equivalent**
1.11 Applies knowledge of pharmacology and principles of safe medication practice.	**62.** (**Verbatim Identical**) Foundations of Practice Applies knowledge of pharmacology and principles of safe medication practice.
1.12	**No Equivalent**

RN ETPC	RPN ETPC (Level of Comparability) and Practice Category
Implements evidence-informed practices of pain prevention, manages client's pain, and provides comfort through pharmacological and non-pharmacological interventions.	
1.13 Implements **therapeutic nursing interventions** that contribute to the care and needs of the client.	**45. (Partial)** Foundations of Practice Implements nursing interventions based on assessment findings, client preferences and desired outcomes.
1.14 Provides nursing care to meet palliative and end-of-life care needs.	**No Equivalent**
1.15 Incorporates knowledge about ethical, legal, and regulatory implications of medical assistance in dying (MAiD) when providing nursing care.	**No Equivalent**
1.16 Incorporates knowledge about ethical, legal, and regulatory implications of medical assistance in dying (MAiD) when providing nursing care.	**No Equivalent**
1.17 Incorporates knowledge of epidemiological principles into plans of care.	**No Equivalent**
1.18 Provides **recovery-oriented** nursing care in partnership with clients who experience a mental health condition and/or addiction.	**No Equivalent**
1.19 Incorporates mental **health promotion** when providing nursing care.	**No Equivalent**
1.20 Incorporates suicide prevention approaches when providing nursing care.	**No Equivalent**
1.21 Incorporates knowledge from the health sciences, including anatomy, physiology, pathophysiology, psychopathology, pharmacology, microbiology, epidemiology, genetics, immunology, and nutrition.	**61. (Partial)** Foundations of Practice Demonstrates knowledge of nursing theory, pharmacology, health sciences, humanities and ethics.
1.22 Incorporates knowledge from nursing science, social sciences, humanities, and health-related research into plans of care.	**61. (Partial)** Foundations of Practice Demonstrates knowledge of nursing theory, pharmacology, health sciences, humanities and ethics.
1.23 Uses knowledge of the impact of evidence-informed registered nursing practice on client health outcomes.	**40. (Partial)** Foundations of Practice Engages in **evidence-informed practice** by considering a variety of relevant sources of information.
1.24 Uses effective strategies to prevent, de-escalate, and manage disruptive, aggressive, or violent behaviour.	**59. (Almost Identical)** Foundations of Practice Applies strategies to prevent, de-escalate and manage disruptive, aggressive or violent behaviour.
1.25 Uses strategies to promote wellness, to prevent illness, and to minimize disease and injury in clients, self, and others.	**No Equivalent**
1.26	**8. (Verbatim Identical)** Professional Practice

RN ETPC	RPN ETPC (Level of Comparability) and Practice Category
Adapts practice in response to the spiritual beliefs and cultural practices of clients	Adapts practice in response to the spiritual beliefs and cultural practices of clients.
1.27 Implements evidence-informed practices for infection prevention and control.	**51. (Inferred)** Foundations of Practice Applies principles of **client safety**.
Role of PROFESSIONAL	
2.1 Demonstrates **accountability**, accepts responsibility, and seeks assistance as necessary for decisions and actions within the legislated **scope of practice**.	**1. (Partial)** Professional Practice Demonstrates **accountability** and accepts responsibility for own decisions and actions. **2. (Partial)** Professional Practice Practices autonomously within legislated **scope of practice.** **3. (Partial)** Professional Practice Displays self-awareness and recognizes when to seek assistance and guidance. **5. (Partial)** Professional Practice Practices within own level of competence. **17. (Inferred)** Professional Practice Identifies and responds to inappropriate behaviour and incidents of **professional misconduct**. **28. (Inferred)** Ethical Practice Adheres to the duty to provide care.
2.2 Demonstrates a **professional presence**, and confidence, honesty, integrity, and respect in all interactions.	**14. (Almost Identical)** Professional Practice Demonstrates a professional presence, honesty, integrity and respect in all interactions.
2.3 Exercises professional judgment when using agency policies and procedures, or when practising in their absence.	**1. (Inferred)** Professional Practice Demonstrates **accountability** and accepts responsibility for own decisions and actions. **2. (Partial and Inferred)** Professional Practice Practices autonomously within legislated **scope of practice.** **5. (Partial)** Professional Practice Practices within own level of competence. **29. (Partial)** Legal Practice Practices according to legislation, practice standards, ethics and organizational policies.
2.4 Maintains client privacy, confidentiality, and security by complying with legislation, practice standards, ethics, and organizational policies.	**25. (Partial and Inferred)** Ethical Practice Preserves the dignity of clients in all personal and professional contexts. **29. (Partial)** Legal Practice Practices according to legislation, practice standards, ethics and organizational policies. **33. (Partial)** Legal Practice Protects clients' rights by maintaining confidentiality and privacy in all personal and professional contexts.
2.5	**21. (Partial and Inferred)** Ethical Practice

RN ETPC	RPN ETPC (Level of Comparability) and Practice Category
Identifies the influence of personal values, beliefs, and **positional power** on clients and the **health care team** and acts to reduce bias and influences.	Takes action to minimize the impact of personal values and assumptions on interactions and decisions. **22. (Partial)** Ethical Practice Demonstrates respect for the values, opinions, needs and beliefs of others.
2.6 Establishes and maintains **professional boundaries** with clients and the health care team.	**20. (Partial)** Ethical Practice Establishes and maintains **professional boundaries**.
2.7 Identifies and addresses ethical (moral) issues using ethical reasoning, seeking support when necessary.	**23. (Partial)** Ethical Practice Applies ethical frameworks and reasoning to identify and respond to situations involving moral and ethical conflict, dilemma or distress.
2.8 Demonstrates professional judgment to ensure **social media** and **information and communication technologies (ICTs)** are used in a way that maintains public trust in the profession.	**57. (Partial)** Foundations of Practice Demonstrates professional judgment in using information and communication technologies (ICTs) and **social media**.
2.9 a Adheres to the self-regulatory requirements of jurisdictional legislation to protect the public by a) assessing own practice and individual competence to identify learning needs.	**4. (Partial)** Professional Practice Adheres to regulatory requirements of jurisdictional legislation. **5. (Partial)** Professional Practice Practices within own level of competence. **10. (Partial)** Professional Practice Engages in self-reflection and continuous learning to maintain and enhance competence.
2.9 b Adheres to the self-regulatory requirements of jurisdictional legislation to protect the public by b) developing a learning plan using a variety of sources.	**4. (Partial)** Professional Practice Adheres to regulatory requirements of jurisdictional legislation. **10. (Partial)** Professional Practice Engages in self-reflection and continuous learning to maintain and enhance competence.
2.9 c Adheres to the self-regulatory requirements of jurisdictional legislation to protect the public by c) seeking and using new knowledge that may enhance, support, or influence competence in practice.	**4. (Partial)** Professional Practice Adheres to regulatory requirements of jurisdictional legislation. **10. (Partial)** Professional Practice Engages in self-reflection and continuous learning to maintain and enhance competence.
2.9 d Adheres to the self-regulatory requirements of jurisdictional legislation to protect the public by d) implementing and evaluating the effectiveness of the learning plan and developing future learning plans to maintain and enhance competence as a registered nurse.	**4. (Partial)** Professional Practice Adheres to regulatory requirements of jurisdictional legislation. **10. (Partial)** Professional Practice Engages in self-reflection and continuous learning to maintain and enhance competence.
2.10 Demonstrates **fitness to practice**.	**15. (Verbatim Identical)** Professional Practice Demonstrates fitness to practice.
2.11 Adheres to the duty to report.	**32. (Verbatim Identical)** Legal Practice Adheres to the **duty to report**.

RN ETPC	RPN ETPC (Level of Comparability) and Practice Category
2.12 Distinguishes between the mandates of regulatory bodies, professional associations, and unions.	**19. (Verbatim Identical)** Professional Practice Distinguishes between the mandates of regulatory bodies, professional associations and unions.
2.13 Recognizes, acts on, and reports, **harmful incidences**, **near misses**, and **no harm incidences**.	**17. (Partial)** Professional Practice Identifies and responds to inappropriate behaviour and incidents of **professional misconduct**. **18. (Partial)** Professional Practice Recognizes, responds and reports own and others' **near misses**, errors and **adverse events**. **30. (Inferred)** Legal Practice Practices according to relevant mandatory reporting legislation.
2.14 Recognizes, acts on, and reports actual and potential workplace and occupational safety risks.	**73. (Inferred)** Collaborative Practice Participates in creating and maintaining a quality practice environment that is healthy, respectful and psychologically safe.
Role of COMMUNICATOR	
3.1 Introduces self to clients and health care team members by first and last name, and professional designation (protected title).	**No Equivalent**
3.2 Engages in active listening to understand and respond to the client's experience, preferences, and health goals.	**66. (Partial and Inferred)** Collaborative Practice Promotes effective interpersonal interaction.
3.3 Uses evidence-informed communication skills to build trusting, compassionate, and **therapeutic relationships** with clients.	**6. (Partial)** Professional Practice Initiates, maintains and terminates the **therapeutic nurse-client relationship**. **64. (Inferred)** Collaborative Practice Communicates collaboratively with the client and the health care team. **66. (Partial)** Collaborative Practice Promotes effective interpersonal interaction.
3.4 Uses **conflict resolution** strategies to promote healthy relationships and optimal client outcomes.	**67. (Verbatim Identical)** Collaborative Practice Uses **conflict resolution** strategies to promote healthy relationships and optimal client outcomes.
3.5 Incorporates the process of **relational practice** to adapt communication skills.	**No Equivalent**
3.6 Uses information and communication technologies (ICTs) to support communication.	**No Equivalent**
3.7 Communicates effectively in complex and rapidly changing situations.	**60. (Inferred)** Foundations of Practice Recognizes and responds immediately when a client's condition is deteriorating. **65. (Inferred)** Collaborative Practice Provides essential client information to the client and the health care team.
3.8	**35. (Partial)** Legal Practice

RN ETPC	RPN ETPC (Level of Comparability) and Practice Category
Documents and reports clearly, concisely, accurately, and in a timely manner.	Documents according to established legislation, practice standards, ethics and organizational policies.
Role of COLLABORATOR	
4.1 Demonstrates collaborative professional relationships.	**75. (Inferred)** Collaborative Practice Initiates and fosters mentoring relationships.
4.2 Initiates collaboration to support care planning and safe, continuous transitions from one health care facility to another, or to residential, community or home and self-care.	**44. (Partial)** Foundations of Practice Develops the care plan with the client, health care team and others.
4.3 Determines their own professional and **interprofessional** role within the team by considering the roles, responsibilities, and the scope of practice of others.	**69. (Verbatim Identical)** Collaborative Practice Determines their own professional and interprofessional role within the team by considering the roles, responsibilities and the scope of practice of others.
4.4 Applies knowledge about the scopes of practice of each regulated nursing designation to strengthen intraprofessional collaboration that enhances contributions to client health and well-being.	**68. (Partial)** Collaborative Practice Articulates own role based on legislated **scope of practice**, individual competence and care context, including employer policies.
4.5 Contributes to health care team functioning by applying group communication theory, principles, and group process skills.	**64. (Partial)** Collaborative Practice Communicates collaboratively with the client and the health care team.
Role of COORDINATOR	
5.1 Consults with clients and health care team members to make ongoing adjustments required by changes in the availability of services or client health status.	**46. (Inferred)** Foundations of Practice Responds to clients' conditions by organizing competing priorities into actions.
5.2 Monitors **client care** to help ensure needed services happen at the right time and in the correct sequence.	**42. (Partial)** Foundations of Practice Formulates clinical decisions consistent with client needs and priorities. **46. (Partial)** Foundations of Practice Responds to clients' conditions by organizing competing priorities into actions.
5.3 Organizes own workload, **assigns** nursing care, sets priorities, and demonstrates effective time management skills.	**78. (Almost Identical)** Collaborative Practice Organizes workload, assigns/coordinates nursing care, sets priorities and demonstrates effective time-management skills.
5.4 Demonstrates knowledge of the delegation process.	**71. (Inferred)** Collaborative Practice Demonstrates leadership, direction and supervision to **unregulated health workers** and others.
5.5 Participates in decision-making to manage client transfers within health care facilities.	**79. (Partial)** Collaborative Practice Prepares client and collaborates with health care team in transition and transfer of responsibility of care.

RN ETPC	RPN ETPC (Level of Comparability) and Practice Category
5.6 Supports clients to navigate health care systems and other service sectors to optimize health and well-being.	**No Equivalent**
5.7 Prepares clients for transitions in care.	**79. (Partial)** Collaborative Practice Prepares client and collaborates with health care team in transition and transfer of responsibility of care.
5.8 Prepares clients for discharge.	**79. (Partial)** Collaborative Practice Prepares client and collaborates with health care team in transition and transfer of responsibility of care.
5.9 Participates in emergency preparedness and disaster management.	**72. (Verbatim Identical)** Collaborative Practice Participates in emergency preparedness and disaster management.
Role of LEADER	
6.1 Acquires knowledge of the Calls to Action of the Truth and Reconciliation Commission of Canada.	**24. (Partial)** Ethical Practice Obtains knowledge of and responds to the *Calls to Action of the Truth and Reconciliation Commission of Canada*[1].
6.2 Integrates **continuous quality improvement** principles and activities into nursing practice.	**13. (Verbatim Identical)** Professional Practice Integrates continuous **quality improvement** principles and activities into nursing practice. **52. (Inferred)** Foundations of Practice Engages in quality improvement and risk management to promote a quality practice environment.
6.3 Participates in innovative client-centred care models.	**No Equivalent**
6.4 Participates in creating and maintaining a healthy, respectful, and psychologically safe workplace.	**73. (Almost Identical)** Collaborative Practice Participates in creating and maintaining a quality practice environment that is healthy, respectful and psychologically safe.
6.5 Recognizes the impact of **organizational culture** and acts to enhance the quality of a professional and safe practice environment.	**12. (Partial)** Professional Practice Collaborates in the analysis, development, implementation and evaluation of practice and policy.
6.6 Demonstrates self-awareness through reflective practice and solicitation of feedback.	**3. (Partial)** Professional Practice Displays self-awareness and recognizes when to seek assistance and guidance.
6.7 Takes action to support culturally safe practice environments.	**8. (Partial)** Professional Practice Adapts practice in response to the spiritual beliefs and cultural practices of clients.
6.8 Uses and allocates resources wisely.	**No Equivalent**
6.9 Provides constructive feedback to promote professional growth of other members of the health care team.	**75. (Inferred)** Collaborative Practice Initiates and fosters mentoring relationships.
6.10	**No Equivalent**

RN ETPC	RPN ETPC (Level of Comparability) and Practice Category
Demonstrates knowledge of the health care system and its impact on client care and professional practice.	
6.11 Adapts practice to meet client care needs within a continually changing health care system.	**77. (Inferred)** Collaborative Practice Demonstrates formal and informal leadership in practice.
Role of ADVOCATE	
7.1 Recognizes and takes action in situations where client safety is actually or potentially compromised.	**51. (Partial)** Foundations of Practice Applies principles of **client safety**.
7.2 Resolves questions about unclear orders, decisions, actions, or treatment.	**31. (Partial)** Legal Practice Recognizes, responds and reports questionable orders, actions or decisions made by others.
7.3 Advocates for the use of Indigenous health knowledge and healing practices in collaboration with Indigenous healers and Elders consistent with the Calls to Action of the Truth and Reconciliation Commission of Canada.	**70. (Partial)** Collaborative Practice Advocates for the use of Indigenous health knowledge and healing practices in collaboration with the client.
7.4 Advocates for health equity for all, particularly for vulnerable and/or diverse clients and populations.	**26. (Partial)** Ethical Practice **Advocates** for equitable access, treatment and allocation of resources, particularly for vulnerable and/or **diverse** clients and populations.
7.5 Supports **environmentally responsible practice**.	**No Equivalent**
7.6 Advocates for safe, competent, compassionate and ethical care for clients.	**27. (Inferred)** Ethical Practice Advocates for clients, especially when they are unable to advocate for themselves.
7.7 Supports and empowers clients in making informed decisions about their health care, and respects their decisions.	**9. (Almost Identical)** Professional Practice Supports clients in making informed decisions about their health care, and respects their decisions.
7.8 Supports healthy public policy and principles of **social justice**.	**No Equivalent**
7.9 Assesses that clients have an understanding and ability to be an active participant in their own care, and facilitates appropriate strategies for clients who are unable to be fully involved.	**No Equivalent**
7.10 Advocates for client's rights and ensures informed consent, guided by legislation, practice standards, and ethics.	**34. (Inferred)** Legal Practice Respond to the clients' right to health care information in adherence within relevant privacy legislation.
7.11 Uses knowledge of **population health**, **determinants of health**, **primary health care**, and health promotion to achieve health equity.	**No Equivalent**
7.12	**36. (Inferred)** Legal Practice

RN ETPC	RPN ETPC (Level of Comparability) and Practice Category
Assesses client's understanding of informed consent, and implements actions when client is unable to provide informed consent.	Obtains **informed consent** to support the client's informed decision-making.
7.13 Demonstrates knowledge of a substitute decision maker's role in providing informed consent and decision-making for client care.	**36. (Inferred)** Legal Practice Obtains **informed consent** to support the client's informed decision-making.
7.14 Uses knowledge of **health disparities** and inequities to optimize health outcomes for all clients.	**No Equivalent**
Role of EDUCATOR	
8.1 Develops an education plan with the client and team to address learning needs.	**48. (Partial)** Foundations of Practice Assesses, plans, implements and evaluates the teaching and learning process.
8.2 Applies strategies to optimize client **health literacy**.	**47. (Partial)** Foundations of Practice Assesses clients' **health literacy**, knowledge and readiness to learn.
8.3 Selects, develops, and uses relevant teaching and learning theories and strategies to address diverse clients and contexts, including lifespan, family, and cultural considerations.	**48. (Partial)** Foundations of Practice Assesses, plans, implements and evaluates the teaching and learning process.
8.4 Evaluates effectiveness of health teaching and revises education plan if necessary.	**48. (Partial)** Foundations of Practice Assesses, plans, implements and evaluates the teaching and learning process. **50. (Partial)** Foundations of Practice Evaluates the effectiveness of health education.
8.5 Assists clients to access, review, and evaluate information they retrieve using information and communication technologies (ICTs).	**38. (Inferred)** Foundations of Practice Selects and uses information and communication technologies (ICTs) in the delivery of client care. **49. (Partial)** Foundations of Practice Provides information and access to resources to facilitate health education.
Role of SCHOLAR	
9.1 Uses best evidence to make informed decisions.	**40. (Partial)** Foundations of Practice Engages in **evidence-informed practice** by considering a variety of relevant sources of information.
9.2 Translates knowledge from relevant sources into professional practice.	**11. (Almost Identical)** Professional Practice Integrates relevant evidence into practice. **40. (Partial)** Foundations of Practice Engages in **evidence-informed practice** by considering a variety of relevant sources of information.
9.3 Engages in self-reflection to interact from a place of **cultural humility** and create culturally safe	**7. (Partial)** Professional Practice Provides client care in a non-judgmental manner.

RN ETPC	RPN ETPC (Level of Comparability) and Practice Category
environments where clients perceive respect for their unique health care practices, preferences, and decisions.	
9.4 Engages in activities to strengthen competence in **nursing informatics**.	**38. (Partial)** Foundations of Practice Selects and uses information and communication technologies (ICTs) in the delivery of client care.
9.5 Identifies and analyzes emerging evidence and technologies that may change, enhance, or support health care.	**16. (Partial)** Professional Practice Maintains current knowledge about trends and issues that impact the client, the RPN, the **health care team** and the delivery of health services.
9.6 Uses knowledge about current and emerging community and **global health** care issues and trends to optimize client health outcomes.	**No Equivalent**
9.7 Supports research activities and develops own **research skills**.	**39. (Inferred)** Foundations of Practice Maintains current knowledge about trends and issues that impact the client, the RPN, the **health care team** and the delivery of health services.
9.8 Engages in practices that contribute to lifelong learning.	**10. (Partial)** Professional Practice Engages in self-reflection and continuous learning to maintain and enhance competence.

Appendix E

Interpretation Statement Comparisons

Note:

Where there are identical ETPC competencies, the RPN interpretation (RPNI)statement (CNO 2019d, pp. 1-18) will be documented in full for a direct comparison.

Where there is no equivalent competency the “Find” function was used to see if the key phrases appeared in other RPNI statements.

Where there are partial or inferred ETPC comparability, the words from the RPNI statement will be in italics. The “Find” function was also used to find any similar words or phrases from the RNI statements in either the RPN ETPC or the RPNI statements that may not have been identified through the ETPC comparison.

Notes in each box will provide insight into findings based on the analysis of the interpretation statements.

A Revised Comparability Chart will be found in Appendix F.

RN ETPC	RN Interpretation (RNI) Statement (CNO 2019c, pp. 1-24)	RPN ETPC (Level of Equivalence) from Appendix D	RPN Interpretation (RPNI) Statement (CNO 2019d, pp. 1-18) Comparison to RN Interpretation Statements and Notes
Role of CLINICIAN			

RN ETPC	RN Interpretation (RNI) Statement (CNO 2019c, pp. 1-24)	RPN ETPC (Level of Equivalence) from Appendix D	RPN Interpretation (RPNI) Statement (CNO 2019d, pp. 1-18) Comparison to RN Interpretation Statements and Notes
1.1	The program provides opportunities for students to learn how to engage clients in identifying their health needs, strengths, capacities and goals within the context of client centred and evidence-based care across the lifespan. Students will have opportunities to provide safe, ethical, competent and compassionate care.	**5. (Partial)** **25. (Partial)** **29. (Partial)** **40. (Partial)** **42. (Partial)** **51. (Partial)**	**RPNI 5 –** *recognize individual competence...should understand how to use the three-factor framework...when determining appropriate care providers to best address clients needs.* **Note:** When looking at the interpretation statement, the partial equivalence of the ETPC is negated as the idea of safe, ethical, and competent care is not addressed in the RPNI statement, and the focus shifts to recognizing one's own competence. I did not identify equivalence to this ETPC or RNI statement. **RPNI 25 –** *respecting clients' individual and unique needs... be familiar with the CNO code of conduct and professional standards document.* **Note:** This addresses the concept of client-centred care without using that terminology. I identified partially equivalent to this competency and RNI statement. **RPNI 29 –** *provides students the opportunity to demonstrate knowledge of and distinguish between ethical responsibilities and legal rights… For example, ethics, jurisprudence, legal issues, human rights, health care legislation* **Note:** Expands on what is meant by legislation, practice standards, and ethics listed in the RPN ETPC. I Identified inferred equivalent to this competency and RNI statement. **RPNI 40 –** *program prepares students to identify reliable sources of information, critique scholarly research and its application to care. Students learn to reflect on current practices they observe in clinical settings against best practices.* **Note:** When looking at the interpretation statement, the partial equivalence of the ETPC is negated as the idea of safe, ethical, competent, and evidence-based care is not fully addressed in the RPNI statement as the focus shifts to credible sources of scholarly information. I identified that they are not equivalent to this ETPC or RNI statement. **RPNI 42 – …***formulate clinical judgments that are consistent with the clients' needs and priorities by responding to changing situations that affect the client's health and safety.* **Note:** The RPNI statement addresses the RNI safety element by using clinical judgment skills. I identified this as partially equivalent to the ETPC and RNI statement. **RPNI 51 –** *assess, respond, and report any risk to client's safety.* Then it has the sentence from RPNI 42 above … *assess and respond to situations and address unique needs to ensure a safe environment for clients, self, health care providers and the public*.

RN ETPC	RN Interpretation (RNI) Statement (CNO 2019c, pp. 1-24)	RPN ETPC (Level of Equivalence) from Appendix D	RPN Interpretation (RPNI) Statement (CNO 2019d, pp. 1-18) Comparison to RN Interpretation Statements and Notes
			Note: Emphasis on safety for the RPN when providing care. I identified this as partially equivalent to the ETPC and RNI statement. **Find Function Results:** The phrase, "health needs" yielded **RPN ETPC 63:** *Engages clients in identifying their health needs, strengths capacity and goals,* which is verbatim part of this RNI statement. Additionally, **RPNI 37:** *…engaging with clients…to identify the clients' health needs.* I identified ETPC 63 and RPNI 37 having partial equivalence with the RNI statement only.
1.2	The program will provide opportunities for students to develop and gain experience in their health history and physical assessment skills. Students will use appropriate assessment tools such as history taking to determine emotional, spiritual, cognitive, developmental, environmental, social and learning needs, including the client's beliefs about health and wellness.	**37. (Partial)**	**RPNI 37 –** *…importance of collaborating with the client and, as necessary, the health care team when performing assessments across the health spectrum and all client populations…holistic approach with interview techniques that ensure clients are part of the development of their care plan…should be taught to perform physical assessments which include inspection, palpation, auscultation and percussion, within their scope of practice. They should also be taught that a comprehensive assessment includes physiological, psychological, social and spiritual assessments.* **Notes:** The RPNI statement is more directive regarding physical assessment skills, whereas the RNI statement is more inclusive in the types of needs the nurse should consider when engaging in assessments with clients. I identified partial equivalence to this ETPC and RNI statement. **Find Function Results:** The phrases, "assessment tools", and "assessment of client's beliefs" yielded no results in the competency or RNI statement.
1.3	The program will provide opportunities for the students to learn about trauma-informed care to respond to those at risk of or who experienced trauma. Students will ensure that the client and family members feel safe, both physically and psychologically. Students will build trust and transparency with	**No Equivalent**	**Find Function Results:** The phrases "trauma-informed care", "at risk" or "trauma" yielded no results. Therefore, I identified that there is no equivalent to this ETPC or RNI statement.

RN ETPC	RN Interpretation (RNI) Statement (CNO 2019c, pp. 1-24)	RPN ETPC (Level of Equivalence) from Appendix D	RPN Interpretation (RPNI) Statement (CNO 2019d, pp. 1-18) Comparison to RN Interpretation Statements and Notes
	clients who survived trauma, and will recognize cultural, historical, and gender issues and set aside cultural stereotypes and biases.		
1.4	The program will provide opportunities for students to learn about the nursing process, how to analyze information collected from assessments and how the data influences planning. Students analyze and interpret data obtained in client assessments to draw conclusions, modify and individualize client care.	**41. (Partial)** **42. (Partial)** **43. (Partial)**	**RPNI 41 -** *analyze and interpret data obtained in client assessments in order to draw conclusions about client health status. Students are taught to report and respond to their assessment findings to develop a range of care options in collaboration with the client and the health care team.* **Note:** Almost Identical phrase in the interpretation RPNI statement to the second sentence of the RNI statement. The RPN is to come up with options where the RN modifies and individualizes care - different level of practice expectation. Therefore, I identified that there is partial equivalence to this ETPC and RNI statement. **RPNI 42 -** *recognizing what assessment outcomes are within normal limits (such as gait or vital signs) and what assessment outcomes are abnormal (such as signs of dehydration and shock).* **Note:** Second sentence above of RPNI is an example of what would constitute an abnormal assessment finding and appropriate actions to take in the circumstance. Therefore, I identified there is partial equivalence to this ETPC and RNI statement. **RPNI 43 -** *teaches students about the nursing process, how to assess information collected from assessments and how this information influences care planning.* **Note:** Nursing process and the influence of assessment data are mentioned in both interpretation statements. Therefore, I identified there is partial equivalence to this ETPC and RNI statement. **Find Function Results:** When searching for "individualize(d) care", **RPNI 54** "*…to evaluate the client's individualized plan of care… In collaboration with the client and the health care team, students modify the individualized client care plan as needed,*". Therefore, I identified that there is partial comparability to RNI 1.4.
1.5	The program will provide opportunities for students to engage in reflective practice, considering	**44. (Partial)** **55. (Partial)** **56. (Partial)**	**RPNI 44 -** *Students collaborate with the client and health care team to develop a plan of care that includes establishing priorities, expected outcomes and health teaching required.*

RN ETPC	RN Interpretation (RNI) Statement (CNO 2019c, pp. 1-24)	RPN ETPC (Level of Equivalence) from Appendix D	RPN Interpretation (RPNI) Statement (CNO 2019d, pp. 1-18) Comparison to RN Interpretation Statements and Notes
	all sources of evidence contributing to clients successfully achieving their health goals. Students will use critical inquiry to support professional judgment and evidence informed decision-making to develop plans of care.		**Note:** This statement aligns with the idea of clients successfully achieving their health goals but lists the elements that would achieve this. Therefore, I identified that there is partial equivalence to this ETPC and RNI statement. **RPNI 55 -** *…demonstrate critical thinking and problem-solving skills. It encourages students to engage in reflective reasoning, considering all sources of evidence that can contribute to clients successfully achieving their health goals. Students should be able to evaluate and refine their decisions and the implications of those decisions in all aspects of nursing care.* **Note:** This part of the RPNI statement is very similar, and for some words, verbatim of the RNI statement. Therefore, I identified there is partial equivalence to this ETPC and RNI competency. **RPNI 56 -** *… opportunity to use critical inquiry to support professional judgment and evidence-informed decision-making.* **Note:** This is almost verbatim to the last sentence of the RNI. The key difference is that the RN "will" and the RPN will be provided "opportunity". Therefore, I identified there is partial equivalence to this ETPC and RNI statement. **Find Function Results:** The find function yielded no additional results for phrases contained within the RNI statement.
1.6	The program will provide opportunities for students to use a critical inquiry process to continuously monitor the effectiveness of client care. Students will monitor client care on an ongoing basis, and modify their plans of care according to one's knowledge, skills and judgement.	**45. (Inferred)** **53. (Partial)** **54. (Partial)** **55. (Partial)**	**RPNI 45 -** *…opportunities to collaborate with the client and health care team to perform appropriate nursing interventions that include assessment findings, meeting client preferences and desired outcomes.* **Note:** The RPNI statement does not reflect the RNI statement as the RPN is focusing on performing interventions that meet desired outcomes, whereas the RN is monitoring for effectiveness. The difference here suggests that the RN has a greater view of the whole client picture than the RPN. Therefore, I identified that there is no equivalence to this ETPC and RNI competency. **RPNI 53 -** *… to evaluate their plans of care by comparing actual outcomes to the expected outcomes outlined in the plans of care.* **Note:** The comparison here is a question of semantics. When the creators of the interpretation statements developed them, was there a difference between evaluating plans of care by comparing actual to expected outcomes and monitoring the effectiveness of client care? One could argue that both are assessing effectiveness. The difference is in modifying the plans of care compared to what is

RN ETPC	RN Interpretation (RNI) Statement (CNO 2019c, pp. 1-24)	RPN ETPC (Level of Equivalence) from Appendix D	RPN Interpretation (RPNI) Statement (CNO 2019d, pp. 1-18) Comparison to RN Interpretation Statements and Notes
			outlined in the plans of care. Therefore, I identified that there is partial equivalence with the ETPC and inferred equivalence with the RNI statement. **RPNI 54 -** *… evaluate the client's individualized plan of care and share it with the health care team. In collaboration with the client and the health care team, students modify the individualized client care plan as needed***.** **Note:** Evaluating the individualized plan of care is semantically close to monitoring the effectiveness of client care but this is more inferred to the RN practice. Therefore, I identified that there is partial equivalence to this ETPC and inferred equivalence to the RNI statement. **RPNI 55 -** *…demonstrate critical thinking and problem-solving skills. It encourages students to engage in reflective reasoning, considering all sources of evidence that can contribute to clients successfully achieving their health goals. Students should be able to evaluate and refine their decisions and the implications of those decisions in all aspects of nursing care.* **Note:** Being able to evaluate and refine one's decisions and their implications, is comparable to modifying plans of care according to one's knowledge, skill, and judgment**.** Therefore, I identified there is partial equivalence to this ETPC and inferred equivalence to the RNI statement. **Find Function Results:** The find function provided no additional results for phrases contained within the RNI statement.
1.7	The program will provide opportunities for students to identify and recognize actual and potential health risks, including implications of possible unintended outcomes, and initiate appropriate client care	**No Equivalent**	**Find Function Results:** The phrases of "potential health risks" and "possible intended outcomes" yielded no results. Therefore, I identified that there is no equivalent to this ETPC or RNI statement.
1.8	The program will provide opportunities for students to formulate clinical judgements that are consistent with client's needs and priorities by proactively responding to	**58. (Inferred)**	**RPNI 58 –** *…identify potential high risk practices and mitigating strategies. For example, requesting a "second reviewer or double check" for a medication calculation. Students should understand that the primary purpose of the nurse is to practise in the best interest of the public and to protect the public from harm…* **Note:** The RPNI statement does not seem to be speaking of the same level of risk to the client. The RPN seems to be responding to preventative

RN ETPC	RN Interpretation (RNI) Statement (CNO 2019c, pp. 1-24)	RPN ETPC (Level of Equivalence) from Appendix D	RPN Interpretation (RPNI) Statement (CNO 2019d, pp. 1-18) Comparison to RN Interpretation Statements and Notes
	changing situations that affect client's health and safety to prevent injury and the development of client complications.		processes but not to thinking beyond what is known and being proactive to prevent injury. Therefore, I identified the ETPC and RPNI as inferred equivalence to this competency and RNI statement. **Find Function Results:** The phrase of "changing situations" yielded results for **RPNI 51 -** *formulate clinical judgements consistent with clients' needs and priorities by responding to changing situations affecting the client's health and safety. Students should be taught to assess and respond to situations and address unique needs to ensure a safe environment for clients, self, health care providers and the public.* This is more in line with the RN ETPC and RNI statement than 58's RPN ETPC or RPNI statement. Therefore, I identified this as partial equivalence to the ETPC and RNI statement. The phrases of "prevent injury", "complications", and "formulate clinical judgments" yielded no results in the RPN ETPC or the RPNI statements.
1.9	The program will provide opportunities for students to recognize and seek immediate assistance, or help others in rapidly changing client conditions affecting client health or safety.	**60. (Verbatim Identical)**	**RPNI 60 –** *The program will provide opportunities for students to recognize and seek immediate assistance and/or help others in a rapidly changing client condition affecting health or patient safety.* **Note:** The difference between the interpretation statements are two grammatical issues: "or" versus "and/or" and singular condition in the RPN statement. The implication being that the RN will have more rapidly changing client conditions than the RPN may have. Therefore, I identified the RPNI as virtually identical to the RNI statement. **Find Function Results:** With the ETPCs and interpretation statements being virtually identical, this operation was not performed.
1.10	In collaboration with the client and health care team, the student prepares client for surgical/diagnostic procedures, treatments and provides follow up care.	**No Equivalent**	**Find Function Results:** The phrase of "preparing/preparation for procedures" yielded results in **RPNI 79** "… *in collaboration with the client and the health care team…preparation for surgical/diagnostic procedures, discharge to home or another health care facility.*" in the context of preparing for transitions in care. Therefore, I identified that RPN ETPC 79 has no equivalence to the RN ETPC and RPNI 79 has inferred equivalence with the RNI statement.

RN ETPC	RN Interpretation (RNI) Statement (CNO 2019c, pp. 1-24)	RPN ETPC (Level of Equivalence) from Appendix D	RPN Interpretation (RPNI) Statement (CNO 2019d, pp. 1-18) Comparison to RN Interpretation Statements and Notes
1.11	The program will provide opportunities for students to learn and implement safe and evidence-informed medication practices. Students will be become familiar with resources that support safe medication practice (e.g., CNO Practice Standard: Medication and CNO Practice Standard: Documentation, Canadian Patient Safety Institute (CPSI) tools, Institute for Safe Medication Practices (ISMP) resources).	**62. (Verbatim Identical)**	**RPNI 62 –** The program will provide opportunities for students to learn and implement safe and evidence-informed medication practices. Students will be become familiar with resources that support safety medication practice, such as CNO's practice standards: Medication and Documentation. **Note:** This is an ETPC that applies to Ontario and BC only. The RNI statement requires the RN to be familiar with more than just CNO practice standards and look to other national safety organizations. Therefore, I identified that the ETPCs are verbatim identical and the RPNI and RNI are almost identical. **Find Function Results:** With the ETPCs and interpretation statements being almost identical, this operation was not performed.
1.12	The program will provide opportunities for students to learn about pain management techniques, including techniques used by other health professions. Students are taught to understand clients' preferences for pain management (e.g. medical marijuana and massage therapy).	**No Equivalent**	**Find Function Results:** Although pain management is part of a particular RPN program's curriculum, there is no mention of the terms "pain management" or "pain" in the RPN ETPC or RPNI. Therefore, I identified that there is no equivalence to this ETPC or RNI statement. Since it is foundational to basic client care, was it considered too obvious to mention as an RPN competency?
1.13	The program will provide opportunities for students to learn and perform therapeutic interventions safely (e.g. positioning, skin and wound care, management of intravenous therapy and drainage tubes, and psychosocial interaction)."	**45. (Partial)**	**RPNI 45 -** *collaborate with the client and health care team to perform appropriate nursing interventions that include assessment findings, meeting client preferences and desired outcomes***.** **Note:** The RNI statement states specific therapeutic interventions and adds the qualifier of doing them safely, where the RPNI statement calls them appropriate nursing interventions and adds on that this includes other elements. Therefore, I identified that the ETPCs are partial in equivalence, and the RPNI has inferred equivalence with the RNI statement. **Find Function Results:**

RN ETPC	RN Interpretation (RNI) Statement (CNO 2019c, pp. 1-24)	RPN ETPC (Level of Equivalence) from Appendix D	RPN Interpretation (RPNI) Statement (CNO 2019d, pp. 1-18) Comparison to RN Interpretation Statements and Notes
			The find function provided no additional results for phrases contained within the RNI statement.
1.14	The program will provide opportunities for students to learn and provide pain and symptom management, psychosocial and spiritual support, and support for significant others to meet clients' palliative care or end-of-life care needs.	**No Equivalent**	**Find Function Results:** The phrases "symptom management," "palliative," or "end-of-life" yielded no results. Therefore, I identified there is no equivalent to this ETPC or RNI statement. Palliative care was identified in a particular school's PN program curriculum and mentioned on a few Ontario colleges' websites as potential clinical placement areas, so this may be a hidden curriculum element of the RPN entry-to-practice.
1.15	The program teaches students about MAiD and their accountabilities including conscientious objection. Students understand that they are accountable for complying with CNO standards, guidelines and legislation as applicable. Students have opportunities to self reflect to examine how their beliefs and values may differ from those of the client and healthcare team. In practice, they incorporate their knowledge and seek assistance when appropriate.	**No Equivalent**	**Find Function Results:** The phrases "medical assistance in dying", or "MAiD" yielded no results. Therefore, I identified that there is no equivalent to this ETPC or RNI statement. However, this content is delivered in a particular school's PN program curriculum in Ontario.
1.16	The program teaches students that the principles of harm reduction are aimed to protect human rights and improve public health. Students will understand that many people are unable or unwilling to stop using illicit	**No Equivalent**	**Find Function Results:** The phrases "harm reduction", "illicit substances", "misuse substances", or "public health" yielded no results. Therefore, I identified there is no equivalent to this ETPC or RNI statement.

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	substances. Students will demonstrate compassion and dignity such as respect, privacy, freedom from cruel, inhuman, and degrading treatment when caring for clients who misuse substances (e.g. students learn motivational interviewing techniques).		
1.17	The program teaches that epidemiology is a discipline within public health. Students are provided opportunities to learn about the distribution (frequency, pattern), and determinants (causes, risk factors) of health-related states and events (not just diseases) in specified populations (community and individuals viewed collectively). Students apply epidemiological principles to address health concerns and implement health promotion strategies.	**No Equivalent**	**Find Function Results:** The term “epidemiology” yielded no results. Therefore, I identified that there is no equivalent to this ETPC or RNI statement.
1.18	The program teaches students about the principles of the recovery model which focus on a person’s lived experience, choices, and self-management. Students will acknowledge that the individuals’	**No Equivalent**	**Find Function Results:** The phrases, “recovery,” “recovery-oriented,” “mental health”, or “addiction(s)” yielded no results. Therefore, I identified that there is no equivalent to this ETPC or RNI statement. However, mental health was a course identified in a PN program and mentioned on a few Ontario colleges’ websites as a course in the program’s curriculum. There are RPNs that work in the mental health specialty areas of practice. As well, mental health issues are prominent in society today, with a reported 1 in 5 experiencing a mental health issue in

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	expectations about themselves have a strong influence on behaviour and outcomes. Students learn and demonstrate collaborative decision-making by understanding that the client's lived experience makes the client the expert in their own care.		Canada (Centre for Addiction and Mental Health, 2023). Should this be a competency for RPNs in the future or should this be an RN only area of practice?
1.19	The program provides opportunities for students to learn and apply strategies that promote mental health for all and creates supportive environments reducing the stigma of mental illness. Students will learn about using evidence-based risk assessment tools which includes actively listening to the client and directly asking about thoughts of suicide. Students learn about the legal responsibility to report findings to the most responsible practitioner, and documenting assessment and findings including who was consulted. Students will gain knowledge of community resources and will promote the use of these resources with the client. Some examples of mental health promotion include: awareness of mental health support groups in the community that	**No Equivalent**	**Find Function Results:** The phrases, "mental health," "mental illness" or "risk assessment tools" yielded no results. Therefore, I identified that there is no equivalent to this ETPC or RNI statement. However, mental health was a course identified in a PN program and mentioned on a few Ontario colleges' websites as a course in the program's curriculum. There are RPNs that work in the mental health specialty areas of practice. As well, mental health issues are prominent in society today, with a reported 1 in 5 experiencing a mental health issue in Canada (Centre for Addiction and Mental Health, 2023). Should this be a competency for RPNs in the future or should this be an RN only area of practice?

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	address determinants of mental health for all age groups, prevention of drug abuse in at-risk youth by encouraging collaboration between schools and community, and supporting education and training of practitioners that includes evidence-based, best practices for hospital and community mental health services.		
1.20	The program provides opportunities for students to learn and incorporate various evidence-based suicide prevention approaches. For example, implementation of the Zero Suicide Initiative which includes directly asking the client about suicidal thoughts, supporting hospitals to improve safety of the physical environment, being knowledgeable about psychosocial treatment interventions including Cognitive Behaviour Therapy and Dialectical Behaviour Therapy. Students will learn how to build a safety plan intervention with the client which may include family and other social supports.	**No Equivalent**	**Find Function Results:** The phrases, “suicide”, “suicide prevention”, “cognitive behaviour therapy”, “addiction(s)”, or “dialectic behaviour therapy” yielded no results. Therefore, I identified that there is no equivalent to this ETPC or RNI statement. However, mental health was a course identified in a PN program and mentioned on a few college’s websites as a course in the program’s curriculum. There are RPNs that work in the mental health specialty areas of practice. As well, mental health issues are prominent in society today, with a reported 1 in 5 experiencing a mental health issue in Canada (Centre for Addiction and Mental Health, 2023). Should this be a competency for RPNs in the future or should this be an RN only area of practice?

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1.21	The program will provide opportunities for students to learn foundational knowledge from various health sciences that can influence a nurse's understanding of clients and their health care needs. Students will have opportunities to apply their nursing knowledge, skills and judgment (e.g. care of clients experiencing stroke, cardiovascular conditions, mental health and addiction, dementia, arthritis, diabetes).	**61. (Partial)**	**RPNI 61 -** *… foundational knowledge from nursing theories, health sciences, social sciences and humanities that can influence a nurse's understanding of clients and their health issues in the context of care.* **Note:** Some identical wording was noted between the RNI and RPNI statements, but the RNI statement provides examples. Therefore, I identified that the ETPCs have partial equivalence and the interpretation statements have almost identical equivalence. **Find Function Results:** The terms, "stroke", "dementia", diabetes", or "cardiovascular" yielded no results in the RPN ETPC or RPNI statements.
1.22	The program will provide opportunities for students to acquire knowledge in areas such as: nursing theories; leadership and change theories; communication and learning; crisis intervention; loss, grief and bereavement; systems theory; diversity; power relations. Students will incorporate this knowledge into plans of care.	**61. (Partial)**	**RPNI 61 -** *… foundational knowledge from nursing theories, health sciences, social sciences and humanities that can influence a nurse's understanding of clients and their health issues in the context of care.* **Note:** This RPNI statement is very generic when comparing it to the examples given in the RNI statement. Therefore, I identified that the ETPCs have partial equivalence, and the interpretation statements have inferred equivalence. **Find Function Results:** There is no mention of the words, "crisis", "grief", "bereavement", "change theories", or "power relations" in any RPNI statements. "Leadership" had 10 results in a search with number 71 RPN ETPC and RPNI statements mentioning developing knowledge and applying leadership skills. In addition, 77 RPN ETPC and RPNI statements mention formal and informal leadership styles. RPNI 78 mentions that "the program teaches students the necessary leadership skills." RPNI 2 mentions upholding a culture of leadership, but does not mention how it is acquired. Therefore, I identified ETPC and RPNI statements 71 and 77 as having inferred equivalence and RPNI statement 78 as having inferred equivalence to this ETPC and RNI statement.
1.23	The program will provide opportunities	**40. (Partial)**	**RPNI 40 -** *teaches students to engage in high-level thinking such as reflection, analysis and synthesis of*

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	for students to support client health outcomes by engaging in reflective practice and decision making that is evidenced informed and in line with best practices (e.g. RNAO best practice guidelines).		*information, or questioning of the status quo or current state… prepares students to identify reliable sources of information, critique scholarly research and its application to care. Students learn to reflect on current practices they observe in clinical settings against best practices.* **Note:** The RNI statement approaches evidence-informed care from an overview perspective whereas the RPNI statement provides more specifics as to what are the steps involved in evidence-informed care practices. Therefore, I identified that there is partial equivalence to the ETPC and RNI statement. **Find Function Results:** Using the term "decision-making" located three instances in the RPN ETPC and RPNI statements. **RPNI 11 -** *…using research-based evidence and BPG (Best Practice Guidelines) to support collaborative decision-making.* This has similar wording to the RNI statement in that the RN makes decisions in line with BPGs and the RPN will use them collaboratively. This suggests that the RN is functioning at a higher level of decision-making as they do not need to collaborate to make decisions whereas, the RPN does. So, this is partial but functioning at a different level of practice. RPN ETPC and RPNI 56 – this speaks more to using critical thinking and critical inquiry with decision-making. These are inferred in that evidence-informed practice requires critical inquiry to be accomplished. RPNI 63 – speaks to engaging clients to be active participants in decision making so it is not related to evidence-informed practice and is not relevant. Therefore, I identified that ETPC and RPNI 11 are partially equivalent and ETPC and RPNI 56 have inferred equivalence to the ETPC and RNI statement.
1.24	The program will provide opportunities for students to acquire a body of knowledge regarding the management or prevention of disruptive or aggressive behaviour, and horizontal violence with clients, families and others (e.g. team members). Students will have opportunities to	**59. (Almost Identical)**	**RPNI 59 –** *The program will provide opportunities for students to acquire a body of knowledge regarding the management or prevention of disruptive or aggressive behaviour and horizontal violence with clients, families and others (for example, team members). Students will have opportunities to prevent, de-escalate and manage disruptive, aggressive, or violent behaviour, often managing these behaviours in collaboration with the health care team.* **Note:** With the exception of commas and the use of "for example" instead of "e.g.", the interpretation statements are identical. The difference comes in the levelling of the action verb in the ETPC statements: RN "uses effective strategies"; RPN "applies strategies", which are the

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	prevent, de-escalate, and manage disruptive, aggressive, or violent behaviour.		same in the cognitive domain but uses has Affective domain of Receiving Phenomena and a Psychomotor domain of Mechanism; and with the adjective of effective, indicates a greater complexity to the role of the RN in this area of clinical practice. If there is to be a difference in RN and RPN practice, then the interpretation statements should indicate this as well. Therefore, I identified that the ETPC is almost identical in equivalence, and the RPNI is virtually identical to this competency and RNI statement. **Find Function Results:** With the ETPCs and interpretation statements being almost and virtually identical, this operation was not performed.
1.25	The program will provide opportunities for students to learn and apply strategies that promote health and disease prevention (for example promoting hand washing, immunization, helmet safety, safe sex) in the community, or in the broader health care system.	**No Equivalent**	**Find Function Results:** The phrases, “promote health”, “health promotion” and “disease prevention” yielded no results. As well, there is no mention of any of the examples provided in the RNI within the RPN ETPC and RPNI statements. Therefore, I identified that there is no equivalent to this ETPC or RNI statement.
1.26	The program will provide opportunities for students to provide care for clients while demonstrating respect for their health/ illness status, their diagnoses, life experiences, spiritual/religious/ cultural beliefs and practices, and health care choices.	**8. (Identical)**	**RPNI 8 –** *The program will provide opportunities for students to provide care for clients while demonstrating respect for their health/ illness status, their diagnoses, life experiences, spiritual/religious/ cultural beliefs and practices and health care choices.* **Note:** I identified these RN and RPN ETPC and interpretation statements as verbatim identical in equivalence to each other. **Find Function Results:** With the ETPCs and interpretation statements being identical, this operation was not performed.
1.27	The program will provide opportunities for students to learn and apply evidenced informed workplace health and safety principles, including	**51. (Inferred)**	**RPNI 51 -** *… Students should be taught to assess and respond to situations and address unique needs to ensure a safe environment for clients, self, health care providers and the public.* **Note:** A safe environment implies that infection control practices are being used to prevent harm to all in the workplace. Therefore, I identified that there

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	bio-hazard prevention and infection control practices, and appropriate protective devices when providing nursing care to prevent harm to clients, self, other health care workers and the public.		was inferred equivalence to the ETPC and RNI statement. **Find Function Results:** In searching for the term "workplace health", RPNI 73 contains the sentence, *Students apply workplace health and safety principles, including bio-hazard prevention and infection control practices, and use of appropriate protective devices when providing nursing care,* which is virtually identical to the RNI statement. ETPC 73 does not mention the workplace. "Participates in creating and maintaining a quality practice environment that is healthy, respectful and psychologically safe" but is inferred in a practice environment. Therefore, I identified that ETPC 73 has inferred equivalence and the RPNI 73 is partially identical in equivalence, as there are additional statements contained within.
Role of PROFESSIONAL			
2.1	The program will provide opportunities for students to learn what it means to be accountable to the public and to the profession by understanding self-regulation, scope of practice, practice standards and associated competencies for safe nursing practice in Ontario. Students have the opportunities to practice within the scope of registered nursing practice as defined in the Nursing Act, 1991. Students articulate the role and responsibilities of a Registered Nurse, and they recognize individual competence within legislated scope of practice, and seek support and assistance as necessary.	**1. (Partial)** **2. (Partial)** **3. (Partial)** **5. (Partial)** **17. (Inferred)** **28. (Inferred)**	**RPNI 1 -** *… demonstrate accountability and responsibility for their role. It provides the opportunity for students to learn that they must be accountable for one's decisions and actions, while also considering the boundaries of workplace, organizational and unit policy and procedures.* **Note:** The RPNI focuses on accountability and responsibility but adds the RPN considers policies and procedures. Policies and procedures are present in safe nursing practice. Therefore, I identified the ETPC and RPNI as partially equivalent to this competency and RNI statement. **RPNI 2 -** *… demonstrate accountability for autonomous practice and responsibility for their scope of practice. It provides the opportunity for students to demonstrate critical thinking, upholding a culture of safety and leadership as well as knowledge of scope of practice.* **Note:** The RPNI focuses on autonomous practice and the responsibility for their scope. The elements listed after are part of autonomous practice and scope of practice as a nurse. Therefore, I identified the ETPC and RPNI as partially equivalent to this competency and RNI statement. **RPNI 3 -** *… opportunity to engage in reflective practice related to individual competence that would identify their own limitations in nursing practice (knowledge deficit, skill deficit). It provides the opportunity to consult with others when necessary to help inform decisions and practice.* **Note:** The RPNI focuses on reflective practice which is an essential element in nursing practice and part of how one develops accountability. Therefore, I identified the ETPC and RPNI as

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			inferred equivalence to this competency and RNI statement. **RPNI 5 -** *… recognize individual competence within their legislated scope of practice and to seek support and assistance as necessary. Students should understand how to use the Three Factor Framework from CNO's practice guideline, RN and RPN Practice: the Client, the Nurse and the Environment when determining appropriate care providers to best address the client's needs.* **Note:** The first sentence of the RPNI is identical to the last sentence in the RNI. The second sentence of the RPNI is related to understanding the Three-Factor Framework which is a decision tool to aid in determining competency and scope. Therefore, I identified the ETPC and RPNI as partially equivalent to the competency and RNI statement. **RPNI 17 -** *… learning opportunities to understand what constitutes unacceptable professional behaviour and professional misconduct. Students are able to identify and professionally respond to inappropriate behaviour. They should be familiar with CNO's Code of Conduct and Professional Standards documents.* **Note:** The RPNI focuses on professional misconduct and identifying inappropriate behaviours, but it is not clear if it is in self or others. Therefore, I identified the ETPC and RPNI as inferred equivalence to this competency and RNI statement. **RPNI 28 -** *… recognize and fulfill their professional obligation to provide care for clients and families. Students must understand they cannot abandon, abuse or neglect clients when responsible for client care (see CNO's Ethics practice standard).* **Note:** This is a competency applicable only in BC and Ontario. The professional obligation is part of accountability and responsibility for nurses; therefore, I identified the ETPC and RPNI as partially equivalent to this competency and RNI statement. **Find Function Results:** The phrase "Nursing Act" yielded one result in RPNI 4 - *… demonstrate and apply the legislated requirements of nursing self-regulation in Ontario. Students must demonstrate knowledge of CNO's mandate and accountability as regulated health professionals under the Regulated Health Professions Act, 1991 (RHPA) and the Nursing Act, 1991, including requirements and mandates of self-regulation.* Self-regulation is stated in the RNI; therefore, I identified this ETPC and RPNI as an

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			inferred equivalence to this competency and RNI statement. Other phrases in the ETPC and RNI statement yielded no further results.
2.2	The program will provide opportunities for students to demonstrate honesty, integrity and respect in all professional interactions. Students will identify, develop and model a professional presence. Examples of professional presence include professional manner respectful communication, attire, punctuality, advocacy for the profession and following CNO's Professional Standards and CNO's Code of Conduct.	**14. (Almost Identical)** Professional Practice	**RPNI 14 -** *… learning opportunities to demonstrate honesty, integrity and respect in all interactions. It helps identify and demonstrate behaviours that reflect professionalism, professional presence among peers and the interprofessional health care team.* **Note:** The difference in the ETPCs was the additional words of "and competence" in the RN ETPC, otherwise they were identical. The first sentence of the RPNI is virtually identical to the first sentence of the RNI with the difference "will provide". The RPNI statement provides rationale for honesty, integrity, and respect, whereas the RNI statement focuses on professional presence and the characteristics of that phrase. Therefore, I identified the ETPC as almost identical in equivalence, and the RPNI as partially equivalent to this competency and RNI statement. **Find Function Results:** The phrases "professional presence" yielded no further results and "code of conduct" and "professional standards" yielded 3 and 4 results respectively that were not relevant to this competency.
2.3	The program will provide opportunities for students to learn about the nursing scope of practice, how specific organizational policies may affect scope of practice, and how students can deal with responsibilities and accountabilities in the absence of organizational policies.	**1. (Inferred)** **2. (Partial and Inferred)** **5. (Partial)** **29. (Partial)**	**RPNI 1 -** *… demonstrate accountability and responsibility for their role. It provides the opportunity for students to learn that they must be accountable for one's decisions and actions, while also considering the boundaries of workplace, organizational and unit policy and procedures.* **Note:** The RPNI discusses accountability considering the workplace policies, whereas the RNI discusses what to do in the absence of policies and focuses on the scope of practice. Responsibility for their role is inferred in scope of practice. Therefore, I identified the ETPC and RPNI as inferred equivalence to this competency and RNI statement. **RPNI 2 -** *… demonstrate accountability for autonomous practice and responsibility for their scope of practice. It provides the opportunity for students to demonstrate critical thinking, upholding a culture of safety and leadership as well as knowledge of scope of practice.* **Note:** The RPNI discusses scope of practice and that their practice is autonomous. This is implied in all registered nursing practice, so I question why this was included. There is no evidence of policy and procedures, but this is inferred in upholding a culture of safety and leadership as policies and procedures

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			are inherent to having this. Therefore, I identified the ETPC and RPNI as inferred equivalence to this competency and RNI statement. **RPNI 5 -** *… recognize individual competence within their legislated scope of practice and to seek support and assistance as necessary. Students should understand how to use the Three Factor Framework from CNO's practice guideline, RN and RPN Practice: the Client, the Nurse and the Environment when determining appropriate care providers to best address the client's needs.* **Note:** The RPNI discusses competence within the scope of practice, but is focused on determining scope based on the Three-Factor Framework. Using the framework infers that there are policies supporting scope, but the RPN must determine their capacity to perform the activity. Therefore, I identified the ETPC and RPNI as inferred equivalence to this competency and RNI statement. **RPNI 29 -** *… demonstrate knowledge of and distinguish between ethical responsibilities and legal rights and their relevance when providing nursing care. For example, ethics, jurisprudence, legal issues, human rights, health care legislation.* **Note:** Although the ETPC mentions organizational policies, the RPNI focuses on understanding responsibilities between legal and ethical rights and responsibilities and provides examples. These are inferred as informing professional judgment; therefore, I identified this ETPC and RPNI as inferred equivalence to this competency and RNI statement. **Find Function Results:** The phrases, "professional judgment", and "organizational policies" yielded results that were not related to practising in the absence of policies.
2.4	The program will provide opportunities for students to learn the difference between ethical and legal considerations and the relevance when providing nursing care. Students demonstrate ethical responsibilities and legal obligations related to maintaining client privacy,	**25. (Partial)** **29. (Partial)** **33. (Partial)**	**RPNI 25 -** *… to respect and care for clients' individual and unique needs. Students need to understand the relationship of privacy, confidentiality, dignity and self-determination to advocate for clients' rights. Students should be familiar with CNO's Code of Conduct and Professional Standards documents.* **Note:** The RPNI discusses respecting the client's rights, which is inferred in ethical and legal obligations; however, the statement discusses advocacy in relation to respecting their rights. Therefore, I identified the ETPC and RPNI as not equivalent to this competency and RNI statement. **RPNI 29 -** *… to demonstrate knowledge of and distinguish between ethical responsibilities and legal rights and their relevance when providing nursing*

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	confidentiality and security in all forms of communication, including social media.		*care. For example, ethics, jurisprudence, legal issues, human rights, health care legislation.* **Note:** The ability to distinguish between ethical responsibilities and legal rights is identical in intent to learning the difference between ethical and legal considerations. The examples in the RPNI clarify what this means. Therefore, I identified the ETPC and RPNI as partially equivalent to this competency and RNI statement. **RPNI 33 -** *… to understand and demonstrate the need for client confidentiality in all forms including social media. Students need awareness about who comprises the circle of care, what that means in terms of sharing client information/respecting confidentiality. They should be aware of what information to share with whom, when and how. Students should be familiar with CNO's Professional Standards document.* **Note:** The RPNI discusses need for client confidentiality which is partially equivalent to the second sentence of the RNI statement. The security around the sharing of information is inferred with the circle of care. Therefore, I identified the ETPC and RPNI as partially equivalent to this ETPC and RNI statement. **Find Function Results:** Since there were no phrases that were different between the competencies and interpretation statements, this was not performed.
2.5	The program provides opportunities for students to engage in client centred care with a focus on recognizing power imbalance in therapeutic nurse-client relationships. Students identify the effect of their own values, beliefs and experiences in relationships with clients, and recognizes potential conflicts while ensuring safe client care. These opportunities also help students self reflect, recognize and respect diversity	**21. (Partial)** **22. (Partial)**	**RPNI 21-** *… reflect upon one's personal values, beliefs and experiences that impact interactions and decisions. Students have the opportunity to take action to minimize the impact of their personal values and assumptions on client relationships and interactions with the interprofessional team.* **Note:** The RPNI is almost identical to the portion of the RNI that discusses "values, beliefs, and experiences" but does not discuss power imbalance as an assumption in client and team relationships. Therefore, I identified the ETPC and RPNI as partially equivalent to this competency and RNI statement. **RPNI 22 -** *… importance of self-reflection to identify their individual values and biases and how it affects their personal and professional relationships. Students learn they may have to collaborate with diverse clients who may hold different world views and values than themselves.* **Note:** The RPNI discusses the effect of values and biases on relationships as in the RN ETPC statement. The RNI discusses recognizing potential conflicts which is inferred with the effect of values

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	in clients and team members while demonstrating an awareness of the influence of existing positional power relationships.		and biases. However, learning how to collaborate with diverse clients is not equivalent with respecting diversity. Therefore, the ETPC and RPNI have a partial equivalence to this competency and RNI statement. **Find Function Results:** The phrase "(im)balance of power" yielded one result in RPNI 20 as one of the example concepts in the therapeutic nurse-client relationship and is inferred in reducing biases; therefore, I identified the ETPC as not equivalent and the RPNI as inferred equivalence to this competency and RNI statement.
2.6	The program provides opportunities for students to establish and maintain appropriate professional boundaries with clients and other health care team members, including the distinction between social and therapeutic relationships.	**20. (Partial)**	**RPNI 20 -** *…establish and maintain a professional relationship with clients, considering the Therapeutic Nurse-Client Relationship (TNCR) practice standard. Students must understand concepts such as the balance of power; building trust, respect, engagement with client; emphasis on honesty; time with client; identifying clients' needs; collaboration/partnering with client; differences between professional and social relationships; the concept of professional boundary. Students recognize that the use of social media can cross the boundary of the professional nurse-client relationship. For example, befriending a client on Facebook.* **Note:** The RN ETPC has the additional phrase of "with clients and the health care team; however, the RPN ETPC and RPNI do not mention the health care team. The RPNI provides several examples of concepts that the RPN must understand, whereas the RNI is silent on the concepts. These are implied in the phrase "appropriate professional boundaries". Therefore, I identified the ETPC and RPNI as partially equivalent to this competency and RNI statement. **Find Function Results:** The phrase "appropriate professional boundaries" yielded no result.
2.7	The program provides opportunities for students to identify ethical dilemmas and moral distress. Students use an ethical framework, evidence informed decision-making process and self	**23. (Partial)**	**RPNI 23 -** *… understand and apply an ethical framework such as CNO's Ethics practice standard. Students learn how to identify ethical dilemmas and moral distress, what resources they can seek out and how to self-reflect. Students should be able to demonstrate how an ethical framework is used to preserve the client's rights in the practice setting.* **Note:** The RPNI is almost identical to the RNI in that both use an ethical framework to identify ethical dilemmas and moral distress, however, the RN must

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	reflection to address situations of ethical dilemmas and moral distress. Students identify what resources to seek when necessary (for example bioethicist).		identify, whereas the RPN learns how to identify. Both discuss the need to self-reflect and the resources to seek out with the RNI giving examples. When reviewing the ETPC, I identified more equivalence in them than I had initially; therefore, I identified the ETPC and RPNI as almost identical in equivalence to this competency and RNI statement. **Find Function Results:** Since there were no phrases that were different between the competencies and interpretation statements, this was not performed.
2.8	The program provides students opportunities to learn about client health records, workload measurement systems, use of social media and other clinical applications used in health care. Students demonstrate responsibility with their technology use, and ensure their use meets legal requirements for privacy and confidentiality.	**57. (Partial)**	**RPNI 57 -** *… to responsibly demonstrate the use of informatics, technology and social media. For example, not sharing passwords, privacy and confidentiality issues related to technology and appropriately accessing client information when students are part of the circle of care. Students need to demonstrate awareness about who comprises the circle of care, specifically what it means in terms of sharing client information/respecting confidentiality.* **Note:** The RPNI statement discusses responsibility with use of informatics, technology and social media but does not discuss legal requirements or maintaining public trust in the profession. The RPNI discusses who is in the circle of care where the RNI does not discuss this. Therefore, I identified the ETPC and RPNI as partially equivalent to this competency and RNI statement. **Find Function Results:** The phrase "privacy and confidentiality" yielded one result in RPNI 38 - *… Students learn about the need to be responsible with their technology use and ensure use meets legal requirements for privacy and confidentiality…* which is virtually identical to the second sentence in the RNI. The RN must "demonstrate responsibility" and the RPN must "learn about the need to be responsible". ETPC 38 does not identify professional judgment to maintain public trust in the profession, rather the RPN selects and utilizes ICTs. Therefore, I identified the ETPC as inferred equivalence and the RPNI as partial equivalence to this competency and RNI statement.
2.9 a	The program provides students opportunities to learn about CNO's Quality Assurance (QA) Program, and fulfill the program's self-assessment	**4. (Partial)** **5. (Partial)** **10. (Partial)**	**RPNI 4 -** *… demonstrate and apply the legislated requirements of nursing self-regulation in Ontario. Students must demonstrate knowledge of CNO's mandate and accountability as regulated health professionals under the Regulated Health Professions Act, 1991 (RHPA) and the Nursing Act,*

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	requirements. Students demonstrate continuing competence and preparedness to meet regulatory requirements by reflecting on their practice and individual competence to identify learning needs.		*1991, including requirements and mandates of self-regulation.* **Note:** The RPNI does not mention the CNO QA program but does mention the accountability as a regulated health profession which includes following a quality assurance program. Part of the CNO's QA program requirements is to use new knowledge when developing a learning plan or influencing practice competence. There is no mention of reflecting on personal practice and individual competence, continuing competence, or self assessment in this RPNI; therefore, I identified the ETPC and RPNI as inferred equivalence to this competency and RNI statement. **RPNI 5 -** *… recognize individual competence within their legislated scope of practice and to seek support and assistance as necessary. Students should understand how to use the Three Factor Framework from CNO's practice guideline, RN and RPN Practice: the Client, the Nurse and the Environment when determining appropriate care providers to best address the client's needs.* **Note:** The ETPC was identified as partially equivalent but when combined with the RPNI, there is no equivalence to this competency or RNI statement. **RPNI 10 -** *… opportunity to demonstrate continued competence and preparedness to meet regulatory requirements by reflecting on one's practice to identify learning needs.* **Note:** The RPNI is almost identical to the second sentence of the RNI. The difference is in the command in the RNI versus opportunity to demonstrate. Therefore, I identified this ETPC and RPNI as partial equivalence to the competency and RNI statement, as the first sentence of the RNI was not included in the RPNI. **Find Function Results:** The phrases, "quality assurance program", and "continuing competence" yielded no results.
2.9 b	The program provides students opportunities to learn about the CNO's Quality Assurance (QA) Program, and fulfill the self-assessment requirements of the program. Students demonstrate	**4. (Partial)** **10. (Partial)**	**RPNI 4 -** *… demonstrate and apply the legislated requirements of nursing self-regulation in Ontario. Students must demonstrate knowledge of CNO's mandate and accountability as regulated health professionals under the Regulated Health Professions Act, 1991 (RHPA) and the Nursing Act, 1991, including requirements and mandates of self-regulation.* **Note:** The RPNI does not mention the CNO QA program but does mention the accountability as a regulated health profession which includes following

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	continuing competence and preparedness to meet regulatory requirements by developing a Learning Plan using a variety of sources. For example self-evaluation and peer feedback.		a quality assurance program. Part of the CNO's QA program requirements is to develop a learning plan or influencing practice competence. There is no mention of this, continuing competence, or self assessment in this RPNI; therefore, I identified the ETPC and RPNI as inferred equivalence to this competency and RNI statement. **RPNI 10 -** *… opportunity to demonstrate continued competence and preparedness to meet regulatory requirements by reflecting on one's practice to identify learning needs.* **Note:** The RPNI discusses continued competence and preparedness to meet regulatory requirements but not to develop a learning plan. The example of self-evaluation and peer feedback in the RNI are related to using a variety of sources to develop the learning plan. Therefore, I identified this ETPC and RPNI as inferred equivalence to the competency and RNI statement. **Find Function Results:** The phrases "learning plan", "quality assurance program" and "continuing competence" yielded no results.
2.9 c	The program provides students opportunities to learn about the CNO's Quality Assurance (QA) Program, and fulfill the self-assessment requirements of the program. Students demonstrate continuing competence and preparedness to meet regulatory requirements by seeking and using new knowledge that may enhance, support or influence competence in practice.	**4. (Partial)** **10. (Partial)**	**RPNI 4 -** *… demonstrate and apply the legislated requirements of nursing self-regulation in Ontario. Students must demonstrate knowledge of CNO's mandate and accountability as regulated health professionals under the Regulated Health Professions Act, 1991 (RHPA) and the Nursing Act, 1991, including requirements and mandates of self-regulation.* **Note:** The RPNI does not mention the CNO QA program but does mention the accountability as a regulated health profession which includes following a quality assurance program. Part of the CNO's QA program requirements is to use new knowledge when developing a learning plan or influencing practice competence. There is no mention of seeking and using new knowledge, continuing competence, or self assessment in this RPNI; therefore, I identified the ETPC and RPNI as inferred equivalence to this competency and RNI statement. **RPNI 10 -** *… opportunity to demonstrate continued competence and preparedness to meet regulatory requirements by reflecting on one's practice to identify learning needs.* **Note:** The RPNI discusses continued competence and preparedness to meet regulatory requirements but not to use new knowledge. Therefore, I identified this ETPC and RPNI as inferred equivalence to the competency and RNI statement.

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			Find Function Results: The phrases "new knowledge", "quality assurance program" and "continuing competence" yielded no results.
2.9 d	The program provides students opportunities to learn about the CNO's Quality Assurance (QA) Program, and fulfill the self-assessment requirements of the program. Students demonstrate continuing competence and preparedness to meet regulatory requirements by implementing and evaluating the effectiveness of one's Learning Plan and developing future Learning Plans to maintain and enhance one's competence as a registered nurse.	**4. (Partial)** **10. (Partial)**	**RPNI 4 -** *… demonstrate and apply the legislated requirements of nursing self-regulation in Ontario. Students must demonstrate knowledge of CNO's mandate and accountability as regulated health professionals under the Regulated Health Professions Act, 1991 (RHPA) and the Nursing Act, 1991, including requirements and mandates of self-regulation.* **Note:** The RPNI does not mention the CNO QA program but does mention the accountability as a regulated health profession which includes following a quality assurance program. Part of the CNO's QA program requirements is to develop and evaluate a yearly learning plan. There is no mention of learning plan, continuing competence, or self assessment in this RPNI; therefore, I identified the ETPC and RPNI as inferred equivalence to this competency and RNI statement. **RPNI 10 -** *… opportunity to demonstrate continued competence and preparedness to meet regulatory requirements by reflecting on one's practice to identify learning needs.* **Note:** The RPNI discusses continued competence and preparedness to meet regulatory requirements and to identify learning needs but not to evaluate a learning plan. Therefore, I identified this ETPC and RPNI as inferred equivalence to the competency and RNI statement. **Find Function Results:** The phrases "learning plan", "quality assurance program", and "continuing competence" yielded no results.
2.10	The program provides opportunities for students to understand the concept of fitness to practice. Students articulate the concept and significance of fitness to practice in the context of	**15. (Verbatim Identical)**	**RPNI 15 -** *… understand the concept of fitness to practice and how to self-assess and reflect on their ability to provide safe and ethical nursing care. Fitness to practice is defined as the necessary physical or mental capacity to practice competently, safely and ethically. Students should be able to articulate the concept and significance of fitness to practice in the context of nursing practice, self-regulation and public protection. They must be aware of the impact of their own health on client care.*

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	nursing practice, self-regulation and public protection. Students will self-assess and reflect on their ability to provide safe and ethical nursing care.		**Note:** The first half of the first sentences after the lead in are verbatim identical in each interpretation statement. The second half of the RPNI is verbatim identical to the third sentence in the RNI. The second sentences are virtually identical, but the RN is commanded to articulate and the RPN "should be able to articulate". Therefore, I identified that the ETPC are verbatim identical in equivalence and the RPNI is virtually identical in equivalence to this competency and RNI statement. **Find Function Results:** Since there were no phrases that were different between the competencies and interpretation statements, this was not performed.
2.11	The program provides opportunities for students to learn about unsafe practice, and the mandatory reporting requirements from a legislative perspective. Students recognize when and to whom to report unsafe practice or professional misconduct of a health care provider, and responds accordingly.	**32. (Verbatim Identical)**	**RPNI 32 -** *… learn about unsafe practice and the reporting requirements from a legislative perspective. Students recognize when to report unsafe practice or professional misconduct of a health care provider and responds accordingly. Nurses have a legal and ethical duty to report incompetent or impaired practice or unethical conduct of regulated health professionals. Provincial legislation requires nurses to report situations in which there is a good reason to believe that a health professional's practice is impaired or incompetent and may pose a significant risk to the public.* **Note:** The difference between RPNI and RNI first sentences is the word "mandatory" and is otherwise verbatim identical. The RPNI has a second sentence that is almost identical to the second sentence of the RNI. The RPNI has an additional sentence that explains mandatory reporting without naming it as such. Therefore, I identified the ETPC as verbatim identical in equivalence and the RPNI as virtually identical in equivalence to this competency and RNI statement. **Find Function Results:** Since there were no phrases that were different between the competencies and interpretation statements, this was not performed.
2.12	The program provides opportunities for students to differentiate and articulate differences between the mandates of the regulatory bodies identified by the	**19. (Verbatim Identical)** Professional Practice	**RPNI 19 -** *… differentiate between the mandate and philosophy of regulatory bodies, professional organizations and unions. For example, regulatory bodies such as the College of Nurses of Ontario; professional associations such as Registered Practical Nursing Association of Ontario (WeRPN), Registered Nurses Association of Ontario (RNAO) and Canadian Nurses Association (CNA); unions*

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	RHPA, 1991. Students will learn about the mandates and authorities of relevant professional associations and unions.		*such as Ontario Nurses Association (ONA), Canadian Union of Public Employees (CUPE).* **Note:** The RPNI is almost identical to the RNI statement. Differences include the RPN must differentiate between the philosophies of regulatory bodies, whereas the RN differentiates and articulates the differences between the mandates. The RPNI lists the different organizations that the RPN needs to know whereas the RNI discusses "relevant" professional associations and unions. Therefore, I identified the ETPC as verbatim identical in equivalence and the RPNI as almost identical in equivalence to this competency and RNI statement. **Find Function Results:** Since there were no phrases that were different between the competencies and interpretation statements, this was not performed.
2.13	The program provides opportunities for students to recognize, reflect and report potentially unsafe situations within the practice environment (for example, needle stick injuries, falls and medication errors). Students recognize when they or their colleagues almost make a mistake or have a "near miss." Students learn the importance of documentation as part of the reporting process.	**17. (Partial)** **18. (Partial)** **30. (Partial)**	**RPNI 17 -** *… understand what constitutes unacceptable professional behaviour and professional misconduct. Students are able to identify and professionally respond to inappropriate behaviour. They should be familiar with CNO's Code of Conduct and Professional Standards documents.* **Note:** The RPNI speaks more to professional misconduct whereas the RNI speaks to issues in the practice environment. Therefore, I identified the ETPC and RPNI as not equivalent to this competency or RNI statement. **RPNI 18 -** *… reflect upon and take action when they or their colleagues have almost made a mistake or had a "near miss." Students have opportunities to learn how to recognize and report potentially unsafe situations within the practice environment and to learn about the importance of documentation as part of the reporting process. For example, needle stick injuries, falls and medication errors.* **Note:** The RPNI has some identical phrases and sentences. The RPN reflects upon and takes action, whereas the RN recognizes, reflects, and reports. The examples are identical in wording, however the RNI is bracketed in a sentence and the RPNI has a unique sentence. The ETPC statements are almost identical in intent though I had originally identified them as partially equivalent. Therefore, I identified the ETPC and RPNI as almost identical in equivalence to this competency and RNI statement. **RPNI 30 -** *… opportunity to recognize and report situations within the practice environment that are potentially unsafe and must be legally reported, according to provincial and federal legislation.*

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			Students must be aware of mandatory reporting of any team member or colleague whose actions and/or behaviours towards clients are unsafe, unprofessional or abusive. For example, students must understand the legal requirement to report any sexual abuse of a client by any regulated health professional (see CNO's Code of Conduct, Professional Standards and Therapeutic Nurse-Client Relationship practice standards). **Note:** The RPNI is not related to near misses and errors in the practice setting but related to significant errors or incompetence that must be reported to the CNO. Therefore, the ETPC and RPNI are not equivalent to this competency and RNI statement. **Find Function Results:** The phrases, "harmful incidents", "no harm incidents", "mistake" and "reporting process" yielded no further results for this competency.
2.14	The program provides opportunities for students to recognize and apply workplace health and safety principles, including bio-hazard prevention and infection control practices, and appropriate protective devices when providing nursing care to prevent harm to clients, self, other health care workers and the public. Students understand reporting requirements, and documents as per agency practices.	**73. (Partial)**	**RPNI 73 -** *… maintaining their own safety and the safety of others. Students apply workplace health and safety principles, including bio-hazard prevention and infection control practices, and use of appropriate protective devices when providing nursing care. Students must demonstrate safety principles, such as the use of client identifiers, safe lifting and transfer practices, use of de-escalation techniques with agitated clients, use of proper body mechanics and double-checks for high-risk medications. Other examples should include horizontal and vertical violence, sexual abuse, team dynamics, bullying and family violence.* **Note:** The RPNI has several words in the second sentence verbatim identical to the first sentence in the RPNI. The RN ETPC is action-oriented in that they must do something about health and safety risks, whereas the RPN ETPC indicates creating and maintaining a safe environment beyond that of occupational risks. Therefore, I identified the ETPC and RPNI as partially equivalent to this competency and RNI statement. **Find Function Results:** The phrases "workplace health" and "reporting requirements" yielded no further results for this competency.
Role of COMMUNICATOR			
3.1	The program teaches students that the titles "Registered Nurse" and "Nurse", are	**No Equivalent**	**Find Function Results:** The phrases, "introduces self" and "professional designation" yielded no results in the ETPC or RPNI.

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	protected titles. Students consistently identify self by first and last name, and uses the title "nursing student" when introducing themselves.		Therefore, I identified that there is no equivalent to this competency. However, performing this action is taught day one in a nursing program and reinforced throughout. Was this an error of omission by the creators of the RPN competencies?
3.2	The program provides students with opportunities to learn how important active listening is and how this communication technique impacts therapeutic relationships. Students demonstrate and engage in active listening techniques to understand and respond to their clients.	**66. (Partial)**	**RPNI 66 -** *… demonstrate effective interpersonal interactions using relational skills such as active listening, empathy and respect when working with clients and the health care team.* **Note:** The RPNI mentions active listening as an example of effective interpersonal interactions, whereas the focus of the RN ETPC and RNI is the process of active listening. Therefore, I identified the ETPC and RPNI as inferred equivalence to this competency and RNI statement. **Find Function Results:** The phrase, "active listening yielded one other result in RPNI 64 as an example of effective interpersonal interaction. Therefore, I identified the ETPC and RPNI as inferred equivalence to this competency and RNI statement.
3.3	The program teaches students that a therapeutic relationship with clients supports them, promotes healing and enhances client functioning. Students will learn that knowing other team members activities and abilities creates trust and respect among team members, and that working together promotes compassion (showing interest in clients' life experiences), trust (being honest, knowledgeable, dependable and accepting) and genuineness (assurances of ongoing interest in	**6. (Partial)** **64. (Inferred)** **66. (Partial)**	**RPNI 6-** *… demonstrate the foundational behaviours required to develop, maintain and terminate a therapeutic nurse-client relationship; initiating, maintaining and terminating a relationship that captures empathy, principles of verbal and nonverbal communication, the attributes of a therapeutic relationship; and the concept of client-centred care.* **Note:** The RN ETPC is more focused on the communication skills used to build therapeutic relationships, whereas the RPN ETPC is focused on the nurse-client relationship, and communication is an example of an element of the relationship in the RPNI. Therefore, I identified the ETPC and RPNI as not equivalent to this competency and RNI statement. **RPNI 64 -** *… opportunity to communicate with the client and the health care team. Students must understand and demonstrate elements of effective communication which include active listening, open-ended questioning and interviewing skills to create a caring environment. They also must be aware of barriers to effective communication.* **Note:** The RPNI lists elements of effective communication skills which have been evidence-based for many years, however the RNI statement focuses on the results of developing the relationship (trust, compassion etc.). Therefore, I identified the

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	the clients' needs). Students will adapt their communication skills so all team members can rely on one another in order to give the best possible care to their clients.		ETPC and RPNI as not equivalent to this competency and RNI statement. **RPNI 66 -** *… demonstrate effective interpersonal interactions using relational skills such as active listening, empathy and respect when working with clients and the health care team.* **Note:** This RPNI is focused on the interactions between clients and professionals and uses examples of effective communication, whereas the focus for the RN is on client relationships. Therefore, I identified the ETPC and RPNI as inferred equivalence to this competency and RNI statement. **Find Function Results:** The phrases, "client functioning", "genuineness", and "dependable" yielded no results for this competency.
3.4	The program teaches students that conflicts may involve the healthcare team, clients and their families or substitute decision-makers. Students will learn and demonstrate conflict management and resolution strategies, and are able to identify when to escalate issues.	**67. (Verbatim Identical)**	**RPNI 67 -** *… knowledge of conflict management and resolution strategies. Students will have opportunities to apply and evaluate these strategies to understand conflict resolution that involves clients, their families or substitute decision-makers as well as the health care team.* **Note:** The RNI statement states that conflicts may involve different parties involved in the healthcare team, however the RPNI does not mention this. The RPNI has the element of evaluating these strategies whereas the RNI has them demonstrating the strategies. Therefore, I identified the ETPC as verbatim identical in equivalence and the RPNI as partially equivalent to this competency and RNI statement. **Find Function Results:** The search for the phrase, "escalate issues" yielded one result in RPNI 76 regarding teaching the basics of conflict resolution and when to escalate issues. However, the ETPC focuses on team dynamics and group processes which could be inferred as where conflict may occur. Therefore, I identified ETPC and RPNI 76 as an inferred equivalence to this competency and RNI statement.
3.5	The program provides students with opportunities to engage in therapeutic relationships with clients. Students will demonstrate compassionate,	**No Equivalent**	**Find Function Results:** The phrase "therapeutic relationship" yielded one results in ETPC and RPNI 6. The RPNI discuses the phases of the therapeutic nurse-client relationship, and the RNI discusses engaging in therapeutic relationships in which the phases of the relationship are inferred. Relational practice goes beyond the therapeutic nurse-client relationship in definition, however you need this relationship to

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	respectful and trustworthy care with the client, and understands that collaboration with the client and the healthcare team, creates better client and professional outcomes.		engage in relational practice. Therefore, I identified that the ETPC and RPNI have inferred equivalence to this competency and RNI statement.
3.6	The program provides students with opportunities to interface with facility technology. Students uses existing health and nursing information systems to manage nursing and healthcare data during client care.	**No Equivalent**	**Find Function Results:** The phrase "information and communication technologies" yielded 2 results in ETPC 38 and ETPC 57. **ETPC 38 -** *Selects and utilizes information and communication technologies (ICTs) in the delivery of client care* was not identified initially as partially compatible because its focus is not on supporting communication, it was "selects and utilizes" in the delivery of care. Therefore, I identified that this is not equivalent to this competency. ETPC 57 pertains to professional judgment when using technology, so it is not relevant to this competency. Therefore, I identified that there is no equivalence to this ETPC or RNI statement.
3.7	The program provides students with learning opportunities to recognize, effectively communicate and seek immediate assistance in rapidly changing client conditions that affect client health and safety. Students understand the challenges they may face with clients who have multiple comorbidities that impact on the situation and care.	**60. (Inferred)** **65. (Inferred)**	**RPNI 60 -** *… opportunities for students to recognize and seek immediate assistance and/or help others in a rapidly changing client condition affecting health or patient safety.* **Note:** The RPNI statement is almost identical to the first sentence of the RNI. The differences are the RN must effectively communicate and focus on the client's health and safety, whereas the RPN focuses on health or patient safety suggesting that the RPN is focused on any changing situation rather than specifically a client. Therefore, I identified that the RPNI as almost identical in equivalence to the RNI statement and the ETPC as inferred equivalence. **RPNI 65 -** *… opportunity to present care-related information to the client and health care team.* **Note:** This RPNI does not emphasize the importance or urgency of the information to be communicated and this may be because it is expected that the RPN would not be caring for patients with complexities and rapidly changing conditions, however I seen in practice that a stable patient can become very ill, very quickly, and the RPN must collaborate with the RN. Therefore, I identified that this is an inferred equivalence to the RN ETPC or RNI statement. **Find Function Results:**

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			The phrases “complex”, “challenges”, and “multiple comorbidities” yielded no results for this competency.
3.8	The program provides students with opportunities to document assessment data in accordance with evidence-informed practice. Students communicates and documents client care and the ongoing evaluation clearly, concisely and accurately. Students apply the CNO Documention [*sic*] Standard, when documenting.	**35. (Partial)**	**RPNI 35 -** *… learning activities to demonstrate documentation of client care according to legislative, practice standards, ethical requirements and organizational policies. Students should be aware of CNO’s Documentation practice standard.* **Note:** The RPNI focuses on the rules and regulations of documentation whereas the focus for the RNI is on the process and quality of the documentation as well as communicating the information. The RPN should be aware of, and the RN apply the CNO documentation standard. Therefore, I identified that the ETPC is partially equivalent and the RPNI has inferred equivalence. **Find Function Results:** The phrase “clearly, concisely and accurately” yielded no results as a collective or when each word was searched individually. The phrase “document” yielded several results as part of words but only ETPC and RPNI 35 were related to the process of documentation.
Role of COLLABORATOR			
4.1	The program provides students with opportunities to reflect on their personal values, beliefs and experiences that impact the relationships among health care team members. Students are encouraged to engage in collaborative interactions within the nursing and health care team, to develop and implement a client centered plan of care.	**75. (Inferred)**	**RPNI 75 -** *… collaborate with other students and health care team members to develop and foster professional relationships that support ongoing professional development and competence.* **Note:** RPNI 75 discusses professional relationships for professional development, whereas the RNI discusses the importance of self-reflection to develop collaborative partnerships to develop and implement a plan of care. Therefore, I identified the RPNI as not equivalent as the purpose behind collaboration is different. The ETPC discusses mentoring relationships which can be, but is not always, a part of collaboration. Therefore, I identified that the RPN ETPC is not equivalent to the RN ETPC. **Find Function Results:** The phrase “reflect on” yielded results related to experiences, whereas the phrase “reflect upon” with “personal values” yielded results in RPNI 7 and 21 regarding being non-judgmental and acting to minimize their impact on interactions and decisions. The phrase “collaborative interactions” yielded no results. Therefore, I identified that there is no equivalence to this competency.

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4.2	The program provides students opportunities to collaborate with other health care team members to develop care plans that promote continuity for clients within the circle of care. This includes discharge planning and connecting clients and families with community resources.	**44. (Partial)**	**RPNI 44 -** *… collaborate with clients to develop a plan of care by developing a range of possible alternatives and approaches to care. Students collaborate with the client and health care team to develop a plan of care that includes establishing priorities, expected outcomes and health teaching required.* **Note:** RPNI 44 discusses collaborating with clients and health care team to develop plans of care (the same as care plan in the RNI) but does not address the issue of continuity for clients. The RPNI discusses elements involved in care planning, whereas the RNI discusses discharge planning and community resources. Therefore, I identified that the ETPC has partial equivalence and the RPNI has inferred equivalence. **Find Function Results:** The phrase "circle of care" yielded results in RPNI 33 regarding understanding who is in the circle of care and RPNI 57 regarding accessing information when students are part of the circle of care. Neither relate to care plan development. The phrase "community resources" yielded one result in RPNI 26 regarding advocating for equitable access for clients and working with clients who access community resources, but is pertaining to connecting clients to resources. There are no further results for this competency.
4.3	The program teaches students about areas of uniqueness and overlap between nursing scope of practice and other health care team members scopes of practice. Students participate and contribute to nursing and health care teams development by building partnerships based on respect for the unique and shared competencies of each team member.	**69. (Verbatim Identical)**	**RPNI 69 -** *… different roles and responsibilities of other health care providers. Students learn to appreciate areas of overlap in roles and the need to seek and advocate for clarity. This includes understanding various roles, both regulated and unregulated, and how these interact on a continuous basis and in varying situations. (see CNO's The RN and RPN Practice: The Nurse, the Client and the Environment and Working with Unregulated Care Providers practice guidelines).* **Note:** The first sentence of the RPNI differs in that it focuses on other health care providers and not just other regulated nursing designations. The second sentences are verbatim identical. The third sentence of the RPNI provides examples of what that understanding includes, whereas the third sentence of the RNI focuses on team development. Therefore, I identified that the ETPCs are verbatim identical and the RPNI is partial in equivalence. **Find Function Results:** The phrases "team development" and "building partnerships" yielded no further results for this competency.

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4.4	The program provides students opportunities to learn about the different roles and responsibilities of each regulated nursing designation. Students learn to appreciate areas of overlap in roles and the need to seek and advocate for clarity. Students participate and contribute to nursing team development by knowing and supporting the full scope of practice of each regulated nursing designation.	**68. (Partial)**	**RPNI 68 -** *… demonstrate knowledge of RPN scope of practice, roles and responsibilities. Students must demonstrate accountability for their own decisions and actions. They must identify their own limitations in practice and consult others when necessary. Students recognize that nursing takes places within an organization and are responsible to verify and clarify institutional and unit policies and procedures.* **Note:** Although the RN and RPN ETPC both mention scope of practice, the RN is required to understand the differences between each regulated nursing designation, whereas the RPN is required to demonstrate knowledge of their own scope of practice. This is not the same level of responsibility for each, as the focus is on scope of personal practice not on all the nursing designations, as in the RN ETPC and RNI statement. Therefore, I identified the RPN ETPC and RPNI as an inferred equivalence to this competency and RNI statement. **Find Function Results:** The phrases "regulated nursing designation" and "team development" yielded no further results for this competency.
4.5	The program provides students opportunities to participate and contribute to nursing and health care team development by promoting collaboration through principles of team functioning, conflict resolution, role clarification, shared problem-solving and decision-making.	**64. (Partial)**	**RPNI 64 -** *… opportunity to communicate with the client and the health care team. Students must understand and demonstrate elements of effective communication which include active listening, open-ended questioning and interviewing skills to create a caring environment. They also must be aware of barriers to effective communication.* **Note:** The RPNI focuses on communication techniques and skills with clients and the health care team, which are only a part of collaboration, yet it resides in the collaborative area of practice in the ETPC. Therefore, I identified that there is inferred equivalence to this competency and RNI statement. **Find Function Results:** The phrase "team collaboration" yielded one result in ETPC 76 - *Applies the principles of team dynamics and group processes in interprofessional team collaboration.* The RPNI does not mention this phrase, but I identified it as partially equivalent to the RNI statement. *The program teaches students the basics of conflict resolution, team dynamics, when to escalate issues and how to come to a resolution. Students should understand group process theories (such as forming, norming, storming, performing, adjourning), the nature of the team's work as well as the perceived hierarchy and individual personalities within the team.* RPNI 76 does not state the phrases "problem solving" or "decision making".

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			Problem-solving was stated in RPNI 55 in relation to demonstrating this skill and decision-making was found in 3 competencies, but these were not related to teams or team functioning. Therefore, I identified RPN ETPC and RPNI 76 as partially equivalent to this competency and RNI statement.
Role of COORDINATOR			
5.1	The program teaches students the difference between coordination and collaboration, and the implications for client care. Students recognize changes in client health status and coordinates aspects of client care within the healthcare team to address and identify strategies for care planning. Students will have opportunities to participate in and contribute to team care conferences (such as rounds), and articulate themselves in a professional manner.	**46. (Inferred)**	**RPNI 46 -** *… respond to the client's condition, collaborating with the client to establish priorities of nursing care.* **Note:** The RPNI statement indicates the RPN responds to the client condition, however the RNI statement recognizes changes in health status. The RNI statement lists coordination and collaboration as part of this competency, but the RPNI does not indicate coordination is a part of ETPC 46. Therefore, I identified that the ETPC and RPNI are not equivalent to this competency and RNI statement. **Find Function Results:** The term "coordinat(e)" is mentioned in ETPC 78 as an element of effective time management skills which I identified as not equivalent to "make ongoing adjustments required by changes…". The phrases "strategies for care planning", "care conferences", "articulate", and "implications for client care" yielded no results for this competency.
5.2	The program provides opportunities for students to establish priorities of care by monitoring and using assessment data. Students advocate for client's best interest and implement aspects of care in a timely manner.	**42. (Partial)** **46. (Partial)**	**RPNI 42 -** *… formulate clinical judgements that are consistent with clients' needs and priorities by responding to changing situations that affect the client's health and safety. For example, recognizing what assessment outcomes are within normal limits (such as gait or vital signs) and what assessment outcomes are abnormal (such as signs of dehydration and shock). Students learn to respond to internal/external factors that may impact the clients' health and safety. For example, an infectious outbreak.* **Note:** There is no mention in the RPNI regarding the phrase in the RN ETPC *ensure needed services happen at the right time and in the correct sequence* which indicates to me that the scope of responsibility for prioritization is greater for the RN. Therefore, I identified the interpretation statements as inferred equivalence to each other. When re-examining the RN and RPN ETPC and interpretation statements, I identified them as having inferred equivalence rather than partial equivalence.

RN ETPC	RN Interpretation (RNI) Statement (CNO 2019c, pp. 1-24)	RPN ETPC (Level of Equivalence) from Appendix D	RPN Interpretation (RPNI) Statement (CNO 2019d, pp. 1-18) Comparison to RN Interpretation Statements and Notes
			RPNI 46 - *… respond to the client's condition, collaborating with the client to establish priorities of nursing care.* **Note:** This RPNI discusses priorities and collaborating with the client, and there is inferred equivalence with the RNI statement, however the RN has a role of advocacy not mentioned in the RPNI statement. Therefore, I identified the ETPC and RPNI as inferred equivalence to this competency and RNI statement. **Find Function Results:** The phrases "using assessment data", "establishing priorities", and "monitoring" yielded no further results for this competency.
5.3	The program provides opportunities for students to organize their own workload and develop time management skills for meeting responsibilities. The program ensures students understand the importance of self-organization and prioritizing client care (for example, prioritizing care of multiple clients, needs of peers/collaborative team, emergencies, conflicts, multiple needs for the same client). Students demonstrates responsibility and honesty by communicating work that is completed and not completed.	**78. (Almost Identical)**	**RPNI 78 -** *… understand the importance of self-organization, prioritization of client care and the importance of time-management. Students learn about asking for help when needed and communicating to the appropriate person(s) when work has not been done. The program teaches students the necessary leadership skills and behaviours to delegate or assign (when, how and to whom) to family and the health care team.* **Note:** The ETPC is almost identical in that the RPN assigns/coordinates nursing care and the RN assigns nursing care. This led me to think that the RPN has greater responsibility. However, when analyzing the two interpretation statements, the examples provided in the RNI indicate that there are multiple responsibilities and accountabilities that are not present in the RPNI. Therefore, I identified that although the ETPC are almost identically equivalent, the RPNI is partially equivalent and may even be more inferred for this competency and RNI statement. **Find Function Results:** The phrases "time management", "prioritize", and "organizes workload" yielded no further results for this competency.
5.4	The program provides opportunities for students acquire knowledge of the legislative requirements for delegation.	**71. (Inferred)**	**RPNI 71 -** *… develop knowledge about leadership, providing direction and supervision to unregulated health care providers (UCP) and others as applicable. Learning opportunities should include student's abilities to consider what care can be assigned and to whom and understand the differences between assigning and delegating Students should have the opportunity to*

RN ETPC	RN Interpretation (RNI) Statement (CNO 2019c, pp. 1-24)	RPN ETPC (Level of Equivalence) from Appendix D	RPN Interpretation (RPNI) Statement (CNO 2019d, pp. 1-18) Comparison to RN Interpretation Statements and Notes
	Students learn about the delegation process, and demonstrate coordination of care by delegating and evaluating the performance of selected health care team members, regulated and non regulated, in carrying out delegated nursing activities.		*demonstrate their ability to assess knowledge deficits of UCPs, work within teams to assign care and evaluate the outcomes of the care provided by UCPs and others. Students should be familiar with CNO's practice guidelines for Working with Unregulated Health Care Providers.* **Note:** There is the word delegating in the RPNI but it is not in relation to knowing the delegation process. There is assessing and evaluating UCPs in the RPNI but not in relation to performance but in relation to outcomes of care. Therefore, I identified this as inferred equivalence in that both the RN and RPN are to delegate but have a different level of accountability. **Find Function Results:** The terms of "delegation", "delegating", and "delegate" revealed one additional result in RPNI 78 *… program teaches students the necessary leadership skills and behaviours to delegate or assign (when, how and to whom) to family and the health care team,* and identified it as inferred equivalence to the RNI statement. However, I identified that the ETPC is not equivalent as it focuses on organization and time management skills. The RPN is taught the skills of delegation but do not seem to need to learn the legislative requirements for delegation. This puzzles me, as to be able to delegate as a nurse, I need to understand the rights and responsibilities associated with the process. Is this an error of omission for the RPN interpretation language?
5.5	The program provides opportunities for students to learn and demonstrate the necessary skills and behaviours related to transfer of client care within a health care facility (for example, change in acuity resulting in a transfer to different care units, using transfer of care accountability policies and procedures that exist in a facility).	**79. (Partial)**	**RPNI 79 -** *… demonstrate collaboration with the client and the health care team to prepare clients for transitions in care which can include movement between units, preparation for surgical/diagnostic procedures, discharge to home or another health care facility. Students must also be able to demonstrate the accountability for transferring client care between shifts and other health professionals.* **Note:** This is a competency applicable only in BC and Ontario. The RPNI is not specific about the parameters for transfer of care within a facility other than to state "between units" and does not mention using policies and procedures to guide the process; however, a nurse must follow the policies and procedures regardless of category of nurse. Therefore, I identified this RPNI as inferred equivalence and the RPN ETPC as partially equivalent to this competency and RNI statement. **Find Function Results:**

RN ETPC	RN Interpretation (RNI) Statement (CNO 2019c, pp. 1-24)	RPN ETPC (Level of Equivalence) from Appendix D	RPN Interpretation (RPNI) Statement (CNO 2019d, pp. 1-18) Comparison to RN Interpretation Statements and Notes
			The term "transfer" yielded one result for lifting and transfer practices and is unrelated to this competency. There are no further results for this competency.
5.6	The program provides opportunities for students to supports clients in making informed decisions about their health care. Students facilitate client ownership of direction and outcomes of care, and empowers the client to identify and access health and other resources in their communities (e.g. other health disciplines, community health services, rehabilitation services, support groups, home care).	**No Equivalent**	**Find Function Results:** The term "navigate" yielded no results but the terms "support" and "decision-making" yielded results in ETPC and RPNI 9, which state *Supports clients in making informed decisions about their health care and respects their decisions;* and … *demonstrate support for clients making informed decisions about their health care and respecting those decisions.* Despite this result, the RN ETPC focuses on navigating the health care system which is not related to this competency. Therefore, I identified that there is no equivalent for this competency.
5.7	The program provides opportunities for students to demonstrate collaboration with the client and the healthcare team, in order to prepare clients for transitions in care (e.g. movement between units, passing accountability of care to a nurse during shift change, preparation for surgical/diagnostic procedures and treatements [*sic*], discharge to home or community facility).	**79. (Partial)**	**RPNI 79 -** *… demonstrate collaboration with the client and the health care team to prepare clients for transitions in care which can include movement between units, preparation for surgical/diagnostic procedures, discharge to home or another health care facility. Students must also be able to demonstrate the accountability for transferring client care between shifts and other health professionals.* **Note:** This is a competency applicable only in BC and Ontario. The first sentence is verbatim until examples are presented. The RNI uses "e.g." and the RPNI states "which can include". The additional word of "treatments" provides me with little distinction between the two interpretations as the RPN would do this in practice also. I am unsure of the importance of the difference here. The RNI states "passing accountability of care" whereas the RPNI states "demonstrate the accountability for transferring client care". The difference between the two indicates that the RN is accountable and implies an imperative, whereas the RPN shows accountability which is not a command. Therefore, I identified that the ETPC has partial equivalence and the RPNI is almost identical in equivalence to this competency and RNI statement.

RN ETPC	RN Interpretation (RNI) Statement (CNO 2019c, pp. 1-24)	RPN ETPC (Level of Equivalence) from Appendix D	RPN Interpretation (RPNI) Statement (CNO 2019d, pp. 1-18) Comparison to RN Interpretation Statements and Notes
			Find Function Results: The phrase "transitions in care" yielded no further results for this competency.
5.8	The program provides opportunities for students to collaborate with clients and coorindate [*sic*] with other health care team members to identify health care needs, strengths, capacities and goals, that may influence discharge planning. Students will document assessment data and discharge teaching in accordance with evidence-informed practice.	**79. (Partial)**	**RPNI 79 -** *… demonstrate collaboration with the client and the health care team to prepare clients for transitions in care which can include movement between units, preparation for surgical/diagnostic procedures, discharge to home or another health care facility. Students must also be able to demonstrate the accountability for transferring client care between shifts and other health professionals.* **Note:** This is a competency applicable only in BC and Ontario. The RPNI is all encompassing in terms of transfers in care while the RNI focuses solely on discharge. There is no mention of discharge teaching in the RPNI. Therefore, I identified this as inferred equivalence with the ETPC remaining partially equivalent to the competency. **Find Function Results:** The term "discharge" yielded no further results for this competency.
5.9	The program provides opportunities for students to learn about emergency codes. Students participate in emergency preparedness and disaster planning, and work collaboratively with others to develop and implement plans that facilitate protection of the public. Students learn what their own responsibilities are as a student of their program and what their role is in protecting themselves and others.	**72. (Verbatim Identical)**	**RPNI 72 -** *… opportunity for students to participate in emergency preparedness and disaster planning and works collaboratively with others to develop and implement plans that facilitate protection of the public. Students are expected to know facility emergency codes and their role-related responsibilities.* **Note:** The organization of the sentences is different in the RPNI statement with emergency codes and role responsibilities. The RNI statement indicates that students need to learn about emergency codes, whereas in the RPNI, the students are expected to know facility emergency codes. The use of words here could mean that the RPN needs to know the codes by rote learning, but this is not clear. It may mean that the RPN must know emergency codes extensively. I am unable to determine the difference. The RNI statement uses several more words to describe responsibilities in an emergency in their role, however the RPNI states it very succinctly and has little difference in intent of meaning. Given this, I identified the ETPCs as verbatim identical in equivalence and the RPNI as having partial equivalence, but could be almost identical in equivalence if greater clarity could be obtained regarding knowledge of emergency codes. **Find Function Results:**

RN ETPC	RN Interpretation (RNI) Statement (CNO 2019c, pp. 1-24)	RPN ETPC (Level of Equivalence) from Appendix D	RPN Interpretation (RPNI) Statement (CNO 2019d, pp. 1-18) Comparison to RN Interpretation Statements and Notes
			The find function yielded no further results for this competency.
Role of LEADER			
6.1	The program provides opportunities for students to learn about the Calls to Action of the Truth and Reconciliation Commission of Canada, and the impact on health and health outcomes for clients, families and nursing practice. Students reflect on how their practice may be influenced by the Call to Action.	**24. (Partial)**	**RPNI 24 -** *… opportunities for students to learn about the Calls to Action of the Truth and Reconciliation Commission of Canada and the impact on health and health outcomes for clients, families and nursing practice. Students reflect on how their practice may be influenced by the Calls to Action.* **Note:** The RPNI is verbatim identical to the RNI statement. The difference between the ETPC is the RPN "obtains knowledge and responds to", whereas the RN "acquires knowledge". Obtain and acquire seem to have a similar meaning, but when examining the two words in the dictionary, acquire is usually attributable to a skill or body of knowledge, and obtain refers more to getting something. The main difference is the use of responds to in the RPN ETPC, giving it an affective domain verb from Bloom's. Here the RPN may have greater responsibility in this competency. Therefore, I identified the ETPC as partially equivalent and the RPNI as verbatim identical in equivalence to this competency and RNI statement. **Find Function Results:** The find function yielded results for the calls to action in ETPC and RPNI 70, however it is related to RN ETPC and RNI 7.3 and not included here.
6.2	The program provides opportunities to understand and apply quality improvement principles. Opportunities could include identification of an opportunity to enhance safety issues and escalation to the health care team, involvement in PDSA's or participation in small or large quality improvement initiatives. The student will understand that	**13. (Verbatim Identical)** **52. (Inferred)**	**RPNI 13 -** *… understand and apply quality improvement principles. Learning activities could include identification of an opportunity to enhance patient safety issues and escalation to the health care team, involvement in Plan-Do-Study-Act (PDSA) activities or participation in small or large quality improvement initiatives. Students will understand that improving quality is a continuous process and everyone is accountable for quality improvement.* **Note:** The RPNI is almost identical to the RNI statement. The differences are that the RPN has learning activities and the RN has opportunities. The final sentence of the RPNI refers to students (plural), and the RNI uses the singular. There is what appears to be a typo/grammatical error at the end of the RNI statement which hinders the ability to determine whether the sentence was meant to be the same. **RPNI 52 -** *… importance of ongoing reflective practice in relation to quality improvement. Students*

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	improving quality is a continuous process and is everyone accountability [*sic*].		*are taught to reflect on their practice and question whether there are better, more evidence-informed ways of practising. Students learn to continuously integrate quality improvement principles and activities into nursing practice. The program provides students with opportunities to reflect upon organizational and system-wide issues with respect to patient safety. They are taught to use a systems approach to patient safety. For example, students participate with others in the prevention of near misses, errors and adverse events including preparing incident reports.* **Note:** This ETPC and RPNI were identified because of the mention of quality improvement, despite having a nearly equivalent example above. The focus of quality improvement activities is on safety; therefore, I identified it as inferred equivalence as it uses the same phrase "quality improvement principles", but the RPN learns to integrate them and the RN understands and applies them. **Find Function Results:** Given the identical and inferred competencies above, there were no additional phrases from the RNI statement to search.
6.3	The program provides opportunities for students to seek out new information, knowledge and best practices of the RN role and client-centred care. Students will learn about the value of nursing care to clients and the broader population by using principles of primary health and participating in evidenced based client centered healthcare models.	**No Equivalent**	**Find Function Results:** The phrases "client-centred care", "value of nursing care", and "healthcare models" yielded no results. Therefore, I identified that there is no equivalence for this competency or RNI statement.
6.4	The program teaches students about maintaining their own safety and others' safety. Students demonstrate a body of knowledge about safe and healthy	**73. (Almost Identical)**	**RPNI 73 -** *… maintaining their own safety and the safety of others. Students apply workplace health and safety principles, including bio-hazard prevention and infection control practices, and use of appropriate protective devices when providing nursing care. Students must demonstrate safety principles, such as the use of client identifiers, safe lifting and transfer practices, use of de-escalation techniques with agitated clients, use of proper body*

RN ETPC	RN Interpretation (RNI) Statement (CNO 2019c, pp. 1-24)	RPN ETPC (Level of Equivalence) from Appendix D	RPN Interpretation (RPNI) Statement (CNO 2019d, pp. 1-18) Comparison to RN Interpretation Statements and Notes
	work environments (for example, safe work practices or techniques, prevention and management of disruptive behaviour, issues of horizontal violence or aggressive behaviour, client safety principles). Students understand legislation and agency reporting and documentation processes.		*mechanics and double-checks for high-risk medications. Other examples should include horizontal and vertical violence, sexual abuse, team dynamics, bullying and family violence.* **Note:** The RPNI discusses maintaining safety, whereas the RNI discusses demonstrating a body of knowledge about safe and healthy workplaces. The examples in the RNI are one of the "other examples" in the RPNI statement. The safety principle examples in the RPNI are examples of what are considered "safe work practices or techniques" as mentioned in the RNI. The ETPC mentions "maintaining a quality practice environment", whereas there is no mention of this phrase in the RN ETPC. Therefore, I identified the ETPC as partially equivalent and the RPNI as inferred equivalence to the competency and RNI statement. **Find Function Results:** The phrases "healthy work environments" and "understanding legislation" yielded no results in any ETPC or RPNI. A search for the phrase "quality practice environment" in the RN ETPC and RNI statements yielded no results.
6.5	The program provides opportunities for students to critically analyze their practice setting and organizational culture. Students have the opportunities to reflect on the influence of facility and unit specific policies and procedures on nursing practice (e.g. what does the professional practice model look like and how does it help or hinder nursing advancement and client safety).	**12. (Partial)**	**RPNI 12 -** *… understand that nursing takes places within an organizational structure with unique policies and procedures affecting nursing practice. Students will have opportunities to identify, develop or revise unit and organizational policies and procedures in collaboration with other health care team members.* **Note:** The RPNI describes understanding an organizational structure, its policies, and procedures, and how the RPN can participate in modifying policies. The RNI describes a critical analysis of the setting and organizational culture and reflects on the influence of policies and procedures on nursing practice and client safety. There is a difference in expectation of performance between the two nurses that indicates a difference between evaluating the organization and assisting in policy development. Therefore, I identified that the ETPC and RPNI are partially equivalent to this competency and RNI statement. **Find Function Results:** The phrases "critically analyze", "organizational culture", and "nursing advancement" yielded no results for this competency.
6.6	The program provides	**3. (Partial)**	**RPNI 3 -** *… to engage in reflective practice related to individual competence that would identify their*

RN ETPC	RN Interpretation (RNI) Statement (CNO 2019c, pp. 1-24)	RPN ETPC (Level of Equivalence) from Appendix D	RPN Interpretation (RPNI) Statement (CNO 2019d, pp. 1-18) Comparison to RN Interpretation Statements and Notes
	opportunities for students to seek constructive feedback from a variety of sources (e.g. clients, peers, team members, faculty, preceptor). Based on feedback received, students will look for opportunities to implement feedback into practice.		*own limitations in nursing practice (knowledge deficit, skill deficit). It provides the opportunity to consult with others when necessary to help inform decisions and practice.* **Note:** The ETPC has "displays self-awareness" and the RN ETPC has "demonstrates self-awareness". When looking at Bloom's taxonomy, displays can be the highest level of affective domain or the second lowest level of the psychomotor domain. Without further clarification of the statement it is challenging to interpret the intent. Demonstrate is at the 3rd level of both the cognitive and affective domains. Despite identifying the partial equivalence noted in the ETPC, the RNI focuses on receiving feedback, whereas the RPNI focuses on reflective practice and therefore are not equivalent to each other. Therefore, I identified the ETPC as partially equivalent and the RPNI as not equivalent to this competency and RNI statement. **Find Function Results:** The phrase "constructive feedback" yielded no results.
6.7	The program teaches students about the importance of cultural safety, culturally competent care and communication. Students demonstrate collaboration with diverse clients who may hold different world views and values than the student.	**8. (Partial)**	**RPNI 8 -** *… opportunities for students to provide care for clients while demonstrating respect for their health/ illness status, their diagnoses, life experiences, spiritual/religious/ cultural beliefs and practices and health care choices.* **Note:** The ETPC statement has the RPN adapting practice to the spiritual and cultural beliefs, and the RPNI provides examples of the things to respect. The RN ETPC and RNI are focused solely on culturally safe practice environments. There is a different level of expectation regarding acting and adapting practice. The RN does something about issues from the highest level of the affective domain of Bloom's whereas the RPN is adapting which is at the second highest level in the psychomotor domain of Bloom's. Therefore, I identified partial equivalence in the ETPC and inferred equivalence in the RPNI statement for this competency and RNI statement. **Find Function Results:** The phrases "culturally competent care" and "cultural safety" yielded no results. "Different world views" was found in RPNI 22 *… learn they may have to collaborate with diverse clients who may hold different world views and values than themselves.* This is almost identical to the RNI statement. The RNI refers to the third person "student" whereas the RPNI uses second person "themselves". The RN "demonstrates collaboration"

RN ETPC	RN Interpretation (RNI) Statement (CNO 2019c, pp. 1-24)	RPN ETPC (Level of Equivalence) from Appendix D	RPN Interpretation (RPNI) Statement (CNO 2019d, pp. 1-18) Comparison to RN Interpretation Statements and Notes
			with diverse clients whereas the RPN "may have to collaborate" with diverse clients. There is a difference in command (RN) versus possibility (RPN). The ETPC 22 mentions demonstrating respect for beliefs but does not focus on culture, therefore, I identified it is not equivalent and the RPNI as partially equivalent to this competency and RNI statement.
6.8	The program provides opportunities for students to evaluate the appropriateness of resources used to provide effective and efficient care. Students learn to manage resources in an environmentally and fiscally responsible manner.	**No Equivalent**	**Find Function Results:** The phrases of "evaluate resources", appropriateness of resources", "allocates resources", "fiscally", and "environmentally" yielded no results. Therefore, I identified that there is no equivalence to this competency or RNI statement.
6.9	The program provides opportunities for students to learn how to give and receive constructive feedback. Students participate in and contribute to nursing and health care team development by providing and encouraging constructive feedback.	**75. (Inferred)**	**RPNI 75 -** *… collaborate with other students and health care team members to develop and foster professional relationships that support ongoing professional development and competence.* **Note:** The ETPC mentions fostering mentoring relationships which entails providing constructive feedback but the RPNI speaks more to supporting ongoing professional development and competence, but it is unclear whether it is providing that for others or setting up mentorship for themselves. Given this lack of clarity, I cannot say with any level of confidence that this is inferred. Therefore, I identified that there is no equivalence to this competency or RNI statement. **Find Function Results:** The phrase "constructive feedback" yielded no results where the phrase "feedback" yielded 2 results both referring to seeking feedback not providing it and not relevant to this competency or RNI statement.
6.10	The program provides opportunities for students to acquire knowledge about the health care system to improve health care services at the national and	**No Equivalent**	**Find Function Results:** The phrase "health care system" was found in one competency and was related to responding to changes, not about knowledge of the health care system. The phrase "improve health care services", "OHIP", "MOHLTC" and "national" yielded no results. The phrase "provincial" yielded one result that discussed provincial legislation but not about the health care system. Therefore, I identified that there

RN ETPC	RN Interpretation (RNI) Statement (CNO 2019c, pp. 1-24)	RPN ETPC (Level of Equivalence) from Appendix D	RPN Interpretation (RPNI) Statement (CNO 2019d, pp. 1-18) Comparison to RN Interpretation Statements and Notes
	international levels, provincial and territorial levels, regional and municipal levels, agency and point of care levels (for example, students learn about WHO, Health Canada, Ontario Health Insurance Plan (OHIP) and the Ministry of Health and Long-Term Care (MOHLTC), hospital, community settings, and clinical areas: unit, clinic, community agency).		is no equivalent to this competency or RNI statement.
6.11	The program provides opportunities for students to identify and understand the effect of transformative change (for example, how political, social or scientific change may impact nursing practice and client care). Students will have opportunities to collaborate with others to adapt nursing practice, reflective of evidence-based outcomes, in response to healthcare system changes.	**77. (Inferred)**	**RPNI 77 -** *… opportunities to take a leadership role and select a leadership style that best suits the situation. Students should understand leadership theory and recognize the impact of both formal and informal leaders in a health care setting. They should also recognize that leadership styles may change based on the context and the outcome of their leadership needs to be evaluated for future practice.* **Note:** Understanding change is part of leadership activities in nursing. However, it is much more complex than selecting a leadership style and understanding the impact of formal and informal leaders. Managing change includes these features and much more including looking at the broader systems involved. Therefore, I identified that this as not equivalent to the RN ETPC or RNI statement. **Find Function Results:** The phrase “transformative change” and “adapt nursing practices” yielded no results.
Role of ADVOCATE			
7.1	The program teaches students how to advocate for clients and how to intervene to ensure client safety (for example, identifying broken equipment and bringing the concern forward). Students have the	**51. (Partial)**	**RPNI 51 -** *… assess, respond and report any risk to a client’s safety in the context of care. Students should be able to formulate clinical judgements consistent with clients’ needs and priorities by responding to changing situations affecting the client’s health and safety. Students should be taught to assess and respond to situations and address unique needs to ensure a safe environment for clients, self, health care providers and the public.*

RN ETPC	RN Interpretation (RNI) Statement (CNO 2019c, pp. 1-24)	RPN ETPC (Level of Equivalence) from Appendix D	RPN Interpretation (RPNI) Statement (CNO 2019d, pp. 1-18) Comparison to RN Interpretation Statements and Notes
	opportunity to examine and address circumstances (or potential circumstances) where misuse of power between individuals may occur. Students need to be informed of their obligations from both legal and professional perspectives. Examples may include, sexual abuse, bullying and family violence. The program also supports the student's acquisition of knowledge regarding mandatory reporting obligation for sexual abuse cases.		**Note:** "Assess, respond and report any risk" are the steps that "ensure client safety". There is a significant departure in the RNI towards misuse of power and obligations to report. Therefore, I identified that the ETPC and RPNI are more inferred than partially equivalent to this competency and RNI statement. **Find Function Results:** The term "power" yielded one result in RPNI 20 in terms of the therapeutic nurse-client relationship and understanding the balance of power. This is focused on the nurse-client relationship and not more broadly as the RNI indicates. Therefore, I identified no equivalence here. The phrase "mandatory reporting" was found in ETPC and RPNI 30**.** Here the RPN must practice according to the relevant legislation, which includes "reporting team members or colleagues … who are unsafe, unprofessional or abusive." This is one element of the RNI statement that was not present in 51. Therefore, I identified that ETPC 30 has inferred equivalence and its RPNI is partially equivalent to this competency and RNI statement.
7.2	The program teaches students to question, in a professional manner, orders that may be unclear, incorrect or unsafe. Students will take action on unclear orders, decisions or actions made by other health care team members that are inconsistent with client outcomes, best practices and health safety standards. Students analyze orders, care plans and actions and do not passively administer medication or perform nursing interventions without question.	**31. (Partial)**	**RPNI 31 -** *… opportunity to question, in a professional manner, orders that may not be clear, correct or safe. Students are required to analyze orders/care plans/actions in an active manner and not passively perform nursing interventions without question.* **Note:** The use of the word "not" rather than stating the problems as they are, indicates that there may be an inability of the RPN to make that determination. Additionally, the RN "takes action", whereas the RPN "analyzes in an active manner and not passively perform" again implies that the RPN may not have the capacity to make the final decisions. Therefore, I identified the ETPC and RPNI as partially equivalent to this competency and RNI statement. **Find Function Results:** Due to the similarity in meaning of the interpretation statements, there were no additional phrases to search for in the other ETPC or RPNI statements.
7.3	The program supports knowledge acquisition regarding	**70. (Partial)**	**RPNI 70 -** *… knowledge acquisition regarding use of Indigenous health knowledge and healing practices, in collaboration with Indigenous Healers and Elders*

RN ETPC	RN Interpretation (RNI) Statement (CNO 2019c, pp. 1-24)	RPN ETPC (Level of Equivalence) from Appendix D	RPN Interpretation (RPNI) Statement (CNO 2019d, pp. 1-18) Comparison to RN Interpretation Statements and Notes
	use of Indigenous health knowledge, healing practices and collaboration with Indigenous healers and elders, consistent with the Calls to Action of the Truth and Reconciliation Commission of Canada. Students reflect on how they may advocate for the use of Indigenous health knowledge and practices in various settings and the impact on nurse practice and client outcomes (e.g. the healing practice of smudging in a hospital chapel).		*and consistent with the Calls to Action of the Truth and Reconciliation Commission of Canada. Students should reflect on how they may advocate to use Indigenous health knowledge and practices in various settings and the impact on nursing practice and client outcomes. For example, the healing practice of smudging in a hospital chapel.* **Note:** The interpretation statements are almost identical. The differences are "in collaboration with" versus "and collaboration with" in the RNI statement; the additional word of "should" reflect for the RPNI; and, the use of "for example" versus "e.g." The lack of should in the RNI statement implies that they will reflect as part of practice. Therefore, I identified the ETPC as partially equivalent and the RPNI as almost identically equivalent to this competency and RNI statement. **Find Function Results:** Due to the almost identical interpretation statements, there were no additional phrases to search for in the other ETPC or RPNI statements.
7.4	The program supports the acquisition of knowledge from nursing and other disciplines that identify health equity issues across population. Students have the opportunity to participate in advocacy activities that address current and emerging health care issues impacting equity (for example, health care needs of older adults, vulnerable and/or marginalized populations, health promotion, obesity, pain prevention and pain management, end-of-life care, addiction, and mental health).	**26. (Partial)**	**RPNI 26 -** *… opportunity to identify the health disparities and inequities of vulnerable populations and the importance of advocacy. They will understand the varied ways to advocate for equitable access for clients, from escalating the issue to the team leader to involvement in system change. Students need opportunities to apply this knowledge by working with clients who access health and other community resources to maximize health outcomes.* **Note: "**Health equity issues" and "health inequities" are similar in meaning; however, issues look beyond the actual problem itself and to system wide sources of problems and solutions. The RPN will understand the ways and will need opportunities to advocate, whereas the RN will have opportunities to participate in advocacy activities. These findings speak to a lower level of Bloom's in both the cognitive and psychomotor domain. Therefore, I identified that there is partial equivalence in ETPC, and the RPNI statement has an inferred equivalence to this competency and RNI statement. **Find Function Results:** The phrases "emerging health care issues" and "knowledge from other disciplines (professionals)" yielded no results.
7.5	The program provides	**No Equivalent**	**Find Function Results:**

RN ETPC	RN Interpretation (RNI) Statement (CNO 2019c, pp. 1-24)	RPN ETPC (Level of Equivalence) from Appendix D	RPN Interpretation (RPNI) Statement (CNO 2019d, pp. 1-18) Comparison to RN Interpretation Statements and Notes
	opportunities for students manage resources in an environmentally responsible manner to provide effective and efficient client care. The program prepares students to be responsible for the resources they use in the healthcare settings (e.g. being careful not to waste equipment or supplies).		The phrase "environmentally responsible" and the term "waste" yielded no results. Therefore, I identified no equivalence to this competency or RNI statement.
7.6	The program teaches students about organization and systemwide issues with respect to client safety and ethical care. The program teaches students about the importance of advocating for clients or their representatives, especially when they are unable to advocate for themselves. Students will collaborate with others in the organization to prevent future incidents to promote a safe environment for clients, self, health care providers and the public, addressing the unique needs of clients within the context of care and ethical practice.	**27. (Inferred)**	**RPNI 27 -** *… teaches students how to advocate for clients within the context of nursing especially when clients or families are unable to advocate for themselves.* **Note:** In choosing this RPN ETPC as inferred in my examination of only the competencies, my nursing knowledge and experience guided me in that ethical care involved advocating for individuals when they could not advocate for themselves and therefore saw the connection. In examining the RNI and RPNI statements, I see one small commonality in that the RPNI is almost identical to sentence 2 in the RNI. However, the other elements of the RNI lead to a much broader view regarding organization and system wide issues, safety, and the unique needs of clients. Therefore, I identified that there is inferred equivalence to this competency or RNI statement. **Find Function Results:** The phrases "systemwide" and "prevent future incidents" yielded no results, whereas the "context of care" yielded two results related to safety and nursing knowledge, but not regarding advocacy as is the focus of the RN ETPC and RNI statement.
7.7	The program teaches students to be respectful and understanding of clients' choices and in their care preferences and decisions. Students	**9. (Almost Identical)**	**RPNI 9 -** … *opportunity to demonstrate support for clients making informed decisions about their health care and respecting those decisions. The program teaches students that a client's decision may not be one in which they necessarily agree with but they must respect their client's wishes and decisions.* **Note:** The difference between the ETPC is that the RN is to empower the clients. There is only partial

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	become aware of their own self biases, values, and beliefs, and understand they may not necessarily agree with the client's decision.		equivalence with the interpretation statements as the RN must be respectful and understanding of client choices, whereas the RPN must support and respect client choices. In my experience, the only way to understand their choices is to develop a relational practice more than a therapeutic relationship. The RPNI does not mention self-awareness as a component of the relationship that allows for greater understanding by the RN. Therefore, I identified the ETPC as almost identical in equivalence and the RPNI as partially equivalent to this competency and RNI statement. **Find Function Results:** The phrase "values" yielded results in ETPC and RPNI 21 and 22 which discuss decreasing the impact of personal values and respecting other's values. RPNI 7 indicated that students should reflect on their personal values, beliefs, and experiences to provide non-judgmental care. Therefore, I identified this as not equivalent to this competency or RNI statement.
7.8	The program prepares students to be aware of healthy public policy and understand how this may impact their practice and the care of clients.	**No Equivalent**	**Find Function Results:** The phrases "social justice", "healthy public", and "healthy public policy" yielded no results for this competency. Therefore, there is no equivalent to this competency or RNI statement.
7.9	The program teaches students the importance of assessing and verifying the client's capacity to be an active participant in their own care, and their understanding of essential information. Students will identify strategies to use in situations when clients are not able to be fully involved, and seek assistance when necessary.	**No Equivalent**	**Find Function Results:** The phrases "client's capacity", "participant", and "fully involved" yielded no results. The phrase "essential" yielded one result in ETPC 65 regarding providing *essential information to the client and health care team*; however, this is not related to assessing clients' ability to understand the information being presented to them which is the focus of this RN EPTC and RNI statement. Therefore, I identified that there is no equivalent for this competency and RNI statement.
7.10	The program teaches students about informed consent as it applies to multiple contexts	**34. (Partial)**	**RPNI 34 -** *opportunity to respond to a client's request for their health information in accordance with relevant privacy legislation such as the Personal Health Information Protection Act (PHIPPA), 2004 and relevant institutional policies.*

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	(for example, consent for care, refusal of treatment, release of health information, consent for participation in research). Students become familiar with CNO practice standards (for example Code of Conduct) and guidelines, and relevant legislation.		**Note:** The RPNI addresses solely the release of health information, whereas the RNI has it as an example of one of the contexts of consent. Therefore, I identified that the ETPC and RPNI has more inferred than partial equivalence to this competency and RNI statement. **Find Function Results:** The phrase "code of conduct" yielded three results. One regarding professional misconduct, another regarding preserving client dignity, and the last regarding reporting legislation and are not relevant to the context of consent. The phrases "refusal of treatment" and "participation in research" yielded one result in RPNI 36 as an example of obtaining informed consent. Therefore, I identified that ETPC and RPNI 36 have inferred equivalence to this competency and RNI statement.
7.11	The program supports the acquisition of knowledge regarding the role of primary health care in health delivery systems and its significance for population health. Students learn about human growth and development, role transitions and social determinants of health. Students understand how social and lifestyle factors impact health, and have opportunities to participate in health promotion strategies across different populations to advocate for health equities.	**No Equivalent**	**Find Function Results:** The phrases "primary health care", delivery systems", "health promotion", and "determinants" yielded no results. Therefore, I identified that there was no equivalence to this competency or RNI statement.
7.12	The program teaches students about ethical and legal obligations for obtaining informed consent (for example, the program teaches students about	**36. (Inferred)**	**RPNI 36 -** *opportunity to demonstrate elements of informed consent, including the ability to apply their knowledge in multiple contexts. Multiple contexts refers to the client situation, the environment and how consent is obtained (oral, written, inferred and substitute decision-maker) and when (refusal of treatment, release of health information, participation in research).*

RN ETPC	RN Interpretation (RNI) Statement (CNO 2019c, pp. 1-24)	RPN ETPC (Level of Equivalence) from Appendix D	RPN Interpretation (RPNI) Statement (CNO 2019d, pp. 1-18) Comparison to RN Interpretation Statements and Notes
	major features of the Health Care Consent Act, 1996 and how this may apply to their practice). Students are taught the steps required to obtain informed consent and how to respond when they perceive their client is unable to provide consent within multiple contexts. Students have opportunities to demonstrate appropriate and effective communication strategies to help clients fully comprehend the informed consent process.		**Note:** The RPN ETPC discusses "obtaining informed consent", whereas the RN ETPC discusses "assesses client's understanding of informed consent" indicating that there is a greater accountability for the RN's practice. The assessment of understanding is more than just obtaining consent. The RNI also discusses what to do if their client cannot provide consent, whereas this is not mentioned in the RPNI statement. Given this difference in distinction of accountability and no mention of it in the RPNI, 36 is not equivalent to 7.12. Therefore, I identified that the ETPC has inferred equivalence and the RPNI is not equivalent to this competency and RNI statement. **Find Function Results:** The phrases "health care consent act", "unable to provide consent", and the term "consent" yielded no further results.
7.13	The program teaches students about the importance of a substitute decision maker's role in a client's plan of care (e.g. the program teaches students about relevant legislation such as the Substitute Decisions Act and how this may apply to their practice). Opportunities are provided for students to demonstrate knowledge.	**36. (Inferred)**	**RPNI 36 -** *opportunity to demonstrate elements of informed consent, including the ability to apply their knowledge in multiple contexts. Multiple contexts refers to the client situation, the environment and how consent is obtained (oral, written, inferred and substitute decision-maker) and when (refusal of treatment, release of health information, participation in research).* **Note:** The RPNI only mentions substitute decision-maker as an example and is not the focus of the RPN ETPC. I identified these as inferred equivalence to the competency and RNI statement. **Find Function Results:** The phrase "substitute decision-maker(s)" yielded one other instance in RPNI 67 in relation to the use of conflict resolution strategies which is not relevant to this RN ETPC or RNI statement.
7.14	The program provides opportunities for students to incorporate knowledge of health disparities and inequities of vulnerable populations (e.g. sexual orientation,	**No Equivalent**	**Find Function Results:** The phrase "health disparities" yielded one result in **RPNI statement 26** – *identify the health disparities and inequities of vulnerable populations and the importance of advocacy. They will understand the varied ways to advocate for equitable access for clients, from escalating the issue to the team leader to involvement in system change. Students need opportunities to apply this knowledge by working with clients who access health and other*

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	persons with disabilities, ethnic minorities, poor, homeless, racial minorities, language minorities, persons with mental health and addictions issues) to contribute to strategies that support positive health outcomes.		*community resources to maximize health outcomes.* The RN incorporates knowledge of health disparities, whereas the RPN identifies them and understand varied ways to advocate. The RN ETPC mentions optimizing health outcomes for all, whereas the RPNI statement maximizes health outcomes for clients. The different use of qualifying verbs indicates a different level of expectation of performance. Optimization is the best use of and maximize means to find the largest or greatest. Underpinning optimization is knowing what is not only the largest or greatest, but choosing the best for the situation. Therefore, I identified RPN ETPC as inferred equivalence and RPNI 26 as partially equivalent to this competency and RNI statement.
Role of EDUCATOR			
8.1	The program provides students with opportunities to collaborate with clients and the health care team to develop and implement education plans addressing identified client learning needs by applying adult learning principles and using different teaching and learning strategies.	**48. (Partial)**	**RPNI 48 -** *understand the teaching and learning process. Students are taught how to assess readiness to learn, implement appropriate teaching strategies and evaluate the outcome, which may require revised teaching strategies into a future plan of care. For example, seeks client's feedback after teaching, evaluates client's knowledge/skill post teaching.* **Note:** The RPNI lists the steps of the teaching process whereas the RNI indicates that the RN develops an education plan. Bloom's creating level is equivalent to develops, but one could argue that the steps of assessing, planning, implementing, and evaluating result in the development and evaluation of a plan. Since the RNI statement is focused on the development, there is only partial equivalence in RPNI 48. As one will see below, the RN ETPC break down the steps and phases of teaching into parts and different numbers of competencies, whereas the RPN ETPC are fewer in number with more overlap between. Therefore, I identified the ETPC and RPNI as partially equivalent to this competency and RNI statement. **Find Function Results:** The find function provided no additional results for phrases contained within the ETPC or RNI statement.
8.2	The program provides students with opportunities to collaborate with clients to identify appropriate health teaching strategies that will enhance	**47. (Partial)**	**RPNI 47 -** *how to assess readiness to learn; the various methods of health teaching (visual, oral, written, modeling, and the situations in which each method would be best used) and types of learning styles (cognitive, psychomotor and affective). Students will be able to identify, in collaboration with the client and health care team, appropriate teaching strategies that will enhance learning.*

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	client's learning (e.g. knowledge of assessment of readiness to learn, the various methods of health teaching including visual, oral, written, modeling and types of learning styles such as cognitive, psychomotor, and affective).		**Note:** The RPNI statement lists teaching strategies but calls them methods, whereas the RNI statement provides that same list of methods as an example of teaching strategies. The key difference is that the RN collaborates with the client to identify them and the RPN collaborates with the client and health care team, which implies that the RPN may need some assistance from other health professionals with the process. The RPN assesses health literacy, whereas the RN applies strategies to optimize health literacy indicating the RN is to function at a higher cognitive domain according to Bloom's (applying versus understanding). Therefore, I identified the ETPC and RPNI as partially equivalent to this competency and RNI statement. **Find Function Results:** The find function provided no additional results for phrases contained within the ETPC or RNI statement.
8.3	The program provides students with opportunities to collaborate with clients to select, develop and use relevant teaching and learning theories and strategies which address diverse clients (for example, consideration of various racial, ethnic and cultural backgrounds, attention to degree of learning disability and cognitive impairment, consideration of developmental stages of learning, and understanding the level of involvement of family and/or support networks in implementing an education and/or learning plan.	**48. (Partial)**	**RPNI 48 -** *opportunities to understand the teaching and learning process. Students are taught how to assess readiness to learn, implement appropriate teaching strategies and evaluate the outcome, which may require revised teaching strategies into a future plan of care. For example, seeks client's feedback after teaching, evaluates client's knowledge/skill post teaching.* **Note:** The RPNI statement focuses on the process of implementing teaching plans, whereas the RNI statement goes into more depth about teaching theories, diversity of clients, learning challenges, growth and development, and the support of family. However, the word "appropriate" for the RPNI teaching strategies would infer all the elements listed in the RNI statement. The RNI statement does not address evaluation and is more focused on development and implementation. Therefore, I identified this as partially equivalent to the competency and RNI statement. **Find Function Results:** The phrases "teaching theories", "learning theories", and "support networks" yielded no results.
8.4	The program provides students with opportunities to evaluate the	**48. (Partial)** **50. (Partial)**	**RPNI 48 -** *understand the teaching and learning process. Students are taught how to assess readiness to learn, implement appropriate teaching strategies and evaluate the outcome,*

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	outcome of health teaching activities (for example, seeks client's feedback, evaluates client's knowledge and skills after teaching). Students will collaborate with the client and team, to revise the education plan as necessary.		*which may require revised teaching strategies into a future plan of care. For example, seeks client's feedback after teaching, evaluates client's knowledge/skill post teaching.* **Note:** There is partial match with the RNI statement. There is greater emphasis on the planning part of health teaching but includes evaluation. If there is a separate ETPC and RPNI for evaluating the outcome of teaching, as in 50 below, why mention it here. Therefore, I identified that this ETPC and RPNI is more inferred equivalence than partial equivalence. **RPNI 50 –** *evaluate the client's learning and refine health teaching strategies as needed. Students are taught to reflect upon the outcome of health teaching activities and incorporates any changes as needed into future planning. For example, seeks client's feedback after teaching, evaluates client's knowledge/skill post teaching.* **Note:** The last sentence of this RPNI statement is identical to RPNI 48. The focus of this RPNI is on the evaluation of teaching rather than evaluating the development of the teaching plan, which is more in line with the RNI statement and is therefore, I identified as partially equivalent to this competency and RNI statement. **Find Function Results:** The term "education" yielded results in ETPC and RPNI 49, but is related to RN ETPC and RNI statement 8.5 rather than 8.4.
8.5	The program provides opportunities for students to teach clients about accessing information using reliable health information sources (for example, client health record, appropriate internet resources). Students help clients understand how to determine if the information sources are reliable (for example, identifying conflict of interests or author biases, and personal opinions). Students	**38. (Inferred)** **49. (Partial)**	**RPNI 38 -** *… students about client health records, workload measurement systems, use of social media and other clinical applications used in health care. Students learn about the need to be responsible with their technology use and ensure use meets legal requirements for privacy and confidentiality…* **Note:** This RPNI does not relate to teaching clients about how to access reliable information, therefore I identified that the ETPC and RPNI are not equivalent to this competency or RNI statement. **RPNI 49 -** *work with clients and families to draw on their strengths and identify appropriate health and other resources. Students have the opportunity to collaborate with other health care team members or health-related sectors to assist clients in accessing resources to support health education.* **Note:** This RPNI does not speak to teaching clients how to access information but assisting clients by collaborating with health care team members. Therefore, I identified this ETPC and RPNI as

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	help clients understand the information they obtain using strategies to optimize client health literacy.		partially equivalent to this competency and RNI statement. **Find Function Results:** The phrase "teach" was found 35 times in the document, but not in relation to teaching the client about accessing reliable information.
Role of SCHOLAR			
9.1	The program provides opportunities for students to critique and understand scholarly research and its application to care planning and nursing interventions in clinical and non-clinical practice. Students have opportunities to seek new information, knowledge and best practices for use in the provision of nursing care, and engage in reflective practice to inform their own decision-making.	**40. (Partial)**	**RPNI 40 -** *teaches students to engage in high-level thinking such as reflection, analysis and synthesis of information, or questioning of the status quo or current state. The program prepares students to identify reliable sources of information, critique scholarly research and its application to care. Students learn to reflect on current practices they observe in clinical settings against best practices.* **Note:** The RNI statement has the addition of "understand" scholarly research. However, when looking at Bloom's taxonomy understanding is at a lower level of cognitive function than "critique" (evaluating). Is the word understand redundant? Both the RNI and RPNI statements include reflection, however, the RN is required to inform their own decision-making through this process whereas the RPN reflects on current practices and compares against best practices. Is this not what the RN is doing when reflecting to inform decision-making? Therefore, I identified partial equivalence of the ETPC and RPNI to this competency and RNI statement. **Find Function Results:** The term "non-clinical" yielded no results in the RPN ETPC or RPNI statements. "Decision-making yielded a result in ETPC and RPNI 56. The ETPC mentions "critical thinking*"* and the RPNI statement discusses*, critical inquiry…to support… decision-making*, which is the focus, therefore, I identified this as a partial equivalence to the competency and RNI statement. RPNI 63 focuses on engaging clients with the decision-making process, so I identified it as not equivalent to this competency or RNI statement.
9.2	The program provides opportunities for students to ask questions, provide opinions and seek additional knowledge. Students will have	**11. (Almost Identical)** **40. (Partial)**	**RPNI 11 -** *opportunity for students to demonstrate health literacy skills to access appropriate resources and integrate evidence-based knowledge to inform practice. For example, using research-based evidence and BPG (Best Practice Guidelines) to support collaborative decision-making.* **Note:** In the ETPC the key difference is in the verb "integrates" versus "translates" in the RN ETPC and

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	learning opportunities such as reading groups or seminars, professional practice activities or client care conferences to support critical inquiry. Students collaborate with the health care team to share new information, knowledge and best practices that may influence or change client care. Students use knowledge of theories and frameworks relevant to health and healing as rationale for providing nursing care.		the use of "evidence" versus "knowledge". There is a different level of Bloom's taxonomy here but the requirement to use evidence in practice is present in both. Therefore, I identified this as inferred equivalence to the competency and RNI statement. **RPNI 40 -** *teaches students to engage in high-level thinking such as reflection, analysis and synthesis of information, or questioning of the status quo or current state. The program prepares students to identify reliable sources of information, critique scholarly research and its application to care. Students learn to reflect on current practices they observe in clinical settings against best practices.* **Note:** Although I saw similarities between the ETPC statements, the interpretation statement indicates that there is no equivalent between the two ETPC or interpretation statements. Therefore, I identified this ETPC and RPNI as not equivalent to the competency or RNI statement. **Find Function Results:** The phrases "share new information", "seek knowledge", "influence or change client care", "health theories", "health frameworks", and "rationale" yielded no results. Therefore, I identified that the RN ETPC and RNI statement have no equivalence.
9.3	The program provides opportunities for students to learn about cultural safety, cultural humility and systemic racism. Students will have learning opportunities such as reading, group discussion, reflective activities or seminars that are focused on understanding health disparities, social inequities, cultural differences and their impact on health and health outcomes. Through self-reflection, students demonstrate awareness of and sensitivity to cultural	**7. (Partial)**	**RPNI 7 -** *… opportunity to provide compassionate and culturally safe client care using self-reflection and self-awareness so that they are aware of potential bias. It provides the opportunity for students to reflect upon one's personal values, beliefs and experiences that may impact the therapeutic nurse-client relationship, which is part of ongoing reflective practice.* **Note:** The RNI statement provides much more detail about cultural competence and uses terms like cultural humility and systemic racism. The RPNI statement focuses on the provision of culturally competent care but not the scope of learning opportunities provided in the RNI statement. The RNI statement demonstrates a greater knowledge base and awareness than the RPNI statement, therefore, I identified the ETPC and RPNI as inferred equivalence to this competency and RNI statement. **Find Function Results:** The term "bias" was searched and was found in one other RPNI statement but was in relation to demonstrating respect for others which is not the same focus as this RN ETPC and RNI statement. The term "cultural" yielded results in ETPC and

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	issues and an increased understanding of others' experiences by acknowledging their own assumptions, biases, values.		RPNI statement 8. Here the RPN adapts their practice to the spiritual and cultural beliefs of clients which is different from acting from a place of cultural humility, as the RN ETPC and RNI statement suggests.
9.4	The program provides opportunities for students to learn about nursing informatics and other information and communication technology in promoting and providing safe nursing care. Students learn about client health records, workload measurement systems, use of social media and other clinical applications used in health care. Students will demonstrate responsibility with their technology use, and ensure their use meets legal requirements for privacy and confidentiality.	**38. (Partial)**	**RPNI 38 -** *The program teaches students about client health records, workload measurement systems, use of social media and other clinical applications used in health care. Students learn about the need to be responsible with their technology use and ensure use meets legal requirements for privacy and confidentiality. Students should be able to demonstrate the use of technology such as electronic documentation systems and glucometers to check blood sugars. Students are able to identify appropriate versus inappropriate technology use to support nursing interventions to ensure safe client care.* **Note:** The fist sentence of the RPNI is identical to the second sentence of the RNI statement. The second sentence of the RPNI is almost identical to the third RNI statement with the difference being that RPNs learn about the need to be responsible and RNs demonstrate responsibility. The RPNI statement then informs the RPN of the types of technology they should be able to operate and how to know what is appropriate and not. The accountability of the RN to act is a key difference between the two statements. Therefore, I identified the ETPC and RPNI as partially equivalent to this competency and RNI statement. **Find Function Results:** The phrase "nursing informatics" is not found in the RPN ETPC or RPNI statements. "Nursing informatics refers to the practice and science of integrating nursing information and knowledge with technology to manage and integrate health information" (CNA, 2023), and not merely the use of technology indicating a different level of practice.
9.5	The program provides opportunities for students to develop a capacity to monitor for trends in nursing knowledge and technologies that change, enhance or support nursing practice and	**16. (Partial)**	**RPNI 16 -** *The program provides students the opportunity to develop the capacity to monitor trends in nursing research and the health care environment. Students should have the opportunity to integrate research into practice. For example, how to integrate new wound care research into practice. The program provides awareness that the registered practical nurse collaborates with the health care team to proactively respond to changes in the health care system.*

RN ETPC	RN Interpretation (RNI) Statement (CNO 2019c, pp. 1-24)	RPN ETPC (Level of Equivalence) from Appendix D	RPN Interpretation (RPNI) Statement (CNO 2019d, pp. 1-18) Comparison to RN Interpretation Statements and Notes
	healthcare. Students demonstrate critical inquiry and engage in high-level thinking such as reflection, analysis and synthesis of information, or questioning of the status quo or current state.		**Note:** The first few words of the first sentence are almost verbatim identical however, the RNI statement departs to a consider not only research and the health care environment but look more broadly to nursing practice that can improve healthcare as a whole. Therefore, I identified the ETPC and RNI as partially equivalent to this competency and RNI statement. **Find Function Result:** The phrase "status quo" yielded one result, RPNI 40 - *The program teaches students to engage in high-level thinking such as reflection, analysis and synthesis of information, or questioning of the status quo or current state.* The RNI requires the RN to demonstrate critical inquiry and not just engage in high-level thinking. Engage in is not listed in the Bloom's Taxonomy list used for this dissertation and when searching through an online thesaurus, a synonym was "try" which could equate application in the cognitive domain, and therefore, similar to the demonstrate (applying in Bloom's) in the RNI statement. However, without the term critical inquiry, I identified that the ETPC has inferred equivalence and the RPNI is partially equivalent to this competency and RNI statement.
9.6	The program provides opportunities for students to demonstrate knowledge about emerging community, population and global health issues and research (e.g. pandemics, mass immunizations, emergency/disaster planning, food and water safety).	**No Equivalent**	**Find Function Results:** The phrases of "emerging issues", "community issues", "population issues" or "global health issues" yielded no results. For the examples listed, only one result was yielded for "disaster planning" which is specifically related to RPN ETPC 72 which is a verbatim identical match for RN ETPC 5.9, and therefore, I identified these as not equivalent for this competency or RNI statement.
9.7	The program provides opportunities for students to contribute to a culture that supports nursing or health research through collaboration and participation in research activities. Students learn what	**39. (Inferred)**	**RPNI 39 -** *The program teaches students about thoughtful care planning by assessing evidence/scholarly research to incorporate into their practice. It teaches students about the importance of research in their practice. Students learn what involvement in research means for the nursing profession and health care as a whole and that they or their clients may be involved in research studies. The program provides students with experience to validate evidence-informed practice which includes research skills and recognizing reliable sources of information.*

RN ETPC	RN Interpretation (RNI) Statement (CNO 2019c, pp. 1-24)	RPN ETPC (Level of Equivalence) from Appendix D	RPN Interpretation (RPNI) Statement (CNO 2019d, pp. 1-18) Comparison to RN Interpretation Statements and Notes
	involvement in research means for the nursing profession and health care as a whole, and that they or their clients may be involved in research studies.		**Note:** There is an implication that the RPN is involved in research but does not contribute to a culture of research or collaborate in research. The second sentence of the RNI and third sentence of the RPNI statements are identical. I identified that the ETPC has inferred equivalence and the RPNI is partially equivalent for this competency and RNI statement. **Find Function Results:** The phrase "participate in research" yielded one result in RPNI 36 as an example of obtaining informed consent, but is not related to the 9.7 RN ETPC or RNI statement.
9.8	The program provides opportunities for students to articulate the significance of continuing competence requirements within professional self-regulation. Students will engage in self-reflection for the purposes of ongoing professional development.	**10. (Partial)**	**RPNI 10 -** *The program provides students the opportunity to demonstrate continued competence and preparedness to meet regulatory requirements by reflecting on one's practice to identify learning needs. It ensures students implement and evaluate the effectiveness of their learning plan and develop future learning plans to maintain and enhance one's competence as a registered practical nurse. Students should be familiar with CNO's Quality Assurance (QA) program to be able to fulfill the self-assessment requirements of the program.* **Note:** The RPNI is directive regarding continuing competence and to know their learning needs, whereas the RNI statement is expecting the RN to be able to state the importance of continuing competence. By the wording of the RNI statement, the RN is more accountable to be self-directed in their professional development, whereas the RPN is expected to follow the rules of regulation. Therefore, I identified the ETPC and RPNI as partially equivalent to this competency and RNI statement. **Find Function Results:** The phrase of "professional self-regulation", "continuing competence", and "professional development" yielded no results.

Appendix F

Revised Compatibility Chart and Summary of Key Differences in Practice Expectations

RN ETPC	Comparability based on ETPC Analysis (from Appendix D)	REVISED Comparability After Interpretation Statement and Find Function Results Analysis (Summary of Appendix E)
Role of CLINICIAN		
1.1	**5.** Partial **25.** Partial **29.** Partial **40.** Partial **42.** Partial **51.**Partial	**5.** ETPC and RPNI – Not Equivalent **25.** ETPC and RPNI – Partial **29.** ETPC and RPNI – Inferred **37.** ETPC and RPNI – Partial with the RNI Statement **40.** ETPC and RPNI – Not equivalent **42.** ETPC and RPNI – Partial **51.** ETPC and RPNI – Partial **63.** ETPC – Not Equivalent and RPNI – Partial with the RNI Statement
1.2	**37.** Partial	**37.** ETPC and RPNI – Partial
1.3	**No Equivalent**	**No Equivalent**
1.4	**41.** Partial **42.** Partial **43.** Partial	**41.** ETPC and RPNI – Partial **42.** ETPC and RPNI – Partial **43.** ETPC and RPNI – Partial **54.** ETPC – Not Equivalent but RPNI – Partial with RNI Statement
1.5	**44.** Partial **55.** Partial **56.** Partial	**44.** ETPC and RPNI – Partial **55.** ETPC and RPNI – Partial **56.** ETPC and RPNI – Partial
1.6	**45.** Inferred **53.** Partial **54.** Partial	**45.** ETPC – Inferred and RPNI – Not Equivalent **53.** ETPC – Partial and RPNI – Inferred with RNI Statement **54.** ETPC – Partial and RPNI – Inferred with RNI Statement **55.** ETPC – Partial and RPNI – Inferred with RNI Statement
1.7	**No Equivalent**	**No Equivalent**
1.8	**58.** Partial and Inferred	**51.** ETPC and RPNI – Partial **58.** ETPC and RPNI – Inferred
1.9	**60.** Verbatim Identical	**60.** ETPC – Verbatim Identical and RPNI – Virtually Identical
1.10	**No Equivalent**	**79.** ETPC – Not Equivalent but RPNI – Inferred with RNI statement
1.11	**62.** Verbatim Identical	**62.** ETPC – Verbatim Identical and RPNI – Almost Identical
1.12	**No Equivalent**	**No Equivalent**
1.13	**45.** Partial	**45.** ETPC – Partial and RPNI – Inferred
1.14	**No Equivalent**	**No Equivalent**
1.15	**No Equivalent**	**No Equivalent**
1.16	**No Equivalent**	**No Equivalent**

RN ETPC	Comparability based on ETPC Analysis (from Appendix D)	REVISED Comparability After Interpretation Statement and Find Function Results Analysis (Summary of Appendix E)
1.17	**No Equivalent**	**No Equivalent**
1.18	**No Equivalent**	**No Equivalent**
1.19	**No Equivalent**	**No Equivalent**
1.20	**No Equivalent**	**No Equivalent**
1.21	**61.** Partial	**61.** ETPC – Partial and RPNI – Almost Identical
1.22	**61.** Partial	**61.** ETPC Partial and RPNI – Inferred with RNI Statement **71.** ETPC and RPNI – Inferred with RNI statement **77.** ETPC and RPNI – Inferred with RNI statement **78.** ETPC – Not Equivalent and RPNI – Inferred with RNI statement
1.23	**40.** Partial	**40.** ETPC and RPNI – Partial **11.** ETPC and RPNI – Partial **56.** ETPC and RPNI – Inferred with RNI statement
1.24	**59.** Almost Identical	**59.** ETPC – Almost Identical and RPNI – Virtually Identical
1.25	**No Equivalent**	**No Equivalent**
1.26	**8.** Verbatim Identical	**8.** ETPC and RPNI – Verbatim Identical
1.27	**51.** Inferred	**51.** ETPC and RPNI – Inferred **73.** ETPC – Inferred and RPNI – Partially Identical
Role of PROFESSIONAL		
2.1	**1.** Partial **2.** Partial **3.** Partial **5.** Partial **17**. Inferred **28.** Inferred	**1.** ETPC and RPNI – Partial **2.** ETPC and RPNI – Partial **3.** ETPC and RPNI – Inferred **4.** ETPC and RPNI – Inferred **5.** ETPC and RPNI – Partial **17.** ETPC and RPNI – Inferred **28.** ETPC and RPNI – Partial
2.2	**14.** Almost Identical	**14.** ETPC – Almost Identical and RPNI – Partial
2.3	**1.** Inferred **2.** Partial and Inferred **5.** Partial **29.** Partial	**1.** ETPC and RPNI – Inferred **2.** ETPC and RPNI – Inferred **5.** ETPC and RPNI – Inferred **29.** ETPC and RPNI – Inferred
2.4	**25.** Partial and Inferred **29.** Partial **33.** Partial	**25.** ETPC and RPNI – No Equivalent **29.** ETPC and RPNI – Partial **33.** ETPC and RPNI – Partial
2.5	**21.** Partial **22.** Partial	**20.** ETPC – Not Equivalent and RPNI – Inferred **21.** ETPC and RPNI – Partial **22.** ETPC and RPNI – Partial
2.6	**20.** Partial	**20.** ETPC and RPNI – Partial
2.7	**23.** Partial	**23.** ETPC and RPNI – Almost Identical
2.8	**57.** Partial	**57.** ETPC and RPNI – Partial

RN ETPC	Comparability based on ETPC Analysis (from Appendix D)	REVISED Comparability After Interpretation Statement and Find Function Results Analysis (Summary of Appendix E)
		38. ETPC – Inferred and RPNI – Partial
2.9 a	**4.** Partial **5.** Partial **10.** Partial	**4.** ETPC and RPNI – Inferred **5.** ETPC and RPNI – Not Equivalent **10.** ETPC and RPNI – Partial
2.9 b	**4.** Partial **10.** Partial	**4.** ETPC and RPNI – Inferred **10.** ETPC and RPNI – Inferred
2.9 c	**4.** Partial **10.** Partial	**4.** ETPC and RPNI – Inferred **10.** ETPC and RPNI – Inferred
2.9 d	**4.** Partial **10.** Partial	**4.** ETPC and RPNI – Inferred **10.** ETPC and RPNI – Inferred
2.10	**15.** Verbatim Identical	**15.** ETPC – Verbatim Identical and RPNI – Virtually Identical
2.11	**32.** Verbatim Identical	**32.** ETPC – Verbatim Identical and RPNI – Virtually Identical
2.12	**19.** Verbatim Identical	**19.** ETPC – Verbatim Identical and RPNI – Almost Identical
2.13	**17.** Partial **18.** Partial **30.** Inferred	**17.** ETPC and RPNI – Not Equivalent **18.** ETPC and RPNI – Almost Identical **30.** ETPC and RPNI – Not Equivalent
2.14	**73.** Inferred	**73.** ETPC and RPNI – Partial
Role of COMMUNICATOR		
3.1	**No Equivalent**	**No Equivalent**
3.2	**66.** Partial and Inferred	**64.** ETPC and RPNI – Inferred **66.** ETPC and RPNI – Inferred
3.3	**6.** Partial **64.** Inferred **66.** Partial	**6.** Not Equivalent **64.** Not Equivalent **66.** ETPC and RPNI – Inferred
3.4	**67.** Verbatim Identical	**67.** ETPC – Verbatim Identical and RPNI – Partial **76.** ETPC and RPNI – Inferred
3.5	**No Equivalent**	**6.** ETPC and RPNI – Inferred
3.6	**No Equivalent**	**No Equivalent**
3.7	**60.** Inferred **65.** Inferred	**60.** ETPC – Inferred and RPNI – Almost Identical **65.** ETPC and RPNI – Inferred
3.8	**35.** Partial	**35.** ETPC – Partial and RPNI – Inferred
Role of COLLABORATOR		
4.1	**75.** Inferred	**75.** ETPC and RPNI – Not Equivalent **No Equivalent**
4.2	**44.** Partial	**44.** ETPC – Partial and RPNI – Inferred
4.3	**69.** Verbatim Identical	**69.** ETPC – Verbatim Identical and RPNI – Partial
4.4	**68.** Partial	**68.** ETPC and RPNI – Inferred
4.5	**64.** Partial	**64.** ETPC and RPNI – Inferred **76.** ETPC and RPNI – Partial

RN ETPC	Comparability based on ETPC Analysis (from Appendix D)	REVISED Comparability After Interpretation Statement and Find Function Results Analysis (Summary of Appendix E)
Role of COORDINATOR		
5.1	**46.** Inferred	**46.** ETPC and RPNI – Not Equivalent **No Equivalent**
5.2	**42.** Partial **46.** Partial	**42.** ETPC and RPNI – Inferred **46.** ETPC and RPNI – Inferred
5.3	**78.** Almost Identical	**78.** ETPC – Almost Identical and RPNI – Inferred to Partial
5.4	**71.** Inferred	**71.** ETPC and RPNI – Inferred **78.** ETPC – Not Equivalent and RPNI – Inferred
5.5	**79.** Partial	**79.** ETPC – Partial and RPNI – Inferred
5.6	**No Equivalent**	**No Equivalent**
5.7	**79.** Partial	**79.** ETPC – Partial and RPNI – Almost Identical
5.8	**79.** Partial	**79.** ETPC – Partial and RPNI – Inferred
5.9	**72.** Verbatim Identical	**72.** ETPC – Verbatim Identical and RPNI – Partial
Role of LEADER		
6.1	**24.** Partial	**24.** ETPC – Partial and RPNI – Verbatim Identical
6.2	**13.** Verbatim Identical	**13.** ETPC – Verbatim Identical and RPNI – Almost Identical **52.** ETPC and RPNI – Inferred
6.3	**No Equivalent**	**No Equivalent**
6.4	**73.** Almost Identical	**73.** ETPC – Partial and RPNI – Inferred
6.5	**12.** Partial	**12.** ETPC and RPNI – Partial
6.6	**3.** Partial	**3.** ETPC – Partial and RPNI – Not Equivalent
6.7	**8.** Partial	**8.** ETPC and RPNI – Partial **22.** ETPC – Not equivalent and RPNI – Partial
6.8	**No Equivalent**	**No Equivalent**
6.9	**75.** Inferred	**75.** ETPC and RPNI – Not Equivalent **No Equivalent**
6.10	**No Equivalent**	**No Equivalent**
6.11	**77.** Inferred	**77.** ETPC and RPNI – Not Equivalent **No Equivalent**
Role of ADVOCATE		
7.1	**51.** Partial	**30.** ETPC – Inferred and RPNI – Partial **51.** ETPC and RPNI – Inferred
7.2	**31.** Partial	**31.** ETPC and RPNI – Partial
7.3	**70.** Partial	**70.** ETPC – Partial and RPNI – Almost Identical
7.4	**26.** Partial	**26.** ETPC – Partial and RPNI – Inferred
7.5	**No Equivalent**	**No Equivalent**
7.6	**27.** Inferred	**27.** ETPC and RPNI – Inferred

RN ETPC	Comparability based on ETPC Analysis (from Appendix D)	REVISED Comparability After Interpretation Statement and Find Function Results Analysis (Summary of Appendix E)
7.7	**9.** Almost Identical	**9.** ETPC – Almost Identical and RPNI – Partial
7.8	**No Equivalent**	**No Equivalent**
7.9	**No Equivalent**	**No Equivalent**
7.10	**34.** Inferred	**34.** ETPC and RPNI – Inferred **36.** ETPC and RPNI – Inferred
7.11	**No Equivalent**	**No Equivalent**
7.12	**36.** Inferred	**36.** ETPC and RPNI – Not Equivalent **No Equivalent**
7.13	**36.** Inferred	**36.** ETPC and RPNI – Inferred
7.14	**No Equivalent**	**26.** ETPC – Inferred and RPNI – Partial
Role of EDUCATOR		
8.1	**48.** Partial	**48.** ETPC and RPNI – Partial
8.2	**47.** Partial	**47.** ETPC and RPNI – Partial
8.3	**48.** Partial	**48.** ETPC and RPNI – Partial
8.4	**48.** Partial **50.** Partial	**48.** ETPC and RPNI – Inferred **50.** ETPC and RPNI – Partial
8.5	**38.** Inferred **49.** Partial	**38.** ETPC and RPNI – Not Equivalent **49.** ETPC and RPNI – Partial
Role of SCHOLAR		
9.1	**40.** Partial	**40.** ETPC and RPNI – Partial **56.** ETPC and RPNI – Partial
9.2	**11.** Almost Identical **40.** Partial	**11.** ETPC – Almost Identical and RPNI – Inferred **40.** ETPC and RPNI – Not Equivalent
9.3	**7.** Partial	**7.** ETPC and RPNI – Inferred
9.4	**38.** Partial	**38.** ETPC and RPNI – Partial
9.5	**16.** Partial	**16.** ETPC and RPNI – Partial **40.** ETPC – Inferred and RPNI – Partial
9.6	**No Equivalent**	**No Equivalent**
9.7	**39.** Inferred	**39.** ETPC – Inferred and RPNI – Partial
9.8	**10.** Partial	**10.** ETPC and RPNI – Partial

Curriculum Vitae

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Post-secondary Education and Degrees:

St. Clair College
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1987-1989 Diploma of Health Sciences – Nursing

University of Windsor
Windsor, Ontario, Canada
1992-1995 B.Sc.N. (Post-RN)

St. Lawrence College
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1997-1999 Diploma Registered Nurse – Occupational Health Nursing

University of Windsor
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2002-2006 M.Sc.(N.)

The University of Western Ontario
London, Ontario, Canada
2015-2023 Ph.D. in Education

Honours and Awards: Western University Graduate Scholarship
2015-2020

Dr. Drake Graduate Research Award - Faculty of Nursing
2005

St. Clair College Entrance Scholarship
1987

Related Work Experience Registered Nurse
Various hospital, long-term care, and industry agencies
1989-2006

Nursing Professor
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Hibbert, K., Faden, L., De Luca, S., Huda, N., & Seabrook, L., & Goldszmidt, M. (2018). A sociomaterial inquiry into the clinical teaching workplace. *Journal of Workplace Learning,30*, 514-530.

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