Article

Working to Full Scope: The Reorganization of Nursing Work in Two Canadian Community Hospitals

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Abstract

Work relationships between registered nurses (RNs) and practical nurses (LPNs) are changing as new models of nursing care delivery are introduced to create more flexibility for employers. In Canada, a team-based, hospital nursing care delivery model, known as Care Delivery Model Redesign (CDMR), redesigned a predominantly RN-based staffing model to a functional team consisting of fewer RNs and more LPNs. The scope of practice for LPNs was expanded, and unregulated health care assistants introduced. This study began from the standpoint of RNs and LPNs to understand their experiences working on redesigned teams by focusing on discourses activated in social settings. Guided by institutional ethnography, the conceptual and textual resources nurses are drawing on to understand these changing work relationships are explicated. We show how the institutional goals embedded in CDMR not only mediate how nurses work together, but how they subordinate holistic standards of nursing toward fragmented, task-oriented, divisions of care.

Keywords

research, qualitative, nursing, organizations, quality of care, health care, teamwork, ethnography, health care administration, discourse analysis, critical methods, interviews

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Nursing shortages are acknowledged at all levels of government, and are leading to new staffing models and more flexible and expanding scopes of practice for nurses (Besner et al., 2005; McGillis-Hall et al., 2006). Consequently, work relationships between registered nurses (RNs) and practical nurses (LPNs)[1] are changing as new models of nursing care delivery are introduced. Scopes of practice are increasingly overlapping to create more flexibility for employers who are trying to utilize human resources more efficiently (White et al., 2009; World Health Organization [WHO], 2008).

In British Columbia, Canada, relationships between RNs and LPNs have changed dramatically with the recent implementation of a controversial nursing care delivery model that shifts from a predominantly RN-based model to a team model consisting of fewer RNs and more LPNs, and introduces unregulated health care assistants or aides (HCAs) on each shift. The changing work relationships, resulting from this shift toward a team-based, functional nursing care delivery model, require further study.

Background and Significance

A review of RN and LPN regulatory documents across Canada (Butcher & MacKinnon, 2015) reveals much variation in how registered and practical nursing roles are conceptualized, and little collaboration between RN and LPN groups regarding expectations for education and practice. This variability and lack of communication raise significant questions regarding how RNs and LPNs are drawing on nursing knowledge and practicing nursing. A recent systematic review reveals that intraprofessional learning experiences help build trust, respect, and understanding of each others' roles and scopes; however, educator and staff attitudes, hierarchies, and lack of role clarity impede learning (Butcher, MacKinnon, Bruce, Gordon, & Koning, 2017). As working relationships between RNs and LPNs are shifting, it is imperative to explore how nurses negotiate their roles in changing care delivery model contexts.

Little evidence addressing changing RN and LPN relationships in practice situations is available. However, a study from Eagar, Cowin, Gregory, and Firtko (2010) suggests that ambiguity and confusion surrounding scopes of practice negatively

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affect nurses in the workplace, which could result in negative outcomes for both nurses and their patients. U.S. researchers (Lang, Hodge, Olson, Romano, & Kravitz, 2004; Lankshear, Sheldon, & Maynard, 2005) suggest that staff mix has an impact on patient outcomes in acute care areas. Staffing models that include more RNs (Aiken, Clarke, Cheung, Sloane, & Silber, 2003; McGillis-Hall, Doran, & Pink, 2004), more educated and experienced nurses (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Rogers, Hwang, Scott, Aiken, & Dinges, 2004), and less fatigued or overstressed nurses (Laschinger & Leiter, 2006) have been shown to enhance patient safety. Aiken and colleagues also documented an inverse association between high nurse-patient ratios and nurses' burnout and job dissatisfaction (Aiken et al., 2002), and between work environments (including staffing) and patient safety (mortality and failure to rescue; Aiken et al., 2011).

A large Canadian study of 8,597 hospital-based nurses demonstrated the link between nursing work environments and patient safety. Laschinger and Leiter (2006) also concluded that nurse leaders who fostered supportive and adequately staffed workplaces decreased burnout and enhanced the engagement of nursing staff. In Canada, the changing work relationships resulting from a shift toward a functional team-based nursing care delivery model requires more study (White, Jackson, Besner, Suter, Doran, McGillis Hall, & Parent, 2009).

A new staffing model was developed in response to three pressing issues: the changing needs of an aging population, the shortage of nurses, and the need to "optimize" the nursing workforce. Observational data gathered to inform the redesign suggested that health care professionals were not working to their full scope and that "a significant proportion of the workload of many professionals is devoted to activities that could be done by assistive personnel" (Stevenson, Parent, & Purkis, 2012, p. 17). In addition, many staff members were engaged in "non-value added activity" such as searching for equipment and supplies (p. 17). These findings prompted the introduction of a functional team model of nursing care known as Care Delivery Model Redesign (CDMR). When implemented, CDMR was intended to ensure that all professionals, including nurses, had the opportunity to "optimize their full scope of practice" and that the "right people [are] in the right positions, doing the right work" (p. 16).

The two hospital sites participating in the present study were involved in pilot programs that moved from a primary care nursing model (with staffing ratios of 80% RNs and 20% LPNs on day shifts, and 100% RNs on night shifts) to the redesigned functional care delivery model (CDMR) that also added assistive personnel. Although the staffing mixes observed varied somewhat by unit, CDMR introduced a return to team nursing. Full-scope LPNs replaced some RN positions, with HCAs added into the staffing mix. CDMR not only changed the nursing staff-mix ratios but also sanctioned a significantly expanded scope of practice for LPNs in these acute care hospital settings, who were now accountable for their own patient assignment.

Purpose and Objectives

The overall purpose of this initial study was to provide the foundation for a program of research that focuses on the social organization of changing work relationships between RNs, LPNs, and other workers who provide nursing services in acute care hospitals. Specific objectives for this study include the following: (a) to identify/describe the experiences and concerns of RNs and LPNs about changing work relationships and scopes of practice, (b) to identify the conceptual (discursive) and textual resources that the nurses are drawing on to understand these changing relationships, and (c) to provide an entry point into further analysis of the social organization of nurses' work experiences.

Methodology

This study, guided by an institutional ethnographic (IE) approach to inquiry, investigates the social organization of experience (Smith, 1999, 2005, 2006). In an IE investigation, researchers pay particular attention to how textually mediated institutional work processes (e.g., policies, procedures, guidelines) and discourses or conceptual resources influence practice (Smith & Turner, 2014). Nurses draw on conceptual and textual resources from their education programs, from professional nursing organizations, and from their workplace.

This study began from the standpoint[2] of RNs and LPNs to understand their experiences working on collaborative teams and "working to full scope" by focusing on discourses activated in social settings. IE interviews usually begin from the standpoint of people as experts in their everyday work (Campbell & Gregor, 2008). This focus on standpoint is highly political, as inquiry begins in the subjectivities of peoples' experiences, not in objectified, theoretical, or authoritative knowledge (Bisaillon & Rankin, 2013). IE uses an emergent design as the social organization of people's work experiences becomes visible to the research team over time (DeVault & McCoy, 2002). Therefore, the kinds of questions asked change as the investigation proceeds.

An IE investigation focuses on "discovering and making observable just how texts enter into, organize, shape and coordinate people's doings" (Smith & Turner, 2014, p. 5). Texts are not treated as objects of research but rather analyzed as they are activated in people's everyday work. Texts also have a variety of material forms (including visual images), and can coordinate work practices (or ongoing sequences of action) across separations of time and space (Campbell & Gregor, 2008). IE attempts to make visible what people actually do.

Analysis focuses on the social organization of (nurses') embodied knowledge and on the textually mediated[3] and therefore replicable social organization of (nurses') work.[4] Some texts directly structure nurses' work processes (e.g., patient assessment forms); while others do not enter into institutionally sanctioned work process and remain invisible to those outside the immediate work setting (MacKinnon & McCoy, 2006).

Discourse is understood as conceptual and textual resources that are used in everyday social interaction and every shift work. Discourse enters the social realm when activated in conversation or through reading texts. In an IE investigation, discourse is understood as a "sphere of activity" (Smith, 2014, p. 225):

> The very process of using a professional or institutional language to make things accountable makes almost everything that is involved in doing the work in actual real- life situations disappear. Professionals talk about their work using professional discourses which take for granted and do not describe what they actually do. (Smith, 2003, p. 61)

Nurses' talk about scopes of practice is important because they reflect how nurses' work is being organized outside the local setting. Exploring the social organization of nurses' experiences helps to identify the unintended consequences of institutionalized discourses and work practices with the goal of making change (DeVault & McCoy, 2002).

Method

We recruited 10 RNs and 10 LPNs from two small community hospitals identified by the health region. These settings were selected because the team nursing care delivery model (CDMR) had been introduced more than 2 years earlier and therefore avoided focusing on the negative impact of the introduction of a new practice change.

Data Collection Methods

After obtaining informed consent, we conducted individual interviews with RNs and LPNs that were audio recorded and later transcribed for data analysis. We began by asking nurses to describe a recent workday, listening for traces of social organization in their accounts that required further clarification. Observations in the practice setting were limited to a tour of each setting and the opportunity to shadow one of the frontline nurse leaders throughout the workday. We observed the morning shift report, a "bed planning" meeting, and an informal report given to nonnursing professionals (a physiotherapist and an occupational therapist). No personal information was recorded in field notes, although mock-ups of visual planning aids (such as whiteboards) and some blank chart forms were collected for further analysis.

Analytic Methods

As we interviewed RNs and LPNs about their workday, analysis began by listening for unrecognized and often invisible forms of work (DeVault, 1990). We listened carefully for traces of the conceptual (discursive) and textual resources that the nurses were drawing on to describe their work as they interacted with each other and with HCAs. We have taken up the standpoint of these frontline nurses (both RNs and LPNs) and analyzed their interview accounts with the goal of "keeping the institution in view" (McCoy, 2006). This approach provides an entry point into further explication of the social organization everyday experiences.

Ethical Considerations

We obtained ethical approval from the joint university and health authority Health Research Ethics Board (University of Victoria HREB Approval No. J2014-041) prior to starting recruitment for the study. Participants were volunteers who were interested in discussing changing scopes of practice and work relationships between RNs, LPNs, and HCAs. Before they signed the consent form, we assured all participants that their responses would be confidential and that they could refuse to participate or withdraw from the study at any time.

Context and Participants

The focus of our study was on general medical and surgical units, where new graduate nurses are frequently hired. However, it was our observation that these nurses provided care for a wide range of people with multiple and complex health challenges requiring both particularized nursing knowledge (Thorne, 2014) and highly specialized, often technical care. Shorter hospital stays may also have increased the acuity of the patients being cared for on these nursing units.

Nurses working in the settings reported being continuously "over census" with high occupancy rates. One nurse noted, "Every unit in the hospital is over-census right now. We're always short [of beds and nurses]" (LPN). Another participant confirmed this workload: "There's 22 patients, usually I think there's 22 . . . and that might be two over census in that we're not funded for [them] but we always have them . . . they're just there all the time" (RN).

Bed pressures also resulted in the creation of a "Bed Allocator" role at one community hospital because managing patient flow was a priority. We had the opportunity to interview one nurse who did this work:

> Our primary goal is to place our surgical same day admits. That's a constant jockeying sort of thing because we have our designated areas but we have to be very open-minded about how we can use absolutely every space. Unfortunately, we have to do a lot of moving because things change continually, you're

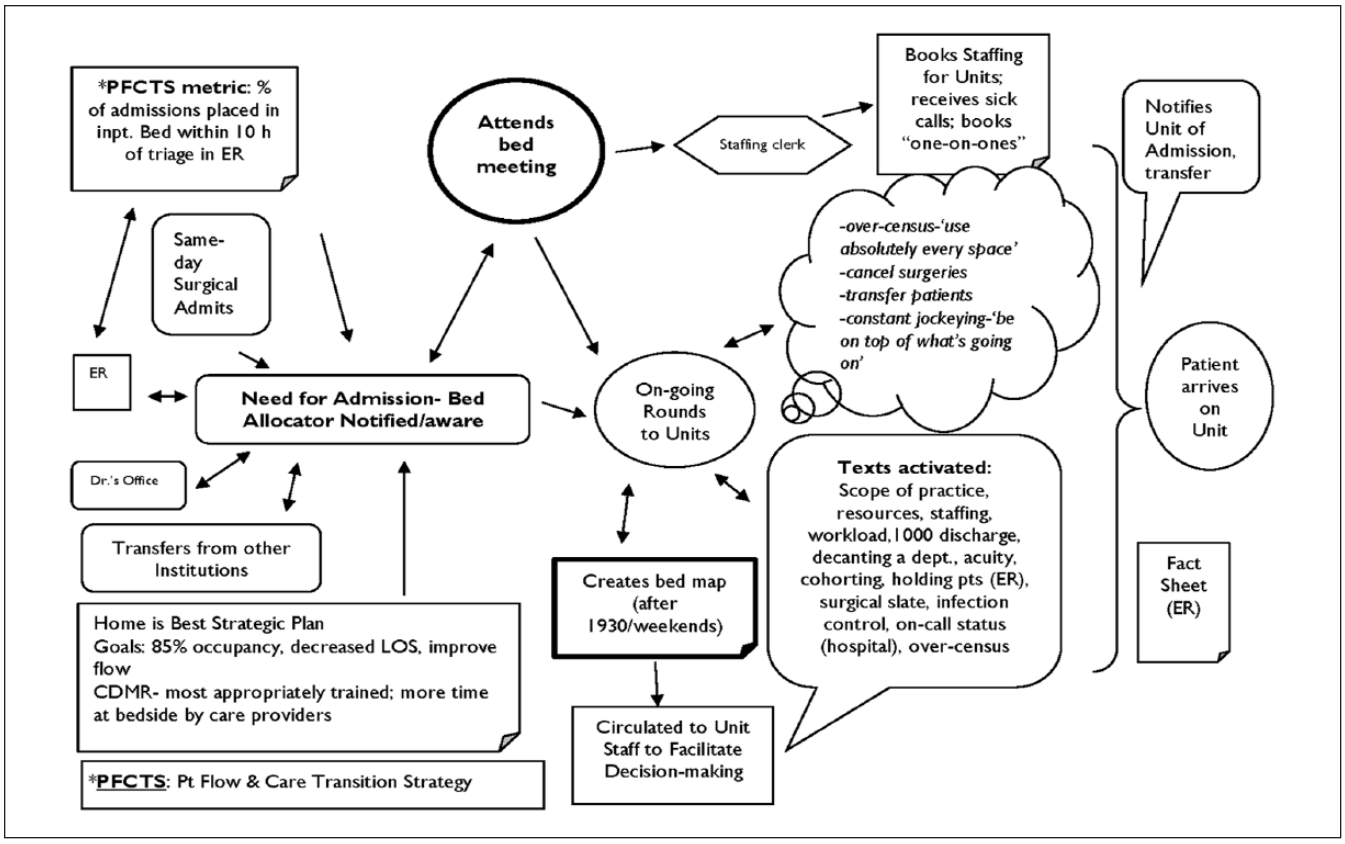

Figure 1. The work of patient flow—Bed Allocator.
Note. CDMR = Care Delivery Model Redesign; PFCTS = patient flow & care transition strategy; ER is Emergency Room; LOS is length of stay; SOP is Scope of Practice.

> constantly doing this movement to keep the facility as full as it can be. (LPN)

Patient moves around the nursing units were common to ensure that every patient had a bed. Our field observations confirmed this contextual feature. We have provided a map that highlights the work of the LPNs hired as Bed Allocators (see Figure 1). This work links to the health region's Patient Flow and Care Transition Strategy document, an extralocal form of textually mediated social organization (Island Health, 2014b).

Other creative strategies included a unit where stable older people (waiting placement) were being transferred or "decanted"[5] from acute care units to units organized like long-term care facilities where LPNs and HCAs provide nursing care. The other community hospital used an "overflow" unit for "people who have been admitted when there isn't enough room in the hospital" (RN).

Our participants also noted the impact of decreasing hospital resources, including both nursing/patient care unit and support services, such as supplies and laundry. One RN stayed after her scheduled shift to share a troubling story about how she had to scrub bedpans as the central supply department had been "leaned," and it was no longer possible to return a bedpan for cleaning within one patient's hospital stay. Nurses are clearly being affected by discourses of scarcity and institutional work processes related to more efficiently managing (the cost of) resources. However, changes to the care delivery model and the overcapacity situation (resulting in a focus on patient flow and discharge) were the two most important contextual features on the nursing units participating in this study.

Our participants. We interviewed 10 RNs and 10 LPNs from these two sites (n = 20 nurses). In an IE investigation, these nurses are considered informants who can provide information about their workday as they are the experts in their everyday/every shift work. The following demographic information (see Table 1) provides some background details about the participants.

It may also be helpful for our readers to know that the length of LPN education in the province had recently increased from a 1-year certificate to a 2-year diploma program. Although most of the RNs we interviewed completed a BSN, some of the older RNs would have completed a 2- or 3-year RN diploma program. HCA qualifications were also changing in British Columbia with provincial competencies outlined in 2014, and a new curriculum guide developed in

Table 1. Nurse Participants (n = 20).

Site	Participants	No. of Years Employed as RN/LPN	No. of Years Working at Current Site	No. of Years on Current Unit
Site A	RN (5)	<5 (2)	<5 (2)	<5 (3)
Roles:	LPN (5)	5–9 (0)	5–9 (2)	5–9 (2)
Staff nurses (10)		10+ (3)	10+ (1)	10+ (0)
		<5 (1)	<5 (3)	<5 (2)
		5–9 (1)	5–9 (1)	5–9 (1)
		10+ (3)	10+ (1)	10+ (2)
Site B	RN (5)	<5 (1)	<5 (1)	<5 (2)
Roles:	LPN (5)	5–9 (1)	5–9 (1)	5–9 (1)
Staff nurses (8)		10+ (3)	10+ (3)	10+ (2)
Nurse leaders (2)		<5 (1)	<5 (2)	<5 (3)
		5–9 (2)	5–9 (2)	5–9 (1)
		10+ (2)	10+ (1)	10+ (1)

Note. RN = registered nurse; LPN = practical nurse.

2015. Most programs are now 6 months or more depending on qualifications at program entry (Province of British Columbia, 2015).

Findings

After repeated engagement with the audio recordings, transcripts, and field notes, our small team analyzed the data according to the three main objectives of the study. Three threads for further exploration identified from our preliminary analysis include (a) the *workful*[6] nature of collaboration, (b) the impact of institutional discourses of "full scope" for RNs and LPNs, and (c) the impact of introducing unregulated care providers or HCAs. Here, we present the initial findings from this IE investigation, providing quotations from the nurses' interviews as clues to the social organization of their experiences and then identifying some of the conceptual and textual resources that the nurses were drawing on in their talk.

The Workful Nature of Collaboration

We were interested in understanding the work required for nurses to accomplish nursing care in a team-based, functional, and stratified model of nursing care provision as this had been "redesigned" by CDMR. The forms of work nurses described as part of a chronological account of their workday included teamwork, communication, developing and maintaining professional working relationships, and thinking work that was oriented toward keeping patients safe. One form of "work" that we did not anticipate involved the negotiation and renegotiation of their patient assignment.

Teamwork. Working in a collaborative team required knowledge of the capacities of all team members as individuals, as well as respecting and acknowledging team member's contributions:

> I feel I've got more of a partner, rather than a hierarchal situation where I'm the boss and you're not, I was always saying, "Hey, how are you doing, what do you need, and how can I help you?" (RN)

> I work really well with RNs and we work together as a team really well. If I see they have a person that's taking their time then we're jumping in and helping them. (LPN)

An important part of teamwork that the nurse participants in our study identified was recognizing the "intensity" of nursing work for stable yet "heavy" patients and "helping out."

In our study, RNs assumed responsibility for planning for safe staffing levels on subsequent shifts. They made out the Patient Assignment Board in advance, considering patient acuity levels and the skill levels of nurses scheduled to work. This work was recorded on an erasable whiteboard that nurses referred to as the "Acuity/Intensity Board." Sometimes this board was used to frame requests for additional staff on subsequent shifts.

Communication. Working within a stratified care delivery model with different nurses caring for different patients and with an HCA providing personal care for part of the shift required clear, concise, and ongoing communication:

> Once we implemented CDMR, we worked around by having team huddles that became really instrumental because we would do our morning stuff, assessments and then the RN, LPN and care aide [HCA] would get together and would review what's happened with the patient, and [then] the RN had the task of prioritizing. (RN)

> We all come into the nursing station and go to our respective nurse who we're relieving, and they give us individual report. Then you do a big, whole unit report all together, then we go into our smaller team and do a quick huddle. (LPN)

Nurses noted that they were under pressure from the administration to decrease the time spent on oral reporting

and in one setting, a structured written report replaced this form of oral, narrative reporting in an effort to increase the time available for interprofessional discharge planning conferences coordinated by the RNs.

Relationship work. The complexity of the nurses' relationship work was apparent in their descriptions. Sometimes, this relationship work included recognizing a grieving or traumatized coworker after a patient death and/or the fear that new graduates and employees might be experiencing. The following quote illustrated the importance of supporting other nurses:

> We need to be very protective of LPNs scope and we need to be protective of everybody, they need to feel safe. It's got to be all of us putting our guards down and me being comfortable saying, "I'm not sure," right? (RN)

Other participants spoke of tensions in their collaborative relationships:

> The workload was way too much so then they decided to make two LPN teams and then making LPNs full scope. So that changed the whole dynamics of the way it was and then you've got these old-school nurses that are like, yeah I'd still like you do all the tasks and do your own work as well. So it's been a bit of a struggle. (LPN)

RNs shared that they clearly needed leadership, team building, and supervisory skills as they assumed more responsibility for setting priorities and supporting the team. This raised many questions for the analytic team, including how organizations can promote ongoing, clear communication and develop nurses' conflict-resolution skills.

Thinking work that was oriented to keeping people safe. On a unit where people with complex medical conditions were cared for during medical treatment and acute exacerbations of their illness, the nurses' work was oriented to monitoring for early signs of deterioration and complications, and intervening in a timely way as needed. Keeping people safe also involved ensuring safe staffing for upcoming shifts by anticipating nursing care requirements. One RN articulated how nurses were taking up discourses of "acuity" and "intensity" to do this safeguarding work by providing the following definitions:

> So acuity are the things an RN needs to handle. Are they [patients] unstable in some way? Someone who's having pain crises, somebody who's in respiratory distress, somebody who's family is very, very, very challenging. Intensity is the amount of nursing time that person is going to use. Are they continent? Are they vomiting? Are they purple-dotted? [code for a safety risk for staff] Do they feed themselves or are they an overhead lift? (RN)

What was surprising was that this form of clinical reasoning and nursing judgment was no longer the focus of formal or institutionally sanctioned communication and not systematically recorded in the medical record. The RNs' care planning work was also being reoriented toward mobilizing the interprofessional team in a timely way to avoid delays in discharge from the hospital.

Negotiating and renegotiating the patient assignment. We were surprised when we observed RNs and LPNs engaged in frequent conversations about their patient assignment, negotiating trades and tracking changes on an erasable whiteboard. Subsequent interviews with the nurses confirmed that negotiating who is responsible for this particular patient as the patient's condition changed required negotiation, and sometimes renegotiation, resulting in several changes in the patient assignment during a single shift. In addition to being *workful*, negotiating care assignments also required a high-level clinical reasoning, assessment, and decision-making skills.

Frequent changes in responsibility for nursing care can affect knowing patients and continuity of care, which increases the risks for fractured, nonholistic nursing care. Some of the nurses also recognized situations that required an LPN remain assigned to an unstable patient resulting in workload negotiations:

> If your patient starts to take a turn, the RN needs to be aware because one of two things happen. The first option and the first choice is that the patient gets turned over to the RN and you take one patient of hers. But I've had incidences where the RN's already got five highly acute patients. They're run off their feet, they're behind in their charting, so I will keep the patient, but the RN will be more closely *monitoring my monitoring* of the patient. And that's where communication is important! (LPN)

> My scope of practice is set but there are gray areas where a patient is not really stable but there's nobody that could take the patient without overdoing their workload. (LPN)

The constantly changing nature of nursing care and patient responses means that categories of "stable" and "predictable" may be problematic in these community hospital settings. Nurses said that this negotiating and reassigning of patients during a shift is common resulting in increased confusion for some patients, discontinuity of patient-centered care, and potential risks for patient safety.

Both RNs and LPNs primarily used the language of skills to describe difference in the tasks that RNs and LPNs were "allowed to do":

> We were talking the other day, really what is different that we do? Well RNs do the IV and IV medications. LPNs can hang the bag of saline and start that but RNs do the IV medications like the Lasix and all that. So really, it's all the same, just that they [RNs' patients] are more acute. (LPN)

> We have to look at what their diagnosis is and we look at their code status, how aggressively we are going to intervene, if they

> are on telemetry, if they need blood transfusions [then] they will automatically go to an RN. (RN)

Nurses used words like acuity, stability, and "predictable outcomes" to describe the differences in RN and LPN responsibilities and scopes of practice:

> RNs are taking very unstable patients, whereas ours are very predictable. (LPN)

> RNs get the freshly acute patients; the LPNs get the patients who have been here for quite a while. RNs get the sicker ones and have to learn to deal with issues as they come along. (RN)

LPNs expanded scope of practice. RNs noted many changes to the LPN scope of practice in recent years, and both groups of nurses noted that there were fewer differences in skills:

> I've seen a lot of change with LPNs since their scope of practice has changed with having to do pharmaceuticals, medications. (RN)

> I think the scopes are pretty close and similar. RNs do blood transfusions and albumin and the NG tubes. [For] people that have more investigations, [are] more acutely ill. But RNs wash like us, they do vital signs like we do, they do assessments like we do, they give medications like we do. We do PRNs like they do. At other hospitals, LPNs do IV medications and IV insertions and blood transfusions. (LPN)

LPNs understood their expanded scope of practice as an opportunity to do more skills, such as intravenous (IV) medications. Some LPNs embraced these changes, while others were not as keen. LPNs also drew on the language of "comfort zones" to describe when a transfer of patient care assignment to an RN was needed:

> We make the decision whether it's comfortable for me [LPN] to keep caring for that patient in collaboration with the RN or if the RN takes that patient on, then if there's another stable and predictable patient then we do a little switcheroo sometimes. (LPN)

> We had a lady a little while ago, she had a leg cellulitis, and it was improving, and then the dressing plan changed, [her] leg was red and swollen and so things about her stability had changed. Because I had to involve the RN more in my assessments, I said, "Well do you just want to take this patient because her acuity is a little bit more right now and it's a bit more out of my comfort zone." (LPN)

The RNs interviewed spoke more about paying attention to the "comfort zone" of the LPN, which may be an important part of their relationship work within a collaborative team:

> If there seems to be a more acute patient then I will have a conversation with the LPN. "How do you feel about taking this patient? Do you feel this patient is too ill right now?" Often they'll say, "I don't feel comfortable, they're on telemetry or having problems," then I'll say "Who do you want to trade?" and it's a very collaborative conversation, and it can be a few minutes or it can be quite lengthy. (RN)

The RNs assumed responsibility for the nursing care of patients when the LPNs no longer felt comfortable because the patient was not "stable" or "predictable." RNs, including new graduate RNs, did not have the opportunity to transfer responsibility for care to a more experienced nurse when outside their comfort zone. In addition, not all of the LPNs were comfortable with their expanded scope of practice.

> The LPNs, more the older ones I guess than the younger ones, don't want all the extra stuff. They don't feel ready for it, they're kind of set in their ways and it scares them. It was just horrible giving medications because it wasn't in their original training and so it's been hard for them. (RN)

RNs expanded scope of practice. Our participants described changes to the RN's scope of practice more as an increase in "administrative" and "paper" work:

> RNs do more administrative type stuff—discharge planning, care plans, [but] we're responsible for these patients and they're pulling us further and further away from [the patient]. (RN)

> The work of charting has increased a lot, it's ridiculous! Like this adult history on admission. It's on the computer. It does not self-populate. The charting is ridiculous! I'm logged on here, watch how long it takes for me to even get on, right? You can't get on to the computer! As a courtesy to the staff going on, and as a safety precaution to the patient, most people now do a written physical assessment because you can access it! (RN)

Expanded scope for RNs seems to imply a shift toward appropriate delegation or negotiation of the patient assignment with LPNs and supervision of unregulated workers or HCAs:

> I have to rely on that LPN to come to me and tell me that something's going on, otherwise I don't know! So I need to have somebody there who's competent and confident in their decisions and [to trust] that they will come and say "I think there's something going on." (RN)

RNs were also required to assume more responsibility for coordination of the multidisciplinary team, ensuring timely discharge of the patient to the community. However, many participants did not want to let go of their responsibilities for working directly with the patient and family:

> We're responsible for these patients and they're pulling us further and further away from them so we're not able to see them. You learn a lot spending time at the bedside, more time at the bedside with a patient. (RN)

> One of my fears is if we do move away from the bedside too much, how much am I going to be able to guarantee that what I want my patient to be having done for them is being done? (RN)

These two RNs are expressing concerns about the quality of care when less educated nurses or HCAs provide more nursing care. Overwhelmingly, our participants appreciated the help with personal care (morning care and evening care) they received from HCAs. However, some participants also expressed concerns about trusting the HCAs:

> Am I able to trust, that the RCAs are doing what I'm expecting them to do? And so because of that experience, that makes me nervous, a little bit, it honestly does. (RN)

> We're trusting that the care aids have reported to me anything that they're concerned about and some are reliable to do that and others, not so much. (RN)

Discussion of Textually Mediated Discourses Organizing the Nurses' Work

In this section of the article, we discuss more explicitly some of the textually mediated discourses that were organizing the nurses' work in these two community hospital settings. When possible we try to *trace up* this discourse into the regulatory or other documents that were influencing the nurses' embodied work. Dorothy Smith refers to these overarching documents as "boss texts" (Smith & Turner, 2014). After exploring some of the institutional texts that framed the introduction of unregulated care providers, we discuss some of the texts that are structuring nurses' "scope of practice" negotiations. We then explore how institutional work processes that reorient nurses' work toward timely discharge subordinate the nurses' work of caring for patients, and briefly revisit functional care delivery model discourses. We offer suggestions for nursing practice, leadership and for further research.

Introducing Unregulated Care Providers or HCAs

To understand how the institutional texts framed the introduction of HCAs, we analyzed a health authority document titled "Moving to Team Care: Introducing HCAs," which outlines the roles of the health care team and the HCA:

> Having HCAs as part of the care team means that patients have dedicated staff on units to help them with their daily care needs.

> HCAs are able to spend this time with patients. They really get to know them. They see changes in how a patient is feeling, whether better or worse, and they have a really good [*sic*] sense of what is important to the patient. HCAs are then able to communicate this to the rest of the care team.

> Moving to team care gives everyone a chance to focus on how all team members communicate with each other. It also allows nurses and other healthcare staff to focus on things such as care planning, patient education and communication with families, while HCAs are looking after the patient's basic needs. (Island Health, 2014a, p. 1)

What has become more explicit within changing care model initiatives is the repositioning of unregulated providers (such as HCAs) as those individuals who note changes in patients' health status and communicate their concerns to RNs and LPNs.

Furthermore, the Ministry of Health's (2016) position paper supporting development of a single regulatory body for RNs and LPNs, and introducing HCA regulatory oversight into the Health Professions Act notes the role of the HCA:

> HCAs are front-line care providers whose work falls along the nursing continuum, as they provide basic nursing care, such as personal hygiene, dressing, feeding and medication assistance, to seniors and other adults in a variety of settings. Their work is usually directed and supervised by nurses, but HCAs may also be directed and supervised by other health care professionals such as physical therapists, occupational therapists, and registered dieticians. (p. 5)

Questions arise within the changing roles of RNs, LPNs, and HCAs as to whether the personal care HCAs provide for patients is, or is not, nursing care. As noted above, RNs and LPNs assist with this care when they have time; however, personal care or body work is considered HCA work when the HCAs are on shift. This raises significant questions for nursing leaders, including those in educational and regulatory realms, about the implications of body work (and assumptions around the skill required for this work) being situated as nursing or nonnursing work.

Providing personal care is a way of creating intimate, emotional social contact between nurse and patient; however, nurses may be uncomfortable with providing this care. Van Dongen and Elema (2001) noted how there is significant ambivalence among nurses surrounding artful touching of patients, as "bed and body work, intimate human contact is often devalued" (p. 162), and bodies are instead treated in "professional," distanced ways. In care hierarchies, the value placed on nurses and nursing care also reflects the value placed on personal care/touch of patients:

> The educated nurse seems to specialize in "high-tech" nursing, leaving the personal, intimate touch to nursing aids, who are not educated in the art of touching but in the technical aspects of body care. (Van Dongen & Elema, 2001, p. 156)

Thus, questions arise as to whether nurses are enacting institutional discourses of the technical, detached nurse, as reinforced through the division of tasks and the categorical nature of teamwork. Nurses may also believe that HCA work

is not nursing work, yet institutionally we have seen that the HCA role is positioned as one along a nursing spectrum. These texts suggest that nursing knowledge and/or skill would underpin the HCA role.

Scope of Practice Defined by Tasks and Functions

From the analysis of working to full scope discussed above, we traced up to prevailing discourses that nurses enact in their every shift work. This language traced up to regulatory documents, particularly those published by the College of LPNs of British Columbia (CLPNBC; 2016), for example, from a document titled "Scope of Practice for Licensed Practice Nurses":

> LPNs care for clients at all life stages. They provide health care services for the: a) promotion, maintenance and restoration of health, with a focus on clients with stable or predictable states of health b) prevention, treatment and palliation of illness and injury, with a focus on stable or predictable disorders and conditions, primarily by: assessing health status, planning, implementing and evaluating interventions and coordinating health services. (p. 3)

RNs currently care for the majority of patients who are unstable or deteriorating in these two hospital settings, although this document also suggests that LPNs with additional training and/or experience can provide nursing care for more complex patients.

The discourse of practicing to *full scope* is more frequently referenced in terms of LPN work. For example, job description documents for the health authority list acute care job titles for LPNs as "Licensed Practical Nurse, Full Scope." These texts state that the LPN "performs assessments, plans and provides personal care, and performs nursing procedures" (Island Health, 2016, p. 1). The job description for LPNs working in residential care is titled "Licensed Practical Nurse, Residential Services," and describes LPN work as "provid[ing] care to complex but stable residents/clients; performs assessments, plans and provides personal care, and performs nursing procedures" (Island Health, 2016, p. 1). The absence of reference to "stable residents/clients" in the acute care posting may suggest that further changes in LPN scope are in motion.

D'Amour, Dubois, Déry, and Clarke (2012) identified six core dimensions of the RNs "full scope" of practice: assessment and care planning, health teaching, communication and care planning, integration and supervision of nursing team members, safety and quality of patient care, and current knowledge utilization (evidence-based practice). Building on this work, Déry, D'Amour, Blais, and Clarke (2015) have studied the influences on and outcomes of RNs' enacted scope of practice. These authors recommended building nursing care delivery models around the professional responsibilities of the RN. Another, possibly more productive way of thinking about nursing work involves investigating "full nursing potential" (Aroke, 2014).

The RN job postings (Registered Nurse, General Duty Nurse) do not reference full scope in the RN job descriptions (Island Health, 2016). Thus, while the LPNs' scope is undergoing change (as is their education) to broaden their practice (and they are encouraged to work to *full scope*), there is little talk about encouraging or supporting RNs to simultaneously work to their full scope of practice. Rather, we see a reorientation of their scope and responsibilities toward team leading, care coordination, and discharge planning. Our participants raised many concerns about the difficulties they experienced doing this work without the particular knowledge gained from some level of direct care provision. However, as we shall explore in the next section, this moment-to-moment and shift-to-shift care planning work was being subordinated to the institutional priorities related to patient flow and timely hospital discharge.

Reorienting Nurses' Work Toward Timely Discharge

A number of changing work processes were identified as shifting the RNs' work away from focusing on caring for the person in hospital and toward coordinating the health care team.

As part of our analysis, we mapped how nursing work was being reoriented toward patient flow and discharge (see Figure 2). This kind of mapping is commonly used in an IE analysis to show how work is textually mediated to accomplish institutional goals. Revealed in this map is the introduction of structured multidisciplinary team reports that were oriented to timely discharge.

Change of shift reports had also recently been replaced with brief written reports, and other creative "work arounds" were used, such as erasable whiteboards to ensure that the patient assignment was appropriate and the nursing unit staffed appropriately. Nursing care planning activities were being replaced with Structured Multidisciplinary Team Reports. We observed that the nurses' role in these reports focused on care coordination and ensuring timely mobilization of other professionals (such as physiotherapists and occupational therapists) to avoid discharge delays.

RNs, and sometimes LPNs, were being pulled away from direct care and replaced by HCAs, as the "eyes and ears" of the nursing team. What is missing is consideration of how direct nursing care provision informs other dimensions of RN practice. One wonders how care planning, safeguarding, and supervising the care team can operate without particular knowledge of the patient and their unique situation. Although prepared for a full scope of nursing practice through baccalaureate education, institutional work processes reorient the RN's work in ways that reflect institutional priorities, such as coordinating efficient flow

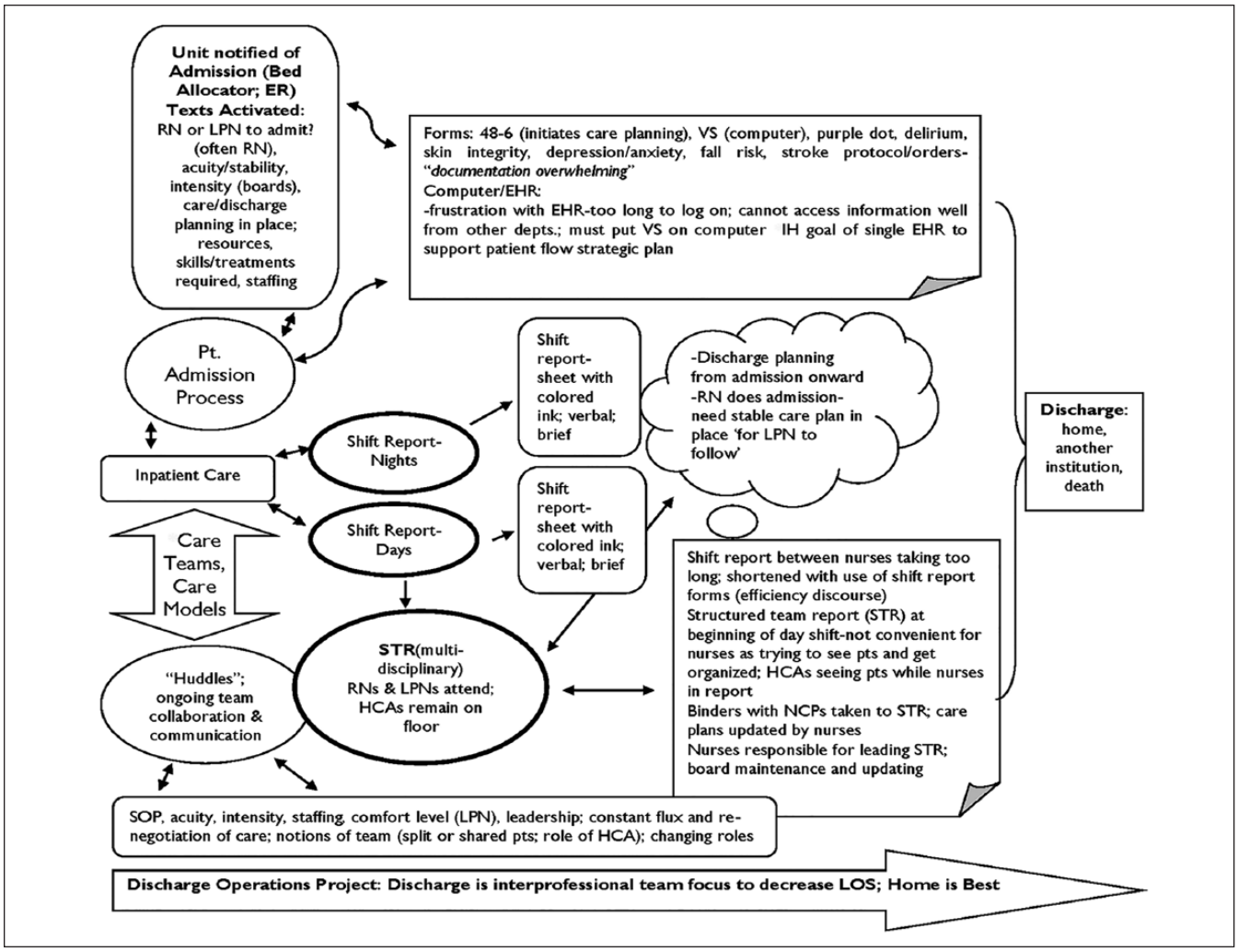

Figure 2. Nurses' discharge/care planning work.
Note. RN = registered nurse; LPN = practical nurse; HCA = health care assistant; STR = structured team report; VS = vital signs; EHR = electronic health record; LOS = length of stay; SOP = scope of practice; NCP = nursing care plan.

processes and discharging the patient back to the community in a timely way. The RN's work of promoting a safe transition home and ensuring that community resources are put in place to prevent readmission become secondary considerations that warrant further study.

We also wondered about the place of LPNs in complex and high-acuity health care environments. There may be settings where stable and predictable patients cannot be "decanted" to a separate unit, and may be cared for most appropriately by an LPN and HCA. This analysis has also led us to identify the need to examine the effects of educational models where LPNs learn to care for more complex patients and families (Butcher, MacKinnon, & Bruce, in press). CDMR was intended to allow professionals, including nurses, to have more time at the bedside for patient education and to "use their skills to assist patients to achieve their goals" (Stevenson et al., 2012, p. 18). We have documented the unintended consequences of the discharge operations project that was implemented in our settings.

We have observed that many RN job postings are for highly specialized acute care units rather than for these more "generalist" high-acuity units. However, despite increased enrollment in baccalaureate RN programs, not all new RN graduates are finding employment in nursing. We have also explored how management discourses of "job-ready" nurses, "flexible workers" with "blurred" scopes of practice are organizing RNs' and LPNs' experiences of learning to work together in intraprofessional teams (Butcher et al., 2017). These textually mediated discourses deflect attention away from the economic drivers that require the "optimization" of nursing staff-mix ratios (Rudge, 2015). Economic considerations for health care sustainability, although important, should not subordinate the nurses' work of safeguarding (MacKinnon, 2011), or result in fragmented and task-oriented divisions of nursing care.

Functional Care Delivery Models

The stated goals of CDMR retrieved from the Health Authority website were to (a) improve patient care quality and safety; (b) optimize the roles, scope, and functions of care team members; (c) increase productivity; and (d) avoid costs (e.g., overtime, injuries). While the goals of avoiding costs and increasing productivity are not specifically within nurses' professional or disciplinary goals, these institutional goals not only mediate how RNs and LPNs work together but also subordinate holistic standards of nursing care toward fragmented, task-oriented, divisions of care.

Furthermore, the nursing shortage has been part of the rationale for reintroducing highly stratified functional and skills-based approaches to the delivery of nursing services in Canadian acute care hospitals. Understanding where this shortage exists—for example, in rural, northern, and underresourced settings globally—is important for workforce and educational planning. McIntyre and McDonald (2014) suggested,

> Increased workloads and work overload, higher patient acuity and care complexity, and increased job insecurity in the workplace have had an overwhelming effect on how nurses experience their work. The impact of the issues that arise from the nature of nurses' work can be seen in the way nurses care for their patients and ultimately contributes to both the quality of the workplace and the quality of the care that they provide. (p. 305)

Investigating the social organization of the nursing shortage as multiple problems that relate to nurses' work environments, working conditions, and opportunities for professional advancement is warranted.

Management discourses suggest a shift from staff-mix to skill-mix or functional care delivery models (D'Amour et al., 2012; Dubois & Singh, 2009). In a mixed-methods study from another Canadian province, Roch, Dubois, and Clarke (2014) identified the influence of workload on nurses' caring practices. Conflict and role ambiguity led to RNs delegating direct care to other members of the nursing team (LPNs and HCAs). However, other aspects of organizational climate, and both nurse and patient characteristics were important considerations. These researchers concluded that "RNs' roles in interacting with patients must be recognized and strengthened without compromising either the quality of care or nurses' well-being and professional satisfaction" (Roch et al., 2014, p. 238).

Further study is also required to enhance our understanding about how to better support nursing students and new graduates who are learning to provide professional nursing care in high-acuity patient care environments. Reports of new graduate nurses' work experiences in these settings have been troubling and may reflect recent changes in nursing work environments (Duchscher, 2009; Sedgwick & Pijl-Zieber, 2015). We have not examined specialty practice in this study, so cannot comment on the impact of the introduction of team nursing care delivery models in highly specialized work settings such as neonatal intensive care. However, the complexity of care on the high-acuity multispeciality units we studied may not be less demanding from a professional nursing practice perspective.

Care delivery models that support professional nursing practice and provide opportunities for personal and professional development are required. We encourage those redesigning nursing care delivery models to actively involve nurses working at the point of care to introduce changes that respect nursing knowledge, support clinical reasoning in particular practice situations, and promote lifelong learning (Butcher & Bruce, 2016; Thompson, Aitken, Doran, & Dowding, 2013).

As with all qualitative and exploratory research, we are unable to generalize findings from the research to other areas and institutions, as the recruitment strategy is purposive rather than random. However, institutional ethnography allows mapping of textually mediated discourses and work processes that people draw on and enact in their everyday work. Texts function in ways that coordinate people's actions across time and setting. Readers will need to decide if the study findings help them understand how work is organized in their particular institutional context.

Summary and Conclusion

This study focused on the social organization of nursing work in two community hospitals where a stratified functional team nursing model (CDMR) was introduced, the scope of practice for LPNs expanded, and unregulated health workers added to the nursing care team. RNs were responsible for providing nursing care for the most acutely ill and unstable patients while responsible for mobilizing the intraprofessional team (including physiotherapists, dieticians, and occupational therapists) and coordinating care to ensure timely patient discharge. LPNs were responsible for identifying when the patient outcome was not predictable, and for transferring care to an RN when the patient was deteriorating or no longer in their "comfort zone."

Acuity and predictability discourses related to scope of practice were organizing nursing work in ways that lead to switching patient assignments during a single shift and frequently over one patient's hospital stay. Similar to the benefits of staffing with educated nurses, the impact of discontinuity of care on patient experience, patient safety, and health outcomes has been extensively studied (Institute of Medicine, 2000). Care hierarchies also result in knowing patients and families in fragmented ways, and increase the potential for fractured communication (Caspar, Phiney, Ratner, & MacKinnon, 2016).

Although CDMR and similar team approaches may be effective in particular contexts, they may be less so in fast-paced, rapidly changing nursing situations. We have shown how the team-based functional care delivery model subordinates holistic standards of nursing care and reorients nursing work toward fragmented, task-focused, and impractical divisions of care. Our analysis also documents an increasing

focus on tasks and skills as a way to differentiate between categories of nurses and a shift away from professional nursing practice models.

Not all of these difficulties arise from CDMR but rather are consequences (some likely unintended) of the intersection of multiple discourses that affect our understanding of nursing work, professional education, and the best ways to organize health services during times of anticipated shortage of nurses both real and imagined. We would very much appreciate continuing the dialogue about these important nursing issues and invite all nurses into this important conversation about the social organization of nursing practice in community hospitals.

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Notes

1. In Canada, practical nurses are known as licensed practical nurses (LPNs) in Western Canada and registered practical nurses (RPNs) in Ontario. As this study was conducted in British Columbia, we use practical nurses or LPNs.
2. *Standpoint* is a common mode of experience. Taking up a person's standpoint as a place to begin locates the knower in her body, in a lived world that avoids the theory/practice split.
3. Textually mediated social relations are written and replicable sites of actions where organizational priorities and control get coordinated across sites of action.
4. Work is something that people do that requires some competence and effort. Work is anchored in material conditions and done in real time (Smith, 1987).
5. "Decanted" is an example of an institutional discourse that was being used as a conceptual resource by one of the participants in our study. In this context, the language implies that older patients awaiting placement in long-term care are transferred off this high-acuity unit to a unit where they are cared for by LPNs and HCAs (health care assistants).
6. Here, workful literally means "full of work."

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