# The Role of the Practice Consultant in Addressing Professional Practice Issues in Nursing: An Integrative Literature Review and Preliminary Development of a Toolkit

By

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**Supervisory Committee**

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**Abstract**

A Professional Practice Consultant provides leadership and guidance around matters of nursing practice. Practice Consultants are called upon to provide support to nurses and to their leaders who work in practice settings by clarifying professional standards of practice, examining issues related to role, scope, and function, and making recommendations that sustain high quality learning and practice environments. Often Practice Consultants are asked for input and advice on difficult practice issues and they offer a unique evidence-informed perspective on practice and/or challenging and complex practice issues. Despite the role being in existence for nearly a decade within British Columbia (BC) Health Authorities, there are still variations in how Practice Consultants carry out their work and inconsistencies in how nurses and their leader's access practice consultation services. A preliminary search for literature also revealed that there are seemingly limited resources and tools to currently guide consultation work.

This project focuses on the role of the Practice Consultant in addressing professional practice issues in nursing. An integrative literature review methodology was utilized to illuminate the current professional practice issues in nursing across Canada, in order to inform the development of a framework for resolving such issues. Additional recommendations for the development a toolkit to further support the work of the Practice Consultant are highlighted and recommendations for further inquiry and research are posed.

*Keywords:* professional practice, practice consultant, professional practice leader, and practice issue

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***The aim of education is to teach us how to think not what to think.***

Author Unknown

# The Role of the Practice Consultant in Addressing Professional Practice Issues in Nursing: An Integrative Literature Review

## Part 1: Focus of the Inquiry

The Professional Practice Consultant provides leadership and guidance around matters of nursing practice. This project relates to exploring the role of the Practice Consultant in addressing professional practice issues in nursing using an integrative review methodology. Through this exploration there is an opportunity to illuminate the significant issues that impact nursing practice across Canada and improve upon processes for addressing such issues by developing a consistent, standardized framework for practice consultation work. To guide the reader through this project, this paper has been divided into seven sections: focus of the inquiry, approach to the inquiry, application of the steps of integrative review, relevance of findings for nursing and nursing practice, project limitations, dissemination/ knowledge translation, and summary and conclusions.

### Background and Overview of the Issue

Professional practice is a broad conceptual term that has multiple and personal meanings for health professionals. According to faculty at the University of Alberta, professional practice or professionalism can be defined as “a decision to acquire and exude knowledge and skills in a chosen field” (Faculty of Graduate Studies and Research, University of

Alberta, nd). The Canadian Nurses Association (CNA) describes professional practice as encompassing registration and licensure, values, entry-level competencies, educational preparation, scope of practice, and continuing competence and development of expertise (2007a). CNA states that the nursing profession has been granted the privilege of self-regulation and in return they are expected to act in the best interest of the public and individual nurses are expected to be safe, competent, and ethical practitioners. Lankshear's definition of professional practice within nursing is " the utilization of specialized knowledge combined with the ability to exercise legitimate control over practice in order to provide collaborative, ethical, client centered care" (2011, p. 134).

In an effort to integrate professional practice into the Vancouver Island Health Authority (VIHA), the Professional Practice department was established in the fall 2000, when the first Chief Nursing Officer (CNO) was hired in the province of BC (Cooke, 2001). Creation of the Practice Consultant role came shortly afterwards in 2001. The Professional Practice Office in VIHA was established to address two challenges facing the health region at that time: supporting nursing and allied health professionals to provide safe, competent, and ethical person-centred care, and attracting and retaining competent professional staff that are highly engaged and feel valued within the organization (Cooke, 2001). Despite the changes and evolutions that have occurred over the past 12 years, the mandate of the Professional Practice office in VIHA remains congruent: "To develop, coordinate, integrate, and support strategies that enable professional disciplines and program staff to deliver safe, competent, ethical person/ patient focused care" (Cooke, 2001, p.7).

Establishment of similar offices within the other Health Authorities across BC further paved the way in demonstrating commitment to professional practice through infrastructure and resources; namely human resources. Northern Health (NH) established their Professional Practice Consultant position in 2003, (A. Stark, personal communication, June 3, 2011), while Fraser Health (FH) and Interior Health (IH) Authorities both established their Professional Practice departments in 2004 (J. Fraser, personal communication, June 5, 2011; M. Adamack, personal communication, June 6, 2011). The role of the Practice Consultant varies somewhat between organizations across Canada in terms of how it is enacted but functions of the role are essentially the same. Alternate titles noted in the job descriptions for this role include: Professional Practice Leader, Nursing (St. Joseph's Health Centre, 2011), Professional Practice Consultant, Nursing (Eastern Health, 2010), Clinical Practice Consultant (FH, 2010), Professional Practice Lead (NH, 2010), and Regional Practice Leader (IH, 2005). For the purposes of this project, I will refer to the role as Practice Consultant (Providence, 2011; VIHA, 2011).

The individual in this system-level position collaborates with a wide range of people and groups, both internally and externally to develop, manage, and communicate region-wide strategic and education initiatives. Practice Consultants support leaders and staff through promoting quality evidence-based practice, and monitoring and evaluating the scope and standards of clinical practice, with the goal of safe, ethical, quality health outcomes for patients, clients, and residents (Providence, 2011; VIHA, 2011; FH, 2010, NH, 2010, IH, 2005). This broad description encapsulates the far-reaching and diverse nature of the role from leading strategic initiatives and programs, to providing education on various topics, and supporting managers and leaders in their work. As one can imagine, obtaining a level of

expertise as a Practice Consultant requires achievement of a wide range of competencies, including knowledge of current and emerging practice issues and trends. Several BC Health Authorities have outlined in their role descriptions that it is an expectation of the role to have a strong knowledge of the health care system and the current issues that affect professional practice (Providence, 2011; VIHA, 2011; FH, 2010; IH, 2005).

While some Practice Consultant roles are concerned specifically with the practice of Nursing (Eastern Health, 2010; NH, 2010), other Practice Consultant roles are utilized to support practice across broadly various disciplines or professions (Providence, 2011; VIHA, 2011; FH, 2010; IH, 2005). This broad scope reflects the understanding that these practice consultants draw upon and apply their understanding of the construct of professional practice and use their unique knowledge regarding scope and standards of practice, in addressing wide-ranging practice issues as they pertain to different disciplines. For the purposes of this project, I will be focusing specifically on the role of the Practice Consultant in addressing nursing practice issues.

Since inception of the role in VIHA, the Practice Consultant focus has evolved and changed, particularly in response to organizational need to better understand and address legislative and regulatory changes. Practice consultants are called upon to provide support to nurses and to their leaders who work in practice settings by clarifying professional standards of practice, examining issues related to role, scope, and function, and making recommendations that sustain high quality learning and practice environments. Often Practice Consultants are asked for input and advice on difficult practice issues and they offer a unique evidence-informed perspective on practice and/or challenging and complex practice issues that is

different from other system-level positions in the organization (e.g. Human Resources, Quality Improvement, and/ or Occupational Health & Safety perspective). Compilation and critical appraisal of all types of evidence (research and non-research) is essential to inform practice (Newhouse, Dearholt, Poe, Pugh, & White, 2007). The Practice Consultant draws on various sources of evidence found internal and external to the organization. Sources of evidence include but are not limited to: peer-reviewed literature and research, relevant legislation and regulation, professional and clinical standards, subject matter expert opinion, and client preferences (Newhouse et al., 2007).

In a published journal article that addresses the Practice Consultant issue from a pan-Canadian perspective, the authors cited that professionals new to the consultant role reported not always being clear about how to approach the work (Lankshear, Laschinger, Kerr, 2007). Mathews and Lankshear further reported that although practice leaders from varied organizations were addressing similar types of practice issues, their approaches were wide-ranging (2003). Despite the role being in existence for nearly a decade within BC Health Authorities, the findings of the national study are congruent; given Practice Consultants across BC informally report that there are still variations in how Practice Consultants enact this role and how health professionals and leaders utilize the role and access practice consultation services. Health care professionals and leaders locally have expressed uncertainty with regards to how the role can benefit them or what issues they can take to a Practice Consultant. Based upon personal conversations with Professional Practice Consultants across the province, it has become apparent to me that consultation processes in our region are generally informal and/ or are not well established, (A. Stark, personal communication, June 3, 2011; M. Adamack,

personal communication, June 6, 2011; A. Swalwell-Franks, personal communication, June 27, 2011), with the exception of the Fraser Health Professional Practice Office, that has begun to develop a process to support the work (A. Wolff, personal communication, June 28, 2011).

It is also evident that there are limited resources and current tools to guide practice consultation work. This, seemingly, has led to inefficiencies and duplication of the work of the Practice Consultant. For example, the consultant may field a call regarding a particular aspect of nursing practice and if that same issue was raised to the same or another consultant in six months' time the second consultant may be unaware or unable to locate how the issue was addressed previously. As a result, the consultant would have to re-work through the issue and possibly end up re-creating resources. The approach taken when reviewing a practice issue also likely varies between practice consultants depending upon their level of experience, clinical background, and understanding of their role. This could lead to incongruence for how issues are addressed and may confuse practice leaders and practitioners when seeking advice, and thus it illuminates an opportunity to improve upon processes for addressing practice issues by developing a consistent, standardized approach to consultation work.

**Review of the Relevant Literature**

It is recognized in the literature that the term "professional practice" is not well defined and there is a certain level of ambiguity regarding the definition and associated characteristics and attributes of this concept (Lankshear, 2011; Mathews & Lankshear, 2003; Pearson et al., 2006). If one is not clear on the concept and what the expected behaviour is, then it becomes

difficult to measure whether or not someone is demonstrating the behaviour. Lankshear (2011) noted that this lack of common understanding is not due to an absence of theoretical or empirical literature on the topic as her review of the literature revealed characteristics commonly used to define a profession and the impact of context (such as organizational structures and roles) on the professional practice of nursing. As a result she was able to articulate professional practice in health care as "those professional activities and behaviours that are operationalized for the purposes of providing optimal effective and efficient patient care" (p. 42). Her synthesis of the literature revealed five attributes of professional practice: Self-regulation, knowledge-based activity, autonomy and control over practice, collaborative relationships, and a demonstrated commitment to patient care. These core attributes were compiled into what Lankshear defined as a Professional Practice Concept Map (see Figure 1).

Having originated from constructivism, whereby constructivists believe that learners actively construct knowledge, the concept map is a way to visually represent ideas, images, or words, and highlight emerging knowledge (Novak, 2010). Lankshear's five core attributes will be addressed later in this paper as they were used as the basis for categorizing professional practice issues, given these attributes provide a common foundation that can be applied to the dynamic nature of professional practice in nursing and address the wide ranging contexts in which nurses operationalize professionalism (2011).

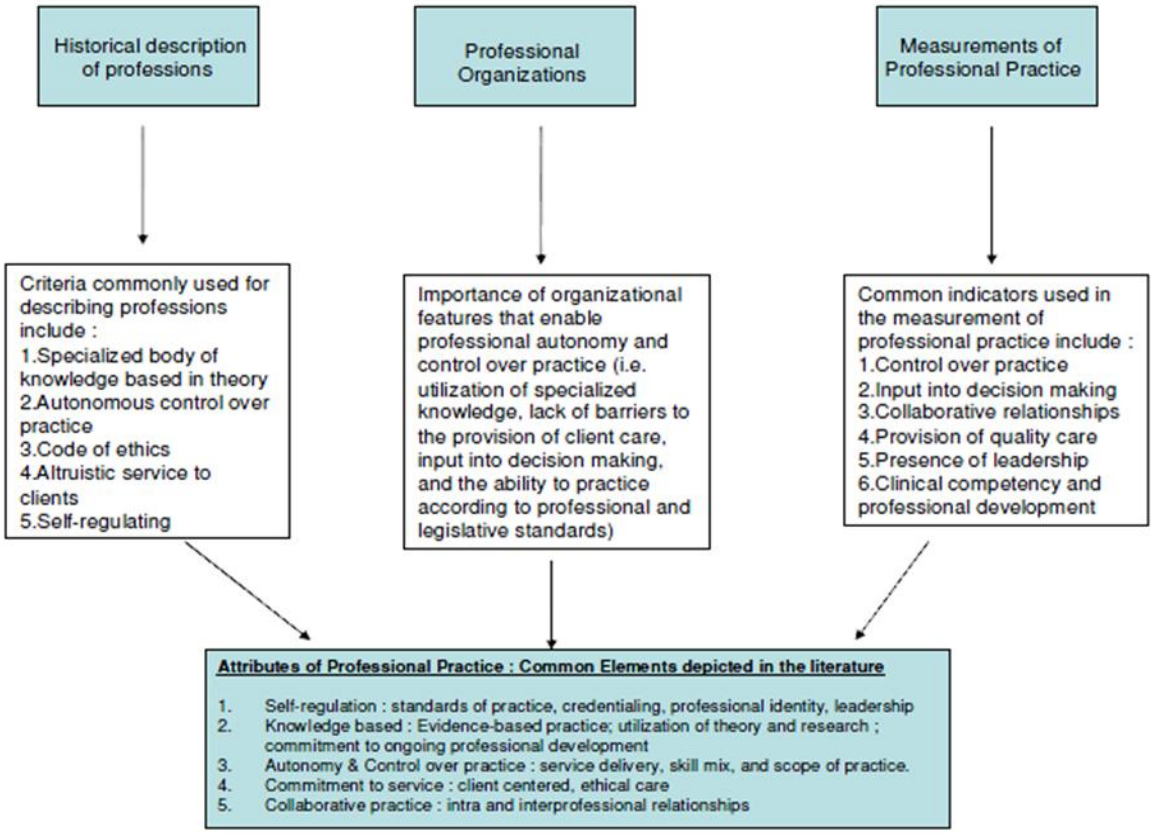


*Figure 1 – Professional Practice Concept Map (Reproduced with permission. Lankshear, 2011)*

The Registered Nurses Association of Ontario (RNAO) define professionalism as "qualities or typical features of a profession or professional; a collection of attitudes and actions" (p. 58, 2007). Through their extensive review to develop a best practice guideline on professionalism in nursing, the RNAO identified a number of attributes that collectively describe professionalism which are congruent with the concept map of professional practice, developed by Lankshear (2011). Having a unique or specialized body of knowledge was a common theme emerging in the literature to describe the hallmark of a profession as well (Mensik & Martin, 2011; Williams, 2001). How professional practice is enacted is often linked with the context or

structures that are in place to support professionals to optimize their roles and yield the best outcomes (Ritter-Teitel, 2002).

In an effort to acknowledge and incorporate a holistic nursing philosophy of care into the practice environment, organizations developed professional practice models in order to guide nursing care delivery, with the goal of empowering nurses and ultimately improving the quality of care provided (Baumann et al., 2001). It is also believed that professional practice models were introduced to address certain issues experienced by health care professionals, such as issues related to role clarity, scopes of practice, and accountability (Mathews & Lankshear, 2003). A number of frameworks or models have been cited in the literature to support nurses as they carry out their role and provide care in a variety of settings. Dickoff and James define a conceptual model or theory as "a set of concepts that are interrelated into a coherent whole and a set of propositions" (cited in Meleis, 2001, p. 150). Conceptual frameworks, models, and theories are terms often used interchangeably which causes confusion and some debate regarding what is appropriate. Rodman submits that conceptual frameworks are more abstract than theories, while Fawcett suggests that a conceptual framework is the stepping stone towards development of a theory (cited in Meleis, 2007). Ritter-Teitel defines a model of care as being "a configuration of nursing practice or a pattern for delivery of care" (2002, p.36). She also describes the various changes that have influenced professional nursing practice over the past fifty years as a result of the changes in patient care delivery systems or models: from the team nursing model of the 1960s, to primary nursing care in the 1970s, and to care and service team models in the 1990s.

In addition to a professional practice model or structure to support practice, the role of the Professional Practice Leader is deemed essential for fostering and enhancing professional practice (Mathews & Lankshear, 2003). Despite the prevalence of the role of the Practice Consultant, otherwise known in the literature as Profession Leader, Professional Practice Leader, Practice Developer, and Regional Practice Lead, within health care institutions, there is very little written about this role and what impact this role has on practice within the published literature (Chan & Heck, 2003; Comack, Brady, Porter-O'Grady, 1997; Lankshear, 2011; Lankshear et al., 2007; Miller, Worth, Barton, & Tonkin, 1999). There is also much variability for how the role is implemented and enacted but despite this, the role is commonly described as being responsible for the promotion and maintenance of standards of practice for discrete professions (Bournes & DasGupta, 1997; Lankshear, 2011; Miller et al., 1999).

While the role of the Practice Consultant is known to have been implemented within British Columbia just over a decade ago, (Cooke, 2001), the role of the Professional Practice Leader was implemented in Eastern Canada in the early to mid-1990's, in response to organizational restructuring and the movement towards a program management organizational structure (Adamson, Shackleton, Wong, Prendergast, & Payne, 1999; Bournes & DasGupta, 1997; Chan & Heck, 2003; Comack, Brady, Porter-O'Grady, 1997; Miller et al., 1999; Ritter-Teitel, 2002; Ross, MacDonald, McDermott, & Veldhorst, 1996). This response was initiated to address the concerns raised by professionals regarding a lack of professional identity and ensuring the professional voice was present in organizational decision making. By 1999, the Professional Practice Network of Ontario was established, providing a forum for leaders to communicate and collaborate on matters pertaining to professional practice (Professional

Practice Network of Ontario, nd). This network has continued to grow into an incorporated entity that offers leadership and guidance for professional practice leaders from Ontario and parts of Eastern Canada.

Noting that the Practice Consultant or Leader role might be impacted by the lack of a theoretical framework to guide implementation of the role, Lankshear et al., examined role descriptions for nursing leaders across 20 institutions within Ontario, to demonstrate the applicability of Kanter's theory to professional nursing practice (2007). Kanter's theory of organizational power describes power as being achieved through formal sources (e.g. job role and functions) and informal sources (e.g. peer alliances), as well as through sponsorship (cited in Lankshear, 2011). Sponsors provide a key alliance and it is simply through the relationship that power is attained and access to information and decision-makers not otherwise available is obtained. An example of sponsorship might be the relationship a Practice Consultant has to the Chief Nursing Officer (CNO); often an executive level position and the 'ultimate' practice leader. Laschinger stated that individuals who have greater access to power structures within their roles have a greater opportunity to achieve organizational goals and empower those around them (cited in Lankshear et al., 2007). This would position the Practice Consultant/ Leader well to promote a positive professional practice environment and ultimately foster improvements to quality and care. While poised to play a vital role in cultivating nursing practice, Practice Consultants need to keep abreast of what issues are most prevalent in nursing, and how they may be able to contribute to resolving any problem issues. Learning what the practice issues are and how best to facilitate the role of the Practice Consultant in making a difference to nursing practice is the focus of this project.

**Purpose/ Objectives of the Project**

The purpose of this project is to explore and better understand what the current practice challenges are for nurses across Canada and to develop a framework to guide the Practice Consultant in enacting a consistent approach and process when addressing practice issues or concerns for nursing. Creating a better understanding of the issues will facilitate an appreciation for what is required of the Practice Consultant role to successfully assist in addressing such issues.

The College of Registered Nurses of BC define a practice problem as being a problem or situation that interferes with meeting regulatory Standards of Practice, employer guidelines, policies, or other clinical standards, and poses a risk to patients (CRNBC, 2011a). In addition to identifying the nursing practice issues and developing a framework to guide practice consultations when addressing practice issues or concerns, I will make recommendations regarding the future development of a "toolkit" that will support enactment of the role and guide professional development in this role.

There are four project objectives:

1. Identify the current professional practice issues in nursing from across Canada;
2. Explore the implications for the Practice Consultant in relation to the professional practice issues in nursing;
3. Develop a framework to guide the practice consultation process in addressing nursing practice issues; and

4. Make recommendations for the development of a "toolkit" to support the Practice Consultant role and guide professional development within this role.

**Importance/ Significance of the Project**

This project will help to illuminate the current practice issues for nursing across Canada in one document. This has significance because it will provide important evidence for what areas of practice may need further attention and will provide the groundwork for further exploration in these areas. In addition the development of a framework outlining the key elements and processes to address professional practice issues will support the Practice Consultant team when responding to such requests in a standardized, consistent format. Further recommendations for a toolkit will also contribute to guiding and support the role.

**Philosophical and Theoretical Underpinnings**

The philosophical perspective guiding this project comes from the interpretive paradigm (Monti & Tingen, 1999). Influential elements of this paradigmatic perspective include the existence of multiple realities, the subjectivity of human experience, and belief that knowing results from multiple sources (Monti & Tingen, 1999).

In addition, I have chosen the educational theory of constructivism to guide my philosophical approach. Iwasiw et al. (2009) states that constructivism views all learners as being connected and knowledge as being constructed, and thus new learning is built upon

knowledge previously held by an individual. They further contend that "with exposure to new perspectives, current understandings are changed, and new knowledge is constructed to make sense of experiences" (p. 176). Belensky & Stanton (2000) describe the constructivist knower as someone who sees self and others as active constructors of knowledge who learn in multiple ways. This reinforces that there is no one single source of knowledge and the process of inquiry is about the journey or discovery of learning. The constructivist approach is particularly relevant due to the nature of the issues Practice Consultants address daily in the midst of new knowledge becoming available on a continual basis. Practice Consultants are also health professionals who bring many years of diverse clinical experience and knowledge with them to the role of Practice Consultant. They are often hired for their strong professional practice competencies and can draw upon this former knowledge when making meaning of new situations they confront from a consultant perspective. The interpretive and constructivist approaches both complement one another in this quest to better understand the Practice Consultant needs, as these approaches acknowledge the lived experience of others and how meaning-making informs understanding and construction of knowledge.

Further, as alluded to earlier, this project will be guided by the domains of professional practice highlighted by Lankshear in 2011. Through an extensive review of the literature Lankshear identified five Attributes of Professional Practice: self-regulation, knowledge based, autonomy and control over practice, commitment to service, and collaborative practice (2011, p. 134). Lankshear's attributes will be used to guide the categorization/ classification of practice consultation information identified in the compiled literature.

## Part 2: Approach to the Inquiry

### Methodology: Integrative Review of the Literature

The methodology that will guide this project is the integrative review approach as outlined by Whittemore and Knafl (2005). They indicate that this approach helps to build a comprehensive understanding of a particular phenomenon and is particularly useful for informing research, practice, and policy development. This particular framework was selected as it provides a structure for gathering a broad range of qualitative and quantitative findings and uses a narrative approach to rigorously and systematically synthesize findings (Polit & Beck, 2008). Whittemore and Knafl identify that the integrative review framework encompasses five stages including: problem identification, literature search, data evaluation, data analysis, and a presentation stage (2005). The problem identification stage involves clearly outlining the issue as this provides focus and sets boundaries for the review process. The literature search stage is a crucial stage that involves well-defined literature search strategies to enhance rigour and minimize bias. Whittemore and Knafl suggest that a comprehensive search for an integrative review ideally involves using two or three search strategies. For the data evaluation stage, it is appropriate to include both theoretical and empirical sources. Data analysis involves reduction, display, comparison, and conclusion components. For this project, tables were developed to organize, compare, and report the data findings. Lastly, the presentation stage is intended to be a culmination of the understanding of a particular phenomenon of concern and is often presented in diagrammatic form (Whittemore & Knafl, 2005). Each of the stages as they pertain to this project will be outlined in Part 3 below.

## Part 3: Application of the Steps of Integrative Review

This section will describe each of the five steps of the integrative review in more detail to highlight the process and rigour applied to this project and the findings.

### Step 1: Problem Identification

This project is intended to explore and better understand the practice issues experienced by nurses across Canada, in order to inform the work of the Practice Consultant. Utilizing the integrative review methodology developed by Whittemore and Knafl (2005), this project aims to inform the development of a framework to guide the Practice Consultant in enacting their role in relation to resolving practice issues. Further, recommendations for a "toolkit" to support the role will also be illuminated.

### Step 2: Literature Search

#### *Literature Search Criteria*

Primary sources of literature comprise of grey literature, including relevant Annual Reports from the Regulatory Colleges and Associations for Nursing across Canada, in order to gather and collate the nature of professional practice issues being reported, including prevalence, as well as any resources or tools that are used to support practice consultation processes and work. A literature search of published papers will also be conducted using a variety of electronic databases, including: The Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medical Literature On-Line (Medline), and Google Scholar. Search words

or phrases (or combinations of same) include: Practice Consultant, Clinical Practice Consultant, Practice Consultation, Consultant, Nurse Consultant, Professional Practice, Practice Issues, and Professional Practice Leader. The literature search will focus on articles published from 1990 – present and only articles that had been published in English and full-text will be used. The electronic search will be complemented by utilizing a second approach titled the "ancestry approach" (Polit & Beck, 2008, p. 109). This search strategy supports the review of citations from literature already located, in order to obtain additional relevant articles that can inform the project. In addition, job descriptions from the respective Health Authorities and/ or Health Agencies where Practice Consultants are employed will be included to inform the "toolkit" development recommendations.

***Literature Search Findings***

A total of 41 references were identified and utilized to inform this project. The literature gathered consisted of published and unpublished articles (n=23) using the search terms and processes defined previously (see Appendix A). While the actual search terms produced many more results (CINAHL - 431 articles; Medline - 326 articles; Google Scholar - 660), a significant number were excluded as they did not pertain to the focus of this project and/ or were not available in English or in full-text. The majority of the articles found in the search were a duplicate of one's found in the other databases used in the literature search for this project. In addition, grey literature, including Regulatory College and/ or Association annual reports for Nursing (n=9) were compiled (see Appendix B). Further grey literature was

sought (see Appendix C), in relation to resources that have been developed to aid in resolving practice issues (n=9). The materials were categorized and compiled into appendices.

**Step 3: Data Evaluation**

In terms of data evaluation, several data tables were constructed to organize the literature reviewed. One table containing relevant literature (published and unpublished) was established to gain clarity about various aspects of professional practice and included articles pertaining to professional practice roles and models. This table was organized to include content organized by citation, research type or methodology (if applicable), methods, findings or summary, and comments by reviewer (see Appendix A).

A second table consisting of two sections of information related to (1) reported practice issues and (2) practice consultations was compiled from Nursing Regulatory College and/ or Association annual reports (see Appendix B). Nine reports were available for review. This table included information regarding the date of the report and demographics. The number of practice issues reported as well as the nature and source of the complaints, and comparison to previous year was compiled in the first section. In the second section, information regarding the nature and number of practice consultations was also collected. A Professional Practice Concept Map encompassing the five attributes of professional practice: self-regulation, knowledge based, autonomy and control over practice, commitment to service, and collaborative practice, highlighted by Lankshear (2011, p. 134) served as the classification system for comparison of the various types of practice consultations noted in the reports. In

addition, an 'other' category was added to capture data that did not fit elsewhere. Lankshear's work resonated for me as a viable organizing structure, given the extensive review that had informed the professional practice concept map development. Her work highlighted and summarized the empirical and theoretical literature available regarding the concept of professional practice. She further acknowledged that there are not vast amounts of literature available regarding the Practice Consultant role, which validated my experience as well.

A similar process was followed in terms of reviewing the literature relating to resources and tools that could support the Practice Consultant role in addressing practice issues. A third table was developed to summarize the definition of a practice issue and to highlight the process steps identified in the literature with regards to resolving practice issues (see Appendix C).

**Step 4: Data Analysis**

Using tables to organize the data facilitated compiling the varied information into a comprehensive display in one location for ease of comparison and visualization for patterns and relationships. Whittemore and Knafl indicate that patterns and trends are much easier to discern from utilizing this method (2005). Once this information was compiled, emerging patterns were analyzed and guided the conclusions drawn in order to inform the recommendations for moving the project forward.

With regards to the literature compiled in Appendix A, it became apparent that a number of professional practice models are in existence and provide infrastructure to support

and guide practice (Girard, Linton & Besner, 2005; Hoffart & Woods, 1996; Wolf, 2000; Wolf, Boland & Aukerman, 1994a; Wolf, Boland & Aukerman, 1994b; Wolf, Hayden & Bradle, 2004). While many organizations embrace a professional practice culture, there is variability for how this is operationalized to achieve that culture and more research and empirical evidence is needed to demonstrate the key elements required to ensure professional practice structures are successful (Mathews & Lankshear, 2003).

In the study by Lankshear et al. (2007), promoting and maintaining profession-specific standards and promoting professional development were predominant activities for professional practice leaders. Interestingly, Baker in 1993 noted that these activities were also the greatest concern to professionals within a program management structure (cited in Lankshear, 2011). One Practice Consultant revealed that of the 1,063 calls her office received in a year, 97% of the calls came from nurses seeking advice related to their professional practice and/ or seeking resource materials to support their practice (Sigouin, 2001).

Overall, there seems to be congruency between the literature and the author's personal experiences of the Practice Consultant role as enacted in BC, regarding the responsibilities or area of foci for the Practice Consultant/ Leader roles. The Professional Practice Leader draws on knowledge from their own experience, as well as professional nursing practice documents, colleague expertise, and literature in being both proactive and reactive to professional practice issues that may impact the RNs ability to practice safely, competently, and ethically and to their full scope (Power, 2001). Support offered by the Practice Consultant is varied and examples noted in the literature and job descriptions developed to guide the role include: providing

internal expertise regarding scope of practice and regulatory requirements; providing consultation regarding professional competencies, credentialing, and standards of practice; providing assessment, advice, and education regarding professional practice matters; promoting evidence-based practice and professional development; and supporting leaders in addressing and resolving professional practice issues (Adamson et al., 1999; Chan & Heck, 2003; FH, 2010; IH, 2005; Lankshear, 2011; Lankshear et al., 2007; NH, 2010; McCormack & Garbett, 2003; Miller et al., 2001; Providence, 2011; Radwin, 2000; VIHA, 2011).

There is a strong consensus in the literature (see Appendix C) that defines a professional practice issue as any problem or situation that interferes with a nurse's ability to practice in accordance with regulatory standards of practice or code of ethics, workplace policies or guidelines, or other relevant legislation or standards, and thus poses a risk to patients/ clients (CRNBC, 2011a; College of Registered Nurses of Manitoba [CRNM], 2005; College of Registered Nurses of New Brunswick [CRNNB], 2009; College of Registered Nurses of Nova Scotia, [CRNNS] 2009; College of Registered Psychiatric Nurses of BC [CRPNBC], nd; Saskatchewan Registered Nurses' Association [SRNA], 2008; Yukon Registered Nurses Association [YRNA], 1997). Some would suggest that a professional practice concern is an issue that is beyond the ability of an individual nurse to resolve (CRNNB, 2009; CRPNBC, nd; SRNA, 2008; YRNA, 1997).

All provincial nursing regulatory bodies are directed by legislation that guides nursing practice. Nurses in British Columbia, Alberta, and Ontario currently come under the Health Professions Act (HPA), with Manitoba joining them by early 2012 (CRNM, 2011). Nurses in other provinces are still governed by the Nurses (Registered) Act. Self-regulation came about in

order to protect members of the public, and nurses maintain the public trust by adhering to their standards of practice as well as by upholding the ethical values of their profession (CNA, 2007b). CRNBC describes four levels of controls on registered nurses' practice: Regulations that set out the scope of practice in broad terms; CRNBC standards, limits, and conditions, which are intended to compliment and further define the scope of practice as articulated in the Regulation; Employer policies, which may further restrict an RNs practice within a particular agency or setting; and finally an individual RNs competence to enact the particular activity (2011).

In light of the HPA and the Nursing Act, all provincial Nursing Regulatory Colleges and/ or Professional Associations have some mechanism for individuals to report significant nursing practice concerns, as well as formalized processes for reviewing and addressing such issues. To inform this project, grey literature was sought from Nursing College and/ or Association annual reports for the reporting period of 2010 (see Appendix B). A total of nine provincial reports were available for review. Each of the reports noted the number of practice issues reported and the categories of issues identified, with some providing detailed information regarding the nature of those reports[1].

Initially, data were systematically and chronologically entered into the table as each report was reviewed. Once the information was down on paper, further analysis and refinement of categories for reported issues emerged over several iterations of the analysis process. Patton in 2002 described this process as a constant comparative method of analysis,

[1] It should be noted that the report from Quebec was only available in French. Although I have some experience reading French, I sought assistance from a French colleague to offer initial translation of the document and augmented this with use of an online language translation tool (Babylon, nd).

which converts extracted data into logical categories, thus facilitating illumination of themes, patterns, and relationships (cited in Whittemore & Knafl, 2005). A decision trail journal was maintained to document this process and the decisions and supporting rationale made at each subsequent review of the data, until the main categories were identified and final placement for the issues within the categories was concluded.

As a result of the analysis process, reported practice issues were eventually categorized according to four main categories: *Professional Incompetence, Professional Misconduct, Professional Incapacity,* and *Criminal Charges/ Convictions*. One example of a placement of an issue within a category was when the issue of "continuing competence" emerged upon reviewing the report from Saskatchewan (SRNA, 2010). While it could be argued that this section could be categorized under the Knowledge-based activity section, given it is a requirement of nurses to maintain professional fitness to practice through competency assessment and professional development, I placed it within the category of Self-Regulation, given this section is tied to registration. Continuing competence is an action of self-regulation and is very much linked to registration. Another example stems from reviewing the Nova Scotia report. They had "practicing without a license" as a stand-alone category but I placed it under professional misconduct to be congruent with what other provinces had done (CRNNS, 2010).

Employers were consistently identified as the primary reporter to the College or Association, followed by the public (patients or families), and then colleagues (co-workers) or others. While the majority of complaints were lodged by employers, it was noted that often time concerns originated with patients and/ or co-workers who then brought their concerns

forward to employers to address (NANB, 2010). Consistently across all reports, less than 1% of the overall total number of registrants had been reported for practice concerns during the 2010 reporting period, with the fewest being 0.11% (NANB, 2010), and the greatest number being 0.73% (Ordre des infirmieres et infirmiers du Quebec, 2010). While detailed reporting was not available in all cases, data that were available was analyzed and compared to illuminate patterns or trends related to the issues. Of the above categories noted, *Professional Misconduct* was found to have the most reported issues (n=519) across the provinces, with abuse, bullying, and harassment ranking the highest sub-category (n=56). This was followed by the category of *Professional Incompetence* (n=317), with the sub-category of lack of nursing assessment, planning etc. being the most reported issue (n=171). *Professional Incapacity* ranked third highest (n=112), with no sub-categories identified, and *Criminal Charges and Convictions* ranked 4th (n=65), with drug or narcotic abuse/ theft being the most reported sub-category (n= 43). A summary of the reported practice issues can be found below (Table 1).

| Reported Practice Issues | |
|---|---|
| **Professional Incompetence** | **317** |
| **Lack of nursing assessment, planning etc.** | **171** |
| Medication admin. practices | 45 |
| Consent Issues | 11 |
| Documentation | 29 |
| Practising outside of scope | 12 |
| Communication/ Interpersonal skills | 20 |
| **Professional Misconduct** | **519** |
| **Abuse, bullying or harassment** | **56** |
| Sexual abuse/ Harassment | 13 |
| Non-professional relationship | 13 |
| Slander | 1 |
| Mishandling of H1N1 vaccine | 7 |
| Breach of confidentiality | 11 |
| Failure to follow employer policies | 1 |
| Improper delegation | 2 |
| Patient abandonment | **11** |
| Unauthorized practice – not licensed | 22 |
| Failure to ensure patient safety | 5 |
| Falsified health records | **2** |
| Give contradictory advice | 1 |
| Breach of agreement | 2 |
| Unauthorized treatment | 1 |
| Breach of Act or Regulations | **5** |
| Conduct unbecoming a RN | 34 |
| **Professional Incapacity** | **112** |
| **Criminal Charges/ Convictions** | **65** |
| **Drug or Narcotic Abuse/ Theft** | **43** |
| Theft from a facility | 2 |
| Fraud/ Deceit/ Dishonesty | 2 |

*Table 1 – Summary of Reported Practice Issues*

When available, the number of reported practice issues was compared with the previous year's reports to look for trends or changes. Of significance, the College of Registered Nurses of Nova Scotia (CRNNS) reported a 163% increase in their numbers but total number of complaints in 2010 was consistent with the numbers of reports from other provinces having similar demographics (CRNNS, 2010). While the CRNBC's numbers were noted to be down from the previous reporting year (-7.9% variance), overall the number of complaints have more than

doubled since 2004, with the category of professional incompetence increasing by 107% in that same time period (CRNBC, 2010). Alberta's College has also seen an 82% increase in reporting since 2005, with issues such as workplace abuse, harassment, or bullying nearly tripling in numbers (College and Association of Registered Nurses of Alberta [CARNA], 2010). A number of reports also indicate that in addition to the new cases being reported annually, many cases require carry over to the next reporting year due to the increasing complexity and time it takes to review and appropriately address such issues (Association of Registered Nurses of Newfoundland and Labrador [ARNFL], 2010; CARNA, 2010; College of Nurses of Ontario [CNO], 2010; CRNBC, 2010).

The analysis process described above was repeated when reviewing the Nursing College and/ or Association annual reports (n=9) for the reporting period of 2010 (see Appendix B). Eight of the nine reports reviewed noted the number of practice consultations with which their agency had been involved as well as the nature of these consultations, in most cases. The five attributes of professional practice: *Self-regulation, Knowledge-based activities, Autonomy and control over practice, Commitment to service,* and *Collaborative practice*, highlighted by Lankshear, were used as the classification system for categorization and comparison of the types of practice consultations, (2011, p. 134). In addition to the five categories identified by Lankshear that are being used for the purposes of categorization and analysis of practice consultations, a sixth category titled "*Other*" was added to capture non-descript consultations identified in the reports that could not be easily captured under the other headings (e.g. "Professional Practice Issues" and "Quality Practice Environments").

The category of *Self-regulation*, which focuses around topics such as standards of practice, credentialing, professional identity, and leadership, had the most number of consults (N=2687), with nursing practice standards identified as the top sub-category focus (n= 1307) across the provinces. Next was the category of *Autonomy and Control over Practice* which focuses around service delivery, skill mix, and scope of practice (n=2156), with the sub-category of RN Scope of Practice being the most requested consultation. The third ranking category was the *Other* category (n=1407). *Commitment to Service*, which addresses topics such as client-centred practice and ethical care ranked 4th (n=1198), with legal/ liability concerns sub-category garnering most of the queries (n=535). Ranked 5$^{th}$ was *Knowledge-based activity* (n=1114), with documentation being the most noted sub-category (n=527). Finally, *Collaborative Practice* (n=609) was 6$^{th}$ overall, with the sub-category of information sharing/ networking being the top consultation focus (n=301). The number of practice consultations reported across the provinces has remained relatively consistent, with some noting slight increases in numbers from one reporting year to the next. A summary of the practice consultation findings can be found below (Table 2).

Overall, I found Lankshear's attributes of professional practice to be useful for categorizing the nature of the practice consultations cited in the reports. As I noted in my decision journal, most of the issues were fairly straight forward in terms of determining where to locate them within the categories, although knowing the context of the issue may be helpful in determining if it is knowledge-based as well, given many of the issues could have an education component to them. My decision to add an "other" category was also validated, given several issues were vague and could have fit in multiple categories.

| Practice Consultations | | |
|---|---|---|
| **Self-regulation: Standards of Practice; credentialing; professional identity; leadership** | **2687** | **29%** |
| **Nursing Practice Standards** | **1307** | |
| Registration | 231 | |
| Continuing competence | 8 | |
| Laws and regulations | 473 | |
| Duty to provide care | 59 | |
| Duty to report | 87 | |
| Certified practice | 125 | |
| Appropriate use of titles | 49 | |
| Health care reform | 43 | |
| Internationally Educated Nurses | 17 | |
| Graduate Nurses | 13 | |
| Nursing councils | 15 | |
| Liability insurance | 142 | |
| Labour relations/ Unions | 123 | |
| Clinical leadership | 1 | |
| **Knowledge Based: Evidence-based practice; utilization of theory and research; commitment to ongoing professional development** | **1114** | **12%** |
| Education | 374 | |
| Best practice | 2 | |
| **Documentation** | **527** | |
| Consent | 19 | |
| Dispensing medications | 49 | |
| Medication administration | 143 | |
| **Autonomy and Control over Practice: Service delivery; skill mix; scope of practice** | **2156** | **23%** |
| **RN Scope of Practice** | **1533** | |
| Care Delivery Models | 36 | |
| Telehealth | 10 | |
| Professional responsibility | 116 | |
| Transitions/ Independent practice | 43 | |
| Finding employment | 1 | |
| Independent nursing practice/ private business | 246 | |
| Complementary and alternative health care | 163 | |
| Career choice/ salary | 1 | |
| Delegated medical functions | 2156 | |
| **Commitment to Service: Client-centered; ethical care** | **1198** | **13%** |
| **Legal/ Liability concerns** | **535** | |
| Ethical | 305 | |
| Safety | 268 | |
| Pandemic | 30 | |
| Confidentiality/ Privacy | 60 | |
| **Collaborative Practice: Intra and interprofessional relationships** | **609** | **7%** |
| **Information Sharing/ Networking** | **301** | |
| Nurse-Client relationships | 49 | |
| Collaborative practice | 183 | |
| Delegating to unregulated care providers | 76 | |
| **Other** | **1409** | **15%** |

*Table 2 – Summary of Practice Consultations*

**Step 5: Presentation and Interpretation**

The final step in the integrative review is intended to highlight the culmination of findings of this methodological process. Whitmore and Knafl indicate that this section is meant to capture the depth and breadth of the topic and play a part in creating new understanding (2005). This project has contributed in meaningful ways to the understanding of the concept of professional practice in nursing and the unique role of the Practice Consultant in addressing apparent diverse and complex practice issues. Highlighting the frequency and nature of reported practice issues and consultations provides empirical evidence regarding the state of nursing practice as identified through Regulatory College and Association reports. In comparing the number of reported practice issues against the number of registrants, consistently the number fell below less than 1% of the total number of registrants in each province. This leads one to believe that a significant majority of nurses are practicing within their scope and are meeting their standards of practice.

In terms of those nurses who are not meeting their standards and for those who may be struggling in practice, this project offers a preliminary view into what issues are impacting nursing practice from a national perspective. Of the reported practice issues, lack of nursing assessment and planning, abuse, bullying or harassment, professional incapacity, and drug or narcotic abuse/ theft top the list, with reporting identified in at least three or more provinces. In terms of practice consultations, advice sought by nurses was overwhelmingly focused around topics such as Nursing practice standards and RN Scope of Practice, as noted in eight of the nine provincial reports, while legal or liability concerns were a major focus in seven provinces.

Documentation and information sharing/ networking were also the most frequently reported consultation categories in three or more provinces. This information is valuable for providing insight into what key topics Practice Consultants need to be knowledgeable about, in order to address practice concerns and support nurses and their leaders to optimize practice.

Despite the role of the Practice Consultant having been implemented across Canada, the literature review revealed that very few resources are available to guide their practice. Although there is a lack of empirical literature available on the subject, a scan of the Nursing Regulatory Colleges and Associations across Canada revealed a number of resources that have been developed (see Appendix C), to guide individual nurses and leaders through identifying and resolving nursing practice concerns (College of Licenced Practical Nurses of BC [CLPNBC], 2010; CRNBC, 2011a; CRNBC, 2011b; CRNBC, 2011c; CRNBC 2010; CRNM, 2005; CRNNS, 2009; College of Registered Psychiatric Nurses of BC [CRPNBC], nd; NANB, 2009; SRNA, 2008; YRNA, 1997). These materials have been developed to support nurses to articulate their concerns to their supervisors regarding unsafe work environments or system issues that may impact their ability to fully meet their professional nursing standards. Additionally, these resources can also be used to guide nurses and their leaders through addressing concerns when an individual nurse's performance or practice is of concern and the nurse is not meeting professional standards.

While all provincial Nursing Regulatory Colleges and/ or Professional Associations have some mechanism for individuals to report significant nursing practice concerns, as evidenced in the summary of reported practice issues and consultations document, a gap still remains

however, for guiding Practice Consultants who work in health agencies to support nurses and their leaders, from an organizational perspective, in addressing professional practice matters. In order to address this gap, the intent of this project is to inform the development of a framework to guide the Practice Consultant in addressing practice issues and offer recommendations for further development of a toolkit to support and inform their work.

The information compiled in this project was used to inform the development of a framework to guide Practice Consultants in addressing practice concerns and to inform recommendations for a toolkit to further support their practice. Both of these elements will be discussed in more detail below.

## Part 4: Relevance of findings for Nursing and Nursing Practice

### Framework for Addressing Practice Questions and Issues

In keeping with the philosophical and theoretical underpinnings of this paper, I embraced a constructivist approach in developing a framework to guide practice consultation work. In 1986, Belensky, Clinchy, Goldberger, and Tartule described a constructed knower as someone who "views all knowledge as contextual; they experience themselves as creators of knowledge and value both subjective and objective strategies of knowing" (cited in Meleis, 2007, p. 23). In subscribing to this view, Schultz and Meleis suggest it is to also acknowledge and accept that knowledge development is a never-ending process and that frames of reference are constructed, only later to be reconstructed, and that knowledge is contextual and

subject to interpretations by others (cited in Meleis, 2007). It seemed fitting that as I systematically combed through published literature and various sources of evidence for this project that I made meaning and use of the work that has been developed before me and build upon that work to create something meaningful for my particular population of interest.

I should also point out that it was my intent to develop a framework to guide and support the practice of the consultant, but not be too stifling and rigid that it would squelch critical thinking. Critical thinking is striking a balance between framework thinking and flexible viewing of a situation (Meleis, 2007). Dewey defined critical thinking as "the ability to suspend judgment on matters of interest" (cited in Meleis, 2007, p. 25). The framework should serve to enhance a new Practice Consultants understanding of the process for consultations and will guide the seasoned consultant through a systematic approach, offering suggestions to ponder and consider based upon contextual circumstances of the situation they are addressing. In addition to this, creating space for self-consciousness (reflection) and continual self-critique (critical reflection) is also vital to build professional practice skills (Williams, 2001), particularly in relation to practice consultations. For this very reason, the creation of a framework is not the only way in which to support the Practice Consultant in their role. Recommendations for development of a Practice Consultant toolkit will also be identified to further enhance Practice Consultant scholarship and practice, and may also serve to guide program planning, resource allocation, and evaluation.

**Presentation of a Framework**

Gottfredson and Mosher's 'Moments of Need' learning framework (cited in Vancouver Island Health Authority, 2009) provides a valuable way of examining the learning needs for Practice Consultants. They describe five specific learning moments of need that can be identified within a workplace setting. These moments of need include:

1. When people are learning how to do something new for the first time;
2. When people are expanding on what they have already learned;
3. When people need to apply what they have learned;
4. When something doesn't work the way it was intended and problems arise; and
5. When people need to learn a new way of doing something that requires changing the skills they currently utilize.

In the first two instances where people need to learn something new or more, the best approach to meet these learning needs is through a formal learning setting, where people are brought together, either in a classroom or online. The last three moments of need are best supported through informal processes, such as mentoring, coaching, performance support, and access to resources and tools. A combination of these approaches is thought to be one of the most successful ways in supporting learners to achieve high levels of mastery and competency in the workplace (Gottfredson & Mosher, 2011; VIHA, 2009).

Gottfredson and Mosher's work informed the development of the structure of the framework by highlighting what Practice Consultant's need to "do" and "know" (2011). This resulted in the creation of a table (see Appendix D) with two columns titled: Actions (the "do") and Resources/ Questions to Consider (the "know"). These columns were then informed by the

literature for this project, and more specifically the subsequent stages of the framework were informed by the review and synthesis of the processes highlighted in the literature regarding resources available to guide or support resolution of practice issues. This material was largely grey literature developed by regulatory and association bodies for nursing as noted above. The stages of the framework include: Establishing a rapport, Clarifying the issue, Explore and validate the facts of the issue, Explore possible actions and next steps, and Documentation of the consultation. This framework is in its preliminary development and it is expected that it will be augmented by additional resources and tools that will be developed as part of the toolkit created to support Practice Consultants in their role.

**Recommendations for Practice Consultant "Toolkit"**

The notion of a "toolkit" is a worthy concept that is intended to address people's need to access resources and tools, while they do their work. While great strides have been made in meeting learners instructional needs, sometimes support falls short at the moment of "apply" in assisting learners in their everyday realities of perhaps having not learned something, or having forgotten or misunderstood what they learned, and this is where performance support comes in (Gottfredson & Mosher, 2011). Rossett and Shafer describe performance support as "a helper in life and work, performance support is a repository for information, processes, and perspectives that inform and guide planning and action" (2006, p. 2). Performance support resources and tools can be paper-based or digital and examples include: print job aids, such as checklists, flowcharts, templates, posters, FAQ's (frequently-asked questions).

In terms of the toolkit of resources that would aid Practice Consultants to perform their work optimally, Table 3 (Recommendations for Practice Consultant Toolkit) below includes 16 recommendations for a target audience that includes Practice Consultants, Managers/ Leaders, and Other Corporate Support (e.g. Human Resources). If implemented the recommendations would guide and support not only the Practice Consultant in their work, but would also support professional practice needs of those they support (e.g. managers, leaders, educators, and staff) as well. In addition, the intent for some of the recommendations is to augment the practice consultation framework process, in order to address context-specific situations that Practice Consultants encounter.

| Recommendations | Target Audience | | |
|---|---|---|---|
| | **Practice Consultant** | **Managers/ Leaders** | **Other Corporate Support (e.g. HR)** |
| Establish a Community of Practice with Practice Consultants (PCs) across BC to collaborate and leverage knowledge and support for practice consultation work; Consider annual forum to connect as a broader group to team up on mutual work | X | | |
| Establish regular connections with Nursing Regulatory Colleges and Professional Associations to share updates and learn from one another | X | | |
| Consider partnering with regulatory colleges/ professional associations/ union, post-secondary institutions to address prominent findings re: practice issues in this paper (e.g. abuse, bullying, harassment; lack of nursing assessment, planning etc; drug/ alcohol abuse and theft; legal liability concerns; documentation questions) | X | X | X |
| Develop a Competency, Assessment, Planning, and Evaluation (CAPE) tool to clarify expectations of the PC role and further assist PCs to focus, plan, and track their learning and monitor own progress | X | | |
| Develop a comprehensive orientation package that can guide what PCs need to "do" and "know" to efficiently and effectively carry out their roles; Include formal/ informal mentoring opportunities for PCs new to their role and/ or new to learning some other aspect of their role | X | | |

| Recommendations | Target Audience | | |
|---|---|---|---|
| | Practice Consultant | Managers/ Leaders | Other Corporate Support (e.g. HR) |
| Validate the usefulness and applicability of the Nursing Practice Consultation Framework by the VIHA Practice Consultant team in Professional Practice; seek input from both experienced and new Practice Consultants and further refine framework | X | | |
| Evaluate the Nursing Practice Consultation Framework | X | | |
| Develop an intake form for practice consultations that is congruent with the categories for reported concerns and practice consultations identified as a result of this project | X | | |
| Develop a reporting tool based upon above intake form assessment information that can be rolled up for regular reporting purposes e.g. data tracking and trending | X | | |
| Create a template for health agencies that assists in examining and addressing scope of practice queries/ issues (e.g. Questions regarding Role, Scope, and Function) | X | X | X |
| Keep abreast of legislation/ regulation changes (e.g. HPA) and develop communication strategy to disseminate information | X | X | X |
| Create a document that addresses professional/ practice standards of practice, policies, guidelines etc. and how the "controls of practice" guide nurses in their work | X | X | |
| Create a definitions (glossary) document that describes:<br>• What is Professional Practice<br>• What is a Professional Practice issue ( include examples based upon categories highlighted in paper)<br>• What a Practice Consultant can do to help you | X | X | X |
| Create a document that identifies the differences between a Regulatory College, Professional Association, and Union | X | X | X |
| Create a RASIC (acronym for responsibility, accountability, supports, informs, consulted) document that clarifies the roles/ responsibilities of various partners that inform the resolution of practice issues from their unique lens (e.g. Professional Practice, Human Resources, Quality, Occupational Health and Safety, Risk Management, and Operational Manager/ Leader/ Educator) | X | X | X |
| Create a Manager/ Leader guide to addressing and resolving professional practice issues, including:<br>• Sample communications (e.g. conversations, letters) for addressing performance/ practice issues<br>• Sample templates for learning plans (see Appendix E for Sample Learning Plan Template) | | X | |

*Table 3 - Recommendations for Practice Consultant Toolkit*

**Recommendations for Further Inquiry and Research**

This paper highlighted the significant professional practice issues affecting nursing across Canada and illuminated the importance of systems, structures, and roles that are vital to support and nurture professional nursing practice. While this paper was supported by some empirical and theoretical literature around the nature of the Practice Consultant role in addressing practice issues, it was surprising that so little has been studied about the role and the impact it has had on nursing practice. There is a need to better understand what influence the Practice Consultant role has had on nurses and optimization of the nursing role. There is also an opportunity to further examine the practice issues nurses face in their daily work environment and look at what is influencing and driving some of these issues, and how we can mitigate some of the challenges or barriers to quality professional practice.

## Part 5: Project Limitations

While this paper offered a valuable opportunity to explore practice issues in nursing from across the nation, there were limitations in data being available in some cases for cross-comparison. For example, while Regulatory Colleges and Associations identified the general number and category of practice concerns reported over a particular time period, not all identified the details regarding the nature of those complaints. To do so, would have provided more fulsome information regarding the professional practice issues for nurses and would have possibly allowed for further trending. As a result, there are limitations in generalizability of the report findings. In addition, there is significant variability for how data is categorized and

identified by the Regulatory Colleges and Associations and although a classification system was utilized as part of the data analysis phase, this information was only reviewed by one person. Some would argue this provided consistency in the application of the approach, but it could also be argued that having only one reviewer may increase the potential for bias.

Another limitation was the amount of empirical and theoretical data available specifically related to the role of the Practice Consultant. Despite the role of the Practice Consultant/ Leader having been around for many years, there is very little written about the impact of this role and what resources are available to support this role.

## Part 6: Dissemination/ Knowledge Translation

This paper marked an opportunity to connect and dialogue with other Practice Consultants from other Health Authorities across BC and learn how they enact the role, as well as to seek out opportunities to learn and share from one another. I plan to share this report with those same colleagues who expressed an interest in the outcome of the project. Also, given the sparse resources available to support the practice consultant role in a health agency setting, it is my intent to seek leadership support within my Health Authority to enact the "toolkit" recommendations noted above and develop resources that could be shared widely with the BC Health Authority Practice Consultants and others.

At the time of writing this paper, I have also submitted an abstract about this project for an innovative peer-reviewed digital poster contest through InspireNet; a network of

researchers, educators, policy makers, practitioners, and students that are striving to improve nursing health services in BC ("Welcome to InspireNet.ca", nd). If selected, I will have an opportunity to share my project at a provincial forum in the fall of 2011.

I will also consider submitting an article about the role of the Practice Consultant, based upon my project, to a peer-reviewed journal publication in order to further share my findings and contribute to the scholarly knowledge base for nurses working in this field. Ideally, I would like to pursue an evaluation research project to look at the impact of the Practice Consultant from a Health Authority perspective, in order to learn more about what people see as a benefit of the role and how we can use this information to improve upon our services.

## Part 7: Summary and Conclusions

This project has provided valuable insight into the role of the Practice Consultant and served to acknowledge the diversity and challenging nature of this practice support position. I have gained so much further insight into a role I thought I was fairly familiar with and this project has just stretched that thinking even further. This paper has illuminated many valuable findings about the Practice Consultant role and how I would like to go forward with the knowledge. The review of looking at reported practice issues from across Canada was valuable in terms of better understanding the issues nurses are facing and the categories of practice consultations provided insight on what issues are of most concern to nurses. Fortunately, findings revealed that a relatively small population of nurses are experiencing significant issues in their personal practice. While this project offered a window into what practice issues are most prevalent for nurses, it obviously could not reveal what is going unreported, and this

might be another area for further exploration. Reviewing the literature on how to address and resolve practice issues provided another level of validation of how to move forward in building a comprehensive framework for Practice Consultants to use, and further corroborated the need for the toolkit. The role of the Practice Consultant is a multi-faceted and dynamic role that if situated well within an organization, has incredible opportunity to make a difference for nursing practice, both in terms of promoting and optimizing the role, scope, and standards of a nurse, and by acting as a guide for nurses and leaders when issues arise.

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**Appendix A – Literature Review**

| Citation | Research type/ Methodology | Methods | Findings/ Summary | Comments |
|---|---|---|---|---|
| Professional Practice Leader/ Consultant Roles | | | | |
| Adamson, B., Shackleton, T., Wong, C., Prendergast, M., & Payne, E. (1999). The creation of a professional leader role in an academic health sciences centre. *Healthcare Management Forum, 12*(2), 42 – 46. | Non-research | Discussion paper re: org re-structuring and creation of professional leader role | Leadership for health care professionals provide through a designated professional leader for each discipline; development of common role description with focus on professional leadership for practice; professional education and research activities; quality improvement; and profession resource planning. Non-nursing also added clinical service. | Professional leader critical to: empowerment of staff in developing new competencies; greater appreciation of inter-dependencies among professions; and ability function more autonomously in transition to program mgmt organizational structure. |
| Bournes, D. & DasGupta, T. (1997). Professional practice leader: A transformational role that addresses human diversity. *Nursing Administration, 21*(4), 61 – 68. | Non-research | n/a | The Professional Practice Leader (PPL) can provide leadership and facilitate a shift from nursing practice based in the totality paradigm to nursing practice in the simultaneity paradigm. | PPL are transformational leaders that can shift care model from provider focused to patient focused through creation of a vision of what can and should be done. They offer support in looking at day-to-day practice and reinforce standards of practice. PPLs invite others to see things differently, to ask |

| Citation | Research type/ Methodology | Methods | Findings/ Summary | Comments |
|---|---|---|---|---|
| | | | | questions and to challenge the status quo. |
| Chan, A. & Heck, C. (2003). Emergence of new professional leadership roles within a health professional group following organization redesign. *Healthcare Management Forum,* 15(4), 47 – *54.* | Quantitative | Cross-sectional study design. Information collected via lit review and self-administered survey (n= 226) and analyzed via SPSS. Purpose: to inform health service managers about emergence of new org structures | 63.2% response rate Findings: Program mgmt. was the org design prevalent in academic settings, while hospitals reported mixed structures. PPL role evolved out of need to address issues of professional practice standards and profession development. Findings support a shared governance model. | PPL role logical consequence of program mgmt. structure and instrumental in achieving profession-specific practice goals; crucial for info sharing and resolving profession-specific issues, advocating for presenting a common voice for profession, setting research goals and directions and promoting continued professional development. |
| Lankshear, S. (2011). The professional practice leader: The role of organizational power and personal influence in creating a professional practice environment for nurses. *Electronic Thesis and Dissertation Repository. Paper 152.* Retrieved May 25, 2011 from http://ir.lib.uwo.ca/etd/152. | Integrated Article | Dissertation comprised of 4 components: literature review describing professional practice; application of theoretical framework (Kanter's theory) to describe professional practice leader (PPL) role, development of instrument to enable measurement of PPL role, and empirical testing of conceptual model depicting | Based upon path analysis with hypothesized model, organizational power had a direct and positive effect on PPL role functions and PPL influence | Noted limited empirical data to draw upon in the literature and first known research study specific to the Nursing PPL role in Ontario. |

| Citation | Research type/ Methodology | Methods | Findings/ Summary | Comments |
|---|---|---|---|---|
| | | proposed relationship of PPL role and nurses' practice environments. | | |
| Lankshear, S., Laschinger, H., & Kerr. M. (2007). Exploring a theoretical foundation for the professional practice leader role. *Nursing Leadership 20*(1), 62 – 71. | Qualitative<br><br>Content Analysis<br><br>Integrative Review | Content analysis of PPL role descriptions at 20+ institutions to explore linkages between the various PPL functions and elements of Kanter's Theory of Structural Empowerment (1993);<br><br>Integrative review of PPL role and practice environment. | Kanter's theory provides an important foundation to describe and support the PPL role. Role intended to promote and maintain professional standards. Sponsorship (e.g. reporting to CNO) is likely to increase both formal and informal power and PPL would have greater access to key information/ decision-makers within the organization thus have greater ability to achieve org. goals and empower those around them. | Scan of literature reveals few articles about the PPL role and also lack of empirical studies regarding impact of role.<br><br>How PPL role has been implemented may be reflection on the lack of theoretical framework to guide implementation of the role. |
| Miller, P., Worth, B., Barton, D., & Tomkin, M. (2001). Redefining leadership responsibilities following organizational redesign. *Healthcare Management Forum, 41*(3), 29 – 33. | Non-research | Discussion paper regarding the need to redefine leadership roles following decision to adopt Program Management model following merger of 2 hospitals – resulted in re-org of leadership roles and Chief of | Need to clarify new roles for both program and professional leadership in terms of accountability/ responsibility. Need for consistency in role responsibilities and addressing professional practice issues. A guide developed to clarify | Profession Leader role to promote/ maintain standards of practice for their profession; accountable to CNO; no line authority or financial responsibility.<br><br>In new structure the program |

| Citation | Research type/ Methodology | Methods | Findings/ Summary | Comments |
|---|---|---|---|---|
| | | Professional Practice (also CNO) and part-time profession leaders support practice in collaboration with Program Directors. | specific and collaborative responsibilities of profession leader and program director. | directors are not always of same professional background as staff member and not aware of professional standards or how to ID/address performance difficulties. |
| McCormack, B., & Garbett, R. (2003). The characteristics, qualities and skills of practice developers. *Journal of Clinical Nursing, 12,* 317 – 325. | Qualitative<br><br>Concept development methodology (adapted from Morse 1995) | Analyze primary and secondary sources of data in 3 stages: Identifying attributes, verifying attributes, and identifying manifestations of the concept via lit review/ thematic analysis/ cognitive mapping | Range of activities noted; with 71 activities drawn up and analyzed to arrive at six descriptive categories:<br><br>Promoting and facilitating change; translation and communication; responding to external influences; education; research into practice; and audit and quality | Role and range of activities complex and ambiguous. Focus more on facilitating change in practice with considerable variation between practice settings. Overlap with other leadership roles e.g. senior clinician or manager. PPL role responsible for promotion and maintenance of professional standards. |
| Pearson, A., Porritt, K., Doran, D., Vincent, L., Craig, D., Tucker, D., & Long, L. (2006). A systematic review of evidence on the professional practice of the nurse and developing and | Systematic Review | Search strategy included both published and unpublished studies written in English; of 4238 papers found in search – with 19 being included in the review | Evidence suggests that professional practice has a positive impact on the work environment in terms of nurses' satisfaction and patient outcomes | For purpose of review professional practice was defined as the practice of regulated nurses in and with multi-professional teams with responsibility for the care of |

| Citation | Research type/ Methodology | Methods | Findings/ Summary | Comments |
|---|---|---|---|---|
| sustaining a healthy work environment in healthcare. *International Journal of Evidence-Based Health Care, 4*, 221 – 261. | | | | clients. Professional practice reflects the values and standards identified by professional nursing organizations and within self-governing professional practice acts. |
| Power, L. (2001). *What is the role of a nursing practice consultant?* St. John's, NL: Author. | Non-research | n/a | Primary role is to promote good nursing practice, which involves being both proactive and reactive to professional practice issues – which can be described as situations in the workplace that impact on the RNs ability to function to full scope of practice and/ or to provide safe, competent, and ethical care. | To carry out role uses nursing process – gather info, develop and implement a plan of care, and evaluate outcomes.<br><br>Draws on knowledge base of professional nursing practice documents, colleague expertise, and literature. |
| Radwin, L. (2000). How do patients' judge the quality of nursing care. *Journal of Nursing Administration, 30*(2), 58. | Qualitative | Longitudinal study following oncology patients over a 3-year period. During course of their care, they were interviewed about nursing – what works, what does not work and how nurses can best make a difference. | Study identified eight hallmarks of quality patient care: professional knowledge, rapport or "human connection" with the patient, shared decision-making and partnership between nurse and the patient, individualized | Researcher wanted to learn about nursing quality through lens of the patient. |

| Citation | Research type/ Methodology | Methods | Findings/ Summary | Comments |
|---|---|---|---|---|
| | | | treatment, caring or nurturing attention, promptness in meeting patient's care needs; having the same nurse as often as possible, and ensuring nurses are coordinating care with other providers. | |
| Ross, E., MacDonald, C., McDermott, K., & Veldhorst, G. (1996). The chief of nursing practice: A model for nursing leadership. *Canadian Journal of Nursing Administration, 9*(1), 7 – 21. | Non-research | Development of the chief of nursing practice role is defined within the context of the changing environment and Kanter's theory of empowerment. | This PPL role stays grounded in practice and attends to problems/ issues, as well as supports new and creative ideas and innovations for care delivery. | Facilitates change and must keep abreast of patient care issues and as well as concerns at corporate level and support nursing at direct care level. |

| Citation | Research type/ Methodology | Methods | Findings/ Summary | Comments |
|---|---|---|---|---|
| Professional Practice/ Models/ Frameworks | | | | |
| Comack, M., Brady, J., & Porter-O'Grady, T. (1997). Professional practice: A framework for transition to a new culture. *Journal of Nursing Administration, 27*(12), 32 – 41. | Non-research<br><br>Literature review/ Engagement | Literature review conducted along with external consultations and internal clarification of the issues, assumptions, beliefs, and values to creation of vision statements. | Shift to integrated care delivery system would require new structure to enable professional staff to practice with greater autonomy and accountability at point of care.<br><br>Essential elements model created and clarifies scope of professional practice within the domains of practice, education, leadership, and research/ quality improvement. | Authors note a lack of literature as well as diverse perspectives from other systems' experience with organizational redesign.<br><br>Distinction between professional leadership and clinical management. |
| Cooke, A. (2001). *Integrating professional practice across the Capital Health Region.* Victoria: Capital Health Region. | Non-research | CNO strategy for infrastructure development to strengthen and support nursing practice across the region. | Development of Professional Practice Office seen as one of the key strategies for integrating professional practice across the CHR. | Purpose of PPO:<br><br>Develop, coordinate, integrate and support strategies that enable professional disciplines and program staff to deliver safe, competent, ethical person/ patient focused care. |
| Girard,F., Linton, N., & Besner, J. (2005). Professional practice in nursing: A practice. *Nursing* | Qualitative/ Quantitative | Focus groups (18) with 156 participants; three groups considered 'expert' groups. Focus group info themed into | From focus group comments and subsequent validation through survey resulted in development of a Professional | Major elements of framework linked to expected competencies for nursing via job descriptions and built into |

| Citation | Research type/ Methodology | Methods | Findings/ Summary | Comments |
|---|---|---|---|---|
| *Leadership, 18*(2), 1 – 8. | Focus Groups/<br>Survey | statements and formed basis of survey for further validation. 482 nurses completed survey. | Practice Framework with the following four components:<br>The art of nursing; competence; attributes of practice; and personal commitment. | ongoing professional development and continuing education plans.<br>Focus now needed on evaluation and research. |
| Hoffart, N., & Woods, C. (1996). Elements of a nursing professional practice model. *Journal of Professional Nursing, 12*(6), 354 – 364. | Qualitative<br>Comparative analysis | Examination of five professional practice models (PPMs) in light of five elements highlighted in literature as essential for professional practice. | Review of five PPMs revealed congruency related to five elements essential for professional practice: values, professional relationships, a patient care delivery model, a management approach, and compensation and rewards. | PPM as system (structure/ process/ values) that support nurses control over delivery of nursing care and environment in which care is delivered.<br>PPM thought of in terms of 5-stranded rope with each strand representing one element of PPM. When strands coiled together the rope is stronger than any strand alone. |
| Mathews, S. & Lankshear, S. (2003). Describing the essential elements of a professional practice structure. *Nursing Leadership, 16*(2), 63 – 73. | Non-research | Small group discussions with members of the Professional Practice Network of Ontario (PPNO) generated a list of sixteen "essential elements" for professional practice. Members then asked to assess | Exploratory work done through the PPNO to identify the essential elements of the "ideal" professional practice structure, key areas of challenge and strategies for adapting these elements into an | Those in roles responsible for professional practice within healthcare org's dealing with similar issues: scope of practice, interdisciplinary practice, client-centered care, care delivery models, |

| Citation | Research type/ Methodology | Methods | Findings/ Summary | Comments |
|---|---|---|---|---|
| | | their current PP structure according to these elements on a continuum of "got it" – "getting there" – "not in place". | organization. 16 elements identified with focus on four key areas consistently identified as challenging: formal communication and clear authority; support to change culture; flexible, non-silo approach; and strong physician linkages.<br><br>Professional Practice Leader (PPL) was identified as a key element.<br><br>Common frustrations expressed by current PPLs about their roles include; lack of clarity about role, challenges in demonstrating outcomes; varying degrees of org support (e.g. lack of formal authority and time allocation for the role) | credentialing and certification processes, and quality of work life.<br><br>Although PP roles/ dept's seem as "accountable" for promoting professional practice in the workplace – very few have clear direct authority relating to these areas as formal authority resides in operations.<br><br>Need clearly defined expectations and processes to support consultation and collaboration between PP and programs.<br><br>Construct of PP not well defined or understood. |
| Mensik, J., & Martin, D. (2008). Development of a Professional Nursing Framework. *Journal of* | Non-research | To develop a Framework for professional nursing practice and development | A framework consisting of 3 interconnected circles around the patient: contribution to the | One hallmark of a profession is to demonstrate a unique body of knowledge – may be |

| Citation | Research type/ Methodology | Methods | Findings/ Summary | Comments |
|---|---|---|---|---|
| *Nursing Administration, 41*(6), 259 – 264. | | | patient, contribution to the profession, and contribution to society. | in the form of a nursing framework, model, or theory. |
| Ritter-Teitel, J. (2002). The impact of restructuring on professional nursing practice. *Journal of Nursing Administration, 32*(1), 31 – 41. | Non-research | Discussion regarding challenges of maintaining professional nursing practice in light of restructuring. | Attributes of professional nursing practice discussed – including autonomy, control of decision-making, collaboration with physicians, responsibility, authority, and accountability.<br><br>Discussion re: impact of different models of care – team nursing, primary nursing, care and service team models. | Deficiency of empirical studies to draw conclusions about relationship between restructuring, professional practice, and patient outcomes. |
| William, B. (2001). Developing critical reflection for professional practice through problem-based learning. *Journal of Advanced Nursing, 34*(1), 27 – 34. | Integrative Literature Review | To explore influence of current learning traditions in nursing on the development of reflection and critical reflection as professional practice skills. Integrative literature review of published literature 1983 – 2000. | Professional education scholars concur that specialized knowledge is clearly essential for professional practice. They also suggest that self-consciousness (reflection) and continual self-critique (critical reflection) are crucial to continuing competence. Problem-based learning based on constructivism is one way to facilitate the development of | Epistemology of Professional practice as judgment and wise action in situations characterized by complexity, uniqueness, uncertainty, and often conflicting values.<br><br>Reflection is necessary to make sense of professional experience including everyday events of practice. It enables |

| Citation | Research type/ Methodology | Methods | Findings/ Summary | Comments |
|---|---|---|---|---|
| | | | these skills. | professionals to access the vast array of knowledge each possesses. |
| Wolf, G. (2000). Vision 2000: The transformation of professional practice. *Nursing administration quarterly, 24*(2), 45 – 51. | Non-research | Discussion regarding need to transform thinking, practices, and systems in order to address future health care needs. | Discussion re: implementation of a transformational model for professional practice across 16 merged or acquired hospitals using 5-step process: determination of the system's future vision; assessment of current reality compared to that future environment; action planning; prioritization; and implementation. | PPM components: professional practice, process component, primary outcome component, and strategic outcome component<br><br>Professional Practice component includes: transformational leadership; care delivery systems; professional growth; and collaborative practice. |
| Wolf, G., Boland, S., & Aukerman, M. (1994). A transformational model for the practice of professional nursing: Part 1, the model. *Journal of Nursing Administration, 24*(4), 51 – 57. | Qualitative<br><br>Phenomenological methodology/ conceptual analysis | Two phases – phase 1 involved approx. 500 nurses sharing reflective experiences of successful patient care situations and ineffective situations and what were contributing factors of each.<br><br>Phase 2 involved nursing exemplars (20) that reflected | Conceptual analysis of both phases highlighted strong consistency in components deemed essential for professional practice:<br><br>Professional Practice component; process component; primary outcomes; | In the professional practice component, assessment and activation of professional practice relationships and support occur. Relationship of nurse, health care team and patient all at core of model. The PP component further broken into sections/ sub- |

| Citation | Research type/ Methodology | Methods | Findings/ Summary | Comments |
|---|---|---|---|---|
| | | expert nursing practice as personally experienced and/ or observed by their peers. | and secondary outcomes. | sections re: transformational leadership, care delivery system, professional growth, and collaborative practice. |
| Wolf, G. Boland, S., & Aukerman, M. (1994). A transformational model for the practice of professional nursing: Part 2, implementation of the model. *Journal of Nursing Administration, 24*(5), 38 – 46. | Non-research | Discussion re: implementation strategies employed to enact PP model of transformational leadership | PP model of transformational leadership; care delivery system; collaborative practice; and professional growth.<br><br>Nelson and Burns (1984) framework of four development levels for organizations utilized, with strategies to evolve from one level to the next. | Nelson & Burns framework describes four levels: reactive, responsive, proactive, and high performing team.<br><br>Transforming professional practice is not a quick fix and a shift in values, attitudes, and beliefs, as well as an investment of time are needed to succeed. |
| Wolf, G., Hayden, M., & Bradle, J. (2004). The transformational model for professional practice: A system integration focus. *Journal of Nursing Administration, 34*(4), 180 – 187. | Non-research | Discussion regarding need for "road map" to create an integrated system of 19 hospitals and need to attend to three major challenges. | Three major challenges: developing "system-ness" while maintaining local identity; achieving consistency within patient care across sites; and development of staff to meet future challenges. | Transformational Model for professional Practice in Healthcare Organizations used as a guiding framework for integrating patient care services.<br><br>Five step process used to implement model: |

| Citation | Research type/ Methodology | Methods | Findings/ Summary | Comments |
|---|---|---|---|---|
| | | | | Strategic visioning and decision-making; assessment and planning; building support structures; administration; and evaluation. |

## Appendix B – Reported Practice Issues and Consultations

| | BC | Alberta | Saskatchewan | Manitoba | Ontario | Quebec | Nova Scotia | New Brunswick | Newfoundland and Labrador |
|---|---|---|---|---|---|---|---|---|---|
| **Source** | College of Registered Nurses of BC | College & Association of Registered Nurses of Alberta | Saskatchewan Registered Nurse Association | College of Registered Nurses of Manitoba | College of Nurses of Ontario | Ordre des infirmieres et infirmiers du Quebec | College of Registered Nurses of Nova Scotia | Nurses Association of New Brunswick | Association of Registered Nurses of Newfoundland and Labrador |
| **Date of Report** | 2010 | 2010 | 2010 | 2010 | 2010 | 2010 | 2010 | 2010 | 2010 |
| **Demographics** | | | | | | | | | |
| *# Registrants* | 40,712 | 33,156 | 10, 584 | 13,275 | 111,717 | 71,371 | 10,071 | 9,324 | 6,731 |
| **Reported Practice Issues** | | | | | | | | | |
| ***New*** | 187 | 179 | 76 | 84 | 581 | 524 | 63 | 11 | 21 |
| *% of members* | 0.46% | 0.53% | 0.71% | 0.63% | 0.52% | 0.73% | 0.62% | 0.11% | 0.31% |
| ***Previous Year*** | 203 | 163 | 54 | 76 | 559 | No data | 24 | 17 | 29 |
| *Variance* | – 7.9% | +9.8% | +41% | +11% | +3.9% | - | +163% | -35% | -28% |
| ***Carried over Previous yrs.*** | No data | 193 | 14 | 8 | No data | 71 | 11 | 2 | 29 |
| *Primary Reporter* | No data | Employer 68% Public 15% Colleague 12% | Employer 51% Colleague 22% Public 21% Other 6% | Employers 55% Public 29% Colleague 12% | No data | Employer 74% Public 13% Colleague 12% Other <1% | Employer 36% Public 24% Other 35% Colleagues 5% | Employer 77% Colleague 15% Public 8% | No data |

| | BC | Alberta | Saskatchewan | Manitoba | Ontario | Quebec | Nova Scotia | New Brunswick | Newfoundland and Labrador |
|---|---|---|---|---|---|---|---|---|---|
| **Nature of Complaints** | | | | | | | | | |
| **Professional Incompetence** | X - 162 | | X - 66 | X | X – 59 | X | X - 20 | X | X - 10 |
| Lack of assessment, planning etc. | | | X - 33 | X - 2 | | X - 136 | | | |
| Medication Admin. practices | | | X - 16 | | | X - 27 | | X - 2 | |
| Consent Issues | | | X - 2 | | | X - 9 | | | |
| Documentation | | | X - 16 | | | X - 12 | | X - 1 | |
| Practising outside of scope | | | X - 12 | | | | | | |
| Communication/ Interpersonal skills | | | X - 19 | | | X - 1 | | | |
| **Professional Misconduct** | X - 88 | | X – 33 | X | X - 371 | X | X - 14 | X | X - 13 |
| Abuse, Bullying or harassment | | X – 31 | | | | X – 24 | | X - 1 | |
| Sexual abuse/ Harassment | | | X – 1 | | X – 12 | | | | |
| Non-professional relationship | | | | | | X - 13 | | | |
| Slander | | | X - 1 | | | | | | |
| Mishandling of H1N1 Vaccine | | X – 7 | | | | | | | |
| Breach of Confidentiality | | | X – 1 | | | X - 10 | | | |
| Failure to follow employer policies | | | X - 1 | | | | | | |

| | BC | Alberta | Saskatchewan | Manitoba | Ontario | Quebec | Nova Scotia | New Brunswick | Newfoundland and Labrador |
|---|---|---|---|---|---|---|---|---|---|
| Improper delegation | | | X - 2 | | | | | | |
| Patient Abandonment | | | X - 2 | | | X - 9 | | | |
| Unauthorized practice – not licenced | | | X - 1 | X | | X - 2 | X - 19 | | |
| Failure to ensure patient safety | | | | | | X - 4 | | X - 1 | |
| Falsified Health Records | | | | | | X - 2 | | | |
| Give contradictory advice | | | | | | X - 1 | | | |
| Breach of Agreement | | | X - 2 | | | | | | |
| Unauthorized treatment | | | | | | | | X - 1 | |
| Breach of Act or Regulations | | | | | | | | | X - 5 |
| Conduct unbecoming a RN | | | | | | X – 24 | | X – 3 | X - 7 |
| **Professional Incapacity** | X – 44 | | X - 4 | | X – 58 | | X - 3 | X - 1 | X - 2 |
| **Criminal Charges/ Convictions** | X – 14 | | | | X – 39 | X - 12 | | | |
| Drug/ Narcotic Abuse/ Theft | | X – 8 | X - 1 | | | X - 32 | | X – 2 | |
| Theft from a Facility | | | X - 1 | | | | | X – 1 | |
| Fraud/ Deceit/ Dishonesty | | | | | | X – 1 | | X - 1 | |

| | BC | Alberta | Saskatchewan | Manitoba | Ontario | Quebec | Nova Scotia | New Brunswick | Newfoundland and Labrador |
|---|---|---|---|---|---|---|---|---|---|
| **Practice Consultations** | | | | | | | | | |
| *# of Practice Consultations* | 3,266<br>3,194 (individual)<br>71 (group) | 1,010 | 647 | 2400 | No Data | 5343 | 854 | 1,062 | 600 |
| *Previous Year* | 3,266<br>3,072 (individual)<br>154 (group) | 981 | No Data | No Data | No Data | No Data | 961 | 990 | No Data |
| *Top Consults* | Top 5 issues:<br>1. Standards<br>2. RN Scope of Practice<br>3. Other<br>4. Registration<br>5. Documentation | Top 3 issues (more than 65% of calls):<br>1. Legal/ Ethical<br>2. Nursing Practice Standards<br>3. Scope of Practice | Top 5 topics:<br>1. Information and networking<br>2. Nursing Practice Standards<br>3. Safety<br>4. Scope of Practice<br>5. Legal Issues | Top 5 issues:<br>1. RN Scope of Practice<br>2. Standards of Practice<br>3. Legal & Professional Liability Issues<br>4. Professional Practice Issues<br>5. Ethical Issues | No Data | Top 5 issues:<br>1. Other<br>2. RN Scope of Practice<br>3. Regulation<br>4. Professional Development<br>5. Standards of Practice | Top five issues:<br>1. Professional Practice Issues<br>2. Policy<br>3. Scope of Practice<br>4. Patient Safety<br>5. Violence in the Workplace | Top 5 issues:<br>1. Professional Practice<br>2. Scope of Practice<br>3. General Information<br>4. Legal/ liability concerns<br>5. Workplace Issues | No Data |
| **Self-regulation:** **Standards of Practice; credentialing; professional identity; leadership** | | | | | | | | | |
| Nursing Practice Standards | X – 613 | X – 218 | X – 150 | X | | X – 326 | X | X | X |
| Registration | X – 231 | | | | | | X | | |
| Continuing Competence | | | X – 8 | | | | X | | |
| Laws and | | | | | | X – 473 | | X | |

| | BC | Alberta | Saskatchewan | Manitoba | Ontario | Quebec | Nova Scotia | New Brunswick | Newfoundland and Labrador |
|---|---|---|---|---|---|---|---|---|---|
| Regulations | | | | | | | | | |
| Duty to provide care | X – 59 | | | | | | | | |
| Duty to report | X – 87 | | | | | | | | |
| Certified practice | X – 125 | | | | | | | | |
| Appropriate use of titles | X – 47 | | | | | | | | |
| Health Care Reform | | X – 43 | | | | | | | X |
| Internationally Educated Nurses | | X – 17 | | | | | X | | |
| Graduate Nurses | | X – 13 | | | | | X | | |
| Nursing Councils | | | | | | X – 15 | | | |
| Liability Insurance | X – 142 | | | | | | | | |
| Labour relations/ Unions | | | | | | X – 123 | X | | |
| Clinical Leadership | | | | | | | | | X |
| **Knowledge Based:** **Evidence-based practice; utilization of theory and research; commitment to ongoing professional development** | | | | | | | | | |
| Education | | X - 12 | | | | X - 362 | X | | X |
| Best practice | | | | | | | X | | X |
| Documentation | X - 153 | | | | | X – 221 | X | | |
| Consent | X - 19 | | | | | | | | |
| Dispensing | X - 49 | | | | | | | | |

| | BC | Alberta | Saskatchewan | Manitoba | Ontario | Quebec | Nova Scotia | New Brunswick | Newfoundland and Labrador |
|---|---|---|---|---|---|---|---|---|---|
| Medications | | | | | | | | | |
| Medication administration | X - 143 | | | | | | | | |
| **Autonomy and Control over Practice:** **Service delivery; skill mix; scope of practice** | | | | | | | | | |
| RN Scope of Practice | X - 571 | X - 201 | X - 100 | X | | X - 661 | X | X | X |
| Care Delivery Models | | | | | | X - 36 | | | X |
| Telehealth | X - 10 | | | | | | X | | |
| Professional responsibility | | | | | | X – 116 | X | | |
| Transitions/ Independent Practice | | X - 13 | | | | X – 30 | X | | |
| Finding employment | | | | | | | X | | |
| Independent nursing practice/ private business | X - 90 | | | | | X – 156 | | | X |
| Complementary and Alternative Health care | X - 7 | | | | | | | | X |
| Career choice/ salary | | | | | | X - 163 | X | | |
| Delegated medical functions | | | | | | | X | | |
| **Commitment to Service:** **Client-centered; ethical care** | | | | | | | | | |
| Legal/ liability concerns | X - 63 | X - 238 | X - 30 | X | | X - 204 | X | X | |

| | BC | Alberta | Saskatchewan | Manitoba | Ontario | Quebec | Nova Scotia | New Brunswick | Newfoundland and Labrador |
|---|---|---|---|---|---|---|---|---|---|
| Ethical | X - 13 | X- combined with legal | X 20 | X | | X - 272 | X | | |
| Safety | X - 7 | X - 111 | X - 110 | | | X - 40 | X | | X |
| Pandemic | | X – 30 | | | | | X | | |
| Confidentiality/ Privacy | X – 60 | | | | | | | | |
| **Collaborative Practice: Intra and interprofessional relationships** | | | | | | | | | |
| Information Networking | | X – 96 | X - 205 | | | | X | | |
| Nurse-Client Relationships | X – 49 | | | | | | X | | |
| Collaborative Practice | X - 47 | X - 18 | | | | X - 118 | X | | |
| Delegating to unregulated care providers | X - 76 | | | | | | | | |
| **Other** | | | | | | | | | |
| Other | X – 412 | | X - 40 | X | | X - 885 | | X | |
| Quality Practice Environments | X - 72 | | | | | | | X | |

**Appendix C – Literature Review - Resolving Practice Issues**

| | College of Registered Nurses of BC | Saskatchewan Registered Nurses' Association | College of Registered Nurses of Manitoba | College of Registered Nurses of Nova Scotia | Nurses Association of New Brunswick | Yukon Registered Nurses Association | College of Registered Psychiatric Nurses of BC | College of Licensed practical Nurses of BC |
|---|---|---|---|---|---|---|---|---|
| **What is a Professional Practice Issue?** | A problem or situation that interferes with meeting regulatory Standards of Practice, employer guidelines, policies, or other clinical standards, and poses a risk to patients | Interferes with RN's ability to practise consistent with the *SRNA Standards and Foundation Competencies for the Practice of Registered Nurses* (2007), other relevant standards and guidelines and/ or workplace policies and procedures (p.3) | *An unsafe situation:* Events or processes that risk harm to clients. These include "near miss" incidents, errors, and adverse events.<br><br>*Incident:* Include events, processes, practice, or outcomes that are noteworthy by virtue of the hazards they create for, or the harms they cause patients. | Any issue or situation that either compromises client care/ service by placing a client at risk or affects a nurse's ability to provide care/ service consistent with the provincial *Standards for Nursing Practice,* the *Registered Nurses Act*, the *CNA Code of Ethics*/ other acts/ legislation, or agency policies/ procedures | Interferes with a nurse's ability to practice in accordance with the *Standards of Practice for Registered Nurses*, the *Code of Ethics for Registered Nurses*, *Nurses Act* or other legislation, workplace policies, procedures or other relevant standards and guidelines | Interfere with a nurse's ability to practice according to YRNA *Standards of Nursing Practice*, or standards set by the employer | Is a situation in the workplace that is beyond the ability and attempts of a nurse to resolve individually and interferes with the nurse's ability to practice according to accepted psychiatric nursing standards | Many practice problems result from a combination of unacceptable behaviours, and not meeting professional Standards. |

| | College of Registered Nurses of BC | Saskatchewan Registered Nurses' Association | College of Registered Nurses of Manitoba | College of Registered Nurses of Nova Scotia | Nurses Association of New Brunswick | Yukon Registered Nurses Association | College of Registered Psychiatric Nurses of BC | College of Licensed practical Nurses of BC |
|---|---|---|---|---|---|---|---|---|
| ***Risk to Patient/ Client Safety*** | Poses a risk to patients | Has or could put clients or staff members at risk | Risk harm to clients | Compromises client care/ services by placing client at risk | Has or could place clients at risk | Have or could have an injurious effect on patients | Has or could have injurious effects on patients | |
| ***Nurse ability to resolve issue*** | | Is beyond the ability of an individual registered nurse to resolve | | | Is beyond the ability of an individual nurse to resolve | Be beyond the ability of an individual nurse to resolve | Is beyond the ability and attempts of a nurse to resolve individually | |
| | | | | | | | | |
| **Identifying and Resolving a Practice Issue - Process** | Establish a Relationship | Identify and describe the issue | Validate the facts of the situation | Identify the issue | Identify/ verify the problem | Identify the issue | Validation | Identifying practice expectations |
| | Clarify the stated question/ issue/ concern | Determine if it is a professional practice issue | Attempt to resolve the issue with the person directly involved. | Define how and when client care/ service is affected | Communicate the problem | Determine what Standards are not being met | Communication | Describing the practice problem |
| | Explore the issue | Notify management of the issue | Be specific in defining the issue. Focus on the risk to safe, ethical care. | Resource Identification | Document the problem | Define how and when client care and/ or service is affected | Document the Concern | Preparing to meet/ meeting with LPN |

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|---|---|---|---|---|---|---|---|---|
| | Summarize Key points | Collect information to document the issue | Work to resolve the issue at the appropriate organizational level. | Discuss and document | Resolve the problem | Determine Resources | If you do not receive a response | Agreeing to next steps |
| | Explore Possible Actions | Submit documentation to Manager | Report the issue as required by legislation and facility policy. | Evaluate the Process | | Discuss and document | Resolution | Follow-up to the meeting |
| | Clarify Next Steps | Meet to resolve the professional practice issue | Document discussions and actions taken. | | | Participate in resolving the issue | Request formal CRPNBC involvement | |
| | Summarize and Close | Submit complete documentation to next level of management if not fully resolved | | | | Evaluate the process | | |
| | Document | Submit complete documentation to the health authority CEO if not fully resolved | | | | If remains unresolved, contact YRHA for assistance | | |

| | College of Registered Nurses of BC | Saskatchewan Registered Nurses' Association | College of Registered Nurses of Manitoba | College of Registered Nurses of Nova Scotia | Nurses Association of New Brunswick | Yukon Registered Nurses Association | College of Registered Psychiatric Nurses of BC | College of Licensed practical Nurses of BC |
|---|---|---|---|---|---|---|---|---|
| | | Call SRNA nursing practice advisor for further discussion | | | | | | |
| | | | | | | | | |
| **Reference** | College of Registered Nurses of BC (2011b). *Resolving professional practice problems.* Vancouver: Author.<br><br>College of Registered Nurses of BC (2008). *Providing practice consultation advice.* Vancouver: Author. | Saskatchewan Registered Nurses' Association (2008). *Tools for resolving professional practice issues.* Regina: Author. | College of Registered Nurses of Manitoba (2005). *Registered Nurse responsibilities related to professional practice issues.* Winnipeg: Author. | College of Registered Nurses of Nova Scotia (2009). *Professional practice issues resolution framework.* Halifax: Author. | Nurses Association of New Brunswick (2009). *A framework for managing professional practice problems.* Fredericton, NB: Author. | Yukon Registered Nurses Association (1997). *Resolving professional practice issues.* Whitehorse, YT: Author. | College of Registered Psychiatric Nurses of BC (nd). *Guidelines for resolving professional practice concerns.* Vancouver: Author. | College of Licensed practical Nurses of BC (2010). *Assisting LPNs with significant practice problems.* Vancouver: Author. |

## Appendix D - Nursing Practice Consultation Framework

| Actions | Resources/ Questions to Consider |
|---|---|
| **1. Establish Rapport:**<br>• Obtain demographic information<br>• Document information on intake form, e.g.<br>  ○ Initiator/ Contact – Name, Title, Phone Number<br>  ○ Initiators role in this situation<br>  ○ Unit/ Dept./ Program/ Site<br>  ○ Date of first contact | Refer to Practice Consultation Intake Form *(to be developed)*<br><br>Practice Consultations may be initiated in person, by phone, or by email.<br>Respond to emails/ phone calls promptly, particularly if there is a safety risk. |
| **2. Clarify the issue:**<br>• Determine if there are concerns re:<br>  ○ Patient/ staff safety<br>  ○ Professional practice, e.g. unethical, incompetent or unsafe practice, or impaired practice<br>  ○ Scope of practice concerns/ questions<br>• Determine if there are gaps in required competencies<br><br>**Note:** ***Competencies*** are statements about the knowledge, skills, attitudes, and judgement required to perform safely and ethically within an individual's nursing practice or in a designated role or setting. | • *What is the practice issue/ behaviour?*<br>• *What workplace problems have been created due to the concern?*<br>• *Is there a pattern of behaviour?*<br>• *Is there an actual patient or staff safety issue?*<br><br>A ***professional practice issue*** is any issue or situation that compromises patient care or impacts a nurse's ability to provide care/ service.<br><br>***Unethical conduct*** is behaviour that violates ethical standards and expectations of professional behaviour.<br><br>***Incompetence*** is behaviour that demonstrates a lack of ability to meet Standards of Practice.<br><br>***Impaired practice*** may be due to a physical, mental, or emotional health concern, or a substance abuse issue that impairs one's ability to practice. |
| **3. Explore and validate the facts of the issue:**<br>• Gain a clear understanding of the issue(s) in order to identify most appropriate actions<br>• Determine and describe the factors that impact the issue – e.g. people, processes, policies, standards etc.<br><br>**Note:** The information you *initially* receive may reflect only one side or one aspect of the issue. | Consider: who/ what/ where/ why/ how/ when.<br><br>• *What steps have already been taken, e.g. how has concern been dealt with thus far and what has been documented (e.g. incident form)?*<br>• *Who else have or do you need to involve :*<br>  • ***Internal resources*** *– Program Leaders, Human Resources, Occupational Health & Safety, Quality program, Privacy office, Risk Management, Union*<br>  • ***External resources*** *- Regulatory College, Association, Post-Secondary Institution* |

| Actions | Resources/ Questions to Consider |
|---|---|
| • Determine what sources of evidence are available to inform this practice issue.<br>• Summarize the key points to clarify and confirm your understanding | Refer to Evidence-informed practice and Informed decision-making document and consider:<br>• Client preference, expert opinion, research evidence, and standards<br><br>Some examples include:<br>• Professional Standards/ Practice Standards<br>• Scope of Practice Standards<br>• Practice Support documents/ websites<br>• Other regulations/ standards<br>• Published literature/ guidelines<br>• Colleagues/ Leaders<br>• Other agencies/ sites |
| **4. Explore possible actions and next steps:**<br>• Clarify:<br>  ○ Expectations of initiator<br>  ○ Roles/ responsibilities for initiator and others re: further involvement<br>  ○ What additional information needs to be gathered<br>• Determine Plan of Action:<br>  ○ Who will do what?<br>  ○ What are the steps?<br>  ○ How can you support them?<br>  ○ What follow-up is necessary?<br>  ○ Who else need to be involved/ notified based upon level of risk/ safety needs? | Most issues can be resolved within the workplace setting with appropriate action and support.<br><br>• *What kind of support are you seeking?*<br>• *What do you hope is the outcome of this consultation?*<br><br>CRNBC:<br>• *Taking action on concerns about practice*<br>• *Resolving professional practice problems*<br>• *Assisting nurses with significant practice problems*<br>CLPNBC:<br>• *Assisting LPNs with significant practice problems*<br>CRPNBC:<br>• *Guidelines for resolving professional practice concerns* |
| **6. Documentation of the Consultation:**<br>• Document:<br>  ○ Issue(s) as stated by Initiator/ Contact<br>  ○ Possible actions/ solutions explored<br>  ○ Who was notified/ involved<br>  ○ Plan of action/ follow-up<br>  ○ Resources referenced | Keep detailed records of all conversations/ written communications surrounding this issue.<br><br>Refer to Practice Consultation Intake Form. |

## Appendix E – Sample Learning Plan Template

**Date:**

**Prepared By:**

**Personal Learning Plan for:** *(Name)*

| Practice Problem | Standard of Practice | Action Plan | Goal | Evaluation Date | Status |
|---|---|---|---|---|---|
| E.g. Post-operative surgical assessments were not completed on all assigned patients (Feb. 9; Feb 11; Mar. 18, 2011) | 3. *Competent application of Knowledge* – 3.1: Collects information on client status from a variety of sources, using assessment skills including observation communication and physical assessment. | • Review Mosby's resource materials for post-operative assessment for general surgeries performed on unit<br>• Review post-operative assessments with unit educator<br>• Demonstrate post-operative assessment skills to educator or assigned RN mentor | • Will perform timely and comprehensive assessments on post-operative patients.<br>• Will demonstrate competence and critical thinking in prioritizing, performing, and documenting patient care. | April 15, 2011 | Completed satisfactorily |
| | | | | | |
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