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Registered Practical Nurses: An Overview of Education and Practice

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Registered Practical Nurses:

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Registered Practical Nurses: An Overview of Education and Practice

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Registered Practical Nurses: An Overview of Education and Practice

INTRODUCTION

Professional practical nurses are designated as Registered Practical Nurses (RPNs) in Ontario and Licensed Practical Nurses (LPNs) in other provinces. This report presents an overview of RPN education and practice in Ontario. It provides the background to a much-anticipated study that will examine more fully the fit between how RPNs are educated and what roles they perform in the workplace. This report will review the evolution of RPN education and its effect on practice. It begins with an overview of the development of RPN education and scope of practice since the inception of the profession. The nature of the RPN role is further explored through tracking the development of RPN education and an analysis of an RPN curriculum from a major Ontario college. Trends in RPN demography during the past two decades are summarized and a current workforce profile of RPNs in Ontario is presented. The report concludes with a review of the literature on issues relevant to the role of practical nurses in the contemporary workforce, particularly their relations with Registered Nurses (RNs) in the nursing team.

Practical Nurse Education in Ontario

Pringle, Green and Johnson (2004) trace the education for practical nurses in Canada through three phases: the establishment of educational programs (1939-1959), the evolution of educational programs (1960-1990) and the subsequent expansion of scope of practice.

The first RPN courses were offered by non-academic private companies in 1938 and were six months in length (Registered Practical Nurses Association of Ontario [RPNAO], n.d.a). In 1946, training centres for nursing assistants were established, providing nine-month courses. Education was later extended to a one-year certificate course taken at either a college or high school (RPNAO, n.d.a).

Over the years, the trend in education has been towards increased length of preparation, with the exception of 1967 when educational programs were reduced to 35 weeks. Other notable amendments include changes to nomenclature. The title *Registered Practical Nurse* has not always been used in relation to this health care profession. In 1963, *Certified Nursing Assistant* was used; this was subsequently changed to *Registered Nursing Assistant* (RNA). In 1993, RNAs were given the right to use the title *nurse* and to adopt the designation of Registered Practical Nurse (RPNAO, n.d.b.). Additional milestones in the development of the profession are described on the RPNAO website (<http://www.rpnao.org/about/whatisanrpn.asp>) and summarized in Appendix A.

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Recent Developments

In the early 2000s, changes were made to the educational criteria for RNs and RPNs in Ontario. In December 2001, the CNO recommended that all new RPNs would require a two-year diploma from a Community College of Applied Arts and Technology as the basic educational requirement, effective January 1, 2005 (CNO, 2004). In 2002, two-year diplomas were offered and approved by the Ministry of Training Colleges and Universities (MTCU). These diplomas were in compliance with the CNO's entry to practice competencies, professional standards and guidelines (CNO, 2004, CNO 2009a).

In 2005, a baccalaureate degree in nursing became mandatory for RNs to enter into practice and diploma programs were discontinued. The MTCU facilitated transition to the new educational standards via financial support for increased enrolment in collaborative college and university degree programs, as well as providing funding for compressed degree programs in universities and the final intake of diploma students to the colleges. The intention was to boost the number of nursing graduates in 2003-2004, the year in which reduced numbers were anticipated due to the elimination of the three-year college diploma. These changes and the existing shortage affected the supply of RNs.

In the new RPN programs, the minimum admission requirement remains an Ontario Secondary School Diploma. Currently, 24 Ontario colleges provide educational programs for RPN diplomas. There is at least one program in each Local Health Integrated Network (LHIN), with the exception of Central West (CNO, 2007) (see Appendix B). To encourage high enrolment, caps on RPN numbers in college programs were removed effective January 2001. Greater numbers of RPNs, many of which are employed in long-term care, would be needed to care for the aging population. Given the general shortage of nurses, higher numbers of RPN graduates might, in the short run, help offset the lower numbers of RNs graduating during the transition to baccalaureate degrees.

The rationale for creating the RPN diploma program was that advancing technology, increased demands in community care and changing skill mix required an expansion of RPN practice. The CNO also argued that the limited mentoring and orientation available in the workplace meant that students needed to be better prepared for immediate responsibilities. In the past, RPNs required an order to carry out certain medical procedures that were previously only permissible for RNs and RNs with extended class designation to perform. An important reason for the modification of the curriculum was to ensure that graduates had the knowledge and skills to practice according to the Regulated Health Provisions Act, 1991 and the Nursing Act, 1991. However, in 2005, amendments were made to regulations under the Nursing Act, 1991. Thus permitting RPNs to initiate controlled act procedures, such as dressing and cleansing wounds, and assisting an individual with the insertion of a catheter (Ministry of Health and Long-Term Care [MOHLTC], 2007).

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The new diploma program is one term longer than the previous three-semester certificate program. Qualifications for entry to the RPN programs have not changed significantly, except that a requirement for grade 11 math has been added. Similarly, some core components of the program (theoretical knowledge, human biology and practical skills) have remained the same. However, course content has been updated in response to the expanded knowledge base and skill set required to meet the range of competences now required.

To gain a preliminary appreciation of the new curriculum, a comparison was made between the certificate and diploma programs in one institution (see Appendix C). The diploma differs from the certificate program in the addition of four courses in professional development held in the first, third and fourth semesters. Non-nursing courses in both programs include psychology, developmental psychology and sociology. The diploma program had added a second sociology course and a course in active citizenship to requirements already present for the certificate. Most importantly, diploma students spend a considerably longer amount of time in their nursing practicum, which allows for more opportunities to acquire the knowledge and skills required in the workplace.

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Past Trends

The evolution of the RPN is closely related to that of the RN. A shortage of RNs prior to the outbreak of the Second World War created pressures to provide nurse assistants with formal nursing education. As a result, practical nurses were created to provide support for professional nurses and to be substitutes for them under certain circumstances (Pringle et al., 2004). The education of RPNs and their numbers in the workforce continue to be related to policy decisions informed by both the supply of RNs and the state of the economy.

Although practical nurses¹ were intended to assist RNs, their numbers in the Ontario workforce were actually very low during the 1940s and 1950s (Pringle et al., 2004). In 1945, there were 107 practical nurse graduates. By 1951, this number had only risen to 471, despite amendments to the Nursing Act in 1950 allowing for the inclusion of Certified Nursing Assistants.

¹ As noted previously, practical nurses were successively called Certified Nursing Assistants, Registered Nursing Assistants and Registered Practical Nurses.

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It was not until the 1960s that the number of practical nurses in the workforce began to increase dramatically, rising from 950 in 1955 to 14,000 in 1967. During the following decade, their numbers doubled. The Ontario Health Care System was expanding rapidly at this time, and numbers of both RNs and practical nurses increased to serve its needs. Following this boom, numbers increased more slowly. Expansion slowed in 1990 and eventually ceased with the shift towards hospital downsizing and restructuring. As a result, both RPNs and RNs found themselves working in part-time or casual employment.

During the late 1990s and early 2000s, the total number of RPNs employed fluctuated, but there was an overall decline in numbers. A low point was reached in 2004. Registered Practical Nurse employment has subsequently rebounded. Owing to improvements in the job market for nurses, there has been steady growth in RPN numbers through 2006-2008. There have been net gains to the profession in the past three years. These gains are attributable both to significant increases in new RPNs joining the profession and to fewer nurses leaving. In 2007 and 2008, gains and losses were respectively at their highest and lowest levels (CNO, 2008c). In 2008, 27,432 RPNs reported employment in nursing in Ontario, an increase of 5% over 2007 and a 12.3% increase over the 2004 low point (CNO, 2008a).

As shown in Table 1, there were 2,471 new RPNs in 2008; an increase of 18.7% over 2007 and the seventh consecutive year of increase. Compared to 2007, new RPNs from Ontario programs increased by 14.0%, new RPNs from programs in other Canadian jurisdictions increased by 33.3% and new RPNs from programs outside Canada increased by 66.3% (CNO, 2008c).

Table 1. Registered Practical Nurses Employed in Nursing in Ontario 1998 - 2007

Year	Number of Registered Practical Nurses Employed
1998	25,459
1999	25,143
2000	26,034
2001	25,008
2002	25,389
2003	25,739
2004	24,428
2005	24,482
2006	25,115
2007	26,135
2008	27,432

CNO (2009b)

The Contemporary Workforce

The supply of RNs has varied across time and regions. According to the current CNO (2008a) *Membership Statistics Report*, 32,137 RPNs were registered in Ontario in 2008.

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Of these nurses, 27, 422 are employed in nursing in Ontario, another 132 are employed in other provinces and 85 are employed abroad. Among those not working as nurses, 7.3% were employed in other fields and 6.0% were not employed (CNO, 2008a). Relatively few of those not employed in nursing were seeking nursing work. It is possible that some of them were temporarily out of the workforce on maternity leave, long-term sick leave or were attending to domestic obligations. Others maintain their registration but do not work in nursing. Of the 2,029 RPNs who renewed their membership for the first time for the 2008 practice year, 91.0 % reported employment in nursing, 2.2 % reported employment in non-nursing and 6.0 % were not employed (CNO, 2008c).

Of RPNs employed in nursing in Ontario, 56.3 % worked full-time, 35.1 % worked part-time and 8.6 % worked casually, representing a 7.6% increase in full-time work over 2007. Employment patterns varied by LHIN, with the highest rate of full-time employment (61.1%) and the lowest part-time rate (28.1%) being Toronto Central. Erie St. Clair had the lowest full-time rate at 52.4%. It is notable that a smaller proportion of RPNs (56.3%) than RNs (64.7%) are in full-time employment (CNO, 2008a).

The five top employers of RPNs are Long-Term Care (LTC) facilities (28.9%), Acute Care Hospitals (25%), Complex Continuing Care/Rehabilitation Hospitals (11.3%), Addiction & Mental Health Centres/Psychiatric Hospitals (6.6%) and nursing and staffing agencies (5.9%). Most RPNs are staff nurses (76.8%) or visiting nurses (6.3%). Geriatrics is the main area of practice for RPNs (33.5%), with just under 10% in Complex Continuing Care (9.6%), Mental Health/Psychiatric/Addiction (8.2%) and Medicine (8.6%) (CNO, 2008a).

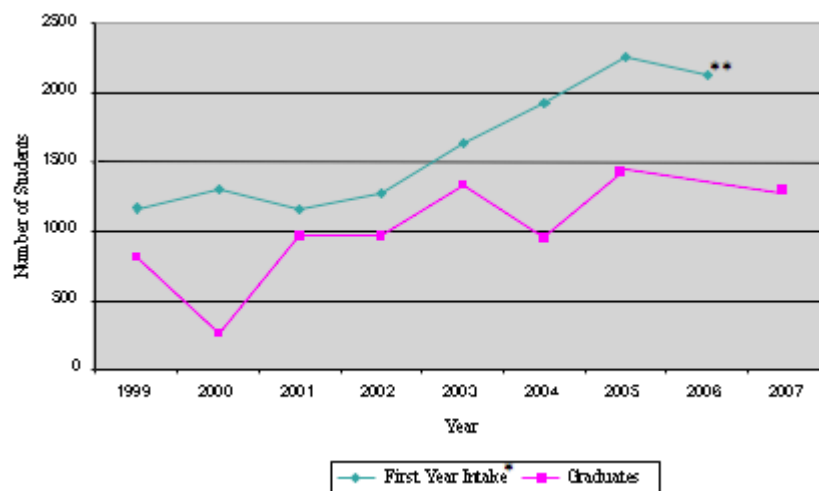
Long-term care continues to be the major employer of RPNs. The government invested in 1200 new RPN positions in LTC in 2007 as a way to affordably increase care from registered staff (MOHLTC, 2007). The number of RPNs working in acute care settings has increased in recent years, this is after a decade in which some hospitals decreased or eliminated their RPN complement. In a new trend currently limited to specific hospitals, RPNs are beginning to specialize in particular areas of practice in acute care settings.

REGISTERED PRACTICAL NURSE GRADUATE TRENDS

There has been an overall increase in RPNs in educational program in Ontario, although there has been some fluctuation in actual numbers enrolling and graduating (see Figure 1). There were 2,125 newly graduated RPNs in 2006- 2007 (CAN, 2007) and 2082 new registrants with the CNO (Baumann et al., 2008). The average age of these new RPNs was 30.9 years, down slightly from 31.0 years in 2006, and most (92%) were female.

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Figure 1. First Year Intake and Supply of Ontario Registered Practical Nurse Graduates (1999-2007)



Note. *The First Year Intake numbers are based on full-time students entering the first year of the RPN program (Baumann et al., 2008).

Baumann et al. (2006, 2008) conducted surveys of new RN and RPN graduates who registered at the Nursing Graduate Employment Portal, which was created in conjunction with the New Graduate Guarantee, an initiative of the Ontario government. They found that RPN graduates were older than their RN counterparts, a factor which likely affects their worklife span, work preferences and career mobility. Reports stemming from the research indicate that the majority of RN and RPN graduates state a preference for full-time work; however, more RPNs than RNs prefer part-time work. This may be the consequence of this older cohort having greater domestic commitments. Registered Practical Nurses working in the community and LTC sectors were much older than their RN counterparts, with more than a quarter being over 40 years of age. The reasons for this warrant further investigation.

Based on the findings of the *Employment of Nursing Graduates* study (Baumann et al., 2008), RPN and RN graduates tend to seek work in the geographic region where they graduated. This accounts for the relatively low percentage of RPN graduates seeking work in Toronto where there are few programs. In 2007, the majority of RPN graduates were seeking employment in medical/surgical (58%) or long-term care (35%). Approximately 22% were considering work outside Ontario, the majority in other provinces, a minority in the United States and very small numbers in other countries (Baumann et al., 2008). In terms of their actual employment, RPNs were working in either an acute care hospital (32.7%) or long-term care (33.4%). Thus there was a similar

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distribution in both the deployment of new RPN graduates and RPNs in the workforce as a whole.

ISSUES IN REGISTERED PRACTICAL NURSE PRACTICE

In Ontario, the General Class of nursing currently constitutes one profession with two registration categories: RN and the RPN. As with RNs, RPNs are regulated through the Regulated Health Professions Act, 1993 and the Nursing Act, 1991 as amended (RPNAO, n.d. b). They are also governed by the same regulatory body, the College of Nurses of Ontario (CNO, 2008b). After graduation, RPN candidates, like RNs, write a national certification examination, renew their CNO membership annually and maintain up to date skills to preserve their professional standing (CNO, 2008a).

Registered Practical Nurses and RNs now have identical authorized acts as outlined in Section 4 of the Nursing Act. The major difference is that while the amended regulations permit RPNs to initiate certain controlled acts independently for their own clients, they are not permitted to order another nurse to perform a controlled act (CNO, 2008b). The CNO (2005, p. 3) explains that:

The foundational knowledge base of RNs and RPNs is different as a result of differences in basic nursing education. Both categories study from the same body of nursing knowledge. RNs study for a longer period of time allowing for greater depth and breadth of foundational knowledge in the areas of clinical practice, decision-making, critical thinking, leadership, research utilization and resource management. RPNs study for a shorter period of time, resulting in a more focused body of foundational knowledge in the areas identified above.

To date, research has not focussed on the practical nurse profession and relevant literature is limited. Registered Practical Nurses rarely initiate academic studies of their own profession, a major reason being that few RPNs are employed by research institutions. In many studies, RNs and RPNs/LPNs are not distinguished from one another. In other studies, the focus is not specifically on the RPN nursing role but on patients or clients. The overlap between the two nursing professions raises issues for nurses and those who study them. These issues are broadly discussed in this paper under three headings: 1) RPN characteristics and attitudes, 2) staff mix and 3) RPN roles and expansion into new practice areas.

Registered Practical Nurse Characteristics and Attitudes

Most studies of RPNs in Ontario use RNs as a comparison group. Two studies note that the RPN workforce is, on average, older than the RN workforce (Letvak, 2002; Tourangeau et al., 2005). However, reasons for this distinction have not been investigated. The shorter period of educational preparation required for RPNs may be attractive to people who are changing careers or are already employed in health care as

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non-professionals. An issue of concern is that proportionately fewer RPNs than RNs have full-time work (CNO, 2008a). Although there is a small quantity of evidence that some RPNs prefer working part-time, there is anecdotal evidence that it is often difficult for RPNs to find full-time work. According to a study by Baumann et al. (2008), new RPN graduates are less likely to find full-time work than RN graduates. Other differences include the greater likelihood of RNs than RPNs to work 12-hour shifts, a circumstance that may be related to the greater propensity of RPNs to be in part-time work.

Tourangeau et al. (2005) also found that RNs and RPNs had similar attitudes to their practice environments. Both groups had relatively low job satisfaction and moderate levels of burnout. McGillis Hall and O' Brien Pallas (2000) found that RNs and RPNs had similar levels of satisfaction with their jobs. They also identified statistically significant differences between RN and RPN respondents on the job dimension of skill variety, with RNs reporting significantly higher skill variety than RPNs.

Differences between RNs and RPNs have been identified in studies of decision-making. A study by Royle et al. (2000) found some differences in RN and RPN decision-making but did not speculate about the reasons for these differences. Using a similar typology, Boblin, Baxter and Alvarado (2008) described and attempted to explain differences in RN and RPN decision-making. While both categories of nurse resembled one another in the way they made decisions, the authors found that RPNs more frequently considered "the risks and benefits to you the nurse." Registered Nurses reported greater frequency than RPNs for eight elements: (a) assessing the client or situation; (b) identifying the problem, need or issue; (c) identifying alternative courses of action; (d) identifying possible outcomes or consequences; (e) considering the likelihood of outcomes; (f) considering the risks and benefits to the client; (g) selecting an intervention or action; and (h) evaluating outcomes. The study suggested that RPNs found it more difficult than RNs to identify possible outcomes or consequences and select an intervention or action. No aspects were found to be more difficult for RNs compared to RPNs.

Boblin et al. (2008) found that nurses varied in their ability to talk about their decision-making. Focus group results revealed qualitative differences among the two groups. Baccalaureate-prepared RNs were more forthcoming and articulate when talking about their decision-making process, followed by RNs with diplomas and then RPNs. This was evident in the nature of their responses and the number of probing questions required for participants to respond to questions about their decision-making. It would be interesting to discover whether or not graduates of the new diploma program differ in their decision-making practices from the nurses in this study who graduated from the certificate program.

An interesting practice-related distinction between RPNs and RNs relates to on-the-job injuries. Tourangeau et al. (2005) report that in their samples, almost twice as many RNs

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than RPNs had received injury from patient-contaminated sharp objects. They suggest that this finding is likely related to the levels of exposure that RNs may have to patient-contaminated sharp materials. Historically, RPNs were less likely to be assigned patients with more complex care needs who require procedures involving objects that can become patient-contaminated and have the potential to injure the nurse. They suggest that as the RPN scope of practice expands, the rate of RPN injury from patient-contaminated sharps is likely to increase.

Staff Mix and the Delivery of Care

Several studies have focused on the affect of models of care with different staff mix on patient outcomes. Rheaume (2003) summarizes this debate. She notes that proponents of a diverse mix of workers (nurses, nursing assistants and unlicensed nursing personnel) argue that freeing nursing personnel from assignments that lesser trained personnel can carry out results in significantly lower hospital-related costs (Ringerman & Ventura 2000). On the other hand, opponents of a diverse skill mix argue that the quality of patient care may be jeopardized by using more auxiliary workers.

Registered Practical Nurses remain the predominant nursing cohort in LTC. However, philosophical differences exist (especially in acute care hospitals) about the value of employing either a solely RN staffing model or a mixed RN/RPN staffing model, with some hospitals preferring the former. One of the arguments against employing RPNs in acute care settings stems from studies that compare patient mortality in situations with varying types of staff mix.

A study by Estabrooks et al. (2005) reported that mortality odds for heart, stroke and pneumonia patients admitted to hospitals in Alberta during the late 1990s were 19% lower for patients in hospitals with a higher proportion of BSN prepared nurses, 17% lower for patients in a hospital with a higher mix of RNs and 26% higher for patients in a hospital with a higher proportion of non-permanent RN staff. A 10% increase in the proportion of RNs with a bachelor's or master's degree across institutions was associated with a 5% decrease in probability of mortality and failure to rescue. Aiken et al. (2002) argued that an increase in workload of one patient per RN was associated with a 6% increase in probability of mortality and a 5% increase in probability of failure to rescue. Tarangau et al (2002) also discussed relationships between staff mix and patient outcomes in Ontario.

A problem with strictly quantitative studies comparing staff mix and mortality rates is that there may be additional or confounding factors that have not been identified in these comparisons. An important issue is the variability of practical nurse education. Because the education and roles of practical nurses differ worldwide, generalizing studies from outside Canada or from other provinces must be done with caution. For this reason, the RPNAO (2004) argues against using studies from the United States to support the claim

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that high ratios of RNs to practical nurses lead to better patient outcomes on the grounds that practical nurse education in the United States is far more limited than in Ontario.

Even in Ontario, care must be taken due to changes in RPN education over time. One of the challenges for researchers in Ontario who are studying RPNs is their heterogeneity. RPN education has changed over time. All nurses are expected to keep themselves up to date through continuing education. However, attitudes to role, scope of practice and interprofessional relations may be established during the early years of practice. In addition, studies characterizing RPNs in the past may not be relevant to RPNs practicing in 2009. There are similar differences among RNs who may have graduated from diploma versus baccalaureate programs.

When considering staff mix, the question of most appropriate care should be emphasized. It is argued that both complex care and relatively stable patients exist in every sector. Therefore, it makes sense to staff according to complexity and stability of patient population instead of arbitrarily by sector. This is especially true as numbers of alternative levels of care patients grow in hospitals and the complexity of residents in LTC increases. Registered Practical Nurses are needed anywhere in acute care where there are stable patients and RNs are desperately needed in LTC to coordinate the care of the more complex patients. Thus the mix should depend on the realities of the average patient population of that particular unit/home (Ontario Association of Non-Profit Homes and services for Seniors, 2000) In some organizations skill mix is considered part of a strategic plan (Dash, 2008; Hamilton Health Sciences, 2008).

Expansion of the Registered Practical Nurse Role

Over the years, the education of RNs and RPNs has increased in breadth and depth. At the same time, the skills and autonomy of practice have also increased. Regulation of the RN and RPN professions has occurred simultaneously. Two issues relevant to the expanding RPN role relate to variation within the profession and the overlap in practice between RNs and RPNs.

Variation Among Registered Practical Nurses

While professional nurses are expected to adapt to changes within their profession and update their practice accordingly, it seems likely that younger diploma RPNs have different opinions about their practice than RPNs educated in earlier programs. There is anecdotal evidence among RPNs which indicates that while many RPNs wish to practice to their full scope, some prefer to care for patients as they have in the past (Hunsberger et al., 2009). It is possible that pressures to change may precipitate retirements among conservative individuals. Distinctions are drawn in the literature between the practice of RNs with diplomas and those with baccalaureate degrees. There may also be differences among RPNs with different basic nursing education.

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Relations Between Registered Nurses and Registered Practical Nurses

Having two nursing professions with similar scopes of practice but different education has led to an overlap in roles and a lack of clarity regarding role boundaries. This not only occurs in nursing but is an ongoing interprofessional problem (Group & Roberts, 2001). The overlapping roles of RNs and RPNs pose difficulties for both groups. Theoretically their greater depth of knowledge allows RNs more autonomy in decision-making relevant to the care of patients however complex or unstable their conditions. Registered Practical Nurses should have autonomy in regard to more stable patients or clients but as complexity increases should increasingly consult with RNs (CNO 2005). The problem is that what is meant by "complex" or "unstable" in practice varies depending on the context. Settings vary in the acuity of their patient population. Therefore, although RPNs take care of the less acute patients in their particular setting, the absolute acuity of the patients and the amount of autonomy they exercise varies in relation to other settings where the range of patient acuity differs. There are no specific rules about when an RPN should seek advice. Furthermore, in a shortage situation, patients must be assigned to nurses who are available. The trend toward RPN specialization among RPNs also blurs professional boundaries.

The 1990s saw the promotion of an all-RN care model, in which RPNs were perceived as surrogates for RNs rather than competent practitioners with a distinct role. Martin (2008) suggested that a lack of respect for an RPN's knowledge base, double standards, belittling, sabotage and poor compensation as evidence of RPN oppression. Registered Practical Nurses sometimes felt their role was compared unfavourably to that of the RN and that they were prohibited from carrying out certain tasks for which they had received instruction. Martin reports that lack of clarity about the RPN role is a workplace issue. In some settings RPNs do not feel appreciated as qualified nurses. In another study, feelings about professional respect varied by age (Seeley, Spadoni, & Strickland, 2004). While RPNs younger than 55 (83%) and older than 55 (93%) felt their judgment was respected, only 75% of RPNs between 45 and 55 felt likewise. No explanation was suggested for this difference, but it is possible that these middle-aged nurses experienced situations where RPNs were being replaced with RNs.

As the numbers of RPNs with diplomas increase, there is pressure from educators, government and organizations to utilize them more fully. Unions and the RPNAO are advocating for RPNs to be allowed to practice to their full scope. Even before the introduction of the diploma, the Canadian Union of Public Employees (2001) conducted a survey on the extent to which RPNs were utilized to their full scope and the extent to which they were employed in all hospital departments. The conclusion was that RPNs were underutilized and that more effective use would ease the nursing shortage and be a more economically propitious solution to managing the provision of patient care.

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Similar conclusions were reached by Seeley et al. (2004), in which nurses were surveyed about their perceptions of their scope of practice and their roles as preceptors. The survey suggested most RPNs did not have opportunities to preceptor. The authors noted that preceptorship experiences were limited to older nurses who planned to retire in the next 5-19 years. In addition, while a greater proportion of younger than older RPNs were prepared to preceptor, most did not have the opportunity to do so.

A report by the RPNAO (2004) suggested that hospitals' operating costs would decrease if more RPNs were appropriately employed. "Appropriate" is a key word here. In considering the future roles of RNs and RPNs, it is essential to ensure that RPNs are not considered cheaper and/less-skilled substitutes for RNs and that the two professions are not put in a position of competing with one another. While the lower wages paid to RPNs encourages employers to use them more fully, it is important that RPNs are not perceived as providing "cheap labour." If they feel professionally threatened and suspect that their jobs are in danger, RNs may react in a hostile manner towards RPNs who carry out advanced nursing tasks (Seeley et al., 2004). In addition, RPNs may experience anger toward RNs and the organization (Baxter et al., 2009)

In the present challenging economic climate and in the midst of a nursing shortage, some hospitals are seeking to employ RPNs in ways that are innovative and/or allow them to practice to their full scope. For example, to improve its standards, the Southlake Regional Health Centre recently enabled each profession, including RPNs, to develop to their best ability (Dash, 2008). These efforts, which involved the input of the RPNAO and CNO as well as nurses themselves, included giving RPNs opportunities for leadership and involving them as mentors for new RPNs. Other health care institutions have undertaken projects, often in partnership with academic researchers, to find ways of ensuring that RPNs work to their full scope while collaborating effectively with RNs. Ross (2006) describes a peri-operative circulating role for the RPN as second circulating nurse at HHS. Although the circulating nurse is always an RN, second circulating nurse may be a RPN.

There has also been a movement towards enhancing the RPN role in acute care facilities to include IV medication and the administration of blood and blood products. A survey of 14 Ontario hospitals conducted by Alvarado and Fozo (2006) suggests that RPNs are administering IV medications in both teaching and community hospitals. At the time of the survey, blood and blood product administration was limited to community hospitals. These latter activities are taught in practical nursing education programs, and recent reports suggest that these RPN skills are now being utilized in teaching hospitals.

Following the changes in both registered nursing and practical nursing programs in 2005, many organizations embarked upon a nursing utilization review. Some completed in depth feasibility studies (HHS, 2008). The thrust of these studies was to engage

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management and frontline nursing staff in determining the most appropriate care provider. The resulting skill mix decisions were generally well received by staff and many RN positions were converted to RPN positions through attrition. In 2008 and 2009, consultants were invited into organizations to assist with benchmarking and identification of cost reduction strategies. This created a philosophical shift away from determining the most appropriate care provider to cost reductions associated with replacement of RN positions with RPN roles. Organizations are now being assessed against those that have implemented skill mix changes.

CONCLUSIONS

The role of practical nurses internationally, nationally and provincially has been under researched. The diversity of practical nurse educational preparation and practice roles means that it is important to conduct studies locally. Although some useful comparisons can be drawn across jurisdictions, the lack of research on practical nurses in Ontario is a clear disadvantage when planning the future nursing workforce. Hence this report has presented an overview of RPN education and practice in Ontario.

Because of changes in regulation, RPN education and in the society in which nurses practice, a new vision is needed about how the RN and RPN professions should develop and relate to one another in the future. However, before such plans are made, current issues must be identified and resolved. Failure to establish definitive roles for RNs and RPNs may affect the credibility of the nursing profession in terms of interprofessional collaboration and public trust. The challenge for policy makers and workforce planners is to ensure that RPNs are used appropriately and to their full scope. Financial savings should not be implemented at the cost of patient care.

RECOMMENDATIONS AND AREAS OF FURTHER STUDY

This overview of the RPNs in Ontario suggest that further investigation needs to be carried out to provide evidence to assist workforce planners, educators and regulators in the future.

1. Baseline knowledge of RPN practice and role are required in all health care sectors where they are employed.
2. Further information on RN/RPN decision-making would reveal whether the distinctions previously perceived by researchers persist despite the changed educational preparation for RNs and RPNs.
3. Clarification is required of “appropriate” contexts in which RPNs can work to their full scope.

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4. Resolution of the issue of RN/ RPN role ambiguity is a priority for nurses, regulators, health human resource planners and other stakeholders because of the potential impact on the future of the nursing profession. Related goals might include the following:
 - a. Clarification of roles and responsibilities of RNs and RPNs
 - b. Education of RNs and RPNs about these roles
 - c. Identification of optimum collaborative arrangements to be implemented by RNs and RPNs and between RPNs and unregulated caregivers
 - d. Educating RNs and RPNs about the differences between their roles in order to reduce potential conflict.
 - e. Education of RNs and RPNs in conflict management
5. Understanding how collaboration influences costs would help health care employers to staff efficiently and effectively.

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Appendix A. Development of Practical Nursing Education in Ontario

Year	Milestone	Length of Program
1938	First courses offered	6 months
1941-1945	Registered Nurses' Association of Ontario sponsored 8 six-month training programs (107 nurses graduated)	6 months
1946	Nine-month courses offered in Toronto, Kingston and Hamilton under the sponsorship of the Ontario Department of Health and the Department of Education	9 months
1947	Nursing Act amended to provide for the title Certified Nursing Assistant, following the recommendations of the Canadian Nurses' Association and the Registered Nurses Association of Ontario	
1950	Five training centres sponsored by the Ontario Department of Health (471 Certified Nursing Assistants)	
1951	Registered Nursing Association of Ontario responsible for registration and standards	
1953	Length of program increased	10 months
1955	Thirteen training centres	
1957	Part-time evening classes and Department of Education secondary school program taken in Grades 11 and 12 available	
1963	College of Nurses of Ontario became the regulatory body Title changed to Registered Nursing Assistant	
1967	Registered Nursing Assistant program reduced in length	35 weeks
1975	Fifty training centres	
1981	Review of Registered Nurse Practitioner curriculum undertaken with a view to greater utilization of Registered Nursing Assistants Instruction in medication administration deleted from curriculum and aseptic techniques added	1 year?

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Year	Milestone	Length of Program
1990	Expansion of Registered Nursing Assistant role to community - 42 training centres	
1993	Nursing Assistant program lengthened Title changed to Registered Practical Nurse	1.5 years
1999	College of Nurses of Ontario published the Entry to Practice Competencies for Registered Practical Nurses (as of 2005), which acknowledged changing competencies expected for beginning Registered Practical Nurses	
2001	Ministry of Training, Colleges and Universities published revised Practical Nursing Program Standards	
2002	Four colleges offering diploma program	2 years
2005	Diploma mandatory for entry to practice	
2009	Practical Nurse the new Registered Practical Nurse Entry to Practice Competencies are in the process of being completed by the College of Nurses of Ontario	

Adapted from the Registered Practical Nurses Association of Ontario Web site:
<http://www.rpnao.org/about/history.asp>

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Appendix B. Ontario Colleges with Registered Practical Nurse Diploma Programs

Local Health Integration Network	College
Erie St. Clair	St. Clair Lambton
Southwest	Fanshawe
Waterloo Wellington	Conestoga
Hamilton Niagara Haldimand Brant	Mohawk Niagara
Central West	-----
Mississauga Halton	Sheridan Humber
Toronto Central	George Brown Centennial
Central	Seneca
Central East	Durham Fleming
South East	St. Lawrence Loyalist
Champlain	Algonquin La Cité
North Simcoe Muskoka	Georgian
North East	Canadore Northern Collège Boréal Cambrian
North West	Sault Confederation

Source: College of Nurses of Ontario, 2007.

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Appendix C. Comparison of a Sample Certificate and Diploma Program Curriculum

	Certificate	Diploma
Length of Program	3 semesters	4 semesters
	All nursing courses are 7 weeks in length except where noted.	
	All other courses 14 weeks in duration.	
Courses Semester 1	LLO41 Communications (langs) 3 SS156 Introductory Psych 3 SS108 Introductory Sociology NB001 Human Biology 3 NB002 Human Biology 3 NE001 Nursing Experience 8 NE002 Nursing Experience 8 NT001 Nursing Theory 5 NT002 Nursing theory 5	LLO41 Communications (langs) 3 SS156 Introductory Psych 3 See Semester 2 PNB11 Health Sciences 11 3 PNE11 Practicum11 14 PNT11 Health and Healing 11 PND11 Professional Development 2
Courses Semester 2	Co291 Computers in Nursing 3 SS271 Developmental Psych 3 NB003 Human Biology 3 NB004 Human Biology 3 NP003 Nursing Practice 15 NP004 Nursing Practice 15 NT0003 Nursing Theory 5 NT004 Nursing Theory 5	Co291 Computers in Nursing 3 See Semester 3 SS108 Sociology 1 3 PNB21 Health Sciences 21 3 PNB22 Health Sciences 22 3 PNE21 Practicum 31 15 PNE2 Practicum 42 15 PNT 21 Health and Healing 21 3 PNT 22 Health and Healing 22 3
Courses Semester 3	NP005 Nursing Practice 8 wks 22.5 NP006 Pre-Grad Practice 16 weeks 37.5 NR005 Nursing Theory 5	SS271 Developmental Psych SS109 Sociology 2 PNE 31 Practicum 31 15 PNE32 Practicum 32 15 PNT 31 Health and Healing 31 3 PNT 32 Health and Healing 32 3 PND31 Prof. Development 31 2 PND 32 Prof .Development 32. 2
Courses Semester4		Comm10034 Active Citizenship 2 PND41 Prof Development 41 3 PNE42 Pre-Grad Experience 40 See Semester 3 PNT41 Health and Healing 41 4 Practicum 41 15.00