

Registered Practical Nurses' (in Post RPN-BScN Education) Experiences of Nurse-to-
Nurse Conflict in the Workplace

by

Yvonne Mais

A Thesis Submitted in Partial Fulfillment
of the Requirements for the Degree of

Master of Health Sciences

in

The Faculty of Health Sciences

Program

University of Ontario Institute of Technology

August, 2017

© Yvonne Mais, 2017

Acknowledgments

First, I would like to acknowledge my research supervisor Dr. Vicki Smye. You have provided me with the utmost support and guidance through my thesis journey. Without your help, expertise and confidence in me I could not have accomplished everything that I did. It has been such a privilege to work with you the past two years.

Second, I would like to thank my thesis committee members Dr. Toba Bryant and Dr. Manon Lemonde for your insight, advice, and feedback that was essential throughout the process of my thesis research. An extended thank you to Dr. Toba Bryant for the rich and wonderful teaching assistant experience. It was a pleasure to work with you as I learned so much. Thank you for igniting my deep interest in the social determinants of health, health equity and policy.

Third, I would not be where I am today without my support system of family and friends. To my parents, Monica Mais, Brian Mais, Ralph Berry, and Jeanette Magic, and grandparents, Eva Zaduban, Maureen Mais, and Robert Mais—thank you for all of your unconditional love, encouragement, and faith in me to accomplish my goals and dreams. I am also appreciative for my brother, Sean Mais, with his much needed, blessing in disguise distractions and laughs. To Brent King for his unfailing support, patience, and reassurance throughout the past 5 years. Thank you for always believing in me, I could not have done it without you. I would also like to mention my closest friends, Karen Cook who sometimes felt like the only person who understood this process and always helped me to push through, Jennifer D'Alessandro for unknowingly giving me the idea to study RPNs, and Claire McConnachie for always reminding me to have some fun! Last but not least, to my new friends Hinaya Cader and Melanie Dissanayake, thank you for giving me

confidence and making this journey both enjoyable and achievable, it would not have been possible without all of the laughs. We did it together!

Abstract

This research examined the experiences of nurse-to-nurse conflict of RPNs enrolled in a post RPN-Bachelor of Science in Nursing program. This study also explored how these experiences shaped their decision to return to school for a BScN to become Registered Nurses (RNs). Interpretative Phenomenological Analysis was used as the methodology to explore the experiences of six participants through in-depth individual interviews. Five themes emerged from the data analysis: the current organizational context of health care; marginalization of the RPN; the in-between space; hierarchy, power, and privilege; and professional development and a drive for change. The findings of this research highlighted how broader contextual factors intersected and influenced conflict between nurses, and how experiencing nurse-to-nurse conflict motivated the participants to return to school for a BScN. The findings from this research have implications for nursing education, health care professionals, employers, and decisions makers when addressing and creating policies around nurse-to-nurse conflict.

Keywords: nurse, conflict, RPN, BScN, school

Table of Contents

Acknowledgement.....	ii
Abstract.....	iv
Chapter One: Introduction.....	1
1.1 Using the First-Person Voice.....	2
1.2 Background: Nurse-to-Nurse Conflict.....	2
1.3 Research Gaps and Rationale.....	3
1.4 Research Questions.....	6
1.5 Goals and Objectives.....	6
1.6 Positionality.....	8
Chapter Two: Literature Review.....	10
2.1 Search and Selection Criteria.....	10
2.2 Background to the Nursing Education and Profession.....	12
2.3 Violence in the Workplace.....	15
2.4 Background: Nurse-to-Nurse Conflict.....	16
2.4.1 Associated Behaviours With Nurse-to-Nurse Conflict.....	18
2.5 Outcomes and Implications of Nurse-to-Nurse Conflict.....	19
2.5.1 Nurse Health and Wellbeing.....	19
2.5.2 Psychological and Physical Outcomes.....	19
2.5.3 Job Stress and Dissatisfaction.....	20
2.5.4 Burnout.....	21
2.5.5 Moral Distress.....	22
2.5.6 Intentions to Leave the Profession.....	25

2.5.7 Patient Health Outcomes.....	26
2.5.8 Health Care System Outcomes.....	27
2.6 Who Experiences Nurse-to-Nurse Conflict?.....	27
2.7 Contextual Factors that Contribute to Nurse-to-Nurse Conflict.....	30
2.7.1 Historical Background.....	30
2.7.2 The Shifting Education and Ambiguous Scopes of Practice.....	32
2.7.2.1 RPNs’ Experiences of Nurse-to-Nurse Conflict.....	34
2.7.3 Hierarchical Structures.....	37
2.7.4 Health Care Restructuring and Organizational Change.....	38
2.8 RPNs’ Pursuit of Higher Education.....	43
2.9 RPNs’ Experiences: Gaps in the Research.....	44
2.9.1 RPNs’ Return to School.....	45
2.10 Research Questions.....	46
2.11 Research Significance and Rationale.....	46
Chapter Three: Methodology, Methods, Data Collection and Analysis.....	48
3.1 Methodology.....	48
3.1.1 Phenomenology as a Philosophy.....	48
3.1.2 Background and Rationale to the Methodology.....	50
3.1.3 Participant-Researcher Relationship.....	53
3.2 Method.....	54
3.2.1 Research Ethics.....	54
3.2.2 Participants.....	54
3.2.3 Participant Recruitment.....	56

3.3 Data Collection and Procedure.....	57
3.3.1 In-depth Individual Interviews.....	57
3.3.2 Setting.....	58
3.3.3 Specific Procedure.....	58
3.4 Data Analysis.....	59
3.5 Scientific Rigour.....	61
Chapter Four: Findings.....	63
4.1 The Current Organizational Context of Health Care.....	63
4.1.1 Budget Constraints, Staff Shortages, and Stress.....	64
4.1.2 Management Issues.....	65
4.1.3 Organization of Care Provision and Teamwork.....	68
4.2 Marginalization of the RPN.....	69
4.2.1 RN-RPN Relations.....	70
4.2.2 Relations with Senior Nurses.....	72
4.2.3 Marginalization and Role Confusion.....	72
4.2.4 RN Vulnerability and Institutional Financial Constraints.....	73
4.3 The In-between Space.....	74
4.3.1 Role Confusion and the Shifting RPN Education.....	74
4.3.2 Transitioning from RPN to RN.....	75
4.4 Hierarchy, Power, and Privilege.....	78
4.4.1 Hierarchical Structures.....	78
4.4.2 Nonconformity and Conflict.....	80
4.4.3 Inequity in Workplace Tasks.....	81

4.5 Professional Development and a Drive for Change.....	83
4.5.1 Coping Strategies.....	83
4.5.2 The Catalyst for Change.....	84
4.5.3 Breaking the Cycle.....	85
Chapter Five: Discussion and Conclusion.....	88
5.1 Powerful Intersecting Forces: The Perfect Storm.....	88
5.1.1 Increased Shortages and Workload.....	90
5.1.2 Increased Patient Acuity.....	90
5.1.3 Shifting RPN Education: Ambiguous Scope of Practice and Role Confusion.....	91
5.1.4 A Culture of Acceptance.....	92
5.1.5 The Nursing Hierarchy.....	94
5.1.6 The Perfect Storm.....	95
5.2 Appropriate Staff Mix and Efficiencies: Never the Twain Shall Meet.....	96
5.2.1 Consequences of Cutting Costs.....	97
5.2.2 Implications of Staff Mix and Efficiencies.....	98
5.3 Empowerment Through Education.....	99
5.3.1 Decision-making Processes.....	100
5.3.2 Mitigating Nurse-to-Nurse Conflict through Leadership and Education.....	100
5.4 Significance of the Findings.....	101
5.5 Implications for Practice.....	103
5.5.1 Suitable Staff Mix.....	103

5.5.2 Addressing Role Confusion and Ambiguous Scope of Practice.....	103
5.5.3 Education.....	104
5.5.4 Teamwork.....	105
5.5.5 Management.....	106
5.5.5.1 Practicing positive leadership.....	107
5.5.6 Changes at the Organizational Level.....	108
5.6 Limitations of the Study.....	109
5.7 Directions for Future Research.....	110
5.8 Conclusion.....	111
Appendix A: UOIT REB Approval.....	113
Appendix B: DC REB Approval.....	114
Appendix C: Verbal Recruitment Script.....	115
Appendix D: Handout Invitation with Contact Information.....	117
Appendix E: Interview Guide.....	118
Appendix F: Letter of Invitation.....	120
Appendix G: Consent Form.....	122
Appendix H: Thank You Letter.....	126
References.....	128

Registered Practical Nurses' (in Post RPN-BScN Education) Experiences of Nurse-to-Nurse Conflict in the Workplace

CHAPTER ONE

Introduction

Nurses provide an essential contribution to the success of the Canadian health care system. There are three regulated bodies of nurses in Ontario, Canada, which consist of: Nurse Practitioners (NPs), who have education and training beyond a baccalaureate degree; Registered Nurses (RNs), who hold a Baccalaureate degree in nursing; and Registered Practical Nurses (RPNs), who have completed a two-year Ontario college diploma (College of Nurses of Ontario [CNO], 2014b). In provinces and territories outside of Ontario, RPNs are titled Licensed Practical Nurses (LPNs). With the frequent number of post RPN-Bachelor of Science in Nursing (BScN) bridging programs offered across Ontario, RPNs have the opportunity to continue their education and obtain their BScN. RPNs may then write the national exam to be licensed and practice as RNs.

All types of nurses provide support and care for people and help them to attain, maintain, and regain health. However, an interesting paradox exists within the nursing profession: conflict, violence, and hostility between nurses. Nurse-to-nurse conflict is ubiquitous within nursing work and has been documented in the literature for nearly three decades (Roberts, 1983, 2015). In this research, I examined the experiences of nurse-to-nurse conflict in the workplace of RPNs enrolled in a RPN-BScN program. In particular, I considered whether these experiences shaped their decision to return to school for a BScN to become RNs.

1.1 Using the First-Person Voice

A qualitative methodology and research paradigm was used to answer my research questions. As a result, the first-person voice is used throughout the following chapters. Webb (1992) argues that the use of first-person in scholarly writing is both acceptable and required, especially in qualitative research, as the researcher plays a crucial role in the formation of ideas and data that are presented. Webb also argues that research is both biased and deceptive if the first-person voice is not used. Using the first-person voice ensures and maintains reflexivity throughout the research process. Conducting qualitative research involves the researcher's inevitable influence, choices, and decisions about the direction and conclusions of the research (Webb, 1992).

1.2 Background: Nurse-to-Nurse Conflict

Nurse-to-nurse conflict is defined as nurses overtly or covertly directing their dissatisfaction towards other nurses—who are of equal or lesser status in the workplace or organization—with inappropriate and disruptive behaviours (Christie & Jones, 2013; Griffin, 2004). These behaviours that constitute nurse-to-nurse conflict involve (but are not limited to): gossip, intimidation, withheld information, ostracism, ridicule, backstabbing, and sabotage (Coursey, Rodriguez, Dieckmann, & Austin, 2013; Griffin, 2004). Research indicates that even though nurses are exposed to conflict in the workplace from several perpetrators, such as patients, managers, administrators, and physicians (Vogelpohl, Rice, Edwards, & Bork, 2013), they are most perturbed about conflict from their fellow nursing peers and colleagues (Farrell, 1997).

Although some research attributes nurse-to-nurse conflict to individual or personality level factors (Coyne, Seigne, & Randall, 2000), other research suggests how

several contextual factors have a stronger impact on the conflict between nurses, particularly between RNs and RPNs. For instance, the history and evolution of the nursing profession, ambiguous scope of practice for RNs and RPNs in the workplace, and the hierarchical nature of the nursing profession contribute to conflict between nurses (Butcher & MacKinnon, 2015; Martin Saarinen, 2008; Meadows & Prociuk, 2012). Structural and organizational factors, such as the restructuring in the health care system (Armstrong & Armstrong, 2010) in Ontario, Canada, also give rise to conflict between RNs and RPNs. For instance, RNs jobs are cut and replaced with lower-paid nurses like RPNs for cost-saving measures (Frketich, 2016; Ontario Nurses' Association [ONA], 2016). Therefore, many RNs feel vulnerable, stressed, and may lash out in the form of hostility causing conflict, as their jobs are being replaced with RPNs (Meadows & Prociuk, 2012).

1.3 Research Gaps and Rationale

There are several negative outcomes associated with nurse-to-nurse conflict. Victims of nurse-to-nurse conflict often experience issues with health and wellbeing. For instance, research has found that nurses suffer psychologically, such as anxiety, depression, mistrust, nervousness, lowered confidence and self-esteem (McKenna, Smith, Poole, & Coverdale, 2003), and low motivation and productivity (Yildirim, 2009). Physical repercussions have also been documented in the literature, such as eating disorders, sleep disturbances (Murray, 2009), weight loss, headaches, angina, and hypertension (McKenna et al., 2003). Research has also found that nurses have reported increased job stress and dissatisfaction with their work (Berry, Gillespie, Fisher, Gormley, & Haynes, 2016; Purpora & Blegen, 2015), increased rate of burnout

(Babenko-Mould & Laschinger, 2014), moral distress (LaSala & Bjarnason, 2010), and intentions to leave the nursing profession (Simons, 2008).

Research has also shown the negative impact of conflict between nurses in the workplace on patient health outcomes and quality of care (Woelfle & McCaffrey, 2007; Yildirim, 2009). Finally, there are repercussions to the health care system. For instance, as a result of an increased risk to the health and wellbeing, nurses are more likely to have an increase in absenteeism, stress leave, and turnover—all of which cost the health care system due to supplementation in employee benefits, retention, and recruitment costs (Canadian Nurses Association [CNA], 2017). Overall, nurse-to-nurse conflict has several negative associated outcomes for nurses, patients, and the health care system and is worthy of continuous investigation.

Research often documents and focuses on RNs' experiences of nurse-to-nurse conflict. Newly licensed RNs and RN students have been cited as some of the most vulnerable groups of nurses that experience nurse-to-nurse conflict (Longo, 2007; McKenna et al., 2003). However, there is a paucity of research that focuses on RPNs' perspective of this phenomenon. For instance, the literature on the negative outcomes of nurse-to-nurse conflict often examines RNs' perspectives. Therefore, through this research I addressed this gap by exploring RPNs perspectives and experiences of nurse-to-nurse conflict and examined how this dynamic also applied to RPNs.

Examining RPNs' experiences of nurse-to-nurse conflict was also crucial as employers throughout Ontario have recently hired and replaced RNs with RPNs (ONA, 2011). The Canadian Institute for Health Information (CIHI; 2015) reported a growth in the supply of RPNs (13.2%) compared to RNs (9.2%) within the last decade. Research

has shown how job replacement (as a response to financial pressures) in the nursing field has contributed to conflict between the two types of nurses, particularly from RNs towards RPNs (Meadows & Prociuk, 2012). Therefore, by exploring RPNs' experiences of bullying and conflict, this research highlighted this phenomenon in the context of broader level factors (such as cost cutting measures) and their impact on nursing relations.

As discussed above, some RPNs return to school to complete a BScN and become RNs. Yet, the expansion of post RPN-BScN programs is counter to the availability of RN job opportunities in Ontario with the rapid rate of RN replacement with RPNs (Frketich, 2016). Research has also shown that RPNs feel motivated to return to school as a result of feeling a lack of respect and mistreatment from fellow RN co-workers (Martin & Weeres, 2012). Therefore, it was important for this research to further examine and understand what motivates RPNs to decide to return to school and become RNs.

Coffey et al. (2013) found that RPNs spent 4.4 years between the completion of the RPN diploma and the beginning of the post RPN-BScN program. Research has also found that newly licensed nurses commonly experience bullying (McKenna et al., 2003) and nurses who have worked fewer than five years are likely to encounter nurse-to-nurse conflict more frequently than those who have been working for longer (Vessey, Demarco, Gaffney, & Budin, 2009). Therefore, could there be a link between experiencing nurse-to-nurse conflict and returning to school for a BScN and become a RN? Research has yet to explore how RPNs' experiences of conflict and bullying shape their decision to go back to school.

1.4 Research Questions

As a result of the existing literature (which is explored further and in depth within the literature review), I proposed the following two research questions to investigate the experiences of RPNs (in a post RPN-BScN program):

- 1) What are the experiences of RPNs in the post RPN-BScN program with nurse-to-nurse conflict in the workplace?
- 2) How do these experiences contribute to RPNs' decision to go back to school for a BScN?

A qualitative approach was taken to address these two research questions, especially as most of the research on this topic is quantitative in examining the prevalence, causes, and effects of nurse-to-nurse conflict. Specifically, Interpretative Phenomenological Analysis was used as the qualitative methodology to explore the phenomenon under study. In-depth individual interviews were conducted to explore RPNs' experiences of nurse-to-nurse conflict in the workplace and determine if these experiences were instrumental in their return to school for a BScN. This research contributes to the existing literature by focusing on a sample of RPNs in a post RPN-BScN program that have had experiences with nurse-to-nurse conflict. It also highlights how broader contextual factors powerfully shape conflict between nurses.

1.5 Goal and Objectives

The goal of this study was to document the lived experiences of RPNs in a post RPN-BScN program and their experiences of nurse-to-nurse conflict in the workplace, as there is scant research that examines this particular sample of nurses regarding conflict between nurses. All types of nurses' (RNs, RPNs etc.) perspectives of this phenomenon

are important in order to effectively address the issue. This study also helped identify how their experiences of nurse-to-nurse conflict shaped their decision to return to school to obtain a BScN and become RNs.

There is inconsistency in the existing literature on the contributing factors that create conflict between nurses. For example, some research suggests that individual level factors such as personality (i.e., Coyne et al., 2000) influence nurse-to-nurse conflict. However, other research suggests that contextual level factors have a more powerful impact on the tensions that arise (Hutchinson, Wilkes, Jackson & Vickers, 2010), particularly between RNs and RPNs. Few studies consider the influence of these factors, thereby decontextualizing nurse-to-nurse conflict. Therefore, this research study will add to the existing literature by examining the perspectives of RPNs, in a post RPN-BScN program, in relation to nurse-to-nurse conflict; this is to assist our understanding of how the current context in which nurses work influences the relationship between them.

Healthcare professionals, including managers and policy makers, can also gain insight and utilize the results of this research when developing strategies and policies regarding conflict in the workplace. Understanding RPNs (in a post RPN-BScN program) perspectives and how the context influences nursing relations is crucial to address the issue. This research will help to avoid the prevalence and future incidences of nurse-to-nurse conflict in the workplace so that all nurses can thrive in a healthy work environment, reduce associated psychological and physical risks, focus on quality patient care, and ensure a sufficient nursing workforce.

1.6 Positionality

Positionality “reflects the position that the researcher has chosen to adopt within a given research study” (Savin-Baden & Howell Major, 2013, p. 71). It is important for me to describe my positionality in this research as a researcher engaged in a phenomenological study.

My inspiration for this research originated from a trip to a local hospital with my father. While waiting to see a doctor in the full and hectic waiting room, I noticed several nurses who appeared very stressed, one of which was hostile and brusque towards her nursing co-workers. With a degree in psychology and an interest in human behaviour, this experience immediately piqued my curiosity; I asked myself how someone in a profession centered on caring and compassion could act in this way. What had started as a Google search quickly progressed into my own graduate thesis research study.

At the beginning of my research journey, I held my own pre-assumptions about nurse-to-nurse conflict, which I documented in a journal and kept throughout the research project. My first-hand experiences of nurse-to-nurse conflict led me to initially think about and attribute the hostile behaviour to micro-level factors, such as personality clashes between RNs and RPNs. However, my position and views shifted as I broadened my knowledge of the topic, investigated the views of several different researchers, and learned about different types of nurses’ experiences. I developed a deeper understanding of the issue and the role that context played. This was only further reinforced as I continued with my research and interviewed RPNs in a post RPN-BScN program. I gained insight to their experiences, which illuminated how broader level contextual factors propagate and influence the tensions that exist between nurses.

The motivation and aim of this research was not to focus on nurses (RNs, RPNs, etc.) or the nursing profession as the problem, but instead to understand nurse-to-nurse conflict. I was able to demonstrate this through the exploration and description of the experiences of RPNs in a post RPN-BScN program in relation to nurse-to-nurse conflict in the workplace. In addition, because I am not a nurse, I was an outsider in this world. In this position as a researcher, I was able to locate nurse-to-nurse conflict as strongly shaped within a particular context and advocate for nurses experiencing this issue.

CHAPTER TWO

Literature Review

2.1 Search and Selection Criteria

The search engines that were used for this literature review were Scholars Portal Journal, PubMed, and Proquest Nursing and Allied Health source. All of these search engines contain a wide range of reliable and credible scholarly sources. These databases allowed for the search of information in an organized fashion, providing relevant results from the refining options, such as searching key words in different fields (such as the title) and setting various search criteria to limit the results. They also show the different articles that have cited a particular article and provide an abstract. For each search engine, a variety of keywords were used (using an asterisk* for many to search for all terms related to the root word) in differing orders to search for articles on the topic of interest. Identifying as many terms associated with the concept of nurse-to-nurse conflict was also important for my search, as they are used interchangeably throughout the literature. These terms include: bullying, hostility, horizontal violence, lateral violence, incivility and aggression. This way content that is pertinent to the topic would not be overlooked. Other terms included in my search were: nurses, education, student, and returning to school. For example, in Scholars Portal Journal, the combination of “conflict” and “nurses” were used as key terms to search for articles that contained them as key words or in the title. The rationale for these key terms is that they are most associated with the topic and can be used to identify the articles that are most relevant to the research project.

Upon selecting the articles to include for this literature review, those that were most relevant to the topic of interest were primarily used. All of the periodicals used were

peer-reviewed. This way, scholarly information that covers the topic is included.

Inclusion criteria for articles included: covering the concept of nurse-to-nurse conflict; quantitative or qualitative primary research; reasons for nurses returning to school; consequences for nurses experiencing nurse-to-nurse conflict; settings/locations that similarly represent the Canadian health care system or have similar nursing practices (included were countries like New Zealand and Australia); and the English language.

Exclusion criteria included: the perspective of patients, senior/charge nurses, and educators on nurse-to-nurse conflict; research published in languages other than English; opinion pieces/essays; and research that only investigated sexual harassment. Overall, the articles that are used in this literature review are those that are most beneficial and relevant to the research, help build the argument, increase knowledge, help to identify the gap within the literature, and coherently construct the literature review.

In the following I review the literature on nurse-to-nurse conflict and explore the different views held by researchers and the factors that contribute to the issue. Some of the key themes revealed by the literature were: the defining behaviours of nurse-to-nurse conflict, the mental and physical impact on nurses, how students and new graduates experience this phenomenon more than experienced nurses, how nurse-to-nurse conflict affects retention and turnover, and how this issue is still pervasive within the nursing workforce despite efforts (i.e., policies in place) to reduce and prevent it. However, the literature is inconsistent about the contributing factors of nurse-to-nurse conflict. For example, some research attributes bullying to individual-level factors such as personality (Coyne et al., 2000), while others attribute it to poor management style and tolerance for the behaviour (Murray, 2009). Research has also argued the impact of broader level

contextual factors, such as ambiguous scopes of practice (Meadows & Prociuk, 2012). Therefore, I review several contextual factors in detail (such as the historical background of nursing, shifts in the RPN education and ambiguous scopes of practice, hierarchical structures, and health care restructuring and organization change).

The few studies that examine RPNs' experiences of nurse-to-nurse conflict are presented in the following literature review. However, several of these studies imply or have the tendency to blame or even vilify RNs for RPNs' experiences with conflict in the workplace. Therefore, it is of paramount importance to acknowledge that I, as the researcher, do not set out to do this in my research study. Rather, the review of this particular literature and research study as a whole is intended to show how examining the experiences of RPNs is key to understanding nurse-to-nurse conflict.

2.2 Background to the Nursing Education and Profession

Nursing is the largest group of health professionals in Canada's health care workforce (CIHI, 2016). This group of health professionals provides an essential contribution whether nurses work in hospitals or community settings, such as home or nursing care facilities. Specifically, in Ontario, the regulated nursing bodies are: Registered Nurses (RNs), who hold a Baccalaureate degree in nursing, and Registered Practical Nurses (RPNs), who have completed a two-year Ontario college diploma (CNO, 2014b). RPNs are titled Licensed Practical Nurses (LPNs) in provinces and territories outside of Ontario. There are also Nurse Practitioners (NPs) who have additional experience and education beyond a baccalaureate degree.

A RN and a RPN work together in the workplace; however, there are both differences and similarities in their educational background, as well as different roles and

responsibilities assigned to each (CNO, 2014b). Throughout their education, RNs and RPNs learn and study some of the same foundational knowledge essential to nursing. However, RNs study for longer allowing them to further develop their skills in the areas of critical thinking, decision making, leadership, resource management, policy and research (CNO, 2014b). RPNs are responsible for the care of a patient with conditions that are less complex. The more complex or unpredictable the patients' condition, the more restricted the autonomy the RPN has and increased counsel from the RN required (CNO, 2014b).

RPNs can return to school to obtain a BScN. They are then required to write a national exam to become a RN. Completing an accredited post RPN-BScN program, which may include a bridging semester, is necessary for RPNs aspiring to become RNs. Research by Aiken, Clarke, Cheung, Sloane, and Silber (2003) suggest reasons and encourage the education of nurses at the baccalaureate level. Aiken et al. conducted a cross-sectional analysis and investigated whether failure to rescue and risk-adjusted mortality was related to the number of nurses who had (at least) a baccalaureate level of education. Results showed that nurses' level of education was associated with patient health outcomes and quality of care. Specifically, Aiken et al. found that the increased proportion of nurses who were educated at the baccalaureate level (or higher), the less likely mortality and failure-to-rescue rates occurred amongst surgical patients.

Research by Coffey et al. (2013) demonstrates that nurses also understand the importance for the advancement of their practice through higher education. Coffey et al. examined nursing graduates' experiences of post-graduation from a post RPN-BScN program and found that graduates experienced many outcomes, such as greater freedom,

autonomy, choice, and flexibility in their current jobs as RNs. They also found that graduates experienced a greater demand for critical thinking and a broader perspective, greater leadership knowledge, self-esteem, confidence, and a sense of heightened professional responsibility compared to their previous role as a RPN. Graduates also found that they felt pride and accomplishment, and had increased autonomy and professional freedom.

Zuzelo (2001) conducted a study with focus groups consisting of nursing students who were advancing their education through a BScN program. Results showed that nurses were motivated to complete their BScN for enhanced career opportunities and sense of personal accomplishment. Parzen's (2010) review of the literature found that RPNs were also motivated to return to school for a BScN as a result of increased monetary benefits from higher education.

A growing trend for RPNs entering post RPN-BScN programs is evident with the expansion of post RPN-BScN programs across Canada and the province of Ontario (Coffey et al., 2016; Cook, Dover, Dickson, & Engh, 2010; Cubit & Lopez, 2011; Miller & Leadingham, 2010; Rapley, Davidson, Nathan, & Dhaliwal, 2008). However, although there were 406,817 regulated nurses in Canada as of 2014 (CIHI, 2015), a recent report demonstrated that the nursing profession is under strain. For the first time in 20 years, the number of regulated nurses who left the profession is higher than those who entered it (CIHI, 2015). The supply of nurses (those who are eligible to work) fell 0.3% between 2013 and 2014. The report proposed several reasons for the shift in the nursing supply. For example, fewer applied for registration, while more did not renew their registration as a result of factors such as retirement or moving outside of Canada (CIHI, 2015).

Interestingly, the CIHI report also suggested that nurses are choosing to leave the nursing profession. An important question is what are the factors that affect nurses' decisions to depart from a career in nursing?

Previous research has examined several contributors that influence nurse retention (e.g., Erenstein & McCaffrey, 2007). For instance, several reviews of the literature have indicated that job stress and satisfaction, management style, workload, and perception of empowerment and control are correlated with nurse retention and turnover (Erenstein & McCaffrey, 2007; Hayes et al., 2012). Despite the many reasons that are associated with nurses' decisions to leave the profession, research argues that job satisfaction is a primary factor that influences nurse retention, and that it is often discussed with amiable interpersonal and co-worker relationships (Al-Maqbali, 2015; Simons, 2008). For instance, Ames et al. (1992) conducted a survey-based study that investigated the factors in the workplace that were important and satisfying to staff. They found that the most important contributor to job satisfaction was team playing, which included teams that were ready to give help, involve new staff, and acknowledge, motivate, and encourage co-workers. Further, Seymour and Buscherhof (1991) examined the sources of satisfaction and dissatisfaction amongst nurses and found that dissatisfaction with nursing co-workers was ranked highly amongst other stresses in the workplace. Nurses' job dissatisfaction is related to negative experiences with others in the workplace, which is also recognized as a form of workplace violence.

2.3 Violence in the Workplace

The Registered Nurses' Association of Ontario (RNAO; 2008) indicates that the supply of nurses is influenced by nurse attrition, with workplace violence as a highly

influential factor. The Ontario Nurses' Association (ONA; 2006) examined three forms of workplace violence: verbal, physical, and sexual. The most common form of violence was verbal abuse, with 67% of nurses reporting that they had been verbally abused on the job, while 36% experienced physical abuse, and 11% reported sexual abuse.

Research identifies several perpetrators from which workplace violence occurs: patients, patient family, manager/administrator, nurse supervisor, physicians, and other health workers (Vogelpohl et al., 2013). Yet, nurses interestingly report that their own peers and fellow nurses are the main perpetrators (Vogelpohl et al., 2013). Forty-four percent of Canadian female nurses and fifty percent of Canadian male nurses reported that they experienced conflict or hostility from their nursing co-workers (Statistics Canada, CIHI, & Health Canada, 2005). Further, Farrell (1997) examined aggression in the workplace from 29 nurses' point of views and found that nurses were most perturbed about intra-staff aggression—that is, experiences of aggression from nurses towards nurses—as opposed to aggression from other sources like doctors or patients. Nurse-to-nurse conflict has been widely documented within the literature for over three decades and was first defined and discussed as lateral violence (Roberts, 1983, 2015).

2.4 Background: Nurse-to-Nurse Conflict

The concept of lateral violence has been well explored in the nursing literature. Griffin (2004) defines this as “nurses covertly or overtly directing their dissatisfaction inward toward each other, toward themselves, and toward those less powerful than themselves” (p. 257). Roberts (2015) conducted an analysis of the literature on this concept and found that there are also other terms used to identify it. For instance, the terms used in the existing literature include, but are not limited to: horizontal violence

(e.g., Duffy, 1995; McKenna et al., 2003); bullying (e.g., Hutchinson, Vickers, Jackson, & Wilkes, 2006a); incivility (e.g., Vickers, 2006); intra-staff aggression (e.g., Farrell, 1997); relational aggression (e.g., Dellasega, 2009); and horizontal hostility (e.g., Thomas, 2003).

It is important to note that these terms are often conflated and used interchangeably throughout the literature to describe the phenomenon of nurse-to-nurse conflict (Christie & Jones, 2013; Roberts, 2015). Some terms, such as bullying or incivility, have different underpinnings for the cause of these disruptive behaviours between nurses (Roberts, 2015). For instance, bullying involves the victimization of a specific target and a power differential between the perpetrator and victim, while incivility does not involve a power differential. Therefore, it is important to use these terms carefully when describing nurse-to-nurse conflict. In this research, I refer to nurse-to-nurse conflict as aggression between nurses that leads to intergroup or interpersonal conflict (Duffy, 1994; Farrell, 1997; McKenna et al., 2003).

Historically, nurse-to-nurse conflict has been imputed to oppressed group behaviour theory (Freire, 1971), such that nurses' position within health care is subordinate and oppressed (Duffy, 1995; Roberts, 1983). Nurses may feel oppressed from groups that are positioned within a more powerful status, such as physicians, and are dominated "by a patriarchal system headed by doctors, male administrators, and marginalized nurse leaders, [and as a result] nurses lower down the hierarchy resort to aggression amongst themselves" (Farrell, 1997, p. 502). Thus, researchers contend that nurses feel powerless and have low self-esteem (characteristics of being oppressed), which can propagate conflict between one another (nurse-to-nurse) or those even less

powerful within the oppressed group (Roberts, 1983). However, even though oppressed group behaviour is a major theoretical explanation for nurse-to-nurse conflict (specifically used when referring to lateral violence), other research suggests that this is not the only explanation (Hutchinson, Vickers, Jackson, & Wilkes, 2006b). Hutchinson et al. (2006b) propose that oppressed group behaviour theory only offers some of the explanation for nurse-to-nurse conflict. Rather, there are also broader organizational factors that contribute to the behaviour. Even though the literature uses different terms or provides other explanations (Hutchinson et al., 2006b) to examine the phenomenon of nurse-to-nurse conflict, Roberts (2015) emphasizes that the existence of these behaviours are still pervasive in the nursing workplace.

2.4.1 Associated Behaviours With Nurse-to-Nurse Conflict

Several constituting behaviours associated with nurse-to-nurse conflict are identified in the literature: ignoring, secluding, allocations of unmanageable workload, being gossiped about, insulting comments, professional opinion ignored, withheld information, unattainable deadlines, ridicule and humiliation, intimidation, verbal abuse, responsibilities taken away and replaced with trivial tasks, using innuendo, backstabbing, ostracizing, sabotaging, making faces or raised eyebrows as a response, and scapegoating (Coursey et al., 2013; Farrell, 1997; Griffin, 2004; Johnson & Rea, 2009; Simons, 2008; Vogelpohl et al., 2013).

In their qualitative study conducted in Australia, Hutchinson et al. (2006a) examined 26 nurses' (24 RNs and 2 RPNs) experiences of nurse-to-nurse conflict in the workplace through in-depth semi structured interviews. The researchers argued that conflict between nurses does not occur accidentally. Rather, it is intentional, ongoing, and

aims to destroy the reputation of the victim, leaving them with psychological trauma. Hutchinson et al. found that nurse bullies form alliances to gain power and bully others. These nurse bullies become a dominant group, enforcing certain rules and control roles, status, and tasks within the workplace. As a result, the victims of bullying are left with low self-confidence from being berated, criticized, and invalidated, and in time they reluctantly either resign or yield to the group of bullies (Hutchinson et al., 2006a). Results from the study also showed that bullying behaviour carried out by alliances was more likely to be tolerated by those in higher management, such as senior nurses and managers.

Similarly, Farrell (1997) found that intra-nurse aggression was a recurrent event and when they reported the incidences to nurse managers, they were often ignored and undermined. Acts of aggression occurred outside of the workplace as well. For instance, one nurse reported that their property was vandalized (Farrell, 1997).

2.5 Outcomes and Implications of Nurse-to-Nurse Conflict

Undertaking research that further examined nurse-to-nurse conflict is important to nurses in addressing several issues. These include the health and wellbeing of nurses, patients' health outcomes, and the health care system outcomes.

2.5.1 Nurse Health and Wellbeing

There are several repercussions for conflict behaviour between nurses, such as psychological and physical outcomes, job stress and dissatisfaction, burnout, moral distress, and intentions to leave the professions.

2.5.2 Psychological and Physical Outcomes

Victims of conflict in nursing may experience or eventually experience problems with their health and wellbeing, such as insomnia, low work morale, disconnect from

others, an increased use of sick leave (Longo & Sherman, 2007), lowered work motivation, and lowered concentration, productivity, and commitment (Yildirim, 2009). Murray (2009) reported that victims of nurse-to-nurse conflict can experience fear of the loss of their job and career advancement, being labeled as a troublemaker, psychosomatic symptoms such as sleep disturbances, eating disorders, nervous tension, onset of chronic illness, and even show symptoms of post-traumatic stress disorder.

McKenna et al. (2003) studied 551 new RN graduates' (in New Zealand) experiences of nurse-to-nurse conflict with a questionnaire and found that experiencing it negatively impacted confidence and self-esteem. McKenna et al. also demonstrated that nurse-to-nurse conflict is psychologically distressing. Respondents often referred to feelings of fear, anxiety, depression, mistrust, and nervousness. Repercussions, as a result of the psychological distress, in the physical form were also mentioned, including fatigue, weight loss, headaches, and one person experienced angina, while another reported hypertension (McKenna et al., 2003). Some participants indicated that they needed to take days off of work due to an event regarding nurse-to-nurse conflict, as well as identifying their intentions to move to another area of practice, or leave nursing (McKenna et al., 2003).

2.5.3 Job Stress and Dissatisfaction

Nurse-to-nurse conflict has been associated with both increased job stress and job dissatisfaction. For instance, Huntington et al. (2011) found that bullying behaviour in healthcare teams exacerbated feelings of job stress and dissatisfaction in the nursing profession. Berry et al. (2016) yielded similar findings regarding increased job stress. Berry et al. conducted a mixed-method study that examined conflict in the workplace and

stress, anxiety, and posttraumatic symptoms amongst RNs. The researchers found that, compared to RNs who did not regularly experience workplace conflict, those who experienced frequent to daily workplace conflict were more likely to experience stress, anxiety, and posttraumatic stress symptoms (Berry et al., 2016).

Job dissatisfaction is also frequently cited when conflict between nurses in the workplace is prevalent. Coursey et al. (2013) conducted a literature review on nurse-to-nurse conflict and reported that experiencing conflict between nurses causes dissatisfaction since it results in poor patient care, poor communication, and increased rates of turnover. Laschinger, Leiter, Day, and Gilin (2009) examined the relationship between co-worker incivility and job satisfaction and found that co-worker incivility was a significant predictor of lower job satisfaction. Purpora and Blegen (2015) investigated the association between nurse-to-nurse conflict, job satisfaction, and peer relationships. Results showed a significant inverted relationship between nurse-to-nurse conflict and job satisfaction, as well as nurse-to-nurse conflict and peer relationships. This suggests that as nurse-to-nurse conflict increases, job satisfaction decreases and peer relationships were less supportive. Further, they found that peer relationships mediated the relationship between nurse-to-nurse conflict and job satisfaction, such that when nurse participants experienced nurse-to-nurse conflict, they were less likely to feel dissatisfied with their jobs when they had positive and supporting peer relationships (Purpora & Blegen, 2015).

2.5.4 Burnout

Research has identified several impacts of nurse-to-nurse conflict. For instance, victims reported feelings of powerlessness (Curtis, Bowen, & Reid, 2007; Longo & Sherman, 2007). Research also shows that there is a positive association between nurse

burnout and experiencing nurse-to-nurse conflict (e.g., Allen, Holland, & Reynolds, 2015). Nurses who experience nurse-to-nurse conflict reported the highest rate of nurse burnout (Thomas, 2003). Babenko-Mould and Laschinger (2014) used a cross-sectional survey design with 126 participants in Ontario, Canada to examine the association between nursing students' experiences of nurse-to-nurse conflict and their feelings of burnout. Results of the study showed that nurses who experienced higher rates of nurse-to-nurse conflict were related to higher levels of burnout (Babenko-Mould & Laschinger, 2014).

2.5.5 Moral Distress

Moral (or ethical; terms are used interchangeably throughout the literature) distress in nursing is a prominent issue. The CNA (2002) defines ethical or moral distress as:

“Situations in which nurses cannot fulfill their ethical obligations and commitments (i.e. their moral agency), or they fail to pursue what they believe to be the right course of action, or fail to live up to their own expectation of ethical practice, for one or more of the following reasons: error in judgment, insufficient personal resolve or other circumstances truly beyond their control (Webster & Baylis, 2000). They may feel guilt, concern or distaste as a result” (p. 6).

The CNA (2003) further describes ethical distress as when “a decision is made regarding what one believes to be the right course of action, but barriers prevent the nurse from carrying out or completing the action” (p. 3). Nurses are often conflicted with barriers that compromise ethical practice, which lead to moral distress. For instance, budget cuts contribute to nurses' feelings of ethical distress, as they have fewer staff

members to care for the patients, which puts patients at risk and compromises the quality of patient care (CNA, 2003). Interestingly, research has also shown that moral distress is linked to nurse-to-nurse conflict (e.g., Katrinli, Atabay, Gunay, & Cangarli, 2010) as one of the barriers to ethical practice. It is important to discuss nurse-to-nurse conflict in the context of moral distress as it strongly infringes upon the fundamental ethical principles in nursing (Katrinli et al., 2010).

Varcoe et al. (2004) conducted a qualitative study with 87 participants using focus group method. The researchers investigated ethical practice in nursing, specifically the meaning of ethics and the enactment of ethical practice from nurses' point of views. One participant discussed her moral responsibility, for instance, how she found it difficult to refuse to work in a setting in which she felt uncomfortable or incompetent. She noted that it took time and education to realize that it was her responsibility to refuse work in an area where she did not feel safe working. This finding relates to how RPNs are used to replace RNs in certain areas, like acute care settings. RPNs, however, do not have the adequate training with their educational background. Feelings of moral distress occur with pressures from the contextual restraints that force nurses to work in settings they may not be comfortable with.

The hierarchy in nursing also was discussed relating to moral distress, such that nurses with less experience were more likely to feel that they could not practice ethically. For instance, they felt they had to let the more experienced nurses make the decisions even if they felt there were ethical issues with the practice (Varcoe et al., 2004). Another nurse in the study described how she was morally conflicted when she recognized a situation where another nurse's practice was unethical. The nurse wanted to avoid repercussions, such as creating conflict with the other staff, and described how they

would be ‘burned’ or ‘bitten’ if they took action against unethical practices (Varcoe et al., 2004).

Sauerland, Marotta, Peinemann, Berndt, and Robichaux (2014) explored 225 RNs’ perceptions of moral distress, moral residue, and the ethical climate in acute care settings using mixed methods. A noteworthy result of the qualitative research demonstrated that the participants discussed and described nurse-to-nurse conflict (Sauerland et al., 2014). For instance, participants felt that they would be ignored or punished if they reported unethical or unsafe practices to their leaders. RNs felt that nurse-to-nurse conflict contributes to feelings and experiences of moral distress.

LaSala and Bjarnason (2010) had similar findings. In particular, they reviewed literature discussing multiple factors and outcomes (including personality and organizational structures) that influence moral courage. LaSala and Bjarnason concluded that nurses take a risk when they practice with moral courage, as it makes them more vulnerable to experiences of nurse-to-nurse conflict, harassment, sabotage, and termination. The researchers argue that an ethical climate and environment is not likely to exist when there is a lack of collaboration, respect, and trust between nurses (LaSala & Bjarnason, 2010). Further, Zuzelo (2007) conducted a mixed-method study with 100 participants that examined moral distress and its frequency in RNs. The results found that RN participants identified working with staff that they felt were incompetent as a distressing event (Zuzelo, 2007). RNs also experienced moral distress when there was a shortage of staff and the level of nursing was perceived as unsafe (Zuzelo, 2007). Moral distress, burnout, frustration, and low morale in nursing are likely to arise when there are unhealthy work environments (Hamric, Spross, & Hanson, 2009).

There are several repercussions for nurses who experience moral distress as a result of nurse-to-nurse conflict. For instance, Corley (2002), who presented a theory of moral distress, argues that when nurses face moral distress, they are likely to experience depression, exclusion, misfortune, frustration, and resignation from the profession. Research by Joseph and Deshpande (1997) examined the impact of ethical climates and job satisfaction and found that moral distress leads to increased job stress and dissatisfaction. Katrinli et al. (2010) issued a questionnaire to investigate nurses' perceptions of organizational political and individual causes of nurse-to-nurse conflict. In their research, Katrinli et al. argued that victims of bullying will not only be affected, but also nurses who observe the behaviour are likely to feel moral distress if they feel powerless to the perpetrator. Moral distress has also been linked to poor quality and safety of patient care (e.g., Sauerland et al., 2014). Corley (2002) argues that moral distress compromises quality patient care, as nurses may avoid patients as a result of feeling frustrated, angry or guilty from moral distress.

Overall, it is important to discuss nurse-to-nurse conflict in the context of moral distress, as it has been shown to create ethical distress and prevent an ethical climate within the workplace. This phenomenon has many implications for nurses, patients, and the health care system.

2.5.6 Intentions to Leave the Profession

Intent to leave the nursing field is also common for nurses who experience conflict with their nursing co-workers. Simons (2008) found similar results, such that 31% of nurses intended to leave the organization due to experiences with nurse-to-nurse conflict in the workplace. Results by Vogelpohl et al. (2013) showed that 35.4% of 135

newly graduated nurses who had been bullied changed their jobs in the last two years as a result of conflict experienced within the workplace. Moreover, Vessey et al. (2009) found that of 212 RNs, 49% lost interest in their jobs if they frequently experienced workplace conflict. Desire to resign (50% of participants) and increased absence (23% of participants) was also linked to experiences of conflict (Vessey et al., 2009). Thomas (2003) reports that when nurses can no longer tolerate the conflict, they will leave the institutions they work for and some will leave the profession permanently.

2.5.7 Patient Health Outcomes

Negative patient health outcomes are likely to arise as a result of conflict between nurses. For instance, research has found that nursing staff are less likely to perform optimally, which can lead to poor patient care, such as errors and accidents (Farrell, 1997; Woelfle & McCaffrey, 2007). Roche, Diers, Diffield, and Catling-Paull (2010) conducted a cross-sectional study that examined nurses' perception of violence, such as emotional abuse, threat of violence, and actual violence, on patient health outcomes (such as falls and medication errors) and nurses' working environment. The results found that as perceived violence increases, nurses are more likely to make medication errors. Further, Yildirim (2009) assessed how bullying among 286 nurses in the workplace affected nursing practice and job performance. Regression analysis showed a significant relationship between workplace conflict and poor patient relationships, such that conflict hindered effective care for patients. Previous research has demonstrated that as long as conflict in the workplace remains between nurses, quality of patient care will suffer (Woelfle & McCaffrey, 2007).

2.5.8 Health Care System Outcomes

The health care organization is also affected by nurse-to-nurse conflict, creating toxic environments within the nursing profession (Embree & White, 2010). Woelfle and McCaffrey (2007) noted how nurse-to-nurse conflict affects the organizations that employ nurses “because staff lack initiative to do their job well, they use more sick time, and staff turnover is increased” (p. 124). Other research yields similar findings; due to lowered health and wellbeing as a result of workplace conflict, nurses are more likely to have an increase in absenteeism, nurse burnout, stress leave, lower job satisfaction, and intentions to leave the nursing field (Griffin, 2004; Hauge, Skogstad, & Einarsen, 2010; Laschinger, Grau, Finegan, & Wilk, 2010; McKenna et al., 2003; Simons, 2008)—these factors contribute to a shortage in nursing and cost the health care system millions of dollars in order to supplement employee benefits, retention, and recruitment costs (CNA, 2017). It is therefore important to further investigate the phenomenon of nurse-to-nurse conflict to reduce these possible negative outcomes.

2.6 Who Experiences Nurse-to-Nurse Conflict?

Different types of nurses have varied experiences of nurse-to-nurse conflict. Vessey et al. (2009) conducted a quantitative study that explored RNs’ perceptions of frequency and patterns of conflict in the workplace. Participants reported that they were most frequently isolated, humiliated, and criticized by senior nurses, charge nurses, and nurse managers (Vessey et al., 2009). New nurse graduates are one of the most vulnerable groups of nurses that experience nurse-to-nurse conflict. Simons (2008) studied 511 participants and found a significant relationship between bullying and nurses’ intent to leave the profession. Results showed that 31% of the nurses who reported being bullied

were newly licensed RNs. Several other studies demonstrate an increase in conflict experienced by new nurses and argue that new nurse graduates are particularly vulnerable to it (Griffin, 2004; Laschinger et al., 2010; Laschinger, Wong, & Grau, 2012; McKenna et al., 2003). Griffin (2004) reports approximately 60% of new nurse graduates leave their place of employment in the first six months as a result of nurse-to-nurse conflict.

McKenna et al. (2003) found that new RN graduates reported experiences of nurse-to-nurse conflict across all clinical settings. The study demonstrated that more than half of the respondents reported that other nurses undervalued their skills. In particular, they felt like they were being treated like students. More than a third reported hindered learning, feelings of neglect, were upset by others' conflict and disputes, and were assigned difficult duties without the necessary supervision. RNs reported the most distressing incidents as abusive, rude and humiliating remarks and being given too much responsibility without support. With regard to overt interpersonal conflict, 34% of the participants reported unjust criticism, abusive, rude, and humiliating verbal statements (McKenna et al., 2003).

Student nurses are also affected by nurse-to-nurse conflict. Randle (2003) conducted a qualitative study and found that student nurses commonly experienced it, which negatively affected their self-esteem as future nurses. Longo (2007) surveyed 33 nursing students in a baccalaureate program and found that many of the student nurses experienced different forms of nurse-to-nurse conflict, including both verbal and emotional abuse. Specifically, being put down by the nursing staff was the most frequently reported behaviour by the student nurses (Longo, 2007). Curtis et al. (2007) explored student nurses' experiences of horizontal violence and found that more than half

of the 152 participants in the study had either experienced or saw the behaviour. Nursing students recounted that employees were also victimized, heightening students' fears of experiencing it after graduation. Examples of mistreatment included comments that caused insecurity and being assigned difficult tasks without assistance or support (Curtis et al., 2007).

Not only does nurse-to-nurse conflict affect the nurse victim, but the nurses who witness the incidences are also affected by the behaviour (Curtis et al., 2007; McKenna et al., 2003). Vogelpohl et al. (2013) found that 46.7% of 135 new RN graduates reported seeing others as the victim of bullying at work throughout the previous six months. Curtis et al. (2007) found that participants spoke more frequently about witnessing horizontal violence, as opposed to experiencing it themselves, with their fellow nursing students as the victims. Evidence shows that merely witnessing events of nurse-to-nurse conflict distresses nurses.

Therefore, it is important to note that various types of nurses have experiences with this phenomenon. An important theme in the existing literature on nurse-to-nurse conflict is that it focuses on RNs, new RN graduates, and student nurses that are in training to become RNs, as these types of nurses appear to be some of the most vulnerable groups in experiencing this phenomenon. Research has demonstrated that it is important to explore how different types of nurses experience nurse-to-nurse conflict; yet, there is a paucity of literature that focuses on RPNs and in particular RPNs who are in transition as students to become RNs. It is crucial to further explore their perspective, as new nurses and student nurses have increasingly experienced the behaviour, thereby increasing turnover and attrition in the nursing workforce (Curtis et al., 2007; Hutchinson,

Wilkes, Vickers, & Jackson, 2008; Laschinger et al., 2012). Providing insight to all types of nurses' experiences of nurse-to-nurse conflict is key to help address the issue.

Research also has shown how RPNs have different experiences of nurse-to-nurse conflict; for instance, how RPNs primarily experience conflict from RNs (i.e., Martin & Weeres, 2012). However, a critical examination of the factors that contribute to nurse-to-nurse conflict is of vital importance for understanding the tensions that exist between RNs and RPNs. In the following section, I discuss the contextual factors that have a powerful influence on nurse-to-nurse conflict and highlight how and why it propagates conflict, with particular emphasis on RPN-RN relations. While RPNs frequently cite experiences with RNs, RNs are forced to work in difficult, stressful and uncontrollable environments that inevitably create sources of tension.

2.7 Contextual Factors that Contribute to Nurse-to-Nurse Conflict

2.7.1 Historical Background

In the early 19th century, Physicians (who were educated in Europe) trained and apprenticed Catholic nuns who were considered the educated nurses in Canada (Butcher & MacKinnon, 2015). There were also nurses (lay nurses and midwives) who had less education and could be hired by middle and upper class citizens. Martin Saarinen (2008) explains that by the late 19th century, the number of hospitals in Canada had significantly increased and although nurses in the hospitals often cared for lower class individuals, the demand for nurses with a more enhanced and extensive skillset was also on the rise in the male-dominated medical profession. However, skilled nurses meant higher costs to health care and therefore administrators who were in control of the funds from the Canadian

government were disinclined to pay nurses a fair wage for their labour (Martin Saarinen, 2008).

A hierarchical nature in nursing began as lower class women were encouraged to train as nurses to be directly involved in patient care and to be supervised by women in the upper class, who were instead encouraged to study for management positions (Martin Saarinen, 2008). However, by the Second World War, there was a threat of a shortage of nurses in Canada as many enlisted and serviced in the Canadian Armed Forces. Enrollment in university and shorter education hospital-based nursing programs increased with the greater amount of funding given by the government in order to counter the potential shortage of nurses in Canada (Martin Saarinen, 2008). The intention was to discontinue the shorter education hospital-based nursing program, which was created as a temporary solution to the shortage in nursing, after the RNs returned from their service in the war. Yet, the shorter education route to becoming a nurse (who were paid less than a RN, identified as nursing aides and over time as practical nurses (RPNs/ LPNs¹) remained with the persisting post-war shortage in nursing. This shortage was also somewhat attributed to the baby boom with the growth in the population (Martin Saarinen, 2008).

Up until the 1970s, categories of nursing workers increased from two (graduate nurses and nurses-in-training) to several more (nursing aides and nursing assistants to name a few; Armstrong & Armstrong, 2010). The growth of RPNs (and LPNs) in the Canadian health care workforce had increased drastically between the 1970s and 1990s. These different categories of nurses were created to do some of the nursing work done previously by RNs, exempting RNs from monotonous and unpleasant duties. With RPNs

¹ Identified as RPNs in Ontario and LPNs in provinces outside of Ontario

fewer years of formal education and preparation, lower pay and restricted duties were justified. As a result, the system's creation of other nurses and delegation of responsibilities from RNs to RPNs fragmented the nursing profession. Armstrong and Armstrong (2010) attribute this fragmentation to the response of financial pressures from the government and hospital directors (Armstrong & Armstrong, 2010).

This restructuring in health care, such as the changes in employment practices, had consequences for nursing relations. Armstrong and Armstrong (2010) discuss how nurses were used against one another. For instance, when there was only a small difference in wage between RNs and RPNs, RNs were hired over RPNs for some jobs (as RNs were able to do the whole range of tasks) and vice versa for other jobs. Furthermore, nursing aides were also being hired as a replacement for RPNs to delegate nursing tasks from RNs. Through the division of work and replacement with the lowest care provider, the fragmentation of nursing was the consequence of efforts to save money (Armstrong & Armstrong, 2010). In addition to the undermining of patient care, poor working relationships between nurses also ensued. The restructuring in health care and the fragmentation of the nursing profession contribute to the conflict that exists between RNs and RPNs today (this is expanded on later in this chapter).

2.7.2 The Shifting Education and Ambiguous Scopes of Practice

In Canada today, the RN and the RPN still remain as two dominant groups of nursing and RPNs still work to compensate for shortages in RNs in areas such as Home Care (Registered Practical Nurses Association of Ontario [RPNAO], n.d.). Although, RNs work primarily in acute care settings, shortages in the past few years have contributed to a shift in the RPN education.

Butcher and MacKinnon (2015) explain that many “[RPN] diploma programs have recently been revised (from one- to two-year programs) to prepare practical nurses for expanded scopes of practice and for working in acute care settings alongside RNs” (p. 232). This shift in education has added to ambiguous scopes of practice for RNs and RPNs, especially since RPNs are now also registered by the Colleges of Nursing throughout many provinces in Canada (the College of Nurses of Ontario first published Entry-to-Practice Competencies for RPNs in 1999 and as of 2005, the RPN entry-to-practice education requirement is a diploma from a College of Applied Arts and Technology [RPNAO, n.d.]). This shift in the education requirements for RPNs has created sources of tension between RNs and RPNs.

In their critical analysis, Butcher and MacKinnon’s (2015) discuss the need for nurses in acute care because of the aging population and the nursing shortage. As a result, RPNs have been enlisted to supplement positions, such as in acute care, broadening their scope of practice. Even though the RPN position in the workforce was initially intended as a short-term solution to the nursing shortage from World War II, RPNs remain employed with health care institutions as a cost-effective measure to fill the gaps in nursing staff (Butcher & MacKinnon, 2015; Martin Saarinen, 2008). It is argued, however, that the RPN education varies based on the needs of both the location/jurisdiction and the employers (Butcher & MacKinnon, 2015; CIHI, 2007). Articles reviewed by Butcher and MacKinnon argue towards a more standardized RPN education and alterations to practice expectations across Canada. However, this contributes to the expansion in their scopes of practice and ultimately their competencies (Butcher & MacKinnon, 2015). The overlapping competencies, which contribute to role

confusion between RNs and RPNs, results in frustration and nurse-to-nurse conflict.

Other research has also found that the ambiguous scopes of practice for RPNs and RNs have contributed to nurse-to-nurse conflict (Eager, Cowin, Gregory, & Firtko, 2010; Limoges & Jagos, 2015; Martin & Weeres, 2012; Meadows & Prociuk, 2012).

2.7.2.1 RPNs' experiences of nurse-to-nurse conflict. The phenomenon of nurse-to-nurse conflict is explored throughout the literature regarding the relationship in and between two scopes of practice: RNs and RPNs. Although RPNs and RNs work together in the workplace the literature indicates how the relationship between them is not always amicable. Robinson (2009) states that there is little collaboration between the two types of nurses as a result of role confusion and neither is familiar with the other's scopes of practice.

Limoges and Jagos (2015) examined how education shapes the intraprofessional relationship between RPN and RN Canadian students in the workplace, power relations, and the division of labour. The results from this qualitative study in which they interviewed 165 RN and 85 RPN students found that students in the RPN and RN programs express concern about segregation during their education and then suddenly having to work together when they enter the workplace. Both types of nurses described how this contributes to further segregation between the two nursing practices. It is noteworthy that nurses' educational background may contribute to conflict in the workplace (Limoges & Jagos, 2015).

While the authors of this study note that some of the student participants have had some form of post-secondary education before entering nursing, they do not specify or acknowledge if there were students in the BScN program who already have an RPN

diploma and are RPNs. Limoges and Jagos examined both the perspectives of RN and RPN students, yet students with previous nursing experience may provide an interesting perspective on how education contributes to intraprofessional working relationships between RNs and RPNs.

In a qualitative study with 30 participants, Eager et al. (2010) found that a misunderstanding of roles and responsibilities are identified as a primary source of conflict between nurses. Eager et al. examined three different hospitals in Sydney, Australia, with two focus groups at each, one containing RNs and the other with ENs (ENs are equivalent to Ontario's RPN). Eager et al. (2010) found that intraprofessional conflict in the workplace was rooted in ambiguous scopes of practice. Scope of practice was commonly discussed between both types of nurses, however ENs talked more about conflict. For instance, ENs felt frustrated with the unbalanced and heavy workload, and how they are treated with a lack of respect for their experience and skills. The administration of medication and patient allocation were also misunderstood scopes of practice that were discussed between the two types of nurses and therefore contributed to conflict. As a result, the qualitative data revealed that many ENs had experiences of bullying, stress and harassment from RNs in the workplace (Eager et al., 2010).

Meadows and Prociuk (2012) conducted a qualitative study in British Columbia, Canada that examined the experiences of both RNs and Licensed Practical Nurses (LPNs; equivalent to Ontario's RPN). The researchers explored the integration of LPNs into home health care settings that were predominantly run by RN nursing teams. Some of the main themes that emerged from the focus groups were collaborative practice, scope of practice, and relationships between RNs and LPNs. One notable finding from the study

revealed that the groups discussed how there is no clear distinction in the scopes of practice between LPNs and RNs. This ambiguity contributed to lack of trust between the two groups.

Meadows and Prociuk (2012) also found several issues with conflict between RNs and LPNs, which were fueled by the ambiguous understanding in the scopes of practice. For instance, the LPNs reported that the RNs deliberately excluded clients' care by LPNs, even if the client needs fit the LPN scope of practice (Meadows & Prociuk, 2012). This exclusionary behaviour is classified as nurse-to-nurse conflict. Yet, this kind of behaviour has been explained as a response to RNs' feelings of job insecurity. For example, Martin and Weeres (2012) investigated 31 RPNs' perception of retention among RPNs and their ability to provide a high quality of care. A notable finding from this qualitative research was that conflict arises between the RNs and RPNs when their scopes of practice overlap. As a result, the RNs may feel threatened about losing their jobs because organizations and institutions can justify hiring RPNs to do the job at a lower cost. Both Meadows and Prociuk (2012) and Martin and Weeres (2012) document how RPNs experience nurse-to-nurse conflict; however, both studies also strongly argue how contextual factors, such as job replacement, create nurse-to-nurse conflict (this is elaborated on in section 2.7.4).

Ambiguous scope of practice is often reported by RNs and RPNs and leads to role confusion (Martin & Weeres, 2012; Robinson, 2009). This contributes to a lack of clarity in RN and RPN roles in the workplace and results in nurse-to-nurse conflict from workplace tension, mistrust and ineffective teamwork (Baranek, 2005; Martin & Weeres, 2012; ONA, 2011; White et al., 2008). Ambiguous scope of practice poses consequences for both RNs and RPNs. In addition to RNs feeling threatened and vulnerable, other

research has indicated that RPNs report frustration and lower satisfaction with their jobs when they have less autonomy, do not feel valued by other nurses (i.e., are treated with a lack of respect), are not working to their full scope of practice and/or being fully utilized in the workplace (Eager et al., 2010; Kramer & Schmalenberg, 2004; Martin & Weeres, 2012; O'Brien-Pallas et al., 2005). An underutilization of nurses in the workplace occurs with health care system funding restraints (White et al., 2008).

2.7.3 Hierarchical Structures

Hierarchical structures exist within the nursing profession and tend to separate RNs and RPNs. Meadows and Prociuk (2012) found that RNs point to skills and concepts (i.e., critical thinking, assessment, competency) as particular to their practice to separate themselves from the LPNs, which unintentionally marginalized and thwarted the integration of LPNs. For example, RNs described how LPNs lack certain competencies and skills that need to be learned or reviewed before practicing in certain settings with RNs. However, Meadows and Prociuk argue that competency described in this way alludes to something that can be learned with experience as opposed to competencies that are related to a scope of practice. From their perspective, these competencies would apply to any new nurse, including both RNs and LPNs. RNs also identified critical thinking, clinical reasoning and judgment as skills that the shorter LPN education does not facilitate. Yet, many RNs were unable to describe specifically how RNs apply these skills, such as critical thinking, over LPNs in a clinical setting. As Meadows and Prociuk ask, "Are these skills acquired in the classroom or learned in the practice setting through experience and reflection?" (p. 277). This research highlights the hierarchical structure between RN and LPN nurses, as RNs distinguish themselves from the LPNs based on

skills acquired from the baccalaureate education. This behaviour inadvertently marginalizes LPNs. This behaviour may be influenced by current RN job loss to LPNs/RPNs.

Curtis et al. (2007) identified the effects of a hierarchy in nursing which fosters nurse-to-nurse conflict. Curtis et al. (2007) conducted a qualitative study that examined 152 second- and third-year RN students. They asked five open-ended questions that inquired about their experiences of horizontal violence (including either their own direct experience or as a witness) during their clinical placements. A notable finding from the study demonstrated how students described nurse-to-nurse conflict as being hierarchical in nature. For instance, students indicated that the RNs acted superior to others and mistreated the Enrolled Nurses (ENs are equivalent to Ontario's RPN) and the nursing students.

Given the existing literature, RPNs' perspective and experience of nurse-to-nurse conflict is worthy of further exploration, as this distinct group of nurses often experience conflict and mistreatment by RNs (e.g., Eager et al., 2010). Yet, as demonstrated, research on this phenomenon often inadvertently blames and portrays RNs as the sole perpetrators for this behaviour. However, there are several contextual factors within the health care system that have a stronger impact and drive this behaviour. These contextual factors exacerbate the tensions between nurses by contributing to the ambiguous scope of practice and the hierarchical structures discussed above.

2.7.4 Health Care Restructuring and Organizational Change

It is evident from the history, the evolution of the nursing profession, and existing research that conflict is widespread within nursing. Certain structures within the

profession, such as the ambiguous scopes of practice (resulting from the creation and initial intent of RPNs and changes to the RPN practice over time) and developed hierarchies, are inherently embedded and lay the grounds for conflict. Oppressed group behaviour theory has been offered as the predominant rationale for explaining and understanding conflict between nurses (Armstrong & Armstrong, 2010; Hutchinson et al., 2006b). However, both RNs and RPNs are victims of nurse-to-nurse conflict with wider contextual factors, such as health care restructuring and organizational influences, which profoundly contribute to this issue (Hutchinson et al., 2006b). In the following section I examine the contextual factors that influence nurse-to-nurse conflict, as several research studies often overlook these as contributors to the issue (such as research by Eager et al., 2010).

Nurse-to-nurse conflict is largely attributed to the health care restructuring in Canada through budget cuts, job insecurity, and loss of support from the organization. Denton, Zeytinoglu, Davies, and Lian (2002) conducted a mixed-method study that examined the outcomes of health care restructuring in Ontario. They attributed an increased level of job stress and dissatisfaction of home care workers (which included nurses) to organizational change, job insecurity, and a decrease in organizational support. These factors have been associated with conflict between nurses. For instance, cutbacks to nursing jobs in Ontario have been an issue for several years. The ONA (2016) reports that Ontario hospitals are cutting RN jobs at an increasing rate to balance budgets. Early in 2016, 406 RN positions were eliminated across Ontario and a total of 775 RN jobs were cut in 2015 (ONA, 2016). It has also been reported that Ontario has the second

lowest ratio of RN staff to residents (specifically one RN for every 100 residents) among Canadian provinces (Boyle, 2015).

Moreover, the ONA (2016) argues that patient care is suffering and patient lives are at risk as a result of fiscal austerity. For instance, Armstrong and Armstrong (2010) argue that the ambiguity in the scopes of practice for nurses is a deliberate strategy. This provides the justification for job replacement and delegating patient care to the lowest-costing provider who often has less education and training (Armstrong & Armstrong, 2010). This leads to jobs done inadequately, compromises the quality of care for patients, and increase the risk of injury or death.

Misguided administrative strategies have also contributed to the cutbacks in RN jobs, as they are intended to manage the constraints in the budget (Hall, 2015). Not only does the restructuring in health care (through the cuts to nursing jobs and lack of support from pressures to cut budgets and costs) contribute to job insecurity, stress, and dissatisfaction (Denton et al., 2002), they also create nurse-to-nurse conflict and hostility. Even though several RN positions were terminated, there was replacement with other lower paid health care providers (such as RPNs; ONA, 2016) as a means to control costs (Frketich, 2016). However, RPNs are not licensed or trained to care for patients with unstable conditions (ONA, 2016), as these types of patients should be cared for by RNs with their extended level of education and training. As a result, RNs feel vulnerable as their jobs are being replaced with RPNs, resulting in tension, stress, and hostility between the two types of nurses.

In addition to the shifts noted above, since 2005, RN entry-to-practice has required a BScN degree, a shift from the previous diploma entry-to-practice requirements

(CNA, n.d.). The higher educational requirement prepares RNs to meet the high acuity needs of patients and clients in general. However, within the last decade health care restructuring resulting from increasing fiscal constraints has resulted in the replacement of RNs with RPNs in many health care settings (see RNAO, 2017). These decisions about the organization of health care are made outside of nursing, often with negative consequences for nurse-to-nurse relations.

As previously mentioned, research by Martin and Weeres (2012) and Meadows and Prociuk (2012) have demonstrated how contextual level factors contributed to nurse-to-nurse conflict. In the study by Martin and Weeres (2012), a RPN participant discussed how RNs feel threatened by RPNs because the organization can hire and train a RPN to do the job for less cost than a RN. These types of changes lead to conflict between the RNs and RPNs. Further, Armstrong and Armstrong (2010) assert that health care workers, like RNs, experience high levels of stress and fear for their jobs and are therefore unlikely or less willing to teach co-workers, like RPNs. Armstrong and Armstrong also argue that assigning jobs and tasks to workers that are not appropriately educated or trained for the job only creates stress among them, such as RPNs.

Meadows and Prociuk (2012) found that RNs reacted negatively and felt threatened when there was reallocation of funding to fill vacant RN positions with LPNs instead. RNs interpreted this as potential job loss and demonstrated aggression against LPNs for that reason. For instance, Meadows and Prociuk reported that RNs “attempted to marginalize LPNs by making them prove their ability to do the work rather than following the accepted practice of relying on the nurse to identify her or his different competencies and skill sets” (p. 278). This is consistent with findings from the

quantitative study by Katrinli et al. (2010). Using a one-sample *t*-test and 232 participants, Katrinli et al. examined the organizational, political and individual reasons for horizontal bullying between nurses. One of the findings from the results of the study suggested that nurses may bully others through isolation to gain a promotion or obtain an important position in the unit. Nurses may even intentionally bully nursing colleagues to negatively affect their performance so that they can enhance their own performance. Katrinli et al. argues that this behaviour creates a competitive organizational culture that encourages bullying behaviour.

Contextual level factors that affect the structure and organization of the health care system (like cutbacks from budget cutting) threaten the RN role and create sources of discomfort for RNs (Meadows & Prociuk, 2012). Consequently, this pits one vulnerable group of nurses against the other, resulting in a hostile work environment. Furthermore, one of the findings from the research by Berry et al. (2016) found that organizational practices, such as the prevention of breaks or down time from the unit and mandatory overtime, increased the incidence of bullying behaviour exhibited by nurses.

Employer inaction has also been found to fuel nurse-to-nurse conflict. For instance, Huntington et al. (2011) conducted a qualitative analysis from nurses' responses to a survey and found that nurses reported a lack of care from the organization and managers which created an unhealthy workplace. Murray (2009) investigated the history of workplace bullying in nursing and argues that the bullying behaviour continues to exist in the workplace as it is both unrecognized and silenced by managers. Longo and Sherman (2007) similarly report that senior managers sometimes tolerate and excuse the bully's behaviour instead of penalizing them. However, these studies do not consider how

management is also constrained by the system; for instance, a lack of education on how to deal with bullying in the workplace would prevent management from appropriately addressing and responding to the behaviour.

Overall, nurse-to-nurse conflict is a multifactorial and complex problem, as it arises from constituents like the evolution of the nursing professions, ambiguous scopes of practice, hierarchies in the profession, and above all the contextual factors regarding certain structures and changes at the organizational level. Huntington et al. (2011) argue that it is imperative that the power and influence of the workplace culture is not underestimated, as it produces negative outcomes such as conflict and hostility between nurses. These factors have particular importance and implications for the tensions that exist between RPNs and RNs.

2.8 RPNs' Pursuit of Higher Education

Martin and Weeres (2012) examined the factors that impact the retention of RPNs in the workplace. One notable finding from the study was that RPNs felt mistreated by their RN colleagues and experienced a lack of respect for their profession (forms of nurse-to-nurse conflict). Further, RPNs did not feel valued and felt the need to go back to school to have more opportunities, such as leadership and autonomy regarding patient decisions.

Interestingly, Coffey et al. (2013) found that the average number of years between the time of completion of the RPN diploma and beginning of the post RPN-BScN program was 4.4 years (they worked as RPNs for an average 3.2 years during this timeframe in between programs), while several other research studies have found that new nurses, or nurses who have worked fewer than five years, experience a particularly

high level of bullying (i.e., Griffin, 2004; McKenna et al., 2003; Vessey et al., 2009).

Therefore, could there be a link between experiencing bullying and returning to school to complete a BScN to gain more skills and abilities? Few studies consider whether nurse-to-nurse conflict experienced by RPNs in the workplace contributes to their decision to go back to school.

2.9 RPNs' Experiences: Gaps in the Research

The bulk of the research on nurse-to-nurse conflict focuses primarily on RNs and is also quantitative, examining the causes, prevalence, and effects. The gaps in the literature will be addressed by exploring RPNs' (in a post RPN-BScN program) experiences and perspective of this phenomenon through a qualitative approach. Research by Eager et al. (2010), for instance, illuminates the importance of examining RPNs' point of views. Previous research has also shown how nurse-to-nurse conflict results in several adverse outcomes such as job dissatisfaction, negatively affecting patient care, and nurse turnover (CNA, 2017; Laschinger et al., 2009; Yildirim, 2009). It is therefore important to examine how this dynamic also applies to RPNs.

It is also significant to explore the experiences of RPNs (especially those who are in a post RPN-BScN program) as employers in Ontario are hiring and substituting RNs with RPNs at a rapid rate. For instance, St. Joseph's Healthcare in Hamilton, Ontario recently replaced RNs with RPNs in the Neonatal Intensive Care Unit (NICU; RNAO, 2015b) and hired 38 RPNs while 60 RN jobs were eliminated across the hospital (Frketich, 2016). Each day, there were five RNs and one NP on every shift, however as of July 2016, St. Joseph's Healthcare planned to have four RNs and one RPN (Frketich, 2016). Moreover, the CIHI (2015) reported that the growth in the supply of RPNs

(13.2%) was higher than RNs (9.2%) in the last decade. Furthermore, the supply of RPNs grew 1.3% in 2014 from the previous year, compared to the 1.0% decrease in RNs.

While the increase in these numbers can be attributed to more RPNs entering the workforce, some hospitals are replacing RNs with RPNs instead for reasons such as budgetary pressures and cost-saving measures (ONA, 2011). In turn, conflict arises between the two types of nurses (Meadows & Prociuk, 2012). Therefore, examining RPNs' experiences of nurse-to-nurse conflict is important for understanding how broader level factors (such as cost cutting measures) shape the relationship between nurses in the workplace. Few studies consider the impact of these factors and attribute this behaviour to the nursing profession, thereby decontextualizing nurse-to-nurse conflict. As a result, this research study will add to the existing literature by examining this phenomenon by focusing on the broader contextual factors that contribute to conflict between nurses.

2.9.1 RPNs' Return to School

Bridging/accelerated nursing programs are offered around the world and are expanding at a fast rate throughout North America (Cook et al., 2010; Cubit & Lopez, 2011; Miller & Leadingham, 2010; Rapley et al., 2008). In Ontario, post RPN-BScN programs have been offered since 2005, with 6 universities and 10 colleges presently involved in the nurse bridging education (Coffey et al., 2016). Yet, the expansion of RPN-BScN programs is counter to the availability of RN job opportunities in Ontario. Compared to the rise in employment rates for RPNs, there is a dearth of RN positions (RNAO, 2015a). As a result, it is important to further understand RPNs' motivation to return to school, obtain a BScN, and become RNs.

Research by Coffey et al. (2013), Martin and Weeres (2012), and Vessey et al. (2009) suggest a potential link between RPNs' experiences of nurse-to-nurse conflict and returning to school for a BScN to become RNs. Therefore, in this research I investigated how nurse-to-nurse conflict shaped RPNs' decision to go back to school.

2.10 Research Questions

As a result of the existing literature on nurse-to-nurse conflict and the current gaps in the research, the purpose of this study was to explore nurse-to-nurse conflict from the perspective of RPNs who are in a post RPN-BScN program to become RNs. It also investigated whether nurse-to-nurse conflict is related to RPNs' decision to return to school to complete a BScN. Thus, I proposed and investigated the following two research questions:

- 1) What are the experiences of RPNs in the post RPN-BScN program with nurse-to-nurse conflict in the workplace?
- 2) How do these experiences contribute to RPNs' decision to go back to school for a BScN?

2.11 Research Significance and Rationale

There is a lack of research that focuses on RPNs' experiences and perspectives of nurse-to-nurse conflict. RPNs also return to school and complete a BScN to become RNs despite the current trends in the job opportunities for RPNs and RNs. This research considered these two issues regarding RPNs and their experiences of nurse-to-nurse conflict to highlight areas and address some of the gaps that exist in the literature on this phenomenon. The qualitative approach used in this study was able to capture participants'

experiences which helped determine if these experiences were influential in their decision to return to school for a BScN.

Focusing on RPNs in the post RPN-BScN program allowed me to explore RPNs' experience of conflict between nurses in the workplace. This focus also addressed how these experiences may have contributed to their decision to return to university. This research involved a sample of RPNs in a post RPN-BScN program—a sample that that has not yet been examined regarding nurse-to-nurse conflict. Furthermore, this research study considered how broader level contextual factors shaped RPNs' experiences of nurse-to-nurse conflict in the workplace, as few studies examine this issue through this lens.

Finally, this research will provide valuable insight into the issue of nurse-to-nurse conflict. Health care professionals and employers will also be able to utilize this research when developing strategies and policies regarding workplace conflict and violence. Examining RPNs' return to school for a BScN and exploring if nurse-to-nurse conflict shaped their decisions is also critical for a further understanding of RPNs experiences of this phenomenon. This was worthy of exploration as there are more job opportunities for RPNs and fewer for RNs. It will also help RPNs remain within their profession and ensure a sufficient RPN workforce, as their role in healthcare is becoming more prominent (with the rise in employment opportunities) and vital for quality patient care.

CHAPTER THREE

Methodology, Methods, Data Collection and Analysis

In this research study I explored the following research questions: (1) What are the experiences of RPNs in the post RPN-BScN program with nurse-to-nurse conflict in the workplace?; and (2) How do these experiences contribute to RPNs' decision to go back to school for a BScN? I used Interpretative Phenomenological Analysis (IPA) as my methodology to explore the experiences of RPNs in a post RPN-BScN program. In this chapter I will discuss this methodology in detail, as well as the methods, data collection, and analysis used for this research.

3.1 Methodology

3.1.1 Phenomenology as a Philosophy

In this research I explored RPNs' (in a post RPN-BScN program) experiences of nurse-to-nurse conflict in the workplace and explored the place of these experiences in shaping their decision-making process regarding their return to school to become a RN. A qualitative, interpretive approach was taken for this research. The chosen methodology was phenomenology, as it is used to describe and explore the meaning of individuals' lived experience of a phenomenon (Creswell, 2006; Speziale & Carpenter, 2007). Phenomenology is the philosophical study of experience (Smith, Flowers & Larkin, 2009). The aim of phenomenology as a methodology is to discern important components of experiences or phenomena that make them distinct and identifiable from others (Pietkiewicz & Smith, 2012). Phenomenology also allows for the researcher to understand the lived experience of the participant in relation to a particular phenomenon (Streubert & Carpenter, 2011).

Phenomenology has strong philosophical elements, drawn from the work of philosopher Edmund Husserl (Creswell, 2006). Specifically, Husserl informed descriptive phenomenology (Gill, 2014) which aims to describe lived experience (Creswell, 2006). He believed that the researcher must identify and remove their preconceived opinions and assumptions of a phenomenon to maintain objectivity which he called bracketing (Creswell, 1994; Husserl, 1970, 1983). Furthermore, the researcher must suspend their preexisting suppositions of the phenomenon in order to understand meaning based on the experiences of participants' descriptions (Creswell, 1994; Husserl, 1970, 1983). However, an interpretive approach to my research was taken to interpret others' experiences. This interpretive approach to phenomenology draws on Martin Heidegger's interpretive phenomenological philosophy (Gill, 2014; Heidegger, 1927/1962).

In contrast to Husserl's descriptive phenomenology, Heidegger developed interpretive phenomenology, which emphasizes interpretation in the use of phenomenology as a methodology (Gill, 2014). Heidegger studied the question of being, the human experience of being, and believed that meaning is embedded in everyday experiences (Gill, 2014; Lopez & Willis, 2004). He further developed hermeneutics (the philosophy of interpretation) to create his interpretive phenomenology (Creswell, 1994).

Heidegger argued that interpretation is an inherent aspect of research (Gill, 2014). Heidegger argued that individuals' realities are strongly influenced by their world and cannot be extracted from it. He expressed this as 'being-in-the-world,' emphasizing the interpretation of the meaning of individuals' or participants' being-in-the-world and how these meanings impact their decisions and shape their experiences (Heidegger, 1927/1962). Through interpretation, lived experiences provide and clarify the meanings

of a given phenomenon based on an individual's perception, rather than discovering or explaining causes (Giorgi, 1997, 2005).

My research investigated RPNs' experiences of the phenomenon of nurse-to-nurse conflict and explored how RPNs create meaning based on their experiences of this phenomenon. This helped to provide an understanding of how this experience might shape/influence their decision to return to school to obtain a BScN. As the researcher, I did not bracket my presuppositions of the phenomenon under study (as in Husserl's descriptive phenomenology). Rather, I acknowledged my own experiences and knowledge throughout the research process, as Heidegger argues that self-awareness is an integral part of phenomenological research (Reiners, 2012).

3.1.2 Background and Rationale to the Methodology

The specific methodology that I used for my research was Jonathan Smith's Interpretative Phenomenological Analysis (IPA) (Smith, 1996), which draws on Heidegger's interpretive phenomenological philosophy (Heidegger, 1927/1962). The aim of IPA is to "explore in detail participants' personal lived experience and how participants make sense of that personal experience" (Smith, 2004, p. 40). I used IPA to explore RPNs' experiences of nurse-to-nurse conflict in depth.

IPA is informed by hermeneutics (the philosophy of interpretation; Creswell, 1994), interpretive phenomenology, and has an idiographic focus (Smith, 2004; Smith et al., 2009). Giorgi and Giorgi (2003) state that IPA is phenomenological, as it involves the perception of one's personal lived experience and how a person interprets their experiences. Further, IPA fits with Heidegger's perspective in "that phenomenological inquiry is from the outset an interpretative process" (Smith et al., 2009, p. 32).

IPA is also idiographic. In using IPA the researcher seeks to make sense of how a certain individual, within a certain context, creates meaning of or understands a phenomenon that directly affects them (Smith, 2004). IPA is different and separate from Heidegger's interpretive phenomenology methodology due to its idiographic nature (Gill, 2014). IPA examines and analyzes each participant's experience and perspective in-depth, focusing on the particular as opposed to the universal (Pietkiewicz & Smith, 2012). For instance, consistent with IPA's idiographic approach, I examined each transcript in detail before moving on to examine others. IPA allowed me to convey and capture the richness of participants' lived experiences of the phenomenon under study (Gill, 2014) and make statements that are specific to certain participants due to the comprehensive case exploration (Pietkiewicz & Smith, 2012). I took a holistic approach to my research through the use of IPA as my methodology, as it amalgamates hermeneutics, interpretive phenomenology, and is idiographic (Smith & Osborn, 2003; Smith et al., 2009). I was able to investigate RPNs' experience of nurse-to-nurse conflict in the workplace and explore, interpret, and understand how RPNs make sense of these experiences and how these experiences may shape/influence their decision to return to school.

I used IPA because it is concerned with how the researcher analyzes and interprets the participants' personal experience (Palmer, 1969). IPA involves examining participants' experiences that are meaningful and significant to them (Smith et al., 2009). An IPA approach embraces the idea that people are psychological and physical beings, such that they "do things in the world, they reflect on what they do, and those actions have meaningful, existential consequences" (Smith et al., 2009, p. 34). The reflection upon personal experience is key to the use of IPA.

Furthermore, IPA incorporates Heidegger's belief that we cannot deny the existence of our own experiences regarding the phenomenon under focus (Heidegger, 1927/ 1962). Using IPA, the researcher "aims at giving evidence of the participants' making sense of phenomena under investigation, and at the same time documents the researcher's sense making" (Pietkiewicz & Smith, 2012, p. 366). IPA focuses on understanding the participant's experiences of given phenomena, making sense and meaning of them, and translating it in such a way that is comprehensible through interpretative activity (Pietkiewicz & Smith, 2012). This is known as a double hermeneutic, such that the participants attempt to make sense or meaning of their world, and the researcher is attempting to also decode this meaning and make sense of the participant making sense of their world (Pietkiewicz & Smith, 2012; Smith, 1996). Therefore, my role as the researcher is acknowledged during this analytic process in IPA.

With regard to my research, I applied the concept of double hermeneutics and did not bracket my preexisting knowledge and experiences. I noted my own inevitable and predisposed knowledge, assumptions, values, and beliefs about my research inquiry by journaling throughout the research process. For example, after I reviewed different researcher's views on the phenomenon, I reflected on how broader level contextual factors influence the tensions between nurses. By identifying and reflecting on these assumptions and experiences, I was able to engage with and interpret participants' perspectives and perceptions of their experiences, enabling me to capture detailed, rich, and insightful data (Larkin & Thompson, 2011). I acknowledged that my assumptions and experiences shaped the findings of my research (Thomas, 2006).

IPA is committed to exploring the lived experience of individuals and how they make sense of their personal and social world (Smith, 2004; Smith & Osborn, 2003). My proposed research inquiry suits IPA, as it is not framed to test a predetermined hypothesis. Rather, it is open, broad, exploratory in nature, and flexible, such that it does not assume answers in advance (Smith & Osborn, 2003). The primary research question (what are the experiences of RPNs in the post RPN-BScN program with nurse-to-nurse conflict in the workplace?) aims to examine how RPNs' think about, understand, and make sense of their lived experiences of the phenomenon under study (Smith et al., 2009). The second research question (how do these experiences contribute to RPNs' decision to go back to school for a BScN?), which was answered at the interpretative stage, is more refined in its inquiry regarding the experiences of RPNs in the post RPN-BScN program with nurse-to-nurse conflict. In keeping with the perspectives of Hudson and Ozanne (1988), my research was an emergent process and continually evolved.

3.1.3 Participant-Researcher Relationship

As the researcher, I took an active role in the research process in the use of IPA. This methodology is most congruent with the interpretivist qualitative paradigm. As a result, the individuals within the sample of my study were referred to as participants. Interpretivists establish an interdependent and mutually responsive relationship between the researcher and participants (Hudson & Ozanne, 1988). Qualitative research involves acknowledging how the participant has an important and active involvement in the research process by illuminating their experiences to help better understand their lived experiences and interactions with the phenomenon under study (Streubert & Carpenter, 2011).

According to the interpretivist point of view regarding the research relationship, Hudson and Ozanne (1988) state, “the social reality is based on individuals’ or groups’ perceptions. Then, in order to be able to understand those perceptions, these individuals must be involved in creating the research process” (p. 512). As a result, I aimed to create an open and interactive relationship with participants that enabled them to feel comfortable conveying their experiences and perspectives. Interpretivist research is also “guided by the researcher’s set of beliefs and feelings about the world and how it should be understood and studied” (Denzin & Lincoln, 2005, p. 22). This is consistent with IPA. I interpreted and created meaning based on how participants interact and experience the world (their workplace experience) with the phenomenon of interest (nurse-to-nurse conflict) in their own individual way.

3.2 Method

3.2.1 Research Ethics

Before the collection of data for this research, ethical considerations and approval was sought and obtained from the Research Ethics Boards (REB) of the University of Ontario Institute of Technology (REB # 14-112; see Appendix A) and Durham College (REB # 126-1617; see Appendix B).

3.2.2 Participants

The participants in my research consisted of RPNs (18 years or older) who had experience with nurse-to-nurse conflict in the workplace and were currently enrolled in a post RPN-BScN program. Participants who did not meet these inclusion criteria were excluded from participating in my research.

The inclusion criteria for participating in this research comprised of:

1. RPNs who were in a post RPN-BScN program.

2. RPNs who had experiences with nurse-to-nurse conflict in the workplace.

Participants had to have experiences with nurse-to-nurse conflict since my research aimed to identify and explore RPNs' (in a post RPN-BScN program) experiences with this issue in the workplace. This criteria also allowed for the investigation of how these experiences may have contributed to their decision to return to school for a BScN.

3. RPNs who had at least six months of workplace experience, but no more than five years.

At least 6 months of workplace experience was rationalized as this research focused on the experiences of nurse-to-nurse conflict as undergone by RPNs. New nurse graduates' main issue within their first year of employment is job conflict (McKenna et al., 2003). A maximum of five years is rationalized as the literature demonstrates that newly licensed nurses have been shown to have more encounters with bullying (McKenna et al., 2003). Vessey et al. (2009) found that nurses who worked five years or less had encountered bullying more often than nurses who worked more than five years. Furthermore, Coffey et al. (2013; a study done at the site of my research) interestingly found that RPNs had approximately 4.4 years of workplace practice before returning to school.

There were 6 participants involved in my research study. This number of participants was consistent with IPA, as it is highly recommended that IPA studies have approximately 3-10 participants in a study since the primary interest of IPA is to conduct a detailed, in-depth analysis of each case (Smith et al., 2009; Smith & Osborn, 2003). Smith and Osborn (2003) suggest that this number "allows sufficient in-depth engagement with each individual case but also allows detailed examination of similarity

and difference, convergence and divergence” (p. 57). The use of IPA focuses on the depth, rather than the breadth of the study (Pietkiewicz & Smith, 2012).

3.2.3 Participant Recruitment

I used purposive sampling for participant recruitment, as this sampling method aligns with the theoretical underpinnings of IPA (Pietkiewicz & Smith, 2012). Smith and Osborn (2003) suggest that IPA researchers select homogenous samples (as opposed to randomized or representative sampling) so that participants share particular characteristics and similar experiences of the same phenomenon under study. The individuals selected to participate in my research study were those who had first-hand experience of the phenomenon under study to provide a greater understanding of it (Streubert & Carpenter, 2011). Smith et al. (2009) state that participants are to be selected on the premise that they can provide a particular and unique perspective on a given phenomenon. I used purposive sampling to provide meaningful knowledge and insight about the phenomenon of interest. The purpose of this research was not to generalize findings to all nurses (Smith & Osborn, 2003). Rather, the aim was to present a detailed account of the experiences of RPNs with nurse-to-nurse conflict and how these experiences influenced their motivation to obtain a BScN.

To recruit participants for my research, I attended pre-requisite/ mandatory courses (with the instructor’s permission) for RPNs in a post RPN-BScN program. I verbally explained the research study to the RPNs in the program. The verbal recruitment included an introduction of myself as the researcher, an explanation of the background and purpose of my research, identified the eligibility criteria to participate in the research, emphasized that participation was voluntary, the information obtained from the research

kept confidential and anonymous, and those who chose to volunteer for the research study were asked to select a time that was most convenient for an interview (see Appendix C for the whole Verbal Recruitment Script).

I provided pieces of paper with a brief explanation of the research study and my contact information (email address) to each of the RPNs (to maintain confidentiality and anonymity of those interested in participating) in the classes (see Appendix D for the Handout Invitation with Contact Information). The inclusion criteria for my research study was made clear to the RPNs from the recruitment materials. I had no prior relationship with potential participants.

3.3 Data Collection and Procedure

3.3.1 In-depth Individual Interviews

The method of data collection was based on the IPA methodology. Specifically, I gathered qualitative data from participants by using individual in-depth interviews. Each interview was approximately 30-60 minutes. Smith and Osborn (2003) suggest that this method is the most useful way to collect data for an IPA study. In-depth individual interviews provide optimal opportunity for participants to discuss the phenomenon under study and expand on their thoughts, ideas, and concerns freely and reflectively (Smith et al., 2009). I explored participants' experiences in the workplace, followed by probing questions to investigate the phenomenon of inquiry. IPA enabled me to adopt a flexible, curious, and facilitating role throughout the interviews as I was able to modify my initial questions based on participants' responses in order to further explore the phenomenon (Smith & Osborn, 2003). The individual in-depth interviews also allowed for flexibility

and left room for new issues and knowledge drawn from participants' responses (Smith & Osborn, 2003).

I created a set of interview questions based on guidelines designed by Pietkiewicz and Smith (2012) and Smith et al. (2009) that helped guide and facilitate discussion regarding participants' experiences of nurse-to-nurse conflict (see Appendix E for the Interview Guide used). The questions were intended to be open without presumptions to guide the interview and be adapted depending on participants' responses to further explore areas that emerged (Pietkiewicz & Smith, 2012; Smith et al., 2009). This enabled me to discover and explore any novel areas generating rich data (Smith & Osborn, 2003). Moreover, I audio recorded the interviews with the participants' permission. Smith and Osborn (2003) emphasize that the researcher audio records the interview so that he/ she can analyze the full interview and capture the important nuances expressed by the participants.

3.3.2 Setting

The participants contacted me via email and selected a date and time to meet to participate in the study. Interviews were conducted in a location most convenient for the participants, such as on the campus. To ensure privacy, participants were interviewed in quiet a room with a closed door.

3.3.3 Specific Procedure

I gave participants a Letter of Invitation and Consent Form (see Appendix F and G) to read and sign before the commencement of the interview. When the participant signed the consent form, the participant was reminded that the interview would be audio-recorded and that anonymity and confidentiality would be maintained throughout the

duration of my research. I also informed the participants that they did not have to answer questions that they did not wish to and that they could withdraw from the research study at any time before or during the interview. Finally, they were apprised that each interview would be transcribed in its entirety from the audio-records. The participant and I kept a copy of the signed consent form for our own records or purposes.

Following the interview, the participant received a Thank You Letter (see Appendix H) and a \$10 Tim Hortons gift card for their completed participation in the study. I reminded participants of the confidential nature of my research study and that information obtained was held in strict confidence. To ensure anonymity participants selected a pseudonym as their identifier for the remainder of the study. I also informed them that after the data had been anonymized, it was no longer traceable back to them.

Each interview was transcribed verbatim from the audio records and made available for review by each participant. Participants had the choice to review their transcript, in which they indicated on the signed Consent Form. The participants received an electronic copy within seven days of the interview and had another seven days to return the transcript to me with any comments, questions, changes, or concerns. If the participant did not give feedback or return the transcript within the seven days, it was presumed that the participant's experiences had been accurately captured.

3.4 Data Analysis

I transcribed each interview in its entirety from the audio records. After each interview, I reflected and discussed initial thoughts and feelings of potential significance, which I also transcribed. I engaged and interpreted the transcripts and attempted to make sense and investigate the meaning of their contents (Smith & Osborn, 2003). The use of

IPA allowed me to understand participants' experiences of nurse-to-nurse conflict in the workplace and how these experiences were instrumental in their return to school for a BScN.

I began by listening intently to the audio records and carefully reading the transcripts multiple times (Pietkiewicz & Smith, 2012). After, I familiarized and immersed myself in the data by making notes of anything of interest in the transcript to gain insight into participants' experiences, such as how they understand, think, and talk about nurse-to-nurse conflict (Gill, 2014; Pietkiewicz & Smith, 2012; Smith et al., 2009). Notes consisted of descriptive, linguistic, and conceptual comments on differences, similarities, echoes, contradictions and amplifications (Smith et al., 2009). Analytic dialogue also occurred such that I commented on what the words, phrases, and sentences meant for me and also for the participant (Smith et al., 2009).

I then transformed my notes into emerging themes, predominately working with the notes rather than the transcript itself (Smith et al., 2009). After, I searched for connections across emergent themes and developed these into more concise themes that grasped the essential quality of participants' comments (Gill, 2014; Pietkiewicz & Smith, 2012). To help organize my data and themes, I created a bristol board and did a mapping of my concepts. After, I clustered the related themes based on conceptual similarities and revealed master themes in the process (Gill, 2014). In this process, I moved from coding to a higher level of analysis. For instance, I thought I noticed an emerging theme with identity, but then I realized there was more to this emerging theme where there was also role confusion and other interesting aspects of the RPN to RN transition. Thus, the theme 'In-between Space' was created as a higher-level theme to capture the participants'

experiences. With an inductive lens I was able to interpret and analyze the data fully and accurately.

3.5 Scientific Rigour

Research that falls within the interpretivist paradigm (qualitative research) establishes rigour differently than research within the positivist paradigm (quantitative research; Webb, 1992). Therefore, I addressed and applied several evaluative criteria to legitimize and enhance the rigor of my qualitative research. Specifically, I considered and adhered closely to Guba's (1981) credibility, transferability, dependability, and confirmability as trustworthiness criteria in order to ensure rigor in my findings.

To enhance credibility, I performed member checks (Guba, 1981) by giving the data back to participants to assess the accuracy of the transcribed interview. This ensured the truth and accuracy of the findings. To achieve transferability, I aimed for others to be able to transfer the results to another, similar context (Guba, 1981). I used thick descriptions by thoroughly describing the research context and phenomenon. For instance, I provided detailed information about the concept and context of nurse-to-nurse conflict. As noted above, my study does not aim to find results that generalize to all nurses (Smith & Osborn, 2003). Instead, my aim was to report a detailed account of RPNs' (in a post RPN-BScN program) experiences with nurse-to-nurse conflict in the workplace and how their experiences shaped their decision to return to school for a BScN.

To establish dependability, I aimed to have the process of my research remain stable over time so that future researchers can replicate the study in other settings, and ensure credibility and consistency to the context studied (Webb, 1992). For example, I

created an audit trail by documenting the steps that I took during the process of my research so that an external auditor, such as a researcher not involved in the research process, could examine my findings to ensure that my interpretations are accurate and consistent with the data (Guba, 1981).

Finally, to enhance confirmability, I worked towards having the results emerge from the data, instead of my own predilections (Guba, 1981). For instance, I used reflexivity, which is the conscious awareness of the researcher's relationship to the research topic and participants (Dowling, 2006). I practiced reflexivity throughout my research process to document my own characteristics and preferences through journaling to understand how they influenced the research and the results I interpreted from participants' experiences and ideas. Reflexivity helped me to avoid a narrow perspective and superficial understanding of the complex issue of nurse-to-nurse conflict.

CHAPTER FOUR

Findings

My research aimed to explore the following research questions: (1) What are the experiences of RPNs in the post RPN-BScN program with nurse-to-nurse conflict in the workplace; and (2) How do these experiences contribute to RPNs' decision to go back to school for a BScN? Nurse-to-nurse conflict is a form of workplace violence defined as inappropriate verbal or non-verbal aggressive behaviour from nurses towards nurses (Christie & Jones, 2013).

Five themes emerged from the data analysis: the Current Organizational Context of Health Care, Marginalization of the RPN, the In-between Space, Hierarchy, Power, and Privilege, and Professional Development and a Drive for Change. Each theme is presented in detail with verbatim quotes from the interviews of Emma, Cassadee, Sage, Faith, Isabelle, and Nini (pseudonyms chosen to ensure the anonymity of each participant).

While there is vast research investigating conflict between nurses in the workplace, there also are broader forces that propagate this behaviour. As discussed in Chapter 2, a number of contextual factors contribute to the issue of nurse-to-nurse conflict. These include the changes at the structural and organizational level that create sources of tension, such as the ambiguous scope of practice and the hierarchical structures that exist within the nursing profession.

4.1 The Current Organizational Context of Health Care

The broader organizational context influencing the nurses' work environment was a central theme that contributed to participants' experiences of nurse-to-nurse conflict. The participants in this study often discussed the contextual factors, such as budgetary

constraints, staff shortages, and stress, and how these factors exacerbate the conflict between nurses.

4.1.1 Budget Constraints, Staff Shortages, and Stress

One participant speaks to the organizational context in the following,

So for me I think partial ownership goes on the RPNs and the RNs who are doing it, partial ownership goes on the hospital itself, the organization for causing that much stress right? And part of it goes on the government because what can the organization do if they're getting a limited budget?... I think it's not just the RNs and RPNs, I don't think it's just [whether you] are mean or you're not, or you are critical or you're not, I think a lot of it does have to do with the situations they're getting put in. (Nini, L. 585-590)

Here the participant points to the budget cuts as one of the broader level factors that influence staff relations between RNs and RPNs. Another participant goes on to explain,

If you notice now there's not a lot of full time jobs, a lot of part time or casual or contract or temporary and so again, if I'm able to not hire 5 full time RNs and get 10 part time RPNs and I may not have to give them benefits I'm golden... that contributes to the stress you know [if] 5 of my friends just got fired to hire 10 of you RPNs... that's where that violence, horizontal violence can come about... but like I can't blame the RNs, it's unfortunate, it's the way the economy is going right now. (Sage, L. 466-479)

Many of the health care institutions have been replacing RNs with RPNs (ONA, 2016).

Here the participant is speaking to the staff mix reality that has created tension, as RNs are being replaced with RPNs in many settings. Another participant speaks further to the consequences of cutting budgets in the following,

[The shortage is] really stressful because that's when nurses are saying hire the staff, we need the support, we can't look for or care for 50+ patients by ourselves and so that's where I can absolutely see the horizontal violence in terms of nursing going and so it would be nice if the government can find a way for the RPNs and RNs to be able to have appropriate staffing ratios. (Sage, L. 492-496)

Here the participant points to the consequences of staff mix issues for workload.

Increased workload is associated with consequences for patient care and potentially

patients' poor health outcomes (CNA, 2003). A participant goes on to discuss this further in the following,

I do see it happening... I think a lot of it is just it's just stress you know people are stressed out, overworked, underpaid, underappreciated, and unfortunately it comes out you know what I mean, even though we are the ones who are supposed to be elevating each other you know sometimes we can't snap at the residents, you can't snap at the PSWs, but it's you know what I mean it's that horizontal violence.
(Faith, L. 267-271)

Here the participant is speaking to the organizational constraints as a factor that negatively affects nurses' work morale and inadvertently propagates nurse-to-nurse conflict, and consequently nurse-to-patient incivility. These constraints strongly shape the issue of violence at many levels in the nursing work environment. In a slightly different vein, another participant elaborates on the impact of the organizational context in the following,

I do work at another hospital and it [is organized]... a lot smoother... there... I would say [that] management and... the system affects [this issue of nurse-to-nurse conflict]. It like trickles down right it's a trickle down effect and I think it's like completely like an institution thing and that affects how people work together.
(Emma, L. 276-280)

Here the participant speaks to differences across institutions created by different management approaches that affect nurses' relations. This issue is picked up further in the following subtheme.

4.1.2 Management Issues

Contextual factors often constrain the ability of management to appropriately address nurse-to-nurse conflict that exists in the workplace. One participant speaks to this in the following,

[An older RPN] was like yelling at me about something and she put her finger up in my face and said, 'that's enough from you' and my supervisor was standing right there and she ran to the supervisor and told them that I was being rude and everything and the supervisor heard what she said and basically came to me and

said I was being inappropriate and [I] said to her like ‘what she did to me that you saw was that inappropriate?’ And she didn’t respond. (Isabelle, L. 230-235)

Here the participant experienced being silenced by her supervisor. This illustrates how a blind eye is turned to nurse-to-nurse conflict. This kind of silencing acts as a barrier to dealing with conflict in the workplace. The same participant further elaborates on this experience,

Nothing really gets done and there’s no follow up and there’s no, that’s the problem like people have cursed people in the nursing station like the ‘F’ word and not towards me but towards other people and nothing gets reported. (Isabelle, L. 634-636)

Here this participant again discusses the lack of attention to conflict in the workplace.

Nurses’ unwillingness to report these incidents because of prior negative experience was noted by several participants. Another participant speaks to the consequences for this in the following,

I think if I would have been supported [and] not bullied and had like a really strong management team who was really willing to you know go above and beyond for new grads then I think that I would probably be in a much different position today. (Cassadee, L. 394-396)

The lack of attention and turning a ‘blind eye’ to nurse-to-nurse conflict has had serious consequences for this nurse. It has affected her personal wellbeing, as well as shifted her career trajectory and attitude towards the profession in a number of important ways. For instance, this participant described how she has experienced low morale and issues with mental health, and noted how it affected her ability to care for patients. Moreover, the same participant discusses the barriers to addressing unit conflict in the following,

I think the thing of it is nurses probably aren’t reporting for the fear of being bullied. Managers are closing their eyes to it because A) if they’re not on the floor they don’t see it B) because it’s an extra task, daunting task that they don’t want to take on C) because maybe they’re not educated on how to fix it. So if you let it go maybe it it’ll get better [sarcasm]. (Cassadee, L. 820-823)

Participants commonly expressed concerns and fear of reprisal such as management's dismissal when bringing these issues forward. In addition, the workload attached to complaints and the lack of knowledge and education act as barriers. Thus, these factors prevent the necessary actions needed to address nurse-to-nurse conflict. The same participant elaborates on this in the following,

We used to have this one main manager who was like the administrator for the building okay and we would do an overhead page and it'd just be 'AK47 please call 50.' AK47 means she's in the building... somewhere and we would all flee. (Cassadee, L. 689-692)

Here the participant speaks to the significant distance, and the lack of trust and respect between nursing staff and management. This is another factor that acted as a barrier to reporting conflict. Other participants go on to explain the problem further in the following interview excerpts,

Why does it continue? It continues because people are complacent... a lot of people are in managerial roles that shouldn't be. If there is the same thing going on for 7-8 years you know anybody can see that that's an issue, but it's the same management for 7-8+ years, right. It's management condoning it. (Faith, L. 123-127)

That's what probably happened to these nurses as they were going up through nursing and getting older so they had the bad things happen to them so they do it to the other people and it continues and continues. (Isabelle, L. 522-524)

It's very... messy... I don't think... the managers don't know how to deal with it. [Instead] I feel like... the higher up people that are in charge of the funding... are not seeing the whole picture. (Emma, L. 271-273)

Here the participants are speaking to the intersecting issues associated with management's inaction. The lack of attention to the conflict that exists between nursing staff and the lack of knowledge and education necessary to deal with these issues create a cyclical effect whereby tensions are exacerbated. In addition, management is seen as

incompetent, burned out, distant, and unwilling to address the conflict between their staff.

However, there are broader level factors at play. A participant explains in the following,

What RN is going to take that line? [The full time night nurse position is] so hard to fill. So we need to you know placate her and... everyone else just because we need that registered nurse at night. Because the ministry says we do, right... In order to get rid of somebody you have to go through union and it's a union environment and then you have to go through that and you have to go through due diligence the whole process you know they could have gotten rid of this person years and years ago but again, right it's easier to sweep it under the carpet then deal with it. (Faith, L. 127-129, 161-164)

Both nurses and management are constrained by the inner workings of the system.

Nurses' work is managed by the system in which budgetary constraints, union regulations, and lack of support for management are endemic, posing serious consequences for nurses and potentially patients. The constraints on management shape their capacity to deal with the issues and tensions between nurses, which led the participants to perceive management as incompetent.

4.1.3 Organization of Care Provision and Teamwork

Participants in this study identified the organization of care provision and teamwork as a contextual factor that shaped nurse-to-nurse conflict. One participant speaks to this in the following,

It's one big unit, so... you're working together and on the same floor... I find [there's] a little bit more teamwork there even for like transferring patients and you work together a little bit more and I think that's because we used to be on that it was called the CCT care something T, I can't remember but that was where you had you know your team of nurses, so everybody kind of has that already kind of engrained in them. (Emma, L. 297-301)

Team nursing was identified as a strength that contributed to collaborative practice between RNs and RPNs. The same participant goes on to elaborate further on the model in the following,

It's not like 5 nurses sitting in a chair and 5 nurses working crazy, or if labour and delivery is busy we'll come over and help and do the baby nurse or scrub or whatever. Right so I think it's just definitely more like a team atmosphere right... it's a busy unit it, but it just it definitely does alleviate some of that like added stress from just unnecessary ... drama. (Emma, L. 331-338)

Working in teams promoted feelings of camaraderie, thus creating a more amicable and satisfying work environment. Other participants also communicated how they valued teamwork such as in the following,

[Teamwork is] not there and I remember I cried because when I got to CCC and rehab I was thinking hospital again, here we go, fend for yourself and it was my first break on my first shift and the two ladies that were working with me came up and said, 'Is there anything you need us to do for you before we go on break?' ... And I'm like 'Nobody's ever asked me if I needed anything before [they] left!' (Nini, L. 448-452)

There are times... if we are short, working short or something like that we'll help each other, outside of my own experience with the night RN, you know we do hold together and do that, it's important. (Faith, L. 230-232)

When nurses do find that coveted teamwork that everybody dreams of having it's like you don't want to leave that unit because you all work well together and you know you're able to kind of help each other. And so yes I'm looking for [that] when I can make that transition and to I guess... a more focused nursing team where everyone's experiencing the same things... so yeah I'm looking for it to happen, that nursing team. (Sage, L. 289-301)

Here the participants note their satisfaction with a team approach to patient care. This model of care delivery was well supported by the nurses in this study. However, different institutions supported different care delivery models, which was a factor that strongly influenced nursing relations differentially.

4.2 Marginalization of the RPN

The participants in the study spoke to how they were marginalized by RNs in the workplace. Specifically, they experienced feeling inferior; often the RN did not recognize their skills. RN-RPN relations, relations with senior nurses, marginalization and role

confusion, and RN vulnerability and institutional financial constraints are subthemes that fall under this theme.

4.2.1 RN-RPN Relations

A participant speaks to the RN-RPN relations from a personal experience in the following,

I think there's a difference [with]... the RNs... that have gotten their degree. There's kind of like a hoity-toity attitude, kind of like [a] superior vibe that you get... doctors will buy us lunch that happens all the time and... sometimes like the RNs work more directly with the doctors and the postpartum side kind of gets pushed aside... and I find like we're supposed to be one unit and you know sometimes the doctors buy lunch and just won't invite the RPNs... It just kind of promotes that kind of attitude right like where... we're this group and they're kind of over there... And I find like there's a lot of like you know this is you've kind of encroached upon our space. (Emma, L. 40-55)

Here the participant points to the lack of recognition for the skills and knowledge of RPNs despite their critical role and involvement in patient care. Another participant speaks to a similar experience,

I was trying to do the right thing but I felt like I was getting undermined and I had to really really fight for getting the care that this patient needed, which isn't fair... [I felt] frustrated, very frustrated especially as an RPN, right because I feel like nope I'm not that RN, so I'm just going to sit back and you know not [get] taken seriously [and] your day is already exhausting that [it's] like I don't want to have to fight with you... I want you to listen to what I say the first time... Turns out I was right, [the] doctor had ordered a bunch of blood work and blood cultures and I said, 'Okay I'll go do that' and she's like, 'No no I better do it.'... [but] she complained about it. She said that I wasn't able to do it and that she had all [of] this extra work to do, right so it's kind of like really? Like what are you 15? Like can we not. (Nini, L. 237-259)

Another participant shared a similar experience,

The nurse RN said to me, 'Oh I'm just going to give you the patient that's dying cuz he's gonna die anyways.'... I took big offense to that cuz I was like... Why should I have [that] patient? Like I don't have [a] problem with the patient who is dying, but why should you give me that? As a brush off kind of thing... So [the supervisor] called us both in and the [RN] actually apologized [and] she said, 'I wasn't meaning to be rude I was really busy'... But she totally didn't acknowledge the problem to say that to me and she didn't understand why I took offense. She

apologized just because the supervisor told her to apologize... I still get upset about that actually today because that's hurtful. (Isabelle, L. 176-187)

Several participants in the study provided accounts of experiences with RNs that left them feeling distressed. They often felt their skills and abilities were not recognized or valued and often experienced being treated with disrespect. In a slightly different but similar vein, a participant shares an experience in the following,

My 'in charge' that night said... 'I'll go with you and like vouch for you, support you' because I was new and she knows the terminology...so she came, we had this meeting with the head of the hospital, the in charge nurse, myself, and the doctor, and the in charge who was supposed to be kind of supporting me ended up kissing [the doctor's] butt...like you said you were going to come here to support me...I went on my own and... that was really frustrating for me because I thought I am just this RPN and this is a physician and the 'in charge' and the head of the hospital. (Nini, L. 704-710)

Here the participant notes feeling isolated and helpless when unsupported by her superior.

This highlights the mistrust and disconnect between the RPN and the RN. Another participant said,

So counting, that's another part of the shift that causes a lot of issues, like [both RNs and RPNs] have to count narcotics at the end of every shift... One of the [RNs], I don't know if she was joking or if she was serious, but she said... 'Well, where are all the RPNs to count? That's all [they] need to do anyways.' And don't know if she was joking or serious, but I was like, well me and this other girl [Friend's name] were like, 'What the hell?' Like we just looked at each other and like let's just count, let's just count...It was really rude yeah and apparently she's said that before cuz another [RPN] said she's said that before a few times. (Isabelle, L. 489-498)

In this case the participant is unclear about the RN comment. Ambiguity and tension were created because of the participant's past hostile experiences with RNs. Another participant shares an experience in the following,

She came running to me in the main hall and said, 'I just got a call from the doctor saying that nobody charted that she went to the new facility with stitches in her leg.' And I went okay? You know thinking like well it's not me? I wasn't even here and she started absolutely screaming at me in the hallway saying, 'This is bullshit. I can't fucking believe that you people are so incompetent, that you don't

even do a skin assessment or even write one little progress note. I can't believe it.' And I threw my hands up and I said 'Whoa, I wasn't even here.' And she said, 'Are you really using that as an excuse? Fucking pathetic.' And she walked in the hallway and I went into the med room, was also my secret place and as much as people target me, and I went in the med room and I shut the lights off and I sat on the floor and I balled my eyes out because I was so, I felt like I was like so small that I did not matter at all and there's no support. (Cassadee, L. 441-451)

Here the participant describes feeling diminished by the incident with the RN. A lack of communication and trust between the participant and this RN had lasting effects on wellbeing.

4.2.2 Relations with Senior Nurses

The participants in the study experienced feeling marginalized by senior nurses because of their age and lack of experience, regardless of whether they were RNs or RPNs. As one participant notes, "I'm younger you know, I'm the RPN, I was new to that floor, not new to nursing, but new to that floor and she just didn't she didn't take me seriously" (Nini, L. 212-213). Another participant speaks to a similar experience,

Anybody under the age of 30 I notice she's hostile towards people...she called us stupid. When I first started working she didn't want to work with me because I was too young... Me and another nurse were both in our twenties and she didn't want to work with us because we were too young and we didn't know anything and we wouldn't be able to support her if she needed support but she doesn't support anybody else. (Isabelle, L. 138-148)

The participants point to how age, years of experience, and being new to a unit are factors that play a role in the negative treatment described. This experience has been documented in the literature; novice nurses are undervalued for their skills and abilities and have several experiences of nurse-to-nurse conflict (McKenna et al., 2003).

4.2.3 Marginalization and Role Confusion

Participants discussed how role confusion promoted nurse-to-nurse conflict in the form of marginalization of RPNs. A participant notes her experience in the following,

You felt you were always trying to defend your role... It's like no like I'm trained and here's the policy that says that I can... and sometimes... you get the opposite, where you have some nurses or RNs that would be like, 'Yeah go ahead and do this now' and 'No, no, no I can't' and they'd get mad at you right. Like that was the other thing. They'd be like, 'Ugh! Oh my gosh you know what good are you?' And it's like, 'Oh thanks, you know like that's really nice there's a lot of things I can do, but there's a few things I can't' ... I'm not going to risk my license for that. (Emma, L. 124-130)

Here the participant speaks to an interesting paradox. In one instance the RPN is admonished for stepping in and taking on certain tasks, but is also rebuked when she does not in another. This points to the consequences for role confusion and overlapping scope of practice experienced by RNs and RPNs. Another participant voices her experience in the following,

Maybe she thought, 'Oh a new RPN working at a lower pay scale, here to take [my] job.' ... the trend of [nurses' employment]... tends to shift with the economy. So it's quite obvious now that RPNs are being employed at a faster rate I'd like to say than RNs because the skill line now is so slight... So the RPN has a bit more skillset than what they used to have and so the RN may have...felt a little threatened that you know, 'Here's a younger nurse working for less, I've been here for 15 years since the home opened and I could possibly lose my job'. (Sage, L. 92-106)

Here the participant's experiences point to the intersection between role confusion and scope of practice and the very real tensions posed by RPN replacement of RNs in several health care institution settings— tensions that have been noted by the ONA (2016).

4.2.4 RN Vulnerability and Institutional Financial Constraints

Participants speak to RN vulnerability in the context of institutional financial constraints in the following,

There are hospitals that are laying off RNs to hire RPNs and so I can see where that anger and frustration comes from in terms of being in a job for 20 years. Giving a large part of your life to this organization and for them to kick you out for a newer model that's cheaper and I've seen that verbatim on Facebook, a 'cheaper model of RN'. (Sage, L. 373-376)

The RN replacement by RPNs is noted as a factor contributing to the relational tensions between RNs and RPNs. Another participant shares a similar experience,

When [the RNs] started getting weaned out or you know, I find that they got a little bit more, not aggressive, like well kind of more aggressive towards like critical, critical, much more critical of you and your work because I think it was that sort of like [they] need to maintain [their] expertise and people need to know that [they're] important here. (Nini, L. 546-549)

Here the participant points to the financial constraints of the system as a factor that breeds tension between RNs and RPNs. The same participant further elaborates on this in the following,

It was a very tense time when all this was happening because the RNs started to pull this 'We know, we're more experienced, we have more expertise than you do'. And they started cutting back our responsibilities, as in RPNs, and they started cutting back RPN responsibility and [started] to really hold on to their roles... [The RN said,] 'Oh guess you don't need me' [sarcasm] and... It's not that I don't need you... We do need them... I see that they feel threatened and I don't think it's fair they're losing all their jobs and stuff, but that's not the fault of RPNs, that's the system. (Nini, L. 289-292, 320-324)

Here the participant discusses how the conflict and hostility between RNs and RPNs play out in the context of RN job cuts. This points to the ripple effect created by the institution's cost-saving measures. Health care cost savings and role restructuring propagates the negative treatment and marginalization described by the participants in this study.

4.3 The In-between Space

The participants describe their experiences with nurse-to-nurse conflict as living in an 'In-between Space' where they encounter role confusion and difficulties with professional identity as they transition from RPNs to RNs.

4.3.1 Role Confusion and the Shifting RPN Education

Several of the participants in the study discuss how issues related to role

confusion and the shifting RPN education contribute to conflict between RNs and RPNs in the workplace. One participant speaks to this following,

Should you be doing this, and you know questioning each thing and it's like it'd be nice if they knew what the RPNs do now as opposed to like say like from when RPNs had like a certificate. (Emma, L. 58-59)

The shift in educational requirements for RPNs is attributed to the tensions that exist among RPNs and between RNs and RPNs. Another participant speaks to this issue in the following,

They were expanding the role of the RPN at the time, you'd think two-year diploma program not much would change but it did and really fast and rapidly... I remember when I first took the course you couldn't do IV initiation, blood products, [no one] talked about like there was no IV anything in the PN program. (Faith, L. 336-342)

Tension and conflict is the result of the confusion that is created by the increasing skill development and the changing role and responsibilities of the RPN. A participant discusses another aspect of this tension,

You hear it like about 'oh you work in postpartum, PP pat pushers'. You know and it's like oh that's kind of degrading you know I have more skills than that, you know what I mean and it's a little bit I guess a slap in the face, but it just kind of puts you down a little bit. (Emma, L. 51-54)

Here the participant again points to the 'in-between space' in which the tensions between RPNs and RNs exist because of the shifting landscape in terms of RPN skills and abilities. The marginalization of RPNs occurs as a consequence of new educational requirements, and therefore role confusion for both the RPN and the RN.

4.3.2 Transitioning from RPN to RN

In this study, participants describe how they were caught in-between the RPN and RN roles as they engage in the BScN education. One participant discusses the confusion experienced during this RPN-RN transition,

I just recently went back to that facility as an RN student, and it was eye opening, the power differential between, I was in role confusion for a few weeks... so my role confusion went from being able to do everything to being a student and following the student guidelines and not being able to do everything. (Cassadee, L. 530-536)

Here the participant discusses the power differential that she felt when she returned to her work facility (where she had worked as an RPN) as an RN student. The participant's movement into a student role immediately translated into a loss of power. Living the in-between space as a student in the BScN program meant no longer being recognized as an RPN with significant nursing knowledge. The same participant says,

Like I have gone through so much in my time of being you know a new grad, RPN, and then entering and even doing clinical experiences as a nursing student again, which is actually horrible, it's almost like a kick in the teeth because it's like you feel like you're downgrading and you're back to being like a student. (Cassadee, L. 61-65)

Here the participant again associates being downgraded with resuming a student role where she was treated and perceived as lacking previous experience and knowledge. This experience is further described in the following,

We're the in-betweeners not really recognized like you know so I decided that I was going to not tell anybody, not even my clinical instructor that I was a bridger². I just decided that I would play it safe and I would be a nursing student because... I thought to myself if I say that I'm an RPN they might expect that I know a lot of this right off the hop and it might be a little harder on me. (Cassadee, L. 341-345)

Living the in-between space also made the participant feel vulnerable. The changing identity from being an RPN in the clinical education realm created some anxiety during this transition.

² As a reminder, a 'bridger' refers to a student in the post RPN-BScN nursing program

Participants also discussed how the RPN to RN transition influenced their experiences of nurse-to-nurse conflict from RNs and RPNs. One participant speaks to this in the following,

[RNs would] be like come hang out in labour and delivery like it really was this kind of like separate like I felt like a little bit in limbo... there were a couple of girls who had [gone back to school to become RNs] and [the RNs were] like 'Great! You get to be with us'... and I found like even my patient loads were changing a little bit like you could see like it was weird, yeah. Very different. (Emma, L. 362-383)

Here the participant speaks again to higher expectations associated with BScN student experience. As a BScN student soon to become a RN, this participant points to a shift in assignments associated and a sense of camaraderie with RNs. Another participant speaks to this in the following,

It's funny though because... when I took that break from work, it was just... [Faith] the RPN, but going back to school and taking an education leave and being so close to finishing, it's amazing how people treat you differently... even the management... conversations I never had before, now there are conversations... now it's [because] I'm finished school... [I have] degree status (Faith, L. 582-594)

Here the participant points to the status and differential treatment associated with the BScN education. Another participant voices,

So as RPNs to RNs, you are treated funny, you're treated funny by the RNs because they're like, 'Oh so you finally figured out that RPN is not where it's at right, so now you're ready to make the big bucks and blah blah blah you know now. Oh are you like a lot smarter and everything like that.' So that's on the one spectrum, then you have the RPNs who are like, '[Are] you too good to be an RPN?' (Cassadee, L. 928-932)

Several participants in this study discussed how the difference in education is cited as a point of difference in terms of status between RPNs and RNs. This change in education during the transition from RPN to RN contributes to the conflict experienced. Another participant discusses this further,

More like these were your people. You know and those are those people... if there was like [a] get together and things like that or like outside of work, oh lets go for dinner after work like if you went out with the RNs it was like 'oh I see you're schmoozing' and I was like really like c'mon you know it was kind of like a very separate thing. (Emma, L. 352-356)

In this instance, the participant highlights a 'them' vs 'us' or 'othering' of RNs by her RPN colleagues. The participant further explained that some RPN colleagues had expressed "resentment" regarding her return to school to become a RN (Emma, L. 373-374). Education and title sometimes create a tension between RNs and RPNs. Participants in this study experienced vulnerability, anxiety, and tension but also camaraderie in the 'in-between space' in their process of transitioning to the RN role.

4.4 Hierarchy, Power, and Privilege

The theme of Hierarchy, Power, and Privilege is associated with the participants' encounters with hierarchical structures, nonconformity and conflict, and inequity in the workplace. Participants discussed these experiences in the context of their encounters with nurse-to-nurse conflict.

4.4.1 Hierarchical Structures

The participants in the study discussed how they were treated as subordinate due to the existing hierarchical structures. A participant speaks to this perception in the following,

I think if I was an RN and we both had times being 'in charge', I think definitely she would have listened to me from the get go. She would have felt more pressure to do something right because she... knows that I know her role.... [but] because I was younger, I'm pretty easy going, I'm not one to very much so cause an argument that she might think okay maybe I'll get away with this a little bit more... You really do have to get a backbone and get it quick because you will get walked on, unfortunately. (Nini, L. 273-280)

Here the participant speaks to the importance of developing confidence and voice in her relationships with RNs. Another participant speaks to hierarchical relations in the following instance,

I don't know if it's jealously motivated or she knows that she's the superior... just her title alone because that's all that's there and I don't really see there being anything else... it's that the whole insubordination, you know I'm a 'Real Nurse' type mentality... It'd be different if she [were] on day or evening shift. You know where [there are] more RNs floating around.... but she's never been a day nurse or evening nurse, she's only been nights so I wonder why... you could pull rank you know you don't have any witnesses. It's all hearsay and you can just say well you know I'm their boss and they don't like me. (Faith, L. 138-157)

Here the participant speaks to status and power relations. Another participant goes on to discuss this further in the following,

I think they just want to make themselves feel better. I think it goes back to that basic you what is that like the burn, you blow out somebody's candle to make yours burn brighter, I really honestly do think that it's that basic 'I want to feel better about myself so I'm gonna make others feel a little lower than me.' Right like I want to be that and we all do, we all want to be that great competent nurse who everybody looks up to and I think that's kind of where it stems from is that they want to feel that they know the best and that they're the expertise...I also think they do it because for like job status in the workplace, right like I want to be a better I want to have better chances I want a better review, I want people to think that I'm better than this person, so therefore if a job comes up somewhere else I'm the one they're gonna give it to. (Nini, L. 386-397)

Here the participant tries to make sense of the tension between RNs and RPNs. In a slightly different vein, another participant also speaks to the tension,

She's an RN and she's been working for I want to say more than 25 years and she sits in that particular spot every single day and if she comes in you need to move like it's not like there's a discussion, 'Oh I've been here all day for a 12 hour shift' and she comes in in the evening and she's like can you please get up this is my spot. (Isabelle, L. 78-81)

In this instance, years of experience and associated perceived privilege intersect to create tension between nurses. This is discussed further in the following interview excerpts,

Older nurses who are 50 plus will see you as I guess as their young... They may even treat you almost in a childish manner... I'm thinking back to something I had

[with] another older nurse... just the point where... I looked young enough to be her daughter and so her mannerism it came off as if it was a mom talking to her child.... I had to step back and think like wait a second I passed my nursing exam just as you did. We are peers. You are not superior. (Sage, L. 304-312)

There was no call for her to put her finger up in my face, I'm not a child, like as far as I'm concerned we are both adults and you don't do that to anybody else why are you doing that to me and when I said that she kind of backed off a bit and was like yeah fair enough. But I think that because of your age they tend to infantile [or] treat you like a child... if you talk back you're considered rude. (Isabelle, L. 241-245)

Here the participant speaks to another powerful intersection creating tension between nurses: age and experience. Despite sharing roles and duties in the workplace with older nurses, the participants experienced being treated as children. More senior nurses often had an air of superiority. Notably nurse-to-nurse conflict associated with these intersections, experience and age, occurred RN-to-RPN, RN-to-RN and RPN-to-RPN. Negative power relations were evident at all levels in the hierarchy. These relations impacted at the level of care provision in several ways.

4.4.2 Nonconformity and Conflict

The participants in the study discussed how they experienced conflict and manipulation from other nurses when they did not comply or yield to their habits or ways of practice. One participant describes this in the following,

She started to get really mean with me... she got mad at me because I wouldn't... conform with what she wanted so she started rumors with other staff basically calling me a rat... I had a lot of people [like] PSWs who would treat me funny... Like it was just so not necessary only because I wouldn't do what she wanted. (Cassadee, L. 151-156)

Here the participant describes the impact of non-conformity in relation to work with an RN. Another participant elaborates on this in the following,

I guess that shift of power where 'I've been here longer, I know more than you, I'm more experienced than you so my way is the right way and if you don't take my advice, I'm not going to help you' and so you'll have to deal with your

patients [on your own], you're trying to remember what you learned in school you're two weeks off of orientation, and so you need the help but if an older nurse, more experienced nurse doesn't think you're taking her [help], you may be sink or swim. (Sage, L. 327-332)

The consequences of non-conformity for this participant meant she was rendered vulnerable to being left on her own without assistance. Another participant notes,

I saw [the RN] every morning she had a bad night and her and another night PSW that worked alongside of her were very upset with me because I organized the resident charts the day before. The facility doctor... asked me... 'This giant wardrobe where all the resident charts are [is] blocking the med room... [it'd] be great if it could be moved' and I said... 'I'll do that.' So I moved the resident chart as per that doctor's instructions [and the RN] lost it on me. Like lost it. I've never seen anything like it, because it's control, it's her unit and someone came in and disrupted it and she was screaming at me. (Faith, L. 82-89)

Here the participant speaks to the rude behaviour of the unit RN in response to a seemingly trite shift in protocol. Non-conformity in this instance was perceived as a threat to the realm of control of the RN in this setting.

4.4.3 Inequity in Workplace Tasks

Several participants in the study discussed inequitable workload associated with their status as an RPN. As one participant shares in the following,

She [a senior RPN] would purposely like leave me with very daunting kind of tasks like just tacking onto evening because evenings has nothing to do [Sarcasm]. So they did a ratio of which home areas were the heaviest, the hardest for nurses and mine was number 1 for evenings, it was the heaviest out of the whole building... Well she of course didn't believe that so... there was always a list of tasks that she would leave me. Right down from you know like the stupidest ones that were just pointless [and] would purposely leave her garbage for me to throw out, yes her garbage from the med cart from the med room it was always full to the point where I couldn't even start my meds until I emptied her garbage first and walked to the other end of the building to put it down the garbage shoot, it's not a big deal right, but it actually takes me time. (Cassadee, L. 198-210)

In this case, workload inequity was associated with a senior RPN's allocation of work to a more junior RPN colleague. In other instances, extra workload tasks were allocated by RNs, as the following example illustrates,

We were discussing the assignment like normal and she [the RN] didn't like the fact that I told her like I wouldn't change my patient with her because I've had that patient all week. We had two difficult patients and she wanted to give me both of them and I said no. (Isabelle, L. 227-230)

Here, the participant was able to refuse the assignment. However, not to refuse could have dire consequences for patient safety (and for the RPN's license to practice). For instance, as the following interview example illustrates,

Truth be told I wasn't doing the treatments properly because I physically could not. You know I was doing the bare minimum of at least you know making sure there was dry dressings on, but the time to clean and to take, nobody had that time, I had no time. (Cassadee, L. 229-231)

Here the participant felt overloaded due to the inequity in the allocation of tasks—with a potential threat to patient safety. Another participant voices,

I find there's a huge big drama deal with getting the assignments from or patient hand over from labour and delivery. A lot of the times you'll find like they'll give kind of the easier patients to their RN or their buddy.... If you're just the only RPN on the floor you're for sure going to get a heavier load or the people with all the blood sugar issues or somebody and you're not supposed to, that's the other thing like if people are not stable you're actually not supposed to get those patients, and you know 'oh they just need a transfusion' and 'oh this one's blood pressure a little high but it's okay' ... but there's nothing you can really do. (Emma, L. 68-75)

Here the participant expresses a sense of powerlessness in her role as an RPN. However, the experience of inequity in workload can (as noted above) have negative repercussions. On the one hand, as noted earlier, RPNs want to have their skills and abilities recognized, however, at the same time there are scope of practice issues that must be acknowledged. There are some tasks that RPNs should not be doing because they are outside their scope of practice. 'Scope of practice' shapes power and privilege and at the same time, vulnerability.

Several participants in this study spoke about conflict and tension avoidance as a response to workload inequity. One participant describes an experience in the following,

Even though one RN is ‘in charge’... she has less patients, but [if] the RN is not ‘in charge’ she should get the admission but they never get it...[if I say something to them] they’re going to make [my] life miserable... and sometimes it’s better to just do it because you want to have a peaceful night. (Isabelle, L. 351-362)

Avoidance of conflict or tension was a common response to what was perceived as inequity in workload. Another participant shared a similar experience,

She had assigned everybody [a dyad] so it’s like mom and baby and I had 5 and the 2 RNs had one each. And I was like really guys? Is that fair? Is that fair? No its not... ‘Well you know I’m ‘in charge’ so I’m dealing with you know scheduling issues and dah dah.’... I’m like... there’s no scheduling issues right now and you’re making excuses. ‘Well hers is the anti-partum patient and you know they have—’ I’m like really?... give her some Gravol and you’re good... certain things where you’re not taken seriously, drama... I’m kind of more of a take it and just stick, you know just [get] through it (Emma, L. 77-88)

The inequity in the workplace tasks points to the privilege RNs hold in the workplace. This left the participant to feel impotent and endure the additional unfair workload. The organizational structures that create the hierarchy, power, and privilege influence the nursing relations and inadvertently threaten patient safety and care.

4.5 Professional Development and a Drive for Change

The participants in the study discuss how their negative experiences with nurse-to-nurse conflict influenced their career trajectories and views on the issue. Coping strategies, motivations to go back to school to obtain a BScN and become RNs, and breaking the cycle of nurse-to-nurse conflict are subthemes integrated under this theme.

4.5.1 Coping Strategies

The participants in this study discuss the measures they developed to cope with the nurse-to-nurse conflict. A participant speaks to this in the following,

[I] don’t tolerate it. Like now I’m at a point which... I showed myself that I don’t tolerate [bullying] anymore and it doesn’t matter what position I’m in... It doesn’t matter if I’m a student I will literally say this is not how this is working like you do not [mistreat me]. (Cassadee, L. 485-488)

Here the participant finds meaning in her experiences in developing confidence and a voice to stand up to other nurses. Another participant shares a similar experience,

When I first started working I was a lot more timid. Now depending on the situation I will stand up for myself and say something and there will be a conversation about it... Personally I think [my experiences] just let me be a lot... less high strung... I don't like to see people taken advantage of, so I tend to speak up... I [also] tend to learn to let things go because I realize at the end of the day I am the one stressed out. I'm the one angry... if I give them power, then what's that supposed to do for me? So I just let it go. If I don't have a reaction they don't have any power over me. So in that sense it lets me be a lot less stressed out. (Isabelle, L. 102-104, 374-380)

The participant gains clarity and an increased understanding from experiences with nurse-to-nurse conflict. This has assisted with gaining a voice to withstand harmful effects on mental health. Another participant describes their experience in the following,

I've become more comfortable and more confident in my skills...I know now with those specific nurses who have... treated me bad in the past I just know to be blunt with them... you're there to do your job and care for your patients and make sure everyone's safe and you go home. (Sage, L. 74-82)

Here the participant found the strength to speak up to the mistreatment she experiences.

This new-found voice builds on their confidence as nurses to develop and utilize their skills and abilities.

4.5.2 The Catalyst for Change

Participants in the study discussed how their experiences of nurse-to-nurse conflict influenced their career path. Specifically, the participants speak to how these experiences were the catalyst to return to school to obtain a BScN and become RNs. One participant notes,

I had always kind of wanted to [go back to school] and... was always in my plan, but I think that [experience with nurse-to-nurse conflict] really did push me because you know I kind of got tired of the treatment... just feeling like you know not appreciated like for what I'm doing or just kind of like a lesser person and not being acknowledged for my knowledge or skills... I think that kind of drove me further to

be like okay I need to go back to school and get my RN so I don't have to deal with this. (Emma, L. 566-575)

Here the participant experiences low work morale and feel her skills and knowledge as an RPN are given little heed and recognition. Gaining power and a voice meant going back to school and obtaining higher education. Another participant elaborates on this issue, "I feel like I'll get noticed a little bit [more] as an RN, and I feel like hopefully it won't be so demeaning, the way that I get treated won't be so demeaning" (Nini, L. 910-911). Here the participants point to going back to school as a way of overcoming the subjugation and being recognized for her nursing experience. Another participant speaks to this further in the following,

I think that [was] the tipping point [and] the ultimate push because I was sitting on [going back to school] for a while... I was really sitting on it [and I thought] how can I do this, but that screaming at me, that was the tipping point for me, I really do think that... I think it was the fact that I thought, 'Okay... what are you doing, you are sitting on the floor crying, [she is] supposed to be a supervisor' like that to me was like a wake up call... I think that every single one of my experiences [with nurse-to-nurse conflict] pushed me in this direction, I really do. (Cassadee, L. 513-522, 559-560)

Here the participant is motivated to take back her power. Going back to school to obtain a BScN and become RNs was a way expressed by the participants to gain power in the workplace, acknowledgement for their skills, and to mitigate experiences with harassment and hostility.

4.5.3 Breaking the Cycle

Participants in the study were motivated by their experiences with nurse conflict to break the cycle of mistreatment. The participants felt that becoming an RN would be instrumental in this process. One of the participants speaks to this in the following,

No matter where you go, no matter what you do [nurse-to-nurse conflict is] going to happen... there's going be those people that are critical or mean... that's why I'm doing the RN. That was actually one of the big reasons is because I'm like I

want to be able to move up, I want to be able to make a difference, I don't like seeing this. I wanted to go back and get the RN because I was thinking I wanted to be in a place where people enjoy their job... I wanted to be able to [be] in a managerial position. I wanted to be able to kind of try to ripple the 'let's be nice to each other and work together'... if you have issues let's actually try to fix them. (Nini, L. 558-582)

Being in a position of power is important to address nurse-to-nurse conflict in the workplace. Another participant speaks similarly,

It kind of hit me even more... I need to be in a position where I have more influence on those around me and you know below me technically... I think what I'm going to be a big promoter of in future when I'm done [my BScN and become an RN] is education on professional relationships in the workplace... I feel myself being a really strong advocate for bullying and like no tolerance. (Cassadee, L. 305-307, 473-481)

The RNs' power, influence, and education inspired the participants to promote change and address these issues in the workplace. Another participant shares an experience in the following,

I am very cautious about not doing that to students when they're on the floor with me. I'm very sensitive about that because these things tend to happen to students as well [as RPNs] and I am very cautious about...not making them feel that way. I was just recently a student and I am a student now, so I am very like sensitive about [mistreating others]... if I do catch myself... I'm going to stop myself because I don't want that to happen. (Isabelle, L. 532-537)

Here the participant points to the cycle of mistreatment created by the structures that exist within the nursing profession and the organizational culture that fails to address the issue.

Another participant speaks to this issue in a similar vein,

When you came into the room and you had explained how there was no real information about RPNs and the different things that we experience, it really hit me like it's a real thing, it's a real problem and it causes real effects. So just because somebody is titled 'RN' or 'RPN' nursing is nursing, healthcare is healthcare, and so I really just wanted to do this to promote for RPNs. (Cassadee, L. 65-69)

The participant is motivated to help other nurses find their voice and strength to stand up for these issues in the workplace. The lack of advocacy and action perpetuates the cycle

of mistreatment and sustain nurses' socialization to these adverse behaviours and practices. The same participant elaborates on this in the following,

This needs to start from the bottom up. You need to reach who is closest to the patients first, being the front-line staff of nurses who is the overall the biggest body. So whether it be... RPNs who have a little experience, or RNs who have a lot of experience with leadership, conflict resolution, actual education on it...it might be easier to sway so that you're more bonded together... I think [you should educate]... the lower ones who are... experiencing the problems and may not admit it... if you start from the top down, you're not going to get results because the top is not going to take the time. (Cassadee, L. 1019-1034)

Professional development was identified as a way to address these issues in the workplace and counteract the inner workings of the system that contribute to conflict and tension between nurses.

In this chapter I discussed the findings for the two research questions: (1) What are the experiences of RPNs in the post RPN-BScN program with nurse-to-nurse conflict in the workplace; and (2) How do these experiences contribute to RPNs' decision to go back to school for a BScN? Five themes that emerged from the data: the Current Organizational Context of Health Care, Marginalization of the RPN, the In-between Space, Hierarchy, Power, and Privilege, and Professional Development and a Drive for Change. In the final chapter, I go on to provide a discussion of the findings and their significance, the implications for practice, limitations, future research, and the conclusions of my study.

CHAPTER FIVE

Discussion and Conclusion

In this chapter I discuss the significance of my research findings. I also present implications for practice and education. In this research I explored the experiences of nurse-to-nurse conflict by RPNs in a post RPN-BScN program and the influence of these experiences to their decision-making processes in relation to their return to school for a BScN. The main points of discussion are the powerful intersecting forces, appropriate staff mix and efficiencies, and empowerment through education. I conclude the chapter with a synopsis of the research, limitations of the study, and directions for future research.

5.1 Powerful Intersecting Forces: The Perfect Storm

The participants in my study discussed their experiences of nurse-to-nurse conflict with a particular emphasis on RPN-RN relations. They reported mistreatment and feeling marginalized, as well as their skills unrecognized or undermined. Although RNs are often insinuated as the perpetrators of nurse-to-nurse conflict towards RPNs in the existing literature (e.g., Curtis et al., 2007), my research situates violence as located within an organizational context. Powerful intersecting forces that strongly shape nursing relations influenced each experience of nurse-to-nurse conflict reported by participants.

Consequently, these forces create the perfect storm in which nurses, especially nursing subordinates (such as RPNs), are condemned to face the negative treatment. Examples of these intersecting factors are staff shortages, the shifting RPN education, increased workload and increased patient acuity. A culture of acceptance and a nursing hierarchy are also contributors that negatively influenced nursing relations. Nurse-to-nurse conflict cannot be understood outside of the broader factors that contribute to it. Given this

understanding I in no way condone violence. Rather, my research inextricably locates violence as shaped and developed within this context.

Participants reported how they experienced conflict from RNs. On the surface, several of these experiences were attributed to their subordinate position as RPNs. However, when nurse-to-nurse conflict is examined through an organizational lens, the complexities that have a powerful impact on nursing relations provide a deeper explanation for the tensions that exist. For instance, one participant described an incident with an RN who exhibited unacceptably rude behaviour towards her for reorganizing the patient charts. This experience could indeed be irrelevant to the participant being an RPN. Yet, this lashing out is a common response to feeling oppressed, as various forces within the organization usurp nurses' control or power (Roberts, 1983; Young, 1990), leading to RNs' mistreatment towards other nurses (regardless of being a RPN or other types of nurses). It would be naïve to say that tensions specifically between RNs and RPNs do not exist at the surface level, but the findings in my study strongly suggest how other intersecting factors shape the RN-RPN relations.

Previous research has also explored bullying in the context of how an individual interacts with the organization. For example, Quine (2001) found that nurses who were bullied had negative perceptions of the organizational climate, such as higher workloads, greater role ambiguity, less participation in decision making, and lower job control than nurses who experienced bullying less frequently. My study found similar results as several of the participants described aspects of the organizational context that influenced their experiences of nurse-to-nurse conflict. The following discusses the intersecting factors that were reported by participants.

5.1.1 Increased Shortages and Workload

The participants in my study reported staffing shortages and increased workload as a factor that contributed to stress and nurse-to-nurse conflict. Conflict between nurses arises during staff shortages by creating an increased workload and additional stress. As demonstrated by the participants, increased workload leads to greater stress and tension. This is consistent with other research that has linked staff shortages and increased workload with stress and nurse-to-nurse conflict (Etienne, 2014; Oulton, 2006; Simons & Mawn, 2010). Participants in my study also experienced additional conflict when they were given extra tasks that were difficult to finish. Roche et al. (2010) also found similar results such that when nursing tasks were incomplete, additional violence occurred (i.e., emotional abuse).

5.1.2 Increased Patient Acuity

Debisette (2010) reports that nurse-to-nurse conflict occurs in highly stressful environments which has become an endemic feature of the nursing profession in addition to increased patient acuity. Roche et al. (2010) found that incidences of emotional abuse were higher when patient acuity and workload increased. Increased patient acuity has been found to create additional stress and workload, as well as inequity in workplace assignments. These factors contribute to nurses' frustrations (Kidd, Grove, Kaiser, Swoboda, & Taylor, 2014). Participants in my study described incidences of how RNs felt frustrated with them when they refused to treat patients that were beyond their scope of practice. Unfortunately, the health care system is not appropriately responding to the increasing patient acuity with appropriate staffing ratios (Berry & Curry, 2012). In turn, this creates increased stress and a poor working environment, and results in nurse-to-

nurse conflict (Huntington et al., 2011), as well as burnout, turnover, and job dissatisfaction (Berry & Curry, 2012). Appropriate staffing ratio is further discussed later in this chapter.

5.1.3 Shifting RPN Education: Ambiguous Scope of Practice and Role Confusion

The participants in my study discussed their experiences of nurse-to-nurse conflict in the context of the RPN education. For instance, participants talked about how the shift in the educational requirements led to conflict because of the expanding role of the RPN. In the past decade, RPN entry-to-practice competencies have been revised to prepare RPNs with the knowledge and skills to meet the changing demands of health care and nursing (CNO, 2014a). However, this and the consequent shift in RPN education (refer to RPNAO, n.d.) have created scope of practice confusion for nurses across roles (RN and RPN) as discussed by the participants in this study. However, as patient acuity increases and more RPNs are hired to care for patients, many are questioning whether or not the RPN education is sufficient to ensure the best quality care. As mentioned above, the health care system is not responding to increasing patient acuity with appropriate staff ratios (Berry & Curry, 2012); this practice runs the risk of being detrimental to both patient outcomes and nursing relations (Roche et al., 2010; White et al., 2008). Therefore, broader level factors, such as the shift in the RPN education, indirectly create tensions between nurses.

Participants also described how the shift in the RPN education also led to RNs' lacking of understanding RPN skills and abilities, contributing to their experiences of conflict and marginalization. This finding points to the unclear distinction between RN and RPNs that creates role confusion and ambiguous scopes of practice. Previous

research has shown how conflict arises when nurses experience role confusion and is unclear about RPNs' skill and knowledge (Meadows & Prociuk, 2012). Research shows that this blurred distinction between RNs and RPNs allows organizations to justify replacing RPNs with RNs to save money (Armstrong & Armstrong, 2010)—another intersecting factor that was discussed by participants within my study. As a result of nursing roles being replaced, RNs may feel vulnerable, stressed, and react with hostility towards RPNs (Martin & Weeres, 2012; Meadows & Prociuk, 2012).

5.1.4 A Culture of Acceptance

It is contended that contextual factors are the most influential factors that promote workplace conflict between nurses (Hutchinson et al., 2010). These factors influence the way nurses interpret and accept the behaviour in the workplace (Quine, 2001). For example, research has argued that the organizational culture (such as the beliefs and norms held by the affiliates within the organization) is a factor leading to tolerance and acceptance of conflict in the workplace (An & Kang, 2016). This factor is arguably one of the strongest related to nurse-to-nurse conflict as it perpetuated the cycle and socialization (An & Kang, 2016).

Participants in this research discussed how they felt unsupported by senior nursing staff in the form of inequitable distribution of workplace tasks. Quine (2001), who examined workplace bullying in nurses, indicates how a lack of support from senior staff is an aspect of the organizational context that promotes a culture of acceptance for the behaviour. Furthermore, Quine (2001) found that nurses who experienced organizational support at work (e.g., from colleagues and managers) were less likely to suffer from the adverse effects of bullying, as indicated by higher job satisfaction and lower depression

scores. My research study yielded similar findings such that participants discussed how organizational factors (e.g., the organization of care provision, work assignments, lack of support) contributed to the acceptance of the behaviour, adversely shaping their work environment and relations with other nurses.

Previous research has demonstrated a socialization effect of nurse-to-nurse conflict behaviour between nurses. For instance, Randle (2003) and Curtis et al. (2007) found that nursing students accepted that hierarchical structures, powerlessness, and horizontal violence were part of the job. Debisette (2010) reports that this hierarchical organizational culture reinforces the view that bullying is tolerated and discourages nurses from reporting the behaviour. The participants in my study described incidences similar to this. For example, some participants avoided conflict and accepted the additional workload and tasks unfairly given to them.

Mabrouk Abd El Rahman (2014) also found that nurses cope with conflict by accepting the behaviour. In my study, participants' fear of reporting incidences and reprisal also demonstrates this notion of socialization and acceptance. Hutchinson et al. (2010) describes how nurses do not report conflict because the organizational climate allows the behaviour, perpetrators go unpunished, and previous reports of conflict are downplayed—all of which normalize the behaviour within the workplace. Mabrouk Abd El Rahman (2014) suggests that the organization needs to encourage the reporting of nurse-to-nurse conflict to avoid the socialization of such behaviour. Further discussion on addressing nurse-to-nurse conflict through changes and restructuring at the organizational level are presented later in this chapter.

5.1.5 The Nursing Hierarchy

A hierarchy in nursing is also a result of intersecting factors. These hierarchical structures were reported as a main factor that contributed to the nurse-to-nurse conflict experienced by the participants in my study. An and Kang (2016) investigated the relationship between workplace bullying and the organizational culture. They found that almost half of their participants worked within a hierarchical-oriented workplace (where members within the organization valued authority and obedience) and found that these nurses experienced bullying most frequently. The findings by An and Kang suggest that nurse-to-nurse conflict is more likely to occur in hierarchy-oriented workplaces due to the inevitable creation of power differentials.

Randle (2003) found that accepting the hierarchical system was part of establishing a professional role as a nurse. Katrinli et al. (2010) describes how the systematic hierarchical structure that exists within the nursing profession creates a competitive environment where nurse-to-nurse conflict and mistreatment is a common expedient to gain power and professional status. These are examples of how certain structures shape the relations between nursing superiors and subordinates in the workplace. The participants in my research had similar experiences. For example, RNs and senior RPNs had power and privilege due to the hierarchical structures in the workplace, contributing to the marginalization of RPNs. This finding aligns with the literature such that the hierarchical organizations in the workplace propagate nurse-to-nurse conflict (Curtis et al., 2007; Meadows & Prociuk, 2012). These findings have important considerations for hospital organizations, decision makers, and managers. The

hierarchical structures that exist need to be eliminated to allow for teamwork, support, and collaboration.

Age and experience were also factors that placed nurses higher-up the hierarchy and contributed to conflict. Regardless of the type of nurse, several participants experienced conflict from those who were older and had more nursing experience. This is consistent with findings in the literature that focus on the experiences of new nurse graduates and horizontal violence. New nurses often report mistreatment from higher-ranked nurses and older nurses (Quine, 2001; Vessey et al., 2009). The concept of power and privilege was also discussed by participants in the context of the hierarchical structures in the nursing profession. The organizational context that shapes the negative power relations create conflict between nurses and separates them at all levels of the hierarchy (young-old, experience-inexperience, RN-RPN, RN-RN, RPN-RPN). The findings in my study support that the more embedded the hierarchies are in the workplace, the more likely nurse-to-nurse conflict will occur (An & Kang, 2016). These findings support the need for a re-organization of the structures, specifically those that facilitate support and encouragement from senior staff.

5.1.6 The Perfect Storm

Participants in my study discussed their experiences in the context of several powerful intersecting forces that influence tensions between nurses. These intersections included staffing shortages, increased workload, increased patient acuity, and the shifting RPN education and training. Ambiguous scope of practice and role confusion was also discussed as factors that shaped conflict with RNs. Each of these factors contributes to the organizational context of nursing in many locales with hierarchical structures and an organizational culture where nurse-to-nurse conflict has become a norm.

Previous literature and the participants in my study describe some of their experiences of nurse-to-nurse conflict as a result of being an RPN, yet this perspective can be shortsighted. Broader explanations for workplace conflict were discussed by the participants in my study as well as other research, which point to the organizational context that affect nursing relations (Hutchinson et al., 2008, 2010). These powerful intersecting forces create the perfect storm from which harmful and very real tensions arise between not only RNs and RPNs, but also RN-RN and RPN-RPN. The organizational factors also create conflict between nurses at all levels of the hierarchy, for instance with RPNs with seniority or several years of experience. These factors result in a loss of control and as a result nurses turn against each other instead out of frustration (Longo & Sherman, 2007). Therefore examining nurse-to-nurse conflict through this lens helps further understand the broader level factors to address and manage this issue that is pervasive in the nursing profession, which has harmful effects on nurses' mental health and wellbeing, as well as on patient care and safety.

5.2 Appropriate Staff Mix and Efficiencies: Never the Twain Shall Meet

The findings in my study illuminate how the organizational structures in the health care system have a negative impact on nursing relations. This is consistent with the findings by Hutchinson et al. (2010) who confirmed that certain aspects of the organization were critical antecedents of bullying, such as organizational tolerance of the behaviour and the misuse of authority, procedures and policies. Specifically, participants reported organizational factors like budget constraints and institutional financial pressures that negatively influenced their experiences of conflict in the workplace.

Budgetary and financial constraints impact the tensions between nurses in several ways. One of the most important is through a suitable staff mix ratio (defined as the combination and number of RNs), which can ensure the right skill mix for treating patients (CNA, 2004, 2005). For instance, thriving workplaces are those that respond to the needs of the patient and patient acuity, and match the patient with the right nurses' (RN or RPN) knowledge and expertise (Canadian Federation of Nurses Unions [CFNU], n.d.). However, within the last two decades health care organizations have attempted to utilize human resources more efficiently as a response to budget cuts, restructuring, and the shortage of healthcare workers (CNA, 2005). When hospital institutions and organizations are faced with financial pressures, staff and skill mix of nurses may be compromised.

5.2.1 Consequences of Cutting Costs

Cost-cutting agendas often create issues within health care and healthcare providers such as nurses. For instance, the current context in nursing that creates role confusion and ambiguous scope of practice between RNs and RPNs encourages organizations to replace RNs with RPNs (CNA, 2005). These organizations justify job replacement with the lowest paid healthcare provider (Armstrong & Armstrong, 2010). In turn, this creates an inefficient staff mix and ratio of nurses, such as RPNs and RNs, which has been linked to increased mortality rates of patients (Aiken et al., 2010). Tension between nurses from ambiguous scope of practice and role confusion also threatens the safety of patients (CNA, 2005).

Inappropriate staff mix has been shown to propagate nurse-to-nurse conflict and harassment (White et al., 2008). Participants in my study discussed their experiences with

RNs who exhibited bullying behaviour when they felt vulnerable as a response to the job replacement with RPNs. Although this seems advantageous for RPNs, several of the participants recognized how this leads to stressful situations for both RPNs and RNs, and especially for patient safety. Budget cuts create a ripple effect where tension breeds between RPNs and RNs as well as prevents the appropriate staff and skill mix in the workplace. Both the safety of patients and nurses are compromised when the substitution of nursing staff is based on efficiencies and financial pressures (CFNU, n.d.).

5.2.2 Implications of Staff Mix and Efficiencies

The findings of my study and the existing literature have several implications for staff mix and skill mix, as they are important for both nursing relations and patient safety. For instance, Roche et al. (2010) found that a richer skill mix, that is a higher percentage of RNs, was linked to fewer incidences of violence between nurses. Furthermore, the literature demonstrates that an appropriate staff mix is linked to increased patient safety (CNA, 2005). Therefore, health care organizations need to focus more on safe practice for patients and appropriate staff mixes rather than productivity and efficiency. Hutchinson et al. (2008) note that health care organizations that focus on productivity place high value on efficiencies and have little concern for how this can be achieved. For instance, nurse-to-nurse conflict is reinforced when staff is promoted (i.e., for meeting performance goals) without consideration to their behaviour (Hutchinson et al., 2008). The negative behaviour thrives in such an environment when it is tolerated and rewarded, as bullying and nurse-to-nurse conflict is often used as a means to an end (Hutchinson et al., 2008; Katrinli et al., 2010). As long as organizations' emphasis is on cost-cutting measures,

efficiencies and financial agendas, the appropriate staff mix will cease to exist, thus never the twain shall meet.

5.3 Empowerment Through Education

The participants in my study discussed their experiences of nurse-to-nurse conflict in the context of their RPN-RN transition. For instance, they described how RNs and managers treated them differently and experienced fewer incidences of conflict when they were in school becoming RNs. Furthermore, the participants created meaning from their experiences with nurse-to-nurse conflict. They discussed how their experiences motivated them to return to school for a BScN and become RNs. This link has not yet been found within the existing literature and provides insight to the second research question posed in my research study (How do experiences with nurse-to-nurse conflict contribute to RPNs' decision to go back to school for a BScN?).

The finding between participants' experiences of nurse-to-nurse conflict in the workplace and their return to school suggests that they found empowerment in the RN education. Participants talked about how becoming a RN was a way to be acknowledged and recognized for their nursing skills and knowledge. Research has found that some nurses experienced conflict and mistreatment due to their perceived lack of skills, knowledge, and experience (Randle, 2003). Participants also talked about how they were treated differently by nursing peers as well as managers. For instance, they experienced conflict less as they transitioned from RPN to RN. This is consistent with the findings by Melrose, Miller, Gordon and Janzen (2012) who asked LPNs (obtaining their BScN to become RNs) about their changing professional identity and found that participants reported how they were perceived differently by other co-workers and patients as they engaged in the BScN education. These findings demonstrate how there is higher status

and respect associated with the RN education, thus fewer incidences of conflict and harassment.

5.3.1 Decision-making Processes

Participants in my study also discussed how they were motivated to become RNs to reduce their own experiences of conflict, something they already experienced during their transition of becoming RNs. These findings are consistent with research by Martin and Weeres (2012) who found that RPNs felt they needed to go back to school to have more opportunities, such as leadership and autonomy, as they experienced a lack of respect and value from RNs. Participants in my study spoke to the feelings of empowerment by obtaining a BScN and use it as a way to take back power and confidence.

Participants' decision to become RNs was also influenced by their experiences with nurse-to-nurse conflict as a way to help combat and break the cycle of nurse-to-nurse conflict and harassment. Randle (2003) found that nurses were able to reflect and develop an understanding of their experiences and how nurses used dominance and took advantage of their power. Curtis et al. (2007) noted that nursing students were motivated to be different after they finished school as RNs. These findings in my study are important, as this collective effort to break the cycle of conflict is one of the many steps that nurses can take at a surface level.

5.3.2 Mitigating Nurse-to-Nurse Conflict through Leadership and Education

Particular aspects of the RN education also helped participants feel empowered to address nurse-to-nurse conflict. For instance, one participant discussed how taking leadership courses and learning about conflict resolution helps to counter nurse-to-nurse conflict. Roche et al. (2010) found that emotional abuse was lower when leadership was

higher in the workplace. Cleary et al. (2009) argue that leaders set the tone for the work environment and have a powerful influence on the staff. When leaders set expectations and model respect, this facilitates a culture of respect between staff members and promotes an environment of collaboration and harmony.

Research suggests how training students (such as in leadership) during their education is an effective way to address conflict so nurses can learn to manage it during their encounters in the workplace as well as helping to break the cycle (Curtis et al., 2007; Randle, 2003). As a result the findings in my study, in addition to the existing literature, point to the importance of leadership and education in mitigating the prevalence and effects of nurse-to-nurse conflict.

5.4 Significance of the Findings

The findings of my study are important for several different reasons. The first is that conflict within the nursing profession is still pervasive which has several negative effects on nurses' mental health and wellbeing (e.g., Long & Sherman, 2007), patient health outcomes (e.g., Woelfle & McCaffrey 2007), and health care system outcomes by creating toxic environments rife with nurse turnover and absenteeism (Embree & White, 2010; Woelfle & McCaffrey 2007).

It was important to explore the perspective of RPNs, as there is a lack of research that examines this group of nurses' experiences of nurse-to-nurse conflict. In particular, my research focused on RPNs who were in a post RPN-BScN program as this certain group of nurses had not yet been examined with regard to nurse-to-nurse conflict. Exploring RPNs' experiences of this phenomenon also enabled me to investigate how these were instrumental in their return to school for a BScN. This inquiry is significant, as the literature (e.g., Coffey et al., 2016) has demonstrated the growth in RPNs' interest and

attendance of post RPN-BScN programs to become RNs in Ontario despite the rise in employment opportunities for RPNs in Ontario (RNAO, 2015a).

My findings demonstrated a link between experiencing conflict and being motivated to become RNs. This provides an explanation (in addition to increased opportunity and monetary benefits) for RPNs returning to school for a BScN despite the increased rate of job opportunities for RPNs due to job replacement of RNs. Providing an understanding of this helps health care organizations comprehend the impact of workplace conflict between nurses and emphasizes how it is important to maintain a sufficient RPN workforce, as their role in patient care is vital.

Finally, the findings highlight the importance of the role of the intersecting factors that exacerbate the tensions between nurses. As opposed to individual-level or personality that has been attributed to bullying behaviour and outcomes (Coyne et al., 2000), my study adds to the body of literature that stresses how these factors influence nurse-to-nurse conflict, regardless of whether it occurs RN-RPN, RN-RN, and RPN-RPN (Hutchinson et al., 2006b, 2008, 2010). My study also reinforces that nurse-to-nurse conflict cannot be understood without considering the contextual and structural organizations in which it is rooted. These organizational factors that impacted participants' relations with other nurses included ambiguous scope of practice and role confusion, hierarchical structures, cost-cutting measures and institutional financial pressures, increased job stress, and inappropriate staff mixes. Each played a role in the tensions that were reported between participants and other RNs, as well as other RPNs. As a result, to manage conflict between nurses changes at the organizational level need to be made. This is further discussed in the next section.

5.5 Implications for Practice

5.5.1 Suitable Staff Mix

There are several implications for practice based on my research. The first is the need for action towards an appropriate staff mix in the workplace, as this has been linked to better patient health outcomes and less violence between nurses (Aiken et al., 2010; Roche et al., 2010). As opposed to replacing RNs with RPNs, RPNs should be utilized in the nursing workforce as complimentary members of the nursing teams to meet the needs of patients (Besner et al., 2005). This way RPNs, as well as other nurses, can work to their full scope of practice instead of being faced with tasks and responsibilities that are beyond their scope—another issue that was reported in my study from participants. Furthermore, if RN job replacement with RPNs is no longer perceived as a threat, RNs will not feel vulnerable in their positions and feel less job stress. Nurse-to-nurse conflict can thereby be mitigated. With this, health care organizations need to focus more on safe practices for patients and nurses as opposed to responding to the institutional financial pressures when deciding on staff mixes.

5.5.2 Addressing Role Confusion and Ambiguous Scope of Practice

My research demonstrated the need to reduce ambiguous scope of practice and a clear delineation of RN and RPN roles. My research as well as previous literature have shown how nurse-to-nurse conflict is created by role confusion (e.g., Meadows & Prociuk, 2012). Therefore, a clear distinction between RPNs and RNs is needed as well as an understanding of the other's role. Besner et al. (2005) examined different nurses' (RNs, LPNs, nurses in specialized roles etc.) perceptions of their scope of practice and the associated barriers and facilitators. The study found that nurses reported role ambiguity

and that there were no clear differences in their roles and tasks despite real differences in their education background, knowledge and skills. Recognizing that these nursing roles are shifting and how they are doing so is also important for nurses to adapt and understand one another's role in the workplace.

Additionally, in my study, role confusion was associated with tension and inappropriate staff mixes in the workplace. Besner et al. suggest that decision makers must collaborate to address the issue of role confusion. Regulatory bodies and unions must come together to help the other understand their roles in the health system. Policy makers have to address the role confusion that exists between nurses by providing a clear understanding of each. Employers and managers must create intraprofessional collaboration by having well defined and shared roles for healthcare providers as well as appropriate staff mix models and successful management strategies. Finally, educators must prepare and educate students of the different responsibilities and roles for different nurses and other healthcare providers (Besner et al., 2005). With efforts to reduce role confusion and ambiguous scope of practice, the diminution of nurse-to-nurse conflict should follow.

5.5.3 Education

It is important for educators to teach students and make a clear distinction between the roles and responsibilities of RNs and RPNs. Research has shown how RNs and RPNs are segregated during their education which contributes to their segregation in the workplace (Limoges & Jagos, 2015). Exposing RPNs and RNs to the importance of collaboration during their education is suggested (Limoges & Jagos, 2015). RNs and RPNs should have more of an opportunity to work together while in school before

entering the workplace. Educators also need to consider the future of the role of RNs and RPNs to prepare students appropriately. In turn, this can help both RNs and RPNs to understand and appreciate the role of the other in the workplace, as well as promote teamwork between the two types of nurses. This will also help RNs understand the current scope of the RPN practice, in which the shift in the RPN education was reported as a source of tension for participants in my study. Moreover, research suggests that nurses should be educated about nurse-to-nurse conflict and conflict management in the academic curriculum as an effective way to deal with nurse-to-nurse conflict (Broome & Williams-Evans, 2011; Cleary et al., 2009). The findings of my study point to how these measures would help to reduce the prevalence of nurse-to-nurse conflict.

Nurses in the workplace would also benefit from being educated on the issue and about one another's competencies. First, Broome and Williams-Evans (2011) suggest providing education to learn about nurse-to-nurse conflict. Cleary et al. (2009) argues for learning about the consequences of the behaviour and zero tolerance policy across all organizations to create an intolerant culture of mistreatment. Griffin (2004) argues that increasing awareness of the issue may work to eliminate nurse-to-nurse conflict. Second, learning about the competencies and education of RPNs would limit the confusion, and clarify roles and responsibilities. As a result, this would help to increase collaboration between nurses (Besner et al., 2005).

5.5.4 Teamwork

Health care organizations also need to promote a culture of teamwork and support. The participants in my study discussed how they preferred and valued a teamwork approach, which influenced nursing relations. A teamwork approach to patient care

should be encouraged and implemented to promote collaboration, especially between RNs and RPNs as teamwork has been linked to fewer incidences of nurse-to-nurse conflict and a positive work environment (Martin & Weeres, 2012). Teamwork approaches have also been linked to positive patient care and outcomes (Wheelan, Burchill, & Tilin, 2003).

Research has shown that a relation-oriented culture can mitigate nurse-to-nurse conflict in the workplace (Yun & Kang, 2014). Relation-oriented workplaces (where individuals hold high regard for trust, respect, and community) were found to experience fewer incidences of conflict between nurses (An & Kang, 2016). Furthermore, An and Kang (2016) argue that a relation-oriented organizational culture that focuses on respect, trust and connectedness be promoted by organizational policy development. This would consequently lead to fewer incidences of nurse-to-nurse conflict.

5.5.5 Management

Participants in my study identified issues with management, such that management lacked the ability or silenced these problems in the workplace. As suggested by Huntington et al. (2011) and Murray (2009), this lack of attention or turning a blind eye acts as a barrier for appropriately addressing nurse-to-nurse conflict and creates an unhealthy workplace. As a result, the behaviour sustains and nurses continue to face the negative consequences (Longo & Sherman, 2007). However, management is constrained by the organizational system, for instance through lack of support or union regulations, but were perceived as incompetent by the participants in my study as a result. This finding yet again highlights the role of the macro level structures that influence tensions between nurses. This has implications for the organization to provide support to

management, such as education on how to address nurse-to-nurse conflict, implementing and adhering to zero tolerance policies (Broome & Williams-Evans, 2011), how to recognize the signs of someone who is experiencing nurse-to-nurse conflict (Quine, 2001), and be supportive and sensitive to staff who report it (Rocker, 2008). Furthermore, Rocker (2008) argues that management should be motivated to create a culture of change, for example, by setting a positive example in the workplace and modeling healthy relationships. However, although needed, these solutions are located at the individual level and need to be paralleled with action at the organizational level.

Solutions that start and are implemented at the organizational level will have a stronger impact in combatting conflict between nurses in the workplace. My study highlights and helps to further understand how nurse-to-nurse conflict operates in the context of intersecting factors. Hutchinson et al. (2010) argues that this helps managers create preventative measures and strategies that address the issue from a broader perspective.

5.5.5.1 Practicing positive leadership. Research highlights the importance of leadership in creating positive nursing work environments (Laschinger et al., 2012). Leadership practices that are unfair and unsupportive promote workplace bullying by forming inconsistent standards of appropriate workplace behaviours (Hauge, Einarsen, Knardahl, Notelaers, & Skogstad, 2011; Laschinger et al., 2012). Studies have shown the influence of positive leadership styles on nurse workplace wellbeing (Laschinger et al., 2012).

Laschinger and Fida (2014) examined the influence of authentic leadership on new nurses' burnout and wellbeing in the workplace. Authentic leadership is a certain leadership style practiced by supervisors that focuses on relationships (Laschinger &

Fida, 2014). Authentic leaders are self-aware of their own strengths, limitations and emotions, and highly regard honesty, trust, integrity and consistency (Avolio, Gardner, Walumbwa, Luthans, & May, 2004). Laschinger and Fida (2014) found that this type of leadership style was protective against nurses' feelings of burnout and its negative outcomes (such as job dissatisfaction and turnover). Moreover, a cross-sectional study by Laschinger et al. (2012) examined authentic leadership and workplace bullying and burnout. They found that authentic leadership decreased bullying in the workplace by creating a supportive environment where bullying was discouraged. In turn, burnout was also less likely to occur.

As indicated by past literature and the results of my research study, organizational factors such as leadership style by nursing supervisors and managers play a vital role in the behaviour that occurs amongst employees. They need to adopt and also understand the importance of positive leadership styles, such as authentic leadership, in mitigating the likelihood of nurse-to-nurse conflict. Practicing positive leadership is essential for bullying prevention in the nursing profession.

5.5.6 Changes at the Organizational Level

The above strategies point to the actions that need to be taken at the organizational level and how such changes are the most effective way to combat and address conflict between nurses. Hutchinson et al. (2008) suggest that informal organizational alliances (for instance, bullies who have alliances in senior positions that cover up for them) counteract policies that are in place to address/reduce conflict between nurses. Reporting incidences to management is an example of this, as this could be an ineffective approach since those involved (management, supervisors etc.) could have their own political or self-interested agendas (Hutchinson et al., 2008, 2010). Instead, if health care

organizations want to implement effective policies, they need to investigate whether factors (such as oppressive procedures/policies and informal organizational alliances) exist that inadvertently contribute to nurse-to-nurse conflict. Health care organizations should also have individuals who do not have a stake in the outcome investigating and managing workplace conflict that is reported (Hutchinson et al., 2010). As a result, this will create a workplace environment where harassment and conflict cannot happen again (Hutchinson et al., 2006; Johnson, 2009).

My study illuminates how the organization should take responsibility for nurse-to-nurse conflict as these broader level factors substantially shape the relations between nurses, as opposed to individual-level factors that have been reported in the literature, such as victims having lower self-esteem or are more anxious than non-bullied counterparts (Coyne et al., 2000). There also is danger in making recommendations for policies that operate at the individual level in isolation (such as zero tolerance policies) of those that actually address the cause of nurse-to-nurse conflict. Effective policies cannot be implemented without understanding the root causes of nurse-to-nurse conflict. Approaching policies with this lens will mitigate the harm being done by virtue of examining the structures that contribute to nurse-to-nurse conflict. Managers and decision-makers need to recognize the impact that the organizational structures have on conflict between nurses.

5.6 Limitations of the Study

This study is not without its limitations. The participants in this study consisted only of females. Participants also were recruited from a single program during one term and therefore the knowledge generated from this research may not be transferable to other

programs or student nursing populations. However, the findings of this study support the existing literature on nurse-to-nurse conflict. This study also included a unique group of RPNs who felt empowered (as demonstrated by their drive to return to school for a BScN) and motivated to participate in this research and advocate for change. This study was also exploratory, especially regarding the second research question that linked the experience of nurse-to-nurse conflict and going back to school for a BScN, and therefore only represents those RPNs who were interested in participating in this research. It must also be noted that nurse-to-nurse conflict was also not the single reason that motivated participants to go back to school to become RNs.

5.7 Directions for Future Research

Based on the findings of my research study, future research could investigate if there is a statistical relationship between experiencing nurse-to-nurse conflict and returning to school for a BScN and becoming an RN. Further research also needs to identify and examine what changes at the structural level can help to prevent nurse-to-nurse conflict. For example, creating opportunities for professional development and developing collaboration and teamwork between different types of nurses (e.g., examining what is happening in Magnet hospital environments and conducting cross site comparisons). Creating effective policies to shift the culture of acceptance and mitigate change is a potential strategy for preventing conflict between nurses. In addition, a study to explore RNs' experiences of nurse-to-nurse conflict might provide another window into this issue.

5.8 Conclusion

In summary, my research explored the experiences of nurse-to-nurse conflict for RPNs (in a post RPN-BScN program) and how these experiences shaped their decision to return to school for a BScN and become RNs. Research has shown how RPNs experience nurse-to-nurse conflict in the workplace and the implications of this behaviour for nurses' wellbeing and health, patient safety, and health care organizational outcomes. This research provided insight regarding the experiences of RPNs' (in a post RPN-BScN program) and how the contextual features of health care influence nurse-to-nurse relations. Effective ways to address nurse-to-nurse conflict cannot be achieved without a full understanding of the lived experiences of each type of nurse (as most of the existing research on this topic focuses on RNs' perspectives).

The findings in my study provide a deeper understanding of the sources that create tension between nurses. My research highlights how there are several intersecting factors that create an organizational structure that propagates nurse-to-nurse conflict. The participants in this study identified these powerful intersecting forces that come together to create negative tensions to arise between nurses, such as inappropriate staff mix and responding to financial pressures. In my study, participants discussed how they felt empowered through education to break the cycle of nurse-to-nurse conflict. Examining RPNs' motivations for returning to school despite the rise in employment for RPNs illuminated how education can be used to mitigate the prevalence and effects of nurse-to-nurse conflict.

The findings from this research have implications for role confusion, nursing education, staff mix, and the critical role that the health care system has for addressing

issues of nurse-to-nurse conflict. Employers, healthcare professionals, and decision makers need to consider the findings from this research, as well as other existing literature, when creating policies around bullying and conflict prevention. Effective strategies that prevent nurse-to-nurse conflict are not only crucial for nurses who experience it, but are ultimately important for patient care and safety.

Appendix A: UOIT REB Approval

6/21/2017

University of Ontario Institute of Technology Mail - Research Ethics Board Approval Notice



Yvonne Mais <yvonne.mais@uoit.net>

Research Ethics Board Approval Notice

researchethics@uoit.ca <researchethics@uoit.ca> Tue, Oct 25, 2016 at 3:31 PM
To: "Dr. Victoria Smye (Primary Investigator)" <victoria.smye@uoit.ca>
Cc: "Yvonne Mais (Student Lead/Post-Doctoral Lead)" <yvonne.mais@uoit.net>, researchethics@uoit.ca

Date: October 25, 2016

To: Victoria Smye

From: Shirley Van Nuland, REB Chair

Title: Registered Practical Nurses' Experiences of Nurse-on-Nurse Conflict in the Workplace

Decision: APPROVED (effective October 24th, 2016)

Current Expiry: October 01, 2017

Notwithstanding this approval, you are required to obtain/submit, to UOIT's Research Ethics Board, any relevant approvals/permissions required, prior to commencement of this project.

The University of Ontario, Institute of Technology Research Ethics Board (REB) has reviewed and approved the research proposal cited above. This application has been reviewed to ensure compliance with the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2 (2014)) and the UOIT Research Ethics Policy and Procedures. You are required to adhere to the protocol as last reviewed and approved by the REB.

Continuing Review Requirements (all forms are accessible from the [IRIS research portal](#)):

- **Renewal Request Form:** All approved projects are subject to an annual renewal process. Projects must be renewed or closed by the expiry date indicated above ("Current Expiry"). Projects not renewed within 30 days of the expiry date will be automatically suspended by the REB; projects not renewed within 60 days of the expiry date will be automatically closed by the REB. Once your file has been formally closed, a new submission will be required to open a new file.
- **Change Request Form:** Any changes or modifications (e.g. adding a Co-PI or a change in methodology) must be approved by the REB through the completion of a change request form before implemented.
- **Adverse or Unexpected Events Form:** Events must be reported to the REB within 72 hours after the event occurred with an indication of how these events affect (in the view of the Principal Investigator) the safety of the participants and the continuation of the protocol (i.e. un-anticipated or un-mitigated physical, social or psychological harm to a participant).
- **Research Project Completion Form:** This form must be completed when the research study is concluded.

Always quote your REB file number (**/14112**) on future correspondence. We wish you success with your study.

Dr. Shirley Van Nuland
REB Chair
shirley.vannuland@uoit.ca

Janice Moseley
Research Ethics Coordinator
researchethics@uoit.ca

NOTE: If you are a student researcher, your supervisor has been copied on this message.

Appendix B: DC REB Approval



Yvonne Mais
c/o UOIT
2000 Simcoe St. North
Oshawa, ON
L1H 7K4

November 15, 2016

REB application: 126-1617 Yvonne Mais – Registered Practical Nurses’ Experience of Nurse-on-Nurse Conflict in the Workplace

Dear Researcher,

The Durham College Research Ethics Board (REB) has considered your application for ethical review of your research study and related documentation, and hereby grants approval for the above-named study. This approval is valid for a one-year period commencing on November 15, 2016 and will expire November 15, 2017. The approval is based on the following:

1. All protocols from your revised application submitted on November 9, 2016 are adhered to;
2. Any unanticipated issues that may increase risk to participants or have other ethical implications that may affect participants’ welfare must be reported to the REB immediately and without delay;
3. The REB must be informed of any substantive protocol changes prior to any changes being implemented;
4. If you require an extension, a study renewal request must be submitted no less than 30 days prior to the expiry of this approval; and
5. Upon completion of the project, a study completion report must be submitted on or before the expiry of this approval.

Forms for all reporting requirements will be distributed to you by email. Please submit all documentation and communications to reb@durhamcollege.ca.

If you have any questions, please feel free to contact me. On behalf of the REB, I’d like to wish you every success with your project.

Sincerely,



Kay Corbier, BA, M.Ed.
Chair, Research Ethics Board

Oshawa Campus
2000 Simcoe Street North
Oshawa, Ontario, Canada L1H 7K
T: 905.721.2000
www.durhamcollege.ca

Appendix C: Verbal Recruitment Script

Hello, everyone!

My name is Yvonne Mais and I am a graduate student here at the University of Ontario Institute of Technology (UOIT) doing my Master of Health Science in Community Health.

I would like to invite you to participate in my research study titled ‘Registered Practical Nurses’ Experiences of Nurse-to-Nurse Conflict in the Workplace’.

The purpose of my research is to investigate RPNs’ (in a post RPN-BScN program) experiences of nurse-to-nurse conflict in the workplace.

Nurse-to-nurse conflict is defined as: aggression between nurses to create intergroup or interpersonal conflict. It is identified in forms such as ignoring, secluding, gossip, bullying, ridicule, intimidation, mistreatment or harassment in forms such as professional opinion ignored, withheld information, responsibilities taken away and replaced with trivial tasks, making faces or raised eyebrows as a response, and scapegoating.

This research will also investigate your motivations for returning to school for a Bachelor of Science in Nursing.

In order to be eligible for this study, you must be an:

- RPN currently enrolled in UOIT’s post RPN-BScN program
- Have at 6 months of workplace experience, have no more than 5 years of workplace experience,
- Have experience with nurse-to-nurse conflict in the workplace.

You will be asked to participate in an interview, which will be 30 - 60 minutes long, which will be audio-recorded during the interview. You will be compensated with a \$10 Tim Hortons gift card for your completion in this research!

Your participation in this research is voluntary and you only have to respond or answer the questions that you feel comfortable with.

You may also refuse to participate or withdraw from the study at any time before or during the interview (even if you have signed a consent form). Your participation will be confidential and anonymous.

Your decision to participate will in no way impact your employment or future employment opportunities, nor your academic standing in the course or program at UOIT. After the data is anonymized, it will be no longer traceable back to you.

Your participation in this qualitative study will help to illuminate RPNs’ (in a post RPN-BScN program) experiences and perspective of nurse-to-nurse conflict, as most of the existing research is quantitative and focuses on RNs. This research will also help other healthcare professionals and employers to develop strategies and policies regarding workplace conflict.

I am giving each of you a piece of paper with my contact information on it. If you are interested in participating in this research, please contact me via email and I will provide you with a Letter of Invitation and Consent to Participation form. You will be asked to

select a time that is most convenient for an interview.

Please feel free to ask me any questions as well. Your participation in this research will be extremely valuable and appreciated.

I am available through email at: yvonne.mais@uoit.net

Thank you!

Appendix D: Handout Invitation with Contact Information

I would like to invite you to participate in this research study titled 'Registered Practical Nurses' Experiences of Nurse-to-Nurse Conflict in the Workplace' with UOIT, Faculty of Health Sciences. My name is Yvonne Mais and I am a student here at the University of Ontario Institute of Technology (UOIT). I am doing my Master of Health Science in Community Health.

The purpose of this research study is to investigate RPNs' (in a post RPN-BScN program) experiences of nurse-to-nurse conflict in the workplace. Nurse-to-nurse conflict is defined as aggression between nurses to create intergroup or interpersonal conflict. It is identified in forms such as ignoring, bullying, secluding, gossip, ridicule, intimidation, mistreatment or harassment in forms such as professional opinion ignored, withheld information, responsibilities taken away and replaced with trivial tasks, making faces or raised eyebrows as a response, and scapegoating. This research will also investigate your motivations for returning to school for a Bachelor of Science in Nursing.

Eligibility criteria to participate include:

- **RPN currently enrolled in UOIT's post RPN-BScN program**
- **Have experience with nurse-to-nurse conflict in the workplace**
- **Have at least 6 months of workplace experience, but no more than 5 years**

You will be asked to participate in an interview, which will be 30 - 60 minutes long. Please note that you will be audio-recorded during the interview. You will be compensated with a **\$10 Tim Hortons gift card** for your completion in this research! Your participation in this research is voluntary and you only have to respond or answer the questions that you feel comfortable with. You may also refuse to participate or withdraw from the study at any time before or during the interview. Your participation will be confidential and anonymous. All information obtained during the study will be held in strict confidence.

If you are interested in participating in this research, please contact me and I will provide you with a Letter of Invitation and Consent to Participation form. You will be asked to select a time that is most convenient for an interview.

Please feel free to contact me with any questions. Email: yvonne.mais@uoit.net
Your participation in this research will be extremely valuable and appreciated.

Thank you,
Yvonne Mais

Appendix E: Interview Guide

1. Can you please describe as detailed as possible a situation in which you experienced nurse- on-nurse conflict? (*Probes Below*)
 - a. What was your response to the incidents?
 - b. What do you think are the causes of nurse-to-nurse conflict?
 - c. How was the conflict resolved?
2. Tell me about the relational aspects of your work (your relationships with other nurses) and your experiences of these relationships in the workplace (*Probes Below*)
 - a. What is your relationship like with other RPNs? What is it like with RNs?
 - i. What challenges have you experienced with your nurse co-workers?
 - ii. How can these be overcome?
 - b. Do you feel there is collaboration between RNs and RPNs in the workplace?
 - i. In your opinion, what makes for effective relationships in the workplace and what does not?
 - c. How is power negotiated?
3. When do you think nurses are most vulnerable to nurse-to-nurse conflict in the workplace (i.e., when have you or your co-workers experienced this the most)? (*Probes Below*)
 - a. Why do you think this behaviour occurs (between nurses, RNs and RPNs)?
 - b. What do you think are the consequences of the behaviour?
4. What (contextual) factors do you think contribute to this behaviour? (*Probes Below*)
 - a. What kind of environment do you think triggers/ contributes to this behaviour?

b. How do you think nurse-to-nurse conflict affects the healthcare system/ those who work within it?

5. How do you think these experiences affected you and your career? (*Probes Below*)

a. How did this affect your job performance/career as an RPN?

b. Do you think you will experience nurse-to-nurse conflict when you become an RN?

Decision to return to school:

1. What kinds of factors resulted in your decision to leave the RPN occupation and return to school to become a RN? (*Probes Below*)

a. Have you had any experiences in the workplace that affected your decision to return to school?

2. After you obtain your BScN and become an RN, what kinds of expectations and changes do you wish to see regarding your job/role in the workplace?

3. Do you think your education (obtaining a BScN) and change in career (becoming an RN) will change/influence your relationships with other nurses? (*Probes Below*)

a. How do you think it will change your relationship with fellow RNs and RPNs?

4. Do you have any further thoughts you wish to share with us before we conclude our session?

Appendix F: Letter of Invitation

Title of Project: Registered Practical Nurses' Experiences of Nurse-to-Nurse Conflict in the Workplace

Researcher(s):

Principal Investigator, Faculty Supervisor: Yvonne Mais, MHSc (cand.) (Graduate CI); Victoria Smye, PhD (Research Supervisor, PI)

Departmental and institutional affiliation(s): Faculty of Health Sciences, University of Ontario Institute of Technology

Contact number(s)/email: yvonne.mais@uoit.net; victoria.smye@uoit.ca

Dear Participant,

I would like to invite you to participate in this research study titled 'Registered Practical Nurses' Experiences of Nurse-to-Nurse Conflict in the Workplace' with the University of Ontario Institute of Technology (UOIT), Faculty of Health Sciences.

The purpose of this research study is to investigate RPNs' (in a post RPN-BScN program) experiences of nurse-to-nurse conflict in the workplace. Nurse-to-nurse conflict is defined as aggression between nurses to create intergroup or interpersonal conflict. It is identified in forms such as ignoring, bullying, secluding, gossip, ridicule, intimidation, mistreatment or harassment in forms such as professional opinion ignored, withheld information, responsibilities taken away and replaced with trivial tasks, making faces or raised eyebrows as a response, and scapegoating. This research will also investigate your motivations for returning to school for a Bachelor of Science in Nursing.

In order to be eligible for this study, you must be an RPN currently enrolled in UOIT's post RPN-BScN program, have at 6 months of workplace experience, have no more than 5 years of workplace experience, and have experience with nurse-to-nurse conflict in the workplace.

This study has been reviewed by the University of Ontario Institute of Technology Research Ethics Board and the Durham College Ethics Board and has received ethics clearance (UOIT REB File #14112; Durham College REB File #126-1617).

You will be asked to participate in an oral interview, which will be 30 - 60 minutes long. Please note that you will be audio-recorded during the interview. Your signature is required to participate in this research study. You will be compensated with a **\$10 Tim Hortons gift card** for your completion in this research!

Your participation in this research is voluntary and you only have to respond or answer the questions that you feel comfortable with. You may also refuse to participate or withdraw from the study at any time before or during the interview (even if you have signed a consent form). Your participation will be confidential and anonymous. All information obtained during the study will be held in strict confidence. Therefore, as your

information will be kept confidential and anonymous throughout this study, your decision to participate will in no way impact your employment or future employment opportunities, nor your academic standing in the course or program at UOIT. After the data is anonymized, it will be no longer traceable back to you.

Your participation in this qualitative study will help to illuminate RPNs' (in a post RPN-BScN program) experiences and perspective of nurse-to-nurse conflict, as most of the existing research is quantitative and focuses on RNs. This research will also help other healthcare professionals and employers to develop strategies and policies regarding workplace conflict.

If you are interested in participating in this research, I will provide you with a Consent to Participate form, which contains further information about the research study.

Please feel free to ask any questions you may have before completing the interview process.

Your participation in this research will be extremely valuable and appreciated.

Thank you,
Yvonne Mais

Appendix G: Consent Form

Title of Research Study: Registered Practical Nurses' Experiences of Nurse-on-Nurse Conflict in the Workplace

You are invited to participate in a research study named above. Please read this form carefully, and feel free to ask the researcher any questions you might have concerning the study. This study has been approved by the UOIT Research Ethics Board REB (REB # 14112) on October 24, 2016, and Durham College Research Ethics Board (REB# 126-1617) on November 9, 2016. Any questions regarding your rights as a participant, complaints or adverse events may be addressed to UOIT Research Ethics Board through the Research Ethics Coordinator – researchethics@uoit.ca or 905.721.8668 x. 3693, or Durham College REB at reb@durhamcollege.ca

Researcher(s):

Principal Investigator, Faculty Supervisor: Yvonne Mais, MHS (cand.) (Graduate CI); Victoria Smye, PhD (Research Supervisor, PI)

Departmental and institutional affiliation(s): Faculty of Health Sciences, University of Ontario Institute of Technology

Contact number(s)/email: yvonne.mais@uoit.net, 647-218-4592; victoria.smye@uoit.ca

Purpose and Procedure:

The purpose of this research study is to investigate and explore RPNs' (in a post RPN-BScN program at the University of Ontario Institute of Technology) experiences of nurse-on-nurse conflict in the workplace. This research will also investigate RPNs' motivations for returning to school for a Bachelor of Science in Nursing. This research involves in-depth individual interviews where you can speak with the researcher about your experiences. The interviews are audio-recorded and will be transcribed verbatim. The researcher may also take notes by hand throughout the interview. The interview will take approximately 30-60 minutes to complete. You will be compensated with a **\$10 Tim Hortons gift card** upon the completion of your interview!

After the interview is complete, the interview will be transcribed verbatim and available for review to the participant within seven (7) days. The participant will have the opportunity to review the transcript, at their discretion, via email to confirm meaning in statements and to provide additional information, as the participant deems necessary. If the participant decides to review the transcript, the participant has the opportunity to send comments, changes, or approval to the principal investigator within seven (7) days. If the participant does not give feedback of the transcript within the seven (7) day time frame, it will be presumed that the participant's experiences have been accurately described and captured in adequate detail. If a following meeting is to occur in person, it will take place on a different, mutually agreeable date and time.

Potential Benefits:

There will be no direct benefits to you from participating in this research; however, your participation in this research will help to illuminate RPNs' (in a post RPN-BScN program) experiences and perspective of nurse-on-nurse conflict, and help other healthcare professionals and employers to develop strategies and policies regarding workplace conflict.

Potential Risk or Discomforts:

Participants may feel uncomfortable, embarrassed, or uneasy speaking about their experiences with nurse-on-nurse conflict in the workplace. Participants do not have to answer any questions that they do not want to. All data collected during the interviews are confidential and anonymized, and will only be accessed by the members on the research team listed on this consent form.

Participants are informed of the counseling services available to them, if need be, with the Student Mental Health Services at the University of Ontario Institute of Technology, which offers a variety of services and options such as short-term or long term counseling, therapy services, and/or specialized mental health services. There is no cost and services are confidential. Further information is found at <https://studentlife.uoit.ca/mentalhealth/>. Contact information for the Student Mental Health Services is found at <https://studentlife.uoit.ca/mentalhealth/Contact.php> or the phone number: 905.721.3392 or email: studentlifeline@uoit.ca

Other services that are available to the participant beyond UOIT Student Mental Health Services are:

- The Durham Mental Health Services (which can be contacted at their 24/7 Crisis Access Linkage Line- 905.666.0483 or 1.800.742.1890 or for more information <http://dmhs.ca/call/>)
- Lakeridge Health: Mental Health Services (which can be contacted at 905-576-8711 ext. 4402 or for more information <https://www.lakeridgehealth.on.ca/en/ourservices/Mental-Health---Pinewood-Centre.asp>)
- A link to the EMentalHealth website which provides several other services: <http://www.ementalhealth.ca/Durham-Region/FindHelp/index.php?m=findHelp>

Storage of Data:

Data will be stored on a personal and password-protected laptop that will be kept in a secure location at all times. Only the researcher (and research Faculty supervisor if need be) will have access to this laptop. All data and findings from the study will be kept in a folder on the laptop that is inconspicuously named and located. Audio-recorded data will be permanently deleted immediately after transcription (within 7 days). Hand-written notes taken during the interview will be shredded and permanently deleted/destroyed after transcription. After the research is concluded, the consent forms and transcriptions will be kept for five (5) years after the completion of the research study in a safe and secure/locked location. After the five (5) year period, all data will be destroyed in a proper manner. Any confidential research data and records in paper format will be shredded. Confidential research data and records in electronic format will be destroyed by reformatting, rewriting or deleting.

Confidentiality:

The participant's experiences of nurse-on-nurse conflict and motivations to return to school for a BScN will be collected for the purposes of informing the research questions and will only be shared with members of the research team listed on this form. All information and data obtained during the study will be held in strict confidence and locked and stored on the researcher's personal and password-protected laptop that will be kept in a secure location. The results of this study may be published in scientific journals and/or presented in scientific conferences. Participants' names or any other identifying personal information will NOT appear or be used in any publications and/or presentations. Participants will be asked to choose a pseudonym that will be used throughout the duration of the research process, such as the recorded interview and during the publication of the research (after which direct identifiers will be destroyed). After the data is anonymized, it will be no longer traceable back to them. Participant privacy shall be respected. No information about participants' identity will be shared

or published without their permission, unless required by law. Therefore, as your information will be kept confidential and anonymous throughout this study, your decision to participate will in no way impact your employment or future employment opportunities, nor your academic standing in the course or program at UOIT. Confidentiality will be provided to the fullest extent possible by law, professional practice, and ethical codes of conduct.

Right to Withdraw:

Your participation is voluntary, and you may answer only those questions that you are comfortable with. The information that is shared will be held in strict confidence and discussed only with the research Faculty supervisor.

Participants may refuse to participate or withdraw from the study at any time before or during the interview without loss of relevant entitlements/benefits. Withdrawal from the research project will not affect participant's access to services or grades in courses. Participants may withdraw from the interview for any reason by verbal request to the researcher before or during the interview, even after signing the consent form. Participants cannot withdraw from the study after the completion of the interview. If a participant has chosen to withdraw from the study, the participant's data will be permanently removed and destroyed and not included in the research.

Participants will not be compensated with the \$10 Tim Hortons gift card if they withdraw before or during the interview.

Participants will not need to offer any reason for why they wish to withdraw their consent. You will be given information that is relevant to your decision to continue or withdraw from participation.

Compensation:

You will receive a \$10 Tim Hortons gift card upon the completion of your interview.

Participant Concerns and Reporting:

This research project has been approved by the University of Ontario Institute of Technology Research Ethics Board on October 24, 2016, and Durham College REB on November 9, 2016.

If you have any questions concerning the research study or experience any discomfort related to the study, please contact the researcher Yvonne Mais at 647-218-4592 or yvonne.mais@uoit.net

By consenting, you do not waive any rights to legal recourse in the event of research-related harm.

Debriefing and Dissemination of Results:

A written Thank You letter and a \$10 Tim Hortons gift card will be provided after participation in the interview process. Participants will be asked to contact the researcher (via the phone number or email included in the thank you form) if they wish to be informed of the results of the study for up to 8 months after the interview. It will be communicated to participants in the thank you form that if they are interested, they can ask the researcher to provide information on how to access an electronic version of the thesis after completion.

Consent to Participate:

If you consent to participate in this study, please read the following and sign below to confirm your consent:

1. I have read the letter of invitation and understand the study being described.
2. I have read this consent form and I indicate that I understand the study being described.

1. I have had an opportunity to ask questions and these questions have been answered. I know that I am free to ask questions about the study in the future.
2. I freely consent to participate in the research study, understanding that I may discontinue participation at any time without penalty. A copy of this Consent Form has been given to me for my records.
3. I give permission to be audio-recorded during the interview.
4. In case I have to withdraw, I give permission to be interviewed at a later time, if I wish to.
5. I give permission/ understand that the information that I provide for this research study may be published with the results in scientific journals and/or presented in scientific conferences.
6. I understand that my name or any other identifying personal information will NOT appear or be used in any publications and/or presentations.
7. I agree that data collected during my interview will be kept for a maximum period of 5 years by the researcher and then will be permanently destroyed.
8. I understand that I can withdraw from the study and interview without reason at any time without penalty.

Participant Full Name

Date

Participant Signature

Date

Researcher Signature

Date

Please circle one of the following:

NO: I do not wish to receive a copy of the interview transcription.

YES: I wish to receive a copy of the interview transcription. Email: _____

Appendix H: Thank You Letter

Dear Participant,

I would like to thank you for participating in my research study entitled ‘Registered Practical Nurses’ Experiences of Nurse-to-Nurse Conflict in the Workplace’ at the University of Ontario Institute of Technology (UOIT), Faculty of Health Sciences.

As you know, the purpose of this research study was to investigate and explore RPNs’ (in a post RPN-BScN program at the University of Ontario Institute of Technology) experiences of nurse-to-nurse conflict in the workplace. The research also investigated RPNs’ motivations for returning to school for a Bachelor of Science in Nursing.

Please remember, as mentioned before, all information obtained during the study will be held in strict confidence. After the data has been anonymized, it will be no longer traceable back to you. Therefore, as your information will be kept confidential and anonymous throughout this study, your decision to participate will in no way impact your employment or future employment opportunities, nor your academic standing in the course or program at UOIT.

Just a reminder- the interview will be transcribed verbatim and if you indicated on the Consent form that you wish to receive them, they will be available to you via email within seven (7) days. With this, you have the opportunity to review the transcript to confirm meaning in statements and to provide additional information, as you deem necessary. If you prefer to meet again in person to review the transcript, it will take place on a different, mutually agreeable date and time.

If you decide to review the transcript, please send comments, changes, or approval to the researcher within seven (7) days from the date you received the transcript. If you do not give feedback with the given time frame, it will be presumed that your experiences have been accurately described and captured in adequate detail.

If you wish to be informed of the results of the study, please contact the researcher (via the phone number or email included in this thank you form) up to eight (8) months after the interview. If interested, you may also contact the researcher (via phone number or email) to provide information regarding how to access an electronic version of the thesis after completion.

Please be informed of the counseling services that are available to you, if need be, with the Student Mental Health Services at the University of Ontario Institute of Technology, which offers a variety of services and options such as short-term or long term counseling, therapy services, and/or specialized mental health services.

There is no cost and services are confidential. Further information is found at <https://studentlife.uoit.ca/mentalhealth/>. Contact information for the Student Mental Health Services is found at <https://studentlife.uoit.ca/mentalhealth/Contact.php> or the phone number: 905.721.3392 or email: studentlifeline@uoit.ca

Other services that are available to the participant beyond UOIT Student Mental Health

Services are:

- The Durham Mental Health Services (which can be contacted at their 24/7 Crisis Access Linkage Line- 905.666.0483 or 1.800.742.1890 or for more information <http://dmhs.ca/call/>)
- Lakeridge Health: Mental Health Services (which can be contacted at 905-576-8711 ext. 4402 or for more information <https://www.lakeridgehealth.on.ca/en/ourservices/Mental-Health---Pinewood-Centre.asp>)
- A link to the EMentalHealth website which provides several other services: <http://www.ementalhealth.ca/Durham-Region/FindHelp/index.php?m=findHelp>

This research project has been approved by the University of Ontario Institute of Technology Research Ethics Board on October 24, 2016 (REB #14112) and the Durham College Research Ethics Board on November 9, 2016 (REB #126-1617). If you have any questions concerning the research study, or experience any discomfort related to the study please contact the researcher(s) at 647-218-4592 or via email yvonne.mais@uoit.net. Any questions regarding your rights as a participant, complaints or adverse events may be addressed to the UOIT Research Ethics Board through the Compliance Office (905 721 8668 ext 3693) or Durham College REB at reb@durhamcollege.ca. By consenting, you do not waive any rights to legal recourse in the event of research-related harm.

Your participation in this qualitative study will help to illuminate RPNs' (in a post RPN-BScN program) experiences and perspective of nurse-to-nurse conflict, as most of the existing research is quantitative and focuses on RNs. This research will also help other healthcare professionals and employers to develop strategies and policies regarding workplace conflict.

I would like to thank you for your time and participation. It is greatly appreciated!

Thank you again!

Yvonne Mais

Phone number: 647-218-4592

Email: yvonne.mais@uoit.net

References

- Aiken, L. H., Clarke, S. P., Cheung, R. B., Sloane, D. M., & Silber, J. H. (2003). Educational levels of hospital nurses and surgical patient mortality. *Journal of American Medical Association, 290*(12), 1617-1623.
- Al-Maqbali, M. A. (2015). Factors that influence nurses' job satisfaction: A literature review. *Nursing Management, 22*(2), 30-37. doi: 10.7748/nm.22.2.30.e1297
- Allen, B. C., Holland, P., & Reynolds, R. (2015). The effect of bullying on burnout in nurses: The moderating role of psychological detachment. *Journal of Advanced Nursing, 71*(2), 381-390. doi: 10.1111/jan.12489
- Ames, A., Adkins, S., Rutledge, D., Hugbart, K., Greeno, S., Foss, J., . . . Trent, M. (1992). Assessing work retention issues. *Journal of Nursing Administration, 22*(4), 37-41.
- An, Y., & Kang, J. (2016). Relationship between organizational culture and workplace bullying among Korean nurses. *Asian Nursing Research, 10*, 234-239.
<http://dx.doi.org/10.1016/j.anr.2016.06.004>
- Armstrong, P., & Armstrong, H. (2010). *Wasting away: The undermining of Canadian health care* (2nd ed.). Don Mills, ON: Oxford University Press.
- Avolio, B. J., Gardner, W. L., Walumbwa, F. O., Luthans, F., & May, D. (2004). Unlocking the mask: A look at the process by which authentic leaders impact follower attitudes and behaviours. *Leadership Quarterly, 15*, 801-823.
<http://dx.doi.org/10.1016/j.leaqua.2004.09.003>

- Babenko-Mould, Y., & Laschinger, K. S. (2014). Effects of incivility in clinical practice settings on nursing student burnout. *International Journal of Nursing Education Scholarship, 11*(1), 145-154. doi: 10.1515/ijnes-2014-0023
- Baranek, P. M. (2005). *A review of scopes of practice of health professions in Canada: A balancing act*. Toronto, ON: Health Council of Canada.
- Berry, P., Gillespie, G., Fisher, B., Gormley, D., & Haynes, J. (2016). Psychological distress and workplace bullying among registered nurses. *The Online Journal of Issues in Nursing, (21)*3. doi: 10.3912/OJIN.Vol21No03PPT41
- Berry, L., & Curry, P. (2012). *Nursing workload and patient care*. Ottawa, ON: The Canadian Federation of Nurses Unions.
- Besner, J., Doran, D., McGillis Hall, L., Giovannetti, P., Gierard, F., Hill, W., . . . Watson, L. (2005). *A systematic approach to maximizing nursing scopes of practice*. Ottawa, ON: Canadian Institute for Health Research. Retrieved from http://www.cfhi-fcass.ca/Migrated/PDF/ResearchReports/OGC/besner_final.pdf
- Boyle, T. (2015, October 22). Nursing cuts hurting hospital care in Ontario, union says. *The Star*. Retrieved October 29, 2016, from <https://www.thestar.com/news/queenspark/2015/10/22/nursing-cuts-hurting-hospital-care-in-ontario-union-says.html>
- Broome, B. S., & Williams-Evans, S. (2011). Bullying in a caring profession: Reasons, results, and recommendations. *Journal of Psychosocial Nursing and Mental Health Services, 49*(10), 30-35. doi: 10.3928/02793695-20110831-02
- Butcher, D. L., & MacKinnon, K. A. (2015). Educational silos in nursing education: A

critical review of practical nurse education in Canada. *Nursing Inquiry*, 22(3), 231-239. doi: 10.1111/nin.12090

Canadian Federation of Nurses Unions [CFNU]. (n.d.). Staffing: Getting the right mix— A nurses union. Retrieved from <https://nurseone.ca/~media/nurseone/page-content/pdfen/staffinggettingtherightmixe28093anursesunionperspectivestaffingcfnuenv02.pdf>

Canadian Institute of Health Information. (2007). *Education trends of licensed practical nurses: Workforce trends of licensed practical nurses in Canada, 2006*. Ottawa, ON: CIHI.

Canadian Institute for Health Information (CIHI). (2015). *Regulated Nurses, 2014*. Ottawa, ON: CIHI.

Canadian Institute for Health Information (CIHI). (2016). Nurses. Retrieved January 25, 2016, from <https://www.cihi.ca/en/spending-and-health-workforce/health-workforce/nurses>.

Canadian Nurses Association [CNA]. (n.d.). RN and baccalaureate education table. Retrieved August 3, 2017 from <https://www.cna-aiic.ca/en/becoming-an-rn/education/rn-baccalaureate-education-table>

Canadian Nurses Association. (2002). *Code of ethics for registered nurses*. Ottawa, ON: Canadian Nurses' Association.

Canadian Nurses Association (CNA). (2003). *Ethical Distress in Health Care Environments*. Ottawa, ON: Canadian Nurses Association.

Canadian Nurses Association (CNA). (2004). *Nursing staff mix: A literature review*. Ottawa, ON: Canadian Nurses Association. Retrieved from <https://www.cna->

aiic.ca/~media/cna/page-content/pdf-
en/final_staf_mix_literature_review_e.pdf?la=en

Canadian Nurses Association (CNA). (2005). *Nursing staff mix: A key link to patient safety*. Ottawa, ON: Canadian Nurses Association. Retrieved from https://www.cna-aiic.ca/~media/cna/page-content/pdf-en/nn_nursing_staff_mix_05_e.pdf?la=en

Canadian Nurses Association (CNA). (2017) *Joint commission statement: Workplace violence and bullying*. Retrieved from: http://cna-aiic.ca/~media/cna/page-content/pdf-en/Workplace-Violence-and-Bullying_joint-position-statement.pdf

Christie, W., & Jones, S. (2013). Lateral violence in nursing and the theory of the nurse as wounded healer. *The Online Journal of Issues in Nursing*, 19(1). doi: 10.3912/OJIN.Vol19No01PPT01

Cleary, M., Hunt, G. E., Walter, G., & Robertson, M. (2009). Dealing with bullying in the workplace: Toward zero tolerance. *Journal of Psychosocial Nursing and Mental Health Services*, 47, 34-41. doi: 10.3928/02793695-20091103-03

Coffey, S., Lindsay, G., Cochrane, M., Cummings, K., Macdonald, K., Mairs, S., Bouchard, S., Lulat, Z., Salamat, N., Bell, R. (2013). *Three-partner collaborative evaluation of student transition, performance, experience, and outcomes in practical nursing – Phase 3 report*. Submitted to ONCAT, January 2013.

Coffey, S., Lindsay, G. M., Cochrane, M., Cummings, K., Macdonald, K., Mairs, S., . . . Bell, R. (2016). Making the grade through the front door: Evaluation and innovation in a registered practical nurse to bachelor of science in nursing program. *Journal of Education and Training Studies*, 4(1), 32-38. doi:10.11114/jets.v4i1.1012

- College of Nurses of Ontario (CNO). (2014a). *Entry-to-practice competencies: For Ontario registered practical nurses*. Retrieved August 9, 2017 from www.cno.org/globalassets/docs/reg/41042_entrypracrpn.pdf
- College of Nurses of Ontario (CNO). (2014b). *Practice guideline: RN and RPN practice: The client, the nurse and the environment*. Retrieved January 10, 2016 from <http://www.cno.org/globalassets/docs/prac/41062.pdf>
- Cook, L., Dover, C., Dickson, M., & Engh, B. (2010). Returning to school: The challenges of the licensed practical nurse-to-registered nurse transition student. *Teaching and Learning in Nursing, 5*(3), 125-128. doi:10.1016/j.teln.2010.02.003
- Corley, M. C. (2002). Nurse moral distress: A proposed theory and research agenda. *Nursing Ethics, 9*(6), 636-650. doi: 10.1191/0969733002ne557oa
- Coursey, J. H., Rodriguez, R. E., Dieckmann, L. S., & Austin, P. N. (2013). Successful Implementation of Policies Addressing Lateral Violence. *Association of periOperative Registered Nurses, 97*(1), 101-109. <http://dx.doi.org/10.1016/j.aorn.2012.09.010>
- Coyne, I., Seigne, E., & Randall, P. (2000). Predicting workplace victim status from personality. *European Journal of Work and Organizational Psychology, 9*(3), 335–349. doi: 10.1080/135943200417957
- Creswell, J. W. (1994) *Research design: Qualitative & quantitative approaches* (1st ed.). Thousand Oaks, CA: Sage.
- Creswell, J. W. (2006). *Qualitative inquiry and research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage.

- Cubit, K., & Lopez, V. (2011). Qualitative study of enrolled nurses transition to registered nurses. *Journal of Advanced Nursing*, 68(1), 206-211.
doi:10.1111/j.1365-2648.2011.05729.x
- Curtis, J., Bowen, I., & Reid, A. (2007). You have no credibility: Nursing students' experiences of horizontal violence. *Nurse Education in Practice*, 7, 156-163. doi: 10.1016/j.nepr.2006.06.002
- Debisette, A. (2010). *Annual review of nursing research: Nursing workforce issues* (Vol. 28). New York, NY: Springer Publishing Company.
- Dellasega, C. (2009). Bullying among nurses. *American Journal of Nursing*, 109(1), 52-58. doi: 10.1097/01.NAJ.0000344039.11651.08
- Denton, M., Zeytinoglu, I. U., Davies, S., & Lian, J. (2002). Job stress and job dissatisfaction of home care workers in the context of health care restructuring. *International Journal of Health Services*, 32(2), 327-357.
- Denzin N. K., & Lincoln, Y. S. (2005). Introduction: The discipline and practice of qualitative research. In N. K. Denzin & Y. Lincoln (Eds.), *The SAGE handbook of qualitative research* (3rd ed., pp. 1-32). Thousand Oaks, CA: Sage.
- Dowling, M. (2006). Approaches to reflexivity in qualitative research. *Nurse Researcher*, 13(3), 7-21. doi: 10.7748/nr2006.04.13.3.7.c5975
- Duffy, E. (1995). Horizontal violence: A conundrum for nursing. *Collegian: Journal of the Royal College of Nursing, Australia*, 2(2), 5-17.
- Eager, S. C., Cowin, L. S., Gregory, L., & Firtko, A. (2010). Scope of practice conflict in nursing: A new war or just the same battle? *Contemporary Nurse*, 36(1-2), 86-95.

- Embree, J. L., & White, A. H. (2010). Concept analysis: Nurse-to-nurse lateral violence. *Nursing Forum*, 45(3), 166-173.
- Erenstein, C., & McCaffrey, R. (2007). How healthcare work environments influence nurse retention. *Holistic Nursing Practice*, 21(6), 303-307. doi: 10.1097/01.HNP.0000298615.25222.de
- Etienne, E. (2014). Exploring workplace bullying in nursing. *Workplace Health and Safety*, 62(1), 6-11. doi: 10.1177/216507991406200102
- Farrell G. (1997) Aggression in clinical settings: Nurses' views. *Journal of Advanced Nursing*, 25, 501-508. doi: 10.1046/j.1365-2648.1997.1997025501.x
- Freire, P. (1971). *Pedagogy of the Oppressed*. New York, NY: Herder and Herder.
- Frketich, J. (2016, March 4). Nursing cuts: St. Joes replaces RNs with RPNs in neonatal intensive care. *The Hamilton Spectator*. Retrieved April 6, 2016 from <http://www.thespec.com/news-story/6375253-nursing-cuts-st-joes-replaces-rns-with-rpns-in-neonatal-intensive-care/>
- Gill, M, J. (2014). The possibilities of phenomenology for organizational research. *Organizational Research Methods*, 17(2), 118-137. doi: 10.1177/1094428113518348
- Giorgi, A. (1997). The theory, practice, and evaluation of the phenomenological method as a qualitative research procedure. *Phenomenological Psychology*, 28(2), 235-260.
- Giorgi, A. (2005). The phenomenological movement and research in the human sciences. *Nursing Science Quarterly*, 18(1), 75-82.
- Giorgi, A., & Giorgi, B. (2003). Phenomenology. In J. A. Smith (Eds.), *Qualitative psychology: A practical guide to research methods*. London: Sage.

- Griffin, M. (2004). Teaching cognitive rehearsal as a shield for lateral violence: An intervention for newly licensed nurses. *The Journal of Continuing Nursing Education in Nursing*, 35, 257–263.
- Guba, E. G. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. *Educational Communication and Technology*, 29(2), 75-91. doi: 10.1007/bf02766777
- Hall, D. (2015, April 9). Nurses face job cuts across Ontario. *The Star*. Retrieved October 29, 2016 from https://www.thestar.com/life/health_wellness/2015/04/09/nurses-face-job-cuts-across-ontario.html
- Hamric, A. B., Spross, J. A., & Hanson, C. M. (2009). *Advanced practice nursing: An integrative approach* (5 ed.). St. Louis: Elsevier Saunders.
- Hayes, L. J., O'Brien-Pallas, L., Duffield, C., Shamian, J., Buchan, J., Hughes, F., . . . North, N. (2012). Nurse turnover: A literature review – An update. *International Journal of Nursing Studies*, 49(7), 887-905. doi: 10.1016/j.ijnurstu.2011.10.001
- Hauge, L. J., Einarsen, S., Knardahl, S., Lau, B., Notelaers, G., & Skogstad, A. (2011). Leadership and role stressors as departmental level predictors of workplace bullying. *International Journal of Stress Management*, 18(4), 305–323. <http://dx.doi.org/10.1037/a0025396>
- Hauge, L. J., Skogstad, A., & Einarsen, S. (2010). The relative impact of workplace bullying as a social stressor at work. *Journal of Psychology*, 51, 426-433. doi: 10.1111/j.1467-9450.2010.00813.x
- Heidegger, M. (1927/1962). *Being and Time*. Oxford: Blackwell. [1962 text J. Macquarrie & E. Robinson, Trans.].

- Hudson, L. A., & Ozanne, J. L. (1988). Alternative ways of seeking knowledge in consumer research. *The Journal of Consumer Research*, *14*(4), 508-521.
- Huntington, A., Gilmour, J., Tuckett, A., Neville, S., Wilson, D., & Turner, C. (2011). Is anybody listening? A qualitative study of nurses' reflections on practice. *Journal of Clinical Nursing*, *20*, 1413-1422. doi: 10.1111/j.1365-2702.2010.03602.x
- Husserl, E. (1970). *The crisis of European sciences and transcendental phenomenology*. Evanston, Ill.: Northwestern University Press. (Original work published in 1936).
- Husserl, E. (1983). *Ideas pertaining to a pure phenomenology and to a phenomenological philosophy*. First book (F. Kersten, Trans.). The Hague: Martinus Nijhoff. (Original work published 1913).
- Hutchinson, M., Vickers, M. H., Jackson, D., & Wilkes, L. (2006a). 'They stand you in a corner; you are not to speak': Nurses tell of abusive indoctrination in work teams dominated by bullies. *Contemporary Nurse*, *21*, 228-238. doi: 10.5172/conu.2006.21.2.228
- Hutchinson, M., Vickers, M. H., Jackson, D., & Wilkes, L. (2006b). Workplace bullying in nursing: Towards a more critical organizational perspective. *Nursing Inquiry*, *13*(2), 118-126.
- Hutchinson, M., Wilkes, L., Vickers, M., & Jackson, D. (2008). The development and validation of a bullying inventory for the nursing workforce. *Nursing Researcher* *15*(2), 19-29. doi: 10.7748/nr2008.01.15.2.19.c6326
- Hutchinson, M., Wilkes, L., Jackson, D., & Vickers, M. (2010). Integrating individual,

work group and organizational factors: Testing a multidimensional model of bullying in the nursing. *Journal of Nursing Management*, 18, 173-181. doi: 10.1111/j.1365-2834.2009.01035.x

Johnson, S. L. (2009) International perspectives on workplace bullying among nurses: A review. *International Nursing Review*, 56, 34-40. doi: 10.1111/j.1466-7657.2008.00679.x

Johnson, S. L., & Rea, R. E. (2009). Workplace bullying: Concerns for nurse leaders. *Journal of Nursing Administration*, 39, 84-90. doi: 10.1097/NNA.0b013e318195a5fc

Joseph, J., & Deshpande, S. P. (1997). The impact of ethical climate on job satisfaction of nurses. *Health Care Management Review*, 22(1), 76-81.

Katrinli, A., Atabay, G., Gunay, G., Cangarli, B. G. (2010). Nurses' perceptions of individual and organizational political reasons for horizontal peer bullying. *Nursing Ethics*, 17(5), 614-627. doi: 10.1177/0969733010368748

Kidd, M., Grove, K., Kaiser, M., Swoboda, B., & Taylor, A. (2014). A new patient-acuity tool promotes equitable nurse-patient assignments. *Official Journal of American Nurses Association*, 9(3), 1-4. Retrieved from <https://americannursetoday.com/wp-content/uploads/2014/03/ant3-Workforce-Management-Acuity-304.pdf>

Kramer, M., & Schmalenberg, C. (2004). Essentials of a magnetic work environment. *Nursing*, 34, 50-54.

Larkin, M., & Thompson, A. R. (2011). Interpretative phenomenological analysis in mental health and psychotherapy research. In D. Harper & A. R. Thompson (Eds.),

- Qualitative research method in mental health and psychotherapy: A guide for students and practitioners* (pp. 101-116). Chichester, UK: John Wiley & Sons.
- LaSala, C. A., & Bjarnason, D. (2010). Creating workplace environments that support moral courage. *The Online Journal of Issues in Nursing*, 15(3), manuscript 4. doi: 10.3912/OJIN.Vol15No03Man04
- Laschinger, H. K. S., & Fida, R. (2014) New nurses burnout and workplace bullying: The influence of authentic leadership and psychological capital. *Burnout Research*, 1, 19-28. <http://dx.doi.org/10.1016/j.burn.2014.03.002>
- Laschinger, H. K. S., Grau, A. L., Finegan, J., & Wilk, P. (2010). New graduate nurses' experiences of bullying and burnout in hospital settings. *Journal of Advanced Nursing*, 66, 2732–2742. doi: 10.1111/j.1365-2648.2010.05420.x
- Laschinger, H. K. S., Leiter, M., Day, A., & Gilin, D. (2009). Workplace empowerment, incivility, and burnout: Impact on staff nurse recruitment and retention outcomes. *Journal of Nursing Management*, 17, 302–311. doi: 10.1111/j.1365-2834.2009.00999.x
- Laschinger, H. K. S., Wong, C. A., & Grau, A. L. (2012). The influence of authentic leadership on newly graduated nurses' experiences of workplace bullying, burnout and retention outcomes: A cross-sectional study. *International Journal of Nursing Studies*, 49(10), 1266–1276. <http://dx.doi.org/10.1016/j.ijnurstu.2012.05.012>
- Limoges, J. & Jagos, K. (2015). The influences of nursing education on the socialization and professional working relationships of Canadian practical and degree nursing students: A critical analysis. *Nursing Education Today*, 35, 1023-1027. <http://dx.doi.org/10.1016/j.nedt.2015.07.018>

- Longo, J. (2007). Horizontal violence among nursing students. *Archives of Psychiatric Nursing, 21*(3), 177-178. doi:10.1016/j.apnu.2007.02.005
- Longo, J., & Sherman, R. O. (2007). Leveling horizontal violence. *Nursing Management, 38*(3), 34-37, 50-51. Retrieved from: www.nursingmanagement.com
- Lopez, K. A., & Willis, D. G. (2004). Descriptive versus interpretive phenomenology: Their contributions to nursing knowledge. *Qualitative Health Research, 14*(5), 726-735. doi: 10.1177/1049732304263638
- Mabrouk Abd El Rahman, R. (2014, April). *Perception of student nurses' bullying behaviors and coping strategies used in clinical settings*. Paper presented at the Sigma Theta Tau International on Nursing Education Research, Indianapolis, IN. Retrieved from <http://www.nursinglibrary.org/vhl/bitstream/10755/316820/1/Final+Submission+Perception+Of+Student+Nurses.pdf>
- Martin, D., & Weeres, A. (2012). *Retaining RPNs: Impact on quality care*. Hamilton, ON: Nursing Health Services Research Unit, McMaster University.
- Martin Saarinen, J. (2008). *Dominant discourses and ideologies that have shaped the education of registered nurses and licensed practical nurses in Canada* (Unpublished master's thesis). University of Victoria, Canada.
- McKenna, B. G., Smith, N. A., Poole, S. J., & Coverdale, J. H. (2003). Horizontal violence: Experiences of the registered nurses in their first year of practice. *Journal of Advanced Nursing, 42*(1), 90-96. doi: 10.1046/j.1365-2648.2003.02583.x
- Meadows, C., & Prociuk, J. (2012). Integrating licensed practical nurses into home care nursing: One health authority's journey. *Home Healthcare Nurse, 30*, 273-9.

- Melrose, S., Miller, J., Gordon, K., & Janzen, K. J. (2012). Becoming socialized into a new professional role: LPN to BN student nurses' experiences with legitimation. *Nursing Research and Practice*, 2012, 1-8. doi: 10.1155/2012/946063
- Miller, C., & Leadingham, C. (2010). A formalized mentoring program for LPN-to-RN students. *Teaching and Learning in Nursing*, 5(4), 149-153.
doi:10.1016/j.teln.2010.03.002
- Murray, J. S. (2009). Workplace bullying in nursing: A problem that can't be ignored. *MEDSURG Nursing*, 18(5), 273-276.
- O'Brien-Pallas, L., Tomblin Murphy, G., Laschinger, H., White, S., Wang, S., & McCulloch, C. (2005). *Canadian survey of nurses from three occupational groups*. Ottawa, ON: The Nursing Sector Study Corporation.
- Ontario Nurses' Association (ONA). (2006). Nurses at high risk of abuse— and worse. *Ontario Nurses Association Vision*, 33(1), 39.
- Ontario Nurses' Association (ONA). (2011). *RNs and RPNs—Room for both, so what's the issue?* Toronto, ON: Ontario Nurses Association.
- Ontario Nurses' Association (ONA). (2016). Registered nurse cuts hit Toronto hospitals: ONA president says “enough is enough”. Retrieved October 29, 2016 from https://www.ona.org/news_details.html?article_id=1129
- Oulton, J. A. (2006). The global nursing shortage: An overview of issues and actions. *Policy, Politics, and Nursing Practice*, 7(3), 34-39. doi: 10.1177/1527154406293968
- Palmer, R. (1969). *Hermeneutics*. Evanston: Northwestern University Press.

- Parzen, M. (2010). Personal investment in higher education. *College Quarterly*, 13(4).
Retrieved from: <http://collegequarterly.ca/2010-vol13-num04-fall/parzen.html>
- Pietkiewicz, I., & Smith, J. A. (2012). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Czasopismo Psychologiczne*, 18(2), 361-369.
- Purpora, C., & Blegen, M. A. (2015). Job satisfaction and horizontal violence in hospital staff registered nurses: The mediating role of peer relationships. *Journal of Clinical Nursing*, 24, 2286–2294, doi: 10.1111/jocn.12818
- Quine, L. (2001). Workplace bullying in nurses. *Journal of Health Psychology*, 6, 73-84.
- Randle, J. (2003). Bullying in the nursing profession. *Journal of Advanced Nursing*, 43(4), 395-401.
- Rapley, P., Davidson, L., Nathan, P., & Dhaliwal, S. (2008). Enrolled nurse to registered nurse: Is there a link between initial educational preparation and course completion? *Nurse Education*, 28(1), 115-119. doi:10.1016/j.nedt.2007.03.006
- Registered Nurses' Association of Ontario (RNAO). (2008). *Healthy work environments best practice guidelines: Workplace health, safety and well-being of the nurse*. Toronto, Canada: Registered Nurses' Association of Ontario.
- Registered Nurses' Association of Ontario (RNAO). (2015a). RN positions at risk. Retrieved April 6, 2016 from <http://rnao.ca/news/rn-positions-risk>
- Registered Nurses' Association of Ontario (RNAO). (2015b). Tell minister Hoskins to stop RN replacement. Retrieved April 6, 2016 from <http://rnao.ca/policy/action-alerts/tell-minister-hoskins-stop-rn-replacement>

- Registered Nurses' Association of Ontario (RNAO). (2017). RNAO says latest nursing stats reveal Ontario's RN workforce continues to decline. Retrieved August 14, 2017 from <http://rnao.ca/news/media-releases/2017/06/01/RN-workforce-decline>
- Registered Practical Nurses Association of Ontario [RPNAO]. (n.d.). History. Retrieved September 5, 2016 from <https://www.rpnao.org/about/history>
- Reiners, G. M. (2012) Understanding the differences between Husserl's (descriptive) and Heidegger's (interpretive) phenomenological research. *Journal of Nursing and Care* 1(5), 1-3. doi:10.4172/2167-1168.1000119
- Roberts, S. J. (1983). Oppressed group behaviour: Implications for nursing. *Advances in Nursing Science*, 5(3), 21-30.
- Roberts, S. J. (2015). Lateral violence in nursing: A review of the past three decades. *Nursing Science Quarterly*, 28(1), 36-41. doi: 10.1177/0894318414558614
- Robinson, M. (2009). *Knowledge and education at entry to nursing practice in Alberta*. KEP Steering Committee. Edmonton, AB: CARNA.
- Roche, M., Diers, D., Duffield, C., Catling-Paull, C. (2010). Violence towards nurses, and the work environment, and patient outcomes. *Journal of Nursing Scholarship*, 42(1), 13-22. doi: 10.1111/j.1547-5069.2009.01321.x
- Rocker, C. (2008). Addressing nurse-to-nurse bullying to promote nurse retention. *Online Journal of Issues in Nursing*, 13(3). doi: 10.3912/OJIN.Vol13No03PPT05
- Sauerland, J., Marotta, K., Peinemann, M. A., Berndt, A., & Robichaux, C. (2014). Assessing and addressing moral distress and ethical climate, part 1. *Dimensions of Critical Care Nursing*, 33(4), 234-245. doi: 10.1097/DCC.0000000000000050
- Savin-Baden, M., & Howell Major, C. (2013). *Qualitative research: The essential guide*

- to theory and practice*. Abingdon, Oxon: Routledge.
- Seymour, E., & Buscherhof, J. R. (1991). Sources and consequences of satisfaction and dissatisfaction in nursing: Findings from a national sample. *International Journal of Nursing Studies*, 28(2), 109-124. doi: 10.1016/0020-7489(91)90001-J
- Simons, S. (2008). Workplace bullying experienced by Massachusetts registered nurses and the relationship to intention to leave the organization. *Advances in Nursing Science*, 31(2), E48-E59. doi: 10.1097/01.ANS.0000319571.37373.d7
- Simons, S., & Mawn, B. (2010). Bullying in the workplace—A qualitative study of newly licensed registered nurses. *American Association of Occupational Health Nurses*, 58(7), 305-311. doi: 0.3928/08910162-20100616-02
- Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology and Health*, 11, 261-271. doi: 10.1080/08870449608400256
- Smith, J. A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology*, 1, 39-54. doi: 10.1191/1478088704qp004oa
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, research, practice*. London: Sage.
- Smith, J. A., & Osborn, M. (2003). Interpretative phenomenological analysis. In J.A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods*. London: Sage.
- Speziale, H. J. S., & Carpenter, D. R. (2007). *Qualitative research in nursing: Advancing the humanistic imperative* (4th ed.). Philadelphia: Lippincott Williams & Wilkins.

- Statistics Canada, Canadian Institute for Health Information, & Health Canada. (2005). *A summary of highlights from the 2005 national survey of the work and health of nurses*. Ottawa, ON: Canadian Institute for Health Information, Health Canada and Statistics Canada.
- Streubert, H. J., & Carpenter, D. R. (2011). *Qualitative research in nursing: Advancing the humanistic perspective* (5th ed.). Philadelphia, PA: Lippincott, Williams & Wilkins.
- Thomas, S. P. (2003). Horizontal hostility – nurses against themselves: How to resolve this threat to retention. *American Journal of Nursing*, 103(10), 87-88, 90-91.
- Varcoe, C., Doane, G., Pauly, B., Rodney, P., Storch, J. L., Mahoney, K., . . . Starzomski, R. (2004). Ethical practice in nursing: Working the in-betweens. *Journal of Advanced Nursing*, 45(3), 316-325.
- Vickers, M. (2006). Writing what's relevant: Workplace incivility in public administration- A wolf in sheep's clothing. *Administrative Theory & Praxis*, 28(1), 69-88. <http://www.jstor.org/stable/25610779>
- Vessey, J. A., Demarco, R. F., Gaffney, D. A., & Budin, W. C. (2009). Bullying of staff registered nurses in the workplace: A preliminary study for developing personal and organizational strategies for the transformation of hostile to healthy workplace environments. *Journal of Professional Nursing*, 25(5), 299-306. doi: 10.1016/j.profnurs.2009.01.022
- Vogelpohl, D. A., Rice, S. K., Edwards, M. E., & Bork, C. E. (2013). New graduate nurses' perception of the workplace: Have they experienced bullying? *Journal of*

Professional Nursing, 29(6), 414-422.

<http://dx.doi.org/10.1016/j.profnurs.2012.10.008>

Webb, C. (1992). The use of first person in academic writing: Objectivity, language and gatekeeping. *Journal of Advanced Nursing*, 17, 747-752. doi: 10.1111/j.1365-2648.1992.tb01974.x

Webster, G., & Baylis, F. (2000). Moral residue. In S. B. Rubin & L. Zoloth (Eds.), *Margin of error: The ethics of mistakes in the practice of medicine* (pp. 217-232). Hagerstown, M. D.: University Publishing Group.

Wheelan, S. A., Burchill, C. N., & Tilin, F. (2003). The link between teamwork and patients' outcomes in intensive care units. *American Journal of Critical Care*, 12(6), 527-534.

White, D., Oelke, N. D., Besner, J., Doran, D., McGillis Hall, L., & Giovannetti, P. (2008). Nursing scope of practice: Descriptions and challenges. *Nursing Leadership*, 21(1), 44-57.

Woelfle, C. Y., & McCaffrey, R. (2007). Nurse on nurse. *Nursing Forum*, 42(3), 123-131.

Yildirim, D. (2009). Bullying among nurses and its effects. *International Nursing Review*, 56, 504-511. doi: 10.1111/j.1466-7657.2009.00745.x

Young, I. M. (1990). Five faces of oppression. In I. M. Young (Eds.), *Justice and the Politics of Difference* (pp. 37-63). Princeton, NJ: Princeton University Press.

Yun, S. Y., & Kang, J. Y. (2014). Factors affecting workplace bullying in Korean hospital nurses. *Korean Journal of Adult Nursing*, 26(5), 553-562. doi: 10.7475/kjan.2014.26.5.553

Zuzelo, P. R. (2001). Describing the RN-BSN learner perspective: Concerns, priorities, and practice influences. *Journal of Professional Nursing, 17*(1), 55-65. doi:

10.1053/jpnu.2001.20252

Zuzelo, P. R. (2007). Exploring the moral distress of registered nurses. *Nursing Ethics, 14*(3), 344-359. doi: 10.1177/0969733007075870