Registered Nurses and Licensed/Registered Practical Nurses: A Description and Comparison of Their Decision-Making Process

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**Abstract**

In many parts of Canada, nursing care is provided by registered nurses (RNs) and licensed/registered practical nurses (L/RPNs). The profession, regulatory bodies and employers are struggling to define their similarities and differences in their attempts to ensure patients are receiving the right care by the right care provider. An understanding of the decision making of nurses presents one way of differentiating between their overlapping roles. Nursing decision-making is a complex cognitive process. Assessment occurs and problems are postulated. Possible alternatives,
with their risks and benefits, outcomes and likelihood of outcomes are identified. Preferences and values are considered, and an intervention is selected. The best way to implement an intervention is determined, implementation follows and evaluation takes place. In this research, a triangulated design was used to examine and compare the decision-making process of RNs and L/RPNs. Analysis revealed that nurses consider themselves to be frequently involved in elements that are part of the decision-making process. Nurses attribute the difficulty encountered to the context within which decision making occurs. Differences exist between the RN and L/RPN in the frequency of their involvement with most of the elements of the process. Differences in difficulty encountered with these elements were less pronounced.

Decision-making is integral to all aspects of patient care. It is a complex cognitive process, involving the selection of an intervention or action from one or more possible alternatives. Much of the research on nursing decision making has focused on the registered nurse (RN); little is known about decisions made by the licensed/registered practical nurse (L/RPN). In addition, much of the recent research has examined factors that influence decision making without looking at differences between these two categories of nurses. This paper presents the results of a study that included both RNs and L/RPNs. A triangulated methodology involving quantitative and qualitative methods was used. Data were collected from RNs and L/RPNs through a survey and focus-group interviews. This paper describes the decision making as reported by RNs and L/RPNs and compares the decision-making process described by these nurses.

**Background**

In Ontario, in the general class, nursing is one profession with two registration categories: the RN and the registered practical nurse (RPN). They are governed by the same regulatory body, practise within the same scope of practice and frequently work in similar settings. In some settings, their roles and responsibilities are shared; in other circumstances, they are distinct (College of Nurses of Ontario [CNO] 2005). Prior to 2005 and during the time the survey was administered, RN education consisted of either a two- or three-year college diploma program or a four-year baccalaureate degree. RPN education showed more variability, requiring a certificate obtained from either a college or high-school program (CNO 2001). In all other parts of Canada, what Ontario calls the RPN is referred to as the licensed practical nurse. Therefore, in the remainder of this paper, the acronym L/RPN is used to designate this nursing group.

The profession, regulatory bodies and employers are struggling to define the similarities and differences between these nurse categories in attempting to
ensure patients are receiving the right care from the right care provider. An aging workforce, changes in nursing education, fiscal constraints and nursing resource shortages contribute to the need for careful planning to ensure the appropriate and efficient use of our health human resources. Key differences between RNs and L/RPNs include educational preparation and subsequently the degree of professional autonomy. “Autonomous practice is the ability to make decisions and independently carry out nursing responsibilities” (CNO 2005: 4). An understanding of the similarities and differences in RN and L/RPN decision-making may help us further differentiate between these overlapping roles and ultimately improve patient care and outcomes.

**Nursing Decision-Making**

Nursing decision-making has long been recognized as essential to nursing practice and as a cornerstone of the nursing profession (Kataoka-Yahiro and Saylor 1994; Tanner et al. 1987). It is defined as the selection of an intervention or action from one or more possible alternative actions. In a nursing clinical context, the aim is to produce a desired outcome (Persut and Herman 1999). The decision-making process involves an individual engaging in a series of cognitive activities. Assessment occurs and problems are postulated. A number of possible alternatives, each with risks and benefits, outcomes and likelihood of outcomes, are identified. Consideration is given to preferences and values. An intervention or action is selected, and strategies through which to implement interventions are chosen (Boblin-Cummings et al. 1999). Implementation follows, and evaluation may or may not take place (Deber and Baumann 1992).

It is assumed that education influences decision-making, although research results have been contradictory. Prescott et al. (1987) found that education positively influenced decision making. Henry (1991) concluded that a positive relationship between education and decision-making has been validated. Shin (1998), when comparing the clinical decision-making of associate-degree and baccalaureate students, found that baccalaureate students had higher scores on clinical decision-making. Girot (2000), in a study comparing critical thinking and perceptions of decision-making skills of nursing students with those of non-academic practicing nurses, found that individuals exposed to advanced study were significantly better at clinical decision-making. These findings can be contrasted with the work of Pardue (1987), Lauri and Salantera (1995) and Hoffman et al. (2004), who found that education was not significantly related to decision-making.

Much of this research investigated the decision-making associated with baccalaureate education. No research has been reported to date that is relevant to the L/RPN or to differences between L/RPN and RN clinical decision-making. The research reported here was designed to address this issue.
Research Purpose
The results presented in this paper are findings from a larger study on nursing decision-making: Registered Nurse and Registered Practical Nurse Decision Making. The purpose of the study was to obtain from nurses their descriptions of their decision-making. These descriptions enabled a comparison of the decision making of RNs and L/RPNs. The decision-making model used for the study consisted of four components: (a) the decision-making process; (b) nursing actions and interventions, typically described according to the tasks nurses perform; (c) considerations prior to implementing, or the strategy decisions that nurses make; and (d) factors influencing decision-making. This paper presents the results of the research that addressed the first of these components: the process that nurses used to make decisions.

Research Design
Methods and approaches
A combination of quantitative (survey) and qualitative (focus groups) approaches was used. The survey identified decisions as described by RNs and L/RPNs, determined the frequency that RNs and L/RPNs made these decisions, and described the difficulty perceived when so doing. A comparison of RN and L/RPN responses was conducted to determine the influence of education. The study also investigated the influence of variables such as setting and experience on these decisions. The results of the survey were further explored through focus groups with nurses.

The survey instrument was modified from an earlier questionnaire, previously used in two surveys of nursing decision making (Baumann et al. 1992; Royle et al. 2000). The Decision-Making Instrument consists of four scales that represent the study model: (a) the Decision-Making Process (the results of which are reported in this paper); (b) Nursing Interventions and Clinical Activities; (c) Considerations Prior to Implementing; and (d) Factors Influencing Decision Making. Each scale consists of two sub-scales: frequency and difficulty. For frequency, a seven-point Likert-like scale was used, ranging from 1 (Never) to 7 (Extremely Frequently). For difficulty, response choices range from 1 (Extremely Easy) to 7 (Extremely Difficult). The Decision-Making Process scale consists of 11 items, which correspond to elements of the decision-making process. Cronbach’s alpha reliability coefficient was used to test the internal consistency of the scales and is reported in Table 1. Reliability for the total instrument was 0.95. Reliability for the Decision-Making Process scale was 0.92 for frequency and 0.94 for difficulty. Cronbach’s alpha for previous administrations of this instrument have not been reported. A reliability coefficient of 0.70 or above was considered acceptable (Nunnally 1978).
Descriptive statistics were calculated to determine the frequency and difficulty of nursing decision-making. Independent sample $t$-tests were used to examine the similarities in and differences between RNs and L/RPNs. Levene’s test for equality of variances was included. Descriptive statistics are reported as mean and standard deviation (SD). For the frequency of involvement, a response of 1 to 1.99 was considered to be “Never”; 2 to 3.5 was considered to be “Infrequently”; 3.6 to 4.4 was considered to be “Occasionally”; a response of 4.5 to 5.9 was considered to be “Frequently”; and a response of 6 to 7 was considered to be “Extremely Frequently.” Similarly, for questions on difficulty, a response of 1 to 1.99 was considered to be “Extremely Easy”; 2 to 3.5 was considered to be “Easy”; 3.6 to 4.4 was considered to be “Neither Easy nor Difficult”; a response of 4.5 to 5.9 was considered to be “Difficult”; and a response of 6 to 7 was considered to be “Extremely Difficult.”

Focus groups (FGs) were conducted to clarify survey results. A purposive sample of nurses was obtained. Members of the study’s Advisory Committee recom-
mended sites to contact. Nurses within the sites were asked to volunteer to participate. There was no attempt to include or exclude nurses who may have completed the survey. Homogeneous FGs were conducted with homogeneity maintained for education and setting. That is, setting-specific focus groups were conducted with either RNs or L/RPNs. A total of 17 FGs involving 87 nurses were conducted. Six FGs were conducted in Northern Ontario and 11 in Southern Ontario. Six were in AC, four in CH, four in LTC and three in PH. Five FGs were conducted with L/RPNs and 12 with RNs. A telephone interview with two diploma-prepared L/RPNs, one from Northern Ontario and one in Southern Ontario, was conducted. These nurses were recent graduates of the two-year diploma program, representing the change in educational requirements for the L/RPN in Ontario. This interview was conducted on the advice of the Registered Practical Nurses Association of Ontario.

The FGs used a semi-structured format. Open-ended questions were posed, such as: “The survey revealed that nurses reported less frequent involvement in ‘Considering the likelihood of outcomes’ as part of the decision-making process. Why do you think this is?” and “Nurses told us they were less frequently involved in planning programs, developing policy and marketing and advertising than other nursing actions or interventions. Can you help me understand this?” Probe questions were used as needed – for example, when speaking to nurses in PH: “Can you give me examples of nursing decisions you made in relation to planning programs, developing policy, and marketing and advertising?” Interviews were audio taped, transcribed verbatim and reviewed to ensure accuracy. Transcripts were stored in and accessed by N-Vivo (Richards 1999). An iterative approach involving a template analysis style (Crabtree and Miller 1999) was used to code and analyze the data. A beginning template based on the four components of the study model was used. Coding categories were added as they emerged from the data. Four research members coded the data independently, with each coder responsible for a component of the model. Codes were then applied to the data stored in N-Vivo, which then assisted with clustering data into themes. Member checking involved a process of “interweaving”: information from previous FGs was verified with nurses in subsequent interviews (Krefting 1991). Emerging findings were confirmed with members of the Advisory Committee and preliminary results were presented to nursing groups, such as the CNO, local hospital and community health organizations.

Research Ethics
Approval for this study was granted from the Hamilton Health Sciences/McMaster University Faculty of Health Sciences Research Ethics Board. For the FGs, the ethical approval process in place at participating agencies was used as an adjunct.
Findings

This paper describes the results for the first component of the model that guided the study: the decision-making process. Results are presented first for the frequency and difficulty described by nurses, followed by a comparison of RN and L/RPN decision-making.

Frequency and difficulty associated with the decision-making process

As is depicted in Table 2, nurses (RNs and L/RPNs combined) told us that they assessed the client or situation “Extremely Frequently” (Mean = 6.12; SD = 1.09). They were “Frequently” involved in the remaining elements of the decision-making process (Mean = 4.5–5.9). The next most frequent elements were identifying the problem, need or issue (Mean = 5.89; SD = 1.10) and considering the risks and benefits to the client (Mean = 5.74; SD = 1.14). The elements in which they reported that they were involved least frequently were “Considering your (the nurse’s) preferred alternatives” (Mean = 4.64; SD = 1.46), “Considering the risks and benefits to you, the nurse” (Mean = 4.97; SD = 1.51) and “Considering the likelihood of outcomes” (Mean = 5.29; SD = 1.27). According to the survey results, nurses considered their involvement in all elements of the decision-making process to be “Easy” (Mean = 2–3.5). Some elements, however, were less easy than others. As is illustrated in Table 2, the more difficult elements were related to identifying possible outcomes or consequences, and considering the likelihood of outcomes.

Similarities in and differences between the decision-making process used by RNs and L/RPNs

RNs and L/RPNs were similar in how frequently they considered two of the 11 elements of the decision-making process: considering the clients’ preferred alternatives and considering their own preferred alternatives. RNs and L/RPNs differed ($p < .05$) in the frequency of involvement for nine elements. As illustrated in Table 3, L/RPNs reported greater frequency than RNs for one element: “Considering the risks and benefits to you, the nurse.” RNs reported greater frequency than L/RPNs for eight elements: (a) assessing the client or situation; (b) identifying the problem, need, or issue; (c) identifying alternative courses of action; (d) identifying possible outcomes or consequences; (e) considering the likelihood of outcomes; (f) considering the risks and benefits to the client; (g) selecting an intervention or action; and (h) evaluating outcomes.

RNs and L/RPNs differed in the amount of difficulty described for two elements of the decision-making process. As is illustrated by Table 4, L/RPNs found it more difficult than RNs to: (a) identify the possible outcomes or consequences; and (b) select an intervention or action. There were no aspects found more difficult for the RN when compared with the L/RPN.
### Table 2. Decision-making process: frequency and difficulty

<table>
<thead>
<tr>
<th>Decision-Making Process Component</th>
<th>Frequency</th>
<th>Difficulty</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>( N )</td>
<td>Mean</td>
</tr>
<tr>
<td>Assessing the client or situation</td>
<td>1097</td>
<td>6.12</td>
</tr>
<tr>
<td>Identifying the problem, need, or issue</td>
<td>1099</td>
<td>5.89</td>
</tr>
<tr>
<td>Identifying alternative courses of action</td>
<td>1093</td>
<td>5.32</td>
</tr>
<tr>
<td>Identifying the possible outcomes or consequences</td>
<td>1095</td>
<td>5.47</td>
</tr>
<tr>
<td>Considering the likelihood of outcomes</td>
<td>1089</td>
<td>5.29</td>
</tr>
<tr>
<td>Considering the risks and benefits to client</td>
<td>1099</td>
<td>5.74</td>
</tr>
<tr>
<td>Considering the risks and benefits to you, the nurse</td>
<td>1063</td>
<td>4.97</td>
</tr>
<tr>
<td>Considering the clients preferred alternatives</td>
<td>1086</td>
<td>5.33</td>
</tr>
<tr>
<td>Considering your preferred alternatives</td>
<td>1064</td>
<td>4.64</td>
</tr>
<tr>
<td>Selecting an intervention or action</td>
<td>1092</td>
<td>5.65</td>
</tr>
<tr>
<td>Evaluating outcomes</td>
<td>1090</td>
<td>5.56</td>
</tr>
</tbody>
</table>

**Focus-group results**

The intent of the FGs was to help understand the results of the survey, and thus the interviews were guided by select questions arising from the survey results. When we spoke with nurses (RNs and L/RPNs) about the decision-making process generally, the elements of the process were confirmed. That is, the nurses described being engaged in a decision-making process similar to the one identified in the study’s model. They discussed assessment and identification of problems. They talked about interventions and the evaluation of outcomes. They talked about the importance of client preferences in the implementation of interventions, and the difficulty in considering client preferences given unit scheduling and family preferences. Discussions of nurse preferences reflected the advocacy role that nurses assume. Nurses discussed the strategy decisions they made. The identification of outcomes and the likelihood of outcomes were elements not
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Nurses varied in their ability to talk about their decision-making. Their language tended to parallel that used with the nursing process and did not include elements more aligned with decision-making. Baccalaureate-prepared RNs were more
forthcoming and articulate when talking about their decision-making process, followed by RNs with diplomas and then by L/RPNs. This was evident not only in the nature of their responses, but also by the number of probing questions required by participants to respond to questions about their decision-making.

Table 4. Decision-making process difficulty: a comparison of RNs and RPNs

<table>
<thead>
<tr>
<th>Decision-Making Process Component</th>
<th>Education</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>P-value (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessing the client or situation</td>
<td>RPN</td>
<td>414</td>
<td>3.15</td>
<td>1.178</td>
<td>.080</td>
</tr>
<tr>
<td></td>
<td>RN</td>
<td>676</td>
<td>3.02</td>
<td>1.213</td>
<td></td>
</tr>
<tr>
<td>Identifying the problem, need or issue</td>
<td>RPN</td>
<td>415</td>
<td>3.28</td>
<td>1.201</td>
<td>.79</td>
</tr>
<tr>
<td></td>
<td>RN</td>
<td>680</td>
<td>3.14</td>
<td>1.260</td>
<td></td>
</tr>
<tr>
<td>Identifying alternative courses of action</td>
<td>RPN</td>
<td>406</td>
<td>3.46</td>
<td>1.183</td>
<td>.216</td>
</tr>
<tr>
<td></td>
<td>RN</td>
<td>681</td>
<td>3.36</td>
<td>1.255</td>
<td></td>
</tr>
<tr>
<td>Identifying possible outcomes or consequences</td>
<td>RPN</td>
<td>411</td>
<td>3.53</td>
<td>1.196</td>
<td>.010</td>
</tr>
<tr>
<td></td>
<td>RN</td>
<td>680</td>
<td>3.33</td>
<td>1.236</td>
<td></td>
</tr>
<tr>
<td>Considering the likelihood of outcomes</td>
<td>RPN</td>
<td>409</td>
<td>3.51</td>
<td>1.142</td>
<td>.139</td>
</tr>
<tr>
<td></td>
<td>RN</td>
<td>678</td>
<td>3.40</td>
<td>1.235</td>
<td></td>
</tr>
<tr>
<td>Considering the risks and benefits to client</td>
<td>RPN</td>
<td>412</td>
<td>3.34</td>
<td>1.219</td>
<td>.156</td>
</tr>
<tr>
<td></td>
<td>RN</td>
<td>676</td>
<td>3.23</td>
<td>1.286</td>
<td></td>
</tr>
<tr>
<td>Considering the risks and benefits to you, the nurse</td>
<td>RPN</td>
<td>411</td>
<td>3.38</td>
<td>1.319</td>
<td>.209</td>
</tr>
<tr>
<td></td>
<td>RN</td>
<td>635</td>
<td>3.28</td>
<td>1.318</td>
<td></td>
</tr>
<tr>
<td>Considering the clients preferred alternatives</td>
<td>RPN</td>
<td>408</td>
<td>3.30</td>
<td>1.228</td>
<td>.331</td>
</tr>
<tr>
<td></td>
<td>RN</td>
<td>670</td>
<td>3.22</td>
<td>1.270</td>
<td></td>
</tr>
<tr>
<td>Considering your preferred alternatives</td>
<td>RPN</td>
<td>403</td>
<td>3.33</td>
<td>1.239</td>
<td>.136</td>
</tr>
<tr>
<td></td>
<td>RN</td>
<td>650</td>
<td>3.21</td>
<td>1.276</td>
<td></td>
</tr>
<tr>
<td>Selecting an intervention or action</td>
<td>RPN</td>
<td>407</td>
<td>3.43</td>
<td>1.318</td>
<td>.012</td>
</tr>
<tr>
<td></td>
<td>RN</td>
<td>678</td>
<td>3.23</td>
<td>1.276</td>
<td></td>
</tr>
<tr>
<td>Evaluating outcomes</td>
<td>RPN</td>
<td>411</td>
<td>3.28</td>
<td>1.275</td>
<td>.526</td>
</tr>
<tr>
<td></td>
<td>RN</td>
<td>671</td>
<td>3.33</td>
<td>1.327</td>
<td></td>
</tr>
</tbody>
</table>

Identification of outcomes and the likelihood of outcomes
Two of the specific FG questions addressed nurses’ involvement with the identi-
fication of outcomes and their consideration of the likelihood of outcomes. The survey analysis revealed that none of the elements of the decision-making process were involved “infrequently”; nor were any of the elements “difficult.” However, of the 11 elements, identifying possible outcomes and considering the likelihood of outcomes were elements considered the least easy. They thus warranted follow-up in the FGs. The survey results were echoed in the FGs. Regardless of the number and depth of probing questions, nurses rarely discussed the identification of outcomes or consideration of the likelihood of these outcomes. The decision-making model identifies these two elements as occurring as part of the selection of an intervention. In the FGs, the identification of outcomes appeared to be linked to evaluation following the selection and/or implementation of preferred interventions or actions. The consideration of the likelihood of these outcomes was not included in these discussions. The link to evaluation is seen in the following comment by an RN with a diploma working in CH in Southern Ontario:

Some of the outcomes could be: Was it cost effective how I dealt with this scenario? Did I use the appropriate supplies? Could I have done it a different way? Did it require this many visits? Could I have utilized some other team members? (SCHRND)

If outcomes were considered prior to selecting an intervention or action, this response was typically from an RN with a baccalaureate degree. As one baccalaureate-prepared nurse working in CH in Northern Ontario described:

I try to sit down with the client or caregiver and look at what their needs are, the areas where they’re declining certain services that put them at risk … To sit down and sort of talk about what are the outcomes if this is refused and to see if they, they fully understand what those outcomes will be if they refuse the service. (NCHRNB)

A second specific question asked of L/RPNs concerned the risk to them. Survey results had revealed that L/RPNs considered the risks and benefits to themselves more frequently than RNs. FGs revealed that L/RPNs considered risk according to client or environmental characteristics, the support they received to make decisions and balancing risk associated with client advocacy.

You get to a person’s home; what’s their driveway like, what’s their walkway like, what are their steps like? Is the door going to hit you … when you get in? Is there going to be a Doberman meeting you there? Are the kids going to come out and kick you, hit you, slap you? You’re in somebody else’s environment; you have no idea what you’re walking into most of the time. (SCHL/RPN)
We’ve also had nurses at risk, put at risk due to patients that become violent. We’ve had nurses that have had injuries. (NACL/RPN)

Let’s say you’ve been asked by an RN to give a certain medication. The first thing you’ll ask yourself is, “Is there an order?” So you’re going to give me an order. Sometimes the RN will say, “Okay, still go ahead and give it,” but then there still there’s no order. So it is a risk to yourself; you cannot proceed to give that medication without the doctor’s order. (SLTCL/RPN)

**Discussion**

This paper reports how RNs and L/RPNs describe their clinical decision making. Comparisons are made between these two categories of nurses. Results revealed that nurses (RNs and L/RPNs combined) consider themselves to be frequently involved in all elements of the decision-making process, with assessment being most frequent. The frequency of involvement in assessment is not surprising, given its importance in planning nursing care. Least frequent was their involvement in considering risks and benefits to themselves and considering their preferred alternatives. These elements are traditionally not considered part of the decision-making process. Work by Boblin-Cummings et al. (1996; 1999) revealed that in addition to identifying risks and benefits to the client and preferences of the client, the decision-making process also involves nurses’ consideration of risks and benefits to themselves and their preferences regarding alternative interventions. This finding supports the inclusion of these elements in this process. The decreased frequency of these elements in comparison to the other elements of the decision-making process is in keeping with the nurses’ focus on meeting the needs of the client rather than on the nurses themselves (CNO 2006).

Paralleling frequency, nurses found assessment the least difficult element of the decision-making process. The most difficulty was experienced with identifying possible outcomes and considering the likelihood of outcomes. These latter elements are essential if optimal interventions with the greatest likelihood of success are to be chosen. These findings might be explained by nurses’ familiarity with language associated with the nursing process model and their limited familiarity with elements more aligned with decision-making. Given the mean years of experience of the nurses completing the survey (Mean = 17.03; SD = 11.92), many of these nurses may have been educated during the 1980s, when the nursing process formed the basis for many curricula. According to Tanner (2006), it was during the 1980s that the nursing process gradually became synonymous with clinical decision-making and clinical
judgment. It formed the basis for much of nursing education and was used to drive nursing clinical practice, including nursing documentation. Nursing faculty relied on the nursing care plan, with its nursing process underpinnings as the primary method for teaching students clinical decision-making (Tanner 1986).

It might also be explained by a lack of formal attention paid to outcomes in clinical practice areas. There has been increasing attention over the past several years on linking outcomes with nursing interventions. The Nursing and Health Outcomes Project at the University of Toronto is a case in point (White et al. 2005). While nurse-sensitive outcomes have been identified, and research is demonstrating the link between nursing interventions and patient outcomes, it does not necessarily mean that nurses are aware of or focus on this element of the decision-making process in their nursing practice. This is an area where increased attention is warranted. Additionally, nursing systems are typically not set up to record outcomes that are nurse sensitive. As Doran et al. (2006) note, little information about the impact of nursing care is recorded in administrative databases. Nurses are thus not socialized to focus on these aspects of their decision making. As Doran et al. conclude, with training, nurses can provide accurate assessments of patient outcomes. This suggests that nurses can be educated to include the identification of outcomes as an integral part of nursing decision-making.

Survey results revealed that nurses found elements of the decision-making process easy, while nurses in the focus groups described the difficulty associated with decision-making. The elements of the decision-making process in and of themselves may be easy, and may account for nurses’ responses to the survey. Decision-making in the clinical environment must take into account the context in which the decision-making situation occurs (Tanner 2006). Decision-making difficulty may be influenced by task complexity (Corcoran 1986; Hughes and Young 1990) and environmental variables such as interruptions and work procedures (Hedberg and Larsson 2004).

These research results provide a way for differentiating between RNs and L/RPNs. The two categories of nurses are different in both frequency and difficulty for several elements of the decision-making process. RNs made decisions related to the majority of decision-making process elements more frequently than the L/RPN. This included assessment, problem identification, identification of alternative courses of action, identifying outcomes, considering the likelihood of outcomes, considering risks and benefits to the
client, selecting an intervention or action, and evaluating outcomes. Two of these elements were also reported as more difficult for the L/RPN: identifying possible outcomes or consequences, and selecting an intervention or action. These elements reflect the dynamic nature of nursing practice and the requirement that nursing care be responsive to changing status and client need. The increased frequency for RNs is likely related to the client population for whom care is provided, the setting within which RNs work, and the roles that are expected of them. In Ontario, the RN autonomously cares for clients regardless of complexity of care needs, predictability of outcomes or stability of the environment; in contrast, the L/RPN autonomously provides care for less complex clients with predictable outcomes in a more stable environment (CNO 2005). The more complex client, with more frequent changes in health status, may require more frequent decision-making. The increased difficulty of two elements may reflect the decreased involvement of the L/RPN in these elements. If the client is more stable, it is less likely that outcomes or interventions will change. If the nurse makes these decisions less often, it is likely that they will be more difficult. As complexity of care requirements increase, the need for the L/RPN to consult with the RN increases. L/RPNs can care for clients with moderately complex care needs when consultative resources are available (CNO 2005). Provision of the right care by the right provider requires consideration of these factors.

L/RPNs consider the risks and benefits to themselves more frequently than RNs do. Similar to the above, this finding is likely related to the client population for whom care is provided, the setting within which each works and the roles expected of the nurse. Historically, L/RPNs may have been more likely to be assigned clients with chronic debilitative conditions involving increased physical- and cognitive-care needs. Regardless of education level, this type of nursing care may increase the need for personal safety measures. Developing and supporting strategies to enhance nurse safety could also lead to a decrease in the amount of time needed to consider personal risks and benefits.

**Implications**

These findings provide a window into nurses’ perceptions of their decision-making. They also depict differences between the RN and L/RPN. Implications extend to nursing education and clinical practice. One area where this is most pronounced is in the identification of outcomes. Educators and administrators would we well advised to provide opportunities for nurses to enhance their skills in identifying outcomes so that nursing interventions can be planned with specific goals in mind. This might be
particularly so for the L/RPN, as the role of this nurse continues to expand. Organizations are encouraged to develop a language more aligned with decision-making, such as with documentation forms. Developing systems to record outcomes would also assist nurses to develop this skill.

As L/RPNs begin to care for clients with moderately complex care needs, they may benefit from additional education related to the interventions and outcomes for the specific client population with which they are working. In addition, they will need to continue to collaborate with an RN or other appropriate healthcare provider. Formal collaborative arrangements, such as assigning a ‘buddy,” may increase the opportunity for considering a range of client interventions and outcomes.

As organizations attempt to provide the right care by the right provider, consideration needs to be given to whether the decision-maker characteristics match the situation. This research revealed that RNs are more frequently involved in most elements of the decision-making process. This suggests that they are better equipped to make decisions where client complexity is increased. If the L/RPN is to be used in these situations, then organizational supports, such as the ability to consult with an RN, need to be in place.

**Conclusion**

Nursing decision-making is an essential component of nursing care. It is a complex cognitive process that is considered a cornerstone of nursing practice. Nursing practice in Ontario at the general level is provided by two classes of nurses: the RN and the L/RPN. This research described the frequency of and difficulty with elements of the decision-making process described by RNs and L/RPNs. Additionally, it compared the responses of these two categories of nurses to highlight their similarities and differences. The results increase our understanding of nursing decision making and suggest ways by which nursing practice can be enhanced.

**Limitations**

In this research, RNs and L/RPNs provided a description of what they consider themselves doing, which may or may not differ from what they actually do. Nurses may have over-inflated their responses in an attempt to portray themselves in a positive light (social-desirability bias). There were discrepancies between responses captured by the survey instrument and those revealed by the FGs. There may have been limitations to the survey instrument that accounted for these differences. Conversely, there may have
been problems with the collection and analysis of the FG data. Although adequate numbers of surveys were returned to support the statistical analyses, a response rate of 37% may limit the generalizability of the survey results.

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References


The function of leadership is to produce more leaders, not more followers.