ATHABASCA UNIVERSITY

ASSESSING THE REGULATION OF SELF-EMPLOYED NURSES IN THREE CANADIAN JURISDICTIONS

BY

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A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF NURSING

FACULTY OF HEALTH DISCIPLINES

ATHABASCA, ALBERTA

MARCH, 2022

Approval of Thesis

The undersigned certify that they have read the thesis entitled

ASSESSING THE REGULATION OF SELF-EMPLOYED NURSES IN THREE CANADIAN JURISDICTIONS

Submitted by

Natalie Thiessen

In partial fulfillment of the requirements for the degree of

Master of Nursing

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March 1, 2022

Acknowledgements

This project would not have been possible without several individuals. Firstly, I would never have taken this daring leap into the world of research if it had not been for Dr. Jennifer Stephens who recognized my passion and potential and reached out to challenge me with this opportunity. Since embarking on this path, I have grown both personally and professionally in ways I could never have dreamed of. Thank you!

I am indebted to Dr. Jennifer Stephens and Dr. Kathleen Leslie, my thesis co-supervisors for their time, guidance, encouragement, and dedication to this project. Your passion for nursing, your expertise, and your personal warmth and insights have been a guiding force that has kept me focused and grounded through the duration of this research and will spur me on to new and greater professional aspirations. I would also like to thank Dr. Roberta Heale for participating as an external committee member and challenging my interpretations with her wealth of experience.

I also would like to extend my gratitude to my support network made up of family, friends, and colleagues who have been a never-ceasing source of support and encouragement. Thank you for sharing in my passion and success, lifting me up in the setbacks and disappointments, and cheering me on to the very end. To my husband Rylan, you have walked this journey with me step-by-step and have sacrificed much so I can pursue my aspirations. Your unconditional support and quiet confidence in me have given me the strength I needed to make it to this incredible milestone.

Finally, I consider it an incredible honor to have been supported with recognition and funding as the recipient of Athabasca University's Excellence in Research and Graduate scholarships, a Canadian Institute of Health Research (CIHR) grant, and a Canadian Nurses Foundation (CNF) grant.

Abstract

Self-employed nursing creates new opportunities with increased autonomy to provide for the needs of Canadians using their unique skills, knowledge, and judgment in alternative settings, yet research demonstrates current provincial nursing regulation is inhibiting nurses in these roles. Using qualitative case study methodology, this research aims to examine how provincial regulation impacts self-employed nurses. The case study compares three provincial registered nurse regulatory bodies by analyzing publicly accessible documents to discover how regulatory actors and context impact the content and processes self-employed nurses engage in. The findings demonstrate specific contextual features and actors as having a significant impact on the regulation of self-employed nurses through their influence on content and processes. Right-touch regulation and other evidence-informed regulatory practices are identified as a facilitator of self-employed nursing regulation which represents a key finding of this research.

Keywords: nursing roles, regulation, self-employment, independent practice, qualitative, case study, Canada

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Acronyms and Key Terms

CARNA	College and Association of Registered Nurses of Alberta – as of January 2022 known as the College of Registered Nurses of Alberta (CRNA)
CCP	Continuing Competence Program
CCRNR	Canadian Council of Registered Nurse Regulators
CNA	Canadian Nurses Association
CNO	College of Nurses of Ontario
ED	Executive Director
HPA	*Health Professions Act* (Alberta)
ICN	International Council of Nurses
IOM	Institute of Medicine
LPN	Licensed Practical Nurse
NCSBN	National Council of State Boards of Nursing
NP	Nurse Practitioner
NPR-FIPP	Nurse Practitioner Regulation Framework Implementation Plan Project
PSA	Professional Standards Authority
RN(AAP)	Registered Nurse with Additional Authorized Practice
RHPA	*Regulated Health Professions Act*
RN	Registered Nurse

RPN	Registered Practical Nurse
QA	Quality Assurance program
SRNA	Saskatchewan Registered Nurses Association - as of November 2021 known as the College of Registered Nurses of Saskatchewan (CRNS)

Chapter 1. Self-Employed Nursing

Organizations such as the Canadian Nurses Association (CNA) (CNA, 2013), the International Council of Nurses (ICN) (Sanders & Kingma, 2012), the Institute of Medicine (IOM) (IOM, 2011), and the World Health Organization (WHO) (WHO, 2020) have all envisioned new roles for nurses that involve innovation, an extended scope of practice, and increased autonomy. These organizations assert that nurses are poised to meet the changing needs of health care, improve access and continuity of care for Canadians, and transform the health care system itself (IOM, 2011; National Expert Commission, 2012; Sanders & Kingma, 2012; Villeneuve & MacDonald, 2006). Current nursing roles have become largely defined by institutional employment which limits the advancement of nursing roles to better achieve these goals. Self-employment provides nurses with an opportunity to practice with increased autonomy to the extent of the scope of practice to provide innovative services to the public that improve health care access. In this way, self-employed nursing roles represent what the CNA, ICN, IOM, and WHO have envisioned the future of nursing to be, highlighting the importance of understanding and removing the barriers that inhibit nurses in these roles.

Background and Statement of Problem

The global pandemic that began in 2020 has exacerbated a chronic dissatisfaction with institutional nursing roles. Recent Canadian surveys estimate between 10% and 33% of nurses plan on or have already left the nursing profession as a result of the pandemic (Grant, 2021; Kalata, 2021; Taekema, 2021). Self-employment offers these nurses the opportunity to apply their unique skills, knowledge, and judgment in new and innovative self-directed roles. Despite representing a potentially attractive alternative for the many experienced nurses exiting the profession, currently less than 5% of nurses are self-employed in Canada (Government of

Canada, 2019) and less than 1% internationally (Sanders & Kingma, 2012). The international literature on self-employed nursing roles suggests this low uptake is related to a number of significant barriers including a resistance to new nursing roles, a lack of education and stable funding, and restrictive regulation practices. In Canada, one author found current provincial nursing regulation practices to be the most significant barrier to self-employed nursing roles (Stahlke Wall, 2011).

This research is particularly relevant due to events following the termination of health care providers who remain unvaccinated against COVID-19 in the fall of 2021. In British Columbia more than 4000 health care workers were on unpaid leaves from their positions within the public health care system, some of which have transitioned into self-employment and opened a wellness clinic (Lao, 2021; Letterio, 2021). Similar province-wide mandates are expected in other Canadian provinces as well (Lao, 2021). These events may trigger an increased interest and uptake of self-employed roles in Canada and reveal the importance of ensuring regulation of self-employed nurses is effective and rigorous to maintain the confidence and safety of the public.

Bachtel (2020) describes the unique opportunity created by the global pandemic of 2020 to make significant changes to existing regulatory practices that support more advanced nursing roles. Nurse practitioners in the United States have struggled with restrictive legislation that limited their role and effectiveness in many states across the country (Bachtel et al., 2020). With the sudden increase in need for health care access and provision, regulatory actors were motivated to make significant changes in many states to allow for fuller utilization of nurse practitioners in the delivery of health care (Bachtel et al., 2020). Bachtel (2020) suggests there is no better time to advocate for the expansion of the nursing role and the modernization of nursing regulation as professional groups and political leaders seek to meet the unprecedented needs of

public health. Perhaps a similar window of opportunity to alter regulatory practices will become available in Canada as the nation and the nursing profession face an impending loss of a significant portion of their nursing workforce.

Purpose

The purpose of this research project has been to examine how and why self-employed nurses are uniquely impacted by regulatory practices. Furthermore, this research was undertaken with the intention to facilitate the effective regulation of self-employed nursing roles in Canada by supporting provincial nurse regulatory bodies and self-employed nurses in understanding the different ways in which self-employed nurses are regulated across jurisdictions and highlighting practices that can be improved.

Research Questions

Nursing regulation is complex and contextual. These qualities require regulatory practices be examined as part of their larger environment to more fully understand how and why self-employed nurses are impacted. The overarching research question driving this project is: **How does provincial nursing regulation impact self-employed nurses in three Canadian provinces?**

Additional research questions are as follows:

- Who are major regulatory actors and how do they influence the content and processes impact self-employed nurses?
- What are the distinct regulatory contextual features and how do they influence the content and processes self-employed nurses engage with?
- Which regulatory content and processes have a specific impact on self-employed nursing practice? Why?

I used qualitative case study to complete an in-depth contextual analysis of multiple provincial nurse regulatory bodies that has provided unique and critical insight around the aspects of regulation that significantly impact self-employed nurses.

Definition of Terms

The following concepts will be referred to throughout the proposal:

- Self-employed nurse - This term refers to a nurse who practices independently, in partnership, or as an employer of others (CARNA, 2019e) with the purpose of applying their nursing knowledge, skills, and judgment in roles that enable individuals, families, groups, communities or populations to achieve optimum levels of health in any domain of nursing practice (SRNA, 2021c). The term nurse can refer to any regulated nursing professional including licensed practical nurses (LPNs), registered practical nurses (RPNs), registered psychiatric nurses (RPNs), nurse practitioners (NPs), and nurse midwives.
- Provincial nurse regulatory body – A regulatory body, also known as a regulatory college in many Canadian jurisdictions, is an organization empowered by legislation to protect the safety and interest of the public by promoting competent practice, preventing unsafe practice, and intervening in cases of misconduct or malpractice (Almost, 2021). The organization is directed by a council and committees made up of an elected or appointed group of nurses and public members who are responsible for establishing registration requirements, articulating, monitoring, and enforcing standards of practice, addressing professional misconduct, and accrediting nursing education programs (Almost, 2021).
- Registrants – This term refers to the group of nurses that are registered with and regulated by a single provincial nurse regulatory body. Several provinces are moving away from the term “member” and using “registrant” instead to convey their representation of the public

interest more clearly. The term “registrant” is used throughout this document for the purpose of clarity and consistency.

Thesis Structure

This chapter introduced the purpose of the study which is to assess the regulation of self-employed nurses and the factors that influence those regulatory practices in three Canadian jurisdictions.

Chapter 2 provides a review of the literature focused on nurse regulation practices in Canada. Additionally, the second chapter provides a review of regulatory contextual features drawn from the literature review including legislative frameworks, organizational mandates, and governance.

Chapter 3 is an overview of relevant theoretical frameworks including the open systems theory as it relates to nurse regulatory bodies, a new conceptual model adapted from health policy analysis models, and the scope of practice framework.

Chapter 4 is a description of the chosen methodology inclusive of the steps used to conduct this study. Additionally, the methods used to protect and enhance the credibility of the research are included.

Chapters 5, 6, and 7 provide the results of the individual cases including the College of Nurses of Ontario (CNO), the College and Association of Nurses of Alberta (CARNA), and the Saskatchewan Registered Nurses Association (SRNA).

Chapter 8 is a cross-case comparison and discussion of key findings.

Chapter 9 includes practice implications, limitations, directions for future research, and the conclusion.

Chapter 2. Review of the Literature

This chapter begins with a review of the literature specific to the impact of nursing regulation on self-employed nursing roles in Canada. The second half this chapter provides an overview of the various contextual features included in the literature that are identified as being potentially influential in the regulation of self-employed nurses.

A review of the literature began with a very broad and extensive search of five databases for peer reviewed articles of all types from all geographic regions published after 2010 to understand the barriers that inhibit the uptake of self-employed nursing roles. There is a general paucity of primary research and theoretical frameworks guiding this field of study. The literature pertaining to self-employed nursing has a wide geographic representation including primary research from Brazil, Turkey, the United States, Canada, Australia, Iran, Finland, and South Korea. The primary research pertaining to self-employed nursing focuses on a variety of topics including the presence of personal entrepreneurial characteristics in nurses and nursing students (Costa et al., 2013; da Paixão Silva et al., 2017; Dehghanzadeh et al., 2016; Ekin & Gungormus, 2019; Eminoglu & Gungormus, 2019; Ispir et al., 2019; Jahani et al., 2018; Leblebicioglu et al., 2018; Lomba et al., 2018; Nurluoz & Esmaeilzadeh, 2019), entrepreneurial education, knowledge, and skill (Backes et al., 2015; Cadmus et al., 2017; Ribeiro Lima et al., 2019; Salminen et al., 2014), the effect of self-employed nurses on access to health care (Currie et al., 2016, 2018, 2019), and the experiences of self-employed nurses and the identification of barriers (Brooks, 2019; Chagas et al., 2018; Dumouchel et al., 2015; Hunter et al., 2021; Jahani et al., 2016; Kirkman et al., 2018; Lyden et al., 2018; Richter et al., 2019; Sharp & Monsivais, 2014; Silva et al., 2019; B. L. Smith, 2016; Stahlke Wall, 2011, 2018; Vannucci & Weinstein, 2017; Waite, 2019; Wong, 2015).

The international literature highlights several significant barriers that inhibit the uptake or success of self-employed roles. The literature demonstrates a pervasive perception of a lack of acceptance of or resistance to self-employed roles from the public (Colichi et al., 2019; Jahani et al., 2016; Wall, 2013b, 2014), nursing colleagues (Colichi et al., 2019; Silva et al., 2019; B. L. Smith, 2016), and other health care professionals (Arnaert et al., 2018; Hourahane et al., 2012; Jahani et al., 2016; Silva et al., 2019; Wall, 2013b; Wilson et al., 2012). Additionally, self-employed nurses are inhibited by a lack of educational preparedness (Arnaert et al., 2018; Cadmus et al., 2017; Chagas et al., 2018; da Paixão Silva et al., 2017; Dehghanzadeh et al., 2016; Jahani et al., 2016; Salminen et al., 2014; Sharp & Monsivais, 2014; Silva et al., 2019). The international literature also points to a lack of stable funding options as having a significant impact on self-employed nurses (Cadmus et al., 2017; Chagas et al., 2018; Colichi et al., 2019; Currie et al., 2016; Dehghanzadeh et al., 2016; Hains et al., 2018; Jahani et al., 2016; B. L. Smith, 2016; Wall, 2013b; Wilson et al., 2012; Wong, 2015). Finally, aspects of nursing regulation are highlighted as inhibitors of self-employed nursing roles (Cadmus et al., 2017; Colichi et al., 2019; Hunter et al., 2021; Jahani et al., 2016; Lyden et al., 2018; B. L. Smith, 2016; Stahlke Wall, 2011, 2018).

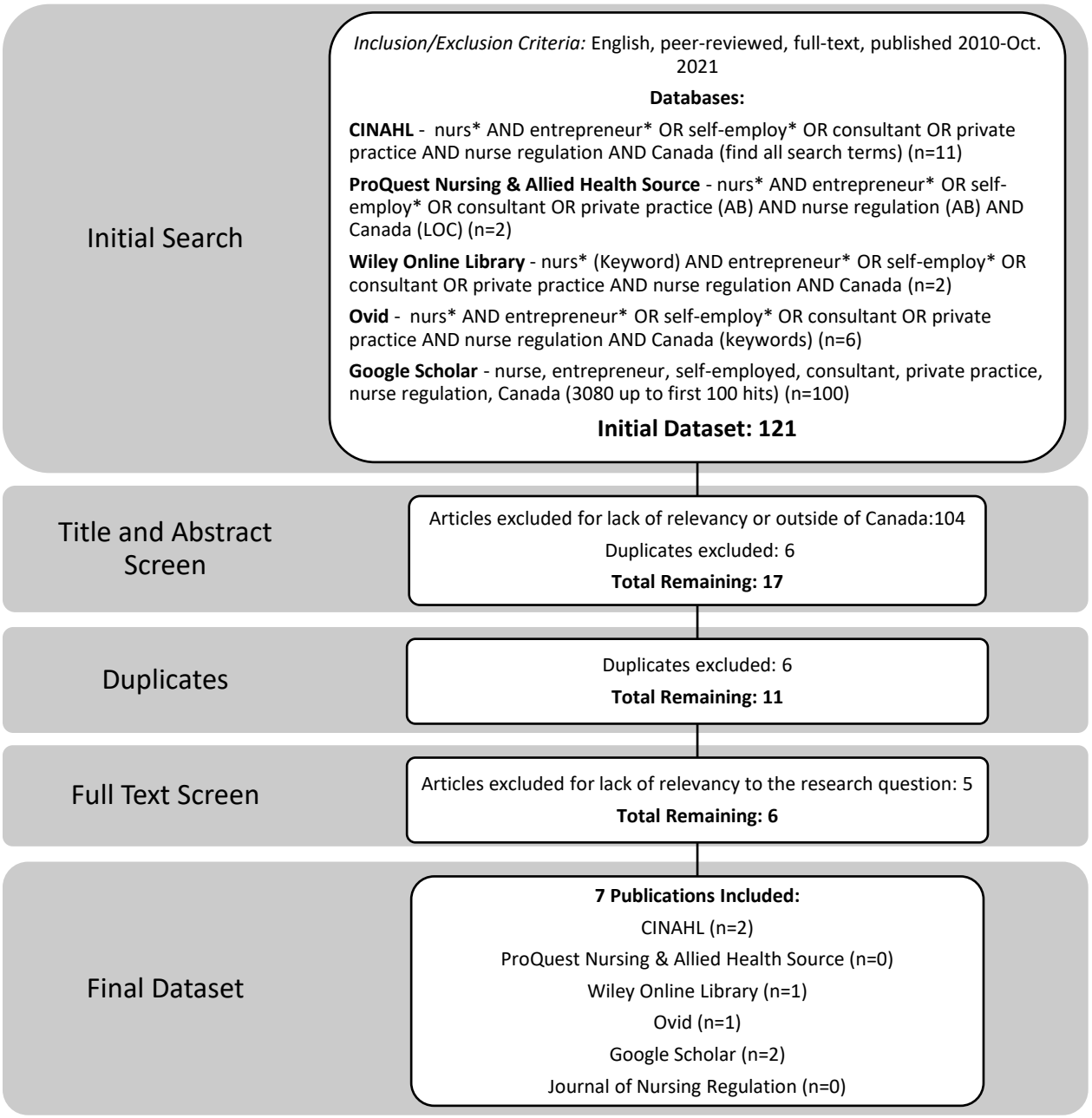
Search Strategy

This initial broad review of the international literature provided a foundation for a secondary, more focused review of the literature to further develop an understanding of the impact of current provincial regulatory practices on self-employed nurses in Canada. This focused search included five databases including the Cumulative Index of Nursing and Allied Health Literature (CINAHL), ProQuest, Wiley, Ovid nursing and allied health, and Google Scholar up to the first 100 results. The search included Canadian peer-reviewed primary research

articles published in English between 2010 and October 2021 with full-text availability. Searches in each database included the following terms: entrepreneur* OR self-employ* OR private OR consult*, nurs*, nurs* regulat*, and Canada. Collectively, these searches resulted in a total of 121 articles. During an assessment of titles and abstracts, 104 of these articles were excluded due a lack of relevancy to the research question. Most of the articles did not focus on self-employed nursing or the impact of nursing regulation on this role. Additionally, despite limiting the search to Canada, many of the articles, particularly on Google Scholar were from outside of this geographic region and were therefore excluded. Of the 17 articles that remained, an additional six were excluded as duplicate results, leaving 11 for full text review. During the full text review, an additional five articles were excluded because they did not provide insight into the impact of regulation on Canadian self-employed nurses. In an additional attempt to find articles related to the topic of study, the I conducted a directed search of the Journal of Nursing Regulation but was unable to find any results related to self-employed nursing. As a result, six articles are included in the literature review, four of which report on the same study. Therefore, the final dataset includes the findings of three primary studies, two by the same author.

Figure 1

Search Strategy Flowchart



Results

There is a dearth of literature pertaining to self-employed nursing in Canada and the regulatory environment they practice within, although the topic has been pursued by two

Canadian scholars. In 2011, Wall (also published as Stahlke Wall) completed a focused ethnographic study designed to explore the experience of 20 Canadian self-employed nurses from a single province. Based on this primary research, Wall published four separate articles each focusing on a distinct angle of her research (Wall, 2010, 2013b, 2013a, 2014). A few years later, Smith (2016) completed her master's thesis using interpretive description to better understand the factors limiting the uptake of self-employed nursing in Canada. Smith's (2016) research incorporated two phases, the first consisted of interviews with 11 nurse entrepreneurs from across Canada while the second was based on informal interviews with six Canadian nurse leaders, seeking their insights and recommendations regarding the findings from phase one. Both these scholars found nurse regulatory processes to be a significant barrier to self-employed nurses in Canada (B. L. Smith, 2016; Stahlke Wall, 2011) which led Wall (2018) to pursue this issue in more depth using interpretive description to explore the effects of provincial regulatory processes on the experiences of eight Canadian self-employed nurses from a single province.

The topic of nursing regulation is complicated by the various regulatory contexts found across Canada, as each province represents a distinct regulatory jurisdiction which is governed by separate legislation, regulatory models, and frameworks (Canadian Nurses Association, n.d.). In her research, Wall (2014) found regulatory requirements to be the most significant stressor for the self-employed nurses she interviewed, however, all the research participants were situated within a single province, representing a single regulatory context. The participants in Wall's second study (Stahlke Wall, 2018) are also from a single province and while the location is not identified, could presumably be the same locale as the first. While the participants in Smith's (2016) study also reported certain regulatory processes to inhibit their practice, it was to varying degrees, perhaps due to their varying geographic locations across Canada, representing the

impact of multiple regulatory jurisdictions. There is currently no published literature investigating the differences between the various regulatory contexts within Canada and how they distinctly impact the regulation of nurses in each provincial jurisdiction, especially in terms of a role such as self-employed nursing that be subject to additional regulatory requirements due to a lack of employer oversight.

Regulatory Barriers Inhibiting Self-Employed Nurses

The studies by Wall (Stahlke Wall, 2011, 2018) and Smith (2016) have identified several specific regulatory practices that they perceive inhibit self-employed nursing practice. These identified regulatory barriers include the operational definition of nursing practice, practice hours and recognition of nursing practice application processes, the peer feedback aspect of the continuing competency program, nursing practice audit processes, and practice consultation services. Specifically, the participants in these studies (B. L. Smith, 2016; Stahlke Wall, 2018; Wall, 2013a, 2013a, 2014) perceived regulatory processes to be restrictive, unsupportive, complex, inconsistent, lacking transparency, time-consuming, and disproportionate which has led to feelings of mistrust, powerlessness, and fear of the regulator.

Discussion

In her research, Wall (2013b) found regulatory barriers to be the most significant to self-employed nurses in Canada. While specific aspects of regulatory content and processes are identified as inhibitors of self-employed nursing roles, the authors do not assess the correlating regulation to corroborate these findings. In her article, Wall (Stahlke Wall, 2018) states “there has been little investigation of the impacts and consequences of existing professional regulatory practices on nurses and nursing” (p. 2) demonstrating the need for such a study. My research will further explore the identified barriers by assessing the regulatory actors, context, content, and

processes to more fully understand how and why nursing regulation may inhibit self-employed nurses and how this role might be more effectively regulated. Additionally, most of these findings pertain to a single provincial regulatory jurisdiction so further comparison between provincial nurse regulatory bodies is needed to determine whether self-employed nurses are affected similarly across jurisdictions.

Overview and Discussion of Regulatory Contextual Features From the Literature Review

The literature review highlighted several contextual features that may influence the regulatory content and processes affecting self-employed nurses. In her article, Wall (Stahlke Wall, 2018) discusses provincial legislative frameworks, the adoption of a single or dual mandate, and more indirectly, the regulatory governance structure as having the potential to influence self-employed nursing practice. It is important to note this list is not inclusive of all potentially influential regulatory contextual features but provides initial insight into how and why self-employed nurses might be regulated differently across jurisdictions.

Legislative Framework

Provincial nurse regulatory bodies across Canada are empowered and directed by one of two styles of legislative frameworks. The first is a profession-specific legislation which exclusively directs the regulation of a single health provider group. The second style is what is called umbrella legislation which provides a standardized framework directing the regulation of many health care provider groups including nurses. So far British Columbia, Alberta, Manitoba, Ontario, Quebec, and Prince Edward Island have enacted this style of umbrella legislation (Government of Alberta, 2021b; Regulated Health Professions Act, 1991; Regulated Health Professions Act, 1988; Code des professions, 1973; Province of British Columbia, 1996; Province of Manitoba, 2009). Umbrella legislation is accompanied by a profession-specific act or

regulations specific to each regulated group including a list of "restricted activities" or "controlled acts" that is included within each professions' scope of practice. These specific activities are not reserved for one profession but allows for overlapping scopes of practice between provider groups. Within the standardized framework provided by the umbrella legislation in Canadian provinces, each profession has an independent regulatory body that maintains its own staff, collects their own fees, and manages their own finances. Some provincial nurse regulatory bodies, such as those Ontario, Quebec, and British Columbia have begun to consolidate the regulation of different nursing groups. For example, the British Columbia College of Nurses and Midwives (BCCNM) regulates LPNs, RPNs, RNs, NPs, and midwives (British Columbia College of Nurses & Midwives, 2021a) while most other nurse regulatory bodies across the country regulate these groups separately (Almost, 2021).

Wall (Stahlke Wall, 2018) opines the umbrella legislation style may be a facilitator of self-employed nursing by "provid[ing] the latitude necessary for innovative role development" (p. 2). To present an opposing view, umbrella legislation frameworks can be very detailed and directive which may limit the agility of nurse regulatory bodies in adapting content and processes that disproportionately impact self-employed nursing practice. In comparison, profession-specific legislation can be more general and less directive which may provide the required agility to review and revise regulatory processes through changes to the bylaws.

There are numerous models with which legislation and regulation can be enacted which makes it challenging to find applicable studies that address this topic. In two separate studies, Benton et al. (2016; 2013) analyze the performance of umbrella and independent nursing boards, but this umbrella model refers to a consolidated entity that shares staff, resources, and processes across several professions. While the findings of these studies do not provide insight into the

effectiveness or impact of the umbrella legislative framework when compared to profession-specific legislation in Canadian provinces, they may apply to those regulatory bodies that govern more than one nursing group. Benton et al. (2016) found independent regulatory bodies have increased levels of autonomy which may allow increased agility to apply regulation more proportionately. Considering this, self-employed nursing roles may be better facilitated in provinces that regulate nursing groups separately. Further comparative studies are required to ascertain the impact these different contextual features have on regulation and the practice of nurses.

Organizational Mandate

The nursing profession is supported by four pillars: regulation, association, the union, and education (Almost, 2021). The regulation pillar represents the mandate to protect the public from unsafe nursing practice (Almost, 2021). The association pillar represents the mandate to protect and advance the interest of the profession (Almost, 2021). The third pillar is the union which represents a socio-economic mandate (Almost, 2021). These pillars are incorporated in different arrangements in regulatory bodies around the world, but most commonly the pillars are represented by separate organizations (Benton et al., 2017). Historically, Canadian provincial nurse regulatory bodies operated with a dual mandate by representing the regulatory and association pillar in a single organization (Almost, 2021). Over the last several years, these provincial nurse regulatory bodies have either chosen or been directed through legislative change to split the two pillars into separate organizations to wholly commit to a single mandate to protect the public (Duncan et al., 2015; Stahlke Wall, 2018). Currently, some of the last provincial regulatory bodies with a dual mandate are in the midst of transitioning to a single mandate (CARNA, n.d.k; SRNA, 2020f).

Wall (Stahlke Wall, 2018) suggests the single regulatory mandate to protect the public may influence nurse regulatory bodies to act in a way that is risk averse. According to Wall (Stahlke Wall, 2018), self-employed nursing roles are less familiar and challenge the rules, norms, and values of the profession causing regulatory bodies to perceive these roles as a risk. Wall (2014) states "conservative regulatory practices and nursing self-employment are threats to each other" (p. 527). If one considers a mandate to protect the public to equate with more conservative regulatory practices, Wall (2014) may be suggesting single mandate organizations are more likely to inhibit self-employed roles. An opposing perspective, however, is that the attempt to balance two potentially conflicting mandates inhibits the regulatory body from fully pursuing either. Perhaps a separate association could allow for stronger advocacy for self-employed nursing roles and the advancement of the profession. Additionally, a single mandate regulatory organization may reduce confusion and frustration for registrants by providing clarity as to its organizational goals.

As provincial nurse regulatory bodies transition to a single mandate, the association is removed from their operations and must begin again as a separate entity. Suddenly losing established nursing associations across the country over the last few years may have a profound effect on the strength of nursing advocacy and the advancement of professional interests in Canada (Duncan et al., 2015). The collective voice of Canadian nurses is likely further diminished through the separate association of individual groups of registered nurses, nurse practitioners, nurse midwives, registered psychiatric nurses, and licensed practical nurses in each province. While considering the influence and strength of the professional voice is beyond the scope of this study, assessing the state of nursing associations is critical to better understand the

current position of the nursing profession and its capacity to successfully advocate for the growth of self-employed roles in Canada.

Governance

Related to the mandate to protect the public, some Canadian provincial nurse regulatory bodies are participating in regulatory trends by changing the make up of council and committees to establish more equal public and professional representation (Benton, 2011). Furthermore, some provincial nurse regulatory bodies are subject to increasing levels of government oversight (Leslie, 2017), corresponding with trends in the greater regulatory environment (Benton, 2011). Wall (Stahlke Wall, 2018) states regulators have become "caught up in the general society's high level of anxiety about risk" (p. 7) and respond by acting conservatively and increasing surveillance out of "fear" of losing the privilege of regulation. Rather than reacting out of fear, it may be that these regulators are committed to their delegated role to protect the public rather than professional interests in the context of changing societal expectations. Perhaps as Wall (Stahlke Wall, 2018) suggests, decreased professional representation on council and committees and an increased commitment to protection of the public interest will make regulators more resistant to and surveillant of new roles. An alternative perspective might suggest these changes to regulatory governance may instead allow for fresh public perspectives that are not embedded within the traditional understanding of the nursing role who may be more open to less familiar roles that positively impact the health of Canadians.

Conclusion

Self-employed nursing is an important avenue by which nurses may use their disciplinary knowledge, skills, and judgment to provide much needed care to Canadians outside the purview of the institutional health care system, yet studies have demonstrated this role is significantly

inhibited by some regulatory practices. Specifically, the operational definition of nursing practice, required practice hours and recognition of nursing practice application processes, the peer feedback and audit aspects of the continuing competency program, and practice consultation services have been identified as having a significant impact on self-employed nurses. Regulatory content and processes such as these are influenced by the environment in which they are created. Contextual features such as the style of legislative framework, the organizational mandate, and the governance structure were identified in the literature as having a potential influence on self-employed nurses through their impact on regulatory content and processes. There is a general paucity of research on the individual impact of these contextual features on regulation practices and registrants. Even more scarce are peer-reviewed articles addressing the role of self-employed nurses in Canada and how that role is impacted by provincial nurse regulation. The purpose of this study is to investigate how provincial regulatory environments including its contextual features and actors uniquely impact the regulatory content and processes affecting self-employed nurses.

Chapter 3. Theoretical Framework

Theoretical frameworks supporting the study of the impacts of nursing regulation are scarce, demonstrating a significant need to build theory through research in this field. While not specific to regulation, open systems theory offers unique insight into how nurse regulatory organizations function within and respond to their environment. Additionally, several policy analysis models provide insight into how key concepts inter-relate which informed an adapted model that guided this study. Finally, a scope of practice framework provides rationale for why the self-employed nurse might be regulated in a way that is distinct from institutionally employed registrants.

Open Systems Theory

One theory that applies to the focus of this study is open systems theory. Open systems theory provides a framework with which to understand, study, and manage organizations that interact with their environment. Nurse regulatory bodies are organizations that interact with environmental forces through inputs and outputs which aligns with this theory. The open systems theory can apply to diverse organizations and has been previously used to study and describe the system of nursing services delivery (Meyer & O'Brien-Pallas, 2010) and trends in nursing regulation (Benton, González-Jurado, Beneit-Montesinos, et al., 2013).

This organizational theory opposes linear models that suggest organizations operate within individual "silos", recognizing organizations interact with and are influenced by their environment (D. C. Benton et al., 2013). An open system organization receives inputs from the external environment in the form of energy, information, and resources or funding (Katz & Kahn, 1978). Inputs are received by the organization where they are rearranged and transformed by interrelated supra- and sub-systems into to outputs (Katz & Kahn, 1978). Suprasystems are

characterized organizational type, size, location, structure, and ideology otherwise described as the shared norms or values of the organization (Katz & Kahn, 1978). The subsystems carry out the work of the organization and are often specialized and arranged in a hierarchy (Katz & Kahn, 1978). The managerial subsystem directs the work of all the interrelated subsystems to achieve a common goal (Kast & Rosenzweig, 1972).

Outputs in the form of products and services are part of an ongoing negative feedback cycle that informs the organization or the original inputs if the outputs are effective (Katz & Kahn, 1978). Additionally, open systems theory operates on the principle of "equifinality" in which different organizations can achieve similar outcomes despite a variety of inputs, supra- and subsystems suggesting there are multiple ways an organization can be structured and still achieve the desired outcome (Kast & Rosenzweig, 1972; Meyer & O'Brien-Pallas, 2010).

Figure 2

Open Systems Theory Applied to Provincial Nurse Regulatory Organizations and Their Impact on Self-Employed Nurses

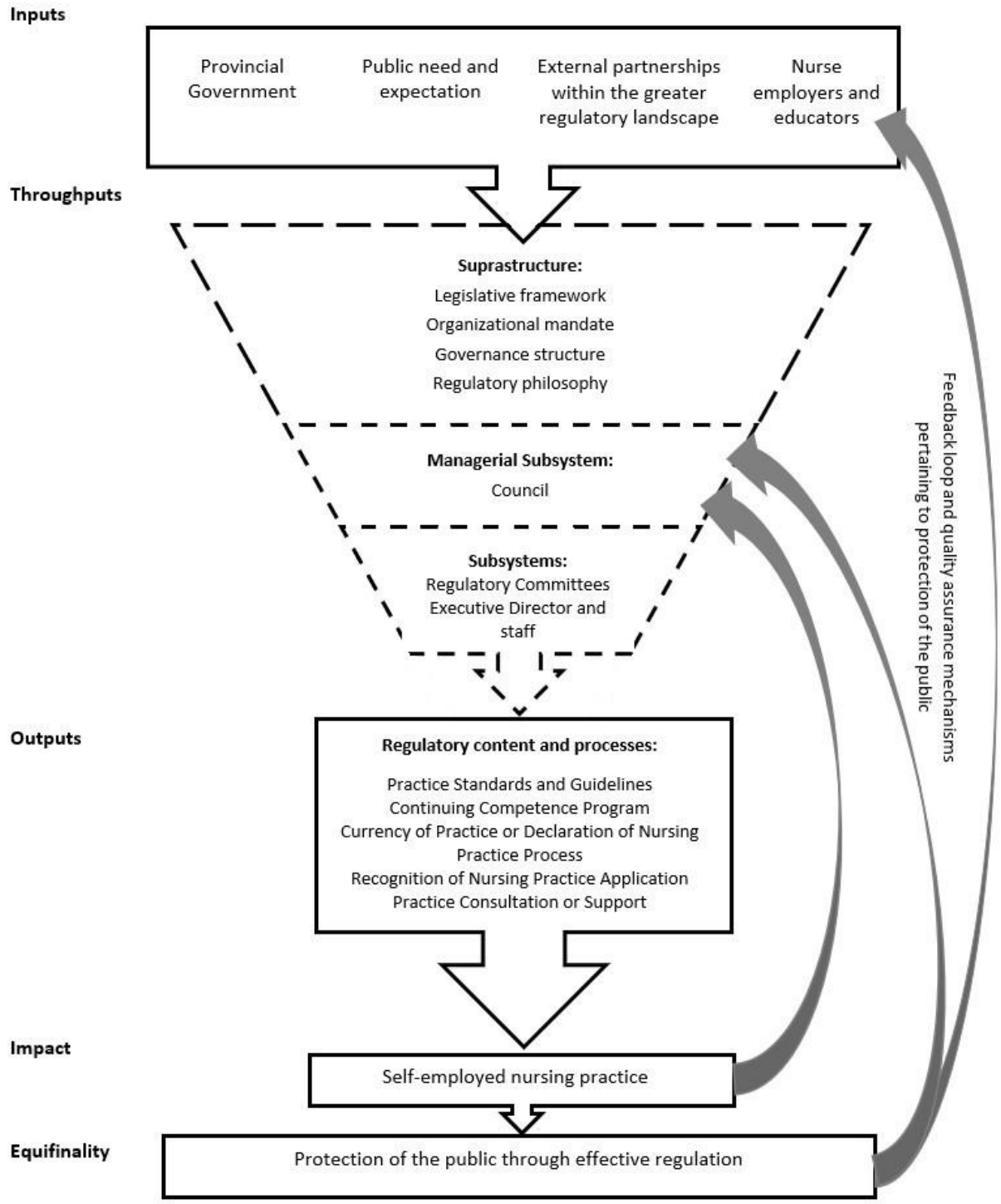


Figure 2 demonstrates how open systems theory can be applied to the provincial nurse regulatory bodies included in the study. In the context of this case study, inputs into the provincial nurse regulatory body are represented by government, the public, employers, nurse educators, and partnerships within provincial, national, and international spheres. Each of these stakeholders are responsible for sharing key information with the regulatory body so the organization can best regulate nurses in the public interest.

These inputs are received by the regulatory organization which is made up of an interrelated suprastructure and subsystems. The overarching organizational suprastructure is represented by the legislative framework, organizational mandate, the number and type of registrants, the governance structure, mandate, and regulatory philosophy that direct the function of the rest of the organization. The managerial subsystem in provincial nurse regulatory organizations is represented by the council. Under their direction, there are additional subsystems including regulatory committees and the executive director and staff that work together to respond to and translate inputs and feedback into appropriate outputs.

The outputs of nurse regulatory bodies are the content and processes they produce to facilitate the regulation of nurses in the public interest. In this case study, the outputs are considered to have a direct impact on self-employed nurses whose practice affects the public. These outputs are connected to a negative feedback loop so when the outputs are not effective in achieving the goal of protecting the public, feedback from external reviews, surveys, government reports, and media inform both the regulatory organization and the original inputs in adjusting to better achieve the equifinality.

All provincial nurse regulatory bodies share the same equifinality which is the overarching mandate to protect the public. Every one of these nurse regulatory bodies respond to

different inputs using a different arrangement of suprastructure and subsystem characteristics to regulate nurses in the public interest. This corresponds with the principle that there are multiple ways organizations can achieve similar outcomes.

Open systems theory provides a framework with which to understand the relationship between provincial nurse regulatory bodies and the environment, although it does not account for the manner with which the various dimensions interact (Benton, González-Jurado, Beneit-Montesinos, et al., 2013). This research further builds upon this theory by considering the relationship between the dimensions and their impact on the practice of self-employed nurses.

Health Policy Analysis Models

In many ways the field of health policy coincides with that of legislation and regulation. At its core, legislation is essential legalized policy which regulatory bodies are held accountable to and are meant to enforce. Additionally, regulatory bodies and their processes are guided by internal policies that impact organizational functions as well as the practice of registrants. For these reasons, the health policy frameworks conceptualized by Walt and Gilson (1994) and Gagnon and Labonté (2013) are applicable to and inform this study on regulation and its impact on self-employed nurses.

Walt and Gilson (1994) created a simple triangular analytical model to demonstrate the complex relationships between the concepts of context, actors, content, and processes to encourage a more holistic understanding of how to engage in effective health policy reform and implementation. In Walt and Gilson's (1994) model, the context is affected by various factors including political forces and culture. Actors both as individuals and as part of groups are influenced by their context on both a macro-governmental level and micro-organizational level. Finally, actors, their context, and the processes they follow will be reflected in the content they

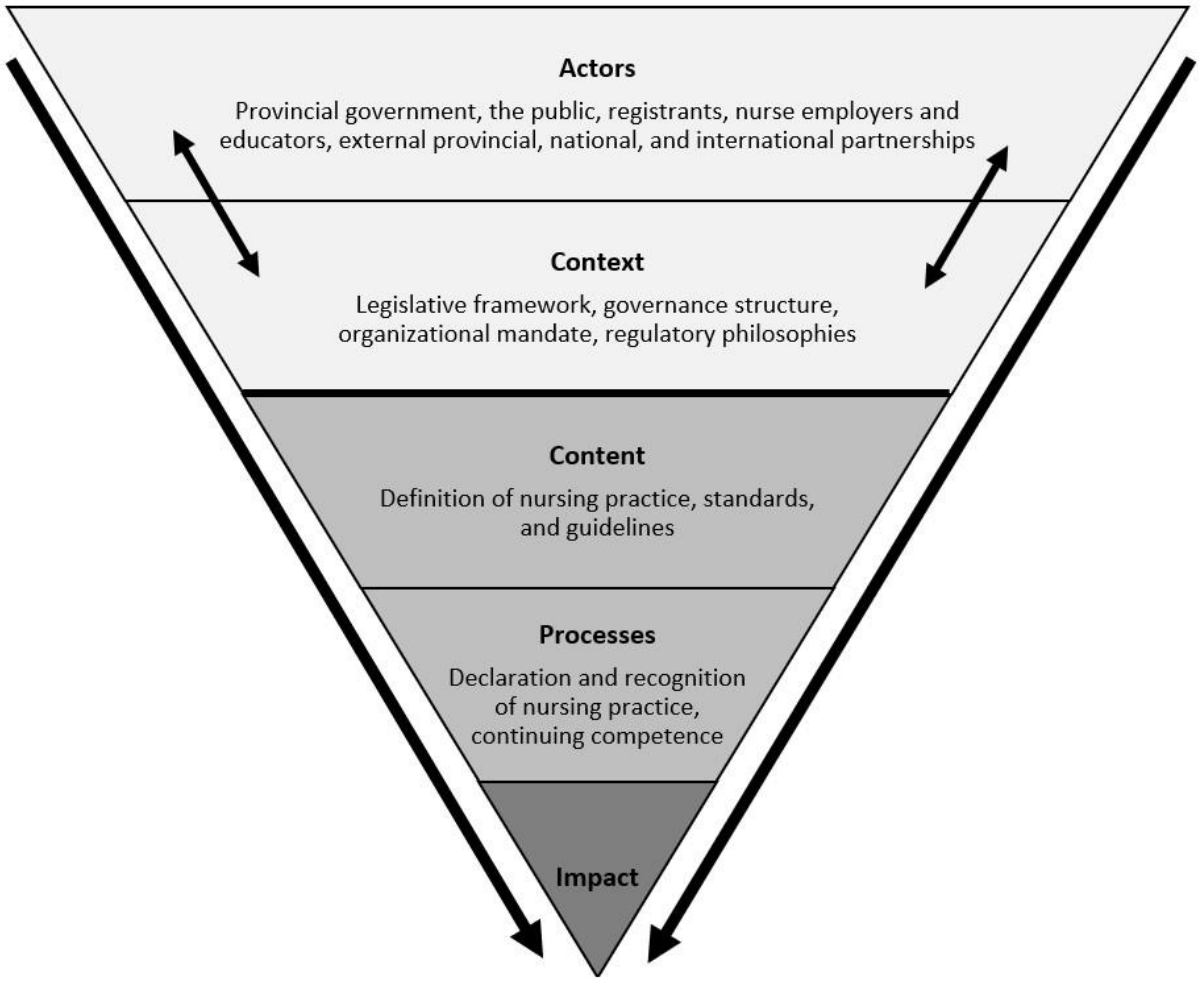
produce. Therefore, Walt and Gilson (1994) argue that considering the content of the policy alone is inadequate as the context, actors, and processes are very influential in the effectiveness of policy and its implementation.

To further build upon this model, Gagnon and Labonté (2013) included an additional concept, impact. In their adapted model, context, process, content, and impact are arranged in a circular conceptual model with actors at the center (2013). This model guides the authors (Gagnon & Labonté, 2013) in considering the context or why the policy is being developed, the actors or who is developing the policy, the process or how the policy is being developed and implemented, and impact or the intended or actual effect of the policy. Including the impact of the policy is a key addition to Walt and Gilson's (1994) original model as the outcome of policy reform and implementation is essential to understanding its effectiveness.

While these models do not directly translate to the topic of nursing regulation, there are commonalities that make these concepts applicable, although in a slightly different arrangement. When studying the impact of nursing regulation on self-employed nursing practice, many may consider a documentary analysis of regulatory content including the practice standards and self-employed nursing practice guidelines to suffice. Like Walt and Gilson's (1994) sentiments, this may provide some insight into the phenomenon but will not come close to illuminating the regulatory actors, context, and processes that have shaped that content or its corresponding implementation which have a direct and significant impact on self-employed nurses. Considering this, an amalgamation and adaptation of both Walt and Gilson's (1994) and Gagnon and Labonté's (2013) models may be used to guide an in-depth analysis of nursing regulation and it's outcomes by more specifically demonstrating the relationship and directional influences between concepts of actors, context, content, processes, and impact as they relate to nursing regulation.

Figure 3

Conceptual Model Representing the Relationship Between Key Concepts in the Provincial Nurse Regulatory Environment



Note. The arrows represent the direction of influence within the regulatory environment.

Provincial nurse regulatory environments include influential actors including the provincial government, the public, registrants, nurse employers and educators, and external provincial, national, and international memberships. These actors play unique roles in influencing the regulatory context which is characterized by the legislative framework, the organizational mandate, governance structure, and regulatory philosophy. The direction of

influence is mainly downstream from actors to contextual features, however, there are some avenues with which the context may influence regulatory actors. Together the actors and context are reflected in the content that is created by the regulatory body which further informs the processes that are established to regulate self-employed nurses. The regulatory environment, made up of actors, context, content, and processes are inextricably linked and together have an impact on self-employed nurses.

This conceptual model works alongside the open systems model to guide a more fulsome analysis of the relationships between key concepts and their impact on the regulation of self-employed nurses. This model directly informs the additional research questions directing the design, data collection, analysis, and findings of this research.

Scope of Practice Regulatory Framework

The CNA published a framework demonstrating the boundaries of the RN's scope of practice (CNA, 2015). The framework includes six layers that progressively narrow the RN's scope of practice. The outermost boundary of the RN's scope of practice is dictated by two layers of provincial legislation. Within that legislative framework, the provincial nurse regulatory body further narrows the scope of practice using practice standards, guidelines, and other regulatory documents. Employer requirements further narrow the individual RN's scope of practice by directing nursing practice using policy and procedures. The individual RN's competence further narrows the scope of practice, which is restricted a final time by the client need.

This framework is particularly applicable to a study concerning the regulation of self-employed nurses, as they are not restricted by employer requirements and thus create their own role requirements using policy and procedures. The scope of practice of self-employed nurses

must still fall within the boundaries created by the provincial nurse regulatory body, however the absence of employer requirements and oversight are what sets this role apart from institutionally employed nurses and impacts the method with which they are regulated.

Conclusion

While theoretical frameworks supporting health professional regulation and its impact on practice are scarce, open systems theory is well-suited to provide insight into how regulatory organizations interact with and respond to their environment. Furthermore, policy analysis models have informed an adapted conceptual model that guides the study of key concepts including actors, context, content, processes, and impact and their affect on the regulation of self-employed nurses. Finally, self-employed nurses practice without the additional requirements and oversight of an employer as demonstrated by the scope of practice regulatory framework. This sets self-employed nurses apart from those who are institutionally employed, providing the rationale for why they might be regulated differently.

Chapter 4. Methods

This chapter provides a description of the research design including the methodology, research design, data collection, analysis, and methods to protect credibility.

Research Question

This study was designed to examine and compare how self-employed nurses are regulated in three Canadian provinces. The goal was to delve beyond a surface description of regulatory processes to a deeper level of contextual analysis to understand if, how, and why nursing regulation impacts self-employed nurses differently than those in institutional employment. To gain this deeper level of insight, an assessment of the full regulatory environment including context and actors was required. Furthermore, the context in which provincial regulatory bodies function vary significantly between jurisdictions, necessitating the inclusion of multiple cases as comparators. Therefore, the research question guiding this study is: **How does provincial nurse regulation impact self-employed registrants in three Canadian provinces?** To further guide the in-depth analysis of the full provincial regulatory environment and its impact on self-employed nurses, the following research questions were included:

- Which regulatory content and processes have an impact on self-employed nursing practice and in what way?
- Who are major regulatory actors and in what ways do they influence the content and processes impacting self-employed nurses?
- What are the distinct regulatory contextual features and in what ways do they influence the content and processes self-employed nurses engage with?

Methodology

Qualitative case study research is particularly appropriate for a study focused on the regulation of self-employed nurses as it facilitates an in-depth, holistic, and contextual analysis of a bounded phenomenon (Sibbald et al., 2021; Squires & Dorsen, 2018; Yin, 2018). Considering the complex and contextual nature of nursing regulation, qualitative case study research allows for the clarification of the deeper, more subtle influences and their consequences rather than describing the symptoms of the issue alone (Flyvbjerg, 2006; Sibbald et al., 2021). Qualitative case studies are highly malleable and can be used in exploratory, descriptive, or explanatory research in a wide range of settings (Sibbald et al., 2021; Yin, 2018). Case studies can also accommodate various epistemological standpoints including qualitative research and constructivism which aligns with the philosophical foundations of this study and the research question (Sibbald et al., 2021; Yin, 2018). This methodology is best suited for seeking answers to how or why a phenomenon occurs in a contemporary setting in which the researcher has little or no control (Yin, 2018). Considering this, qualitative case study research is an appropriate methodology for describing and analyzing complex contextual cases in which there may not be a clear set of outcomes such as how and why provincial nurse regulatory environments impact self-employed nurses.

Methods

This qualitative case study follows the steps of Yin's (2018) case study methodology. When compared with other case study methodologists such as Merriam (1998) or Stake (2005), Yin (2018) provides the more structured and well-defined case study methodology and emphasizes methods for protecting credibility which is advantageous to the novice researcher (Yazan, 2015). First, I prepared for the research process by completing several pre-study tasks

before designing the case study and selecting the cases. Next, I collected the data and analyzed it using a case study protocol as a guide. The resulting individual cases and the cross-case comparison present the findings of this qualitative case study. Table 1 summarizes the methodological steps and the associated rationale. Each of the steps of the research process are further described in this section.

Table 1

Outline of Methodological Steps and Rationale

Steps	Related Actions	Rationale
Pre-Study Tasks	Review the literature	Demonstrates knowledge of the topic and situates research
	Evaluate and develop research skills	Prepares the researcher to act as an effective research instrument
	Engage in reflexivity	Protects the confirmability and dependability of the research
Design	Define the cases	The cases must be chosen to accurately reflect the research question
	Select a case configuration	Appropriate arrangement of cases according to the research question allows for accurate analysis and findings
Selection of Cases	Outline case boundaries	Cases must be clearly bounded to allow for accurate data collection and analysis
	Complete selection process	Provides rationale for the inclusion of each case and how they are applicable to the research question
Data Collection	Identify multiple sources of data	Allows for triangulation data which is a cornerstone of case study research
	Create a case study protocol	Outlines procedures for proceeding through the research in a systematic and rigorous fashion
	Establishing a study database	Stores and organizes data for future retrieval
	Piloting a case	Trials the case study protocol and design on one case before proceeding to the others
	Maintain a chain of evidence	Demonstrates the confirmability of results
Data Analysis	Analysis begins with collection	Searches for initial themes and patterns
	Consider data from multiple perspectives	Acknowledges different realities that may be represented within the data
	Inductive approach	Seeks to build understanding of evidence from the ground up
	Individual case descriptions	Provides rich understanding of each case in itself
	Cross-case analysis	Provides patterns and themes across cases while maintaining the integrity of each
	Investigate all plausible rivals	Demonstrates acknowledgement of multiple realities and protects the rigor of the results.

Note. Methodologic steps and rationale from Yin (2018).

Pre-Study Tasks

To facilitate quality research, several tasks were completed to serve as a thoughtful foundation on which to scaffold the study design and data collection. The literature review in Chapter 2 built knowledge of the field of regulation and the experience of self-employed nurses which shaped the research questions and the research design (Sibbald et al., 2021; Yin, 2018). Additionally, a reflexive journal was initiated prior to the design of the study and maintained throughout the research process to provide space for reflection and recording research decisions (Yin, 2018). The reflexive journal was helpful in identifying philosophical assumptions which provided a foundation for research design and execution.

This research is focused on a highly contextual phenomenon and its influence on self-employed nurses. This requires a research approach that recognizes and acknowledges the contextual and subjective nature of reality and knowledge. The constructivist paradigm is founded upon the belief that reality is socially constructed and that knowledge is subjective (M. E. L. Brown & Dueñas, 2020). When applied to this research topic, constructivism acknowledges the phenomenon being studied is constructed within and influenced by its context and therefore must be included as a part of the study (Creswell & Poth, 2018; Sibbald et al., 2021). To state this more explicitly, nursing regulation is contextual, and the experience of self-employed nurses is influenced by that context, creating a need to include the full regulatory environment within the study. While the legislation and regulations themselves may be considered to represent a singular reality, regulatory representatives, self-employed registrants, and the researcher may interpret their meaning differently due to individually socially constructed realities. A constructivist lens supports the existence of these unique realties and may even provide insight into how regulations could be misinterpreted, highlighting the importance of clear, detailed, transparent, and consistent regulatory content and processes.

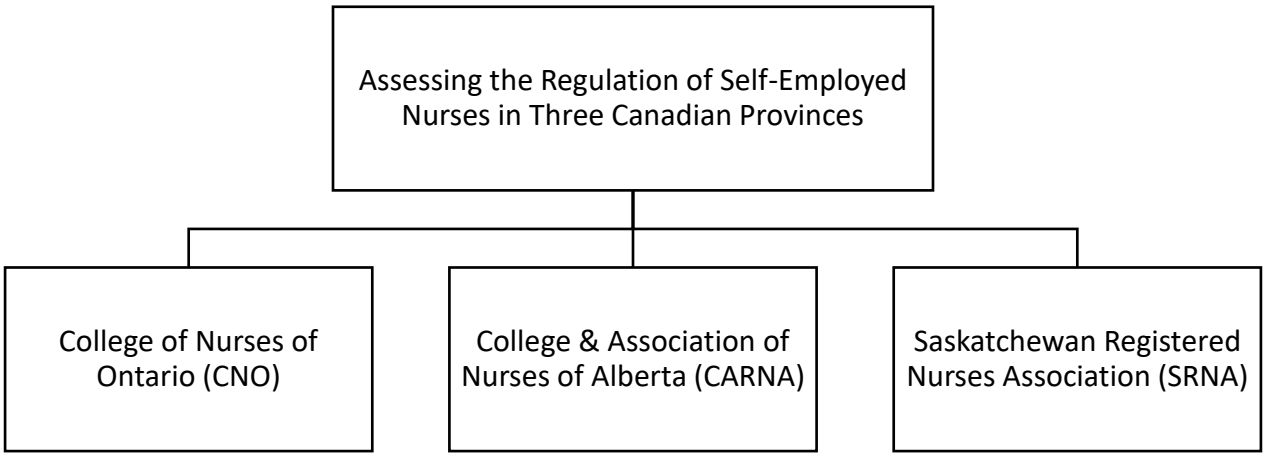
Constructivism recognizes the inevitable influence of the researchers' context on data interpretation making the exact replication of findings impossible (Sibbald et al., 2021). While this may be viewed by some as a weakness of qualitative research, recognizing the researcher and their position as a tool of research analysis is a strength. The researcher's unique context including disciplinary position and previous experience provides additional insight into the topic which, when openly declared, strengthens the credibility of the research. I am a nurse registrant with considerable experience in institutional employment, but I am not a self-employed nurse or a regulatory representative. My disciplinary expertise provides a necessary lens with which to analyze the impact of nursing regulation on self-employed nurses. As a registrant, I have identified socially constructed biases about the role of the regulator and can recognize similar biases in research conducted by other nurses on the topic of regulation. I have remained engaged in reflexivity to best explore those biases prior to and throughout the research process.

Research Design

The design stage of this case study included defining the cases and selecting a case configuration demonstrating how those cases will be studied in relation to each other (Yin, 2018). The study included three individual holistic cases each consisting of a single provincial nurse regulatory body and its distinct environment. Figure 4 is a representation of this simple case study design.

Figure 4

Visual Representation of the Theoretical Case Configuration Used in This Study



Selection of Cases

A study with only one or two cases would not adequately account for the range of features that make each provincial nurse regulatory environment unique which may threaten the confirmability and transferability of the findings. Therefore, I used purposive case selection to include three bounded cases in the study. Each case consists of a single provincial registered nurse regulatory body and all the data published by that regulatory body pertaining to the research questions available in the public domain. The majority of the data available in the public domain was published after 2013 which facilitated a fulsome review of the regulatory environments. Given the scope of the present study it would not be feasible to explore the effect of regulation on self-employed nurses in all nursing designations, as in some provinces they are regulated by separate organizations and under distinct legislation. Wall's (Stahlke Wall, 2011, 2018) and Smith's (2016) research focused specifically on the experiences of self-employed RNs and NPs, so this study will continue to build upon that research by focusing on registered nurse

regulatory bodies. Further research is required to examine how nurse regulation specifically impacts LPNs, RPNs, and nurse midwives across Canada and how that compares to the experience of RNs and NPs.

The cases are themselves bounded by the research questions and therefore include only data that is relevant to understanding the influence of regulatory actors, contextual features, content, and processes that impact self-employed registrants. These cases do not include all aspects of regulation as they are not all relevant to the overall research aims of this study. Furthermore, self-employed nurses and associations are not included as this study focuses on the regulation of self-employed practice rather than aiming to understand the experience of self-employed nurses which has been previously researched.

Inclusion Criteria for Cases.

To select cases that represent various contextual features, I conducted a two-phased screening of candidate cases. The regulatory context of each province and territory was briefly surveyed by researching and collecting data from each of the Canadian provincial government and registered nurse regulatory body websites. Appendix A demonstrates the contextual features that were assessed including the style of provincial regulatory legislation, the number of nursing groups regulated by a single body, and the enactment of a single or dual organizational mandate. The second phase of the selection process included a survey of the existing practice guidelines for self-employed nursing practice from each jurisdiction. All Canadian provinces and territories except Prince Edward Island and the Yukon have published documents pertaining to self-employed nursing. The date of publication of was recorded alongside the information collected in phase one of the selection process.

Three provincial regulatory bodies representing diverse contextual features and recently revised self-employed practice guidelines were selected to create maximum variation between cases. The first case is based on the College of Nurses of Ontario (CNO) which is represented by an umbrella legislation style, a single regulatory mandate, the regulation of multiple nursing groups, and large number of registrants. The College and Association of Registered Nurses of Alberta (CARNA) makes up the second case which is characterized by a unique combination of contextual features including an umbrella legislation style, a dual mandate in the midst of transitioning to a single mandate, the regulation of a single nursing group, and a moderate number of registrants. The final case is based on the Saskatchewan Registered Nurses Association (SRNA) which has a profession-specific legislation style, regulates a single nursing group, a small number of registrants, and a dual mandate that will soon be transitioning to a single mandate. Including the various contextual features in this way illuminates the potential influence of each on the regulation of self-employed nurses.

Data Collection

Data collection followed the steps described by Yin (2018) which includes creating a case study protocol, incorporating multiple sources of data, establishing a study database, and piloting a case.

Prior to beginning data collection, I created what Yin (2018) calls a "case study protocol" consisting of an overview of the case study, data collection procedures, guiding questions, and a tentative outline for the report (See Appendix B). The research protocol includes a list of data sources and the order in which they are collected which directed the data collection process in each of the cases. The protocol guided the study and protected the philosophical and methodological integrity of the research by ensuring the research process remained connected

with its original aims and providing consistency between cases. Additionally, the research protocol provides the rationale for data collection which is an important link in the chain of evidence.

The triangulation of data was achieved by including documentary evidence from multiple sources. The data included standards, documents, forms, web pages, videos, presentations, news releases, and magazines published by the nurse regulatory bodies. Additionally, statutes, annual reports, and other publications from provincial government websites supplemented and corroborated the data from the first source. A third source of data is media news releases that reflected public perception of nursing regulation which connected with changes to legislation and regulatory practices within the organization. Finally, during the analysis process, additional documentary evidence from other publicly accessible sources became relevant and were included to corroborate findings from the other sources.

All the data included in the study was available in the public domain and accessible on public websites. Therefore, the data collection process was made up of several systematic web-based searches to locate and download all the relevant documents and multi-media sources for further analysis. Near the end of the analysis process, some specific pieces of information appeared to be missing in only two of the cases, so I corresponded by email with the CNO's and the CARNA's practice support department to obtain additional documents. The email responses did not provide any additional documents that were not available in the public domain. The responses themselves are not included as data and as such, ethics board approval was not required to complete this study.

A case study database was created using the reference manager application, Zotero, which was effective due to the large number of text-based data sources. The case study database

served to organize the data as well as protect the reliability of the research by storing the necessary retrieval information which facilitates further investigation into the research findings. The database also includes research notes and memos, the reflexive research journal, documents, and tables made throughout the analysis process to maintain a clear chain of evidence. Each of the entries includes the author, title, publication date, retrieval information such as the URL, and access or download date.

Data Analysis

Evaluation of the data began with an initial superficial examination of the data during its collection. After compiling and storing the evidence pertaining to a single case, all the documentary evidence was uploaded to NVivo data analysis software (2020) which facilitated a second, more in-depth analysis and the simultaneous coding of the data. The research protocol questions shaped the analysis process by guiding the creation of codes which later became themes and sub-themes within the data. In this way, the analysis employed deductive reasoning. The data was also analyzed from an inductive approach, however as I searched for emerging concepts and themes that may not have been previously considered which resulted in additional sub-themes. As part of a third iteration, I simultaneously analyzed and reported on the case including its context, actors, content, and processes. Each case was completed in this fashion, one at a time to maintain the integrity of each case. When all the initial case reports were complete, I conducted an initial cross-case analysis which highlighted areas in each case that needed further investigation. As a result, each individual case was subject to a fourth iteration before returning to the cross-case analysis and reporting the interpretations.

As described, I analyzed the data in an iterative fashion, looking at the evidence multiple times from new perspectives. This aspect of the analysis process included creating notes and

memos as well as multiple charts, diagrams, and conceptual models to understand the concepts within the data and the relation between them. I employed several analysis techniques to understand the data including *pattern matching* by which connections were made within the data and with potential rival explanations (Yin, 2018). This technique worked in conjunction with a second, called *explanation building* which consisted of continually shaping and reshaping conceptions of the interrelating concepts (Yin, 2018). I also employed *time-series analysis* in select instances to trace changes over time which assisted in illuminating potential connections and relationships within the data (Yin, 2018). Finally, the *cross-case synthesis* technique helped to identify patterns across cases (Yin, 2018). Throughout the analysis process I sought out and examined plausible craft rivals related to the design of the research and real-world rivals such as alternative explanations for my interpretations which significantly enhanced the credibility of the research findings (Yin, 2018).

Protecting Rigour Through Research Methods

Although it is now becoming recognized as a distinct and credible methodology, case study research has long been misrepresented and misunderstood as a weak and non-scientific research tool (Flyvbjerg, 2006; Sibbald et al., 2021; Yin, 2018). As a result of this scrutiny, it is important to be attentive to ensuring the rigour of case study research to deconstruct the wrongful assumptions about its inherent lack of credibility (Yin, 2018). Considering its philosophical underpinnings, the rigour of this qualitative research is assured by attending to credibility, dependability, confirmability, and transferability (Creswell & Poth, 2018; Houghton et al., 2013). Supplementing these quality indicators are Thorne's (2016) qualitative research evaluation criteria which address a variety of considerations including disciplinary integrity.

Credibility

Credibility, or the trustworthiness of the research findings (Houghton et al., 2013), is assured by using replication logic within the design, triangulation of data sources, prolonged engagement, and the analytic ability and relevancy of the researcher. Incorporating three cases rather than one or two provides strength to the findings especially through use of replication logic by which certain contextual features are represented by more than one case. For example, two provincial regulatory bodies in the study have an umbrella legislation style, two represent a dual mandate, and two represent only RN and NP nursing groups. In this way, the cases allow for stronger comparisons and more credible interpretations as they can be verified between cases. As a demonstration of what Thorne (2016) calls "representative credibility" the use of three cases that represent a range of contextual features found in nurse regulatory environments across Canada aligns with the claim that findings may be applicable to nurse regulatory jurisdictions nationally. It should be noted that while the research findings may be applicable across Canadian provinces, this only includes registered nurse regulatory bodies pertaining to the practice of specifically self-employed nurses.

Triangulation is key to the credibility of case study research which aims to corroborate evidence through the convergence of many sources of data (Creswell & Poth, 2018; Houghton et al., 2013; Yin, 2018). Despite being almost exclusively documentary evidence accessible in the public domain, the triangulation of data is achieved by collecting evidence from multiple sources including provincial nurse regulatory bodies, provincial governments, the media, and other organizational websites. Additionally, the inclusion of multiple cases is a form of triangulation in which interpretations related to one case can be corroborated or challenged by the others, offering different perspectives on the subject from alternate yet complementary contexts.

The credibility of this research is strengthened through prolonged and in-depth engagement with the data which was analyzed in an iterative fashion over several months (Creswell & Poth, 2018; Houghton et al., 2013; Thorne, 2016). Finally, credible qualitative research findings rely on the ability of the researcher to demonstrate competency, authority, transparency, and integrity throughout the research process (Creswell & Poth, 2018). As a regulated nursing professional, my disciplinary expertise and positionality offers credibility to the research.

Dependability

Dependability refers to the reliability or stability of the data and the findings which is strengthened by following established case study methods, using data in exclusively in the public domain, and maintaining an audit trail (Houghton et al., 2013; Sibbald et al., 2021). The consistency and reliability of the research is achieved by conducting the research according to Yin's (2018) published methods and the pre-determined steps associated with case study research. Additionally, the use of a research journal, case study protocol, database, and the preservation of research notes and memos establish an audit trail that make the decision-making process transparent (Houghton et al., 2013; Yin, 2018). This audit trail attends what Yin (2018) calls "maintaining a chain of evidence" and includes what Thorne (2016) labels "analytic logic" which allows the reader to connect the final interpretations to the original research question and through the stages of design, data collection, and analysis.

Confirmability

Confirmability is a measure of the accuracy of data interpretation (Houghton et al., 2013) which is a matter of specific concern for case study researchers as many believe this methodology has a bias toward verification (Flyvbjerg, 2006). Flyvbjerg (2006) provides

evidence to the contrary and asserts that case studies contain no greater risk of bias than all other qualitative methodologies, yet measures must be put in place to placate those who remain wary. To this end and to attend to what Thorne (2016) labels “contextual awareness”, I engaged in reflexive journaling to identify and disclose personal biases such as disciplinary training and related exposure to socially constructed ideas regarding the role of nursing regulation to understand and disclose the ways my position will influence the analysis and findings (Creswell & Poth, 2018; Houghton et al., 2013). It is important to note that the findings of this study represent probable truth because they are contextually bound in the current time in history and within the nursing discipline (Thorne, 2016).

Confirmability and what Thorne (2016) calls “epistemologic integrity” is assured through the maintenance of an audit trail including reflexive notes, the research journal, research team meeting minutes, the research protocol, notes, and memos which make decision-making transparent. In this way the reader can confirm that the epistemology underlying the research aligns with the research question, design, all ensuing research decisions, and the final interpretations (Thorne, 2016; Yin, 2018). Finally, I made every effort to continually seek out, investigate, and report on all rivals, both craft and real-world, to ensure that all plausible alternative explanations have been carefully considered to avert all suspicion of self-verification. To aid in this process, research supervisors provided peer debriefing to challenge research interpretations and offer alternate perspectives. As a result of these efforts and as a demonstration of what Thorne (2016) calls “interpretive authority”, the research findings were very different than the researcher’s original assumptions which demonstrates a commitment to considering all rival explanations to reveal a truth that is outside of the researcher’s bias or experience.

Transferability

Another point of contention surrounding case study research lies within the measure of transferability or the generalizability of the findings to similar contexts (Flyvbjerg, 2006; Houghton et al., 2013). Critics suggest that findings of a single case study cannot be generalized and therefore add no contribution to scientific advancement (Flyvbjerg, 2006). Flyvbjerg (2006) opines that generalizability is overvalued as the driver of scientific advancement stating case study research has considerable power in its "force of example" to create meaningful and applicable scientific knowledge (Yin, 2018). The transferability in this case study research is strengthened by designing the case study to include three cases that represent a range of contextual features which are common amongst Canadian nurse regulatory bodies, making results applicable to different Canadian nurse regulatory environments. Additionally, extensive description of both the methods and each regulatory environment including its actors, context, content, and processes allows for comparison to other regulatory jurisdictions which enhances its applicability and transferability.

Disciplinary Integrity

Disciplinary integrity is not included within the four most commonly accepted measures of qualitative research quality; however, research that does not contribute to the disciplinary science or align with disciplinary values will not be received as credible (Thorne, 2016). This research is conducted by a nurse focused on understanding the impact of nursing regulation on self-employed nurses which is evidently relevant to the nursing profession. As one of the first studies to investigate the impact of regulation on self-employed nurses, this study also advances nursing science in the fields of nursing professionalism and regulation, demonstrating what Thorne (2016) calls "disciplinary relevance".

The nursing discipline is aligned with the "humanitarian health care agenda" (Thorne, 2016, p. 236) and as such, must demonstrate what Thorne (2016) calls "moral defensibility". This marker of quality is related to ethics such that the researcher must provide adequate rationale for the collection and use of the data. The data included in this research is accessible in the public domain which does not require consideration of human participants, however, rationale for the use of the findings remains of import. The research was designed with key audiences in mind including nurse scholars, self-employed nurses, and nurse regulatory representatives and provides a benefit to all of them. The findings are morally defensible because they not only benefit nurses, but also members of the public through improved regulation of self-employed nurses. Another indicator of rigorous qualitative research is "pragmatic obligation" (Thorne, 2016). The nursing profession is an applied discipline which values what Thorne (2016) calls a "practice mandate" requiring practical and applicable research findings. In alignment with this measure of quality, the findings are meant to be put into practice in hopes of facilitating positive change in the regulation of self-employed nurses.

Chapter Summary

This chapter introduced the qualitative case methodology and the methods used to investigate how self-employed nurses are regulated and the factors that influence those regulatory practices in three Canadian provinces. The study design includes three cases, each based on a different provincial registered nurse regulatory body. The cases were selected using a staged approach to include maximal variation of contextual features and recently updated and relevant self-employed nursing practice guidelines. Each case consists of data accessible in the public domain which was collected primarily from regulatory, government, and media sources. Analysis was an iterative process that included both deductive and inductive approaches to

examine each case individually before completing a cross-case analysis and interpretations. Credibility, dependability, confirmability, transferability, and disciplinary integrity are attended to using a wide variety of strategies which enhance the rigour of the research.

Chapter 5.

Case 1 - College of Nurses of Ontario (CNO)

The CNO represents the first case and has several unique contextual features including umbrella legislative framework, regulation of multiple nursing groups, a large number of registrants, and a single organizational regulatory mandate. Additionally, the CNO's *Practice Guideline: Independent Practice* was recently updated in 2021. This chapter is made of up four main sections including *Actors*, *Context*, *Content,* and *Processes* which together reveal the provincial nurse regulatory environment and the regulation of self-employed nurses in Ontario.

Actors

Key actors in the CNO's regulatory activities include the provincial government, the public, registrants, employers, nurse educators, and provincial, national, and international partnerships. Part of the CNO's *Strategic Vision for 2021-2024* (n.d.b) includes strengthening relationships with stakeholders to facilitate better engagement and collaborative relationships which suggests the influence of stakeholders may become stronger over time.

Government

Empowered through legislation and accountable to the minister of health, the government is positioned as a key stakeholder in nursing regulation. The government exercises their authority through legislative change, ministerial directives (Hoskins, 2014, 2016; Ministry of Health and Long-Term Care, 2019; Wynne, 2016), councillor appointments, and government oversight (Regulated Health Professions Act, 1991). The government has initiated legislative changes to expand scopes of practice for RPNs, RNs, and NPs (CNO, 2017d, 2020a, 2021n; Health Professions Regulatory Advisory Council, 2018; Wynne, 2016) to utilize resources and personnel more efficiently while improving health care access. In response to the COVID-19

pandemic, the government of Ontario responded quickly with legislative change to support the needs of health care leaders and calls in the media for increased staff and streamlined registration processes amid the pandemic (CNO, 2021q, 2021t; Gillis, 2021; Global News, 2021; Kalata, 2021; Lampa, 2021; Ward, 2021). The government has an additional role in nursing regulation through the appointment of public representatives to the CNO council (Regulated Health Professions Act, 1991).

The CNO's council and committees work within a context of government oversight that is demonstrated in several forms. Reporting to the minister, the fairness commissioner is responsible to audit the regulatory body's registration practices to ensure they are transparent, objective, impartial, and fair to those wishing to join the profession (Government of Ontario, 2020; Regulated Health Professions Act, 1991). Additionally, the Health Professions Appeal and Review Board is given the responsibility to provide independent reviews and advice regarding a registration hearing, complaint, or review (Regulated Health Professions Act, 1991). If a decision made by this board is appealed, it will come before Divisional Court (Government of Ontario, 2021; Regulated Health Professions Act, 1991). Furthermore, in December 2020, the minister of health in Ontario introduced the *College Performance Measurement Framework* (CPMF) to "strengthen accountability and oversight of Ontario's health regulatory Colleges" (CNO, 2020b, p. 2) requiring the health profession regulatory bodies to provide evidence of their performance in several domains.

Public

As the consumers of health care and the entity that regulation is meant to protect, the public is positioned as a major stakeholder in nursing regulation in both formal and informal ways. Although they make up the minority, public representatives are appointed to the CNO

council and committees. The CNO is partnered with the Citizen Advisory Group (CAG) which is made up of patients and caregivers from across the province who review changes to regulation to ensure the protection of the public (CNO, 2020a, 2020b). Furthermore, the public is invited to provide feedback on regulatory initiatives such as the newly enforced *Code of Conduct* (CNO, 2019a) during a consultation period in which draft documents are provided online for review (CNO, 2020i). In these formal ways, the public is included as a key stakeholder and has influence over regulatory activities.

Informally, public perception and media has a unique role in influencing regulatory bodies. One example of the influence of public perceptions is the changes that followed the highly publicized trial of a nurse found guilty of murdering eight Ontario patients (CNO, 2020a; Crawley, 2016; Dubinski, 2018; Fitzpatrick, 2020; LeBel, 2018). The CNO's leadership conducted a public inquiry following the incident and followed up by making changes to their policies and procedures (CNO, 2020f), their communication about professional responsibilities (CNO, 2021j), and updating nursing education guidelines to teach student nurses to recognize and report intentional harm (CNO, 2020a). The CNO's reporting process was also changed to make it clearer and more accessible (CNO, 2020a). Both formally and informally, the public acts as a key stakeholder and has direct influence over the regulatory content and processes.

Registrants

As those being regulated, the CNO's registrants are positioned as a key stakeholder. Registrants make up the majority of the CNO's council and committees where they are meant to use their expertise to regulate nurses in the interest of the public (CNO, 2019c). Registrants of the CNO are also invited to provide feedback on regulatory content or processes during a formal consultation period (CNO, 2020e). For some projects, such as the modernization of practice

standards, the CNO's council may establish a time-limited advisory group of nurses as a resource (CNO, 2017b, 2021r). On a less formal basis, provincial nursing associations and unions are recognized as stakeholders in CNO publications and communications (CNO, 2017c; Registered Nurses' Association of Ontario & Ontario Nurses' Association, n.d.). Despite recognizing registrants as stakeholders in some aspects of regulation, it is clear throughout all communications that the CNO serves only in the interest of the public, not that of the nursing profession and its leadership is seeking to make changes to its governance structure to better align with that mandate (CNO, 2017a, 2020j, n.d.b). In this way, registrants play a key, but changing role in nursing regulation as the CNO council aims to make professional representation equal to that of the public.

Educators and Employers

Nurse educators and employers are actors in nursing regulation in Ontario. Nurse educators have a unique role in nursing regulation as nursing education programs must be reviewed and approved by a CNO committee. Employers are recognized as stakeholders due to their role in directing and overseeing the practice of nurses in their employ (CNO, 2020b). In recognition of these unique stakeholders, the CNO's leadership initiated separate Academic and Employer Reference Groups to facilitate the sharing of information and collaboration on nursing regulatory issues of mutual concern (CNO, 2020a, 2020b, 2021b, 2021c).

Greater Regulatory Landscape

The CNO's council and committees operate within a larger regulatory environment that has a significant impact on the CNO's content and processes. The CNO's strategic plan (CNO, 2020a) references the "regulatory landscape" and the need to be constantly monitoring this landscape to stay current with evidence-informed regulation and changing societal expectations.

Recognizing the importance of partnerships within the greater regulatory environment, the government requires a report on how the organization has engaged with external partners to strengthen the execution of its mandate (CNO, 2020b). Keeping abreast of and contributing to the regulatory landscape is facilitated through several collaborative initiatives on provincial, national, and international levels.

Provincially, CNO representatives co-founded the Advisory Group for Regulatory Excellence (AGRE) with other health care professional regulators in Ontario who have worked to enhance transparency of information about health care providers on public registers in the province (AGRE, 2021; CNO, 2019h; Rosen Sunshine LLP, 2015). The CNO is also a member of the Health Profession Regulators of Ontario (HPRO) (HPRO, n.d.). On a less formal basis, the CNO's leadership collaborates with other provincial regulatory bodies as demonstrated by the adaptation of the sexual abuse resources published by the College of Physicians and Surgeons of Ontario (CNO, 2020b).

On a national level, the CNO is a member in the Canadian Council for Practical Nurse Regulators (CCPNR) and the Canadian Council of Registered Nurse Regulators (CCRNR) (CNO, 2020b). Related to their membership in the CCRNR, the CNO's council has adopted the national NCLEX-RN entry-level exam for registered nurses, the entry-to-practice competencies (CCRNR, 2021), and is involved in the NP Regulation Framework Implementation Plan Project (NPR-FIPP) which aims to standardize NP regulation across Canada (NPR-FIPP, 2020). In addition to these formal memberships, the CNO's leadership is engaged in a collaborative relationship with the nurse regulator in British Columbia to "share and innovate in the field of nursing regulation" (CNO, 2016b, p. 1). In a report to the government, the CNO's council and committees are described as contributing to the national regulatory environment by sharing

processes and tools for internationally educated nurses bridging and NP programs with other Canadian jurisdictions (CNO, 2020b).

Internationally, the CNO is in partnership with the National Council of State Boards of Nursing (NCSBN) based in the US (CNO, 2020b; National Council of State Boards of Nursing, 2021) which contributed to the development of "NURSYS Canada", an electronic repository for nurse registration and discipline information meant to facilitate the trans-jurisdictional movement of nurses between Ontario and British Columbia (CNO, 2020b). The CNO is also a member of the International Nurse Regulator Collaborative (INRC) which includes nine nurse regulators from around the world (CNO, 2020b; INRC, 2021). Presumably related to this connection, the CNO's council recently instated the *Code of Conduct* which was adapted from the nurse regulator in New Zealand who is also a member of the INRC (CNO, 2019b). Furthermore, the CNO's leadership commissioned American governance expert, Cathy Trower, to perform an external evaluation which informed the CNO's task force and council's resulting plan to change their governance structure and processes to meet current regulatory best practices (CNO, 2017b, 2020a, n.d.b). These examples demonstrate the primary influence of the greater regulatory environment on the CNO's content and processes

Context

Key actors can influence regulatory contextual features including the legislative framework, governance structure, and regulatory philosophies.

Legislative Framework

The regulation of health care providers in Ontario is determined by the *Regulated Health Professions Act* (RHPA) (RHPA, 1991) which is an overarching umbrella legislation that dictates regulatory board composition, the type and number of regulatory committees,

registration practices, the presence and goals of the Quality Assurance (QA) program, and the process of investigating and disciplining malpractice, among other things.

The RHPA (1991) is supplemented by the *Nursing Act* (Nursing Act, 1991) which together creates a provincial legislative framework to which the minister of health holds the CNO's leadership accountable (CNO, 2020g). The *Nursing Act* (1991) includes "controlled acts" which outline the high-risk skills that may be performed by nurses based on considerations of scope of practice and level of education (College of Nurses of Ontario, 2020e, 2020c). Through these two acts, the CNO's council is delegated the authority to regulate RPNs, RNs, and NPs in Ontario which currently represents over 188,500 nurses (CNO, 2020j, 2021h). The CNO is a single-mandate organization that carries out the legislated duty of protecting the public and the reputation of the profession by ensuring public trust (CNO, n.d.b).

Regulatory Governance

Regulatory governance refers to the regulatory bodies' council's size, structure, and processes (CNO, 2020a). The council is empowered by the RHPA (1991) to protect the public and structure nursing regulation in Ontario by establishing policies and bylaws. Bylaws govern the operation of the CNO including its governance structure, administration, and regulatory functions (CNO, 2019g). Currently the CNO council is made up of 37 members, 21 are elected to council including 14 RNs and seven RPNs (CNO, 2000; RHPA, 1991). Although NPs are represented by the CNO (CNO, 2020j), the bylaws do not require a specific number of NP representatives on council. The other part of the council is made up of a minority of 16 ministry-appointed public members (CNO, 2019c). The council elects a president and two vice presidents, an RN and an RPN from among its members and the executive director (ED) who must be a registrant of the CNO (CNO, 2000). The ED is the CNO's chief executive officer and is

responsible for the organizational and regulatory functions of the CNO in the manner directed by the council (CNO, 2000).

Ontario's RHPA (1991) establishes the seven statutory committees including the executive, registration, inquiries, complaints and reports, discipline, fitness to practise, quality assurance, and patient relations committees which are further described in the bylaws (CNO, 2000). The legislation states the council is responsible to appoint members to and determine the composition of the committees (RHPA, 1991). The CNO's council has also established four standing committees including the election and appointments, conduct, finance, and compensation committees (CNO, 2020c). Currently, all committees are made up of a majority of registrant members (CNO, 2000).

Based on an external review of its governance, the leadership of the CNO is committed to changing the make up of the council to an appointed board made up of 12 members with equal numbers of nurses and public members to better reflect evidence-informed regulatory practice and their mandate to protect the public interest (CNO, 2017b, n.d.a). The CNO council submitted a proposal to the minister of health in 2019 requesting an amendment to the current legislation to allow them to modernize their regulatory governance structure in this way, however, they continue to await the required legislative change (CNO, 2017b, 2020a, n.d.b).

Regulatory Philosophy

A *regulatory philosophy* is a system of thought that the regulatory body uses to frame regulatory activities. The approach with which regulatory bodies conduct regulation impacts the content and processes they establish as they work to align with a specific set of principles and values. According to their webpage, the organizational vision of the CNO is "leading in regulatory excellence" (CNO, 2021g). The organization's governance is guided by the principles

of accountability, adaptability, competence, diversity, independence, integrity, and transparency (CNO, 2016a). On an organizational level, the leadership of the CNO has aligned their operations with two different established regulatory philosophies, "right-touch" and "risk-based" regulation. (CNO, 2017b, 2020b, n.d.b). Right-touch regulation originates with the Professional Standards Authority (PSA) in the UK and is a risk-based approach to regulation that focuses interventions on the prevention of harms to the public by promoting high-quality, evidence-based nursing practice (PSA, 2015). Additionally, right-touch regulation is meant to use only the means necessary to achieve desired outcomes which include the protection of patients, the promotion of professional standards, and maintaining public confidence in the profession (PSA, 2015, 2019). To expand, right-touch regulation is based on the principles outlined in the *Standards for Good Regulation* (PSA, 2015) which state regulation should be proportionate, consistent, targeted, transparent, accountable, and agile to the benefit of both the regulatory body, registrants, and public safety. The CNO's leadership has incorporated these principles in several of their programs and processes including the Quality Assurance (QA) program and the management of complaints (CNO, 2020b).

A risk-based approach to regulation utilizes a proactive approach by identifying and mitigating risks to prevent harm from occurring (CNO, 2017b). The CNO's leadership is planning to establish a data analytics program, called the "Insights Engine," that will help in identifying risks and applying the principles of the risk-based approach through education initiatives (CNO, 2021s, n.d.b). Additionally, the risk-based approach influenced recent changes to the QA program, the process of approving nursing education programs, the establishment of a sexual abuse project, and the creation of the Nurses' Health Program to encourage nurses with substance use or mental health disorders to seek treatment (CNO, 2019e, n.d.b). All these

programs and processes are targeted at preventing harms from occurring which is meant to reduce the number of complaints, reports, and investigations that indicate there is risk of harm to the public.

The CNO's strategic plan states the following, "concepts such as Right-touch regulation and risk-based Regulation are fundamentally changing the approach to regulatory activities in Ontario" (CNO, n.d.b, p. 9). This demonstrates the impact regulatory philosophies have on regulatory content and processes and therefore, the regulation of nurses. Continued commitment to these regulatory philosophies is demonstrated in the *Strategic Plan 2021-2024* (CNO, n.d.b) which incorporates right-touch and risk-based philosophies in three out of four key goals for the future indicating these philosophies will continue to influence regulatory content and processes.

Content

Regulatory content affecting self-employed nurses includes the definition of nursing practice, practice standards, and the practice guideline for independent nursing practice.

Definition of Nursing Practice

Nursing and nursing practice are defined in the *Nursing Act* (1991) which is interpreted, communicated, and enforced by the CNO's council and committees (CNO, 2021s). The *Nursing Act* (1991) defines nursing practice as "the promotion of health and the assessment of, the provision of care for and the treatment of health conditions by supportive, preventative, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function" (c. 2(3)). The CNO's webpage and publications further explain that nursing practice is not defined by role, title, practice setting, activity, or employment, but is diverse and includes clinical and non-clinical roles (CNO, 2018a, 2019d, 2019i, 2021e). The *Entry-to-Practice Competencies for Registered Nurses* (CNO, 2018b) outline nine roles that are included in nursing

practice including clinician, professional, communicator, collaborator, coordinator, leader, advocate, educator, and scholar. This document also recognizes five domains of nursing practice including direct patient care, administration, academic, research, and policy (CNO, 2018b). A CNO publication states, "you can still be practicing nursing even if you are not required to be a nurse in your role" (CNO, 2019i, p. e1).

Practice Standards

The standards of practice published by the regulatory body provide a framework for nursing practice and are considered authoritative (CNO, 2021k). These standards are the benchmark to which nurses are held accountable by the regulator and the public and therefore impact the practice of nurses, including those who are self-employed (CNO, 2021s). The CNO's council and committees have published nine practice standards and 11 practice guidelines (CNO, 2021o). The core practice standards include *Entry-to Practice Competencies* for RPNs, RNs, and NPs, *Professional Standards*, *Nurse Practitioner Practice Standards*, *Ethical Standards*, and a *Code of Conduct* to which nurses are held accountable (CNO, 2021o). Furthermore, nursing practice must adhere to additional standards related to confidentiality, documentation, medication administration, and nurse-client relationship (CNO, 2021c). All CNO documents are classified as either a standard or guideline to give clarity to which of them nurses are accountable to (CNO, 2021o, 2021s). The council briefing from March 2021 (CNO, 2021s), describes the goal to modernize the standards of practice to be more accessible, defensible, and relevant to nurses and their stakeholders.

Practice Guidelines for Independent Practice

Practice guidelines are meant to assist in the application of the standards of practice and code of conduct by elaborating on the expectations surrounding specific practice areas such as

independent practice (CNO, 2021o). The independently practicing nurse is defined as one who is self-employed and or operates their own nursing business (CNO, 2021i). Nurses in independent practice may use their nursing knowledge and expertise to provide services that have a direct or indirect effect on patient care or health systems including, but not limited to, direct patient care, the coordination of care, education, and consulting services (CNO, 2021i). The practice guideline for nurses in independent practice is eight pages long and covers topics such as a definition of independent practice, health professional corporation, creating policies and procedures, record keeping, setting fees, selling products and medications, liability insurance, and advertising (CNO, 2021i). According to the reference provided in the document, the guidelines were first published 1996 and have been updated several times, last in 2013, 2019, and then in 2021 to clarify the section pertaining to health professional corporation (CNO, 2021i). The guideline does not include information regarding how regulation processes change when practicing in self-employed roles or when or why the guideline might be subject to a review or revision.

Processes

Regulatory processes used to regulate self-employed nurses include the Declaration of Nursing Practice, Quality Assurance program, and the practice support.

Declaration of Practice

The legislation in Ontario does not require nurses to practice a set number of hours to demonstrate competency as part of the annual registration renewal process. Instead, registrants are required to declare they have practiced nursing within the last three years (CNO, 2018c). NPs must provide additional declarations for each specialty certificate they hold (CNO, 2018c). The CNO's webpage provides a list of reflective questions to assist registrants in determining if they have been practicing nursing which includes questions such as:

- Do you have a direct or indirect effect on health care systems?,
- Are you using your nursing knowledge, skill, and judgment in your role?, and
- What are your reasons for using the protected titles of Nurse, RPN, RN, or NP? Is it because you wish people to know that you have that credibility, expertise, knowledge, skill, or ability? (CNO, 2019d, p. e1).

The CNO's web page states "if requested by the College, members must provide evidence to support their declaration" (CNO, 2019d, p. e1), however, it is not clear if the declaration of nursing practice has an associated audit process and, if it does, what specifically constitutes evidence of nursing practice. There is no required application process for self-employed nurses to be recognized as a nursing practice by the CNO.

Quality Assurance Program

All registrants must complete the annual QA program requirements to be eligible for registration renewal. The RHPA (1991) directs the QA program by stating:

> A quality assurance program … shall include,
>
> (a) continuing education or professional development designed to,
>
> (i) promote continuing competence and continuing quality improvement among the members,
>
> (ii) address changes in practice environments, and
>
> (iii) incorporate standards of practice, advances in technology, changes made to entry to practice competencies and other relevant issues in the discretion of the Council;
>
> (b) self, peer and practice assessments; and

> (c) a mechanism for the College to monitor members' participation in, and compliance with, the quality assurance program (c. 80(1)).

Based on this framework, the CNO's QA program includes two general steps: practice reflection and developing a learning plan (CNO, 2021l, 2021p). The practice reflection requirement includes a self-reflection of strengths in practice and gaps in learning (CNO, 2021p). The second step requires registrants to develop an annual learning plan including learning goals that correlate with the code of conduct (CNO, 2021p). Nurses must evaluate the learning plan after the learning goals have been met and reflect on how the learning can be applied into practice (CNO, 2021p). Due to the more autonomous nature of self-employed roles, the independent practice guideline states these registrants may be required to collaborate with professional networks and identify relevant peers to provide a peer review (CNO, 2021i). It appears that the requirement for peer assessments may have recently changed, however, as there is no indication of a required peer assessment elsewhere in the CNO website or publications.

The RHPA (1991) directs regulatory bodies to maintain a QA committee that is responsible for ensuring participation and compliance with the QA program (CNO, 2020c). Registrants are required to retain a copy of their completed QA requirements for a minimum of two years (CNO, 2021f). Each year registrants are randomly selected for an audit of their participation which requires the submission of their learning plan and the completion of a "Code of Conduct practice activity" (CNO, 2021m). NPs are also required to complete an "additional assessment", but the nature of that assessment is not disclosed (CNO, 2021m). The independent practice guidelines (CNO, 2021i) reinforce the authority of the CNO's council and committees to perform an audit or practice visit as part of the QA program but there is no indication nurses in these roles are audited more often or differently than institutionally employed nurses.

Practice Support

Self-employed nurses will likely engage with practice support resources due to their unique role, potentially making these registrants more reliant on the CNO's practice support department. The CNO's web page states practice support staff are available by phone and email to assist with decision-making, answer questions, provide clarity on regulations, and help registrants access practice resources (CNO, 2020h). The CNO's practice support webpage states they will respond to practice-related inquiries within one to three business days (CNO, 2020h). There is no information regarding how the Practice Support department manages or tracks consultations.

In addition to contacting them directly, the CNO's leadership use social media platforms to provide updates to registrants and other stakeholders (CNO, 2021n). The CNO website includes several educational resources including a publication called *The Standard*, videos, webcasts, teleconferences, and a unique page called *Ask Practice* to assist registrants in translating regulations into practice (CNO, 2012, 2021o). Only a few of these additional resources provide guidance for nurses in independent practice including brief information on the requirements for documentation and record retention, setting fees, and selling products and medication (CNO, 2021a).

Chapter Discussion and Summary

The CNO's regulatory environment is influenced by a variety of actors and contextual features that have a distinct impact on self-employed nurses in that jurisdiction. Key actors have a unique role in influencing the regulatory context, content, and processes through formal and informal engagement. The CNO's context is defined by a detailed umbrella legislative framework, a single mandate to protect the public, a professional majority on council and

committees, and right-touch and risk based regulatory philosophies. The CNO's regulatory content is clear and detailed although there is no indication when or under what circumstance content would be reviewed or revised. Registrants of the CNO must declare they have practiced nursing, but it is not clear what constitutes evidence of nursing practice. Overall, the CNO's regulatory environment does not significantly impact self-employed nurses when compared to those who are institutionally employed although clarity and transparency surrounding regulatory processes could be improved.

Chapter 6.

Case 2 - College and Association of Nurses of Alberta (CARNA)

The CARNA makes up the second case which is characterized by an umbrella legislative framework, regulation of a single nursing group, a moderate number of registrants, and a dual mandate in transition. Additionally, rather than a single document, the CARNA's guideline for self-employed nurses is made up of two short checklists. This chapter is made of up four main sections including *Actors*, *Context*, *Content,* and *Processes* which together reveal the provincial nurse regulatory environment and its regulation of self-employed nurses in Alberta.

Actors

The government of Alberta, the public, registrants, and nurse educators and employers are key actors in nursing regulation. Representatives of the CARNA partner with external actors in provincial, national, and international spheres which have a direct influence on the CARNA's content and processes. The CARNA's *Strategic Directions* (CARNA, 2020e) publication outlines the leadership's commitment to improving engagement with stakeholders which indicates the influence of these actors may continue to grow over time.

Government

The minister of health has the responsibility of directing the provision of health care services and the regulation of health care providers in the province of Alberta (Government of Alberta, 2021b; Government Organization Act, 2000). The minister of health oversees the regulation of 31, soon to be 36, distinct health care provider groups in Alberta (Government of Alberta, 2021b). The government is a key stakeholder in nursing regulation as the CARNA is empowered by and accountable to the minister of health. The government directs regulatory practices through legislation, ministerial directives, councillor appointments, and measures of

oversight. In 2020, the provincial government initiated Bill 30 to amend the *Health Professions Act* (HPA) (2000), directing Alberta's regulatory bodies to alter the make-up of their councils and certain committees to increase public representation (CARNA, 2020a, n.d.k, n.d.f). Additionally, Bill 46 directed the CARNA and other regulatory bodies to operate with a single mandate and divide from the association to improve their accountability to the public interest (CARNA, 2020a, n.d.f). The proposed changes aligned with the findings of a commissioned external review of the CARNA's governance structure which contributed to their readiness to support these legislative changes (CARNA, 2020a). The CARNA's council voted unanimously in November 2020 to move to a single mandate and to adopt a new governance structure just before Bills 30 and 46 were proclaimed (CARNA, 2020a, n.d.f, n.d.k, n.d.m; Government of Alberta, 2021a).

There are additional instances of legislative changes that allowed for increased agility and "flexibility" (CARNA, 2018, p. 6) in CARNA's regulatory practices including changes to exam requirements, requiring indirect rather than direct supervision of RNs on the provisional register, and providing the regulatory body increased control over the Continuing Competence Program (CCP) (CARNA, 2018). The minister of health has also initiated legislative change to improve regulatory response to sexual assault at the hands of health care providers and broaden the scopes of practice of health care providers to improve public access, wait times, efficiency, and cost (Bennett, 2019; CARNA, 2016a; Heidenreich, 2015).

Operating with delegated power, the CARNA is accountable to the minister of health and is subject to a degree of oversight from the ministry. The HPA (2000) states the minister has the authority to make, change, or review regulations, bylaws, and amendments to standards of practice, as well as require annual and any additional reports. Since the proclamation of Bill 21

in 2018, all health care provider regulatory colleges must now submit an annual report disclosing the number of complaints received concerning sexual abuse or misconduct, the number of findings, and the resulting decision or imposed restrictions (Heelan et al., 2018, p. 21).

Public

The CARNA is mandated to protect the public interest, which positions the public as a key stakeholder in nursing regulation (CARNA, 2020e, 2021c, n.d.ac). As a result of Bill 30, public representation on the CARNA's council and committees are now equal to that of registrants. Beyond their involvement within the organization, the CARNA has established a patient advisory group and an Indigenous Advisory Committee (CARNA, 2019a) to incorporate public and Indigenous perspectives in the regulation of nursing (CARNA, 2020e). The public is also offered a consultation period to provide the opportunity for feedback on some new or changing regulations and standards (CARNA, 2016a, n.d.p; Mertz, 2020).

Informally, the public influences legislation governing regulation. For example, the minister of health made significant changes to the HPA (Heelan et al., 2018; Lee, 2019) following a highly publicized incident in which a physician was convicted of two counts of sexual assault (Bellefontaine, 2018; Bennett, 2018; Blais, 2016; Clancy, 2018; Gerein, 2018a, 2018b; Johnston, 2016). Both formally and informally, the public are key actors in nursing regulation.

Registrants

The role of registrants as a key actor in nursing regulation in Alberta has shifted significantly in the since the introduction of Bills 30 and 46 in 2020 (CARNA, 2020a). Previously a primarily profession-led organization, professional representation on council, hearing tribunals, and the investigation and discipline committee are now equal to that of the

public (CARNA, 2020a, n.d.a). Simultaneously, the association is being divided from the regulatory body which removes the professional interest from the CARNA's activities altogether (CARNA, 2020a, n.d.ac). Registrants are still offered a formal consultation period to provide feedback on select new and revised regulatory content and may influence regulation in this way (CARNA, n.d.p; Mertz, 2020).

Educators and Employers

Despite being directly impacted by the CARNA's nursing education program approval process, nurse educators are not included on any published list of stakeholders and are not mentioned in the CARNA's web page or publications. In contrast, the largest Albertan nursing employers, Alberta Health and Covenant Health, are included alongside other stakeholders in CARNA's publications (CARNA, 2016a, 2020e) and in a public statement to the press (Mertz, 2020). There are several mentions to "other stakeholders" in the CARNA's publications, but they are not further defined.

Greater Regulatory Landscape

The CARNA's council and committees operate within a greater provincial, national, and international landscape. Provincially, the CARNA is a member of the Alberta Federation of Regulated Health Professions (AFRHP) along with 29 other regulatory colleges who collaborate with the aim of ensuring the delivery of safe, competent, and quality health care (AFRHP, n.d.; CARNA, 2020a, n.d.w). Furthermore, representatives of the CARNA collaborated with other health care provider regulatory bodies, employers, Alberta Health Advocates, and the Health Quality Council of Alberta (HQCA) on a revision of the "patient concerns framework" and the "Just Culture" project (CARNA, 2016a). When instating the Medical Assistance in Dying (MAiD) program, the CARNA representatives collaborated with employers, the Alberta College

of Pharmacists, and the College of Physicians and Surgeons of Alberta to create standards of practice for NPs (CARNA, 2016a). Additionally, representatives of the CARNA collaborated with the LPN and RPN regulators in Alberta in projects related to the delivery of the MAiD program (CARNA, 2016a) and the webinar presentation, *Nurses in Independent Practice* (CARNA, 2020f).

On a national level, the CARNA is an organizational member of the CCRNR which has led to the adoption of the national NCLEX-RN entry-level examination, the Entry-Level Competencies for RNs and NPs (CARNA, 2016b, 2019b), and the regulation of NPs as part of the NPR-FIPP (NPR-FIPP, 2020). Additionally, during the June 2021 council meeting, CARNA representatives describe collaborating with the SRNA on an inter-jurisdictional project (CARNA, 2021a, 2021d).

Internationally, the CARNA is a member of the NCSBN based out of the US (NCSBN, 2021). The CARNA's council and committees also demonstrate a commitment to stay abreast of the national and international regulatory landscape by requesting and responding to several external reviews led by a local law firm (CARNA, n.d.y; Field Law, 2019) and regulatory experts (CARNA, 2019d; Governance Solutions, 2020). The CARNA's leadership has commissioned Harry Clayton, a former chief executive of the UK's PSA, to conduct an evaluation of the CARNA's complaints processes (CARNA, 2019a, 2020a; Clayton, 2019) and a full review of all aspects of the CARNA's regulatory processes to be complete in 2022 (CARNA, n.d.ac). Related to the organization's dual mandate, the CARNA is also a member of the CNA and the International Council of Nurses (ICN) (CARNA, n.d.r, n.d.ae) until 2022-2023 when CARNA officially splits the public and professional mandates into two separate organizations (CARNA, n.d.k). As an indicator of the CARNA's affiliation with the CNA,

registrants of the CARNA are held accountable to the CNA's *Code of Ethics for Registered Nurses*.

Context

Legislative Framework

All of Alberta's health care provider groups are directed by the *Government Organization Act* (2000) and the HPA (2000) which create a detailed framework for the structure and function of the regulatory bodies including their council and committees, mandate, scope of practice, and regulatory processes such as registration, continuing competency, and investigations and discipline (CARNA, n.d.t). This umbrella legislation is supplemented by profession-specific regulations outlining "restricted activities" that may be performed by competent members of each profession (Government of Alberta, 2021b). The *Registered Nurses Profession Regulation* (2005) outlines the specific restricted activities RNs and NPs may perform within their scope of practice. The CARNA regulates more than 38,000 RNs and NPs in Alberta (CARNA, 2020a, n.d.d) and is currently transitioning from a dual to a single mandate to regulate solely in the public interest (CARNA, n.d.k).

Regulatory Governance

The HPA (2000) provides the direction for the CARNA's governance structure including the council's size, structure, and processes (CNO, 2020a). Building on this legislative framework, CARNA's bylaws, policies, and protocols further define and direct the CARNA's governance and council structure (CARNA, 2020b). Related to impending changes to legislation (CARNA, n.d.f; Goulet, 2020) and the results of an external review (CARNA, 2020a), the CARNA's governance structure was significantly changed in 2020 to include equal parts appointed public representatives and vetted, elected registered nurses on council for a total of 16

councillors (Governance Solutions, 2020). The council chair and vice-chair are elected by the council and can be either a public or nurse representative (CARNA, 2020c). The chief executive officer is a RN appointed by and accountable to the council as a non-voting member who is responsible for the operation and oversight of the administrative responsibilities of the regulatory body (CARNA, n.d.h). The legislation and bylaws also direct the structure and function of a set of five governance committees and seven regulatory committees who are accountable to the council to fulfill their individual responsibilities outlined in legislation including appeals, nursing education approval, competence review, complaint review, hearing tribunal, and more (CARNA, 2020a). While both RNs and NPs are registered with the CARNA, there is no mention of a requirement for NP representation on the council or committees.

Regulatory Philosophy

The CARNA's webpage states the organizational vision is "excellence in nursing regulation and practice for the health of all Albertans" which is served by their mission that prioritizes safety, competency, and ethics while encouraging "innovative leadership" that will influence health policy (CARNA, n.d.u, p. e1). The webpage also states the values of integrity, respect, accountability, and professionalism guide the CARNA's council and committees (CARNA, n.d.u). Beyond the mission and values, the CARNA's leadership have chosen to align with two specific regulatory philosophies to frame and direct their work in the public interest; a risk-based approach and right-touch regulation.

Resultant of the external review of their governance structure, the CARNA's leadership has committed to changing their policy framework to be consistent with Enterprise Risk Management (ERM) (CARNA, 2020e, 2020a, n.d.h). The principle of ERM is to create a systematic approach to reporting and managing organizational risks, enabling the regulatory

body to achieve strategic objectives while reducing the effects of uncertainty (CARNA, 2020a). The CARNA's publications describe the development and implementation of a Risk Assessment and Direction (RAD) framework and tool to evaluate risks consistently and ensure it is actioned appropriately (CARNA, 2020e, 2020d). Using a risk-based approach, the CARNA's council and committees are positioned to balance an "upstream" perspective to prevent harms by directing resources into areas such as accreditation, setting standards and qualifications, and other applicable aspects of governance with a "downstream" perspective that includes risk-based principles in processes related to reporting, investigating, and adjudicating complaints (Governance Solutions, 2020). So far, risk-based principles have been incorporated into the CARNA's inquiry, complaint agreement, and disciplinary agreement processes (CARNA, 2020d).

In tandem with the risk-based approach, right-touch regulatory principles are being implemented into all aspects of CARNA's regulation practices (CARNA, n.d.h, n.d.k). The CARNA's leadership has commissioned a full "right-touch review" (CARNA, n.d.ac, n.d.k) and changes have already been made to align with this philosophy (CARNA, n.d.j). Some examples of the application of Right-touch principles are changes to the CCP and the discontinuation of the requirement for registrants to submit their mandatory annual CCP requirements on their account online (CARNA, n.d.j). Another example of the application of right-touch principles is the discontinuation of the requirement for registrants to report all blood-borne virus infections due to the low risk of transmission of these infections (CARNA, 2018). As a final example, the complaints director may choose to resolve complaints using a variety of tools allowing the process to be proportionate to the complaint (CARNA, 2016a). Due to the ongoing "right-touch

review" (CARNA, 2020e), right-touch regulation principles will continue to be influential the CARNA's content and processes.

Content

Definition of Nursing Practice

The definition of nursing practice is of paramount importance to the self-employed nurse as they seek to apply their knowledge, skills, and judgment in new roles, ensuring their practice aligns with the legislated and interpreted definition of nursing. The HPA (2000) defines nursing practice as:

> In their practice, registered nurses do one or more of the following:
>
> (a) based on an ethic of caring and the goals and circumstances of those receiving nursing services, registered nurses apply nursing knowledge, skill and judgment to:
>
> (i) assist individuals, families, groups and communities to achieve their optimal physical, emotional, mental and spiritual health and well-being,
>
> (ii) assess, diagnose and provide treatment and interventions and make referrals,
>
> (iii) prevent or treat injury and illness,
>
> (iv) teach, counsel and advocate to enhance health and well-being,
>
> (v) co-ordinate, supervise, monitor and evaluate the provision of health services,
>
> (vi) teach nursing theory and practice,
>
> (vii) manage, administer and allocate resources related to health services, and

(viii) engage in research related to health and the practice of nursing, and

(b) provide restricted activities authorized by the regulations (Schedule 24.3(a)).

The definition of nursing is further interpreted in the CARNA's scope of practice documents for RNs (CARNA, 2021c) and NPs (CARNA, 2021b). These documents do not explicitly define what nursing practice is but provide a very general and overarching description of how nurses use their skills, knowledge, and ethics in the domains of clinical practice, administration, education, research, and policy. Additionally, according to the *Entry-level Competencies for Registered Nurses* (CARNA, 2019b) and the *Scope of Practice for Registered Nurses* (CARNA, 2021c), nurses embody nine roles including clinician, professional, communicator, collaborator, coordinator, leader, advocate, educator, and scholar.

Practice Standards

Practice standards are influential in the practice of self-employed nurses as they are not guided by protocols or procedures published by their employer, referring to regulatory documents instead. The CARNA's core standards directing nursing practice include the *Practice Standards for Regulated Members*, *Entry-level Competencies for Registered Nurses* or *Nurse Practitioners in Canada*, *Scope of Practice for Registered Nurses* or *Nurse Practitioners*, and the *Code of Ethics for Registered Nurses* (adopted from the CNA) (CARNA, n.d.n). In addition to these, there are practice standards pertaining to restricted activities, use of title, documentation, supervision, privacy and health information management, advertising, and protecting patients from sexual abuse (CARNA, n.d.n). To further guide nurses in their practice the CARNA has also published coinciding practice guidelines for incorporating these standards into practice (CARNA, n.d.n). The CARNA's document library contains 24 different practice standards and 16 guidelines (CARNA, n.d.n). The documents each state they are not meant to be used in

isolation but in combination with as many as 12 other standards and guidelines (CARNA, 2013a, 2019c, 2019b). The 40 practice standards and guidelines are all listed in alphabetical order and are not otherwise organized to facilitate their use.

Practice Guidelines for Independent Practice

The CARNA's webpage defines self-employed practice as RNs or NPs who engage in nursing practice independently, in partnership, or as an employer of others (CARNA, 2019e). The webpage further describes the applicability of self-employed practice in a variety of settings including clinical practice, administration, education, research, and consultation and lists several common roles that might be performed by self-employed nurses (CARNA, 2019e). The CARNA's website provides a statement supporting the contributions of self-employed nurses to Alberta's health care while emphasizing the risks and restrictions associated with this type of role (CARNA, 2019e). None of the 16 practice guidelines published by the CARNA guide self-employed practice, instead these registrants are guided by two checklists (CARNA, n.d.e; n.d.aa).

The first checklist (See Appendix C) is meant to assist registrants in recognizing whether they are indeed practicing nursing within the bounds of the HPA (2000) and the CARNA's interpreted definition (CARNA, n.d.aa). Some of the items included on this checklist are seemingly contradictory which may contribute to confusion while others could be perceived to further restrict the CARNA's legislated and interpreted definition of nursing practice. For example, at the top of the checklist, a statement suggests that all the listed items should be "checked yes" to be considered nursing practice but the ninth item on the checklist is phrased in such as way that suggests that if the item is "checked yes", this may mean the service may not be considered nursing practice, conflicting with the statement at the top and context of the rest of

the listed items (CARNA, n.d.aa). Additionally, the checklist includes a list of four items describing roles that are not considered nursing practice such as those that consist primarily of activities that fall within the scope of unregulated or other health provider jurisdictions, focus on the sale of products, or those that are "too restrictive or limited in scope" (CARNA, n.d.aa, p. 2). It is unclear what process and evaluators are used to determine if a practice is "primarily" in the scope of another provider or "too restrictive or limited in scope".

Once it has been established that the self-employed practice is indeed nursing practice, a second checklist (CARNA, n.d.z) provides self-employed nurses with several cautions, recommendations, and requirements. This second checklist (CARNA, n.d.z) is two and a half text pages consisting of five main sections, the first revisits the need to ensure the service is a nursing practice. The other sections remind nurses they are accountable to a several practice standards and that there must be policies in place regarding maintaining competence, referring clients, and all the standards they must uphold throughout their practice. Several lines on the checklist encourage self-employed to seek out the expertise of accountants, bankers, the Canadian Nurse Protective Society, insurance brokers, lawyers, and other third parties in addition to a representative from the CARNA. The checklist items are listed in point form without much further direction or information, it is also unclear which are recommendations, and which are requirements (CARNA, n.d.z). The checklists do not provide a publication date and it is unclear when these documents will be subject to review or revision.

Beyond these two checklists, self-employed nursing practice is mentioned on a few other webpages scattered throughout the CARNA's website which requires nurses comb through the website to find those relevant pieces of information to guide their practice. Additionally, neither checklist nor the CARNA's web site provide any information regarding the process required to

apply for recognition as a nursing practice beyond the repeated recommendations to contact the CARNA practice support directly (CARNA, 2019e, n.d.ab, n.d.z; n.d.aa).

Processes

Currency of Practice

Self-employed nurses are specifically impacted by the CARNA's Currency of Practice process that requires registrants declare the number of nursing practice hours they have completed on their annual registration renewal application. According to legislation, RN registrants are required to complete 1125 practice hours within the last five years to meet the requirement for registration renewal (Registered Nurses Profession Regulation, 2005). The CARNA's website (CARNA, n.d.l) states NPs are additionally required to declare 1000 NP practice hours over a four-year period, 500 of which must be within their designated stream of practice. If NPs are in an educator role, only 200 hours per year count toward their total practice hours and must be declared as "non-clinical" hours (CARNA, n.d.l). For nurses in self-employed roles, the CARNA's web page states they "may only count these hours if [their] self-employed practice has been recognized as nursing practice by CARNA" (CARNA, n.d.l, p. e1). Yet, in a video webinar for nurses in independent practice, the presentation slides state "application is not needed for independent practice" (CARNA, 2020, 21:16). There are no further references describing what this approval process includes, there is no available application form, and there is no information about what type of documents are required as proof of nursing practice. Furthermore, the website does not provide information as to who is responsible for giving approval, how the process ensures consistency between applications, how a nurse can contest that decision, or how long the approval process will take. Additionally, there is no indication

whether the Currency of Practice process has an associated audit process to ensure nurses have met the required number of hours.

Continuing Competency Program

The HPA (2000) provides broad direction for the CARNA's CCP by stating, "A continuing competence program must provide for regulated members … to maintain competence and to enhance the provision of professional services, and may, if authorized by the regulations, provide for practice visits of the regulated members of categories of regulated members" (50(2)). The components of the CCP are further outlined in the *Registered Nurses Profession Regulation* (2005) which includes the following four components: practice reflection, continuing professional development, competence assessment, and practice visits.

The practice reflection aspect of the program requires nurses to provide a self-assessment of their learning needs based on the practice standards (Registered Nurses Profession Regulation, 2005). Feedback is meant to build upon the self-assessment which can be a formal, informal, or direct process and provided by someone who is familiar with the nurses' role and practice setting including a manager or supervisor, a RN, NP, or other colleague, another health care professional, and clients or their families (CARNA, n.d.q, n.d.o). The second step of the CCP, continuing professional development, includes a written learning plan outlining learning needs based on the practice standards and how the nurse plans to address them in the coming practice year (Registered Nurses Profession Regulation, 2005). Additionally, learning modules pertaining to jurisprudence (CARNA, n.d.s) and protecting patients from sexual abuse and misconduct (CARNA, n.d.w) are mandatory as part of the CCP (CARNA, 2016a, 2018). To follow up, registrants must complete an evaluation to assess how their learning activities impacted their

practice and retain their record of participation for five years (CARNA, n.d.q; Registered Nurses Profession Regulation, 2005).

The final steps of the program, competence assessment and practice visits, are completed by CARNA's competence committee who evaluate the registrants' competence using multiple sources of feedback, case studies, peer review, practice visits, and examinations (Registered Nurses Profession Regulation, 2005). According to previous annual reports (CARNA, 2017, 2018) registrants who submitted incomplete CCP requirements to the mandatory online portal were subject to a "directed" audit. There is no report demonstrating how many practice visits were conducted and how the committee selects a practice to visit. The CARNA's website currently states the CCP's associated audit process is under review to better align with right-touch regulation principles and will be reinstated in the 2022-2023 practice year (CARNA, n.d.j).

Professional Practice Support

The CARNA's practice support and consultation is available by phone, email, in-person, and by mail to assist registrants and stakeholders, although there is no indication of a response time (CARNA, 2020a, n.d.i). While consultation requests are tracked and reported on, there is no information as to the system the department uses to manage consultations to facilitate consistency (CARNA, 2020a). Social media tools are used to communicate with registrants and other stakeholders (CARNA, 2016a) and registrants have access to a variety of educational opportunities such as the *Ask Us* page (CARNA, n.d.f), webinars (CARNA, n.d.x), learning modules (CARNA, n.d.s, n.d.w), professional practice huddles (CARNA, n.d.v), and case studies (CARNA, n.d.g). The CARNA also hosts specialty practice groups such as the Alberta Association of Registered Nurses in Private Practice but will likely transfer that responsibility to the new association (CARNA, n.d.ad, n.d.c).

Chapter Discussion and Summary

The CARNA has unique features that make a distinct impact on self-employed nurses. Key regulatory actors each have a unique role in influencing regulatory context, content, and processes. The CARNA's context is defined by a detailed and directive umbrella legislative framework, a dual mandate undergoing transition, a governance structure made up of equal parts professional and public representation, and risk-based and right-touch regulatory philosophies. Regulatory content includes a broad and inclusive definition of nursing practice, 40 overlapping practice standards and guidelines directing nursing practice, and two checklists meant to guide self-employed nurses. These checklists have significant inconsistencies, lack detail, and could be perceived to further limit the scope of nursing practice. Registrants of the CARNA are required to report a minimum number of practice hours although there is no information about the process of applying for recognition as a nursing practice or on the process of auditing self-employed practice hours. The CCP audit process is currently under review, therefore it is unclear how this process may impact self-employed registrants in the future. Finally, professional practice support does not appear to significantly impact self-employed nurses, but the accountability and transparency of this service could be improved by including information as to the CARNA's consultation management process and a commitment to an inquiry response time. Overall, there are aspects of CARNA's content and processes that distinctly impact self-employed nurses that could be significantly improved to increase clarity and transparency.

Chapter 7.

Case 3 - Saskatchewan Registered Nurses Association (SRNA)

The SRNA is the third and final case which is characterized by its profession-specific legislative framework, its regulation of a single nursing group, its dual mandate, and relatively small number of registrants. Furthermore, the SRNA has recently completed a revision of their *Self-Employed Practice Guidelines* (SRNA, 2021c). This chapter is made of up four main sections including *Actors*, *Context,* and *Content,* and *Processes* which together reveal the provincial nurse regulatory environment and its regulation of self-employed nurses in Saskatchewan.

Actors

Key actors in SRNA's regulatory activities include the government of Saskatchewan, the public, registrants, and nurse educators and employers. The SRNA council and committee members participate in the greater regulatory environment through provincial, national, and international partnerships which influence the SRNA's content and processes and, therefore the practice of self-employed nurses in Saskatchewan.

Government

The SRNA is empowered by and accountable to the minister of health, positioning the provincial government as a major stakeholder in nursing regulation. The SRNA is accountable to respond to legislative change (The Registered Nurses Act, 1988; SRNA, 2015c, n.d.o), and ministerial directives (Saskatchewan Health Authority, 2018). Due to its general framework, most regulatory change in Saskatchewan does not require amendments to legislation. *The Registered Nurses Act* (1988) has only undergone minor changes in the last number of years; however, significant legislative change will be required to align with the council's recent

decision to transition to a single mandate and split from the association. All amendments to the SRNA's content and bylaws must be approved by the minister before being enacted. The SRNA's Legislation and Bylaws Committee is tasked with identifying legislative and regulatory change that may impact the nursing profession and respond by outlining potential proposals and amendments to recommend to the minister (SRNA, 2018b, 2020d). In some cases, the SRNA's website and documents describe a collaborative relationship with the ministry of health such as participating in dialogue with ministry officials during a council meeting to discuss the effects of the pandemic on nurses and the public (Koch, 2020d).

Public

The public is considered a key stakeholder in the SRNA as the protection of the public interest is the primary goal of nursing regulation. The public formally influence regulatory activities through participation on the SRNA's council and committees although public representatives make up a minority in this setting (SRNA, 2020c, n.d.q). Additionally, the SRNA also collaborates with a public advisory committee including patients and family members who provide perspective on the public interest (SRNA, n.d.q). The SRNA offers a consultation period for members of the public to respond to new or revised regulatory content and processes (SRNA, n.d.q). To further assess the public response to nursing regulation, the SRNA commissions a biennial survey of the public (SRNA, 2020b), but it is unclear how the results of these surveys impact regulatory activities.

Informally, public perception through the media is a key influence in the SRNA's regulatory practices. In 2015, an SRNA committee found an RN guilty of professional misconduct for using social media to discuss the care her elderly parents received at a health care institution in Saskatchewan (Saskatoon StarPhoenix, 2019; SRNA, 2018b). This case became

highly publicized across the nation and interveners including the Saskatchewan Union of Nurses, B.C. Liberties Association, and the Canadian Constitution Foundation were allowed to participate in the case as it was appealed, dismissed, and then appealed again (Baxter, 2019; Canadian Lawyer, 2020; Perron et al., 2020; Saskatoon StarPhoenix, 2019; Sciarpelletti, 2020; Short, 2020; Taylor, 2019; The Canadian Press, 2019; Vescera, 2020b). The verdict was eventually overturned by the Saskatchewan court of appeal in October 2020, stating the SRNA's discipline committee had "erred" in their processes (Taylor, 2019, p. e1) and unjustifiably infringed on the nurse's right to freedom of expression to the detriment of the public interest (Perron et al., 2020).

Although the rationale is not explicitly stated, several actions resulted from this national incident, the Saskatchewan government introduced legislation protecting health care whistleblowers in December of 2020 (CBC News, 2020), the SRNA leadership published a new *Social Media resource* in 2021 (SRNA, n.d.x), and the SRNA's council commissioned an external review of their investigations and discipline processes around the same time the notice of appeal was filed with the Saskatchewan court of appeal in May, 2018 (SRNA, 2018b, 2019b). The responses from the government and the SRNA demonstrate the impact of public perception in influencing legislative and regulatory change.

Registrants

Registrants are also a key stakeholder in SRNA's regulatory activities in several formal ways. Registrants make up the majority of members on SRNA's council and committees (SRNA, 2020c, n.d.q). Additionally, the SRNA's council commissions a biennial survey of the experiences of nurses in relation to regulation and workplace experiences (Dobni et al., 2019; SRNA, 2020b) and invites registrants to consult on new or revised regulatory content and

processes such as the revision of the self-employed practice guidelines (SRNA, 2020a), and changes to the CCP (SRNA, n.d.c). Furthermore, legislation dictates the SRNA's council must present all proposed changes to regulatory bylaws and practice standards for approval by a majority of nurse registrants present at the annual meeting (SRNA, 2020d) before being presented to the minister of health (The Registered Nurses Act, 1988). In this way, the SRNA's registrants have a strong influence as a key stakeholder in nursing regulation which may become more limited as the SRNA transitions to a single mandate.

Educators and Employers

The SRNA's publications reference nurse educators and employers as key stakeholders in nursing regulation. The SRNA's council consulted with nurse educators and employers during a role clarity and collaboration project involving all three nurse regulators in Saskatchewan (SRNA, 2016a). Additionally, the SRNA president meets annually with the deans of nursing education programs in Saskatchewan to "connect and identify opportunities to better work together" (Koch, 2020a, 2021). Additionally, the SRNA collaborates with the largest employer of nurses in the province, the Saskatchewan Health Authority (SHA) to discuss and collaborate on regulatory activities such as transitioning to a single mandate (Koch, 2020a), nursing practice and supply throughout the pandemic (Koch, 2020d), the delivery of the Medical Assistance in Dying program (SRNA, 2016a), and other changes to RN or NP scopes of practice (SRNA, 2018b, 2019b).

Greater Regulatory Landscape

The SRNA operates within and is influenced by a greater regulatory environment on provincial, national, and international levels. On a provincial level, representatives of the SRNA collaborate with other provincial health care professional regulatory bodies such as those that

regulate LPNs, RPNs (SRNA, 2016a, n.d.p), physicians and surgeons (SRNA, 2016b, 2019b, n.d.p), paramedics (Koch, 2020a), and pharmacists (Koch, 2020a; SRNA, 2016b). The SRNA is also a partner organization in the Network of Inter-Professional Regulatory Organizations (NIRO) (NIRO, n.d.; SRNA, n.d.p) and the Interdisciplinary Advisory Committee (SRNA, 2016a, 2019b). Different arrangements of these provincial professional regulatory bodies and organizations have worked together on projects such as the Collaborative Decision-Making Framework, guidelines for Medical Assistance in Dying (SRNA, 2016a, 2017), the Opioids Use Disorder program for NPs (SRNA, 2019b), and the Clinical Decision Tools for RN(AAP)s (SRNA, 2016b, 2019c).

The SRNA is also impacted by the greater regulatory environment on a national level. In January 2020, the SRNA council voted unanimously to move to a single mandate regulatory body (C. Smith, 2021; SRNA, 2020c, n.d.d). The SRNA's council did not make this change due to legislative change or apparent scrutiny from the provincial government, instead the SRNA's publications and public statements suggest it is in response to the changes occurring in the greater regulatory environment across Canada and the world (SRNA, 2020f; Vescera, 2020a). Furthermore, to assist in the preparations for this transition, external governance consultants (Koch, 2020b) and nurse regulatory representatives from the Alberta (Koch, 2020c), Manitoba, and British Columbia (SRNA, 2019b) were invited to present and share their experiences of moving to single mandate organizations. In another demonstration of the influence of the national regulatory environment, the SRNA is partnered with the CCRNR (CCRNR, 2021; SRNA, n.d.p) and the CNA (C. Smith, 2021; SRNA, n.d.p) which have influenced the SRNA's content and processes including the adoption of the NCLEX-RN examination (SRNA, 2016a), the entry-level competencies, RN(NP) practice standards (SRNA, 2017), the processes

surrounding the regulation of NPs (NPR-FIPP, 2020; SRNA, n.d.o), and the CNA's code of ethics (2017). Additionally, the SRNA's council and committees have adopted the CNO's process for registering internationally educated nurses and are currently partnered with the CARNA in an interjurisdictional project (CNO, 2020b).

Internationally, the SRNA council and committees interact with the greater regulatory environment. The SRNA's council initiated an environmental scan across Canada and North America to assess current practices in the delivery of a CCP that aligns with right-touch and relational regulation which informed a revision of this program (SRNA, 2017). Additionally, the SRNA's council commissioned PSA representatives from the UK to assess and report on the SRNA's investigation and discipline processes (SRNA, 2019b, 2019g). The SRNA's council demonstrates a commitment to meeting internationally accepted standards for best practice in professional regulation by meeting all the recommendations included in the resulting report (SRNA, 2016a, 2019a). The SRNA is an organizational member of the NCSBN (SRNA, n.d.p) based out of the US although the influence of this partnership is unclear.

Context

Legislative Framework

In Saskatchewan, the regulation of health care providers is directed by individual acts specific to each of the 27 regulated professional groups (NIRO, n.d.). *The Registered Nurses Act* (1988) describes the role and scope of RN and NP practice but does not provide a list of restricted activities that may be performed by these professionals. The legislation empowers the SRNA as a dual mandate regulatory organization and contains a section related to the association and its membership (The Registered Nurses Act, 1988). The legislated governance structure dictates there be a council of not less than nine members with no more than three public

representatives to be appointed by the lieutenant governor (The Registered Nurses Act, 1988). The legislation provides a generalized framework which is supplemented by the SRNA's bylaws (SRNA, n.d.g) which is first approved by a majority vote by registrants and then by the minister of health (SRNA, 2019a, n.d.b). The SRNA bylaws further define the organization's governance structure, committees, processes, as well as council numbers, terms, and functions (The Registered Nurses Act, 1988; SRNA, 2020d).

The SRNA has been empowered by legislation to regulate over 13,000 RNs and 285 NPs in Saskatchewan (SRNA, 2020c). The SRNA has also established another nursing designation, the RN with additional authorized practice or RN(AAP), who practice within an extended scope to serve northern remote populations (SRNA, n.d.u). The SRNA is a dual mandate organization that is charged with the responsibility of regulating RNs and NPs in the public interest and advocating for the advancement of the profession (SRNA, 2015a, 2016a). Organizational functions related to promoting the professional interest include representing the profession when working collaboratively with stakeholders, encouraging registrants to become leaders and influence health policy, and promoting evidence-based nursing practice through education resources and networking opportunities (SRNA, 2016a). The SRNA council voted unanimously in January 2020 to begin transitioning to a single mandate to align with current regulatory best practice and ensure the protection of the public interest (SRNA, 2020c, n.d.d). It is unclear how this transition may impact the SRNA's legislation and actors, contextual features, content, and processes as regulation practices are reviewed and revised to align with a single mandate.

Regulatory Governance

The SRNA's council is made up of 13 members, nine elected registrants including the president and president-elect and four appointed public representatives (The Registered Nurses

Act, 1988; SRNA, 2019c, n.d.f). The ED is appointed by the council to a non-voting position in the SRNA (The Registered Nurses Act, 1988) to serve as the only link between the council and SRNA's operational functions (SRNA, 2014a). The SRNA's governance structure is based on Dr. John Carver's policy governance model (SRNA, 2014a, 2019a) in which the council uses policy to separate the issues of organizational purpose, also called "ends" from other organizational functions, called "means" (Carver & Carver, 2016). The various policies outline the priorities and methods of the council, describe the delegation of council's authority to the ED, define ethics-based boundaries within which the ED may operate freely, and outline the ways in which the council oversees the work of the ED (SRNA, 2014a, 2014c, 2014b, 2015b). This model is referred to within *The Registered Nurses Act* (1988) and is thought to reduce council workload, provide clear expectations, and therefore facilitate a more relevant and complete evaluation (Carver & Carver, 2016).

Council members are also involved in several committees that focus on specific areas of regulatory work. *The Registered Nurses Act* (1988) requires the establishment of investigations and discipline committees but otherwise provides latitude for the SRNA's council to "establish any committees that are provided for by the bylaws or that it considers necessary" (c. 13(1)). Further committees empowered by the SRNA bylaws include the Registration and Membership Committee, the Nursing Education Program Approval Committee (NEPAC), and several advisory committees and working groups (SRNA, 2020c, 2020d). These committees are made up of a mix of public and professional representatives, with registrants making up the majority of all the committees (The Registered Nurses Act, 1988; SRNA, 2020d).

Regulatory Philosophy

The mission of SRNA's leadership is to see "RNs and NPs [become] leaders contributing to a healthy population" (SRNA, 2020c, p. 8). This mission is pursued through three key goals including "accountable, effective, transparent profession-led regulation in the public interest", "excellence in professional practice", and inspiring RNs and NPs to become "integral partners in health" (SRNA, 2020c, p. 8). The SRNA's council and committees operate with six guiding values including excellence, service, accountability, collaboration, visionary leadership, and relational ethics (SRNA, 2020c). Relatedly, strategic objectives include advancing the scope of practice and role clarity, public and registrant engagement, staff engagement and stewardship, and relational and right-touch regulatory processes (SRNA, 2020c). Relational regulation focuses on strengthening relationships with stakeholders including the public and registrants (Nova Scotia College of Nursing, 2021b). This principle is demonstrated in the provision of public and registrant consultation periods and biennial surveys (SRNA, 2018b, n.d.c).

The SRNA's leadership has also adopted the right-touch regulation philosophy which has guided the revision of various aspects of regulatory content and processes (SRNA, 2016a, 2019a, 2019d). For example, the SRNA council commissioned PSA representatives to complete an external right-touch review of their investigation and discipline processes in 2019 and the resulting recommendations were rapidly incorporated (SRNA, 2019a). Other right-touch initiatives include increasing the number of public representatives on some committees, establishing a family and patient advisory committee to improve accountability to the public interest (SRNA, 2018b), revising the nursing education program approval processes, creating the Clinical Decision Tools to guide RN(AAP)s in safe practice, and the establishment of a new

online member portal allowing for greater transparency with the public and employers who now may look up the status of a nurses' registration (SRNA, 2019b).

Content

Definition of Nursing Practice

For self-employed nurses, the legislated and interpreted definition of nursing practice provides the boundaries of their innovative roles and thus impacts their practice. Nursing practice in Saskatchewan is defined by *The Registered Nurses Act* (1988) as:

> Performance or co-ordination of health care services including but not limited to:
>
> (i) observing and assessing the health status of clients and planning, implementing and evaluating nursing care; and
>
> (ii) the counselling, teaching, supervision, administration and research that is required to implement or complement health care services;
>
> for the purpose of promoting, maintaining or restoring health, preventing illness and alleviating suffering where the performance or co-ordination of those services requires:
>
> (iii) the knowledge, skill or judgment of a person who qualifies for registration (c. 2(k)).

The SRNA further interprets this legislated definition by describing RNs as "self-regulated health care professionals who work autonomously and in collaboration with others" (SRNA, 2015a, p. 1) to assist individuals, families, groups, communities, and populations optimize their health through the coordination and delivery of health care and the support of self-care in all situations and stages of life (SRNA, 2015a). RNs and NPs practice in clinical, education, administration, research, and policy domains in various settings (SRNA, 2015a) and fulfill nine

roles including clinician, professional, communicator, collaborator, coordinator, leader, advocate, educator, and scholar (SRNA, 2019e). The SRNA's *Interpretation of the RN Scope of Practice* (2015a) describes the scope of nursing as "evolving" and responsive to changing health care systems and public needs (SRNA, 2015a).

Practice Standards

Registrants of the SRNA are held accountable to a code of ethics adopted from the CNA, Entry-Level Competences for RNs and NPs, and Practice Standards for RNs and NPs (SRNA, n.d.t, n.d.k). The SRNA has published 17 additional guidelines such as the *Self-Employed Practice Guidelines* (SRNA, 2021c) that are meant to support the application of the standards and code of ethics into nursing practice in various settings (SRNA, n.d.g, n.d.t, n.d.k). There are minimal overlapping standards and the document library is categorized by nursing designation to increase ease of use (SRNA, n.d.n).

Self-Employed Practice Guidelines

Self-employed nurses registered with the SRNA are guided by an 11-page practice guideline (SRNA, 2021c). The guideline defines self-employed practice as an RN or NP "applying their knowledge, skills and judgment in many roles that enable individuals, families, groups, communities and populations to achieve optimum levels of health" (SRNA, 2021c, p. 2). This work can be done in individual, collaborative, or administrative settings which is demonstrated with a list of self-employed practice exemplars (SRNA, 2021c). The guideline covers a variety of topics including a definition of the role of the self-employed nurse, how they fit into regulatory legislation, the recognition of nursing practice process, liability protection requirements, and the responsibilities of a self-employed role. The guideline includes a "Self-

Employed Practice Checklist" as an appendix which lists the various contacts and documents that may apply to nurses in these roles.

The SRNA's *Self-Employed Practice Guideline* (2021c) was recently revised although it is unclear what initiated the review. The latest version was published in 2021 (SRNA, 2021c), which compared with the late version from 2012 (SRNA, 2012) provides additional clarity as to the SRNA's expectations of the self-employed role, how it fits within the other regulatory standards, and what process is required to achieve recognition as a nursing practice. Several items were removed from the revised guideline including a section pertaining to business insurance, the recommendation that nurses must have experience before pursuing self-employed roles, and the requirement that nurses share with their clients how to report their concerns to the SRNA. Overall, the updated *Self-Employed Practice Guideline* is clear, consistent with the rest of the SRNA's published content and processes, and descriptive of the expectations pertaining to this role.

Processes

Recognition of Nursing Practice

The process of being recognized as a nursing practice has a critical impact on self-employed nurses who, without approval from the SRNA's registrar, are unable to use their professional title, apply for liability insurance, and count their practice hours toward registration renewal (SRNA, 2021c). *The Registered Nurses Act* (1988) provides the SRNA with the authority to create bylaws "respecting the granting of membership" (c. 15(1)). To renew their registration, the SRNA's bylaws (SRNA, 2020d) require RNs to practice at least 1125 nursing hours in the last five years. In addition to this requirement, RN(AAP)s and NPs must complete at least 900 hours in their advanced scope in the last three years (SRNA, 2020d). To count their

hours toward these totals, self-employed nurses must first apply to the SRNA for recognition as a nursing practice (SRNA, 2021c, n.d.r).

The SRNA's council and committees have established the recognition of nursing practice process to evaluate services being offered by nurses in "non-traditional or complex roles" (SRNA, n.d.j) to determine whether it can be classified as RN or NP practice (SRNA, n.d.j, n.d.r). SRNA registrants must apply to the registrar or their designate by submitting the following requirements (SRNA, n.d.r, n.d.j):

- evidence of SRNA registration in good standing,
- a completed *Request for Recognition of Practice as Approved RN or NP* application form,
- a written description of how the provided service meets the SRNA's practice standards and entry-level competencies with at least two examples supporting each indicator,
- a job description including required qualifications, responsibilities, and education,
- proof of required education completion, and
- additional documents and references upon request (SRNA, n.d.r, n.d.j).

The application forms for RNs and NPs require a description of how the service falls within the scope of nursing, how the nursing process is applied in their practice, and how the applicant meets and intends to maintain the required competencies (SRNA, 2021b, 2021a). Furthermore, the forms require the applicant to describe how the practice standards are applied in the position (SRNA, 2021b, 2021a). It is unclear if the application form also fulfills the listed requirement to provide a written description of how the service meets the practice standards and entry-level competencies. Notably, the SRNA's *Self-Employed Practice Guidelines* (SRNA, 2021c) highlight three out of five practice standards and three out of nine entry-level

competencies that particularly apply to self-employed roles, yet all the practice standards and entry-level competencies must be demonstrated on the application and in the additional written description (SRNA, 2021b, 2021a, n.d.r).

The SRNA's web page states the "amount of time required to render a decision is impacted by the completeness and thoroughness of the documentation submitted to support the request" (SRNA, n.d.r, p. e1) and does not provide any further indication on how long it will take to receive a response. Following an initial review of the application, the SRNA's representative may respond with a partial or full approval, request additional information before deciding, forward the request to the Registration and Membership Committee for review, or deny the application outright (SRNA, n.d.r). There is no available information indicating if or how applicants can appeal the committee's decision.

The SRNA's audit program was established to ensure registrants are meeting the required number of practice hours (SRNA, n.d.i). Registrants including those who have applied for recognition of practice are randomly selected to participate in the audit (SRNA, n.d.s). When in institutional employment, the SRNA requires the employer to complete and send in an audit form to verify hours worked (SRNA, n.d.i). There is no further information as to what constitutes proof of practice hours in the case of self-employment.

Continuing Competence Program

The Registered Nurses Act (1988) does not direct the SRNA's CCP outside of defining its purpose which is "reviewing and improving the quality of nursing care provided by members" (s. 38.1(a)). Based on this framework, the SRNA's bylaws further direct the CCP which currently includes four main components, a self-assessment, a learning plan, peer feedback, and a learning plan evaluation (SRNA, 2020d, 2020e). Written feedback is accepted in the form of direct

feedback from a colleague, a performance evaluation, participation in a presentation or workshop, or from attendees at a presentation delivered by a registrant as indicated by several example templates provided on SRNA's website (SRNA, n.d.h, n.d.e). There is no indication that self-employed nurses have additional considerations when selecting a "colleague" to provide feedback. There is indication that SRNA was developing a mandatory jurisprudence module (SRNA, 2015c, 2017) and that CCP requirements may be collected into an online member portal in the future, but it is unclear if these projects are still in progress (SRNA, 2019c). The CCP is currently undergoing a review process that includes the perspectives of registrants using surveys and focus groups to determine how the CCP can be made more effective and align with right-touch regulation principles (SRNA, n.d.c).

Registrants are required to maintain proof of their completion of CCP requirements for a period of five years (SRNA, 2017). Each year an SRNA committee completes a random audit to assess compliance with the CCP program (SRNA, 2016a). Selected RNs and NPs are required to submit components of their CCP files to demonstrate successful completion (SRNA, 2020e). Those who are not compliant with the CCP are issued letters outlining required improvements and some are required to meet with a nursing advisor in Regulatory Services to review CCP requirements (SRNA, 2015c).

Practice Consultation Services

The SRNA's Practice Consultation Services department provides support to registrants by phone, email, and in person and commit to providing a response to inquiries within 24 hours on the weekdays (SRNA, 2020c, n.d.m). Practice Consultation Services are aided using a consultation management software (FLO) which is used to document consultations and provide consistency in responses and provide registrants with access to resources online (SRNA, 2018b,

2019b). SRNA representatives further communicate with registrants using several mediums including social media and other publications (SRNA, 2017, 2019b, n.d.v, n.d.x) and provide various learning and networking opportunities such as Webinar Wednesdays (SRNA, 2018a), the Online Communities of Practice (SRNA, 2017, 2018a, n.d.w, n.d.l), and Professional Practice Groups (SRNA, n.d.l). As the SRNA transitions to a single mandate, some of the current initiatives will likely change focus or move to the new association although no announcement has been made in this regard.

Chapter Discussion and Summary

Self-employed nurses are uniquely impacted by the distinct features of the SRNA's regulatory actors, context, content, and processes. The government, public, registrants, nurse educators, and employers as well as the provincial, national, and international regulatory landscape have a primary influence on regulatory context, content, and processes. The SRNA's context includes a generalized profession-specific legislation, a transitioning mandate that will be accountable to only the public interest, a governance structure made up of a strong majority of professional members, and relational and right-touch regulation philosophies. The SRNA's regulatory content includes an inclusive definition of nursing practice, well organized practice standards and codes that minimize overlap, and a recently updated and descriptive self-employed practice guideline. The recognition of nursing practice process is noted to have some duplicate and inconsistent requirements and there is a lack of transparency regarding the processing time and an option for appeal. The CCP does not specifically impact self-employed registrants although further clarity regarding what constitutes acceptable feedback sources would be beneficial. Practice Consultation Services are accountable to a response time and use computer software to improve consistency between consultations. Overall, the SRNA's regulatory

environment does have additional regulatory requirements that specifically impact self-employed nurses and the clarity, consistency, and transparency surrounding some regulatory processes could be improved.

Chapter 8. Cross-Case Analysis and Discussion

The CNO, CARNA, and SRNA each have distinct regulatory environments that impact self-employed nursing practice in unique ways. This chapter is a cross-case analysis which provides insight into what makes each provincial regulatory body unique and how self-employed nurses are affected by regulatory actors, context, content, and processes. Deviating from the layout of the individual cases, the first half of the chapter compares and analyzes regulatory content and processes. Having considered the aspects of regulatory content and processes that specifically impact self-employed nurses, the influence of the regulatory context and actors is explored in the second half of the chapter.

Content

Definition of Nursing Practice

The definition of nursing practice has a significant impact on self-employed nurses as it defines the boundaries of their innovative practice. Institutionally employed nurses must practice within the legislated and interpreted definition and scope of nursing and the narrower scope endorsed by their employer (CNA, 2015). Considering self-employed nurses practice without these additional limitations to their scope, they are more likely to be impacted by the definition provided by the legislation and regulatory body. The legislated definitions of nursing practice in the three cases have significant differences yet the interpretations of the nursing role provided by the provincial regulatory bodies are almost identically broad and inclusive, enabling a wide variety of nursing roles (CARNA, 2021c; CNO, 2019i; SRNA, 2015a). This finding is in contradiction to what participants in Wall's (Stahlke Wall, 2018) and Smith's (2016) research reported as a limiting and clinically focused operational definition of nursing practice.

Practice Standards and Guidelines

Practice standards published by the nurse regulatory bodies have distinct similarities as demonstrated in Table 2. Related to their partnership with the CCRNR, the CNO, CARNA, and SRNA utilize the same entry-level competencies for RNs and NPs (CARNA, 2019b; CNO, 2018b; SRNA, 2019e). Additionally, the CARNA and the SRNA have both adopted the CNA's *Code of Ethics* (2017). Due to their single mandate, the CNO is not associated with the CNA, but their ethical standards (CNO, 2019f) are very comparable to the CNA's *Code of Ethics* (2017) with only a few exceptions. Furthermore, the CARNA and the SRNA have nearly identical practice standards for RNs (CARNA, 2013b; SRNA, 2019f). The CNO's practice standards for RNs (CNO, 2018d) have commonalities with those adopted by the CARNA and the SRNA, but additionally include standards related to leadership and relationships.

Table 2

Comparison of Practice Standards and Codes Directing Nursing Practice

Document Type	CNO	CARNA	SRNA
Code of conduct	Y	N	N
Code of ethics/ Ethical standards	Y	Y (CNA)	Y (CNA)
Entry-level competencies	Y (CCRNR)	Y (CCRNR)	Y (CCRNR)
Standard of practice for each nursing group	Y (NP only)	N	Y (RN, RN(AAP), NP)
Standard of practice for combined nursing groups	Y	Y	N
Scope of practice for each nursing group	N	Y (RN, NP)	N
Other practice standards	4	19	0
Total standards	9	24	5
Total practice guidelines	11	16	17
Combined total	*20*	*40*	*22*

Note. "Y" signifies yes, as the regulatory body includes a document of that type. "N" signifies no, there is not that type of document directing the practice of nurses. "Other practice standards" refers to standards pertaining to documentation, supervision, advertising, etcetera.

Both the CNO and the SRNA websites present the practice standards and guidelines in an organized and systematic manner which facilitates their access and use (CNO, 2021s). The CARNA is distinct for publishing almost twice as many practice standards and guidelines than the CNO and SRNA (See Table 2) which are presented in a single alphabetized list, making it more challenging to identify which may be applicable to practice. Additionally, each of the CARNA's standards and guidelines are meant to be used in combination with several other standards and guidelines, requiring registrants to maintain a knowledge of a majority of the 40 published practice standards and guidelines. In the absence of employer policies and procedures, self-employed nurses are held directly accountable to regulatory practice standards and guidelines and will likely be required to access and incorporate more of them due to the independent nature of their practice, therefore the number and the manner in which these documents are presented is important in facilitating their use. Considering this, self-employed nurses registered with CARNA may be at higher risk of inconsistently incorporating practice standards and guidelines into practice to the detriment of public safety and the success of the self-employed registrant.

Self-Employed or Independent Practice Guidelines

The CNO's, CARNA's, and SRNA's websites provide published guidelines for nurse registrants that are interested or engaged in self-employed or independent practice. These documents are critical to self-employed registrants as they navigate the transition to becoming self-employed while remaining in good standing with the regulatory body. The CNO's and SRNA's guidelines are both descriptive multi-page documents that cover a variety of pertinent topics. The CNO's guidelines (CNO, 2021i) are unique in the invitation for nurses to corporate their self-employed practice with the CNO or the Ontario government. When compared to the

others, the CNO's eight-page document includes the most specifications for fees, the sale of products, advertising, record keeping, and medication administration. The CNO's independent practice guidelines do not describe any processes nurses must engage in to be recognized as a nursing practice by the regulatory body.

In contrast, the CARNA's checklists guiding self-employed practice (See appendixes C and D) (CARNA, n.d.z; n.d.aa) are unclear, contain contradictions, and lack detail, limiting their effectiveness. Checklist items seemingly contradict and narrow the legislated and interpreted definition of nursing practice by specifically excluding services that:

- could be completed primarily by unregulated providers,
- are within the jurisdiction of other health care regulators,
- are focused on the sale of products, or
- is "too restrictive or limited in scope" such as leading CPR courses (CARNA, n.d.e, p. 1).

It is unclear how these subjective evaluators are used to assess self-employed practices as the checklist could be perceived to indicate that time spent providing services such as activities of daily living might not be counted as RN practice as they can also be provided by LPNs or other providers. In comparison, RNs in institutional employment can count all their activities as RN practice hours while working in their position. For example, during their shift, an RN might empty trash cans, stock supplies, complete activities of daily living, and provide medications. Many, if not all these listed tasks could be completed by other regulated and non-regulated care providers but are still counted toward the required number of practice hours by the regulatory body. It is important that the CARNA's webpage and publications improve transparency,

consistency, and clarity by providing clear indicators of what specifically counts as nursing practice and the process with which that is determined.

The SRNA's 11-page *Self-Employed Practice Guideline* (SRNA, 2021c) is the most comprehensive. The SRNA's guideline is distinct due to its description of how the role fits within the entry-level competencies and practice standards and how self-employed nurses can apply for recognition as a nursing practice. Furthermore, the guidelines are unique in outlining specifications pertaining to informed consent, confidentiality, information management, policy and procedure development, quality improvement, and risk management. The SRNA's guidelines also provide the most detailed information about which external consultations self-employed nurses should seek as they start and maintain their practice.

None of the regulatory bodies' web pages or bylaws provide information on whether these guidelines are reviewed on a consistent basis or what would stimulate a revision. The CNO's guidelines provide a record of amendments to the document on the second page which indicates the document was last updated in 2021 and 2019 (CNO, 2021i). The SRNA's guideline does not provide a record of minor updates, but very recently reviewed and revised the guideline. It is unclear what specifically prompted the revision of the guideline and there is no information as to how often it is reviewed for accuracy. The CARNA's checklists do not provide a date of publication or any information about when or why it may be revised.

Comparing the three regulatory bodies' self-employed guidelines from the perspective of a self-employed nurse, self-employed registrants of the CNO may have additional specifications and requirements to consider but benefit from the additional transparency and frequent updates of the guideline. Registrants of the SRNA benefit from the clarity and comprehensiveness of their guideline. CARNA registrants utilizing the provided checklists are impacted by the lack of

clarity, consistency, transparency, and accountability which could result in miscommunication, inconsistent enactment of the responsibilities required of self-employed nurses, delays in application processing time, and inconsistencies between applicants. This finding aligns with the participants experiences in Wall's (Stahlke Wall, 2011, 2018) research who reported perceiving the regulator's definition of nursing practice to be "narrow" and processes pertaining to self-employment to be inconsistent, confusing, time consuming, and lacking information.

Processes

Declaration or Currency of Practice Processes

The CARNA's and SRNA's RN registrants are required to complete 1125 hours of nursing practice within the last five years and for NPs, 900 to 1000 hours of practice within the last three or four years (Health Professions Act, 2000; SRNA, 2020d). This process requires nurses to track their hours and declare them on the annual registration renewal application. The SRNA has established a practice hour audit process to confirm nurses have completed the required number of hours declared on their registration renewal (SRNA, n.d.s). Registrants are selected at random and are required to submit proof of completed nursing practice hours (SRNA, n.d.s) although the there is no information as to what constitutes proof of nursing practice hours when nurses are self-employed. The CARNA's web page and published documents do not describe a comparable audit program of their Currency of Practice requirements.

Registrants of the CNO are not required to complete a specific number of practice hours, but instead complete a Declaration of Practice on their registration renewal to report they have practiced nursing within the last three years (CNO, 2018c). The CNO's web page references "Evidence of Practice" which seemingly describes information that would prove the applicant has practiced nursing in the last three years (CNO, 2021e). The web page does not provide any

information as to what qualifies specifically as "evidence" or if there is an audit process that requires the submission of that evidence.

The lack of clarity and transparency regarding processes surrounding reporting practice hours and declaring recent nursing practice, their associated requirements, and the potential for an audit may negatively affect self-employed nurses as they may not be prepared for such an audit should they be selected. Furthermore, being selected for an audit they were not aware of may lead to the perception they are disproportionately targeted as was described by participants in Wall's (Stahlke Wall, 2018; Wall, 2013a, 2014) and Smith's (2016) research.

Recognition or Proof of Nursing Practice

Related to the requirement to report a minimum number of practice hours, the self-employed registrants of the CARNA and the SRNA are required to apply for approval as a nursing practice before they may use their title, apply for liability protection from CNPS, and count their hours toward their annual registration renewal (CARNA, n.d.z, p.; SRNA, n.d.r). According to Wall's (Stahlke Wall, 2018; Wall, 2013b) and Smith's (2016) research, this application process was reported to be ill-suited to self-employed roles, inconsistent, and time consuming. Given the significance of gaining approval as a nursing practice, it is crucial that regulatory bodies establish processes are consistent, targeted, transparent, accountable, and agile so nurses know what to expect when applying and that the decision is reached in a transparent and timely manner.

Besides stating self-employed nurses "may only count these hours if [their] self-employed practice has been recognized as nursing practice by CARNA" (CARNA, n.d.l, p. e1), the CARNA's webpage and publications do not provide any information guiding nurses in understanding the process of gaining recognition as a nursing practice. I reached out to the

CARNA to request the application form their registrants use to apply for approval as a nursing practice, but the CARNA does not have such a form. In fact, a video presentation describing nurses in independent practice states that for CARNA registrants, “application is not needed for independent practice” (CARNA, 2020, 21:16). The lack of transparency surrounding the process of applying for recognition as a nursing practice is a may inhibit nurses entering self-employment as they must engage in the process without any prior knowledge as to what the process involves, what proof and paperwork will be required, or how long it will take. Furthermore, without an established and published process, there is a significant propensity for the regulatory process to lack of accountability and consistency to the detriment of public safety and the success of self-employed registrants.

The SRNA’s website provides a description of the Recognition of Practice application, review, and decision processes (SRNA, n.d.r). Additionally, the SRNA’s webpage provides application forms for RNs and NPs on their webpage, openly accessible to the public and registrants (SRNA, 2021b, 2021a). To gain recognition of nursing practice, the SRNA registrant must complete an application form and submit several required documents. There appears to be overlapping requirements that create redundancy and may create delays in processing time if requirements are inadvertently missed due to a lack of clarity. Furthermore, the SRNA webpage does not provide information on how long nurses can expect to wait for the regulatory body to reach a decision regarding the application or how that decision can be appealed.

With the exception of the CNO, all Canadian RN regulatory bodies require registrants to report a minimum of 1125 practice hours over five years (British Columbia College of Nurses & Midwives, n.d.; CARNA, n.d.l; College of Registered Nurses of Manitoba, n.d.b; College of Registered Nurses of Newfoundland & Labrador, n.d.; College of Registered Nurses of Prince

Edward Island, n.d.; Nova Scotia College of Nursing, n.d.; Nurses Association of New Brunswick, n.d.b; Ordre des infirmières et infirmiers du Québec, 2009; Registered Nurses Association of the Northwest Territories and Nunavut, 2022; SRNA, n.d.j; Yukon Registered Nurses Association, n.d.), but the rationale supporting that specific number is unclear. There is no evidence to support a specific number of practice hours in effectively assuring continued competency. While it may be reasonable to assume that actively engaging in nursing practice is essential to maintain competence, there is no evidence to suggest that requiring a minimum number of practice hours is more effective in assuring continued competency of registrants when compared with the declaration method used by the CNO. Additional research is required to determine how the continued competency of registrants is best assessed and assured to most effectively regulate registrants practicing in self-employed and other emerging nursing roles.

Quality Assurance or Continuing Competence Programs

The CNO, CARNA, and SRNA are each required by legislation to establish and maintain a program that ensures registrants maintain their competence and participate in professional development over the duration of their registration. While the QA program or CCP is described marginally differently across jurisdictions, they are made up of similar components including a professional self-reflection, peer feedback, the creation of a learning plan incorporating the practice standards, and an evaluation of the learning plan and its impact on the registrant's nursing practice.

Participants in Wall's (Stahlke Wall, 2018; 2013b, 2014) and Smith's (2016) research specifically reported feeling restricted by who or what constituted an "appropriate peer" to provide feedback due to their practice in more independent roles. CNO registrants are not required to obtain written peer feedback and the CARNA's list of acceptable is very inclusive

and should be applicable to nurses in any role. The SRNA does not explicitly define who is an acceptable "colleague", but their various example feedback forms give the impression the SRNA committee may be open to various types of written feedback from a variety of sources. SRNA registrants would benefit from additional clarity in this regard.

Related to the required components of the QA or CCP, participants in Wall's (Stahlke Wall, 2018; 2013b, 2014) and Smith's (2016) research reported perceiving they were targeted for audits by the regulatory bodies in comparison with nurses in institutional employment. The CNO's and the SRNA's websites state registrants are selected at random for audits to verify CCP requirements. The CARNA's audit process is currently under review, however annual reports suggest they previously completed "directed" audits of registrants who submitted continuing competence requirements that were incomplete (CARNA, 2017, 2018).

Both the CARNA and SRNA CCPs and associated audit processes are currently undergoing revisions to better align with right-touch principles. While self-employed nurses will likely benefit from a process that is more proportionate, consistent, transparent, accountable, and agile, regulatory bodies may choose to target self-employed nurses for audits as they practice without the additional layers of oversight experienced by nurses in institutional employment. Following a review of their CCP program, representatives of the College of Registered Nurses in Manitoba (CRNM) report changing their annual CCP audit process to include 5% of RNs and 20% of NPs due to their "expanded scope of practice and the associated higher risk to the public" (S. Brown & Elias, 2016, p. 50), demonstrating the concept of "targeting" practice areas perceived to pose a higher risk to the public. While it may be reasonable to target self-employed nurses for audits of practice hours and CCP requirements, it is essential these processes are transparent and well communicated so self-employed registrants do not perceive themselves to

be victim to disproportionate surveillance by being made aware of the need for this additional oversight.

Practice Consultation or Support

Self-employed nurses will inevitably engage with practice consultants as they navigate the process of being recognized as a nursing practice and as they encounter new practice issues related to their non-institutional roles. Participants in Wall's (Stahlke Wall, 2018) and Smith's (2016) research report strongly negative experiences with practice consultants due to inconsistencies between one contact and the next and a perceived lack of experience working with nurses in "non-traditional" roles. All three nurse regulatory bodies included in the study offer practice support by phone, mail, email, and in-person. There is no information provided as to who qualifies as practice consultants and who manages inquiries specifically from self-employed nurses at each of these regulatory bodies. The SRNA is unique for using a consultation management system, FLO, which stores records of practice consultations and makes them easy to retrieve which assists consultants in providing consistent information (SRNA, 2018b, 2019b). As for the timeliness of their responses, the CNO and SRNA's webpages commit to timely responses, an accountability not provided by the CARNA.

The introduction of consultation management software may be pivotal in breaking down barriers for self-employed nurses who interact with multiple consultants on several occasions. Research is needed to confirm its effectiveness in reducing inconsistencies and inefficiencies for those providing and utilizing practice consultation services. Additionally, nurse regulatory bodies and their self-employed registrants may benefit from a targeted initiative that includes a nurse with experience in non-institutional roles as a practice consultant who may better understand and more clearly communicate regulations and requirements to their peers in this unique practice

area. Other than the web page, the practice support and consultation staff are the only contact point for registrants, making it essential that it this department is positioned to enact the principles of good regulation including consistency, accountability, and agility to the benefit of the registrants, including those who are self-employed as they seek to align with regulatory requirements to practice safely in the public interest.

Table 3 demonstrates the various regulatory content and processes that impact self-employed nursing practice. Regardless of what is included in the content and processes utilized by regulatory bodies, the effective regulation of self-employed nursing is facilitated when content and processes are clearly and consistently described, easily accessible and applicable to practice, and transparent and accountable. Ultimately, content and processes that are proportionate, consistent, transparent, targeted, accountable, and agile will improve self-employed nurses trust in the regulator, facilitate self-employed nursing practice, and ensure public safety through effective regulation.

Table 3

Summary of Regulatory Content and Processes Compared Across Jurisdictions

Aspect of Regulatory Content or Processes	CNO	CARNA	SRNA
Definition of nursing practice	"The promotion of health and the assessment of, the provision of care for and the treatment of health conditions by supportive, preventative, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function" (Nursing Act, 1991, c. 2(3). - Endorses five domains of RN practice - Includes nine roles of the RN	"In their practice, registered nurses do one or more of the following: (a) based on an ethic of caring and the goals and circumstances of those receiving nursing services, registered nurses apply nursing knowledge, skill and judgment to: (i) assist individuals, families, groups and communities to achieve their optimal physical, emotional, mental and spiritual health and well-being, (ii) assess, diagnose and provide treatment and interventions and make referrals, (iii) prevent or treat injury and illness, (iv) teach, counsel and advocate to enhance health and well-being, (v) co-ordinate, supervise, monitor and evaluate the provision of health services, (vi) teach nursing theory and practice, (vii) manage,	"Performance or co-ordination of health care services including but not limited to: (i) observing and assessing the health status of clients and planning, implementing and evaluating nursing care; and (ii) the counselling, teaching, supervision, administration and research that is required to implement or complement health care services; for the purpose of promoting, maintaining or restoring health, preventing illness and alleviating suffering where the performance or co-ordination of those services requires: (iii) the knowledge, skill or judgment of a person who qualifies for registration" (The

		administer and allocate resources related to health services, and (viii) engage in research related to health and the practice of nursing, and (b) provide restricted activities authorized by the regulations" (Health Professions Act, 2000, Schedule 24.3(a)) - Endorses five domains of RN practice - Includes nine roles of the RN	Registered Nurses Act, 1988, c. 2(k). - Endorses five domains of RN practice - Includes nine roles of the RN
Practice standards and guidelines	- 20 total documents - Organized into subgroups - Minimal overlap between documents	- 40 total documents - Single alphabetical list - Overlapping, requires simultaneous use of multiple documents	- 22 total documents - Organized by role - Minimal overlap between documents
Self-employed practice guidelines	- Single document - Eight text pages - Option for incorporation - Unique for specifications for fees, sale of products, advertising, record keeping, and medication administration - No information on how self-employment impacts registration - Provides record of amendments - No information regarding what prompts future review	- Two checklists - Not official guideline - Inconsistent information noted on first checklist - Could be perceived to limit RN scope of practice - Lack specific expectations regarding self-employed roles - No information on how self-employment impacts registration - No publication date or information regarding what prompts future review	- Single document - 11 text pages - Describes how role fits within the practice standards and entry-level competencies - Unique for specifications pertaining to informed consent, confidentiality, information management, policy and procedure development, quality improvement and risk management, and recommendations for external consultations - No information regarding what prompts future review
Practice hours/declaration of nursing practice	- Does not require minimum number of hours - Simple process - No information regarding what constitutes "evidence of practice" when self-employed - No information about an associated audit process	- Requires 1125 minimum number of hours - Not clear on how to track self-employed hours - Not clear on associated audit process	- Requires 1125 minimum number of hours - Not clear on how to track self-employed hours - Associated audit process
Recognition of nursing practice application	- Not required	- Required - Conflicting information as to requirement to apply - No information regarding the application process, requirements, how the decision is made, time to reach a decision, or how to appeal a decision	- Required - Application requirements provided - Duplicated requirements to describe how role meets all practice standards and includes all entry-level competencies - No information regarding the time to a decision or how that decision can be appealed
Continuing competence program	- No required written peer review - Associated random audit	- Required written peer review but list of appropriate peers is inclusive - Associated audit process under review; previously directed audits on incomplete requirements of all RNs	- Required written peer review - Lack of clarity as to who qualifies as a peer - Associated random audit of all RNs

Practice consultation or support	- Response time: 1-3 days - No information regarding the process of managing consultations - No information as to the qualifications of the consultants or who manages calls from self-employed registrants	- No response time provided - No information regarding the process of managing consultations - No information as to the qualifications of the consultants or who manages calls from self-employed registrants	- Response time: 24 hrs - Utilizes consult management program to enhance consistency - No information as to the qualifications of the consultants or who manages calls from self-employed registrants
Overall assessment of content and processes	*- Simplest processes for self-employed nurses* *- Content and processes presented clearly with few exceptions*	*- Additional registration processes required for self-employed nurses* *- The least clear content and processes for self-employed registrants* *- Registrants rely on practice consultation to navigate registration*	*- Additional registration processes required for self-employed nurses* *-Content and processes presented clearly with a few exceptions*

Context

The content and processes used to regulate self-employed nurses are influenced by the regulatory environment including its context and actors. Contextual features include the legislative framework, governance structure, and regulatory philosophies. Table 4 demonstrates which contextual features are represented by each jurisdiction. Additionally, key actors including provincial, national, and international partners, the government, the public, registrants, and nurse educators and employers influence the environment and the content and processes impacting self-employed nurses in each jurisdiction. Each of the contextual features and actors are examined for their influence on the regulatory content and processes used to regulate self-employed nursing practice. In this way, those features that have a significant or direct impact on self-employed nursing practice will be illuminated.

Table 4

Summary of Contextual Features Represented in Each Jurisdiction

Aspect of Regulatory Context	CNO	CARNA	SRNA
Legislative framework	- Umbrella legislation with controlled acts	- Umbrella legislation with restricted activities	- Profession-specific legislation
Organizational mandate	- Single mandate: protect the public interest	- Transitioning from dual to single mandate	- Will soon transition from dual to single mandate
Regulated nursing groups and number of registrants	- RPNs, RNs, and NPs, - 188,500 registrants	- RNs and NPs, - 38,000 registrants	- RNs, RN(AAP)s, NPs, - 13,000 registrants
Governance structure	- 37 members on council, 21 elected professional members, - 57% professional representation on council	- 16 members on council, 8 elected professional members, - 50% professional representation on council	- 13 members on council, 9 elected professional members, - 70% professional representation on council
Regulatory philosophy	- Right-touch, risk-based regulation	- Enterprise Risk Management (ERM), - Right-touch regulation	- Relational regulation, - Right-touch regulation

Legislative Framework

The CNO and the CARNA are both operating within an umbrella legislative framework which directs many detailed aspects of their regulatory practices (RHPA, 1991; HPA, 2000). This type of legislation may facilitate the effective regulation of self-employed nurses through improved transparency and accountability of the regulatory body, potentially reducing the risk of malpractice through increased clarity and consistency in regulatory content and processes. However, umbrella legislation may simultaneously inhibit regulatory bodies' agility in responding to the changing needs of the public, registrants, and the greater regulatory environment which is demonstrated by the CNO's ongoing process to initiate legislative change to update their governance structure (CNO, n.d.a).

Unlike the CNO and the CARNA, the SRNA is directed by a single, profession-specific act (The Registered Nurses Act, 1988) which provides a comparatively less-detailed legislative

framework. The general nature of the legislative framework suggests the SRNA's leadership has a degree of latitude to design and conduct their own regulatory duties. However, the SRNA processes specifically impacting self-employed nurses such as the practice hours requirement, the recognition of practice process, and the CPP are very comparable to those of the CARNA. In Saskatchewan, the general nature of the profession-specific legislation may give the impression of increased agility as the SRNA does not require full legislative processes to make changes to content and processes, however, it is legislated that the SRNA's registrants must vote on these types of changes annually before getting ministry approval which limits the agility they might have had (The Registered Nurses Act, 1988). As the SRNA transitions to a single mandate, this process will likely be changed to reduce the influence of registrants on nursing regulation, potentially improving the SRNA's agility, providing relative autonomy to pursue regulatory best practice.

In sum, despite both being empowering by umbrella legislation, the CNO's and CARNA's content and processes impact self-employed nurses in these jurisdictions in very different ways. In contrast, despite having very different legislative frameworks, the CARNA and the SRNA have very similar content and processes, which impact self-employed nurses on these registers similarly. This finding may suggest the style of legislation has little to no impact on self-employed nurses.

Rather than the style of legislation, the content included in the legislation appears to have a greater impact on self-employed nurses. For example, the legislation directing the CARNA includes a minimum number of hours registrants must complete to qualify for registration renewal which necessitates a recognition of practice process (HPA, 2000). In contrast, legislation empowering the CNO (RHPA, 1991) does not include such a stipulation and as a result, does not

have an additional process that requires self-employed nurses prove they are engaging in nursing practice.

Interestingly, the legislation directing the SRNA does not include a set number of hours nurses must practice, however the SRNA's leadership have elected to align their requirements for registration with the CARNA and other provincial nurse regulatory bodies by including the same requirement for a minimum number of hours in the bylaws (SRNA, 2020d). So, while what is included in the legislation directly impacts self-employed nurses in those jurisdictions, the greater regulatory landscape appears to be just as influential in some cases. Furthermore, despite being legislated as a dual mandate organization, the SRNA has recently chosen to follow the CARNA in transitioning to a single mandate, again demonstrating the strong influence of the greater regulatory landscape when compared to that of legislation, specifically at the SRNA.

In summary, it appears that, due to several potential factors, the type of legislation does not have a significant, direct impact the regulation of self-employed nurses in these jurisdictions. Instead, what is included in the legislation impacts nurses much more significantly as it directs the content and processes developed by regulatory bodies. It would be reasonable to assume more general legislation may provide regulatory bodies with an increased measure of autonomy however the SRNA's content and processes are almost indistinguishable from the CARNA which governed by umbrella legislation.

Regulatory Governance

In alignment with noted regulatory trends (Benton, 2011) and as demonstrated by the governance and process review reports of the CNO (CNO, 2017b), CARNA (Governance Solutions, 2020), and SRNA (SRNA, 2019a), a single mandate and equal parts public and professional representation are essential to ensuring regulatory bodies are unequivocally

committed to their mandate to protect the public. These trends are demonstrated by the CARNA's and SRNA's recent decision to transition from a dual mandate to a single regulatory mandate to be more accountable to the public interest.

Until recently all three regulatory bodies were all led by a professional majority on council and committees. In 2019, the CARNA elected, in alignment with the impending Bill 30, to move to a single regulatory mandate and equalize the public and professional representation on council and certain committees (CARNA, n.d.f). Likewise, the CNO, a single mandate regulatory organization, has requested legislative change to shift from a large council with a majority of professionals to a small board with equal representation of the public and profession (CNO, 2021g). While the SRNA has also recently decided to move from a dual to a single mandate regulatory organization, the data did not provide any information as to whether that change would stimulate a similar shift to equal representation.

The current SRNA council is made up of almost 70% professional representation and all committees have a majority of professional members (SRNA, 2020d). Despite being a strongly profession-led organization with the dual mandate of "promoting the professional interest of its members in the public interest" (SRNA, 2016a, p. 10), there is very little observable difference in regulatory content and processes when compared with the other nurse regulatory bodies that have a single mandate or councils with equal professional and public representation. It is unclear if the arrangement of the regulatory and association mandates or the ratio of public and professional representation on council and committees makes a significant impact on the regulation of self-employed nurses.

Regulatory Philosophy

The chosen regulatory philosophy, which in all three cases was represented by right-touch and risk-based regulation, has a significant impact on regulatory content and processes. The leadership of all three nurse regulatory bodies have demonstrated commitment to aligning with their regulatory philosophy by initiating reviews and revisions of their processes. Participants in Wall's (Stahlke Wall, 2018; 2013b) and Smith's (2016) research reported perceiving regulatory processes lacked transparency and were inconsistent, disproportionate, lacking information, unaccountable, and time consuming. Self-employed registrants may, therefore, benefit greatly from their regulatory bodies' commitment to making processes proportionate, consistent, targeted, transparent, accountable, and agile to align with *The Standards of Good Regulation* (2019) and right-touch regulation philosophy. Considering the relative speed with which these regulatory bodies are working to incorporate these principles, the regulation of self-employed nurses may become more effective as they are aligned with this philosophy. Additionally, as has been demonstrated by the CNO, CARNA, and the SRNA councils, nurse regulatory bodies are inclined to revise content and processes with the goal of aligning with their underlying philosophy, potentially creating opportunities for self-employed nurses to address regulatory barriers to their practice. On the other hand, with nurse regulators aligning with risk-based approaches to regulation, self-employed nurses may find regulatory bodies openly target this practice area with additional oversight to ensure patient safety. Either way, an alignment with the principles of right-touch regulation can make the regulation of self-employed nurses more effective and rigorous to the benefit of the public, self-employed registrants, and the regulator.

Actors

Regulatory bodies are strongly influenced by their participation with the greater regulatory environment, provincially, nationally, and internationally. The government, the public, registrants, and nurse educators and employers are key organizational actors that have a complex and significant impact on nursing regulation.

Greater Regulatory Landscape

All three regulatory bodies formally collaborate with other regulatory bodies within their provincial jurisdiction. Regulatory content and processes have been directly influenced by provincial partnerships with other regulatory groups including formal advisory groups and less formal collaborations. The CARNA and the SRNA both report working collaboratively with the other nurse regulatory bodies in the province on select projects. When compared to the CNO who regulates all the nursing groups in that province, it is unclear if or how the regulation of a single or multiple groups influences the content and processes impacting self-employed nursing.

Nationally, the CNO, CARNA, and SRNA are all members of the CCRNR (CCRNR, 2021). Self-employed nurses registered with the SRNA are required to justify how their practice meets each of the entry-level competencies on their recognition of practice application (SRNA, 2021b, 2021a), demonstrating the direct impact of the CCRNR on the practice of these nurses in this jurisdiction. The CARNA and the SRNA, as dual mandate organizations, have historically been associated with the CNA and have both adopted the CNA *Code of Ethics* (CNA, 2017), thus impacting the practice of nurses by their membership and participation in this national organization. In addition to their membership with national organizations, each of the nurse regulatory bodies participate in inter-jurisdictional initiatives which influence regulatory content and processes. The CNO has partnered with British Columbia nurse regulators (CNO, 2016b)

and separately, the CARNA and the SRNA have joined forces (CARNA, 2021d) to collaborate on inter-jurisdictional projects. These projects may influence the partnered regulatory bodies to establish and maintain processes that align to reduce barriers between jurisdictions. Furthermore, national regulatory trends are instrumental in influencing regulatory councils to elect to transition to a single mandate organization (CARNA, n.d.a; SRNA, 2020).

On an international level, both the CARNA and the SRNA councils commissioned representatives from the PSA in the UK to complete reviews of various regulatory processes to better align with the right-touch regulation philosophy and the *Standards for Good Regulation* which has an instrumental impact on regulatory content and processes as previously discussed (PSA, 2019). External reviews by the international governance experts led regulators to enhance public representation on council and some committees (CNO, 2017; SRNA, n.d.). All the studied nurse regulatory bodies are also affiliated with the NCSBN based in the US that has an international membership (NCSBN, 2021). As an organization, the CNO is additionally partnered with the International Nurse Regulator Collaborative (INRC) (INRC, 2021) and CNO representatives have collaborated directly with the Nursing Council of New Zealand which has specifically influenced their adoption of their *Code of Conduct* (CNO, 2019b). The studied regulatory bodies' leadership each demonstrate commitment to assessing, contributing to, and drawing from regulatory best practices in the greater regulatory landscape. Participation in the provincial, national, and international spheres have a direct and significant impact on the content and processes that effect nursing practice, including that of self-employed nurses.

Government

As the entity that empowers regulatory bodies through legislation, the provincial government and the minister of health have unparalleled influence over the practice of nurses in

each jurisdiction. Regulatory bodies like the CNO, CARNA, and SRNA exist to regulate the profession on behalf of the government, using their professional expertise to protect the public (Almost, 2021). Through legislation and ministerial directives, the minister defines nursing scope and practice as well as regulatory governance structure, content, and processes. Acting with delegated authority, regulatory bodies are accountable to the government and are influenced directly by the current government's political goals. In this way, legislative and ministerial directives and specifically the members of government and their political goals impact nursing practice with the potential of having a direct impact on self-employed nurses.

Each provincial government has established different methods of oversight with the CNO's council and committees experiencing the highest level of oversight as they are accountable to multiple government appointed entities. Increased levels of oversight could be associated with regulatory processes that are more transparent, accountable, and consistent as demonstrated by the intention of the annual *College Performance Measurement Framework* instituted by the Ontario government (CNO, 2020b). Alternatively, higher levels of oversight could potentially cause regulatory bodies to become more cautious in facilitating unfamiliar nursing roles which may be perceived by regulators as an increased risk. Further research is required to better understand the consequences of increased government oversight on regulatory body functions its impact on the regulation of nursing practice.

Public

Nurse regulatory bodies exist to protect the public. As such, the public is necessarily a key stakeholder in nursing regulation. The public interest is expressed and incorporated in several ways including participation in the governance structure, public advisory committees, consultation periods to provide feedback on regulatory changes, and surveys. Informally, the

public also demonstrates influence over regulatory legislation and processes through feedback in the media which is demonstrated in separate events in all three jurisdictions. In both formal and informal ways, the public can have significant influence on legislative and regulatory change.

Registrants

Nurse registrants are also major actors in nursing regulation as they are both involved in shaping and delivering regulations and represent the professional body being regulated. Registrants are included in nursing regulation in several formal ways including participation in nurse regulatory governance, consultation periods, time-limited advisory groups, and surveys. There are a few references in which nurse regulatory bodies engage with nursing unions or associations, demonstrating another form of registrant influence on nursing regulation. SRNA registrants have a comparatively instrumental influence on regulatory activities due to the requirement for registrants to vote on changes to the bylaws and practice standards (SRNA, 2020d). This legislated process provides registrants with power greater than that of the public and, in some respects, the regulatory body itself. Again, it could be assumed that the power of the registry combined with the dual mandate may influence the content and processes of the SRNA, yet they have remarkable similarities when compared to the CARNA and the CNO where professional representation is limited.

Nurse Employers and Educators

Nurse educators and health care employers are also significant actors in nursing regulation. The nurse regulatory body in each province has a committee dedicated to approving, monitoring, and evaluating nursing education programs within the province to ensure curriculum and delivery align with nursing regulation and standards such as the entry-level competencies. Due to their role as both one educating new nurse registrants and as one governed by the

regulatory body, nurse educators are considered stakeholders in nurse regulation although their influence on regulatory content and processes is unclear.

Employers offer an additional layer of oversight for nurses in institutional roles and further determine the nursing scope of practice within the broader scope provided by the regulatory body (CNA, 2015). As those directing the work of the majority of registrants, employers are considered a key stakeholder in nursing regulation. Employers are invited to advise on regulatory content and processes in formal and informal ways, however their influence on these aspects of regulation is unclear.

In these three Canadian provinces, the minister of health is responsible for the delivery and regulation of health care as well as the function and regulation of provincial health authorities which employ the majority of nurses. In this way the provincial government is not only the ultimate authority over the regulation of nursing, the definition of nursing practice, and their professional scope, but also over their employment and the role the profession has in delivering health care in the province. It is estimated that less than five percent of nurses in these three Canadian jurisdictions are self-employed (Government of Canada, 2019), therefore employers, and correspondingly, the minister of health the most powerful actors in nursing regulation, nursing practice, and the future of the nursing profession in Canada. This reality highlights the importance of self-employed nursing which offers an opportunity to explore alternatives to institutional roles.

Open Systems Theory

Considering the theoretical framework that shaped this work, open systems theory reflects the structure and function of these regulatory bodies as it pertains to self-employed nursing. All three provincial nurse regulatory bodies are guided by the same equifinality or

purpose, regulation in the public interest, which explains why these three jurisdictions can have such distinct contexts and actors yet produce similar content and processes. The regulatory philosophy is a feature that crosscuts all the hierarchical subsystems of the organization to guide the production of uniform outputs. Accordingly, the degree to which the regulatory bodies align their regulatory outputs with the regulatory philosophy in many ways will determine the impact of regulatory content and processes on the experiences of self-employed nurses.

Media, commissioned reviews, required government reports, and even this research are methods of feedback which provide regulatory bodies with information as to how the equifinality can be better achieved. Additionally, feedback motivates the government, a key input, to adjust the "energy" and information supplied to organization to guide the nurse regulatory body to better achieve the desired outcome. Overall, the open systems theory is an effective model with which to understand and study nursing regulatory organizations' interactions with their environment as well as their outcomes and impact on registrants and the public.

Summary of Key Findings

The regulation of self-employed nurses in Canada is enacted very differently across jurisdictions. There is little research to guide regulatory bodies in the effectiveness of processes such as the minimum practice hours requirement, the declaration of nursing practice and the QA or CCP and their respective audits which limits their ability to incorporate regulatory best practice. Whatever the means of regulation, processes that align with right-touch regulation principles and *The Standards of Good Regulation* (PSA, 2019) can facilitate the effectiveness of those processes both for self-employed registrants and regulators through practices that are proportionate, targeted, consistent, transparent, accountable, and agile. Aspects of the content

and processes used to regulate self-employed nurses in some jurisdictions require a right-touch review to better align with these principles.

The three cases included in the study each have unique contextual features and actors that influence the provincial regulatory environment. Contextual features such as the style of legislation, the organizational mandate, the ratio of professional and public representation on council and committees, the size of registry, and the regulated nursing designations were not found to be significantly influential in the content and processes used to regulate self-employed nurses. Instead, the content included in legislation and the chosen regulatory philosophy can have a direct and significant influence on the regulation of self-employed nurses. Additionally, actors in the greater provincial, national, and international regulatory environment, the government, and the public are pivotal influences in nursing regulation in these three jurisdictions due to their direct impact on regulatory structure, content, and processes. The findings of this research support open systems theory as an effective framework with which to understand and study the provincial nurse regulatory organization as it pertains to self-employed nursing.

Chapter 9. Implications, Limitations, and Conclusion

The findings of this research have practical implications for nurse scholars, self-employed nurses, and nurse regulators. Additionally, there are theoretical implications. Firstly, this research builds upon the literature base related to self-employed nursing and the regulation of unique nursing roles in Canada. Secondly, this research demonstrates how self-employed nurses are regulated differently across Canadian jurisdictions and provides insight into the aspects of the regulatory environment that have a significant impact on self-employed nurses. With a more fulsome understanding of the factors that enhance the effectiveness of self-employed nursing regulation, both regulators and self-employed nurses can work more strategically toward a goal of more effective regulation. For example, recognizing right-touch regulation principles may enhance the effectiveness of self-employed nursing regulation, these registrants may support and advocate for regulatory change that aligns with these principles. Considering this, the findings of this research support self-employed nurses in better understanding, navigating, and engaging their voice in the regulatory processes impacting their practice.

This research implicates nurse regulators who are provided with an in-depth assessment of the content and processes regulating self-employed nurses. It is recommended Canadian nurse regulators address the lack of information and transparency identified within the regulatory content and processes to facilitate the safe and effective enactment of self-employed roles. These research findings also support nurse regulators in adopting evidence-informed or best practice regulation such as right-touch regulation practices to better protect the public interest through more effective regulation of self-employed nurses. Some of the content and processes regulating self-employed nurses have yet to undergo an alignment to right-touch regulation

principles. It is recommended that regulators prioritize a full assessment and alignment of these processes with their adopted regulatory philosophies to make regulatory requirements easier to navigate by enhancing clarity, transparency, and accountability.

Self-employed nurses in Smith's (2016) and Wall's (2011, 2018) research report a strongly negative view of the regulator, perceiving they are resistant to roles that are unfamiliar. Provincial regulatory councils must carefully reflect on any potential implicit biases or reservations pertaining to the role of the nurse or the ability of nurses to practice independently and for a profit, especially in the context of socialized health care in Canada. It is critical that self-employed and other emerging nursing roles are not marginalized for being different but supported with thoughtful and proportionate regulation that protects the public and facilitates the advancement of the nursing profession which is ultimately in the best interest of the public. Additionally, nurse regulators should not hesitate to collaborate with other health care provider regulatory bodies in the areas in which they lack familiarity. Within the greater regulatory landscape, the regulators of physiotherapists, physicians, dental hygienists, and others have much higher rates of self-employment and will have much to offer pertaining to the regulation of self-employed or independent practice roles.

The CNO leadership is planning to move away from an electoral process to the appointment of vetted, qualified professional representatives to the regulatory board once the required regulatory changes have been enacted (Governance Solutions, 2020). Provincial nurse regulators should consider also moving away from the election of professional representatives to council, to the appointment of professionals who represent diverse nursing roles and designations in various domains of nursing practice, including self-employed nurses, to provide their unique insights into the impacts of regulatory content and processes when they are being reviewed and

enacted. Similarly, self-employed nurses would be better served by practice consultation or support staff that have experience in self-employed roles to communicate regulatory requirements more effectively to these registrants. In the absence of self-employed representation on the regulatory council or staff, regulatory bodies could alternatively establish a self-employed nurse advisory group to consult when revising regulations that will impact self-employed nurses. Representation and collaboration are imperative in ensuring regulators are enacting regulatory practices that are targeted, effective, and proportionate from both the perspective of the regulator and the self-employed nurse.

It is also recommended that provincial nurse regulators track and report the number of nurses practicing in self-employed roles annually, what types of services they provide, and the number of complaints or investigations that involve self-employed nurses. The number of nurses practicing in self-employed roles will provided critical information as to the state of self-employment across jurisdictions and will provide data pertaining to rate of growth of this role. The number of complaints and investigations involving self-employed nurses will provide insight into the risk self-employment poses to the public which will guide the development of targeted and proportionate regulation practices.

The theoretical implications of this research are also significant. Organizational open systems theory provided key insights into the influence of the regulatory actors and context on organizational outputs including content and processes. The findings suggest that the contextual features including the style of legislation, the organizational mandate, the number or designation of nurses, and the ratio of public versus professional representation on council did not have a significant or direct impact on the regulatory content and processes impacting self-employed nursing regulation. The CARNA and the SRNA are making significant organizational changes,

such as transitioning to a single mandate in the public interest, under the assumption that this will translate into outputs that reflect that organizational aim, yet their regulatory outputs published under the context of the dual mandate were very similar to those of the CNO, a single mandate organization. This is one example of a disconnect between the underlying context and the regulatory outputs. While the theoretical reasoning behind these changes may be logical, perhaps these findings illuminate a reliance on trends in the regulatory landscape rather than evidence in the creation and implementation of regulatory content and processes. There is a possibility the disconnect between context and outputs is due to a lack of research guiding regulators in selecting evidence-informed regulatory practices that have been proven to be effective. It is recommended that regulatory bodies establish committees of nurse scholars that focus on conducting and participating in regulatory research to strengthen this field and establish rigorous regulatory practices that are based in research. In some ways, unclear and confusing regulatory practices directing self-employed nurses demonstrates an over-reliance on the employer to regulate the vast majority of nurse registrants, highlighting the need to actively pursue evidence in the field of regulation, not only to facilitate the effective regulation of self-employed or other emerging nursing roles, but to strengthen the effectiveness of nursing regulation in general.

Open systems theory proved useful in demonstrating the function of provincial nurse regulatory environments as it pertains to self-employed nursing regulation. This theory may facilitate the further study of provincial nurse regulatory bodies including their interaction and response to the environment, their outputs, and impact. This theory may also be a useful teaching tool with which to educate on the function and impact of provincial nurse regulatory bodies.

Limitations

The public domain documents gathered for this study lacked information regarding specific processes such as the recognition of practice application, and why and when regulatory content and processes are updated and by whom. This information could have been supplemented with verbal reports from regulators or other internal regulatory documents. Additionally, none of the regulatory bodies included in the study publish the number of registrants engaged in self-employed practice which limits the comparison between regulatory environments. However, the number of nurses in self-employed roles in each jurisdiction will be impacted by many factors outside of nursing regulation such as the level of awareness of self-employed options, presence of role models, education opportunities, public receptiveness, and economical factors such as business regulation and taxation which ultimately limits its usefulness as a comparator.

The point in time at which this study is completed is not founded upon a significant event or a particular phenomenon. Instead, the study represents a relatively arbitrary time frame within a continuously evolving regulatory environment. While findings are relevant to the time of study, specific findings may no longer apply as nurse regulatory bodies continue to change. This is particularly applicable to the CARNA and the SRNA which were undergoing significant change at the time of the study which may have impacted the findings.

Nursing regulation is complex and contextual. No two jurisdictions have identical contexts, actors, content, or processes, limiting the ability to replicate results. Relatedly, transferability is restricted by the small sample size that does not wholly represent every Canadian regulatory environment. However, there are commonalities across the Canadian

regulatory environment that are represented within the study which have practice implications for nurse regulators across Canada.

Directions for Future Research

Further research is required to determine what level of additional risk self-employed nursing roles pose to the public to better understand what targeted regulatory oversight is required. A key finding of this research suggests the right-touch regulation philosophy is instrumental in the effective regulation of self-employed nursing through the alignment of regulatory content and processes with the principles of right-touch regulation and *The Standards of Good Regulation* (2019). This finding would be further confirmed with action research that assesses the before and after effect of implementing a right-touch review and revision of the content and processes specifically impacting self-employed nurses. Furthermore, the effectiveness and impact of current regulatory trends such as transitioning to single mandate organizations, and balancing public and professional representation on council and committees should be further investigated. Finally, programs and processes including the QA program or CCP, the requirement to practice a minimum number of practice hours, and the recognition of nursing practice process should be further evaluated to determine their effectiveness in ensuring the competence of self-employed registrants.

Additionally, this research assesses regulatory environments through the lens of self-employment. The open systems theory, conceptual model, and research methods could be used to assess provincial regulatory environments with alternative endpoints such as the impact of these environments on internationally educated nurses, nurses who have been investigated and disciplined by regulatory bodies, and nurses seeking registration after a lapse. It would be

enlightening to discover whether the same aspects of regulatory environments are most influential on the practice of those nurses as well.

To further build upon the literature base supporting self-employed nursing in Canada, more research is needed to investigate how education, awareness, and opportunity including funding impact self-employed nursing practice and how this role fits within the greater entrepreneurial business landscape. Relatedly, research should be done to assess the number of nurses in self-employed roles across Canada and the effectiveness of these practices in improving professional satisfaction and health care access for the public.

Conclusion

Self-employed nursing represents a largely unexplored avenue for nurses to use their unique knowledge, skills, and judgment in ways that align with their professional values and meet the health and wellness needs of Canadians. Exploring new and innovative roles that offer nurses increased autonomy and satisfaction is critical to the future of nursing and the Canadian health care system. Additionally, given the effects of the current COVID-19 pandemic and the exodus of nurses from the profession, new roles such as self-employment may be helpful in the preventing a significant loss of nursing knowledge.

This study represents an important step in exploring how self-employed nurses are regulated across three Canadian jurisdictions and the factors that influence that regulation. Self-employed registrants of the CNO have the least requirements to start and maintain their own practice while those registered with the SRNA and the CARNA must apply for recognition and report their practice hours annually. While the CNO's regulation practices are the simplest, it is not clear if they are correspondingly the most effective. Rigorous, proportionate, consistent, targeted, transparent, accountable, and agile regulation benefit both regulators and self-employed

registrants by protecting the public through high-quality practice without disproportionate oversight. Therefore, self-employed nurses should challenge their regulatory body to review and revise regulatory content and processes to align with right-touch regulation and other evidence-informed regulation practices. Effective and evidence-informed regulation of new and innovative nursing roles creates opportunities for registrants to safely challenge the boundaries of the familiar and shape a new future for the profession.

References

Advisory Group for Regulatory Excellence. (2021). *About AGRE*. Retrieved October 18, 2021, from http://agre-on.com/about-agre.html

Alberta Federation of Regulated Health Professions. (n.d.). *Our members – AFRHP*. Retrieved July 20, 2021, from https://afrhp.org/find-a-health-profession-college/

Almost, J. (2021). *Regulated nursing in Canada: The landscape in 2021*. Canadian Nurses Association. Retrieved November 4, 2021, from https://hl-prod-ca-oc-download.s3-ca-central-1.amazonaws.com/CNA/2f975e7e-4a40-45ca-863c-5ebf0a138d5e/UploadedImages/documents/Regulated-Nursing-in-Canada_e.pdf

Arnaert, A., Mills, J., Bruno, F. S., & Ponzoni, N. (2018). The educational gaps of nurses in entrepreneurial roles: An integrative review. *Journal of Professional Nursing*, *34*(6), 494–501. https://doi.org/10.1016/j.profnurs.2018.03.004

Association of Registered Nurses of Newfoundland and Labrador. (2016). *Self-employed registered nurses and nurse practitioners*. Retrieved April 14, 2021, from https://crnnl.ca/site/uploads/2022/03/self-employment.pdf

Bachtel, M. K., Hayes, R., & Nelson, M. A. (2020). The push to modernize nursing regulations during the pandemic. *Nursing Outlook*, *68*(5), 545–547. https://doi.org/10.1016/j.outlook.2020.05.006

Backes, D. S., Obem, M. K., Pereira, S. B., Gomes, C. A., Backes, M. T. S., & Erdmann, A. L. (2015). Learning incubator: An instrument to foster entrepreneurship in nursing. *Revista Brasileira de Enfermagem*, *68*(6), 794–798. https://doi.org/10.1590/0034-7167.2015680615i

Baxter, D. (2019, June 4). Interveners allowed in appeal of nurse fined $26K for criticizing long-term care home. *Global News*. https://globalnews.ca/news/5352891/interveners-allowed-appeal-nurse-fined-26000-over-criticizing-long-term-care-home/

Bellefontaine, M. (2018, November 8). Alberta doctors convicted of sexual abuse will face lifetime ban. *CBC*. https://www.cbc.ca/news/canada/edmonton/doctors-sexual-abuse-bill-1.4898379

Bennett, D. (2018, October 3). Alberta proposes tougher rules on health-care provider misconduct. *Global News*. https://globalnews.ca/news/4612715/alberta-health-care-sexual-misconduct-rules/

Bennett, D. (2019, October 17). Alberta to expand duties of licensed practical nurses. *Global News*. https://globalnews.ca/news/6045744/alberta-lpn-duties/

Benton, D. C. (2011). International issues and trends in nursing regulation. *Journal of Nursing Regulation*, *1*(4), 4–8. https://doi.org/10.1016/S2155-8256(15)30316-1

Benton, D. C., Brekken, S. A., Ridenour, J., & Thomas, K. (2016). Comparing performance of umbrella and independent nursing boards: An initial review. *Journal of Nursing Regulation*, *7*(3), 52–57. https://doi.org/10.1016/S2155-8256(16)32324-9

Benton, D. C., González-Jurado, M. A., & Beneit-Montesinos, J. V. (2013). Defining nurse regulation and regulatory body performance: A policy Delphi study. *International Nursing Review*, *60*(3), 303–312. https://doi.org/10.1111/inr.12027

Benton, D. C., González-Jurado, M. A., Beneit-Montesinos, J. V., & Fernández, M. P. F. (2013). Use of open systems theory to describe regulatory trends. *Journal of Nursing Regulation*, *4*(3), 49–56. https://doi.org/10.1016/S2155-8256(15)30131-9

Benton, D. C., Thomas, K., Damgaard, G., Masek, S. M., & Brekken, S. A. (2017). Exploring the differences between regulatory bodies, professional associations, and trade unions: An integrative review. *Journal of Nursing Regulation*, *8*(3), 4–11. https://doi.org/10.1016/S2155-8256(17)30154-0

Blais, T. (2016, June 2). Edmonton doctor convicted of sexually assaulting one co-worker, assaulting another. *Edmonton Sun*. https://edmontonsun.com/2016/06/02/edmonton-doctor-convicted-of-sexually-assaulting-one-co-worker-assaulting-another

British Columbia College of Nurses & Midwives. (2021a). *Regulation of nurses & midwives*. Retrieved April 11, 2021, from https://www.bccnm.ca/Public/regulation/Pages/Default.aspx

British Columbia College of Nurses & Midwives. (2021b). *Self employment*. Retrieved April 11, 2021, from https://www.bccnm.ca/NP/learning/selfemployment/Pages/Default.aspx

British Columbia College of Nurses & Midwives. (n.d.). *Practice hours*. Retrieved January 6, 2022, from https://www.bccnm.ca/RN/applications_registration/practicehours/Pages/Default.aspx

Brooks, B. (2019). The smartphone generation as new nurse entrepreneurs. *Nursing Economic$*, *37*(6), 332–335.

Brown, M. E. L., & Dueñas, A. N. (2020). A medical science educator's guide to selecting a research paradigm: Building a basis for better research. *Medical Science Educator*, *30*(1), 545–553. https://doi.org/10.1007/s40670-019-00898-9

Brown, S., & Elias, D. (2016). Creating a comprehensive, robust continuing competence program in Manitoba. *Journal of Nursing Regulation*, *7*(2), 43–52. https://doi.org/10.1016/S2155-8256(16)31080-8

Cadmus, E., Johansen, M. L., Zimmer, P. A., & Knowlton, D. L. (2017). Entrepreneurship: Assessing the readiness of the New Jersey APN workforce. *Nursing Administration Quarterly, 41*(1), 48–55. https://doi.org/10.1097/NAQ.0000000000000203

Canadian Council of Registered Nurse Regulation. (2021). *Home: CCRNR*. Retrieved April 11, 2021, from https://www.ccrnr.ca/index.html

Canadian Lawyer. (2020, October 20). *Disciplining a nurse who criticized long-term care via social media infringes free speech: Case*. Retrieved July 27, 2021, from https://www.canadianlawyermag.com/practice-areas/medical-malpractice/disciplining-a-nurse-who-criticized-long-term-care-via-social-media-infringes-free-speech-case/334410

Canadian Nurses Association. (2015). *Framework for the Practice of Registered Nurses in Canada*. Retrieved April 11, 2021, from https://www.cna-aiic.ca/en/nursing/regulated-nursing-in-canada/rn-practice-framework2

Canadian Nurses Association. (2013). *Registered nurses: Stepping up to transform health care*. Retrieved August 3, 2020, from https://silo.tips/download/registered-nurses-stepping-up-to-transform-health-care

Canadian Nurses Association. (2017). *Code of ethics for registered nurses*. Retrieved July 27, 2021, from https://www.cna-aiic.ca/en/nursing/regulated-nursing-in-canada/nursing-ethics

Canadian Nurses Association. (n.d.). *Regulation of nurses*. Retrieved April 11, 2021, from https://web.archive.org/web/20210412142711/https://cna-aiic.ca/en/nursing-practice/the-practice-of-nursing/regulation-of-nurses

Carver, J., & Carver, M. (2016, April 4). *The Policy Governance® model—An overview*. PolicyGoverance.Com. Retrieved August 18, 2021, from https://www.carvergovernance.com/model.htm

CBC News. (2020, December 13). Sask. government introduces legislation to protect health-care whistleblowers. https://www.cbc.ca/news/canada/saskatchewan/govt-health-care-whistleblower-protection-legislation-1.5839718

Chagas, S. de C., Milagres, P. N., Silva, M. C. R., Cavalcante, R. B., Oliveira, P. P. de, & dos Santos, R. C. dos. (2018). Business entrepreneurship among nurses. *Revista Enfermagem Uerj*, *26*. https://doi.org/10.12957/reuerj.2018.31469

Clancy, C. (2018, September 21). NDP aim to protect patients from health-care provider sexual abuse. *Edmonton Examiner*. https://sherwoodparknews.com/news/provincial/ndp-aim-to-protect-patients-from-health-care-provider-sexual-abuse

Clayton, H. (2019). *A review of complaints processes and outcomes conducted for the College and Association of Registered Nurses of Alberta*. Retrieved July 9, 2021, from https://web.archive.org/web/20210513053733/https://nurses.ab.ca/docs/default-source/latestnews/cayton-report.pdf?sfvrsn=2df588fc_10

Code des Professions, SQC 1973, c. C–26. http://legisquebec.gouv.qc.ca/fr/document/lc/c-26

Colichi, R. M. B., Lima, S. G. S. e, Bonini, A. B. B., & Lima, S. A. M. (2019). Entrepreneurship and nursing: Integrative review. *Revista Brasileira de Enfermagem*, *72*(1), 321–330. https://doi.org/10.1590/0034-7167-2018-0498

College and Association of Registered Nurses of Alberta. (2013a). *Documentation standards for regulated members*. Retrieved July 8, 2021, from

https://www.nurses.ab.ca/media/zvhmc0yl/documentation-standards-for-regulated-members-jan-2013.pdf

College and Association of Registered Nurses of Alberta. (2013b). *Practice standards for regulated members*. Retrieved July 8, 2021, from https://www.nurses.ab.ca/media/ztap24ri/practice-standards-for-regulated-members-2013.pdf

College and Association of Registered Nurses of Alberta. (2016a). *Annual report 2015-2016*. Retrieved July 8, 2021.

College and Association of Registered Nurses of Alberta. (2016b). *Entry-level competencies for nurse practitioners in Canada*. Retrieved July 8, 2021, from https://www.nurses.ab.ca/media/pibjny1j/entry-level-competencies-for-nurse-practitioners-in-canada-dec-2016.pdf

College and Association of Registered Nurses of Alberta. (2017). *Annual report 2016-2017*. Retrieved July 8, 2021.

College and Association of Registered Nurses of Alberta. (2018). *Annual report 2017-2018*. Retrieved July 8, 2021.

College and Association of Registered Nurses of Alberta. (2019a). *Annual report 2018-2019*. Retrieved July 8, 2021.

College and Association of Registered Nurses of Alberta. (2019b). *Entry-level competencies for the practice of registered nurses*. Retrieved July 8, 2021, from https://www.nurses.ab.ca/media/5ndpyfar/entry-level-competencies-for-the-practice-of-registered-nurses-mar-2019.pdf

College and Association of Registered Nurses of Alberta. (2019c). *Incorporating a restricted activity into practice*. Retrieved July 8, 2021, from https://www.nurses.ab.ca/media/i1aiuejp/incorporating-a-restricted-activity-into-practice-guidelines-sep-2019.pdf

College and Association of Registered Nurses of Alberta. (2019d). *Provincial council launches governance review*. Retrieved July 8, 2021.

College and Association of Registered Nurses of Alberta. (2019e, May 13). *Are you considering self-employed RN or NP practice?* Retrieved July 8, 2021.

College and Association of Registered Nurses of Alberta. (2020a). *2019-2020 annual report*. Retrieved July 8, 2021, from https://www.nurses.ab.ca/media/kgdg5esm/annual-report-2019-2020.pdf

College and Association of Registered Nurses of Alberta. (2020b). *GP09—Governance and communications protocol*. Retrieved July 9, 2021, from https://www.nurses.ab.ca/how-we-operate/governance/governance-policies/gp09-governance-and-communications-protocol/

College and Association of Registered Nurses of Alberta. (2020c). *GP10—Council selection policy*. Retrieved July 9, 2021, from https://www.nurses.ab.ca/how-we-operate/governance/college-bylaws/

College and Association of Registered Nurses of Alberta. (2020d). *Professional conduct review action plan and updates*. Retrieved July 8, 2021, from https://web.archive.org/web/20210513061541/https://nurses.ab.ca/docs/default-source/conduct/professional-conduct-review-action-plan-1march2021.pdf?sfvrsn=1212547e_6

College and Association of Registered Nurses of Alberta. (2020e). *Strategic directions* [PowerPoint]. Retrieved July 8, 2021.

College and Association of Registered Nurses of Alberta. (2020f, September 16). *Nurses in independent practice*. Retrieved April 11, 2021.

College and Association of Registered Nurses of Alberta. (2021a). *Council meeting—June 25, 2021*. Retrieved July 8, 2021, from https://web.archive.org/web/20210623004026/https://nurses.ab.ca/about-us/council-and-committees/council/june-2021

College and Association of Registered Nurses of Alberta. (2021b). *Scope of practice for nurse practitioners*. Retrieved July 8, 2021, from https://www.nurses.ab.ca/media/5ocdiht4/scope-of-practice-for-nurse-practitioners-mar-2021.pdf

College and Association of Registered Nurses of Alberta. (2021c). *Scope of practice for registered nurses*. Retrieved July 8, 2021, from https://www.nurses.ab.ca/media/ruwb0xql/scope-of-practice-for-registered-nurses-mar-2021.pdf

College and Association of Registered Nurses of Alberta. (2021d, June 25). *Council meeting—June 25, 2021*. Retrieved July 8, 2021.

College and Association of Registered Nurses of Alberta. (n.d.a). *3. Council*. Retrieved October 19, 2021, from https://www.nurses.ab.ca/how-we-operate/governance/college-bylaws/part-2-governance/3-council/

College and Association of Registered Nurses of Alberta. (n.d.b). *8. Regulated members*. Retrieved October 19, 2021, from https://www.nurses.ab.ca/how-we-operate/governance/college-bylaws/part-4-college-register/8-regulated-members/

College and Association of Registered Nurses of Alberta. (n.d.c). *34. Specialty practice groups*. Retrieved October 19, 2021, from https://web.archive.org/web/20210513065557/https://nurses.ab.ca/about-us/college-bylaws/part-8-administration/34-specialty-practice-groups

College and Association of Registered Nurses of Alberta. (n.d.d). *About us*. Retrieved April 11, 2021, from https://web.archive.org/web/20220110012330/https://nurses.ab.ca/about-us

College and Association of Registered Nurses of Alberta. (n.d.e). *Am I practising as an RN or NP?* Retrieved July 8, 2021.

College and Association of Registered Nurses of Alberta. (n.d.f). *Ask us*. Retrieved July 9, 2021, from https://web.archive.org/web/20210514074816/https://nurses.ab.ca/separation/ask-us

College and Association of Registered Nurses of Alberta. (n.d.g). *Case studies*. Retrieved July 8, 2021, from https://web.archive.org/web/20210513053640/https://nurses.ab.ca/standards-and-learning/learning-opportunities/case-studies

College and Association of Registered Nurses of Alberta. (n.d.h). *College bylaws*. Retrieved July 8, 2021, from https://www.nurses.ab.ca/how-we-operate/governance/college-bylaws/

College and Association of Registered Nurses of Alberta. (n.d.i). *Contact us*. Retrieved July 8, 2021, from https://web.archive.org/web/20220110040017/https://nurses.ab.ca/about-us/contact-us

College and Association of Registered Nurses of Alberta. (n.d.j). *Continuing competence program*. Retrieved July 8, 2021, from

https://web.archive.org/web/20210618022240/https://nurses.ab.ca/become-a-nurse/registration-requirements/continuing-competence

College and Association of Registered Nurses of Alberta. (n.d.k). *Council voted unanimously to move to a single mandate regulatory organization with a commitment to develop and grow a new association*. Retrieved July 8, 2021, from https://web.archive.org/web/20210514075321/https://nurses.ab.ca/news/news-story/singlemandate

College and Association of Registered Nurses of Alberta. (n.d.l). *Currency of practice*. Retrieved July 8, 2021, from https://web.archive.org/web/20210514064033/https://nurses.ab.ca/become-a-nurse/registration-requirements/currency-of-practice

College and Association of Registered Nurses of Alberta. (n.d.m). *Develop and grow a new nursing association*. Retrieved July 8, 2021, from https://web.archive.org/web/20210514070944/https://nurses.ab.ca/develop-and-grow-a-new-nursing-association

College and Association of Registered Nurses of Alberta. (n.d.n). *Document library*. Retrieved July 8, 2021, from https://www.nurses.ab.ca/protect-the-public/standards-for-rns-and-nps/

College and Association of Registered Nurses of Alberta. (n.d.o). *Feedback collection tool*. Retrieved July 8, 2021, from https://web.archive.org/web/20200925093316/https://nurses.ab.ca/docs/default-source/continuing-competence/feedback-collection-tool.pdf?sfvrsn=b32f4683_10

College and Association of Registered Nurses of Alberta. (n.d.p). *Feedback needed on documents*. Retrieved July 8, 2021, from https://www.nurses.ab.ca/news/feedback-needed-on-standards-and-guidelines/

College and Association of Registered Nurses of Alberta. (n.d.q). *Information and tools to assist registrants in completing continuing competence program (CCP) requirements*. Retrieved July 8, 2021.

College and Association of Registered Nurses of Alberta. (n.d.r). *Knowledge check*. Retrieved July 8, 2021, from https://web.archive.org/web/20210513055545/https://nurses.ab.ca/standards-and-learning/learning-opportunities/knowledge-check

College and Association of Registered Nurses of Alberta. (n.d.s). *Learning modules*. Retrieved July 8, 2021, from https://web.archive.org/web/20210513070754/https://nurses.ab.ca/standards-and-learning/learning-opportunities/learning-modules

College and Association of Registered Nurses of Alberta. (n.d.t). *Legislation*. Retrieved July 8, 2021, from https://www.nurses.ab.ca/protect-the-public/understanding-nursing-regulation/legislation/

College and Association of Registered Nurses of Alberta. (n.d.u). *Our vision, mission, and values*. Retrieved July 8, 2021, from https://web.archive.org/web/20210422202305/https://nurses.ab.ca/about-us/our-vision-mission-and-values

College and Association of Registered Nurses of Alberta. (n.d.v). *Professional practice huddles*. Retrieved July 8, 2021, from

https://web.archive.org/web/20210513070643/https://nurses.ab.ca/standards-and-learning/learning-opportunities/professional-practice-huddles

College and Association of Registered Nurses of Alberta. (n.d.w). *Protecting patients from sexual abuse and sexual misconduct*. Retrieved July 8, 2021, from https://web.archive.org/web/20210514075607/https://nurses.ab.ca/protect-the-public/protecting-patients-from-sexual-abuse-and-sexual-misconduct

College and Association of Registered Nurses of Alberta. (n.d.x). *Register for a session*. Retrieved July 8, 2021, from https://web.archive.org/web/20210513054947/https://nurses.ab.ca/standards-and-learning/learning-opportunities/event-and-conferences

College and Association of Registered Nurses of Alberta. (n.d.y). *Review of registration process for internationally educated nurses*. Retrieved October 19, 2021, from https://web.archive.org/web/20210422194421/https://nurses.ab.ca/about-us/reviews/review-of-registration-process-for-internationally-educated-nurses

College and Association of Registered Nurses of Alberta. (n.d.z). *Self-assessment checklist for self-employed RN or NP practice*. Retrieved July 8, 2021.

College and Association of Registered Nurses of Alberta. (n.d.aa). *Self-employed assessment checklist: Am I practising registered nursing?* Retrieved July 8, 2021.

College and Association of Registered Nurses of Alberta. (n.d.ab). *Self-employed practice*. Retrieved April 11, 2021, from https://web.archive.org/web/20210514080445/https://nurses.ab.ca/maintain-your-permit/self-employed-practice

College and Association of Registered Nurses of Alberta. (n.d.ac). *Separation of the college and association*. Retrieved July 8, 2021, from https://www.nurses.ab.ca/separation-of-the-college-and-association/

College and Association of Registered Nurses of Alberta. (n.d.ad). *Specialty practice groups*. Retrieved July 8, 2021, from https://web.archive.org/web/20210514073310/https://nurses.ab.ca/standards-and-learning/learning-opportunities/specialty-practice-groups

College and Association of Registered Nurses of Alberta. (n.d.ae). *What we do*. Retrieved July 8, 2021, from https://web.archive.org/web/20210514074600/https://nurses.ab.ca/about-us/what-we-do

College of Nurses of Ontario. (2000). *By-laws*. Retrieved April 19, 2021, from https://www.cno.org/en/what-is-cno/regulation-and-legislation/by-laws/

College of Nurses of Ontario. (2012). *Educational tools*. Retrieved October 18, 2021, from https://www.cno.org/en/learn-about-standards-guidelines/educational-tools/

College of Nurses of Ontario. (2016a). *Governance principles*. Retrieved October 16, 2021, from https://www.cno.org/en/what-is-cno/councils-and-committees/council/governance-principles/

College of Nurses of Ontario. (2016b, August 30). *Four regulators. Two provinces. One great opportunity.* Retrieved April 21, 2021, from https://www.cno.org/globalassets/1-whatiscno/newsreleasesandnotices/releases/bc-ont-announcement.pdf

College of Nurses of Ontario. (2017a). *Developing standards*. Retrieved April 22, 2021, from https://www.cno.org/en/learn-about-standards-guidelines/standards-and-guidelines/developing-standards/

College of Nurses of Ontario. (2017b). *Final report: A vision for the future*. Retrieved April 19, 2021, from https://www.cno.org/globalassets/1-whatiscno/governance/final-report---leading-in-regulatory-governance-task-force.pdf

College of Nurses of Ontario. (2017c). *Practice support model*. Retrieved April 22, 2021, from https://www.cno.org/en/learn-about-standards-guidelines/Practice-Support/practice-support-model/

College of Nurses of Ontario. (2017d, February 23). *Health minister announces plans to change laws to allow RN prescribing*. Retrieved May 7, 2021, from https://www.cno.org/en/news/2017/february-2017/minister-announces-plans-to-change-laws-to-allow-rn-prescribing/

College of Nurses of Ontario. (2018a). *Am I practising nursing in my new role?* Retrieved October 18, 2021, from https://www.cno.org/en/learn-about-standards-guidelines/educational-tools/ask-practice/am-i-practising-nursing-in-my-new-role/

College of Nurses of Ontario. (2018b). *Entry-to-practice competencies for registered nurses*. Retrieved September 9, 2021, from https://www.cno.org/globalassets/docs/reg/41037-entry-to-practice-competencies-2020.pdf

College of Nurses of Ontario. (2018c). *FAQs: Declaration of practice*. Retrieved October 18, 2021, from https://www.cno.org/en/maintain-your-membership1/declaration-of-practice/

College of Nurses of Ontario. (2018d). *Practice standard: Professional standards, revised 2002*. Retrieved April 22, 2021, from https://www.cno.org/globalassets/docs/prac/41006_profstds.pdf

College of Nurses of Ontario. (2019a). *Code of conduct*. Retrieved April 21, 2021, from https://www.cno.org/globalassets/docs/prac/49040_code-of-conduct.pdf

College of Nurses of Ontario. (2019b). *Code of conduct FAQs*. Retrieved October 18, 2021, from https://www.cno.org/en/protect-public/code-of-conduct-for-nurses/code-of-conduct-faqs/

College of Nurses of Ontario. (2019c). *Council*. Retrieved October 16, 2021, from https://www.cno.org/en/what-is-cno/councils-and-committees/council/

College of Nurses of Ontario. (2019d). *FAQs: Non-Practising Class*. Retrieved April 28, 2021, from https://www.cno.org/en/maintain-your-membership1/nonpractising-class-faq/

College of Nurses of Ontario. (2019e). How we changed and grew in 2018. *The Standard*. Retrieved October 16, 2021, from https://www.cno.org/en/learn-about-standards-guidelines/magazines-newsletters/the-standard/june-2019/2018-annual-report/

College of Nurses of Ontario. (2019f). *Practice standard: Ethics*. Retrieved April 22, 2021, from https://www.cno.org/globalassets/docs/prac/41034_ethics.pdf

College of Nurses of Ontario. (2019g). *Regulation, legislation & by-laws*. Retrieved October 16, 2021, from https://www.cno.org/en/what-is-cno/regulation-and-legislation/

College of Nurses of Ontario. (2019h). *What is AGRE?* Retrieved April 26, 2021, from https://www.cno.org/en/what-is-cno/transparency-a-commitment-to-clarity-and-openness/what-is-agre/

College of Nurses of Ontario. (2019i). Do you know what counts as "practicing nursing"? *The Standard*. Retrieved April 25, 2021, from https://www.cno.org/en/learn-about-standards-guidelines/magazines-newsletters/the-standard/february-2019/what-counts-as-practicing-nursing/

College of Nurses of Ontario. (2020a). *Achieving impact: 10-year strategic plan report (2011-2020)*. Retrieved April 25, 2021, from https://www.cno.org/globalassets/1-whatiscno/newsreleasesandnotices/releases/10-year-report.pdf

College of Nurses of Ontario. (2020b). *College performance measurement framework (CPMF) reporting tool*. Ontario Ministry of Health. Retrieved April 21, 2021, from https://www.cno.org/globalassets/1-whatiscno/cpmf/cpmf-report-202103.pdf

College of Nurses of Ontario. (2020c). *Committees*. Retrieved October 16, 2021, from https://www.cno.org/en/what-is-cno/councils-and-committees/committee/

College of Nurses of Ontario. (2020d). *Fact sheet—Legislation and regulation: An introduction to the Nursing Act, 1991*. Retrieved April 21, 2021, from https://www.cno.org/globalassets/docs/prac/41064_fsnursingact.pdf

College of Nurses of Ontario. (2020e). *FAQs: Changing nursing regulation*. Retrieved October 18, 2021, from https://www.cno.org/en/learn-about-standards-guidelines/scope-of-practice--proposed-changes/faqs-changing-nursing-regulation/

College of Nurses of Ontario. (2020f). Our response to the long-term care homes public inquiry recommendations. *The Standard*. Retrieved October 18, 2021, from https://www.cno.org/en/learn-about-standards-guidelines/magazines-newsletters/the-standard/January-2020/Our-response-to-the-Long-Term-Care-Homes-Public-Inquiry-recommendations/

College of Nurses of Ontario. (2020g). *Practice guideline: Authorizing mechanisms*. Retrieved April 22, 2021, from https://www.cno.org/globalassets/docs/prac/41075_authorizingmech.pdf

College of Nurses of Ontario. (2020h). *Practice support*. Retrieved April 22, 2021, from https://www.cno.org/en/learn-about-standards-guidelines/Practice-Support/

College of Nurses of Ontario. (2020i). *Public consultations*. Retrieved October 18, 2021, from https://www.cno.org/en/what-is-cno/public-consultations/

College of Nurses of Ontario. (2020j). *What is CNO?* Retrieved April 11, 2021, from https://www.cno.org/en/what-is-cno/

College of Nurses of Ontario. (2021a). *Ask practice*. Retrieved April 12, 2021, from https://www.cno.org/en/learn-about-standards-guidelines/educational-tools/ask-practice/

College of Nurses of Ontario. (2021b). *CNO submits college performance measurement framework report*. Retrieved April 21, 2021, from https://www.cno.org/en/news/2021/march-2021/cno-submits-cpmf-report/

College of Nurses of Ontario. (2021c). *College documents*. Retrieved October 18, 2021, from https://www.cno.org/en/learn-about-standards-guidelines/list-of-all-publications/

College of Nurses of Ontario. (2021d). *Employer reference group*. Retrieved October 18, 2021, from https://www.cno.org/en/protect-public/employer-resources/employer-reference-group/

College of Nurses of Ontario. (2021e). *Evidence of practice*. Retrieved October 18, 2021, from https://www.cno.org/en/become-a-nurse/registration-requirements/evidence-of-practice/

College of Nurses of Ontario. (2021f). *FAQs: Quality assurance*. October 18, 2021, from https://www.cno.org/en/myqa/faqs-quality-assurance/

College of Nurses of Ontario. (2021g). *Governance vision*. Retrieved October 16, 2021, from https://www.cno.org/en/what-is-cno/councils-and-committees/council/governance-vision-2020/

College of Nurses of Ontario. (2021h). *Membership totals at a glance*. Retrieved October 16, 2021, from https://www.cno.org/en/what-is-cno/nursing-demographics/membership-totals-at-a-glance/

College of Nurses of Ontario. (2021i). *Practice guideline: Independent practice*. Retrieved November 7, 2020, from https://www.cno.org/globalassets/docs/prac/41011_fsindepprac.pdf

College of Nurses of Ontario. (2021j). *Preventing harm*. Retrieved October 18, 2021, from https://www.cno.org/en/protect-public/preventing-harm/

College of Nurses of Ontario. (2021k). *Professional standards*. Retrieved April 22, 2021, from https://www.cno.org/en/learn-about-standards-guidelines/educational-tools/learning-modules/professional-standards/

College of Nurses of Ontario. (2021l). *Quality assurance: A commitment to safe, quality care*. Retrieved October 18, 2021, from https://www.cno.org/en/myqa/qa-public-information/

College of Nurses of Ontario. (2021m). *Quality assurance assessment*. Retrieved October 18, 2021, from https://www.cno.org/en/myqa/quality-assurance-assessment/

College of Nurses of Ontario. (2021n). *Scope of practice – Proposed changes*. Retrieved April 22, 2021, from https://www.cno.org/en/learn-about-standards-guidelines/scope-of-practice--proposed-changes/

College of Nurses of Ontario. (2021o). *Standards & guidelines*. Retrieved October 18, 2021, from https://www.cno.org/en/learn-about-standards-guidelines/standards-and-guidelines/

College of Nurses of Ontario. (2021p). *Your guide to self-assessment*. Retrieved April 22, 2021, from https://web.archive.org/web/20211215160419/https://www.cno.org/globalassets/docs/qa/2021/qa-self-assessment-guide-en.pdf

College of Nurses of Ontario. (2021q, January). Nurses to administer the COVID-19 vaccine without an order. *The Standard*. Retrieved May 7, 2021, from

https://www.cno.org/en/learn-about-standards-guidelines/magazines-newsletters/the-standard/January-2021/Nurses-to-administer-the-COVID-19-vaccine-without-an-order/

College of Nurses of Ontario. (2021r). *We need your input and expertise to modernize the practice standards*. Retrieved April 25, 2021, from https://www.cno.org/en/learn-about-standards-guidelines/magazines-newsletters/the-standard/January-2021/We-need-your-input-and-expertise-to-modernize-the-practice-standards/

College of Nurses of Ontario. (2021s). *Council briefing package*. Retrieved April 25, 2021, from https://www.cno.org/globalassets/1-whatiscno/council/meetings/2021/meeting-materials-0321.pdf

College of Nurses of Ontario. (2021t, April 23). *IMPORTANT UPDATE: New provincial orders – change to scope of practice in hospitals*. Retrieved April 30, 2021, from https://www.cno.org/en/news/2021/april-2021/important-update-new-provincial-orders--change-to-scope-of-practice-in-hospitals/

College of Nurses of Ontario. (n.d.a). *Governance reform*. Retrieved April 19, 2021, from https://www.cno.org/globalassets/trending-topics/cno-governance-reform.pdf

College of Nurses of Ontario. (n.d.b). *Strategic plan 2021-2024*. Retrieved April 19, 2021, from https://www.cno.org/en/news/2021/january-2021/new-strategic-plan-2021-2024/

College of Registered Nurses of Manitoba. (n.d.a). *About the college: What we do*. Retrieved April 11, 2021, from https://www.crnm.mb.ca/about/college

College of Registered Nurses of Manitoba. (n.d.b). *Frequently Asked Questions.* Retrieved January 6, 2022, from https://www.crnm.mb.ca/services/renewal/faqs

College of Registered Nurses of Manitoba. (n.d.c). *Self-employed practice handbook*. Retrieved April 18, 2021, from https://www.crnm.mb.ca/uploads/ck/files/self-employed%20handbook_jun18%20FINAL.1.pdf

College of Registered Nurses of Newfoundland & Labrador. (2014). *Legislation and by-laws*. Retrieved April 11, 2021, from https://www.crnnl.ca/legislation-and-laws

College of Registered Nurses of Newfoundland & Labrador. (n.d.). *Practicing Licence*. Retrieved January 6, 2022, from https://crnnl.ca/registration-renewal/renewal/practicing-licence/

College of Registered Nurses of Prince Edward Island. (2020). *About us*. Retrieved April 11, 2021, from https://crnpei.ca/about/

College of Registered Nurses of Prince Edward Island. (n.d.). *Assessment of nursing practice hours*. Retrieved January 6, 2022, from https://crnpei.ca/rn-information/assessment-of-nursing-practice-hours/

Consolidation of Nursing Act, SNWT 1998, c. 38, s. 4. https://rnantnu.ca/wp-content/uploads/2019/10/Nunavut-Nursing-Act-S.N.W.T.-1998.c.38-s.4..pdf

Costa, F. G., Vaghetti, H. H., Martinello, D. F. G., Mendes, D. P., Terra, A. C., Alvarez, S. Q., & Lemos, L. A. P. (2013). Enterprising tendencies of nurses in a university hospital. *Rev Gaucha Enferm*, *34*(2), 147–154.

Crawley, M. (2016, October 26). How nurses and nursing homes are regulated in Ontario. *CBC*. https://www.cbc.ca/news/canada/toronto/nurse-charged-murder-woodstock-ontario-college-1.3820263

Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.). SAGE.

Currie, J., Chiarella, M., & Buckley, T. (2016). Workforce characteristics of privately practicing nurse practitioners in Australia: Results from a national survey. *Journal of the American Association of Nurse Practitioners*, *28*(10), 546–553. https://doi.org/10.1002/2327-6924.12370

Currie, J., Chiarella, M., & Buckley, T. (2018). Privately practicing nurse practitioner services in Australia and patient access to care: Results from realist interviews. *Journal of the American Association of Nurse Practitioners*, *30*(6), 344–353. DOI: 10.1097/JXX.0000000000000038

Currie, J., Chiarella, M., & Buckley, T. (2019). Realist evaluation of privately practising nurse practitioners in Australia: Development and refinement of theories. *Collegian*, *26*(1), 8–15. https://doi.org/10.1016/j.colegn.2018.01.006

da Paixão Silva, A. C., Cavalcanti Valente, G. L., & Cavalcanti Valente, G. S. (2017). Entrepreneurship as a tool for the nurse's work. *Revista de Enfermagem*, *11*(4), 1595–1602. DOI: 10.5205/reuol.9763-85423-1-SM.1104201705

Dehghanzadeh, M. R., Kholasehzadeh, G., Birjandi, M., Antikchi, E., Sobhan, M. R., & Neamatzadeh, H. (2016). Entrepreneurship psychological characteristics of nurses. *Acta Medica Iranica*, *54*(9), 595–599.

Dobni, B., Nickel, B., Case, T., & Comm, B. (2019). *RNs and NPs: Membership survey biennial accountability report—2019*. Saskatchewan Registered Nurses Association. Retrieved July 27, 2021, from https://www.srna.org/wp-content/uploads/2020/02/RN-Membership-Survey-2019.pdf

Dubinski, K. (2018, June 5). Red flags about killer nurse Elizabeth Wettlaufer were ignored, inquiry documents show. *CBC*. https://www.cbc.ca/news/canada/london/elizabeth-wettlaufer-day-one-public-inquiry-1.4692559

Dumouchel, M., Boytim, M., Gorman, N., & Weismuller, P. (2015). Does moral distress differ between California certified registered nurse anesthetists in independent versus medically supervised practice: An exploratory study. *AANA Journal*, *83*(3), 203–209.

Duncan, S., Thorne, S., & Rodney, P. (2015). Evolving trends in nurse regulation: What are the policy impacts for nursing's social mandate? *Nursing Inquiry*, *22*(1), 27–38. https://doi.org/10.1111/nin.12087

Ekin, F., & Gungormus, Z. (2019). Entrepreneurial feelings and potentials with opinions on innovation in nursing education of nursing students. *International Journal of Caring Sciences*, *12*(1), 107–123.

Eminoglu, A., & Gungormus, Z. (2019). Entrepreneurial characteristics and inclinations of nursing students. *International Journal of Caring Sciences*, *12*(2), 684–698.

Field Law. (2019). *Review of the College & Association of Registered Nurses of Alberta's Approach to Fitness to Practise*. Retrieved July 8, 2021, from https://web.archive.org/web/20210513062940/https://nurses.ab.ca/docs/default-source/latestnews/review-of-approach-to-fitness-to-practise.pdf?sfvrsn=2cdfc3f5_2

Fitzpatrick, M. (2020, July 26). Caressant Care and Ontario College of Nurses at odds over serial killer Wettlaufer's firing. *CBC*. https://www.cbc.ca/news/canada/caressant-care-and-ontario-college-of-nurses-at-odds-over-serial-killer-wettlaufer-s-firing-1.4222735

Flyvbjerg, B. (2006). Five misunderstandings about case-study research. *Qualitative Inquiry*, *12*(2), 219–245. https://doi.org/10.1177/1077800405284363

Gagnon, M. L., & Labonté, R. (2013). Understanding how and why health is integrated into foreign policy—A case study of health is global, a UK government strategy 2008–2013. *Globalization and Health*, *9*(1), 24. https://doi.org/10.1186/1744-8603-9-24

General Regulations (2018). PEI Reg. EC349/18. https://www.princeedwardisland.ca/sites/default/files/legislation/R%2610-1G-Regulated%20Health%20Professions%20Act%20General%20Regulations.pdf

Gerein, K. (2018a, April 17). Edmonton doctor convicted of sexual assaults allowed to practise again. *Edmonton Journal*. https://edmontonjournal.com/news/local-news/edmonton-doctor-convicted-of-sexual-assaults-allowed-to-return-to-practice

Gerein, K. (2018b, April 20). "Knots in stomach" over doctor reinstatement. *The Sherwood Park News*. https://www.sherwoodparknews.com/2018/04/20/knots-in-stomach-over-doctor-reinstatement

Gillis, L. (2021, April 13). 'Constant state of burnout': Pandemic stress causing nurses to leave the profession in droves. *Sudbury.Com*. https://www.sudbury.com/local-news/constant-state-of-burnout-pandemic-stress-causing-nurses-to-quit-their-jobs-in-droves-3627169

Global News. (2021, March 16). *Ontario premier Ford unveils new Humber College nursing degree program*. https://globalnews.ca/video/7699841/ontario-premier-ford-unveils-new-humber-college-nursing-degree-program/

Goulet, J. (2020, July 6). Bill proposed to improve Alberta's health care system. *Lethbridge News Now*. https://lethbridgenewsnow.com/2020/07/06/bill-proposed-to-improve-albertas-health-care-system/

Governance Solutions. (2020). *The College and Association of Registered Nurses of Alberta (CARNA): Governance review findings report with recommendations*. Retrieved July 8,

2021, from https://web.archive.org/web/20220108034459/https://nurses.ab.ca/docs/default-source/latestnews/governance-review-findings-report.pdf?sfvrsn=867323df_2

Government of Alberta. (2021a). *Improving public health care*. Retrieved September 10, 2021, from https://www.alberta.ca/improving-public-health-care.aspx

Government of Alberta. (2021b). *Regulated health professions and colleges*. Retrieved April 11, 2021, from https://www.alberta.ca/regulated-health-professions.aspx

Government of Canada. (2019). *Job prospects for Registered nurses and registered psychiatric nurses*. Job Bank. Retrieved October 18, 2021, from https://www.jobbank.gc.ca/outlookreport/occupation/696

Government of Ontario. (2015). *To zero: Independent report of the minister's task force on the prevention of sexual abuse of patients and the Regulated Health Professions Act, 1991*. Retrieved July 5, 2021, from https://www.health.gov.on.ca/en/common/ministry/publications/reports/sexual_health/taskforce_prevention_of_sexual_abuse_independent_report.pdf

Government of Ontario. (2020). *Our four principles*. Fairness Commissioner. https://www.fairnesscommissioner.ca/en/About/Pages/Our-Four-Principles.aspx

Government of Ontario. (2021). *What is divisional court? - Ministry of the attorney general*. Queen's Printer for Ontario. Retrieved June 22, 2021, from https://www.attorneygeneral.jus.gov.on.ca/english/courts/divisional/What_is_Divisional_Court_EN.html

Government Organization Act, 2000, RSA 2000. c. G-10. https://www.qp.alberta.ca/1266.cfm?page=g10.cfm&leg_type=Acts&isbncln=9780779814824

Grant, K. (2021, July 16). Canadian nurses are leaving in droves, worn down by 16 merciless months on the front lines of COVID-19. *The Globe and Mail*. https://www.theglobeandmail.com/canada/article-canadian-nurses-are-leaving-in-droves-worn-down-by-16-merciless-months/

Hains, T., Strand, H., & Turner, C. (2018). Complexities of the Australian perioperative nurse entrepreneur. *Australian Journal of Advanced Nursing*, *36*(1), 48–55.

Health Profession Regulators of Ontario. (n.d.). *Home*. Retrieved April 30, 2021, from http://www.regulatedhealthprofessions.on.ca/index.html

Health Professions Act, RSA 2000. c. H-7. https://www.qp.alberta.ca/570.cfm?frm_isbn=9780779826650&search_by=link

Health Professions Act, RSBC 1996, c. 183. https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96183_01

Health Professions Regulatory Advisory Council. (2018, March 12). *Registered Nurse Prescribing*. Retrieved April 30, 2021, from http://www.hprac.org/en/projects/Registered-Nurse-Prescribing.asp

Heelan, J. J., Stratton, B. J., & Birchall, N. (2018, November 19). Bill 21: An act to protect patients applies to 30 health regulatory colleges in Alberta. *Bennett Jones*. Retrieved July 20, 2021, from https://www.bennettjones.com:443/Blogs-Section/Bill-21-An-Act-to-Protect-Patients-Applies-to-30-Health-Regulatory-Colleges-in-Alberta

Heidenreich, P. (2015). Alberta allows more health professionals to administer fentanyl antidote. *Global News*. https://globalnews.ca/news/2395324/alberta-allows-more-health-professionals-to-administer-fentanyl-antidote/

Hoskins, E. (2014). *Letter from minister Hoskins* [Letter from minister of health to the CNO]. Retrieved July 7, 2021, from https://www.cno.org/globalassets/1-whatiscno/transparency/6.2.2-b-letterfromministerhoskins.pdf

Hoskins, E. (2016, January 11). *Mandate letter progress: Health and long-term care* [Letter from the minister to the premier]. Retrieved July 7, 2021, from https://www.ontario.ca/page/mandate-letter-progress-health-and-long-term-care

Houghton, C., Casey, D., Shaw, D., & Murphy, K. (2013). Rigour in qualitative case-study research. *Nurse Researcher*, *20*(4), 12–17.

Hourahane, G., West, N., Barnes, R., Rees, S., Bowyer, A., Dundon, J., & Allen, D. (2012). Supporting trail-blazing: A systematic review of the factors that facilitate or inhibit the implementation of new nursing roles: The experiences of UK consultant nurses. *JBI Library of Systematic Reviews*, *10*(50), 3146–3294.

Hunter, J., Dixon, K., & Dahlen, H. G. (2021). The experiences of privately practising midwives in Australia who have been reported to the Australian Health Practitioner Regulation Agency: A qualitative study. *Women and Birth*, *34*(1), e23–e31. https://doi.org/10.1016/j.wombi.2020.07.008

Institute of Medicine. (2011). *The future of nursing: Leading change, advancing health*. National Academies Press. Retrieved September 14, 2020, from http://www.ncbi.nlm.nih.gov/books/NBK209880/

International Nurse Regulator Collaborative. (2021). *College of Nurses of Ontario*. Retrieved April 30, 2021, from https://www.inrc.com/ontario.htm

Ispir, Ö., Elibol, E., & Sönmez, B. (2019). The relationship of personality traits and entrepreneurship tendencies with career adaptability of nursing students. *Nurse Education Today*, *79*, 41–47. https://doi.org/10.1016/j.nedt.2019.05.017

Jahani, S., Abedi, H., Elahi, N., & Fallahi-Khoshknab, M. (2016). Iranian entrepreneur nurses' perceived barriers to entrepreneurship: A qualitative study. *Iranian Journal of Nursing and Midwifery Research*, *21*(1), 45–53. https://doi.org/10.4103/1735-9066.174749

Jahani, S., Babazadeh, M., Haghighi, S., & Cheraghian, B. (2018). The effect of entrepreneurship education on self-efficacy beliefs and entrepreneurial intention of nurses. *Journal of Clinical & Diagnostic Research*, *12*(6), 18–21. https://doi.org/10.7860/JCDR/2018/31525.11654

Johnston, J. (2016, July 13). Edmonton doctor convicted of sexual assault gets 30 days in jail. *CBC News*. https://www.cbc.ca/news/canada/edmonton/30-days-in-jail-for-edmonton-doctor-convicted-of-sexual-assault-1.3677651

Kalata, N. (2021, January 28). 1 in 3 Ontario registered practical nurses considering quitting due to pandemic, poll suggests. *CBC News*. https://www.cbc.ca/news/canada/toronto/nurses-ontario-covid-19-burnout-survey-1.5890799

Kast, F. E., & Rosenzweig, J. E. (1972). General system theory: Applications for organization and management. *Academy of Management Journal*, *15*(4), 447–465.

Katz, D., & Kahn, R. L. (1978). *The Social Psychology of Organizations* (2nd ed.). John Wiley and Sons.

Kirkman, A., Wilkinson, J., & Scahill, S. (2018). Thinking about health care differently: Nurse practitioners in primary health care as social entrepreneurs. *Journal of Primary Health Care*, *10*(4), 331–337. https://doi.org/10.1071/HC18053

Koch, W. (2020a, February 12). *A message from the SRNA president*. Retrieved July 27, 2021, from https://mailchi.mp/02289d73be57/a-message-from-the-srna-president-278365

Koch, W. (2020b, June 11). *A message from the SRNA president*. Retrieved July 27, 2021, from https://mailchi.mp/e4fcbc19a022/a-message-from-the-srna-president-278466

Koch, W. (2020c, September 2). *A message from the SRNA president*. Retrieved July 27, 2021, from https://mailchi.mp/f92ac5659b2d/a-message-from-the-srna-president-278486

Koch, W. (2020d, November 12). *A message from the SRNA president*. Retrieved July 27, 2021, from https://mailchi.mp/e46110aacdd9/a-message-from-the-srna-president-278546

Koch, W. (2021, February 8). *A message from the SRNA president*. Retrieved July 27, 2021, from https://mailchi.mp/55e8b3272b85/a-message-from-the-srna-president-278578

Lampa, N. (2021, April 29). Nursing grad waiting on licence upset by Ont. looking for health-care workers internationally. *CTV News*. https://kitchener.ctvnews.ca/nursing-grad-waiting-on-licence-upset-by-ont-looking-for-health-care-workers-internationally-1.5408014

Lao, D. (2021, October 31). Advocates concerned over where unvaccinated nurses will work amid mandates. *Global News*. https://globalnews.ca/news/8339617/covid-vaccine-mandates-nurses/

LeBel, J. (2018, July 26). College of Nurses of Ontario knew Elizabeth Wettlaufer was an alcoholic since 1995: Caressant Care lawyer. *Global News*.

https://globalnews.ca/news/4355896/college-of-nurses-of-ontario-knew-elizabeth-wettlaufer-was-an-alcoholic-since-1995-caressant-care-lawyer/

Leblebicioglu, H., Baysal, E., & Khorshid, L. (2018). Investigation of relationship between entrepreneurship and individual innovativeness in nurse academicians. *International Journal of Caring Sciences*, *11*(3), 1812–1821.

Lee, J. (2019, March 13). Doctors, nurses prepare for new bill to protect patients from sexual abuse. *CBC News*. https://www.cbc.ca/news/canada/calgary/bill-21-health-professionals-sexual-abuse-misconduct-patients-1.5054762

Leslie, K. M. (2017). *Balancing tensions in regulatory reform: Changes to regulation of health professions in Australia, the United Kingdom, and Ontario, Canada* [Doctoral dissertation]. University of Toronto.

Letterio, A. (2021, October 29). Unvaccinated nurses open wellness centre in Kamloops, B.C. *Global News*. https://globalnews.ca/news/8335999/unvaccinated-nurses-wellness-centre-kamloops/

Loi sur les Infirmières et les Infirmiers, SQC 1973, c. I-8. http://legisquebec.gouv.qc.ca/fr/document/lc/I-8

Lomba, M. de L. L. de F., Toson, M., Weissheimer, A. S., Backes, M. T. S., Büscher, A., & Backes, D. S. (2018). Social entrepreneurship: Translation of knowledge and practices in Brazilian nursing students. *Revista de Enfermagem Referência*, *4*(19), 107–115. http://0-dx.doi.org.aupac.lib.athabascau.ca/10.12707/RIV18064

Lyden, C., Sekula, L. K., Higgins, B., & Zoucha, R. (2018). Job satisfaction and empowerment of self-employed nurse practitioners: A mixed methods study. *Journal of the American*

Association of Nurse Practitioners, *30*(2), 78–91. https://doi.org/10.1097/JXX.0000000000000007

Merriam, S. B. (1998). *Qualitative research and case study application in education*. Jossey-Bass.

Mertz, E. (2020). Some Alberta nurses worry proposed social media policy would muzzle health advocacy and criticism. *Global News*. https://globalnews.ca/news/7422553/alberta-nurses-social-media-policy-draft-freedom-criticism/

Meyer, R. M., & O'Brien-Pallas, L. L. (2010). Nursing services delivery theory: An open system approach. *Journal of Advanced Nursing*, *66*(12), 2828–2838. https://doi.org/10.1111/j.1365-2648.2010.05449.x

Ministry of Health and Long-Term Care. (2019, June 13). *Letter from the ministry to CNO*. Retrieved July 7, 2021, from https://www.cno.org/globalassets/trending-topics/2019-06-13-scope-of-practice-letter---college-of-nurses-of-ontario.pdf

National Council of State Boards of Nursing. (2021). *Associate Members*. Retrieved August 24, 2021, from https://www.ncsbn.org/associate-members.htm

National Expert Commission. (2012). *A nursing call to action*. Canadian Nurses Association. Retrieved August 26, 2020, from https://www.deslibris.ca/ID/239857

Network of Inter-professional Regulatory Organizations. (n.d.). *NIRO: Health Professions*. Retrieved August 16, 2021, from http://www.nirosask.ca/health-professions/

Nova Scotia College of Nursing. (2020). *Self-employed practice guideline for nurses*. Retrieved April 12, 2021, from https://cdn1.nscn.ca/sites/default/files/documents/resources/SelfEmployed.pdf

Nova Scotia College of Nursing. (2021a). *Purpose, mission, vision & values*. Retrieved April 11, 2021, from https://www.nscn.ca/explore-nscn/who-we-are/purpose-mission-vision-values

Nova Scotia College of Nursing. (2021b). *Regulatory philosophies*. Retrieved August 12, 2021, from https://www.nscn.ca/explore-nscn/who-we-are/regulatory-philosophies

Nova Scotia College of Nursing. (n.d.). *Currency of Practice*. Retrieved January 6, 2022, from http://www.nscn.ca/registration-licensing/general-licensing-information/currency-practice

Nova Scotia Regulated Health Professions Network. (2021). The Network: Nova Scotia Regulated Health Professions Network. *The Network*. Retrieved April 12, 2021, from http://www.nsrhpn.ca/

Nurluoz, O., & Esmaeilzadeh, S. (2019). Assessment of the entrepreneurial characteristics and hopelessness status of nurses working in theonetraining and research hospital. *Cyprus Journal of Medical Sciences*, *4*(3), 208–215. https://doi.org/10.5152/cjms.2019.832

Nurse Practitioner Regulation Framework Implementation Plan Project. (2020, June). Project News #1. *Canadian Council of Registered Nurse Regulators*. Retrieved September 8, 2021, from https://www.ccrnr.ca/npr-fipp.html

Nurses Association of New Brunswick. (2002). *Nurses act*. Retrieved April 12, 2021, from http://www.nanb.nb.ca/media/resource/NANB-NursesAct-2008-Bilang.pdf

Nurses Association of New Brunswick. (2015). *Guidelines for self-employed registered nurses*. Retrieved April 12, 2021, from http://www.nanb.nb.ca/media/resource/NANB-Guidelines-SelfEmployedPractice_2021-E_Amended_Oct_2021.pdf

Nurses Association of New Brunswick. (n.d.a). *About NANB: Vision, mandate, values & public protection*. Retrieved April 11, 2021, from http://www.nanb.nb.ca/about/nanb

Nurses Association of New Brunswick. (n.d.b). *Registration Renewal*. Retrieved January 6, 2022, from http://www.nanb.nb.ca/registration/renewal

Nurses (Registered) and Nurse Practitioners Regulation (2020), BC Reg. 167/20. https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/284_2008

Nursing Act, SNS 2019. c. 8. https://nslegislature.ca/sites/default/files/legc/statutes/nursing.pdf

Nursing Act, SO 1991, c. 32. https://www.ontario.ca/laws/statute/91n32

Nursing Profession Act, SNWT 2003, c. 15. https://rnantnu.ca/wp-content/uploads/2019/10/Nursing-Profession-Act-S.N.W.T-2003-C.15-NPA.pdf

Ordre des infirmières et infirmiers du Québec. (2009). *What you need to know about the regulation respecting periods of refresher training and refresher courses nurses may be required to serve*. Registrar's Office. Retrieved January 6, 2022, from https://www.oiiq.org/sites/default/files/uploads/pdf/admission_a_la_profession/retour_a_la_profession/Info_regulation_refresh_training.pdf

Ordre des infirmières et infirmiers du Québec. (2019a). *Pratique infirmière dans le secteur privé* [Nursing practice in the private sector]. Retrieved April 12, 2021, from https://www.oiiq.org/pratique-professionnelle/encadrement-de-la-pratique/pratique-infirmiere-dans-le-secteur-prive

Ordre des infirmières et infirmiers du Québec. (2019b). *Profession infirmière: Champ d'exercice et activités réservées* [Nursing profession: Scope of practice and reserved activities]. https://www.oiiq.org/pratique-professionnelle/exercice-infirmier/infirmieres-et-infirmiers

Ordre des infirmières et infirmiers du Québec. (2019c). *Qui sommes-nous?* [Who are we?]. Retrieved April 11, 2021, from https://www.oiiq.org/l-ordre/qui-sommes-nous-

Perron, A., Gagnonis, M., & Stake-Doucet, N. (2020, October 15). Opinion: SRNA should celebrate ruling along with Strom and other nurses. *LeaderPost*. https://leaderpost.com/opinion/columnists/opinion-srna-should-celebrate-ruling-along-with-strom-and-other-nurses

Practice of Registered Nursing Regulation (2017), MB Reg. 113/2017. https://web2.gov.mb.ca/laws/regs/pre-versions.php?reg=113/2017

Professional Standards Authority for Health and Social Care. (2015). *Right-touch regulation*. https://www.professionalstandards.org.uk/right-touch-regulation-2015

Professional Standards Authority for Health and Social Care. (2019). *The standards of good regulation*. Retrieved November 1, 2021, from https://www.professionalstandards.org.uk/docs/default-source/publications/standards/standards-of-good-regulation-2018-revised.pdf?sfvrsn=ce597520_4

Province of British Columbia. (2021). *Professional regulation*. Retrieved April 11, 2021, from https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/professional-regulation

QSR International Pty Ltd. (2020). *NVivo* (released in March 2020) [Computer software]. https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home

Registered Nurses Act, SNL 2008. c. R-9.1. https://www.assembly.nl.ca/Legislation/sr/statutes/r09-1.htm

Registered Nurses' Association of Ontario, & Ontario Nurses' Association (n.d.). [Letter to the CNO council president and executive director]. *Letter Re: Expanding RPN scope of*

practice. Retrieved May 7, 2021, from https://rnao.ca/fr/policy/letters/rnao-ona-joint-letter-re-expanding-rpn-scope-practice

Registered Nurses Association of the Northwest Territories and Nunavut. (2019a). *About us*. Retrieved April 11, 2021, from https://rnantnu.mystagingwebsite.com/about/

Registered Nurses Association of the Northwest Territories and Nunavut. (2019b). *Assessment of nursing practice hours*. Retrieved April 14, 2021, from https://rnantnu.mystagingwebsite.com/np-information/assessment-of-nursing-practice-hours/

Registered Nurses Association of the Northwest Territories and Nunavut. (2022). *Online Renewal 2022: Frequently Asked Questions*. Retrieved January 6, 2022, from https://rnantnu.ca/wp-content/uploads/2021/10/Renewal-FAQ-2022.pdf

Registered Nurses Profession Regulation (2005). AB reg 232/2005. https://www.qp.alberta.ca/1266.cfm?page=2005_232.cfm&leg_type=Regs&isbncln=9780779807123&display=html

Registered Nurses Regulations (2008), NL Reg. 66/13. https://www.assembly.nl.ca/Legislation/sr/Regulations/rc130066.htm

Registered Nurses Regulations (2018). PEI Reg. EC350/18. https://www.princeedwardisland.ca/sites/default/files/legislation/r10-1-9-regulated_health_professions_act_registered_nurses_regulations.pdf

Regulated Health Professions Act, RSPEI 1988, c. R-10.1. https://www.princeedwardisland.ca/sites/default/files/legislation/r-10-1-regulated_health_professions_act.pdf

Regulated Health Professions Act, SO 1991, c. 18. https://www.ontario.ca/laws/statute/91r18

Ribeiro Lima, K. F., Pinheiro, A. S., da Silva, P. L., Maltezi Cavalini, A. F., dos Santos Bispo, A., de Carvalho Andrade, A., & de Medeiros, J. S. (2019). Nurse entrepreneur profile: Contribution of academic training. *Revista de Enfermagem*, *13*(4), 904–914.

Richter, S. A., dos Santos, E. P., Kaiser, D. E., Capellari, C., & Ferreira, G. E. (2019). Being an entrepreneur in nursing: Challenges to nurses in a strategic leadership position. *Acta Paulista de Enfermagem*, *32*(1), 46–52. DOI:10.1590/1982-0194201900007

Rosen Sunshine LLP. (2015, February 27). The advisory group for regulatory excellence. Retrieved August 26, 2021.

Salminen, L., Lindberg, E., Gustafsson, M.-L., Heinonen, J., & Leino-Kilpi, H. (2014). Entrepreneurship education in health care education. *Education Research International*, 1–8. https://doi.org/10.1155/2014/312810

Sanders, E. M., & Kingma, M. (2012). *Handbook on entrepreneurial practice: Nurses creating opportunities as entrepreneurs and intrapreneurs*. International Council of Nurses. Retrieved September 2, 2020, from https://www.icn.ch/sites/default/files/inline-files/2012_Handbook_entrepreneurial_practice_eng.pdf

Saskatchewan Health Authority. (2018). *Governance framework*. Retrieved July 27, 2021, from https://www.saskhealthauthority.ca/sites/default/files/2021-04/SHA-Governance-Framework-2018-12-04-Governance-v01.pdf

Saskatchewan Registered Nurses Association. (2012). *Self-employed practice guidelines*. Retrieved November 7, 2020.

Saskatchewan Registered Nurses Association. (2014a). *Policy branch: Global council-ED relationship*. Retrieved July 27, 2021, from

https://web.archive.org/web/20210414035710/https://www.srna.org/wp-content/uploads/2020/02/Council-and-ED-Relationship.pdf

Saskatchewan Registered Nurses Association. (2014b). *Policy branch: Global executive Limitations*. Retrieved July 27, 2021, from https://web.archive.org/web/20210414052240/https://www.srna.org/wp-content/uploads/2020/02/ELs.pdf

Saskatchewan Registered Nurses Association. (2014c). *Policy Branch: Global governance process*. Retrieved July 27, 2021, from https://web.archive.org/web/20210615225848/https://www.srna.org/wp-content/uploads/2021/03/Council-Global-Governance-Process.pdf

Saskatchewan Registered Nurses Association. (2015a). *Interpretation of the RN scope of practice*. Retrieved July 27, 2021, from https://www.srna.org/wp-content/uploads/2017/09/Interpretation_of_the_RN_Scope_2015_04_24.pdf

Saskatchewan Registered Nurses Association. (2015b). *Policy branch: Ends*. Retrieved July 27, 2021, from https://web.archive.org/web/20210414052000/https://www.srna.org/wp-content/uploads/2020/02/ENDs.pdf

Saskatchewan Registered Nurses Association. (2015c). *Saskatchewan Registered Nurses' Association annual report 2015*. Retrieved July 27, 2021, from https://www.srna.org/wp-content/uploads/2017/11/AR2015.pdf

Saskatchewan Registered Nurses Association. (2016a). *Annual report 2016: Safe, trusted care through collaboration*. Retrieved July 27, 2021, from https://www.srna.org/wp-content/uploads/2017/11/AR2016.pdf

Saskatchewan Registered Nurses Association. (2016b). *News bulletin: Insight edition*. Retrieved July 27, 2021, from https://www.srna.org/wp-content/uploads/2017/12/NB2016Summer.pdf

Saskatchewan Registered Nurses Association. (2017). *SRNA Annual Report 2017*. Retrieved July 27, 2021, from https://www.crns.ca/wp-content/uploads/2018/04/2017_CRNS_Annual_Report.pdf

Saskatchewan Registered Nurses Association. (2018a). *News bulletin: Harm reduction edition*. Retrieved July 27, 2021, from https://www.srna.org/wp-content/uploads/2018/04/NB2018SpringWeb.pdf

Saskatchewan Registered Nurses Association. (2018b). *SRNA annual report 2018*. Retrieved July 27, 2021, from https://www.crns.ca/wp-content/uploads/2019/04/2018-CRNS-Annual-Report-Digital.pdf

Saskatchewan Registered Nurses Association. (2019a). *A review conducted for the Saskatchewan Registered Nurses Association*. Retrieved July 27, 2021, from https://www.srna.org/wp-content/uploads/2019/05/Professional-Standards-Authority-Review-May-2019.pdf

Saskatchewan Registered Nurses Association. (2019b). *Annual report 2019*. Retrieved July 27, 2021, from https://www.crns.ca/wp-content/uploads/2020/04/2019-CRNS-Annual-Report-Digital.pdf

Saskatchewan Registered Nurses Association. (2019c). *Everything you wanted to know about regulation but were afraid to ask.* Retrieved July 27, 2021, from https://www.srna.org/wp-content/uploads/2019/11/NewsBulletin_Fall_2019_Web.pdf

Saskatchewan Registered Nurses Association. (2019d). *News bulletin: Legacy edition*, *21*(3). Retrieved July 27, 2021, from https://www.srna.org/wp-content/uploads/2019/06/NewsBulletin_June_2019_Web.pdf

Saskatchewan Registered Nurses Association. (2019e). *Registered nurse entry-level competencies*. Retrieved July 27, 2021, from https://www.srna.org/wp-content/uploads/2019/09/RN-Entry-Level-Competencies-2019.pdf

Saskatchewan Registered Nurses Association. (2019f). *Registered nurse practice standards*. Retrieved July 27, 2021, from https://www.srna.org/wp-content/uploads/2019/09/RN-Practice-Standards-2019.pdf

Saskatchewan Registered Nurses Association. (2019g, May 13). *UK-based Professional Standards Authority report findings indicate no threat to public safety*. Retrieved July 27, 2021, from https://www.srna.org/wp-content/uploads/2019/05/SRNA-Media-Release-Professional-Standards-Authority-Review-May-2019.pdf

Saskatchewan Registered Nurses Association. (2020a). *External consultation for self-employed practice guidelines*. Retrieved November 7, 2020, from https://www.srna.org/rn/self-employed-practice-consultation/

Saskatchewan Registered Nurses Association. (2020b). *Public & member survey reports*. Retrieved July 27, 2021, from https://www.srna.org/about-us/how-we-govern/public-member-survey-reports/

Saskatchewan Registered Nurses Association. (2020c). *Saskatchewan Registered Nurses Association annual report 2020*. Retrieved July 27, 2021, from https://www.srna.org/wp-content/uploads/2021/04/SRNA-Annual-Report-2020.pdf

Saskatchewan Registered Nurses Association. (2020d). *SRNA bylaws*. Retrieved July 27, 2021, from https://www.srna.org/wp-content/uploads/2021/09/SRNA-Bylaws-2021.pdf

Saskatchewan Registered Nurses Association. (2020e). *SRNA continuing competence program*. Retrieved July 27, 2021, from https://www.srna.org/wp-content/uploads/2020/09/SRNA-Continuing-Competence-Program-QA-final-2020-09-10.pdf

Saskatchewan Registered Nurses Association. (2020f, October 6). *SRNA move to single mandate*. Retrieved July 27, 2021, from https://www.youtube.com/watch?v=RAnNVgVLvh0&t=6s

Saskatchewan Registered Nurses Association. (2021a). *Request for recognition of practice as approved NP*. Retrieved July 27, 2021, from https://www.crns.ca/wp-content/uploads/2020/10/Recognition-of-Practice-NP.pdf

Saskatchewan Registered Nurses Association. (2021b). *Request for recognition of practice as approved RN*. Retrieved July 27, 2021, from https://www.crns.ca/wp-content/uploads/2020/10/Recognition-of-Practice-RN.pdf

Saskatchewan Registered Nurses Association. (2021c). *Self-employed guideline*. Retrieved April 11, 2021, from https://www.srna.org/wp-content/uploads/2021/02/Self-Employed-Guideline.pdf

Saskatchewan Registered Nurses Association. (n.d.a). *About the SRNA*. Retrieved April 11, 2021, from https://www.srna.org/about-us/

Saskatchewan Registered Nurses Association. (n.d.b). *Act & bylaws*. Retrieved July 27, 2021, from https://www.srna.org/about-us/how-we-govern/act-bylaws/

Saskatchewan Registered Nurses Association. (n.d.c). *CCP review*. Retrieved July 27, 2021, from https://www.srna.org/licence_membership/continuing-competence/ccp-review/

Saskatchewan Registered Nurses Association. (n.d.d). *Changing mandate*. Retrieved July 27, 2021, from https://web.archive.org/web/20210615221620/https://www.srna.org/about-us/changing-mandate/

Saskatchewan Registered Nurses Association. (n.d.e). *Continuing competence program*. Retrieved July 27, 2021, from https://www.srna.org/licence_membership/continuing-competence/

Saskatchewan Registered Nurses Association. (n.d.f). *Council members*. Retrieved July 27, 2021, from https://www.crns.ca/about-us/how-we-govern/crns-council/council-members/

Saskatchewan Registered Nurses Association. (n.d.g). *Document definitions and descriptions*. Retrieved July 27, 2021, from https://www.srna.org/wp-content/uploads/2019/05/Document-Definitions-and-Descriptions.pdf

Saskatchewan Registered Nurses Association. (n.d.h). *Example feedback form 1*. Retrieved July 27, 2021, from https://www.crns.ca/wp-content/uploads/2021/10/Feedback-form-for-a-colleague-to-complete.pdf

Saskatchewan Registered Nurses Association. (n.d.i). *License & membership*. Retrieved July 27, 2021, from https://www.srna.org/licence_membership/

Saskatchewan Registered Nurses Association. (n.d.j). *Maintaining eligibility for registration: Nursing practice hours*. Retrieved July 27, 2021, from https://www.srna.org/licence_membership/renew-licence-membership/rn-renewal/maintaining-eligibility/

Saskatchewan Registered Nurses Association. (n.d.k). *NP practice resources*. Retrieved October 19, 2021, from https://www.srna.org/nursing-practice/nursing-practice-resources/rnnp-resources/

Saskatchewan Registered Nurses Association. (n.d.l). *Nursing community*. Retrieved July 27, 2021, from https://www.srna.org/nursing-practice/nursing-community/

Saskatchewan Registered Nurses Association. (n.d.m). *Nursing practice consultation*. Retrieved July 27, 2021, from https://www.srna.org/nursing-practice/nursing-practice-consultation/

Saskatchewan Registered Nurses Association. (n.d.n). *Nursing practice resources*. Retrieved October 19, 2021, from https://www.srna.org/nursing-practice/nursing-practice-resources/

Saskatchewan Registered Nurses Association. (n.d.o). *Nursing practice updates*. Retrieved July 27, 2021, from https://www.srna.org/nursing-practice/nursing-practice-updates/

Saskatchewan Registered Nurses Association. (n.d.p). *Partnerships*. Retrieved July 27, 2021, from https://www.srna.org/about-us/how-we-operate/partnerships/

Saskatchewan Registered Nurses Association. (n.d.q). *Public representation and participation*. Retrieved July 27, 2021, from https://www.srna.org/about-us/how-we-govern/public-representation-participation/

Saskatchewan Registered Nurses Association. (n.d.r). *Recognition of practice*. Retrieved July 27, 2021, from https://www.srna.org/licence_membership/recognition-of-practice/

Saskatchewan Registered Nurses Association. (n.d.s). *RN practice hour audit*. Retrieved July 27, 2021, from https://www.srna.org/licence_membership/renew-licence-membership/rn-practice-hour-audit/

Saskatchewan Registered Nurses Association. (n.d.t). *RN practice resources*. Retrieved July 27, 2021, from https://www.srna.org/nursing-practice/nursing-practice-resources/rn-resources/

Saskatchewan Registered Nurses Association. (n.d.u). *RN with additional authorized practice*. Retrieved October 19, 2021, from https://www.srna.org/license_membership/becoming-a-nurse-in-sask/registered-nurse-sask/additional-authorized-practice/

Saskatchewan Registered Nurses Association. (n.d.v). *SRNA council updates*. Retrieved July 27, 2021, from https://www.crns.ca/about-us/how-we-govern/crns-council/council-updates/

Saskatchewan Registered Nurses Association. (n.d.w). *SRNA Facebook groups*. Retrieved July 27, 2021, from https://www.crns.ca/nursing-practice/nursing-community/crns-facebook-groups/

Saskatchewan Registered Nurses Association. (n.d.x). *SRNA news bulletins*. Retrieved July 27, 2021, from https://www.srna.org/about-us/how-we-inform/news-bulletin/

Saskatoon StarPhoenix. (2019, September 16). *Carolyn Strom vs. The Saskatchewan Registered Nurses' Association* [Video]. https://www.youtube.com/watch?v=N6yyXfQJUss

Sciarpelletti, L. (2020, October 6). Sask. nurse who was disciplined over Facebook comments wins court appeal. *CBC News*. https://www.cbc.ca/news/canada/saskatchewan/sask-nurse-carolyn-strom-wins-appeal-1.5752592

Sharp, D. B., & Monsivais, D. (2014). Decreasing barriers for nurse practitioner social entrepreneurship. *Journal of the American Association of Nurse Practitioners*, *26*(10), 562–566. https://doi.org/10.1002/2327-6924.12126

Short, A. (2020, September 20). Misconduct hearing for Sask. nurse who blurred boundaries with patients starts Monday. *Regina Leader-Post*. https://thestarphoenix.com/news/local-news/misconduct-hearing-for-sask-nurse-who-blurred-boundaries-with-patients-starts-monday

Sibbald, S. L., Paciocco, S., Fournie, M., Van Asseldonk, R., & Scurr, T. (2021). Continuing to enhance the quality of case study methodology in health services research. *Healthcare Management Forum*, *34*(5), 291–296. https://doi.org/10.1177/08404704211028857

Silva, E. K. B., da Silva Junior, J. N. O., Neto, N. M. G., da Costa, L. S., Rodrigues, K. F., & Alexandre, A. C. S. (2019). The art and science of caring: Appreciation, established and outsiders in the autonomy of the nursing liberal. *Revista Online de Pesquisa*, *11*(2), 370–376.

Smith, B. L. (2016). *The perspectives of Canadian nurse entrepreneurs and related policy implications: An interpretive description study* [Master's thesis, Trinity Western University]. Trinity Western University Online Thesis Repository.

Smith, C. (2021, March 26). *From the desk of the executive director*. Retrieved July 27, 2021, from https://mailchi.mp/22904ca233af/a-message-from-your-srna-executive-director-278626

Squires, A., & Dorsen, C. (2018). Qualitative research in nursing and health professions regulation. *Journal of Nursing Regulation*, *9*(3), 15–26. https://doi.org/10.1016/S2155-8256(18)30150-9

Stahlke Wall, S. (2011). *Self-employment in nursing: Precariousness, professionalism, and possibilities in non-traditional nursing work* [Doctoral dissertation]. University of Alberta.

Stahlke Wall, S. (2018). The impact of regulatory perspectives and practices on professional innovation in nursing. *Nursing Inquiry*, *25*(1), 1–8. https://doi.org/10.1111/nin.12212

Stake, R. E. (2005). *The art of case study research* (3rd ed.). SAGE.

Taekema, D. (2021, July 24). Ontario nursing groups fear mass exodus from workforce following pandemic burnout. *CBC News*. https://www.cbc.ca/news/canada/toronto/nurse-shortage-pandemic-burnout-1.6113553

Taylor, S. (2019, September 17). Freedom of expression or personal attack? Sask. nurse appeals fine for Facebook post. *Global News*. https://globalnews.ca/news/5913560/legal-errors-saskatchewan-nurse-facebook-comments-fine/

The Canadian Press. (2019, September 24). *"It's not right:" Sask. nurse fined $26,000 for Facebook comments* [Video]. Retrieved July 27, 2021, from https://www.youtube.com/watch?v=YpG7ExS5SJw

The Registered Nurses Act, SS 1988, c. R-12.2. https://www.canlii.org/en/sk/laws/stat/rss-1978-c-r-12/latest/rss-1978-c-r-12.html

The Regulated Health Professions Act, SM 2009. c. R117. https://web2.gov.mb.ca/laws/statutes/2009/c01509e.php

Thorne, S. E. (2016). *Interpretive Description: Qualitative Research for Applied Practice* (2nd ed.). Routledge.

Vannucci, M. J., & Weinstein, S. M. (2017). The nurse entrepreneur: Empowerment needs, challenges, and self-care practices. *Nursing: Research and Reviews, 7*, 57–66. https://doi.org/10.2147/NRR.S98407

Vescera, Z. (2020a, February 10). Nurses prepare for major governance change. *Regina Leader-Post*. https://thestarphoenix.com/news/saskatchewan/nurses-prepare-for-major-governance-change

Vescera, Z. (2020b, October 6). Sask.'s top court rules regulatory body infringed nurse's right to free expression. *Saskatoon StarPhoenix*.

https://thestarphoenix.com/news/saskatchewan/court-rules-regulatory-body-violated-nurses-right-to-free-expression

Villeneuve, M., & MacDonald, J. (2006). *Snapshot—Toward 2020: Visions for nursing*. Canadian Nurses Association. https://www.nln.on.ca/wp-content/uploads/2013/11/Toward-2020-Vision-for-Nursing-CNA.pdf

Waite, A. (2019). Highlighting the lived experience of nurse practitioners in independent practice. *The Journal for Nurse Practitioners*, *15*(10), 787–791. https://doi.org/10.1016/j.nurpra.2019.07.020

Wall, S. (2010). Critical perspectives in the study of nursing work. *Journal of Health Organization and Management*, *24*(2), 145–166. https://doi.org/10.1108/14777261011047327

Wall, S. (2013a). Nursing entrepreneurship: Motivators, strategies and possibilities for professional advancement and health system change. *Nursing Leadership*, *26*(2), 29–40. doi: 10.12927/cjnl.2013.23450

Wall, S. (2013b). "We inform the experience of health": Perspectives on professionalism in nursing self-employment. *Qualitative Health Research*, *23*(7), 976–988. https://doi.org/10.1177/1049732313490077

Wall, S. (2014). Self-employed nurses as change agents in healthcare: Strategies, consequences, and possibilities. *Journal of Health Organization and Management*, *28*(4), 511–531. https://doi.org/10.1108/JHOM-03-2013-0049

Walt, G., & Gilson, L. (1994). Reforming the health sector in developing countries: The central role of policy analysis. *Health Policy and Planning*, *9*(4), 353–370. https://doi.org/10.1093/heapol/9.4.353

Ward, K. (2021, April 25). Nurses in Ont. hospitals can now give care outside of 'regular scope of practice. *Global News*. https://globalnews.ca/news/7787589/nurses-ontario-covid-19-new-measures/

Wilson, A., Whitaker, N., & Whitford, D. (2012). Rising to the challenge of health care reform with entrepreneurial and intrapreneurial nursing initiatives. *Online Journal of Issues in Nursing*, *17*(2), 1. https://doi.org/10.3912/OJIN.Vol17No02Man05

Wong, R. A. (2015). Nurse practitioners: Barriers and facilitators to independent practice [Doctor dissertation, Carlow University]. In *ProQuest Dissertations and Theses*.

World Health Organization. (2020). *Key Messages: 2020 The International Year of the Nurse and the Midwife*. https://www.who.int/campaigns/annual-theme/year-of-the-nurse-and-the-midwife-2020

Wynne, K. (2016, September 23). *September 2016 mandate letter: Health and long-term care* [Letter from the premier to the minister of health in Ontario]. https://www.ontario.ca/page/september-2016-mandate-letter-health-and-long-term-care

Yazan, B. (2015). Three approaches to case study methods in education: Yin, Merriam, and Stake. *The Qualitative Report*, *20*(2), 134–152.

Yin, R. K. (2018). *Case Study Research and Applications* (6th ed.). SAGE.

Yukon Registered Nurses Association. (2020). *Yukon Registered Nurses Association bylaws*. https://drive.google.com/file/d/1pQToVshwZCTibIEjFoX3OOEA1-2ANyZU/view

Yukon Registered Nurses Association. (2021). *Home*. https://www.yrna.ca/

Yukon Registered Nurses Association. (n.d.). *Registration—General Information*. https://www.yrna.ca/registration/information

Appendix A

Case Selection Chart

Province/Territory	Date data retrieved	Provincial/ territorial umbrella legislation	Legislated restricted activities	Single mandate regulatory body	Body regulates exclusively RNs and NPs	Year self-employed guidelines were last updated
British Columbia	April 9, 2021	Yes (Health Professions Act, 1996) (Province of British Columbia, 2021)	Yes: "Restricted activities" (Nurses (Registered) and Nurse Practitioners Regulation, 2008)	Yes (British Columbia College of Nurses & Midwives, 2021a)	No: BCCNM regulates LPNs, RNs, RPNs, midwives, and NPs (British Columbia College of Nurses & Midwives, 2021a)	Webpage - 2021 (British Columbia College of Nurses & Midwives, 2021b)
Alberta	April 9, 2021	Yes (Health Professions Act, 2000)	Yes: "Shared scope of practice/ Restricted activities" (Registered Nurses Profession Regulation, 2005)	No: Dual mandate, but voted in 2020 to transition to single mandate (CARNA, n.d.d)	Yes (CARNA, n.d.d)	Webpage – 2019 (CARNA, n.d.ab)
Saskatchewan	April 9, 2021	No: Profession-specific act (The Registered Nurses Act, 1988)	No	Yes: Transition from dual mandate began in 2020. No association available. (SRNA, n.d.a)	Yes (SRNA, n.d.a)	2021 (SRNA, 2021c)
Manitoba	April 9, 2021	Yes (The Regulated Health Professions Act, 2009)	Yes: "Reserved acts" (Practice of Registered Nursing Regulation, 2017)	Yes (College of Registered Nurses of Manitoba, n.d.-a)	Yes (College of Registered Nurses of Manitoba, n.d.-a)	Webpage and document - n.d. (College of Registered Nurses of Manitoba, n.d.c)
Ontario	April 9, 2021	Yes (Regulated Health Professions Act, 1991)	Yes: "Authorized acts" (Nursing Act, 1991)	Yes (CNO, 2020j)	No: RNO regulates RPNs, RNs, and NPs (CNO, 2020j)	2021 (CNO, 2021a, 2021a)
Quebec	April 9, 2021	Yes (Code des professions, 1973)	Yes: "Restricted acts" (Loi sur les Infirmières et les Infirmiers, 1973; Ordre des infirmières et infirmiers du Québec, 2019b)	Yes (Ordre des infirmières et infirmiers du Québec, 2019c)	No: OIIQ regulates RPNs, RNs, and NPs (Ordre des infirmières et infirmiers du Québec, 2019c)	Webpage – 2019 (Ordre des infirmières et infirmiers du Québec, 2019a)
Newfoundland/ Labrador	April 9, 2021	No: Profession-specific regulation although midwives fall under separate umbrella legislation (Registered Nurses Act, 2008; Registered Nurses Regulations, 2008)	No	Yes: Transitioned to single mandate in 2019. No association available. (College of Registered Nurses of Newfoundland & Labrador, 2014)	Yes (College of Registered Nurses of Newfoundland & Labrador, 2014)	2016 (Association of Registered Nurses of Newfoundland and Labrador, 2016)
New Brunswick	April 9, 2021	No: Profession-specific legislation (Nurses Association of	No	Yes: No association available. (Nurses Association of	Yes (Nurses Association of New Brunswick, n.d.a)	2015 (Nurses Association of New Brunswick, 2015)

		New Brunswick, 2002)		New Brunswick, n.d.a)		
Nova Scotia	April 9, 2021	No: Profession-specific legislation with legislated voluntary collaboration amongst regulated groups called "The Network" (Nursing Act, 2019; The Network, 2021)	No	Yes: Single mandate as of 2019. No association available. (Nova Scotia College of Nursing, 2021a)	No: NSCN regulates LPNs, RNs, and NPs (Nova Scotia College of Nursing, 2021a)	2020 (Nova Scotia College of Nursing, 2020)
Prince Edward Island	April 9, 2021	Yes (Regulated Health Professions Act, 1988; General Regulations, 2018)	Yes: "Reserved activities" (Registered Nurses Regulations, 2018; Regulated Health Professions Act, 1988)	Yes: Transitioned to single mandate in 2018. No association available. (College of Registered Nurses of Prince Edward Island, 2020)	Yes (College of Registered Nurses of Prince Edward Island, 2020)	None
Yukon	April 11, 2021	No: Profession-specific act (Yukon Registered Nurses Association, 2020)	No	No: Dual mandate (Yukon Registered Nurses Association, 2020)	Yes (Yukon Registered Nurses Association, 2021)	None
Northwest Territories/ Nunavut	April 11, 2021	No: Profession-specific act (Nursing Profession Act, 2003; Consolidation of Nursing Act, 1998)	No	No: Dual mandate (Registered Nurses Association of the Northwest Territories and Nunavut, 2019a)	Yes (Registered Nurses Association of the Northwest Territories and Nunavut, 2019a)	Webpage – 2019 (Registered Nurses Association of the Northwest Territories and Nunavut, 2019b)

Appendix B

Case Study Protocol

Section A: Overview of the Case Study

- Study Aim: This research aims to examine how self-employed nurses are regulated and which aspects of provincial nurse regulatory practices specifically impact self-employed nurses. Furthermore, this research is meant to facilitate self-employed nursing roles in Canada by supporting provincial nurse regulatory bodies and self-employed nurses in enhancing the effectiveness of self-employed nursing regulation.
- Research Question: How does provincial nurse regulation impact self-employed nurses in three Canadian provinces?

Section B: Data Collection Procedures

1. Data Collection Plan:
    - Documentary evidence in the form of scope of practice documents, policy documents regarding self-employed nursing, informational documents, recognition of application forms, continuing competency forms, and any applicable news articles pertaining to nursing regulation in the study province
    - Multimedia including webpages, presentations, videos, and social media posts published by the regulatory body and other sources available in the public domain
2. Expected Preparation Prior to Data Collection:
    - Complete further research into internal organizational contextual features and adapt research design as necessary
    - Create case study database
    - Pilot case

Section C: Protocol Questions

1.Actors
- How and from whom is influence being exerted?
- What is the purpose and goals of the actors involved and how do these impact regulatory content and processes?

2.Context
- Which type of legislative framework directs nursing regulation and what aspects of regulation does it direct?
- What is the governance structure and how does it impact regulatory content and processes?
- Which regulatory philosophies direct regulatory content and processes?

3.Content
- How is nursing practice defined by legislation and the regulatory body?

- What is included in the practice standards and guidelines and how do they impact self-employed nurses?
- What is included in the guidelines for self-employed nursing practice and how do they effect these registrants?

4. Processes
    - Which processes uniquely impact self-employed nurses and why?
    - What resources are in place to assist nurse entrepreneurs with these processes?
    - Who is involved in monitoring and evaluating the effectiveness of these processes?
    - How do the regulatory processes surrounding self-employed nursing differ from that of institutionally employed nursing?
5. Impact
    - How would nurses be affected by this regulatory environment?
    - How would nurses perceive the processes and content that regulate their practice?
    - Are there ways in which the regulation of self-employed nurses can be made more effective?

Section D: Tentative Outline for the Case Study Report

- Audience: Faculty of Health Disciplines at Athabasca University, nurse regulators, policymakers, nurse entrepreneurs, nursing scholars
- Individual case descriptions
- Cross-case analysis
- Findings related to external provincial context and actors and its impact on regulation
- Findings related to internal organizational context and actors and its impact on regulation
- Findings related to the impact of content and resulting processes on nurse entrepreneurs
- Suggestions for regulators and self-employed nurses

Appendix C

CARNA's Self-Employed Assessment Checklist

CARNA College & Association of Registered Nurses of Alberta

Self-employed Assessment Checklist: Am I Practising Registered Nursing?

If you are practising nursing as an RN or NP in Alberta, you must be registered and hold an active practice permit with CARNA before you start working (including any orientation), use protected titles, count your practice hours, and have Canadian Nurses Protective Society (CNPS) professional liability protection.

Are you interested in practising as a self-employed RN or NP in Alberta?

Find out more about the risks and resources of self-employment by completing the *Self-Assessment Checklist for Self-employed RN or NP Practice* found here.

Requirements for RN or NP practice

If you don't check all the boxes in this section, please contact CARNA by calling 780.451.0043 or toll free at 1.800.252.9392 ext. 504 and ask to speak to a policy and practice consultant or email practice@nurses.ab.ca.

- ☐ Is there a public need for this health-care service?
- ☐ Are your clients an individual, families, groups, communities or a population?
- ☐ Does the public require services from an RN or NP to directly or indirectly meet their health-care needs? That is, non-regulated members cannot provide this service?
- ☐ Is the health-care service within the scope of RN or NP practice as outlined in Schedule 24 of the *Health Professions Act*.
- ☐ Do you provide any RN or NP restricted activities as part of the health-care service and are you authorized to provide them?
- ☐ Does the health-care service require nursing knowledge, skills and judgement of an RN or NP as outlined in the *Registered Nurses Profession Regulation* and scope of practice?
- ☐ Can you meet expectations for fitness to practice, responsibility, and accountability as outlined in the Standards of Practice, Guidelines, *Code of Ethics* and relevant legislation?
- ☐ Does the health-care service require RN or NP entry level competencies, advanced competencies or specialized certification in nursing?
- ☐ Does the totality of the service being offered consist of unregulated activities (e.g., doula, reiki), within the jurisdiction of another health-care regulator (e.g., naturopath, LPN), or is limited in scope (CPR courses). If you answered "yes" to any of these, or if the practice relates to dual registration, contact a CARNA policy and practice consultant.
- ☐ Do you have the knowledge, skills, judgment and experience to provide this health-care service and maintain competence over time?
- ☐ Is the focus of the health-care service one or more of the following areas: clinical practice, administration, education, research or consultation services?
- ☐ Does the health-care service include one or more of the following roles: clinician, professional, communicator, collaborator, coordinator, leader, advocate, educator or scholar?
- ☐ As a clinician, do you provide safe, competent, compassionate, client-centered, and evidence-informed nursing care in response to client/public needs/well-being?

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CARNA's Self-Employed Assessment Checklist Continued

- ☐ As a clinician, is your practice based on the ethics of caring and on the goals and circumstances of clients
- ☐ Are the steps of the nursing process used as an integral part of your practice?
- ☐ Does the health-care service require critical thinking, problem solving, professional judgement, accurate interpretation of complex information from various sources?
- ☐ Do you engage in quality improvement activities with the aim to improve practice and client outcomes?

Specific requirements for NP practice in addition to RN practice

If you are an NP and don't check all the boxes in this section, please contact a CARNA policy and practice consultant to discuss further by calling 780.451.0043 or toll free at 1.800.252.9392, ext. 504 or email practice@nurses.ab.ca:

- ☐ conduct advanced health assessments
- ☐ diagnose health/illness conditions
- ☐ order and interpret screening and diagnostic tests
- ☐ prescribe pharmacotherapy
- ☐ perform treatment and advanced interventions
- ☐ treat and manage acute and chronic illness
- ☐ monitor client outcomes
- ☐ provide follow up care
- ☐ consult and refer

This may not be RN or NP practice

If you check off any of the following boxes, please contact CARNA to discuss further.

- ☐ Is the primary focus of the health-care service unregulated activities?
- ☐ Is the primary focus of the health-care service the sale of products?
- ☐ Is the primary focus of the health-care service too restrictive or limited in scope?
- ☐ Is the practice within the jurisdiction of another health care regulator (e.g., naturopath, LPN)?

Still unsure if you are practising as an RN or NP

If you have any questions, please contact CARNA by calling 780.451.0043 or toll free at 1.800.252.9392:

- For questions related to your self-employed practice, ask to speak to a policy and practice consultant at ext. 504 or email practice@nurses.ab.ca.
- For questions related to your self-employment and practice hours, ask to speak with a registration assistant or email registration@nurses.ab.ca.

Appendix D

CARNA Self-Assessment Checklist for Self-Employed Practice

CARNA College & Association of Registered Nurses of Alberta

Self-assessment Checklist for Self-employed RN or NP practice

Practising nursing as a self-employed RN or NP brings certain opportunities and inherent risks. This checklist has been developed **for your own records** to assist you in

- determining if your practice is within the scope of practice of an RN or NP practice based on the definition of Schedule 24 of the *Health Professions Act*;
- identifying and analyzing some of the potential self-employed practice risks; and
- providing various resources that may help mitigate these risks.

Should you have any questions, please contact CARNA at practice@nurses.ab.ca or call 780.451.0043 or toll free at 1.800.252.9392 ext. 504 and ask to speak to a policy and practice consultant.

Requirements for self-employed practice

For sections A-D, all boxes need to be checked in order to use protected titles, count your hours, and have professional liability protection by the Canadian Nurses Protective Society.

If you do not check all the boxes or have questions, please contact CARNA for further consultation at practice@nurses.ab.ca or call 780.451.0043 or toll free at 1.800.252.9392 ext. 504 and ask to speak with a policy and practice consultant.

A. Are you practising registered nursing?

- ☐ Is your self-employed practice RN or NP practice based on the practice statement outlined in Schedule 24 of *Health Professions Act (HPA)*? If unsure, please complete the *Self-employed Assessment Checklist: Am I Practicing Registered Nursing?* If after completing the checklist you are unsure, please contact CARNA for further discussion.

B. Are you competent in the practice you have chosen for your self-employed practice?

- ☐ Do you have the required RN or NP knowledge, skills, judgment, work experience and capacity in the proposed area of self-employed practice to meet all required standards of practice?
- ☐ Do you have the required competence based on the standards to perform any restricted activities you may provide in your practice?
- ☐ Do you have the required competence based on the standards to perform any complementary and alternative therapies you may provide in your practice?
- ☐ Do you have the required competence based on the standards to ensure infection prevention and control standards are met?
- ☐ Is your practice current and evidence-informed?
  - ☐ Do you have additional education, training, certification required based on current evidence-informed practice and industry standards?
  - ☐ Do you have an established professional support system and referral system that you can rely on when clients require services beyond your own competence and capacity in the event the nurse-client relationship must end?

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CARNA Self-Assessment Checklist for Self-Employed Practice Continued

CARNA College & Association of Registered Nurses of Alberta

- ☐ Do you have the capacity to maintain your competence (e.g., sufficient clients, available resources, continuing education, referral and mentoring support system, professional support systems, process to evaluate your practice)?

C. Did you develop a job description, policies and procedures?
As a self- employed RN or NP, you are now responsible to have these in place to guide your practice.

- ☐ Do you have a written job description that reflects the nursing services you will provide that is congruent with your nursing knowledge, skills, judgement and experience? Is it reviewed by someone else who is knowledgeable and updated regularly?
- ☐ Do you have policies and procedures in place to support your practice and maintain your professional standards (e.g., advertising, assessment and consent forms, documentation and record keeping, infection prevention and control)? Are these reviewed and updated regularly?
- ☐ Do you have policies and procedures in place to support your compliance with privacy and management of health information standards? Are they reviewed and updated regularly?
- ☐ Are you the custodian of health information and reviewed your roles and responsibilities?

D. Did you consider your legal/regulatory obligations?

- ☐ Do you have an active RN or NP practice permit with no conditions with CARNA?
- ☐ Did you complete the jurisprudence module in MyCARNA under My Learning Space?
- ☐ Does your business reflect well on the nursing profession and maintain the public's trust in the profession?

Things to consider before engaging in self-employed practice

For section E, only check boxes that apply.

E. Did you consult with the following:

- ☐ **Accountant** can provide advice on reporting taxes, setting reasonable fees, issuing receipts, bookkeeping services, confirm worked hours and assess potential financial losses.
- ☐ **Banker/banks** can assist with financing a new business.
- ☐ **Canadian Nurses Protective Society** (CNPS) can provide legal advice and extra professional liability protection.
- ☐ **CARNA policy and practice consultant** can explain how you can meet the practice standards and abide by the *Code of Ethics* while engaged in a self-employed practice (e.g., use of title, infection prevention and control, documentation, consent, nurse-client relationship, conflict of interest, advertising).
- ☐ **Current employer** can determine if there is an actual or perceived conflict of interest with continuing employment and being self-employed.

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CARNA Self-Assessment Checklist for Self-Employed Practice Continued

- ☐ **CNA certification program and education institutions/programs** can provide nursing specialty credentials, additional courses, certificates and training required to meet evidence-informed practice and industry standards.
- ☐ **Insurance broker** can help assess your practice and business insurance needs.
- ☐ **Government of Alberta** can provide information on self-employment training program.
- ☐ **Lawyer** can discuss legal issues and potential risks related to a self-employed practice, business type, name, licence, vicarious liability, labour laws, assess potential losses (e.g., professional, reputation, risk of physical/psychological harm).
- ☐ **Local and municipal government** can inform you of various licences and regulation related to starting and operating a business.
- ☐ **Office of the Information and Privacy Commissioner of Alberta** can help you determine if you need to submit a privacy impact assessment if you collect, use and disclose health information.
- ☐ **Other health-care professional regulatory bodies** can verify that the health-care professionals you are working with have the required expertise, practice permit in good standing and liability protection.
- ☐ **Other nursing regulatory bodies** can determine if you require registration in their jurisdiction when providing telehealth services across provinces.
- ☐ **Specialty practice groups** can provide support and mentoring when establishing a self-employed practice.