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Editor's Note

JPNEP is devoted to sharing scholarly work that contributes to the discourse of nurse education and professional practice in Canada and beyond. We are grateful to our contributors as we publish our fourth volume. Our journal is open access and shares content that is relevant and easily accessible to our readers and stakeholders. The **editorial board** appreciates the support we have been receiving from Nichelle Carriere and Dawn Witherspoon, Institute for Teaching, Learning and Technology at NorQuest College for providing editorial support to the journal.

Healthcare providers work in diverse and complex environments where ethical decisions are made frequently. The first manuscript is this issue is by Dr. Cindy Ko critically discusses the benefits of integrating the main principles of relational ethics and the theory of intersectionality in relation to ethical decision-making processes made by healthcare providers. Dr. Ko encourages us to reflect on respectful therapeutic patient and healthcare provider relationships where ethics and intersectionality are intertwined in clinical settings.

The landscape and healthcare delivery models continue to change. The changes include shortage of healthcare providers such as registered nurses. Consequently, the scope of practice for practical nurses continue to evolve. In this issue, Anita Baldoni and Dr. Lindsey Ford shared the pilot results of program at Pennsylvania hospital that was designed to support practical nurses as they transition into the acute care setting that had more responsibilities. The article is a must read for all nurse educators and programs that support professional development for practical nurses.

Starting in fall 2024, the journal will issue certificates to our reviewers. We would like to thank the authors who trust us with their work and contribute towards scholarly discussions. Please help us disseminate the **link** with your peers so that they can contribute as authors or reviewers. Thank you for your support!

Sincerely,

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Relation-Intersectional Ethics Trestle: A Harmonious Merging of Relational Ethics and Intersectionality

Cindy Ko

Abstract

This article endeavours to merge relational ethics with the theory of intersectionality to create a harmonious platform that could support understanding and applications of their essential concepts in today's diverse and complex healthcare environments. The key tenets of both frameworks are provided, followed by an explanation of a coalesced conceptualization and illustration of a relation-intersectional ethics trestle for consideration of its adaptability in the healthcare workplace and post-secondary education curriculum. The main objective of this article is to explain and promote the benefits of integrating the chief precepts of relational ethics and the theory of intersectionality to further strengthen the way healthcare providers support patients in ethical decision making. The relation-intersectional ethics trestle aims to support the construction of authentic and mutually respectful therapeutic relationships in clinical settings where ethics and intersectionality unite. The relation-intersectional ethics trestle aims to support the construction of authentic and mutually respectful therapeutic relationships in clinical settings where ethics and intersectionality unite.

Key words*: Relational ethics, intersectionality, ethical decision making, social justice, diversity-equity-inclusion*

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Relation-Intersectional Ethics Trestle A Harmonious Merging of Relational Ethics and Intersectionality

This article endeavours to merge relational ethics with the theory of intersectionality to create a harmonious platform that could support healthcare providers and students in understanding and applying their essential concepts in today's diverse and complex healthcare environments. The intention is neither to critique the original authors, nor to develop a new framework; rather to respectfully expand on their relevance and applicability. The key tenets of relational ethics and intersectionality are provided, followed by an explanation of a coalesced conceptualization trestle. An illustration of a *relation-intersectional ethics trestle* is presented for consideration of its adaptability in the healthcare workplace and post-secondary education curriculum.

The main objective of this article is to explain and promote the benefits of integrating the chief precepts of relational ethics and the theory of intersectionality to further strengthen the way healthcare providers support patients in ethical decision making. The term *trestle* is selected because it is a "fixed, foldable, or adjustable supportive frame" that allows a flat surface to be placed on top, such as a carpenter's sawhorse, a trestle bridge, or a trestle table (Ryan, 2021, para. 1). Ryan explains that the functionality of modern-day trestles is endless because they "can be manufactured to take on any shape required" (para. 5). Once the top piece is secured above the trestle base, one can see or move across from one end to the other. Metaphorically, regardless of the conversation or perspective, crossing or meeting in the middle is inevitable, and possibly the centre is the perfect observation deck because it has a 360-degree view. The relation-intersectional ethics trestle aims to launch a platform in which one could see across, meander from one end to the other, or meet in the middle for optimum-essential contemplation and the

application of relational ethics and the theory of intersectionality. The trestle will support the construction of authentic and mutually respectful therapeutic relationships in clinical settings where ethics and intersectionality unite (McGroarty, 2021).

A large number of ethical decision-making frameworks exist in the healthcare environment (Oberle & Raffin Bouchal, 2009; Starzomski et al., 2023; Walker & Lovat, 2017). Butcher and Mackie (2021) identified 36 in their annotated bibliography with varying degrees of similarity in terms of steps such as the following: identify the facts, identify any cultural traditions and/or beliefs that could impact the issue or decision, identify values, identify any alternatives, and finally, make a decision. Each framework mentioned by Butcher and Mackie includes key ethical philosophical underpinnings such as autonomy, social justice, fairness, equity, evidence-based, beneficence, non-maleficence, relevance, empowerment, and transparency. Comparably, Oberle and Raffin Bouchal in their timeless text, as well as Starzomski et al. discuss a variety of normative ethics and classical philosophies that ground the development of modern-day ethical frameworks.

It is also fair to say that many contemporary ethical frameworks usually have their foundational principles based on classical Western ethical philosophies such as deontology, teleology, and virtue ethics, or some level of exploration in Eastern philosophies such as Buddhist ethics (Garfield, 2022; Sutrop, 2011; Walker & Lovat, 2017). Furthermore, there is no shortage of ethical frameworks in the healthcare environment from specialty areas to disease specifics, all of which have relational ethics at the core (Butcher & Mackie, 2021). Therefore, the goal of this paper is not to suggest a new process for reaching ethical decisions because the steps for doing so have been well-established by numerous ethicists and scholars. The relation-

intersectional ethics trestle is a supplementary tool that could facilitate further understanding of the theory of intersectionality and relational ethics.

An Overview of Relational Ethics

Roach (2002) pioneered the emphasis of the relational elements that are embedded in the healthcare professions. In both editions of Roach's text, she emphasizes the ethical responsibility healthcare providers have to care for patients compassionately because humans are relational beings. Roach discusses the importance of meaningful dialogues wherein humans may be able to perceive the self and others. Thus, caregivers are called to concede their self-fragility and suspend personal views to actively listen and consider their patients' individual experiences, health states, and expectations in order to support them.

The relational ethics project by Bergum and Dossetor (2005/2020) is perhaps the most recognized body of work that investigated healthcare ethics from the daily experiences of practitioners. Bergum and Dossetor emphasize the importance of relational connections and believe that the nuances and moral contexts of individual relationships are critical factors in the ethical decision-making process. They assert that relational ethics honours the clinician's own moral compass while recognizing the patient's moral values, thereby creating a mutually respectful therapeutic environment. Thus, relational ethics promotes a non-hierarchical relationship between care providers and patients to ensure person-centred care.

In addition, Bergum and Dossetor (2005/2020) expound on the significance of dialogues because intentional conversations support the enactment of ethical practice by invoking deeper understanding of agency and meaning. Bergum (1999), in her influential publication, asserts that ethical conversations offer the opportunity to view ethics as a kind of questioning of various notions of truth that constructively attend to the individual patient's moral needs. That is, truth

may be as objective as ice is cold; however, the intersubjectivity of truth may be obtained through the engagement of subjective exchanges in evocative dialogues. Therefore, relational ethics includes people's lived experiences or *descriptive knowledge,* which they perceive as their truths in conjunction with objective, evidence-based *inherent knowledge* (Bergum, 1999, p. 169). Bergum also emphasizes the need to consider the intricacy of medical scientific knowledge and its amalgamation with people's lived experiences.

Essential Tenets of Relational Ethics

Mutual Respect

Mutual respect is respect for oneself and reciprocal respect for others (Bergum, 2012b). Healthcare providers, the interdisciplinary team, the patients, and their families demonstrate mutual respect by acknowledging and recognizing one another as unique individuals with varied skills, roles, worldviews, values, and beliefs. There is an inherent imbalance of expert power in the healthcare environment, where patients either lack medical knowledge or are too sick to voice it. This imbalance produces an interdependence that oscillates between the care provider and the patient (Bergum & Dossetor, 2005/2020). Healthcare professionals are entrusted to perceive and demonstrate mutual respect. Relational ethics calls for a kind of respectful relationship where the patient is empowered as an integral part of the interaction and decision-making process. This requires healthcare providers to check their proclivity to assume they know best and commit to engaging with their patients in mutually respectful dialogues (Bergum, 2012a).

Engagement

Engaging with the patient means that the healthcare provider acknowledges and accepts their patient's perspectives. The healthcare provider's self within the context of relational ethics can only exist when this self is engaged in a mutually respectful relationship with the patient, who is the other. Engagement always begins with a conversation in which the healthcare provider recognizes the patient's position in their state of health and the decisions they believe are the best for them (Bergum, 2012a). In addition, ethical decisions or moral actions could have a domino effect on the patient's moral health and well-being; thus, engagement speaks to the interdependence between the patient and the care provider (Bergum & Dossetor, 2005/2020).

Furthermore, relational ethics emphasizes the intrinsically relational engagement people have with one another in the broader interdependent societal context. It is beyond the scope of this paper to expand on the applicability of relational ethics in a global context. Notwithstanding, it is intuitive to appreciate the far-reaching applicability of relational ethics in other industries or in the political arena because of its emphasis on human relations (Kavalski, 2020).

Embodied Knowledge

The origin of the English word *embody* is from the 16th-century Latin *incorporāre*, which means to make into a body, to form, or to shape (Online Etymology Dictionary, 2024). Embodied knowledge is the integration of the wisdom that is the living, experiencing, and knowing experiences of all who are engaged (Bergum & Dossetor, 2005/2020). The authors also refer to this as a "participatory consciousness through relationship" that requires "one's full, somatic, and immediate presence" (p. 140). Hence, the complex and dynamic multifaceted knowledge one contributes to a relationship is known as *embodied knowledge*. This knowledge may encompass academic achievements, general knowledge about various social issues and

events, social and emotional intelligence, and any lived experiences. It is through the embodied knowledge of the patient and the healthcare provider in their mutually respectful and engaging discourse that yields a best course of decision making for the best possible patient outcome and experience.

Bergum and Dossetor (2005/2020) also contend that although it is important for practitioners to keep up to date in medical and informational knowledge for diagnostic and treatment purposes, embodied knowledge is not simply factual knowledge; rather, it is the objective (thinking/intellectual) and subjective awareness (feeling) of people's entire being. Therefore, the healthcare provider's responsibility to care for the patient is part of their embodied expert or informational knowledge that includes empathetic ethical discussions, which could guide patients to make the best moral decisions for themselves.

Environment

The environment is the mutually respectful space, both figurative and physical, where ethical reflections, dialogues, and actions take place. Bergum and Dossetor (2005/2020) assert that in the context of the society, the environment is a "moment-to-moment creation, … and integrates the micro and the macro" (p.165). That is, the individual and the larger society are intertwined; for example, an individual patient who is dying viewed in the context of contentious end-of-life issues and legislation such as Medical Assistance in Dying (MAiD) in Canada where amendments are being tabled (Grant, 2023; Parliament of Canada, 2024). Thus, relational ethics addresses the environment that is a place or space where people coexist, as well as the time in which they engage in building community and nurturing the environment. In their discussion regarding a community or environmental standard, Bergum and Dossetor highlight the relational

elements that are connected to the classical ethical philosophical traditions that focus on the notions of care, compassion, empathy, and sensitivity to the concerns of others.

Uncertainty

Humans are complex beings, and relationships are complicated. The healthcare space is filled with uncertainties with respect to care decisions, given patients' individual values, beliefs, preferences, choices, and health state. Relational ethics considers morality as contextual (Bergum & Dossetor, 2005/2020). That is, what may be morally acceptable in one circumstance for a patient may not be in another, and relationships are embedded in the ethical decision-making process that is contextual to the patient. Therefore, embodied knowledge must be accompanied by an acknowledgment and humility that uncertainty is in fact the only undeniable contextual constant. Bergum and Dossetor recommend keeping the dialogue alive as a way of recognizing the complexities of human relations that arise from uncertainty. It is when we are fully engaged with one another without a script that we can proceed to the act of discovery and fill in the blanks.

Relational Ethics as Everyday Ethics

Bergum and Dossetor (2005/2020) argue that humans do not only make difficult decisions in extraordinary circumstances such as life and death events. Relational ethics provides constructive insights for considering various ethical and moral issues by propelling people to contemplate the potential influence of their decisions and/or actions on others and by encouraging the prioritization of compassion and empathy. The authors present relational ethics as everyday ethics because all kinds of decisions are made each day in personal, family, professional, political, and community relationships. Ideally, these daily decisions require people

to be mutually respectful in their engagement and to recognize each other's embodied knowledge in a society (environment) that has many uncertainties.

Moreover, although relational ethics generally applies to the care relationship between the healthcare provider and the patient, it could be expanded to include wider social justice issues (Crosweller & Tschakert, 2020; Kavalski, 2020). Bergum and Dossetor (2005/2020) cite the German philosopher Hans-Georg Gadamer, who wrote that finding our place in the world includes our ability to co-exist with others because human existence is a shared-collective responsibility. In order to sustain one's own internal balance, one needs to co-operate and participate within the larger society to "discover new possibilities for a more humane arrangement of things as they have been developed in our instrumentalized social organization" (Bergum & Dossetor, 2005/2020, pp. 219–220). In summary, relational ethics is action ethics as it is situated within the relational space of the practitioners and the patients. The components of relational ethics are the guidelines by which healthcare providers may support patients to make actionable ethical decisions. Therefore, relational ethics is applicable in the critiquing and examination of social justice issues by underscoring the crucial elements of empathy, compassion, mutual respect, and understanding in society. The framework fuses compatibly with the theory of intersectionality.

A Synopsis of Intersectionality

The earliest documented expression of the notion of intersectionality was when Frances M. Beal, an American Black feminist wrote about the double jeopardy of being Black and female in 1970. Subsequently, in 1977, a group of Black feminists in Boston, Massachusetts, composed a manifesto and declared the impossibility to "separate race from class from sex oppression because in our lives, they are most often experienced simultaneously" (Combahee River

Collective, 1977/1995, p. 234). The theory of intersectionality was developed and popularized by Dr. Kimberlé Crenshaw (1989), a Black feminist and lawyer who is well versed in critical race theories. Crenshaw succinctly described intersectionality as the compounded obstacles that are the inequalities and injustices encountered daily by marginalized people. She originally deployed intersectionality as a framework for understanding the unique experiences of oppression experienced by Black American women as the various social determinants intersect to perpetuate the marginalization, racism, and discrimination of these women. Crenshaw (1989, 1991, 2016) promulgated that historically Black women experience compounded discrimination and subordination because they are gendered as well as racialized. For example, only Black men were first granted the right to vote in 1870 in the United States; thus, Black women have been verifiably and perpetually oppressed and vulnerable (Carbado & Crenshaw, 2019). Crenshaw focuses on Black women's experiences because she believes that they are inimitably in a separate sphere. It is not the focus of this paper to elaborate on Black history, the history of Black slavery, Black feminism, or the history of sexism and other forms of discrimination in the United States and other nations that are integral to many scholars and historians who are dedicated to the social justice issues related to diversity, equity, and inclusion (DEI) matters. Notwithstanding, intersectionality is embraced by scholars and researchers to address multiple social justice issues beyond Crenshaw's initial intent to separate white feminism to examine and illuminate the distinctive injustices experienced by Black women and to analyze multiple failures in law, politics, and social structures within feminism and antiracism (Collins & Bilge, 2020; Collins et al., 2021). Intersectionality has gained popularity in its applicability across disciplines. For the purpose of this paper, the following well-accepted and Crenshaw-approved working definition of intersectionality is used to anchor the discussion:

> Intersectionality investigates how intersecting power relations influence social relations across diverse societies as well as individual experiences in everyday life. As an analytic tool, intersectionality views categories of race, class, gender, sexuality, nation, ability, ethnicity, and age—among others—as interrelated and mutually shaping one another. Intersectionality is a way of understanding and explaining complexity in the work, in people, and in human experiences (Collins & Bilge, 2020, p. 2).

Intersectionality asserts that some people or groups are vulnerable as a consequence of the embedded unjust social and institutional structures, accepted social norms, and discriminatory policies that situated them (Carbado et al., 2013; Collins & Bilge, 2020). That is, the social systems in laws and policies fail to acknowledge the overlapping and intersecting elements such as race and ethnicity, culture, gender and sexual orientation, abilities, values and beliefs, health practices, and socioeconomics that vulnerable individuals must navigate daily as they face ongoing systematic oppression and discrimination. For example, a transgender senior Indigenous woman living with limited physical ability will likely experience distinctive multilevel discrimination that would require an analysis beyond the silos of racism, agism, ablism, and sexism. Therefore, considering intersectionality will facilitate improved understanding of social justice issues by acknowledging that people's convergent experiences are greater than the sum of any one element of discrimination such as ableism or racism (Carbado et al., 2013; Collins & Bilge, 2020). Intersectionality does not presume that one person is less or more oppressed than another; rather, it aims to understand and consider the social impact of each person's multiple social identities. Intersectionality also highlights that those who appear to have similar social identities or belong to the same community will still face unique and individual challenges (Crenshaw, 1989, 1991, 2016; Carbado & Crenshaw, 2019). For example, a group of

people with the same ethnicity may practise a given religion differently by virtue of denomination or in combination with some form of cultural variation. Thus, intersectionality is a tool for considering the nuances in the multiplicity of people's social identities and experiences.

In addition, much like the social determinants of health (SDH), intersectionality emphasizes the overlapping factors that contribute to racism, oppression, and discrimination—ultimately, any kind of injustice that could impact people's health and health outcomes (López & Gadsden, 2017). Intersectionality is a holistic approach that advances social justice efforts by underscoring intersecting power dynamics such as systemic and structural oppression, and unjust laws and policies that perpetuate disadvantaged social and health outcomes for many individuals (Carbado & Crenshaw, 2019; Cho et al., 2013; Crenshaw, 2016; Collins & Bilge, 2020). Thus, it is a practical framework that offers understanding of the challenges marginalized groups endure within their shared-interlacing narratives and the synchronized social identities that frame their experiences.

Many social scientists claimed that intersectionality is too complex to understand, vague, lacking a concise purpose, unreliable as a methodology, and perhaps a mere buzzword (Guan et al., 2021; Tomlinson, 2013). Collins and Bilge (2020) recognize the opposing opinions as well as the various characterizations in how people understand and apply intersectionality. Notwithstanding, Collins and Bilge emphatically state that despite the endless debates over its definition, applicability, or whether it is indeed the accurate term, intersectionality is the term that "has stuck" (p.2). Cho et al. (2013), in which one of the authors is Crenshaw, concur and urge scholars and practitioners to stop obsessing over what intersectionality is and instead embrace what it does and can do. Crenshaw (1991) steadfastly responds to her critics by calling them "vulgar constructionists" who aimed to skew "the possibilities for meaningful identity

politics ” (pp. 1296–1297). Arguably, it is precisely the contentiousness and exaggerated critique of its seeming ambiguity that renders intersectionality so applicable and adaptable, and is the very reason that the idea of amalgamating relational ethics with intersectionality emerged.

What Intersectionality Is Not

It is relevant to briefly discuss what intersectionality is not. Crenshaw stated in an interview:

> … there has been distortion. It’s not identity politics on steroids. It is not a mechanism to turn white men into the new pariahs. It’s basically a lens, a prism, for seeing the way in which various forms of inequality often operate together and exacerbate each other. We tend to talk about race inequality as separate from inequality based on gender, class, sexuality, or immigrant status. What’s often missing is how some people are subject to all of these, and the experience is not just the sum of its parts (Steinmetz, 2020, para. 2).

Respectively, Statham’s (2021) report on poverty and inequality in Scotland for the Poverty and Inequality Commission succinctly states that intersectionality is not a “synonym for diversity” (p. 12). Therefore, the focus must be on understanding how people face compounded experiences of injustices in order to recognize those interlocking factors and create fairer policies, laws, services, and access. In addition, it is not about “adding up different kinds of inequality,” but instead considering the various layers of inequality that directly impact people’s lives (p. 12). Furthermore, it is not an “oppression Olympics” where people compete against each other to see who is the most marginalized or experiences the most inequalities (p. 12). Instead, the goal is to acknowledge that countless oppressions and imbalance of power exist and focus on the ongoing effort required to address them. Moreover, intersectionality is not a method

to "construct a hierarchy of inequality where some forms of oppression are seen as more important than others" (p. 13). This is because intersectionality seeks to prioritize the analysis of compounded factors and how they interact to create inequality, and by so doing, devise strategies for improvement.

Relational Ethics and Intersectionality: A Side-by-Side Comparison of Similarities

Table 1 shows a side-by-side comparison of the similarities between relational ethics and the theory of intersectionality; Figure 1 is an interface of both frameworks based on Table 1.

Table 1

Side-by-side Similarity Comparison of Relational Ethics and the Theory of Intersectionality.

Relational Ethics	Intersectionality
Premise – All human relationships are relational – Shared responsibility and responsiveness in the moral space as human beings co-exist in this world – The nuances of multiple perspectives and lived experiences that influence ethical decision making – Caring is relational; healthcare professionals have a commitment and an ethical-relational responsibility	**Premise** – The reciprocal human interactions, connections, and their multiple social identities that are intricately intertwined in the social systems that perpetuate inequities, oppression, and discrimination – The nuances of power dynamics and layers of unique social contexts impact people's quality of life and opportunities – A wholistic perspective for understanding social responsibilities
Mutual Respect – Respect and compassion for oneself, patients, families, colleagues, healthcare institutions, and the healthcare system – Healthcare providers respectful and cognizant of the inherent power imbalance between	**Mutual Respect** – Respect for human dignity, autonomy, and agency because social relationships and power dynamics are inherently relational

themselves and their patients; e.g., an educated patient who may in fact be a physician has less power by virtue of being sick and in care – Sincere acknowledgment of shared commonalities and differences	– Explore one's own privilege and the intersecting relational power that is indivisibly connected to the analysis of power and structural inequalities – Authentic receptivity
Engagement – With self, patients, team, healthcare institutions, and the healthcare system to come to mutually respectful ethical decisions – Recognizing that everyone engaged in the care of the patient has their own unique perspectives and lived experiences – A professional commitment to engage with patients and provide the best possible care – Engaging actions and behaviours that are intentionally conducive to building therapeutic trust	**Engagement** – Understanding intersectionality requires engagement with others from oneself, immediate communities, and global community – Engaging intersectionality as a tool to understand multiple dimensions of interlocking factors that shape people's lives and perspectives – A transformative commitment to improve policies, laws, and systemic social structures, which involves engaging committed actions and behaviours – Engaging actions to advance social change within intersectional spaces and junctions
Embodied Knowledge – Expert knowledge, information knowledge, and lived knowledge that support ethical decision making and are rooted in mutually respectful engagements – The healthcare provider embodies relational ethics to the extent that they know how and commit to continuing to gain understanding	**Embodied Knowledge** – Diverse knowledge and skills – Knowledge required to comprehend, contemplate, and address complex intersecting social factors
Environment – The healthcare space, personal and professional space, and the bedside where mutually respectful engagements based on embodied knowledge that support ethical decision making take place – A moral awareness of the social obligation to understand social justice issues as part of the responsibility of being healthcare providers	**Environment** – The social environment, the layers of society, and society as a whole – Infrastructure, resources, laws, policies, and programs where social change and justice can advance
Uncertainty	**Uncertainty** – Vulnerability from the individual to the institutional level

– The humility of the unknowns and unresolvable tensions between ethical positions and perspectives – The inquisitiveness to gain meaningful insights to support patients in decision making – The limitations of relational ethics not yet identified	– The ongoing quest for understanding the ontological and epistemological premise and praxis of intersectionality – The limitations of intersectionality not yet identified

Figure 1

Interface of Relational Ethics and the Theory of Intersectionality

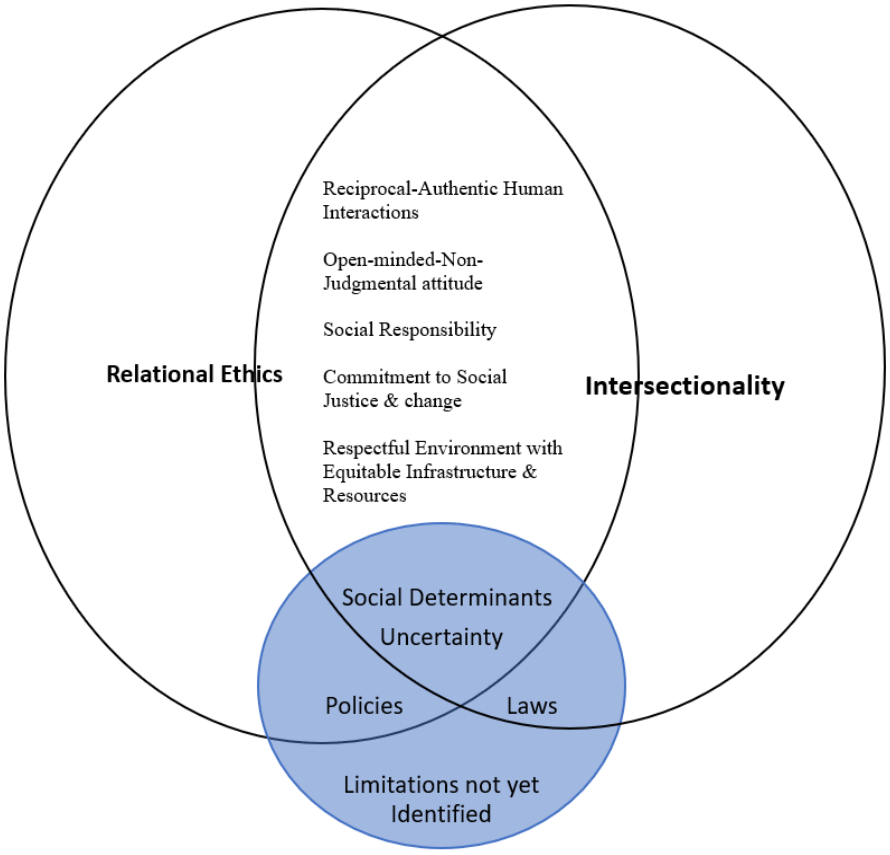


Figure 2 illustrates their harmonious coexistence in the proposed trestle to validate that ethics and intersectionality impact all stages in the clinical setting and demand that patients and practitioners consider their own social identities and the potential influences they may have on

one another (McGroarty, 2021). Intersectionality has broadened outside Crenshaw's original framework and advanced its foundational objectives of exploring Black feminism and critical race studies to interdisciplinary applications worldwide (Collins & Bilge, 2020; Collins et al., 2021; UN Women, 2021). Authored by a global team of experts, the 2021 United Nations *Intersectionality Resources Guide and Toolkit: An Intersectional Approach to Leave No One Behind* is a testimony to the power of applying the theory of intersectionality. The authors call upon the international community for a complete shift in mindset to explore:

> … the relational nature of power and discrimination both within and beyond UN systems … to better understand and address the different and intersecting effects of policy on marginalized persons … to inquire into and embrace "the messiness of difference" that exists when all users and practitioners begin to recognize that there is no such thing as a single-issue struggle because we do not live single-issue lives (p. 4).

Many international experts agreed that intersectionality is an open-ended approach that is generative, and users can creatively interpret its scope to adapt its premise. The unfolding and evolution of its applications continues as it propagates knowledge production (Collins et al., 2021; Gemignani & Hernández-Albújar, 2019; Hankivsky, 2014; Masquelier, 2022; UN Women, 2021). Organizations, individual practitioners, researchers, educators, policy and law makers, and social justice experts can address intersectionality issues in their policies, programs, and curricula designs to work toward an equitable future by using it. Therefore, the concept of intersectionality being combined with relational ethics is part of its attributive process of fluidity, creativity, reflexivity, and flexibility that adds to the harmonious dynamics of the relation-intersectional ethics trestle.

Likewise, relational ethics is person-centred and immersed in dialogical engagement that is flexible and reflexive. The elements of relational ethics hold themselves between its tenets and their intended purpose of building a therapeutic-collaborative relationship with patients (Bergum, 2012b; Bergum & Dossetor, 2005/2020). Relational ethics reminds healthcare professionals of their inherent expert knowledge and calls on them to be mindful of the power imbalance; that is, to practice mutual respect. It is paramount to be conscious of and confront relational power, including one's own, because humans experience power differently through diverse and intersecting contexts, time, and space (UN Women, 2021). Therefore, recognizing where the healthcare provider's power is as it intersects with the patients' will further enhance the practitioner's accountability to understand how their attitudes and the healthcare system can impact power dynamics and allow them to be more intentional in establishing mutually respectful engagement.

Relation-Intersectional Ethics Trestle

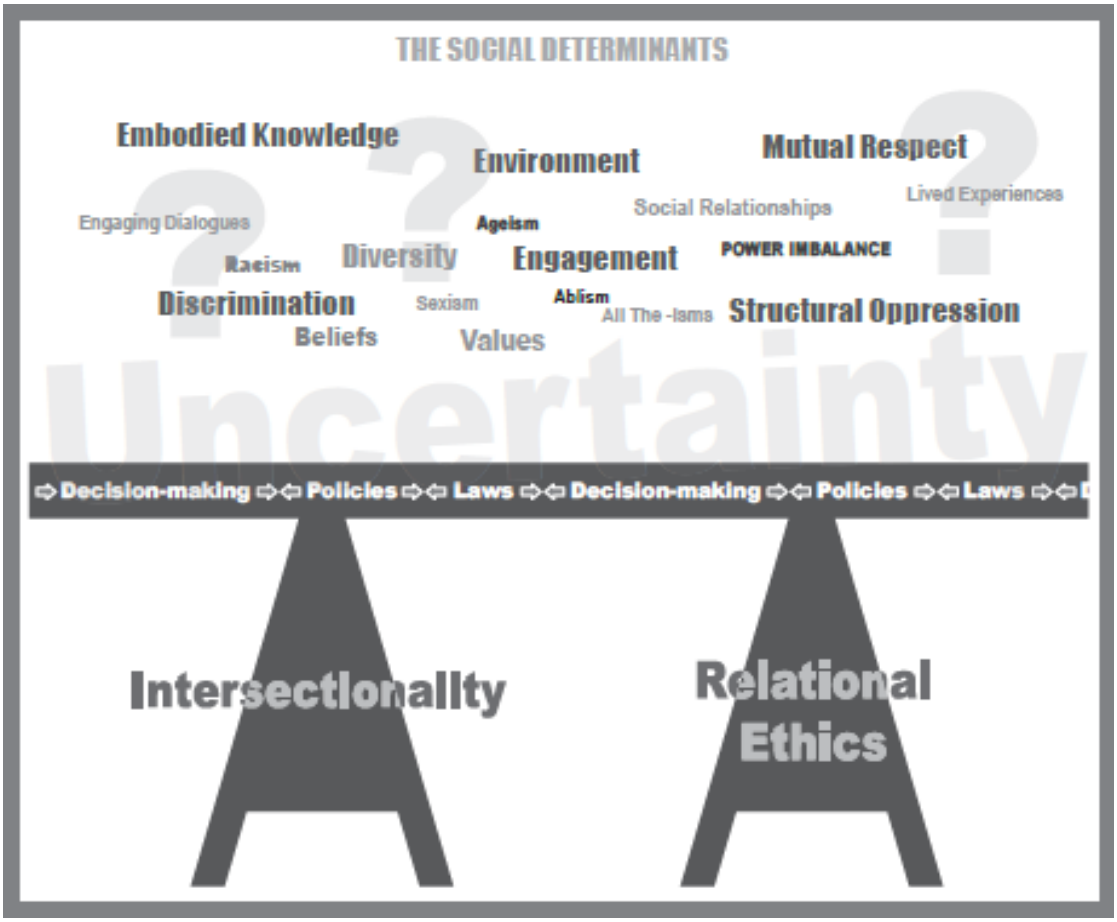
The trestle presents a synthesized platform that accentuates and contextualizes the essential components of the theory of intersectionality and relational ethics as a powerful duo to improve healthcare providers' and students' orientation toward their applications. The goal is not to revise the frameworks; rather, to extend their usage.

Relational ethics and the theory of intersectionality are already part of the curricula in many university and college programs (Ko, 2022a; Ko, 2022c; Ko, 2023; MacDonald, 2007; Mitchell, 2019; Naples, 2009; Simola, 2021; Wolbring & Nguyen, 2023). Both resonate with students and instructors by virtue of their relatability and understandability at the introductory level (Ko, 2022a; Ko, 2022c; Ko, 2023; Mitchell, 2019). Therefore, it makes sense to merge them for comprehension and application enhancement.

In the diagrammatic representation of the relation-intersectional ethics trestle (Figure 2), the bases are the chief tenets of relational ethics and the theory of intersectionality, which are represented by their titles. The social determinants are at the top because their existence is indisputable. The platform is a sample of all the free-floating factors that influence and will continue to impact the direction of understanding. Uncertainty is always looming and signifies the issues, factors, narratives, or understanding that are yet to be discovered. The free-standing question marks denote all other unknown factors beyond those that are incessantly debated. Policies and laws are juxtaposed at the bottom to designate the need for their ongoing evolution by recognizing factors that continue to weigh on inequity, social injustice, and the power imbalance that negatively impacts people's lives and that consequently influences healthcare decision making and health outcomes. One may contend that polices and laws could also be exemplified at the top along with the social determinants because it is through sound social policies and laws that decisions are made to address social determinants. The advantage of the trestle is that one may envision and place the components in ways that resonate most to generate dialogues, facilitate thinking, and expand the applications of the dual power of relational ethics and intersectionality.

Figure 2

Relation-Intersectional Ethics Trestle



Note. The relation-intersectional ethics trestle was created by Dr. Cindy Ko, PhD, and illustrated by Canadian artist Kyra Crilly. Copyright 2024.

Relation-Intersectional Ethics Trestle Applications

Macro Level

The relation-intersectional ethics trestle could be an added lens for understanding and addressing social justice issues. The relational elements on the trestle platform are the basic principles of ethical relationships, which emphasize the daily human experiences that are

grounded in intersectional relationships. Metaphorically, the relational elements and their connections with the intersecting social factors serve as the symbolic, intertwining physiological and behavioural responses of a human body to maintain homeostasis by constantly regulating and adjusting to reach a sense of equilibrium (Libretti & Puckett, 2023). From a societal perspective, Rodolfo (2000) concurs and states that a fair and just society can also maintain homeostasis in the midst of conflicting social factors such as politics, economy, environmental concerns, global health issues, and other international affairs. Likewise, the features of relational ethics and the theory of intersectionality are contextual to relationship building and encourage global societies, governments, and law and policy makers to form mutually respectful bonds that facilitate homeostasis for ongoing positive social change.

The assertion of intersectionality is that oppression is interconnected, overlapped, and interdependent in the structural social systems of discrimination and injustice. Intersectionality acknowledges that anything can result in the marginalization of people, and each person has their personal unique experiences and factors that subject them to unfair treatments (UN Women, 2021). The relation-intersectional ethics trestle is fluid and dynamic. It is attuned to the intersectionality of people's experiences as they oscillate with the relational elements. The trestle offers another vantage point for navigating some of the blind spots and challenging the status quo by putting them all on the free-floating platform. For example, power imbalances will continue to exist, and they should be checked instead of normalized to give space for practice, policy, and law improvement opportunities. Case in point, in Canada, policy makers could apply the trestle to existing gender-based-analysis programs to understand the numerous perspectives gender-diverse people may experience in policies, programs, and initiatives. In 1995, the Government of Canada declared a commitment to developing policies, programs, and legislation

that are mindful of gender and acknowledge the various identity factors that can impact people's experiences with government initiatives (Government of Canada, 2022). The trestle may be helpful for supporting best practices when designing effective and appropriate programs and initiatives.

In the Healthcare Environment

The relation-intersectional ethics trestle is unrestricted and can include anything that may influence someone's decisions when making health-related care or treatment choices. The trestle may be helpful to healthcare providers by linking relevant elements to enhance the ethical decision-making process. The trestle allows for manifold interpretations of the theory of intersectionality and the applications of relational ethics, so people are free to address their unique positions in the complexity of their environments or society.

The trestle may be introduced in training programs and workshops to help address discrimination issues in the healthcare workplace. The healthcare environment is becoming increasingly diverse owing to numerous factors such as immigration, migration, and refugees seeking asylum from war zones or inhumane persecution (Byrd & Scott, 2024; Khan et al., 2023; Lane & Vatanparast, 2022; Tuck et al., 2019; Wolbring & Nguyen, 2023). More importantly, many nations are recognizing and reconciling historical injustices that certain groups of people suffered. For example, the Government of Canada is finally increasing focus on the ongoing oppression and transgenerational trauma endured by Indigenous Peoples because of colonialism and imperialism (Indigenous Services Canada, 2023; Khan et al., 2023; University of Alberta, 2023). Consequently, most healthcare organizations now have a diversity, equity, and inclusion (DEI) policy and committee, as well as Indigenous health programs that hold them accountable for inclusive policies, processes, and practices (Bishop et al., 2022; Chantarat et al., 2023; Khan

et al., 2023, University Health Network, 2023). Khan et al. emphasize that DEI policies must not stand stagnant because there is still much to explore, examine, and analyze. The authors state poignantly that "reform and reconciliation are not a one-time event, but require thoughtful planning, collaboration with communities, investment in labour (i.e., resources and staff), reflection, and deep reckoning" (p. 1). The relation-intersectional ethics trestle may offer a wing-in-levitation where leaderships and employees can continue to consider how to advance the diversity and inclusion agenda beyond what they already do.

Leslie and Flynn (2022) and Byrd and Scott (2024) concur with the aforementioned authors by underscoring the immense need to integrate the historical dimensions of diversity so that practices and processes do not become automatic drills to check a box. For example, understanding the history and transgenerational trauma of Indigenous Peoples in Canada is a form of trauma-informed care (TIC) because it aims to prevent the retraumatization of patients and healthcare providers regardless of disclosure (Fleishman et al., 2019). Dowdell and Speck (2022) agree by indicating that TIC recognizes human rights and encourages an inclusive healthcare environment that supports therapeutic relationships while being respectful of healthcare ethics. It is out of scope here to elaborate on the TIC approach, but suffice it to say that it is in alignment with the relational ethics elements and the premises of intersectionality, as well as DEI-related issues. Hence, the relation-intersectional ethics trestle could be a tool that ignites introspection for healthcare providers because it encourages them to pause and think about the interlocking factors on the platform for each patient they encounter, thus offering a more informed understanding. The trestle could also inspire organizations to align their policies and processes with actionable strategies to propel more social justice and change.

Moreover, the relation-intersectional ethics trestle is a quick, at-a-glance visual representation that reminds practitioners of the chief principles of both relational ethics and the theory of intersectionality to support decision making with patients. It can be printed into pocket-size as a visual guide at the fingertips. A laminated, dry-erase-pen-friendly skeleton version (Figure 3) may be posted in meeting rooms to allow practitioners to write in the relevant factors for patient case review or discussion. It could enhance any ethical discussion regardless of the decision framework to draw out the issues surrounding the situation and problem, background and context, and assessment and analysis to consider options and resolutions and/or recommendations for actions. For example, in advance planning with patients, healthcare providers can use the trestle to support their conversations with patients and families in end-of-life decision making.

In the Classroom

Writer's Reflection

The idea for the trestle evolved from the ill-drawn whiteboard diagrams that helped students to understand relational ethics and the theory of intersectionality each time topics regarding DEI issues in health care and healthcare ethics were introduced. Students would shout out or write in the components that they believed would fit on the whiteboard. The murky diagrams inevitably made clear students' comprehension of both frameworks and continued to anchor further discussions and understanding throughout the semester.

The moment when it was clear that the relation-intersectional ethics trestle was effective in enhancing students' understanding was when a student asked to present a real-life case study. Without breaching any privacy identifiers, the student described a friend who was Black, gay, a

single parent who was also taking care of their elderly mother, had dwarfism, lived with a diagnosis of bipolar disorder and depression, was unemployed for several years due to a workplace injury, was without health insurance, and at the time had been diagnosed with stage 3 cancer (type undisclosed). This person was contemplating applying for MAiD. This case was captured on the blank trestle (Figure 3) where students jotted down all the known and potential intersecting factors and imagined a mutually respectful therapeutic relationship and the dialogue they might have with this patient. The students considered the elements of relational ethics and how to support this patient to clarify whether MAiD would be an ethically sound option.

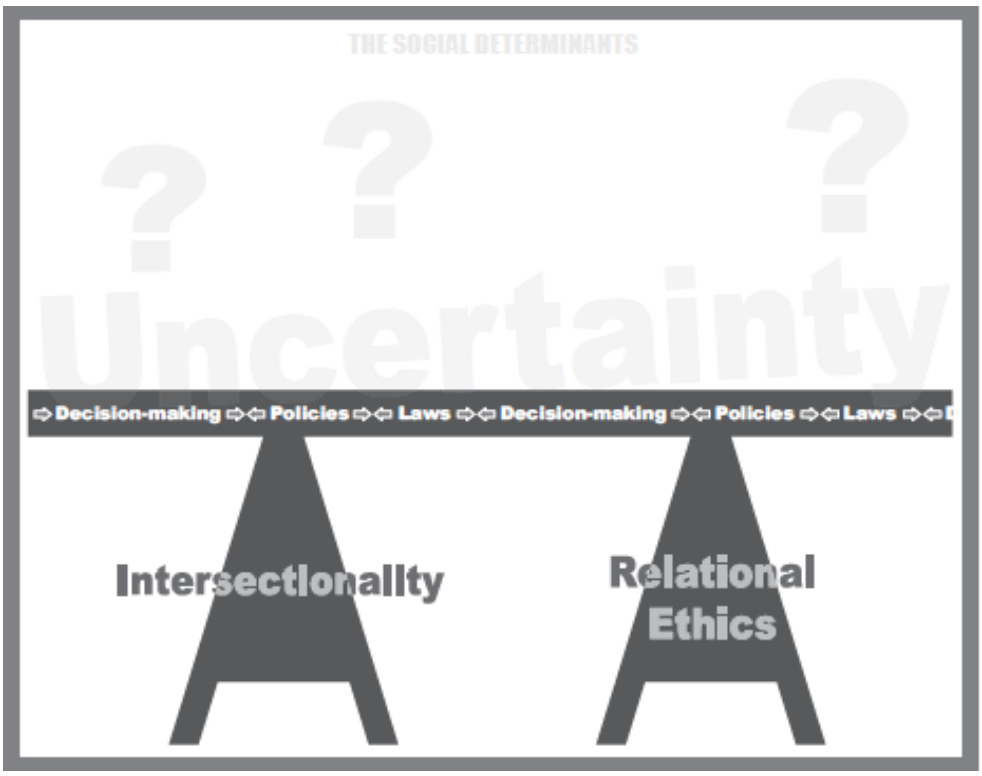
It may be difficult for anyone to study either framework in depth, nor is it the objective of any nursing or health sciences curricula. The full comprehension of both relational ethics and the theory of intersectionality requires ongoing reading, study, reflection, and arguably a passion to embrace them. Thus, the relation-intersectional ethics trestle could facilitate understanding, encourage deeper reading, and evoke an *a-ha* moment that would promote the application of both models in clinical-learning settings, as well as in courses where critical discourse theory is introduced in the classroom. Students tend to be intimidated by the depth and length of the articles and textbooks; however, the majority enjoyed the activity of filling out the blank trestle on the whiteboard. Many students have expressed that the exercise made it easier to return to the readings. The trestle is also useful for case studies in conjunction with various ethical decision-making frameworks as a side-by-side comparison to help students appreciate the different ethical models. Usually a handful of students in each semester would request more reading materials because the pictorial *a-ha* moment of the trestle inspired a yearning to learn more.

Deferentially, the trestle may be of interest to the newly launched Canadian Association for Medical Assistance in Dying Assessors and Providers (CAMAP) (2023). CAMAP developed

the first accredited, evidence-based comprehensive MAiD curriculum nationally to support MAiD practitioners. Perhaps CAMAP will consider the trestle as part of the tools they use to facilitate their modules and case-based discussions. The trestle would be an appropriate fit for two of their modules: Clinical Conversations that Include MAiD and Navigating Complex Cases with Confidence. The trestle may also be applicable as part of their reflective practice module to support MAiD practitioners to reduce distress, safeguard resilience, and promote professional satisfaction (CAMAP, 2023).

Figure 3

Fill-in-the-blank Relation-Intersectional Ethics Trestle



Note. The fill-in-the-blank relation-intersectional ethics trestle was created by Dr. Cindy Ko, PhD, and illustrated by Canadian artist Kyra Crilly. Copyright 2023.

In Research

There are infinite opportunities for researchers to utilize both relational ethics and the theory of intersectionality in health care and the social sciences. Authors such as Colombo and Rebughini (2022), who extracted McCall's (2005) analysis on using intersectionality as a research method and concur with MacKinnon (2013), discuss the possibilities of adapting an optimal combination of methods that could complement one another. The relation-intersectional ethics trestle could be helpful in strengthening the research process because it supports a visualization of the key tenets, as well as prompts users to weave in essential components that might enhance the locus of their research goals.

The trestle may support researchers in reaching a common ground in terms of selecting a research method to address their questions. Relational ethics and the theory of intersectionality are recognized across disciplines; however, most research that includes either framework is qualitative in nature (Bergum & Dossetor, 2005/2020; Bishop et al., 2022; Tomaselli et al., 2020; Walker & Lovat, 2017; UN Women, 2021). Guan et al. (2021) in their systematic review found that there is not sufficient quantitative research in the social sciences that is informed by intersectionality. The authors suspect that most researchers are unable to quantify the meanings of its concepts and definitions because of their multi-encompassing interpretativeness. Conversely, Bauer et al. (2021), in their systematic review, argue that intersectionality is increasingly used in quantitative research in the health sciences. They emphasize that comprehensive quantitative analyses that apply the chief tenets of intersectionality can extensively and accurately enhance the investigation of health equity issues, with the capacity to impact the execution of more just and fair public policies. Bauer et al. also insist that to exclude intersectionality as a quantitative method may in fact be "a potential missed opportunity" (p. 5).

It is noteworthy to remember that the goal of intersectionality is to push social justice and equity, and it was not conceived as an experimental research method, so there is no particular quantitative approach that is compatible with its complexities. Relational ethics, unlike intersectionality, has been applied to countless research studies that utilized various research methods (Tomaselli et al., 2020; Walsh et al, 2021). Analogously to intersectionality, relational ethics emphasizes human rights, fairness, and advocacy (Starzomski et al., 2023; Tomaselli et al., 2020). Therefore, the relation-intersectional ethics trestle could be a useful tool for researchers to develop more innovative methods to bridge the gap between the theories and research methods.

The intended goal of the trestle is not to replace either relational ethics or the theory of intersectionality; however, it could be used as a research framework or supplemental framework for conducting qualitative research to explore phenomenological experiences in health care and other sectors. The trestle fits within the category of phenomenological research design because it is descriptive and aims to uncover the meaning of a particular experience or an ethical decision (van Manen 1997, 2014). For example, MAiD was legalized in Canada in 2016. The trestle could be a research framework for exploring the meaning of choosing to die, the burden of complex illness, or the meaning of supporting patients to choose to die. Using the trestle in phenomenological research will allow the researcher to bracket their own biases and prejudices and describe their lived experiences objectively, then reflect *intersubjectively* (van Manen 1997, 2014, pp. 159, 227). The exercise to fill in the blank trestle is the phenomenological *patho* that evokes the meaning of people's experiences and provides *pathic understanding*; that is, the way people generate insights that are situated, relational, embodied, and enactive to human experiences (Ko, 2022b; van Manen, 2014, pp. 17–19, 267–278).

Conclusion

It is beyond the scope of this article to elaborate on the various criticisms of relational ethics and intersectionality. The terrain of intersectionality is vast and continues to expand. The theory situates itself as a prominent global framework that is fluid and adaptable to any field despite critics who wish to limit it by labelling it a subspeciality (Carbado et al., 2013; UN Women, 2021). Similarly, relational ethics is a well-established ethical framework in health care that has also been adopted in other disciplines; it is a robust model for supporting patient advocacy and ethical decision making (MacDonald, 2007; Bergum, 1999; Bergum & Dossetor, 2005/2020).

Society and the healthcare environment are changing amid rapid advancement in technologies and science. Healthcare professionals now, more than ever, need to understand the significance of ethics and the social justice issues that intersect within practice, education, research, laws, and policies, where they can contribute and advocate for social change. This article presents a relation-intersectional ethics trestle that merges relational ethics with the theory of intersectionality to create a harmonious platform that could support healthcare providers and students as they engage and care for diverse or vulnerable people in all stages of life. The intention of the trestle is to respectfully expand on the relevance and applicability of both frameworks as they journey globally and across disciplines. An illustration of the relation-intersectional ethics trestle offers a potential consideration of its adaptability in the healthcare workplace, research, and classroom. The accessibility of the trestle may further strengthen the mutually respectful and engagingly constructive dialogues that could enhance the way healthcare providers support and care for their patients.

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Developing an LPN Transition to Practice Program to Support the Changing Nursing Landscape

Anita Baldoni and Lindsey Ford

Abstract

Due to the registered nurse shortage, acute care hospitals are adjusting and changing care delivery models by incorporating additional licensed practical nurses (LPNs) into care delivery models. As this landscape and care delivery model changes, it is important to ensure there are resources in place to help support nursing teams. Many organizations have programs to help support RNs as they transition into practice or are referred to a nurse residency program. A Pennsylvania hospital recognized the need to add an LPN transition to the practice program to support new nurses as they transition into the acute care setting. A program was created, developed, and piloted to help support new graduate LPNs transitioning into acute care to help support and guide them. The program was piloted for six months with a variety of learning experiences: shadowing experiences, content experts, simulation, and mentorship. The program has proven to be successful, and an avenue was created for new graduate LPNs to feel supported during their initial months in the hospital by providing them with the knowledge required to develop from novice to competent nurses. It is important for hospitals to have support for nursing professional development opportunities for LPNs as they transition to acute care nursing models.

Keywords: licensed practical nurse; transition to practice; nurse residency, retention, recruitment

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LPN Transition to Practice Program to Support the Changing Nursing Landscape

Healthcare organizations strive to provide their communities with safe, convenient, high-quality care regardless of any barriers that may arise. The recent COVID-19 pandemic has decreased retention of nurses, as well as decreased enrollment rates in nursing academia, which have all put a large strain on health care. The mounting nursing shortage has forced organizations to re-evaluate their models of care, education, and licensure scope of practice to bridge the nursing gap. According to the American Association of Colleges of Nursing (2022), the United States is projected to experience a shortage of registered nurses (RNs) that is only expected to intensify as Baby Boomers age and the need for health care grows. Hospitals are searching for innovative methods to recruit and retain nurses and to provide effective professional development opportunities to assist with nursing educational needs. One of these opportunities includes hiring more licensed practical nurses (LPNs) into acute care practice. Prior to the COVID-19 pandemic, many LPNs worked primarily in outpatient settings such as clinics, urgent care, physician offices, and long-term care (LTC) facilities. As these care teams shift, there is a need to understand how best to support new graduate nurses and how to prepare LPNs for the evolving acute care practice arena (Whitmore et al., 2019). The pandemic has demonstrated the need for cross-functional teams and creative staffing models to fulfill the growing needs and increased acuity of patients in our communities. A literature review was completed to evaluate the necessity of LPNs at the bedside as well as additional educational needs.

Literature Review

Reports of an emerging nursing shortage have been reported since the mid-1930s (Flood, 1981). The main reason for this situation has been limited supply and increased demand for decades. As the population of critically ill patients increases, the ability to properly care for them

has become more difficult. Nursing shortages lead to medical errors and higher morbidity and mortality rates.

As per McElroy (2023), nursing academia offers limited admission into this competitive field of study. Universities and colleges are restricting the number of nursing students they can properly educate due to the lack of nursing educators and clinical facilities available. Despite the decrease in enrolled students, nursing schools turned away thousands of qualified applicants last year due largely to a shortage of faculty and clinical training sites (McElroy, 2023). The scarcity of nurses during an increase in demand for care and an aging population can be detrimental to our communities.

According to data released by the American Association of Colleges of Nursing in 2023, the number of students in entry-level baccalaureate nursing programs decreased by 1.4% last year, ending a 20-year period of enrollment growth in programs designed to prepare new registered nurses (McElroy, 2023). Declines were also recorded in master's and PhD programs, which are required to obtain nursing faculty positions (Smiley et al., 2021). Collective action must be taken to strengthen pathways into nursing to ensure the nation's healthcare needs are met.

Changing Team Models

As the landscape and care delivery model change, organizations must provide supportive programs designed for all nurses. A workforce analysis and operational assessment was completed to identify an innovative staffing solution and team model of care. An acute care facility located in northeastern Pennsylvania (comprising three hospitals within the same system, two of which are Magnet® designated) opted to increase the LPN population in their acute care

settings. With the increasing number of LPNs at the bedside, hospitals are transitioning from a primary nursing model to a team nursing model of care. Team nursing involves an integration of caregivers, such as nursing assistants, LPNs, and RNs, under the supervision of an RN team leader. This model decreases the workload of overwhelmed nurses and uses the diverse skills, education, and first-hand experiences of other members of their team.

Team nursing allows for collaboration and shared responsibility for patient care (Dickerson & Latina, 2017). This model of care allows each staff member to provide care based on their scope of practice, such as a nursing assistant obtaining vital signs, providing personal care, toileting, and bathing. Each team member is assigned specific tasks or roles to complete based on their scope of practice. Including LPNs as part of the care team alleviates some staffing concerns related to the RN shortage while maximizing opportunities to provide comprehensive essential patient care, ensuring healthcare professionals are performing to their full scope of practice. Literature has illustrated that team nursing models have allowed RNs to feel that their assignments are more manageable, and LPNs have been excited about being part of an integral team in the acute care hospital setting (Robinson et al., 2023).

Healthcare organizations are taking action to help their communities. Recruiting, retaining, and educating practical nurses is opening a pathway for greater diversity in the nursing profession, improving patient care and advancing the nursing team model (Garner & Boese, 2017). As organizations fill the staffing gap with LPNs, they also need to work to retain them. A valuable resource that organizations use to retain their nurses as well as increase overall satisfaction is through residency programs or transition-to-practice (TTP) programs. These programs are designed to support new nurses (or those with less than one year of acute care experience) within their first year of employment in an acute care facility. The inability for new

nurses, despite their level of education, to properly transition into a new practice has major consequences for organizations, including safety concerns, stress, burnout, turnover, and deceased quality of care. Although information is dated, in a TTP study conducted by the National Council of State Boards of Nursing (2014), new graduates in an established TTP program indicated they made fewer errors and had fewer negative safety practices, higher ratings of competence, less stress, increased job satisfaction, and a lower rate of turnover when compared to the other programs. Nurse residency programs have been shown to decrease stress, increase confidence, and assist in the effective transition of newly licensed RNs (Williams et al., 2007). Currently, these programs are aimed at registered nurses, but with the increase of LPNs at the bedside, opportunities to support and retain LPNs exist.

Although the literature review supports a changing care model with the increase of LPNs at the bedside, limited research is available to support the addition of a transition-to-practice program for the licensed practical nurse scope of practice. More research is needed to validate the effectiveness of this program.

Supporting Newly Graduated LPNs in Practice

Although many healthcare systems currently support RN residency programs to support newly graduated RNs transitioning from academia into their professional acute care career, formal educational programs for licensed practical nurses in an acute care setting are limited. This gap has introduced the need for a variety of educational opportunities in health care.

Creation of a Licensed Practical Nurse Transition-to-Practice Program (LPN TTP)

Upon implementation of the team model, a needs assessment identified the necessity of a program designed to support LPNs throughout their first year as acute care nurses. A homegrown program was developed and piloted for a system region within a larger healthcare network that

mirrors an already successful RN residency program. Content was created based on feedback obtained from various meetings involving the director of nursing professional development, nurse residency coordinator, and local LPN academic faculty. Knowledge obtained included imperative information related to gaps in LPN curriculum and opportunities for continuing education. A six-month pilot program was developed based on current research and feedback was obtained from not only academic facilities, but also current LPNs.

Overview of Curriculum

Based on Patricia Benner's nursing theory Novice to Expert Model (1984), the curriculum was designed to foster a supportive relationship with the new graduates while providing and exceeding continuous educational needs. A variety of different learning tools were used in the monthly four-hour sessions, which included content experts, shadowing experience, clinical reflections, and simulation.

Various content experts participated each month to discuss relevant topics such as ethics, legal issues in nursing, end of life, LPN scope of practice, and wound care. Presenters included chaplains, nurse ethicists, litigation attorneys, and nurse navigators within the organization. Prior to their topic presentation they met with the residency coordinator to review topic content. All presenters were asked to use interactive activities, games, and/or simulation to ensure participation and engagement.

The curriculum was designed to allow the new LPNs the opportunity to shadow distinct areas of the acute care setting to gain a critical understanding of patient flow and care within a multidisciplinary team. Shadowing experiences included areas such as the Emergency Department, Surgical Services, Speech Therapy, and Respiratory Therapy. Each shadowing

experience was conducted for two hours during each monthly session. This shadowing experience afforded the new LPNs the opportunity to network, learn, and build relationships with other areas of the patient care team.

Clinical reflections included smaller subgroups of the LPN TTP program participants. Each small group of LPNs are assigned to an unbiased mentor for the clinical reflections session. Each unbiased mentor was personally chosen and interviewed by the nurse residency coordinator and director of nursing education to ensure that they had no direct involvement in the assigned nurse's unit or any connection to the new nurse. Each mentor was a leader throughout the system willing and had to be able to meet with the LPNs for one hour, once a month during the scheduled transition-to-practice session. Each mentor was trained by the nurse residency coordinator, highlighting areas of coaching, managing crucial conversations, and facilitating a therapeutic confidential discussion. Mentors were provided with a worksheet from the coordinator that included icebreakers and topics to help facilitate engagement each month. Icebreakers include discussing vacation plans and open-ended conversational questions such as "If you could live anywhere in the world, where would you live and why?" These icebreakers were designed to facilitate open discussion and social interaction. Icebreaker questions helped create a warm, welcoming environment where everyone felt comfortable sharing, which then segued into deeper topics. These topics included first code experiences, team nursing, and difficult patient situations, which encouraged the nurses to share stories of strengths, weakness, and opportunities in a confidential, safe environment. Moreover, this open dialogue allowed nurses to speak freely while learning from peer experiences. All the information was confidential within the group unless there was concern for harm to the nurse or anyone else.

Additionally, simulation with high-fidelity equipment was incorporated into each session to give hands-on learning experiences to promote and increase confidence in nursing skills. These hands-on simulations included intravenous pump and feeding tube training, as well as chest tubes and tracheostomy care. One skill was chosen every month based on the feedback gained from the prior months' evaluation.

Launch of the LPN TTP Program

The first official LPN transition-to-practice (LPN TTP) pilot program started in June 2022 in the 700-bed combined total regional hospitals. Eighteen new graduate LPNs were enrolled into the first program. This transition-to-practice program afforded all the LPNs in the program the opportunity to connect with other LPNs throughout the region with a similar knowledge base, skill set, and uncertainty in the acute care setting. The transition-to-practice program was developed in addition to their classroom and unit orientation to help guide and support them as they transitioned into bedside practice.

While developing the program's expectations, the RN residency program was used as a guide to mirror some priorities, such as attendance. Both programs promoted mandatory attendance for each session. The goals of the program included nurse retention, improved working relationships, improved confidence in nursing skills, and distinguishing the LPN scope of practice while supporting a nurse's transition from novice to competent.

Methods

Participant Population and Criteria

Upon initiation of the program in June 2022, the 18 new LPNs hired between January 2022 and June 2022 were automatically enrolled. Requirements for the program included all LPNs with less than one year of acute care experience and with an unrestricted nursing licence or scheduled to test within three months.

After the initial session, two participants were unsuccessful in passing their board examinations, while two other participants decided that the acute care environment was not the right fit for them. Likewise, one of the enrolled LPNs asked to be excused from the program based on personal and/or family reasons that made it difficult for her to attend. Due to the pilot program's nature, an exemption was approved. The remaining 13 LPNs completed the program in November 2022. Since the launch of the initial program, there have been three additional cohorts, with cohort two completed in fall 2023 with 17 total graduates.

Data Collection

Using Microsoft Forms, a monthly survey was created to evaluate the effectiveness of the coordinator, content experts, assigned mentors in clinical reflections, shadowing experiences, topics, and suggestions for future sessions.

As part of the pilot LPN TTP program, participants completed the following surveys: the Casey Fink Survey, monthly session evaluations, and overall program evaluation. The Casey Fink Survey is a tool used to evaluate new nurse stressors, transition experience, and the efficacy of transition to practice or residency programs. An initial Casey Fink Survey was conducted during the first session in June 2022 and at the program's conclusion in November 2022. Monthly session evaluations were completed to identify strengths and opportunities throughout

the program. Based on the feedback, real-time adjustments were made to the program to enhance the participants' learning needs and development. The program evaluation was a tool used to identify overall effectiveness in increasing self-confidence levels, session content, session timing, learning outcomes, and coordinator efficiency.

Results

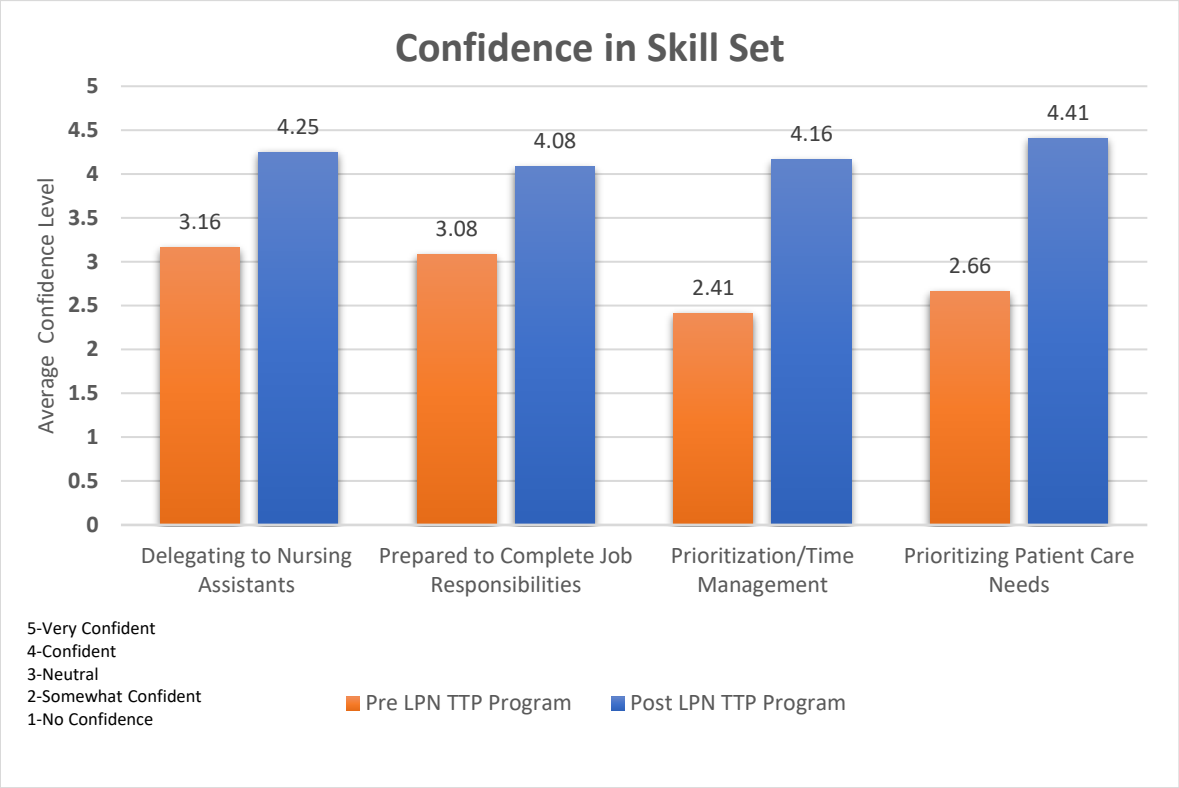
Program Evaluation

Of the participating LPNs, 67% responded to the overall program evaluation. Ninety percent of participants responded that the program assisted with their transition into acute care practice. Similarly, 90% identified that the program afforded them the opportunity to gain valuable experience from other departments or units and learn about patient flow throughout the hospital and assisted them in building relationships with other departments or units.

Pre- and post–LPN TTP, Casey Fink Survey comparison showed an overall increase in the following skills and categories: self-confidence, autonomy, and time management. From pre-survey to post-survey, there was an improvement in various inquiries, including: "I feel I may harm a patient due to my lack of knowledge and experience," "I am having difficulty organizing patient care needs," and "I feel overwhelmed by my patient care responsibilities and workload." Participants identified the strong commitment the program coordinator has for helping new nurses succeed by answering "Strongly" to the following questions: "I feel the program coordinator provides encouragement and feedback about my work," and "My program coordinator is helping me to develop confidence in my practice." Table 1 showcases pre and post comparison in confidence in skill set for delegation to nursing assistants, prepared to complete job responsibilities, prioritization and time management, and prioritizing patient care needs.

Table 1

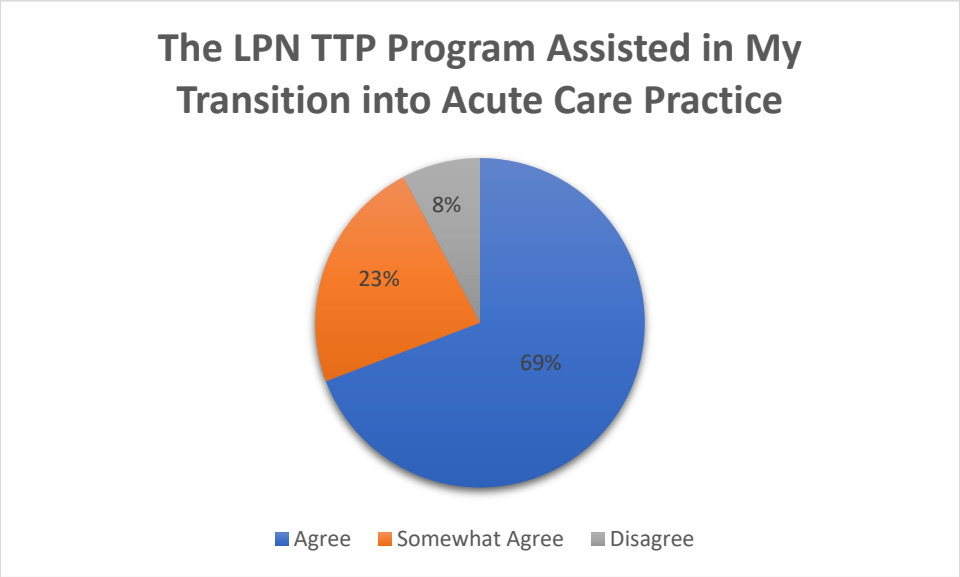
Pre and Post Confidence in Skill Set



At the conclusion of the pilot program, a graduation was held to celebrate the 13 LPNs who completed the program. During this celebration, the nurses were recognized and awarded a certificate and stethoscope. Some LPN residents also shared first-hand experiences, learning outcomes and gratitude for the support they received during the program, stating their excitement to continue their career and professional growth within the organization. As part of the overall evaluation of the program, one of the questions asked if the LPN TTP assisted them in the transition to acute care practice (Figure), 69% responded agree.

Figure 1

Perceived Relevance of the LPN TTP



Strengths and Opportunities Identified

Post–LPN TTP graduation, one-on-one interviews were conducted to gain qualitative feedback concerning the program and to warrant proper development and success of future cohorts. Overall, the participants concluded that the six-session program duration was sufficient, and they expressed more self-confidence in their skills and career choice at the conclusion. Participants indicated that the shadowing experiences were an integral and valuable contribution to the program, expressing that the continuum and evolution of patient care was informative.

The participating LPNs identified the need to extend the shadowing time from two hours to four hours. They also suggested that shadowing experiences would be more beneficial in the morning rather than the afternoon (the pilot time was 1 p.m. to 2 p.m.), thus allowing peak care hour experiences and interdisciplinary meetings. Morning participation would also afford the opportunity to participate in interdisciplinary meetings surrounding patient care with a variety of

care team members. LPNs participating in the pilot program worked both day and night shifts. Nurses working the night shift were suggested to not self-schedule work the night prior to an LPN TTP session to encourage engagement and active participation.

Many participating LPNs expressed that all aspects of the program were beneficial, including the topics covered by content experts, simulations experiences, and clinical reflections. The LPN TTP participants identified the need for more mock code simulations, expressing anxiety related to real-time code situations, which require skill repetition to build confidence. The success of this program proved a valuable resource in transitioning LPNs into practice while providing the necessary support, education, and experiences to be successful in a team model. Although the sample size was not optimal, further evaluation is needed as LPNs continue to be hired in the acute care setting.

Post-Pilot

After completion of the pilot, an additional three LPN TTP cohorts were established using the feedback obtained from the pilot program. Alterations to the program included extending the session timeframe from four hours to eight hours to allot additional essential time to the shadowing experience as well as to adequate content delivery. The length of the program was also extended to be completed over one full year, with the cohort meeting every other month. The program has also been launched in additional regions within the healthcare system to offer support for those new to practice LPNs. Overall, TTP LPN retention has been 94% based on all three cohorts with a total of 38 participants.

Conclusion

With the ongoing nursing shortage, it is essential that healthcare organizations bridge the education gap with changes in the patient care model. Organizations can retain, recruit, and

increase both patient and nursing satisfaction by moving to a new model of care that uses LPNs in the acute care practice area. The LPN transition to practice program included education regarding scope of practice, effective communication techniques, and delegation to help support the team model in delivering nursing care. In addition, organizations must identify innovative methods for supporting LPNs as they transition into acute care practice. Various educational opportunities exist to facilitate programs designed to support healthcare providers such as LPNs amid current staffing limitations.

Current RN residency programs have paved the way to improving retention and providing support to new graduate nurses, with proven positive results. Transition-to-practice programs are designed to enhance knowledge base, confidence, and critical-thinking skills. The need for a similar educational platform to support and guide new LPNs during the initial crucial months in acute care is definitely needed. Combating the nursing shortage has not been easy, but with innovative programs, organizations can support their new LPNs by offering a transition-to-practice program with mentors, shadowing experiences, and content designed to increase self-confidence and skill sets, and support their transition into practice.

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