RESEARCH ON ROLES AND UTILIZATION

Licensed Practical Nurses and Care Aides in BC

PREPARED FOR

Health Employers Association of British Columbia and the Association of Unions – Health Services & Support Facilities Subsector (HEU, BCGEU, IUOE, CSWU, IBEW, USWA, BCNU, UBCJA, UAJAP&P, IBPAT)

Licensed Practical Nurses and Care Aides in B.C.
Research on Roles and Utilization
Fall 2000

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Finally, we wish to thank our researchers, Barbara Greenlaw, Wendy Williams and Amanda Walker. Barbara's chief involvement in the project related to the development of the B.C. context, the conduct and preparation of the key informant interviews, and the fact sheets relating to LPN roles, education and utilization in other provinces. Wendy, in addition to her role as co-ordinator of the research, conducted and compiled the case studies and role profiles. Wendy was assisted by Amanda in the development of the surveys and the tabulation of the data.

contents

Please see the first page of each section for a more detailed table of contents.

6 introduction

8 recommendations

11 PART 1 executive summary

17 PART 2 the BC context

18 Education

26 Employment and utilization

31 Regulation

33 Summary

34 References

35 PART 3 surveys

36 Executive summary

41 Survey of LPN employment in BC

55 Survey of LPN skill utilization in BC

103 PART 4 case studies

105 Kelowna General Hospital

145 Lions Gate Hospital

199 Malaspina Gardens

219 Saanich Peninsula Hospital

233 Terraceview Lodge

243 Yaletown House Society

257 PART 5 role profiles

259 Fast track LPN

261 Community foot care LPN

263 Total care worker

267 PART 6 key informants

268 Key informants: Major findings from the interviews

270 Current activities

274 Ideas for future action

281 Summary of key points

285 PART 7 across canada

289 LPN and care aide roles in Canada

301 LPNs in acute care
- 301 Royal Alexandria Hospital, Edmonton
- 303 Queen Elizabeth II Health Sciences Centre, Halifax
- 305 Chalmers Hospital, Fredericton

307 LPNs and care aides in continuing care
- 307 McConnell West, Edmonton
- 309 Park Manor Personal Care Home, Winnipeg
- 311 The Poseidon Centre, Winnipeg
- 313 Hoyles-Escasoni Complex, St. John's

315 Specialized LPN roles
- 315 LPNs providing footcare
- 317 LPNs in the operating room

319 Overview of LPNs in other provinces

introduction

In the summer of 1998, publicly funded health care employers in British Columbia (represented by the Health Employers Association of B.C.) and employees (represented by an Association of Unions[1]) agreed in collective bargaining to examine the current and future potential role of licensed practical nurses (LPNs) and care aides.

A joint committee comprised of three union and three employer representatives (the "joint committee") was given responsibility for reviewing the current utilization practices at three health care facilities that employ LPNs and care aides. The expectation was that the joint committee would consider the type of duties performed, as well as those not performed, but for which LPNs and care aides were trained. The joint committee was also mandated to consider the cost and impact on the quality of health care services and efficiency resulting from changes in utilization.

Upon completion of its work, the joint committee was required to make joint recommendations regarding effective utilization of LPNs and care aides to the Regional Health Boards and Community Health Councils.

Joint committee members were: employer representatives Najeeb Hassan (HEABC), Philomena Janzen (Director of Acute Clinical Services, Cranbrook Health Council) and Janice Mitchell (Administrator, George Derby Centre); and union representatives Zorica Bosancic (Assistant Secretary-Business Manager, Hospital Employees' Union), Irene Jansen (Researcher, Hospital Employees' Union), Doreen Plouffe (LPN, Hospital Employees' Union) and Jean Holt (LPN, B.C. Government and Service Employees' Union). A representative of the B.C. Nurses' Union sat in joint committee meetings as an observer.

During the planning stages of the joint committee's work, the provincial government announced that $5 million had been allocated to health authorities to increase the number of LPNs and care aides in continuing care facilities, backed up with funding for training. In addition, the provincial government allocated $200,000 to support the joint committee's research. This allowed the joint committee to retain the services of Barbara Greenlaw and Wendy Williams, who carried out the research and prepared this report under the direction of the joint committee.

With the funding support of the Ministry of Health, the joint committee agreed to expand the depth of its research by developing six site specific studies, three role profiles, a review of utilization practices in other provinces and two surveys designed to identify

[1] The Association of Unions, Health Services & Support – Facilities Subsector includes the following unions: the Hospital Employees' Union, the British Columbia Government and Service Employees' Union, the International Union of Operating Engineers, the Construction and Specialized Workers' Union Local 1611, the International Brotherhood of Electrical Workers Local No. 230, the United Steelworkers of America Local 9705, the British Columbia Nurses' Union, the United Brotherhood of Carpenters and Joiners of America Local No. 1598, the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada Local No. 324, and the International Brotherhood of Painters and Allied Trades Local No. 138.

the type of facility where LPNs were being employed and what specific skills were being utilized by them. The research also expanded to include consideration of the views of educators, regulators, and more employers and employees regarding the effective utilization of LPNs and care aides. Because this project was initiated through facilities sub-sector collective bargaining, it addressed the role of LPNs and care aides in acute and continuing care facilities only; home care and community agencies were excluded.

The parties agreed early in research planning that successful completion of the project required the establishment of supportable and feasible recommendations regarding the role and utilization of LPNs and care aides. The parties were committed to decision making in the research process through consensus, cooperation and collaboration. Although the parties at times had differing perspectives regarding certain aspects of the research and the results, through open, honest and timely communication, the parties were able to arrive at a common understanding of the issues.

Throughout the process, the parties obtained input from their various constituents. HEABC conducted two employer focus groups and the Hospital Employees' Union discussed the research with its nursing team committee and activists.

The joint committee established a working group that met almost weekly, in person or via conference calls. The working group subcommittee was in regular contact through e-mail, fax, courier and regular mail exchanges of information. The full joint committee met on four occasions between September 1999 and June 2000.

The parties agreed upon recommendations supported by the findings of the research set out below. A copy of this report has been forwarded to the Ministry of Health, the Regional Health Boards and Community Health Councils, HEABC member employers and the constituent unions comprising the Association of Unions – Health Services & Support Facilities Sub-Sector.

recommendations

1. That the Ministry of Health make the necessary funding adjustments to create new LPN positions, taking into consideration the needs of health care employers.
2. That the Ministry of Health and the Ministry of Advanced Education, Training and Technology assess the demand for practical nurses and consider the need for increases in practical nursing education programs, including both the regular and LPN Access programs.
3. That the Ministry of Health provide base funding for continuing education of care aides and practical nurses.
4. That the Ministry of Health make adequate funding available to ensure that care aide and practical nurse education and credentialing programs continue, such as those offered through the Healthcare Labour Adjustment Agency.
5. That HEABC member employers explore the potential benefits of coordinating in-service education with each other.
6. That the Ministry of Health explore options for making the expertise of clinical nurse educators available to HEABC member employers who lack resources to provide in-service to practical nurses and care aides.
7. That the Ministry of Advanced Education, Training and Technology establish the provincial home support/care aide curriculum as the standard in all educational institutions, both public and private, that offer the care aide certificate.
8. That the Ministry of Advanced Education, Training and Technology support the development of provincial curricula and programs for advanced practice LPN roles in areas such as operating room and foot care.
9. That the Ministry of Advanced Education, Training and Technology facilitate improved coordination between the care aide, practical nurse and registered nurse articulation committees.
10. That the Ministry of Advanced Education, Training and Technology ensure that care aide, practical nurse, registered nurse, and registered psychiatric nurse education programs teach collaborative practice and knowledge of each others' competencies.
11. That the Ministry of Advanced Education, Training and Technology continue the B.C. Health Care Scholarship program.

12. That the College of Licenced Practical Nurses of British Columbia and the Registered Nurses' Association of British Columbia continue to offer joint presentations regarding the roles and competencies of LPNs and RNs, and that these continue to be affordable and accessible.
13. That HEABC member employers be encouraged to provide opportunities for managers and staff to learn about the roles and competencies of the different nursing groups (LPN, RN and RPN as relevant) – for example, in orientation and, where possible, through regular staff meetings.
14. That the Ministry of Health, HEABC member administrators and health authority governors be advised of the findings and recommendations of the LPN and Care Aide Research Committee through a joint publication of the report.

executive summary

Responding to a number of factors, health care facilities in British Columbia are re-examining the roles and utilization of licensed practical nurses and care aides. The research undertaken for this project revealed considerable variation in the utilization of LPNs and care aides between and even within facilities, though it also highlights the growing interest in expanding education and practice opportunities for both groups of care providers. Changes in patient profiles, funding levels, education programs, professional regulation and nursing labour supply all contribute to this focus on nursing team staffing mix and roles.

LPN Employment

British Columbia has fewer LPNs in proportion to registered nurses than any other province. In 1998, there were 4,424 licensed practical nurses employed in nursing in British Columbia. This represents a ratio of 1 LPN to 6.4 registered nurses; the average for other provinces is 1 LPN to 3 RNs.

Licensed practical nurses are an aging workforce. More than 80 per cent of LPNs are over the age of 35, and half (51 per cent) are over the age of 45. The average age of an LPN in B.C. is 45.

Licensed practical nurses are employed throughout the health care system, though the highest concentration is found in facilities, particularly in acute care. In 1998, over half (57 per cent) of LPNs were employed in acute care hospitals and one-third were employed in extended and continuing care facilities. Among the facilities surveyed in this project, 71 per cent (17) of the hospitals employ LPNs, as do 31 per cent (38) of the continuing care facilities (including intermediate, stand alone extended and multi-level) and 91 per cent (40) of the combined acute/extended care facilities. LPNs were most frequently employed in facilities that have 100 to 200 beds.

In the acute care (including acute/extended care) facilities surveyed, LPNs were most commonly used on medical, surgical and extended care units. The highest level of utilization was on medical units; specifically, 83 per cent of facilities reported using LPNs on medical units. The other units most likely to employ LPNs were surgical, extended care, rehabilitation, palliative/oncology, geriatric, pediatric, subacute/transitional, and operating room/day surgery. Utilization on these units ranged from 31 to 74 per cent.

LPN Skill Utilization

There is considerable variation in LPN utilization – between facilities and within facilities – and LPNs are frequently not practising to their full scope of competencies. Results of our *Survey of LPN Skill Utilization in B.C.* indicate an underutilization in some competencies – for example, administering oral medications, dressing simple wounds, and performing certain assessments – and a higher utilization in other competencies – for example, administering topical medications and assisting with deep breathing and coughing. Many

of the competencies canvassed in the survey have been covered by the curriculum and considered entry level since the first practical nursing program was offered in the late 1940s. A number were added at later stages – for example, catheterizations and medication administration in the early 1980s and psychogeriatrics and subcutaneous injections in the 1990s. Though now well established in the curriculum and in regulatory standards, these competencies are not consistently part of LPN duties in B.C. facilities.

The inconsistency in LPN utilization was also raised in the case studies and key informant interviews, where it was noted that an LPN's job will be different from one facility to the next, and can vary significantly between units in the same facility.

Contributing Factors

Participants in this research project identified a number of factors that contribute to the divergence in LPN utilization. One of the issues raised repeatedly in the case studies, the key informant interviews and the survey responses is the lack of awareness among managers, staff and patients about the current competencies and regulatory framework for LPNs. Many people are not familiar with the current education program, standards of practice, accountability obligations and other aspects of LPN practice. A government-sponsored review of the practical nursing curriculum conducted a few years ago similarly concluded that "the new graduate and their complement of skills are not well understood by employers or widely marketed in B.C." (Layton, 1998).

Another significant factor influencing LPN utilization cited by employers in this study is that of work jurisdiction conflict with registered nurses.

As a result of the variation in nursing mix and roles across the industry and over time, combined with changes that have occurred in education programs, individual LPNs are at different levels of knowledge and skill. Furthermore, not all practical nurses are registered with the College of Licensed Practical Nurses of B.C.

An additional barrier to LPN utilization identified by employers was their inability to recruit qualified LPNs for vacant positions.

Toward Change

Despite these challenges, a number of employers have made changes to the nursing team staff mix and the roles of team members; upgrading and credentialing needs have consequently come into the forefront. The case studies presented in this report describe how six facilities expanded the role of LPNs and, in one case, of care aides. Meanwhile, the demand for continuing education and credentialing programs for both LPNs and care aides has risen across the sector. Comments from survey respondents and key informants suggest that these changes will continue to accelerate in the future as facilities cope with funding pressures, nursing labour shortages and changing patient needs.

With change come certain hurdles and tensions. Stress points were cited by survey respondents and key informants, and the case studies were able to explore these issues in greater depth. Some of the challenges repeatedly raised by survey respondents and interview participants were the following: inconsistent knowledge among co-workers and

managers of LPN competencies and regulatory standards (including accountability for practice), diversity of current LPNs' competency levels and the need for upgrading and continuing education, paucity of funding for education, inadequate time and resources for planning and evaluating changes in staffing mix and roles, confusion regarding overlap in nursing team members' roles, job security concerns, and inadequate opportunities for ongoing discussion on nursing practice and roles due to heavy workload, funding pressures, uncertain environments and other factors.

Managers and staff identified a number of important steps that contributed to successful implementation of new LPN and care aide roles in their facilities. It was widely felt that change should be carried out using a process that is inclusive and transparent – a process that allows for open communication between staff and between management and the union. Involvement of all members of the nursing team, and sometimes staff beyond direct patient care, was considered important. Other features of effective nursing team reorganization include: clear articulation of roles and responsibilities (documented where possible), orientation of new employees, opportunities for continuing education, avenues for positive resolution of conflicts, encouragement of team work, and involvement of all nursing team members in care planning.

Research participants identified a number of positive outcomes from the expansion of LPN utilization; however, to date there is a lack of data on the costs and benefits of different staffing mixes.

Some of the positive dividends of nursing team reorganization identified by case study participants include: improved workload organization and staff supervision, improved staff morale, positive union-management relations, and effective care provision. While the case study interviewees offered their assessment of the nursing team mix and tried to provide relevant financial information, for the most part there has been minimal data collection and analysis of changes in terms of costs, patient outcomes and quality of worklife. Managers said they would like to have this information, but do not have the time and resources to carry out this type of research.

Learning from Other Provinces

In other provinces, LPNs and care aides work in a variety of settings and roles. Some of those roles are profiled in this report, as are the contextual factors related to education, regulation and employment patterns for selected provinces. Be it the LPN team leader in a Manitoba nursing home, the "resident companion" in an Alberta home for seniors with cognitive impairment, or the LPN working to full scope of practice in an Edmonton hospital, all of these roles offer examples of innovative care delivery. Specialized areas of practice, such as foot care and operating room, are emerging in tandem with broader utilization of LPNs in medication administration and other established competencies. Also informative are initiatives such as the New Brunswick government's doubling of LPN positions in long term care, achieved by converting care aide positions and offering those workers upgrading to become LPNs. Across the country, employers are looking at how to maximize the utilization of all nursing team members.

As in British Columbia, other provinces are examining nursing scopes of practice and developing resources, such as competency profiles and delegation frameworks, to support collaborative nursing practice. Following the 1997 National Nursing Competency Project, provinces have taken different routes to articulating LPN and other nurses' competencies; for example, Alberta developed a detailed reference document for employers that identifies the range of LPN competencies (mainly entry-level, some advanced) as they apply to 23 clinical practice settings. Other provinces, such as Ontario and British Columbia, have avoided a skills-based approach and have geared their material to registrants for continuing competency purposes.

Advancing Education

As the regulatory system evolves and the roles of LPNs and care aides change, education becomes a pivotal issue. The curriculum for both practical nurses and care aides in B.C. has advanced considerably in recent years, and resources for continuing education and credentialing have come into greater demand.

Four B.C. colleges offer the practical nursing program, and one offers a full refresher program. With the provincial government's investment in new practical nursing seats, the four colleges will admit 207 practical nursing students in 2000/20001. At least three other colleges are considering offering the practical nursing program, and two of the existing programs will offer the LPN bridging option for care aides this year. Educators meet twice annually to work on common issues and, since 1992, the colleges have offered a standard provincial curriculum. The program was increased to 12 months in 1992 to incorporate additional competencies; it shifted from a task-oriented model to one that emphasizes critical thinking and independent problem solving. A review of the curriculum in 1998 concluded that it is well-received by faculty, students and employers; however, nine of the 15 employers surveyed were unaware of the changed curriculum.

The certificate program for care aides, the Resident Care Attendant program, is offered by 16 publicly funded colleges and 26 private training facilities in B.C. Since 1991, the public colleges and at least one private college have offered a standard provincial curriculum that is 20 weeks in length. The curriculum was designed to enable a combined RCA and Home Support Worker credential, and more colleges are offering it in that format. The curriculum will be reviewed and updated later this year.

There is no requirement that the provincial curriculum be used by the private colleges. Employers and public college faculty have expressed concern about the lack of supervised clinical learning experiences in these programs. The admission requirements in private programs may also be different, and there is no obligation for the educators to collaborate on the provincial articulation committee to maintain standards and consistency across programs. Oversight of private colleges is limited to a voluntary accreditation process that protects students from losing their entire tuition if the school closes; it does not attend to quality issues such as clinical practice.

Refresher courses and credentialing programs have come into greater demand as advances in entry-level education and changes in LPN and care aide roles take effect. The

Healthcare Labour Adjustment Agency has developed prior learning assessment resources to enable care aides and LPNs to receive credit for on-the-job and related learning. Continuing education for care aides and LPNs is available through in-service workshops and college courses. Some courses are relevant to both groups – for example, psychogeriatrics, rehabilitation or activation assisting – while others, such as medication administration or intravenous therapy, are specific to LPNs. While the education programs exist, there are inadequate resources available to support workers in taking these courses.

A number of valuable training resources are in place for health care workers; however, the demand far outstrips their capacity. The B.C. Health Care Scholarship Fund awards 3,000 bursaries of $3,500 each to health care workers for continuing education. The Healthcare Labour Adjustment Agency supports credentialing, refresher education and post-basic courses for LPNs and care aides across the province. As part of its broader LPN and care aide staffing initiative, the provincial government has supported upgrading for a number of workers; however, this was one-time only funding. A message that was repeated in all of the case studies, the key informant interviews and the survey responses, is that continuing education is critical to successful implementation of new roles for LPNs and care aides. Without exception, employers and staff felt that resources for this education are seriously inadequate.

SUMMARY OF REPORT CONTENTS

The B.C. Context

This section presents an overview of the education, regulation and employment/utilization issues related to licensed practical nurses and care aides in British Columbia. It serves as a background document for the research findings. In it, the current education programs for practical nurses and care aides are described, as are upgrading and post-basic course offerings. Statistics on the nursing labour force, current wage rates, and reference to nursing human resource planning activities are also provided. Finally, the regulatory framework for LPNs is described, including the current review of nursing scopes of practice.

Surveys

This section presents the results of two surveys on LPN employment and utilization. The first survey provides a provincial snapshot of where LPNs work – specifically, it identifies the proportion of hospitals and continuing care facilities that employ LPNs and the type of units to which they are assigned. The second survey took a sample of those facilities and examined the range of duties that LPNs perform on three of the most common units: medical, surgical and extended care. Managers were also asked to identify factors that influence their utilization of LPNs – a significant number offered additional comments about current and anticipated nurse staffing mix and roles.

Case Studies

LPN and care aide roles and utilization are explored in case studies of six facilities around the province, including three hospitals and three continuing care facilities. Researchers interviewed workers and managers at each site and reviewed documentation such as job descriptions, education plans, and policies on nursing team roles. This information was used to create a profile of LPN and care aide practice at each facility.

Role Profiles

Three distinct LPN and care aide roles are described in this section. One profile describes the job of an LPN in a fast track emergency unit at a regional acute care facility. Another presents the role of an LPN providing foot care to residents at three continuing care facilities in a northern community. The third applies to a care aide position in a psychogeriatric assessment unit. In addition to the description of duties and responsibilities for each position, the reports include a description of the unit, the patient population, staffing levels and the education and related qualifications for the position.

Key Informants

"Key informants" to this project provided their views on issues related to the employment, utilization and education of LPNs and care aides in B.C.'s evolving health care system. Individual and group interviews were conducted with employers, workers, educators and staff of the College of LPNs. Key informants discussed a variety of issues, including changes in patient acuity, health care restructuring, professional regulation, workload pressures, and the nursing shortage. Their accounts reflect a dynamic environment – one where the practice of LPNs and care aides is being re-examined and reformulated, education programs are evolving, and issues like role overlap and changes to scope of practice are being confronted. Key informants made specific recommendations for actions that would enhance the education and the utilization of both LPNs and care aides in British Columbia.

Across Canada

This section presents information on LPN and care aide roles in other provinces. It consists of the following fact sheets:

- national overview fact sheets that compare the education, regulation and employment of LPNs and care aides across the provinces
- profiles of the LPN role in three acute care hospitals
- profiles of LPN and care aide roles in four continuing care facilities
- profiles of two specialized LPN roles – operating rooms and foot care, and
- provincial contexts for LPN practice in Alberta, Manitoba, Saskatchewan, New Brunswick and Nova Scotia, including statistics on LPN registrants and place of employment, the status of regulatory or practice issues, basic facts on entry-level and continuing education programs and reference to distinct, new or emerging roles.

PART 6 key informants

"Key informants" to this project provided their views on issues related to the employment, utilization and education of LPNs and care aides in B.C.'s evolving health care system. Individual and group interviews were conducted with employers, workers, educators and staff of the College of LPNs. Key informants discussed a variety of issues, including changes in patient acuity, health care restructuring, professional regulation, workload pressures, and the nursing shortage. Their accounts reflect a dynamic environment – one where the practice of LPNs and care aides is being re-examined and re-formulated, education programs are evolving, and issues like role overlap and changes to scope of practice are being confronted. Key informants made specific recommendations for actions that would enhance the education and the utilization of both LPNs and care aides in British Columbia.

CONTENTS

268 key informants: major findings from the interviews

- 268 Purpose and Process
- 268 Introduction to the Findings
- 269 Overall Context for Issues Raised

270 current activities

- 270 Education and Training
- 271 Employment, Role and Utilization

274 ideas for future action

- 274 Education and Training
- 278 Employment, Role and Utilization

281 summary of key points

key informants

MAJOR FINDINGS FROM THE INTERVIEWS

Key informant interviews were planned and implemented in keeping with this project's research plan. This report first outlines the purpose and process of the interviews, and then provides both an introduction to the findings and the overall context for issues raised in the interviews. Finally, key findings are presented, first for the area of employment, role and utilization, and then for the area of education and training.

Purpose and Process

The overview of this project's research plan includes:

Interviews with stakeholders (e.g. College of LPNs, educators, directors of care) to identify major trends and action ideas regarding employment, role/utilization and education/training for LPNs and care aides in the evolving health care system.

In planning discussions, it was noted that a scan of major trends in health care was not necessary, as trends such as increased acuity and the shift to closer to home are well documented elsewhere. The primary focus of the interviews was to solicit input and action ideas from key informants about employment, role/utilization and education/training for LPNs and care aides.

Planning for this phase of the project began in 1999. A protocol was developed for the interviews and key informants were interviewed in April and May, 2000. A list of key informants' areas of expertise, the interview protocol, and sample questions are attached as appendices to this report.

In general, questions focused on two key areas: current activities and ideas for future activities. Questions were tailored so that key informants provided feedback in their area of expertise (for example, educators were asked to focus on issues related to education and training).

Introduction to the Findings

Participants in the interviews freely shared information about both current and potential programs and initiatives related to LPNs and care aides. As participants frequently shared information about issues in their workplace, these issues are summarized below as a context for understanding their comments.

It may be helpful to note that key informant interviews are part of the larger LPN/care aide project looking at the role and utilization of these two care providers in B.C. It is useful to view the comments of key informants in light of other findings.

Furthermore, the findings that follow are the perceptions and represent the understanding of interview participants. It was not within the scope of this component of the research to confirm findings through additional or independent research. Editorial

notes are provided when the perception of participants varies from other data sources available to the project consultant.

The findings of the key informant interviews are presented under the major headings *Current Activities* and *Ideas for Action,* both of which are divided into two sections: *Employment, Role and Utilization* and *Education and Training.*

Overall Context for Issues Raised

Key informants often shared information about issues that significantly impact on the role and utilization of LPNs and care aides in their workplace. The following list highlights issues that arose from nine sets of interviews. These issues, summarized here in the general categories role issues and workplace issues, provide a context for understanding comments made by the key informants.

Although these issues are challenging, participants did not focus on complaints; their comments are presented to provide a context to understand the current reality of their workplaces.

Role issues include:

- perceived underutilization of LPNs and care aides
- overlap and confusion regarding the roles of LPNs, care aides and RNs
- limited understanding of each other's role
- changing and evolving roles and scope of practice
- outdated policies related to role and utilization, perceived as inconsistent with provincial curriculum and scope of practice
- job/role descriptions that varied tremendously across acute and continuing care
- different meaning of terms, such as job/role descriptions, duties, protocols and competencies
- varied levels of competence within each category across acute and continuing care
- different education preparation due to program changes for LPNs
- different education for care aides (publicly funded community colleges offering a standard provincial curriculum and private training programs that may or may not offer the standard curriculum), and
- licensure/non-licensure of LPNs and certification or standardization of the care aide role.

Workplace issues include:

- increased acuity of clients in both acute and continuing care
- 20 years of restructuring and reform
- a very heavy workload
- perception of limited leadership and managerial support
- off-site managers and non-nurse managers
- an acute nursing shortage

- no time or money for education
- major concerns about violence and aggression in the workplace posing a threat to personal safety
- conflict, acrimony, turf protection or rifts among care providers, unions, employers and regulatory bodies
- numerous models of care delivery
- insufficient information systems to support human resources planning
- perception of highly structured, complex, hierarchical systems that resist change
- particular challenges in rural and remote settings, and
- history.

current activities

EDUCATION AND TRAINING

While activities in the previous section often had education components, this section focuses specifically on activities that are primarily about education and training. In general, education was seen by participants as an area that needs attention. Focus groups were particularly strong in advocating education ideas for a number of reasons, including that three of the nine interviews were comprised of educators, and that several interview questions probed specifically for action ideas related to education.

LPN Education

As is outlined at length in the B.C. Context section of this report, entry level practical nurse education is provided at four community colleges in B.C.: Malaspina University College, Okanagan University College, College of the Rockies and Vancouver Community College. A refresher program is offered through the Open College. Access programs for care aides to ladder or bridge into practical nurse programs are emerging at several community colleges. Entry level practical nurse education programs are approved by the College of LPNs of B.C. Continuing education and upgrading of competencies is available though the community colleges and the workplace (for example, in some acute care facilities).

Care Aide Education

Entry level education for care aides is offered through the public education system in Resident Care Aide programs at community colleges and through private training facilities. Community colleges use a standard provincial curriculum and have been working collaboratively with colleges in other provinces in Western Canada to identify common standards.

Participants saw a deficiency in RCA programs not having a provincial approval or accreditation system similar to what exists for LPN programs. Comments focused on

private training programs, with particular reference to a lack of supervised clinical opportunities for students to complete a practicum. Managers noted that they preferred to hire graduates from community colleges using the standard provincial curriculum, as they knew the graduate had received both content and practical learning experience. Participants' ideas for action regarding approval and accreditation for RCA programs are discussed in the next section.

Participants noted that continuing education offerings are very limited for care aides. The Vancouver Community College course on caring for clients with dementia is an example of a course that is highly regarded. They reported health and illness topics needing attention, as well as more general issues, such as cultural awareness. Educators noted that there is a need to assist learners in becoming culturally competent – to develop cultural awareness, knowledge and skills – in order to provide quality care to residents from all cultural backgrounds.

HLAA Education Role

According to the representative of the Healthcare Labour Adjustment Agency, support for education and training is a central part of its mandate. HLAA plays an active role in supporting educational activities using upgrading, access programs and Prior Learning Assessment.

PLA offers learners the opportunity to have previous learning and experience assessed for credit towards certificate or diploma programs. The PLA approach is very useful for care aides who are bridging into the LPN program. Former LPNs who have been working as care aides can also access funds for PLA and courses to convert back into LPN roles.

According to the HLAA representative, the system for accessing HLAA funds is currently being streamlined. This is important, as key informants had many questions about how to access funds, determine eligibility, and understand other features of the system. HLAA participates in the initiative to assist practical nurses who have been working as care aides to upgrade their competencies and again practise as LPNs. According to HLAA, the demand for this upgrading program is increasing daily.

EMPLOYMENT, ROLE AND UTILIZATION

Utilization of LPNs

Participants noted that the LPN role is currently being introduced and reintroduced into acute and continuing care facilities. In some cases this is a return to a previous model of care delivery (for example, team nursing in acute care settings). In other cases, it is a completely new role for a facility or unit (for example, special care units in continuing care). The LPN role is being introduced into long term care facilities due to the increasing acuity of resident care. New models of care delivery were noted, such as the "paired

caring" model at Richmond General Hospital, where an LPN and RN work in partnership to provide care to patients. There was frequent mention of the renewal of team nursing models in practice settings.

Participants were clear that LPNs are not seen as replacing RNs, but as complementary to the RN role, and that there is untapped potential in the LPN role. As one LPN said, "Ask what we can do, not tell us what we can not do... And listen to us." Some participants also noted that LPNs have been working in the health care system very effectively in a range of settings. (Editorial note: Data on LPN staffing levels are provided in the *Surveys* section of this report.)

Utilization of Care Aides

Participants noted that care aides, whose role and title vary considerably, are most commonly utilized in residential continuing care. Care aides reported positive experiences with team nursing (LPNs, care aides and RNs) in acute care. This is of particular interest because manager participants expressed the idea of introducing the care aide role in acute settings. Key informants identified that new models of care delivery are needed when a new role is introduced. Participants were consistently clear that when a new role was introduced, everyone's role changed.

Utilization of Competencies and Skills

As LPN and care aide roles are introduced or reintroduced, participants were consistent in their view that they should be able to use their competencies and skills and work to their full scope of practice. Education programs to upgrade competencies and skills have been provided to assist care providers to work to their full capability. Workplace upgrading programs for LPNs were identified by managers and educators as occurring or developing at a number of facilities, including Vancouver General Hospital, Lions Gate Hospital, St Paul's Hospital and Peace Arch Hospital. (Editorial note: While a comprehensive listing of agencies offering upgrading courses was beyond the scope of the interviews, it is important to note that participants were aware and supportive of these courses.)

Concurrent with education upgrading is an attempt to create a common standard for the care provider role so that expectations are the same across a facility or region. Participants suggested that care aides who received on-the-job training (as opposed to formal education) should have access to upgrading to obtain the skills and knowledge covered in the RCA program. Participants noted that job/role descriptions for LPNs and care aides are being updated and rewritten as part of the process of introducing and reintroducing these roles in various settings.

Health Professions Council Review

The nursing scope of practice review by the Health Professions Council was seen as timely in terms of opening up dialogue around the LPN role. Health Professions Council hearings

and discussion of the revised scope of practice for LPNs have raised interest as the health system looks for ways to deal with the nursing shortage.

Regulatory Body for LPNs

The work of the College of LPNs of B.C. was noted as significant in raising awareness of the potential role of LPNs. It has provided presentations throughout the province on scope and standards of practice and use of the title "LPN." It has been actively involved in the Health Professions Council review of the LPN role. It has also been involved in other significant regulatory activities, including: approval of LPN entry level education programs for the purpose of licensure; professional conduct review; registration and renewal; and monitoring the continuing competence of LPNs. The College of LPNs has created position statements to provide guidance to members, employers and the public on the utilization of LPNs; for example *The Appropriate Utilization of Licensed Practical Nurses* (1999).

The College of LPNs has worked collaboratively with RNABC to develop and offer joint presentations to nurses and employers to increase understanding of the RN and LPN roles and how they can work together to provide quality care to patients and residents. This program was praised consistently by interview participants. In a related activity, work is being done to clarify the meaning and approach to "delegation" and "assigning" tasks within the nursing team. The Health Professions Council review is attending to this issue, as are the nursing regulatory bodies.

Risk Management

Risk management is an important part of health care workplaces. The College of LPN's risk management activities, outlined in its position statement, are similar to the approach described by the B.C. Healthcare Risk Management Society.

1. Review the education/training of the care provider.
2. Become familiar with/review benchmarks and job descriptions.
3. Review what similar facilities are doing.

As roles evolve and change, risk management and liability need to be considered and addressed.

HEU Nursing Team Forums

The Hospital Employees' Union "Nursing Team Forums," which are attended by LPNs and care aides, were frequently cited by care providers and the College of LPNs as an activity that should be supported. These meetings provide an opportunity for members to learn about each other's roles as they work on shared initiatives. Dialogue around important workplace issues and problem solving was generally seen as a luxury in the fast-paced health care system. This opportunity for dialogue around workplace issues problem solving was seen as serving an important need.

ideas for future action

Participants said they were pleased to be able to discuss ideas that might enhance or improve both the employment and education aspects of the LPN and care aide roles. Activities with an educational component were most commonly identified, and most ideas for action in the employment area also included some education component.

EDUCATION AND TRAINING

Increase LPN Education Seats

At the entry (or basic education) level there was a consistent recommendation to increase the number of seats in LPN programs. Finding enough clinical placements for student learning has become challenging; determining ways to encourage facilities to take more students is needed. In some regions (Lower Mainland, Kootenays), a shortage of qualified faculty has created problems. Creating a "pool" of faculty in the Lower Mainland was suggested as one option to address the issue in this region.

LPN Upgrading Courses

Participants identified a number of areas where they see a need for upgrading the competencies of LPNs to the current provincial curriculum. These include:

- pharmacology
- staple/suture removal
- glucometers
- IV maintenance
- assisting with procedures (paracentesis, thoracentesis), and
- tube feeding.

Participants suggested that upon successful completion of courses, learners should be "certified" so that their skills are recognized for the purposes of job mobility and continuing competence/licensure requirements. Upgrading courses are currently being offered in a variety of formats (independent learning materials, lecture, lab, etc.), primarily in the workplace. Some participants pointed out that these courses should be offered and accessible throughout the province.

Advanced or Post-Basic Courses

Participants identified courses that could be offered as advanced or post-basic courses for LPNs (in keeping with their scope of practice):

- perioperative nursing
- obstetrics/maternity
- pediatrics
- post-anaesthetic recovery

- day care surgery
- ICU
- ambulatory day care
- orthopedic technician
- burn care
- cardiology (e.g. ECGs)
- phlebotomy
- emergency
- endoscopy/x-ray clinics and other diagnostic clinics, and
- foot care.

These courses are not readily available. Learners wishing to pursue them frequently need to go out of the province (for example, LPN perioperative nursing in Alberta or Saskatchewan).

Innovative Approaches in Education

Innovative approaches to teaching and learning are needed. Distance education approaches and part-time education need to be enhanced through Internet based learning approaches.

Access programs in selected community colleges enable care aides to enter LPN programs with credit for what they have already learned. More access programs for care aides are being developed at other community colleges. Educators suggested that a collaborative approach among the colleges would be desirable, both in terms of cost savings and ensuring consistency. While the access programs are popular, colleges have limited funding and learners often have limited resources in financing their education.

RCA educators noted that the 20 week Resident Care Attendant training program is too short to accommodate all the content and skills required by employers. As the provincial curriculum is 10 years old, they noted that it needs to be reviewed and updated. Educators suggested that the RCA and Home Support programs be combined. (Note: Home Support employers were not included in the key informant interviews as this was outside of the scope of the research. Thus, the perspective of these employers was not solicited on this topic.)

Participants noted that care aide needs for continuing education are not being adequately addressed and should include the following:

- additional education or upgrading in dementia care
- psychogeriatric training
- skin care
- caring for patients/residents with immobility problems
- lifts/transfers and using equipment
- dealing with violence and understanding clients who are violent, and
- dealing with aggression.

English Proficiency

English as a Second Language (ESL) and English as an Additional Language (EAL) training are a particular challenge in care aide certificate programs. Vancouver Community College's popular RCA program for ESL students has a five year waiting list and needs to be expanded.

Colleges have different systems for assessing students' English proficiency. Vancouver Community College is exploring a new ESL assessment method – called VELA, the Vocational English Language Assessment – that it will share with other colleges.

ESL and EAL support is a significant issue for RCA programs, as career counsellors often recommend it as a career path. It is also popular because it is a short program resulting in what is seen as a well paid entry level position. Educators noted that support for English language proficiency needs to be addressed in both educational and practice settings.

Teaching the Roles of Nursing Team Members

Key informants said entry level education programs should be reviewed to ensure they teach about the roles and competencies of all members of the nursing team. They also advised that care providers should learn to work in a variety of models and in collaborative partnerships. Different models of decision making, such as shared decision making, need to be introduced into entry level programs.

Student Support

In addition to accessible education that is offered in a variety of formats, there is a need to examine and enhance student support. Financial support is a significant problem. Eligibility for student loans requires a stipulated number of course hours that may not accommodate part-time work and study approaches. Funding from Employment Insurance normally applies only to the unemployed. Key informants felt that financial assistance through scholarships should be increased and that additional and creative funding options should be considered. Student support, particularly for part-time and distance studies, is seen as critical to successful completion of programs.

Education Funding

Participants suggested that educational institutions should be more responsive to employer and learner needs. Different models of funding may need to be considered. While base funding was perceived as reasonable, cost recovery programs were described as very expensive. With base funding from government, costs are shared between the educational institution and learners. With limited base funding available, cost recovery approaches are becoming more common. In cost recovery, all costs are covered by tuition fees. Cost recovery funding does not allow for stable and consistent programming that can be depended on by learners and employers. These funding approaches need to be reviewed

and innovative approaches to funding need to be examined. Participants also suggested that different sources of funding should be investigated and accessed.

Approval/Accreditation of Care Aide Programs

Participants noted that there is wide variation between private programs and the public programs offered by the colleges. They are also concerned that the provincial accreditation system focuses on the financial stability of the private agency, rather than assuring educational standards. The interview participants identified that the standard provincial curriculum should be offered by both private and public educational institutions and that both should include supervised clinical practice. This is one way to standardize the care aide role so that employers know what to expect from graduates, and care aides have a certificate that is recognized. The private training programs are not always accepted by employers; graduates waste their own money, as well as government subsidies, if they cannot get hired. Some way of certifying care aides or standardizing the curriculum for public and private training programs was recommended by participants.

Orientation and In-Service

Interview participants noted that orientation and in-service education for LPNs and care aides vary widely throughout the health system. It was suggested that more time and funding need to be allocated to orientation and in-service. There was a specific suggestion from participants in the manager focus group that a “shared basic orientation program in the Lower Mainland (for acute, continuing care and community)” be considered. This shared orientation would facilitate consistent education in workplaces. Specific orientation to the policies, procedures and environment of a particular facility would still be required, but issues that are common to all could be included in the “shared orientation.” Due to heavy workloads and lack of funding, there is limited time available for in-service education. This was seen as a significant loss and needing of attention, particularly around such emerging issues as increasing acuity, aggression and psychogeriatrics.

Provincial Educational Planning

Key informants noted that coordinated and collaborative educational planning is needed. As noted above, there are many needs and innovations in education. Participants indicated that an assessment of strengths and gaps in the nursing education system would be a worthwhile endeavour. It was suggested that there be a long range and broadly based planning forum, including all stakeholders with an interest in the nursing education of LPNs, care aides and RNs. This would facilitate current activities and could draw on groups such as the three separate provincial articulation committees (LPN, care aide, RN), employers, unions, and related groups such as HLAA. This comprehensive planning initiative could be a provincial effort; at a minimum, participants suggested that this planning should occur at the regional level.

HPC Scope of Practice Review

Following the review by the Health Professions Council, the provincial government will legislate the new scope of practice statements and reserved acts for LPNs, RPNs and RNs. Education will be needed on these new standards. This may also be an excellent opportunity to educate patients, residents, families and the public about the role of different members of the nursing team.

EMPLOYMENT, ROLE AND UTILIZATION

The Nursing Shortage

Participants indicated that the nursing shortage, witnessed by hundreds of registered nursing vacancies, has been a significant factor motivating a closer look at the utilization of LPNs. LPNs were viewed as potential nursing team members, complementary to the RN or in a collaborative partnership with the RN in acute care, and working more independently in long term care.

Change and Transition Planning

A planned change process was advocated by manager, educator and regulator focus groups. All participants were clear that change requires time and energy, and that change theory needs to be applied as new roles are introduced and teams are reconstructed.

A transition plan was considered essential; long term planning is also required. Participants suggested that the following factors and issues be included in transition planning.

Use change theory:

- develop a plan that includes key stakeholders and apply change theory
- examine successful models of change, for example Richmond's paired caring model, and
- be open to different models of care delivery and choose what works for patients/residents, staff and the unit/facility.

Attend to roles and responsibilities:

- describe and define team, partnership, and collaboration
- clarify roles and responsibilities in the team and differences between roles
- develop clear job or role descriptions
- develop job routines, and
- introduce LPN practice as independent and in collaborative partnership with RN.

Support and evaluate the change:

- develop guiding principles for the change process and evaluate against them
- bring in resources like the joint presentation offered by the College of LPNs and RNABC, the faculty of LPN and care aide programs.

- support the three groups (LPNs, care aides and RNs) through the transition with education and ongoing support
- support the development of collaborative partnerships
- recreate teams and provide team building sessions, and
- evaluate change and outcomes.

Review decision making:
- develop protocols for decision making about patient/resident care within the nursing team, and
- define who makes what decisions.

Set reasonable time lines:
- don't proceed too quickly, and
- give adequate time and support.

Models of Care Delivery

Participants agreed that models of care delivery (primary care or total patient care, team nursing, etc.) can and should vary depending on the competencies of care providers, the mix of care providers, the needs of patients and residents and the needs of the unit or facility. No one model was seen as the ultimate or best model. As noted above, clarity of roles and decision making within the model of care delivery are the critical issues. Good communication skills and open lines of communication are foundational to effective teamwork. Teamwork also needs rebuilding and ongoing support in the workplace. This may be in the form of "team nursing" or be considered in a more general sense of team work. Regardless, members of the nursing team and health care team need to learn how to effectively work together toward the common goal of providing quality care for patients and residents.

Unions and Regulatory Body Relationships

Participants advised that unions representing LPNs, care aides and RNs should work together. They should also promote understanding of each other's needs in serving their memberships. Care providers suggested that the Hospital Employees' Union should have LPNs on staff to assist with professional practice issues.

Respect for the role of professional regulatory bodies was also seen as essential by care providers. It was very clear from participants that licensure for LPNs was a significant issue. Participants were consistent in their comments that LPNs should be licensed to practise. Licensure is an expectation of professional practice and provides assurance to the public. Continuing competence activities should be supported.

Respect and Recognition

Participants repeatedly discussed how effective collaboration requires respect and recognition. It is essential that each care provider is respected for what they have to offer.

Communication lines must be open. LPNs and care aides need to be part of patient care conferences and rounds.

Participants in the interviews were sensitive about language and terminology. They advised that terms such as care provider or employee should be used to describe care aides, rather than "non-professional" which was perceived to be demeaning and disrespectful.

Provincial Standards

Consistency of expectations for roles and competencies is considered crucial, both across an organization and preferably across the province. Provincial standards, i.e. competencies that are consistent across the province, would be useful. Standardization can come through different processes, such as certification, licensure and standardization of education. The LPN curriculum is standardized by the Ministry of Advanced Education, Training and Technology. Furthermore, the LPN education program must be approved by the College of LPNs, and LPNs have annual licensing requirements. (Note: The annual licensing process applies only to licensed practical nurses; not all practical nurses have an LPN license.)

Participants suggested that standardization processes need to be established for the care aide education program. At present there is a provincial curriculum used by the publicly funded colleges. Private training operations also have access to the provincial curriculum, but those using it do not always implement it in the same way (for example, practicum experience may be limited and/or unsupervised by instructors). There is no system to ensure the same standards for the public system and private schools. Some participants noted that alternative options for standardization should be considered, such as some type of certification (for example, examinations at the end of a course).

Working to Scope of Practice

Participants noted that, in this time of nursing staff shortages, all care providers should be working to their full scope of practice. This can be facilitated in a number of ways. Encouraging and supporting LPNs to upgrade their competencies to the current curriculum level is one step that was discussed. Another is to introduce LPNs into units in acute care and residential continuing care where they have not recently been employed. Participants noted that it is important to ensure that care providers have the opportunity to continue to use their new competencies so that they can maintain their skills.

Management/Leadership of New Nursing Teams

New methods of management and leadership may be needed to support new nursing workgroups or teams. Participants advised that when professional nursing issues are under discussion, a nurse manager/leader needs to be available. It was also noted that orientation to new teams or workgroups is a good beginning step. Long term support is essential for successful team building.

summary of key points

In summary, participants encouraged approaches to enhance quality in the workplace in order to support quality care. They promoted basic, post-basic, continuing education, upgrading, orientation and in-service programs. They advised that nursing team members need to learn more about each other's roles and to respect and recognize each other's strengths. Members within the nursing team and stakeholders should support ongoing dialogue using strong communication skills. All participants were consistent in advising that the focus should be on the common goal of quality care for patients and residents by drawing on the full capabilities of all care providers.

APPENDIX I

key informant list and interview protocol

KEY INFORMANTS

Regulatory bodies Two sets of interviews, one for the LPN College and one for RNABC.

Employers One focus group of about seven to eight employers. HEABC identified the employer representatives.

Care providers Two focus groups, one for LPNs and one for care aides, of seven to 10 participants each. HEU identified the care providers.

Educators Three sets of interviews:

- one with LPN educators
- one with RCA educators, and
- one with in-service educators.

Other Two individual interviews - HLAA (education); and B.C. Health Care Risk Management (liability insurance).

INTERVIEW PROTOCOL

Introductions Round table for focus groups.

Project overview Introductory comments to set context and provide background information on project activities.

Goal of interview To solicit input from key informants about action ideas regarding the following: employment/role/utilization; education/training; and regulation.

Selection of key informants and questions The key informants have been identified as including educators, employers, care providers and regulators. Questions were developed for each of these groups and/or individuals focusing on their area of knowledge/expertise.

SAMPLE QUESTIONS

Educators

(LPN faculty, RCA faculty, in-service instructors and HLAA educator.)

There are two general questions which provided a context for more specific questions.

1. What are current activities in your program/school (or facility) and the region/province related to:
   a. LPN training/education…
   b. Care aide training/education?
   (Probe for: basic/entry level… post basic… continuing education… in-service.)

2. Are there other ideas for action regarding training/education that you would like to share with the project?
   (Probe for: basic/entry level… post basic… continuing education… in-service.)

Manager/Employer and care providers

There are two general questions which provided a context for more specific questions.

1. What are current activities/initiatives that you perceive as significant to the employment/role/utilization of: LPNs… care aides?
   (Probe for decision making re staffing and/or care models; staffing ratios/patterns; skills utilization.)

2. What are other actions that you think should/might be taken in relation to the employment/role/utilization of: LPNs… care aides?

PART 5 role profiles

Three distinct LPN and care aide roles are described in this section. One profile describes the job of an LPN in a fast track emergency unit at a regional acute care facility. Another presents the role of an LPN providing foot care to residents at three continuing care facilities in a northern community. The third applies to a care aide position in a psychogeriatric assessment unit. In addition to the description of duties and responsibilities for each position, the reports include a description of the unit, the patient population, staffing levels and the education and related qualifications for the position.

CONTENTS

259 fast track LPN

261 community foot care LPN

263 total care worker

role profiles

This section profiles three examples of some of the unique and emerging roles for LPNs and care aides in B.C. These role profiles provide detailed information on how the skills of some LPNs and care aides are being used in three distinct settings.

Employers, workers, educators and the College of Licenced Practical Nurses of B.C. were canvassed for ideas regarding such roles.

In considering which roles to highlight, the joint committee that oversaw this project determined that it would be most beneficial to the industry to profile roles that have the broadest potential application. The committee did not select roles that, although unique or interesting, were unlikely to be adapted to other sites due to fact that the role was related to a health care service not widely provided (e.g. burn units).

Consequently, the joint committee identified two LPN roles and one care aide role for profiling:

- an LPN in the fast track emergency unit at Matsqui-Sumas-Abbotsford General Hospital, a regional acute care facility
- an LPN providing foot care to residents at Rotary Manor, Peace River Haven and Pouce Coupe Care Home in the northern community of Dawson Creek, and
- a care aide working as a Total Care Worker in a nursing team at Vancouver General Hospital's psychogeriatric assessment unit.

In addition to the description of duties and responsibilities for each position, the reports include a job classification for the position, a description of the unit, patient population and staffing levels, and the education and related qualifications for the position.

fast track LPN

CLASSIFICATION PC 8

Facility

Matsqui-Sumas-Abbotsford General Hospital (MSA) is an acute and extended care facility in Abbotsford. Following an increase in the volume and acuity of patients seen in emergency, the emergency department manager reorganized the department in 1999, including adding a fast track unit. Up to 50 patients are now treated in the unit's seven beds between 9 a.m. and midnight daily.

Patient Profile

Patients arriving at emergency are assessed by the registered nurse at triage and referred to either the emergency department or the fast track unit. This triage assessment is based on whether a patient's condition will be affected by a wait of up to six hours to see a physician. Once in the fast track unit, patients are generally seen on a first come, first served basis.

Patients of all ages are treated for a variety of non-urgent and semi-urgent conditions, such as earaches, lacerations for suturing, sprains and antibiotic intravenous therapy.

Role

The role of the fast track LPN includes:

- greeting patients and providing comfort
- assisting the RN with assessment, including taking vital signs and patient history
- providing patient care, such as simple dressings and catheterizations
- assisting physicians in such activities as applying casts and suturing
- ordering special supplies for the fast track unit, as well as maintaining supplies in the emergency department
- delivering specimens to labs
- completing requisition forms and taking data from the computer, and
- transporting patients to other treatment areas.

The fast track LPNs enjoy working collaboratively with other professionals – both RNs and MDs. The LPNs have a high degree of job satisfaction as they develop and assert themselves in this new role.

Staffing

Each shift is staffed with one LPN and one RN. LPNs works 7.2 hours, from 9 a.m. to 4:47 p.m. or 4:48 p.m. to 12:30 a.m. There are two full time and two part time LPNs. RNs rotate throughout the emergency department, while the LPNs are assigned to the fast track unit.

Continuing Education

The hospital provides in-service education on topics such as Code White – the hospital's emergency response protocol – and the Waste Hazardous Information Management System. LPNs have attended educational courses, such as CPR, outside of the hospital.

Information Contact

Manager
Emergency Department
MSA Hospital, 2179 McCallum Road, Abbotsford, B.C. V2S 3P1

community foot care LPN

CLASSIFICATION PC 8

Facility

The LPN works in three continuing care facilities in Dawson Creek: Rotary Manor, an intermediate care facility with 45 residents; Peace River Haven, an intermediate care facility with 60 residents; and Pouce Coupe Care Home, an extended care facility with 55 residents.

Services Provided

Foot care is provided to the residents of Rotary Manor, Peace River Haven, and Pouce Coupe Care Home.

Patient Profile

Residents are mainly elderly people requiring assistance with the activities of daily living. Some younger adults with disabilities also live in the three facilities. For most, these care homes are their permanent residence, though some are on short stays as part of a respite program.

Education

The LPN holds a license from the College of LPNs. This position was created in December 1999. The job description was not available at the time of the interview.

In the past, this practical nurse worked as a care aide at one facility where she provided foot care as part her job as a bath aide. In addition to her LPN education she completed a Victorian Order of Nurses program on foot care in Edmonton, Alberta. She had previously attended two workshops on foot care, which were funded by her employer. She also upgraded her skills in pharmacology in 1995 on her own initiative.

Role

The LPN conducts an initial foot assessment on residents in the three facilities. In the future, she will do the foot assessment on admission. Staff members may also refer clients to her.

After the assessment of a resident's feet, the LPN develops a care plan that might include foot soaks, foot massage, care of calluses and corns and skin care after treatments. She contacts the RN/director of care with any problems she finds. The director of care of Rotary Manor oversees the foot care program.

The employer purchased the tools the LPN needs for her practice, and also pays for her mileage to travel to the sites.

It is anticipated that the LPN will expand her practice to include changing dressings and performing catheterizations. The potential exists to offer this foot care service to other health care facilities in the area.

General Comments

This is the first LPN position in these facilities. The position was created with funds from the Ministry of Health as part of the 1999/2000 “$5 million” initiative for increased LPN and care aide staffing. When the provincial government announced funding to upgrade practical nurses working as care aides, the employer convened committees in the facilities, including RNs and representatives of the B.C. Nurses’ Union, the employer, and the Hospital Employees’ Union. The committee met many times to discuss how to use the funds, and all three facilities were invited to submit ideas. The proposal by Rotary Manor for an LPN to provide foot care was selected for funding. The provincial government initiative covered the costs associated with the conversion of the care aide position to an LPN position.

Information Contact

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total care worker

CLASSIFICATION ACTIVITY WORKER 11 PC9 (8-2)

Facility

The STAT Centre (Short Term Assessment and Treatment) at Vancouver General Hospital is a psychogeriatric assessment unit in an acute care facility. This unit has both an in-patient and a day hospital program. As VGH is a teaching hospital, students from many disciplines use this unit as a clinic placement. The STAT Centre is a regional referral centre with an educational and research mandate, in addition to the care provided to patients admitted to the unit.

In the 1980s, the federal Department of Veterans Affairs provided a grant for a day hospital to accommodate war veterans who had both a medical and a behavioural problem. In 1985, in-patient beds were added to the STAT Centre because other units were reluctant to admit such patients. The centre is now open to the general public.

Services at the STAT Centre include:

- 17 beds for in-patients
- a day hospital program with 15 spaces per day
- medical assessments
- multi-disciplinary assessments, and
- short term treatments.

Patient Profile

Patients are at least 65 years old, with an average age of 83. Patients have five to six chronic medical problems, plus cognitive impairment that might include dementia or pseudo-dementia (depression or delirium). People are admitted so that changes in their cognitive status can be assessed. Work over the four to eight week admission is focused on rehabilitation. In recent years, more clients have demonstrated aggressive behaviour.

Referral Process

The primary referral source has been and remains the family practitioner. When the STAT unit opened in 1980, staff in continuing care began to refer their clients here, and STAT continues to receive referrals from workers in this sector. Community geriatric mental health services treat individuals who can live in their homes and respond to care. If community geriatric mental health services cannot support people in their homes, they are referred to the STAT Centre.

Qualifications

The unit's policy of hiring staff with a wide range of education and experience allows it to offer a range of services. Requirements in the job description include grade 12, a

recognized care aide certificate, and training or experience in a therapeutic recreation program or equivalent education and experience. The preference is to hire care aides with rehabilitation skills and adult learning principles. For example, one total care worker has care aide experience and a resident care attendant certificate, a class four driving license, experience as a hairdresser and as an activity worker at an extended care unit. Several total care workers were trained in other countries, but their professional qualifications are not recognized in Canada.

Role

A team of two provides the direct patient care – a registered nurse and a total care worker. The TCW provides much of the personal care and helps with activities of daily living, and is thus able to recognize changes in a patient's mood, affect or functional ability. When a patient is admitted, the TCW marks the personal clothing they will wear on the unit, and orients the patient to the unit, including accompanying them to the dining room to introduce them to other patients. Total care workers help with patient meals as needed and provide morning care, including baths and hair washing as needed. They make beds, do laundry and clean equipment. On weekends, a TCW might run a group activity such as an exercise or craft program.

Two teams attend medical rounds with each physician. Rounds include members of all disciplines: social workers, physiotherapists, occupational therapists, dieticians, nurses and psychiatrists. Both members of the nursing team contribute to a report to the next shift.

Total care workers are part of the interdisciplinary team that assesses and discusses future options for clients. This aspect of a team's work is done mainly through a family conference that takes place when the assessment is complete, about three to four weeks after admission. The purpose of the conference is to discuss assessment, diagnosis and options for the patient when discharged. The family and the patient are usually at this conference, along with members of the assessment team: a physician, social worker, physiotherapist, occupational therapist and dietician, registered nurses and the total care worker.

This total care worker role is an integrated job under the collective agreement and is paid at the higher rate of PC 9 – $18.97 an hour.

Staffing

Weekdays	A unit clerk works from 8 a.m. to 4 p.m.
	Three RNs work with two TCWs from 7 a.m. to 7 p.m.
	A third TCW works from 6 p.m. to 10 p.m.
	Two RNs work from 7 p.m. to 7 a.m.

Weekends There is no unit clerk.
Three RNs work with one TCW from 7 a.m. to 7 p.m.
A second TCW works from 10 a.m. to 10 p.m.
Two RNs work from 7 p.m. to 7 a.m.

Continuing Education

There are several opportunities for staff continuing education. There is a weekly, one-hour in-service education for the entire hospital. When the topic is of interest and useful to their jobs, staff can ask to take their lunch and attend. The STAT Centre has a policy that supports staff to attend an educational day. There is some financial support for programs outside the hospital to cover registration fees and, occasionally, wages. Funding for this continuing education comes from two sources: the hospital budget and donations to the unit.

Recommendations to Facilities Considering This Role

1. Examine the type of service your clients need and hire staff to provide those services.
2. Try to hire people with recreational education.
3. Be flexible on the mix of experience and education.
4. Try to keep a generational mix of staff, as geriatric clients respond best to people two generations younger.
5. Given that people with dementia and memory problems may already misinterpret reality, and that staff cannot look after people if they cannot communicate with them, the hospital has instituted an English language requirement. Approximately half of applicants for total care worker positions do not pass the English test.

General Comment

There is a low staff turnover on this unit.

Information Contact

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PART 4 case studies

LPN and care aide roles and utilization are explored in case studies of six facilities around the province, including three hospitals and three continuing care facilities. Researchers interviewed workers and managers at each site and reviewed documentation such as job descriptions, education plans, and policies on nursing team roles. This information was used to create a profile of LPN and care aide practice at each facility.

CONTENTS

105 Kelowna General Hospital

145 Lions Gate Hospital

199 Malaspina Gardens

219 Saanich Peninsula Hospital

233 Terraceview Lodge

243 Yaletown House Society

case studies

Six case studies are presented in this section to allow an in-depth investigation of LPN and care aide roles and utilization across British Columbia.

The objective of the joint committee that oversaw this project was to examine facilities that had introduced or expanded the role of LPNs or care aides, in order to obtain a profile of the staffing mix and roles as well as an understanding of the process by which this was achieved. Employers, workers, educators and the College of LPNs were canvassed for ideas on facilities that would be beneficial to study, and the sites were selected by the joint committee.

Apart from the principle criteria of having expanded LPN or care aide roles, the sites were selected to be representative on the following grounds:

- geographic distribution
- range of health care services (including acute care and all types of residential continuing care)
- size of the catchment population
- inclusion of both not for profit and proprietary facilities, and
- size of facility.

Six facilities were selected, including three hospitals and three continuing care facilities. Researchers undertook intensive research, including face-to-face interviews with employees and management staff, and detailed reviews of documentation such as job descriptions, education plans, and policies on nursing team roles.

This information was used to create a profile of LPN and care aide practice at each facility. Each report includes:

- a description of the facility – its location, the services provided, number of beds, and other relevant features
- background to the current staffing mix and utilization of LPNs and care aides, including factors that prompted changes in the mix and roles, and the process by which those changes were made
- an overview of nursing team staff and the role of each team member, both in terms of specific patient care responsibilities and the process for working together and planning care delivery
- outcomes related to the expansion of LPN and care aide utilization, in terms of costs, quality of care, and impact on workers
- identification of the challenges faced in the process of changing LPN and care aide roles, as well as the actions taken to meet those challenges, and
- recommendations from interview participants to other facilities considering changes to the role and utilization of LPNs and care aides.

CASE STUDY

Kelowna General Hospital KELOWNA, BC

TABLE OF CONTENTS

1. Facility Description 105
2. Background 106
3. Roles and Responsibilities of Nursing Staff 106
4. The Change Process 109
5. Outcomes 111
6. Challenges and Solutions 112
7. Suggestions for Other Facilities 114

Appendices 116

1. FACILITY DESCRIPTION

In the Okanagan Similkameen Health Region, acute care services are offered at Kelowna General Hospital. KGH is a regional referral centre with 337 acute care beds. As KGH serves this region as well as other parts of the interior and eastern B.C., it acts much the same as a tertiary hospital. KGH offers long term care through an extended care unit (380 beds) and other health services on site (for example, a cancer clinic). As well as in-patient care, KGH offers a range of outpatient services. Acute care services include five medical units, five surgical units, five specialized units and two transitional (LTC) units.

The surgical units include orthopaedics, urology, ENT (ear, nose and throat), plastic surgery, neurology, vascular, thoracic, gynaecology and general surgery. Medical units include cardiology, renal, respiratory, family practice, neurology, palliative care, gastrointestinal and general medicine as well as geriatric assessment and geriatric medicine. Specialized units include intensive care, psychiatry, obstetrics, nursery, pediatrics, emergency and rehabilitation. Two additional units have been designated as transitional (LTC). In addition to patient care services, KGH has a teaching role. The hospital provides clinical learning experiences to a number of health care workers, including LPNs and care aides.

The focus of this case study is on the role and utilization of LPNs and care aides in acute care.

2. BACKGROUND

For most of the 1990s, KGH performed workload measurements to assess workload and determine appropriate staffing. In early 1998 these workload measurements indicated that the workload was more than the existing staff could manage. Management began to consider what mix of RN to LPN was needed to meet the workload. The workload management coordinator, an RN who was responsible for data collection and compilation related to nursing workload at KGH, researched the nursing skills and competencies used on a surgical and a medical floor. This workload measurement data and two other factors (financial pressures and a labour/management issue related to the question of whether RNs should be performing "non-nursing duties") led management to carry out a skill mix study on two units.

Also in 1998, in an independent initiative, LPNs approached the director of patient care services to advise her that they believed LPNs were not being used to their full potential. They identified a list of skills and competencies they felt LPNs should be able to perform. The LPN Skill Mix Task Group was established in 1998 in response to this request.

3. ROLES AND RESPONSIBILITIES OF NURSING STAFF

KGH employs licensed practical nurses, registered nurses and care aides on its nursing staff. Care aides have been utilized extensively in extended care; in late 1999 a care aide position was introduced on a surgical floor.

LPNs work on approximately half of the acute care units, including the medical, surgical, orthopaedics, rehabilitation, obstetrics and respiratory units. The nursing care delivery model is team nursing wherein the nursing staff work together as a team to provide nursing care. On the emergency department and on the cardiac, intensive care, pediatrics and renal units, the nursing care delivery model is primary nursing, wherein the units are staffed only with RNs. These nurses are responsible for all nursing care for their assigned patients.

The team model of nursing care delivery is based upon principles that have been identified by KGH Nursing Services. Competencies and Assignment of Care Interventions: Decision Guide for Determining the Appropriate Care Provider, a copy of which is provided in the appendices, was developed to provide guidance to nurses (RNs, RPNs, LPNs) to determine the appropriate care provider given the care requirements. Guiding principles have been identified to assist nursing staff in working together. For example:

> *KGH Nursing Services believes a collaborative, complementary partnership between nursing professionals is key to providing successful patient outcomes that are safe and effective. In this context, KGH Nursing Services believes RNs, RPNs and LPNs fulfil a valuable role as a member of the nursing care delivery team and a participant in providing comprehensive and appropriate nursing care.*

This collaborative partnership acknowledges the interdependent roles of RNs/RPNs and LPNs and that certain knowledge and skills may be shared by RNs, RPNs and LPNs while others may be unique to each nursing professional's scope of practice or competency.

Differentiation in the RN/RPN role and the LPN role is related to the scope of practice/competencies, elements of judgement and attitude. The LPN will seek out the RN as the Care Leader for decision making and problem solving. KGH Nursing Services is committed to promoting an atmosphere of intercollegial trust and respect to promote the effectiveness of this interdependent nursing care team.

RN: LPN Staffing Patterns and Ratios

Staffing patterns and ratios vary between the acute care units. Three examples presented below represent a surgical unit, a medical unit and a specialized unit. Shifts are most commonly 12 hours; however, there are also four and eight hour shifts. The shifts identified below are 12 hour shifts unless otherwise noted.

Surgical unit – 4West (Orthopaedics, urology, plastic surgery and ENT – 38 beds)

- **DAYS** six RNs (includes a head nurse who works eight hours), and four LPNs (includes a four hour shift in the afternoon).
- **NIGHTS** three RNs (one in charge and one for eight hours), and two LPNs.

Medical Unit – 4A (Respiratory – 30 beds)

- **DAYS** four RNs (includes a head nurse who works eight hours), and three LPNs (two work eight hours from 7:00 a.m. to 3:00 p.m.).
- **NIGHTS** three RNs, and three LPNs (two LPNs work 3 p.m.– 11 p.m).

Rehabilitation Unit (38 beds)

- **DAYS** four RNs (includes a head nurse who works eight hours) and four LPNs (includes one four hour shift)
- **NIGHTS** two RNs, and three LPNs (includes one four hour shift).

On Friday afternoon, 12 patients are discharged for the weekend leaving 26 beds; the staffing is adjusted (days: two RNs, two LPNs; nights: two RNs, one LPN).

In these examples, the staffing ratios range from 1:1 (RN:LPN) to 2:1. They vary based upon the type of patient care requirements (e.g. surgery or medicine) and whether the shift is during the day, when more treatments/interventions are required. These staffing ratios were established in 1999. The impetus and process to change the staffing ratios is discussed in more detail later in this case study.

The LPN Role in Acute Care

The practice of LPNs is outlined in job descriptions and other documents, such as the Standards of Practice and Competencies of the College of Licensed Practical Nurses of B.C.

The LPN job description at KGH includes the following job summary:

Under the direction of a registered nurse, positions of this level perform nursing procedures such as catheterizations and simple sterile dressings in addition to patient care duties relating to feeding, personal hygiene and transporting patients.

Job qualifications include graduation from a recognized program of practical nurses and/or a valid B.C. practical nurse license. The employer encourages all LPNs to maintain their license with the College of LPNs of B.C.

LPNs at KGH interviewed for this case study highlighted the following duties in their practice.

- performing head to toe visual assessment (LPNs from the respiratory unit noted that their assessment includes listening to chest and bowel sounds)
- providing oral (but not deep) suctioning, doing intermittent catheterizations, taking capillary blood for glucose monitoring, providing tube feeds, discontinuing intravenous, changing dressings, removing staples, taking pulse oximetry, and assisting in the provision of humidified air via a nebulizer
- receiving reports on admission of new patients to the floor
- patient teaching (for example, on the rehabilitation floor this includes teaching patients how to dress and wash themselves), and
- communicating with patients and health team members (for example, LPNs participate in weekly multi-disciplinary care conferences that may include a speech therapist, occupational therapist, physiotherapist, doctors, psychologists, dieticians and social workers).

Nursing Practice Discussions

In the last two years, LPNs were actively involved in two initiatives that examined the role of the LPN in the nursing team at KGH. LPNs who were interviewed for this case study noted that there are currently no ongoing committees where they participate in nursing practice discussions to consider care issues, role issues and the like. Nurses have recommended that a group be formed to discuss ongoing nursing practice issues.

The New Care Aide Role in Acute Care

A nursing service aide, a six-hour day shift care aide position, was introduced late in 1999 on a surgical unit. According to the job description and based upon interviews, the nursing service aide, under the direction of a registered nurse or licensed practical nurse, performs service aide duties according to unit specific standards.

Job duties include working with the nursing team giving basic physical care to patients…and carrying out patient requests as appropriate.

Taking temperatures, pulses and respiratory rates, collecting urine, stool and sputum samples, changing non-sterile dressings and reporting observations to the nursing team.

Assisting patients with meals.

Cleaning items and areas such as utility rooms as assigned.

Performing other related duties as assigned (e.g. stocking the utility room, serving ice water to patients, making unoccupied beds, emptying the laundry and replacing supplies in patient rooms).

4. THE CHANGE PROCESS

The two initiatives relating to enhancing LPN utilization are described in this section.

Workload Analysis Study

The purpose of the Analysis of Skill Mix by Intervention study was to determine the best mix of nursing staff to meet patient care requirements. KGH drew on its workload management system to analyze patient care requirements on two units (4A and 4W). For example, the original skill mix on 4A was 85% RN and 15% LPN. Direct care, non-patient care activities and consultation (e.g. communication with the team) performed by RNs and LPNs were reviewed for five shifts. The conclusion of the study was that, for an average workload, a skill mix of 64% RN and 36% LPN would be reasonable and appropriate for 4A. A similar analysis led to a similar conclusion for 4W. Each unit was assessed individually to identify a suitable staffing mix.

LPN Skill Mix Task Group

In 1998, LPNs presented management with a list of competencies and skills they felt should be added to their duties. The list included:

- receiving reports from the intensive care and post-anesthetic units and the emergency department
- maintaining tube feeds
- changing chest tubes
- changing IVs to saline locks
- clearing occlusions from medical pumps
- removing hemovacs and sutures, and
- removing midline, central and picc line catheters.

Management acknowledged the request and set up an LPN Skill Mix Task Group with terms of reference that included:

- a purpose (to examine each of the requested LPN skills/competencies and make recommendations for change at KGH)

- objectives (review hospital and provincial competencies, review the literature, obtain input from LPNs, assess the skill mix on 4A and 4W, make recommendations to the director of patient services and the Nursing Education Committee
- specified membership (three LPNs, two RNs, two educators, one manager), and
- directives for quorum and meetings.

The group met twice monthly for three months. The workload management coordinator, who was the manager representative on the committee, chaired the task group. The employer paid for staff to attend these meetings, as discussion and the collaboration of all members of the nursing team was considered important.

The LPN Skill Mix Task Group conducted a survey of 125 LPNs in KGH, asking them to identify whether each of the proposed skills were: "essential," "important," "desirable," or "not required." The survey also asked LPNs whether they felt they had the knowledge, skill and time to perform these skills competently. In addition to the survey, the task group worked to promote understanding of the role and competencies of the LPN by holding an open forum, encouraging discussion and circulating relevant materials, such as the College of LPNs of B.C. literature on standards and competencies. The open forum included a panel with representatives of the College of LPNs, the Registered Nurses' Association, LPN and RN representatives, managers and educators from the hospital, and instructors from the practical nurse program at Okanagan University College. Presentations and a question and answer session explored issues such as accountability for one's own professional practice, shared and unique competencies within the nursing team, and the context of practice of team members.

The task group developed and implemented a Competencies and Assignment of Care Interventions Decision Guide for Determining the Appropriate Care Provider, a copy of which is provided in the appendices. Each proposed skill was examined using this decision guide. Step 1 included an assessment of skills in terms of overall care requirements (complexity of patients' care needs, predictability of patients' conditions, cognitive and technical requirements, and the level and range of negative patient outcomes). Step 2 assessed circumstances or environmental factors (level of autonomy required, opportunity to maintain competence, and the type and level of available resources for nurses to consult for assistance). Each factor was assessed as low, medium or high.

The outcome of this two step review of each skill was a judgement by the task group as to whether the appropriate care provider was an RN, RPN and/or LPN. Cost implications were then considered and noted for education, equipment and labour costs. Each skill was designated as department-wide or unit-specific (i.e. limited to one unit only). Education support was identified (including time, approach and format). At each phase of the review, the decision guide included a "comments" section that was used to record key points discussed by the task group. Based on their analysis, the task group put

forward recommendations to the director of patient services and the Nursing Education Committee. (A sample decision guide is appended).

Based upon the review of the skills assessed in this process, four new skills were added to the standards of practice for LPNs.

- resetting occlusion alarms on IV pumps
- maintaining well established tube feeds
- receiving reports from the intensive care and post-anesthetic units and the emergency department, and
- removing hemovacs, drains and sutures.

When the recommendation to add the new skills was accepted, in-service education was developed and provided for all LPNs on staff. Materials that review the steps of performing each competency are available in print and on KGH's computer system.

5. OUTCOMES

An evaluation form was developed to assess the impact of the addition of new LPN duties. The evaluation form was distributed to the LPNs and RNs on the units where LPNs had completed in-service education on the four new competencies. The evaluation form included questions about the impact of the change on patients or patient outcomes, the impact on workload, and nurses' satisfaction with the change. General demographic information was also requested from the LPN and RN respondents. At the time of this research, the evaluation forms had been collected, but not analyzed. Although at this point there is no documented evaluation of the effect of adding the four additional competencies, there are plans to prepare, and hopefully publish, a report.

The change in staffing ratios of RNs and LPNs has not been documented at this time, as the workload management system is no longer being implemented due to heavy patient care demands. Furthermore, the workload coordinator position was deleted. The person in this role had been responsible for the workload analysis study and was the chair of the LPN Skill Mix Task Group.

At the time of this research, KGH representatives were not able to provide evaluation data regarding the impact of the new nursing service aide position in acute care.

System Outcomes (Costs/Savings)

KGH estimated the costs of adding each new LPN skill. In general, cost estimates were based on a 30 to 60 minute in-service education session for 126 LPNs. Costs were estimated by KGH as follows:

a) Removing hemovacs, drains and sutures – 30 minute in-service
30 minutes x 126 LPNs @ $19.02/hour = $1,198.26

b) Receiving report – no calculated costs.

Costs for developing criteria for improving the consistency of reports were not factored in, nor were costs associated with increasing RNs' awareness that LPNs could take on this competency area. It was also noted that LPNs would need to learn when they should not assume responsibility for receiving reports (for example, patients that are still very acutely ill/unstable).

c) Maintaining tube feeding – 60 minute in-service
1 hour x 126 LPNs x $19.02 = $2,400

d) Resetting occlusion alarms on IVs – 30 minutes
30 minutes x 126 LPNs x $19.02 = $1,200

Total estimated in-service costs identified by KGH were $4,800. Costs for educators to develop print materials and set up for computer access were not calculated, as this is considered to be part of an educator's role. Costs for LPNs to complete any preparatory reading before the in-service sessions were also not calculated.

Task group costs were not compiled by KGH. However, a rough estimate for the purposes of this case study was $1,102.00 for the task group's planned meeting time. This estimate is based on six meetings of one hour each for eight individuals with an average hourly wage of $22.96 (i.e. the average of the LPN hourly rate at 12 months of $19.41 and the RN hourly rate at five months of $26.50). Preparation for the meetings and follow-up activities (preparing and circulating the survey; preparing reference materials; meetings and communication with staff; printing materials; preparing for the open forum) are not included in this estimate.

The salary/benefits savings of changing the staff mix from the previous ratios (e.g. 85% RN to 15% LPN) to current ratios (e.g. 64% RN to 36% LPN) were not available from KGH at the time of this research. Costs/benefit information on the nursing service aide position was also not available.

Nurse and Patient Outcomes

An evaluation form to assess nurse job satisfaction, workload impact and patient outcomes was developed and circulated, but data has not yet been analyzed. However, one significant outcome is the Decision Guide for Determining the Appropriate Care Provider. The opportunity to discuss and share issues of shared and unique competencies within the nursing team and the principles identified to guide practice (collaborative, complementary partnership; interdependent roles) are a lasting contribution.

6. CHALLENGES AND SOLUTIONS

Challenges identified by KGH as it added skills to LPNs' practice and changed staffing ratios fall into the two general categories of education and resistance to change.

Education

KGH faced the immediate task of preparing LPNs to perform new skills. As noted above,

education strategies were implemented. Support was provided on the units as LPNs practised the new skills. This support came from other LPNs, head nurses, patient educators and clinical resource nurses.

Education about roles, responsibilities and accountability was needed to improve understanding and recognition of each individual's contribution to the nursing team. For example, in regard to accountability, the RNs interviewed for this case study felt they were accountable for all patient care provided on their unit; they were not aware that LPNs are directly accountable for their own practice. If another staff member, physician or manager identified a problem regarding the care provided by the LPN, the RNs thought they would be held accountable. LPNs know they are accountable for their own practice. The confusion about accountability results in frustration. As one LPN said:

> *Even some seasoned nurses [RNs] will tell you it does not matter what you do. You may be very good, excellent, but I am responsible for you.*

In another example, LPNs spoke about their roles in specialized units staffed by RNs. When sufficient RN staff is unavailable, LPNs may be assigned to work in units that normally only use RNs. In this situation, LPNs perceived a lack of understanding and recognition of their competencies, as exemplified in the following comment.

> *There are units within the hospital that do not have LPNs. I have worked on some of them as a casual. It is upsetting because you figure, we are not good enough to be there all the time, but when they are in a crunch we are good enough to come in to pick up the load.*

The challenge of addressing these issues and preparing nursing teams for change was met in several ways. The LPN Skill Mix Task Group developed the decision guide, organized the open forum, shared information and resource materials, and created opportunities for dialogue. One of the recommendations from the task group was to re-establish a professional practice committee. This strategy has not been implemented, and neither the LPNs nor the RNs interviewed could identify a forum where they have an opportunity to discuss practice issues such as role overlap. The opportunity for ongoing dialogue is further impeded by heavy workloads and shift work that prevents the nursing team from meeting collectively. One person described this concern as follows.

> *We need more of that [opportunities for dialogue about roles, competencies and overlap in roles]. But it is the nature of the job, too. You are so busy, you're so stressed, you're so overworked that people come in on their days off quite often. Even staff meetings, the occasional one you do have, maybe a third of the people come in. It is not a whole cohesive group.*

A related challenge was the need to educate decision makers about LPN practice. The College of LPNs was invited to describe the role and professional responsibilities of the LPN to the Regional Health Board. The Association of LPNs met with the KGH

Quality Improvement Committee to share information about the practice of LPNs and their role in providing quality care to patients.

Resistance to Change

Some RNs expressed opposition to expanding the practice of LPNs. They expressed a concern that changes in LPN role and utilization might have a negative impact on patient care. The primary strategy to address this challenge was to use collaborative approaches to initiate and manage change. One example was that the LPN Skills Mix Task Group involved both LPNs and RNs. The minutes and printed resources of the task group were shared in a central location. Nursing team members were encouraged to raise concerns at meetings and at the open forum. Another strategy, still in progress, is to evaluate the impact of the changes.

Fear of job loss contributed to resistance to the changes. To reduce this fear, staff were informed that there would be no jobs or positions lost. Staff interviewed for this case study confirmed that this commitment had been met.

Some LPNs resisted expanding their practice. This resistance was based on several factors. Some LPNs said they were concerned that they would spend money to get additional education that would not be used. KGH approved the changes in practice before education was provided, and it paid for the entire cost of the education involved.

There was concern about adding new responsibilities. Resisting additional responsibilities is not an uncommon response, perhaps more so as many LPNs at KGH are approaching retirement. One LPN described this resistance as follows.

> *A lot of LPNs in the hospital are getting close to retirement, and they're not in favour of getting more skills. That caused quite a few conflicts. We had quite a few remarks like "I don't want to take on that added responsibility."*

In addition to the general strategies listed above, specific resistance was addressed in a number of ways. For example, some staff did not understand why LPNs would want to take on extra responsibilities. LPNs answered these questions by discussing the changes to patients care requirements. Questions arose from representatives of the local union in terms of why LPNs would want to expand their responsibilities without a change in wages. LPNs explained that this was a professional issue for them related to working to their full scope of practice.

7. SUGGESTIONS FOR OTHER FACILITIES

Suggestions for other facilities considering changes to the role and utilization of LPNs were offered by LPNs, RNs and the manager. These suggestions are a combination of their own experiences and what they might do differently in future.

- Set up a coordinating committee with broad representation, including both nursing unions.
- Use a collaborative team process with leadership from LPNs and management.

- Use a consultant to research the skills/interventions being performed in the facility, the skill mix needed to do those interventions and the cost of that skill mix.
- Gather information from all disciplines, their unions and professional bodies. Share information about LPN practice with all disciplines.
- Provide staff with information in different forms, such as printed information, computer access, open forums and meetings. Provide information in a timely fashion, reviewing it frequently to provide an opportunity for all staff to hear about and understand proposed changes.
- Evaluate all changes by documenting the impact on patients, staff and the health care system (costs/benefits). Share this information with all staff.

This case study is one in a series prepared for the Licensed Practical Nurses and Care Aides in B.C. project. The joint committee overseeing project activities included representatives from the Health Employers Association of British Columbia and the Association of Unions represented by the Hospital Employees' Union and the B.C. Government and Service Employees Union. The LPNs and care aides in this case study are represented by HEU.

APPENDICES

Job Description of Nursing Service Aide **pp. 116 - 177**

*Decision Guide for Determining the Appropriate Care Provide*r and sample worksheet **pp. 118 - 124**

Assessment Guide for Skills and Competencies Required of the LPN **pp. 125 - 144**

Making Recommendations (see previous page)

CASE STUDY

Lions Gate Hospital

NORTH VANCOUVER, BC

TABLE OF CONTENTS

1. Facility Description 145
2. Background 145
3. Roles and Responsibilities of Nursing Staff 146
4. The Change Process 149
5. Outcomes 151
6. Challenges and Solutions 152
7. Suggestions for Other Facilities 154

Appendix 155

1. FACILITY DESCRIPTION

Lions Gate Hospital is an acute care and continuing care facility in the City of North Vancouver. With approximately 320 beds, LGH serves the North Shore community and outlying communities (north to Whistler and the Sunshine Coast). This case study focuses on the role of licensed practical nurses in acute care. Acute care services include: medical-surgical units including palliative care, neurosurgery, orthopedics, cardiology and gynaecology; emergency and ambulatory departments; maternity and pediatric units; and the intensive care unit.

The hospital employs both LPNs and registered nurses on the nursing team in acute care. All the usual health care disciplines and support services of a regional hospital are involved in patient care on the units.

In addition to patient services, LGH serves as a teaching hospital, offering clinical learning experiences to many health care workers, including nursing students in both LPN and RN education programs.

2. BACKGROUND

A brief history of the role of LPNs at LGH provides a context for how their utilization and role has changed. In the 1980s, the ratio of RNs to LPNs varied among the units, between 60:40 and 50:50. In the mid-1980s, like many other acute care hospitals at that time, LGH changed its staff mix to increase the number of RNs. LPN positions were converted to RN positions. There was a sufficient pool of RNs available at that time to fill those positions.

Some LPNs whose positions were eliminated took positions as care aides, unit clerks, housekeeping staff or other staff.

In the late 1980s, LPNs at Lions Gate Hospital began to organize, as they wanted to establish more consistency in their role and duties throughout the hospital. LPNs worked closely with a nurse administrator who was supportive of their role in health care. The LPNs convinced the hospital to conduct an LPN skills assessment, develop a new, expanded LPN skills list and provide in-house training for LPNs. In effect, LPNs were enhancing their skills to work towards their full scope of practice. This experience was significant, as it was the beginning of an ongoing process that was successful in enhancing the practice of LPNs at LGH. The establishment of a sound working relationship between the administration and the LPNs supported activities in the following years.

In 1993, LPNs once again requested a review of their practice at LGH. In December 1994, the Ad Hoc LPN Education Group was formed to identify the short and long term educational needs of LPNs. In May, 1995 the College of LPNs of B.C. was invited to make a presentation on the scope of practice for LPNs. One outcome of the review was a change to LPNs' role and duties. To support the change, the hospital developed and presented a four-hour workshop for 48 LPNs. More detailed information on the educational upgrading is outlined later in this case study.

The next significant change came in 1996, when the hospital faced increased financial pressures. As a cost saving measure, the administration decided not to reduce the staff/patient ratio, but instead to increase the ratio of LPNs to RNs. RN positions were converted to LPN positions. At this time, a committee was struck to develop a new job description and training program for LPNs. LGH documented its process to enhance the role of LPNs (see appendix).

3. ROLES AND RESPONSIBILITIES OF NURSING STAFF

A number of nursing care delivery models, including team nursing, are used on different units at LGH. Within the team model, nursing staff provide total patient care to patients assigned to them on their shift. For example, team nursing was being used on the neurosurgery unit at LGH. In team nursing, RNs and LPNs work together to provide care to a group of patients. On some units in the hospital, a particular duty may be assigned to an individual nurse, for example, one LPN assigned to take blood pressure readings for all patients on the unit.

It was reported in the case study interviews that the approach to patient care delivery was in a period of transition. Participants said there is support for each unit to identify their own philosophy of nursing care delivery. Methods of enhancing team work on each unit are being encouraged.

Nursing Staffing

LPNs work on all seven medical-surgical units, including general medical and surgical units, neurosurgery, gynaecology and orthopaedics. In the current staffing pattern at LGH, LPNs are not utilized in the emergency and ambulatory departments, or the discharge planning, maternity, operating room, day surgery or intensive care units.

The RN to LPN ratio and staffing patterns vary by unit, and by shift or day of the week. The ratio of RNs to LPNs varies from 1:1 to 3:1. For example, on day shift, on a surgical unit with 12 patients, the nursing team includes two RNs and one LPN. The LPN is assigned to care for up to six patients, depending on patient acuity.

In another example, on one floor with two units, on a typical day shift, one RN and one LPN will care for eight patients. On the evening shift, one RN and one LPN will care for all 24 patients on each unit. On the night shift, two RNs and one LPN will care for all 48 patients on the floor.

LPNs work 12 hour shifts. One LPN described her work at the hospital and on the nursing team in this way.

> *I have been working at this hospital for 10 years. It is a 12 hour day. We usually work with one RN, and we get an assignment of eight to 10 patients. From my point of view, it works very well. It's very good teamwork and a very good partnership. The RNs do mostly the medications, computer work and paper work, but they're available most of the time to work with us as a partner.*

Roles and Duties of LPNs

The following summaries of the role and duties of LPNs are based on the job description (1996) and interviews completed at LGH in 2000.

- **Assessment** Assesses and monitors the physiological, psychological, sociocultural and spiritual needs of patients and significant others in coordination with the RN.
- **Care Planning** Provides input in the development and maintenance of patient care plans.
- **Interventions** In coordination with the RN, provides nursing care according to the patient's care plan and hospital policies and procedures.
- **Psychomotor Skills** Performs technical procedures such as:
  - patient assessment – e.g. taking temperature, pulse, respirations, blood pressure, height and weight
  - assists patients to meet hygiene needs – e.g. bathing, toileting, skin and foot care
  - maintains and discontinues intravenous therapy – e.g. discontinue saline locks
  - performs diagnostic tests/collects specimens – e.g. diabetic urine testing and capillary blood glucose monitoring
  - administers oxygen
  - performs oral-pharyngeal suctioning
  - maintains and removes nasogastric tubes

  - performs ostomy care
  - inserts and cares for urinary catheters
  - provides wound care – e.g. dressing change, emptying drains
  - removes sutures and staples,
  - administers topical, rectal and vaginal medications as per orders, and
  - performs special skills required on specified units (e.g. care of traction equipment on the orthopedic unit, position and care of unconscious patients on neurosurgery).
- **Communication** In coordination with the RN, keeps patients and families informed about treatments and related information. Communicates the patient's condition verbally and in writing.
- **Education** In coordination with the RN, assists with orientation and continuing education. Maintains own knowledge and skills.
- **Professional Responsibilities** Participates in continuing quality improvement, education and committees, e.g. weekly team conferences for patient care planning.

Additional information on the role and duties of LPNs at LGH is outlined in the LGH Quality Assurance Manual (1997). The manual uses the six standards of practice of the College of LPNs of B.C. as a framework. For each standard statement, specific competencies and criteria are listed. An LPN evaluation form, based on the job description and the standards/competencies document, provides another source of information on the role and expectations of LPNs.

LGH has also developed a Psychomotor Skills Inventory for RNs and LPNs (November 1996 Edition). The purpose of this document is to identify skills required to practice in medical-surgical units, provide an opportunity for self-assessment, and assist with orientation. Skills that can be performed by LPNs are identified. The decision as to whether a skill is performed by an LPN or RN is based upon the acuity and complexity of a patient's needs, the context or particular situation, and the LPN and RN standards of practice.

LPN practice includes being involved in planning and decisions about nursing care. Each unit has a council where LPNs and RNs discuss nursing care. Staff volunteer to be on the unit council for one to two years. There are an average of eight members on a unit council, each representing four other nurses. The unit council meets once a month, and all nurses are welcome to attend. The agenda is posted before the meeting, and anyone can add items to the agenda. An RN serves as the chair, and minutes are recorded and made available to nurses who cannot attend.

In addition to the unit councils, there is a hospital-wide nursing council made up of the chairs of the unit councils. As registered nurses chair all of the unit councils, LPNs are not able to participate on the hospital-wide nursing council at this time.

All LPNs at LGH maintain their registration with the College of Licensed Practical

Nurses of B.C., although this is not required by the collective agreement. Everyone interviewed reported that maintaining a license is an important component of an LPN's professional role. LPNs spoke about using GROWTH, the College of LPNs' continuing competence program, to document their professional development, including updates of their psychomotor skills.

4. THE CHANGE PROCESS

To enhance the role of LPNs to the current competency level, LGH used a planned change process that included committees, surveys, educational workshops, the preparation of educational packages and other printed materials, and an evaluation. Each of these components of the change process are presented below.

Committees

Two committees contributed to the expansion of LPN practice at LGH. In 1994, a committee of LPNs set out to address their education needs. The Ad Hoc LPN Education Group identified the short and long term educational needs/requirements for LPNs. As a first step, the LPNs were involved in developing and administering a skills survey to LPNs. In July 1995, a second survey was distributed to head nurses and instructors who worked with LPNs. The purpose of this second survey was to assess head nurses' and instructors' perceptions of the LPNs' learning needs. The results of the two surveys were compiled and analyzed. A third survey was developed and distributed to eight acute care hospitals requesting information on the role, competencies/skills and education programs for LPNs at those facilities. Data from the surveys led the committee to recommend a review and revision of the LPN job description, the addition of new duties, and the provision of education.

Subsequently, in 1995, a second committee was formed to review the role of LPNs at LGH. Membership in the LPN Job Description Committee included LPNs, RNs, management and local representatives of the B.C. Nurses' Union and the Hospital Employees' Union. The committee was chaired by an RN who was respected by the staff. The committee's role included recommending revisions to the LPN job description, identifying educational needs and facilitating discussion and communication with staff. The employer paid for time spent on this committee because it was considered essential to have an inclusive and well-informed process. Many meetings were organized by the committee, both within individual units and between the LPNs and RNs. The coordination activities of the committee were recognized by participants as a significant factor in the success of the change process.

The outcome of the LPN Job Description Committee's work was a recommendation to revise the LPN job description and approve additional skills, based upon the educational preparation and scope of practice of LPNs in B.C. The job description and skills lists were approved by upper management and the union. These documents have provided a

framework for ongoing education and development of nursing practice at the hospital. (See Appendix for details)

Education

A variety of educational sessions and material were developed as part of the process to enhance the practice of LPNs. In 1995, 48 LPNs attended a four hour workshop that reviewed the findings of the LPN skills surveys described above, provided a presentation by the College of LPNs of B.C. on standards of practice, and delivered sessions on effective communication skills and universal precautions.

An LPN Skills Review Handbook, developed as a resource for LPNs, described procedures for which LPNs had identified they were in need of review. Examples of skills covered in the handbook include urinary catheterization, skin care and ostomy care. Each skill is presented in a concise, summarized format, and includes the purpose of the procedure, key elements, steps in the procedure, special considerations and available resources.

Comprehensive, self-directed learning packages were also developed to support LPNs in learning the added skills. Topics covered include intravenous therapy, enteral feeding therapy, computer skills, capillary blood glucose monitoring, and removal of staples, sutures and drains. The learning packages included objectives, content about the skill and how to perform it, associated policies, information on documentation, performance criteria, a self-test, resources and an evaluation form. After LPNs reviewed the print package, they participated in an educational session and practised the skill with an RN or nurse clinician.

There were workshops for LPNs and RNs to discuss the change in the LPN role and role overlap. They discussed ways to determine the most appropriate assignment of skills in the nursing team.

There were also workshops specifically designed for RNs to become informed about the changes in LPN practice. A three hour workshop was offered over five days. These sessions were also an opportunity for RNs to raise their concerns and discuss issues such as role overlap between their practice and LPNs' practice.

A process was implemented to plan, implement and evaluate educational components. Institutional support for this education included paid time to attend workshops and develop written material. A tool was developed for LPNs and head nurses to document when skills were learned and practised.

Written Material and Resources

LGH has developed extensive written resources to support the change in LPN practice. For example, there is a psychomotor skills inventory for RNs and LPNs. There are self-directed learning packages and the handbook noted above. Job descriptions for both RNs and LPNs were revised.

5. OUTCOMES

Outcomes of the change are drawn from the interviews and from an evaluation that was completed one year after the additional skills were added to the LPN role. This evaluation process included a survey and a subsequent focus group to review the survey results, identify benefits and challenges, and brainstorm possible solutions.

All nurses were invited to complete an anonymous questionnaire seeking feedback about the change. Each unit selected an LPN and an RN to present the aggregate findings of the survey from their unit (i.e. the compiled benefits and challenges as a result of LPNs practising the additional psychomotor skills). The benefits identified by the LPNs and RNs were:

- enhanced teamwork
- improved job descriptions
- efficient use of time, and
- improved patient outcomes, including
  - increased continuity of care
  - increased communication with family, and
  - increased patient safety.

Challenges identified were:

- having RNs "let go" of skills and become more aware of LPN skills
- further enhancing LPN skills (e.g. IV pumps, patient teaching)
- having team members value each other's role on the team, and
- expanding communications on LPN and RN roles.

Initial brainstorming developed possible solutions to the challenges, including:

- providing orientation of all new staff
- informing RNs about the educational preparation of LPNs
- having LPNs communicate what they can do
- bringing the challenges identified to nursing council for review, and
- considering an LPN representative for the hospital-wide nursing council.

While detailed data on cost/benefits were not available, some general information was discussed. A cost saving of $20,000 per full time equivalent position was reported with the conversion of RN positions to LPN positions. This amount does not reflect any of the costs of meetings or educational upgrading. Researching data on costs savings from past years would have been very time-consuming for the hospital and was not pursued at the time of this study.

The only data on patient outcomes come from the perceptions of staff in the evaluation survey. The effect of the addition of LPN skills on any other measurable patient outcomes (for example, unusual incidents) was not available.

The perceived effect of the change on nurse job satisfaction and similar outcomes was considered in the LGH survey. Data such as sick time and injuries had not been documented in relation to this change.

6. CHALLENGES AND SOLUTIONS

Challenges and solutions discussed during the interviews for this case study fall under the general categories of education, role overlap, and the loss of RN jobs. This section also reviews factors that contributed to the success of the committee that coordinated the change in LPN practice.

Education

An immediate challenge was the need for education for LPNs to prepare them to take on additional skills. As noted earlier, there was an educational program for LPNs that included written materials, workshops and opportunities for practice. The LPNs have access to ongoing support to upgrade their skills. LPNs can page any of several nurse clinicians, each of whom has a different area of responsibility, to review a skill and discuss their practice.

Informing all RNs on staff of the change in LPN practice was another challenge dealt with through education. Workshops have been one approach to share information on the scope of LPN practice. A second strategy has been to provide written information, including updated skills lists and revised job descriptions. Orientation programs were updated to include a discussion on the role of LPNs on teams.

Understanding each other's role continues to be a challenge. The RNs interviewed acknowledged that there was a lack of knowledge by RNs of LPNs' education and skills and a similar lack of knowledge by LPNs of the RN role. Both LPNs and RNs raised the need for ongoing, up to date information on each other's scope of practice.

Role Overlap

Both LPNs and RNs raised issues related to the overlap of their roles. Although they were clear about how to resolve conflicts that arose between individuals, the resolution of role conflicts between the two groups has been more challenging.

For example, both groups spoke of the challenge of coping with the different levels of skills and the variety of skill sets that individual nurses bring to the workplace. A specific example arises when nurses float to other units. Staff pointed out that policies for LPN skills vary on different units. For example, there are specific skills that LPNs perform only on orthopedic and neurosurgery units. A float LPN may or may not have these specialized skills. These variations are compounded by the different levels of skills that nurses bring to their practice, from the novice to the expert. The following quote by an RN makes apparent how skill sets can vary and how that impacts on team work.

> *I had one practical [nurse] who was floated on my ward for four hours. She had worked in activation for a few years. Activation is entirely different from a surgical ward. She said she hadn't done any staples or suture removal for 10 years and did not feel comfortable doing staple removal.*

When there is no opportunity to practice a skill, it is difficult to stay current. The LGH skills list is useful for LPNs to assess their practice. One challenge for LPNs is to inform colleagues of their skills and learning needs. LPNs are aware that they have a professional responsibility to clarify what they can and cannot do.

Compounding the challenge of the different skill sets of individual nurses was the acuity and diversity of patients' conditions. The expanded skill set of LPNs was seen as a cost effective way to address the increased patient needs and workload at LGH. Patients are being assigned and grouped on units differently than in the past, again challenging nurses to learn and maintain a wide range of skills.

While most LPNs were taking on the challenge of learning the new skills, it was noted that some LPNs were reluctant to upgrade or to practice to their full scope. The reasons for this were not fully explored in the interviews, but participants did identify several possible factors, including workload demands, differences in individual experience and education, and the need for diverse skills to care for different patients.

Loss of RN Jobs

Another challenge faced by the nursing team was the loss of RN jobs. Even though there was a shortage of RNs at the time of this research, and the loss had happened four years ago, LPNs felt it was still having an impact. LPNs reported that they perceived that the RNs were worried about job security.

The role of the two unions was also discussed in terms of how they influenced the change to LPN practice. The information package prepared by LGH noted that, because of the long history of cooperation between HEU and BCNU members at the local level, the change was achieved with a minimum of disruption to staff and patients. However, two issues were raised by LPNs in relation to the unions. The public advertising done by the B.C. Nurses' Union was cited as contributing to the lack of understanding that LPNs are nurses. This advertisement suggested that only RNs are "nurses," thereby excluding LPNs. In a related issue, LPNs noted that their collective agreement does not require that LPNs be licensed. They felt this also leads to a perception that they are not professional nurses.

The process of changing LPNs' practice was viewed as dynamic, and it was recognized that individuals all manage change in their own way and in their own time. LGH has attempted to put structures and policies in place to support these changes. The updated orientation for all new staff was seen as important, as was the commitment to ongoing education. Both LPNs and RNs spoke of the hospital's support for attending in-service on topics such as standards of practice. Both groups of nurses identified that ongoing opportunities to learn about each other's practice are needed.

7. SUGGESTIONS FOR OTHER FACILITIES

Participants in the interviews made the following suggestions to other facilities contemplating changes in nursing staff mix and roles.

- Convene a committee with membership representing all staff and include unions and management.
- Ensure the active and consistent involvement of LPNs and support from management.
- Invite input and participation in planning and implementing change in a number of different ways, including committee membership and meetings, surveys and workshops.
- Evaluate the process and the impact of the change.

In addition to these suggestions, the following success factors were identified at a 1999 workshop co-facilitated by a manager and an LPN involved in the LGH process.

- LPNs were very active and involved in the process from the very beginning. They were organized and had established a working relationship with management.
- LPN members were approached and informed individually about the changes to their practice.
- Both unions were involved, and there was good communication between HEU and BCNU at the local level.
- Management supported the process, and all levels of management were kept informed.
- The change process was democratic, transparent and gradual.
- The College of LPNs of B.C. was supportive, and its new standards of practice were timely and useful.

This case study is one in a series prepared for the Licensed Practical Nurses and Care Aides in B.C. project. The joint committee overseeing project activities included representatives from the Health Employers Association of British Columbia and the Association of Unions represented by the Hospital Employees' Union and the B.C. Government and Service Employees Union. The LPNs and care aides in this case study are represented by HEU.

APPENDIX

Information Package on Licensed Practical Nurses' Utilization and Training at Lions Gate Hospital. The Information Package includes:

- Background **p. 155**
- Lions Gate Hospital LPN Proposal (1995) **pp. 156-159**
- LPN Job Description and Skills Lists **pp. 160-188**
- Evaluation of LPN Additional Skills **pp. 189 - 197**

CASE STUDY

Malaspina Gardens

NANAIMO, BC

TABLE OF CONTENTS

1.	Facility Description	199
2.	Background	200
3.	Roles and Responsibilities of Nursing Staff	201
4.	The Change Process	203
5.	Outcomes	204
6.	Challenges and Solutions	205
7.	Suggestions for Other Facilities	207
	Appendices	209

1. FACILITY DESCRIPTION

Malaspina Gardens is a privately owned, 165 bed intermediate care facility in Nanaimo, B.C. The facility has four units: Main and Kennedy in an older building and Franklyn 1st and 2nd in a newer wing that opened in 1992.

Each unit has a different number of residents and offers a different variation in care. The most independent intermediate care residents live on Main, which has 58 beds. There are 42 intermediate care residents who require higher levels of care on Kennedy. Franklyn 1st is a 33 bed unit for extended care residents, and Franklyn 2nd is a 32 bed special care unit for patients with dementia (SCU).

Direct care for residents is provided by licensed practical nurses, care aides and registered nurses. Activity and recreation staff offer programs five days a week. Other services for residents on site are offered by a physiotherapist, chiropractor, podiatrist and hairdresser.

Malaspina Gardens is planning to build a new wing for 50 additional residents, using "multilevel" care guidelines. The new wing will be designed to meet the needs of both current and future residents. These new multilevel care beds will bring an additional 50 positions to the facility, and changes in staffing and rotations are anticipated.

In addition to services for residents, Malaspina Gardens serves as a teaching site for health care workers. The facility takes student placements for care aide (Resident Care Attendant) and practical nurse programs at Malaspina University College. The care aides on staff are mentors to resident care attendant students, and LPNs act as preceptors for

practical nursing students. The facility also offers high school students and adult learners an opportunity to visit and observe staff as a way to learn about health care careers.

2. BACKGROUND

Interview participants noted that originally all of the residents of Malaspina Gardens required intermediate care. Over time this has changed as the residents aged and required higher levels of care, including extended care and dementia care. One interview participant described the change in residents this way.

> *The acuity level in all aspects of health care is increasing, and that is no different here. It is far more complex than it used to be. Particularly in dementia, we are seeing people that would have been in psychiatric facilities. They are not simple dementias anymore, they are complex, long term mental health disorders. The whole face of psychogeriatrics has changed.*

The design of the facility was identified as having an impact on the care provided. The older wing (Main and Kennedy units) was not designed for residents needing a high level of assistance and care. Franklyn 1st and 2nd were specifically designed for the dementia SCU and extended care units.

As residents' needs and care levels have increased, staffing levels and mix have also changed. The focus of the change in this case study is the introduction of LPNs into the staffing mix in the early 1990s. Factors identified as leading to the decision to add LPNs were: the care needs of the residents, the budget, the shortage of RNs, and the opening of the new Franklyn wing.

When the new Franklyn wing was being planned, the administrator took the opportunity to review residents' needs, the staffing mix and rotations. Opening the new wing was seen as a good time to consider different options for staffing and rotations.

> *It was an opportunity to introduce change. It was a new building; we had brand new staff hired. We could do new rotations, so the whole concept was introduced at the right time. That really helped.*

When the new Franklyn wing opened in 1992, residents on the new dementia SCU and the extended care unit both required a higher level of care, yet there was not enough money in the budget to staff each unit with an RN. This led to the decision to allocate one RN position to the SCU and use LPNs as team leaders on the extended care unit.

Following their introduction into the new Franklyn wing, LPNs were also introduced into the original building (Main unit) on days and evenings. Historically, in the older building, RNs had worked with a team of care aides to provide care. In the most recent staffing change, LPN positions were added to the night shift on Main, Kennedy and Franklyn 2nd. This change was made possible when the facility was able to access funds from the Ministry of Health to convert three care aide positions into LPN positions. Additional care aide positions were added to replace the converted positions, with funds

specially designated by the Ministry of Health for this purpose, and therefore no positions were lost.

3. ROLES AND RESPONSIBILITIES OF THE NURSING STAFF

LPNs, care aides and RNs work as a team to provide care. The staffing mix and the duties and responsibilities of each team member are described. The LPN, RN and care aide job descriptions are appended.

Staffing Mix

Staffing is organized around three shifts, each eight hours long. Below is an example from Franklyn 1st (33 ECU residents) where the LPN is the team leader:

- **DAYS** one LPN and three care aides, plus one additional care aide three days/week
- **EVENINGS** one LPN and two care aides, plus one additional care aide for 5.5 hours
- **NIGHTS** two care aides.

On night shift, an LPN is responsible for care issues and medication administration on Franklyn 2nd, Main and Kennedy. The “in-charge” RN administers medications on Franklyn 1st and is responsible for monitoring staff and the building. The staffing mix for all four units is appended.

LPN Role

The LPN job description includes the following description and summary of duties.

> *The position of licensed practical nurse...plays a significant role in the provision of quality care to all residents – physically, mentally, emotionally and spiritually in all their activities of daily living.*
>
> *Summary of Duties:*
> 1. *Give and chart daily medications.*
> 2. *Assist care aides in the implementation of resident care, when necessary.*
> 3. *Consult with the RN/care aide about changes in resident condition.*
> 4. *Assist to formulate, implement and evaluate resident care plans and activity of daily living plans for individual residents.*
> 5. *Chart any daily information into resident chart.*
> 6. *Assist with daily dressings as needed.*
> 7. *Participate in the Direct Care Team to support quality care of the residents.*

LPN practice includes psychomotor skills such as catheterizations, administering medications including insulin, changing dressings, assisting residents with personal care and ambulation and other tasks such as filling oxygen tanks.

One LPN described her practice as follows:

Our employer believes that LPNs can do anything they're trained to do, so if we're trained to do that, she allows us to work in our full scope of practice.

LPNs work both as team members (e.g. Franklyn 2nd, Main) and team leaders (e.g. Franklyn 1st). As team leaders, LPNs assign care aides to care for residents and provide direction and guidance to care aides on their teams, as necessary. LPN team leaders are responsible for assessing residents in consultation with RNs.

LPNs are team leaders on Franklyn 1st on day and evening shifts. LPNs are assigned specifically to Franklyn 1st and do not rotate to other units. It was reported that not rotating among units contributes to consistency in the care of residents. Franklyn 1st has a reputation in the facility for being very organized.

LPNs work directly with physicians, communicating with them about residents' needs and processing physicians' orders. LPNs communicate with other members of the team, as well as residents and families. When LPNs identify problems, they are accountable to follow up with the appropriate team member, such as the RN. In the interviews, LPNs expressed satisfaction with the level of team work at Malaspina Gardens, as noted in the following comment.

RNs trust that we can do our job competently. The RNs have become accustomed to us being there, they know that we can do our job. They consider us part of the nursing team.

LPNs noted that they are responsible for the care they provide. They considered it important to maintain their license with the College of LPNs of B.C., which they described as one aspect of being accountable. All LPNs at Malaspina Gardens are licensed with the College of LPNs, although this is not required in the collective agreement. LPNs reported using GROWTH, a continuing competence program of the College of LPNs, as one approach in maintaining their competence and documenting their professional development.

Care Aide Role

Titles used at Malaspina Lodge for the care aide role have changed over time and include: long term care aide, continuing care aide, and resident care attendant. For consistency, the title care aide is used in this case study.

According to the job description and information provided, the care aide:

- assists residents with activities of daily living
- assists residents at meal time to ensure adequate intake of food and fluids and socialization with others
- performs and/or assists residents with bathing and personal grooming, and promotes self-care
- assists with transfers in and out of bed, and to and from wheelchairs/chairs
- provides social stimulation

- performs bed changes and other housekeeping as needed, and
- reports changes in residents' condition.

There is a specific team assigned to bathe residents. A care aide works on a "bath team" for several weeks at a time. The care aide's work is done inside the facility, and the job does not include accompanying residents outside the facility.

Care aides said they have seen changes in the care that residents require. One care aide described the change this way.

> *I used to have six patients, all of whom would make their own bed. I would help dress three or four people. Now there is maybe only one person that makes his or her own bed. I am helping to dress just about everybody.*

Other Team Members

In addition to the RNs involved in direct care, there is a registered nurse care coordinator (a union position) who works five days a week. The administrator/care director is an RN, and the assistant care director who works four days a week is an RN; both are non-union positions.

An RN is the charge nurse on weekends, nights and evenings. The charge nurse is responsible for overseeing the management of the facility and ensuring that staffing is adequate during these times. When the director of care is not available to chair the weekly care conferences, the charge nurse takes on this role.

Team Care Planning

Each floor has a weekly resident care conference attended by LPNs, care aides, RNs and the RN care coordinators. One LPN described it as follows.

> *Every Tuesday we have a care conference. It is an update on the residents' care. The care coordinators come in with us, and we focus on a few residents. The resident may be ill, they may need a medication change, or their behaviour may have changed.*

In addition to the weekly care planning conference, staff participate in the mandated medical review of each resident, which is completed within six months of admission and yearly thereafter. The LPN, RN, physician, dietician, recreation program staff, pharmacist and care director attend the medical review.

4. THE CHANGE PROCESS

The administrator identified that the need and opportunity for change in the nursing staff mix arose with the opening of the new Franklyn wing in 1992. Other interview participants identified that part of the success was due to the fact that the administrator had built a good relationship with and among the staff. Participants spoke about the strength and importance of this relationship in facilitating the change process. They discussed the following factors as important in facilitating the introduction of LPNs into

the nursing team: the role and approach of the administrator, union-management relations, support for education, and effective team relationships.

The administrator had formerly worked in the facility as a registered nurse and in that capacity had gained legitimacy and respect from staff. As an administrator, she is seen as an approachable person who listens to concerns and supports staff in resolving issues. It was reported that management and the union work well together.

The LPN and care aide participants discussed the importance of having an active local union. They recognized the efforts of their local executive to pursue educational opportunities for members. Staff were aware of the shortage of education funds, and appreciated management's support for education. This facility has supported several staff members to increase their education. For example, one care aide continued her education to become an RN and is now working as care director.

Education included formal courses, as discussed below, and non-formal education. Non-formal education was recognized as significant at this facility. Both LPNs and RNs said they approach each other to ask for help. For example, if a nurse needs to do a skill that she has not performed recently, she would feel comfortable asking a colleague for assistance.

Effective team relationships were discussed in terms of problem solving, respect and appreciation for each individual's contribution. Interview participants reported that staff work together effectively to solve problems. Employees commented that their input was sought, welcomed and considered by management. They observed that there is respect for each person's opinions and input. In addition to respect, staff said they feel appreciated by their co-workers. A care aide gave this example of the mutual respect among staff.

> *People have a lot of respect for each other. We do not have those definite lines here, you're an RN, you're an LPN. If somebody is climbing out of bed and a nurse goes by you ask for help. They are not going to say: "That is not my job, I do not have time right now, or call somebody else."*

5. OUTCOMES

The impact of introducing LPNs at Malaspina Gardens can be considered from the perspective of system outcomes (cost/benefit), nurse outcomes (job satisfaction, injury rate, role conflict) and quality of care outcomes (resident outcomes). While there has been no specific research to analyze the impact of introducing LPNs, the administrator shared some of the parameters she believed would be important.

System Outcomes

To meet resident care needs and address budget limitations, LPNs were hired to help staff the new Franklyn wing. The administrator noted that the salary difference between the LPN and RN resulted in savings for the facility. Detailed cost analysis of salary and

benefits was not available at the time of the case study. Additional funds were accessed through the Ministry of Health initiative to support the utilization of LPNs in health care and to create care aide positions. Any other costs associated with the change in staff mix (e.g. meetings, education) have not been tracked.

Nurse Outcomes

The administrator noted that if workload is too high, sick time increases. In her experience, casual staff may also decline to work there. She predicts that staff sick time should show a positive change with the addition of the LPN role. This is an area that could be tracked in the future.

Quality of Care Outcomes

While there is a process to document unusual incidents such as medication errors, these have not been analyzed in relation to any staffing change, such as changes in staffing levels or roles. The administrator believes that residents and families could be consulted as part of the change process to ascertain how they feel about the change.

The administrator pointed out that anecdotal data, such as how people think and feel about the change, is also very important. She noted that staff usually let administration know if something is not working and offer solutions to remedy the problem in order to improve the quality of care.

6. CHALLENGES AND SOLUTIONS

A number of challenges were encountered with the introduction of LPNs into the staffing mix. The challenges and solutions discussed by staff included providing education regarding the LPN role, developing a process for conflict resolution, and resolving work jurisdiction issues.

Education

Education was needed for all members of the team, including LPNs, care aides and RNs. The RNs were unsure of LPNs' scope of practice and were concerned about accountability for their practice. To deal with this concern, administration developed the LPN Definition Statement which helped define the standard of care provided by LPN, describe the role of LPN and their standards of practice, and indicate when an RN is to be called for assistance. For example, an LPN will request assistance for any unusual occurrence, acute changes in resident status, verification of the assessment of any acute change, and interventions that are beyond the LPN scope of training. (The LPN Definition Statement is appended.)

A major challenge was to clarify who was accountable for LPNs' practice. As RNs were concerned that they were accountable, the administrator clarified that as licensed nurses, LPNs knew what to do and were fully responsible for resident care on their units. This message was given consistently.

> *We had to keep saying [to the RNs]: "The LPN knows and she will call you. You go look after your people, she can look after hers. If anything goes wrong … then you tell us and we can go and talk to her. You can not take over her floor for her, or else it is defeating the purpose."*

LPNs needed support to take on new duties, for example, the administration of medications. Malaspina University College was contracted to deliver a medication administration course for LPNs who needed updating if they had not been performing this skill. Education included pre-reading, classroom/laboratory instruction at the college, and clinical practice at the facility under the supervision of an RN. As new duties are added (for example, administering insulin) this educational process is repeated.

LPNs identified that management supported their continuing education. The local union also supported continuing education for both the LPNs and the care aides. Participants noted that educational needs are ongoing. For example, the LPNs would like to have access to a post-basic course in gerontology.

A related educational challenge is the orientation of new LPN graduates to the enhanced role of team leader at Malaspina Gardens. The administration is hoping to support new graduates by developing an orientation program to cover the LPN team leader role. The administration has also invited the local college to place students in its facility to complete a preceptorship experience in the LPN team leader role. As a result, Malaspina Gardens was expecting three LPN preceptorship students in July and August, 2000.

Process for Conflict Resolution

The process for resolving conflict was discussed. Staff did not offer specific examples of conflict, but the process for resolving conflict between individuals was clear to all. The RNs noted there were no ongoing mechanisms for the care aides, LPNs and RNs to discuss general issues that arise during their practice. The weekly resident care conference focused on specific residents and was not seen as an appropriate place to raise more general workplace issues. Recording problems on a posted list was mentioned, but it was not seen as the beginning of a dynamic process to discuss issues or resolve conflicts.

The care aides interviewed for this case study did not identify any significant conflicts between the care aide and LPN roles.

Work Jurisdiction Issues

Participants noted that issues of work jurisdiction between LPNs and RNs presented challenges to the change process. Greater flexibility in the assignment of work without the risk of labour relations implications was noted as a possible solution to this challenge.

7. SUGGESTIONS FOR OTHER FACILITIES

The staff at Malaspina Gardens offered suggestions for other facilities that wish to introduce LPNs into their staff. Their suggestions are grouped under the headings of communication and collaboration, managing the change process, education and facility design.

Communication and Collaboration

Open communication is important. Respect and trust and a willingness to listen among all parties was stressed as important for an effective change process. Participants advised a collaborative process involving all staff affected by the change.

Manage the Change Process

Participants suggested that facilities plan the change strategically.

- Use opportunities as they arise, for example when a new wing opens, introduce a new staff mix.
- Avoid job loss. In this facility, no one lost their job with the change in staff mix.
- Recognize that as the residents' needs change, staff must be able to meet these needs.
- Identify one key person, someone who is respected and trusted, to facilitate the change. The administrator at Malaspina Gardens led the change process.
- Evaluate all change. Establish a process to review the impact of the changes on residents' health, staff morale and other outcomes.

Education

Staff recommended that education be provided to support the change in staff mix and roles. Change requires ongoing educational support, both orientation for new employees and continuing education for all staff. Preceptorships for LPN students were recommended. Enlisting LPNs to provide continuing education was identified as one way to support their role and facilitate mentoring of others, for example, new graduates.

Participants advised that all staff must learn about the new role and recognize that LPNs are accountable for their practice. This can be supported by management reinforcing that all staff are accountable for the care they provide. Furthermore, reference can be made to the provincially mandated standards of the LPN regulatory body, the College of LPNs of B.C.

Facility Design

Consider the design of the facility when introducing change. The design of a facility impacts on the delivery of health care. One hindrance at Malaspina Gardens was that the small work space on some units interfered with work flow and efficiency. New wings need to take into account both residents' and staff needs.

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APPENDICES

Job descriptions: LPN, care aide and RN* **pp. 209 - 214**

(*Malaspina Gardens was formerly called Malaspina Lodge)

LPN Definition Statement – Focus: Standard of Care **pp. 215 - 216**

Facts on the facility, unit description and staffing **pp. 217 - 218**

CASE STUDY

Saanich Peninsula Hospital SAANICHTON, BC

TABLE OF CONTENTS

1. Facility Description 219
2. Background 219
3. Roles and Responsibilities of Nursing Staff 220
4. The Change Process 222
5. Outcomes 223
6. Challenges and Solutions 224
7. Suggestions for Other Facilities 226

Appendix 227

1. FACILITY DESCRIPTION

Saanich Peninsula Hospital provides acute and continuing care health services in the community of Saanichton on Vancouver Island. The hospital is part of the Capital Health Region in Victoria. There are 150 extended care and 63 acute care beds in the facility. Acute care services offered by the hospital include emergency, obstetrics, day care, medicine, surgery and palliative care. This case study focuses on the licensed practical nurse role in acute care, specifically on one medical unit where the types of patients changed, the ratio of LPNs to RNs was increased, and team nursing was introduced.

In addition to patient services, Saanich Peninsula Hospital has a teaching function. Clinical learning experiences are provided for LPNs and RNs

2. BACKGROUND

Change within the region and the hospital, in concert with data on patient outcomes, were key variables that led to a change in patient care delivery. Examples of these changes and patient outcome data are briefly reviewed to provide background to the change.

The hospital has experienced many changes during the provincial health regionalization process. Since joining the CHR, hospital administrators have noted a higher occupancy rate at Saanich Peninsula Hospital. In the past three years, the acuity of patients has risen, due in part to new medical practices at the hospital. There has been an increased use of epidural and patient controlled analgesia. Cardiac patients are being treated with the administration of aminopyhylin and nitroglycerine intravenously. The

specific impact of these changes has not been documented by the hospital; however, the general result of increased acuity and increased occupancy has been an increased workload.

The hospital tracks patient outcomes (such as patient falls and complaints) and uses that information to make decisions about nursing care delivery. An important tool in tracking patient outcomes is the quality improvement report (Appended). Staff members complete this report for any unusual occurrence such as patients falls, medication errors and professional practice issues. Management reviews the analysis of the reports in a hospital multi-disciplinary committee. Management also collects data on complaints made by patients and their families. Tracking of these types of patient outcomes is done over time to identify any patterns.

Data from quality improvement reports and patient complaints was used as a base for determining the most appropriate approach to nursing care delivery. The nursing manager considered this information in concert with patient care requirements, patient acuity, the workload and the skill mix of the LPNs and RNs on staff. The manager brought her experience with both team and primary models of nursing care to this process. The manager spoke about the challenges of organizing and providing care to patients at the hospital.

> *We were at times mixing the patients needing a longer stay with the short stay acute patients. Their needs were very different. The longer stay patients' needs were not being met. The longer stay patients and the demented/confused patients were in the highest traffic area. Often the LPNs would have a huge number of patients to care for.*
>
> *Many complaints came from families of longer stay patients because they perceived that the acute care patients were getting most of the care and attention. When I charted these reports over a six month period with the nursing workload, I noticed a pattern. I was getting many quality assurance reports around work environment such as "we do not have enough staff" or "we do not have the right mix."*

The nursing units were reorganized to group the longer stay patients together. Longer stay patients, including patients with dementia and patients requiring palliative care, were grouped together on Medical South, a secured unit. The more acutely ill patients were grouped on the second medical-surgical unit, Central Unit.

The nursing care delivery model of team nursing was introduced on the Medical South Unit with a high ratio of LPNs to RNs. While a number of changes have occurred at the hospital, this case study focuses on changes in LPN practice on Medical South.

3. ROLES AND RESPONSIBILITIES OF NURSING STAFF

LPNs rotate between the two medical-surgical units in the hospital, Medical South and Central Unit. At the time of this case study, LPNs were not utilized in any other acute care units of the hospital (emergency, obstetrics, day care).

Medical South is a 22 bed unit for longer stay, more stable medical patients and patients needing palliative care. The average age of patients on the Medical South unit is 85, requiring a high level of assistance with activities of daily living.

Team nursing was introduced on Medical South in 1999. In this model of care delivery, nurses (RNs and LPNs) are assigned individual patients to care for during their shift. LPNs are responsible and accountable for all nursing care, with the exception of medications, for all assigned patients. According to the job description at Saanich Peninsula Hospital, the LPN job summary is as follows.

> *Under the direction of an RN, performs nursing procedures and patient/resident care duties in accordance with the unit philosophy, competency guidelines, procedures, policies, and the BCCLPN Standards of Practice for the Licensed Practical Nurse in British Columbia. Receives guidance and direction from the registered nurses as required.*
>
> (Job Description appended)

Based on the job description and data collected in interviews at the hospital, the duties and responsibilities of LPNs include the following.

Assessment Completes physical assessments including taking and recording temperature, blood pressure, pulse, respiration; assesses patient condition and communicates observations; identifies and reports basic physical, emotional and social needs.

Care Planning Contributes to the development and changes to patient care plans; participates in patient rounds.

Interventions Provides emotional support and comfort to dying patients and their families; provides patients with information or instruction as required; provides assistance to patients with activities of daily living; promotes patient safety, activity, comfort and independence.

Psychomotor Skills Performs procedures such as catheterization, wound care, colostomy care; collects urine and stool specimens; applies topical medications; changes and discontinues intravenous therapy; stocks supplies.

Communication Communicates with patients and families; participates in multidisciplinary team conferences and nursing team meetings; reports observations and records on nursing forms according to established policies.

Professional Role LPNs are involved in nursing committees such as the Nursing Practice and Education Committee.

Job qualifications for LPNs include graduation from a recognized education program and/or a valid license. Maintaining a license with the College of LPNs of B.C. was raised by LPNs during the interviews for this case study. The LPNs reported that they felt a

valid license was an important part of their professional responsibility, although not required by the collective agreement.

On Medical South, there are weekly rounds for all medical patients and separate weekly rounds for patients receiving palliative care. LPNs, social workers, physicians, dieticians, and RNs attend rounds. Palliative care rounds last 30 minutes for the two or three patients receiving care. One LPN described her contribution as follows.

[We consider] how they are eating, how their pain control is, skin integrity, emotionally how they are doing and their family. The family is a big part of our care for palliative patients. Sometimes you are dealing with the family more than with the patient.

LPNs participate in the recently reactivated hospital-wide Nursing Practice and Education Committee. Membership includes LPNs and RNs from both acute and extended care, clinical resource nurses and management. The committee discusses nursing practice and procedures, new products being introduced, and educational needs arising from any changes.

RN to LPN Staffing Ratios on Medical South

LPNs work eight hour shifts and RNs work 12 hour shifts. The staffing and ratios of RNs and LPNs is:

DAYS one RN, three LPNs

EVENINGS one RN, two LPNs, and

NIGHTS one RN, one LPN.

On the day shift, an LPN is assigned between six and eight patients. An LPN described the delivery of care as follows.

On evenings, we [the RN and LPN] care for the 22 patients together. We make our rounds together. When it comes to charting, one will chart on one side and one will chart on the other side.

4. THE CHANGE PROCESS

The reorganization of the medical-surgical nursing units to group longer stay patients together on Medical South has been completed. The change to team nursing as the model of nursing care delivery has been completed on Medical South and is still in process on the other medical-surgical unit (Central Unit).

LPNs and RNs reviewed their roles, responsibilities and accountability as part of the change process. A two-hour meeting of RNs and LPNs was organized to discuss their roles. The meeting served as a time for clarification of roles and team building, as evidenced by the following comment from an LPN.

What came out of the meeting is the RNs and the LPNs have an appreciation of the other's role. I had a great deal of sympathy for problems that the RNs were encounter-

ing. RNs came to an understanding of our situation. Those who went came away with more of a sense of togetherness, that we are all nursing and our primary focus is the patient. Some anger and splits that had been happening were diffused. I just hope that more of that can happen.

In the Spring of 2000, a survey on role clarification for the two nursing groups was developed by RNs and LPNs with support from the human resources department. Nursing management supported the survey, but it was an initiative of the nurses working on Medical South. The two page survey included four questions about roles. Respondents were asked to identify areas needing clarification in their role as an LPN or RN. Role overlaps were to be identified and areas that were unclear in terms of roles/expectations of LPNs and RNs were to be documented. The survey results were not yet available when this case study was completed.

Another component of the change process included the identification of education needs of LPNs. The hospital provided in-service education on the following competencies: skin care, sterile dressing changes, and care of peripheral intra-continuous catheter lines. The LPNs identified an ongoing need for this type of upgrading education. In addition to education through the hospital, the Capital Health Region has arranged for Camosun College to provide continuing education for the entire health region. Planning for region-wide continuing education is still underway.

5. OUTCOMES

Patient Outcomes

In general, the hospital tracks patient outcomes through the quality improvement reports and complaints from patients and families. Patterns that emerge are addressed through management and/or a hospital multi-disciplinary committee. At the time of this research, there had been no specific evaluation of patient outcomes related to the reorganization on Medical South or the implementation of team nursing. However, the acute care manager reported that patient complaints for the hospital as a whole have reduced from an average of eight per month, which was identified as very high compared with most facilities, to an average of two per month.

The families of the patients on Medical South have given positive feedback, according to the unit manager. Less frequent patient call bell ringing was seen as indicative that patient needs are more promptly met. Confused patients are no longer wandering around the facility, thus staff are not spending time looking for them.

Nurse Outcomes

Some LPNs explicitly reported that they enjoy working on the Medical South unit. Team nursing will also be implemented on the second medical-surgical unit. Role overlap and conflicts are being raised and addressed in that process.

System Outcomes

The manager of the acute care units reported that, even in times of increasing workload, she considers ministry standards, safety and budget parameters when considering budgets. However, she focuses on information related to patient outcomes as the priority when making budget and staffing decisions.

At the time of this research, more specific costs/benefits data on the changes to Medical South had not been collected or compiled by the facility.

6. CHALLENGES AND SOLUTIONS

Interview participants identified a number of challenges to implementing the new nursing mix and roles on Medical South. The challenges are grouped under the headings of communication and role overlap, shift schedules, uncertain environment, and LPN advocacy.

Communication and Role Overlap

One significant challenge to successful change was the lack of a shared and common understanding of the roles and responsibilities of the two groups of nurses. The two groups identified concerns about accountability for LPN practice. LPNs reported in the interviews that it is important to have an assigned patient case load for which they are accountable. On Central Unit, LPNs do not have a patient assignment and it is more difficult to be clear about who is accountable for patient care. On Medical South, LPNs have an assigned patient case load for which they are accountable. RNs felt that, while LPNs are responsible for the care they give, they, as RNs, are responsible for the delegation of care to LPNs. The RNs believed that when there were shared roles and competencies, the RN was “delegating” and thus responsible for the LPN’s work. Attempts to resolve these issues have been met through a number of activities, including the dialogue and survey noted above.

Role overlap and conflicts between RNs and LPNs are being addressed through discussion, education and the role clarification survey. Nurses reported that they would resolve conflicts by raising their concerns on a one on one basis, something that is possible in a small hospital where staff know each other. Others identified staff meetings as a place one might raise nursing practice issues. Some employees, however, indicated that they were reluctant to raise issues of conflict directly with a co-worker. In some instances, an employee who was dissatisfied with the quality of another’s work would simply redo the work (for example, reassess the patient). One way of working through this problem was the development of the quality improvement report outlined above, which documented staff concerns regarding such issues. The report is forwarded to the manger of acute care services for follow up.

Shift Schedules

The difference in RNs 12 hour shifts to LPNs eight hour shifts was identified as a challenge to working effectively as a team. At every shift change, a report on patient care is given by the staff leaving to the staff arriving. The only time that the shift change coincides for both groups of nurses is at 7 a.m. Reports must be given twice each shift to accommodate the schedules of the two nursing groups. This practice is both time-consuming and disruptive for both groups. Changing the length of shifts so that both groups could be on the same schedule was explored. LPNs reported that 100 per cent support is needed to make this type of change, as per the collective agreement. The 100 per cent support was not present, and thus there has been no change to the length of shifts. At the time of this research, no other strategies had been identified to address this particular challenge.

Uncertain Environment

Another challenge identified in the interviews with staff was the impact of other changes undertaken by Saanich Penninsula Hospital due to regionalization and restructuring. In addition, as noted in the background section above, there have been changes to patient care, acuity, higher occupancy and thus increased workload. LPNs reported that while staff is adjusting to these changes it is difficult to introduce an additional change – that of changing their practice. Acknowledging the ongoing impact of these changes was reported as an important approach to support staff in coping with additional change.

Staff also reported that the higher workload was being addressed by using a "workload staff" system, wherein a unit that is unable to handle the heavy workload can request "workload" staff to come and provide assistance in delivering care. Management is not always successful in getting this "workload" staff, as it has difficulty maintaining enough people in the casual pool. However, staff gave management credit for trying to address this issue.

LPN Advocacy

Another challenge reported by LPNs is their perceived "loss of voice" in the health care system. LPNs reported that, due to the elimination of many LPN positions in the early 1980s, the role and collective voice of LPNs was reduced, leaving the remaining ones feeling silenced. One LPN described it this way.

> *We tend to be our own worst enemies because we have lost a great deal of our voice and support, and acknowledgement of the fact that we do have a specific and significant role within the health care system.*

One strategy is to encourage LPNs to contribute to all committees. Supporting LPNs as they find their confidence and re-establish their role and contribution to health care is occurring in a number of ways. For example, the Hospital Employees' Union was identified as having a significant role through activities such as its nursing team conference.

7. SUGGESTIONS FOR OTHER FACILITIES

Suggestions for other facilities considering this kind of change to their nursing staff mix included:

- provide opportunities for LPNs and RNs to learn about each others' practice
- have written guidelines for nursing practice
- provide in-service education to enable staff to meet changing patients needs, and
- use a nursing care delivery model that allows LPNs to practice to their full complement of competencies, and to be accountable for their practice.

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APPENDICES

Job Description – Licensed Practical Nurse **pp. 227 - 228**

Role Clarification Survey **pp. 229 - 230**

Quality Improvement Report **pp. 231 - 232**

CASE STUDY

Terraceview Lodge

TERRACE, BC

TABLE OF CONTENTS

1. Facility Description 233
2. Background 234
3. Roles and Responsibilities of Nursing Staff 234
4. Outcomes 237
5. Challenges and Solutions 238
6. Suggestions for Other Facilities 240

Appendix 241

1. FACILITY DESCRIPTION

Terraceview Lodge is a 76 bed intermediate care facility in Terrace, B.C. The City of Terrace has a population of 13,372 and is located in northern B.C. between Prince Rupert and Prince George. Of the 76 residential continuing care beds that Terraceview Lodge provides to the community, 20 are designated as extended care and 55 are dedicated to intermediate care, including a 28 bed special care unit (SCU). The SCU cares for residents with Alzheimer's Disease and other dementias. One bed is available for use by long term care clients from the community to provide respite to family caregivers.

Services provided at Terraceview include 24 hour nursing care, therapeutic recreation programs, occupational therapy assessments, nutrition counselling and visits from a podiatrist, dentist and pharmacist. Terraceview hosts an Alzheimer's education and support group for the community.

In addition to resident services, the facility serves a teaching function for health care workers. Students from the care aide program at Northwest Community College in Terrace gain clinical learning experience at the facility. There is currently neither a practical nurse nor a registered nurse education program in Terrace.

Terraceview administration and staff have worked together to create a home-like environment. A philosophy of gentle care is followed by the staff. Residents get up in the morning according to their own routines. Residents have their own schedules and preferences, documented on their charts and in their rooms. Two resident cats contribute to the homelike atmosphere.

Many residents' room doors have a large poster that describes the resident. The poster includes several pictures of the resident, both current and from their past. Pictures

of other important people and family members in the resident's life are often included on the poster.

Terraceview has two units, East and West. The West Unit has three wings, and the East has two wings. There is a secured (or locked) area on the East Wing for the special care unit. The secured area includes a garden where residents can go out of doors safely. The garden has flower beds at both wheelchair and standing height. The facility also utilizes electronic bracelets to monitor those residents who are at risk of wandering away from the facility. An alarm is sounded if the resident leaves the secured area.

2. BACKGROUND

Terraceview opened in 1984 as a continuing care facility in a new building on the site of the former psychiatric facility called Skeenaview. The extended care wing was opened in 1989 and the special care unit opened in 1994.

Staff interviewed for this case study spoke about the increase in the acuity of illness and needs of residents. They noted an increase in the number of residents requiring either intermediate care at level three, extended care or care in the SCU.

When the current long term care manager arrived at this facility in 1990, there were registered nurses, registered psychiatric nurses and care aides on staff. After her review of the organization of nursing care, she decided to introduce the role of "team leader." Team leaders are staff members with practical nurse education, a valid license from the College of LPNs of B.C.; or an equivalent combination of education, training and experience at that level. The first team leader position was added in 1991.

In 1994, when the special care unit was opened, another team leader position was created. While there were RNs available to serve in the team leader role, the budget would not have covered the cost of hiring additional RNs. The manager reported that for approximately one dollar more per hour above the wage of a care aide, the facility was able to hire practical nurses to fill the team leader position. Since the position was first created, the team leader position has been filled by LPNs, practical nurses, and occasionally by RNs.

This case study focuses on LPNs as team leaders and the phrase "LPN team leader" will be used. However, it was noted that the decision to maintain a license with the College of LPNs of B.C. rests with the practical nurses.

3. ROLES AND RESPONSIBILITIES OF NURSING STAFF

The roles and responsibilities of care aides, RNs/RPNs and the LPN team leader are discussed. The nursing care delivery model is team nursing. The team consists of the LPN team leader, care aides and a charge nurse (an RN or RPN). At Terraceview, the title for the care aide position is Health Care Worker, but for the purpose of consistency with other case studies, the title of care aide will be used.

Staffing

All staff work 7.5 hour shifts; there are three shifts in every 24 hour cycle. To care for the 76 residents on day shift, the team includes one charge nurse (RN/RPN), two LPN team leaders (one in ECU and one in SCU) and nine care aides. Staffing on night shift decreases to one charge nurse and two care aides.

Care Aides

There are 50 care aides employed at Terraceview. The primary role of care aides is to assist residents with activities of daily living. Duties include feeding residents, helping residents dress, assisting in the transfer of residents and assisting with personal hygiene. Care aides provide the first line of communication with family members. One RN described the care aide role with families as follows.

> *The families are a very important part of the facility. We encourage the care aides to talk to the family about what clothing the resident may need and things that may make them more comfortable.*

Care aides are involved in family care conferences. One RN discussed the importance of involving the care aide in this way.

> *The family came in. I asked a care aide to come in with me. It is just more comprehensive to have everybody involved in the decisions and knowing what the residents need. I certainly don't feel threatened that I am going to lose my job because of that, there is so much work here.*

The care aides direct any concerns that they cannot handle to the LPN team leader (in ECU or SCU), or to the RN. When physicians are visiting, RNs and LPN team leaders invite care aides to contribute to discussions on the care of residents.

The care aides contribute to both a communication book and a date planner. The communication book is used to share ongoing workplace issues on the unit. The date planner is used to chart appointments for residents, such as medical tests.

Charge Nurse

Both RNs and RPNs work as "charge nurses" at Terraceview. There is one charge nurse per shift. Six RN/RPNs work in the charge nurse position. Their role includes direct nursing care (such as tube feeding) as well as administrative duties (such as assigning the care of residents to both care aides and LPN team leaders). The charge nurse is responsible for administering medications that are given intramuscularly or subcutaneously, and also takes physicians' orders over the phone. Under the collective agreement the charge nurse receives an in-charge premium when designated as in charge of the facility; typically this occurs when both the resident care coordinator and the manager of long term care are not on site. The position of resident care coordinator was added in 1993 and is filled by a registered nurse.

LPN Team Leader

Six individuals are employed in the 4.5 full time equivalent team leader positions. The team leader position is classified as PC 11. The LPN team leader role is utilized in the extended care unit and the special care unit. According to the job summary, the team leader directs, advises and supervises care aides and performs nursing procedures and resident care duties to meet the needs and interests of the residents (Job Description appended).

The duties are summarized as follows:

- supervises care aides while working with them as part of the team
- coordinates work assignments and determines training and orientation requirements
- assists residents with activities of daily living
- reports changes in residents' condition and documents same as required
- provides input into care planning
- performs nursing procedures such as taking vital signs, changing sterile dressings, administering medications and reporting problems or changes
- orients new care aides and team leaders to job routines, and
- participates in rehabilitation programs.

Staff interviewed for this case study reported that LPN team leader duties include direct care, supporting residents' activities on the unit, medication administration, assessment, and organizing the workload of the care aides. The LPN team leaders work with care aides to care for 20 residents in ECU and 28 in the SCU, and they come to know the residents' needs very well.

Providing direct care includes assistance with activities of daily living such as toileting, dressing, and providing skin and nail care. When the team leaders have time, they support residents to take part in the activities of the unit, for example, helping to set tables for meals and folding laundry. They help in the delivery of some aspects of the therapeutic recreational program, such as playing music, showing videos and reading to the residents.

An important part of a team leader's responsibilities is the administration of medications, including medications administered by feeding tube. LPN team leaders administer oxygen, take capillary blood with glucometers before the charge nurse gives insulin and change dressings, including those with drains.

LPN team leaders are responsible for assessing residents and referring them to the RN or physician as needed. They chart and are accountable for the care they provide.

LPN team leaders organize the workload of care aides. This includes providing direction and ensuring an open line of communication. As one senior RN noted, this is recognized as a challenging role that is still being integrated into the nursing team.

> *The team leaders have had a really hard time. I think it has been really tough for them because they had a lot of changes in 15 years. Each one trying to find their niche.*

They are in the middle, trying to do some of the nursing job and some of the care aide job. Their job is probably the most difficult job in this facility.

The Team's Role

Members of the nursing team work together with a resident care focus on activation and individual personal care. Communication within the team is important. To support communication and increase safety, the administration provides a call pendant. If a team member needs help, she uses the call pendant to summon assistance. The nursing team cares for residents within the facility. When there are activities for residents off the premises, recreation department staff accompany the residents.

Team Meetings and Care Planning

There are meetings for each group of workers to discuss residents' care and workplace issues, including one for charge nurses, one for LPN team leaders and one for care aides. Examples of committees where the staff work together include the occupational health and safety committee and the lifting and transfer committee.

There are care plan review meetings attended by the charge nurse, resident care coordinator, LPN team leader, recreation coordinator, dietician and care aides. Care plan reviews covering approximately three residents occur a couple of times each week. There are annual case conferences attended by the RPN/RN, LPN team leader, pharmacist, dietician, physician, recreational co-ordinator and family. The yearly case conference of each resident is required by licensing authorities.

4. OUTCOMES

Participants noted that there were no specific procedures to document outcomes related to the introduction of the LPN team leader role. However, a number of points were raised related to outcomes, including issues related to costs, level of supervision and workplace issues.

System Outcomes

Costs associated with the addition of the team leader role relate to the salary differential between a care aide (PC 3) and an LPN team leader (PC 11). Specific costs related to salary and benefits for this initiative were not available when the case study site visit was conducted. Costs for education, meetings and ongoing orientation and support for the team leader role have not been tracked.

Nurse Outcomes and Quality of Care Outcomes

No specific data regarding job satisfaction, staff morale and sick time were available. The manager has observed that the organization of workload and supervision of staff has improved as a result of the introduction of the team leader. Before the introduction of the

LPN team leader, an RN was expected to supervise all care aides and 76 residents. The manager noted that it is very difficult to identify the effect on the quality of care of residents as there are so many intervening variables.

Care aides commented on their perspective of labour management relationships and the fact that there are very few grievances at Terraceview.

The union has always been there for the workers…able to give help if (workers) need it; or just for the moral support from that person.

All members of the focus groups spoke positively about the low turnover of staff. They identified that this low attrition rate at the facility helps staff maintain awareness of residents' needs.

5. CHALLENGES AND SOLUTIONS

Staff interviewed for this case study identified that the change process to introduce the team leader role went smoothly. They identified that this positive response to the change was due to respect among staff, respect for residents and open communication.

The respect among staff was evidenced in effective team work and the willingness of staff to help each other. Respect for residents was evidenced in the gentle care philosophy, which created a homelike atmosphere wherein residents' needs and routines were supported.

Open communication at Terraceview was discussed in interviews by all three staff groups. For example, care aides said management was responsive to their concerns. They reported the introduction of call pendants, which were provided in response to their concerns about the safety of residents and staff.

The care aides said that when they raise a concern with the long term care manager or the resident care coordinator, they often get a response the same day. Staff appreciated that the resident care coordinator spends time on the floor, making it easy for staff to approach her with problems. As one senior staff person described:

I think we have tried to promote an atmosphere of flexibility. Nothing is etched in stone. We can look at things if staff think they should be different. Sometimes I won't budge with the way I think it should be. But sometimes there is room to manoeuver or to negotiate.

Three challenges with the introduction of the LPN team leader were identified as:

- the need to prepare and support the LPN team leaders for the new role
- the need to inform other staff and ensure they understand the LPN team leader's role, and
- having a means to discuss shared roles/duties between care providers.

Preparation and Support of the New LPN Team Leaders

The very first practical nurse team leader had worked as a care aide at Terraceview and did not need an orientation to the facility. For new staff taking on this role, orientation is

individualized and provided by a peer, another LPN team leader. The ongoing meetings of the LPN team leaders are useful for preparing and supporting them in their role. Administration has worked one-on-one with the team leaders, helping them to learn skills such as conflict resolution and co-ordinating staff.

Education of Other Staff About the Team Leader's Role

One challenge raised by the charge nurses was their initial concern about team leaders taking responsibility for administering medications. One strategy used by the manager to address their concern was to share the requirements of the legislation covering the licensing of the facility in relation to medication administration.

> *I used the Community Care Facility Licensing Act to show that if they had a proper orientation and knew the residents well enough [the LPN team leaders] could give out meds; and, team leaders have successfully given out meds.*

Another challenge was that new care aides needed to be oriented to the team leader role. LPN team leaders partner with new staff members to role model the team leader role.

Having team leaders provide them with direction was a new experience for care aides. Furthermore, most care aides had worked at Terraceview for many years, while some of the team leaders had much less experience at this facility. Care aide and charge nurse meetings were used as opportunities to familiarize staff with the team leaders' role and to consider the best ways to integrate team leaders into the team.

A general strategy used by the resident care coordinator is to approach team members at the end of their shift. She listens to their perspectives and elicits their suggestions on how to make improvements in how the staff work together:

> *[The Resident Care Coordinator gets] the team together at the end of their shift saying, "I noticed things were rough today. There seemed to be a lot of confusion. Tell me in your view what went wrong? How do you see that could change? What could we do to make that change? To make that better?"*

Ongoing staff education is a commitment of Terraceview. For example, the long term care manager delivers educational workshops. A recent workshop took place at the community college, so that both care aide staff and college students could participate. Different workshops have been offered to deal with care of residents with dementia and elder abuse. A one-day gentle care course is available for all new staff. Education programs have been developed in-house or adapted from other sources, tailored to the needs of Terraceview staff.

Discussion of Shared Roles/Duties

Role conflict and overlap of duties was a challenge that arose with the addition of new team members. All three nursing groups described a process that was used when conflict arose. The first step was to speak with the other staff person involved. If that did not

resolve the problem, further discussion involved another team member. For example, in the case of a conflict between a care aide and an LPN team leader, the expectation was that they would speak with the charge nurse. If the issue was not resolved, they would involve the resident care coordinator.

6. SUGGESTIONS FOR OTHER FACILITIES

Introducing Team Leaders

The staff and manager at Terraceview made a number of suggestions for other facilities that are considering adding the LPN team leader role. These suggestions are based on what they tried and what they have learned.

Communication and Respect

Effective communication and respect for all involved was very significant to the positive change process at Terraceview. Participants suggested that open lines of communication should be developed. Sharing information with all staff through a number of approaches (meetings, one-to-one, etc.) was recommended.

Managing the Change Process and Staffing Patterns

Before any change is implemented, it should first be introduced to all staff. Timing of change is significant. One team leader position was introduced in 1991 in the extended care area. In 1994, an opportunity to add another team leader position arose with the opening of the special care unit. The team leaders at Terraceview recommended the role to other LPNs. It was also suggested that staff be assigned to one area on a regular basis to become familiar with the new role of team leader.

Education

Educational workshops were suggested as an effective approach to support the integration of the new team leader position (for example, workshops on providing direction and supervision in team nursing).

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APPENDIX

Job Description of Team Leader

CASE STUDY

Yaletown House Society

VANCOUVER, BC

TABLE OF CONTENTS

1. Facility Description 243
2. Background 243
3. Roles and Responsibilities of Nursing Staff 245
4. Outcomes 247
5. Challenges and Solutions 247
6. Suggestions for Other Facilities 250

Appendices 252

1. FACILITY DESCRIPTION

Yaletown House is a continuing care, non-profit facility in downtown Vancouver. Constructed in 1985, this four-story structure houses 130 intermediate care beds. The care needs of residents have become more complex over time. When the facility opened, there were residents requiring all levels of care, from personal care to intermediate care level three. Now the majority of residents are assessed as requiring intermediate care level three and there are between four and eight extended care residents.

Yaletown House provides specialized services for residents including care of clients with dementia and respite for home care clients. The special care unit (SCU), which offers care for residents with Alzheimer's disease and other forms of dementia, is located on the second floor. One bed is available for use by long term care clients from the community to provide respite for family caregivers.

Security systems are in place to protect residents and staff. For example, visitors ring a doorbell to gain entry to the front door. A receptionist opens the door electronically. Direct patient care staff carry phones so that they can call for assistance whenever necessary. The facility employs licensed practical nurses, care aides, registered nurses and recreational therapists.

2. BACKGROUND

The increasing acuity of illness and complexity of care of the residents has led to changes in the type and mix of nursing staff employed by Yaletown House. Changes reported in the interviews for this case study included the transition from employing Licensed Graduate

Nurses to RNs in 1989 and the introduction of LPNs in 1992. The changes in 1989 are briefly reviewed to set the context for more recent staffing changes.

In 1988, the administrator, who was new to the facility, worked with the board of directors to examine and develop policies to raise the educational qualifications of staff in order to meet resident needs. Licensed Graduate Nurses on staff in 1989 were offered financial support from special funds allocated by the board. Five of the seven LGNs on staff completed their qualifying studies, wrote the national examination and became registered nurses. At the same time, in 1989, a policy was implemented that, as vacancies occurred, all new nurses hired would be RNs rather than LGNs.

This new initiative was, in part, the result of changes in the licensing of nurses in B.C. at the time. In 1988, the special category of Licensed Graduate Nurse was established with changes to the Nurses' (Registered) Act. LGNs are graduates from schools of nursing who have not written the national registration examinations for RNs. Nurses in the LGN category were encouraged by the registering body and employers to complete qualifying courses to become RNs. The LGN category was established with the expectation that future registrants wishing to use the title "nurse" would be licensed as RNs (or RPNs – registered psychiatric nurses) or LPNs. No new nurses were to be added to the LGN category; currently less than 100 are licensed in this category in B.C. Similar circumstances exist now for LPNs with the proposed changes to the LPN scope of practice and the existence of conditionally licensed LPNs.

In 1992, management noted an increased acuity in residents and a concurrent increase in medications being administered. To meet these changes, management chose to introduce the role of LPNs into the staffing mix at Yaletown House. LPNs are able to take on additional clinical nursing responsibilities required by residents in the facility. One manager described the process of adding LPNs into the staffing mix as follows.

> *Over the last six years we have slowly been implementing LPNs. The reason we did that is, we felt that the registered nurses needed more clinical support. There is too wide a gap between the capabilities of the care aides and the registered nurses. We needed something in the middle that would better support the clinical needs of the resident.*

Before introducing LPNs, management made a commitment that no employees would lose their job as a result of the change. Management advised nursing staff, specifically the RNs, that there would be no change in the number of RN positions. However, based upon attrition, the number of care aide positions would be reduced to allow for the LPN positions to be added. As care aide positions became vacant, they were replaced by LPNs. The challenges and solutions associated with the change in staff mix are discussed below.

Cost was also a factor in making the decision to change the staff mix. The manager noted that, from a budget perspective, for an additional $3,000 per year (above the salary of a care aide) the facility was able to hire an LPN. These LPNs brought more education

and more clinical nursing skills, and the role was perceived as contributing to a better staff mix to meet resident needs.

3. ROLES AND RESPONSIBILITIES OF NURSING STAFF

Staff at Yaletown House are assigned to unit teams for each floor. LPNs, care aides and RNs work together as a nursing team. The recreational therapy staff member and housekeeper are included as part of the unit team. LPNs were first introduced to the day and evening shifts. In early 2000, they were added to the night shift. Nursing teams are organized on the three shifts to care for the 130 residents as follows.

DAYS and EVENINGS

On the 4th floor	Days: one LPN, one RN and two care aides
	Evenings: one RN and two care aides
On the 3rd floor	Days: one LPN, one RN and two care aides
	Evenings: one LPN, one RN and one care aide
On the 2nd floor	
(Special Care Unit)	Days: one LPN, one RN and five care aides
	Evenings: one LPN, one RN and two care aides

An additional RN is available to all floors for 7.5 hours (Day/Evening split).

NIGHTS

On the 4th and 3rd floor: one care aide per floor and access to the RN on 2nd floor
On the 2nd floor: one LPN, one RN and one care aide

Note While the majority of care aides and LPNs work a 7.5 hour shift, there is also a six hour shift on some teams.

Job Descriptions and Performance Expectations

The duties and responsibilities of LPNs include direct nursing care and participation in committees and team meetings. (The LPN Job Description and Performance Expectations are appended).

As outlined in the job description and reported during interviews, LPN duties are to:

- assist residents to meet psychological, social, emotional and spiritual needs
- perform procedures such as vital signs, use glucometers, provide bowel care
- provide personal care (e.g. assist residents with activities of daily living)
- administer and record medications
- identify and report changes in client status to the RN and document this on charts
- participate in the admission, discharge and transfer of residents
- communicate with other members of the interdisciplinary team
- advocate on behalf of residents, and
- assist with orientation of new staff.

The duties outlined are completed in accordance with facility policies and procedures and the resident's care plan. For each of the duties or "key results areas" noted above, Yaletown House has identified "performance expectations" that define in more detail the responsibilities of LPNs. Examples of these performance expectations set out that an LPN:

- involves other members of the interdisciplinary team as indicated to meet needs or as requested by the resident
- is aware of resident's sensory and cognitive deficits and adjusts communication accordingly, and
- is proficient using the computerized documentation system to access and update information and to document new information.

Working with other staff was seen as an important part of LPNs' work. One LPN gave an example of consulting with a recreational therapist.

I do a lot of liaising. If I noticed a resident is in their room a lot, then I might speak to the recreational therapist and suggest that they might want to see the resident.

Aspects of their practice that LPNs reported they enjoyed were the opportunity to use their problem solving skills, to share their findings with RNs, and to carry out interventions based on that assessment and collaboration. A major part of the LPNs' nursing duties is the administration of oral medications and the taking of capillary blood for glucometer tests. LPNs also give reports at the end of their shifts to incoming LPNs to enhance continuity of care.

We have a formal report. You come up five or 10 minutes before shift so you can talk to the LPN that is assigned to the unit. She will tell you anything special that happened and what is supposed to be monitored.

The LPN role includes participation in committees and team meetings where care is discussed. Yaletown House has a policy of encouraging all staff to participate in committees. LPNs participate on the unit teams, the nursing team, the human resources committee and the care team. Each unit team has a monthly meeting for each shift. Nursing team meetings were changed to include LPNs. Care teams are responsible for reviewing each resident's care annually as part of the medical assessment and budgeting process.

LPNs were added to the staff mix because they bring the education and competencies needed to care for the residents, who are requiring higher levels of care. All LPNs working at Yaletown House maintain their license with the College of LPNs of B.C.

Yaletown House has a number of features to support care providers. The communication system provides all direct care staff with portable telephones that they use to call for assistance. The communication system of the facility was praised by one LPN.

That is something they do well here, the phones and the communication are a big issue. Sometimes you cannot leave the patient because he is high risk for a fall or something. If you need help you can call on the phone and talk to the nurse. It saves time. It is very handy and very safe too.

4. OUTCOMES

System Outcomes

An analysis of costs or benefits involved in introducing LPNs is not available, as systems were not in place to track this information. In the past, Yaletown manually tracked costs based on departments. It is hoped that its new computerized system will assist with outcome analysis in the future. The only specific budget information that could be calculated is the difference in the rate of pay between care aides and LPNs. Education costs have been assumed by the facility, as funding was not available for adding LPNs to the staff mix. Details regarding the extent of the education costs were not available for this case study.

Quality of Care Outcomes and Nurse Outcomes

Data on measurable resident outcomes and nurse outcomes related to the introduction of LPNs at Yaletown House were not available at the time this case study was completed.

5. CHALLENGES AND SOLUTIONS

Challenges involved in introducing the LPN role included budget concerns, educating staff on the roles and responsibilities of LPNs, establishing a pool of LPN casuals, and addressing the reduction in care aide positions. These challenges and their solutions were discussed by interview participants.

Budget

Higher salary costs resulting from the employment of LPNs was not originally anticipated in the funding formula for Yaletown House. The Ministry of Health's funding guidelines for continuing care facilities were developed in the 1980s and have not been revised. Yaletown receives a global budget with little flexibility for funding beyond basic staffing levels. The facility had to find the additional revenue for salaries from other areas in the budget.

A second budgetary challenge reported by management is that funding from the Ministry of Health does not cover all labour costs. An example given was that, because the facility has been successful in retaining staff, some employees earn 30 days vacation each year. The funding formula, however, covers only 24 or 25 days.

A third budget challenge is that there is limited funding for staff education. Yaletown House tries to provide both in-service education and courses outside the facility. Managers interviewed identified that the major cost is not in tuition or registration fees, but rather the cost of replacing staff. In-service education is done without replacing staff and draws on staff expertise in designing and delivering programs. Attendance at courses outside the facility often requires staff replacement. The line in the budget for staff replacement has to cover competing priorities, such as compassionate leave, Workers Compensation leaves and vacation.

Education of Staff on the Roles and Responsibilities of LPNs

When a new position is added to a team, all team members are affected. Participants gave examples of the education needs of care aides, RNs and other staff. For example, RNs were concerned about LPNs taking on skills such as medication administration. The RNs also brought up their fears of job loss. A manager gave this perspective on what the RNs were feeling.

I'll start with the RNs first. They were the most vocal. They felt that we were going to do away with RNs. They felt that although LPNs have training appropriate to medication administration, there were professional risks with having an LPN administer medications. We had to spend a considerable amount of time working with the staff to address those concerns.

LPNs described their frustration with co-workers' lack of knowledge about the role of LPNs. They perceived that other staff, including RNs, were uninformed about LPN duties and abilities. One LPN expressed her feelings this way.

It's even the nurses, which is very frustrating. I thought the nurses would be more informed and broader in thinking. I thought they would be more open to us because we are here to help them. There are nurses who try to belittle what we learned.

In-service education was an important strategy for helping staff understand the LPN role. A workshop was presented by the College of LPNs and the Registered Nurses Association of B.C. to provide an up-to-date picture of the roles and responsibilities of both LPNs and RNs, and to discuss ways that they could work together. An LPN gave this impression of the workshop.

It was definitely meant for the both of us. It was just a short meeting, but it was really good because it opened the mind of some of the RNs, to see the role and responsibilities of an LPN. The only difference is education. RNs have more knowledge and theory, in what they have learned, compared to an LPN who has only one-year education. And that's all the difference.

Another significant strategy has been managerial support for LPNs in using their training and education in the workplace. One LPN gave an example of that support.

There's a liquid narcotic Tylenol 3. For a while, the LPNs were not allowed to pour it. One RN said I was not allowed to give it. I discussed this with another RN and then spoke with the director of care. I asked her, are we allowed to give it or not? Her answer was, "Were you trained to give narcotics?" I said, "Yes…but I want to know the policy here". She said, "The policy is as long as you are trained in school you are allowed to do it here." Now we are giving it.

Another LPN gave an example of how a dietary staff member learned about the LPN role. This example also speaks to the need for in-service education for all staff, not just nursing staff. It was felt that this orientation should be explicit and that individual LPNs should not have the entire responsibility of educating co-workers.

When I first starting working here I filled in a dietary request form and I signed it using my last name and LPN. A dietary worker told me to ask the nurse to fill it out. I explained I was a licensed practical nurse and I filled it out. I brought it up with my manager. I said, "They do not seem to realize our role. It's not just nursing, it's that dietary and recreation therapy have to realize what we can do."

Using correct terminology to reflect the new role of the LPN is an associated educational issue that was discussed during the interviews. LPNs reported that their new role is being introduced into the language of Yaletown House. For example, when LPNs first started to work at the facility, they did not have an appropriate place to record because forms were printed for the care aide's signature. After an LPN asked that the term "care aide" be changed to "care giver," the documents were revised to reflect the new role. In a second example, LPNs did not feel that the language of the facility had integrated their role because the term "nurse" was often used in reference to an RN and was perceived to not include LPNs.

The education of staff is an important aspect of implementing change. However, funding from the Ministry of Health is seen as inadequate to meet this need. The staff interviewed reported that this inadequate funding had been experienced with other education needs, for example, education about HIV and MRSA (Methicillin-Resistant Staphylococcus Aureus).

Staff also had to learn to deal with questions of role overlap and role conflict. The strategy adopted was to develop a process to deal with conflicts in practice. LPNs described the first step in the process as speaking directly to the person involved. If that did not resolve the situation, they spoke to the nurse in their unit. The director of care was seen as the final step in the conflict management process.

LPN Casual Pool

Another challenge identified at Yaletown House is the need for a pool of casual LPNs. Management reported that the casual pool for LPNs is small, with the result that an absent LPN is often replaced by a care aide. In these cases, the LPN duties have to be divided between the care aide and RN, leading to role confusion.

One option to meet the need for casual LPNs is to support care aides to access LPN education. Management has approached care aides to see if they are interested in returning to school and has sought funding from the Ministry of Health initiative for care aides/LPNs.

The Loss of Care Aide Positions

The effect on care aides of the introduction of LPNs has been quite significant. Care aide positions that became vacant were replaced by LPNs, reducing the pool of care aide positions. LPNs are aware of this tension.

So that is the main issue... we are not only a threat to their work, but to their income...

They ask: "What can LPNs do?" To argue makes the issue worse. I don't blame them. They are bumped to accommodate us.

Management is also aware of the effect on care aides.

Care aides started to see that positions being posted were for LPNs. The casual care aides weren't given an opportunity to apply for those positions. There is still a concern about what the care aides feel. They may see that the LPN is spending more time doing medication administration and assessment of residents, and therefore seeing fewer residents and therefore not helping their workload. The nurses see that the LPNs are helping their workload. The care aides see an extra body on the floor, but don't see it making a significant difference to them.

As noted earlier, one attempt to meet this challenge has been through education. Care aides are encouraged to access LPN education.

6. SUGGESTIONS FOR OTHER FACILITIES

The staff at Yaletown House shared lessons they had learned from this process. Their suggestions for others considering adding LPNs to the nursing staff included:

- ensuring an adequate planning time to introduce the change to the staff mix
- introducing the change in such a way that no one loses their job
- establishing a coordinating committee with broad staff representation, and
- building in opportunities to discuss the change and its impact for all staff.

Ensure Adequate Time to Plan and Introduce the Change to the Staff Mix

Yaletown managers recognized that changing the staff mix would not be easy and that thoughtful long range planning was the preferred approach. They also pointed out that, in the best case scenario, they would have addressed many more issues before introducing the first LPN position. However, when the opportunity arose to introduce an LPN, management chose to act. A manager stated it this way.

It is not an easy transition. I'm sure if we were to do it over we would have more lead time in the planning process and address all of these issues before making a change, but when a position became available, we acted and we got that position in.

Avoid Job Loss

Yaletown House changed the nursing staff mix while ensuring that no regular staff members lost their job. Staff recommended that changing the staff mix be done in such a way that loss of jobs be avoided.

Establish a Coordinating Committee for the Change Process

Participants noted that it would be very helpful to have a coordinating committee introduce and manage the change in the nursing staff mix. Broad staff representation was

recommended to ensure that as many issues as possible are anticipated from the different perspectives of all departments.

Communication About the Change in Staff Mix

A clear process should be established to communicate the change. Providing a number of opportunities to discuss the change and its meaning and impact on staff was recommended.

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APPENDICES

Job Description of the Licensed Practical Nurse **pp. 252 - 253**

Performance Plans for the LPN (Key Results Area and Performance Expectations) **pp. 254 - 256**

PART 3 surveys

This section presents the results of two surveys on LPN employment and utilization. The first survey provides a provincial snapshot of where LPNs work – specifically, it identifies the proportion of hospitals and continuing care facilities that employ LPNs and the type of units to which they are assigned. The second survey took a sample of those facilities and examined the range of duties that LPNs perform on three of the most common units: medical, surgical and extended care. Managers were also asked to identify factors that influence their utilization of LPNs – a significant number offered additional comments about current and anticipated nurse staffing mix and roles.

CONTENTS

36 executive summary

41 survey of LPN employment in BC

55 survey of LPN skill utilization in BC

surveys executive summary

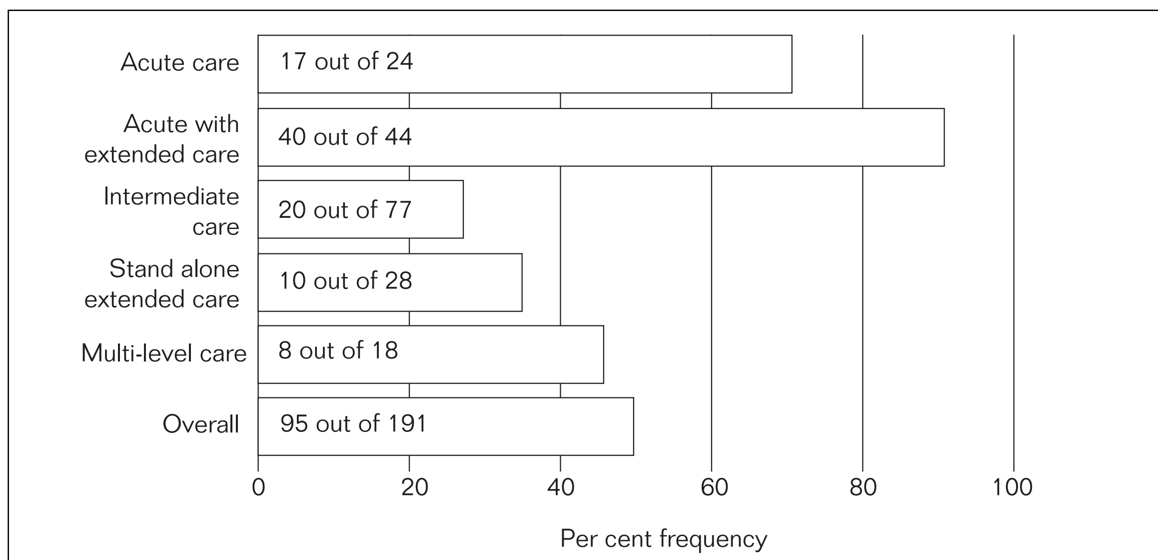
Two surveys were conducted for this project. The first survey provides a provincial snapshot of where LPNs work – specifically, it identifies the proportion of hospitals and continuing care facilities that employ LPNs and the type of units to which they are assigned. The second survey took a sample of those facilities and examined the range of duties that LPNs perform on three of the most common units: medical, surgical and extended care. Managers were also asked to identify factors that influence their utilization of LPNs – a significant number offered additional comments about current and anticipated nurse staffing mix and roles.

The results of each survey are presented later in this section. Highlights are presented here.

HIGHLIGHTS OF THE SURVEY OF LPN EMPLOYMENT IN B.C.

The first survey, the *Survey of LPN Employment in B.C.,* was sent to all unionized health care facilities that are part of the Health Employers Association of B.C. It was aimed at obtaining an overview of where LPNs are employed. Of the 263 facilities surveyed, 193 facility responses were used to compile the data, a response rate of 73 per cent.

Facilities Employing LPNs



Among the facilities surveyed in this project, 71 per cent (17) of the hospitals employ LPNs, as do 31 per cent (38) of the continuing care facilities (including intermediate, stand alone extended and multi-level) and 91 per cent (40) of the combined acute/extended care facilities.

In the acute care facilities surveyed (including acute with extended care units), LPNs were most commonly used on medical, surgical and extended care units. The highest level of utilization was on medical units; 83 per cent of facilities reported using LPNs on medical units. On surgical and extended care units, utilization was 74 per cent and 71 per cent, respectively. Other units most likely to employ LPNs included: rehabilitation, palliative/oncology, geriatric, pediatric, subacute/transitional, and operating room/day surgery. Utilization on these units ranged from 31 to 57 per cent. (For this summary, we have excluded units with responses "not applicable" or "no answer".)

LPNs Employed in Acute Care (with Extended Care) Facilities*

	Yes		No	
Medical unit	29	82.9%	6	17.1%
Surgical unit	17	73.9%	6	26.1%
Extended care	25	71.4%	10	28.6%
Rehabilitation unit	8	57.1%	6	42.9%
Palliative/oncology unit	9	45.0%	11	55.0%
Geriatric unit	7	43.8%	9	56.3%
Pediatric unit	9	42.9%	12	57.1%
Subacute/transitional units	5	38.5%	8	61.5%
Day surgery	10	34.5%	19	65.5%
Operating room	9	31.0%	20	69.0%
Mental health/psychiatric unit	6	30.0%	14	70.0%
Maternal/newborn	7	29.2%	17	70.8%
Emergency	9	29.0%	22	71.0%
Ambulatory/outpatient care	8	28.6%	20	71.4%
Float pool	6	26.1%	17	73.9%
Discharge planning	5	23.8%	16	76.2%
Perinatal unit	3	17.6%	14	82.4%
Critical care	2	8.7%	21	91.3%
Occupational health unit	1	8.3%	11	91.7%

**Number and percentage of units employing LPNs, for those facilities that have such units. Note that some respondents did not offer information for this question. Detailed responses are provided in the Survey of LPN Employment in B.C.*

Many respondents provided additional information in the “Comments” section at the end of the survey. For example, 17 facilities reported that they had LPNs working in other jobs, most commonly in care aide positions. Many acute and continuing care managers reported that their facilities were, or were considering, changing the staff mix to increase the number and utilization of LPNs.

Some respondents gave reasons for expanding the utilization of LPNs. The shortage of RNs was the reason given by five respondents. Having a new unit or facility was identified as another factor in deciding to expand the utilization of LPNs. Several facilities reported on change already underway using funds from the Ministry of Health to convert care aide positions to LPNs. Three facilities responding to the survey wrote about staff with RN education working as care aides or LPNs. Two facilities used foreign trained nurses. One facility noted that it is considering adding care aide positions.

HIGHLIGHTS OF THE SURVEY OF LPN SKILL UTILIZATION IN B.C.

The second survey, the Survey of LPN Skill Utilization in B.C., was targeted to a sample of facilities that responded to the first survey; it examines in greater depth the role and utilization of LPNs. The survey had an extensive pretest process, including a review of similar surveys from across Canada and consultation with regulatory bodies, educators, managers and nursing directors. The survey was mailed to 62 health care facilities: 33 acute care and 29 continuing care facilities. All acute care sites were sent three copies of the survey: one for a medical unit, one for a surgical unit and one for an extended care unit. In total, 70 surveys from 59 facilities were returned, a response rate of 75 per cent. The College of LPNs confirmed that all of the competencies in the survey are within the scope of practice and reflect the current standards of LPNs in B.C. All competencies highlighted here are entry level LPN competencies.

Survey Results for Specific Competencies

There is considerable variation in LPN utilization – between facilities and within facilities – and LPNs are frequently not practising to their full scope of competencies. Results of the competencies survey indicate an underutilization in some competencies – for example, administering oral medications, dressing simple wounds, and performing certain assessments – and a higher utilization in other competencies – for example, administering topical medications and assisting with deep breathing and coughing. Many of the competencies canvassed in the survey have been covered by the curriculum and considered entry level since the first practical nursing program was offered in the late 1940s. A number were added at later stages – for example, catheterizations and medication administration in the early 1980s and psychogeriatrics and subcutaneous injections in the 1990s. Though now well established in the curriculum and in regulatory standards, these competencies are not consistently part of LPN duties in B.C. facilities.

Finally, the results indicate that consistency in utilization of LPNs can vary from one facility to the next, and also can vary significantly between units in the same facility.

Survey Results for General Utilization Issues

Following the competencies section of the survey, respondents were asked about general employment issues.

Respondents were also asked to choose from a list of possible explanations for their overall use or non-use of LPNs. The most common response to this question was historical practice. For facilities that do not employ LPNs, the next most common answer was "work jurisdiction issues with other unions" (36 per cent), followed by lack of knowledge by manager and staff of current LPN scope of practice and competencies (31 per cent). For facilities that do employ LPNs, over 60 per cent correlated this practice to hospital and administrative policy and confidence that LPNs have the appropriate skills for patient or resident needs.

Managers were also asked to identify factors that influence their utilization of LPNs. Respondents wrote a great deal in answer to this question. The most common factor cited was the shortage of RNs. Variation in LPN practice and education was also cited by a number of respondents, many of whom called attention to the lack of available education programs to upgrade LPNs' skills and knowledge. Some noted the change in patients' needs and increased patient acuity. Many respondents commented on changes they are making to the staff mix – in particular, the addition of LPN positions and/or expansion of their duties.

The final section of the survey invited respondents to add additional comments. Many offered explanations for why LPNs are not used in the unit or facility. Among the reasons cited were: adding another "level" presents a certain increase in administration time and decrease in flexibility of continuing care; licensing rules restricted the facility's ability to use LPNs; and that LPNs were already employed as care aides. Some respondents wrote about their positive experience with the LPN role in their facility, while others described changes in the role of LPNs that were already underway at their facility.

SURVEY 1

survey of LPN employment in BC

TABLE OF CONTENTS

Introduction	41
Methodology	41
Responses	41
Facilities Employing LPNs	42
Employment of LPNs, by Bed Ranges	43
Employment of LPNs in Acute Care Facilities, by Unit	45
Comments	49
Appendix A: Survey Form	52

INTRODUCTION

Two surveys were conducted for this project. This first survey was sent to all unionized health care facilities that are part of HEABC and was aimed at obtaining an overview of where LPNs are employed. A second survey was targeted to a sample of facilities; it examines in greater depth the role and utilization of LPNs.

Methodology

The project surveyed health care facilities that are members of the Health Employers Association of British Columbia. The mailing list was edited to eliminate duplication of facilities, health care centers, health societies, regional health boards, information bureaus and Ministry of Health contacts. The survey was mailed to 263 facilities.

Responses

A total of 210 surveys were received. This included blanks, duplicates and surveys from facilities with no beds. The correct number of surveys is 193, which represents a response rate of 73 per cent.

FACILITIES EMPLOYING LPNS

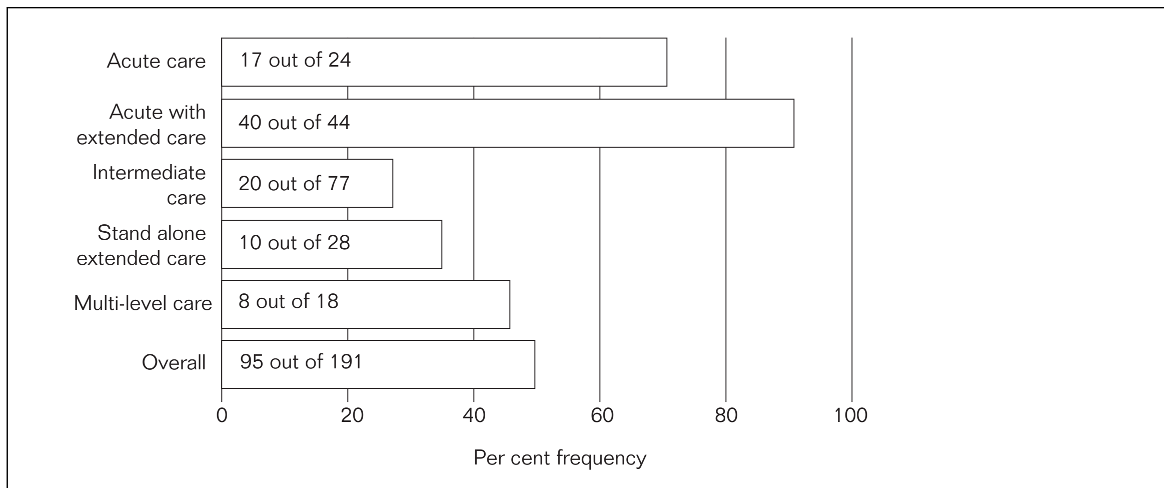
Of the 191 facilities that responded to the survey, 50 per cent reported that they employ LPNs. In the acute care facilities without extended care units, 71 per cent reported employing LPNs. In the acute care facilities with extended care, 91 per cent said they employ LPNs.

Responses in the continuing care sector indicate that 26 per cent of intermediate care facilities employ LPNs. Responses from stand alone extended care facilities indicate that 36 per cent employ LPNs. Of the 18 multi-level facilities that answered the survey, eight (44 per cent) use LPNs.

Figure 1a: Facilities Employing LPNs

Facility Type		Yes		No		Total	
Acute care	12.6%	17	70.8%	7	29.2%	24	100%
Acute with extended care	23%	40	90.9%	4	9.1%	44	100%
Intermediate care	40.3%	20	26%	57	74%	77	100%
Stand alone extended care	14.7%	10	35.7%	18	64.3%	28	100%
Multi-level care	9.4%	8	44.4%	10	55.6%	18	100%
Total	99%	95	49.7%	96	50.3%	191	100%
No answer	1%	1	50%	1	50%	2	100%

Figure 1b: Facilities Employing LPNs



EMPLOYMENT OF LPNs, BY BED RANGES

Among the acute care facilities surveyed, including those with extended care units, all but one of those with 51 beds or more reported that they employ LPNs.

Figure 3: Acute Care Facility Bed Ranges

LPNs	Overall	Bed Ranges				
		1-50	51-100	101-200	201-300	301+
Yes	17 70.8%	9 56.2%	4 100%	0 0	2 100%	2 100%
No	7 29.2%	7 43.8%	0 0%	0 0	0 0%	0 0%
Total	24 100%	16 100%	4 100%	0 0%	2 100%	2 100%

Figure 4: Acute With Extended Care Facility Bed Ranges

LPNs	Overall	Bed Ranges				
		1-50	51-100	101-200	201-300	301+
Yes	40 90.9%	12 80%	10 100%	8 100%	3 100%	7 87.5%
No	4 9.1%	3 20%	0 0%	0 0%	0 0%	1 12.5%
Total	44 100%	15 100%	10 100%	8 100%	3 100%	8 100%

In the continuing care sector, no pattern of use or non use of LPNs was found based on the number of beds in the facility.

Figure 5: Intermediate Care Facility Bed Ranges

LPNs	Overall		Bed Ranges								
			1-50		51-100		101-200		201-300		301+
Yes	20	26%	2	10.5%	8	21.6%	8	47.1%	2	50%	0
No	57	74%	17	89.5%	29	78.4%	9	52.9%	2	50%	0
Total	77	100%	19	100%	37	100%	17	100%	4	100%	0

Figure 6: Stand Alone Extended Care Facility Bed Ranges

LPNs	Overall		Bed Ranges								
			1-50		51-100		101-200		201-300		301+
Yes	10	35.7%	2	28.6%	2	25%	3	30%	3	100%	0
No	18	64.3%	5	71.4%	6	75%	7	70%	0	0%	0
Total	28	100%	7	100%	8	100%	10	100%	3	100%	0%

Figure 7: Multi-level Care Facility Bed Ranges

LPNs	Overall		Bed Ranges									
			1-50		51-100		101-200		201-300		301+	
Yes	7	41.2%	0	0%	2	28.6%	4	57.1%	1	100%	1	100%
No	10	58.8%	2	100%	5	71.4%	3	42.9%	0	0%	0	0%
Total	17	100%	2	100%	7	100%	7	100%	1	100%	1	100%

EMPLOYMENT OF LPNS IN ACUTE CARE FACILITIES, BY UNIT

Of the 24 acute care facilities that responded to the survey, 17 (71 per cent) reported that they employ LPNs.

Figure 8: Acute Care Facilities Employing LPNs

Yes	17	70.8%
No	7	29.2%
Total	24	100%

Figures 9 and 11 present a breakdown of where LPNs work in these facilities. Figure 9 includes facilities that defined themselves as acute care, and Figure 11 includes acute care facilities with an extended care unit.

The medical unit was the unit most often identified as employing LPNs. Other units where LPNs commonly work are surgical, exended care, rehabilitation, palliative/oncology, geriatric, pediatric, subacute/transitional, and operating room/day surgery.

Figure 9: Acute Care Facilities Employing LPNs, by Unit

Units	Frequencies									
	Yes		No		N/A		No answer		Total	
Medical unit	11	45.8%	1	4.2%	3	12.5%	9	37.5%	24	100%
Surgical unit	9	37.5%	2	8.3%	4	16.7%	9	37.5%	24	100%
Rehabilitation unit	7	29.2%	3	12.5%	7	29.2%	7	29.2%	24	100%
Ambulatory/outpatient care	6	25%	9	37.5%	2	8.3%	7	29.2%	24	100%
Maternal/newborn	6	25%	5	20.8%	4	16.7%	9	37.5%	24	100%
Palliative/oncology unit	5	20.8%	5	20.8%	6	25%	8	33.3%	24	100%
Pediatric unit	5	20.8%	5	20.8%	6	25%	8	33.3%	24	100%
Operating room	4	16.7%	6	25%	6	25%	8	33.3%	24	100%
Float pool	3	12.5%	6	25%	7	29.2%	8	33.3%	24	100%
Geriatric unit	3	12.5%	2	8.3%	11	45.8%	8	33.3%	24	100%
Extended care	2	8.3%	3	12.5%	11	45.8%	8	33.3%	24	100%
Day surgery	2	8.3%	9	37.5%	6	25%	7	29.2%	24	100%
Emergency	2	8.3%	11	45.8%	3	12.5%	8	33.3%	24	100%
Mental health/psychiatric unit	2	8.3%	5	20.8%	9	37.5%	8	33.3%	24	100%
Subacute/transitional units	2	8.3%	4	16.7%	10	41.7%	8	33.3%	24	100%
Occupational health unit	1	4.2%	9	37.5%	6	25%	8	33.3%	24	100%
Critical care	1	4.2%	8	33.3%	5	20.8%	10	41.7%	24	100%
Discharge planning	0	0%	10	41.7%	6	25%	8	33.3%	24	100%
Perinatal unit	0	0%	6	25%	10	41.7%	8	33.3%	24	100%

Of the 44 facilities that defined themselves as acute care with an extended care unit, 40 (91 per cent) employ LPNs. Respondents reported that LPNs work on medical, extended care, surgical, day surgery, emergency, operating room, palliative care and pediatric units.

Figure 10: Acute with Extended Care Units

Yes	40	90.9%
No	4	9.1%
Total	44	100%

Figure 11: Acute with Extended Care Facilities Employing LPNs, by Unit

Units	Frequencies									
	Yes		No		N/A		No answer		Total	
Medical unit	29	65.9%	6	13.6%	2	4.5%	7	15.9%	44	100%
Extended care	25	56.8%	10	22.7%	1	2.3%	8	18.2%	44	100%
Surgical unit	17	38.6%	6	13.6%	9	20.5%	12	27.3%	44	100%
Day surgery	10	22.7%	19	43.2%	6	13.6%	9	20.5%	44	100%
Emergency	9	20.5%	22	50%	3	6.8%	10	22.7%	44	100%
Operating room	9	20.5%	20	45.5%	7	15.9%	8	18.2%	44	100%
Palliative/oncology unit	9	20.5%	11	25%	14	31.8%	10	22.7%	44	100%
Pediatric unit	9	20.5%	12	27.3%	12	27.3%	11	25%	44	100%
Ambulatory/outpatient care	8	18.2%	20	45.5%	8	18.2%	8	18.2%	44	100%
Rehabilitation unit	8	18.2%	6	13.6%	20	45.5%	10	22.7%	44	100%
Geriatric unit	7	15.9%	9	20.5%	17	38.6%	11	25%	44	100%
Maternal/newborn	7	15.9%	17	38.6%	11	25%	9	20.5%	44	100%
Mental health/psychiatric unit	6	13.6%	14	31.8%	14	31.8%	10	22.7%	44	100%
Float pool	6	13.6%	17	38.6%	13	29.5%	8	18.2%	44	100%
Discharge planning	5	11.4%	16	36.4%	15	34.1%	8	18.2%	44	100%
Subacute/transitional units	5	11.4%	8	18.2%	20	45.5%	11	25%	44	100%
Perinatal unit	3	6.8%	14	31.8%	18	40.9%	9	20.5%	44	100%
Critical care	2	4.5%	21	47.7%	11	25%	10	22.7%	44	100%
Occupational health unit	1	2.3%	11	25%	23	52.3%	9	20.5%	44	100%

The survey also attempted to distinguish units within continuing care facilities that use LPNs (question five). While some continuing care facilities did identify which units employ LPNs, most did not provide that breakdown. Being incomplete, responses to question five are not presented in this report.

In question six, the survey asked for information on the full time equivalent ratio of registered nurses, registered psychiatric nurses, licensed practical nurses and care aides. The responses were inconsistent, and in many cases, no answer was given.

COMMENTS

Many respondents provided additional information in the "Comments" section at the end of the survey. These comments are grouped into five general themes:

- LPNs working in other jobs
- change in the employment of LPNs
- reasons LPNs are not employed
- use of foreign trained/former registered nurses and,
- employment of other workers.

1. LPNs Working in Other Jobs

Seventeen facilities said they had LPNs working in other jobs, most commonly in care aide positions. Several respondents said these staff were licensed with the College of LPNs, but were not working as LPNs.

2. Change in the Employment and Utilization of LPNs

a) Many managers said their facilities were considering changing the staff mix to increase the employment of LPNs. This change is occurring in both acute and continuing care facilities. Others spoke about a change in the use of the LPNs already working in the facility. The following quotations reflect this theme.

We have two units – extended care and acute care. There is a move to staff ECU mainly with LPNs. There will also be an LPN on day shift on acute care.

We are currently developing an LPN position and investigating upgrading our nurse aides to LPNs through education.

We are considering creating new LPN positions in extended care, geriatric unit, medical unit and operating room.

I have worked at other facilities utilizing LPNs in the roles of giving medications and doing dressings, and I am reviewing the opportunity to introduce these roles at our care centre.

b) Some respondents gave reasons for expanding the utilization of LPNs. The shortage of RNs was the reason given by five respondents. Having a new unit or

facility was identified as another factor in deciding to expand the utilization of LPNs.

Two facilities indicated that rising patient acuity promoted the change.

As extended care units have more complex residents requiring more resources, it would be beneficial to have care staff who have nursing knowledge and skill equivalent to the LPN curriculum and some rehabilitation (mobility).

Several facilities reported on change already underway using funds from the Ministry of Health to convert care aide positions to LPNs. One site linked its change this way.

We are currently developing a job description for two reasons: 1) LPN funding initiative, and 2) alternative to RN shortage.

c) Two facilities indicated they will decrease the use of LPNs. One reported it will continue using LPNs in acute areas, while in extended care the jobs will become long term care aide positions by attrition.

3. Reasons LPNs Are Not Employed

Several facilities gave reasons for not employing LPNs.

Given the small number of staff, having a third category would create numerous problems, such as an adequate casual pool, for no significant improvement in hours of care per resident.

Another facility reported that care aides would provide the needed care, and that there is a shortage of LPNs even if the facility were to change.

Our facility educates care aides with a pharmaceutical course, and then they give out the oral medications. If LPNs were more readily abundant, I would change those position requirements to LPNs. Also, a bridging program for care aides to train up to LPN would be beneficial and well used.

Several facilities spoke about their decision to employ RNs.

This is a very small facility located across town from an acute care hospital. Therefore, it is felt more appropriate to have RN staff on day shift. The RNs are on call the days they work to ensure continuity of care when providing support to care aides.

One respondent reported that LPNs work in continuing care but, due to patient acuity, are not used in acute care.

LPNs and aides work in the multi-level area. Acute care has two RNs working 24 hours, seven days a week. This is the minimum RN staffing required due to patient acuity. Emergency and obstetric expertise is required.

Another facility explained that having two RNs provides mentoring for new graduates and ensures availability of RN staff during peak times.

4. Use of Foreign Trained Nurses/Former RNs

Three facilities responding to the survey wrote about staff with RN education working as care aides or LPNs. Two facilities used foreign trained nurses.

> *Please note we have no LPNs on staff. However, we have three staff members who are foreign trained RNs working as care aides.*

A second facility noted that foreign trained nurses are studying to write the LPN examination.

> *We currently have two staff upgrading at the Open Learning Agency. They are foreign nurses working on LPN status. We hope to receive funding for the LPN position.*

Another respondent wrote about employing a former RN who had let her license lapse and then obtained an LPN license.

> *With the level of care, both physically and psychogeriatric, LPNs would be an asset. We do not have a specific job description for the LPN; she was hired into a position that was vacant and we were unable to fill with an RN. She was an RN who did not renew her license but instead received an LPN license.*

5. Employment of Other Workers

One facility is considering adding care aide positions.

> *We have a significant number of alternate levels of care on our medical unit, which makes for a heavy workload. It would be beneficial for us to add health care workers or care aides to the mix of staff to assist with personal care issues such as bathing, feeding, toileting, and bed making. This will lighten loads for RNs and LPNs and help address the issue of non-nursing duties.*

Survey of LPN Employment in B.C.

Together, the Health Employers Association of British Columbia (HEABC), the Association of Unions represented by the Hospital Employees Union (HEU), and the British Columbia Government and Service Employees Union (BCGEU) are conducting this survey to gather general information about Licensed Practical Nurses (LPNs) working in BC health care facilities.

Completion of this survey will ensure that the profile of BC facilities includes your facility. By completing this survey you will help to make the BC picture complete.

Your participation will help us get an understanding of where LPN's are currently working in BC's health care facilities.

The survey has both open and closed ended questions. We've also provided space at the end of the survey for comments, and if you wish to add more, feel free to use the other side of the paper.

The abbreviations used in this survey, are:

RN - Registered Nurse

RPN - Registered Psychiatric Nurse

PN - Practical Nurse: Includes both Practical Nurses who are licensed with the College as a Licensed Practical Nurse (LPN) and those that are not licensed. We know there are practical nurses working in other jobs but this survey is interested in those working in nursing positions.

CA - Care Aide: Includes many job titles such as, Nursing Aide, Resident Care Attendant, Long Term Care Aide and others.

Please complete this survey and return it and copies of job descriptions of LPNs to Wendy Williams, Avalon Health Consulting, in the envelope provided or by fax.

LPN's Current Staffing Levels Survey

1. Please provide the name and contact information of the facility for which you are supplying this information:

Name of facility: ____________________ ____________________

Street: ____________________

City: ____________ **Postal Code:** ____________

Telephone: ____________ **Fax:** ____________

E-mail: ____________

2a. Please identify the type of facility you work in:

- ❑ acute care
- ❑ acute care with long term/extended care
- ❑ intermediate care
- ❑ stand alone long term/extended care
- ❑ multi-level care

2b. Number of beds in your facility: ____________

3. Currently, are there Practical Nurses as defined on the front page of this survey, working within the facility: . . . . ❑ Yes ❑ No
If yes, proceed to question 4. If no, please skip to question 6.

4. If you are an acute care facility or an acute care with long term/ extended care facility, please indicate the areas where LPN's work within the facility, and how many FTE LPN's positions there are.
If a unit is not applicable to your facility, please check off N/A.
If you are a continuing care facility, please go to question 5.

Ambulatory/Outpatient Care	❑ yes	❑ no	❑ N/A	# of LPN's ______
Critical Care	❑ yes	❑ no	❑ N/A	# of LPN's ______
Extended Care	❑ yes	❑ no	❑ N/A	# of LPN's ______
Day Surgery	❑ yes	❑ no	❑ N/A	# of LPN's ______
Discharge Planning	❑ yes	❑ no	❑ N/A	# of LPN's ______
Float Pool	❑ yes	❑ no	❑ N/A	# of LPN's ______
Emergency	❑ yes	❑ no	❑ N/A	# of LPN's ______
Geriatric Unit	❑ yes	❑ no	❑ N/A	# of LPN's ______
Medical Unit	❑ yes	❑ no	❑ N/A	# of LPN's ______
Mental Health/Psychiatric Unit	❑ yes	❑ no	❑ N/A	# of LPN's ______
Maternal/ Newborn	❑ yes	❑ no	❑ N/A	# of LPN's ______
Occupational Health Unit	❑ yes	❑ no	❑ N/A	# of LPN's ______
Operating Room	❑ yes	❑ no	❑ N/A	# of LPN's ______
Palliative/Oncology Unit	❑ yes	❑ no	❑ N/A	# of LPN's ______
Pediatric Unit	❑ yes	❑ no	❑ N/A	# of LPN's ______
Perinatal Unit	❑ yes	❑ no	❑ N/A	# of LPN's ______

Rehabilitation Unit .... ❑ yes ❑ no ❑ N/A # of LPN's _____
Subacute/Transitional Units .... ❑ yes ❑ no ❑ N/A # of LPN's _____
Surgical Unit .... ❑ yes ❑ no ❑ N/A # of LPN's _____
Other: (please specify) ______________________________ # of LPN's __
Total # of LPN's .... ________

5. If you are an intermediate care, extended care or multilevel care facility, please indicate the areas where LPNs work within your facility, and how many LPN's work within each unit. If an acute care facility, please go to question 6.

Alzheimer's/Special Care/Locked Unit ..... ❑ yes ❑ no ❑ N/A # of LPN's _____
Geriatric Psychiatric Unit .... ❑ yes ❑ no ❑ N/A # of LPN's _____
Palliative Care Unit .... ❑ yes ❑ no ❑ N/A # of LPN's _____
General .... ❑ yes ❑ no ❑ N/A # of LPN's _____
Other: (please specify) ______________________________ # of LPN's __
Total # of LPN's .... ____

6. Based on a regular FTE position equalling 1872 hours per year, what is the number of regular FTE in these categories within your facility?

RN _______ RPN ________ LPN _______ CA _______

7. When you return this survey, please enclose copies of LPN job descriptions used in your facility.

Any personal information that you submit, is strictly confidential. Contact people may be needed if we have any follow up questions to the survey, so we are asking participants to include their:

Name: ____

Job Title: ____

Thanks for giving us your name. We will enter it in the draw for a basket of BC products. The draw will be held December 15, 1999.

Comments? (Please use other side of paper if more room is needed) ____________________

____

____

____

Thank-you for your co-operation in completing this survey. Your time and input are appreciated!

SURVEY 2

survey of LPN skill utilization in BC

TABLE OF CONTENTS

Introduction to the Survey 55
Introduction to the Findings 56
Facilities Employing LPNs 57
LPN Registration and General Nursing Practice Role 58
LPN Responsibilities
  Acute Care 61
  Continuing Care 71
LPN Employment 80
Comments 86
Appendix A: Detailed Methodology 89
Appendix B: Survey Form 91

INTRODUCTION TO THE SURVEY

Two surveys were conducted for this project. The first was sent to all health care facilities; it identifies the units where LPNs most commonly work. This second survey was targeted to a sample of facilities; it examines in greater depth the role and utilization of LPNs.

Methodology

The survey had an extensive pretest process. Organizations that provided comments include the College of Licensed Practical Nurses of British Columbia and the Licensed Practical Nurses Association of British Columbia. LPN educators, health care facility managers and nursing directors also reviewed the survey.

The competencies used in this survey were drawn from various B.C. and national sources. Competencies of licensed practical nurses include the knowledge, skills, attitudes and judgement required for practice. Questions were chosen from surveys by the Registered Practical Nurses Association of Ontario, the PEI Licensed Nursing Assistant Association, and a working document of 144 competencies from the College of LPNs of B.C.

The College of LPNs confirmed that all of the competencies in the survey are within the scope of practice and reflect the current standards of LPNs in B.C. All but three of the competencies – complex wounds, peritoneal dialysis and hemodialysis – are entry level LPN competencies.

A detailed methodology is provided in Appendix A.

Responses

The survey was mailed to 62 health care facilities: 33 acute care and 29 continuing care facilities. All acute care sites were sent three copies of the survey: one for a medical unit, one for a surgical unit and one for an extended care unit. One survey was sent to each continuing care facility.

In total, 70 surveys from 59 facilities were returned. In the acute care sample, not all facilities had extended care units. Smaller facilities did not have separate medical and surgical units. The maximum number of surveys we could have received was 93. The response rate, based on 70 returned out of a possible 93, is 75 per cent.

INTRODUCTION TO THE FINDINGS

The first section – *Facilities Employing LPNs* – presents the distribution of LPNs and care aides among the acute and continuing care units that responded to this survey.

The following two sections present the survey findings on LPN utilization. The first – *LPN Registration and General Nursing Practice Role* – covers the issues of LPN licensure and the LPN role in evaluation, planning and implementing nursing interventions. The responses for both acute care and continuing care are presented. The second section – *LPN Responsibilities* – presents the findings on LPN skill utilization by distinct categories of intervention. Acute care and continuing care responses are presented separately. The continuing care responses include the extended care units attached to hospitals.

For the sections on LPN utilization, we present the responses for those units that employ LPNs. Further, only the active responses are given; that is, we did not include responses where no answer was given. Also, included in the continuing care responses is one respondent that noted the facility was currently making the transition to employ LPNs. This explains why the numbers do not always add up to the full sample of units that employ LPNs (30 acute care and 14 continuing care).

With the exception of three interventions – packing complex wounds and providing peritoneal dialysis and hemodialysis – all of the competencies in the following tables were confirmed by the College of LPNs as entry level competencies.

As noted earlier, competencies encompass knowledge, skills and judgment. By its nature, a survey cannot capture the full complexity of LPN practice. This survey focused on the “skills” element of LPN competencies, and it was not intended to be an exhaustive list of the entry level skills of LPNs in B.C.

FACILITIES EMPLOYING LPNS

Of the 70 units that responded to the survey, 44 (63 per cent) reported that they employ LPNs. Of these 44 units, 30 are acute care and 14 are continuing care.

Figure 1: LPNs Employed in Acute and Continuing Care

LPNs in unit	Overall		Type of Unit			
			Acute care		Continuing care	
Yes	44	62.9%	30	85.7%	14	40%
No	26	37.1%	5	14.3%	21	60%
Total	70	100%	35	100%	35	100%

In the acute care sector, 17 surveys came from medical units, 18 from surgical units, and five from units that provide a combination of services.

Figure 2: Survey Respondents Acute Care Facilities, by Unit

Units	Overall		LPNs in Unit			
			Yes		No	
Surgical unit	18	51.4%	15	50%	3	60%
Medical unit	17	48.6%	16	53.3%	1	20%
Other	4	11.4%	4	13.3%	0	0%
All of the above	1	2.9%	1	3.3%	0	0%
Extended care unit	0	0%	0	0%	0	0%
No answer	2	5.7%	1	3.3%	1	20%

LPN REGISTRATION AND GENERAL NURSING PRACTICE ROLE

All 29 of the acute care units that responded to this question indicated that LPNs are required to maintain registration with the College of Licensed Practical Nurses of B.C.

All but one of the continuing care facilities require LPNs to maintain their license.

Figure 3: LPN Registration in Acute Care Facilities

Does the facility require LPNs working at this facility to maintain their license with the College of LPNs?		
Yes	29	100%
No	0	0%
Total	29	100%

Figure 4: LPN Registration in Continuing Care Facilities

Does the facility require LPNs working at this facility to maintain their license with the College of LPNs?		
Yes	14	93.3%
No	1	6.7%
Total	15	100%

LPNs practise independently within their scope of practice in 97 per cent of acute and 93 per cent of continuing care facilities.

Figure 5: LPN Professional Responsibility in Acute Care

Practises independently within the scope of practice		
Yes	29	96.7%
No	1	3.3%
Total	30	100%

Figure 6: LPN Professional Responsibility in Continuing Care

Practises independently within the scope of practice		
Yes	14	93.3%
No	1	6.7%
TOTAL	15	100%

For over 80 per cent of the total facilities surveyed, LPN practice includes a role in evaluating the effectiveness of nursing interventions and participating in quality assurance and improvement.

Figure 7: LPN Evaluation in Acute Care Facilities

Frequencies	Yes		No		Total	
Evaluates effectiveness of nursing interventions by comparing actual outcomes to anticipated outcomes	26	92.9%	2	7.1%	28	100%
Participates in quality assurance and improvement activities to enhance client care and nursing practice	29	96.7%	1	3.3%	30	100%

Figure 8: LPN Evaluation in Continuing Care Facilities

Frequencies	Yes		No		Total	
Evaluates effectiveness of nursing interventions by comparing actual outcomes to anticipated outcomes	12	80%	3	20%	15	100%
Participates in quality assurance and improvement activities to enhance client care and nursing practice	14	93.3%	1	6.7%	15	100%

Respondents reported that LPNs organize their own workload in 93 per cent of facilities. The role of teaching in LPN practice varies depending on the learning topic. The lowest involvement in teaching was reported for the development of client learning plans – 35 per cent of acute care and 23 per cent of continuing care facilities reported a role. Of the acute care respondents, 73 per cent reported that LPNs play a role in teaching about wound management, but only 31 per cent reported such a role for teaching about medications.

Figure 9: LPN Planning in Acute Care Facilities

Planning	Frequencies					
	Yes		No		Total	
Organizes own workload, plans, implements and evaluates own work pattern	27	93.1%	2	6.9%	29	100%
Develops learning plans for clients	10	34.5%	19	65.5%	29	100%

Figure 10: LPN Planning in Continuing Care Facilities

Planning	Frequencies					
	Yes		No		Total	
Organizes own workload, plans, implements and evaluates own work pattern	13	92.9%	1	7.1%	14	100%
Develops learning plans for clients	3	23.1%	10	76.9%	13	100%

LPN practice includes managing multiple nursing interventions simultaneously as well as managing physical resources.

Figure 11: Implementation in Acute Care Facilities

Implementation	Frequencies					
	Yes		No		Total	
Manages multiple nursing interventions simultaneously	23	76.7%	7	23.3%	30	100%
Provides appropriate client teaching	24	82.8%	5	17.2%	29	100%
Manages physical resources (equipment supplies, medication, linen) in order to provide effective and efficient care	26	86.7%	4	13.3%	30	100%

Figure 12: Implementation for Continuing Care

Implementation	Frequencies					
	Yes		No		Total	
Manages multiple nursing interventions simultaneously	13	92.9%	1	7.1%	14	100%
Provides appropriate client teaching	10	71.4%	4	28.6%	14	100%
Manages physical resources (equipment supplies, medication, linen) in order to provide effective and efficient care	12	85.7%	2	14.3%	14	100%

LPN RESPONSIBILITIES: ACUTE CARE

Assessment

Facilities were asked about the LPN role in patient assessment. All acute care facilities reported that LPNs use inspection and interviewing for data collection and that LPNs document their assessments. Responses to other questions on the LPN role in assessment varied from 90 per cent for the integumentary system, to only 21 per cent for the neck, lymph nodes and breast.

Figure 13: Assessment in Acute Care Facilities

Assessment	Frequencies					
	Yes		No		Total	
Is the initial assessment done by an LPN?	23	79.3%	6	20.7%	29	100%
Uses palpation for data collection with clients	17	58.6%	12	41.4%	29	100%
Uses inspection for data collection with clients	30	100%	0	0%	30	100%
Uses interviewing for data collection with clients	29	100%	0	0%	29	100%
Uses auscultation for data collection with clients	16	57.1%	12	42.9%	28	100%
Collaborates with clients to perform holistic assessments of cognitive needs	23	79.3%	6	20.7%	29	100%
Collaborates with clients to perform holistic assessments of emotional needs	24	82.8%	5	17.2%	29	100%
Collaborates with clients to perform holistic assessments of cultural needs	23	79.3%	6	20.7%	29	100%
Collaborates with clients to perform holistic assessments of physical needs	28	96.6%	1	3.4%	29	100%
Assesses abdomen	22	75.9%	7	24.1%	29	100%
Assesses cardiovascular system	18	62.1%	11	37.9%	29	100%
Assesses head, eyes, ear and throat	15	51.7%	14	48.3%	29	100%
Assesses chest	16	55.2%	13	44.8%	29	100%
Assesses integumentary system	26	89.7%	3	10.3%	29	100%
Assesses musculoskeletal system	24	82.8%	5	17.2%	29	100%
Assesses neck, lymph nodes, breast	6	20.7%	23	79.3%	29	100%
Assesses neurologic system	17	58.6%	12	41.4%	29	100%
Assesses peripheral vascular system	21	72.4%	8	27.6%	29	100%
Assesses respiratory system	18	62.1%	11	37.9%	29	100%
Uses the unit's usual assessment tools to guide data collection for assessing	28	93.3%	2	6.7%	30	100%
Documents assessment	30	100%	0	0%	30	100%
Assesses the learning needs of clients	24	82.8%	5	17.2%	29	100%

Facilities were also asked about the patients being assessed. Respondents included the medical, surgical and extended care units of acute care hospitals. Most facilities surveyed do not provide services to children, infants or neonates.

Figure 14: Assessment in Acute Care Facilities

Assessment	Frequencies							
	Yes		No		Service not provided here		Total	
Performs comprehensive and holistic assessments of elderly adults	24	80%	5	16.7%	1	3.3%	30	100%
Performs comprehensive and holistic nursing assessments of adults	23	76.7%	5	16.7%	2	6.7%	30	100%
Performs comprehensive and holistic assessments of families	7	23.3%	18	60%	5	16.7%	30	100%
Performs comprehensive and holistic nursing assessments of adolescents	7	23.3%	9	30%	14	46.7%	30	100%
Performs comprehensive and holistic nursing assessments of children	3	10%	10	33.3%	17	56.7%	30	100%
Performs comprehensive and holistic nursing assessments of infants	2	6.7%	11	36.7%	17	56.7%	30	100%
Performs comprehensive and holistic nursing assessment of neonates	1	3.3%	12	40%	17	56.7%	30	100%

Medication Management

In 1984, pharmacology and medication administration in continuing care, gerontology and community care was added to the B.C. practical nursing curriculum. Administering medications via G-tube has been part of the curriculum since that time. In 1995, the curriculum was expanded to include the administration of oral narcotics, insulin and subcutaneous injection. This could explain the low utilization of LPNs for medication administration in the acute care facilities surveyed. One exception is that 80 per cent of acute care respondents indicated that LPNs administer topical medications. Only slightly more than 40 per cent of the respondents reported that LPNs use glucometers, even though this is now defined as an entry level competency.

Figure 15: Medication Management in Acute Care Facilities

Medication management	Frequencies					
	Yes		No		Total	
Administers topical medications	23	79.3%	6	20.7%	29	100%
Uses glucometers	12	41.4%	17	58.6%	29	100%
Provides appropriate client teaching	9	31%	20	69%	29	100%
Administers eye medications	5	17.2%	24	82.8%	29	100%
Assists with narcotic count	4	13.8%	25	86.2%	29	100%
Administers ear medications	3	10.3%	26	89.7%	29	100%
Administers inhalation therapy	3	10.3%	26	89.7%	29	100%
Administers oral narcotics	1	3.4%	28	96.6%	29	100%
Administers oral medications	1	3.4%	28	96.6%	29	100%
Administers medications via G-tube	0	0%	29	100%	29	100%
Administers insulin	0	0%	29	100%	29	100%
Administers subcutaneous injections	0	0%	29	100%	29	100%

Participants were asked to specify any other LPN role in medication management. Responses included:

- reinforces RN teaching
- LPNs give meds only on nights in ECU
- oral medications and oral narcotics administered are blister pack, and
- in collaboration with the RN, LPNs do explain care practices to clients.

Wound Management

Wound management is part of LPN practice in acute care settings. All sites reported that the management of simple wounds is done by LPNs. Medical and surgical asceptic wound care and appropriate client teaching were reported to be provided by LPNs in over 77 per cent of the acute care units surveyed. Packing complex wounds is a post-basic competency; all of the other wound management interventions in Figure 16 are entry level.

Figure 16: Wound Management for Acute Care Facilities

Wound Management	Frequencies							
	Yes		No		Service not provided here		Total	
Cares for simple wounds	30	100%	0	0%	0	0%	30	100%
Provides medical aseptic wound care	27	90%	2	6.7%	1	3.3%	30	100%
Provides surgical aseptic wound care	23	76.7%	3	10%	4	13.3%	30	100%
Provides appropriate client teaching	22	73.3%	8	26.7%	0	0%	30	100%
Packs simple wounds	18	60%	12	40%	0	0%	30	100%
Irrigates wounds	16	55.2%	13	44.8%	0	0%	29	100%
Care of drains	16	53.3%	12	40%	2	6.7%	30	100%
Cares for complex wounds	13	43.3%	16	53.3%	1	3.3%	30	100%
Removes sutures	11	36.7%	17	56.7%	2	6.7%	30	100%
Removes clips	10	33.3%	18	60%	2	6.7%	30	100%
Packs complex wounds	9	30%	20	66.7%	1	3.3%	30	100%
Removes drains	5	16.7%	22	73.3%	3	10%	30	100%

Airway Management

All LPNs in the acute care units surveyed collect sputum specimens as part of their nursing practice. Care of oral and nasal airways was reported to be part of LPN practice by 52 per cent of respondents. The administration of oxygen by LPNs varied by mode of delivery from 90 per cent via nasal cannula to 10 per cent via transtracheal.

Figure 17: Airway Management in Acute Care Facilities

Airway Management	Frequencies							
	Yes		No		Service not provided here		Total	
Administrates oxygen by nasal cannula	27	90%	3	10%	0	0%	30	100%
Administrates oxygen by face mask	26	86.7%	4	13.3%	0	0%	30	100%
Administrates oxygen by venturi mask	11	36.7%	18	60%	1	3.3%	30	100%
Administrates oxygen by rebreathing mask	8	26.7%	21	70%	1	3.3%	30	100%
Administrates oxygen by oxygen tent	4	13.3%	11	36.7%	15	50%	30	100%
Administrates oxygen by transtracheal delivery	3	10%	21	70%	6	20%	30	100%
Collects sputum specimens	30	100%	0	0%	0	0%	30	100%
Positions	28	93.3%	2	6.7%	0	0%	30	100%
Deep breathing and coughing	26	89.7%	2	6.9%	1	3.4%	29	100%
Provides pulse oximetry	22	73.3%	8	26.7%	0	0%	30	100%
Provides nasogastric care	21	70%	8	26.7%	1	3.3%	30	100%
Provides appropriate client teaching	20	66.7%	10	33.3%	0	0%	30	100%
Suctions oropharyngeal	20	66.7%	10	33.3%	0	0%	30	100%
Provides humidified air (i.e. nebulizer, humidifier)	19	63.3%	10	33.3%	1	3.3%	30	100%
Cares for oral and nasal airways	15	51.7%	13	44.8%	1	3.4%	29	100%
Provides incentive spirometry	15	50%	14	46.7%	1	3.3%	30	100%
Provides postural drainage	9	30%	21	70%	0	0%	30	100%
Provides pulse Doppler	7	23.3%	18	60%	5	16.7%	30	100%
Suctions nasopharyngeal	6	20%	23	76.7%	1	3.3%	30	100%
Percusses (i.e. cupping)	5	17.2%	24	82.8%	0	0%	29	100%
Vibrates chest	5	17.2%	24	82.8%	0	0%	29	100%
Cares for stable tracheostomy	5	16.7%	21	70%	4	13.3%	30	100%
Cares for chest tubes	4	13.3%	24	80%	2	6.7%	30	100%
Cares for chest drainage system	3	10%	25	83.3%	2	6.7%	30	100%

Elimination Management

Elimination management is part of LPN practice in most of the acute care facilities surveyed. All respondents indicated that LPNs apply condom catheters and collect urinary specimens. No LPNs were reported to perform peritoneal dialysis or hemodialysis as part of their practice; these were identified by the College of LPNs as post-basic competencies. All other competencies in Figure 18 are entry level. Catheterization has been part of the required LPN entry level competencies since 1981.

Figure 18: Elimination Management in Acute Care Facilities

Elimination Management	Frequencies							
	Yes		No		No service		Total	
Applies condom catheter	30	100%	0	0%	0	0%	30	100%
Collects urinary specimens	30	100%	0	0%	0	0%	30	100%
Collects midstream urine specimens	30	100%	0	0%	0	0%	30	100%
Cares for indwelling catheter	29	96.7%	0	0%	1	3.3%	30	100%
Collects catheter specimens	29	96.7%	1	3.3%	0	0%	30	100%
Administers enemas	29	96.7%	1	3.3%	0	0%	30	100%
Collects stool specimens	29	96.7%	1	3.3%	0	0%	30	100%
Monitors intake and output	29	96.7%	1	3.3%	0	0%	30	100%
Removes indwelling catheter	28	93.3%	1	3.3%	1	3.3%	30	100%
Administers suppositories	28	93.3%	2	6.7%	0	0%	30	100%
Assesses for urinary retention	27	90%	3	10%	0	0%	30	100%
Removes fecal impaction	27	90%	3	10%	0	0%	30	100%
Provides appropriate client teaching	26	89.7%	3	10.3%	0	0%	29	100%
Manages stable ostomy care/stoma	26	86.7%	3	10%	1	3.3%	30	100%
Performs urinary catheterization	26	86.7%	4	13.3%	0	0%	30	100%
Provides bladder training	25	83.3%	4	13.3%	1	3.3%	30	100%
Provides appropriate client teaching	25	83.3%	5	16.7%	0	0%	30	100%
Performs intermittent catheterization (i.e. I & O catheter)	25	83.3%	5	16.7%	0	0%	30	100%
Provides bowel training	24	80%	4	13.3%	2	6.7%	30	100%
Inserts rectal tube	21	70%	7	23.3%	2	6.7%	30	100%
Records intake and output of gastric gavage	20	66.7%	9	30%	1	3.3%	30	100%
Cares for ileal conduit	19	65.5%	6	20.7%	4	13.8%	29	100%
Monitors gastric gavage	19	63.3%	10	33.3%	1	3.3%	30	100%
Irrigates urinary catheter	14	46.7%	15	50%	1	3.3%	30	100%
Manages continuous bladder irrigation	12	40%	11	36.7%	7	23.3%	30	100%
Changes bags for gastric gavage	11	37.9%	17	58.6%	1	3.4%	29	100%
Performs gastric gavage (i.e. enteral feeds/nutrition)	9	30%	20	66.7%	1	3.3%	30	100%
Administers laxatives	7	23.3%	23	76.7%	0	0%	30	100%
Irrigates stoma	6	20%	23	76.7%	1	3.3%	30	100%
Performs peritoneal dialysis	0	0%	13	44.8%	16	55.2%	29	100%
Performs hemodialysis	0	0%	13	43.3%	17	56.7%	30	100%

Participants were asked to specify any other LPN role in elimination management. Responses included:

- LPNs monitor gastric gavage only on chronic/stable patients
- only specialized LPNs do peritoneal dialysis, and
- LPNs have been inserviced on catheterization but do not practise skills.

Infusion Management

Some aspects of infusion management are part of LPN nursing practice in the acute care units surveyed. Over 63 per cent of those units reported that LPNs assess clients with IV therapy, and 60 per cent use LPNs to discontinue IVs. Monitoring the rate of blood transfusion and managing IV infusion pumps are rarely done by LPNs.

Participants were asked to specify any other LPN role in infusion management. Responses included:

- maintains check of sites for peripheral lines, and
- observation of most IV lines only.

Figure 19: Infusion Management in Acute Care Facilities

Infusion Management	Frequencies							
	Yes		No		Service not provided here		Total	
Assesses client with IV therapy	19	63.3%	10	33.3%	1	3.3%	30	100%
Discontinues an IV	18	60%	11	36.7%	1	3.3%	30	100%
Provides appropriate client teaching	12	41.4%	16	55.2%	1	3.4%	29	100%
Manages kangaroo pump	11	36.7%	17	56.7%	2	6.7%	30	100%
Hangs non-medicated solutions/infusions	9	30%	20	66.7%	1	3.3%	30	100%
Co-signs blood transfusion administration	8	26.7%	20	66.7%	2	6.7%	30	100%
Documents rate/solution of an IV	6	20%	23	76.7%	1	3.3%	30	100%
Maintains peripheral venous lines	5	16.7%	24	80%	1	3.3%	30	100%
Monitors blood transfusion therapy	4	13.3%	24	80%	2	6.7%	30	100%
Calculates flow rate	3	10%	26	86.7%	1	3.3%	30	100%
Monitors rate of blood transfusion	2	6.7%	26	86.7%	2	6.7%	30	100%
Manages IV infusion pump	1	3.3%	28	93.3%	1	3.3%	30	100%
Monitors parenteral nutrition	0	0%	24	80%	6	20%	30	100%
Documents parenteral nutrition	0	0%	24	80%	6	20%	30	100%

Communication

There is consistency in LPN practice in the area of communication for both acute and continuing care facilities. All respondents reported that LPNs maintain clear, concise, accurate and timely records, collaborate as a member of an interdisciplinary health team, promote team problem solving, decision making and interdisciplinary collaboration by jointly assessing shortfalls in nursing practice, and report situations that are potentially unsafe for clients. In both acute and continuing care, 75 per cent of respondents reported that LPNs present nursing knowledge regarding clients in interdisciplinary team interactions. One respondent reported that LPNs take physicians' orders over the phone in the ECU. Very few reported the transcription of physicians' orders or transcription of medication orders are part of LPN duties.

Figure 20: LPN Communication in Acute Care Facilities

Communication	Frequencies					
	Yes		No		Total	
Maintains clear, concise, accurate and timely records of client care	30	100%	0	0%	30	100%
Collaborates as a member of an interdisciplinary health team	30	100%	0	0%	30	100%
Promotes team problem solving, decision making and interdisciplinary collaboration by jointly assessing shortfalls in nursing practice	30	100%	0	0%	30	100%
Reports situations that are potentially unsafe for clients	30	100%	0	0%	30	100%
Presents nursing knowledge regarding the client in interdisciplinary team interactions	23	76.7%	7	23.3%	30	100%
Transcribes physician's orders	2	6.7%	28	93.3%	30	100%
Transcribes medication orders	2	6.7%	28	93.3%	30	100%
Takes physician's orders over the phone	0	0%	30	100%	30	100%

LPN RESPONSIBILITIES: CONTINUING CARE

Assessment

Facilities were asked about the LPN role in patient assessment. Over 85 per cent of continuing care facilities reported that LPNs use inspection, interviewing, and the unit's usual assessment tools to assess the patient. LPNs document this work.

Figure 21: Assessment in Continuing Care Facilities

Assessments	Frequencies					
	Yes		No		Total	
Is the initial assessment done by an LPN?	8	57.1%	6	42.9%	14	100%
Uses palpation for data collection with clients	5	35.7%	9	64.3%	14	100%
Uses inspection for data collection with clients	12	85.7%	2	14.3%	14	100%
Uses interviewing for data collection with clients	13	92.9%	1	7.1%	14	100%
Uses auscultation for data collection with clients	5	35.7%	9	64.3%	14	100%
Collaborates with clients to perform holistic assessments of cognitive needs	9	69.2%	4	30.8%	13	100%
Collaborates with clients to perform holistic assessments of emotional needs	9	69.2%	4	30.8%	13	100%
Collaborates with clients to perform holistic assessments of cultural needs	9	69.2%	4	30.8%	13	100%
Collaborates with clients to perform holistic assessments of physical needs	10	76.9%	3	23.1%	13	100%
Assesses abdomen	9	64.3%	5	35.7%	14	100%
Assesses cardiovascular system	8	57.1%	6	42.9%	14	100%
Assesses head, eyes, ear and throat	9	64.3%	5	35.7%	14	100%
Assesses chest	8	61.5%	5	38.5%	13	100%
Assesses integumentary system	11	78.6%	3	21.4%	14	100%
Assesses musculoskeletal system	8	57.1%	6	42.9%	14	100%
Assesses neck, lymph nodes, breast	2	14.3%	12	85.7%	14	100%
Assesses neurologic system	3	21.4%	11	78.6%	14	100%
Assesses peripheral vascular system	6	42.9%	8	57.1%	14	100%
Assesses respiratory system	10	71.4%	4	28.6%	14	100%
Uses the unit's usual assessment tools to guide data collection for assessing	13	92.9%	1	7.1%	14	100%
Documents assessment	12	85.7%	2	14.3%	14	100%
Assesses the learning needs of clients	7	53.8%	6	46.2%	13	100%

Facilities were also asked about the patients being assessed. Most of the patient categories in this survey question are not cared for in continuing care facilities.

Figure 22: Assessment in Continuing Care Facilities

Assessments	Frequencies							
	Yes		No		Service not provided here		Total	
Performs comprehensive and holistic assessments of elderly adults	10	76.9%	3	23.1%	0	0%	13	100%
Performs comprehensive and holistic nursing assessments of adults	4	28.6%	5	35.7%	5	35.7%	14	100%
Performs comprehensive and holistic assessments of families	4	28.6%	7	50%	3	21.4%	14	100%
Performs comprehensive and holistic nursing assessments of infants	2	14.3%	2	14.3%	10	71.4%	14	100%
Performs comprehensive and holistic nursing assessments of children	2	14.3%	2	14.3%	10	71.4%	14	100%
Performs comprehensive and holistic nursing assessments of adolescents	2	14.3%	2	14.3%	10	71.4%	14	100%
Performs comprehensive and holistic nursing assessments of neonates	1	7.1%	2	14.3%	11	78.6%	14	100%

Medication Management

In 1984, pharmacology and medication administration in continuing care, gerontology and community care were added to the B.C. practical nursing curriculum. In 1995, the curriculum was expanded to include the administration of oral narcotics, insulin and subcutaneous injection. Figure 23 shows responses related to medication administration in continuing care facilities. Respondents indicated that LPNs administer oral medications in 43 per cent of these facilities.

Figure 23: Medication Management in Continuing Care

Medication Management	Frequencies					
	Yes		No		Total	
Administers topical medications	13	92.9%	1	7.1%	14	100%
Uses glucometers	9	64.3%	5	35.7%	14	100%
Administers eye medications	8	57.1%	6	42.9%	14	100%
Administers ear medications	7	50%	7	50%	14	100%
Provides appropriate client teaching	6	50%	6	50%	12	100%
Administers oral medications	6	42.9%	8	57.1%	14	100%
Administers inhalation therapy	6	42.9%	8	57.1%	14	100%
Assists with narcotic count	4	28.6%	10	71.4%	14	100%
Administers oral narcotics	3	21.4%	11	78.6%	14	100%
Administers medications via G-tube	2	14.3%	12	85.7%	14	100%
Administers insulin	0	0%	14	100%	14	100%
Administers subcutaneous injections	0	0%	14	100%	14	100%

Participants were asked to specify any other LPN role in medication management. Responses included:

- usually referred to RN for medication instruction, and
- plan to upgrade LPNs and allow them to give subcutaneous injections.

Wound Management

The care of simple wounds was reported as part of LPN practice by all of the continuing care facilities surveyed. The care of medical aseptic wounds was reported by over 84 per cent of respondents. The removal of sutures, clips and drains was reported by one facility. Teaching clients was reported to be a part of LPN practice at 77 per cent of the facilities.

Figure 24: Wound Management in Continuing Care Facilities

Wound Management	Frequencies							
	Yes		No		Service not provided here		Total	
Cares for simple wounds	14	100%	0	0%	0	0%	14	100%
Provides medical aseptic wound care	11	84.6%	0	0%	2	15.4%	13	100%
Provides appropriate client teaching	10	76.9%	3	23.1%	0	0%	13	100%
Provides surgical aseptic wound care	7	53.8%	3	23.1%	3	23.1%	13	100%
Cares for complex wounds	6	42.9%	6	42.9%	2	14.3%	14	100%
Packs simple wounds	6	42.9%	6	42.9%	2	14.3%	14	100%
Care of drains	5	35.7%	3	21.4%	6	42.9%	14	100%
Irrigates wounds	3	23.1%	8	61.5%	2	15.4%	13	100%
Packs complex wounds	2	14.3%	10	71.4%	2	14.3%	14	100%
Removes sutures	1	7.1%	10	71.4%	3	21.4%	14	100%
Removes clips	1	7.1%	10	71.4%	3	21.4%	14	100%
Removes drains	1	7.1%	8	57.1%	5	35.7%	14	100%

Airway Management

The administration of oxygen by nasal cannula and by face mask, and the positioning of patients are part of LPN practice in 93 per cent of continuing care facilities.

Figure 25: Airway Management in Continuing Care Facilities

Airway Management	Frequencies							
	Yes		No		Service not provided here		Total	
Administrates oxygen by nasal cannula	13	92.9%	1	7.1%	0	0%	14	100%
Administrates oxygen by face mask	13	92.9%	1	7.1%	0	0%	14	100%
Administrates oxygen by venturi mask	2	14.3%	5	35.7%	7	50%	14	100%
Administrates oxygen by rebreathing mask	3	21.4%	4	28.6%	7	50%	14	100%
Administrates oxygen by transtracheal delivery	1	7.1%	5	35.7%	8	57.1%	14	100%
Administrates oxygen by oxygen tent	2	14.3%	4	28.6%	8	57.1%	14	100%
Collects sputum specimens	14	100%	0	0%	0	0%	14	100%
Positions	13	92.9%	1	7.1%	0	0%	14	100%
Deep breathing and coughing	12	85.7%	1	7.1%	1	7.1%	14	100%
Provides appropriate client teaching	8	61.5%	4	30.8%	1	7.7%	13	100%
Provides pulse oximetry	8	57.1%	3	21.4%	3	21.4%	14	100%
Provides humidified air (i.e. nebulizer, humidifier)	8	57.1%	5	35.7%	1	7.1%	14	100%
Suctions oropharyngeal	8	57.1%	5	35.7%	1	7.1%	14	100%
Cares for oral and nasal airways	7	50%	4	28.6%	3	21.4%	14	100%
Provides nasogastric care	6	46.2%	3	23.1%	4	30.8%	13	100%
Provides postural drainage	6	42.9%	6	42.9%	2	14.3%	14	100%
Cares for stable tracheostomy	5	35.7%	3	21.4%	6	42.9%	14	100%
Percusses (i.e. cupping)	4	28.6%	10	71.4%	0	0%	14	100%
Provides incentive spirometry	3	21.4%	5	35.7%	6	42.9%	14	100%
Vibrates chest	2	14.3%	10	71.4%	2	14.3%	14	100%
Suctions nasopharyngeal	2	14.3%	9	64.3%	3	21.4%	14	100%
Cares for chest drainage system	1	7.1%	3	21.4%	10	71.4%	14	100%
Cares for chest tubes	1	7.1%	3	21.4%	10	71.4%	14	100%
Provides pulse Doppler	0	0%	5	35.7%	9	64.3%	14	100%

Participants were asked to specify any other LPN role in airway management. One respondent noted:

- LPNs provide basic client teaching in relation to use of oxygen.

Elimination Management

Some examples of LPN practice that 100 per cent of respondents recorded are: applies condom catheter, provides bladder training, collects urinary specimens (including midstream and catheter specimens), administers suppositories, administers enemas, collects stool specimens and monitors intake and output.

Figure 26: Elimination Management in Continuing Care Facilities

Elimination Management	Frequencies							
	Yes		No		Service not provided here		Total	
Applies condom catheter	14	100%	0	0%	0	0%	14	100%
Provides bladder training	14	100%	0	0%	0	0%	14	100%
Collects urinary specimens	14	100%	0	0%	0	0%	14	100%
Collects midstream urine specimens	14	100%	0	0%	0	0%	14	100%
Collects catheter specimens	14	100%	0	0%	0	0%	14	100%
Administers suppositories	14	100%	0	0%	0	0%	14	100%
Administers enemas	14	100%	0	0%	0	0%	14	100%
Collects stool specimens	14	100%	0	0%	0	0%	14	100%
Monitors intake and output	14	100%	0	0%	0	0%	14	100%
Cares for indwelling catheter	13	92.9%	0	0%	1	7.1%	14	100%
Manages stable ostomy care/stoma	13	92.9%	1	7.1%	0	0%	14	100%
Assesses for urinary retention	12	85.7%	2	14.3%	0	0%	14	100%
Provides appropriate client teaching	11	78.6%	3	21.4%	0	0%	14	100%
Inserts rectal tube	11	78.6%	2	14.3%	1	7.1%	14	100%
Performs intermittent catheterization (i.e. I & O catheter)	10	71.4%	4	28.6%	0	0%	14	100%
Removes fecal impaction	10	71.4%	4	28.6%	0	0%	14	100%
Provides bowel training	10	71.4%	4	28.6%	0	0%	14	100%
Provides appropriate client teaching	10	71.4%	3	21.4%	1	7.1%	14	100%
Removes indwelling catheter	9	64.3%	4	28.6%	1	7.1%	14	100%
Performs urinary catheterization	9	64.3%	5	35.7%	0	0%	14	100%
Administers laxatives	9	64.3%	5	35.7%	0	0%	14	100%
Irrigates urinary catheter	8	57.1%	5	35.7%	1	7.1%	14	100%
Monitors gastric gavage	6	42.9%	4	28.6%	4	28.6%	14	100%
Records intake and output of gastric gavage	5	35.7%	2	14.3%	7	50%	14	100%
Manages continuous bladder irrigation	5	35.7%	2	14.3%	7	50%	14	100%
Cares for ileal conduit	4	28.6%	4	28.6%	6	42.9%	14	100%
Irrigates stoma	4	28.6%	9	64.3%	1	7.1%	14	100%
Changes bags for gastric gavage	4	28.6%	4	28.6%	6	42.9%	14	100%
Performs gastric gavage (i.e. enteral feeds/nutrition)	3	21.4%	7	50%	4	28.6%	14	100%
Performs peritoneal dialysis	0	0%	5	35.7%	9	64.3%	14	100%
Performs hemodialysis	0	0%	4	30.8%	9	69.2%	13	100%

Infusion Management

Infusion services are not provided in all continuing care facilities; where they are, LPNs are often not involved.

Figure 27: Infusion Management in Continuing Care Facilities

Infusion Management	Frequencies							
	Yes		No		Service not provided here		Total	
Provides appropriate client teaching	5	38.5%	3	23.1%	5	38.5%	13	100%
Assesses client with IV therapy	4	28.6%	4	28.6%	6	42.9%	14	100%
Discontinues an IV	4	28.6%	4	28.6%	6	42.9%	14	100%
Manages kangaroo pump	4	28.6%	4	28.6%	6	42.9%	14	100%
Manages IV infusion pump	3	21.4%	5	35.7%	6	42.9%	14	100%
Documents rate/solution of an IV	2	15.4%	5	38.5%	6	46.2%	13	100%
Maintains peripheral venous lines	2	14.3%	6	42.9%	6	42.9%	14	100%
Calculates flow rate	2	14.3%	6	42.9%	6	42.9%	14	100%
Co-signs blood transfusion administration	2	14.3%	5	35.7%	7	50%	14	100%
Monitors blood transfusion therapy	1	7.1%	5	35.7%	8	57.1%	14	100%
Hangs non-medicated solutions/infusions	0	0%	7	53.8%	6	46.2%	13	100%
Monitors parenteral nutrition	0	0%	5	35.7%	9	64.3%	14	100%
Documents parenteral nutrition	0	0%	5	35.7%	9	64.3%	14	100%
Monitors rate of blood transfusion	0	0%	6	42.9%	8	57.1%	14	100%

Participants were asked to specify any other LPN role in infusion management. Responses included:

- we will be providing this service within the year with upgrade for older LPNs, and
- client teaching is usually done by the RN or physician on duty.

Communication

The pattern of LPN practice in the area of communication was consistent in both acute and continuing care. All surveys reported that LPNs maintain clear, concise, accurate and timely records, collaborate as a member of an interdisciplinary health team, promote team problem solving, decision making and interdisciplinary collaboration by jointly assessing shortfalls in nursing practice, and report situations that are potentially unsafe for clients. No facilities reported that LPNs take physicians' orders over the phone. Only 14 per cent reported that the transcription of physicians' orders or transcription of medication orders are part of LPN duties.

Figure 28: Communication in Continuing Care Facilities

Communication	Frequencies					
	Yes		No		Total	
Maintains clear, concise, accurate and timely records of client care	14	100%	0	0%	14	100%
Collaborates as a member of an interdisciplinary health team	14	100%	0	0%	14	100%
Reports situations that are potentially unsafe for clients	14	100%	0	0%	14	100%
Promotes team problem solving, decision making and interdisciplinary collaboration by jointly assessing shortfalls in nursing practice	13	100%	0	0%	13	100%
Presents nursing knowledge regarding the client in interdisciplinary team interactions	13	92.9%	1	7.1%	14	100%
Transcribes physician's orders	2	14.3%	12	85.7%	14	100%
Transcribes medication orders	2	14.3%	12	85.7%	14	100%
Takes physician's orders over the phone	0	0%	14	100%	14	100%

LPN EMPLOYMENT

Staffing Ratios

Facilities were asked to report staffing of RNs, RPNs, LPNs and care aides. Regular FTE figures were requested for the 1999-2000 fiscal year, based on a full time equivalent of 1,872 hours.

Thirty acute care facilities that returned surveys said they employed LPNs. One respondent indicated answers for both a medical and a surgical unit. Thirty-one answers were given to this question. One acute care facility reported employing care aides and one reported employing registered psychiatric nurses. All answers are converted to ratios for ease of comparison.

Figure 29: Staffing Ratios in Acute Care Facilities

RN	RPN	LPN	CA
8.9 (includes RPN)		1	0
1	0	1	0
1	0	1	0
11	0	1	0
11	0	1	0
6	0	1	0
4.82	0	1	0
4.31	0	1	0
3.67	0	1	0
3.5	0	1	0
3.33	0	1	0
3.24	0	1	0
2.94	0	1	0
2.78	0	1	0
2.67	0	1	0
2.64	0	1	0
2.55	0	1	0
2.47	0	1	0
2.41	0	1	0
2.35	0	1	0
2.23	0	1	0
2.15	0	1	0
2.15	0	1	0
2.11	0	1	0
2	0	1	0
1.8	0	1	0
1.61	0	1	0
1.42	0	1	0
1.08	0	1	0
1	0	1	0
4.75	0	1	1

While 14 continuing care facilities reported employing LPNs, not all completed this question.

Figure 30 includes staffing numbers from two extended care units in acute care facilities.

Figure 30: Staffing Ratios in Continuing Care Facilities and Extended Care Units

RN	RPN	LPN	CA
9	1	7	15
1	0	2.67	4.17
1	2.2	2	11.81
1	0	1.12	0
1.34	0	1	0
1.99	0	1	5.89
3.16	0	1	0
2.75	0	1	5.63
2.66	0	1	7.02
2.16	0	1	5.43
1.09	0	1	0

Explanation for Use or Non-Use of LPNs

Facilities were asked to choose from a list of possible explanations for their overall use or non-use of LPNs. The most common response to this question was historical practice.

For facilities that do not employ LPNs, the next most common answer was “work jurisdiction issues with other unions” (36 per cent), followed by lack of knowledge by manager and staff of current LPN scope of practice and competencies (32 per cent).

For facilities that do employ LPNs, over 63 per cent correlated this practice to hospital and administrative policy and confidence that LPNs have the appropriate skills for patient or resident needs.

Figure 31: Overall use/non-use of LPNs

Reason	% response	# of response	Units that employ LPN	Units that do not employ LPN
Historical practice	61.4%	43	61.4%	72.7%
Hospital or administrative policy	48.6%	34	63.6%	27.3%
Cost effectiveness	44.3%	31	56.8%	27.3%
Confidence that LPNs have appropriate skills for patients'/ residents' needs	42.9%	30	63.6%	9.1%
Availability of LPNs	30.0%	21	43.2%	9.1%
Knowledge by managers and staff of current LPN scope of practice and competencies	30.0%	21	47.7%	0.0%
Work jurisdiction issues with other unions	28.6%	21	27.3%	36.4%
Unavailability of RNs or RPNs	25.7%	18	38.6%	4.5%
Lack of knowledge by managers and staff of current LPN scope of practice and competencies	25.7%	18	25.0%	31.8%
Ability to have higher staffing levels with this staff mix	22.9%	16	34.1%	4.5%
Availability of training for LPNs (Upgrading and/or post basic)	20.0%	14	18.2%	0.0%
Availability of RNs or RPNs	17.1%	12	15.9%	22.7%
Lack of confidence that LPNs have appropriate skills for patients'/residents' needs	15.7%	11	18.2%	13.6%
Unavailability of training for LPNs	14.3%	10	18.2%	9.1%
Unavailability of LPNs	11.4%	8	13.6%	9.1%
Other	18.6%	13	6.8%	40.9%
No answer	4.3 %	3		

Participants were provided space to specify any other reason for their unit or facility's overall use or non-use of LPNs. Four sites noted changes they are making in staff mix. Other issues raised were budget concerns, confidence that needs are being met by the present staff mix, lack of available LPNs, and education of LPNs.

- Three respondents said they were in the process of introducing LPNs. Two of those sites were converting care aide positions to LPN positions. However, one site had changed its staff mix by replacing LPNs with RNs due to an increase in patient acuity.
- One respondent noted budget concerns, stating that it was too expensive to replace care aides with LPNs.
- One respondent said the present staff mix of RNs and care aides met their needs.
- One respondent said LPNs are not available as readily as care aides.
- Three respondents raised the issue of variation in LPN competencies. In the words of one respondent:

[There are] huge discrepancies [between] what LPNs feel is within their scope of practice.

- Another respondent stated that

[A] large component of staff that trained in the '60s and '70s ... did not get a lot of these skills as part of basic training.

Factors Influencing LPN Utilization

Facilities were asked to list the factors that would influence their decision to increase the number of LPNs or add duties to the existing complement. Respondents wrote a great deal in answer to this question.

The most common factor cited was the shortage of RNs. Difficulty in recruiting LPNs was the next most common factor. Variation in LPN practice and education was cited by a number of respondents. Suggestions made with regard to this issue included: ensure the competence of LPNs trained many years ago, promote increased training for staff as a percentage of staff were grandfathered into the LPN designation, and provide upgrading or at least some form of testing to assure managers that current LPNs are up-to-date on skills not used since being hired at that facility.

Many respondents called attention to the lack of available education programs to upgrade LPNs' skills and knowledge. Some noted the change in patients' needs and increased patient acuity. Three factors related to budget concerns were cited: the cost of providing upgrading education for LPNs, funding for the conversion of care aide to LPN positions, and a decrease in funding for staffing. Administrative policy changes were raised by a number of respondents. One noted a change in administrative policies to allow the transfer of function; another cited hospital policy not allowing LPNs to be used to their fullest abilities.

Two respondents noted the impact of provincial legislation:

[We would] increase [the] number of LPNs if we were able to still meet licensing criteria for staffing.

Scope of practice legislation (Health Professions Council decisions on reserved Acts).

Some concerns were based on union issues including "the opposition of BCNU to the views of RNs," union jurisdiction and HEU collective agreement rigidity.

One respondent needed to have confidence that additional skills being performed by LPNs would not affect the current level of basic care. Another raised the issue of LPNs' willingness to expand their present practice. An example of this concern is voiced in the following statement.

LPNs on medical, surgical, pediatric units are mostly experienced and able to take on more duties, but many are not willing.

One respondent said an increase in the number of hospital programs would be required for there to be an increase in the use of LPNs. Two respondents asked for more information on what the LPN scope of practice encompasses and what upgrading would be required for LPNs currently on staff.

Many respondents commented on changes they are making to the staff mix – in particular, the addition of LPN positions and/or expansion of their duties.

We are planning to add to current LPN duties in LTC (e.g. medication administration, monitor gastric feedings, IV therapy, blood glucose monitoring).

We will increase by eight LPN FTEs to complement existing RN/RPN role and provide higher levels of care based on training expertise and knowledge.

We will have an LPN and care aide on each shift. The LPN will have a "team leader" role on afternoons and nights when there is no RN on duty. LPNs will do the medications and treatments and provide basic nursing care.

I have increased a 48 bed unit to 50 per cent LPN.

I believe LPNs are extremely underrated and underutilized.

We have added LPNs this past year to activation. They have the appropriate level of skills for the activation patient. The RN shortage may have precipitated looking at increasing the LPN complement, but now, even if there were more RNs we would not go back to all RNs because the LPN role meets the needs of our patients.

We will be adding medication administration to LPN duties upon completion of upgrading which will take place in the summer.

We will be moving the LPNs to … [our new] … multi-level care facility.

Facilities were also asked to list the factors that would influence their decision to decrease the number of LPNs or delete duties from the existing complement.

Some respondents pointed out that they have no LPNs on staff. Others said they would not be decreasing the number of LPNs or deleting duties. For those who did indicate factors that would prompt them to decrease LPN utilization, the most common factors (in order of decreasing frequency) were:

- an increase in patient acuity and a decrease in length of patient stay
- the availability of RNs
- the availability of LPNs
- the narrow salary differential between RNs and LPNs
- the education of LPNs (which was seen as lacking in some areas such as critical thinking and communication)
- differences in scope of practice between LPNs and RNs, and
- replacement of LPNs with care aides, prompted by an assessment of patient needs.

The following factors were cited only once:

- patient care would deteriorate
- a decrease in the number of LPNs would be made if management made that decision
- the HEU collective agreement
- if the bed count were reduced, then LPN positions would be deleted
- pressure from the RNs may have some influence
- difficulties in altering staff mix and ensuring role clarity
- a preference to focus on comprehensive, holistic caring rather than task-oriented care, (which was seen as the focus of many LPNs), and
- lack of funds to hire more RNs.

COMMENTS

The final section of the survey invited respondents to add additional comments. Some wrote about the role of LPNs. Several wrote about changes in the role of LPNs. Two respondents detailed their facilities' change process while one documented anticipated problems.

The most common general comment was that LPNs are not used in the unit or facility. Some provided reasons for why LPNs are not employed:

- adding another "level" presents a certain increase in administration time and decrease in flexibility of position
- licensing does not allow us to add LPNs, due to staff ratios
- we employ LPNs as care aides
- no LPNs are routinely scheduled to work, and
- LPNs are only used if RNs are not available or if workload increases.

Some respondents wrote about their positive experience with the LPN role in their facility.

LPNs are very valuable and cost effective in LTC. In this facility, they work as team leaders to organize and supervise health care workers on the extended care and special care units.

LPNs have been performing well and meeting the needs of the residents at our facility. I personally feel that the training of LPNs is adequate to care for LTC residents in most cases, providing an RN is available as a consultant or backup.

Some respondents spoke about changes underway in the role of LPNs.

The responsibility and duties of LPNs may be increased to include checking charts, transcribing and taking physicians' orders. There is union resistance as well as resistance from some LPNs to take on more.

We are currently working closely with our staff, [encouraging them to become] more independent and take on more of a teaching role and more of a presence on the multidisciplinary team.

One facility detailed its change process.

LPN numbers at the facility were increased a number of years ago as a method to cut costs. A process we developed and implemented included: reach an understanding of the skills needed by all LPNs at the hospital, as well as specific skills/competencies needed in certain units; compare the education received at the colleges with the expectations of the job and educate for the gaps (for example, drain shortening and removal); achieve resolution from RNs and LPNs re: the LPN scope of practice at this facility; provide evaluation sessions around RNs and LPNs working together, including the process of delegation.

Other respondents identified some of the challenges in changing the mix and roles of staff. Ideas for overcoming those challenges came out in some of the comments.

RN/RPN staff nurses' opposition to use of LPNs is due to a perception that their jobs are threatened, that LPNs will replace the RN/RPN position – difficult transition and acceptance. Care aides feel that LPNs are replacing them and resent the introduction. Both groups had an opportunity to discuss and share concerns at many planned education sessions.

In bringing LPNs into the staffing mix, [I] would anticipate the following issues: unavailability of LPNs initially (until schools are able to increase the number of LPN graduates). Difficulty (perception mainly) for LPNs who currently work as aides going back to an LPN role, e.g. perception from other co-workers. Major work jurisdiction issues between RNs and LPNs, and a potential loss of RN positions which could lead to decreased quality care for residents.

In some facilities LPNs give medications, and if this practice were to spread to other facilities I feel that LPNs require more training in medication administration in their LPN training program, also more emphasis should be put on communication within their practice, especially with clients/patients and families.

There needs to be a clear delineation of the scope of practice for LPNs and a [structured] opportunity for them to learn new skills and to be tested regularly on their competencies. LPNs are underutilized in some areas and some skills at present.

APPENDIX A: DETAILED METHODOLOGY

Survey Sample

The potential population for this survey was all British Columbia health care facilities covered by the facilities subsector collective agreement. This includes both acute care hospitals and continuing care facilities.

Two methods of selecting the sample were used. In the acute care sector, we used a system called Resource Intensity Weights (RIW). In the continuing care sector, a list of criteria was developed, and a random sample was chosen.

Dr. Cathie Dunlop, Director of the Evaluation Unit in Continuing Studies at Simon Fraser University, reviewed the design of the survey and the sampling technique.

Acute Care Sample

The Ministry of Health provided a list of 99 acute care facilities, including RIW numbers.

The Canadian Institute for Health Information developed the Resource Intensity Weights system. RIW is a resource allocation methodology for estimating a hospital's inpatient costs for both acute and day procedure care. RIW is used to standardize the expression of hospital case volumes, recognizing that not all patients require the same health care resources. The Canadian Institute for Health Information uses several steps and pieces of information to determine an RIW, including the number of cases, the age of the population, the sickness/complexity of the patients, and the length of stay.

For our survey sample, we developed a grid using Resource Intensity Weights. Given that the total RIW for the province was 604468.9806, the acute care facilities were divided into six groups with each group using approximately 100,000 RIW. We sampled from all six groups. Group one had one facility, group two had two facilities, group three had four facilities, group four had five facilities. All of the facilities in the first four groups were surveyed. In group five, six of the 10 facilities were randomly selected. In group six, 15 of the 77 facilities were randomly selected.

Continuing Care Sample

The Ministry of Health has no RIW or similar system to compare facilities in the continuing care sector. For this project our criteria for sample selection were: all facilities will be unionized, the sample will include both not for profit and private facilities, and the sample will include intermediate, extended and multi-level care facilities.

The facilities were grouped into intermediate, extended and multi-level care, and a random sample of 25 was selected, in proportion to the total number of facilities in each category.

The researcher then checked to ensure that all of the selected facilities were unionized and

that both private and not for profit facilities were included. Four additional sites were added to the sample as a result of this check. In total, 19 intermediate care facilities, five stand alone extended care facilities and five multi-level care facilities were sent surveys.

Mailing and Follow Up

The survey was mailed on February 9, 2000. On March 14, follow up postcards were sent to remind facilities that we had not received their surveys. In early April, facilities that had not yet returned their surveys were phoned, and some were sent additional surveys. Follow up faxes were sent to facilities that returned the survey but had not completed the section on the staff ratio. All surveys received by the cut off date of April 20 were analyzed.

Survey of LPN Skill Utilization in B.C.

Thank you from the Health Employers Association of British Columbia (HEABC) and the Association of Unions represented by the Hospital Employees' Union (HEU) and the British Columbia Government and Services Employees' Union (BCGEU) for completing the survey we sent in November 1999.

Once again we are asking for your help as we continue our research on the utilization of LPNs in British Columbia. In this second phase of the research we are asking fifty-eight health care facilities in BC to complete a detailed survey on the use of LPNs. Our goal is to get a snapshot of the current practice of LPNs.

The survey is being sent to thirty-three acute care and twenty-five continuing care facilities including intermediate, multilevel and stand alone extended care facilities. In each acute care facility being surveyed we are requesting information from a medical unit, a surgical unit and where it exists the extended care unit. In the continuing care sector the survey applies across the entire facility.

In addition to this survey, ten facilities will be identified to participate in a site visit by our researcher to obtain more information.

The survey applies to both licensed and unlicensed practical nurses who are working in practical nurse positions in the facilities subsector. It does not include LPNs working in other jobs such as care aides and unit clerks.

All information will be kept confidential.

Thanks to the Registered Practical Nurses Association of Ontario and PEI Licensed Nursing Assistant Association for allowing us to use questions from their surveys. The LPN competencies used in this survey were drawn from various BC and national sources and were verified by LPN practice and education leaders in BC.

INSTRUCTIONS

This survey should take approximately thirty minutes to complete. All responses will be handled anonymously. Data will be reported in aggregate form and destroyed at the end of the project. If you work in an acute care facility, please complete the survey for your unit. If you are a continuing care facility, please answer the questions for your entire facility.

Definition of LPN
The survey applies to both licensed and unlicensed practical nurses that are working in practical nurse positions in the facilities subsector. It does not include LPNs working in other jobs such as care aides and unit clerks.

1. Facility Information

Name of facility: ______________________________

Street: ______________________________

City: ____________________ Postal Code: __________

Regional or Community Health Board ____________________

Name and job title of person completing survey ____________________

Telephone ______________ Fax ______________

E-mail ______________

If you are an acute care facility please indicate which unit you are answering for.

❑ medical unit ❑ surgical unit ❑ extended care unit

Please describe the unit i.e. bed size, type of service and type of client __________

____

____

2. Use of LPNs

Currently, are there Licensed Practical Nurses (as defined above) working within this unit (if an acute care facility) or this entire facility (if a continuing care facility) ? .... ❑ Yes ❑ No

If yes, proceed to question 3.
If no, please skip to question 17.

.... ❑ Yes ❑ No

Instructions

Question 3 to 13 ask about the current practice of LPNs. An individual LPN's ability to carry out some or all of these skills and competencies will vary, depending on the LPN's basic, post basic and experiential learning and the facility's policies. This list includes skills that we have come to understand are taught in the current practical nurse curriculum and may be done in BC health care facilities.

3. Assessment

For many of the following questions there are three answers. Yes indicates the LPN does this as a part of her/his practice. No indicates that the LPN does not do this as a part of her practice but another health care professional such as an MD or RN does. The third option indicates no one provides this service in this unit/facility.

Is the initial assessment done by an LPN? .... ❑ Yes ❑ No

Uses palpation for data collection with clients .... ❑ Yes ❑ No

Uses inspection for data collection with clients .... ❑ Yes ❑ No

Uses interviewing for data collection with clients .... ❑ Yes ❑ No

Uses auscultation for data collection with clients .... ❑ Yes ❑ No

Performs comprehensive and holistic nursing assessments of neonates .... ❑ yes ❑ no ❑ service not provided here

Performs comprehensive and holistic nursing assessments of infants .... ❑ yes ❑ no ❑ service not provided here

Performs comprehensive and holistic nursing assessments of children .... ❑ yes ❑ no ❑ service not provided here

Performs comprehensive and holistic nursing assessments of adolescents .... ❑ yes ❑ no ❑ service not provided here

Performs comprehensive and holistic nursing assessments of adults .... ❑ yes ❑ no ❑ service not provided here

Performs comprehensive and holistic assessments of elderly adults .... ❑ yes ❑ no ❑ service not provided here

Performs comprehensive and holistic assessments of families .... ❑ yes ❑ no ❑ service not provided here

Collaborates with clients to perform holistic assessments of cognitive needs ❑ Yes ❑ No

Collaborates with clients to perform holistic assessments of emotional needs ❑ Yes ❑ No

Collaborates with clients to perform holistic assessments of cultural needs ❑ Yes ❑ No

Collaborates with clients to perform holistic assessments of physical needs ❑ Yes ❑ No

Assesses abdomen .... ❑ Yes ❑ No

Assesses cardiovascular system .... ❑ Yes ❑ No

Assesses head, eyes, ear and throat .... ❑ Yes ❑ No

Assesses chest .... ❑ Yes ❑ No

Assesses integumentary system .... ❑ Yes ❑ No

Assesses musculoskeletal system .... ❑ Yes ❑ No

Assesses neck, lymph nodes, breast .... ❑ Yes ❑ No

Assesses neurologic system .... ❑ Yes ❑ No

Assesses peripheral vascular system .... ❑ Yes ❑ No

Assesses respiratory system .... ❑ Yes ❑ No

Uses the unit's usual assessment tools to guide data collection for assessing clients .... ❑ Yes ❑ No

Documents assessment .... ❑ Yes ❑ No

Assesses the learning needs of clients .... ❑ Yes ❑ No

Other (please specify) ____

____

____

4. Planning

Organizes own workload, plans, implements and evaluates own work pattern .... ❑ Yes ❑ No

Develops learning plans for clients .... ❑ Yes ❑ No

Other (please specify) ____

____

____

5. Implementation

Manages multiple nursing interventions simultaneously .... ❑ Yes ❑ No

Provides appropriate client teaching .... ❑ Yes ❑ No

Manages physical resources (equipment, supplies, medication, linen) in order to provide effective and efficient care. .... ❑ Yes ❑ No

Other (please specify) ____

____

____

6. Medication Management

Administers oral medications .... ❑ Yes ❑ No

Administers eye medications .... ❑ Yes ❑ No

Administers ear medications ❑ Yes ❑ No

Administers topical medications ❑ Yes ❑ No

Administers inhalation therapy ❑ Yes ❑ No

Administers medications via G-tube ❑ Yes ❑ No

Administers insulin ❑ Yes ❑ No

Administers subcutaneous injections ❑ Yes ❑ No

Administers oral narcotics ❑ Yes ❑ No

Uses glucometers ❑ Yes ❑ No

Assists with narcotic count ❑ Yes ❑ No

Provides appropriate client teaching ❑ Yes ❑ No

Other (please specify) ______________________________

____

____

7. Wound Management

For many of the following questions there are three answers. Yes indicates the LPN does this as a part of her/his practice. No indicates that the LPN does not do this as a part of her practice but another health care professional such as an MD or RN does. The third option indicates no one provides this service in this unit/facility.

Provides medical aseptic wound care ❑ yes ❑ no ❑ service not provided here

Provides surgical aseptic wound care ❑ yes ❑ no ❑ service not provided here

Care of drains ❑ yes ❑ no ❑ service not provided here

Removes sutures ❑ yes ❑ no ❑ service not provided here

Removes clips ❑ yes ❑ no ❑ service not provided here

Removes drains ❑ yes ❑ no ❑ service not provided here

Cares for simple wounds ❑ yes ❑ no ❑ service not provided here

Cares for complex wounds ❑ yes ❑ no ❑ service not provided here

Irrigates wounds ❑ yes ❑ no ❑ service not provided here

Packs simple wounds ❑ yes ❑ no ❑ service not provided here

Packs complex wounds ❑ yes ❑ no ❑ service not provided here

Provides appropriate client teaching ❑ Yes ❑ No

Other (please specify) ______________________________

____

____

8. Airway Management

There are three answers. Yes indicates the LPN does this as a part of her/his practice. No indicates that the LPN does not do this as a part of her practice but another health care professional such as an MD or RN does. The third option indicates no one provides this service in this unit/facility.

Deep breathing and coughing ...... ❑ yes ❑ no ❑ service not provided here

Positions .... ❑ yes ❑ no ❑ service not provided here

Percusses (i.e. cupping) .... ❑ yes ❑ no ❑ service not provided here

Vibrates chest .... ❑ yes ❑ no ❑ service not provided here

Provides postural drainage .... ❑ yes ❑ no ❑ service not provided here

Collects sputum specimens .... ❑ yes ❑ no ❑ service not provided here

Provides humidified air (i.e. nebulizer, humidifier) .... ❑ yes ❑ no ❑ service not provided here

Administrates Oxygen by :

Nasal cannula .... ❑ yes ❑ no ❑ service not provided here

Face mask .... ❑ yes ❑ no ❑ service not provided here

Venturi mask .... ❑ yes ❑ no ❑ service not provided here

Rebreathing mask .... ❑ yes ❑ no ❑ service not provided here

Transtracheal delivery .... ❑ yes ❑ no ❑ service not provided here

Oxygen tent .... ❑ yes ❑ no ❑ service not provided here

Suctions oropharyngeal .... ❑ yes ❑ no ❑ service not provided here

Suctions nasopharyngeal .... ❑ yes ❑ no ❑ service not provided here

Cares for oral and nasal airways .... ❑ yes ❑ no ❑ service not provided here

Cares for stable tracheostomy ...... ❑ yes ❑ no ❑ service not provided here

Provides nasogastric care .... ❑ yes ❑ no ❑ service not provided here

Provides incentive spirometry ...... ❑ yes ❑ no ❑ service not provided here

Provides pulse oximetry .... ❑ yes ❑ no ❑ service not provided here

Provides pulse Doppler .... ❑ yes ❑ no ❑ service not provided here

Cares for chest tubes .... ❑ yes ❑ no ❑ service not provided here

Cares for chest drainage system .... ❑ yes ❑ no ❑ service not provided here

Provides appropriate client teaching . ❑ yes ❑ no ❑ service not provided here

Other (please specify) ____

____

____

9. Elimination Management

There are three answers. Yes indicates the LPN does this as a part of her/his practice. No indicates that the LPN does not do this as a part of her practice but another health care professional such as an MD or RN does. The third option indicates no one provides this service in this unit/facility.

Performs urinary catheterization ...	❑ yes	❑ no	❑ service not provided here
Performs intermittent catheterization (i.e. I & O catheter)	❑ yes	❑ no	❑ service not provided here
Cares for indwelling catheter	❑ yes	❑ no	❑ service not provided here
Removes indwelling catheter	❑ yes	❑ no	❑ service not provided here
Applies condom catheter	❑ yes	❑ no	❑ service not provided here
Irrigates urinary catheter	❑ yes	❑ no	❑ service not provided here
Manages continuous bladder irrigation	❑ yes	❑ no	❑ service not provided here
Cares for ileal conduit	❑ yes	❑ no	❑ service not provided here
Provides bladder training	❑ yes	❑ no	❑ service not provided here
Assesses for urinary retention	❑ yes	❑ no	❑ service not provided here
Collects urinary specimens	❑ yes	❑ no	❑ service not provided here
Collects midstream urine specimens	❑ yes	❑ no	❑ service not provided here
Collects catheter specimens	❑ yes	❑ no	❑ service not provided here
Provides appropriate client teaching .	❑ yes	❑ no	❑ service not provided here
Administers laxatives	❑ yes	❑ no	❑ service not provided here
Administers suppositories	❑ yes	❑ no	❑ service not provided here
Administers enemas	❑ yes	❑ no	❑ service not provided here
Removes fecal impaction	❑ yes	❑ no	❑ service not provided here
Inserts rectal tube	❑ yes	❑ no	❑ service not provided here
Collects stool specimens	❑ yes	❑ no	❑ service not provided here
Provides bowel training	❑ yes	❑ no	❑ service not provided here
Manages stable ostomy care/stoma ..	❑ yes	❑ no	❑ service not provided here
Irrigates stoma	❑ yes	❑ no	❑ service not provided here
Performs peritoneal dialysis	❑ yes	❑ no	❑ service not provided here
Performs hemodialysis	❑ yes	❑ no	❑ service not provided here
Performs gastric gavage (i.e. enteral feeds/nutrition)	❑ yes	❑ no	❑ service not provided here
Monitors gastric gavage	❑ yes	❑ no	❑ service not provided here

Changes bags for gastric gavage .... ❑ yes ❑ no ❑ service not provided here

Records intake and output of gastric gavage .... ❑ yes ❑ no ❑ service not provided here

Monitors intake and output .... ❑ yes ❑ no ❑ service not provided here

Provides appropriate client teaching . ❑ yes ❑ no ❑ service not provided here

Other (please specify) ______________________________

____

____

10. Infusion Management

There are three answers. Yes indicates the LPN does this as a part of her/his practice. No indicates that the LPN does not do this as a part of her practice but another health care professional such as an MD or RN does. The third option indicates no one provides this service in this unit/facility.

Assesses client with IV therapy .... ❑ yes ❑ no ❑ service not provided here

Maintains peripheral venous lines ... ❑ yes ❑ no ❑ service not provided here

Calculates flow rate .... ❑ yes ❑ no ❑ service not provided here

Hangs non-medicated solutions/infusions .... ❑ yes ❑ no ❑ service not provided here

Discontinues an IV .... ❑ yes ❑ no ❑ service not provided here

Documents rate/solution of an IV ... ❑ yes ❑ no ❑ service not provided here

Manages IV infusion pump .... ❑ yes ❑ no ❑ service not provided here

Monitors parenteral nutrition .... ❑ yes ❑ no ❑ service not provided here

Documents parenteral nutrition .... ❑ yes ❑ no ❑ service not provided here

Manages kangaroo pump .... ❑ yes ❑ no ❑ service not provided here

Monitors blood transfusion therapy . ❑ yes ❑ no ❑ service not provided here

Monitors rate of blood transfusion .. ❑ yes ❑ no ❑ service not provided here

Co-signs blood transfusion administration .... ❑ yes ❑ no ❑ service not provided here

Provides appropriate client teaching . ❑ yes ❑ no ❑ service not provided here

Other (please specify) ______________________________

____

____

11. Evaluation

Evaluates the effectiveness of nursing interventions by comparing actual outcomes to anticipated outcomes .... ❑ Yes ❑ No

Participates in quality assurance and improvement activities to enhance client care and nursing practice .... ❑ Yes ❑ No

Other (please specify) ____

____

____

12. Communication

Maintains clear, concise, accurate and timely records of client care ... ❑ Yes ❑ No

Collaborates as a member of an interdisciplinary health team .... ❑ Yes ❑ No

Promotes team problem solving, decision making and interdisciplinary collaboration by jointly assessing shortfalls in nursing practice .... ❑ Yes ❑ No

Reports situations that are potentially unsafe for clients .... ❑ Yes ❑ No

Takes physician's orders over the phone .... ❑ Yes ❑ No

Transcribes physician's orders .... ❑ Yes ❑ No

Transcribes medication orders .... ❑ Yes ❑ No

Presents nursing knowledge regarding the client in interdisciplinary team interactions .... ❑ Yes ❑ No

Other (please specify) ____

____

____

13. Professional Responsibilities

Practises independently within the scope of practice .... ❑ Yes ❑ No

Other (please specify) ____

____

____

14. Registration

Does the facility require the practical nurses working at this facility to maintain their license with the College of Licensed Practical Nurses? ... ❑ Yes ❑ No

Approximately what percentage of your staff working as LPN's, maintain their license with the College of LPNs?

❑ 0-25% ❑ 26-50% ❑ 51-75% ❑ 76-100% ❑ I do not know

16. Based on a Full Time Equivalent (FTE) of 1872 hours per year, what were the number of Regular FTE in the following categories within your unit (for acute care) or your facility (for continuing care) based on the 1999- 2000 fiscal year ? (i.e. Do not include casual hours)

Registered Nurse ________ Registered Psychiatric Nurse______________
Licensed Practical Nurse________ Care Aide____________

You have been focusing on the specific competencies and skills of LPNs. We now want you to shift your thinking from these details to broader issues.

17. Please check all the reasons that explain your unit/facility's overall use or non use of LPNs:

❑ hospital or administrative policy
❑ historical practice (i.e it has always been this way)
❑ cost effectiveness
❑ ability to have higher staffing levels with this staff mix
❑ work jurisdiction issues with other unions
❑ availability of LPNs for the positions
❑ unavailability of LPNs for the positions
❑ availability of RNs or RPNs
❑ unavailability of RNs or RPNs
❑ availability of training for LPNs (upgrading and/or post basic)
❑ unavailability of training for LPNs (upgrading and/or post basic)
❑ knowledge by managers and staff of current LPN scope of practice and competencies
❑ lack of knowledge by managers and staff of current LPN scope of practice and competencies
❑ confidence that LPNs have appropriate skills for patients'/residents' needs
❑ lack of confidence that LPNs have appropriate skills for patients'/residents' needs

Other, please specify ____
____
____

18. If your unit were going to increase the number of LPNs or add duties to the existing complement, please list all the factors that would influence your decision.

____
____
____
____
____
____
____
____

19. If your unit were to decrease the number of LPNs or delete duties from the existing complement, please list all the factors that would influence this decision.

____

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____

Please add any comments here. The other side of paper may be used if more space is needed.

____

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____

Thank-you for your co-operation in completing this survey. Your time and input are appreciated!

PART 2 the BC context

This section presents an overview of the education, regulation and employment/utilization issues related to licensed practical nurses and care aides in British Columbia. It serves as a background document for the research findings. In it, the current education programs for practical nurses and care aides are described, as are upgrading and post-basic course offerings. Statistics on the nursing labour force, current wage rates, and reference to nursing human resource planning activities are also provided. Finally, the regulatory framework for LPNs is described, including the current review of nursing scopes of practice.

CONTENTS

18 education

- 18 LPN Education
- 22 Care Aide Education
- 25 Other Education Issues

26 employment and utilization

- 26 LPN Employment and Utilization
- 30 Care Aide Employment and Utilization

31 regulation

- 31 Regulation of LPNs
- 33 Regulation of Care Aides

33 summary

34 references

the B.C. context

The collection of data for this project occurred within the context of B.C.'s current health care system. This description of the B.C. context serves as a background for the project findings.

Areas addressed for LPNs and care aides in B.C. include:

- education
- employment and utilization, and
- regulation.

education

LPN EDUCATION

Entry Level Education

Practical nurses have been formally educated in B.C. for over 50 years. LPNs currently receive their entry level educational program at four B.C. colleges: Malaspina University College, Okanagan University College, Vancouver Community College and College of the Rockies. These four colleges admit 160 students each year; all have indicated they have the capacity to increase the number of student admissions or "seats" in response to the nursing shortage. An additional 47 seats are scheduled to open in 2000/2001 for entry level students and those upgrading through LPN Access, a bridging program for care aides who want to work as LPNs (10 at College of the Rockies, 12 at Malaspina and 25 at VCC). The colleges report high interest from applicants and demand from employers (as discussed in *Key Informants)*. The College of LPNs notes that, in addition to the four colleges cited, another three are exploring program options for practical nurses.

Refresher Program

The Open College offers a practical nurse refresher program in a continuous entry, distance education format. The OC is also experiencing an increase in enrolment.

Standard Curriculum

The five colleges involved in practical nursing education follow a standard curriculum, providing consistency across the province. Through the provincial Practical Nurse Articulation Committee of the Ministry of Advanced Education, Training and Technology, educators meet twice a year to resolve common issues and maintain consistency in the standard curriculum.

The current curriculum, first offered in 1992, is a departure from the traditional skills or task-oriented training of the past. The curriculum is based on a conceptual framework that emphasizes holistic care, independent problem solving, critical thinking and collaborative practice. The program was increased to 12 months in 1992 to accommodate the additional competencies (knowledge, skills, attitudes and judgment) that were deemed essential in a 1991 needs assessment. The 1991 needs assessment, as cited by Layton (1998), was conducted on behalf of the Centre for Curriculum and Professional Development of the education ministry and was based upon an extensive review of LPNs in the health care system. The current program has increased emphasis on continuing and community care. Particular emphasis is placed on gerontology in keeping with the trend of an aging population.

The current 48 week program is delivered in three semesters over 12 months. The curriculum includes four main themes: health, healing, human relationships and professional growth. The first semester addresses health/wellness and community care and the second, aging and gerontology. The third semester focuses on acute care nursing. The program includes 754 hours of clinical learning experiences (laboratory skills, supervised clinical practice and a preceptorship) and 610 hours of classroom studies, for a total of 1364 hours. Clinical learning experiences occur throughout the program and are supervised by college faculty. A preceptorship at the end of the program includes four weeks of full-time clinical practice, supervised by a staff nurse preceptor.

The length of the B.C. program is comparable to other provinces (12 months over four semesters in Alberta; 13 months of study over a 14 month period in Manitoba; and 12 months in Ontario (Layton, 1998).

Curriculum Review

A review of this current curriculum, completed in 1998, reports that it is well-received by faculty and students. Six of the 15 employers surveyed by Layton (1998) were aware of the changed curriculum and made positive comments about the enhanced competencies of the new graduates.

Layton also pointed out that nine of the 15 employers contacted were unaware of the changed curriculum. “New graduates only make up approximately 8 per cent of the B.C. LPN workforce and are hired as casuals, with little seniority for job openings,” reported Layton. “The new graduate and their complement of skills are not well understood by employers or widely marketed in B.C.”

Revised Admission Requirements

Until the curriculum was revised in 1992, the basic program for practical nurses was 10 months and, as noted earlier, was based on skills rather than competencies. As the program evolved to meet the needs of the health care system, admission criteria also changed. Since the review in 1998, all students are required to have Grade 12 or

equivalent, Biology 12, English 12, a math assessment (Grade 10 level required) and/or an Adult Basic Education assessment, and an English as a Second Language assessment.

The LPN Access program was developed to enable care aides to "bridge" into the practical nursing program, taking into account the education and experience that care aides have already acquired. While the regular program is 12 months (three semesters), the LPN Access program is two semesters. Successful completion prepares graduates to write the national practical nursing exam and apply for a license from the College of LPNs. The LPN Access program is currently offered by the College of the Rockies. Vancouver Community College and Malaspina University College plan to offer the program in 2000/2001. Admission requirements include: a recognized RCA (care aide) certificate; six months work experience as a care aide; Grade 12 (or equivalent), including a C grade or above in Biology 12; math and English assessments; and a satisfactory criminal records search.

Provincial Approval of Programs

As of 1996, all entry level education programs for LPNs must be approved by the College of LPNs. The approval process, comparable to other accreditation systems in nursing education, assesses the education program against standards to evaluate structure, process and outcomes (program, curriculum, student progress and graduate performance). All practical nurse programs in B.C. have been, or are being, reviewed in this new approval process, including the Open College refresher program for LPNs.

National Examinations

Graduates of an approved program are eligible to write national examinations and, if they achieve a passing grade, are eligible for licensure by the College of LPNs. The national exam is based on competencies related to client care, communication and professional responsibility. As practical nurse programs vary across the country, there are supplemental sections in the examination (e.g. medications, infusion therapy) that provinces may or may not require. B.C. graduates are required to complete all sections of the exam. The national exam was recently updated based upon reviews of nursing competencies completed by provinces and at the national level (the National Nursing Competency Project, 1997).

LPNs in B.C. have been writing the national examinations since 1977. Approximately 115 new B.C. graduates pass the national exams each year (Table 1).

Table 1: B.C. Practical Nurse College Graduates

Year	Number of Graduates
1995	113
1996	120
1997	124
1998	115
1999	115

Source: College of LPNs

Post-basic or Advanced Courses

A number of post-basic or advanced courses are offered to LPNs, care aides, RNs and other health care providers in B.C. These courses prepare practising LPNs and care aides to take on expanded roles beyond entry level competencies. Camosun College offers an activity assistant course, University College of the Cariboo offers a gerontology course and Okanagan University College offers a rehabilitation assistant course. The Vancouver Regional Health Board offers the Geropsychiatric Education Program. George Pearson Centre offers LPNs tracheostomy care, ventilator care and gastrostomy care.

Other post-basic courses in demand by LPNs include perioperative nursing and foot care. In the absence of these programs in B.C., LPNs are enroling in distance education courses in other provinces, sometimes with employer support (e.g. Saskatchewan's perioperative nursing course).

The demand for these post-basic courses and other continuing education has been identified by the College of LPNs and by surveys of LPN learning needs. Responses to a 1999 College of the Rockies survey of LPNs in the Kootenays indicated a high interest in post-basic and continuing education. LPNs indicated a need for highly specialized post-basic courses, such as perioperative nursing, as well as more general continuing education topics like conflict resolution.

Continuing education programs within the general field of nursing are available at community colleges. In-service programs in health care facilities are generally limited, due to heavy workloads and lack of funding (as discussed in *Key Informants).*

Upgrading Programs

Upgrading programs are available through a number of workplace initiatives, primarily in acute care settings. These upgrading programs are useful for LPNs trained before the new

curriculum was implemented and also for practical nurses who have been unable to practise their full complement of skills. Lions Gate Hospital, for example, has offered a series of upgrading courses for LPNs (as discussed in *Case Studies*), including intravenous therapy, oxygen therapy, catheterization, and frail elder care. Other facilities identified similar initiatives (as discussed in *Key Informants).*

An important upgrading opportunity is the "$5 Million" initiative for staffing in residential continuing care. Through this 1999/2000 project, the provincial government provided regional health authorities with funding to support 218 practical nurses working as care aides in becoming LPNs. Many will receive refresher education to meet current licensing criteria and be able to practise to full scope. This initiative is being implemented by regional joint union-management committees in close collaboration with the Healthcare Labour Adjustment Agency.

Another initiative is found in Quesnel, where the Quesnel and District Community Health Council, the Hospital Employees' Union and the College of New Caledonia are collaborating to support care aides in accessing practical nurse education.

Open College Modules

Open College offers the refresher program in distinct modules that can be separated (if the LPN needs only some courses/elements) or offered as a whole program (if the LPN needs the entire program). This provides an important and accessible learning opportunity for LPNs who want to upgrade a particular competency area, such as medication administration. With financial support more LPNs could access these distance education courses.

GROWTH Competence Program

In 1997, the College of LPNs of B.C. adopted a continuing competence program called "GROWTH" – Growth, Reflection, Opportunities, Worth, Thoughtfulness and Healing. This program includes self-assessment and learning plans assessed by the college in a number of different ways, including peer review and observation of practice. The GROWTH program is in the initial stages of implementation and will eventually be required of all LPNs for licensure by the College of LPNs.

CARE AIDE EDUCATION

Entry Level Education

The Resident Care Attendant (RCA) certificate, the certificate program for care aides, is offered by 16 publicly funded colleges and 26 private training facilities across B.C. Formerly known as Long Term Care Aide or Nursing Aide programs, current public programs have used the RCA title and a standard provincial curriculum since 1991. At that time, the RCA Articulation Committee developed a standard curriculum, with funding from the education ministry. The process included input from employers in

different regions of the province. Informal collaboration between the developers of the RCA curriculum and the LPN curriculum led to some congruency in the conceptual foundations of the two programs.

The curriculum was originally envisioned by educators as a combined RCA and Home Support Worker (HSW) program and some colleges offered it in that format. Currently, a number of colleges are investigating the possibility of merging the two programs. This possibility, combined with awareness that the curriculum has not been updated for approximately 10 years, has led RCA educators to apply to the provincial government for a program review and revision (as discussed in *Key Informants*).

In the publicly funded programs, the curriculum now includes a 20 week course involving classroom and laboratory work (300 hours) and supervised clinical practice experience (300 hours, including 180 in ECU and 120 in Intermediate Care). The combined RCA/HSW program extends the period of study by two to four weeks. Grade 10 or an acceptable equivalent is required for admission.

Private Training Facilities

While the standard provincial certificate program is available to the 26 private training facilities, there is no requirement that it be used. Admission requirements and curriculum in private training facilities can vary widely from public college courses. The major concern about private programs, as expressed by public college faculty and employers, is the lack of supervised clinical learning experiences in these programs. In contrast, B.C.'s public colleges require clinical learning experiences supervised by qualified faculty (as discussed in *Key Informants*). The number of private facilities using the standard RCA curriculum is not known, but anecdotal information identified one private training facility using the standard curriculum.

Accountability of private training facilities is limited to a voluntary accreditation process that protects students from losing their tuition if the school closes. (While the accreditation process is voluntary, for students to be eligible for student loans through the B.C. Student Assistance Program, the program must be accredited.) The accreditation process does not attend to such issues as supervised clinical learning experiences. Educators and employers report that graduates of these private programs may be very disappointed to find that, after paying very high tuition fees, they are not accepted for care aide positions (as discussed in *Key Informants*).

Curriculum Content

The public college curriculum focuses on personal care skills – assisting residents with activities of daily living. Courses include human relations (communication skills), health and healing (personal care skills), work role and practical/clinical experiences. Supervised clinical learning experiences in both intermediate and extended care settings are required in the B.C. public college program.

English as a Second Language

English as a second language is a particular challenge in Resident Care Aide programs. Because the care aide course is short and entry level salaries are good, career counsellors promote the program. As communication skills are an essential component of the work, proficiency in English is required. While some programs have integrated ESL into the RCA program (Vancouver Community College, for example), most programs report that ESL is a very challenging issue for students, faculty and facilities.

Provincial Standards for the Care Aide Role

The standard care aide curriculum in B.C. public colleges offers one type of standardization for the care aide role. As with the LPN program, there is a provincial RCA Articulation Committee of the Ministry of Advanced Education, Training and Technology. The committee works to achieve consistency for entry level training of RCAs. At this time there is no provincial licensing or certification system for the care aide role. There is a provincial benchmark for care aides and coordination of job descriptions through a provincial bargaining structure/classification system.

Currently, there are no national education standards for the care aide role. RCA training programs vary across the country, from on-the-job training to 32 week college programs. Content may be limited to learning how to provide physical care, such as assistance with personal hygiene, or be broader, such as attending to the special needs of residents experiencing changes in mental functioning, as is the case in B.C. (Capilano College, 1998). Many titles are used across the country to describe the care aide role (as discussed in *Across Canada).*

Continuing Education

Continuing education for care aides is available through workplaces and colleges. The University College of the Cariboo offers a distance course in gerontology available to care aides as well as LPNs. The VCC program, “Caring for Clients with Dementia” is a 120 hour course that can be taken on a full time or part time basis, and may be offered collaboratively with a health care facility. The Vancouver/Richmond Health Board Geropsychiatric Education Program is available to care aides. Camosun College offers an “Activity Assistant” course based upon the RCA program. Malaspina University College offers “Mental Health Support for the Older Person.” While in-service sessions may be available to care aides in the workplace, workload and lack of funding limit these opportunities.

Skills Upgrading

Education initiatives are being offered to assist care aides in upgrading their skills. For example, care aides educated before the current RCA program may be able to upgrade to the RCA certificate level through Vancouver Community College. Care aides may also

choose to pursue the LPN Access program discussed above. There is currently a high demand for this program (as discussed in *Key Informants)*.

OTHER EDUCATION ISSUES

Prior Learning Assessment

An important related development in the education sector is Prior Learning Assessment. The B.C. education system has adopted the following definition of PLA:

> PLA is assessment by some valid and reliable means, by a qualified specialist, of what has been learned through nonformal education/training or experience, that is worthy of credit in a course or program offered by the institution providing the credit.

PLA is used in a number of programs, providing another avenue for LPNs and care aides to access programs and receive credit for previous learning and experience. Funding of PLA for LPNs and care aides is provided by the Healthcare Labour Adjustment Agency through a collaborative project between the colleges and the Hospital Employees' Union. The College of LPNs was also a partner in developing the PLA for LPNs.

Foreign Trained Nurses

The B.C. Ministry of Multiculturalism and Immigration has brought together a committee with representatives of government, health employers, trainers and regulatory bodies to identify and address barriers facing foreign trained nurses who want to practise in B.C. (Rivers and Associates, 2000). A discussion and background paper on employment issues and opportunities for foreign trained nurses is currently being circulated. A report by the Health Employers Association of B.C., the B.C. Nurses' Union and the provincial government, *Assess and Intervene*, also discusses the issue of foreign trained nurses and supports leadership and consultation among involved parties.

Foreign trained nurses may find that prior learning assessments offer options for entering the B.C. workforce. The Open Learning Agency refresher program may be particularly relevant to this group.

The LPN route is one avenue for foreign trained nurses to practise in B.C. Five per cent of all nurses licensed with the College of LPNs of B.C. between 1995 and 1999 were from outside of Canada.

Financial Support for Learners

LPNs and care aides pursuing continuing education may be eligible for funding through the B.C. Health Care Scholarship, which awards $3,500 bursaries to 300 health care workers each year. LPNs and care aides have used these bursaries in pursuing LPN refresher courses, upgrading or continuing their education in nursing.

employment and utilization

LPN EMPLOYMENT AND UTILIZATION

Information on the employment and utilization of LPNs was drawn from *Rollcall Update '98*, *Inventory Update '98*, surveys undertaken as part of this project, and a Human Resources Development Canada (HRDC) report by Dussault et al entitled *The Nursing Labour Market in Canada: Review of the Literature* (1999). Information on other members of the nursing team – registered nurses (RNs) and registered psychiatric nurses (RPNs) – is included for comparison purposes and was also drawn from *Rollcall Update '98, Inventory Update '98*, and the HRDC report.

Wages

Wages for different members of the nursing team are noted below in Table 2. The LPN and care aide wage rates apply to those working in facilities (both acute and continuing care). Home care and other "community subsector support workers" are covered by a separate collective agreement.

Table 2: Wages for Care Aides, LPNs and RN/RPNs

Job Category	Starting Wage	Maximum Wage
Care Aide (PC 3)	$19.27	$19.67 (12 mo.)
Practical Nurse (PC 8)	$20.25	$20.66 (12 mo.)
RN/RPN	$21.40	$26.50 (sixth year)

Source: HEABC and HEU

Note: The issue of pay equity must be factored into any further analysis of wages. The target date to reach pay equity is expected to be about 2010. Pay equity target rates are adjusted by any general wage increases that may be achieved in the future.

There is one salary schedule in the Facilities Sub-sector Collective Agreement (which governs the PC 3 and PC 8 benchmarks). Each benchmark covers different jobs/job descriptions. Most care aides are classified as PC 3 and most LPNs are PC 8.

Wage rates in Table 2 are not implemented at most long term care facilities; most pay 95 per cent of these wages or more, depending on whether they are fully "levelled." There are over 200 individual wage schedules where LPN and care aide wages may be less than set out in the Facilities Sub-sector wage schedule.

The current benchmarks for the PC 3 and PC 8 were established in 1987. In the last round of collective bargaining, the unions and employers agreed that, following the conclusion of this research, the LPN benchmark will be updated "to include those duties and responsibilities which are appropriate to be included in the benchmark." Furthermore, the parties agreed that "the benchmark review and any changes arising from it to the benchmark will not result in a change in the rate of pay associated with the benchmark" (Facilities Sub-sector Collective Agreement, 1998 – 2001).

Survey on B.C. Facilities' Employment of LPNs

As part of this project, a general survey on LPN employment patterns was conducted in November 1999, and a more in-depth survey on LPN utilization was carried out in March 2000. The results of both are presented in the Surveys section. To set the B.C. context for this study, highlights of the general survey are cited here.

Among the facilities surveyed, 71% (17) of the hospitals, 26% (20) of the continuing care facilities, and 91% (40) of the combined acute/extended care facilities employ LPNs. In the acute sector, medical units are most often identified as using LPNs. Other units that frequently employ LPNs include surgery, rehabilitation, ambulatory/outpatient, maternal/newborn, pediatric and palliative/oncology. Of the hospitals that reported using LPNs, most employ LPNs in a range of units. Seventeen facilities reported LPNs working in care aide positions. Many managers reported that they were considering changing staffing to increase the number of LPNs on staff.

Survey respondents offered many reasons for not employing LPNs on particular units. For example, with a small complement of staff, a third category of worker was seen as creating additional problems. Others noted that the level of acuity demanded another type of worker. When noting that the competencies of LPNs are not understood by employers, Layton (1998) added that: "This fact, job policy, union and professional constraints as well as marginal cost savings for unregulated workers, limits employer implementation of the actual scope of practice of LPNs in B.C."

Provincial Employment Statistics

It is useful to consider employment data on nurses (LPNs, RNs and RPNs), using *Rollcall '98* statistics. Ratios are noted for comparison purposes.

Table 3: Nurses Employed in Nursing in B.C.

LPNs	4,424	
RNs	28,181	Ratio of RNs to LPNs: 6.4 : 1
RPNs	2,200	Ratio of RNs and RPNs (combined) to LPNs: 6.9 : 1

Source: *Rollcall '98*

These statistics can be viewed in the broader picture of the family of nursing in Table 4, where the total number of registered/licensed LPNs, RNs, and RPNs is compared to the population of B.C. Changes from 1997 to 1998 indicate that, while the population has increased, the number of nurses in all three nursing groups has decreased.

According to *Rollcall '98*, in 1998 there were 5,252 LPNs in B.C. and 4,424 were employed in nursing. The majority were employed in acute care general hospitals (2,308) followed by extended care and long term care (1,279). A total of 472 LPNs reported working as LTC aides/nurses aides.

The number of LPN registrants can be expected to increase as a result of recent initiatives, principle among them the "$5 million" initiative for staffing in residential continuing care. Through this 1999/2000 project, the provincial government provided regional health authorities with funding to support 218 practical nurses working as care aides in becoming LPNs. Many will receive refresher education to meet current licensing criteria and be able to practise to full scope. This initiative is being implemented by regional joint union-management committees in close collaboration with the Healthcare Labour Adjustment Agency.

Table 4: Nursing Personnel and Population in BC, 1997 and 1998

Nursing Services	Number		Number per 10,000 Population		
	1997	1998	1997	1998	% Change
LPN	4,485	4,242	11.44	10.64	-5.4
RN	27,642	28,181	70.49	70.68	1.9
RPN	2,210	2,200	5.64	5.52	-0.5
B.C. Population	3,921,546	3,987,011			

Source: *Rollcall '98*

National Employment Statistics

The Human Resources Development Canada report by Dussault et al (1999) presents national statistics on nursing in Canada. The report notes that the average ratio of RNs to LPNs in Canada is 3 : 1. This ratio varies across Canada from 2 : 1 in Newfoundland to 5.4 : 1 in B.C. (Dussault et al used Statistics Canada data and included non-practising LPNs, thus their ratio is different from the 6.4 : 1 noted in Table 3, which is based on *Rollcall '98. Rollcall '98* data for "nurses employed in nursing in B.C." were used in Table 3, as all three groups were reported in this way, allowing for comparison.)

Dussault et al noted that the number of nurses has decreased in the last decade. The number of LPNs across Canada decreased by 8.4 per cent from 1992 to 1997. In B.C., the College of LPNs notes that there has been a decline of 1,500 registrants over the past five years. It attributes this to a decline in applicants, changing roles, continued downsizing and reorganization of facilities, and new procedures for out of province applicants (CLPNBC, 1999).

Dussault et al also report on the aging of the nursing workforce. Over half of LPNs in B.C. are over the age of 45 (CLPNBC, 1998).

National Human Resource Planning

National human resource planning is under review by the Federal/Provincial/Territorial Advisory Committee on Health Human Resources, which reports to deputy health ministers. A working group of this committee is developing a strategy to improve the supply and management of the nursing workforce. It is currently circulating a paper outlining 12 proposed strategies, including: establishing appropriate planning bodies; improving data sets and research; increasing coordination; increasing nursing education seats by 10 per cent; establishing a formal Nursing Education Plan; recognizing the full continuum of nursing practice, including full utilization of each category of nurses, most notably LPNs; implementing retention strategies, including utilizing an appropriate nurse mix; and encouraging nurses to re-enter the workforce.

Provincial Human Resource Planning

Human resource planning in B.C. is currently coordinated by the Health Human Resources Advisory Committee, a Ministry of Health multi-stakeholder advisory group. Its mandate is to gather and share information, promote a coordinated approach, provide advice to government and identify emerging issues in health human resources. Initial issues include sector specific analyses, educational issues and research (HHRAC, 2000).

The retention and recruitment of RNs and RPNs in B.C. has been thoroughly reviewed and reported in: *Assess and Intervene*, a 2000 report prepared by the Health Employers Association of B.C., the B.C. Nurses' Union and the provincial government. The report examines the general problem of nursing shortages and considers measures to enhance retention and recruitment. It offers 34 recommendations, grouped under the general headings of education, health human resource activities, research and database development, recruitment and retention strategies.

Human Resource Planning and Care Delivery Models

One significant factor in nursing human resource planning is the model of care delivery used by facilities. A variety of nursing care delivery and staffing models are currently in use in B.C. and the rest of Canada. As Dussault et al note, there is insufficient research to indicate which model is best. "Most models have not been systematically defined and

empirically assessed to determine their potential in making the utilization of the nursing workforce more effective, or more efficient," states the report. "Their impact on the role assigned to other providers of care is not clear either" (Dussault et al, 1999).

Key informants to this project indicated there is no single model to fit every unit and that models should be selected to match the needs of the unit, staff mix and client needs. Cost effective approaches to staffing within the nursing team were raised as a factor in care delivery models. As noted in several of the studies cited earlier, more research is needed to determine the most effective models.

Retention and Recruitment

According to Dussault et al (1999), LPNs have specific recruitment and retention difficulties related to such factors as fewer job opportunities and limited in-service education. "LPNs say there are administrative obstacles to the performance of procedures which they are legally entitled to perform," states the Dussault report. "Legal issues relating to the delegation of tasks and the need to work in some jurisdictions under the direction of medical practitioners or other health team members, limit their autonomy."

CARE AIDE EMPLOYMENT AND UTILIZATION

In this project, the care aide role has focused on continuing care residential facilities. Care aides are employed in intermediate care and extended care throughout the province. Recently, care aides have been reintroduced to acute care. Their role, which is viewed as fairly consistent across continuing care facilities, focuses on assisting residents with personal care.

With the increasing acuity of illness, especially related to forms of dementia, there has been an identified need to support care aides with additional education in the area of psychogeriatrics. Facilities may focus on upgrading the care aide role and may also consider introducing the LPN role.

regulation

REGULATION OF LPNS

Role of Regulatory Body

Regulation of LPNs is legislated to the College of LPNs of B.C., which carries out the typical regulatory functions of licensure, approval of schools of nursing, professional conduct review and discipline, continuing competence programs and consultation on standards of practice, entry-level competencies and position statements.

Background

Regulation of the LPN role began in B.C. in 1951 when the Council of Practical Nurses was established through the *Practical Nurses Act.* The Act and Council were renamed in 1985 to emphasize the licensing requirement, i.e. the Council of Licensed Practical Nurses.

"The 1993 *Health Professions Statutes Amendment Act* set out the duties and objectives of the Council of Licensed Practical Nurses, enhanced the Council's powers to investigate the practice of members of the profession, and permitted the Council to suspend or impose limits, in appropriate circumstances, on the member pending the completion of a hearing concerning the member's practice. In May, 1995, the *Nurses (Licensed Practical) Act* was repealed, and LPNs are now governed by the *Health Professions Act* and the *Nurses (Licensed Practical) Act Regulation*. The name of the regulatory body was changed to the College of Licensed Practical Nurses" (Health Professions Council, 2000).

Health Professions Council

The Health Professions Council (HPC) is currently reviewing the scope of practice of nurses, including LPNs, RNs and RPNs. In its *Preliminary Report on the Licensed Practical Nurses Scope of Practice* (HPC, April 2000), the HPC recommends a new scope of practice with a broader description of the LPN role.

The other major change is the level of independence of the professional role. The current scope of practice sets out that "Except in an emergency, all nursing services provided by a registrant must be carried out under the direction of a medical practitioner who is attending the patient or under the supervision of a registered nurse who is providing services to the patient" (CLPNBC, 1995). New Brunswick and Alberta have similar supervision requirements. In Ontario, which established health professions legislation in the early 1990s, the supervision requirement has been deleted. Other provinces are reviewing the supervision component in LPN legislation and considering removal or revision. For example, Manitoba recently removed the "under direction" limitation from the LPN scope of practice (Registrars Conference, 1999).

The Health Professions Council recommends that certain selected "reserved acts" be granted to LPNs and recommends a provision related to the process of delegation of reserved acts. It also recommends that the titles of licensed practical nurse, LPN, practical nurse, PN and "nurse" be reserved for this nursing group. The term "nurse" is shared with other regulated nursing professions.

Hearings to discuss the HPC recommendations were complete in July. The HPC plans to forward its recommendations to government by fall 2000.

Independent and Interdependent Practice

The issue of independent practice is a significant one for professionals. A Health Professions Council report states that, for the College of LPNs of B.C., "LPNs are responsible and accountable for the care and services they provide to clients through their Standards of Practice, the Code of Ethics and other practice guidelines. An important part of this role is ensuring that its members practise within their level of competence, and that LPNs are provided with guidance to determine when services must be carried out as part of an interdependent team."

The two concepts of competency and interdependence are important to the College of LPNs. Earlier this year, the college put out a document identifying entry-level LPN competencies, and it will soon release a second document on post-basic and specialized competencies. These build on the research and consultation that the college undertook in 1998 to confirm the relevance of LPN competencies identified in the National Nursing Competency Project (described in *Across Canada*). The College of LPNs consultations confirmed that all of the 155 competencies identified in the national project are required in this province; it also identified additional competencies required for entry-level practice in B.C.

One of the interesting aspects of the competency studies is the high number of competencies shared among the nursing groups – LPNs, RNs and RPNs. For example, all three groups share assessment competencies, though the depth and breadth of the knowledge, skills and judgement used to assess clients varies in the three groups. (The *Across Canada* section of this report provides further information on shared competencies.) The level of LPN independence becomes important in situations where competencies are shared. LPNs entering practice are prepared to care for individuals who have well defined health challenges and predictable health outcomes. LPNs are also prepared to work in partnership with other members of the nursing team to provide care for clients with less predicable outcomes and/or increasingly acute conditions.

Upgrading Competencies in Team Work

In addition to work by nursing regulatory bodies at the national and provincial levels, a 1997 study on the learning needs of health caregivers by the Health Management Resource Group identified trends in the B.C. health care system and the implications for competency upgrading. The study was forwarded to the Ministry of Health and has not yet been acted upon. However, some of the areas needing renewed attention (e.g. the importance of team work) have been identified by other studies as well.

The issue of enhanced inter- and intra-disciplinary team work was an important competency area identified in a national study on collaborative relationships (Health and Welfare Canada, 1990). Collaborative partnerships are considered very important, but receive limited attention in entry-level programs, where the focus of study tends to be on the nurse-client relationship. For LPNs who depend on it to carry out their role, understanding the collaborative partnership model is even more critical. While LPN curriculum covers working in partnership with other care providers, more needs to be done in other nursing curricula. Opportunities for nursing students to practise collaboratively are also needed. Key informants to this project frequently spoke of problems when care providers were unaware of the roles and responsibilities of other nursing team members.

REGULATION OF CARE AIDES

Standardization of the care aide role is addressed by the standard Resident Care Aide curriculum offered in B.C. public colleges since 1992, as well as through provincial benchmarks and coordination of job descriptions. There is currently no legislation mandating the scope of practice of care aides in B.C. or other provinces.

summary

The B.C. context shapes the possibilities and roles of all care providers, including LPNs and care aides. Entry level education lays the framework for practice. Continuing education, post-basic courses and in-service sessions can provide a supportive environment for career development. The employment and utilization of LPNs varies across the province and across facilities, while care aides are consistently employed in residential continuing care facilities. The professional regulation of LPN practice provides parameters and expectations for the LPN role. The LPN scope of practice is currently under review by the Health Professions Council of B.C.

references

Advisory Committee on Health Human Resources. (2000). *Towards a Nursing Strategy for Canada: A consultation Paper for Stakeholders*. Ottawa, ON.

Capilano College. (1998). *Resident Care Attendant Brochure*. North Vancouver, B.C.

CLPNBC. (1996). *Practical Nurses Education Approval Handbook.* Burnaby, B.C.

CLPNBC. (1997). *GROWTH – Continuing Competence through Reflection*. Burnaby, B.C.

CLPNBC. (1999). *Report to the Registrars Conference*. Edmonton, AB: LPN Registrars Conference.

CLPNBC. (2000). *Understanding the Role of the LPN: Entry to Practice Competencies for LPNs in B.C.* Burnaby, B.C.

CLPNBC. (2000a). *Position Statements: The Appropriate Utilization. Medication Administration. Telephone Orders.* Burnaby, B.C.

Facilities Sub-sector Collective Agreement. (1998 – 2001). *Health Services & Support Facilities Sub-sector Collective Agreement between the Association of Unions and HEABC.* Vancouver, B.C.

College of the Rockies. (1999). *Kootenays Continuing Education Survey. LPN Responses.* Cranbrook, B.C.

Dussault et al. (1999). *The Nursing Labour Market in Canada: Review of the Literature.* Montreal, PQ: University of Montreal. Commissioned by Health Human Resources Canada.

Health and Welfare Canada. (1990). *National Strategy for Enhancing Preventative Practice of Health Professionals – Prevention through Partnership: Collaborating for Change.* Ottawa, ON.

Health Human Resource Advisory Committee. (2000). *Terms of Reference.* Victoria, B.C.

Health Human Resources Unit. (1998). *Rollcall 98 and Inventory Update 98*. Vancouver, B.C.: University of British Columbia.

HMRG. (1998). *Development of Entry-Level Competencies for Licensed Practical Nurses in B.C.* Vancouver, B.C.

Health Professions Council. (2000). *Licensed Practical Nurses Scope of Practice – Preliminary Report.* Vancouver, B.C.

Layton, D. (1998). *Practical Nursing Curriculum Update Study.* Victoria, B.C.: MAETT.

Ministry of Health and Ministry Responsible for Seniors, Health Employers Association of B.C. and the Nurses Bargaining Association. (2000). *Assess and Intervene.* Vancouver B.C.

National Nursing Competency Project. (1997). *Final Report.* Ottawa, ON.

PLA. (1994). *Prior Learning Assessment of B.C.* Burnaby, B.C.: Open Learning Agency.

Private Post-Secondary Education Commission of B.C. (1998). *Accreditation Overview and Guide.* Vancouver, B.C.

Rivers and Associates. (2000). *Foreign Trained Nurses in B.C.: Employment Issues and Opportunities.* Prepared for the Ministry of Multiculturalism and Immigration. Victoria, B.C.

Stakeholders Meeting Minutes. (2000). *Credentialling of Foreign Trained Nurses.* Vancouver, B.C.

PART 7 across Canada

This section presents information on LPN and care aide roles in other provinces. It consists of the following fact sheets:

- national overview fact sheets that compare the education, regulation and employment of LPNs and care aides across the provinces
- profiles of the LPN role in three acute care hospitals
- profiles of LPN and care aide roles in four continuing care facilities
- profiles of two specialized LPN roles – operating rooms and foot care, and
- provincial contexts for LPN practice in Alberta, Manitoba, Saskatchewan, New Brunswick and Nova Scotia, including statistics on LPN registrants and place of employment, the status of regulatory or practice issues, basic facts on entry-level and continuing education programs and reference to distinct, new or emerging roles.

CONTENTS

289 LPN and care aide roles in Canada
- 289 LPNs in Canada
- 295 Competency Frameworks for LPNs
- 299 Care Aides in Canada

301 LPNs in acute care
- 301 Royal Alexandria Hospital, Edmonton
- 303 Queen Elizabeth II Health Sciences Centre, Halifax
- 305 Chalmers Hospital, Fredericton

307 LPNs and care aides in continuing care
- 307 McConnell West, Edmonton
- 309 Park Manor Personal Care Home, Winnipeg
- 311 The Poseidon Centre, Winnipeg
- 313 Hoyles-Escasoni Complex, St. John's

315 specialized LPN roles
- 315 LPNs providing foot care
- 317 LPNs in operating rooms

319 overview of LPNs in other provinces
- 319 LPNs in Alberta
- 321 LPNs in Saskatchewan
- 323 LPNs in Manitoba
- 325 LPNs in New Brunswick
- 327 LPNs in Nova Scotia

across canada

Objective

To inform the investigation of LPNs and care aides in acute and residential continuing care facilities in B.C., this project undertook an exploration of LPN and care aide roles and utilization in other provinces.

Process and Methodology

The initial step in this research was to contact other Canadian jurisdictions by writing to provincial and territorial LPN and RN regulatory bodies. A letter was sent with a form requesting information on new, emerging and distinctive roles and on positive models of utilization. Information on this project was included to provide recipients with an understanding of the context for these enquiries.

Representatives of the provinces and territories forwarded materials by mail, fax and e-mail. As materials were received, follow-up calls were made to set up interviews. Interview questions were drafted with the assistance of a research team. Representatives from New Brunswick (LPN) and Nova Scotia (RN) volunteered to be interviewed. The western provinces and Ontario were contacted again and invited to participate in the interviews. Data from the forms, interviews and supporting materials were compiled and summarized to form the fact sheets.

The regulatory authorities provided names of organizations and facilities that could serve as examples of the utilization of LPNs and care aides. An additional round of interviews was conducted to obtain more detailed information. Some interviewees provided supporting documentation.

Interviews were conducted with the following regulatory bodies representatives.

- Pat Frederickson, LPN Registrar, Alberta
- Verna Holgate, LPN Registrar, Manitoba and President of the Canadian Association of Practical Nurses
- Ede Leeson, LPN Registrar, Saskatchewan
- Normand McDonald, LPN Registrar, New Brunswick
- Michelle Kucie, Practice Consultant, RN Association, Nova Scotia

While no interview took place, a package of materials was received from the College of Nurses of Ontario.

Interviews were also conducted with representatives of the following organizations and facilities from across Canada.

- Mary Ellen Gurnham, Director of Nursing, Queen Elizabeth II Hospital, Halifax, Nova Scotia
- Theresa Kendrat, Regional Manager, Central Park Lodge, Winnipeg, Manitoba
- Rob Ivany, Director of Nursing, Park Manor, Manitoba

- Paula Dembeck, Director of Nursing, Chalmers Hospital, Fredericton, New Brunswick
- Gwen Tweddle, Care Manager, McConnell West, Alberta
- Heather Crawford, Royal Alexandria Hospital, Alberta

Document Review

The following documents served as the major sources of written information for the fact sheets.

Canadian Practical Nurses Association: Position Statements on Utilization of Practical Nurses; Education; Continuing Education; Self-Governing Legislation; Community Nursing; Unregulated Health Care Workers; Submission to the Nursing Task Force, Ontario Ministry of Health.

College of Nurses of Ontario: Registered Practical Nurse Entry to Practice: A Situational Analysis; Entry to Practice Competencies (draft); A Decision Guide for Determining the Appropriate Category of Care Provider; Professional Standards.

College of Licensed Practical Nurses of Alberta: Competency Profile for Licensed Practical Nurses.

Registered Nurses Association of Nova Scotia: Position Statement on the Role of the Licensed Practical Nurse; Regulation of Personal Care Workers; Report and Recommendations of the Committee on Unlicensed Assistive Personnel.

Association of New Brunswick Registered Nursing Assistants: Competencies for New Brunswick Registered Nursing Assistants.

Council for Licensed Practical Nurses of Newfoundland: Scope, Standards and Competencies.

Ontario Council of Hospital Unions: Report of the 1997 OCHU/CUPE Registered Practical Nurses Skill Utilization Survey.

Registered Practical Nurses Association of Ontario: RPNAO 1995 Utilization Survey.

Association of Registered Nurses of Newfoundland: Modular Nursing: Report on the Project (LTC); Delegation of Nursing Tasks to Support Workers in Community Settings; Patient Needs, Nurse Competencies and Level of Nurse Provider; Draft – Guidelines Regarding Shared Scope of Practice with LPNs.

Newfoundland's College of Licensed Practical Nurses and Association of Registered Nurses: Collaborative Nursing Practice – Guiding Principles.

Manitoba Association of Licensed Practical Nurses: Role and Scope of Practical Nursing; Information on Care Management Course.

Registrar's Conference (1999): Information provided from all provincial and territorial Registrars of LPNs in Canada.

Canadian Nurses Association: Fact Sheets on Roles and Delegation.

British Columbia documents: Practical Nursing Curriculum Update Study, Ministry of Advanced Education; Home Support Attendant (or Equivalent) Programs: A survey of Canadian Educational Offerings from Open College; RN and LPN statistics.

CINAHL: U.S. references regarding the Pew Commission and West Virginia information on the role of licensed nurses.

Dussault, G. et al. (1999): The Nursing Labour Market in Canada: Review of the Literature Report Presented to the Invitational Roundtable of Stakeholders in Nursing. Montreal, Quebec: University of Montreal.

FACT SHEET OVERVIEW OF LPN AND CARE AIDE ROLES IN CANADA

LPNs in Canada

This fact sheet offers a snapshot of the practice of LPNs in Canada in relation to role and utilization, staffing mix, regulation and education. The practice of Canadian LPNs has evolved over time. In keeping with these changes, there have been corresponding changes in basic and continuing education programs for LPNs.

Role and Utilization

LPNs are part of nursing and health care teams in all provinces and territories. While LPNs may be employed in all sectors of the health care system, the major places of employment are in hospitals and residential continuing care facilities (also called long term care or nursing homes). Their primary areas of responsibility, as reported by their regulatory bodies, are geriatrics and medical-surgical units. Tables 1 and 2 illustrate where LPNs are employed by primary area of responsibility (geriatrics, medical-surgical or other) and place of employment (hospital, nursing home or other).

Staffing Mix

The overall ratio of RNs to LPNs in Canada is 3:1. There is a wide variation in the number of RNs to LPNs across the country. Table 3 provides the ratios for all provinces.

Table 1 – LPN Employment by Type of Facility, 1998

	Hospital	LTC/Nursing Home	Other
BC	70	15	15
Alberta	–	–	–
Saskatchewan	75	11	14
Manitoba	33	48	18
Ontario	35	11	54
Quebec	22	52	26
New Brunswick	41	44	14
Nova Scotia	38	33	29
PEI	32	50	18
Newfoundland	44	52	3
NWT	74	12	14
Yukon	–	–	–

Only two main areas of LPN employment are included in Table 1. “Other” refers to LPNs working in multiple locations or worksites or in areas not included on registration forms.

Source: LPN Registrars, National Conference Report, 1999.

This data reveals fewer LPNs to RNs in Western Canada (4 RNs : 1 LPN in Saskatchewan and Manitoba; 4.5:1 in Alberta; and 5.4:1 in B.C.). In Central and Eastern Canada, there are proportionally twice as many LPNs on the nursing team (for example, roughly 2 RNs : 1 LPN in Ontario and Newfoundland; 3:1 in Quebec).

A literature review reveals that little published research is available on the most effective models of care delivery in nursing, including RNs, RPNs, LPNs and care aides (Dussault et al, 1999). Team nursing, functional nursing, modular nursing and other models can be found across the country.

Health Canada and Human Resources Development Canada are examining issues related to human resource planning in nursing. HRDC is currently undertaking a National Nursing Sector Study; the first phase, a literature review, has been completed (Dussault et al, 1999). This literature review provides an overview of the nursing workforce, including an overall decline in numbers (a 2.8 per cent decrease in RNs and 8.4 per cent decrease in LPNs between 1992 to 1997). Dussault et al (1999) discuss recruitment and retention issues and review problems related to the effective utilization of the skills of LPNs.

Problems related to effective skill utilization of practical nurses have been documented in some provinces. The Registered Practical Nurses Association of Ontario conducts a survey of the utilization of registered practical nurses every two years. One key finding is a need for greater awareness of RPN competencies.

Table 2 – LPN Employment by Type of Unit, 1998

	Geriatrics	Medical-Surgical	Other
	%	%	%
BC	30	37	28
Alberta	26	29	40
Manitoba	50	16	14
Saskatchewan	15	24	52
Ontario	15	15	60
Quebec	52	12	30
New Brunswick	50	15	30
Nova Scotia	38	–	18
PEI	–	–	–
Newfoundland	58	10	21
NWT	19	61	9
Yukon	–	–	–

Only two main areas of LPN employment are included in Table 2. “Other” refers to LPNs working in multiple locations or worksites or in areas not included on registration forms.

Source: LPN Registrars, National Conference Report, 1999.

Regulation

The scope of practice of LPNs is governed by provincial legislation. Each province's statute recognizes LPNs (or their equivalent title) as self-regulating professionals and, in some provinces, includes LPNs in omnibus health professional legislation (e.g. Health Professions Acts in Ontario, Alberta and B.C.). In B.C., the scope of practice of LPNs is currently under review by the Health Professions Council. Over the last decade, legislation and scopes of practice have been reviewed and revised in several provinces. Some examples include:

- change in title from "nursing assistant" to "licensed practical nurse" in Nova Scotia and New Brunswick
- requirement for licensure to practise as a "licensed practical nurse" in Saskatchewan
- revision to scope of practice to recognize professional accountability in Manitoba, and
- deletion of the requirement that LPNs be under the direct supervision of an RN or other professional, in Manitoba and Saskatchewan.

Competencies (knowledge, skills, attitudes and judgement) for LPNs are established at the provincial level. Competencies vary somewhat from one province to another, but are becoming more similar as provinces seek standardization to support worker mobility (in part prompted by interprovincial trade agreements). A 1997 national study identified shared and unique entry level competencies for regulated nurses (RNs, RPNs and LPNs) in Canada and noted that many entry level competencies are shared by all three nursing groups (NNCP, 1997). This study focused on new graduates entering the profession, based on revised and expanded education programs. This national work has been useful for developing provincial competency documents. (The fact sheet *Competency Frameworks for LPNs* provides further information.)

In general, LPNs entering practice are prepared to care for individual patients or residents who have well defined health challenges and who have health outcomes that are predictable. LPNs are also prepared to work in partnership with other members of the nursing team to provide care for clients who have less predictable outcomes and/or increasingly acute conditions. Specific definitions are identified in the legislation of each province and territory.

Education

Basic or entry level practical nurse education occurs in public post secondary educational institutions. Programs vary in length, but average 12 months.

- Nova Scotia – 10.5 months
- Ontario – 12 months

- Manitoba – 14 months
- British Columbia – 12 months

There is consistency in curriculum content across Canada, based upon scope of practice and competencies. National examinations, which are continuously revised based on changes to competencies, are also an important factor in standardizing practical nurse education programs. As new skills, such as medication administration or intravenous therapy maintenance, are required for entry into practice, the exam is expanded accordingly. However, not all provinces require that applicants are examined on such topics as medication administration and intravenous therapy maintenance at this point in time.

Recently, a number of provinces added student seats to increase the number of practical nurse graduates (for example, in Manitoba student seats have more than doubled; in New Brunswick an additional distance education program was added). In addition, there are efforts in some provinces to support career laddering of care aides into practical nurse programs. In New Brunswick, when the staffing ratio in long term care was established to be at 20 per cent RN, 40 per cent LPN and 40 per cent others, a collaborative venture saw hundreds of care aides become LPNs.

Continuing education, upgrading, refresher and post basic courses are also offered. For example:

- upgrading courses in medication administration, dressings, assessment, and IV therapy through workplace in-service and by educational institutions in Alberta, Newfoundland, New Brunswick, PEI, and Nova Scotia

Table 3 – RN and LPN Employment and Ratios, 1997

	RN	LPN	Radio of RN to LPN
B.C.	28,974	5,385	5.4 : 1
Alberta	21,428	4,723	4.5 : 1
Manitoba	10,510	2,488	4.2 : 1
Saskatchewan	8,456	2,187	3.9 : 1
Ontario	78,067	34,623	2.3 : 1
Quebec	59,160	18,082	3.3 : 1
New Brunswick	7,589	2,517	3.0 : 1
Nova Scotia	8,587	3,220	2.7 : 1
PEI	1,281	617	2.1 : 1
Newfoundland	5,210	2,838	1.8 : 1
Canada	229,990	76,680	3.0 : 1

Source: Dussault, G. et al.; The Nursing Labour Market in Canada: Review of the Literature (1999); based upon statistics collected by nursing regulatory bodies for the Canadian Institute for Health Information.

- a physical assessment program for members to be required by regulatory bodies in Alberta and Manitoba by 2002
- refresher/re-entry courses offered continuously or as needed, often through distance education
- continuing education, such as a two-day foot care workshop, (see the LPNs in Foot care fact sheet) offered in Newfoundland, Saskatchewan, Manitoba and Ontario
- team leading workshops offered in Alberta
- various post-basic courses offered across the country, such as OR and critical care nursing for LPNs in Saskatchewan and the post-basic course in care management for LTC in Manitoba
- various courses, such as leadership and team nursing, offered by regulatory bodies in their role as registered education institutions, in provinces such as Alberta, and
- various courses similarly offered by professional associations in other provinces.

References

Dussault, G. et al. (1999). The Nursing Labour Market in Canada: Review of the Literature - Presented to the Invitational Roundtable of Stakeholders in Nursing. Montreal, Quebec: University of Montreal

Registered Practical Nurses of Ontario. (1995). Registered Practical Nurses Skill Utilization Survey. Toronto, Ontario: RPNAO.

National Nursing Competency Project. (1997). Final Report. Ottawa, Ontario: NNCP.

FACT SHEET OVERVIEW OF LPN AND CARE AIDE ROLES IN CANADA

competency frameworks for LPNs

The competencies of licensed practical nurses include the knowledge, skills, attitudes and judgement required for practice. At the national level, competencies are identified as a basis for the national examination required for licensure.

A national perspective is important to allow for the mobility of workers in Canada, in accordance with interprovincial trade agreements. As legislation for health care practitioners falls within provincial jurisdiction, most competency statements have been developed at the provincial level. However, there are currently few differences in the competencies of LPNs across Canada. Even the title "LPN" has now been adopted in most provinces.

PURPOSE

LPN competencies outline the skills and abilities that the public and employers can expect from an LPN. Competencies may be developed for the purpose of describing job requirements, for educational purposes and for regulatory issues such as continuing education needs.

FRAMEWORKS

Competencies are identified and organized in a number of ways, depending on the purpose and use for which the competencies are intended. For example, competencies developed from an occupational analysis are usually present oriented, detailed and context-specific. On the other hand, competencies developed to guide curriculum development for entry level practice are usually more future oriented, fairly broad, and have less emphasis on a particular context. Some, like those developed in Alberta, identify LPN skills in detail. The College of LPNs in B.C. recently completed a study to identify entry level competencies and is in the process of developing a related document to identify post-basic competencies. Several different Canadian competency initiatives are summarized below.

National Nursing Competency Project (NNCP)

- A project undertaken by Human Resources Development Canada and 29 nursing regulatory authorities/associations (Quebec's college of nurses did not participate).
- The final report was presented in 1997.
- The report identified unique and shared competencies of RNs, LPNs and RPNs for entry level practice for 1996 and 2001, and the context of practice for the three

nursing groups. (For example, LPNs in the project reported that 51 per cent of the list of 304 competencies were required in 1996.)
- Of the 226 competencies that were "context-specific," five per cent were performed independently, 16 per cent with consultation and 24 per cent under direction.
- LPNs predicted that, in 2001, 72 per cent of the listed competencies would be required.
- Of the 226 "context-specific" competencies identified for 2001, it was predicted that 16 per cent would be performed independently, 32 per cent with consultation, and 18 per cent under direction.
- The NNCP report has been used by many provincial regulatory authorities as a starting point for identifying entry level competencies and context of practice.
- The National Nursing Competency Project (1997) - Final Report is available from the College of LPNs of B.C.

New Brunswick
- Developed by New Brunswick's regulatory authority for nursing assistants.
- Revised September, 1999.
- Focus on entry level practice.
- Competencies are organized under three major headings: Assessment, Planning, Implementation and Evaluation, with technical skills specifically identified, Communication Skills, and Professional and Personal Responsibilities.

Ontario
- Developed by Ontario's regulatory authority for registered nurses and registered practical nurses.
- Drafted September 1999 for entry level practice.
- Organized under the headings of its Standards for Practice. Standards are organized under the characteristics of a profession (e.g. service to the public, competent application of knowledge, responsibility and accountability).
- Attends to type of client (e.g. stable with predictable outcomes).
- Includes cognitive, technical and attitudinal skills sets in a general fashion.

Alberta
- Developed by Alberta's regulatory body for licensed practical nurses, in partnership with Alberta Health.
- Adopted in November, 1998 for both basic and advanced practice.
- Detailed listing of competencies for a multitude of clinical contexts.
- General competency areas of knowledge, nursing process, safety, communication, nursing practice (technical skills identified), and 16 clinically oriented sets (e.g.

surgical nursing, cardiovascular nursing, etc.), medication administration, infusion therapy, professionalism, team leading, and seven "advanced" competencies sets (e.g. orthopedic nursing, OR, etc.).

Information on British Columbia competency initiatives is provided in the *B.C. Context* part of this report.

FACT SHEET OVERVIEW OF LPN AND CARE AIDE ROLES IN CANADA

care aides in Canada

This fact sheet offers a snapshot of the role and utilization of care aides in health care in Canada. The majority of care aides are employed in residential continuing care providing residents with assistance in activities of daily living. There is a wide variation in the roles and utilization of care aides, which are also known by a number of titles. The focus of this summary is the role of care aides in residential continuing care.

Titles

Some of the titles held by care aides across Canada are:

- residential care aide
- personal care aide/worker
- geriatric aide
- residential care aide
- nurses aide, and
- personal support aide/worker.

Role

In continuing care facilities across Canada, care aides provide personal care to residents. Residents may have mild to severe physical or cognitive disabilities. The care aide role includes physical care for residents, with emphasis on assistance with the normal activities of daily living, such as assistance with personal hygiene, dressing and eating.

Training

Training programs are offered in both public and private educational institutions. The length of care aide programs varies from seven weeks for personal support workers in Ontario to as long as 32 weeks for LTC attendants in the Northwest Territories. This latter program includes general education upgrading as well as occupation focused training. In comparison, the B.C. Resident Care Attendant Program is currently 20 weeks in length. The curricula offer content and practice related to personal care skills, communication and common health problems.

Some provinces offer initiatives enabling care aides to “bridge-in” to practical nurse training programs by giving credit for selected courses or semesters (for example, the New Brunswick government has funded a major initiative in this regard).

The Unregulated/Assistive Role

Care aides are not covered by the kind of professional legislation and regulations seen for other members of the nursing team – LPNs, RPNs and RNs.

FACT SHEET LPNs IN ACUTE CARE

Royal Alexandria Hospital, Edmonton

Facility Profile

Royal Alexandria Hospital in Edmonton, Alberta, is a major referral centre for the province and Northern Canada. One of five acute care hospitals in Edmonton, this 500 bed facility is a full service hospital, including medicine, surgery, obstetrics, pediatrics and psychiatry.

The Pilot Project

In January, 1999 one of the medical units, Unit 54, began a pilot project wherein LPNs and RNs would practise to their full scope of practice, using all of the skills they are mandated to perform.

One impetus for this project was the provincial upgrading training for all LPNs in the areas of physical assessment, IV maintenance and medication administration. This upgrading program was implemented by the LPN regulatory body as part of its required continuing competence program.

Staffing

Staffing is determined by patient acuity, with patients' needs matched with nurses' competencies.

- Days: three LPNs and three RNs.
- Evenings: two LPNs and three RNs.
- Nights: one LPN and two RNs.

Roles

LPNs provide total patient care, including IV maintenance and medication administration. They problem solve issues as they arise.

As part of the pilot project, LPNs and RNs completed a one week orientation before patients were admitted. Together, they learned about each other's roles and developed approaches to teamwork. They also worked together to develop common values, and draft vision and mission statements.

Project Status

After one year, the project was considered a success as measured by patient and family feedback, job satisfaction from RNs and LPNs, and other outcome measures (for example, sick time was reduced; there was no difference in the number of medication errors). The

project is seen as a model that has potential for other units in the hospital and other agencies in the health region. A written report is in development.

Factors that were identified as important in creating success include:

- the one week orientation and preparation before patients were admitted, when LPNs and RNs worked and learned together
- assignment of a clinical nurse educator to support this unit and the change process
- support from the regulatory colleges, which assisted staff in understanding roles and scope of practice
- support from the LPN union, which was involved from the beginning of the project, and
- ongoing support for the change process by nursing leadership.

For further information, contact Heather Crawford, Patient Care Director, at (780) 477-4111.

FACT SHEET LPNs IN ACUTE CARE

Queen Elizabeth II Health Sciences Centre, Halifax

Facility Profile

The Queen Elizabeth II Health Sciences Centre (QEII) is a multi-level health care organization serving the city of Halifax and the province of Nova Scotia. It is the major referral agency for acute care in the Atlantic provinces. QEII's 11 sites comprise the continuum of care, from long term care (e.g. veterans, rehabilitation) to all aspects of acute care (e.g. Victoria General Hospital and the Halifax Infirmary). QEII employs LPNs on nursing teams in a number of units, including the following.

Staffing and Roles

Transitional Care Unit

- Similar to discharge planning units in B.C.
- Client health conditions are stable and outcomes predictable.
- LPNs, RNs and care aides work together to provide care.
- LPNs provide the majority of nursing care, including giving medications.
- LPNs assume responsibility for supervising care aides.

Long Term Care

- Long term care for veterans.
- LPNs used effectively, but do not administer medications as per Department of Veterans Affairs policy.
- Ratio of RNs to LPNs is approximately 1:1.

Rehabilitation

- LPNs and RNs provide nursing care.
- RNs administer medications.
- Ratio of RNs to LPNs is 1.5:1.

Medical-Surgical Units

- LPNs have always been employed in medical-surgical units.
- Ratio of RNs to LPNs varies from 9:1 to 2.3:1.
- Pilot programs are underway to change staffing so that more units are at the 2.3:1 ratio.

Dialysis

- RNs have traditionally provided nursing care.
- LPNs are being considered as caregivers for clients receiving peritoneal dialysis.
- Selected clients would be stable on the dialysis regime.

For further information, contact Mary Ellen Gurnham, Director of Nursing, at (902) 428-3586.

FACT SHEET LPNs IN ACUTE CARE

Chalmers Hospital, Fredericton

Facility Profile

Fredericton's Chalmers Hospital is a full service tertiary hospital with 430 beds. It has medical, surgery, maternity, pediatrics and psychiatry units, as well as several speciality areas. Chalmers is part of a hospital corporation that encompasses many sites throughout the city. It serves as a major referral hospital for New Brunswick.

Skill Mix Project

Until recently, all nursing positions at Chalmers were staffed by RNs. The hospital had considered hiring LPNs (known as RNAs - registered nursing assistants - in New Brunswick) a number of times in the past. Due to recent changes, including a change to program management, Chalmers has begun hiring RNAs on specific units.

Initially, RNAs were assigned to work in a central float pool. However, this system did not allow RNAs to integrate into units and have continuity with patients and other staff.

In 1996, a budget review and a study of nursing issues revealed workload as a major issue needing attention. A nursing council, established with the change to program management, explored ways to address the workload issue. A Skill Mix Project resulted in a change to equal numbers of RNs and RNAs in work groups as a way to handle the heavy workload.

Staffing

The full RN staffing model has changed – most nursing floors now have three to four RNAs, matching the number of RNs. According to the executive director of New Brunswick's RNA association, RNAs have since been hired at Chalmers on maternity and pediatrics units, as well as on medical-surgical units. The project is still considered to be a "work in progress"; outcomes are not yet measurable. However, the director of nursing noted that there is a clear and strong commitment to continue the Skill Mix Project.

Prerequisites to Success

The director of nursing shared her thoughts about the factors she thought were important to success at Chalmers. A critical first step was RNs and RNAs learning about each other's role and scope of practice. The RN and RNA professional associations and unions provided support to assist staff in understanding roles, qualifications and competencies. Education

sessions on delegation were considered critical. It was also noted that this change was not an easy process.

For further information, contact Paula Dembeck, Director of Nursing, at (506) 452 5400.

FACT SHEET LPNs AND CARE AIDES IN CONTINUING CARE

McConnell West, Edmonton

Facility Profile

McConnell West is one of seven continuing care facilities managed by the Capital Care Group, which has been operating for four years and is publicly funded. McConnell West includes three houses, with 12 residents in each, that aim to create home-like environments for seniors. Residents are ambulatory, but require residential care due to cognitive impairment. The houses do not accommodate wheelchairs or hospital beds. Each house has its own kitchen, laundry facilities and common areas, as well as residents' individual rooms. Breakfast and supper are provided; lunch is prepared by the residents and the care aides, known at McConnell West as resident companions (RCs).

Staffing

LPNs, RCs and RNs work together on eight hour shifts. Staff shift changes are staggered to avoid disruption to the residents. Generally, on a day shift there are two RCs in each house, and one RN and two or three LPNs for all 36 residents.

Roles

LPNs serve as team leader in each house.

- Cover all shifts.
- Carry own resident assignments.
- Are responsible for nursing activities, such as dressing changes, treatments and medication administration.
- Communicate with physicians and other professionals.
- Assign RCs to residents.
- Report unusual incidents or resident problems to the RN.

RNs serve as care managers for the facility (the care manager is a management position).

- Report to the CEO of the Capital Care Group.
- Troubleshoot as needed for resident or staff problems.

RCs assist residents with activities of daily living.

- Provide personal care.
- Assist with activities and food preparation.
- Assist residents in taking routine medications.

Education and Training

The provincial upgrading program for LPNs (sponsored and required by the LPN regulatory body) was noted as critical to the success of the team model in this facility. All LPNs in Alberta have received training in team leading, medication administration and sterile dressing techniques as part of a continuing competence program of the Alberta College of LPNs. All resident companions are trained on site. Ongoing in-service/training is valued at McConnell West and is perceived as critical to team work.

For more information, contact Gwen Tweddle, Care Manager, at (780) 413-4772.

FACT SHEET LPNs AND CARE AIDES IN CONTINUING CARE

Park Manor Personal Care Home, Winnipeg

Facility Profile

Park Manor is a stand alone, multi-level personal care home in Winnipeg. It has two floors and 100 residents. In Manitoba, care for residents is rated from Level 1 to Level 4, with Level 1 requiring the least care and Level 4 the most. Personal care homes normally serve residents categorized as Level 2, 3 or 4. Eighty-eight per cent of Park Manor clients are Level 3 and 4.

Staffing

Staffing is organized around three shifts each day. Teams include LPNs, care aides and RNs. On day shifts, there are two LPNs per floor, plus one LPN who "floats." There is one RN per floor on day shift.

Roles

LPNs serve as team leaders on days and evenings.

- Set up schedules, e.g. bath times.
- Plan assignments for care aides in consultation with the RN.
- Assist care aides to organize their care.
- Administer medications and nursing treatments.
- Participate in all aspects of residents' care.
- Refer emergencies and changes in physical or mental status of residents to the RN.

RNs provide overall nursing care.

- Conduct complete physical/mental status assessments.
- Provide care planning and evaluation.
- Respond to resident changes and emergencies.

Care aides assist clients with activities of daily living

- Care for residents who are stable.
- If a resident's status changes, an LPN is notified and may be assigned responsibility for care.

The success of the team model used at Park Manor is attributed to clear distinctions between the roles of LPNs, care aides and RNs, including clarity of policies and job descriptions. A positive work culture further contributes to this success.

For additional information, contact Rob Ivany, Director of Nursing, at (204) 222-3251.

FACT SHEET LPNs AND CARE AIDES IN CONTINUING CARE

The Poseidon Centre, Winnipeg

Facility profile

Central Park Lodge is a private long term care provider with six homes in Winnipeg. The Poseidon Centre is a free-standing facility with 218 residents. In Manitoba, care for residents is rated from Level 1 to Level 4, with Level 1 requiring the least care and Level 4 the most. Personal care homes normally serve residents categorized as Level 2, 3 or 4. Currently almost all of the Poseidon residents are classified as Level 3 or 4. The five storey facility has 23 residents on the first floor and 48 or 49 residents on each of the other floors.

Staffing

Staffing includes RNs, LPNs and care aides. The facility has two RNs on day shifts and one RN on night shifts.

For one floor of 48 to 49 residents, staffing includes:

- Days: Two LPNs, four to seven health care aides (HCAs), and one RN shared with other floors.
- Evenings: One to two LPNs (one is shared with other units), four to five HCAs, and one RN shared with other floors.

Roles

LPNs serve as team leader for each wing (24 residents)

- Responsible for medication administration and nursing treatments.
- Complete assessment of residents.
- Communicate with families and other health care providers.

Health care aides assist clients with activities of daily living.

RNs serve as a resource when critical situations arise and provide 24 hour coverage of the facility

Education and Training

Practising LPNs are trained for team leadership roles through post basic courses offered by community colleges. Team leadership is now covered in the basic LPN program and expected of all new graduates. The change to team leadership roles for LPNs has taken time and has not been an easy transition for some staff. Training and support has been a critical component of the change process. Several other factors are considered important.

- The Union (Manitoba Nurses Union) was involved early.
- Other staff were oriented to the LPN role.
- The Manitoba Association of LPNs, the regulatory authority, provided education on the scope of practice and standards of LPNs.
- When new facilities come on stream, experienced LPNs serve as role models for newly hired LPNs.
- Peer support occurred between LPNs.
- LPNs report that their work is more satisfying and they are very supportive of the change in role.

For more information, contact Theresa (Teri) Kendrat, Regional Director, at (204) 452-6204.

Hoyles-Escasoni Complex, St. John's

Facility Profile

Hoyles-Escasoni Complex is a long term care facility within the St. John's Long Term Care Board. The complex includes 13 units and serves 400 residents requiring a high level of care.

Staffing

The facility has 425 staff members in the nursing department. Before modular nursing was introduced, the complex used a modified form of team nursing with an RN team leader and a complement of RN, LPN and PCA (patient care attendant) staff.

In modular nursing, residents and staff are divided into small group modules. Groups of residents are geographically clustered into groupings of nine to 14 residents. The module is led by one full-time RN (the modular leader) and a group of modular members (RNs, LPNs and PCAs). The module group shares responsibility for planning, implementing and evaluating resident care for a rotation of eight weeks. This system is a combination of team and primary nursing, but the responsibility for care planning is shared by the group rather than resting solely with the RN.

Current Status

The two units that originally volunteered to pilot the model continue to use it. It was reported that, due to other more urgent priorities, the modular project has not been expanded.

Advantages

Modular nursing is discussed in the literature as having a number of advantages, including:

- increased continuity of care for residents
- increased accountability
- greater flexibility to utilize skill levels of different staff
- enhanced teamwork
- decreased coordination time, and
- enhanced opportunities for leadership and growth.

Reference
Anderson, C. L. & Hughes, E. (1995). An Evaluation of Modular Nursing in a Long Term Care Setting. Canadian Journal of Nursing Administration. May-June, 1995, pp. 63-86.

FACT SHEET SPECIALIZED LPN ROLES

LPNs providing foot care

Post-basic courses in foot care are now offered to practical nurses in several provinces. As this practice has evolved, the standard of care has also been documented. For example, Ontario has developed a comprehensive set of standards to guide this practice (College of Nurses of Ontario, 1997). According to these standards, LPNs can provide foot care in a number of settings, including hospitals, residential continuing care and in clients' homes.

Scope of Practice

The Ontario standards state that nursing foot care is a non-invasive procedure. It includes the following activities:

- assessment, which includes
- general information about the patient's health
- specific data about the status of the feet
- interventions, which may include
- skin care
- nail care
- callus care, and
- corn management.

Decision making regarding whether to proceed with foot care procedures is an important skill. LPNs must determine whether they have the knowledge, skills and judgement (i.e. the competencies) to care for a particular patient or resident. Infection control, including care of equipment, is another important area of competence required by the LPNs.

Training

Courses vary in length from 48 hours in Manitoba to two days in Saskatchewan. The course offered in Saskatchewan (University of Saskatchewan, 1999) includes the following content:

- anatomy and physiology
- common conditions and pathology of the feet
- associated physical predisposing conditions (e.g. diabetes)
- geriatric foot care
- foot care procedures, and
- instrument care.

The course includes both knowledge and practice components and is taught by registered nurses and podiatrists. The course is offered to LPNs, RNs and RPNs.

For more information, contact the College of Nurses of Ontario at (416) 928- 0900.

References

College of Nurses of Ontario. (1997) Nursing Foot care Standards. Toronto, Ontario: CNO.

University of Saskatchewan - College of Nursing. (1999). Foot care modalities for the elderly person. Saskatoon, Saskatchewan: University of Saskatchewan.

Note: A role profile on this practice in B.C. is provided in the *Role Profiles* section.

FACT SHEET SPECIALIZED LPN ROLES

LPNs in operating rooms

LPNs have successfully participated in operating room teams for over 30 years (Canadian Practical Nurses Association, 1999). CPNA has established competencies and standards of practice for LPNs to act in the scrub and circulating role and to serve in assisting anaesthetists. With advanced education, LPNs are prepared to practise in operating rooms in both urban and rural facilities. Training programs are offered in Alberta, Saskatchewan, Ontario, New Brunswick and Nova Scotia.

LPNS are currently working in some B.C. operating rooms. According to the surveys conducted for this project, 13 of 68 acute care facility respondents identified that LPNs work in the OR of their facilities. It has also been reported that an LPN in B.C. is currently completing the SIAST Operating Room training program discussed below.

Training

In the past, training programs were offered as on-the-job training in hospitals. Current programs are taught by registered nurses in college settings. These programs must meet standards set by regulatory bodies and educational institutions.

The Alberta and Saskatchewan programs offer two examples of operating room training programs for LPNs. Grant MacEwan College in Alberta began offering an OR course for LPNs in January and April of 2000. Saskatchewan has a long history of providing OR training for LPNs. The Saskatchewan Institute of Applied Science and Technology (SIAST) offers a post-basic program in operating room nursing for LPNs. The program includes five theory courses (offered through distance education) and a four day technical skills lab and examination in Regina or Saskatoon. With successful completion of these first two steps, the student completes 50 days of clinical learning experience. Theory courses are set up for independent study with faculty telephone support. The courses are usually completed on a part-time basis over eight months (equivalent to 16 weeks of full-time study). SIAST notes that students should be prepared to study eight to 10 hours per week.

To be admitted, LPNs must be licensed, have completed 2,000 hours of recent experience, preferably in acute care, be competent to administer medications, have a current CPR certificate and have a satisfactory health status. Upon completion of all course requirements, the graduate receives an Advanced Certificate in Operating Room Nursing and Techniques/LPN and is prepared for employment in hospitals, ambulatory surgery centres and clinics.

Reference

For further information, contact SIAST's Wascana Campus at (306) 933-7331 (www.siast.sk.ca), or Grant MacEwan College in Edmonton at (780) 497-5188.

Canadian Practical Nurses Association. (1999). Strategies for Marketing the Operating Room Project. Ontario.

FACT SHEET OVERVIEW OF LPNs IN OTHER PROVINCES

LPNs in Alberta

Fast Facts*

1998 number of registered members: 4,297
Place of employment: Not Reported

Primary area of responsibility for three highest areas:
- Geriatrics: 1,001 (27 %)
- Medical-Surgical: 1,147 (31 %)
- Other: 1,585 (42 %)

Regulatory and Practice Issues

The Health Professions Act was recently passed in Alberta. This statute regulates 29 professions, including LPNs.

A new education standard for LPNs has been implemented. All registered members are required to complete three courses (medication therapy, infusion therapy and physical assessment) through continuing education in order to maintain their license. This change was initiated to ensure that all LPNs meet new entry level standards and are competent to practise. All LPNs had to complete the courses to be eligible for registration in 1999. These three areas are currently included in the basic education program and are required for entry to practise.

A detailed competency profile has also been developed. The profile describes the LPN role from novice to expert in all areas of health care. It will serve as the basis for the LPN Continuing Competence Program.

Basic Education Program

Alberta's basic education program for practical nurses is 12 months (48 weeks) in length. The current demand for graduates exceeds supply. Programs are offered in three main sites and in smaller communities. A new distance delivery format is in the first phase of implementation.

Post Basic Programs

Many post basic programs for LPNs are offered in Alberta, including medication therapy, adult and pediatric physical assessment, infusion therapy, community care, leadership,

*Numbers are quoted from the September, 1999 LPN Registrars Conference unless otherwise noted. "Psychiatry" includes psychogeriatrics. "Other" is the category chosen when the LPN works in several areas, which is common in smaller institutions, and when the LPN works in more than one agency on a part time or float basis.
See the *LPNs in Canada* fact sheet for comparison to other provinces.

team nursing and advanced orthopedics. An operating room program at Grant MacEwan College is being offered in 2000.

Distinctive, New and Emerging Roles

LPNs in Alberta's long term care facilities are team leaders. They assume leadership of LPNs and care aides, and administer medications and treatments. A good example of the LPN as team leader in LTC is found at Capital Care facilities in Edmonton. In this coordinating role, LPNs are responsible for communication with physicians and other external referrals.

The Capital Regional Health Authority (Edmonton) has the highest number of LPNs, with a ratio of approximately 4 RNs : 1 LPN, compared to the Calgary Regional Health Authority's ratio of 9 RNs : 1 LPN. In Edmonton, Royal Alexandria Hospital has completed a six month pilot project on full utilization of LPNs and RNs on a 1:1 basis. In rural settings, the ratio is estimated to be 1.5 RNs : 1 LPN.

Growth in the area of gerontology is an important trend in Alberta. Another is the addition of advanced training in orthopedics (for example, managing a plaster room). A new community care program will also prepare LPNs for providing health care in the community.

Finally, the College of LPNs has partnered with a health authority in a program to prepare LPNs to work in emergency departments and intensive care units. There has been a change in the health authorities involved in this project, and outcomes are not yet available.

According to the registrar of the College of LPNs of Alberta, LPNs can work anywhere in the province's health care system and, as client acuity increases, there will be a corresponding change in LPNs work in collaboration with RNs in areas such as emergency and ICU. The registrar also points out that it is critical that provinces do strategic planning to prepare human resources for future challenges.

For further information, contact Pat Fredrickson, Registrar, College of LPNs of Alberta, at (780) 484-8886.

FACT SHEET OVERVIEW OF LPNs IN OTHER PROVINCES

LPNs in Saskatchewan

Fast Facts*

1998 number of registered members: 2,144

Place of employment:
- Hospital: 1,493 (75 %)
- Nursing home: 221 (11 %)
- Other: 274 (14 %)

Primary area of responsibility for three highest areas:
- Geriatrics: 308 (17 %)
- Medical-Surgical: 482 (26 %)
- Other: 1,042 (57 %)

Regulatory and Practice Issues

To maintain a license, LPNs must maintain practice hours in activities approved by the Saskatchewan Association of LPNs (SALPN). To support LPNs in meeting minimum requirements, SALPN allows LPNs who are working as care aides to count some of these hours towards their license. This policy uses an employer verified process to identify LPN activities within the care aide role.

New health professional legislation is under review. A final draft of new standards, competencies and policies is currently being prepared.

Basic Education Program

Saskatchewan's practical nurse basic education program is currently 11 months in length, but may be expanded. The number of seats has increased in the last year. The first semester is available through distance education. Recently, with the transition to BSN for RNs, the common core curriculum for LPNs and RNs was lost. However, practical nurses who complete their program are given 21 credits at the University of Saskatchewan if they choose to pursue a registered nurse program.

Care aides can do the first semester of the practical nurse program as part of the care aide program. Eight per cent of the care aide program counts towards a practical nurse diploma.

*Numbers are quoted from the September, 1999 LPN Registrars Conference unless otherwise noted. "Psychiatry" includes psychogeriatrics. "Other" is the category chosen when the LPN works in several areas, which is common in smaller institutions, and when the LPN works in more than one agency on a part time or float basis.
See the *LPNs in Canada* fact sheet for comparison to other provinces.

LPN Post Basic Programs

Saskatchewan has had a nurses' operating room program for many years. Recently, the combined OR program for RNs and LPNs was split into two separate programs. SALPN has an association of LPNs and OR technicians that is comparable to the Operating Room Nurses of Canada (ORNAC) for registered nurses.

The University of Saskatchewan offers a foot care nursing program for LPNs, RNs and RPNs. Home-based nursing, assessment skills, basic critical care programs and other courses and workshops are also offered.

Distinctive, New and Emerging Roles

There are several new initiatives underway in Saskatchewan. In the Regina Health District, LPNs are now being used more fully, and are allowed to practise skills that were denied in the past (for example, catheterization and suture removal). In Saskatoon, a pilot project to introduce LPNs into home care (giving medications, etc.) has been introduced. At the William Booth long term care home, a joint education project is currently underway to enhance the utilization of registered nurse, psychiatric nurse and LPN roles. Finally, a number of long term care agencies are now placing LPNs in charge on night shifts.

For further information, contact Ede Leeson, Registrar, SALPN, at (306) 525-1436.

FACT SHEET OVERVIEW OF LPNs IN OTHER PROVINCES

LPNs in Manitoba

Fast Facts*

1998 number of registered members: 2,582

Place of employment:
- Hospital: 763 (34 %)
- Nursing home: 1,081 (48 %)
- Other: 418 (18 %)

Primary area of responsibility for three highest areas:
- Geriatrics: 1,135 (51 %)
- Medical-Surgical: 358 (16 %)
- Psychiatry: 423 (19 %)
- Other: 327 (15 %)

Regulatory and Practice Issues

The Manitoba Association of LPNs has been very involved in reviewing and updating LPN legislation. The new legislation deletes the requirement for "direct supervision" of LPNs by RNs or physicians. This will open up more opportunities for LPNs in private practice (for example, foot care). The association is also hoping to establish a role for LPNs in Manitoba's operating rooms. Currently, OR nursing practice is considered a speciality for RNs.

Basic Education Program

The current program is 14 months. In May, 1999, the Manitoba government announced that it would more than double enrolment – 100 government-funded seats have been added to the LPN program.

Post Basic Programs

Manitoba's numerous post basic courses include team leading, VON foot care, physical assessment, IVs, and care management programs. Some post basic courses are now part of the basic education program (e.g. initiating IVs has been added to the basic program). (Note: Administering medications is a well established competency area for LPNs in Manitoba, with a 45 year history.)

*Numbers are quoted from the September, 1999 LPN Registrars Conference unless otherwise noted. "Psychiatry" includes psychogeriatrics. "Other" is the category chosen when the LPN works in several areas, which is common in smaller institutions, and when the LPN works in more than one agency on a part time or float basis.
See the *LPNs in Canada* fact sheet for comparison to other provinces.

Distinctive, New and Emerging Roles

In smaller and rural communities, the number of LPNs in acute care is increasing (the current ratio is 4 RNs : 1 LPN). This trend has not yet occurred in tertiary/urban hospitals because of an "all RN staffing" model. However, the current government advocated for an increased presence of LPNs in tertiary care in its 1999 election campaign, and it is anticipated that LPNs will be employed in acute care in tertiary/urban hospitals in the near future. Some tertiary hospitals, such as Brandon General, never completely eliminated LPNs in acute care, while those such as St. Boniface and Health Science Centre in Winnipeg did.

Many new and emerging roles for LPNs in Manitoba are found in long term care and community settings.

In LTC, where LPNs have a well established role, LPNs now assume the team leader or case manager role. As team leaders, LPNs are responsible for assigning care to care aides, supervising care aides and providing leadership to other LPNs. There is a post basic course in Manitoba specifically for LPNs preparing for this leadership role. There are 800 new LTC beds opening in the province. On average, RNs and LPNs make up about 30 per cent of nursing staff in long term care, while care aides make up 70 per cent.

In the community, LPNs are assuming a coordinator role for other home support workers. This role involves assessment of client needs and supervision of support workers.

Other Manitoba Information

Retention and recruitment funding is available through a special Health Ministry program for skills upgrading/refresher programs, additional positions, professional development at work, training for speciality practice, and other initiatives.

Finally, the Manitoba Association of LPNs has a "Generic Position Description" that outlines responsibilities (job related and professional) similar to the competency documents of other provinces.

For more information, contact Verna Holgate, Registrar, Manitoba Association of LPNs, at (204) 663-1212.

FACT SHEET OVERVIEW OF LPNs IN OTHER PROVINCES

LPNs in New Brunswick

Fast Facts*

1998 number of registered members: 2,575

Place of employment:
- Hospital: 941 (41 %)
- Nursing home: 1,000 (44 %)
- Other: 312 (14 %)

Primary area of responsibility for three highest areas:
- Geriatrics: 1,124
- Medical-Surgical 328
- Other: 694

Note: This is an increase of 1,000 registrants in the last five years. New Brunswick is currently experiencing a shortage of LPNs.

Regulatory and Practice Issues

Entry level competencies and new standards being developed by the New Brunswick Association of RNAs (NBARNA) were expected to be available in 2000. New Brunswick's current use of the registered nursing assistant (RNA) title will change to LPN in the near future.

Basic Education Program

New Brunswick's basic education program for practical nurses is 50 weeks long and is offered in four public and six private education institutions. Additional seats have been funded.

A collaborative project in New Brunswick promotes care aides in upgrading to the LPN role. This came about due to the provincial government's decision to change staffing ratios in long term care, which saw the number of LPN positions increase from 20 to 40 per cent of nursing staff. Under this initiative, care aide upgrading was supported to avoid displacement. According to the registrar of the NBARNA, hundreds of care aides have completed the upgrading programs to become LPNs.

*Numbers are quoted from the September, 1999 LPN Registrars Conference unless otherwise noted. "Psychiatry" includes psychogeriatrics. "Other" is the category chosen when the LPN works in several areas, which is common in smaller institutions, and when the LPN works in more than one agency on a part time or float basis.
See the *LPNs in Canada* fact sheet for comparison to other provinces.

Post Basic Programs

Medication administration is offered to practising LPNs. As of September, 1999 this skill became part of the basic education program. An operating room program is also available to the province's LPNs.

Distinctive, New and Emerging Roles

In New Brunswick nursing homes and long term care facilities, the current staffing ratio for RNs, LPNs and care aides is 20:40:40. This ratio is set by government policy and is required in facilities funded by government. In acute care, ratios vary from 50:50 to 100 per cent RN staff. As the government provides global funding to acute care hospitals, it does not prescribe staffing levels as it does for LTC.

One new initiative in LTC is that LPNs are now giving medications in nursing homes. (Nursing home residents are considered "stable" with predictable outcomes.) This new role is an important one for LPNs in New Brunswick, as the majority practise in geriatrics. The Victoria Order of Nurses is also actively hiring LPNs for home care nursing.

Finally, "extra mural hospitals" or "hospitals without walls" (i.e. mainly outpatient and integrated with community or long term care) are considering the role of the LPN in community outreach work.

Staffing Models

There are a number of staffing models employed in New Brunswick's health care facilities. For example, a team model of staffing was described at a Moncton acute care facility. Of three teams on a neurology unit, two are made up by an LPN and an RN, while the third is made up of two RNs. The registrar of the NBARNA reported that these LPN/RN teams are very effective. Both know each other's roles and capabilities and there is minimal overlap and conflict.

Another example is found at Chalmers Hospital, which replaced an older Fredericton hospital in the 1980s. When the new hospital opened, only RNs were hired on acute care units, consistent with the trends of that time. This remained the norm until recently, when LPNs were hired on medical-surgical units, and then on maternity and pediatric units. Those job descriptions are under review.

Finally, the registrar of the NBARNA notes a climate of change for LPNs in New Brunswick. He sees a steady increase of LPNs in acute care and the possibility that this role will be expanded to reflect LPNs' educational preparation. Community is another area offering new opportunities for LPNs in New Brunswick, while long term care in considered to be stable, with no anticipated role changes.

For further information, contact Normand McDonald, NBARNA Registrar, at (506) 453-1747.

FACT SHEET OVERVIEW OF LPNs IN OTHER PROVINCES

LPNs in Nova Scotia

Fast Facts*

1998 number of registered members: 3,209

Place of employment:
- Hospital: 987 (38 %)
- Nursing home: 867 (33 %)
- Other: 754 (29 %)

Primary area of responsibility for three highest areas:
- Geriatrics: 867 (38 %)
- Acute care: 987 (33 %)
- Psychiatric: 278 (11 %)
- Other: 476 (18 %)

Regulatory and Practice Issues

The RN and LPN regulatory bodies jointly list competencies that can be delegated to LPNs.

Basic Education Program

Nova Scotia's basic education program for practical nurses is 10.5 months in length, offered over three semesters. Four community colleges teach the program.

Post Basic Programs

Post basic education available to LPNs in Nova Scotia include refresher, medication administration, pharmacology and community health programs.

LPN Role

There are a number of trends affecting the role of LPNs in Nova Scotia. In acute care, where LPNs have a historical role, working under the direction of RNs, the LPN role is expanding and the number of LPN positions is increasing.

In long term care, especially with the nursing shortage, new models of care are emerging. LPNs are assuming a unit "in-charge" role, working with RNs who have overall

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responsibility for nursing care in the facility. LPNs in Nova Scotia's long term care facilities also administer medications.

LPNs are also beginning to work in home care nursing.

It has been identified that discussion and clarification is needed regarding the roles and scope of practice for all members of the nursing team. The RN Association of Nova Scotia and the Practical Nurses Licensing Board have been collaborating on this issue.

Care Aide Role

Training programs for care aides vary considerably in Nova Scotia. There are about a dozen categories of workers in the care aide role. Care aides training ranges from "on-the-job" to programs in private and public educational institutions. The major change related to care aides in Nova Scotia is the increased numbers of these workers. Because programs are not standardized, expectations for the role vary. Therefore, delegation and supervision of the various types of care aides by LPNs and RNs pose a challenge.

Care aides are primarily employed in long term care and other types of residential care (including caring for clients with mental and physical disabilities). Although a few "nurses aides" are employed in acute care, they are not involved in direct care to clients. Personal care workers (PCWs) assist residents with activities of daily living, such as assistance with feeding or ambulation. This role seems to be most consistent with roles in other provinces, such as the care aide role in B.C.

For further information, contact Ann Mann, Registrar, Practical Nurses Licensing Board, at (902) 423-8517.