Effectively Utilizing BC LPNs and Care Aides:

Follow-up Report

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FBA Joint Policy Committee

Submitted by:

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1.0 Background

In June 2008, the Nursing Directorate released the report "*Effectively Utilizing BC's Licensed Practical Nurses (LPNs) and Care Aides (CAs).*[1]" The impetus for the report was the 2006 policy discussions between the Ministry of Health Services (MOHS), the Health Employers Association of BC (HEABC), health care employers and the Facilities Bargaining Association (FBA). The discussions focused on factors that contribute to effective utilization of LPNs and CAs and resulted in the MOHS funding a report to (1) examine the evolving utilization of LPNs and CAs across BC; (2) identify approaches that promote effective utilization; and (3) recommend strategies that would support optimal utilization of LPNs and Care Aides in the future.

Two categories of recommendations were proposed in the report:

1. A strategic approach to change management (i.e., planned approach to implementing new roles and/or skill mixes):
   - Use a change management process;
   - Assemble a leadership team;
   - Attend to roles and responsibilities of all staff;
   - Communicate and encourage input from staff;
   - Support and evaluation change;
   - Review decision making processes; and
   - Set reasonable time limits

2. Optimal utilization of LPNs and CAs:
   - Transition to practice opportunities for new graduate LPNs;
   - Professional development and education opportunities for LPNs and CAs;
   - Networking opportunities for CAs;
   - Leadership training and leadership opportunities for LPNs;
   - Collaborative practice opportunities to assist LPNs' and CAs' participation in clinical practice issues;
   - Participation of LPNs and CAs on formal decision-making structures, as appropriate; and

[1] www.health.gov.bc.ca/library/publications/year/2008/Effectively_Utilizing_LPN_Care_Aide_Report.pdf

- Mechanisms to support the on-going sharing of promising practices and change management processes.

This report is a follow-up to the June 2008 report "*Effectively Utilizing BC's Licensed Practical Nurses (LPNs) and Care Aides (CAs).*" The purpose of this report is to summarize progress on the recommendations in the June 2008 report, review facilitators and barriers to implementation and suggest priority areas for continued movement forward.

This report is preceded by two newsletters (*Promoting Positive Change: BC's LPNs and Care Aides*), one released in June 2009 and one in December 2009. The newsletters highlighted promising practices and new opportunities for LPNs and Care Aides in each HA.

Because the original report "*Effectively Utilizing BC's Licensed Practical Nurses and Care Aides"* was initiated through policy discussions with the FBA, it addressed the role of LPNs and Care Aides in acute and residential/continuing care facilities only. The perspective of employers, LPNs and Care Aides working in home care and the community were not solicited or included in the original report, the newsletters or this follow-up report.

2.0 Methodology

The development of this follow-up report was guided by the Utilization Sub-Committee, a sub-committee of the FBA Joint Policy Committee. Input was provided in several ways, which included:

1. Two status update reports submitted by the Chief Nursing Officer (CNO) of each HA, one in March 2009 and one in September 2009, describing promising practices. See Appendix 1 for a list of these practices.

2. Interviews with thirteen managers/practice leaders from across BC held between November 2009 and January 2010 (interviewees identified by the CNOs). See Appendix 2 for a list.

3. Four focus groups, two with LPNs and two with CAs held in November/December 2009 (participants identified by HEU). See Appendix 3 for a list of focus group participants.

4. Presented the draft report to the FBA Joint Policy Committee and CNOs in January 2010.[2] Feedback from each of these sources was incorporated into this final report.

The final report was submitted to the FBA Joint Policy Committee in February 2010.

[2] The CNO Council reiterated that their purpose was to provide feedback on the report but in doing so were not endorsing the report or its recommendations.

3.0 Progress on Recommendations

This section summarizes progress on each of the recommendations in the report "*Effectively Utilizing BC's Licensed Practical Nurses and Care Aides.*" For a detailed list of promising practices/initiatives underway or completed in BCs HAs (as per the Chief Nursing Officers' status reports), see Appendix 1.

3.1 A Strategic Approach to Change Management

The first (and most significant) recommendation was to adopt a strategic approach to change management when introducing new roles and/or skill mixes.

HAs undertook considerable efforts to develop change management strategies for the introduction of new roles and/or skill mixes. While the terminology and focus of the approach varied across HAs (e.g., care delivery redesign, collaborative practice, optimizing scopes of practice), the goal of improved utilization of all types of care providers was consistent. Initial efforts have focused on optimizing the role of RNs and LPNs in acute and residential care; the focus on CAs in acute care has been more recent and is less developed. The upcoming provincial collaborative on care delivery redesign will help to provide the structure to continue to move forward in this area.

LPN and CA focus group participants provided several examples where change management strategies were applied in the introduction of new roles and/or skill mixes. The outcomes in these examples were reported to be very positive. Participants also provided examples, however, where roles were introduced and/or skill mixes changed without adequate planning, communication or education. The outcomes in these examples were less positive and roles and relationships continue to be problematic. Consistent application of change management strategies across settings will require an ongoing focus.

Some HAs have been proactive in spreading the successful introduction of new roles and/or skill mixes from a "pilot setting" to similar settings in the same or other hospitals. Generally speaking, however, progress in this area has been slow. Across the province there are successful examples of LPNs working in mental health, maternity care, renal care, emergency departments, operating rooms, specialty clinics (e.g., orthopaedic/cast clinics), primary health care clinics, and on Aboriginal reserves but the numbers are relatively few.

Similarly, CAs have been introduced to medical/surgical areas, but progress has been slow and has varied considerably across units/hospitals/HAs, even when the practice settings and patient populations are similar.

The role of CAs in residential care, for the most part, has not changed. Many commented that while they had been educated to take on an expanded role (e.g., taking vital signs, performing simple dressing changes, charting outcomes), they did not have the time to take on additional duties. If care aide hours were to be increased, they felt they could be more effectively utilized (e.g., taking vital signs, performing simple dressing changes, charting observations). Several commented that more inclusion of CAs in collaborative activities (e.g., use of the SBAR tool and safety and patient care huddles) would be of benefit.

Where a change management approach was utilized, the following was noted:

- HAs identified improved utilization of LPNs and CAs as a priority "project" and used project methodology in the development of their plans.
- Resources to lead the "project" were identified (usually the Professional Practice Office with support from the Education Department).
- Unit managers/clinicians were identified as implementation leads at the unit level. This worked well when the managers/clinicians were experienced/educated about change management, believed in the change and had sufficient time to lead the implementation.
- Where skill mix changes occurred/are occurring, committees of representative managers, RNs, LPNs and CAs were/have been established to provide input on the design and implementation (e.g., redesign committees, practice councils, unit committees/councils). These committees were most successful when all impacted units were represented.
- Much effort went into clearly defining roles (particularly RNs and LPNs). Role documents, job descriptions and detailed job routines were developed and, in many cases, educational sessions on roles and working effectively together were provided, often with the involvement of the College of Registered Nurses of BC (CRNBC) and the College of Licensed Practical Nurses of BC (CLPNBC).
- Communication plans were developed and have/are being implemented to keep nursing staff and others abreast of the changes. Communication included presentations and dialogue about upcoming changes in various HA, hospital and unit meetings and written communication in e-mails, memos, newsletters and HA websites. One HA (VIHA) established an LPN-specific SharePoint site. As with all projects, communications was/will continue to be one of the biggest ongoing challenges. There can never be enough!
- Changes were well planned and supported by education (educational support was acknowledged more for LPNs than CAs).

Facilitators and barriers to implementing a strategic approach to change management are included in section 4.0 (facilitators and barriers).

3.2 Supporting the Optimal Utilization of LPNs and CAs

The report identified seven initiatives to support the optimal utilization of LPNs and CAs. Progress (at a high level) on each of these initiatives is provided in this section. Facilitators and barriers to implementing these initiatives are included in section 4.0 (facilitators and barriers).

3.2.1 Transition to practice opportunities for new graduate LPNs

None of the HAs have implemented formalized transition to practice programs for new graduate LPNs, although some offer extended orientations. While there is recognition that a structured education and consolidation period would be of benefit, funding was noted as the major limitation.

Some HAs have created LPN mentor positions (FHA, VCH/Lion's Gate, Providence Health Care, VIHA/Victoria General/neurosciences). These positions support new LPNs and have been very positively received. The impact of these positions provincially is limited by their small numbers.

3.2.2 Professional development and education opportunities for LPNs and CAs

All HAs have provided significant professional development and education opportunities for LPNs. Opportunities for CAs have much fewer but are increasing. Both groups reported challenges in utilizing these opportunities as it was difficult for them to "leave the floor" and/or come in on a day off to participate. LPNs and CAs working in rural and remote settings reported further challenges with respect to the availability of courses and travel.

Combined education days for RNs, RPNs, LPNs and CAs (with perhaps some role specific break-out groups) offered by many HAs have been very successful. Topics have included roles, respectful working relationships and the use of structured tools to support planning (e.g., CAPE tool) and communication (e.g., SBAR tool). The care delivery redesign learning collaborative underway in VIHA (and soon to extend provincially) was also noted as a useful forum for such discussions.

Education days for CAs have been very well received. These serve to reinforce the importance of the CA role, provide opportunities for CA networking and facilitate the transfer of current, applicable information that is helpful to CAs in their daily work.

Some HAs provided LPNs and CAs with structured education days/courses to assist in their moving from residential care to acute care. This was particularly important for CAs as acute care is not part of the BC CA curriculum. It was also helpful for LPNs who had not worked in acute care since they took their basic LPN training.

3.2.3 Networking opportunities for CAs

No formal structures have been implemented in HAs for CA networking. Networking does occur, however, through CA education sessions/conferences and participation on decision-making committees. The HCA Registry was also noted as a potential vehicle for future CA networking. CAs were very appreciative of these opportunities (as evidenced by the comments on education session evaluations and in the CA focus groups).

3.2.4 Leadership training and opportunities for LPNs

Leadership training/support for LPNs was identified by many managers, LPNs and CAs as an educational priority, particularly by those working in residential care.

Several LPNs benefited from the 3 day leadership workshop offered by Vancouver Community College (VCC) and funded by the MOHS in 2006/07. Some HAs have provided one to two day LPN leadership workshops since 2006/07. These have been well received but more are needed.

Opportunities for LPNs to work in leadership positions are increasing. While most of the opportunities are currently in residential care, new regional and acute care LPN leader/educator/mentor positions have recently been established (but the number to date is very limited). LPNs were also provided leadership opportunities through active involvement on a variety of policy, practice, CLPNBC professional development and union committees at provincial, HA and local levels. LPN leadership opportunities were welcomed by managers and LPNs alike.

Leadership opportunities have also started to emerge for CAs, such as coaching on safe, patient handling/lifting techniques and preceptoring CA students and/or colleagues. In addition, CAs were provided opportunities to participate on a variety of policy, practice and union committees.

3.2.5 Collaborative practice opportunities to assist LPN and CA participation in clinical practice issues

For some interviewees/focus group participants, collaborative practice was interpreted as an "approach" to change (working together to design and implement change); for others, it was interpreted as an "outcome" of change (working collaboratively together). Progress on the recommendation from those

interpreting collaborative practice as an "approach" to change was noted in section 3.1 (a strategic approach to change) while progress from those interpreting it as an "outcome" of change is noted below.

"Collaborative practice" is defined as RNs, RPNs, LPNs and CAs working together as teams, each to their optimal scope. On many units (residential care and acute care), this has required the introduction of new roles and/or changes in the skill mix. This has necessitated a more deliberate focus on collaborative practice. On units where a change management approach was utilized and roles and accountabilities were clearly defined, collaboration has been a positive experience. On units where this has not occurred, roles and accountabilities are not clear and tension was reported to exist amongst team members. Tensions were mostly noted between RNs/RPNs and LPNs and between LPNs and CAs and were attributed to roles and concerns re job functions and job security.

3.2.6 Participation of LPNs and CAs on formal decision-making structures, as appropriate

The number of opportunities for LPNs and CAs to participate on formal decision-making structures has increased significantly over the course of the past few years.

LPNs and CAs are represented on committees at multiple levels:

- Provincial committees (e.g., FBA Joint Policy Committee, Residential Care Policy Committee)
- HA committees (e.g., occupational health & safety committees, violence in the workplace committees, care delivery redesign committees, practice committees)
- Unit committees (e.g., staff meetings, family conferences, peer-based resource groups).

The addition of LPNs and CAs on committees has been well received by all groups - further opportunities would be welcomed.

3.2.7 Mechanisms to support the on-going sharing of promising practices and change management processes.

Several mechanisms were/are in place to assist with the sharing of promising practices and change management processes. These include:

- Provincial committees (e.g., FBA Joint Policy Committee, Residential Care Policy Committee)
- HA committees (e.g., practice councils, redesign/collaborative practice committees, manager/clinician/educator meetings)
- Unit committees (e.g., staff meetings, unit councils)
- Education sessions and conferences
- HEABC, FBA and MOHS communication mechanisms (websites, newsletters, bulletins, etc)
- Two newsletters published as part of this project

While several mechanisms exist to assist with sharing of promising practices and change management processes, many of these mechanisms are one-time. Mechanisms to support sharing on an *ongoing* basis are more limited and would be of benefit in the future.

4.0 Facilitators and Barriers

The introduction of new roles, skill mix changes and related initiatives has not been without challenges. Most of these challenges, and many of the anticipated facilitators and barriers to these challenges, were identified in the June 2008 report.

The next section highlights the facilitators and barriers that were identified in the focus groups and interviews conducted in preparation for writing this report.

4.1 Facilitators

Factors identified as *facilitators* to implementation included (*when in place, these were noted as facilitators; when not in place, some of the same items are noted as barriers):*

Provincial-level facilitators:

- Legislative framework for LPNs: Health Professions Act, LPN Regulations (need updating; see section on barriers), CLPNBC Bylaws, CLPNBC Standards of Practice & Competencies, CLPNBC approval of basic LPN education programs (1996), new licensing standards that required educational upgrades for many LPNs (2005) and the requirement for all practical nurses to register with CLPNBC (2007).
- DRAFT Baseline Competencies for LPNs' Professional Practice (dated February 9, 2009) (also noted as a barrier as competencies have not yet been approved).
- Provincial LPN curriculum is in place (implemented in 1993); will be updated after baseline competencies are approved.
- Support from RN and LPN regulatory colleges (CRNBC and CLPNBC), including role/scope workshops and related documents (e.g., Working Together for Client Safety, 2008).
- Provincial CA competencies (CA Framework of Practice, 2007).
- Provincial CA curriculum (approved in 2008; currently being implemented).
- FBA Joint Policy Committee (includes MOHS, HAs, unions, HEABC, LPNs, CAs and others with mutual interests).
- Provincial education funding:
  - LPN upgrade fund (2002-2007; Nursing Directorate): funded more than 100 LPNs per year to complete pharmacology and physical assessment modules to enable LPNs to practice to optimize their scope of practice.
  - LPN leadership course (2006/07): funded 160 LPNs to take the 3-day Fundamental Leadership Skills for LPNs course at Vancouver Community College (VCC). Funding was one-time.

- $3.5M fund (2006-2010; Health Education Foundation): funded LPN specialty, post-basic and continuing education.
- $5M skills upgrading & career mobility training fund (2006 – 2010; all FBA members): funded training for 400 CAs (acute care CA course, upgrade to become an LPN, activity assistant or unit clerk, KEES workshop).

Health authority level facilitators:

- "Project" leadership provided by Professional Practice Offices (PPOs).
- LPN positions at decision-making/senior levels (at this point, this is in FHA only).
- Committees of representative managers, RNs, RPNs, LPNs, CAs and union leaders provide input on the design and implementation of changes.
- Clearly defined roles, with regular reinforcement.
- Common job descriptions, competencies and orientation for similar practice areas.
- Regular meetings amongst managers/clinicians of units undergoing skill mix changes to discuss successes and challenges and ensure consistency.
- Managers/clinicians who are experienced/educated about change management, believe in the change and have sufficient time to lead the implementation at a unit level.
- Regular mechanisms for staff impacted by the changes to provide input and feedback (e.g. practice councils, staff meetings, e-mail, SharePoint site).
- Structured education programs:
  - Orientation of new LPNs and CAs (general and specialty specific education).
  - Combined RN, LPN and CA workshops on roles and working effectively together. Including managers/clinicians was also noted to be very helpful.
  - LPN and CA education to support movement to new practice areas (e.g., acute care, mental health and maternity).
  - LPN and CA preceptorship/mentorship workshops.
  - Education/programs to address the increased complexity of patient/resident care (e.g., palliative care, psychogeriatrics, tracheostomy care, etc). The recently developed course for LPNs to work in renal nursing was positively noted.
  - Annual workshops/conferences for RNs, RPNs, LPNs and CAs.
  - Education on change management for unit managers/clinicians.
- LPN educators/mentors (for LPNs); CA educators/mentors (for CAs).
- Collaborative practice tools that facilitate structured communication: Competence Assessment, Planning and Evaluation or CAPE tool; Situation-Background-Assessment-Recommendation or SBAR tool; patient and safety huddles; care conferences).
- Patient assignments according to intensity and acuity of patients (rather than by geography).
- Staffing levels that allow staff enough time to assume added responsibilities (e.g., CAs having the time to take vital signs and perform simple dressing changes in addition to their responsibilities in providing basic patient care).

4.2 Barriers

Factors identified as *barriers* to implementation included:

Structure/infrastructure barriers:

- The scope of practice for LPNs is set out in the Nurses (Licensed Practical) Regulation under the Health Professions Act. The Regulation restricts LPNs to carrying out nursing services "under the direction of a medical practitioner" or "under the supervision of a RN" (except in an emergency). This language limits the autonomy of LPNs and is inconsistent with current practice. Legislation in most other Canadian provinces (e.g., Alberta and Ontario) allows LPNs to independently perform specific restricted activities that are taught in the basic LPN program.
- Baseline Competencies for LPNs' Professional Practice (draft February 9, 2009) have not yet been approved. Once approved, these competencies will serve as a foundation for updating the LPN curriculum.
- Some HA policies are inconsistent with optimization of the LPN and/or CA role (e.g., LPNs are not allowed to obtain, take and/or transcribe medication orders or start IVs; CAs are not allowed to take blood pressures or provide basic ostomy care; CAs do not have access to the chart on some units).
- The FBA collective agreement does not recognize additional education required by LPNs to work in many of the specialty areas.
- Much of the success of implementation of role and skill mix changes depends on the experience/education, engagement and time of the unit manager/clinician. Inadequate preparation or insufficient time for the manager/clinician to support the changes was noted to be a barrier to success on some units.
- The decision to utilize LPNs and/or CAs in a particular acute care practice setting varies across units in the same hospital, across hospitals and across HAs. This situation exists even for two like units within the same hospital.

Role barriers:

- While much effort has gone into clarifying RN, RPN, LPN and CA roles, there are still many that feel more clarity is necessary. Role clarity will be a topic of ongoing discussion.
- Some team members (including some LPNs) are not able to accept the concept of LPNs practicing independently yet in collaboration with RNs/RPNs. This problem is reinforced by the current language in the Nurses (Licensed Practical) Regulation (see point under structure/infrastructure barriers).
- LPN and CA roles vary across units, practice settings, hospitals and HAs. This situation exists even for two like units within the same hospital or residential care facility. This creates confusion for managers and staff.

- Interviewees and focus group participants noted existing tension between RNs/RPNs and LPNs and between LPNs and CAs (less so between RNs/RPNs and CAs). This tension has increased as new roles have been introduced and/or staffing mix changed. The tension is attributed to the resulting impact of role changes on job functions and job security. RNs/RPNs feel they are being replaced by LPNs (in acute and residential care), LPNs feel they are being replaced by CAs (in acute care) and CAs (in residential care) feel that the "brunt" of direct care is falling to them as RNs/RPNs and LPNs assume a broader role. CAs perceive that many RNs/RPNs and LPNs no longer consider direct care a part of their role (creating a hierarchy).
- While LPNs participants felt their level of respect from others on the team had increased with the optimization of their role, CA participants perceived they were not respected by some of their colleagues on the team. This issue was identified in the original report and does not appear to have improved. One positive note is that CAs are now participating in care conferences/team meetings in most settings.

Education barriers:

- Expectations for LPNs have increased but the length of the basic educational program has remained the same (12 months). This compares to a 16 month program in Manitoba, Saskatchewan and Nova Scotia and a 2 year program in Alberta, Ontario and New Brunswick. A new LPN graduate mentorship program in BC was proposed by many interviewees and focus group participants as a means of "bridging this gap."
- As LPNs assume roles in non-traditional areas that require knowledge and skills beyond that taught in basic LPN programs (e.g., operating room, dialysis units, advanced orthopedics), there is a need for structured dialogue at a provincial level on the educational requirements and methods. Lack of access and funding for such education may be limiting the numbers of LPNs that are utilized in these areas.
- LPNs and CAs reported difficulty in accessing continuing education/workshops as backfill is difficult to find and/or courses are not available and/or require travel (the latter two are particular issues for LPNs and CAs working in rural and remote settings). Both groups identified a need for more education.
- The provincial CA curriculum (2008) prepares CAs to work in residential care and home support-type settings. It does not prepare CAs to work in acute care or other specialty areas. There is need for further discussion about the types of patient care roles required in acute care settings, the competencies required to meet patient needs in these roles, as well as how to meet the competency needs of those working in these roles. Inadequate preparation of some CAs negatively impacted the introduction of the CA role into some acute and specialty settings.

- Basic education for RNs, RPNs, LPNs and CAs continues to occur in isolation. This contributes to an ongoing lack of understanding and appreciation for each other's roles. This issue has been raised in multiple forums and reports but there are no imminent plans for change.

Resources:

- Resource limitations have restricted the pace at which changes could be implemented. The slow rate of change was commented on by LPN and CA focus group participants (education for LPNs to optimize their scope was completed in 2005; some LPNs are still not utilized to their optimal scope (some units that could utilize LPNs still do not).
- Skill mix changes require significant resources, including resources to lead the project at a HA and unit level, educate "change leaders" and staff, enable staff to participate in the design and implementation of the change and construct and conduct an evaluation. Resource limitations have required HAs to prioritize activities.
- Sustaining skill mix changes also requires resources to provide ongoing coaching "at the bedside," addressing emerging issues and developing/modifying tools. This issue will become more apparent with time, particularly as the managers and staff that initially implemented the changes retire or move to new positions. Addressing this issue will require creative strategies in an environment of limited resources.
- Staffing levels in some areas do not allow staff enough time to assume added responsibilities. This was noted as a particular issue for CAs working in residential care.

5.0 Summary & Priority Areas for Moving Forward

Considerable progress has been made on the effective utilization of LPNs and CAs since the release of the June 2008 report.

This is especially true in the following areas:

- Utilizing a strategic approach to change management in the implementation of new roles and/or skill mixes.
- Making professional development, education and networking opportunities available to LPNs and CAs.
- Creating collaborative practice opportunities to assist LPNs' and CAs' participation in clinical practice issues.
- Enabling participation of LPNs and CAs on formal decision-making structures.

Progress has been slower, but continues to move forward in the following areas:

- Creating transition to practice opportunities for new graduate LPNs.

- Providing leadership training and leadership opportunities for LPNs.
- Creating mechanisms to support the ongoing sharing of promising practices and change management processes.

Priority areas for continued movement forward:

1. Continue the focus on effective utilization of LPNs and CAs using a planned, change management approach.

2. To assist in optimizing LPN and CA roles, incorporate promising practice examples such as those highlighted in the "*Effectively Utilizing BC's Licensed Practical Nurses (LPNs) and Care Aides (CAs)*" report and subsequent newsletters, where applicable.

3. Engage in a provincial level dialogue on educational requirements and methods for LPN's who work outside of traditional work settings.

4. Implement a process to review (a) care aide roles in acute care settings; (b) competencies required to meet patient needs in these roles; and (c) how best to meet these competency needs.

5. Promote interprofessional education including education that includes RN's, RPN's, LPN's and CA's.

6. Develop transition to practice supports for new graduate LPNs in regular positions.

7. Continue to establish new LPN leadership positions such as LPN leaders/educators/mentors.

8. Support LPNs to develop leadership competencies within specific settings.

9. Support managers and clinicians to use appropriate change management techniques when implementing LPN and CA roles in their programs.

10. Develop mechanisms to support the spread and ongoing sharing of promising practices throughout BC.

Appendix 1: Promising Practices

(as per CNO Status Reports, March 2009 and September 2009)

1. Transition to practice opportunities for new graduate LPNs

HA	Promising Practice
FHA	Profession Practice & Integration is in the development stage of a New Grad program for LPN new grad's to help facilitate the transition to practice.
VCH	Continuation of "LPN Mentor" position to assist the transition of new LPNs and CAs in the float pool into their roles.
PHC	Mentorship role developed for one LPN across 2 acute sites to support LPNs in their collaborative practice
VIHA	Expanded Mentorship program now allows for LPN's to participate as Mentor Champions (attend two preparatory training sessions) and facilitate Foundational Mentorship Workshops for their peers.
VIHA	LPN mentors supported through attendance at Foundation Mentorship Workshops
NHA	New grad and mentor event. LPNs can attend - one registrant signed up.

2. Professional development and education opportunities for LPNs and CAs

a) LPNs

HA	Promising Practice
PHSA	Professional development sessions offered to all inpatient nursing staff (SH)
PHSA	Adult assessment workshops provided for LPNs in Spring 2009 (BCCA; collaboration with VCC); examining LPN roles for various program areas.
IHA	Mental health certification provided for 15 LPNs; role integrated with Kamloops, Williams Lake, Penticton, Trail and Cranbrook MH units/facilities.
IHA	4 hour workshop offered on Accommodating Responsive Behaviours in Dementia Care using the MAREP Program through the University of Waterloo. Developed for RNs & LPNs but many Care Aides are also attended.
IHA	New approach to assignment of patients to RNs and LPNs using a tool developed by the Professional Practice Office of IH.
IHA	Utilization of LPNs within peri-operative settings. Within select IH Operating rooms, the LPN scrubs for surgical procedures as well as providing initial assessment/checks prior to patient surgical events.

HA	Promising Practice
IHA	Utilization of LPNs in cast room procedures. Four IH Emergencies/Ambulatory clinics also have specially trained LPNs.
IHA	Skill days offered within Kootenay Boundary and Thompson Cariboo Shuswap facilities focusing on a variety of LPN competencies (art and science)
IHA	Heightened Expectations – an advanced 3 – day assessment course that facilitates critical thinking and decision-making. IH wide.
IHA	Immunization certification for LPNs that work in Kamloops, Penticton, Vernon, Creston, Kelowna Emergency departments.
IHA	Dementia Pathway training – IH wide. Development of e-learning opportunities for LPNs who care for residents/patients/clients with dementia.
IHA	Development of standardized orientation and mentorship plans for LPN's and RCA's across Residential Care in IH.
FH	New roles for LPNs in many areas, including Emergency Department, maternity, mental health, home & community care (6 FTEs, visit clients in their homes) and public health (10 FTEs; provided one month orientation to enhance competencies for mass immunizations)
FHA	7 LPNs successful completed the Grant MacEwan OR course. All are working in FH ORs.
FHA	Fraser Hope Lodge (96-bed residential care facility) has successfully moved LPNs into a new staffing model. RN consultative support is available to LPNs which is off-site but available 24/7 from the attached hospital.
VCH	LPN forums developed to discuss practice issues and offer networking opportunities (LGH but may extend via telehealth to other sites); plan to offer q 3 months.
VCH	Many LPNs attended various clinical workshops (e.g., Ins and Outs of RC, pharmacology workshops, Eden Associate training, end of life, decision making, etc).
VCH	4 LPNs obtained their Immunization certificate.
VCH	Aboriginal nursing exchange creates an opportunity for nurses from remote sites to intern at LGH and for urban nurses to work in remote sites (up to 5 days). Open to RNs/RPNs/LPNs.
VCH	New LPN mentor role established at LGHs. Works in float pool (0.6 FTE) and reports to the Educator. Assists with practice issues and system knowledge and provides support to new LPNs.
VCH	LPNs in Richmond Community; LPN educator also in place.
VCH	Ongoing education sessions for LPNs: pharmacology; clinical decision making and assessment; collaborative nursing practice (e.g., competencies, conflict resolution, critical thinking).

HA	Promising Practice
VCH	Pool Post newsletter sent out monthly to update float LPNs and CAs at Lion's Gate Hospital.
VCH	Additional LPN & PCA positions added (collaborative nursing practice initiative). Education on collaborative nursing practice (e.g., competency assessment, scope of practice) is provided for all levels of nursing staff. Developed Competencies grid (independent, shared and dependent). Standardized process for adding additional "advanced" skills (post licensure or hire).
PHC	8 LPNs trained for expanded role in HD (education and training included as part of the role development).
PHC	LPN mentor role (2.0 FTEs) created (temporary; could not sustain due to lack of resources) to support casual LPNs working on Collaborative Practice Units.
PHC	37 LPNs across the organization will participate in a leadership development course through Vancouver Community College by March 31, 2010.
VIHA	LPNs participate in many workshops/education sessions/conferences (e.g., LPN Skiill Days, infection control, clinical assessment, pain management, provincial LPN Professional Practice Conference, wound and skin care conferences, CTAS, collaborative RN/LPN practice, interpreting lab results)
VIHA	Self learning packages and DVD library developed and evaluated by LPNs.
VIHA	LPNs preceptor LPN students individually and in groups.
VIHA	LPNs acted as peer mentors during the Cerner (IMIT Core Clinicals) rollout & the Stroke Collaboration & Care Delivery Model Redesign processes.
VIHA	LPNs trained as MSIP delegates for the Heart Health and Adult ICU (NRGH).
VIHA	Experienced LPNs led a PDSA (Plan-do-study-act) where they coached fellow LPNs around transcribing orders to increase their competency (Rehab NRGH).
VIHA	LPNs have been trained as Flu Champions and administering staff immunizations.
NHA	LPNs at PGRH ambulatory care now starting IVs (accessed distance education project).
NHA	LPN Perinatal Workshop offered at 3 NT sites.
NHA	LPNs participate in the More OB program alongside RNs and MDs; this QIP initiative has promoted the work of the interdisciplinary team like none other in recent past.
NHA	LPNs have completed the immunization course and work with RNs to provide routine immunizations with RN support.

HA	Promising Practice
NHA	Geriatric practicum has been offered for several years and includes experience in specialty units in Vancouver and Surrey. BCHEF has provided dedicated funding for LPN education.

b) Networking opportunities for CAs

HA	Promising Practice
PHSA	CA roles being explored in some areas
IHA	Training of new RCAs (through BC Education Foundation)
IHA	InterRAI training for both LPNs and RCAs
VCH	Residential Care Practice Team conducted workshops for RCAs
VCH	The "Key Education Elements and Skills" (KEES) sessions (4 full day sessions) was offered last year and was open to and well attended by Care Aides working in Vancouver. Consequently another 4 sessions will be offered starting in September 2009 until May 2010. Content includes: the essential role of the CA, end of life care, ins and outs of residential care and understanding your resident.
PHC	RCAs funded for 1 day of education/10 sessions held/360 CAs attended (med delivery, communication using SBAR, dysphagia etc); add'l education provided to RCAs wishing to work in acute care areas.
VIHA	CAs participate in many workshops/education sessions (e.g., MSPI, pain management, infection control, clinical assessment, dementia care)
NHA	CAs participated in psychogeriatric workshop; numerous CAs also attend an annual workshop in NH
VIHA	Charting documentation module to enable CAs to document on patient care records.
VIHA	Skills day for CAs - "Orientation to practice in acute care settings."
VIHA	Medical unit at CRH: CAs have been integrated, with a new job description, as a full member of a 3-person team (RN, LPN, Patient Care Aide); extra education provided to PCAs.

c) Leadership training and leadership opportunities for LPNs

HA	Promising Practice
PHSA	LPNs on various practice councils.
IHA	New approach to assignment of patients to RNs and LPNs using a tool developed by the Professional Practice Office of IH.
IHA	Development of standardized orientation and mentorship plans for LPNs and RCAs in RC is underway.
IHA	MSIP peer leader groups, practice council involvement and site champions for CA InterRAI training.

HA	Promising Practice
IHA	At local colleges (both private and public) LPN's are becoming an effective part of (supervised) LPN and RCA instruction teams for demonstration labs and professional practice instruction.
FH	Workshops for LPNs and clinical leadership to network and discuss roles, responsibilities and scope of LPNs across the region ("Shifting Horizons: Collaborative Nursing Practice")
FH	LPNs have access to mentorship opportunities in FH; specific mentorship workshop developed for LPNs (facilitated by LPN instructors); LPNs also access FH ID mentorship workshops.
FHA	FH Residential is offering 60 LPNs to attend the Clear Leadership® course that is 4 day course to enhance their leadership skills.
FHA	Professional Practice & Integration has hired the first LPN into a Clinical Practice Consultant position to support LPN practice in the health region
VCH	27 LPNs attended a RN and LPN series of 5 workshops for Leaders in Implementing Nursing Knowledge
VCH	Professional Practice Research grant ($5000) available for each HSDA and is open to all nursing & allied health staff
PHC	33 LPNs participated in the Essential Leadership for LPN program through VCC
VIHA	Nursing Week 2009: RNPC highlighted LPN Practice Support Position as a leadership position in a filmed roundtable conversation with Dr. Lynn Stevenson, other nurses and care aides who have demonstrated leadership in the organization.
VIHA	MSIP coaching sessions.
VIHA	Community Hospitals ALC Unit CRH: unit is lead day to day by a team of 2 LPNs, working with an RCA. LPNs work to full scope and have access to an RN on another floor if required. RN attends once a week to work with the LPNs to update care plans.
VIHA	RGH Floor 4 and Floor 5, RJH 2 West: LPNs are MSIP coaches for their units (one shift per week).
VIHA	Creation of a new Job Description for a "Practice Support" role.
VIHA	Assuming leader and mentor roles and part of interprofessional mentorship program
NHA	17 LPNs attended a 2 day LPN Leadership Workshop. LPNs are functioning in team leader roles in residential care facilities.

d) Collaborative practice opportunities to assist LPNs' and CAs' participation in clinical practice issues

HA	Promising Practice
PHSA	LPNs participate in ID rounds, unit council and team/family meetings

HA	Promising Practice
VCH	Collaborative practice has been implemented at 4 units at VGH and will be implemented in 5 other units. Rolled out in medicine and surgery and soon in Evergreen
VCH	82 LPNs attended LINK (Leaders in Nursing Knowledge) workshops. Funding provided through BCHEF funding. 5 part series offered from June 2008 to Feb 2009. Each day session was offered twice. Salary replacement for 455 RN/RPN days and 100 LPN days. If 25% of RN/LPN staff from one unit attend the series, become part of the CHAIN GANG. Commit to PDSA cycle to make a change. Follow up teleconferences organized to discuss change.
PHC	Collaborative Practice Initiative: 3 days education for LPNs and 1 - 2 days for team. Focus on optimizing the scope of practice for LPNs
PHC	Transforming Care at the Bedside: reviewing all nursing roles to ensure nursing staff are functioning at optimal scope; LPNs and PCAs involved in process
PHC	LPN coach role to support collaborative practice on each unit during transition
VIHA	Nursing Week 2009: Two Care Aides were also a part of this discussion, highlighting their involvement within the Care Delivery Model Redesign (CDMR) initiative and practice changes they have advocated for at Yuculta Lodge. This video-clip was broadcast on the VIHA intranet for <u>all</u> staff to see.
VIHA	Inclusion of LPN's onto Care Delivery Model Redesign (CDMR) Teams/ working groups involved in collaborative process.
VIHA	CRNBC web conferences, wound care champions, MSIP champions, ethics consultations, patient care and patient flow huddles, falls prevention collaborative, etc

e) Participation of LPNs and CAs on formal decision-making structures, as appropriate

HA	Promising Practice
PHSA	LPN on C&W Nursing Advisory Council, LPNs preceptor new staff and present at conferences (SH)
PHSA	LPN rep being added to BCCA Nursing Practice council
IHA	Most sites developing practice councils; LPNs and Care Aides are invited to participate.
FH	CA rep added to Nursing Professional Practice Committee
VCH	LPNs within VA and RHS are involved in nursing practice advisory councils
VCH	Quarterly meeting of HEU (LPNs and CAs) with CNO and Professional Practice Leadership Team
VIHA	LPNs participate in Regional Nurses Practice Council

VIHA	2 LPN reps on Regional Nurses Practice Council

Appendix 2: Manager/Practice Leader Interview Participants

HA	Name
IHA	Kathy Chouinor
FHA	John Tully
	Anita Dickson
VCH	Romilda Ang
	Khairrunnissa Rhemtulla
	Monica Redekopp
	Johanne Fort
PHC	Barb Lawrie
	Candy Garossino
VIHA	Linda Latham
	Colleen Butcher
NHA	Norma John
PHSA	Sherry Hamilton (via CNO meeting)

Appendix 3: Focus Group Participants

Group	Date	HA/Area	LPN or CA
1	Nov 18, 2009	IHA/100 Mile House, residential care, some acute	LPN
		IHA/Kootenay Boundary, residential care, some acute	LPN
		VCH/Lion's Gate, acute	LPN
		VIHA/Port Alberni, acute & residential care	LPN
		VIHA/Royal Jubilee, acute	LPN
2	Nov 18, 2009	FH, Royal Columbian/Eagle Ridge, acute (previously worked residential care)	CA
		VCH/Vancouver General, acute (previously worked residential care)	CA
		VCH/Vancouver General, acute (previously worked residential care)	CA
		VIHA/Nanaimo Regional, psychiatry	CA
		VIHA/Cowichan District, acute	CA
3	Dec 16, 2009	IHA/Kootenay Boundary, acute	LPN
		FHA/Hollywood Manor, residential care (+ works some acute)	LPN
		VCH/Lion's Gate, acute	LPN
		VCH/Vancouver General, emergency	LPN
4	Dec 16, 2009	IHA/Overlander EC, residential care	CA
		IHA/Overlander EC, residential care	CA
		VCH/, Evergreen House, residential care	CA
		VIHA, Saanich Peninsula, residential care	CA
		NHA/Rotary Manor, residential care	CA
		NHA/Bulkley Lodge, residential care	CA
		NHA/Bulkley Lodge, residential care	CA
Total LPNs			**9**
Total CAs			**12**