

Effectively Utilizing BC's Licensed Practical Nurses and Care Aides



EXECUTIVE SUMMARY

During 2006 policy discussions between the Ministry of Health, the Health Employers Association of BC, health care employers and the Facilities Bargaining Association, representatives discussed many of the factors that contribute to effective utilization of Licensed Practical Nurses (LPNs) and Care Aides. Based on these discussions the Ministry of Health agreed to fund a report (the Report) to: 1) examine the evolving utilization of LPNs and Care Aides across the province, 2) identify some current approaches that promote effective utilization and 3) recommend strategies that would support optimal utilization of LPNs and Care Aides in the future.

A series of focus groups with LPNs and Care Aides and interviews with practice leaders from rural and urban areas throughout BC were conducted to gain a better understanding of the factors that influence the optimal utilization of LPNs and Care Aides. While both employee and employer groups discussed the benefits of newly emerging or enhanced roles for LPNs and Care Aides, both groups also acknowledged that there are often challenges with the implementation of these changes. As a result, this Report focuses on strategies that would assist change management, as well as support optimal utilization of LPNs and Care Aides.

A Strategic Approach to Change Management

A majority of participants talked about the need for a planned change management process when new roles are being introduced and/or skill mix is being reconfigured. Participants were clear that change requires planning, time and energy. Factors and opportunities that are important considerations include:

- 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 evaluate change
- Review decision making processes
- Set reasonable time limits

Optimal Utilization of LPNs and Care Aides

Additionally, initiatives that would further support the optimal utilization of LPNs and Care Aides and assist with the change management inherent in enhanced roles or reconfiguring skill mix are:

- Transition to practice opportunities for new graduate LPNs
- Professional development and education opportunities for LPNs and Care Aides
- Networking opportunities for Care Aides

- Leadership training and leadership opportunities for LPNs
- Collaborative practice opportunities to assist LPNs' and Care Aides' participation in clinical practice issues
- Participation of LPNs and Care Aides on formal decision-making structures, as appropriate
- Mechanisms to support the on-going sharing of promising practices and change management successes

A follow-up to this Report is being planned for January 2009 to learn about the progress and development of these Recommendations and other initiatives that will support the optimal utilization of LPNs and Care Aides in British Columbia.

TABLE OF CONTENTS

EXECUTIVE SUMMARY	1
TABLE OF CONTENTS	3
ACKNOWLEDGMENTS	4
Terminology and Acronyms	4
Similar Terms	5
INTRODUCTION	6
Objectives	6
Approach	6
Scope	7
Associated Projects	8
About this Report	8
CHAPTER 1 THE CURRENT LPN WORKFORCE	10
Nature of Work	10
Role in the Health Care Team	10
History	10
Education	11
Workforce Size and Distribution	13
CHAPTER 2 THE CURRENT CARE AIDE WORKFORCE	15
Nature of Work	15
Role in the Health Care Team	15
History	15
Education	15
Workforce Size and Distribution	16
CHAPTER 3 CHANGING SKILL MIX	18
Skill Mix Decision Making	18
The Importance of Change Management	18
<i>Case Study - A Systematic Approach to Skill Mix Changes at Vancouver Island Health</i>	21
CHAPTER 4 CHALLENGES & OPPORTUNITIES	29
LPNs	29
<i>Historical Perceptions</i>	29
<i>Case Study - Letting Off Steam: How Kootenay Boundary Regional Hospital is Transforming Frustration into Empowerment</i>	34
<i>Shared Skill Sets between RNs and LPNs</i>	38
<i>Education and Training</i>	42
<i>Rewards of the Job</i>	45
Care Aides	47
<i>Recognition and Inclusion in the Care Team</i>	47
<i>Work Responsibilities</i>	51
<i>Case Study - Care Aides Selected for Skilled Tasks in Emergency Department</i>	52
<i>Advocacy and Engagement</i>	57
<i>Education and Training</i>	59
CHAPTER 5 – RECOMMENDATIONS	62
APPENDIX A	65
Membership of the FBA Joint Policy Committee and the LPN/CA Utilization Sub Committee	65
ENDNOTES	66

ACKNOWLEDGMENTS

The preparation of this Report was one of the terms of reference of the FBA Joint policy Committee (FBAJPC). The FBAJPC would like to express its appreciation to the numerous individuals and organizations that participated in the preparation of this Report. We are grateful for the time, effort and expertise that was contributed by health sector employees and employers who took part in the interviews and focus groups and candidly discussed their past and present experiences. Their contributions form the substance of this Report.

We would also like to thank the College of LPNs of BC, Camuson College, HEABC, and the consultants involved in the Care Aide Competency Project and the "Let's Talk" project for providing information and data during the preparation of this Report.

The FBAJPC is also appreciative of the work of the Utilization Subcommittee which provided guidance and direction in the research and writing of this Report. The membership of the FBAJPC and the Utilization Subcommittee is contained in Appendix A to this Report.

The FBAJPC would also like to express its gratitude to Wynona Church and Christine Vandebek, managing partners of Howegroup Public Sector Consultants, for conducting action research with Practice Leaders, LPNs and Care Aides across BC, presenting the challenges and opportunities that were identified with these participants, and suggesting recommendations to the Utilization Subcommittee.

The FBAJPC is also grateful to the Chief Nursing Officers of the Province for their dialogue and support of the Report and the Recommendations. Finally, the FBA JPC would also like to thank the Nursing Directorate, Ministry of Health for providing funding for the work of the FBAJPC and this Report.

Terminology and Acronyms

This Report has endeavored to keep acronyms and jargon to a minimum.

These acronyms are used in the paper:

LPN	Licensed Practical Nurse (also called Registered Practical Nurse in Ontario)
RN	Registered Nurse
RPN	Registered Psychiatric Nurse
CLPNBC	College of Licensed Practical Nurses of BC
CRNBC	College of Registered Nurses of BC
HEABC	Health Employers Association of BC
HEU	Hospital Employees' Union
FBA	Facilities Bargaining Association
FBAJPC	Facilities Bargaining Association Joint Policy Committee
CNOs	Chief Nursing Officers

Similar Terms

- Unless otherwise specified, the term “nurse” is used to refer to the following regulated nursing professions: RNs, RPNs and LPNs.
- The term “Care Aide” is used to refer to the combined group of terms used by Practice Leaders and Care Aides themselves and in health employer’s job descriptions including Health Care Aides (HCAs), Resident Care Aides (RCAs); Patient Care Aides or Personal Care Attendants/Assistants (PCAs); Nurse aides and Nursing attendants.

INTRODUCTION

Health care in British Columbia and in Canada has undergone considerable change over the last few years and more change is expected. Population growth, an aging population and technological advances in diagnosis and treatment contribute to increasing demands for health services. British Columbia, like all other provinces, is currently facing nursing shortages and waiting lists for health services. This pressure is expected to continue in the future and is leading governments to explore alternative options for the delivery of high quality health care. The BC government and health care employers are actively seeking opportunities to improve the utilization of all health care personnel, including Licensed Practical Nurses and Care Aides. In 2006, the Facilities Bargaining Association Joint Policy Committee was established, with representatives from the FBA; Ministry of Health; health care employers; and the Health Employers Association of BC, all collaborating to enhance the utilization of LPNs and Care Aides.¹

Objectives

The objective of *Effectively Utilizing BC's Licensed Practiced Nurses and Care Aides* is to support decision makers in effectively utilizing LPNs and Care Aides across BC.

Research on Roles and Utilization: LPNs and Care Aides in BC (the "2000 Report"), a report jointly prepared in 2000 for the FBA and HEABC, is an important reference point for this current work. Particular attention has been paid in this Report to identifying progress and emerging roles for LPNs and Care Aides since 2000.

This Report provides:

- ✓ Identification of some challenges and opportunities for effective utilization of LPNs and Care Aides.
- ✓ Retention and recruitment strategies for LPNs and Care Aides in BC – with particular emphasis on improving the profile of LPNs and Care Aides in the care team.
- ✓ Factors that promote career satisfaction for LPNs and Care Aides in BC.
- ✓ Examples of optimal utilization of LPNs and Care Aides through the use of case studies and "promising practices" that are being utilized by health employers in BC.
- ✓ Recommendations for implementing strategies that promote optimal utilization of LPNs and Care Aides in BC.

Approach

The FBAJPC appointed a sub-committee, called the Utilization Sub-committee, to oversee the research and writing of this Report. The Howe Group was retained to interview Practice Leaders, conduct focus groups and interviews with LPNs and Care Aides, present key challenges and opportunities that arose in this research to the Utilization Subcommittee and describe the history and current state of both LPN and Care Aide workforces in draft reports.

To understand the challenges and opportunities for LPN and Care Aide utilization, interviews were conducted between February and June 2007 with the following:

- 7 health care executives
- 12 directors / site managers
- 1 Clinical Nurse Educator
- 1 Clinical Nurse Specialist
- 1 union representative
- 1 educator
- the Utilization Subcommittee

BC's Chief Nursing Officers were asked to identify 2 to 3 Practice Leaders from their Health Authorities to participate in in-depth interviews. Members of the Utilization Subcommittee facilitated recruitment of LPNs for focus groups and Care Aides for focus groups and interviews. In February and March 2007, 25 LPNs and Care Aides from Health Authorities participated in three focus group sessions and individual interviews to discuss their perceptions of their work environments as well as barriers to and enablers of effective utilization. Additionally, between May and July 2007, sites that demonstrated approaches that promoted effective utilization of LPNs and Care Aides were identified by Practice Leaders who were interviewed to obtain their expertise and discuss these approaches.

Additionally, a meeting was held with the Chief Nursing Officers of the Province to discuss the Report and recommendations prior to finalization. The Report was finalized by the Utilization Subcommittee in alignment with the strategic direction of the FBAJPC.

A follow-up to the Report is planned for January 2009 to learn about the progress and development of the Recommendations and other initiatives that will support the optimal utilization of LPNs and Care Aides in British Columbia.

Scope

This Report outlines the key themes that arose in the focus groups and interviews regarding the challenges and opportunities for effectively utilize LPNs and Care Aides across BC. It does not provide staffing ratios. The literature and Practice Leaders all agreed that decisions must be made at a local level, based on the demographics of the health region and patient needs, as well as financial and human resource considerations.

As noted, this project was initiated through policy discussions related to the Facilities Health Services Subsector. As a result, it addressed the role of LPNs and Care Aides in acute and continuing care/residential facilities only. Therefore, the perspective of employers, LPNs and Care Aides working in home care and the community were not solicited or included in this Report.

Associated Projects

This document complements three associated projects that were underway at the time of this Report's production:

1. The Care Aide Competency Project, conducted by the Ministry of Health, will describe competencies for Community Health Workers and Resident Care Aides in BC. The Care Aide Competency Project focuses on describing the broad based responsibility of Care Aides, their day-to-day activities, how they should carry out each activity (indicators of competent performance) as well as the skills and knowledge needed to carry out their work. A new provincial curriculum and standards for training Care Aides and Community Health Workers are being developed that will reflect these competencies. *Effectively Utilizing BC's Licensed Practiced Nurses and Care Aides* supplements the Care Aide Competency Project by describing approaches for effectively utilizing Care Aide competencies.

2. The Responsive Shift Scheduling Initiative, another FBAJPC endeavour that is part of the 2006-2010 FBA Policy Discussions, is underway to assess interest and feasibility in responsive shift scheduling for LPNs, Care Aides and employers. The Responsive Shift Scheduling Initiative aims to increase awareness, openness, and understanding of responsive scheduling with respect to LPNs and Care Aides across BC.

3. *Let's Talk*, another FBAJPC project that is currently underway, will provide tools to support collaborative practice in the workplace. Directed to all members of the health care team, the guide is intended to improve communication among all health care workers through the use of structured communication tools that are broadly understood and consistently used by the entire health care team.

About this Report

The report is organized into five chapters.

- ◆ **Chapter 1** describes the current state of the LPN workforce, including the employment characteristics of the LPN workforce, education, scope of practice and legislation related to the work of LPNs.
- ◆ **Chapter 2** provides a general description of the current state of the Care Aide workforce.
- ◆ **Chapter 3** discusses changing skill mix and identifies the need for change management strategies.
- ◆ **Chapter 4** details the challenges in the dynamics of health care teams and opportunities for improving the status of LPNs and Care Aides and their utilization.
- ◆ **Chapter 5** provides recommendations for implementing strategies to promote optimal utilization of LPNs and Care Aides in BC.

***Also Contained
in this Report***

Promising Practices – Approaches that Promote Effective LPN and Care Aid Utilization

1. An LPN Pioneers Clinical Guidelines for Her Peers - Fraser Health
2. Introducing LPNs as Integral Contributors to Unit Operations – Vancouver Island Health
3. Developing Distinct Roles and Responsibilities - Fraser Health
4. Handing Off In Ways That Work - Vancouver Coastal Health
5. Shared Learning: A New Approach to Practice Education – Vancouver Coastal Health
6. Learning Together Enhances Geriatric Care - Provincial Networks
7. An Established Culture of Relying on Care Aide Observations - Vancouver Coastal Health
8. Including Care Aides in Care Planning - Fraser Health
9. Including Care Aide Expertise in Policy Development - Northern Health
10. Learning Together Creates Teamwork - Providence Health Care's Youville Residence
11. Promoting Care Aide Leaders - Vancouver Coastal Health
12. An Upsurge of Support for Care Aide Training - Northern Health

Case Studies

1. A Systematic Approach to Skill Mix Changes at Vancouver Island Health
 2. Letting off Steam: How Kootenay Boundary Regional Hospital Nurses Traded in Frustration for Empowerment (Interior Health)
 3. Care Aides Selected for Skilled Tasks at the Royal Columbian Hospital (Fraser Health)
-

CHAPTER 1 THE CURRENT LPN WORKFORCE

Nature of Work

LPNs are regulated health care professionals who provide nursing services to individuals, families and groups of all ages. LPNs are now, and have historically been, a necessary part of the health care workforce in BC's hospitals, long-term care facilities, and other organizations that provide health care services. LPNs combine nursing knowledge, skills and judgment to assess patients/residents, promote health, prevent illness, provide palliative and/or rehabilitative care, and assist patients/residents to achieve an optimal state of health. LPNs assess, plan, implement and evaluate care for patients/residents throughout all stages of life. LPNs practice in a variety of settings and contexts including hospitals, residential care facilities, public health units, community nursing agencies, private practices, clinics, physicians' offices, industry, schools, adult day-care centres, private homes and community health centres.

Role in the Health Care Team

LPNs are regulated health professionals who work along side other health care personnel, including physicians, allied health professionals, RNs, RPNs and Care Aides. Under the current regulatory framework, LPNs must carry out all nursing services "under the direction of a medical practitioner" or "under the supervision of an RN".ⁱⁱ At the same time, LPNs are regulated by their own professional College and responsible for their own practice. Over time, LPNs have been increasingly undertaking leadership roles in residential care facilities, health authority leadership teams, policy committees, and CLPNBC professional development initiatives.

History

The Canadian Nurses Association first gave recognition to Practical Nurses in BC in 1914. In 1951, the Practical Nurses Association was established (now the Licensed Practical Nurses Association of BC). In the same year, the BC legislature passed the Nurses (Licensed Practical) Act to regulate the practice of Practical Nursing but the Act did not take effect until 1965. This Act established the BC Council of Licensed Practical Nurses (BCCLPN) as the licensing body for practical nurses and represented the first time that Practical Nursing was recognized as a self-regulating profession. Several amendments were made to the legislation over the years and the requirement that Practical Nurses pass a national exam to obtain licensure was introduced in 1977.

In the 1980s, the health care system moved to a more RN-focused model of care which resulted in LPN displacements, especially in acute care.ⁱⁱⁱ During this period, many health care facilities opted to hire RNs instead of LPNs due to scope of practice and financial considerations at that time. Despite this, LPNs continued to advance as a professional body. In 1986, a Disciplines Committee was established under the Nurses (Licensed Practical) Act to oversee LPN conduct and licensure became mandatory.

Practical Nurses with on-the-job training and some orderlies were "grandparented" into the BCCLPN through a conditional license without writing the registration exam. In 1989, "LPN" became a restricted professional title that could only be used by those registered with the BCCLPN. At that time, some Practical Nurses continued to work under that

title and were not required to register with the BCCLPN. Nonetheless, this was the first of multiple steps to ensure all Practical Nurses working in BC belonged to the regulatory body.

At the start of the 1990s, the Seaton Royal Commission recognized the underutilization of LPNs and called for increased scope and staffing for LPNs in the acute, long-term care and community settings.^{iv} The 1991 *Report of the British Columbia Royal Commission on Health Care and Costs* (Seaton Commission) noted that the existing legislation governing the health care professions created persistent jurisdictional disputes and a distinct lack of cooperation among the health professions, despite the fact that all health professional colleges have the same mandate - to protect the public from preventable harm.^v In the same year, the BCCLPN was created as a regulatory body of the Ministry of Health. A Code of Ethics and Standards of Practice for LPNs in BC were developed between 1992 and 1994. In 1996 the BCCLPN was designated under the *Health Professions Act* and the name was changed to the College of Licensed Practical Nurses of BC.

The 2000 Report on LPN and Care Aide utilization represented an important collaboration between health care employers and unions regarding the utilization of LPNs and Care Aides. The 2000 Report made several recommendations, including:

- Increase awareness among managers and staff about the roles and competencies of the different nursing groups (LPNs, RNs and RPNs).
- Provide funding and Clinical Nurse Educators to support the continuing education of Care Aides and LPNs.
- Standardize provincial home support/Care Aide education.
- Facilitate improved communication and collaborative practice at the site level.

Professional Advancement

LPNs are now taking on a wider scope of responsibilities, including taking physician orders and administering medications. Under prescribed conditions, LPNs can also pronounce death. As LPNs' scope has expanded so has demand for their services.^{vi} Additionally, increased attention has been placed on effectively utilizing LPNs due to shortages of RNs and the expansion of LPNs into leadership roles in long-term care.

The new licensing standards have required educational upgrades for LPNs to achieve their full scope of practice. By 2005, LPNs who previously held a conditional license were no longer allowed to practice as LPNs unless they completed upgrading courses and successfully passed the registration exam required for full licensure. Although LPN became a restricted title in 1989, it was not until the start of 2007 that all practical nurses in BC were required to register with the CLPNBC.

Education

BC's inaugural Practical Nursing Program at Vancouver Vocational Institute (VVI) issued its first diplomas in 1948. Practical Nurses in BC currently complete a 12-month program that includes skills oriented training – such as observations and measurement of vital signs, catheterizations, dressings, and resuscitation measures, as well as critical thinking and independent problem-solving. Since LPNs may practice in a variety of settings or contexts, the curriculum includes a 4-month focus

on each of the following three components of the health care system:

1. Health promotion and illness prevention.
2. Gerontology.
3. Medical-surgical health.

The curriculum for Practical Nurses has advanced considerably in recent years. Since 1992, public educational institutions have offered a standard provincial curriculum and since 1998, the Provincial Practical Nursing Articulation Committee has met annually to discuss provincial curriculum and ensure that it continues to meet BC's changing health care needs.^{vii} In the 2000 Report, *Role and Utilization of LPNs and Care Aides in BC*, employers and faculty from public educational institutions expressed concern about the lack of supervised clinical learning experiences in these programs. The program now includes 605 hours of practicum and preceptorship experience in a variety of contexts including medical-surgical, pediatrics, obstetrics, gerontology, palliative and community care for residents across the lifespan with various health care needs.

BC offers LPN education programs through public educational institutions, as well as private educational institutions, with 6 of the 16 educational institutions being private.^{viii} As of 1996, all entry level education programs for LPNs must be approved by the CLPNBC

BC's 12-month program is shorter in length than other provinces. For example, the LPN program is 16 months in Manitoba, Saskatchewan and Nova Scotia and 2 years in Alberta, Ontario and New Brunswick.^{ix} Despite the shorter program, BC graduates had a higher pass rates for the national exam in 06/07 than the national average.^x

As the complexity of patient/resident care has increased, so has the demand to intensify areas of LPN continuing and post basic education. Educational institutions and employers have responded by offering additional courses, including foot care, palliative care, psychogeriatrics, and tracheostomy care, to name just a few.

Implementing steps to support increased utilization of LPNs across BC is seen as a critical part of the solution to the current nursing shortage. Some steps in supporting the enhanced utilization of LPNs have already been taken and include:

- 1. Funding LPN Upgrading:** From 2002 until 2007, the Nursing Directorate established the LPN Upgrade Fund. It provided funding for more than 100 LPNs per year to complete pharmacology and physical assessment modules that enable LPNs to practice at their full scope.^{xi}
- 2. Developing LPN Leaders:** In 2006/2007, coming out of the FBA joint policy committee discussions, the Nursing Directorate funded the LPN Leadership Program for 160 LPNs to take the *Fundamental Leadership Skills for Licensed Practical Nurses* course at Vancouver Community College (VCC).^{xii}
- 3. Operating Room LPNs:** In 2005 the Nursing Directorate funded a pilot project to provide post-basic training for LPNs to work in the operating room.

4. **Ongoing LPN Education:** Between 2006 and 2010, the BC Health Education Foundation has \$3.5 million dollars to be granted for LPN specialty and continuing education.^{xiii}

**Workforce
Size and
Distribution**

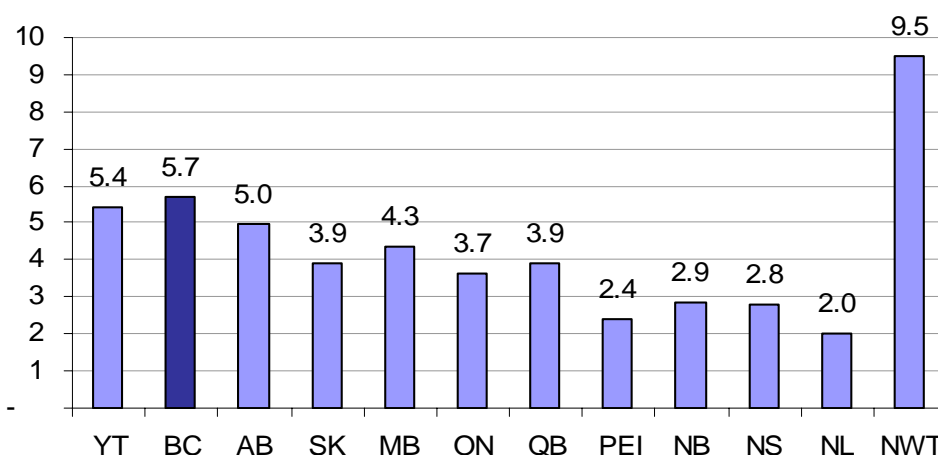
According to estimates from the Canadian Institute of Health Information (CIHI), there were 4,844 active practicing LPNs in BC in 2005. This figure, however, is lower than the total number of active LPN licenses and number of jobs held by LPNs.^{xiv} Table 1 compares figures from various sources.

Table 1: 2005 LPNs in BC

Source	Measure	Total
CIHI	Number of active, practicing LPN registrations received in first 6 months of 2005	4,884
Health Sector Compensation Information System (HSCIS)	Number of LPNs employed by health employers who are HEABC members received funding from MOH in 2005	5,278
CLPNBC	Total Number of Active Full LPN Licenses in 2005	5,590

Data from BC Stats Population Forecast^{xv} shows that there are about six times as many RNs as there are LPNs per 100,000 people in the BC population. Since 1998 the number of LPNs in comparison to RNs has increased so that ratio has changed from 6.4:1 in 1998 to 5.7:1 in 2005. However, the ratio of RNs per LPNs is still higher in BC than in most other provinces. The number of LPN graduates from BC educational programs has risen consistently in past years, from 247 in 2001 to 746 in 2006, representing a 202% increase.^{xvi}

Figure 1: Ratio of RNs per LPN by Province, 2005



Source: *CIHI Workforce Trends of Regulated Nurses in Canada, 2005*

As shown in Table 2, the majority of LPNs work within BC hospitals. Compared to 1998 more LPNs are being used in residential settings while the proportion of LPNs working in acute care has decreased. Today, at least one-third of LPNs work in residential settings.

Table 2: LPN Place of Work, 1998 to 2005

	1998	2002	2003	2004	2005
Hospital	70%	62% (2,639)	56% (2,460)	52% (2,520)	55% (2,667)
Nursing Home / Long Term Care	15%	27% (1,158)	32% (1,400)	35% (1,658)	34% (1,667)
Other Place of Work	15%	11% (465)	12% (531)	13% (633)	11% (550)

Sources: *Role and Utilization of LPNs and Care Aides in BC* (1998 figures only) and *CIHI Workforce Trends of Licensed Practical Nurses in Canada, 2002-2005*

In summary, LPNs are regulated health care professionals who provide nursing services to individuals, families and groups of all ages. LPNs are now, and have historically been, a necessary part of the health care workforce in BC's hospitals, long-term care facilities, and other organizations that provide health care services. As LPNs' scope of responsibilities has expanded so has demand for their services. Additionally, increased attention has been placed on optimally utilizing LPNs due to shortages of RNs and the expansion of LPNs into leadership roles in long-term care. Opportunities for the enhanced utilization of LPNs, is seen as a critical part of the solution to the current nursing shortage.

CHAPTER 2 THE CURRENT CARE AIDE WORKFORCE

Nature of Work

Care Aides are an important part of a health care team. In hospitals, residential care facilities, and other health care institutions. Care Aides provide patients/residents with assistance in activities of daily living, such as bathing, dressing and grooming. Care Aides provide basic patient/resident care, which includes answering patient/resident call signals and supplying and emptying bed pans. Sometimes they serve meal trays and assist patients/residents with meals. To help patients/residents recover, they lift, turn and position patients/residents, and may also supervise patient/residents' exercise routines. As directed by nursing staff, they take basic measurements, such as blood pressure, temperature and pulse. They collect specimens, such as urine, feces or sputum, administer suppositories, colonic irrigations and enemas, and perform other procedures. They transport patients/residents in wheelchairs or stretchers for treatment or surgery, carry messages, reports, requisitions and specimens from one department to another, and maintain an inventory of supplies. In acute care as well as in long term care settings, some Care Aides with training perform procedures, such as catheterization and sterile dressings, under the direction of a nurse.

Role in the Health Care Team

Care Aides, unlike nurses and allied health professionals, are not regulated under the *Health Professions Act of BC*. As such, Care Aides work under the supervision of a regulated health care professional, including nurses, physicians and other health care professionals.

History

Care Aides are now, and have historically been, a necessary part of the health care workforce in hospitals, long-term care facilities, and other organizations that provide health care. Although health support workers have been used in BC for more than a century, there is little in the literature about the introduction, practice, work, demand or efficient utilization of the Care Aide. Throughout Canada, there appears to have been an increase in the patient care roles of Care Aides in the 1980s.^{xvii} Care Aides were, and still are, employed mainly in residential care facilities, such as long term care facilities, extended care facilities, intermediate care facilities and community living settings for people with mental and/or physical disabilities. Traditionally Care Aides employed in hospitals were used mainly as porters and ward aides. However, with the current shortage of RNs and LPNs, there is now an increased interest in Care Aides fulfilling some patient/resident care roles in acute care hospitals.

Education

Care Aides were traditionally trained "on the job". Most Care Aides today have completed an educational institution program, about six months in duration, which includes training in personal care and support for seniors and other patients/residents in short-term hospital stays or long-term care. The certificate program for Care Aides, the Resident Care Attendant program, is offered by 10 publicly funded colleges and at least as many private training facilities in BC.^{xviii} Beginning in the 1990s, the public colleges and some private colleges have followed a provincial curriculum. The curriculum, designed as a combined Resident Care Aide and

Community Health Worker (e.g. Home Support Worker) credential, is currently 23 weeks in length.

In the late 1990s, the unions worked with educators to develop a bridging education program, the 'LPN Access' Program, which was developed to enable Care Aides to bridge into the LPN program with credit given for their previous education and experience.

A provincial Home Support/Resident Care Attendant Program Articulation Committee meets annually to discuss entry requirements, curriculum and student mobility between programs. This provides the essential link between autonomous institutions offering Home Support/Resident Care Attendant programs. In BC, oversight of private colleges is limited to a voluntary accreditation process by the Private Career Training Institutions Agency (PCTIA). PCTIA offers consumer protection but puts educators under no obligation to use provincial curriculums or maintain standards and consistency across programs, including standards for English proficiency as an admission requirement.

As previously noted, the Care Aide Competency Project that is currently being conducted by the Ministry of Health will describe competencies for Community Health Workers, Home Support Workers and Resident Care Aides in BC. A new curriculum and standards based on these competencies are currently under consideration.

Education programs for Care Aides are available through in-service workshops and educational college courses. While some resources exist, it is challenging at the local level to release Care Aides to take these courses. Additional opportunities for education have come into greater demand as Care Aides are:

- Taking on more personal care roles in acute care.
- Caring for patients/residents of an increasingly high acuity in every care setting.
- Required to use new technology.

Workforce Size and Distribution

As an unregulated health care workforce there is no single database providing information about the number of Care Aides in the province. Information about the size and employment characteristics of this workforce must be obtained from a variety of different sources. According to the 2001 census, there were 19,117 nurse aides in BC.^{xix} Today, it is estimated that there are between 19,000 and 21,000 Care Aides in BC. Approximately, 7 out of 10 of Care Aides in the province are captured in HSCIS as shown below in Table 3.

Table 3: Estimated Care Aides in BC, 2006

Source	Measure	Total
HSCIS	Number of Care Aides employed by health employers who are HEABC members and received funding from MOH in 2006/2007	13,536
BC Stats	Industry and Occupation Projections for Nurse Aides, Orderlies and Patient Service Associates 2006	18,590

While the HSCIS data does not account for every Care Aide in BC, it does indicate the care settings in which Care Aides are relied upon most. As shown in Table 4 below, nearly half of Care Aides are primarily employed in long-term care. However, the past few years have brought increased utilization in acute care settings with some employers and educational institutions providing education and training in acute care skills for Care Aides.

Table 4: Care Aides Place of Work, 2005 to 2007

Place of Work	2005/2006	2006/2007
Acute Care	29%	32%
Residential Care*	55%	54%
Mental Health	2%	2%
Other	14%	12%

*Residential care includes long-term, extended and privately-operated care.
Source: Health Sector Compensation Information System

In summary, Care Aides are an important part of the health care team in today's hospitals, residential care facilities, and other health care institutions. Care Aides provide patients/residents with assistance in activities of daily living and provide basic patient/resident care. Most Care Aides in BC are employed in residential care facilities; however the past few years have brought increased utilization in acute care settings. Based on the nursing shortage and the aging of the population, there is every indication that both the demand for care aides and their utilization in a broader range of settings will increase in the future.

CHAPTER 3 CHANGING SKILL MIX

Skill Mix Decision Making

Appropriate skill mix is an important component in providing quality health care. Effectively achieving appropriate skill mix can present some challenges. Practice leader interviews provided the following insights into some of the factors to be considered.

“Putting LPNs or Care Aides in a work environment where they haven’t traditionally been seen is a matter of organization and a system, unit or program being prepared to take that feeling of discomfort on and test it out.”

- Practice Leader

“There is not enough time spent upfront before changing the care delivery models or skills mix at sites. In health care, we tend to want to get on with things. There is more time trying to fix the resulting problems than pre-empting them by investing in appropriate change management and people development up front.”

- Senior Nurse Leader

“In part, [a review of staff mix] is financially driven; part of it is driven by a shortage of nurses, LPNs or RNs. We also look at it when we’re developing a new program. That is the best time to look at it because that allows us to look at what it is that the resident needs and who is the best health care provider to do that work.”

- Practice Leader

The Importance of Change Management

The implementation of a new skill mix can improve the utilization of Care Aides, LPNs, RPNs and RNs. New skill mix configurations can also result in changes for patient care delivery, staff satisfaction, workload, teamwork, communication within and between workgroups and education and professional development. Because of this multi-faceted impact, health care leaders and focus group participants agreed that a planned change management process is necessary to facilitate the effective implementation of new roles and/or changes in skill mix.

Practice Leaders pointed towards a project management approach as key to a successful change. Taking a structured approach sets the expectations for commitment from the Executive, site directors, managers, and staff. Without a project management approach, required skill mix changes may take a second priority to other initiatives directors and site managers are responsible for and/or may not be understood or supported by all of the affected staff.

As in the 2000 Report, this current Report also wishes to highlight the need for a planned change management process when new roles are being introduced or skill mix is being reconfigured. The planning process is very important for successful integration of new roles and/or a new staffing mix.

Participants in this Report were clear that change requires planning, time and energy and that the factors and challenges that were identified in the 2000 Report continue to be important considerations. Additionally, participants in this Report stressed the need for the leadership team to promote and sustain the changes, for effective communication to occur and for staff to provide input into strategies.

A useful outline of the factors and opportunities to consider is as follows:

- ✓ Use a change management process:
 - Develop a plan that includes key stakeholders and apply change theory
 - Examine successful models of change
 - Research different models of care delivery and choose what works best based on patients/residents needs, and staff and the unit/facility resources

- ✓ Assemble the leadership team:
 - Ensure support for the change from senior management and dedicated resources to lead the change management process
 - Develop a leadership structure focused on the change management process

- ✓ 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
 - Introduce LPN practice as independent and in collaborative partnership with RN
 - Consider the roles of other direct care and support staff in the team

- ✓ Communicate and encourage input from staff:
 - Develop tools and processes for communicating changes to staff at each stage of the process
 - Provide opportunities for staff to provide constructive input into the change process and throughout the project

- ✓ Support and evaluate change:
 - Develop guiding principles for the change management process and evaluate against them
 - Bring in resources as necessary, such as the joint presentation offered by the professional colleges

- Support groups through the transition with education and on-going support
 - Support the development of collaborative partnerships
 - Recreate teams and provide team building sessions
 - Evaluate change and outcomes
- ✓ Review decision making:
- Develop protocols for decision making about patient/resident care within the nursing team
 - Define who makes what decisions
- ✓ Set reasonable time limits:
- Don't proceed too quickly
 - Give adequate time for training, communication and support
-

The following case study provides an exemplary model for deploying a structured project management framework.

Case Study - A Systematic Approach to Skill Mix Changes at Vancouver Island Health

ABOUT THE SOUTH ISLAND - VICTORIA GENERAL HOSPITAL & ROYAL JUBILEE HOSPITALS

Vancouver Island Health (VIHA) serves approximately 700,000 residents (17% of BC's population) on Vancouver Island. The South Island comprises over half of VIHA's population and is home to VIHA's two tertiary care hospitals: Victoria General Hospital (VGH) and the Royal Jubilee Hospital (RJH). A network of services currently exists between RJH and VGH to provide medical and surgical services and significant sub-specialty care. This allows the two hospitals to operate as one tertiary facility.

THE CHALLENGE

VGH and RJH are the only two sites providing tertiary care services in VIHA. VIHA is facing the challenge of having to serve an increasing older population with higher nursing care needs while under ongoing financial and human resource constraints. The leadership of VIHA recognized the need to evaluate the current nursing strategy, capacity and care delivery model, in order to meet this challenge. A preliminary review revealed the need to change the model from a predominantly Registered Nurse (RN) model to a combined RN/Licensed Practical Nurse (LPN) model of care. The purpose of this new nursing approach was to maintain patient/resident centric care while promoting sustainability and appropriateness of services within VIHA's medicine program.

Royal Jubilee Hospital



THE STORY: HOW TO EFFECTIVELY INTRODUCE LPNs ONTO A MEDICAL INPATIENT UNIT

In 2005, VIHA's Director of Medicine introduced LPNs onto multiple medical inpatient units at RJH and VGH. In an environment where four out of seven medical units in the South Island were utilizing LPNs, the Director of Medicine sought out lessons learned from these sites to ensure that this implementation process was well-planned, well-executed, and in the best interest of patient care. The following steps illustrate the project management methodology VIHA chose to implement.

Step 1: Strategically Research and Assess Care delivery model

Victoria General Hospital



The Director of Medicine chose one of her patient care managers to act as Project Lead because of her recent experience in introducing LPNs to her service area and thus her ability to bring valuable lessons learned to the project. The Project Lead was asked to recommend the care delivery model for each of the three medical units that were undergoing change. Over the next eight months, the Project Lead conducted a literature review for information on:

- staff models;
- patient classification systems / patient acuity;
- nursing workload; and
- the interdependencies between these three factors.

The Project Lead's recommendations were guided by a 2004 internal report commissioned by the VIHA Chief Nursing Officer that examined Nursing Service Delivery in the South Island. The Project Lead also reviewed current activity data (available beds, average occupancy, patient acuity) and staffing data

(approved FTEs and nursing hours per patient day for each unit). Focus groups were conducted with staff from each of the three units involved in the project, as well as a group of float nurses who worked in all areas. The focus groups were intended to support the understanding of workload, patient acuity and complexity differences between the units.

The Project Lead was a member of the VIHA's Care Delivery Model Working Group mandated to investigate optimal care delivery models for VIHA's diverse care settings. This relationship allowed her to inform and be guided by other care delivery reviews occurring in the region. She shared her research findings and the Working Group, in turn, shared their research findings.

The Project Lead recommended staffing that was customized to the specialty, patient acuity and complexity for each of the three medical units. The recommended care delivery model was presented to and approved by the Director of Medicine in consultation with the Chief of Professional Practice and Nursing. The next steps were to plan the roll out of the new care delivery model in each medical inpatient unit.

Step 2: Build the Foundation by Creating an Effective Leadership Structure

Under the direction of the Director of Medicine (who served as the Project Sponsor), the Project Lead assembled a **Steering Committee** comprised of Managers, Professional Practice staff, and allied health professionals. A *Terms of Reference* was developed that clearly outlined the mandate and roles and responsibilities of the Steering Committee. The mandate of the Steering Committee was to plan, oversee, facilitate, and evaluate the implementation of a collaborative multidisciplinary practice model in the specified medical units. The Steering Committee outlined key deliverables, such as resource manuals, and oversaw plans for communication,

education, orientation, team development and evaluation.

The Director of Medicine, together with the Project Lead, hired a full-time Project Coordinator to manage the implementation processes required to change the care delivery model on the medical inpatient unit. The Project Coordinator was recruited from her role as a front line staff nurse. This allowed her to quickly establish a rapport with the nurses in her new role, understand points of resistance, identify needs for additional support and liaise with the Steering Committee. The full-time Project Coordinator was also responsible for reporting on progress with respect to the activities and milestones outlined in the project plan. After the intensive 6-month project planning period, the Project Coordinator's time commitment was reduced to 0.6 FTE.

Step 3: Intimately Understand the Current Situation by Engaging Staff

The first order of business for the Project Coordinator was to survey the staff for baseline data on their perceptions of the work environment prior to changing the care delivery model. Questions focused on workload, job satisfaction, utilization of skills, team functioning, knowledge of LPN competencies, and the current quality of patient/resident care. Staff were asked to comment on their overall satisfaction, concerns about the change, and perceptions about different levels of nursing. A one-page paper-based survey was circulated. The Project Coordinator personally spoke with staff to encourage them to complete the survey and to approach her with any questions or concerns.

The survey served a dual purpose: it elicited staff concerns and suggestions related to the change and provided baseline data for comparison post implementation. The results from the survey were used to customize communication and training strategies for the implementation phase.

Step 4: Communicate with the Team

Based on her previous project experience, the Project Lead knew strong leadership and effective communication were key to the successful introduction of LPNs. The Project Team endeavoured to engage staff through multiple channels:

- a) The Project Coordinator developed a **newsletter for staff**, the *Collaborative Chronicles*. This newsletter discussed issues related to the care delivery model at all stages of the implementation and was distributed to all staff in print. This monthly publication included frequently asked questions (FAQs) on the implementation of the new care delivery model, information on developing a collaborative practice environment, and RN responsibilities when assigning patients/residents to LPNs. Information in the newsletter was also discussed at staff meetings. Staff were provided with opportunities to submit questions or stories for the newsletter. This could be done either anonymously or directly to the Project Coordinator.
- b) Staff were made aware of how they could **raise issues** in Unit Council meetings or with their direct manager.
- c) Through regular **team meetings**, staff were encouraged to listen to each other's opinions and remained focused on patient centric care.

Step 5: Provide Thorough and Appropriate Training and Education Sessions

In preparing staff for the new care delivery model, a strong emphasis was placed on the Collaborative Practice Model. This model required a foundational understanding of LPN and RN standards and scope of practice, and the ways in which the two nursing roles could work together to complement each other's skills in the best interest of patient/resident care. The Project Team worked together to offer staff a range of learning opportunities.

Workshops facilitated by the College of RNs of BC (CRNBC) and the College of Licensed Practical Nurses of BC (CLPNBC)

were held with LPNs and RNs to promote respect and understanding of the respective roles and functions of each nursing body. The emphasis of the co-facilitated **workshops** was **on the Collaborative Practice Model for LPNs and RNs**. Additionally, RNs and LPNs from units who were successfully using the Collaborative Care Model were asked to speak with staff from units about to implement this change.

The Project Coordinator developed a series of **case studies** entitled, *If you were this nurse*, as a part of the training package. The case studies typically examined a patient/resident experience and provided the opportunity to engage staff in scenario planning from the perspective of the RN and the LPN. This allowed the staff to see how LPN and RN nursing team members can effectively contribute to patient/resident care following the assessment, planning, intervention, and evaluation aspects of RN and LPN scopes of practice. Staff used case study scenarios to understand the respective roles of LPNs and RNs during patient/resident hand-off.

The Project Lead had a **Competency, Assessment, Planning and Evaluation (CAPE) tool** for LPNs that was developed during the initial pilot of LPNs on her medical unit. This tool was made available to the Clinical Nurse Educators (CNEs) for customization to their unit's specialty and was subsequently adapted for use on two units preparing for implementation. The CAPE tool incorporated standards from the regulatory bodies, and provided a format that promoted reflection, self-assessment and self-directed learning at a practical level.¹ The CAPE tool was used for all new LPNs and RNs hired for the unit as part of their orientation and as a post-orientation

guide for evaluation of their developing competency. The Project Coordinator also developed a document that outlined differences between RN and LPN scopes of practice. For new LPNs and RNs, this helped to clarify what they could and could not do within their scope of practice on a particular medical unit. The decision support tool rounded out the information available to support staff in this new collaborative practice environment.

The CNEs and Clinical Nurse Leaders were given additional information and education by the Project Coordinator on: 1) LPN and RN scope of practice for appropriate patient/resident assignments and 2) collaborative practice.

VIHA's Learning and Development Department provided teambuilding sessions for all staff to facilitate effective working relationships and support collaborative practice.

A **Unit Council** was developed on each unit as a subgroup of interested LPNs and RNs. This was intended to problem solve issues and create a knowledge capacity on site. The LPNs and RNs were paid for their time. On one unit, after the implementation was complete, the Unit Council merged with the existing Nursing Practice Committee that then included LPNs in its membership. On another unit, the Unit Council continued in its original form.

Step 6: Enhanced Orientation

The introduction of LPNs onto the floor was gradual and supported by what the Project Team referred to as "enhanced orientation". Most orientations include a limited amount of buddying or shadowing of a more experienced care provider. In comparison, the enhanced orientation included:

- **Structure:** The CNE developed an LPN-specific orientation plan with clear outcomes and timelines. It focused on elements for full scope of practice LPNs as well as skill and knowledge development in the clinical specialty area.

¹ Van Stolk, Dori. (2006). *A "Grounded Theory" Approach Cultivating the Site for IPE & Collaborative Practice*. Retrieved from: <http://www.in-bc.ca/docs/forum06/DoriVanStolk.ppt>² The Canadian Nurses Association. (2005). *Evaluation Framework to Determine the Impact of Nursing Staff Mix Decisions*. Retrieved from: http://www.cna-nurses.ca/CNA/documents/pdf/publications/Evaluation_Framework_2005_e.pdf

- **Specialty focus:** The involvement of the CNE ensured that the content of the training was customized to the unit.
- **More time:** LPNs received four, 7.5-hour classroom days (35 hours total) with the CNE. Each LPN also worked four buddy shifts with an RN. This shadowing period could be extended depending on the comfort level of both the LPN and RN. After the implementation of LPNs on the unit, new LPN hires would be partnered with an LPN with experience working on that unit.
- **Checkpoints:** On one unit the CNE instituted 'boot camps'. Through observation and interaction with the new LPNs, the CNE identified learning needs and then offered focused sessions on particular areas of practice (e.g. monitoring IV). These "boot camps" were offered on an ad hoc basis or were planned as two-hour drop-in sessions over several days. Staff could attend for as long as they needed or were able. Oral quizzes were used by the CNE to promote learning. In most instances, on-duty staff attended these learning sessions. For a period of weeks following rollout, the CNE, Clinical Nurse Leader, and Project Coordinator continued to monitor learning needs and find ways to meet these needs.
- For example, the ongoing monitoring led the Project Coordinator to recommend more training on formal LPN/RN reporting and communication. After one month, the LPNs were practicing to their scope on the unit. LPNs were given specific patient assignments during their shifts and were given the authority and responsibility to care for patients according to their scope as outlined by the CLPNBC. During implementation, a representative from an LPN training institution was invited to join the Steering Committee to understand the additional learning requirements that could be integrated in LPN training programs.

Step 7: Evaluate Progress

An evaluation framework was created at the onset of the implementation plan.² The summative evaluation framework was developed to measure the following outcomes over the long term:

- Patient/resident outcomes and quality of care.
- Sustainability.
- Appropriateness.
- Staff Satisfaction and quality of work life.
- Implementation.

Measures and reports around these indicators are being developed at this time.

Step 8: Sustain the Change

The Project Coordinator recognized early on that implementing a new care delivery model within a complex care setting can be challenging enough but sustainability is an even greater challenge. In order to achieve this, the Project Team focused on maintaining the project structure and resources after LPNs had been introduced onto the unit.

1. The Project Coordinator was retained for four to five months following rollout to:
 - Provide ongoing coaching at the bedside.
 - Address emerging issues.
 - Develop/modify tools, as required.
 - Support the evaluation process.
2. After this period, the Project Coordinator handed over the ongoing advancement of tools, such as decision-support tools for patient assignment and guidelines on the LPN and RN scope of practice, to the CNE.
3. The Project Coordinator handed over responsibility to monitor the adoption of practice changes, realize project objectives and coach staff to a dedicated Clinical Nurse Leader, CNE and/or Unit Manager.
4. Unit Councils continued to meet indefinitely and advance tools and strategies for staff.

SUMMARY

In December 2005, only three of the seven medical units in the South Island were utilizing LPNs. One year later, after effectively introducing LPNs at VGH and RJH and transferring the best practices, six of the seven medical units across the South Island are utilizing LPNs. Implementation on the last of the seven medical units has been postponed pending resolution of pre-existing operational challenges.

Implementing a new care delivery model is a challenging process. The steps taken by VIHA provide insight into how to introduce LPNs onto a medical inpatient unit. The same principles and processes can be applied when implementing a change in care delivery model to any unit. Careful planning with direction and input from the right people provides the foundation for a successful implementation. Although staff resistance to the project was relatively average, the Project Team had hoped their communication and orientation efforts would have produced greater staff engagement on some units. In an era where many health care staff experience change overload, it is ideal to schedule projects at a time that does not coincide with other major operational or organizational change initiatives. This is rarely feasible, however, in today's ever changing health care environment Sites undertaking a change in care delivery models are advised not to underestimate the difficulty in successfully engaging staff.

CRITICAL SUCCESS FACTORS

1. Use an effective leadership structure with executive sponsorship, a Project Coordinator, and an engaged interdisciplinary Steering Committee to provide overall advice and direction.
2. Apply a project management structure to the implementation process.
3. Develop an implementation framework and tools that can be modified to suit a variety of care settings.
4. Where possible, second a well respected nursing team member to lead the process. Ensure the Project Coordinator role is filled for the duration of the project.
5. Engage staff by providing meaningful opportunities for input and listening to staff feedback.
6. Use simple and effective communication tools and continuously evaluate and improve communication tools and methods.
7. Provide training opportunities for staff. Schedule the training at times where the most staff can attend. Offer multiple training sessions. Pay staff to attend the training.
8. Develop a sustainability plan that includes comprehensive orientation for new staff joining the care team.
9. Develop a long-term outcome focused evaluation plan to guide the formal review upon project completion.

ACKNOWLEDGEMENT

Thank you to Anne Gloster, Manager, Renal Services, for her insightful contributions that guided this case study.

PERMISSION

This case study has been written with permission from Vancouver Island Health.

The VIHA case study itself identifies critical success factors which made that initiative successful and provides useful guidance to others who are embarking on a change management process. Additionally, there are steps within the different phases of the project management process that may improve the effectiveness of the overall process.

The project management process can be divided into the following four phases:

- ◆ Project Initiation
- ◆ Project Planning
- ◆ Project Execution
- ◆ Project Evaluation

Some specific steps to consider in the phases are as follows:

Phase I: Project Initiation Phase

- Prepare a workplan detailing the project management, education, and evaluation resources required as well as milestones/timelines and target outcomes of the project. Resources may include:
 - Project coordinator
 - Project manager
 - Clinical Nurse Educator
 - Support from Communications department
 - Support from Human Resources department
 - Support from Organizational Development department
- Obtain Executive sign off on the workplan and commitment to providing the needed resources.

Phase II: Project Planning Phase

- Consult with Organizational Development team within the organization to develop a vision in support of the change and to determine required staff change-readiness efforts.
- Link with union representative(s).
- Designate a project manager.
 - Collect baseline data that are appropriate to the project scope and breadth, such as patient/resident outcomes, staff satisfaction, metrics such as amount of overtime, sick time usage, etc.
- Present vision for change to staff, the “what’s in it for me” for staff and commitment to supporting staff throughout the change.
- Open up two-way dialogue to determine staff concerns.
- Identify formal and informal leaders at all levels that are respected by frontline staff. Involve leaders in disseminating project goals and objectives and encouraging staff adoption.
- Involve frontline staff in developing roles and responsibilities and departmental policies and unit routines.
- Involve the professional practice office, education services, Clinical Nurse Educators as needed regarding appropriate assessment, education and training for each work group.

Phase III: Project Execution

- Ensure team-building and education/training support such as:
 - Creation of mentor-mentee pairs,
 - Organization of team building sessions,
 - Provision of training during work schedules,
 - Provision of session(s) on effective communication.

Phase IV: Project Evaluation

- Collect and compare data with pre-implementation data.
- Present project successes and areas for improvement to all levels of staff who were involved in the project and to the Executive team.
- Continue two-way dialogue with staff as a regular on-going expectation.

CHAPTER 4 CHALLENGES & OPPORTUNITIES

The key informant interviews with managers and focus group discussions with LPNs and Care Aides yielded a great deal of information about scope of practice issues, relationships with their own and other occupational groups, and the importance of education and training. Further interviews, focusing on Promising Practices and case studies, provided additional information on ways to address some of the challenges and opportunities identified by both management and front line staff.

LPNs

Challenges and opportunities for effective utilization of LPNs are presented under the following four headings:

1. Historical perceptions.
2. Shared skill sets between RNs and LPNs.
3. Training and education.
4. Rewards of the job.

Historical Perceptions

Challenges

Perceptions about Supervision

One of the themes that emerged from the LPN focus groups was that a perception still exists in some worksites that LPNs are auxiliary or supporting workers, rather than professional nurses.

This was illustrated by LPNs providing examples involving patient/resident observations. Even in circumstances where LPNs were qualified to conduct start of shift patient/resident assessments they reported that they are not always performing this function and that there are often significant differences from unit to unit even within the same facility.

Additionally, LPNs also identified that the apparent “contradiction” of working under the direction of an RN, while at the same time having their own professional scope, created difficulties for them in how their professional practice was viewed. A theme that emerged from the LPN focus groups was that they

“The biggest thing is respect. [We] want to feel respected for what we do, the knowledge we have, for the ability to deliver quality care, ...”

- Female LPN Leader from an Urban, Acute/Long Term Care Setting

“I would like more autonomy. I am regularly overruled in my clinical judgments within my scope of practice.”

- Male LPN Leader from a Rural, Long Term Care Setting

were continuously faced with the challenge of having to assert their skills and abilities.

LPNs Depicted as the Cost-Effective Solution

Another theme that arose from interviews with Practice Leaders and LPN focus groups was a view that the messaging that accompanies a change in skill mix is a critical element in subsequent relationships between RNs and LPNs. At sites where the increase of LPNs was positioned in economic terms or where cost savings were emphasized, rather than in terms of the skills LPNs bring to the team, LPNs felt that they were considered the 'cheaper labour' – both by the LPNs themselves and the RNs they worked with.

Participants also identified that this type of messaging may present the dual problem of devaluing LPNs' contributions to a team and giving rise to RNs' concern that they could be replaced by LPNs as a "less expensive" nurse resource. Participants identified that a challenge for health care leaders is not only to allocate nursing resources to best support patient/resident outcomes within a fixed and limited budget, but also to include effective communication about the decision in the change management process to promote good working relationships between LPNs and RNs.

LPNs Lack Profile among Nursing Professionals

LPN participants reported inconsistencies across health care sites, and even within the same site, with respect to how well they are profiled as a member of the nursing team and concerning their role in patient/resident care. LPNs felt that they are less frequently recognized for their contributions to patient/resident care and often find the recognition going to the RNs. LPNs also expressed disappointment about the extent of provincial recruitment and retention efforts that were directed towards their profession. Overall, a theme of the LPN focus groups was that they lacked profile among nursing professionals and they see the consequences of that as providing them with a limited role in patient/resident care planning and a perpetuation of a culture where they feel lack of respect and poor recognition of their role.

"There has to be a whole culture change at work. We aren't always referred to as nurses. For example, an announcement will be 'LPNs and RNs, your medications are ready for pick up.' I don't know why they can't just call us 'nurses'."

- Female LPN from a Long-Term Care Setting

"I do not want to have to explain on a daily basis what I can do as an LPN and constantly state 'I am a nurse.'"

- LPN Leader from an Urban Acute Care Setting

Opportunities

Reinforce LPNs' Professional Accountabilities

As with all regulated health care professionals, LPNs are accountable to their regulatory College to work within their scope of practice and their employers' policies and procedures. In particular, the CLPNBC formed a partnership with the College of Registered Nurses of BC (CRNBC) to co-facilitate workshops that build LPN and RN collaborative practice. The workshop begins with the reminder that RNs and LPNs are both part of the nursing profession and accountable to their respective regulatory bodies. Participants suggested that as health employers hire and orientate new nurses (RNs, RPNs and LPNs) it is important to communicate that LPNs are professionals with specific professional accountabilities.

"In long-term care, LPNs can be the team-leaders. Free up the RNs. Let the LPNs refresh their skills and address the RN shortage..."

- Female LPN Leader
from an Urban,
Acute/Long Term
Care Setting

Position LPNs as the Skill-Appropriate Decision

Participants felt that many of the strained relationships between LPNs and RNs developed or intensified during the implementation of new skill mixes where LPNs are utilized to a greater extent. To assist in preventing this, participants suggested that the skill mix change should be respectfully constructed to convey the employer's continued commitment to providing safe and effective care and articulating that the purpose of the change is having the right health care provider fill the right role.

"We have nurse councils at our hospital and we are valued."

- Female LPN Leader
from a Rural, Acute
Care Setting

Encourage LPNs to Develop and Demonstrate their Critical Thinking and Leadership Skills

Many opportunities exist to demonstrate that LPNs are capable of caring for patients/residents within their scope of practice.

- When asked how LPNs themselves can affect change, Practice Leaders and LPN focus group participants suggested becoming involved in Practice Councils. This experience helps LPNs understand how to influence change but also allows LPNs to showcase their critical thinking and problem solving abilities.
- Safety Huddles and Care Team meetings were another method identified to provide an excellent mechanism for LPNs to demonstrate their critical thinking skills as they bring up patient/resident issues and discuss ways to improve care. Participants felt that when RNs have the first hand experience of seeing and hearing how LPNs problem solve, their perception of LPN competence can dramatically increase.
- The Situation-Background-Assessment-Recommendation (SBAR) is one communication technique that helps LPNs (as well as other health

"Join some of the committees then you will learn more about how things run."

- LPN from an Urban
Care Setting

"[If I was an LPN], I would make sure I could go to staff meetings or local councils and try to be an active participant in those meetings."

- Practice Leader

care providers) assert their professional body of knowledge when communicating with other health care professionals. As noted in the Introduction, a “Let’s Talk” handbook with strategies to help managers reinforce the use of effective communication techniques is being developed by the FBA Joint Policy Committee and will be available to nursing managers and staff across BC.

An LPN Pioneers Clinical Guidelines for Her Peers

A Promising Practice from Fraser Health

Anita Dickson, an LPN at the Royal Columbian Hospital (RCH), developed a Practice Council that advocates for, supports, educates and mentors LPNs. In her role as an Emergency Department nurse, Ms. Dickson also recognized the lack of resources to enable nurses to interpret lab results. Accurate and timely interpretation of results can make a significant impact on patient/resident care planning, especially for patients in the acute setting. Ms. Dickson recognized the value of nurses being able to effectively interpret lab results in order to notify physicians of patients requiring urgent attention. With this realization and the encouragement of Fraser Health’s leadership and management, Ms. Dickson proceeded to develop a resource guide that would meet this need. She single-handedly conducted the necessary research and sought physician review and support. The guide is now being used to teach nurses across the health authority about lab values. In the development of this resource guide, Ms. Dickson made inroads to enhance respectful communication between nurses and physicians. Not only did this LPN display exemplary leadership in taking the initiative to develop a resource guide, she also boosted the LPN profile by showing leadership in research and patient/resident care. The need for this resource is supported by comments from several Practice Leaders who expressed concerns that LPNs do not always know how to appropriately interpret lab results and are apt to call upon RNs or physicians too frequently to discuss ‘normal’ results. Sites outside Fraser Health have requested a copy of the Lab Value resource guide. In recognition for her dedication, Ms. Dickson was awarded the inaugural HEABC’s Health care Hero award and Fraser Health’s Above and Beyond award in 2007.

Recognize and Build LPN Leadership Roles

Opportunities exist at the health employer level to increase the profile of LPNs by inviting them to sit on Practice Councils of all levels. LPNs can take the knowledge gained at the Practice Councils back to the site level and share information with the entire care team. Not only do Practice Councils promote learning together and collaborative practice but they also develop LPN leaders. It should be noted that several health employers have developed LPN Practice Councils, but opportunities still exist to bring RNs and LPNs together under a common Practice Council to increase the profile of LPNs in decision making. Another opportunity that exists is for health employers to seek input from and profile LPN leaders

Other opportunities include LPNs taking a leadership role in education for LPNs and other care team members, LPN participation in nursing-related activities (e.g. nursing week celebrations), profiling LPNs in and encouraging LPN contributions to newsletters and health care focused publications, as well as supporting professional development, networking and conference opportunities for LPNs. Additionally, LPNs are now working as team leaders in many residential care facilities and, along with others in leadership roles, can benefit from education and support related to that role.

Introducing LPNs as Integral Contributors to Unit Operations

A Promising Practice from Vancouver Island Health

To support the introduction of LPNs to a medical inpatient unit, VIHA's Directors of Patient Care assembled a subgroup of interested LPNs and RNs from the unit to problem solve issues. This group was called a Unit Council. The LPNs and RNs were paid for their time to participate. After the implementation was complete, the Unit Council merged with the Nursing Practice Council that expanded to include LPNs in its membership. In this unit, where many of the RNs had not worked with LPNs before, the forum allowed LPNs to demonstrate their professional knowledge and problem-solving skills.

To learn more about the implementation of a new skill mix at Victoria General and Royal Jubilee Hospitals, please read [*A Systematic Approach to Skill Mix Changes at the Vancouver Island Health Authority.*](#)

The following case study from Kootenay Boundary Regional Hospital reviews strategies developed in one hospital to ensure a more collaborative work environment, improve patient care, and overcome negative communication patterns among staff and between staff and management.

Case Study - Letting Off Steam: How Kootenay Boundary Regional Hospital is Transforming Frustration into Empowerment

ABOUT THE KOOTENAY REGIONAL BOUNDARY HOSPITAL (KBRH)

Interior Health was formed in December 2001 when 19 former health employers serving the interior of British Columbia were merged into a single entity. Interior Health serves just over 15 percent of the province's population, including a large percentage that resides in rural and remote areas. In 2003, Trail's hospital became the regional hospital for the Kootenay Boundary health service area of Interior Health. Renamed Kootenay Boundary Regional Hospital (KBRH), it is now one of six regional hospitals operating in Interior Health's network of health care facilities. KBRH is a 75-bed facility that provides acute care for a population of more than 80,000.

REGIONALIZATION OF CARE

The regionalization of health services in the Kootenay Boundary brought with it benefits and challenges. There was significant restructuring, including displacements for some hospital employees. While people in rural and remote communities must travel to Trail for specialized acute services, there are many benefits. KBRH now provides more comprehensive services than the previous collection of small community hospitals. Today, KBRH provides 50 medical/surgical beds, 6 intensive care beds, 12 psychiatric beds, 4 pediatric beds, and 3 maternity beds.

A STIMULOUS FOR CHANGE

In 2006, Interior Health engaged in a review process that provided both specific and general recommendations for KBRH. The review process recognized the importance and role of workplace culture, including calling for support for a "culture of compassion" and empowerment for better decision-making.

WORKING RELATIONSHIPS

Similar to other facilities across BC and Canada, KBRH has challenges recruiting and retaining nurses. Some units use a staffing mix of Licensed Practical Nurses and Registered Nurses and, if there is an inability to meet the planned RN staffing level, an LPN may be utilized.

The RN Perspective

A medical-surgical RN at KBRH pointed out that she and other RNs had perceived a gradual replacement of RNs with LPNs in the community setting. In the acute setting, RNs had a heightened sensitivity to day-to-day decisions that hinted at future displacement. For example, tensions between LPNs and RNs may have run higher when a unit manager relied on an LPN to manage patients/residents rather than calling in additional RNs. While this trend was part of a change across the province and Interior Health to bring LPNs into their full scope of practice and utilize RNs' expertise to direct care, KBRH RNs were vocal in expressing their concerns. The increasing use of LPNs – and Care Aides - fed a growing tension between RNs and LPNs at KBRH.

Fear of displacement caused some RNs to assume a defensive position with respect to the utilization of LPNs. Some RNs held the perspective that, although LPNs had the technical skills for most care scenarios, LPNs did not have the training to make appropriate, complex clinical decisions. Some RNs also expressed concerns that expanding the scope of LPNs would put patients at risk. It was stated that RNs teaching and supervising LPNs were additional responsibilities on top of an already heavy workload.

The LPN Perspective

Interior Health was supportive of LPNs' desire to practice to the full scope of their training. The Chief Nursing Officer (CNO) developed a guide for Interior Health's site managers to change their staffing mix to accomplish this goal. However, despite initiatives to advance their utilization at KBRH, some LPNs stated they felt unsupported at a local level. LPNs felt they had to continually justify their skills, abilities and role in the health care team. They were contending with strained relationships and compromised communication with RNs on a day-to-day basis. Some LPNs expressed concerns that they were taking on increasing responsibilities without adequate training and supportive mentoring.

IMPROVING WORKPLACE CULTURE

Changing the workplace culture at KBRH was and continues to be a challenge. KBRH staff have experienced significant change. Many staff negatively viewed the changes of the past years, including the regionalization of care, which they feel is the result of top-down decision-making. On a day-to-day basis, KBRH's frontline staff was struggling with workload and felt they were constantly under-resourced. When smaller subsequent changes were made with what some staff deemed inadequate consultation or communication, it confirmed an "us and them" view of management and the belief that their perspectives didn't count.

Cultural change involves shifting the basic values and norms among members of the organization in order to improve organizational performance. Management cannot deliver quality care; it has to come from the front line. A top-down, management-led approach would not work. Yet KBRH staff, especially those at the frontline, had little experience in participating in and leading change. For years, staff felt that there was a lack of two-way communication and consultation before implementing change.³

When Interior Health's Organization Development (OD) Consultant was asked by Interior Health's executive to help improve work environments within KBRH, he knew he had to help create an environment where different perspectives could be articulated and new possibilities created. At the same time, it would be critical that front line staff be engaged in the process in order to build trust in this change initiative. In other words, it was time for staff, physicians and managers to tell their story. With executive support, the OD Consultant and a team of formal and informal leaders at KBRH carefully designed a series of exercises to elicit stories that would shed light on the workplace culture at KBRH. The team spent months working with staff to collect nearly 400 narratives where each participant analyzed their own stories. Unexpectedly for some staff, the body of stories revealed a significant number of staff-versus-staff themes in addition to staff-versus-management themes. All stakeholder groups spoke of not being heard and respected, and some spoke of loud, impolite, rude and even abusive behaviour from fellow staff. This realization gave staff an internal locus of control – the belief that the culture at KBRH was a product of their personal efforts and actions.

³ Canadian Council on Health Services Accreditation. (October 2004). Accreditation Survey Report. <http://www.interiorhealth.ca/NR/rdonlyres/529F3564-5943-4D41-BA5F-7FFDD75A37D3/2004/AccreditationSurveyReport2004.pdf>

EMPOWERING CHANGE

At KBRH, executive level support for this cultural change initiative was in place. The executive committed OD resources to this purpose. However, cultural change required active participation from the frontline and KBRH staff was immobilized by a culture of blame and compromised working relationships. To develop a sense of empowerment in changing this workplace culture, mixed teams of physicians, managers and staff participated in a "Sense-Making Workshop." Among the notable initiatives emerging from this workshop were the following:

1) A PDSA Approach to a Healthy Workplace

Following the Sense-Making Workshop, which utilized the familiar Plan-Do-Study-Act (PDSA) model, the Healthy Workplace Collaborative – a committee comprised of staff, physicians and managers dedicated to fostering a healthy workplace - was developed. Some of their work included assessing current workplace relationships at KBRH, delivering communications and leadership training, and facilitating the decision-making process.

The OD Consultant and his team also used a more in-depth, qualitative approach to taking stock of the workplace culture at KBRH. Throughout Interior Health, the 'act' component of the PDSA cycle included a Respectful Workplace Policy, increased administrative consultation with frontline staff, and the creation of opportunities for interdisciplinary collaboration. The group is also currently revising KBRH's Code of Conduct. The Code of Conduct will be made visible so all patients, visitors and staff that enters the KBRH facility will be aware of their obligation to communicate with others in a respectful manner. For continuous improvement, the Collaborative intends to compare progress against the 2006 baseline.

2) Leadership Training

Interior Health's Organization Learning & Development Team, the Professional Practice Office and the Healthy Workplace Collaborative worked together to develop and deliver the "Leader Within" program to 325 front line staff and managers. This 2-day course was aimed at bolstering staff's internal locus of control. Whereas many organizations offer management training to formal leaders, Interior Health's leadership demonstrated its commitment to organizational change by offering the "Leader Within" program to all levels of staff at Interior Health. The program developed participants' self-awareness by encouraging them to take inventory of their personal values and then understand how these values influence behaviour and decision-making at work, at home and in the community. The curriculum also provided communication methods for influencing change regardless of the participant's level within the organization. Decision-making tools in a team setting were also learned and practiced. For KBRH staff that participated, this training reinforced the sense that they could have an impact on the culture of their facility.

3) A Communications Committee

The Healthy Workplace Collaborative at KBRH was formed from the action plans developed at the Sense-Making Workshop and played a major role in responding to the communication challenges identified in the internal and external reports. The team is now focused on creating strong communication protocols for handoff and patient transfer points.

4) Professional Practice Council

Over the past few years, many health employers have initiated Practice Councils at the site level and the regional level. Some were motivated by evidence that professional practice councils support organizational empowerment of nurses and the creation of effective work teams.⁴

⁴ Laschinger HKS, Havens DS. (1996.) Staff Nurse Work Empowerment and Perceived Control over

At KBRH, an Inter-Professional Practice Committee (IPPC) was developed. The committee is inclusive of RNs, LPNs, physicians and other allied health professionals. The structured forum provided by the IPPC enables the inclusion of various clinical perspectives in the development and revision of hospital policies, directions and decisions. The IPPC has already facilitated staff contributions to the revision of the discharge policies. The new discharge protocol will include processes to improve communication between LPNs and RNs. The IPPC has also benefited from frontline perspectives as to how KBRH can become a more elder-friendly facility.

KEY LESSONS LEARNED

While these initiatives have motivated participants to improve workplace relationships and communication, some key lessons learned have been identified.

One key lesson learned is that orientation is the foundation for healthy workplace relationships. At KBRH, RNs struggle with the feeling that they are being displaced by LPNs. This sentiment is a result of informal communication between members of a professional group rather than formal messaging from the health authority. A common orientation for LPNs and RNs is a valuable opportunity to formally establish the unique roles of each level of nursing and the respective value to the organization. It is also the ideal forum to affirm the professionalism of LPNs and the accountability of LPNs and RNs to their respective regulatory bodies. Lastly, orientation provides the first opportunity to build habits in respectful and effective communication.

Another key lesson is executive commitment to participate in cultural transformation. Besides executive endorsement of empowerment initiatives, these initiatives require an ongoing

commitment from the executive to participate in a new culture of open communication. Sustainability of empowerment initiatives rests on the ability of newly empowered staff to make a perceptible impact. To sustain staff empowerment, the executive should find opportunities to meaningfully engage staff in solving issues and developing innovative approaches that improve both patient care and their workplace environment.

APPLICATION

There are many warning signs that a team may not be working well. These include instances where:

- Arguments occur at team meetings, and are not resolved
- Team performance drops off for no obvious reasons
- Team members are more reluctant to support/assist each other
- There is an increased dissatisfaction with decisions made by leaders or administrators
- Small groups develop with their own agendas and begin to function autonomously within the unit
- Team members are unclear about their roles or role boundaries⁵

If these symptoms arise, staff may need help realizing that they are part of the problem as well as part of the solution. Clearing the air and allowing staff to express their frustrations is an important first step. In the KBRH case study, the revelations from the storytelling exercise allowed staff, administration and physicians to reflect on their role in KBRH's workplace as well as the role of their colleagues. This has restored a sense of self-efficacy in being able to effect change.

Nursing Practice: Conditions for Work Effectiveness. *Journal of Nursing Administration*. 26(9):27-35.

⁵ Ontario Ministry of Health and Long Term Care. Guide to Collaborative Team Practice. http://www.health.gov.on.ca/transformation/fht/guides/fht_collab_team.pdf

CRITICAL SUCCESS FACTORS

The case imparts several critical success factors for other sites wishing to engage staff and include staff perspectives and insights into the decision-making process. The culture of a health care facility is an outcome of the behaviours and attitudes of all who work within the facility. Consequently, when the culture requires improvement or change, all of the

members of that culture have a role to play. Culture cannot be “fixed” by one specific group within that culture; it is a collective process.

PERMISSION

This case study has been written with permission from Interior Health.

Shared Skill Sets between RNs and LPNs

Challenges

Lack of Role Clarity between RNs and LPNs

LPNs, RPNs and RNs share some overlapping practice activities and nursing responsibilities and the similarities and differences between these activities and responsibilities is not always understood or clearly articulated. Participants felt that this lack of clarity contributed to role confusion and tension in working relationships and clarity could positively impact the quality of patient/resident care.

Ineffective Communication Habits Hinder Effective Collaboration

While communication is an important aspect of any team relationship, it is particularly important when providing patient/resident care. Nurses are expected to consult with others when any situation is beyond their competence. Specifically, when patient/resident complexity increases, LPNs need additional support from other health care professionals and do not work in isolation.^{xx} This support may involve:

1. Increased consultation with the RN/RPN.
2. Sharing part of the patient/resident assignment with the RN/RPN.
3. The RN/RPN taking the lead role or taking full responsibility for care of the patient/resident whose needs can be met only by the RN/RPN.

In the focus groups, LPNs reported not feeling heard or respected for their opinions and found it challenging to hand off patients/residents to RNs once they felt they had reached their scope of practice. The RNs’

“You can take well-trained, highly motivated great people and put them into a lousy system and the system will win every time. The problems come from poor systems . . . not bad people.”

- CRNBC and CLPNBC Collaborative Practice Presentation

“It’s us and them (RNs) right now, and it’s awful. Who wants to work like that? We are all supposed to be on the same team.”

- Female LPN from a Long-Term Care Setting

responses were sometimes perceived as dismissive by LPNs who also felt that the RN's perception was that LPNs are incapable of a care task or that the RN has to step in as a 'supervisor' to solve the LPN's "problem". Practice Leaders, in turn, noted that LPNs did not consistently request support in a manner that conveyed their professional body of knowledge.

Focus on Professional Differences takes away from Patient/Resident Care

Participants noted that in a demanding patient/resident care environment RNs, LPNs and care aides can become consumed by their own responsibilities, tasks and stress and team members may identify more with their occupational group than with their care team. They identified that one of the consequences may be a breakdown in communication between team members which could affect patient/resident care.

Opportunities

Clarify Roles and Responsibilities between RNs and LPNs

Roles and responsibilities of all team members need to be understood by all other team members at the site level. It is particularly important that potential areas of overlap related to shared competencies of different team members be identified. This needs to occur before starting any new initiative or when integrating a new staff member.

Role clarity also needs to be reviewed regularly as projects advance, to ensure all care providers are aware of their respective roles. Team members need to know to whom they are accountable and for what, and their training, confidence, and competencies need to be appropriate for the tasks assigned or assumed.

Participants suggested the use of orientations and established communication channels to provide opportunities for Executives, managers and staff to learn about the roles and competencies of the different nursing groups

The Practice Leaders and LPN focus group participants revealed that some BC health employers have supported collaborative practice workshops and team building exercises for staff. These sessions tend to be most effective with:

- Executive and leadership support.
- Paid time to attend.

"I think the most important thing that we could do [to improve working relationships between RNs and LPNs] is get to some clarity about how those roles all work together and what they contribute." - Chief Nursing Officer

"One of the biggest things that we had to negotiate [with the RNs] was the relationship [with LPNs], so that no one looked at [LPNs] as a lesser team member or someone that RNs could dump on. We're constantly vigilant about that." - Practice Leader

"We held sessions with all staff [RNs, LPNs, and Care Aides] to clarify their roles and define accountability and

- Well-respected leaders facilitating the workshops who treat staff respectfully and prepare materials appropriate to staff needs.
- Relevant case studies used to supplement the illustration of collaborative practice.

responsibility. We worked through sample case studies with the staff and have set the expectation that all staff need to work together [to achieve the best care for patients]."

- Practice Leader

Developing Distinct Roles and Responsibilities *A Promising Practice from Fraser Health*

When representatives from the CLPNBC and CRNBC co-facilitate workshops on the LPN and RN scopes of practice, they emphasize collaboration as "a joint communication and decision-making process with the expressed goal of working together toward identified health outcomes while respecting the unique qualities and abilities of each member of the group". Sites themselves must carry on this work.

For example, the Royal Columbian Hospital worked with the CLPNBC and CRNBC's scope of practice documents, alongside the health authority job descriptions to develop shift routine documents that detail the responsibilities of the LPN and RN (and where applicable, the Care Aide) during a shift. Clinical competencies, also from the CRNBC and CLPNBC scope of practice documents, are reviewed with each new staff member upon orientation and their progress is noted during performance evaluations. This practice allows the leader to spend time one-to-one with each staff person upon orientation, thereby demonstrating leadership commitment to the individual's professional success and collaborative practice within the work area.

"I think [teams] work well in an environment where [team members] respect the work that each person brings to the team, the skill and expertise."

- Practice Leader

Reinforce Effective Communication

Effective communication skills are critical to successful consultation and collaboration. Methods such as SBAR and "repeat back" hand-off protocols are widely used in nursing. While both of these methods are effective, it is challenging to sustain their use unless formal communication protocols are established within the unit. Employers can play a role in sustainability by modeling the communication framework for change initiatives.

[With SBAR], individuals speak up, and state their information with appropriate persistence until there is a clear resolution."

- Institute for Health Improvement

Handing Off In Ways That Work

A Promising Practice from Vancouver Coastal Health

As one of two floors at the Vancouver General Hospital initially implementing LPNs on medical-surgical units, there were few on-site mechanisms in place to support LPNs. As a result, the Patient Services Manager took the lead by having the Patient Services Coordinator (PSC) facilitate sessions with LPNs and RNs to promote good working relationships on its medical-surgical units. Framed in the language of “so how do you negotiate this,” the PSC worked with LPNs and RNs during patient/resident assignments.

Patients/residents were mostly stable, with only a few being unstable and requiring multiple levels of care. An LPN/RN partnership was implemented whereby RNs and LPNs would meet in the morning to determine how to divide up the workload. The LPNs and RNs would have independent assignments, but throughout the day there would be collaboration on the care of the patient/resident, including any changes in status and or patient care that required RN support. The RNs practiced respectful ways of asking LPNs if there was anything they could do for the LPNs that was not in the LPN scope of practice. In return, the LPNs practiced respectful ways of asking what could be taken over by the RN to ensure that the workload stayed balanced. Good communication habits take time to develop. Each site is required to reinforce communication practices at multiple touch points, including team meetings and orientation for new hires.

Shift Focus from Professional Differences to Patient/Resident Care

In a collaborative practice environment, team members need to understand their own roles as well as those of others. This means that staff need to find the common ground that exists between them and realign traditional division of labour to a collaborative patient/resident centered model. Focusing on patients/resident's needs and acuity will bring to light specific roles and responsibilities for care team members. Some sites create a patient/resident centered vision to help individuals identify with a team goal rather than their professional goals. It provides a common framework to guide teams and organizational processes.

Challenges

Education and Training

Practice leaders noted that when it comes to utilizing LPNs to their full scope there is a disparity in some cases between what LPNs are legislated and competent to do and how they are actually utilized, i.e. not to the full extent that they could be. Some Practice Leaders felt the composition of LPN basic education is sufficient while others felt that LPNs need more practical experience. All agreed that the following challenges exist: (1) LPN education and training occurs in isolation – many RNs do not know what practice preparation LPNs receive, and (2) insufficient opportunities exist to reinforce LPN skills through upgrading or further education and training.

“In rural areas, we need to travel for every educational opportunity. If they’re not going to do a paid in-service, it’s not going to work.”

- LPN Leader from a Rural Care Setting

LPNs Learn in Isolation – RNs May Not Know what Training LPNs Receive

Health care professionals are generally trained independently and taught to think autonomously yet as soon as they enter the health care team setting they are expected to know how to collaborate with each other. RNs may know very little of the “practices, expertise, responsibilities, skills, values, and theoretical perspectives” of LPNs because they are not included in the training.^{xxi} Practice Leaders felt that this practice of discipline specific training may impact on RNs’ confidence of LPNs’ abilities to provide appropriate care and practice to their full scope.

System Circumstances Inhibit Professional Development for LPNs

LPNs and practice leaders identified that a key operational challenge associated with on-going LPN education was the lack of ability to support LPNs in attending training. This is not for a lack of desire to support LPNs but rather because:

- LPNs are responsible for providing a great deal of bedside care. Combined with the shortage of health care professionals, this makes it challenging for LPNs, like all frontline care providers, to step away from their patient/resident care role to attend education sessions.
- Formal education is offered at major cities within BC, which precludes LPNs from BC’s many rural and remote locations from attending due to travel costs and insufficient staff to backfill.
- Leaders often do not have the budget to pay LPN staff to attend education sessions.

“For us the training is great but it’s always out of town and I’d like to see it come more local so more of us can get involved. I’d like to see training across the lines, including the Care Aides and the RNs so we are all doing it together.”

- Female LPN in Long Term Care Setting

While many participant LPNs report attending education sessions on their own time for their own professional development, they noted that not supporting LPNs to further their education (when other nursing groups are supported) may send a negative message about how LPNs are valued.

Focus groups also identified that inadequate ongoing LPN education (including leadership education) may perpetuate a perception that LPNs play only a support role or do not have their own scope of practice.

Opportunities ‘Train in Teams those who are Expected to Work Together’

The education system is one of the main determinants of interprofessional collaborative practice as it “represents the principle lever for promoting collaborative values among future health care professionals”.^{xxii} “Learning together” is when members of the care team are trained together and are consequently taught skills to be applied according to their unique scopes of practice. Participants felt that when members of a care team learn together they are better positioned to collaborate about patients/residents.

Shared Learning: A New Approach to Practice Education

A Promising Practice from Vancouver Coastal Health

Kwantlen College and Vancouver Coastal Health Authority have joined together to create, implement, and evaluate the effectiveness of a “Shared Learning Unit” (SLU) as an alternative to older placement practice models. In the proposed model, all staff members in the unit share in the responsibility for student learning. A group of students from various health care disciplines enter the unit as a team and in collaboration with an instructor, learning experiences are developed. In the SLU model, students from different courses, programs, and years are included. For example, students from a unit clerk program, various nursing programs, a resident care attendant program, and a geriatric recreation program might all complete their practicum placements together in a particular unit. Collaboration, teamwork, and mentoring are consistently emphasized from training to placement.

“New health professionals and health science students already are working together in new ways. We want to keep practicing like this because it works. It’s better for patients, communities and health professionals. But the way the system and education are structured really don’t facilitate that kind of practice.”^{xxvii}
- Michael Garreau, President, Canadian Nursing Students Association

The U.S. Institute of Medicine (IOM) has identified five principles and strategies for achieving safe health care. In addition to leadership, respecting human limits in process design, anticipating the unexpected and a creating a learning environment, effective team functioning is noted as a strong indicator of safe health care.^{xxiii}

Learning Together Enhances Geriatric Care *A Promising Practice from Provincial Networks*

The Acute Care Geriatric Nurse Network (ACGNN) and the Geriatric Emergency Network Initiative (GENI) provide good examples of collaborative professional nursing education for older adult care. These examples are commonly known as the knowledge, skills and abilities to slay the Geriatric Giants.^{xxiv} Both are provided in two-day education workshops which are offered to RNs, RPNs and LPNs. When asked how training is tailored for different care providers, Marcia Carr, a Clinical Nurse Specialist with the Fraser Health Authority noted that the RNs, RPNs and LPNs are all regulated nurses with the “knowledge, skills, and abilities” to learn and then implement within their scope of practice.^{xxv} The information is taught using practical case scenarios with the philosophy that all input, regardless of the care provider’s role, is valued. During the education, a collaborative approach is emphasized, as Ms. Carr states, “ensuring that an LPN knows when to call in an RN and an RN knows when to call in the physician”. Worth noting is that Care Aides (along with allied health care professionals) also attended this training in rural and remote areas of BC.

Enhance New Graduate LPNs’ Transition to Practice

With the nursing shortage and the demands of increased complexity of care in BC’s health care facilities, increasing attention has been placed on supporting a more effective transition to practice for new nurse graduates. Some regions offer comprehensive programs. For example, Fraser Health’s New Graduate Nurse Program includes: professional practice orientation; learning plan development using a Competency Assessment Planning and Evaluation (CAPE) tool; networking with other new graduate nurses; mentored shifts with experienced RNs and other customized learning opportunities.^{xxvi} Some Practice Leaders and LPNs reported that informal LPN mentorship arrangements

“We need to encourage mentoring amongst ourselves – peer mentoring.”

– Female LPN
Leader from an
Acute Care Setting

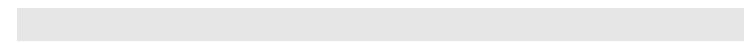
exist and most practice leaders arranged shifts with experienced RNs for LPNs' orientation to a unit or work area. However, participants noted that these opportunities for LPNs were limited compared to the thorough transition to practice programs that have been developed for RNs.

Practice leaders and focus group participants supported the concept of a more developed LPN new graduate transition to practice program and some suggested it could include a joint professional practice orientation session for all nurses. Participants were also of the opinion that it is important to ensure that a formal mentorship program includes LPN mentors for new LPN graduates to demonstrate confidence within their scope of practice. Another theme that arose was that an LPN transition to practice program should include access to Clinical Nurse Educators that are proficient in LPN education.

Facilitate Access to Clinical Nurse Educators

Practice Leaders and focus group participants indicated that education and training opportunities are needed at the local level to assist in making it more feasible for LPNs and other care team staff to attend. Another option that was suggested was to have CNEs work with the entire care team to provide training and support. Some participants noted that the benefit of having CNEs provide support to the entire care team were as follows:

- Education sessions provided on site and therefore opportunities exist for all staff to attend together ("learning together" concept).
- LPNs have an additional resource to call upon for support. This helps LPNs to feel more confident in their own scope of practice.
- Front-line RN sense of responsibility for training LPNs may be reduced.



Rewards of the Job

Challenges

LPNs Report Dissatisfaction with Compensation Levels

LPNs in the focus groups reported dissatisfaction with their compensation given the increased responsibility and workload that they had assumed. All LPNs spoken to as a part of this study reported enjoying caring for patients/residents and feeling proud of their work.

Opportunities

Recognize Additional Workplace Motivators

There are many drivers of workplace satisfaction including compensation, relationships with colleagues and the intrinsic value of the work to the individual.

Many participants felt that improving working relationships with other health care professionals and helping to ensure the intrinsic value of the work is maintained are important for workplace satisfaction. Ensuring LPNs receive acknowledgements provided by patients/residents, families or other staff helps to maintain their commitment and engagement.

"I enjoy working with people, making people better."

– Female LPN Leader
from a Rural, Acute
Care Setting

Care Aides

Challenges and opportunities for effectively increasing the utilization of Care Aides are presented under the following four headings:

1. Recognition for patient/resident care and inclusion in the care team.
2. Work Responsibilities.
3. Advocacy and Engagement.
4. Training and education.

Recognition and Inclusion in the Care Team

Challenges

Practice leaders express that Care Aides provide the “high touch” care that is essential to quality of life for patients/residents and that Care Aides are the nursing team’s “eyes and ears”. While the practice leaders spoke to the value Care Aides bring to patient/resident care, a theme that emerged in the focus groups with Care Aides was that their jobs lack respect, autonomy, or recognition from other members of the nursing team. Interestingly, in several of the interviews with Care Aides, there was also the perception that Care Aides are treated with more respect in acute care hospitals (than in long term care) and that the acute care work is considered to require more technical skill and be more interesting.

Care Aide Patient/Resident Observations are Considered to be Insignificant

Care Aides are often able to spend more time with each patient/resident than nurses are. In the focus group and interviews, Care Aides expressed concern that their patient/resident observations were not taken seriously and an RN or LPN may “brush off” an observation as unworthy of further investigation. Care Aide participants felt that this could affect patient/resident care and also may reduce Care Aides’ willingness to bring patient/resident observations forward in the future. Additionally, on occasions where a Care Aide observation was investigated and determined to be significant, Care Aides felt they rarely received credit for their ability to recognize a change in a patient/resident’s condition and the impact their vigilance can have on patient/resident care.

“If I make an observation, the nurses don’t always carry forward with it. The RN doesn’t think I’m educated or have enough experience.”

- Male Care Aide
from an Urban,
Acute Care Setting

“The overwhelming majority of untoward events involve communication failure”.^{xxix}

- Michael Leonard
Institute for Health
Improvement

Care Aides are Excluded from Team Meetings

The focus group and interviews with Care Aides and their employers revealed that the practice of including Care Aides in team meetings varied from site to site.^{xxviii} While the Care Aides in the residential settings tend to spend more time with residents than any other team member, many sites do not ask Care Aides for their input or include them in care planning with other health care professionals. Some practice leaders acknowledged that Care Aides are not given adequate opportunities for input because they are not part of the “nursing team”. Other managers spoke frankly about their desire to include Care Aides but staffing shortages prevented them from doing so.

“I do not have the power or authority to do the job. The management listens to RNs and LPNs not the Care Aides.”

- Female Care Aide from an Urban, Affiliated Multi-Level Care Facility

Opportunities

Profile Care Aides

Participants noted that opportunities exist to increase the profile of Care Aides by publicly recognizing their contributions to patient/resident care. Especially in the residential setting, residents and their families often send letters of appreciation and it was felt that it is particularly important for these letters to be shared with Care Aides and for other health care personnel to hear about the contributions that Care Aides make. It was suggested that health employers can also profile Care Aides in their local newsletters, in health focused publications and internal posters.

Follow-Up on Patient/Resident Observations

Communication of patient/resident observations between Care Aides and nurses and timely follow-up when needed is important for patient/resident care and well-being. Participants noted that some Directors and Site Managers publicly recognize Care Aides for their observations during team meetings and felt that this “good catch” recognition is an important lever for developing and maintaining a patient/resident safety culture and for modeling respect for Care Aides to other frontline staff.

An Established Culture of Relying on Care Aide Observations

A Promising Practice from Vancouver Coastal Health

Minoru Residence is a complex care facility that provides 24-hour professional nursing care, together with regular and ongoing medical supervision for individuals who have a high level of need for care. A team consisting of approximately 70% Care Aides, 20% LPNs and 10% RNs work together to provide care to the residents at Minoru. At the shift handover, an LPN reviews each resident with all the outgoing Care Aides and LPNs to determine any physical, behavioural, and emotional changes. The Care Aides come prepared with notes on their residents (based on information received during the previous shift). All Care Aide comments are noted in the daily report binder. Any concerns are flagged by the LPN for follow up either with an LPN, RN, or an allied health member.

Facilitate Care Aides Participation in Team Meetings

Participants noted that effective formal leaders demonstrate their commitment to and model a respectful workplace environment in which the entire health care team plays an important role in patient/resident care. Participants noted that there are different ways to involve Care Aides in care team meetings and care planning sessions. It was suggested that actively soliciting input from Care Aides may increase Care Aides' level of comfort with participating in care planning. There is evidence that mid-level managers who are receptive to Care Aides' advice and open to discussing care plans with them are able to reduce their turnover rates.^{xxx}

"At the hospital I used to work at, everyone participated (physicians, RNs, LPNs, care aides) in the Care Planning Meetings. The RN or LPN is there for the medications but we should be there to address the personal care. We learn about patients at these meetings too."

– Female Care Aide
from a Rural,
Subacute Care
Setting

Including Care Aides in Care Planning

A Promising Practice from Fraser Health Authority

Care Aides play an indispensable role in the daily operations of every residential care setting in BC. They are responsible for an increasingly wide range of resident care activities. Especially when faced with a shortage of health care staff, it is difficult to take Care Aides off the floor for team meetings. Many site managers find themselves at an impasse between recognizing the value of Care Aides' contributions and desperately needing their labor on the floor. Oftentimes, Care Aides are asked to carry on tending to residents while other members of the patient/resident care team meet. The residential site manager at Langley Memorial Hospital deliberately avoids scheduling Resident Care Meetings around meal times because of the pivotal role Care Aides play in assisting residents with meals. Whereas meal times are inflexible, some of Care Aides' other duties can be completed at any time during their shift. The site manager also ensures that the resident's personal care is the first or last item on the Resident Care Meeting agenda, making it possible for Care Aides to participate in either the first 10 minutes or last 10 minutes of the discussion.

Including Care Aide Expertise in Policy Development

A Promising Practice from Northern Health

Clinical practice guidelines are often developed in nursing practice councils or focused working groups by RNs with input from LPNs, but when Northern Health set about developing clinical practice guidelines for residential care, their best practices working group sought the input of several team members, including Care Aides, who deliver the majority of bedside care in Northern Health's residential care settings. Their input to guidelines with respect to dementia care and other common resident conditions was invaluable. In this way, Care Aides were recognized as having important contributions to the personal care components of the health authority's clinical practice guidelines. A one-page "Information Sheet" developed for each guideline summarizes key points and provides support for Care Aides.

Challenges

Work Responsibilities

Care Aide Work can be Demanding

The work of Care Aides can be physically and emotionally demanding. Care Aides are expected to observe and care for patients/residents' personal needs; ensure the unit and patients/residents' rooms are well stocked and maintained and take instruction from the nursing team and physicians for routine and non-routine tasks.

Care Aides in the focus groups noted that the impact of care team staffing shortages meant that a heavy workload was a major obstacle in their work environment. For some of the Care Aides, keeping up with the workload meant no time for breaks, not enough time with patients/residents and, at times, no time to cope with a patient/resident's death.

Care Aides felt that their workload has increased with patient/resident acuity but also as the competencies of other members of the care team have advanced. In the focus group and individual interviews, Care Aides mentioned that they were asked by some RNs and LPNs to perform routine tasks that are formally assigned to Nurses. Care Aides also voiced frustration that RNs and LPNs did not "pitch in" to assist with the workload.

Roles Evolve within the Care Team

In the focus group and individual interviews, Care Aides expressed mixed feelings on the potential enhancement of their role in residential care, such as providing certain types of medication. Some welcomed the opportunity as long-awaited recognition of their capability and a means to elevate their status within the health care team. Others questioned how they could add this responsibility to their current workload. Care Aides also expressed concern that added responsibilities would come at the cost of the personal interaction with patients/residents, which is presently a significant source of fulfillment. (For further discussion of this topic see the Promising Practice from Providence Health care, Youville Residence).

Additionally in the acute care setting, the role of Care Aides is shifting from room care (e.g., stocking supplies and cleaning rooms, etc) toward more personal patient care. The case study that follows is an excellent example of how one facility effectively introduced Care Aides into a very busy emergency department.

"If I could change one thing about my job it would be lower workload and more time to listen to residents."

– Care Aide from a Long Term Care Setting

"A lot of [Care Aides] are just there doing their work and you don't hear a report and it's 5 minutes to 3 and they still haven't come and told you anything."

– Female LPN from a Long Term Care Setting

"LPNs are now doing the work that RNs used to do. Care Aides are relied on more and more. Patients are very much in a state of flux rather than 'stable' or 'predictable' and LPNs are required to make decisions about their care and Care Aides are required to care for them."

– Practice Leader

"Management wants to increase utilization of Care Aides but I don't know that all Care Aides want their scope increased. Personally, I don't want to see Care Aides' scope (e.g. changing tubes, etc.) increase. Who would be left for the hands-on care?"

- Female Care Aide from a Rural, Residential Care Setting

Case Study - Care Aides Selected for Skilled Tasks in Emergency Department

ABOUT THE ROYAL COLUMBIAN HOSPITAL

The Royal Columbian Hospital is a provincial referral hospital (tertiary/trauma care centre) within Fraser Health. Fraser Health provides tertiary care to close to 1.5 million people, approximately one third of the total provincial population. Fraser Health has almost doubled in size since 1981 and is the fastest growing of the health employers. The demand for health services within Fraser Health is expected to increase and become more complex because of anticipated population growth and demographic shifts. Currently, nearly 12% of the population in Fraser Health is over 65 years old.⁶ By 2010, this is expected to increase by 18% or 32,718 people – a significant increase because as people age, they place higher demands on the health care system.

Royal Columbian Hospital is the sole provider of obstetric, psychiatric, and 24-hour emergency services in New Westminster. Royal Columbian Hospital has 402 acute care beds and a medical staff of approximately 385 physicians (150 family physicians and 235 specialists). Tertiary care focus is on cardiac services, maternal and neonatal services, trauma services, and neurosciences. The 24-hour Emergency Department handles approximately 150 - 200 patients per day.

Royal Columbian Hospital



THE CHALLENGE – INCREASING EMERGENCY RELIANCE

The Royal Columbian Hospital Emergency Department serves a growing, aging population requiring complex and emergency services. It is responsible for over 20% of the trauma and accident surgery in BC. The aging population, combined with the rising Emergency Department utilization has resulted in a significantly increased demand for emergency health services. The short supply of health human resources – both family physicians and nurses -- and fixed budgets provided the basis for Royal Columbian Hospital to look for ways to maximize the utilization of their staff. This case study focuses on the shift from Care Aides stocking supplies and providing basic supports to a greater role in patient/resident care. At the same time as the role of the Care Aides was shifting, Licensed Practical Nurses were also beginning to practice to full scope.

⁶ Fraser Health Authority. (2005). *The Fraser Health Strategic Plan*. Retrieved from: <http://www.fraserhealth.ca/NR/rdonlyres/ewl5fwjzde tn3x5mgrsrn3ly5xwa7trlwv4eli7autau2jexytu2n7ljqe g3biphmniqs7y3fwtq63ddlkcycdt664qc/FHStratPlan05 01.pdf>

THE CASE FOR UTILIZING Care Aides TO THEIR POTENTIAL

Royal Columbian Hospital's Emergency Department is continuously faced with staffing challenges. These challenges created the opportunity to implement full scope LPN practice in the Emergency Department and to maximize effective use of Care Aides. At Royal Columbian Hospital, Care Aide roles included Patient Care Nurse Aides and Transport/Trauma Nurse Aides. As with any skill mix change careful planning and diligence provided the foundation for utilizing Care Aides (and LPNs) to their full potential. The result: safe patient/resident care and a well functioning team.

UTILIZING UNREGULATED CARE PROVIDERS

Implementing full scope LPN practice included shifting the role of Care Aides from less-skilled tasks, such as stocking supplies, to providing more direct care. As Care Aides are an unregulated profession, it was essential to consider all the aspects associated with enhancing the role of one group:

- How well would the Care Aides adapt to the changing expectations?
- How would the nursing team react?
- What supports would need to be in place?
- What other options were in place should this change not be feasible?

Royal Columbian Hospital closely followed the guidelines developed by the College of Registered Nurses of BC (CRNBC) for delegating tasks to unregulated care providers.⁷ Specific factors included the patient/resident's variability and acuity, the risk of harm related to the Care Aide providing the task, the care environment (i.e. appropriate training, supports, and policies), and the care aide's knowledge and experience.

⁷ College of Registered Nurses of BC. *Delegating Tasks to Unregulated Care Providers: Practice Standard for RNs and NPs*. Retrieved from: <http://www.crnbc.ca/downloads/429.pdf>

While the more patient/resident focused role did not consist of delegated tasks per se, Royal Columbian Hospital followed these guidelines as a mechanism to ensure the highest quality of safe patient/resident care.

ENSURING SAFE PATIENT/RESIDENT CARE

Ensuring safe patient/resident care remained at the forefront during the shift toward a more direct patient care role for Care Aides at Royal Columbian Hospital. The skill mix ratio remained 80% RNs, 10% LPNs, and 10% Care Aides. Accordingly, the Emergency Department closely followed the 'Staffing Decisions for the Delivery of Safe Nursing Care' by the Canadian Nurses Association.

Specifically⁸:

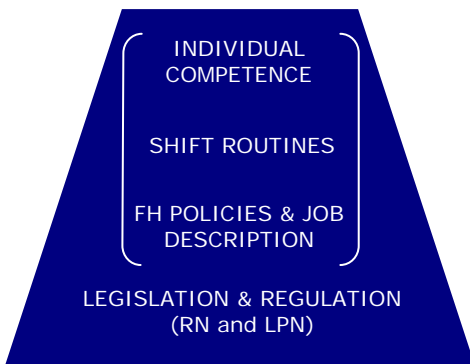
- The staff mix decision was based on ensuring safe, competent and ethical care.
- Leaders maintained responsibility for ensuring the appropriate staff mix.
- Legislative (Health Professionals Act), Professional (RN and LPN Scope of Practice), and Organizational (Fraser Health) parameters were respected.
- The staffing decision making process recognized the unique and shared competencies of the RNs, LPN, Care Aides, allied health professionals, and physicians.
- Responsibility and accountability of care providers were clearly established and communicated.
- Staffing decisions were evidence-based.
- RNs were recognized as the leaders in implementing collaborative practice and promoting effective communication among all members of the health care team.

⁸ Adapted from the Canadian Nurses Association *Staffing Decisions for the Delivery of Safe Nursing Care*. Available at http://www.cna-nurses.ca/cna/documents/pdf/publications/PS67_Staffing_Decisions_Delivery_Safe_Nursing_Care_June_2003_e.pdf

WHAT WORKED

The Emergency Department manager extensively reviewed the Fraser Health Care Aide policies and job description (approved by the People and Organization Development department and the Hospital Employees' Union (HEU) and further developed the job description duties and responsibilities into more detailed shift routines. These were then reviewed with each Care Aide to ensure their individual competency (as illustrated in figure 1). The current health care legislation was taken into account in the Fraser Health policies.

Figure 1: Approach to reviewing Care Aide shift toward patient/resident care tasks:



As the Care Aide role shifted to more patient/resident care the nursing staff and Care Aides themselves expressed the need for clear routine expectations. Detailed shift routine documents were developed for both Patient Care Nurse Aides and Transport/Trauma Nurse Aides. This served a dual purpose: 1) more clarity on the Care Aide role and 2) clarity between the two types of Care Aides within the Emergency Department.

To safely integrate Care Aides into more of a care provider role, Royal Columbian Hospital framed Care Aide competencies in terms of their job descriptions and shift routines. These clear and specific guidelines enabled Care Aides to gain confidence in their ability to provide and

support patient/resident care. This also allowed Care Aides to gain credibility in the eyes of the nursing staff.

TRAINING SUPPORTS

At the same time as the Care Aides' roles shifted to more direct patient/resident care, the LPNs were being utilized to full scope. A strong emphasis was placed on understanding the LPN and RN standards and scopes of practice in order to determine how the two nursing roles could best work together and complement each other's skills (*workshops were facilitated by (CRNBC) and the College of Licensed Practical Nurses of BC (CLPNBC)*).

Royal Columbian Hospital applied this approach by holding team meetings to understand the role of the Care Aide in patient/resident care. Shift routines were reviewed with Care Aides in team meetings (and individually for orientation and during evaluations). Once the Care Aides were familiar with their roles, team meetings were held with the staff to familiarize them with the role that Care Aides would play in the Emergency Department. Fraser Health's People and Organizational Development team supported the Emergency Department by holding team-building sessions on collaborative and respectful communication (after the joint College presentations with the entire team).

The challenge in any care setting is bringing staff together for training. This challenge was ten-fold in the Emergency Department. Staff did their best to communicate with each other and bring information forward to others who were not able to attend. The training was supplemented by training and support offered by the Clinical Nurse Educator (CNE) at Royal Columbian Hospital. "*CNEs are responsible for all professionals – this includes RNs, LPNs, and Care Aides*", stated the Emergency Department Manager. With limited CNE time, this was a progressive approach to include the entire care team in training opportunities.

This approach to training is aligned with Canada's future vision of collaborative care provider education⁹ and also promotes a respectful way for care providers to learn together. the ED to provide the best possible care to RCH's emergency patients.

ACKNOWLEDGEMENT

Thank you to Carole Edwards, Emergency Room Manager, Royal Columbian Hospital, for her insightful contributions that guided this case study.

PERMISSION

This case study has been written with permission from Fraser Health.

⁹ Toward 2020: Visions in Nursing. <http://www.cna-nurses.ca/CNA/documents/pdf/publications/Toward-2020-e.pdf>

Opportunities

Support Care Aides' Intrinsic Value of Providing Care

Care Aides noted that they were motivated by their desire to help patients, residents and their families. It was suggested by participants that commitment to patient/resident care can be strengthened by optimizing opportunities for Care Aides to provide their input during patient/resident reports, receive feedback on the progression of patients'/residents' care, and receive acknowledgments from patients/residents and families.

Develop a Mutual Understanding of Team Members' Work Responsibilities and Roles

Care Aides are needed to provide routine care so that nurses can provide advanced care that only nurses can perform. Just as it is important for RNs and LPNs to know and respect what each group of nurses can provide to patient/resident care and well-being, participants felt that knowing and respecting what Care Aides provide was critical in the development and functioning of patient/resident care teams.

"I enjoy working with the residents in our facility and finding out more about the individual so you can make them relate to the place they're in so they more and more feel it is their home."

- Male Care Aide
from an Urban,
Extended Care
Setting

"What I value about Care Aides is what I miss. I am a nurse by background and what I value is the way that they can connect on a personal level with patients and families on a day to day basis."

- Practice Leader

Learning Together Creates Teamwork

A Promising Practice from Providence Health Care's Youville Residence

Youville Residence is a licensed complex residential care facility. Operated by Providence Health Care (PHC), Youville offers a home for 84 residents and has one floor dedicated for special care residents with dementia. As the fifth PHC residential care home to have Care Aides delivering some medications (initially implemented as a pilot at one site), Youville's approach to training benefited from lessons learned from previous implementations at other sites. This resulted in the implementation of a comprehensive training program where Care Aides learned together with other health care providers in a classroom setting and applied their knowledge and skills with RNs acting as coaches. While the training was directed to Care Aides, having RNs attend the training served two purposes: (1) RNs had greater confidence in the Care Aide's ability to deliver medication after receiving sufficient training and (2) as supported by the literature, there are significant benefits to enhancing collaborative practice by "training in teams those who are expected to work in teams" (Institute of Medicine). Care Aides began to deliver medication with close RN support and progress was evaluated daily to ensure there was no impact on patient safety as a result of Care Aides delivering routine medications to residents. To support learning and workload, the site adjusted break times to ensure a full staff complement was available during peak medication administering times.

Challenges

Advocacy and Engagement

Care Aides Lack the Benefits of a Professional Body

Care Aides in the focus groups expressed concern that their "voices were not heard" because they did not have a professional organization or professional college to speak on their behalf.

"Our voice is not recognized."

- Care Aide

Cultural Barriers Impede Mobilization

Many Care Aides in BC have diverse social roots. Particularly in the urban areas of BC, the Care Aide workforce includes immigrants who may have professional credentials from their country of origin. Participants in the focus groups identified that some

"One area that prevents Care Aides from speaking out is English as a second language."

- Female Care Aide
from an Urban Care
Setting

Care Aides find their primary support from colleagues with similar ethnic backgrounds or value systems. The focus groups felt that this tendency may limit Care Aides' capacity to advocate for themselves as an entire group.

Care Aides feel Disempowered

As unregulated health care providers, Care Aides work under the supervision of an RN, RPN or LPN. Care Aide focus group participants felt that they are often given little room for initiative and usually not much benefit of the doubt. In the focus groups and individual interviews, Care Aides perceived that they are for the "lowly" work. Many noted that they come from difficult socio-economic situations or personal circumstances (e.g. single mothers) and felt silenced by the thought that their job could be easily terminated.

"There are some Care Aides that have low self-confidence and think that they are lucky to have their job..."

– Female Care Aide from an Urban, Acute Care Setting

Opportunities

Formalize Opportunities for Care Aides

As significant demands are placed on the health care system (e.g. aging population, patients/residents presenting with more complex needs, etc), Care Aides will increasingly be relied upon to provide and support patient/resident care. Some Care Aides expressed the desire to self-organize to promote their profession, while all of the focus groups expressed the need to have more opportunities to learn together and to network with other care aides. Participants felt that providing opportunities for Care Aides to meet and learn from each other at professional development, conference and networking events would allow them to share experiences and develop professionally.

Provide Leadership Roles for Care Aides

Participants suggested that methods to raise the profile of Care Aides included encouraging them to take on leadership roles as appropriate, enabling Care Aides to take part in training opportunities and modeling the expectation that Care Aides are a valuable member of the care team.

A few Practice Leaders suggested asking Care Aides to participate in Practice Councils and then take the lead in introducing new Clinical Practice Guidelines to their sites. BC health care facilities are increasingly establishing organizational structures and policies for patient safety and could provide an excellent opportunity for Care Aides to contribute by using their frontline experience to suggest safer processes.

"For healthcare organizations today, the challenge of diversity is not about shedding 'other' (read non-Western) people's values and beliefs until they act 'like Westerners'. It is about respectfully inquiring about worldviews that are unfamiliar. It is about interrogating existing assumptions about how things ought to be done, and learning, in collaboration with our culturally diverse staff, how to develop more inclusive, sharable habits of respectful workplace practice."

Anne Vanderbijl,
Director of Diversity,
Providence Health
Care

Promoting Care Aide Leaders

A Promising Practice from Vancouver Coastal Health

Because of their status as unregulated health workers, Care Aides are not usually a first choice for leadership opportunities. While Care Aides play a highly essential role in providing personal care to patients and residents, many managers cannot afford to release Care Aides from these traditional responsibilities to take part in leadership opportunities. Despite these operational challenges, managers at a Lower Mainland residential care facility recognized that Care Aides are best suited to train other Care Aides, as well as their LPN and RN colleagues in using ceiling lifts. Rather than selecting a nurse in a supervisory role, a team of Care Aides was trained to ensure they were familiar with safety procedures to reposition residents. During this training, Care Aides were taught how to effectively communicate information to their team and how to maximize the use of the lifts to improve patient care as well as workflow for the staff. Using a “train the trainer” approach, Care Aide team members trained all staff in formal training sessions and individually as they were beginning to use the ceiling lift for resident care. Training occurred during all shifts (day, evening and night). The feedback from one Care Aide trainer was that she felt valued because she was a part of the training team and was listened to by her nursing colleagues.

Including Care Aides in Collaborative Practice Initiatives

The collaborative tool kit, *Let's Talk*, described in the introduction to this Report, is intended for Care Aides as well as LPNs and RNs. Supporting Care Aides to use methods such as SBAR, and to participate in “safety huddles” is one method of increasing their role and profile as full members of the team.

Education and Training

Care Aides Lack Standardized Education and Certification

As discussed earlier, there are over 20 public and private training institutions offering Care Aide training across BC - all with a slightly different training curriculum, program lengths and practicum requirements. Some participants felt that the lack of a common standards of training outcomes leaves

“I think there should be a college for our practice and standardized training, qualifications and expectations. I feel like the decision-

Challenges

employers with a lack of confidence in Care Aides' competencies generally and could contribute to a lack of respect for Care Aides by other care team members. As noted earlier in this report, the Care Aid Competency Project and new provincial curriculum will assist with this challenge.

Care Aides Lack Sufficient Training Opportunities

A message repeated in the interviews with Practice Leaders and focus groups is that continuing education is critical to advancing the role of Care Aides in BC. The same challenges that were identified for LPNs were voiced with respect to Care Aide education :

- Care Aides are responsible for providing a great deal of bedside care, therefore making it challenging for Care Aides to step away from their patient/resident care role to attend training.
- Formal training is offered at major cities within BC, which precludes Care Aides from BC's many rural and remote locations from attending due to travel costs and insufficient staff to backfill.
- Practice Leaders often do not have the budget to pay staff to attend training.

Additionally, Care Aides at some sites, reported what they see as a "cyclical" pattern of not being recognized for their role in patient/resident care, not included in care team meetings, and consequently being overlooked for training opportunities.

Opportunities

Provide a Variety of Training Opportunities

Training opportunities that were identified as being beneficial for Care Aides included:

- Provide specific education so Care Aides are better equipped to care for an increasingly diverse and higher acuity patient/resident base.
- Help Care Aides cope with the increasing reliance on their skills (especially in the Residential setting).
- Support the development of new skill sets (i.e. in acute care).

It was also suggested by some participants that on site training opportunities, held with LPN training, would expand the capacity of Care Aides "learning together" with their colleagues and increase the profile of Care Aides as a credible member of the health care team.

makers won't take us seriously unless we have this.

Secondly, communicating with the public about what we do and why it is so important."

- Female Care Aide from an Urban, Acute Care Setting

"It's good to redirect [Alzheimer's patients/residents] but if you don't have the training its very frustrating."

-Female Care Aide from an Urban, Residential Care Setting

"All levels of nursing are used more extensively now than they ever have been before because of the acuity of care. I think the training will have to change with the times and LPNs and Care Aides will need greater depths of knowledge with respect to anatomy and ability to recognize things that are wrong with patients."

- Practice Leader

An Upsurge of Support for Care Aide Training *A Promising Practice from Northern Health*

Care Aides working for Northern Health had a powerful advocate in their director of Resident Care. The director discussed the need for Care Aide training opportunities with her colleagues. Before long, the majority of site managers were on board and the executive had expressed interest in the idea as well. However, the initiative required a formal commitment from the executive to allow residential sites to backfill their Care Aides with casuals. With ongoing support from the executive for the last few years, Northern Health has hosted three annual conferences and brought an estimated 120 Care Aides and community support workers in the region together to share experiences and develop professionally.

Summary

This Chapter has identified a number of challenges and opportunities that can arise in the effective utilization of LPNs and Care Aides. It has also highlighted some Promising Practices and Case Studies that demonstrate how employers and employees have addressed some of the issues that they face in providing sustainable quality care. Without limiting the variety of opportunities and Promising Practices that are available there are some specific factors and opportunities that were identified by participants in this Report as items that would further support the optimal utilization of LPNs and Care Aides and assist with the change management inherent in enhancing roles and/or reconfiguring skill mix. Those items are:

- The provision of transition to practice opportunities for new graduate LPNs
- Professional development and education opportunities for LPNs and Care Aides
- Networking opportunities for Care Aides
- Leadership training and leadership opportunities for LPNs
- Collaborative practice education opportunities to assist LPNs' and Care Aides' participation on clinical practice issues
- Participation of LPNs and Care Aides on formal decision-making structures, as appropriate

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

CHAPTER 5 – RECOMMENDATIONS

The interviews with practice leaders and the focus groups with LPNs and Care Aides identified a number of current challenges and opportunities that are being used by health care employers and employees to assist in the effective utilization of LPNs and Care Aides.

A Strategic Approach to Change Management is Recommended

As in the 2000 Report, *Research on Roles and Utilization: LPNs and Care Aides in BC*, one issue that was identified by the majority of participants was the need for a planned change management process when new roles are being introduced or skill mix is being reconfigured. We appreciate that many health care employers utilize change management strategies and hope that the example presented in the Case Study: *A Systematic Approach to Skill Mix Changes at Vancouver Island Health* will be of benefit to the audience when they are planning changes.

Participants in this Report were clear that change requires planning, time and energy. The Promising Practices in this Report are examples of how employers and employees have addressed some of the challenges and opportunities in their workplaces.

Although progress has been made since the 2000 Report, change management factors remain important considerations in the effective utilization of LPNs and Care Aides when new roles are being developed and/or skill mix is being changed.

Factors and opportunities that are important considerations include:

- 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 evaluate change
- Review decision making processes
- Set reasonable time limits

Recommended Strategies for Optimal Utilization of LPNs and Care Aides

Additionally, specific factors and opportunities that were identified by participants in this Report are strategies that will further support the optimal utilization of LPNs and Care Aides and assist with the change management inherent in enhancing roles or reconfiguring skill mix. Those recommended strategies are:

- The provision of transition to practice opportunities for new graduate LPNs
- Professional development and education opportunities for LPNs

and Care Aides

- Networking opportunities for Care Aides
- Leadership training and leadership opportunities for LPNs
- Collaborative practice opportunities to assist LPNs' and Care Aides' participation on clinical practice issues
- Participation of LPNs and Care Aides on formal decision-making structures, as appropriate
- Mechanisms to support the on-going sharing of promising practices and change management successes

A meeting was held with the Chief Nursing Officers of the Province, following the finalization of the body of the Report, to help identify effective strategies to promote the dissemination and effectiveness of the Report and the ability to measure progress in January 2009.

The CNOs were supportive of the need for a change management process that is specifically tailored to the initiatives that are being implemented. Additionally, they noted that the specific strategies that are recommended will require the support and involvement of key stakeholders within their organizations. They also recognized that at present there were no additional or dedicated resources to assist with the implementation of any of the recommended strategies and noted there would be challenges in fully realizing the opportunities to act on some of the recommended strategies.

As at the FBA JPC discussions, there was support for broad distribution of the Report, including placing it on websites for easy access. The CNOs will be examining opportunities within their organizations for the themes and Recommendations from this Report to be presented and discussed e.g. meetings with staff and nursing leaders as appropriate in their particular health authorities. The 2009 follow-up will include a description of the dissemination strategies and of opportunities provided for the presentation of the themes and Recommendations in this Report. The CNOs will also encourage others in their Health Authorities to collect additional "Promising Practices" and information about new initiatives so that those can hopefully be shared through a newsletter and/or in the 2009 follow-up.

The CNOs also offered the following comments on the specific recommended strategies:

i. Transition to practice opportunities for new graduate LPNs

There are benefits in taking a system-wide approach to developing transition to practice opportunities for new graduate LPNs and recognition that orientation needs may vary between individuals with some requiring an additional reasonable amount of time. No standard method exists for transition to practice and, as such, varies across the Health Authorities and their contracted service providers. By 2009 the CNOs estimate they will have a more comprehensive understanding of the quality of LPN transition to practice opportunities and will be able to identify the challenges and opportunities at a systems level. In some cases the Health Authorities may be able to implement new or further transition to practice

opportunities for LPNs before 2009.

ii. Professional development and education opportunities for LPNs and Care Aides

There is support for professional development and education opportunities for LPNs and Care Aides. This includes opportunities for all staff on the patient care team to attend sessions together where appropriate and practical. The CNOs have overall responsibility and accountability within their Health Authorities for funding that is provided through various sources, including the BC Health Education Fund. The FBA education fund is another source of funding that can be used to support group educational and professional development opportunities for LPNs and Care Aides. . As LPNs and Care Aides are utilized in new roles or working in areas that they have not traditionally been utilized in it is important that the appropriate orientation, education and professional development be provided. The CNOs can assist in providing information on some of the learning opportunities that have been made available for LPNs and Care Aides for the January 2009 follow-up.

iii. Networking opportunities for Care Aides

The importance of Care Aides as team members who have significant contact with patients and residents was acknowledged and the value of providing opportunities for them to be able to network and develop professionally was recognized. The CNOs pointed to a number of opportunities and conferences that have occurred and the desirability of continuing such opportunities. Additionally they saw benefits in health care managers highlighting situations where Care Aides are leading or delivering teaching opportunities.

iv. Leadership training and leadership opportunities for LPNs

There are a number of components to the “leadership” role for LPNs as noted in the Report. There are LPNs in team leader roles in residential care. LPNs are increasingly being involved in mentorship programs and opportunities to teach skills to LPNs as well as other care providers in formal and informal education roles. The CNOs acknowledged the importance of these various opportunities and, as with any leadership role, the need for support. Further development of these roles and opportunities will be updated in the 2009 follow-up.

v. Collaborative practice opportunities to assist LPNs’ and Care Aides’ participation on formal decision-making structures, as appropriate

There is general support for participation by LPNs on Nursing and Interprofessional Councils and for further involvement of care aides in care planning activities. Hopefully the update in 2009 will report progress in these areas.

As noted previously, a follow-up to this Report is being planned for January 2009 and the FBA JPC looks forward to learning about the progress and development of these Recommendations and other initiatives that will support the optimal utilization of LPNs and Care Aides in British Columbia.

APPENDIX A

Membership of the FBA Joint Policy Committee and the LPN/CA Utilization Sub Committee

FBAJPC	
Name	Title
Gulrose Jiwani (Chair)	Executive Director, Nursing Directorate, MoH
Marcy Cohen	Research and Policy Planner, HEU
Harry Gray	Director, Consulting - Human Resources / HEABC
Karen Jewell	Advocate/General Counsel, HEABC
Liz Bloomfield	Manager, George Pearson Centre, VCHA
David Byres	Director, Nursing Practice, PHC
Kathy Chouinor	Manager, Residential Support Dept., IHA
Heather Cook	Director, Residential Services, VIHA
Boni Barcia	Care Aide, HEU
Joanne Dickie	LPN, HEU
Pat Doyle	Chief Human Resources Officer, IHA
Noni Eastman	Manager, Staffing Services, FHA
Joanne Henderson	Care Aide, BCGEU
Linda Ingham	Administrator, EBCS
Carolyn Unsworth	Care Aide, HEU
Sylvia Neden	LPN, HEU
Bobbi Pettett	LPN, BCGEU
Doreen Plouffe	LPN, HEU
Pat Semeniuk	Regional Director, Learning & Career Development, VCHA
Val Waymark	NI Area Director, Home & Community Care, NHA
Joyce Winter	LPN, IHA
Jacqueline Zilkie	LPN, HEU

LPN/CA Utilization Sub Committee	
Name	Title
Harry Gray	Director, Consulting – Human Resources / HEABC
Karen Jewell	Advocate/General Counsel, HEABC
Joanne Henderson	Care Aide, BCGEU
Marcy Cohen	Research and Policy Planner, HEU
Barbara Mildon	Chief Nursing Executive & V.P. Professional Practice & Intg., FHA
Doreen Plouffe	LPN, HEU
Pat Semeniuk	Regional Director, Learning & Career Development, VCHA
Gulrose Jiwani	Executive Director, Nursing Directorate, MoH

ENDNOTES

- ⁱ (May 9, 2006). Official Report of Debates of the Legislative Assembly. 11(4):4606. Retrieved from: <http://www.leg.bc.ca/Hansard/38th2nd/H60509p.htm>
- ⁱⁱ Queen's Printer. (March 22, 1996). Licensed Practical Nurses Regulation of Health Professions Act of BC. http://www.qp.gov.bc.ca/statreg/reg/H/HealthProf/71_96.htm#section%204
- ⁱⁱⁱ CUPE Hospital Employees' Union. (May 15, 2006). LPNs: A History of Activism. http://www.heu.org/~DOCUMENTS/Newsletters_PFV/LPNfactSheet.pdf
- ^{iv} Licensed Practical Nurses Association of BC. History of LPNABC. Retrieved from <http://www.lpnabc.ca/history.html>
- ^v Epstein IE, Kazanjian A, MacAulay D. (April 2000). Health Professions Council Licensed Practical Nurses Scope of Practice Preliminary Report <http://www.hlth.gov.bc.ca/leg/hpc/review/part-i/scope-lpnurse.html>
- ^{vi} BC Work Futures for Trades and Technical Occupations . Licensed Practical Nurses (3233). <http://www.handson.workfutures.bc.ca/profiles/profile.cfm?noc=3233&lang=en&site=graphic>
- ^{vii} British Columbia Council on Admissions and Transfer and the Centre for Curriculum, Transfer and Technology (October 1999). Articulation Telecommunication Project 1998 Report. Retrieved from: http://www.bccat.bc.ca/pubs/articulation_all.pdf
- ^{viii} CLPNBC. (February 27, 2007). BC Practical Nursing Education Programs. Retrieved from: http://www.clpnbc.org/content_images/documents/PN%20Education%20Table%20A%20February%2027,%202007.pdf
- ^{ix} <http://www.anblpn.ca/English/home/dynamic.cfm?id=95>
- ^x Information obtained on January 8, 2008 from CLNPBC (Registration Exam – Exam Statistics at www.clpnbc.org/index.php?dbq=10#6110)
- ^{xi} Ministry of Health Nursing Directorate Nursing Initiative. (October 6, 2006). LPN Upgrading Fund 2006/07. http://www1.hlth.gov.bc.ca/ndirect/nstrategies/lpn_0607.html#purpose
- ^{xii} (August 4, 2006). Fundamental Leadership Skills for Licensed Practical Nurses .<http://www.iuoe882.com/HC-Bulletins/BUL-LPN%20COURSE.htm>
- ^{xiii} BC Government and Service Employees' Union. (October 17, 2006). BC Health Education Foundation. <http://www.bcgeu.bc.ca/files/BC%20Health%20Education%20Foundation-edit.pdf>
- ^{xiv} CLPNBC reports the total number of "Active" registrations received during the registration year. CIHI excludes LPNs employed in other than practical nursing, LPNs not employed, and LPNs failing to state their employment status from most CIHI analyses. Canadian Institute for Health Information. (2006). Workforce Trends of Licensed Practical Nurses in Canada, 2005.
- ^{xv} Figures from BC Stats are estimated using Statistics Canada census data to forecast and as of July 1st of the year stated. BC Stats. (February 2007). Retrieved from: <http://www.bcstats.gov.bc.ca/data/pop/pop/project/bctab1.asp>
- ^{xvi} Information obtained from the Nursing Directorate, BC Ministry of Health on January 8, 2008
- ^{xvii} Pyper W. (November 2004). Employment Trends in Nursing. http://www.cerforum.org/conferences/200505/papers/pyper_cerf05.pdf
- ^{xviii} British Columbia Council on Admissions and Transfer (BCCAT). Education Planner. Retrieved from: <http://www.educationplanner.bc.ca/>

-
- ^{xix} BC Ministry of Advanced Education. (2005). Work Futures BC Occupational Outlooks for NOC 3413. Retrieved from <http://www.workfutures.bc.ca/profiles/profile.cfm?noc=3413&lang=en&site=graphic>
- ^{xx} Practice Expectations. Registered Nurses and Licensed Practical Nurses.
- ^{xxi} San Martin-Rodriguez L, Beaulieu D, D'Amour M, Ferrada-Videla M. (2005). The determinants of successful collaboration: A review of theoretical and empirical studies. *Journal of Interprofessional Care*, 19(1 Suppl), 132-147
- ^{xxii} San Martin-Rodriguez L, Beaulieu D, Ferrada-Videla M. (2005), *supra*
- ^{xxiii} Institute of Medicine (1999). *To err is human: Building a safer health system*. Washington, DC: National Academy Press
- ^{xxiv} San Martin-Rodriguez L, Beaulieu D, Ferrada-Videla M. (2005), *op cit*
- ^{xxv} San Martin-Rodriguez L, Beaulieu D, Ferrada-Videla M. (2005), *op cit*
- ^{xxvi} <http://www.fraserhealth.ca/NR/rdonlyres/ey55rc5am6yefah26b6jsng5o3zdn35gsvnkylqtjlqqpegdfx5zow5snezyvbcp3usz6iyqkffdze/InfocusApr06.pdf>
- ^{xxvii} Canadian Nurses Association. (2006). *Toward 2020: Visions in Nursing*. <http://www.cna-nurses.ca/CNA/documents/pdf/publications/Toward-2020-e.pdf>
- ^{xxviii} The term care team is used to include nursing staff, Care Aides, and allied health professionals where applicable.
- ^{xxix} Leonard M, Bonacum D, Taggart B. (June 29, 2007). Using SBAR to Improve Communication Between Caregivers. – IHI Presentation.
- ^{xxx} Banaszak-Holl J, Hines MA. (1996). Factors associated with nursing home staff turnover. *Gerontologist* 36(4):512-7.