

## **PART 4**

# case studies

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

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# case studies

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

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

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

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

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

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

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

**CASE STUDY**

# Kelowna General Hospital

KELOWNA, BC

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**1. FACILITY DESCRIPTION**

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

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

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

## 2. BACKGROUND

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

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

## 3. ROLES AND RESPONSIBILITIES OF NURSING STAFF

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

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

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

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

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

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

### **RN: LPN Staffing Patterns and Ratios**

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

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

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

Medical Unit – 4A (Respiratory – 30 beds)

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

Rehabilitation Unit (38 beds)

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

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

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

### **The LPN Role in Acute Care**

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

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

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

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

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

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

### **Nursing Practice Discussions**

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

### **The New Care Aide Role in Acute Care**

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

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

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

*Assisting patients with meals.*

*Cleaning items and areas such as utility rooms as assigned.*

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

#### **4. THE CHANGE PROCESS**

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

##### **Workload Analysis Study**

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

##### **LPN Skill Mix Task Group**

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

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

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

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

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

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

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

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

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



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

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

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

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

## 5. OUTCOMES

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

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

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

### **System Outcomes (Costs/Savings)**

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

- a) Removing hemovacs, drains and sutures – 30 minute in-service  
30 minutes x 126 LPNs @ \$19.02/hour = \$1,198.26
- b) Receiving report – no calculated costs.

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

- c) Maintaining tube feeding – 60 minute in-service  
1 hour x 126 LPNs x \$19.02 = \$2,400
- d) Resetting occlusion alarms on IVs – 30 minutes  
30 minutes x 126 LPNs x \$19.02 = \$1,200

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

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

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

### **Nurse and Patient Outcomes**

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

## **6. CHALLENGES AND SOLUTIONS**

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

### **Education**

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

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

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

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

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

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

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

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

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

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

### **Resistance to Change**

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

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

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

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

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

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

## **7. SUGGESTIONS FOR OTHER FACILITIES**

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

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

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

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

## **APPENDICES**

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

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

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



















**Making  
Recommendations  
(see previous  
page)**















































**CASE STUDY**

# Lions Gate Hospital

NORTH VANCOUVER, BC

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## 1. FACILITY DESCRIPTION

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

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

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

## 2. BACKGROUND

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

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

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

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

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

### **3. ROLES AND RESPONSIBILITIES OF NURSING STAFF**

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

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

### Nursing Staffing

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

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

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

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

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

### Roles and Duties of LPNs

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

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

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

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

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

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

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

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

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

#### **4. THE CHANGE PROCESS**

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

##### **Committees**

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

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

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

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

### **Education**

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

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

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

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

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

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

### **Written Material and Resources**

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



## 5. OUTCOMES

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

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

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

Challenges identified were:

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

Initial brainstorming developed possible solutions to the challenges, including:

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

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

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

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

## 6. CHALLENGES AND SOLUTIONS

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

### Education

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

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

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

### Role Overlap

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

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

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

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

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

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

### **Loss of RN Jobs**

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

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

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

## 7. SUGGESTIONS FOR OTHER FACILITIES

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

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

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

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

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

## APPENDIX

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

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

































































































**CASE STUDY**

# Malaspina Gardens

NANAIMO, BC

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## 1. FACILITY DESCRIPTION

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

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

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

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

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



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

## 2. BACKGROUND

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

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

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

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

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

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

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

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

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

### 3. ROLES AND RESPONSIBILITIES OF THE NURSING STAFF

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

#### Staffing Mix

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

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

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

#### LPN Role

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

*The position of licensed practical nurse...plays a significant role in the provision of quality care to all residents – physically, mentally, emotionally and spiritually in all their activities of daily living.*

*Summary of Duties:*

1. Give and chart daily medications.
2. Assist care aides in the implementation of resident care, when necessary.
3. Consult with the RN/care aide about changes in resident condition.
4. Assist to formulate, implement and evaluate resident care plans and activity of daily living plans for individual residents.
5. Chart any daily information into resident chart.
6. Assist with daily dressings as needed.
7. Participate in the Direct Care Team to support quality care of the residents.

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

One LPN described her practice as follows:

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

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

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

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

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

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

### **Care Aide Role**

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

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

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

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

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

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

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

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### **Other Team Members**

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

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

### **Team Care Planning**

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

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

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

## **4. THE CHANGE PROCESS**

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

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

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

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

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

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

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

## 5. OUTCOMES

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

### System Outcomes

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

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

### **Nurse Outcomes**

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

### **Quality of Care Outcomes**

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

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

## **6. CHALLENGES AND SOLUTIONS**

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

### **Education**

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

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

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

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

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

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

### **Process for Conflict Resolution**

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

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

### **Work Jurisdiction Issues**

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

## 7. SUGGESTIONS FOR OTHER FACILITIES

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

### Communication and Collaboration

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

### Manage the Change Process

Participants suggested that facilities plan the change strategically.

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

### Education

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

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

### Facility Design

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



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

**APPENDICES**

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

(\*Malaspina Gardens was formerly called Malaspina Lodge)

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

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























**CASE STUDY**

# Saanich Peninsula Hospital

SAANICHTON, BC

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**1. FACILITY DESCRIPTION**

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

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

**2. BACKGROUND**

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

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

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

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

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

*We were at times mixing the patients needing a longer stay with the short stay acute patients. Their needs were very different. The longer stay patients' needs were not being met. The longer stay patients and the demented/confused patients were in the highest traffic area. Often the LPNs would have a huge number of patients to care for.*

*Many complaints came from families of longer stay patients because they perceived that the acute care patients were getting most of the care and attention. When I charted these reports over a six month period with the nursing workload, I noticed a pattern. I was getting many quality assurance reports around work environment such as "we do not have enough staff" or "we do not have the right mix."*

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

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

### **3. ROLES AND RESPONSIBILITIES OF NURSING STAFF**

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

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

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

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

(Job Description appended)

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

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

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

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

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

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

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

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

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

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

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

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

#### **RN to LPN Staffing Ratios on Medical South**

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

**DAYS** one RN, three LPNs

**EVENINGS** one RN, two LPNs, and

**NIGHTS** one RN, one LPN.

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

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

#### **4. THE CHANGE PROCESS**

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

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

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

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

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

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

## **5. OUTCOMES**

### **Patient Outcomes**

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

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

### **Nurse Outcomes**

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



**System Outcomes**

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

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

**6. CHALLENGES AND SOLUTIONS**

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

**Communication and Role Overlap**

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

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

### **Shift Schedules**

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

### **Uncertain Environment**

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

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

### **LPN Advocacy**

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

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

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

## 7. SUGGESTIONS FOR OTHER FACILITIES

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

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

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

### APPENDICES

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

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

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















**CASE STUDY**

# Terraceview Lodge

TERRACE, BC

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**1. FACILITY DESCRIPTION**

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

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

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

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

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

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

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

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## **2. BACKGROUND**

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

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

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

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

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

## **3. ROLES AND RESPONSIBILITIES OF NURSING STAFF**

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

**Staffing**

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

**Care Aides**

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

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

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

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

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

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

**Charge Nurse**

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

### LPN Team Leader

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

The duties are summarized as follows:

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

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

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

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

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

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

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

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

### **The Team's Role**

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

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### **Team Meetings and Care Planning**

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

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

## **4. OUTCOMES**

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

### **System Outcomes**

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

### **Nurse Outcomes and Quality of Care Outcomes**

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

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

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

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

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

## 5. CHALLENGES AND SOLUTIONS

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

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

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

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

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

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

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

### Preparation and Support of the New LPN Team Leaders

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

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

### **Education of Other Staff About the Team Leader's Role**

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

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

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

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

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

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

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

### **Discussion of Shared Roles/Duties**

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



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

## 6. SUGGESTIONS FOR OTHER FACILITIES

### Introducing Team Leaders

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

### Communication and Respect

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

### Managing the Change Process and Staffing Patterns

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

### Education

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

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## APPENDIX

Job Description of Team Leader





**CASE STUDY**

# Yaletown House Society

VANCOUVER, BC

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**1. FACILITY DESCRIPTION**

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

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

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

**2. BACKGROUND**

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

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

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

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

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

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

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

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

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

### 3. ROLES AND RESPONSIBILITIES OF NURSING STAFF

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

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#### DAYS and EVENINGS

On the 4th floor      Days: one LPN, one RN and two care aides

Evenings: one RN and two care aides

On the 3rd floor      Days: one LPN, one RN and two care aides

Evenings: one LPN, one RN and one care aide

On the 2nd floor

(Special Care Unit) Days: one LPN, one RN and five care aides

Evenings: one LPN, one RN and two care aides

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

#### NIGHTS

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

On the 2nd floor: one LPN, one RN and one care aide

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

#### Job Descriptions and Performance Expectations

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

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

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

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

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

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

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

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

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

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

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

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

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

## 4. OUTCOMES

### System Outcomes

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

### Quality of Care Outcomes and Nurse Outcomes

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

## 5. CHALLENGES AND SOLUTIONS

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

### Budget

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

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

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



### Education of Staff on the Roles and Responsibilities of LPNs

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

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

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

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

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

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

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

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

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

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

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

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

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

### **LPN Casual Pool**

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

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

### **The Loss of Care Aide Positions**

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

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

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

Management is also aware of the effect on care aides.

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

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

## **6. SUGGESTIONS FOR OTHER FACILITIES**

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

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

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

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

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

### **Avoid Job Loss**

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

### **Establish a Coordinating Committee for the Change Process**

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

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

### **Communication About the Change in Staff Mix**

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

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## **APPENDICES**

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











