

Optimized Practice

Optimizing the Role of the RN, LPN and Assistive Personnel in Acute Care

A Program to Support the Model of Care Initiative in Nova Scotia

MODULE: Core Concepts – Participant

Introduction

Through a partnership between the Nova Scotia Department of Health, Professional Practice at Capital Health, College of Registered Nurses (CRNNS), College of Licensed Practical Nurses (CLPNNS) and the Registered Nurses Professional Development Centre (RN- PDC), a new education program was launched in January 4, 2010. The program is titled "**Optimized Practice: Optimizing the Role of the RN, LPN and Assistive Personnel in Acute Care**".

This program was developed as part of the Model of Care Initiative in Nova Scotia to provide education and support to the nursing staff and managers across the province that have, or will be implementing the Collaborative Care Model¹. Together all nine District Health Authorities and the IWK have implemented a new Collaborative Care Model in 14 selected acute care inpatient medical surgical and maternal child units in Phase 1 (October 2008-June 2009) and are preparing to introduce an additional 25 units in Phase 2 (September 2009- March 2010). The Collaborative Care Model is an innovative, evidence informed model that was developed early in the initiative by a provincial design team of over 55 people to enable healthcare providers to make the best use of their talents by enabling them to work to their full potential, using efficient processes, information and modern technology to provide patient-centered, high quality, safe, and cost effective care.

Contributing Partners include the following members:

- Department of Health
- Professional Practice Capital Health
- College of Registered Nurses of Nova Scotia
- College of Licensed Practical Nurse of Nova Scotia
- Registered Nurses Professional Development Centre

Special Note:

The partners gratefully acknowledge the generous contribution and unrestricted access to *Optimized Practice: Optimizing the role of the RN, LPN and AP* that was originally developed by Professional Practice, Capital Health. Given without condition, this gesture was significant, serving both as a foundation for this provincial education program and a display of interagency collaboration.

*** The Assistive Personnel Role Description was developed with the intent of the collaborative care team in mind. The role description focuses on the contributions of assistive personnel ... not position titles. It is recognized that various titles are and will be used for individuals in this role in acute care.**

**** Nurses are professionals who make care decisions independently; however, when necessary consult and collaborate with all members of the health care team including physicians.**

Objectives

Overall Objective: Participants will be able to optimize the role of the RN, LPN and Assistive Personnel within the Collaborative Care Model.

Following completion of this education session participants will be able to:

1. INTRODUCTION

- a. Discuss current healthcare trends which are driving the need for change in care delivery models.
- b. State the absolute principles to consider when changing a care delivery model.
- c. Explain the role communication plays when implementing a new care delivery model.
- d. Describe specific concepts relating to nursing practice and care delivery.

2. DECISION MAKING

- a. Explain the difference between RN and LPN decision-making.
- b. Identify the types of clients where decisions are maximized for RNs and LPNs.
- c. Define the process of critical thinking as it applies to each individual role.

3. PROFESSIONAL LEGISLATION/ACCOUNTABILITY

- a. Discuss examples of practice as it relates to the RN Act and the LPN Act.
- b. Identify the meaning of accountability as it applies to both the role and the individual practice of the RN and LPN.

4. ROLE AND SCOPE OF PRACTICE OF RN'S, LPN'S AND AP'S

- a. Describe the differences between the scopes of practice of RNs, LPNs & Assistive Personnel.
- b. Explain the relationship between knowledge (shared and differentiated) and decision making.
- c. Describe decision making as it relates to scope of practice.
- d. Discuss the importance of a plan of care.
- e. Differentiate between the role accountabilities for RNs and LPNs in the nursing process.
- f. Discuss the expansion and contraction of LPN decision making in relation to patient populations.

5. ASSESSMENTS

- a. Differentiate between the components of an assessment as it relates to the role of the RN and LPN.

6. CRITICAL THINKING

- a. Apply the components of a critical thinking framework/algorithm in the discussion of specific case scenarios.

7. EDUCATION

- a. Identify how each role contributes to the Tri-Support Provider Model within the education framework.

8. ASSIGNMENT/DELEGATION

- a. Describe the difference between assignment and delegation as it applies to the role of RN, LPN & AP.

9. CASE STUDIES

- a. Apply information learned from education session through the use of selected case studies.

Collaborative Care Model

The Collaborative Care Model: Defining a New Model of Care in Nova Scotia

The new Collaborative Care Model is founded on the premise that all care starts with the patient and family. Collaborators include the patients, family members, and the interdisciplinary team. The role of all collaborators is to contribute to the patient's care, as needed, to ensure safe and optimal outcomes.

This is a new model of care for acute care in-patient care delivery that is patient-centred, high quality, safe, and cost effective.



PRACTICE NOTE

Optimized Practice of RNs, LPNs and APs is one component of the Collaborative Care Model and falls directly under the key area of **PEOPLE**, however it will have impact in all the key areas.

Why Change?

Currently, health care in Nova Scotia is simultaneously experiencing four trends. These trends are driving our need to change the way we do business, meaning deliver quality care. We know, by looking at the data, both internal and external, that we cannot sustain the current delivery model in this “perfect storm context”.

1. Underutilization of Health Care Providers

The scope of practice of some care providers has not been optimized in that there are not current operational supports in place to allow professionals to practice to the full capacity of legislation.

2. Sicker Patients

Patients are coming into our system with greater care needs, more co-morbidities and requiring more care and treatments which grow in complexity every day. Patients are also coming to our organization with different and higher expectations of the care they receive.

3. Tighter Resources

There is an ongoing competition for space, money, time, infrastructure, and support staff. Competition reaches far beyond each health district and impacts the province, the nation and the global healthcare community.

4. Shortage of Qualified Health Care Providers

The health care provider shortage is upon us. This not only is affecting Registered Nurses, but Licensed Practical Nurses as well. This being said, nursing is not the only health profession experiencing difficulty recruiting and retaining qualified health care providers. All health disciplines are experiencing the same struggle. The PHSOR report notes that in 2010 20% of staff in key health professional groups will be eligible to retire. That number escalates to 44% in 2015.

We can sustain quality care delivery by developing collaborative practice models which are based on the optimized scopes of practice and the needs of the patients.

PRACTICE NOTE

There are multiple issues at play in health care at this time. The bottom line is we have to be able to deliver safe, effective, efficient and ethical care within an envelope of financial recourses.

Absolutes: RN & LPN Practice

There are several absolutes we must consider when changing care delivery models.

1. All patients expect safe, efficient, effective, ethical and quality care every time they access the healthcare system, no matter where they access the health care system.
2. The Standards of Nursing Practice, as set forth by the Colleges of Registered Nurses and Licensed Practical Nurses in Nova Scotia, requires that nurses provide safe, efficient, effective, ethical and quality care to patients every time they access the healthcare system, no matter where they access the healthcare system.
3. **Registered Nurses (RNs)** are most efficiently utilized in caring for patients with **complex** (new, changed or complex) challenges and/or **unknown** health outcomes.
 - a. RN specific decisions within the care team include: **Interpretation** of the data (What does this mean), **Integration** of the data (How does this fit into the plan of care) and **Coordination** of the care (Who do I consult or How do I make this happen).
4. **Licensed Practical Nurses (LPNs)** are most efficiently utilized in caring for patients with **predictable** (identified, unchanged, predictable) challenges and/or **known** health outcomes.
 - a. LPN specific decisions within the care team include: **Review** of the data (Am I seeing what I expect to see) **Evolution** of the plan (Is the patient responding as anticipated) and **Facilitation** (What things do I need to do to help this patient).
5. Scope of practice are the roles, functions and accountabilities which members of a profession are educated and authorized to perform and **are often expressed in the form of decisions around a task and not the task itself.**
 - a. RNs can make nursing care decisions independently regardless of patient type.
 - b. LPNs can make nursing care decisions independently for patients who have predictable outcomes. As the acuity or complexity of care increases, and/or the outcomes are not predictable and an advanced level of knowledge is required, the LPN works in collaboration and/or under the general direction of a registered nurse or medical practitioner (CLPNNS 2005)

*Complex is defined as any problem that is **NEW, CHANGED or COMPLEX/ COMPLICATED** or has **Unknown/ Unexpected Outcomes.***

*Predictable is defined as any problem that is **IDENTIFIED, SAME or PREDICTABLE/ UNCOMPLICATED** or has **Known/Anticipated Outcomes.***

PRACTICE NOTE

The absolutes are a set of guidelines from which everything else must stem. They are important because they will guide all actions of an optimized collaborative care model.

DIFFERENTIATED PRACTICE

SCOPE of PRACTICE (SOP): Roles, functions and accountabilities which members of a profession are educated and authorized to perform. For nurses, this is governed by legislation.

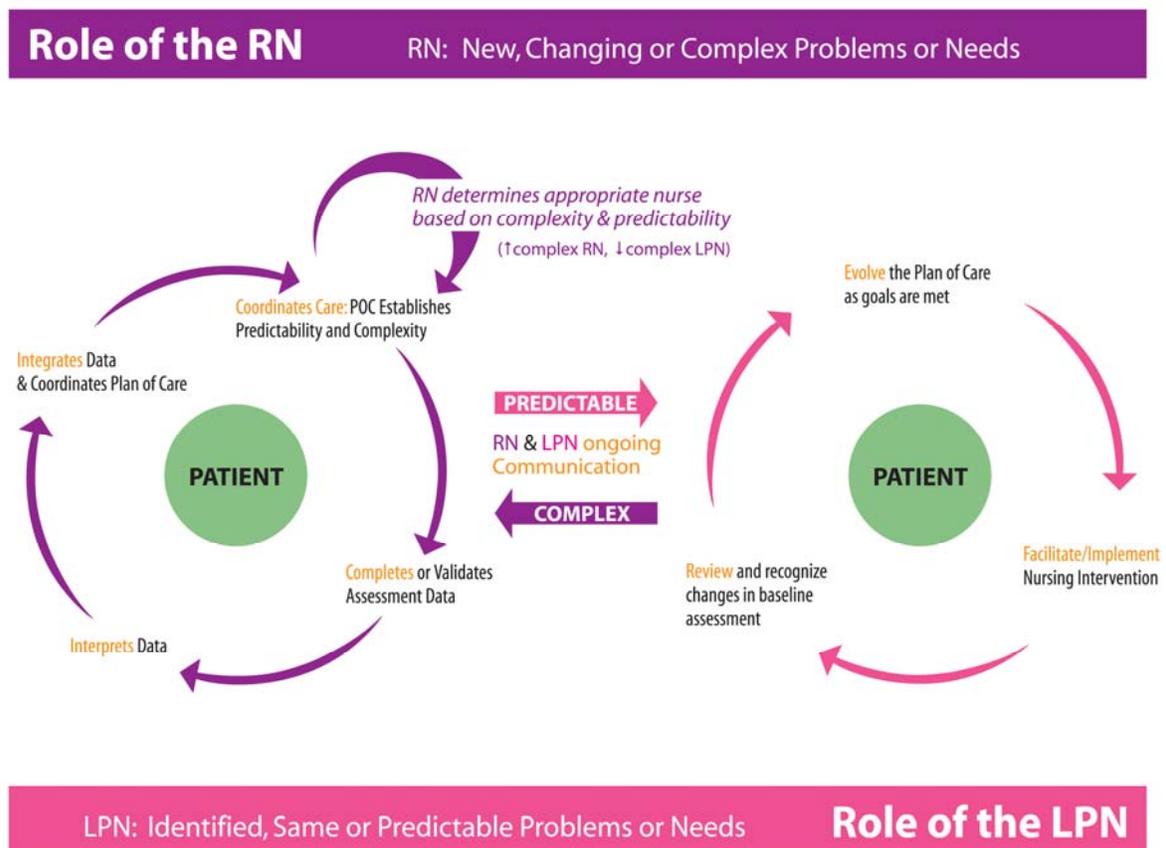
SCOPE of EMPLOYMENT (SOE): Roles and function of a particular job classification. May be based on legislation (IE RN and LPN) or educational curriculum (IE Assistive Personnel)

Both SOP and SOE are contextual to practice areas and as such, sometime are based on the supports in that particular practice area. For instance, a nurse with an advanced competency (radial artery puncture for example) is able to perform the competency in an area where there is sufficient people, process and infrastructure to support the practice (ICU), but may not be able to perform the skill in a different area, where there is insufficient people, process or infrastructure to support the practice. (Long Term Care)

The term "nurse" refers to either RN or LPN; APs support nurses and care delivery.

***It is important to note that the scope of practice of LPNs is within the RN scope of practice.*

Collaborative RN and LPN Relationship



98% Relationships

Communication is critical to the Collaborative Care Model. An optimized collaborative practice model is based on strong communication and collaborative relationships among the providers on the team. Communication should be consistent, constant and multi-directional to ensure effective care delivery.

Quality care is best achieved by ensuring the *right care provider is in the right place for the right patient at the right time using the most efficient recourses to achieve the best possible outcomes.*

Communication is more than the exchange of information.

“Mr. Smith rang while you were at lunch and requested something for pain. I gave him two Tylenol”

Collaborative communication involves the exchange of information, ideas, experiences, responses and provides a deeper and broader understanding, and therefore more effective and quality driven results. **Collaborative communication between health care professionals often produces interventions that could not have been created individually.**

“Mr. Smith rang while you were at lunch. He requested something for pain. I gave him two Tylenol, but I notice that he has been getting the Tylenol almost ever 4 hours for 2 days. Have you talked to the doctor about this?”

“Well no, as Mr. Smith does not want to take anything ‘stronger’ than Tylenol.”

“Do you think this is the best option for him? I wonder why he thinks that.”

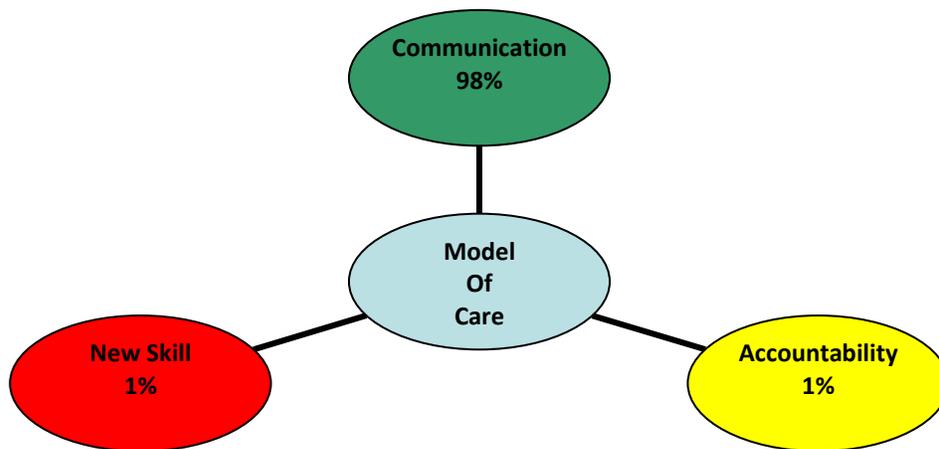
“Do you think I should ask him? Its seems like I’m prying?”

“No it’s not prying. I see it more as trying to uncover his beliefs about pain medicine that are having a negative impact on his own pain control. Maybe if you and the Acute Pain Service nurse spent some time talking about the issues, we may be able to change the treatment plan to get better pain control”.

Practice Note

The reality is that an optimized collaborative practice model is all about communication and relationships. Unscientifically, 98 % of any model is based on communication, 1 % is new skill and 1% accountability. It is important for nurses to understand that the changes that will occur in the Collaborative Care Model will be focused on the way they communicate with each other.

Framework of Communication



Fear and Anxiety

Often times, staff becomes anxious when there is discussion of model of care changes. It is important to understand the origins of the fear and anxiety that arises when changes are being discussed and/or implemented. Care must be taken with teams to explore these feelings thoroughly if any change is to be successful.

PRACTICE NOTE

Nurses are knowledge based professionals and as such, will often focus on the development of new competencies as a response to the fear and anxiety generated by change. When this happens, the new competencies begin to look and feel larger and bigger than the reality. This perpetuates fear and anxiety. Focusing on communication (the highly unscientific 98% for example) as the framework for an optimized collaborative practice model will help keep fear and anxieties to a minimum.

Never underestimate the fear of loss (spoken or unspoken) in these conversations. Ensuring the whole team has the opportunity to express the fear and anxiety will also help keep fear and anxiety in perspective.

Core Concepts

1. Critical Thinking

Critical thinking is the process of applying what you know to what you do not know and arriving at a reasonable logical answer. Nurses critically think through a lens of their professional practice standards.

KNOWLEDGE	LEGISLATION		PATIENT ISSUE	DECISION
	RN	LPN		

Critical thinking is an opportunity for conversation between care providers at all levels and keeps nursing interventions specific to the patient and their particular needs at hand rather than applying routine interventions. **Routine interventions are customized using critical thinking.**

PRACTICE DIFFERENTIATION

There is a myth that says, the only differences between RN and LPN practice is some medication administration and hourly wage. The truth is that RNs and LPNs are different care providers within the profession who share basic nursing knowledge. RNs have additional education and knowledge and therefore have a **broader and in-depth understanding** of the fundamentals. RN practice is best focused on complex problems and LPN practice is best focused on predictable problems. **Complex patient problems require RN level decision making.** RNs and LPNs share basic nursing knowledge, which means **that predictable patient problems can be managed with decisions by an LPN or RN.** The bottom line here is, RNs and LPNs are different care providers within the same profession and have different decision making abilities because they are educated differently. (FYI...This is neither right, nor wrong; it's just the way it is!)

PRACTICE NOTE	
Routine Intervention	Customized Intervention
Turn q2h to prevent skin breakdown	Turn q2h R-back-R-Back-L repeat (avoid frequent turns to L hip r/t old fracture)
O2 4L N/C for O2 sat of 88%	O2 1L N/C for O2 sat of 88% for a patient with chronic COPD and a sat baseline of 90%
Place all GYNE patients on the OR table in stirrups raised to the 11 inch mark.	Reduce the stirrups to 7 inches on the Left side for client with 4% mobility. Set up table on right hand side of OR table.

2. Accountability

Nurses are accountable for their actions at all times and for what they know or what they should have known. Nurses are only accountable for the actions of others if they have knowledge of the action.

3. Predictability/Complexity Continuum

Each patient falls somewhere on the P/C Continuum. This dynamic point is determined in relation to: 1) The number and nature of problems identified; 2) The number and nature of interventions; and 3) The variability of the patient's response to the interventions. This is made visible in an established plan of care (POC). As RNs are accountable to establish the nursing component of the POC, the RN is the most accountable nurse to determine the level of predictability or complexity for patients; however, this can be done in collaboration with LPNs.

PREDICTABLE ↑Predictability ↓Complexity	ACUTE = Predictability/Complexity	COMPLEX ↓Predictability ↑Complexity
Patients whose health challenge is known and trajectory of care/recovery has little variation from others with same health experience	Patients whose health challenge is not always well known and changes often, however has some degree of predictability by process, but variations often occur in individual patients.	Patients whose health challenge is not well known and frequently changes. Even though there is some degree of predictability by process, variations in care, patient needs (technical and/or psychosocial) are often significant. Patients whose health challenge is consistently variable.

DIFFERENTIATED PRACTICE

Understanding the patient type is important to ensure the right care provider is in the right place at the right time. **REMEMBER:** RNs are most effectively used caring for **COMPLEX** patients and LPN are most effectively used caring for **PREDICTABLE** patients. The plan of care determines where the patient lies on the predictability and complexity continuum. (The assumption is the greater the number of problems identified the greater the complexity and vice versa.) It is important to note the predictability and complexity are contextual to practice environments. This means that the types of care providers, the supports available to a care unit and the kinds of patients generally cared for on that unit can impact the overall level of complexity and predictability. Along this line, specific care events, episodes or interventions can also impact where a patient lies on the predictability/complexity continuum.

PRACTICE NOTE

A patient's position is rarely static on the predictability/complexity continuum. Individual nurses, both RN and LPN are accountable to communicate with each other when the predictability or complexity of their patients changes.

4. The right nurse in the right place, for the right patient using efficient resources to achieve the best possible outcomes

Scope of practice is **decisions about tasks and not just the tasks alone.** The difference in the practice of RNs and LPNs is related to their ability to make nursing care decisions independently.

Registered Nurses can make nursing care decisions **INDEPENDENTLY**** regardless of level of patient complexity, what is known versus unknown or presence/absence of a developed POC/NCP.

Licensed Practical Nurses can make nursing care decisions **INDEPENDENTLY** for** patients who have predictable outcomes and known health challenges within an established and visible POC/NCP. The LPNs ability to make decisions is dependant upon the complexity of the patient which results in 3 levels of decision making:

- INDEPENDENT** with patients who have a low degree of complexity and high degree of predictability
- COLLABORATIVE** with the RN with patients who have equal degrees of complexity and predictability
- DIRECTED** by the RN with patients who have a high degree of complexity and low degree of predictability

LPN	LPN/RN	RN
PREDICTABLE ↑Predictability ↓Complexity	ACUTE = Predictability/Complexity	COMPLEX ↓Predictability ↑Complexity
LPN Practice (decisions) is INDEPENDANT of the RN	LPN Practice (decisions) is COLLABORATIVE with the RN.	LPN practice (decisions) is DIRECTED by RN
The LPN is solely accountable for outcomes of care (once the original POC is developed by the RN).	RN & LPN share accountability for outcomes of care (once the original POC is developed by RN).	RN is solely accountable of outcomes of care.
Larry LPN is caring for Mr. A. who rings his call bell stating that he has a headache and requests <i>Pill X</i> as it is ordered for his headache		
Larry reviews the orders and the clinical picture and determines that <i>Pill X</i> is an appropriate intervention and administers <i>Pill X</i>	Larry reviews the orders and clinical picture and collaborates with the RN to determine if <i>Pill X</i> is the appropriate intervention. When the appropriateness is determined between the RN and LPN, Larry administers <i>Pill X</i>	Larry reviews the orders and communicates the request to the RN who interprets the clinical picture and determines the appropriateness of the intervention. The RN assigns the medication administration to Larry who administers <i>Pill X</i> .

5. Plan of Care

The overall Interprofessional Plan for the patient. It defines actual and potential issues, accountability for the interventions, supports and outcomes. It is a vehicle to communicate, monitor and track progress and is developed collaboratively by the person and the health care team. (CDHA Professional Practice, June 2009).

6. Nursing Component of the Plan of Care (Nursing Care Plan)

A plan specific to the discipline of nursing which fits into the broader POC and consists of 3 components: **Problem** Identification (What is the patient issue?) **Outcome/Goal** Setting (What is to be achieved when issue is corrected/reduced?) **Nursing Interventions** (What actions will be taken to correct/reduce issue?)

Registered Nurses are accountable to develop/coordinate the nursing component of the POC. Licensed Practical Nurses are accountable to both: 1) contribute to the nursing POC and 2) collaborate with the RN in the development and evolution of the nursing POC.

DIFFERENTIATED PRACTICE

The **RN is accountable** to ensure that a nursing care plan (NCP) is developed on every patient in the health care system and is **responsible to make sure that all existing and new problems have the necessary interventions in place to address them.**

LPNs are accountable to enact the interventions developed in the nursing care plan. LPNs are accountable to identify new problems and alert the RN and/or other professionals when new problems are discovered.

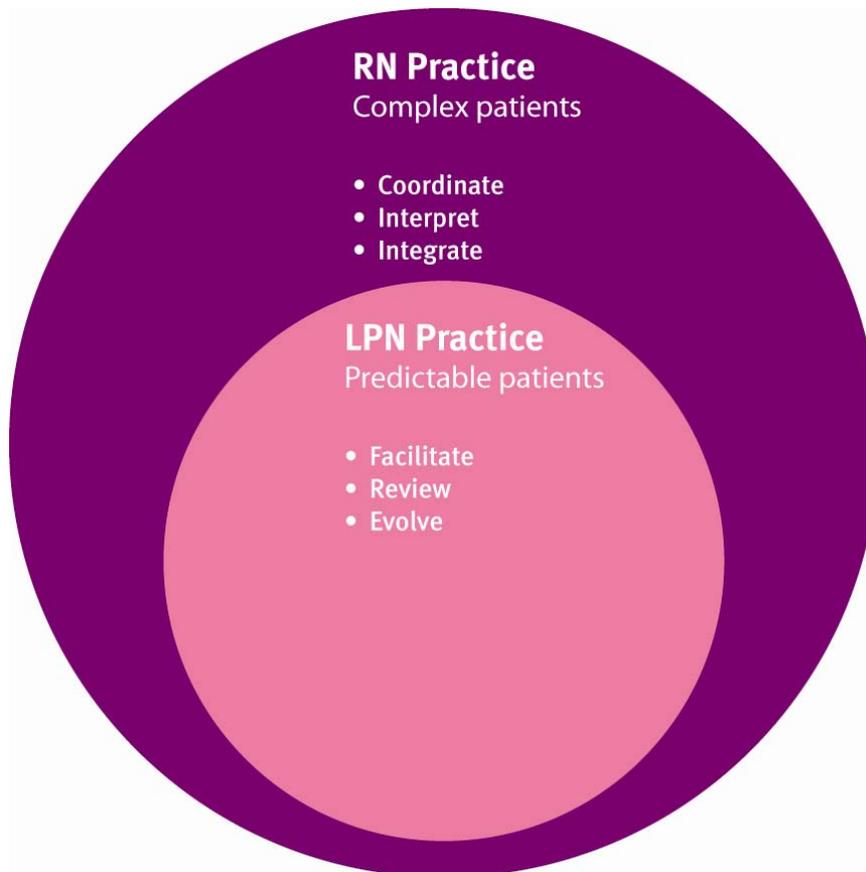
RNs evaluate the entire nursing care plan to ensure the overall nursing outcomes are being achieved. LPNs evaluate patient responses to specific interventions to make sure that goals within the plan are being achieved.

Plan development is the RN accountability however he/she does not do that in isolation and the LPN is accountable to participate in plan development, implementation and evaluation.

7. Role and Scope of the RN and LPN

RN's and LPNs are legislated provincially and have a scope of practice which sets out standards of practice. Assistive Personnel (AP's) are not legislated and have a scope of employment that is based on the curriculum for the training programs which educate AP's. RN's, LPN's and AP's work in collaboration with other members of the health care team to provide care.

The roles for RN's and LPN's regulated health care professionals are clearly identified within their legislated scope of practice. Although health care providers (RN's and LPN's) have distinct roles and scopes of practice, some *interventions* that are within the AP scope overlap with those of other health care providers. Shared knowledge allows providers to communicate in the clinical area. Care providers have different levels of formal education which contributes to their knowledge bases.

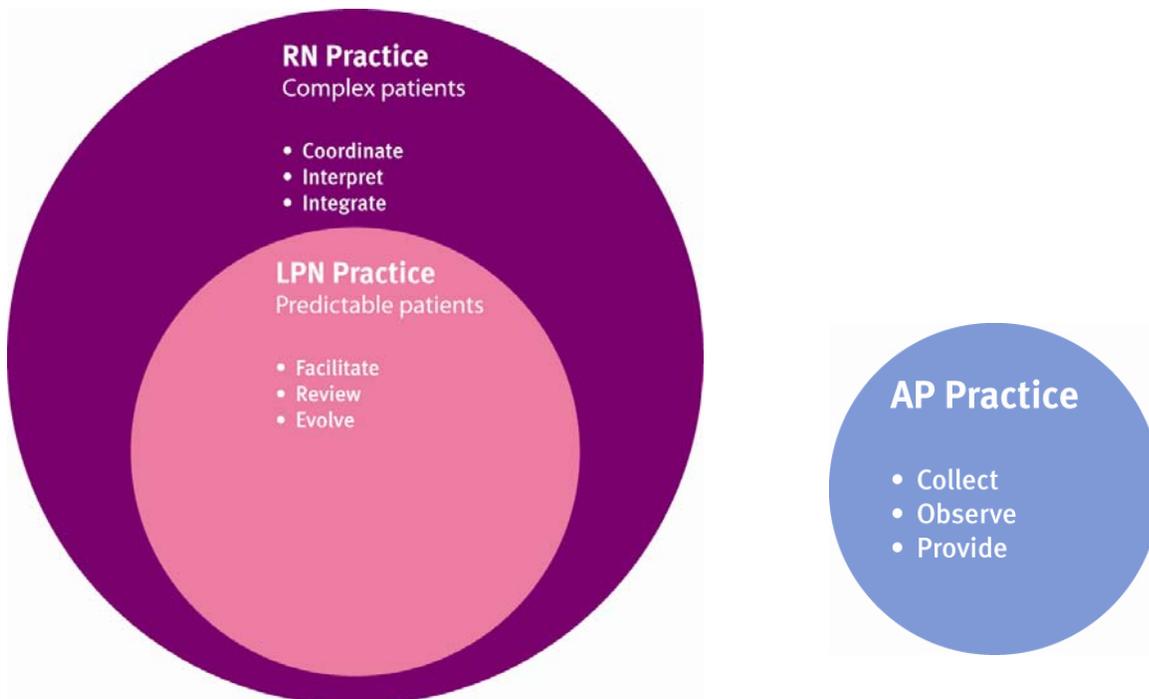


Role and Scope of the AP

Assistive Personnel contribute to the delivery of professional care by providing direct, hands-on care *under the direction and supervision of regulated professionals*. The AP role does not substitute for a regulated health care professional.

Assignment of duties to AP is determined by a regulated health care professional(s) based on the needs of the patient and/or unit and an assessment of the required skill mix to fulfill those needs. Regulated professionals are responsible and accountable for ensuring that the AP has the skills and knowledge required to perform the assigned duties. AP are responsible and accountable for accepting assigned tasks they are competent to perform and communicating when they do not feel competent to complete the assigned task.

Patient acuity and complexity will influence the assignment of duties to AP. If the acuity of the patient is high and treatment outcomes are unpredictable, regulated health care professionals are expected to retain responsibility for those tasks, even though the AP is qualified to perform such tasks.



Role and Decision Making

RN

Interpretation of Patient Data

Monitors patient data/assessment and makes care decisions that result in and the creation of a clinical picture EXAMPLE: Patient has history of CHF and presents with increasing SOB, crackles and diminished breath sounds. Assesses patient understanding of self medication, I/O, fluid balance and self-care.

Integration of Patient Data

Makes care decisions that results in the creation or revision of a NCP to address the new issue. EXAMPLE: Consult physician, develop education plan in relation to understanding of disease process, medications, I/O and, strict fluid balances, monitors lab results

Coordination of Patient Care

Consults the appropriate interprofessional team members to share knowledge, assessment results and co-develop interventions/plan to address issues. EXAMPLE: Consults dietician and respiratory therapy to co-develop interventions aimed at increasing patients understanding of the impact of diet on CHF maintenance.

Complex patients with unknown outcomes or new, changed or complex problems. Develops, changes or revises an existing plan because existing plan was not addressing issues.

LPN

Review of Patient Data

Scans patient data/assessments and responses to interventions and makes care decisions to ensure outcomes or goals of the NCP are being achieved. EXAMPLE: reviews I/O, daily weights, lung sounds and adds DB&C to interventions.

Evolution of the Established POC/NCP

Makes care decisions in regards to the nature, type and quality of nursing interventions by altering actions in intensity or frequency in an effort to move the patient towards the established outcomes/goals. EXAMPLE: As patient shows a reduction in SOB, crackles, DB&C and ambulation schedules are increased.

Facilitation of Patient Care

Makes care decisions to enact interventions or plans. EXAMPLE: Works with other care providers to ensure patient has adequate time to self-ambulate and attend in house dietician education program.

Predictable patients with an established plan of care with known outcomes, identified, same or predictable problems. Evolves the existing plan to move patient toward goals.

Decision Making of RN and LPN: Similarities and Differences

Decision		Similarities	Differences
RN	LPN		
Interpretation	Review	Both involve looking at the patient data or the assessment	Interpretation indicates that something is unknown or a patient is responding or presenting in a manner that is not expected. The goal of interpretation is to determine what the priority issues is or what is causing the patient data/assessment to be as it is. Review indicates that something is known or anticipated. The goal of review is to determine if the data is what we expected or want it to be. If it is not, then it must be interpreted .
Integration	Evolution	Both are a result of evaluating the patient's response to interventions	Integration indicates that the responses are unknown or unexpected and the patient is not achieving goals as planned. The goal of integration is the development of a plan/interventions that will address the patient's problems. Evolution indicates that responses are expected and that the patient is achieving the goals of their care as expected. If goals are not being achieved, the data must be integrated into a new set of interventions.
Coordination	Facilitation	Both involve monitoring and (co)creating interventions or enacting interventions	Coordination indicates new or unknown issues that require an interprofessional approach to co-create actions to address problems. Facilitation suggests actions are developed and are ready to be carried out. When issues prevent actions from being carried out, there must be further coordination to support them.

Decision Making Framework by Role and Legislation

Registered Nurses have in-depth nursing knowledge and can make nursing care decisions independently about all patients regardless of complexity. In-depth knowledge is required to make nursing care decisions about **NEW, CHANGED or COMPLEX** patient problems. These decisions generally result in a NEW, CHANGED or DIFFERENT NCP/POC

Licensed Practical Nurses have basic nursing knowledge and can make nursing care decisions independently about **PREDICTABLE** patient problems *after* the POC/NCP has been developed by the RN to address the problems. Basic knowledge is required to make decisions about **IDENTIFIED, SAME or PREDICTABLE** patient issues. These decisions generally result in an EVOLUTION of the established NCP/POC.

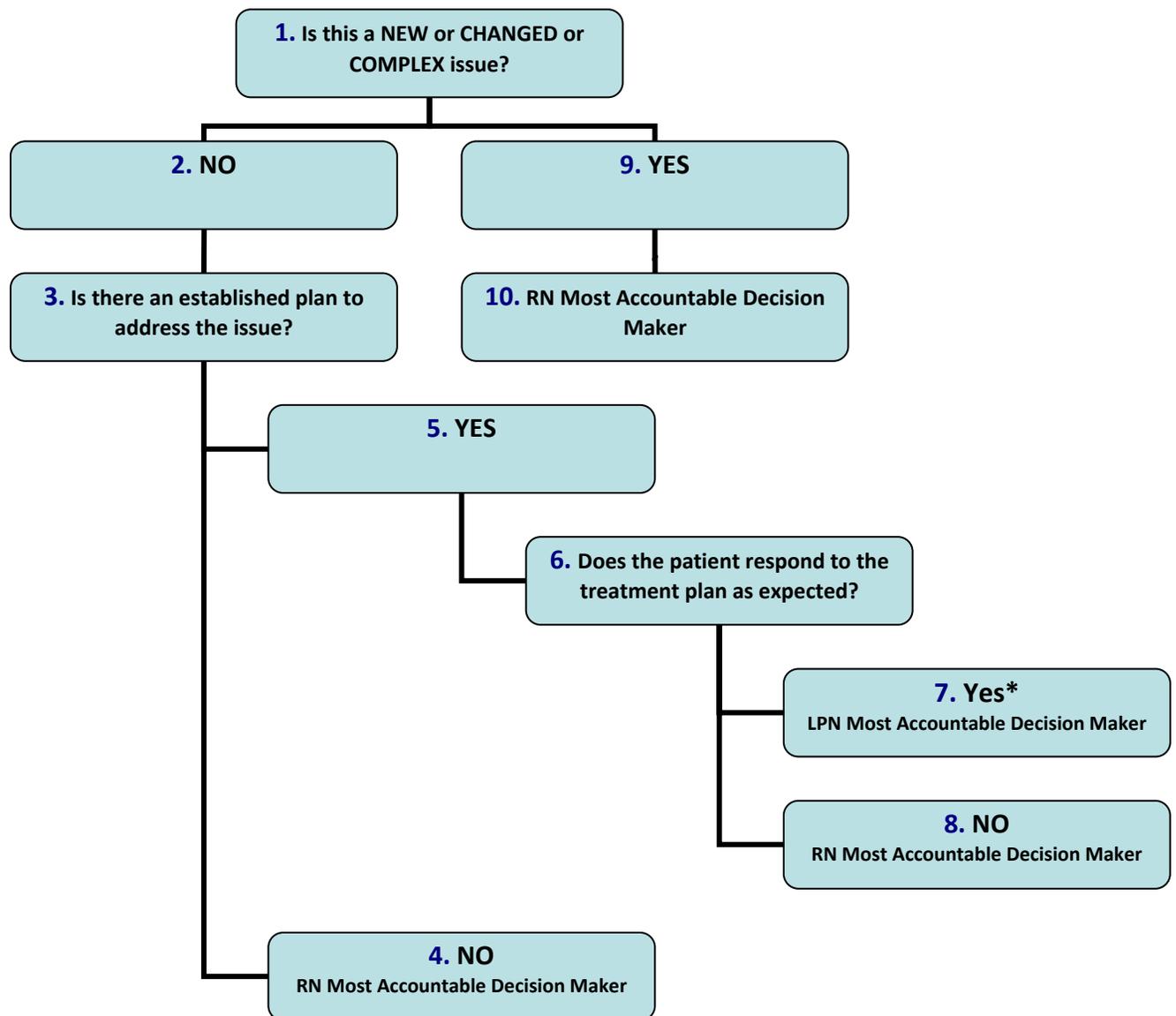
When patient acuity rises and the **IDENTIFIED, SAME or PREDICTABLE** problems become **NEW, CHANGED or COMPLEX**, LPNs are expected and accountable to: 1) notify the RN of the change in acuity 2) collaborate with the RN to make care decisions.

Decision Making Framework by Role and Legislation Algorithm

The goal of this algorithm is to provide a framework to illustrate key points to stimulate critical thinking and discussion between RNs and LPNs.

This framework can be applied to:

- POC/NCP decision making
- Decisions that relate to tasks (medication administration)
- Consultation (calling a physician)



Decision Making Framework by Role and Legislation Algorithm: Supporting Rationale

1.	New, Changed and Complex issues are the starting point for legislative decision making because this is where the RN practice separates from LPN practice.
2.	Identified, Same and Predictable issues can warrant decisions by either and RN or LPN
3.	An established POC means there are set expected outcomes for the specific issue and as such there are interventions already in place to address them
4.	If a set POC is NOT established, the decisions/action becomes related to RN practice because the PREDICTABILITY and COMPLEXITY of the patient have not been fully established. Legislatively, LPNs cannot develop initial plans independently. Developing or changing a POC is the role of the RN.
5.	An established POC means there are set expected outcomes for the specific issue and as such there are interventions already in place to address them
6.	LPNs are legislated to manage EXPECTED patient responses IE Pain scale decreases from 5 to 2 after administration of pain medication. This means the established POC is working. If the patient response is UNEXPECTED the assumption is the POC will need to be changed. Legislatively, LPNs cannot develop initial plans independently. Developing or changing a POC is the role of the RN.
7.	The LPN can independently make decisions about patient care and outcomes if the POC is established and the patient is responding to the POC as expected. * (PREDICABILITY is high and COMPLEXITY is low). The LPN would be expected to collaborate with the RN as needed.
8.	Legislatively, the RN must make the decisions if the POC is not established or the patient responses are not expected. (PREDICTABILITY has decreased and the COMPLEXITY has increased) Legislatively, LPNs cannot develop initial plans independently. Developing or changing a POC is the role of the RN.
9.	New, Changed and Complex issues are the starting point for legislative decision making because this is where the RN practice separates from LPN practice.
10.	

8. Nursing Process

Registered Nurses assess, plan, intervene and evaluate. Licensed Practical Nurses assess, plan, intervene and evaluate. Care plans establish the level of predictability or complexity of a patient and the **RN is accountable** to make certain a care plan is visible on each patient and as such, are often the nurse to create the initial plan. (In some settings, such as long term care, a tentative plan is developed by an RN who is assigned to assess the patient's applicability for LTC prior *to admission* and the LPN would be accountable to continue to use the plan upon arrival). LPNs are expected to collaborate with the RN in the development of plans as they do are unable to create nursing plans independently for any patient population. **The planning element is especially critical when addressing new, changed, complex or unknown patient problems.** Once a plan is developed, (either by an RN alone or an RN/LPN collaborative effort) the LPN may independently *evolve* the plan as long as the patient is achieving the intended outcomes and/or responding to interventions as expected.

	RN	LPN
A Assessment	Interprets new actual and potential problems	Reviews identified problems and recognizes changes
P Planning	Integrates findings into a POC	Evolves the POC toward the patient goal
I Intervention	Coordinates actions designed to mitigate or reduce identified problems	Facilitates and enacts actions as necessary
E Evaluation	The POC , including patients responses to interventions	Patients' responses to interventions to make sure goals are being met.

9. 'Change' versus 'Evolution' of the POC

CHANGE: A plan that takes on an entirely different direction/outcome as a result of a **new, changed or complex problem**. This is associated with the role and scope of the RN.

EVOLUTION: Revisions in the plan that result in the patient moving closer to achieving expected outcomes/goals. This is associated with the role and scope of the LPN.

Differentiated Practice

A **change** in patient condition (regardless of the change) means it's a **complex** problem which must be addressed by an **RN**

The **same** patient condition (as long as patient is responding to the plan as expected) means a **predictable** problem which can be addressed by an **LPN**.

10. Assessment: Data, Decide and Do

An Assessment consists of 3 components: **Data, Decision, and Do** and each of these components are tied directly to the legislation that supports the RN or LPN practice. It is important to note that data that has been collected by another professional can be used by a nurse as the basis of a nursing care decision as long as the data matches the clinical picture. It is also important to note that nurses can collect data, make a decision, and assign or delegate the "do" to another qualified health care provider.

The primary role of the RN in the physical assessment is the **INDENTIFCATION/ INTERPRETATION** of new/changed or complex problems. For the RN, the assessment is the **BASIS FOR PROBLEM IDENTIFICATION AND PLAN OF CARE DEVELOPMENT.**

The primary role of the LPN in the physical assessment is the **REVIEW** of problems identified by the RN. For the LPN the assessment is the **PROCESS OF MAKING CERTAIN THAT IDENTIFED PROBLEMS ARE BEING CORRECTED BY THE NURSING INTERVENTIONS.**

RN Focus		LPN Focus
Identification of new, changed or complex problems with the goal of creating a plan to reduce, mitigate, manage or eliminate them		Review of identified problems with the goal of ensuring the interventions developed in the plan are working to reduce, mitigate, manage or eliminate them.

11. Delegation and Assignment

DELEGATION is when the responsibility for performing an intervention is transferred to a provider in which that task **DOES NOT FALL** into their scope of employment or practice. The delegator retains the **ACCOUNTABILITY** for A) the decision to delegate and B) the outcome of the intervention. The delegatee retains the accountability for completing the task correctly. Delegation generally requires the delegatee to have additional education, training and support to perform the delegated task

ASSIGNMENT is when the accountability for performing a task is transferred to a provider in which that task **FALLS** in to their scope of practice. The assignee retains the **ACCOUNTABILITY** for A) performing the task and B) the outcome of the task.