

---

## **I have completed the physical assessment course. Can I do an admission or initial assessment?**

Nurses use the terms *admission* and *initial assessment* to mean the first assessment completed when a patient arrives to the care area. The purpose of an assessment is to gather the patient data that they need to develop a plan of care and make care decisions.

LPNs who possess the necessary competency (knowledge, skill and judgment) can independently collect necessary patient data, complete health histories, and perform health assessments on any client. However, LPNs do not develop the plan of care alone; they collaborate with other care providers in this task. LPNs collaborate with RNs to develop the nursing component of the plan of care (LPN Act, 2006).

The process of collaboration requires the LPN and RN to discuss the LPN's assessment findings. Together, they may determine that the assessment findings are sufficient or an additional or more comprehensive assessment is required to develop a complete picture of the client's needs. When the RN and LPN are satisfied that the data collected reflects a true and accurate client picture, they work together to create the plan of care.

In some settings, LPNs collect the necessary data, perform assessments and create a *preliminary plan of care*. After the preliminary plan of care is developed, the RN and LPN collaborate to review the data, assessment findings and plan. The RN provides oversight to the process to determine the following:

1. If additional assessments are required
2. If the problems, interventions, and outcomes identified are appropriate and comprehensive

When the RN and LPN are satisfied that the plan is appropriate, it is *validated*. LPNs make care decisions independently using validated care plans as a guide. Nurses should be aware, that RN oversight or collaboration is not a process which can be deferred for long periods of time. The practice environment and needs of the client determine how quickly oversight is to be provided, but in most cases LPNs and RNs should aim for a time to collaborate of less than 60 minutes. The processes of communication and oversight are documented in the client record.

Two examples of documentation:

1. 1000 Client plan developed. Plan reviewed with R. Smith RN.....B. Martin LPN

2. 1000 Client plan developed.....B. Martin LPN  
1030 Client plan reviewed and new interventions added.....R. Smith RN

**The ISMP High Alert Medication List that is used to reference the IV Medication Administration Practice Guideline lists a few medications that I routinely administer PO in my clinical area. Does this mean I can no longer give them?**

LPNs may administer medications that are noted on the ISMP High Alert list (including chemotherapy) via the PO or SC route, as long as they possess the necessary competency (knowledge, skill and judgment) to do so. LPNs cannot administer medications listed on the ISMP High Alert via the **IV route** because of the risk associated with possible outcomes.

The administration of IV narcotics is generally not a part of the LPN scope of practice. However, in **limited and specific** contexts such as Palliative Care the LPN may administer IV narcotics under the following circumstances:

1. The LPN has the necessary competency to administer IV medications (intermittent or IV push)
2. The client has a well-defined plan of care that includes the use of IV narcotics to manage or control ongoing pain/discomfort as a part of end-of-life care.
3. The client has been receiving IV narcotics and their responses to the medication are predictable, consistent, anticipated, and can be managed by the LPN.
4. An RN has assessed the client and reviewed the plan, and they have determined that the client's needs may be met by an LPN.

**Can LPNs use a PCA Pump?**

LPNs who have obtained the necessary competency (through additional employer-based education, learning, and mentored opportunities) may care for clients receiving PCA analgesia in any practice context. In the course of caring for the client, they may manage and use an *established* PCA pump. This may include the following:

1. Assess, monitor, and care for the client with an *established* PCA pump.
2. **Decrease** rates or dosages on the *established* pump, as prescribed by the physician in accordance with organizational policies (e.g. double checks, documentation).
3. Discontinue the PCA pump.

When a PCA is **initialized** for the first time, or when syringes/cartridges are replaced and changes are required (in drug, drug concentration, or increased dosage), LPNs may be the *second* care provider/co-signature to the RN. LPNs **may replace ongoing PCA cartridges or syringes of the same medication** (in the same concentration at the same or lower rate) acting as the first or second care provider/co-signature after completing the required client assessments.

**Occasionally I get floated to the intermediate care unit (IMCU) and have been asked to work in the intensive care unit (ICU). Can I care for unstable patients in the IMCU or ICU?**

LPNs can work with unpredictable clients in care areas such as IMCU or ICU in a ***collaborative relationship*** with the RN. LPNs are expected to communicate and collaborate with the RN as they provide care for these clients. For example, if a post-operative client requires PRN analgesia to manage pain, the LPN should discuss the nursing action with the RN before administering the drug (even if it is an analgesic familiar to the LPN). Collaboration, (the RN and LPN discuss any additional assessments that should be performed before and after administering medication for a changing or unpredictable client), is required in the IMCU/ICU context because the unpredictable client may have an *unpredictable response* to a medication that is familiar to the LPN. It is vital to recognize that collaboration is a process to share information about a client, determine the best course of action, and identify the most appropriate nurse to provide it. Collaboration is not about asking permission.

The level of independent decision making and practice will be limited for an LPN who is caring for an intermediate, unpredictable or complex client. In this practice context, the role of the LPN is always collaborative, and care assignments should reflect this ongoing collaboration. LPNs should not work in an IMCU/ICU area without RN support present in the unit.

It is very important to remember that patients who are waiting discharge from the ICU or IMCU, (declassified) or if they have been placed in an IMCU/ICU bed due to a floor bed shortage are not considered "true" IMCU or ICU patients. If these circumstances, LPN practice is the same as if the client was in a floor bed.

**I have recently taken a new job in women's services. Can LPNs auscultate fetal heart tones? Apply a fetal heart monitor? Run a fetal heart rhythm strip?**

These tasks are shared competencies. Shared competencies are those skills or tasks that require additional employer-based education and clinical learning before LPNs may perform them in the workplace.

Auscultating fetal heart tones and applying a fetal heart monitor are informal shared competencies. Obtaining a fetal heart rhythm strip is a more complicated process and therefore a formal shared competency.

LPN practice is based on one of the two potential outcomes of these skills:

1. *Recognize, understand, and manage the care of the normal or expected findings (FHT or rhythm strip is "normal").*
  - a. Communicate expected finding to the RN or other practitioner as part of collaboration and routine discussion about the care of the client

- b. Make independent decisions about the care of the client based on normal or expected findings
2. *Recognize findings that are considered outside of normal or unexpected findings (FHT or rhythm strip is "not normal").*
- a. Report unexpected findings to RN or other practitioner as soon as noted.
  - b. Collaborate with the RN or other practitioner to make care decisions for the client based on the unexpected findings.

**LPN practice** focuses on recognition and management of expected outcomes, and recognition of variations from expected outcomes. To accomplish this, LPNs need to rely on basic nursing knowledge as well as knowledge based on the *typical response from most clients*. This excludes clients whose baseline is atypical but not abnormal (i.e. a baby who has an intrauterine heart block). In these cases, the RN (or other care provider) is expected to interpret the FHR and communicate with the LPN if any additional assessments are needed.

**RN practice** (and practice of other care providers) focuses on the recognition and management of expected outcomes, and recognition and **management** of variations from expected outcomes.

LPNs are expected to document findings, consultations, and/or nursing actions as per organizational policy.

## References

- College of Licensed Practical Nurses of Nova Scotia. (2008). *Continuing Competency Profile for Licensed Practical Nurses of Nova Scotia*. Halifax: Author.
- College of Licensed Practical Nurses of Nova Scotia. (2011). *LPNs and the Administration of IV Medications*. Halifax: Author.  
([http://www.clpnns.ca/practice\\_memos/March2011\\_ELCandSC.pdf](http://www.clpnns.ca/practice_memos/March2011_ELCandSC.pdf))
- College of Licensed Practical Nurses of Nova Scotia. (2008). *Practice Memo/Update: entry Level Competency and Shared Competency*. Halifax: Author.  
([http://www.clpnns.ca/practice\\_memos/March2011\\_ELCandSC.pdf](http://www.clpnns.ca/practice_memos/March2011_ELCandSC.pdf))
- Government of Nova Scotia, *Licensed Practical Nurses Act*, Statutes of Nova Scotia, c.7, Halifax, 2006.
- Government of Nova Scotia, *LPNs Regulations of the Licensed Practical Nurses Act*, c.7, Halifax, Registry of Regulations, 2006.