CLPNNS
COLLEGE OF LICENSED PRACTICAL NURSES OF NOVA SCOTIA

Starlight Gallery
7071 Bayers Road, Suite 302
Halifax, NS B3L 2C2

You Asked Us!!

Care Planning, Triage and TB Testing

Can LPNs independently create nursing care plans for stable and predictable clients?

LPNs collaborate to develop the nursing component of the plan of care (LPN Act 2006) and in doing so work with RNs and other care providers to establish a client's level of predictability or complexity. It is incorrect to say that an LPN can create a nursing care plan independently for a stable client, because the clinical determination of a client's level of predictability or complexity results from a critical review and analysis of an **established** nursing care plan. This means that a client's level of predictability or complexity is determined *after* the nursing care plan is created. Once a plan of care is established, and a client's needs are identified and found to be predictable, the LPN may practice independently within the plan of care for that client.

Does "collaborate to develop the care plan" mean that an RN has to recheck assessments done by an LPN or has to "sign off" on a care plan written by an LPN?

RNs are not expected to recheck any data that is collected by an LPN, unless there is a clinical reason to do so. For example;

> An LPN performed a respiratory assessment on a client at 1000. She found the upper lobes to be clear, but noted fine crackles and wheezes to the bases bilaterally. The LPN noted the respiratory rate to be 26 at rest and oxygen situations 94% on room air. When the RN enters the room at 1035, the client is returning from the bathroom and is visibly short of breath, and wheezes are noted on expiration. The RN who notes the changes in the client performs another respiratory assessment.

The RN must coordinate the care plan process, and provide consultation or oversight. The oversight process will look different depending on the context of practice, the skill of the individual nurses (LPNs and RNs) and the needs of the client. Communication is a fundamental component of care provision (Alvarado et al 2006, Frank 2008) and is how coordination, oversight, and consultation between the LPN and RN are made possible. LPNs and RNs are expected to communicate with each other about the needs of the client in the process of creating the plan of care. The collaboration of the LPN and RN is generally reflected in the nursing or progress notes of the client. For example;

> **1000** Lungs clear to upper lobes, fine crackles and wheezes noted in both bases. RR 26 at rest and 02 sats 94% on RA……………………………………………………………….…B. Smith LPN
> **1035** Client returning from BR. RR increased to 32. Expiatory wheezes audible with and without auscultation. PRN nebulizer given…………..…………………………………..……L. Brown RN

Can LPNs change a plan of care once it is established?

An established plan of care includes expected outcomes for clients. As long as the client is achieving the necessary outcomes, LPNs can independently *evolve* the plan of care to make sure clients continue to reach intended targets. Evolution means that new interventions are added as the client progresses towards the expected outcomes. For example;

> Mrs. H. is a postoperative patient. The expected outcomes of her care include ambulating three times a day without assistance. On day one, interventions include turning Mrs. H. every four hours to prevent post-operative pneumonia, and dangling at the bedside twice. As Mrs. H. successfully achieves the targets, LPNs can create new interventions towards the expected outcome. On day two, Mrs. H. stands at the bedside in the morning, takes a few steps to the chair for lunch, and is helped by two care providers to walk to the bathroom at supper time. On day three, she is helped by one care provider to ambulate in the hall for five minutes in the morning, ten minutes after lunch and 15 minutes in the evening. On day four she is able to self-ambulate for 20 minutes once a day.

When clients do not achieve expected outcomes, LPNs collaborate with RNs to *change* the plan of care, by adjusting expected outcomes and/or creating new or different interventions.

> Mr. Smith is admitted for treatment of pancreatitis. The expected outcomes of his care include adequate rest and sleep. He is prescribed Morphine for pain management. For the first two days, Mr. Smith reports satisfactory pain management and he is able to sleep for 5-6 hour periods. On day three, Mr. Smith requests pain medication every 4 hours and is only able to sleep 3 hours. In the morning of day four, he reports that the pain medication is not relieving his pain. The LPN consults the RN, and together they create a plan that includes consulting the attending physician for a medication change.

Can LPNs work in triage?

As the competencies within the LPN scope of practice have changed, so has the role of the LPN in the emergency department (ED), particularly in rural emergency departments. In larger urban centres, the LPN is often practicing in the treatment or care areas of the ED. The LPN in the triage area is more common in rural facilities.

In *specific contexts,* where the LPN has completed the necessary additional education and mentorship, the LPN may work ***collaboratively with the RN*** in the triage area of the emergency department. The minimum education needed by the LPN in triage is the completion of the Canadian Triage Assessment Scale (CTAS) course. However, individual organizations may require other education programs to be completed as well.

The LPN may independently perform a rapid or focused patient assessment, complete a health history, and collect any necessary subjective or objective patient data. LPNs <u>review</u> the assessment findings and use the appropriate organizational supports, tools, and assessment guides to assign and document a ***preliminary*** CTAS score. Once a preliminary CTAS score is assigned, the LPN must collaborate with the RN to <u>interpret</u> the assessment findings. Interpretation is the process of validating the CTAS score by making sure it is consistent with the patient's clinical presentation, and results in the assignment of a ***final*** CTAS score. The preliminary score and final score will often be the same number. Not all scores need to be labeled as preliminary or final. However, if the score

changes as a result of additional assessment findings, the new score must documented in the client record.

The LPN is expected to think critically and apply clinical judgment to decide the intensity of collaboration with the RN. The intensity or urgency of the collaboration between the LPN and RN is related to the preliminary CTAS score. The LPN should collaborate **immediately** with the RN for clients who are assigned a preliminary CTAS score of 1, 2 or 3. For clients with a preliminary CTAS score of 4 or 5, the LPN should aim for a time to collaborate of less than 30 minutes.

Important points to remember

◊ The role of the LPN in triage is ***always collaborative*.** This means the LPN and RN *must* communicate about the needs of the clients. Even when clients are assigned a high preliminary CTAS score (4 or 5), the LPN and RN must collaborate to validate the CTAS score.

In some cases, the LPN makes a decision and verifies their decision with the RN.

> **LPN:** Mr. J. presents with complaints of a sore throat since yesterday. He swallows easily, there is no excessive salivation and his airway is patent. VS are 120/84, 82, 37.0 and 99% on room air, lungs clear and mucous membranes are pink and moist. Tonsil bed is slightly red, but very little, if any edema. He says he has been taking Tylenol every 12 hours at home with good results. He scores his pain right now at 1 out 10. He is here tonight to see if he needs antibiotics. I have scored him at 5, given him some salt water to swish and swallow, and registered him, and he is in the waiting room.
> **RN:** He has no fever. 5 is a good score for him.

In other cases, the LPN defers the decisions to the RN.

> **LPN:** Mrs. H. presents with complaints of an intermittent sore throat for 2 days and no other cold- or flu-like symptoms. She is 45 pounds overweight and a smoker. Her throat is not red or inflamed. BP 160/90, 112, 36.5, 93% room air. Skin slightly cool. She has a cardiac history and I have scored her a 3. She is in bay 7 and I need you to see her now. Do you want me to give an ASA and do an ECG?
> **RN:** Please do both, draw some troponins as well, and have the clerk call Dr. Smith stat. She may be a 3 or a 2, and I will see her right now.

◊ A triage assessment is a rapid assessment to figure out a client's emergent priorities, not a full and detailed nursing assessment (CAEP n.d., Bullard et al. 2008), and therefore **cannot be the only assessment** used to determine a client's overall predictability or complexity.

LPNs can make nursing care decisions independently for clients who have predictable problems and known health outcomes. A client's predictability or complexity is determined after a review or analysis of the nursing component of the plan of care. A triage assessment *alone* is not comprehensive enough to find a client's overall predictability or complexity.

Can LPNs administer TB tests?

This is a shared competency. This means that LPNs can perform TB testing if they have the necessary additional education and the opportunity for clinical learning. Employer learning modules for TB testing should include the necessary information about the medications, the technical

competencies associated with intradermal injections, the practice of the LPN in recognizing the normal or expected outcomes, and the practice of the LPN when expected outcomes are not achieved.

What is a shared competency?

Shared competencies are advanced skills gained through additional or specialty education, or clinical practice provided by the employer. LPNs have the necessary *general* education and knowledge to support these competencies, but not the *specific* education and knowledge to enact them. Shared competencies represent *a specific practice.* As such, some competencies need annual or regular recertification, beyond the additional education, to show continuing competence.

Some employers refer to shared competencies as beyond or post entry level competencies. For more information see Continuing Competency Profile for LPNs in Nova Scotia (2008) or CLPNNS Practice Update March 2011 @ http://www.clpnns.ca/practice_memos/March2011_ELCandSC.pdf

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