

**I have recently completed the 2-year PN Diploma program from a local Community College. I have been told that this program replaces the 2-year RN Diploma program. Is this true?**

No. Even though the length of the previous RN diploma and the current LPN diploma is the same, the content and focus of the nursing education for RNs and LPNs is different. Although both study from the same body of foundational nursing knowledge, since 2008 LPNs have a college diploma that includes **basic** nursing knowledge and clinical practice. This education results in the development of critical thinking, decision making and leadership skills as well as the ability to participate in research and contribute to decisions about resource utilization.

Registered nurses, since 1995, have a university education that includes **in-depth** nursing knowledge and clinical practice. This education results in the development of critical thinking, decision making, and leadership skills and prepares RNs to conduct research and make decisions about the allocation of resources.

The scope of practice of the LPN and RN is defined in legislation for both LPNs and RNs. The education that LPNs and RNs receive is based on this legislation.

This figure represents LPN and RN education.



The inner box represents **basic** nursing knowledge and reflects the scope of practice of LPNs. The outer box represents **in-depth** nursing knowledge reflecting the broader scope of practice of RNs.

The inner box represents basic nursing knowledge, which is shared by the LPN and RN **regardless of their length of program**. Shared **basic** knowledge represents the nursing knowledge to practice independently and manage stable clients with predictable outcomes.

The outer box represents in-depth nursing knowledge and is unique to the RN **regardless of the length of their program**. RNs have always been educated to provide all levels of nursing care whether it is health promotion, caring for stable clients with predictable outcomes or clients whose health needs are unknown, acute, complex and rapidly changing.

**I work in a collaborative team. When we can, the RN and I (and sometimes CCA) do a "round" together, to see all the patients at the beginning of our shift. Sometimes 'we' get introduced to the patient as your 'nurses'. (I am guilty of doing this myself) I realize that patients should know who is providing their care, but is using the term "nurse" to describe us all enough?**

Patients have the right to know who is providing their care. CLPNNS expects every LPN to introduce her/himself with their name and credentials.

*Good evening Mr. MacDonald. My name is Ron and I am a licensed practical nurse, this is Mary, who is a continuing care assistant and this is Linda, a registered nurse. We will be your care team tonight and will be on shift until 11PM.*

Patients may not understand the meaning of abbreviations like *LPN, CCA or RN*, so where possible, use the full title. Nurse is a protected title and it only applies to LPNs, RNs or NPs. CCAs/PSWs cannot legally use the title 'nurse'.

**All my life, I have used a nickname and not my birth name. Can I use my nickname in my signature?**

You are required to sign your name as it appears on your license. You are required to notify CLPNNS if your name changes so this can be reflected in your file and subsequent licenses. Your signature includes first initial and full last name and designation. *M. Smith, LPN*. To use just your initials on a patient document, you must first sign your full signature and credentials and initials to indicate that *MS* is *M. Smith LPN*.

**I work in a position, where my PN education was required to get the job, but my role is not a traditional LPN role. Can I count these hours towards my license?**

The hours can be applied to your annual requirement as long as an active LPN license is required the specific (traditional or not) role. LPNs in non-traditional roles may be required to submit their job description to CLPNNS to verify this.

**Does CLPNNS offer remedial modules or courses if I want to upgrade my learning?**

CLPNNS works in partnership with the community college and other educators to ensure the necessary education is available to members, however, does not provide the specific education.

**I understand that RNs can recommend over the counter (OTC) medication. Is it within the role and scope of the LPN to do the same?**

At this time, recommending OTC medication(s) to in or out-patients **is not part** of the role and scope of the LPN.

Making such recommendations requires in-depth nursing knowledge and the ability to independently interpret client data or assessment findings. This level of *independent* practice, with any client population, is outside the scope of the LPN.

**I work in IMCU and sometimes ICU. I work collaboratively with the RN to care for patients. Nearly every patient is on a cardiac monitor for one of many reasons. I have attended an education session on Cardiac Monitoring and feel comfortable recognizing heart rhythms. Occasionally, I may be assigned to a patient that is required to leave the unit to go for testing, such as CT Scan or X-Ray. My practice has been to go, because I feel comfortable recognizing heart rhythms and I take the transportation/emergency drugs with me. Is this OK?**

No. First of all, let's set the context. During the transportation of a client (for however long or short), whereby you are the only health care provider, your practice is considered independent practice. Independent practice means you are solely accountable to make the nursing decisions to manage the client's needs and outcomes. Independent practice for LPNs in Nova Scotia is limited to clients with ***predictable problems and known health outcomes***. IMCU/ICU clients (as evidenced by the need for cardiac monitoring) would be considered complex, or at least, variable or changing. In this population, LPN practice is collaborative or under the direction of the RN and ***not*** independent. Given the high end needs of the IMCU/ICU clients, *it would not be appropriate* to make the case that collaboration or guidance /direction can be adequately provided while you are transporting a client alone in an elevator, even if it seems like only a few minutes.

Second, let's talk about the heart rhythm and what that really means. In the case of cardiac (or any external) monitoring, the role of the LPN is *recognition*. Recognition of 'normal' (or what is expected 'normal' for this client) and recognition of variations in 'normal'.

*Interpretation* is a combination of recognition and action. Action is the determination of what nursing interventions are required to manage whatever has been recognized. Interpretation, in this complex unpredictable client base, is the role of the RN. (See page 1: *The outer circle represents in-depth nursing knowledge and is unique to the RN (regardless of the length of their program). In-depth nursing knowledge represents the nursing knowledge and practice to independently manage varying or unpredictable clients.*)

In the critical care context, the LPNs role is limited to recognition of variation and the implementation of ***role and scope specific*** actions, such as calling a code, initiating CPR or supporting oxygenation. These actions, while valuable, **may not be comprehensive enough** to sufficiently support a client during a crisis event. Clients in cardiac or respiratory arrest may require life supporting cardiac medications given by rapid direct IV push, cardioversion/defibrillation or have an artificial airway initiated. These skills are outside your scope of practice.

Next, let's discuss accountability. If you knowingly accept an assignment whereby you are required to practice in a manner that is not consistent with your standards of practice, you will be held accountable for any untoward outcome a client experiences. It is also equally important to recognize that a nurse (LPN or RN, including the nurse

manger) who knowingly permits practice that is inconsistent with your standards of practice can be held accountable for any untoward outcome a client experiences.

Remember, independence of LPN practice and decision making is directly related to the needs of the client. The more predictable the needs the greater the independence of practice and decision making. The greater the complexity of needs, the greater the need to consult with other care providers before making a nursing decision. When clients are predictable, you can readily anticipate what things you may see or encounter. When clients are unpredictable, it is more difficult to anticipate what may or may not happen. It's true that clients experience all kinds of outcomes, unexpectedly, but the *risk* of this happening, is lower in predictable clients and higher in unpredictable ones. LPNs are educated and legislated to independently manage predictable clients where the risk of an unexpected or unanticipated outcome is low. IMCU/ICU clients would fall into the high risk category.

There are contexts where transporting a client independently by an LPN is appropriate. Transporting a client to a test from a non IMCU/ICU unit or transporting a client to the medical or surgical unit upon discharge from the IMCU/ICU is just two examples.

Bottom line is that, in this context (client is deemed to require IMCU/ICU level of care), you should refrain from performing this activity independently and only do so in collaboration with another care provider capable of managing any client situation during transportation.

**I'm an LPN and I work on a busy medical unit. Generally, we get about 3-4 admissions every day. Most times the ER will fax up a preliminary report to the unit before calling the verbal report. There have been occasions that it is clear from the faxed report, that the client is ill and complex. I am comfortable taking report; however, I feel that when the patient is obviously sick and complex, the RN is the most appropriate nurse to take verbal report. To me, this is more efficient and effective for the patient but some of the LPNs I work with get highly offended by this. Suggestions?**

If you feel uneasy, talk to the RN and express the reasons for your uneasiness. (*I think the needs of this patient are going to be complex. She has an epidural and a CVAD. As you know, I have some experience with epidurals, but cannot manage them. I worry that I might miss some information in the report about the management of the Epidural. Do you think it would be better if you took the report?*). Work with the RN and to review the preliminary report to plan questions that you may ask of the reporting RN. (*What questions should I be asking the ER nurse about the pain medicine?*) Determine if there are areas in which you should be paying particular attention.

That said, there will be occasions where the needs of the client and the comprehensiveness of the information to be exchanged is such, that the right nurse to give and receive report is the RN. Both LPNs and RNs are accountable to make sure that the necessary client data is passed on the appropriate care provider. The sending or receiving nurse could be held accountable for an untoward client outcome if it resulted from knowingly passing on information to an inappropriate care provider or failing to seek clarification about the information they have been given. All nurses should recognize and understand this and not view it as a commentary on their individual value or abilities.

### **It used to be that LPNs could only manage wounds 2.5 cm and less. Has this changed?**

Entry level competencies in 2005 stated that LPNs could manage wounds 2.5 cm or less. This was a starting point and the expectation was then, and continues to be, *as LPNs increase their proficiency and competency in wound care, the capacity of their practice to manage wounds grows.* In 2011, the starting point is related to the nurse's individual competency and the needs of the client and not so much a specific depth of a wound.

LPN practice is contextual to the needs of the client. As long as clients are responding to the interventions and outcomes are reasonably anticipated and predicted, LPNs practice independently within the plan of care which has been established to manage the wound. When clients fail to achieve expected outcomes and/or responses become unpredictable, the LPN must consult with another care provider (generally an RN) to work together to adjust, modify, revise or change the existing plan of care.

Below are assumptions about LPNs and wound care.

1. LPNs cannot develop a client's *initial* plan of care independently, however are expected to do so in collaboration with another care provider (generally the RN). This is as outlined in the LPN Act 2006. Initial is

defined as the first plan, if when a client arrives from one area to another area with a plan in place, this would be considered the *continuation* of a plan.

2. LPNs can manage wounds, at whatever depth or packing requirements, as **long as they have the necessary knowledge, skills and judgement (competency)** to do so. (Competency can be achieved a variety of ways such as attending work sponsored education programs, workshops, additional certification or on the job clinical learning.) Once competent, LPN practice can be independent (a plan is established and the client is responding to the plan) or collaborative (when a plan is not fully formalized or the client's condition or wound bed is changing or not responding as anticipated).
3. Employer policies create the employment context and in doing, may set up a practice that is less than the professional or individual scope of practice. For example, if an employer policy states that LPN practice is restricted to packing wounds 4 cm and less on the buttocks only, then in *this* practice setting, within *this* agency, LPN practice is limited to the parameters as set by the policy, regardless for the professional or individual scope of practice.
4. The leadership role of the LPN involves engaging the entire care team in conversations about making sure that the organizational policies match current entry level competencies, nursing research and best practices.

### **Do I need to take a 'course' to be able to give vaccinations or immunizations?**

As with all medications, LPNs are required to have the necessary knowledge, skill and judgement (competency) to administer vaccinations or immunizations. Immunizations are a *beyond entry level competency* for LPNs. Competency may be achieved in two (2) ways:

1. Complete an accredited/approved post-graduate immunization program, such as the one offered at Nova Scotia Community College (NSCC);
2. Complete an employer-based learning module and clinical learning opportunity.

Accredited/approved programs are fully transferable across all practice areas in Nova Scotia and all jurisdictions across the country. Employed-based programs are employer and practice specific. They **do not transfer** to other employers or jurisdictions. Employers set the practice context with policies and in doing so may specifically require a post-graduate program, employer based program or both.

### **References**

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