



# Optimizing LPN Practice in Alberta Health Services

## Phase 2 Report

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Hastings, S., Stiphout, M., Tarraf, R., & Pentz, B. (2017). *Optimizing LPN Practice in Alberta Health Services: Phase 2 Report*. Calgary, AB: Workforce Research and Evaluation, Alberta Health Services.

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## Executive Summary

### Background

The goal of this study was to examine the roles and opportunities for Licensed Practical Nurses (LPNs) in different practice settings within Alberta Health Services (AHS). Specifically, we examined LPNs' utilization in emergency departments (EDs), mental health (MH) units, and labour and delivery (L&D) units. We used four factors (individual, team, organization, and system) identified in earlier research to answer the following research question:

Are there gaps in how LPNs are utilized?

- a. What facilitators and barriers impact LPN's ability to work to full scope?
- b. How are decisions made about whether to include LPNs in EDs, L&D units, and MH units?
- c. How are decisions made about what activities LPNs are allowed to perform?

### Methods

We selected units with and without LPNs for in-depth review. We interviewed frontline staff members, management/supervisory staff, and higher-level leaders for each unit. We also interviewed a small number of participants from both AHS and the College of Licensed Practical Nurses of Alberta (CLPNA) to understand current issues around LPN scope, utilization, and policy. A total of 89 interviews were conducted across 13 units (4 ED, 5 MH, and 4 L&D) and all five AHS zones; relevant documents were also reviewed.

### Results

Thematic analysis of the interviews revealed a number of themes common across units and some that were unique to units. Only the common themes are listed here for brevity.

**Individual:** Most of the LPNs we interviewed were satisfied with their work and would recommend it to others. Many felt valued and thought they were using as much of their scope as possible in their care setting, although some skills were rarely or never used because of the nature of the care provided on each unit. ED and L&D LPNs felt their formal education and previous experience had prepared them for work and did not identify specific gaps. LPNs on MH units, however, typically noted that they received very little MH training in school; other providers also noted gaps in LPN preparation for work in this setting. On the whole, there was confusion among interviews about how much education LPNs receive; interviewees on units without LPNs tended to believe LPNs were unable to provide high quality care without substantial on-unit training. Many non-LPN interviewees questioned LPNs' critical thinking skills.

**Team:** All of the units we examined used primary nursing models, which often led to role overlap between Registered Nurses (RNs) and LPNs. Because of this overlap, most interviewees felt that having LPNs on a unit (or adding LPNs) did not or could not enable other providers to work to full scope. On most units, LPNs were able to get assistance from an RN to provide care outside the LPN scope of practice, but LPNs on a few units felt some resentment from the RNs when approached for assistance. All interviewees understood that LPNs needed to be assigned patients in fairly stable condition with predictable courses of care, but beyond this there was significant confusion and misinformation about LPN scope of practice. There was also confusion about what resources to access to get accurate information and we heard complaints about inconsistencies between various sources.

**Organization:** Interviewees flagged education and orientation as major challenges for LPNs. Some units provided similar orientation to RNs as to LPNs, whereas others provided extensive standardized orientation packages to RNs and a handful of buddy shifts to LPNs. Finding time and funding to attend additional off-site courses was also challenging and some units had non-existent or limited support from nurse educators. Opportunities for advancement for LPNs were said to be limited.

**System:** We could find no specific policies limiting LPN scope of practice beyond the regulations in the Health Professions Act. That said, there were some activities that most interviewees agreed LPNs should be allowed to perform but are not (e.g., bladder scanning) due to the language in the Health Professions Act and/or updates to LPN education that are not reflected in the Act. Some also said the LPN regulatory college had, in the past, not been given opportunities to engage with AHS on decisions affecting LPN scope, but that this was improving recently. Interviewees tended to believe the biggest challenge to optimizing LPN scope of practice within AHS was a lack of understanding of what LPN scope entails.

### **Conclusion and Recommendations**

We found a number of gaps in how LPNs are utilized. On most units without LPNs, at least some interviewees identified ways in which LPNs could provide support. On units with LPNs, they were used similarly to RNs, suggesting that models of care could be altered to better support all providers to work to full scope and be more cost-efficient.

Barriers to working to full scope were not based on formal policies or guidelines; instead, a lack of understanding of what LPNs should be allowed to do seemed to be the biggest obstacle. There were challenges obtaining accurate information about LPN scope, so units tended to err on the side of caution by limiting the care LPNs could provide. Other barriers included education and orientation and lack of understanding from other staff about what

LPNs are educated to do. Facilitators to working to full scope included having supportive and available leadership and a supportive team environment.

Decisions about whether to include LPNs in ED, L&D, and MH staff mix seemed to have been made many years ago and not revisited since. A few managers were considering making changes to staff mix but in general, LPN utilization seemed to be a result of legacy hiring practices rather than a planned and deliberate process.

Decisions about what activities LPNs are allowed to perform seemed to be made based partly on actual regulations and partly on potentially erroneous beliefs about what LPNs are capable of doing. At the unit level, decisions about what LPNs are allowed to do seemed to be based on how things have always been done rather than through analyses of unit and patient needs and current scope documents.

Based on the results of this study, we offer a number of recommendations:

AHS and CLPNA:

- Improve ease of access to and awareness of guidance on LPN scope of practice by (a): developing a communication mechanism to provide clear, consistent, regularly updated information to unit managers, educators, and LPNs that outlines information about LPN practice within AHS, (b) making clear to all that the CLPNA Competency Profile is not entirely consistent with AHS documents that provide specific information related to restricted activities and role clarity and the AHS documents should guide practice at this time, and (c) having a clear document outlining which AHS guidelines are inconsistent with the CLPNA Competency Profile.
- Develop a single repository for scope documents, easily accessible from the AHS Insite main page, with easy to understand file names and consistent information. Rather than requiring managers to check multiple files to access information, combine existing documents.
- Ensure that provincial guidance documents that support scope of practice are accessible and that managers are aware that they supersede site- or unit-level policies that may limit scope.
- Provide educational support for sites or managers whose policies may be restricting LPNs' ability to work to full scope.
- Increase awareness of and access to specialty orientation opportunities for LPNs.
- Provide increased opportunities for advanced certification for LPNs from across the province, either by opening new training programs or by providing funding for LPNs to travel to receive training (e.g., peri-operative certification).

- Further develop ways for the AHS Health Professions Strategy and Practice consultation team and the CLPNA consultation team to proactively identify inconsistencies in scope of practice regulations and work together to find solutions and communicate to affected providers.
- Create awareness among stakeholders that the LPN competencies are aligned with and supported by the approved Alberta LPN education curriculum.
- Continue to advance regulation changes to further LPN scope of practice.

Sites or units:

- Educate all unit staff, including RNs, RPNs, and LPNs, on LPNs' scope of practice and specific role on each unit.
- Hold all team members accountable for creating a welcoming environment and being supportive of other staff.
- If a staffing change is to be made, provide strong leadership and change management both before and after the introduction of LPNs.
- Redesign models of care to ensure staff are caring for the right type of patient and supporting each other to work to full scope of practice.
- Recognizing that scopes do overlap, units could reduce perceived job threat to other providers by ensuring that each provider type has a defined role on the unit rather than using RNs and LPNs interchangeably.
- Examine patient and unit needs to determine most appropriate providers rather than relying on legacy hiring practices to guide decisions.
- Provide unit-specific orientation with defined learning objectives that is specific to the LPN role and capitalize on shared learning opportunities with RNs and/or other disciplines.
- Make ongoing education resources available for all staff; consider training all providers together to ensure consistent information is shared about which providers can do any restricted activities involved.
- Organize placements and preceptorships to provide LPNs with exposure and experience on units where AHS would like to better utilize LPNs.

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## Background

In 2011, the College of Licensed Practical Nurses of Alberta (CLPNA) collaborated with Alberta Health Services (AHS) and other groups on a research study entitled *Understanding Licensed Practical Nurses' Full Scope of Practice* (Shimoni & Barrington, 2012). This study identified gaps in Licensed Practical Nurses' (LPN) scope utilization across Alberta and listed several ways in which to address these gaps. The current project is focused on the recommendation to study the roles and opportunities for LPNs in specific areas; we selected emergency departments (ED), mental health units (MH), and labour and delivery units (L&D) for review in this project. The study also identified four specific areas that affect LPN scope utilization across Alberta:

**Individual factors:** nursing skills, experience, education, and personal initiative

**Team factors:** patient assignment and workload, team dynamics, and team leadership and supervision

**Organization factors:** unit staffing, employer support for professional development

**System factors:** supportive policies and practices

The current project was broken into two phases. The first phase consisted of an examination of how LPNs are distributed in EDs, MH units, and L&D units across AHS using administrative data from Human Resources and patient databases<sup>1</sup>. The second phase, reported here, was an in-depth examination of a selection of these units with and without LPNs in their staff mix. We used interviews and policy/document analysis to determine how the four factors identified above influence whether and how LPNs are included in the model of care and to identify opportunities for improvement.

The research question addressed in Phase 2 was as follows:

Are there gaps in how LPNs are utilized?

- d. What facilitators and barriers impact LPN's ability to work to full scope?
- e. How are decisions made about whether to include LPNs in EDs, L&D units, and MH units?
- f. How are decisions made about what activities LPNs are allowed to perform?

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<sup>1</sup> See Hastings et al. (2016) report for results from Phase 1.

## Methods

Approval from the University of Calgary’s Conjoint Health Research Ethics Board and AHS Research Administration were obtained prior to beginning this work. Based on the results from Phase 1, we selected two units with and two without LPNs for each of the service types under review. We chose units based on setting (urban/suburban vs. rural) and AHS zone to ensure that units were as varied as possible. We contacted site, program, and/or unit managers to seek approval for each site.

To protect the confidentiality and anonymity of our research participants, we do not provide specific details about each unit. A summary of the types of units included in the study is shown in Table 1.

*Table 1. Unit Characteristics*

Unit Type	Number of Units
ED	4
MH	5 <sup>ii</sup>
L&D	4
Zone	
Calgary	2
Central	4
Edmonton	2
North	3
South	2
Setting	
Urban/Suburban	9
Rural	4

### **Participants**

We sought to interview frontline staff, management/supervisory staff, and higher-level leaders for each unit. One unit without LPNs initially agreed to have staff participate in interviews but were faced with job eliminations during the study period. As a result, managers were concerned that this study’s subject matter might cause additional stress for the staff and asked to delay data collection until the eliminations were complete and remaining staff adjusted to the changes. We elected to interview management staff only rather than extend the study period for several months.

We also interviewed a small number of participants from both the CLPNA and AHS to understand current issues around LPN scope and utilization and relevant policies. The total number of interviewees is shown in Table 2.

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<sup>ii</sup> One manager requested that we add an additional unit under their portfolio to the study and as a result we examined five MH units.

*Table 2. Number of interviewees*

Unit Type	Number of Interviewees
ED	21
MH	35
L&D	25
Participant Type	
Frontline staff	54
Management (includes educators, assistant managers/assistant head nurses, unit managers)	24
Leaders (includes program managers, site managers) and consultation/policy-focused (includes policy development, interpretation, scope considerations)	11
<b>Total</b>	<b>89</b>

### ***Interviews***

Interview questions were designed to tap into all four factors (individual, team, organizational, and system) identified by Shimoni and Barrington (2012). Semi-structured interviews were held over the phone or in person. Separate interview guides were designed for units with and without LPNs, as well as for managers and frontline staff. A set of questions was also designed for interviewees involved in policy development and interpretation. Interviews began with an affirmation of consent to be interviewed. We recorded the interviews in all but a few cases and took detailed notes when participants declined to be recorded. We took notes on all recordings and used realist thematic analysis (Braun & Clarke, 2006) to analyze the interviews based on those notes.

### ***Document Review***

We asked interviewees to share documents pertaining to LPN utilization and scope. We also searched the AHS internal website and the CLPNA website for relevant documents and policies. We relied heavily on the CLPNA Competency Profile for LPNs (3<sup>rd</sup> edition, 2015; hereafter “Competency Profile”), which outlines the “knowledge, skills, behaviors, judgments and attitudes” required for LPNs in Alberta. We used the AHS Health Professions Strategy and Practice (HPSP) concept of scope of practice to guide this report (AHS, 2013). HPSP translates provincial regulations and legislature and provides advice on healthcare providers’ practice based on appropriateness in the AHS context. They define scope using the Health Professions Act (HPA) practice statement, profession-specific regulations, college standards, employer policy, and individual competence as shown in Figure 1. The HPA defines a provider group’s broadest possible scope, which is then narrowed by each successive step in the hierarchy to arrive at individual provider’s enacted scope of practice. When the information in various documents conflicted, we consulted the scope hierarchy to make decisions about which document would take precedence. We used the document review to understand whether specific activities and tasks were or were not allowed to be performed by LPNs based on areas of confusion arising from the interviews.

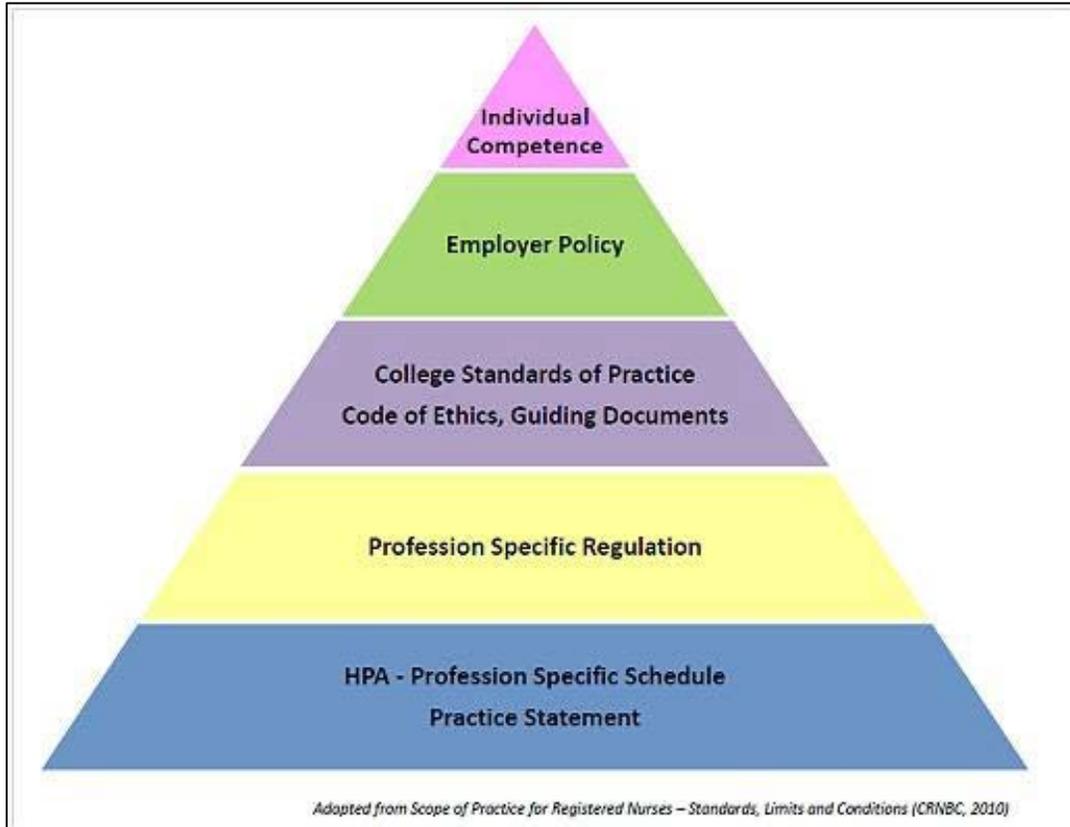


Figure 1. HPSP scope of practice hierarchy

## Results

Our interviews revealed a number of themes common across units, as well as themes specific to each unit. We first present the overarching themes organized by individual, team, organizational, or system level, and then present the additional findings for each unit. Many of our interviewees had questions about whether LPNs were allowed to perform specific tasks or activities; these have been compiled in Table 3 at the end of the results section along with the results of our document review on these topics.

### **Common Themes**

*Individual.* Most of the LPNs we interviewed expressed satisfaction with their work and said they would recommend it to other LPNs. Many felt like valued members of their teams and felt that, with some exceptions, they were using as much of their scope as possible in their care settings.

*“I feel honored to be working here. I would not have done this when I was younger, it can be intimidating. I came here in my late 40’s and feel very privileged to be working on this unit...for me I’m doing more than what I dreamed I would be doing.” (LPN)*

They did acknowledge, though, that because of the specialty care settings in which they were employed, some of their skills and knowledge were not used often or at all (e.g., MH LPNs rarely if ever started intravenous medications because the patient population infrequently requires them). A few LPNs at one hospital where we interviewed on multiple units were very dissatisfied and did not feel valued. Dissatisfaction often stemmed from team factors rather than the work itself, so this topic is discussed in the next section.

On the ED and L&D units, LPNs typically felt their formal education and previous work experience had prepared them to work on their units and most did not identify any specific gaps. LPNs working on the MH units noted that they typically received very little formal training in mental health in their education. This was also the most common concern cited by other providers on MH units with and without LPNs. Some mentioned they had specifically sought placements in school that would prepare them for work in their current setting. When we asked non-LPN interviewees about LPNs’ education, there was a surprising amount of confusion about what LPNs did and did not learn in school, how much time was spent on topics specific to ED, MH, and L&D care, and whether LPN students received any on-unit days in these specialty areas. Specifically, staff on units with LPNs often disagreed on the amount and quality of education LPNs received, even within units. In contrast, staff on units without LPNs tended to believe LPNs did not receive adequate, if any, education in the specialty area, and felt they would be unable to provide safe, high-quality care without substantial training on the unit. Non-LPN interviewees tended to feel that LPNs’ education focused on “tasks;” some thought their skills in performing those tasks were very similar to those of an RN.

*“As far as we know they don’t have mental health training.” (RN, unit without LPNs)*

In addition, many non-LPN interviewees on units with and without LPNs felt that LPNs lacked adequate education and training on critical thinking. Most interviewees explained critical thinking as the process of understanding why a patient might have certain symptoms, why certain treatments were needed, or constantly integrating past experience and knowledge to inform patient care.

*“RNs are taught to critically evaluate that, I don’t know what LPNs get. I think anybody can critically look at a situation but how is that supported by curriculum I don’t know – there is a difference between RN and LPN but I don’t know how to quantify it, RNs have more ownership and [are] curious about what will happen to patients when they go home.”* (Management, unit without LPNs)

*“One thing I see consistently is that LPNs don’t come out of their school with great critical thinking, that’s a piece I see as consistently lacking as a [management type] and I really challenge them to ask the question why... Every time they do something they have to ask the question why. Some of them really grasp that concept and some are still very task-oriented because that’s the model they learned in school, is to be task-oriented, not necessarily finding out why they are doing this task and what’s the benefit or risk to the patient if they do this task.”* (Management, unit without LPNs)

Despite the feeling that LPNs generally do not get adequate training in critical thinking, some interviewees on units with LPNs noted that this varies based on individuals. Some LPNs were said to have better critical thinking skills than some of the RNs, and we heard often that a good, experienced LPN is indistinguishable from an RN in many ways.

*“I 100% disagree with that, critical thinking skills some people have it innately but it’s something you gain with experience and I have seen LPNs with phenomenal critical thinking skills, I don’t think critical thinking skills are innate to one profession – I’ve had RNs that I’ve struggled to teach critical thinking skills.”* (Management, unit with LPNs)

*Team.* All of the units we examined used primary nursing models such that individual nurses receive a patient assignment and provide most or all care for their set of patients. The details of the provision of care varied based on unit type, but the primary nursing model often led to role overlap between RNs and LPNs. On most units, (exceptions are described in the unit-specific sections below), LPNs performed very similar work to RNs and could substitute for an RN if the unit was short on staff. Because the work RNs and LPNs did was similar or identical, few interviewees felt that having LPNs in place (or adding LPNs to the team) enabled or could enable other providers to work to full scope of practice without major changes to the model of care.

Two units, one with and one without LPNs, used a modified primary nursing model. In this model, each nurse had a patient load as well as specific responsibility for a task or activity for the entire unit (e.g., admissions, medication, charge nurse). LPNs working in this model still had an almost identical role to the RNs. The only difference was that LPNs could not take on the charge nurse role

and they could not give medications to patients leaving on a pass. Overall LPNs were seen as equal members of the team on this unit.

*“Other than the areas that I mentioned [charge nurse role and being able to give pass meds], for the most part we all have a similar scope. The charge nurse role, the IV stuff notwithstanding. The mental status exams, the admissions, the discharges, all that kind of stuff we all do very competently. We seem to integrate our own practices and skillsets quite seamlessly.”* (RN, unit with LPNs)

When a patient’s needs were too complex for an LPN to adequately care for, all units agreed that care would be taken over by an RN. Similarly, LPNs sought out RNs to perform any tasks or activities outside their scope of practice. On most units with LPNs, interviewees felt the team worked well enough together that these were not major obstacles to overcome. On a few units, however, some LPNs felt the RNs were not willing to provide fast assistance, left the LPNs to wait, and resented having to do these tasks for the LPNs. These were the units that tended to have the least satisfied LPNs, with some reporting feeling bullied and not valued. In some cases, this was thought to be due to RNs’ feelings that their jobs were being threatened by LPNs; other reasons given were the attitude of older RNs who started working before significant changes to LPNs’ education increased their abilities and scope of practice.

*“LPNs are not appreciated here. The way they spoke to me was not pleasant when they found out I was an LPN – [there was an] attitude that I don’t know anything and shouldn’t be here.”* (LPN)

*“Some people’s idea of what LPNs and what RNs do and the difference between us, it just boggles my mind that they are not totally informed of our roles and the slight differences between our roles. It’s unbelievable how some people think there is more differences than there really is. There are only three or four things that we can’t do, and that’s changing.”* (LPN)

All staff and management shared an understanding that LPNs needed to be assigned patients in fairly stable condition with predictable courses of care. Beyond that, though, there was a fair amount of confusion and misinformation. Across almost all units without LPNs, we found a lack of knowledge about LPNs’ scope of practice and competencies. Staff and management alike were unsure of what LPNs could and could not do, and typically had not had any reason to consult LPN scope documents or educational curriculum. Surprisingly, the same was true on several of the units with LPNs. Although there were often specific activities that staff knew LPNs were not allowed to do, many interviewees had questions about the full range of skills and competencies LPNs are expected to possess and felt that the scope was changing so often that it was difficult to stay on top of the latest information. Most of the LPNs we interviewed reported having glanced at the CLPNA Competency Profile at some point but said they were not very familiar with its contents, although a few had examined it more closely. None noted any major discrepancies but some felt the framework was too vague or did not contain much information about their specialty area.

When we asked what resources staff and management accessed to get answers about LPN scope of practice, we heard a range of answers. Some interviewees said that LPNs are expected to know their own scope of practice, so they would start by asking LPNs. Some said they would first check the CLPNA website but could not name a specific document, others consulted the CLPNA's Competency Profile, and others said they would direct their questions to Health Professions Strategy and Practice (HPSP), AHS's internal resource for questions around healthcare delivery. Most agreed there were limitations to all of these sources such as inconsistencies between them, vague or confusing wording, frequent scope changes that are not kept updated, and "cyclical" answers where one body (e.g., HPSP) refers the question to another (e.g., CLPNA) and that body cannot answer the question, so refers the question back to the other, and so on.

*"It almost encourages me to not even bother asking the question in the first place because I literally never once have received a straight answer of yes or no."* (Management, unit with LPNs)

*"To some extent I kind of know what we're doing now is OK, but to actually know, concrete, I don't have a list of this is the scope of practice for RNs and this is for LPNs and this is what AHS says we can do, I don't really have access to those things. I kind of know it, but not as well as I would prefer to."* (Management, unit with LPNs)

*"They took away all documentation at the site that said specifics.... we now just follow what is on the CLPNA website."* (Management, unit with LPNs)

Perceptions of workload varied across units; some staff felt they usually had enough time to do what they needed to do whereas others felt constantly pressed for time. Most interviewees felt they could ask others for help as needed to manage the workload, but often felt that they did not have enough time to spend with patients when the unit was busy. They said that patient teaching was often minimal or skipped altogether at busy times, and that prioritization of patient needs was critical for managing the workload. Generally, interviewees felt that the patient care provided on their unit was safe and of high quality, but many wished they could spend more time talking with patients and making sure patients understood their conditions and how to care for themselves upon discharge. Most interviewees felt their unit would benefit from additional staff; several management and RN staff noted that RNs would be the most beneficial provider to hire since they are the most "flexible" in terms of the activities they can perform.

*Organization.* The major organizational challenge noted by interviewees was around education. Some units provided the same orientation to RNs as to LPNs, whereas others provided an extensive standardized orientation package for RNs but only gave LPNs a handful of buddy shifts. Some LPNs reported receiving ongoing support and education via in-services, educators, and AHS-offered courses, while others – mostly those working in rural settings – worked on units with no educator or very limited offerings by the educators. When LPNs did receive an appropriate orientation and ongoing educational support, it was noted as being very positive.

Most felt there were opportunities available for education, but many said that finding time and funding to attend off-site courses was challenging. No units with LPNs – and only one without LPNs - had any sort of formal or informal mentorship program in place, though LPNs typically said they could ask anyone experienced on the unit for support. Another challenge was that in some units, LPNs are only able to audit courses rather than receiving full certification. A number of interviewees commented on the fact that LPNs also need to receive appropriate support to be successful. Two interviewees shared examples of how LPNs face challenges when given new tasks or introduced to new situations (e.g., working in the ED) because training or support was limited or not available. Multiple interviewees commented on the importance of providing this support, but also noted that often it is challenging to do so.

*“There is no support for them when they go out on the unit. That’s a huge barrier as to why we don’t have LPNs in the emergency. A part of the barrier is the budget, the finances, but a second barrier is they don’t want to go into emergency if they are not being mentored.”*  
(Management, unit without LPNs)

*“If you’re an LPN who may work in a setting where it’s been fairly prohibitive for the skills they can do and then they start to open up, if you don’t feel well supported it’s hard to step up and say I need additional support to be able to do this.”* (Leader/consultation, AHS)

Other organizational barriers mentioned included the lack of advancement opportunities for LPNs. Whereas RNs can move on to become clinical educators, nurse clinicians, unit managers, or take on other formal leadership roles, such opportunities were not available to LPNs in any of the units or sites we examined. Some managers felt this was a problem, but at least one noted that given LPNs’ education and scope limitations, they should not be moved into higher-level roles.

*“How do you say to them, you’re only an LPN and that’s all you get to do?”* (Management, unit with LPNs)

*“There’s not a lot. It’s kind of ... that’s it. I have LPNs on the unit and that’s what they are. It’s basically you’re a full time or a part time.”* (Management, unit with LPNs)

We asked LPN interviewees whether their job descriptions matched the work they do. Most said they had seen their job description back when they applied to the unit, but had not reviewed it since. Some thought the job description was too vague, others thought it was a reasonably fair depiction of the work, and at least one said she had asked for a copy of hers but had never been given one.

*“I don’t think so. Other than when I applied but it was very vague when I applied. It didn’t really ... give an outline of exactly what I do. I didn’t know it was strictly postpartum, I just thought it was maternal and newborn care.”* (LPN)

*“I would say yes but probably most of the staff doesn’t look at their job description.”*  
(Management, unit with LPNs)

We asked policy-related interviewees about job descriptions and were told that AHS Human Resources writes all the job descriptions. Further, job descriptions should not be developed or altered at the unit level because they directly affect pay rates and other elements developed in the collective agreements. That said, one management interviewee indicated plans to update the LPN job description for her unit to better reflect the duties required.

One additional organizational factor that was mentioned in some interviews, particularly interviews with managers, was the new Operational Best Practice initiative in AHS. The stated goal of the initiative is to compare healthcare delivery costs within Alberta and across Canada to ensure AHS is operating as efficiently as possible. Some managers felt the initiative might actually limit LPN utilization based on how the worked hours are calculated. That said, other units were already looking ahead to cost saving strategies and had identified rotations where LPNs could be utilized instead of RNs. This created some challenges around RNs' perceptions of job security and some thought it might have increased tensions on some units with and without LPNs. In fact, RNs on at least one unit without LPNs had taken time before our interviews to review LPNs' scope of practice and identify tasks they felt LPNs would not be able to do on their unit.

*"It's primary nursing and I don't think their scope of practice covers specific primary nursing. Also their educational background doesn't give them training for being primary nurses to very acutely ill patients." (RN, unit without LPNs)*

*"LPNs can't be in charge. If they can't be in charge, depending where they are in the rotation and who's working that means that whoever is in charge if they were working with LPNs, means that they can't legally leave the unit to go on a break because the LPNs can't be in charge." (RN, unit without LPNs)*

*System.* We asked policy interviewees how policies related to scope of practice are developed. They reported that AHS's policy department focuses on developing provincial policies and that zone and local level policies are supposed to be consistent with the provincial policies. They noted that changing or developing provincial policies typically takes between three months and one year. Zone and local policies typically take less time, but depending on the topic and the level of support they could also take as long as a year. Development of and changes to zone and local policies are usually led by directors or clinical educators. We heard that policy development usually involves a working group including a senior leader to sponsor the policy, a project lead, and subject matter experts. Once the policy is changed or developed, it is sent to AHS stakeholders for review. If the policy includes regulatory or legal components, it may be sent to the professional college or the AHS legal department as well. AHS's HPSP team also sometimes assists with AHS's policies. Interviewees noted that HPSP interprets legislation and regulations primarily from the perspective of the employer, but that they try to take into consideration the perspective of all of the AHS providers as well.

The AHS policy experts we interviewed all reported that when possible they try to avoid mentioning specific healthcare providers in the policies. They intentionally keep the language

related to providers vague to allow for ongoing changes in regulations and scopes of practice. Instead, they use statements such as, “the authorized healthcare professional” with the understanding that each group’s regulated scope of practice dictates which providers can and cannot do those tasks. That said, policies are created at the provincial, zone, and local levels and interviewees noted there are many historical policies still in circulation that do specifically mention healthcare providers.

*“Especially with some of the older documents and some of the specific ones, you do definitely see, ‘the RN shall’ or ‘the LPN shall’ and then it specifies it in that regard. I always cringe a little when I see that. The reason for that is that it may be correct at that time, but if there are changes to the restricted activities or to competency requirements that may not be the case in the future.” (Leader/consultation, AHS)*

Of all AHS frontline, management, and leadership staff interviewed, only one was able to provide us with a policy that specifically referred to LPNs. The policy was a guideline that outlined new competency training requirements for LPNs at one site. Besides the HPA, the CLPNA Competency Profile, and HPSP documents that outline nursing providers’ restricted activities (HPSP, 2016a; HPSP, 2016b), none of the interviewees could think of specific policies or documents that limit LPNs’ scope of practice. All frontline and management interviewees were asked what system level barriers restrict LPNs from practicing to their full scope and none listed policies or other governance documents as a barrier. One leader/consultation interviewee reported that policies such as guidelines or protocols *could* include recommendations for staffing (e.g., stating an activity can only be done by a specific provider). However, they noted their facility currently does not have any policies that limit scope of practice.

Interviewees discussed the regulations informing LPNs’ scope of practice. One interviewee told us that in 2003, when LPNs were included in the HPA, the CLPNA met with Alberta Health and selected the restricted activities that LPNs would be approved to provide. Based on LPNs’ education at that time and the CLPNA’s understanding of the definition and interpretation of different activities, a set of restricted activities were chosen. Interviewees noted that although the CLPNA was engaged in that process, those regulations are now an ongoing limitation for LPNs. One reason is that the education program for LPNs changed from a one-year certificate to a two-year diploma program in 2007. Another reason given was that restricted activities were selected in 2003 based on the CLPNA’s understanding of how those activities were classified. For instance, at the time the CLPNA did not consider bladder scanning to be administering non-ionizing radiation, which is a restricted activity. They classified it as a bedside nursing intervention rather than a form of diagnostic imaging. Between 2003 and now, bladder scanning was confirmed as administering non-ionizing radiation and, therefore, is now considered a restricted activity for LPNs. One interviewee described the process of selecting restricted activities as like trying to “*see through a crystal ball*” because it was challenging to predict how these activities could be interpreted in the future.

*“Because our regulation is very old, there are some limiting factors with that regulation.”*  
(Leader, CLPNA)

Many commented that since LPNs were included in the HPA in 2003, LPNs' education and scope of practice has grown immensely. To better reflect LPNs' current competencies and training, interviewees reported that the CLPNA is in the process of revising those regulations under the HPA. The proposed changes have gone through multiple phases of consultations and will be eventually submitted to and approved by the government. The consultations included representatives from Alberta Health and other stakeholders throughout the system such as policy makers, employers, managers, clinical educators, and regulatory partners. One interviewee noted that feedback from the consultations revealed that some stakeholders had concerns about the qualifications of the LPNs to do some of the newly proposed activities. This interviewee felt that these concerns might come from stakeholders who are not familiar with the LPN competencies and the updated educational curriculum.

AHS policy interviewees felt that LPNs could work to their full scope of practice within AHS; CLPNA interviewees disagreed. They felt that AHS's interpretation of specific items in the HPA had restricted LPNs. They also commented that they usually did not have the opportunity to be engaged with AHS in the process of discussing or providing feedback on decisions or changes to practice that affect LPNs. However, this was said to have improved over time and the CLPNA is more involved and informed. For the most part, interviewees thought AHS agreed with the activities outlined in the CLPNA Competency Profile but some noted inconsistencies. Interviewees believed that some of these inconsistencies were technicalities; for instance, we heard that although LPNs had done bladder scans and distributed pass medications for years, AHS recently confirmed those tasks as being restricted activities. Therefore, although LPNs are no longer allowed to do these activities, participants in this study agreed that LPNs could or should be able to do them when the regulations support it. There were some activities that AHS leader/consultation interviewees felt LPNs should not be doing. One noted that as part of the Competency Profile development the CLPNA asked LPNs what tasks they were currently doing, and added those tasks to the framework. An interviewee from AHS contested that just because LPNs were doing a specific activity did not mean that it was appropriate for them.

*"That's a perfect example where the regulation interpretation got into some struggles after we'd been working it for years. So our LPNs have been performing bladder scanning since bladder scanners have been brought into nursing practice, probably three decades at least. Now there's been a roll-back within many healthcare settings because the interpretation of what bladder scanning actually is, that it's a restricted activity and LPNs do not have authorization. It makes no sense from a practical point of view because it's low risk, they have been doing it for years, and now all of a sudden because we've identified it as a restricted activity we have to stop them doing it. That is an example of how restricted activities can be very problematic." (Leader, CLPNA)*

*"Fetal monitoring is another big issue that we have a lot of misunderstanding because that's an activity that they're not authorized to perform... It's the non-ionizing radiation. From the CLPNA's perspective is that they think LPNs should be allowed to do heart monitoring...I'm very open minded I think, understanding that the LPN education has greatly changed since it*

*went to a diploma program in 2007. But ... maternal/new born education is very focused on the same LPN who may work in a physician clinic, that prenatal check-up, and then lots around postpartum Mom and babe care. But not delivery care and certainly not interpretation of fetal monitoring in any way.” (Leader/consultation, AHS)*

Although there were differences in opinions about some LPN tasks, overall the AHS policy interviewees understood the LPNs’ scope of practice and supported them working to full scope in AHS facilities. Some thought the bigger issue was that the LPNs’ scope of practice was not consistently understood throughout AHS. Interviewees described this lack of understanding as limiting the utilization and optimization of LPNs.

*“That could be why they are not being used to full scope, it’s a lack of awareness and understanding of the education of an LPN.” (Leader, CLPNA)*

*“The problem is that this information is not being trickled down to managers. LPNs are well-educated on what they can do so they have frustration on-site when they have policies around what meds they can or can’t give – differs from site to site – and I tried to work with the sites but they wouldn’t budge.” (Leader/consultation, AHS)*

*“I find it interesting that the RNs, when they graduate are automatically to full scope and the LPNs are to the scope of the site – so whatever your site deems that you can do.” (LPN)*

Policy and frontline interviewees reported cases where LPNs were prohibited from doing activities they were allowed to do on other sites and cases where LPNs were actually doing activities that were outside of their scope of practice. For example, some interviewees shared their experiences working on units that would not allow LPNs to administer any medication or take doctors’ orders. While those activities are approved by AHS, interviewees noted that it is ultimately up to the managers to decide what providers can and cannot do on their units. HPSP tries to work with managers who limit LPNs’ scope but we were told there is no formal mechanism to force these managers to change their formal or informal policies around this.

*“I think we need to help managers, clinical educators, RNs understand the knowledge that the new curriculum brings...I’ve had discussions with colleagues on my team that say, ‘I can’t believe they want to work peds’ and I’m like, ‘they take a 45 hour pre-credit pediatric course’, and they go ‘really?’ and I go ‘ya, they really do’. I think that if their education program is more understood, they would not be so hesitant to allow them to expand their scope or just working to full scope, working to the scope that they have.” (Leader/consultation, AHS)*

### **Emergency Departments**

Across four EDs, we interviewed 21 staff, managers, and leaders. Two units had dedicated LPN staff and two did not.

### Units with LPNs

ED-A. On one small rural ED (ED-A), one RN and one LPN were assigned on days and evenings and one RN was scheduled on nights. Because it was a small site, many of the staff floated between ED and other floors as needed. Patients were assigned based on workload and patient triage scores, with RNs and LPNs either providing care independently or as part of a team with the RN acting as a lead. LPNs were able to independently care for patients assigned Canadian Triage and Acuity Scale (CTAS) levels 4 and 5. LPNs could work on higher triage levels (1 and 2) but required an RN to be a lead and monitor the care. For CTAS 3 patients, care assignment was said to be “*a little wishy washy*.” According to management directives, those scores required an RN to lead care but all staff interviewed noted that LPNs could care independently for some those patients. If LPNs had the required competencies and felt comfortable, they were allowed to care for the patient as long as they discussed it with the RN and kept the RN informed about the patient.

*“I can still be taking care of the patient but just needing to verbalize.”* (LPN)

Although the LPNs felt valued at work and recognized that having an RN involved in care was never a detriment, one LPN felt they should be able to use their own judgment on whether or not to involve RNs in any given case. This was in regards to LPNs’ inability to independently care for CTAS level 3 patients especially given the fact that on acute care units in the same hospital, LPNs could independently assess and treat similar patients. This rule was said to make it more difficult for LPNs to use their full knowledge, skills, and abilities.

LPNs had been staffed on ED-A for about a year. The most commonly cited reason for their introduction was to lighten the workload for RNs. Initially, the unit only received funding to have LPNs for eight hours each day but funding has since doubled. This was said to be a testament to LPNs’ ability to help with patient flow as they could handle a lot of the outpatient care and assist with procedures. This was thought to be especially valuable given that most staff acknowledged that the workload can be tough to manage when they do not have enough beds or enough staff. Staff felt that they would have even more time to spend with patients and complete their paperwork if the unit introduced a triage nurse and/or a unit clerk.

*“I think we proved our worth in how many patients we see.”* (LPN)

*“It’s very helpful to have them here.”* (RN)

All of the LPNs interviewed felt valued at work and noted how satisfied they were in their jobs. Most of the staff working on the unit had come to realize that LPNs’ training and education has changed quite drastically in the last decade or so and most non-LPN staff were said to recognize the new LPN role and scope.

All interviewees agreed that teamwork and open communication were working well on the unit. The fact that the unit is smaller and rural was said to mean that everyone knows each other and are more likely to develop strong relationships with their coworkers.

*“Because we are a small site, there is not a lot of hierarchy and we have a lot more open communication.” (Management)*

In terms of education and training, interviewees all noted when LPNs were first introduced on ED-A, no formal orientation shifts were offered. LPNs were expected to *“figure it out”* on the job. Some thought LPNs were not transitioned properly into this ED unit, which caused miscommunication and confusion around what LPNs could and could not do and what courses they needed to take before starting.

*“They [LPNS] were just kind of put there and we just kind of had to orient them as they were working with us.” (RN)*

One LPN mentioned that as of recently, new LPNs do receive a formal orientation. LPNs also said that formal mentoring would be of great value to new LPNs who might not have a lot of previous experience. One LPN interviewee felt that new LPN graduates should gain medical experience working on other units before coming into an ED. A management interviewee noted that with better resources, they would be keen to have LPNs buddy with an RN at a bigger site to allow LPNs to gain perspective and diversity in experience. LPNs felt their formal education prepared them to work on an ED unit. When they noticed gaps, LPNs either took extra courses off- or onsite or asked the RNs for help.

*ED-B.* On the other unit with LPNs (ED-B), the model of care used was primary nursing. LPNs and RNs were each given their own assignment. LPNs could do full assessments and work independently in their own area. Similar to RNs, though, they also have to report to a charge nurse. Work was organized into four different areas: the LPNs ran the “fast-track” and the treatment chair areas, both of which treat lower acuity, non-urgent patients with CTAS scores of 4 or 5, and the RNs ran the trauma and cardiac rooms. A triage nurse assigned patients to areas based on acuity. Non-LPN interviewees commended LPNs’ ability to identify when to bring in extra assistance from an RN.

*“We have very high level and competent LPNs who are very good about questioning if they are unsure.” (Management)*

All interviewees noted that the workload was heavy. Staff also mentioned that while some days were good, many days were very busy, unmanageable, and sometimes not safe. One LPN interviewee thought that the workload could be overwhelming for new graduates. This unit was said to experience a lot of turnover, potentially due to stress and new graduates’ inability to cope with life and death. This caused some resentment for one of the LPN interviewees, as she spent a great time of time training new LPNs only to have them leave shortly after. In addition to the high volume of patients seen, work was sometimes thought to be unmanageable if a unit clerk called in sick which would require RNs and LPNs to do a lot of work they would not normally be doing (e.g., answering the phone). When an RN called in sick, it was usually an LPN who filled in because the site used an LPN float pool. One of the management interviewees noted that having an LPN fill in for an RN was not always helpful as this meant other RNs would have to double check the LPN’s work.

When we asked the RN interviewees whether having LPNs allowed them to work to full scope, we heard mixed thoughts. On the one hand, LPNs were thought not to make a difference because in emergency settings, everyone had to be working to full scope. On the other hand, some believed LPNs helped RNs work to full scope on this unit because they have very competent LPNs who can relieve the RN patient load. This was consistent with the main reason given for why LPNs were introduced on the unit: to get more patients seen and out the door.

We asked LPNs whether they felt they were working to full scope and, unlike what we heard in management interviews, the LPNs did not believe they were using their full scope. LPN interviewees felt AHS restrictions and misguided interpretations of their new scope of practice prevented them from doing all they could. One management interviewee described how non-LPNs did not want the scope of LPN practice to change or expand because it would be “*taking away*” from the RNs. She noted that this would be a barrier to having more LPNs included in the staff mix and to having them work to full scope.

*[Asked how RNs feel about LPNs] “There’s been a lot of that fight of ‘you’re taking my job away from me to put in an LPN but in emerg you can’t take RNs away then you’re putting your patient at risk’. There’s a lot of stigma that we don’t want a scope of practice for them [LPN] to change because it’s taking a lot of our jobs away and there’s that threat of us losing our jobs to replace with LPNs.” (Management)*

*“Now we have some new regulations, there is some confusion over how far our scope can be implemented due to new and old policy.” (LPN)*

Although one manager noted that everyone needs to respect people’s knowledge, experience, and ability, the LPNs interviewed on ED-B did not feel valued or respected. One of the reasons for this was that their decisions were sometimes overridden by RNs and they did not feel supported by management. Non-LPN interviewees felt that some older RNs were more likely to treat LPNs with less respect.

*“Some of it is personality, some of it is RN and LPN dynamics, I’ve been putting up with it for my entire LPN career, LPNs are very disrespected among other professions especially among RNs, they are mean girls, I believe they are taught it in school, if you are an RN you delegate to the LPN, they will do it, a lot of them have that attitude so an LPN has to be very strong-willed” (LPN)*

*“There is a ‘we’re an RN vs. LPN’ instead of ‘we are a healthcare team.’” (Management)*

When asked what was working well in the unit, management interviewees pointed to teamwork, open communication, and staff efficiency. Frontline staff talked about how having a small core group of providers over time has allowed them to work well together. LPNs were not overly satisfied working on this unit; one said she was considering leaving the profession altogether. LPN dissatisfaction stemmed not only from the lack of respect they experienced from their co-workers, but also from a perceived lack of opportunities. Being an LPN was said to be a very “*dead-end*” job,

and LPNs felt all the opportunities for advancement were for the RNs. For instance one LPN noted that RNs were hired to teach LPNs so she could not find a job even teaching in an LPN college program.

There was said to be a marked difference between RN and LPN orientations. Before starting on ED-B, an RN was required to attend a 30 day classroom orientation. The orientation is intensive and involves core courses, online modules, PowerPoint presentations, and guest speakers. Following the classroom training, RNs receive two weeks of buddy shifts. In comparison, LPNs received no classroom training and only five buddy shifts before starting on the unit.

*"[We] would be so much more comfortable and confident in our skills if we had that and it would be useful for new hires and for the ones currently working because although I know fast track, in the other areas I don't know what to do."* (LPN)

Management interviewees had noticed that new LPNs were always eager to do and learn more activities and procedures. One of the RN interviewees said that as long as an activity is within LPN scope, she was happy to teach LPNs. No interviewees thought that there were any gaps in LPN education, but almost everyone thought new graduate LPNs needed to gain experience. For this reason, management did not hire LPNs right out of school.

*"We try not to hire them out of school, the biggest gap we would notice is inexperience. In ER experience is a key factor. Even with the RNs I don't like hiring out of school..."* (Management)

Almost all the non-LPN interviewees on ED-B indicated they were unfamiliar with LPN education and scope. When non-LPNs needed information on LPN scope and education they either consulted with the educator or an LPN on the unit who is well-informed.

### Units without LPNs

**ED-C.** Care on Unit ED-C was organized into different areas or pods. These included two critical care rooms, an intake area, one monitored and one unmonitored pod, mental health beds, and a pediatric area. Patients were seen at intake and assessed by an RN. Staff was made up of RNs, Health Care Aides (HCA), unit clerks, and orthopaedic technicians (specialized LPN roles not included in our analysis). The model of care was a modified primary assignment, such that RNs were assigned patients but staff worked in teams and helped each other as needed. Due to ongoing staffing changes, we were only able to interview management staff on this unit.

Interviewees noted that staff's sense of responsibility, open-mindedness, and flexibility contributed to the unit's efficient flow of patients. Management also praised staff's teamwork and commitment to improving patient experience. Regardless, everyone seemed to acknowledge that the workload was heavy. RNs were said to be consumed with paperwork which took time away from patient care. This also restricted RNs' ability to work to full scope. The work expected of staff was thought to not be commensurate with their job description in that it did not reflect the quality or quantity of work.

*“The job description is so simplistic, can’t possibly reflect what you do on a day to day basis, it minimizes what happens in the ER department.” (Management)*

All interviewees agreed that LPNs would not fit well on ED-C. Their ED cares for a lot of acute patients - patients that LPNs could not independently care for, according to interviewees - and because they do not have a fast-track area, LPNs could end up doing housekeeping or clerk duties. Interviewees felt this would lead to resentment and poor working relationships. A few interviewees discussed how introducing LPNs would take away tasks from the RNs and cause role confusion. The model they found most effective and fiscally responsible was to have a HCA in charge of the physical care such as meal preparation, feeding, and bathing, and the more complex tasks (e.g., IVs and medications) done by the RN. This manager thought introducing an LPN into the mix would generate role confusion as tasks would not be as clearly divided as in the current model. One manager was worried that staffing LPNs would open the door to patient safety risks.

*“In the ER with the acute patients I’m not necessarily agreeable to that, there is so much confusion, and things get missed or done twice...” (Management)*

When discussing why LPNs were not currently part of the staff mix, other than legacy hiring practices, interviewees felt that LPNs did not have the skillset to care for high acuity patients. The ED was said to be a highly specialized care setting and due to policy restrictions and guidelines, LPNs are not able to get certified in necessary courses.

*“LPNs are brought into departments to save money but they need to be able to work to full scope but in emerg it’s highly specialized and LPNs can’t even take those certification courses, they can audit them but won’t be credited, there will always be advanced competencies that they won’t have.” (Management)*

Interviewees were generally unfamiliar with LPN scope. Most were not aware and others were in the process of educating themselves on it. That said, they recognized that LPN training has advanced significantly. One interviewee noted it was challenging to learn about LPN scope and competencies because information was not consistent across sources.

*ED-D.* The final unit (ED-D) was a smaller rural hospital with only one RN assigned on the day shift and one float RN who worked on the ED as well as the adjacent acute care unit. In the evenings and overnight, ED-D had one dedicated RN with the understanding that if they needed help they could pull someone from acute care. ED-D is attached to acute and long-term care units that do have LPNs in their staff-mix. ED-D often pulled LPNs from those units to care for ED patients when it was very busy. The model of care is primary nursing and patients were assigned based on acuity and RN experience.

As it is a smaller hospital, all interviewees noted that it is understaffed and that the RNs take on responsibilities that they normally would not have to (e.g., housekeeping, stocking, etc.). Staff felt that because they were caught up in these activities as well as a lot of paperwork, time was taken

away from being bedside with their patients. The “bare-bones” staffing model also meant that interviewees felt the care provided was not always safe.

*“It depends, it’s so scattered, we have a very small staff so 80% of the time it’s fine but the other 20% it’s unreal and sometimes not safe, especially on night if one sick patient comes in all the nurses are attending to them and there is no one looking at the other people, it takes away from the care, on days it’s more manageable because there is way more support and at night there is nobody.” (RN)*

That said, interviewees thought the staffing model also meant nurses were working to full scope. Nurses saw a large diversity and high volume of patients. When asked what was working well, management and staff commented on the experience of the nurses, teamwork, open communication, and everybody’s willingness to help out when work was overwhelming.

All the interviewees strongly supported the inclusion of LPNs on the unit. They felt LPNs could care for the majority of patients seen, and thought that while RNs may have more critical thinking skills since their training is longer, RN and LPNs have the same manual skills. As long as LPNs were oriented to work on the unit, interviewees thought they could provide relief to the flow of the emergency by caring for patients with lower acuity CTAS scores.

*“The LPNs could handle the vast majority of patients, if they worked to their full scope of practice and were formally on the unit. They are able to help with everything: starting IVs, dressings, administering medications, and assessing.” (RN)*

The main reasons given for not currently having LPNs in the ED staff mix were legacy hiring practices and financial restrictions. Although LPNs were not formally in the ED staff mix, LPNs did work there informally when pulled over from the acute care unit. A management interviewee hoped that in time, they would be able to formally introduce LPNs onto the unit.

*“They could fit into emerg; I have this idea that through attrition or as I get retirement in the RN work I don’t see why that float position couldn’t be an initial place to use LPNs.” (Management)*

To properly introduce LPNs on ED-D, there were thought to be a few barriers to overcome. Interviewees thought LPNs needed proper orientation. LPNs who currently work informally on ED-D are not oriented to the unit so are not always comfortable being pulled in as they are not informed on the procedures and policies. Other issues surrounded older RNs and LPNs. Older RNs were said to be less trusting of LPN skills and expertise and thus were resistant to having them care for ED patients. These RNs were unaware that LPN education has drastically changed over the last decade. Another barrier noted was getting the older LPNs to come to full scope. This included having LPNs complete the required certifications and overcome their fears of working in an ED.

*“The training, the orientation, they don’t get any time in emerg, there’s pushback from certain nurses who are not very welcoming to them and that discourages them and makes them too shy to join in.” (RN)*

### **Mental Health Units**

We interviewed 35 staff and managers across five MH units. Three units staffed LPNs and two did not. In addition to RNs, some of these units also used Registered Psychiatric Nurses (RPNs); we have used the terms interchangeably in this section to avoid identifying specific interviewees.

#### **Units with LPNs**

*MH-A.* Unit MH-A had a staff mix of 50% RNs/RPNs and 50% LPNs and used a primary nursing model. All interviewees reported a very positive and supportive work environment and felt that if someone needed help because they were either too busy or dealing with a challenging patient, others on the team would help out.

On day and evening shifts, each nurse had a patient load of four to six patients; nurses on overnight shifts had a patient load of six to ten. Patient assignments were based on a number of factors: patient acuity, staff skill set, staff seniority, or patient requests (e.g., female vs. male staff). Patient assignments were not based on LPN or RN designation.

*“The assumption is that most people are trained to deal with the dynamic changing needs of our patients and can deal with the crises and deal with the conflict situations. If there is an issue with that or if that person feels overwhelmed, then generally the expectation is that they will delegate to another member of the team, or come to [the team] and we will come to a solution to fix that problem. So there is ongoing support and collaboration.” (RN)*

The interviewees reported that the workload was manageable, but that it *“depends on the day.”* They felt that they always had time to get their work done; but smaller activities like being able to spend time with and talk to their patients sometimes slipped through the cracks.

LPNs were introduced to the unit a few years ago. Management interviewees could not comment on exactly why that decision was made but they thought it was related to budget. LPNs and RNs were considered equal and interchangeable on this unit. The only difference was that LPNs could not be in the charge nurse role and could not distribute pass medications. LPNs noted they used to be able to give out pass medications. Because LPNs cannot be in charge, interviewees noted that if a group of LPNs was working with only one RN, the RN could not take a break. All of the interviewees noted that the fact that LPNs could not do these activities were nuisances but not barriers; they also did not blame the LPNs for these limitations.

The RNs interviewed commented that they have confidence in the LPNs’ ability to fulfil their duties and that their trust in their team members was based on the individual, not the title. One LPN said that new team members have to prove themselves when they join the unit, but that this was the same for new LPNs and new RNs. All providers noted that their scope of practice was limited

working in MH (e.g., doing less medical care) but both the RNs and LPNs felt that they were working to full scope within the MH context.

Interviewees agreed that the LPNs on this unit were very well respected and gaps in education and lack of experience, while acknowledged, were not seen as a barrier to LPNs being able to work in MH. One RN commented that LPNs are not trained in MH or addiction but that they “*get up to speed*” quickly. Another said that new LPNs are similar to new RNs and emphasized the importance of supporting new nurses to learn on the job. LPNs reported that they received good orientation by supportive staff and that they were provided the support and structure to learn and be successful.

*“For this kind of unit, you have to dive in and have a good team to support you while you learn.”* (LPN)

*“You can learn how to pour meds at school but to actually sit with a patient and try and be supportive and non-judgmental, that comes with being on the job and learning it.”* (LPN)

Both LPNs and RNs commented on the “*great*” team environment on this unit. Job satisfaction was high for all interviewed and they all felt that they provided high quality care. LPNs were seen as equal members of the team and their role was understood by all interviewees.

*“The LPNs aren’t being brought in as a lower qualified nurse; we all work together as a team. They’re not my bosses and I don’t work for them.”* (LPN)

The LPNs interviewed reported that they had experienced negativity from RNs in other areas and on other teams, but never on this unit. The management and leadership were credited with fostering a cohesive team environment.

*“[Have I ever felt unwelcome on a unit?] Not on mental health, and I think that on this unit that was due to our manager. [The manager] wanted everybody to ... work together and not demean anyone because they spent less time at school.”* (LPN)

*MH-B.* Unit MH-B used a modified primary nursing model. Five nurses work the day shift, as few as three work the evening and weekend shifts, and three work the night shifts. Interviewees reported that usually one LPN works the day shift and the evening shift. The unit also staffs undergraduate nurses so they try to avoid having more than two LPNs or undergraduate nurses on a shift. In addition to the nurses, psychiatric aides (PAs) are also staffed on the unit. Nurses are assigned individual responsibilities (i.e., admissions, medications, vitals, specimen collection, and charge duties) as well as patient caseloads. The charge nurse determines the patient assignments. A management interviewee, some RNs, and the LPNs reported that patient assignments were based on patient acuity, individual specialties (e.g., some LPNs are more comfortable with wound care), and continuity of care. They said there was no difference between patients assigned to LPNs or RNs. Some RNs reported that ideally, more acute patients would be assigned to either the charge nurse or one of the RNs, but that was not always the case. The workload was described as manageable but

interviewees said that it could quickly become overwhelming. If additional patients are admitted and the unit is over capacity, they have the option to call for additional staff.

LPNs were introduced on this unit because of budget constraints, but also because the facility was seeing more of an interest from LPNs to work in MH. It was noted that in the past, they had tried to recruit LPNs for MH units but they found that LPNs had little MH training and that there was little interest.

*“They have less of an impact on your budget so it’s an opportunity to see where we can fit them in order to save money. Another part is that the LPNs did not have that mental health background in their training. They do have it in their curriculum now, but they didn’t before. And there was no interest before, no draw.”* (Management)

Interviewees reported that LPNs do all the same activities as RNs except being able to be in charge and give pass medications. Some noted that it would be nice if LPNs could be in charge, even if it was just to cover RN breaks. When asked whether they thought LPNs were capable of taking on the charge role, interviewees said that like RNs, some LPNs have the experience and skill to take on that role while others do not. It was noted that being in charge was a limitation that AHS put on LPNs and that they had seen LPNs in a charge nurse role with other organizations. Although they felt they could take on a charge role, one LPN reported that were “okay” with not being in charge and that the RPNs should be in charge because mental health is their specialty.

*“...I’ve been in charge with other organizations, private home care, and private extended care. According to the CLPNA LPNs can be in charge, it’s just with AHS.”* (LPN)

Interviewees commented that there could be quite a difference in the skills of a new LPN and of an experienced LPN. Some reported that experienced LPNs were interchangeable with the RNs; less experienced or less skilled LPNs were said to be harder to work with because the RNs had to help them out more (e.g., answering questions, helping make decisions). Although all interviewees agreed that the LPNs did a good job on the unit, a few RNs said they are more comfortable working with other RNs than with LPNs. They said this was because they felt that they often had to do more work when working with LPNs.

*“They are all good staff so I don’t want it to come across that I resent them, but I find I have more work to do with LPNs on the floor versus grad nurses.”* (RN)

Other interviewees did not feel that there was a notable difference between LPNs and RNs. In addition, some reported that both RNs and LPNs often started with a similar level of MH background and experience.

*“I don’t even look at people’s name tags. I’m just thankful to have regular staff when I come in. They should be treated as equal, no matter where they go...They work just as hard.”* (RN)

*“I don’t see a whole of difference between a brand new RN and a brand new LPN at this point in time.”* (Management)

All nursing staff receive the same orientation when they are hired. It was reported that they receive a two- or three-day orientation to the hospital and then six orientation shifts on their specific unit. The LPNs interviewed felt that their education alone was not enough to prepare them to work in mental health, but that they could gain that training and experience on the job; this included support from their colleagues on the unit. They did note that additional training is self-directed and an LPN working in MH would need to be motivated to learn.

*“If an LPN has a question then the senior staff are always very helpful. I’ve never seen any type of, I don’t know if abuse is the right word, or dismissiveness or anything like that. I’ve never seen that line, like oh, you’re just an LPN, or oh you’re just an RPN. It’s very rare that you see someone who’s like, just nose up in the air because they’re an RN.” (RN)*

Some RNs commented that the staffing ratio with LPNs works better if there are a higher number of RNs to LPNs; for instance one commented that it is easier working with LPNs during the week when there are five nurses compared to working on the weekend when there are only three. LPNs’ perceived lack of education and experience was seen as more of a barrier on this unit than on Unit MH-A. Some interviewees noted concerns about new LPNs’ ability to independently make decisions and “[understand] how to handle things when they go sideways.” These concerns were unique to less experienced staff as many interviewees reported that experienced LPNs were more or less interchangeable.

*“We can tell the ones who are new or haven’t worked in there for a long time. But then we have someone who’s worked in psych for [many] years and you probably wouldn’t be able to tell she’s an LPN.” (RN)*

Finally, when the LPNs were asked if they were satisfied working in MH they reported that they enjoyed their job and felt respected. However, a number of interviewees commented that LPNs should be paid more.

*MH-C.* Unit MH-C used a primary nursing model. Currently, LPNs only work on evening and night shifts, but that will be changing soon because of the Operational Best Practice initiative. LPNs are increasingly being brought in to cover day shifts as well. Four RNs work on the day shift; one takes on the charge role and the patients are divided between the other three nurses (5-6 patients each). In the evening, there are three RNs and one LPN, and for the night shift there are two RNs and one LPN. During the evening shift, the LPNs take a patient load, and then over the night shift they are assigned a night duties checklist to complete. Night duties include activities such as printing client lists, clearing out the medication cupboard, wiping down surfaces, and emptying the linen bags. Interviewees acknowledged that a PA could do many of these activities, but a “higher level of ability” was also needed during the night shifts for some patient needs. During the night shift, the two RNs can also do those night duty activities, but they primarily take on other responsibilities like checking patient charts.

When LPNs are assigned a patient load, interviewees said that LPNs are supposed to be assigned lower acuity patients, but that that was not always the case. Further, some interviewees reported

that patient assignments are based on the charge nurse's assessment of the complexity and acuity of the patient but as there is no tool to assess acuity one interviewee felt this process was subjective. Therefore, LPNs could end up with higher acuity patients. Some RNs interviewed complained that because RNs are supposed to be assigned higher acuity patients, they end up with a more challenging workload when working with LPNs. Interviewees described their workload as busy but mostly manageable.

When LPNs have a patient load they were said to function essentially the same as the RNs, with the exception of being in charge, giving pass medications, and taking doctors' orders. Unlike the other two units, where interviewees saw the LPNs' restricted activities as minor inconveniences, on unit MH-C some RNs were frustrated and felt burdened that the LPNs could not do those tasks. Some RNs also questioned the skills and abilities of LPNs, reporting that they can miss signs of escalation during assessments and do not know how to effectively de-escalate an agitated patient.

*"I find the training isn't full, there are often holes in care, they are unable to fill the patient load up or complete the patient assignment, and they are unsure of how to de-escalate or properly handle a patient." (RN)*

Most of the LPNs interviewed reported that their role and scope of practice were not well understood on the unit. There was said to be confusion and inconsistencies around tasks that LPNs were and were not allowed to do, for instance, receiving doctors' orders.

*"We can take doctors' orders – but not on this unit. Only RNs can take doctors' orders on this unit. Only on this unit can we not take doctors' orders. It is within our scope. RNs are stubborn about giving up their authority. It would be how things function on this unit. It depends on who is charge. The charge will [sometimes] let me take doctors' orders." (LPN)*

LPNs' perceived lack of education was a central concern on the unit. The RNs commented frequently on the LPNs' lack of education and limited experience in MH and one LPN reported that they are constantly reminded of their "lack of education." That said, consistent with the other two units, the managers agreed that LPNs, like new RNs, had limited exposure to MH in school but that they learned those skills on the job.

*"LPN qualifications are not in the area of mental health." (RN)*

*"The basic knowledge isn't there dealing with mental health and if you don't take the time to learn it you will be deemed incompetent or difficult to work with because then they'll need extra support and it is busy here to take extra time to help. The charge nurse deals with all nurses and doctors so they can't help them either." (RN)*

LPNs reported positive and negative aspects about the orientation and education on this unit. One LPN commented that the orientation to the hospital allowed them to get advanced certifications that were helpful when starting on the unit. However, interviewees also reported that orientation to the unit was only two day shifts and two night shifts, and that that was not enough. Further, this

unit did not have an educator and therefore learning and education once on the unit were seen as limited. This was noted as a concern by managers, RNs, and LPNs.

*“Clinical educator is a key piece for all staff. We have never had a clinical educator. That would be a big step for all staff not just LPNs.” (Management)*

Most of the LPNs interviewed reported not feeling valued on the unit. Some noted that their happiness on any given shift was dependent on the RNs working that shift; some RNs were fine to work with and others were “terrible.” RNs agreed that the team had “a morale problem” and expressed concern around the potential of RNs losing their jobs in favour of LPNs.

*“There is always the fear of LPNs coming and taking over the unit. Which we’re not, we don’t have the additional education that they have. It is real now because this unit will switch to have more LPNs. I am anticipating extra nastiness over the next months. I have already told [my manager] I won’t take one of those new positions, I will stay casual. I have been misused enough over the years.” (LPN)*

Another area of concern was the process to contact staff to cover shifts. The main goal was to “replace with same”; they contact casual RNs first and contact LPNs only if going into the overtime pool. Many interviews emphasized the preference for filling those shifts with RNs and noted concerns with replacing an RN with an LPN. Interviewees also reported that now, because of Operational Best Practice, LPNs are being called before RNs to cover shifts.

*“My personal opinion is that when an RN phones in sick, an RN should be replaced with an RN. You struggle on a day shift if an RN’s replaced with an LPN, you already have an LPN working, you now have two LPNs on the unit that often struggle with the acuity of the unit.” (RN)*

*“LPNs are now being offered shifts before others which is upsetting people. RNs’ overtime is going away and their money is dwindling.” (RN)*

Another factor in the RNs’ dissatisfaction with working with LPNs came from the LPN float pool. This MH unit would exclusively receive LPNs to cover shifts when unit staff were unavailable. This was noted as a significant challenge for many RNs interviewed because these LPNs were inexperienced working in MH and required more oversight and support. However, most RNs acknowledged that experienced, strong LPNs were useful.

*“There is a divide between RNs and LPNs. If you are competent then we will get along.” (RN)*

Team dynamics aside, all the LPNs interviewed reported that they enjoyed their job, though not always the work environment. They would recommend working in MH to other LPNs, but maybe not on this specific unit and not as a new graduate.

*“With the actual job satisfied, but I guess with the environment and the vibe, [high] dissatisfaction.” (LPN)*

Interviewees reported that another challenge was that management was new and not on the unit full time. This was mentioned as a concern because some interviewees felt that management in general did not understand the unit and working in mental health. As a result, one interviewee commented that management made decisions based on numbers instead of other factors such as patient safety and morbidity. Many LPNs on the unit did report that they felt supported and encouraged by management.

*“As far as my head nurse and my manager goes, I for sure feel like a valued member of the team. Neither has ever given me a hint of ...bullying.” (LPN)*

### Units without LPNs

**MH-D.** Unit MH-D used a modified primary nursing model. The unit provides care for medically stable patients with acute MH conditions. Three RNs and two PAs work the day shift and two RNs and two PAs work the evening and weekend shifts. The nurses are assigned specific duties (e.g., charge, admissions, and medication) as well as a patient caseload. Interviewees reported that the team and team environment worked well, as did the very structured routine of the unit. All interviewees understood the roles of the providers working on the unit, reported working to full scope, felt that they provided excellent care, and reported high job satisfaction.

The workload was described as manageable and interviewees said that if they get overwhelmed either the team helps each other out or they can bring in additional staff as support – but they rarely have to call in additional staff. Interviewees pointed out some activities (e.g., supervising a shave, opening the locked door) that could be done by another provider (e.g., a PA); however, they felt that doing those activities were a part of working as a team and would do those tasks if they had the time.

At this facility, decisions about having LPNs on the units were at the managers’ discretion. The interviewees unanimously agreed that LPNs could do the work on the unit. Most had worked with LPNs at some point in time, were familiar with the LPNs’ role on MH units, and felt that *“they are good on teams.”* They agreed that the only reason that LPNs were not on the unit was because LPNs could not be left in charge and if they worked the evening and weekend shifts the RNs could not take breaks. While enough RNs work on the day shifts to cover breaks, the manager noted that having an evening or weekend LPN line would be *“inefficient for our budget”* and lead to *“overages”* because the staff rotate between the day, evening/weekend, and night shifts. They said that it would make sense to replace one of the PA positions with an LPN position, but that they did not have the budget for that.

*“LPNs could do the job just as well, it’s just a matter of that one barrier.” (RN)*

The manager noted that it would be helpful if LPNs could take on the charge role, even if it was just to cover breaks. It was mentioned that technically an RN could take a break when only working with LPNs if an RN from a neighbouring unit agreed to cover the unit when they were gone. However, they said that other RNs never agree to that because it is too much work.

*MH-E.* Unit MH-E used a primary nursing model. They worked with very high acuity, challenging patients. Interviewees reported that primary nursing was the most appropriate model of care to work safely and properly with this population. To cover the unit, four RNs or RPNs and six PAs worked the day shifts. Interviewees reported that the unit had a good staff mix, worked well as a team, and did a good job communicating (which was said to be especially important working with this population). Interviewees reported feeling supported; to them this meant making sure that the staffing numbers were always maintained or that they could call for extra staff (RN/RPN or PA) if needed.

While the interviewees understood the roles of the team members on their unit, they did not have a good understanding of the LPNs' role and particularly their role in MH. Some interviewees had reviewed the LPNs' scope of practice prior to the interviews, but few had actually worked with LPNs and therefore there was some confusion about what the LPNs' role would actually look like in practice. Many interviewees reported that LPNs' education did not prepare them to work on MH units, that they were more focused on medical tasks and not MH training, and that they lacked critical thinking skills. Further, different interviewees were dubious that LPNs could do activities that were essential on the unit such as primary nursing, constant observations, handling aggressive patients, and assessing suicide risk.

*"We don't do serious medical here so I don't know what LPNs would do here?" (RN)*

*"[Is there a place for LPNs on this unit?] No, not on this unit. Other than doing the same thing as the HCA. It would be a waste of their skills." (RN)*

*"...as an RN you do your mental health rotation, and also they (RNs) have an extra couple years for critical thinking that they learn. They learn to research the background of the patients. Critical thinking is very important here." (RN)*

Management interviewees did not agree with the frontline staff that LPNs were not appropriate on this unit. Although it is a challenging work environment because of the patient population, they noted that PAs currently on the unit were as likely to excel as highly trained RNs and that performance is more about an individual's ability to cope with the challenging work environment than their education. That said, one member of the management team noted that they take special care to hire staff that have experience in MH and try to select team members who will fit in well with the work environment and the team.

*"I don't see any barriers. If they have the proper education, the practicum in their curriculum. If there was specialized training provided for them, for orientation, if there was a separate thing for them about [specialty]. I couldn't see any barrier." (Management)*

Despite the perceived barriers and facilitators to having LPNs on the unit, there were no official policy or governance documents dictating whether LPNs could or could not be staffed on the unit. The main reason given for why LPNs were not staffed on the unit is that *"this is how it's always*

been.” One management interviewee commented that there was little interest from LPNs to work on the unit in the past; however, they noted that they “*see LPNs being very valuable in our future.*”

*“Our current staff mix has forevermore been our staff mix and it didn’t, for whatever reason, didn’t include LPNs.”* (Management)

The main barrier to introducing LPNs on the unit was the anticipated response from the current staff: “*they’re not going to be happy, they are going to be really pissed off.*” On unit MH-E, like unit MH-C, LPNs were seen as a threat to RN/RPN job security. Many of the RNs interviewed appeared to be fearful that if LPNs were brought onto the unit their jobs would be at risk. LPNs are being integrated into nearby units and as a result, suspicions and nerves were running high. They were also concerned that the LPNs coming in would not have the appropriate skills to work with this challenging population and would, therefore, create more work for the RNs or be a safety risk.

*“We don’t know what they are doing. The job security issue, but we have been told it’s not an issue, that it’s going to be very slow integration and there’s still that fear, it’s for sure. It’s making us all worried. I wish we knew what it would look like, I wish they would give us an example, in the event that they come, this is what it will look like.”* (RN)

### **Labour and Delivery Units**

We interviewed a total of 25 staff, managers, and leaders on four L&D units. Two units had LPN staff and two did not.

#### **Units with LPNs**

*L&D-A.* One unit (L&D-A) with LPNs used a single room maternity model, where patients stay in the same room for their full time in hospital. On L&D-A, RNs work in two-person teams to care for five or six patients and one LPN is available per shift to take over three or four postpartum patients (that is, three or four mothers and their babies) from the RNs in order to give those RNs time to focus on their labouring patients. Patients are considered postpartum one to two hours after delivery. LPNs provide all care to those patients and are given the assignments by the charge nurse. In a few cases, LPNs have been asked to provide backup care for deliveries (i.e., be in the room to care for the baby after delivery) but this was said to be fairly rare. On occasion an LPN will be used to fill in for an RN, which can create challenges for the RN teammate who then has to care for all labouring patients in the patient assignment while the LPN manages postpartum patients. This unit had also recently introduced an LPN in a specialty role<sup>iii</sup>, which was said to be well accepted by all staff.

LPNs were introduced to the unit several years ago to help manage the workload, then removed from the unit, and were brought back within the last few years. One interviewee felt RNs might

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<sup>iii</sup> We cannot provide details of the specialty role to avoid identifying the unit or provider.

have originally thought LPNs were coming to replace RN jobs, but now see that LPNs are very helpful and have accepted the role. LPNs we interviewed felt valued and thought they could contribute to patient care decisions, but noted that the workload can be quite demanding. Other staff agreed that the workload can be hard to manage; deliveries at the site had been increasing substantially for the last few years and there were questions about whether a single room maternity model was sustainable in light of the patient volume. When we asked interviewees what could be done to optimize their role on the unit, almost all requested additional staffing so help manage the workload. Some were concerned that adding an LPN might mean cutting an RN position as has happened in the past.

One management interviewee on L&D-A was quite new to the unit and recognized that the LPNs might not have been used efficiently to date. She hoped to review the LPN role in the future and thought LPNs might be able to go into operating rooms for scheduled C-sections because they receive the same neonatal resuscitation training as do RNs, do initial assessments when patients arrive at the unit, or help with labour and delivery rather than only focusing on postpartum patients to further alleviate RNs' workload. It was also noted that on days with few postpartum patients, LPNs do not have much work to do. Likewise, on days with only a few labouring patients, RNs are not being used effectively either. A review of the distribution of work was said to be necessary to avoid this. That said, a few interviewees thought LPNs were uncomfortable helping with labouring patients and preferred to work with stable postpartum patients.

Interviewees agreed that teamwork and communication on the unit were going well and felt well supported by the new management group. Most interviewees thought that having LPNs to take on postpartum care helped RNs work to their full scope as this gave them time to focus on labouring or highly acute patients. There are only a few LPNs on the unit, so it can be difficult to backfill if one is away. One interviewee noted that the RNs feel the difference when the LPN is not there, as they have to care for more patients. Some noted that there was no difference in postpartum care provided by an RN compared to an LPN, and all felt the role of the LPN was well understood by other staff. Only one interviewee felt there was any tension between RNs and LPNs on the unit; the remainder felt the relationships were very open and that the RNs appreciated the help. One non-LPN interviewee noted that some RNs have tried to take advantage of LPNs by asking them to do additional work such as checking vitals or giving baths to patients assigned to the RN, even when the RN has time to do this work. Some charge nurses were also said to sometimes assign the LPNs only C-section postpartum patients, which take more work than patients who have delivered vaginally.

*"I feel like the girls like having me around because if they need something done, they can come to me.... I'm told often that I'm appreciated."* (LPN)

Some interviewees thought orientation for LPNs was inadequate; one received only two buddy shifts. That said, most interviewees thought education was available through the unit educator or by simply asking other staff for guidance. Until recently, education generally on the unit was said to be lacking; the unit recently hired a new educator so interviewees were optimistic that they would

receive more in-services in future. One management interviewee noted that LPNs often have no obstetrics experience and thus require a lot of training on site; this lack of experience was said to have resulted in gaps in confidence rather than in specific skills. One LPN interviewee said her education had focused more on labour and delivery than on postpartum care.

*L&D-B.* The other unit with LPNs (L&D-B) had one set of rooms for labouring patients and another set of rooms for postpartum stays. Similar to L&D-A, LPNs here worked only with postpartum patients. The postpartum side of the unit used two RNs and two LPNs on every shift; each nurse is assigned four beds (i.e., four mothers and four babies) and provides all care for those patients. Very rarely, LPNs are pulled over to the labour side of the unit to provide care after a baby is delivered. The unit sometimes has to be staffed with one RN and three LPNs due to sick calls. Care assignments on the postpartum side are made based on workload and geography; nurses typically get patients close together on the unit but charge nurses try to assign particularly complex patients to an RN if possible. If an LPN's patient requires care activities outside the LPN scope, an RN will help with that part of the care.

*"We all do the same thing. We all get a patient load. I do all their care, I do all their doctor's orders, I do all their meds."* (LPN)

The workload on the unit was said to vary; some days were quite busy whereas others were very manageable. This unit is preparing for upcoming physical changes to the unit setup. In advance of that, management has been trying to determine how to best use their staff and whether any changes will need to be made. One management interviewee initially believed that additional RNs would be the most useful, but had noticed that nurses spend a fair amount of time doing tasks like stocking and cleaning beds or doing unit clerk duties on shifts without a clerk. As a result, it was thought that adding service workers or more unit clerks would free up nurse time to focus on patient care. The new hospital will also mean moving to a single-room maternity model, so decisions will need to be made about how best to use LPNs.

Teamwork and collaboration on the postpartum side were said to be going well, although a few interviewees noted that a small handful of RNs refuse to do certain tasks such as stocking linens and insist on leaving that for LPNs. Because LPNs and RNs take on the same number and type of patients, there was general agreement that having LPNs did not enable RNs to work to their full scope (i.e., focus on the more complex patients). Although the unit does get some complex patients on occasion, the majority of patients are fairly stable and predictable. Most interviewees thought LPNs were providing high quality care to patients; one management interviewee noted that there are some LPNs with so much experience that other staff ask them for help rather than going to an RN.

*"For the most part everyone here's pretty good, they will even ask you if you're running around 'do you need anything?'"* (LPN)

*"On this floor, I love the LPNs. I think they're a huge asset on this floor.... They contribute, honestly, like some of them I would go to them... they've been on the floor, their experience,*

*they're very hands on....They're just as much a part of the team as the other RN on the floor.”*  
(RN)

*“[some LPNs have told me] they don't want that responsibility of having to be in charge and having to call the doctors and stuff, but they are doing that too even though they don't think that they're doing it.”* (RN)

No interviewees on L&D-B were able to answer our question about when and why LPNs were introduced to the unit. They were said to have been on the unit “forever.” Most interviewees thought job satisfaction was quite high and LPNs reported feeling valued, but one management interviewee thought staff on the postpartum side as a whole were less engaged than were the labour and delivery staff. Interviewees were thought to be using their full scope for the care area but noted a few specific tasks that would be helpful for LPNs to be able to do (see Table 3).

Education on the unit was not specific to LPNs but all education was offered to all staff and all interviewees felt they would be supported to obtain additional education. Orientation typically consists of classroom sessions and buddy shifts. New LPNs can be paired with RNs or LPNs as the work done is essentially identical. One LPN interviewee noted that she spent two weeks on the unit during her schooling but thought that this had changed and LPNs were no longer coming to the unit during their education. Another LPN agreed with this and thought the only time LPN students come to the unit is at the end of their program for a specialty preceptorship. One noted that new graduate LPNs do not know how to do newborn assessments when they are first hired on the unit because their education now focuses more on long term and medical/surgical care.

### **Units without LPNs**

*L&D-C.* Unit L&D-C uses an RN-only model to cover triage, a fetal assessment clinic, and actively labouring patients. At the time of the interviews, the unit was also preparing to introduce a dedicated obstetrical operating room (OB-OR). The unit did not have a service aide so RNs were doing stocking and some cleaning duties due to the housekeeper's workload. The unit staff were said to work well as a team and understand each other's roles. There were conflicting opinions about whether education on the unit was sufficient.

Interviewees agreed that workload could be manageable or chaotic depending on the patient volume. Staffing was thought to be adequate for the time being, but might be insufficient once the new OB-OR opens and dedicated RNs are needed for that area. RNs were said to be working to full scope within the care setting, especially with the addition of the OB-OR and an eventual intensive care unit for obstetrical patients. RNs are assigned to different sections of the unit (e.g., triage, active labour) on different days to keep their skills up to date in all areas.

Some interviewees felt LPNs would be a valuable addition to the unit, particularly in a scrub nurse role in the OB-OR. However, according to one interviewee, peri-operative training is only available in Edmonton and it would be too costly to send new hires there to obtain the certification. Another interviewee noted that the hospital already has LPNs working in the general operating room and thought they could “definitely” work in the new OB-OR; the interviewee felt that LPNs were

providing great care in the OR and there were very few differences between the RNs and LPNs there. This interviewee also thought that due to the challenges of making sure all nurses were trained for the new OB-OR, adding LPN staff to the unit to manage the workload would be helpful. Some interviewees thought LPNs could also do well baby checks and vital signs, and report assessments to the RNs as long as patients were stable, but one said they would not be able to work alone with actively labouring patients since they would need to be under the supervision of an RN. Another thought having LPNs on the unit would not help at all, since LPNs' patients need to be stable but labouring patients can move quickly to being unstable, meaning an RN would always need to be available.

*“At the same time, if I had to choose between an LPN and an RN, I would choose the RN because she could do the active labour patient.” (Management)*

When we asked what barriers there might be to introducing LPNs to the unit, we heard that understanding the LPN role would be a challenge since some staff do not know what the LPN scope includes. It was thought there might also be resistance if LPNs' scope was limited, since RNs would need to do certain tasks for them anyway. Facilitators to the introduction of LPNs included clearly explaining to staff what the LPN role would look like and making sure that LPNs are added on top of existing RN positions rather than substituting providers.

*L&D-D.* Unit L&D-D is a single-room maternity unit staffed with RNs and HCAs. The unit cares for ante-, intra-, and postpartum patients, and also has a dedicated OB-OR, triage, early gestational assessment, and outpatient clinics. The majority of RN staff are trained to work in all of these areas and are assigned a section on each shift. The workload was said to be generally manageable, although a few disagreed and thought the unit was getting close to being overloaded. The quality of care was said to be excellent on the unit and most thought RNs were working to their full scope of practice because of the breadth of care provided. RNs on the unit receive substantial orientation and ongoing educator support and are expected to also engage in self-directed learning to advance their own practice. That said, one interviewee noted that education is lacking for staff working nights and that more debriefing would be useful. All staff on the unit receive information about the different roles on the unit during their orientation.

HCAs are trained to provide labour support, baby baths, and maternal vital signs, and they reinforce education provided by the RNs and they help everywhere but the OB-OR. A few interviewees noted that HCAs are not being used as effectively as they could be, since RNs prefer to provide a lot of the care themselves. The HCAs end up focusing more on postpartum care since RNs like to handle labours alone.

Most of the interviewees on this unit were open to the idea of having LPNs working there, particularly in postpartum care where they could provide education that HCAs are not currently allowed to provide and RNs are sometimes too busy to do fully, do discharges, and do basic assessments and medications. Other ways they could provide support on the unit included being scrub nurses in the OB-OR or being a second set of hands in the delivery room to receive the baby.

Management staff recognized there were scope limitations to LPNs' ability to work in labour and delivery care. One manager noted that it might be challenging to introduce LPNs because RNs are unaware of LPNs' scope of practice and are themselves often too task-focused, meaning they would have to learn to work in a team to take focus away from tasks and consider who would be the best provider to do the work that needs to be done for a patient. One RN interviewee noted she had worked with LPNs in postpartum previously in a unit where all staff received their own patient assignment. This did not enable RNs to work to full scope since each person just cared for their own patients rather than sharing tasks.

*"That would help out tremendously" [to have LPNs in postpartum] (Management)*

*[Asked whether RNs understand LPN scope of practice] "[RNs] feel responsible for everybody else's work. So 'if an HCA makes a mistake, or an LPN makes a mistake, then it's my fault, I'm accountable to that – my license is at risk because of that.' No – your license is only at risk if you knew that that person was doing that and you didn't do anything to intervene and you knew it was wrong. They are accountable to their practice just like you are." (Management)*

When we asked why LPNs were not currently staffed on the unit, we heard that there had been some discussion around this and HCAs were chosen instead due to some "bias" about having LPNs in L&D units. Another thought it was because there had been a "big push" to have HCAs on the unit and leadership did not want too many different roles on the unit as the varying scopes would be confusing for everyone. This manager noted that the biggest barrier to introducing LPNs would be role confusion among the three provider groups. Two interviewees thought that LPNs would not be able to work to full scope on the unit; they might be able to do more than the HCAs can but the critical nature of L&D and "lesser critical thinking skills of LPNs" would mean they could not take over much of the work of the RNs. She noted, however, that HCAs could be replaced with LPNs who could do more work and would provide better critical thinking and judgment. RN interviewees on this unit tended to believe LPNs did not have the skills, education, and knowledge to work in L&D. One noted that LPNs are only taught "normal values" in school, not what abnormal values mean and what to do about them, and that LPNs are "taught to give and not think about meds."

*"[T]hey don't have the scope to operate independently in an environment like labour and delivery because the patients are not stable. When you've seen one labouring patient, you've seen one labouring patient. You can't apply what you did with the last patient to this patient, you have to be able to assess each individual situation. It's not a task-based area." (RN)*

One manager had worked to introduce LPNs to Neonatal Intensive Care units in the past and felt the same could be done on her unit; she noted that it would probably be best to start them in postpartum care where only a few patients would need extra care from RNs. This would require educating current staff about LPN scope, what they can offer, and how to make them part of the care team to support everyone working to full scope. From there, with "strong change management," it was thought that LPNs could move into other areas. The same manager acknowledged that with current budget constraints it was important to examine salary costs and

determine whether some work could be done for less. However, she noted that LPNs will eventually begin to demand more money as their scope increases so cost savings will diminish over time.

*“It’s about educating staff, recognizing that RNs aren’t losing their jobs or ability to do the work they do now, it’s about supporting each other to do that.” (Management)*

Table 3. Activities with Scope Questions

Activity	Unit Type	Document Review
<p>Administer blood products</p> <p>Many LPNs expressed frustration that they cannot administer blood products but can monitor as soon as an RN has “spiked the bag.” One LPN believed LPNs are allowed to do blood transfusions at other sites.</p>	<p>ED L&amp;D</p>	<p>CLPNA Competency Profile and HPSP Restricted Activities for Nurses (AHS, 2016a) documents agree that LPNs are not authorized to provide the restricted activity of administering blood or blood products. HPSP Nursing Activity Reference (AHS, 2016b) notes LPNs can monitor and discontinue blood products with additional education/qualifications.</p>
<p>Bladder scan</p> <p>All agreed LPNs had been doing bladder scans for years before being told it was not allowed. One unit believed LPNs could still do bladder scans with additional training provided by the site.</p>	<p>ED L&amp;D</p>	<p>CLPNA Competency Profile notes LPNs should demonstrate knowledge and ability to manage elimination needs including bladder scanning.</p> <p>HPSP Restricted Activities for Nurses document: LPNs are not authorized by the HPA to provide the restricted activity “to order and apply non-ionizing radiation in ultrasound imaging, including any application of ultrasound to a fetus;” examples listed include bladder scans.</p>
<p>Care for CTAS 1-3 patients</p> <p>Some interviewees said LPNs are only allowed to care for CTAS 4 and 5 patients. Many interviewees noted that LPNs may get higher CTAS score patients if score assigned due to certain modifiers (pain, non-cardiac); some argued that some CTAS 3 patients could be cared for by LPNs without assistance from RNs. Policy interviewee said LPNs cannot independently take patients with CTAS scores of 1 and 2 but they can be part of the team working with those patients.</p>	<p>ED</p>	<p>CLPNA Competency Profile states that LPNs can <i>assign</i> CTAS scores with additional training but provides no information on what CTAS scores LPNs can care for/care for independently. A CLPNA (2010) position statement indicates that ongoing monitoring and team collaboration may be necessary for CTAS 3 patients and that LPNs should immediately involve the appropriate professional for CTAS 1 and 2 patients but may continue to participate in care and interventions.</p> <p>A memorandum from the Emergency Strategic Clinical Network and by HPSP indicates that an RN designation is the minimum acceptable to take responsibility for CTAS 1 or 2 patients throughout the high acuity phase.</p>
<p>Charge nurse</p> <p>Interviewees noted that because LPNs cannot be in charge, they cannot be the only staff members on a unit at any given time. This can complicate scheduling breaks for RNs.</p>	<p>L&amp;D MH</p>	<p>CLPNA Competency Profile does not explicitly state that LPNs can perform charge nurse duties but does include specific items about formal leadership competencies including “Demonstrate knowledge and ability to supervise a team and assign client care.”</p> <p>United Nurses of Alberta (UNA) collective agreement prohibits LPNs from acting as charge nurses within AHS except under specific circumstances. The UNA collective agreement states that where the person designated in charge of a unit as of June 14, 2010 was an RN, the person designated in charge must continue to be an RN. If an LPN was in charge previously on a unit, that unit may continue to have an LPN in charge (AHS Negotiations and Labor Relations, personal communication, 2017).</p>
<p>Comprehensive mental health assessments</p>	<p>MH</p>	<p>CLPNA Competency Profile notes that “LPNs should be able to perform comprehensive mental health assessments of client, family and groups in a variety of healthcare</p>

One manager wondered whether LPNs were capable of and allowed to perform comprehensive assessments of mental health patients; this would affect staffing decisions going forward.		settings.” This does not appear to be a restricted activity.
Delivery Interviewees on some units were unsure whether LPNs could work alone in delivery rooms.	L&D	CLPNA Competency Profile: LPNs can assist authorized professionals in delivery process. HPSP Restricted Activities for Nurses document: LPNs are not authorized by the HPA to provide the restricted activity of managing labour.
Epidural administration One manager questioned whether LPNs can administer epidurals independently.	L&D	CLPNA Competency Profile notes LPNs should demonstrate knowledge of epidural infusions; demonstrate knowledge and ability to manage complications of epidural and spinal infusion therapy; knowledge and ability to monitor and regulate epidural infusions with additional qualifications. Also notes LPNs are not authorized to initiate or remove epidural and spinal catheters. HPSP Nursing Activity Reference (2016b) notes LPNs can do patient assessment and pump management with additional qualifications but cannot administer medication via pump or regulate/change infusion rates.
Fetal heart rate monitoring LPNs on one unit are doing fetal heart rate monitoring; interviewees compared this to bladder scans and noted that if they can do fetal heart rate monitoring they should also be allowed to do bladder scans.	L&D	HPSP Restricted Activities for Nurses document: LPNs are not authorized by the HPA to provide the restricted activity “to order and apply non-ionizing radiation in ultrasound imaging, including any application of ultrasound to a fetus;” examples listed include fetal heart rate monitoring.
Internal/vaginal exams Some L&D unit interviewees thought LPNs could do vaginal exams; others believed it was not within LPN scope of practice.	L&D	CLPNA Competency Profile states that LPNs should demonstrate knowledge and ability to assist authorized professionals during management of labour including vaginal exams. HPSP Restricted Activities for Nurses document: LPNs cannot do assessment of cervical dilation or bimanual examination.
IV push medications One educator questioned whether LPNs are allowed to do IV push medications.	ED L&D	CLPNA Practice Memo dated December 9, 2008 indicates change to LPN scope of practice to allow direct IV push as an additional competency. HPSP Nursing Activity Reference notes additional qualifications are required to perform this activity.
Lactation Consultant One LPN recently took the Lactation Consultant courses but noted her manager was unsure whether LPNs would be allowed to work in that role.	L&D	CLPNA Competency Profile notes that with additional education/qualifications LPNs should demonstrate knowledge and ability to provide advanced health teaching and coaching as a lactation/breast feeding consultant. This does not appear to be a restricted activity. AHS’s internal website has an article dated February 25, 2016 highlighting an LPN Lactation Consultant.
Mental health group treatments and psychosocial interventions	MH	CLPNA Competency Profile notes that LPNs should demonstrate knowledge and ability to implement or assist with psychosocial interventions in consultation with authorized

<p>One manager was unsure whether LPNs would be allowed to run mental health groups.</p>		<p>professionals. This is consistent with an Alberta Health document that outlines psychosocial interventions as a restricted activity (Government of Alberta, 2014).</p> <p>HPSP Restricted Activities for Nurses document states the same; LPNs can provide psychosocial interventions as a member of an interdisciplinary team and while under the direction of an authorized practitioner.</p>
<p>Newborn resuscitation</p> <p>One manager questioned whether LPNs can provide newborn resuscitation; LPNs on at least one unit are trained and able to provide this activity.</p>	L&D	<p>CLPNA Competency Profile notes that LPNs should “demonstrate knowledge and ability to perform resuscitation of newborn” with additional training.</p> <p>This does not appear to be a restricted activity; however, the intubation of the newborn, if required, is beyond the scope of the LPN according to CLPNA.</p>
<p>Pass medications/to-go medications</p> <p>Many interviewees mentioned that until 2015, LPNs were allowed to pass medications and to-go medications. Interviewees were unsure if this was a result of CLPNA policy; some believed it was the RN union or regulatory college responsible for the change. Others thought there had been an incident at a site that precipitated the change.</p>	ED MH	<p>HPSP Restricted Activities for Nurses document notes LPNs are not authorized by the HPA to perform the restricted activity of dispensing or compounding Schedule 1 (i.e., drugs that require a prescription as a condition of sale), or Schedule 2 drugs. Only NPs, RN, and RPNs are allowed to perform these functions.</p>
<p>Physician orders</p> <p>Some RNs on one unit thought LPNs were not allowed to take or process verbal or other orders from physicians and would not allow LPNs to take any orders.</p>	MH	<p>CLPNA Competency Profile states that LPNs should be competent to accept, transcribe, and initiate orders electronically, verbally, by phone, or in writing and can contact authorized health providers to clarify as needed.</p> <p>HPSP Nursing Activity Reference document states that LPNs can receive verbal or phone orders and process orders.</p>

## Discussion

The goal of this project was to understand whether there are gaps in how LPNs are utilized. The specific research questions were:

Are there gaps in how LPNs are utilized?

- a. What facilitators and barriers impact LPN's ability to work to full scope?
- b. How are decisions made about whether to include LPNs in EDs, L&D units, and MH units?
- c. How are decisions made about what activities LPNs are allowed to perform?

Although our focus was on identifying opportunities for improvement, it is important to note that we found reasons to be encouraged by AHS's use of LPNs. The majority of LPNs we spoke with were happy with the organization and their work, and most said they would recommend it to others. They often felt supported by management and other staff, and many said teamwork and communication were working well on their unit. Interviewees understood the importance of working to full scope and we found that almost all managers we contacted were very enthusiastic about participating in this study.

### ***Are there gaps in how LPNs are utilized?***

Our results show that LPNs are generally satisfied with their work and feel they are, for the most part, working to full scope. However, we identified a number of gaps in LPN utilization. On most units without LPNs, at least some interviewees identified ways in which LPNs could provide support to the unit. LPNs in these units could potentially care for lower acuity patients to shift RNs' workload towards higher acuity patients with more complex needs. That said, though, units with LPNs tended to use them very similarly to RNs – in some cases interchangeably. This suggests that models of care could be altered to better support all providers to work to full scope and be more cost-efficient. Only one unit (ED-C) unanimously agreed that there was no place for LPNs in the staff mix. This unit's model of care was set up in such a way that low-acuity patients were not separated from high-acuity patients via a fast track system. Introducing LPNs on ED-C would require a major overhaul of the unit's functioning. On units that did have LPNs, there were a number of ways in which LPNs could be used more effectively. For instance, L&D units could train and allow LPNs to act as the second nurse in a delivery instead of an RN. EDs could develop more specific, evidence-based guidelines about which patients can be independently treated by LPNs. MH units could better coordinate break coverage for RNs across units to allow a higher proportion of LPNs to work on any given shift.

### ***What facilitators and barriers impact LPNs' ability to work to full scope?***

We were surprised to find that the majority of barriers to working to full scope were not based on formal policies or guidelines. The major challenge to LPN utilization seemed to be a lack of understanding of what their scope actually includes. We heard that as an organization, AHS does try to encourage staff to work to full scope, but from the team level to the system level, we heard confusion about what LPNs should be allowed to do. The common thread appears to be the

challenges in accessing accurate, up-to-date, easily understandable information about what AHS allows LPNs to do. Many of our interviewees noted that they access the CLPNA website for information on scope, but as noted in the Results section and in Table 3 there are inconsistencies between that and AHS's guidelines. Figure 1 makes clear that AHS can narrow the scope of practice for any provider, meaning that AHS' decisions must be followed. Without awareness of or easy access to specifics of AHS guidelines, units tended to err on the side of caution by even further limiting the kinds of care LPNs can provide.

Other barriers included the perception that LPNs do not receive enough education on specialty care areas such as ED, L&D, and MH. Further, many interviewees thought that LPNs did not receive adequate training on critical thinking, which was felt to be crucial to providing care in these settings. This also might have translated into lack of knowledge about advancement opportunities for LPNs; although opportunities do appear to be available (e.g., Lactation Consultant certification) almost none of our interviewees could identify ways for LPNs to move beyond floor nursing. Similarly, orientation and education opportunities for LPNs on many units were limited relative to those for RNs. As a result, many LPNs did not always feel comfortable or confident working on the unit. Those that did provide solid education for LPNs tended to have staff that were better utilized and felt more supported.

Dissatisfied LPNs tended to work on units where multiple staff members noted that managers were very busy and not available to hold all staff accountable for their work and ensure that LPNs were being treated well. Interviewees of all provider types on units with supportive and available leaders were more likely to report being satisfied and feeling valued. One unit in particular fully credited their leadership team with building a strong team environment that was welcoming and supportive of all providers.

Along the same lines, having a supportive team seemed to facilitate LPNs working to scope and feeling satisfied with the work. On some teams, RNs pitched in to help LPNs and did not mind doing the few tasks that LPNs cannot, whereas on others RNs seemed to resent LPNs for needing assistance at times.

#### ***How are decisions made about whether to include LPNs in EDs, L&D units, and MH units?***

Information on how decisions about including LPN in the staff mix were made was hard to come by. Leadership and management interviewees mostly agreed that decisions seemed to have been made many years ago and not revisited since. A few units were considering making changes to their staff mix, but this tended to be a reshuffling of existing LPNs rather than introduction or removal of LPNs. Our results here suggest that LPN utilization is not necessarily a planned and deliberate process based on unit and patient needs at this point, but merely a result of legacy hiring practices.

#### ***How are decisions made about what activities LPNs are allowed to perform?***

As mentioned above, decisions about what activities LPNs are allowed to perform are made based partly on actual regulations (e.g., bladder scanning) and partly on seemingly erroneous beliefs about what LPNs are capable of doing. The CLPNA and AHS both appear to be trying to optimize

LPNs' work. Nonetheless, differences in interpretation of the relevant legislature have caused some misunderstandings and have required LPNs to stop doing tasks they were previously allowed to do (e.g., pass medications). At the provincial level, interviewees told us that AHS staff creating or modifying policies avoid using language that might limit any provider's scope of practice. Further, on individual units, we could not find any formal policies or guidelines that specify whether an LPN can or cannot perform a given task. Similar to decisions about hiring practices, at the unit level decisions about what LPNs can do tended to be guided by how things have always been done rather than by an analysis of unit and patient needs and current scope documents.

### ***Limitations***

Our results are based on interviews with only a portion of staff on each unit so may not be representative of all staff. Our interview questions covered a broad range of topics but might not have uncovered all of the factors that influence LPN utilization.

### ***Recommendations***

Based on the results of this study, we offer a number of recommendations to consider for improving LPN utilization across the province:

AHS and CLPNA:

- Improve ease of access to and awareness of guidance on LPN scope of practice by (a): developing a communication mechanism to provide clear, consistent, regularly updated information to unit managers, educators, and LPNs that outlines information about LPN practice within AHS, (b) making clear to all that the CLPNA Competency Profile is not entirely consistent with AHS documents that provide specific information related to restricted activities and role clarity and the AHS documents should guide practice at this time, and (c) having a clear document outlining which AHS guidelines are inconsistent with the CLPNA Competency Profile.
- Develop a single repository for scope documents, easily accessible from the AHS Insite main page, with easy to understand file names and consistent information. Rather than requiring managers to check multiple files to access information, combine existing documents.
- Ensure that provincial guidance documents that support scope of practice are accessible and that managers are aware that they supersede site- or unit-level policies that may limit scope.
- Provide educational support for sites or managers whose policies may be restricting LPNs' ability to work to full scope.
- Increase awareness of and access to specialty orientation opportunities for LPNs.
- Provide increased opportunities for advanced certification for LPNs from across the province, either by opening new training programs or by providing funding for LPNs to travel to receive training (e.g., peri-operative certification).
- Further develop ways for the HPSP consultation team and the CLPNA consultation team to proactively identify inconsistencies in scope of practice regulations and work together to find solutions and communicate to affected providers.

- Create awareness among stakeholders that the LPN competencies are aligned with and supported by the approved Alberta LPN education curriculum.
- Continue to advance regulation changes to further LPN scope of practice.

Sites or units:

- Educate all unit staff, including RNs, RPNs, and LPNs, on LPNs' scope of practice and specific role on each unit.
- Hold all team members accountable for creating a welcoming environment and being supportive of other staff.
- If a staffing change is to be made, provide strong leadership and change management both before and after the introduction of LPNs.
- Redesign models of care to ensure staff are caring for the right type of patient and supporting each other to work to full scope of practice.
- Recognizing that scopes do overlap, units could reduce perceived job threat to other providers by ensuring that each provider type has a defined role on the unit rather than using RNs and LPNs interchangeably.
- Examine patient and unit needs to determine most appropriate providers rather than relying on legacy hiring practices to guide decisions.
- Provide unit-specific orientation with defined learning objectives that is specific to the LPN role and capitalize on shared learning opportunities with RNs and/or other disciplines.
- Make ongoing education resources available for all staff; consider training all providers together to ensure consistent information is shared about which providers can do any restricted activities involved.
- Organize placements and preceptorships to provide LPNs with exposure and experience on units where AHS would like to better utilize LPNs.

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