Remedying role confusion: Differentiating RN and LPN roles

Nursing leaders at one hospital developed role-delineation guidelines based on regulatory standards and evidence-based practice.

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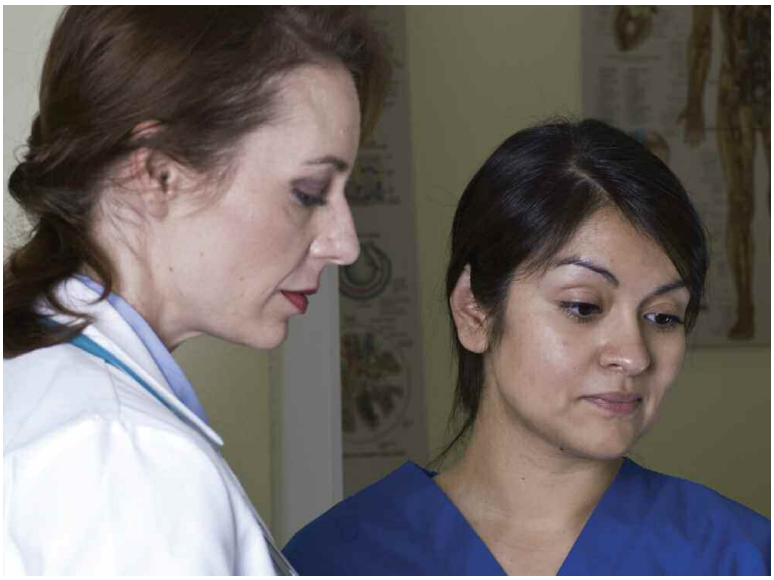
In today's constantly changing healthcare system, a key challenge is to better define, differentiate, and demarcate the roles of the registered nurse (RN) and licensed practical nurse (LPN). For years, our profession has struggled with this issue, which can be especially knotty as each state has the legal authority to regulate the RN's and LPN's scope of practice.



Defining the problem

At our 411-bed community hospital in Virginia, the Practice Council (made up entirely of RNs) believed the lines between RNs' and LPNs' practice roles had become blurred. Roles varied from unit to unit—and even from nurse to nurse.

Informal discussions with front-line staff and managers confirmed the Council's beliefs. Some of our nurses said our LPNs were practicing "just like our RNs." Others said our RNs had allowed LPNs to function beyond their legal scope of practice and "much too" independently. These viewpoints convinced the Practice Council of the need to clearly define the two roles.

Researching the issue

The Practice Council created a subcommittee chaired by one of the Practice Council members and supported by the Practice Council advisor and Magnet® director. (One of the authors was the subcommittee chair; another served as advisor to both the Council and subcommittee; and the third, who was the hospital's Magnet Director, also sat on subcommittee.)

Subcommittee members were solicited from front-line staff to achieve a mix of 60% RNs and 40% LPNs. Representatives from the renal, pulmonary, oncology, orthopedic, telemetry, and behavioral health units were chosen, as were those from the intensive care unit and the float pool.

The subcommittee's first task was to define the issue and develop goals. To determine how to best define the LPN's and RN's roles in actual practice, members decided to rework and develop role-delineation guidelines using regulatory standards and evidence-based practice. We began by reviewing:

- Virginia's Nurse Practice Act (which we found to be vague)
- American Nurses Association (ANA) Scope and Standards of Practice, Principles of Delegation, Principles of Nurse Staffing, Code of Ethics for Nurses, Nursing Social Statement, and Scope and Standards for Nurse Administrators
- Practice Standards for the Licensed Practical/Vocational Nurse from the National Federation of Licensed Practical Nurses (NFLPN)
- Joint Commission Standards.

The subcommittee also conducted exhaustive Internet searches to determine how other hospitals had approached this issue and whether their solutions were pertinent to our situation.

Developing statements

Next, the subcommittee developed the following statements to be presented to the Practice Council for discussion and approval:

Statement #1: *The LPN functions in a task-oriented*

role under an RN's direction, as follows: The LPN provides direct patient care; functions as a member of the health-care team; provides input into the assessment, planning, and evaluation of nursing care; and implements the plan of care under the RN's direction.

Statement #2: *Delegations are competency-based and not automatic.*

This statement would help ensure that our RNs served as primary caregivers and coordinators of patient care. During initial meetings, the subcommittee recognized this issue was extremely sensitive for both RNs and LPNs. LPNs might have difficulty relinquishing some of their current responsibilities, and RNs would need to be reeducated to understand their full accountability for patient care.

We were able to call on the expertise of our shared governance and Magnet consultants to review these statements for clarity and relevance. All consultants recommended we provide a clean definition of each role, fully delineated by tasks or clear examples. We also used care-delivery models influenced by Dr. Joyce Dungan's Practice Model of Dynamic Integration and the professional practice model of shared governance. This model enables us to practice holistic nursing care in an environment of shared decision making, delivering care in a holistic, collaborative manner while maintaining the RN's accountability for nursing care provided.

In subsequent meetings, we clearly defined each role, along with such terms as assessment, planning, implementation, and evaluation as they pertain to the RN and LPN (supported by the ANA Scope and Standards of Practice and the NFLPN Nursing Practice Standards for the Licensed Practical/Vocational Nurse). We defined care levels by adapting work done by Vanderbilt University and the acuity management tool we currently use. (See *Using the QuadraMed® Acuity System*.)

When we examined current nursing-unit staffing patterns to determine the accuracy and feasibility of the defined care levels, we realized staffing patterns would have to change on some units to ensure an appropriate RN-LPN mix. Also, we determined that the required level of communication between RNs and LPNs would depend on patient complexity and predictability of actual outcomes.

Tackling the delegation issue

The subcommittee addressed delegation as well. Virginia's Nurse Practice Act defines delegation as an act that occurs between an RN and unlicensed assistive personnel. The LPN holds a license to practice in the state, and the RN assigns and supervises parts of the nursing process to the LPN as defined by the organization. (To make sure we understood how the state defines delegation, we contacted the Virginia Board of Nursing.) Then we submitted an initial draft of the RN/LPN role-delineation policy to the Practice Council, which accepted it.

Using the QuadraMed® Acuity System

Winchester Medical Center in Virginia uses the QuadraMed Acuity System, which has six acuity types and five complexity levels. The acuity types were matched to specific levels of care to better define the levels. Complexity levels reflect the average complexity of patients on the unit and determine the skill-mix distribution. Managers decided to assign only stable patients with complexity scores of 4 or below to licensed practical nurses.

Acuity type	Hours of care/24 hours	Level of care
1	0 to 4 hours	Ambulatory
2, 3	4 to 10 hours	General care
3, 4	10 to 14 hours	Stepdown/intermediate care
4, 5, 6	10 to 20+ hours	Critical/intensive care

Changing our documentation practices

The next step was to address the need to enhance our documentation to support policy compliance. We worked with nursing informatics specialists to develop these changes along with a monitoring system to ensure compliance with the new policy. New programs were created so that a daily charge-nurse report would be generated to allow daily documentation auditing. Charting changes included:

- adding a field in which the LPN charts updates to the RN every 4 hours on the patient's status, with the RN's full name updated
- placing the supervising RN's name in the care assignment board to show who supervised the LPN during a particular shift.

We held a town hall–style meeting to initiate an open-comment period and present the draft policy to the nursing staff. The draft and task lists were posted on the units so staff nurses unable to attend the meeting could review them and leave comments. The subcommittee finalized the policy based on staff feedback and developed an education plan to disseminate the new guidelines.

Piloting the new policy

In June 2007, after completion of required education and policy implementation, an 18-bed surgical unit was selected to pilot the new policy. Its nursing staff consisted of 60% RNs and 40% LPNs, with the

latter practicing on day and night shifts. Charge RNs were responsible for completing daily audits to track compliance with the new policy. The nurse educator helped train charge nurses in how to complete the audits to make sure the tools were completed in a timely manner.

When the pilot was completed, the subcommittee performed a documentation audit and found the following problems:

- 29% of the time, LPNs didn't correctly document updates to the supervising RN every 4 hours.
- 51% of the time, LPNs didn't chart the full name of the supervising RN receiving patient updates.
- 3% of the time, LPNS weren't assigned to patients at the proper levels of care, as defined by the policy.
- 9% of the time, administrative associates entered patient assignments incorrectly, making it hard to determine the supervising RN. In many cases, no supervising RN's name was entered in the assignment database.

Adjusting the policy

Based on feedback from staff and data from the pilot, the policy was adjusted in August 2007. A subsequent educational effort trained LPNs across all inpatient units about the required documentation changes.

In January 2008, our subcommittee reviewed results of a random report showing all patients in the previous 24 hours to whom an LPN had been assigned as a primary care nurse. Data showed some improvement on all units, although many units still struggled with the problems revealed in the pilot study. Only the original pilot unit was 100% compliant with all charting requirements.

We shared this information with nurse leaders. With some nurses still confused as to why the RN and LPN roles needed to be delineated, we decided to continue educating both RNs and LPNs about the policy changes.

By July 2008, friction caused by policy implementation had started to fade, and the staff showed greater understanding of why role delineation is crucial not just for patient safety but also to protect both RNs and LPNs. The goal was to continue to print care-provider assignment reports every 24 hours on each unit. The charge nurse reviews the reports to assist nurses in proper documentation and administrative associates in placing assignments in the system correctly.

A change of the magnitude created by our new policy takes many months to engrain into a work culture that previously hadn't promoted RN-LPN role delineation. With perseverance, our nurses are learning to better understand the role differentiation, as shown by audit outcomes in 2009.

Although we're still challenged in the same areas outlined by the pilot, we've made huge strides. Current data show:

- 69% compliance with the administrative associate inputting the correct supervising RN's name
- 86% compliance with LPNs charting every-4-hour updates
- 68% compliance with LPNs charting the full name of the correct supervising RN who's receiving the every-4-hour update.

Role clarification promotes nursing excellence

Delineating the RN and LPN roles is important not only from a regulatory and compliance standpoint but also for improving patient safety and outcomes. Our subcommittee's comprehensive process to clearly define and demarcate these roles helps us make significant progress toward changing our work culture and achieving nursing excellence.

Our organization has learned that blurring of RN and LPN roles can occur easily in times of nursing shortage and economic challenge. Today, the need for nurses to care for a greater number of patients with higher acuity levels can compound role confusion as nurses strive to meet the needs of patients, families, physicians and the ever-growing administrative and regulatory requirements.

Although we succeeded in defining our nurses' roles and changing our work culture, our journey isn't over. We will continue to identify and address the new challenges that are sure to arise from the dynamic flux in our healthcare system. ■

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