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Building nursing role clarity on a foundation of knowledge and knowledge application

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Abstract

Although a number of factors such as legislation, regulatory frameworks, healthcare system structures and supports impact the optimization of nursing roles, a new look at the nursing process can provide a strong foundation. This article discusses the ambiguity related to the expansion of the licensed practical nurse role over the past 67 years and provides evidence that nurses and healthcare executives, including nurse leaders, still have difficulty in clearly articulating the overlap in categories of nurse, despite the frameworks and tools available to support decision-making. To provide safe, high-quality care using effective and efficient models of care, every category of nurse is essential and role clarity must begin with understanding how to focus on knowledge and knowledge application to make effective decisions in daily practice.

Introduction

All nurses are knowledge-based professionals, regardless of the designation: Licensed Practical Nurses (LPNs), known as Registered Practical Nurses (RPNs) in Ontario,[1] Registered Nurses (RNs), or Nurse Practitioners (NPs). The amount of knowledge held will vary for each role, but every nurse contributes to client care with the appropriate knowledge for his or her scope of practice. In each province, there are various categories of nurse and distinct roles and all nurses are members of their respective regulating body. Although each regulatory body describes practice competencies for each category of nurse, role ambiguity still surrounds the LPN role.

There are several reasons for role confusion. The first is related to a misdirected focus on the implementation of tasks. When the LPN role is compared to the RN role, the focus on tasks within the role results in the knowledge and critical thinking attained through education being excluded.[1] For example, in Ontario, for many years, the College of Nurses of Ontario (CNO) had a "standard of practice" that provided a specific task-based list pertaining to the RN and LPN roles. Confusion arose when this restrictive task-based list was eliminated and the focus shifted to using the CNO Three-Factor Framework, which helps nurses use nursing knowledge and knowledge application to make effective decisions based on the individual nurse (with the appropriate nursing knowledge), the client factors, and the environmental supports.[2]

This change, in conjunction with the change in entry to practice education that moved to a RN baccalaureate and LPN diploma, resulted in the development of entry to practice competencies. The purpose is to guide the expected competencies at entry to practice and to evaluate nursing education programs. Over the years, they have evolved and been revised to ensure a current guide is available in each jurisdiction for public and employers' awareness of the practice expectations for entry-level nurses.[3] Despite the availability of these resources, confusion about what LPNs can do persists among nurses and nurse leaders.

As a knowledge-based profession working in a rapidly changing healthcare landscape, it is vital that nurse leaders optimize all nursing roles to maintain the needs of our clients. If nurses and nurse leaders cannot articulate the appropriate use of all categories of nurse, the result may be the underutilization of nurses in some areas or misallocation, gaps in care, or role conflict in others, resulting in implications to patient safety and nurse satisfaction.[4]

This article will discuss the progression of the LPN role, the evidence that role ambiguity is still prevalent in 2016, and, more importantly, how nurses and nurse leaders need to refocus their approach to making decisions based on nursing knowledge and knowledge application to ensure the right nurse for the right client in our quest for quality care.

Background

The current LPN role was initially introduced as a short-term solution as early as 1941 to address a World War II nursing shortage and was expected to eventually be phased out. However, the role has evolved, and with it, there has been a corresponding enhancement in the quality of practical nursing education. As the needs of clients increase in complexity, LPNs are continuing to receive more education to enable them to provide the highest quality care to their clients.

In 1941 in Ontario, the six-month training program graduated 107 practical nurses. However, the shortage continued, and by 1947, the Nursing Act was amended to include the evolved role of the Certified Nursing Assistant (CNA). By 1954, the education expanded to 10 months to enhance CNA knowledge, and in 1963 under the Nursing Act, with the establishment of the CNO, whose mandate was to protect the

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public interest in regard to the nursing profession, the title was changed to Registered Nursing Assistant (RNA). The number of RNAs grew rapidly from 14,000 in 1967 to 31,000 by 1975. As the healthcare system evolved, education progressed, and by 1993, education expanded to one and a half years with the title evolving once again from RNA to RPN under the Regulated Health Professions Act, 1991. Finally, in 1999, the CNO entry to practice competencies were developed as the foundation for the Practical Nursing Program Standards, and by 2002, all practical nurse programs expanded to a 2-year diploma program under the Ministry of Training, Colleges and Universities.[5] Similar changes took place throughout Canada, and today, there are over 107,923 LPNs employed in nursing and registered to practice throughout Canada.[6]

Evidence informing practice

The Registered Practical Nurses Association of Ontario (RPNAO) is the professional body for RPNs. In 2010, RPNAO conducted a provincial survey, which identified that overall LPNs "loved the profession," but one of the major factors that impacted LPNs leaving the role was related to ambiguity between the RN and LPN role.[7] The RPNAO was committed to further understanding the factors related to role ambiguity, leading to the Role Clarity Project entitled *It's All About Synergies* conducted by researchers Janet Rush, PhD, and Sara Lankshear, PhD. The project engaged nurses and nurse leaders to share their knowledge and insights about the critical factors that impacted the appropriate utilization of the LPNs and their ability to work to full scope of practice within healthcare teams.[8]

The study found that the term "scope of practice" as it related to Ontario's LPNs is widely misunderstood and often wrongly equated with a task-based list that LPNs are allowed to perform in their practice environments. When asked if the LPN's role was clear, only 53% of administrators (inclusive of managers, directors, and clinical educators), 48% of RNs, and 46% of LPNs believed it was, in contrast to faculty who had the lowest level of agreement at 17%.

When participants were asked if LPNs were familiar with the scope of the RN role, 63.8% of administrators, 65.1% of RNs, and 68.4% of LPNs felt it was. However, in contrast, when asked if RNs were familiar with the scope of the LPNs role, only 22.6% of administrators, 23.3% of RNs, and 23.8% of LPNs were in agreement. This result was concerning as RNs are often providing leadership to nursing teams and leaders and are making decisions related to utilization of nursing roles. This lack of understanding can contribute to the inappropriate or underutilization of LPNs.

In an effort to address this problem, one of the report's recommendations suggests that nurse leaders take an "it depends" approach in each scenario rather than relying on task-based lists. Such an approach would allow nurse leaders an opportunity to review the common questions pertaining to the LPN scope of practice and refocus their attention on the various factors that contribute to role ambiguity. Other recommendations include accessing evidence-informed frameworks for decision-making, such as the entry-to-practice competencies and the nursing process embedded in this framework[9]; the Three-Factor Framework, which shows how using a systematic framework like the nursing process supports nurses in meeting client needs[2]; and Staff Mix Decision-Making Framework for Quality Nursing Care, the comprehensive, evidence-informed tool developed by the Canadian Nurses Association,[10] which provides a systematic approach to staff mix decision-making focused on the nursing process and nurses' scope of practice.

Despite the availability of evidence-informed tools and frameworks, ambiguity about the appropriate role for practical nurses remains widespread among nurses and nurse leaders across the country. One factor could be related to the misguided focus on the implementation phase of nursing care instead of the actual purpose of the entry to practice frameworks, which are based on knowledge and knowledge application.

Role clarity through knowledge and knowledge application

Currently in Canada, the motivation to understand and articulate the differences in roles and practice of different categories has never been more important as nurse leaders redesign roles and models of care delivery while needing to ensure high-quality care. A number of factors such as legislation, regulatory frameworks, healthcare system structures and supports impact the optimization of nursing roles. In the absence of any clear descriptions of how knowledge and knowledge application varies among categories of nurses or common practice language, many have attempted to define the roles through task-based lists that may be carried out by various categories of nurses in their day-to-day practice. Task-based lists have been developed in environments from the organizational level right up to the provincial level, in some cases.

Once implemented, these task-based lists can become problematic as they do not take other factors, such as complexity and predictability of clients, individual knowledge of nurses, and supports within the practice environment into consideration. Although in some cases, actions listed may indeed be primarily appropriate for one category or another, mitigating factors and situations can sometimes make task-based lists artificially restrictive or permissive. These artificial restrictions have the potential to leave nurses frustrated at the barriers that can be put between them and the excellent client care they are best situated to provide, whereas permissive assumptions can lead to patient safety implications. In order to alleviate these issues and create safer, clearer approaches to ascribing care to a particular type of care provider, nurse leaders need to use a common knowledge-based language and approach. Role clarity must begin upon a strong foundation of understanding nursing knowledge and knowledge application.

The nursing process

The nursing process is a scientific problem-solving model using the five clear and sometimes recurring steps: assessment,

nursing diagnosis (or problem identification), planning, implementation, and evaluation.[11] First described in the 1950s, this process provides an efficient method of organizing thought processes for clinical decision-making and problem-solving and for the delivery of higher quality, individualized client care.[12] Included in the steps of the nursing process are assessment, during which a systematic collection of data relating to the client, both subjective and objective, is gathered; nursing diagnosis, during which the data are analyzed and the underlying need or problem is identified; planning, a two-part process of identifying the client's goals and desired outcomes and selecting the appropriate nursing interventions; implementation, putting the plan of care into action; and evaluation, a step that examines the client's movement towards the goals and monitoring of the client's response to nursing interventions, including evaluating for any adverse outcomes.[12]

Described in its most simple format, the nursing process is somewhat at risk of being misconceived as a linear process or as a process that always has a distinct beginning and end. In reality, engaging well in the nursing process requires nurses to form a continuous circle of thought and action that recycles through the client's contact with the healthcare system.[12] As well, in using the nursing process, there are some risks that the focus of nursing practice will not be client centred, particularly if the focus of practice then becomes problem focused rather than a more holistic focus on the client. This may be significantly mitigated through client engagement using client-centred care principles.

The nursing process, despite its limitations, does serve to engage our critical thinking skills throughout our work.[13] As well, the inclusion of the step of evaluation ensures the follow-through of nursing work, a critical step that may be forgotten when nurse leaders focus on the step of implementation, a potential problem of task-based lists. Additionally, the nursing process has the potential to provide a common language and approach to nursing care that will help provide clarity to contemporary nursing roles.

Considering the nursing process in establishing role clarity

In a nursing environment where a great deal of focus has been put on the fourth step in the process, implementation, nurses are at risk of neglecting the other very important steps. This is a very problematic approach to care, since in all circumstances, our greatest focus should be on the first steps of assessment, nursing diagnosis (decision-making), and planning, and on the final step of evaluation. This should not imply that the step of implementation is unimportant or does not require significant nursing knowledge and critical thinking. Rather it is to emphasize that the greatest variances in depth and breadth of knowledge among categories of nurses often exist in the other steps. Indeed, many nurses have experienced situations where non-healthcare family members have been taught to implement a wide variety of nursing actions. Overlapping nursing roles and the desire for role clarity have also moved focus away from the knowledge application and critical thinking aspects of nursing practice, leaving implementation as the primary focus. However, the real depth and breadth of nursing knowledge is utilized in the other steps, and nurse leaders should return their attention to this, especially when assigning nurses to clients. Figure 1 shows the five steps in the nursing process. The relative size of each of the steps represents the amount of knowledge, knowledge application, and critical thinking that might be required to carry out that specific step. This view of the nursing process helps us evaluate the nursing care needed to match client needs to the appropriate nurse to ensure competent care.

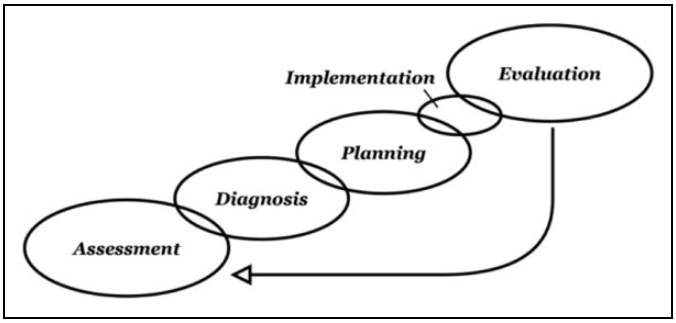

Figure 1. The steps in the nursing process

If nurse leaders recognize that the steps requiring the greatest depth and breadth of nursing knowledge are assessment and evaluation, followed closely by nursing diagnosis and planning, it would become clear that delineating the roles of RN and LPN solely by virtue of the tasks, or the implementation steps involved in the care would not provide them with parameters to ensure safe competent care while at the same time optimizing the scope for all healthcare professionals. Yet that is frequently the step in the process used to define roles.

Once nurse leaders have established the nursing knowledge required to carry out all steps in the nursing process, they can set about assigning the right nurse to provide the right care to the right clients in the right place. A layer of complexity is added to role clarity of nurses, in that nursing knowledge is not identical from nurse to nurse within a category but rather is a culmination of knowledge gathered through primary nursing education, continuing nursing education, and experience. These factors must be considered as well.

Nursing executives, supervisors, and team leads all need to master the articulation of the needs of a client in relation to the assessments, decision-making, and evaluation they will require. Once that is established, the client can then be matched to the nurse with the most appropriate knowledge, skill, and judgment to carry out those steps as well as the implementation of the care.

Conclusion

As Canada's healthcare system evolved over the past 67 years, there has been a significant advancement in the role and a corresponding enhancement in the quality of practical nursing education. But as practice developed across the country,

confusion about the appropriate role of the LPN arose among nurses, nurse leaders, and administrators, resulting in an underutilization of LPNs in some settings and misallocation and gaps in care in others. Research shows that the problem of LPN role ambiguity remains widespread, despite the availability of a number of good resources intended to enhance LPN practice, facilitate nursing skill mix decision-making, and ultimately improve patient care and patient outcomes.

Contributing to the problem is the fact that nurses often do not focus on the application of nursing knowledge as a foundation for establishing care needs of clients nor do they use a common language when making decisions about client care and care providers. A possible solution to the problem is for nurses to revisit the nursing process using the model discussed in this article as a source of common language, a method of establishing nursing knowledge needed through each step of the nursing process for that particular client, and a way in which the knowledge of each individual nurse is considered in the decision-making. This ensures that nurse leaders acknowledge nursing as a knowledge-based profession to make appropriate staffing decisions and plans of care based on the client's needs.

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