Regulation of Licensed Nursing Practice in Nursing Homes: How RN and LPN Scopes of Practice are Enacted

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Changing Nature of LPN Practice in Residential Long-term Care

- LPNs as licensed nursing ‘backbone’
  - Over the last decade, increase in hours per patient day was twice as high for LPNs as for RNs \(\text{(AHCA, 2012)}\)
  - LPNs comprise majority of licensed nurses in long-term care; U.S. mean is 67% of all licensed nursing FTEs \(\text{(AHCA, 2012)}\)

- Changing context of residential long-term care
  - Higher acuity of residents; Increasing proportion of rehabilitation patients \(\text{(Ng et al., 2010)}\)
  - Increasing demand for long-term care; Globally, nursing workforce shortages to meet demand \(\text{(Frenk & Chen, 2010)}\)
The RN-LPN regulatory challenge in nursing homes

- Between-state differences in LPN scope (Corazzini et al, 2011)
- Organizational barriers to LPNs practicing within scope (Mueller et al, 2012)
- Need for effective models of RN-LPN collaboration
  - Institute of Medicine’s Future of Nursing (2011) acknowledges LPN contributions to care:
    - LPNs viewed as essential to performing delegated care in the context of RN role expansion
Conceptual Model

State Nurse Practice Act regulations of RN and LPN practice

Nursing home practice patterns of how RNs and LPNs enact their scope

Quality of nursing home care

State regulatory context, e.g., facility licensure & certification

Facility scope of practice context, e.g., job descriptions, policies & procedures

Facility quality context, e.g., staffing levels, case-mix of residents
Study Aims

1. To describe facility-level licensed nursing practice patterns of RNs and LPNs in nursing homes in MN and NC
   • What do RNs and LPNs do, including behaviors and strategies, to enact specific components of their scope of practice?

2. To develop a facility-level tool to measure these licensed nursing practice patterns
Design & Data

- Comparative, multiple case study of RN and LPN nursing practice
  - 10 NC and MN nursing homes sampled by Area Health Education Region
    - 10 RN Directors of Nursing
    - 34 Additional RNs and LPNs

- Individual, semi-structured telephone interviews
  - Questions elicited strategies and behaviors used to enact scope, defined as assessing, planning care, supervising and delegating
Analysis

- Immersion/crystallization analytical approach; hermeneutic paradigm of qualitative data analysis (Crabtree & Miller, 1999)
  - Data coded by multiple members of research team for strategies and behaviors
  - Coded data read by team and analyzed for higher order themes

- Quality was examined in relation to:
  - Co-occurrence of CMS Quality Measures
  - Descriptions nurses provided of outcomes of strategies and behaviors

- Purpose is to generate testable hypotheses (vs. statistically representative findings)
Facility-level practice patterns of enacted scope

Three intersecting dimensions differentiated practice patterns of care planning and assessment, delegation and supervision:

1. Quality of the connections between RNs and LPNs
2. Degree of interchangeability between RNs and LPNs
3. RN to LPN staffing ratios
Quality of RN-LPN Connections

- Degree to which formal and informal connections exist in assessing and care planning, supervising and delegating

“I just try to communicate with [the RNs]...so they can make sure that [acute changes] get to the right people. [The RNs]...do the care plans and they’ll come around and...ask us questions” –LPN
RN-LPN Interchangeability

- Degree to which LPNs are considered interchangeable with RNs in assessing, care planning, delegating and supervising
  - RNs and LPNs may be indistinguishable from one another in organizational role
  - Job title drives practice

“As far as duties, there are some duties that an RN has to be immediately available… but pretty much they’re tit for tat in what they do do…we don’t have any…nursing skills here that both an LPN or an RN cannot do” – DON
RN to LPN Staffing Ratios

- Degree to which there are adequate RNs in the nursing home for RN-level clinical expertise and management in assessing, care planning, delegating and supervising

“Because we have problems getting RNs... we do have LPNs functioning in roles that RNs should be filling” −DON

“For where I’m at, it usually flows down from the DON to not many RNs, so LPNs and then from the LPN to the CNA to ‘let’s get the job done’” −LPN
Enacted Practice Dimension: Assessment

RN assessment clearly connected to LPN contributions

LPN observations unlinked to RN-level assessment

“Assessments are... done by the RNs...it’s real defined between what the LPNs are doing and what the RNs are doing...If we have falls or anything, we have to always make sure we have an RN for those additional assessments” −LPN

“The LPN gets the admission package...this is what you need to do...it’s up to you to get the package done; this means your pain assessment, the actual assessment, everything...it’s not passed on, you have to get that done” −LPN
Enacted Practice Dimension: Care Planning

High Connections
Low Interchangeability
High RN/LPN Ratio

Care plan linked to RN assessment; embedded in RN-LPN information exchange

Low Connections
High Interchangeability
Low RN/LPN Ratio

Care plan automatically generated by MDS nurse; unlinked to ongoing RN-LPN communication

“We do the initial assessment…fill out the papers and it goes to MDS and she makes up the care plan from the information we give…she may not even see the patient” -LPN
Enacted Practice Dimension: Delegation

Delegation is considered in relation to 5 rights of delegation.

"The [LPN] unit coordinators do the day to day delegation of the tasks to the... LPNs and RNs on the floor...[and they]... do the day to day delegation to the CNAs" –DON
Enacted Practice Dimension: Supervision

Direct RN supervision of all levels of staff that informs RN assessment & care planning

Little direct RN supervision; LPNs provide primary oversight of licensed & unlicensed staff

“You try to just be vigilant of what’s going on, on your unit with the residents…if I’m not able to track what it is that may be a factor, then I’m going to bring in my RN and have my RN do an assessment, and then they usually will carry it from there…everything that we do here is basically going through the RNs throughout the course of any given day.” −LPN
Three Cases

Case 1
- Non-profit
- Urban, NC
- 120 beds
- DON, 2 RNs, 3 LPNs
- 5-star CMS rating

Case 2
- Non-profit
- Suburban, NC
- >130 beds
- DON, 1 RN, 3 LPNs
- 4-star CMS rating

Case 3
- For-profit, chain
- Rural, NC
- >130 beds
- DON, 1 RN, 2 LPNs
- 2-star CMS rating

High Connections
Low Interchangeability
High RN/LPN Ratio

Low Connections
High Interchangeability
Low RN/LPN Ratio
## Case 1: High Capacity for Quality Care

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Assessment &amp; Care Planning</th>
<th>Delegation &amp; Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Connections</td>
<td>Dynamic, real-time process; multiple system redundancies for communication</td>
<td>Supervision integrated into assessment and care planning</td>
</tr>
<tr>
<td>Low Interchangeability</td>
<td>LPN observations distinct from RN-level assessment; valued</td>
<td>Delegation is linked to scope of practice</td>
</tr>
<tr>
<td>High RN/LPN Ratio</td>
<td>LPNs required to seek face-to-face RN-level involvement in assessments</td>
<td>Direct, RN supervision of all nursing staff</td>
</tr>
</tbody>
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Case 1: High Capacity

An LPN explains how she collaborates with RNs for assessments

“If there’s something that needs immediate assessment, we usually make sure the RN is on the unit, then we do those things together...a lot of what we do here our RNs are very, very involved, and we know that there are things that we just don’t do. Assessments and stuff like that, those things are done by RNs.” –LPN
## Case 2: Mixed Capacity for Quality Care

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Assessment &amp; Care Planning</th>
<th>Delegation &amp; Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mixed Connections</td>
<td>Formal, top-down documentation systems; depend on LPN or NA to seek out RN</td>
<td>One-way chain of command</td>
</tr>
<tr>
<td>Mixed Interchangeability</td>
<td>Differences are role-based or task-based; RNs in different roles</td>
<td>RN-level, role-based function</td>
</tr>
<tr>
<td>High RN/LPN Ratio</td>
<td>RN approval of formal documentation systems</td>
<td>RN-level supervision of all staff by checklist/audit</td>
</tr>
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Case 2: Mixed Capacity

- An LPN describes role-based interchangeability

“In our facility, if you’re an RN you’re a supervisor, or there are a few who are floor nurses, but mostly you’re a supervisor…And the RNs are able to do all the care planning, and my main functions are medication administration, treatments, the weekly assessments…when an RN is on the floor passing medications, they…just do what an LPN does on the floor.” –LPN
## Case 3: Low Capacity for Quality Care

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Assessment &amp; Care Planning</th>
<th>Delegation &amp; Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Connections</td>
<td>Checklist/Audit focus to ensure complete documentation</td>
<td>Little direct supervision; go to DON if difficulty with supervised staff</td>
</tr>
<tr>
<td>High Interchangeability</td>
<td>Differences are mostly task-based</td>
<td>Depend on everyone ‘knowing their job’; confusion about how to supervise given RN-LPN differences</td>
</tr>
<tr>
<td>Low RN/LPN Ratio</td>
<td>LPNs assess when RNs not available; must do what is needed</td>
<td>Depend on everyone ‘knowing their job’; reliance on DON</td>
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Case 3: Low Capacity

- An LPN describes a level of uncertainty in how to supervise given differences between RNs and LPNs.

“As far as CNAs, I think that I am able to approach them, and if there’s something that maybe they...like, if they’re not doing, as a charge nurse on the floor...I am able to say something about that...If it’s not done or whatever, I approach the RN” –LPN
## Cross-Case Comparison

<table>
<thead>
<tr>
<th>Number of Cases</th>
<th>RN/LPN Staffing Ratio</th>
<th>CMS Overall 5-star Rating</th>
<th>Quality of RN-LPN Connections</th>
<th>RN-LPN Interchange ability</th>
<th>Potential Capacity for Quality Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Low</td>
<td>2-stars (below average)</td>
<td>Low</td>
<td>High</td>
<td>Low; requires significant resources</td>
</tr>
<tr>
<td>5</td>
<td>Mixed; e.g., may vary from shift to shift</td>
<td>4-stars (above average)</td>
<td>Mixed; e.g., may depend on unit or shift</td>
<td>Mixed; e.g., may be role-based</td>
<td>Mixed; untapped capacity</td>
</tr>
<tr>
<td>3</td>
<td>High</td>
<td>5-stars (much above average)</td>
<td>High</td>
<td>Low</td>
<td>High</td>
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Developing a Scale of Facility-level Practice Patterns

Step 1: Item development

- Item pool generated of practice dimensions
  - N=24 items
- Survey conducted to identify range of possible practice dimensions
  - N=40 Directors of Nursing from 22 states
  - Semi-structured interviews conducted following survey completion
  - Each dimension rated by DONs for:
    - Clarity
    - Whether approach to practice could occur
Sample Items

- The modal value for all items for clarity was ‘very’ clear
- All items rated ‘somewhat’ or ‘very’ possible by >50% of respondents
<table>
<thead>
<tr>
<th>Item</th>
<th>Mean</th>
<th>sd</th>
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<tbody>
<tr>
<td>1. The roles of RNs and LPNs/VNs differ in collecting daily assessment data.</td>
<td>2.68</td>
<td>.53</td>
</tr>
<tr>
<td>2. The roles of RNs and LPNs/VNs differ in collecting MDS assessment data.</td>
<td>2.36</td>
<td>.63</td>
</tr>
<tr>
<td>3. Care plans are viewed by all nursing staff throughout the day to inform care</td>
<td>2.35</td>
<td>.70</td>
</tr>
<tr>
<td>4. RNs or LPNs may serve as MDS nurses.</td>
<td>2.23</td>
<td>.84</td>
</tr>
<tr>
<td>5. LPNs/VNs may delegate to RNs if they are in a supervisory role</td>
<td>1.85</td>
<td>.90</td>
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Summary

- RNs and LPNs require tools to develop effective RN-LPN collaboration
- Potential impact on quality

- Facility scope of practice context, e.g., job descriptions, policies & procedures
- Nursing home practice patterns of how LPNs enact their scope
- Quality of nursing home care

Facility quality context, e.g., staffing levels, case-mix of residents

context, e.g., facility licensure & certification
Ensuring High Quality Nursing Home Care

- Implications for Regulation and Practice
  - Potential levers for change in each of three dimensions of how RN and LPN scopes of practice are enacted:
    - Quality of RN-LPN relationships
    - RN-LPN Interchangeability
    - RN/LPN Staffing ratios

- Limitations
  - Qualitative, hypothesis-generating study

- Next Steps
  - Develop measure of practice patterns
  - Relate to CMS quality of care outcomes in nationally representative sample
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