NCSBN

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Practical Nurse Scope of Practice White Paper

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Executive Summary

The Practical Nurse Scope of Practice White Paper was written as a recommendation from the April 2004 PN Focus Group that was held at the NCSBN offices in Chicago. This national Fo
there was general agreement that LPNs/VNs in most states don't:

- Independently develop the plan of care
- Make changes in the plan of care
- Perform telephone triage

Seago et al. (2004) comprehensively studied LPNs/VNs and made 11 evidenced-based recommendations, based on their findings. Their report found contention around the words "assessment," "delegation," "supervision," "decision making," and "critical thinking."

A strong recommendation in this white paper is that dialogue with nursing practice, regulation and education must take place, addressing:

- Developing initiatives to enhance the mobility of practical nurses by establishing statewide articulations programs.
- Establishing a national practical nurse curriculum.
- Decreasing the wide disparity that is present in the Nurse Practice Acts regarding the practical nurse scope of practice.
- Developing a national clearinghouse for practical nurse data.
- Providing education to all health care workers about the LPN/VN scope of practice.
- Conducting more research on the practical nurse scope of practice.

Background

At the December 2–4, 2003, NCSBN Board of Directors meeting, one key action of the Board was stated as, "Based on the *2003 LPN/VN Practice Analysis* findings, the Board discussed the expanding role of PNs, questioned whether PNs receive adequate preparation for practice and if regulatory boards need to reevaluate the PN scope of practice. The Board approved a focus group to be convened to identify PN practice and education issues and provide the board with options for next steps." Therefore, a practical nurse (PN) focus group was convened in Chicago to discuss the findings of the *2003 LPN/VN Practice Analysis* (Smith & Crawford, 2003) and to make recommendations to the NCSBN Board of Directors.

One of the recommendations of the PN focus group was to write a White Paper about the focus group discussion of the scope of PN practice and highlighting any PN data that has either been collected here at NCSBN or by external groups. By distributing

this White Paper widely to all the stakeholders, the focus group anticipated that it would stimulate an important dialogue about the PN scope of practice. One of the issues that the focus group would like to be addressed is the wide disparity in the PN scope of practice in the nurse practice acts and the nursing administrative rules. The focus group also hoped there would be discussion

- The question of adequate supervision was raised. Oftentimes an LPN/VN may be supervised by someone who doesn't understand the legal scope of practice.

Group 2 — Blue Group

- What precisely is meant by "scope?" It is a legal term and refers to the body of knowledge in a profession and it is mandated by legislation.
- "Scope" encompasses the nurse's judgment and is affected by the setting, staff mix, etc.
- When legislating "scope," one must think towards the future, at least five years in advance.
- "Knowledge" can't be delegated, though technical tasks, etc. can be. Delegation is an important part of this discussion of "scope of practice."
- Consider the patient. Our responsibility is to protect the patient.

Group 3 — Red Group

- What do these findings mean? It is hard to generalize because it varies from jurisdiction to jurisdiction and facility to facility. Do these facilities make their decisions based on the practice act and rules and regulations in that state?
- There is a variance between education and practice of the LPN/VN. Practice evolves over time. A third of LPN/VNs need more education to practice in entry-level jobs.
- RNs don't have an understanding of the LPN/VN scope of practice.
- What are the differences between LPN/VN practice? Does the RN think more critically? The intangible differences (i.e., synthesis, application, critical thinking) are harder to measure.
- Supply and demand issues often drive using the LPN/VN in a more expanded role, sometimes outside their legal scope of practice.
- Safety is the most important consideration in all of this discussion.

Summary of Group Discussion: The delegates concluded that the practice of LPN/VNs is evolving and they questioned whether there is a gap between education and practice. Further, all three groups mentioned safety and protection of the patient as the most important consideration in these discussions. One group asserted that RNs and facilities don't always understand "scope of practice issues," and many of the delegates lamented that often employers and RNs don't understand the responsibilities associated with delegation and supervision. The groups made the point that the survey represented the perceptions of LPN/VNs, and some questioned whether this was necessarily an accurate vision of what is happening in practice. One group thought the discussion of scope of practice would be clearer were we able to specifically spell out the differences between LPN/VNs, yet the delegates realized that there are hard-to-measure intangibles.

2. What are the implications of the *2003 LPN/VN Practice Analysis*, related to the LPN/VN scope of practice, to NCSBN?

Group 1 — Yellow Group

- Why is the core curriculum of the LPN/VN so inconsistent?
- Why are the LPN/VN scopes of practice in different states so inconsistent?
- Is there a better regulatory model?
- Are practice acts too restrictive?
- What are the drivers of change?
- More clarity with delegation is needed.
- More information on transition from education to practice is needed.

Group 2 — Blue Group

- Revisit the model practice act and rules to differentiate basic differences of the RN/LPN. Don't leave the nursing assistants out of the loop.
- A white paper on LPN/VN and RN differences would be helpful.

- Raise the level of discussion between the boards of nursing so as to address the inconsistency with practice acts and rules and regulations.
- NCSBN should create dialogue between the consumers, education, regulation and practice to address this scope of practice issue. Patient rights were specifically addressed, referencing the American Nurses' Association "Social Policy Statement."
- NCSBN should be a clearinghouse for LPN/VN data, including NCSBN data (from the Taxonomy of Error, Root Cause Analysis and Practice Responsibility or TERCAP project, Profiles of Member Boards and Research Services), as well as other organizations that might collect such data.
- Collaboration with other groups and organizations was stressed.
- Drivers of society were discussed, such as the economy and technology.

Group 3 — Red

- We need to tap the resources of other groups — be a resource of data.
- Is the Member Board Profiles publication collecting enough data on LPN/VNs?
- First and foremost, the concern of NCSBN should be safety. Can NCSBN encourage states to collect and analyze data regarding practice issues/complaints?
- The LPN/VNs stated that they were best prepared for direct patient care, documentation, care planning and medications. They stated they were least prepared to interact about the patients and to supervise the care of others. These are important aspects for nursing education/regulation/practice to address.
- Delegation should be addressed by NCSBN.
- Labor Unions may be an issue.
- We can't look at LPN/VNs in isolation.

Summary of group discussion: NCSBN needs to revisit the model rules regarding scope of practice of the LPN/VN versus that of the RN. NCSBN should summarize their own data regarding PN practice, as well as look at the findings of studies of other groups. NCSBN should create a dialogue about LPN/VN scope of practice between the boards of nursing, consumers, educators and practice. Again, clarifying delegation came across strongly, as well as NCSBN's goal being to address patient safety. Two of the groups also mentioned the importance of not just looking at the LPN/VN practice issues in isolation, but with other health care providers, such as nursing assistants and RNs.

3. What are the implications of the *2003 LPN/VN Practice Analysis*, related to the scope of practice, for education and practice?

Group 1 — Yellow

- Increased collaboration and communication.
- Support mentoring.
- Drivers
  - Practice: third party payers, special interests, consumer, society, quality outcomes and safety.
  - Education: best practices, model curriculums.

Group 2 — Blue

- Developed excellent models of current practice, evolving practice and future visions.
- Is regulation futuristic enough to be a driver?
- See Appendix III: The Desired Evolution of Regulation (p. 121)

Group 3 — Red

- Regulation
  - Too restrictive.
  - Boards of Nursing need to be active in order to drive health care decisions.

    - Mutual recognition is a means of evolving.
- Education
    - Need more uniform LPN/VN curriculums.
    - Competencies should be spelled out.
    - How time is counted should be uniform across programs.
- Practice
    - Need to deliver safer care
    - Do their job descriptions fit the state's scope of practice?
    - Are expectations of new graduates too high?
    - Yet, need to utilize LPN/VNs to their capacity.

Summary of group discussion: There should be stronger links and more collaboration between education, regulation and practice because of the disconnect between practice and education. Perhaps there is the need for a national model LPN/VN curriculum and/or best practices. Likewise, regulation needs to be more proactive in promoting health care decisions. The mutual recognition model is one way for regulation to continue to evolve. The utilization of the LPN/VN should be discussed in the practice arenas, especially regarding safe practice. Two of the groups identified the drivers of health care, including the consumer and quality care, economics, special interests, education, practice and regulation.

4. What are possible strategies of attaining greater universality regarding the scope of practice of LPN/VNs, across jurisdictions?

Group 1 — Yellow

- Develop white paper of these discussions and share with stakeholders to open a discussion.
- Develop model scope of practice and base national curriculum on it.
- Develop PN education best practices/standards.
- Research PN outcomes.

Group 2 — Blue

- Practical nurses need to be at the table when these education/regulation/practice decisions are being made (e.g., ANA, JACHO, etc.). This seldom occurs.
- Model curriculum — will it work?
- Identify regulatory barriers that inhibit the scope of practice.
- Educate RNs about the LPN/VN scope of practice in that state.
- Likewise, the employer must understand the state's scope of practice in order to decide upon the correct qualifications for the job.

Group 3 — Red

- There needs to be better communication of LPN/VN needs with organizations; encourage more LPN/VN representation on panels, committees, etc., that address health care issues.
- The data at the federal level should clearly differentiate LPN/VN data from RN data.
- There should be more online offerings geared toward the LPN/VN.
- We should establish a forum where educational, practice and regulatory consistency are discussed in order to increase consistency across the states, increase competency and ultimately to increase safety.

Summary of the discussion: The overwhelming finding here was that there should be greater cooperation and communication between all parties and that there is a clear need for a forum (e.g., a white paper was brought up several times) to facilitate this. PN involvement in panels, committees, etc., was also felt to be very important. Again, the idea of a model curriculum, or even a

model scope of practice, was discussed. Collecting LPN/VN data and researching the LPN/VN role was also discussed by two of the groups.

Recommendations to the NCSBN Board of Directors

    - Dr. Seago provided NCSBN with the first national sample survey of LPN/VNs, from 1984 (Bentley, Campbell, Cohen, McNeill, & Paul, 1984)
  - Minnesota Board of Nursing study (McEvoy, 2005).

4. NCSBN's Committee Format Should Support LPN/VNs: While there are subcommittees at NCSBN that support other groups of nurses (e.g., the APRN Subcommittee), there is not a committee that just addresses LPN/VNs. Concern was expressed that not all LPN/VN issues are discussed in NCSBN committees. There wasn't consensus, however, on whether to have a

A total of 163 activity statements were included in the *2003 LPN/VN Practice Analysis* (Smith & Crawford, 2004). The activity statements were developed by a panel of experts to cover the full range of possible LPN/VN practice topics. Survey respondents indicated whether or not the activities applied to their specific work setting and if they did apply, they recorded the frequency with which they personally performed the activities on their last day of work. Some activities (such as those relating to care planning, assessment and teaching) were included on the survey in two ways, one indicating independent performance of the activity and the other describing a more directed role.

Of those newly licensed LPN/VNs responding to the *2003 LPN/VN Practice Analysis*, 48% reported that they independently developed clients' plans of care and 83% reported that they contributed to the development of clients' plans of care. In the area of education, 91% reported that they assisted in or reenforced education to clients/families about safety precautions and 78% reported that they independently planned and provided education to clients and families on the same topic. When asked about components of assessment, 84% reported collecting data for initial or admission health histories and 72% reported comparing the data collected for the health history to expected norms for decision-making or care planning.

Ten activity items on the *2003 LPN/VN practice analysis* addressed various aspects of IV therapy. Respondents reported involvement in those activities in the following proportions:

› 58% gave IV fluids or IV piggyback medications through peripheral IV lines.

› 32% provided medications through peripheral IV lines by IV push.

› 38% gave IV fluid, IV piggyback or IV push medications though central venous catheters.

› 53% gave total parenteral nutrition (TPN).

› 55% started initial peripheral IV lines on adult clients.

› 47% restarted IV lines on adult clients.

› 19% started or restarted IV lines on pediatric clients (age 16 years or younger).

› 28% administered blood products.

› 40% monitored the transfusion of blood products.

› 74% assessed clients' IV sites and flow rates.

An Employers Survey (Smith & Crawford, 2004a) and a Practice and Professional Issues Survey (Smith & Crawford, 2004b) were performed during the fall and winter of 2003. These surveys were designed to collect the same types of information from nurses in their first six to 18 months of practice and from nurse employers. Respondents to each of these studies were asked to comment on the working relationships of RNs and LPN/VNs in their settings. Of those respondents writing comments about RN and LPN/VN working roles, 39% of employers, 52% of LPN/VNs and 62% of RNs wrote that RNs and LPN/VNs in their settings held the same role and performed the same work or that their roles were the same e4poles8t9pae6.3(rformed the s)-5628csa

- Student/Faculty ratios.
- Boards requiring clinical education facilities to be approved by the board of nursing or boards that mandate on-site visits be made to clinical facilities.
- State requirements for clinical teaching assistants in LPN/VN programs and LPN/VN student-preceptor ratios.
- Regulation of students in clinical settings.
- Guidelines for clinical experiences in non-traditional settings.
- Curriculum guidelines in LPN/VN nursing programs.
- Distance learning guidelines.
- LPN/VN criteria by for licensure by examination, including equivalency programs, such as the military programs.
- Eligibility to sit for the NCLEX-PN® examination, including those from military programs, limitations on number of times a candidate can sit for the exam and limitations on the number of times a candidate can attempt to pass the NCLEX-PN® exam without further study.
- LPN/VN qualifications for licensure by endorsement.
- Eligibility for LPN/VN licensure by endorsement.
- Temporary or Interim Permits.
- Verification of licensure.
- Required course work.
- American Disabilities Act guidelines.
- Licensure data, such as number of years license is valid, fees and licensure questions.
- Continuing education requirements.
- Periodic refresher courses.
- Competency requirements.
- Criminal background checks.
- Mandatory reporting of violations of the nurse practice act required in state.
- Investigation of complaints.
- Standard of proof.
- Alternative disciplinary approaches.
- Formal disciplinary processes.
- Disciplinary remedies.
- Characteristics of probation and fees.
- Telenursing information.

Information in the *2002 Profiles of Member Boards* (Crawford & White, 2003) that is particularly important to the LPN/VN scope of practice is the question about whether delegation appears in the nurse practice act or rules and regulations for LPN/VNs. Please see Table 1 for that information.

Table 1 — Delegation is Addressed for LPN/VNs (Crawford & White, 2003)

Delegation in the Rules, Practice Act or Other References	Delegation is Inferred

Alabama Alaska Arkansas District of Columbia Idaho Iowa Kansas Kentucky Maine Maryland Massachusetts Montana New Hampshire New Jersey New Mexico New York North Carolina North Dakota Ohio Oklahoma Oregon Rhode Island South Carolina South Dakota Tennessee Utah Vermont Washington Wisconsin Wyoming	Arizona — Questions referred to scope of practice committee — review and recommend to board. California-VN — In basic nursing program within supervision content area. Florida — Listed in statute, board rule. Louisiana-PN — Board memo, newsletter, Web site. Missouri — Specific board opinions/decisions, MSBN newsletter, board position statements, MSBN Web site, etc. Pennsylvania — Licensees may not delegate. Virgin Islands — Planning workshop for nurses and employers. West Virginia-PN — Published “guidelines on scope and delegation” approved by RN and LPN boards, mailed to all RNs and LPNs and used to answer all practice questions. West Virginia-RN — Special joint publication between RN and LPN boards which includes a scope of practice model and a delegation model.

NCSBN SCOPE OF PRACTICE SURVEY RESULTS

In preparation for writing this White Paper the Practice, Regulation and Education (PR&E) Committee at NCSBN recommended that we conduct an electronic survey of the boards of nursing and the two LPN/VN organizations to answer some important questions on the LPN/VN scope of practice. The survey to the two organizations was slightly adapted from the survey to the boards of nursing. The specific questions on LPN/VN tasks that were addressed (e.g., IV therapy, administering blood transfusions, etc.) all were questions asked in the *2003 LPN/VN Practice Analysis* (Smith & Crawford, 2003). Since the PN Focus Group was convened to discuss the results of that survey, it made sense to use those specific task questions in this survey of the boards of nursing and LPN/VN organizations. The PR&E Committee reviewed the final draft of the survey and it was sent out electronically in February of 2005. Of the 60 boards of nursing, 48 completed the survey. The results and individual comments can be reviewed on the Education page of our Web site, which is www.ncsbn.org. Each question will be summarized here.

Question 1 — Do LPN/VNs independently develop the client’s plan of care?

A large majority of the boards (46 to 2) responded “no” to this question. A large number of respondents (14) commented that the LPN/VN should contribute to the plan of care, but that the RN or physician must approve it. One board of nursing said that this might be allowed with further education of the LPN/VN.

Question 2 — Can the LPN/VN make changes to the client’s plan of care?

Again, a large majority of the respondents replied “no” (41)

Thirty-one boards of nursing answered “no” to this question, while eight replied yes. Four of the boards said that is was allowed only when protocols or standing orders were in place. Another said that all abnormal findings must be reported to the physician or RN, while two boards of nursing said that this may be allowed with further education.

Question 4 and 8 — Can the LPN/VN independently plan and provide education to clients/families about safety

Thirty-six boards of nursing allow LPN/VNs to monitor blood transfusions, though five do not. However, only 18 boards of nursing allow LPN/VNs to administer blood products, while 22 do not. One board commented that its law is silent on both issues. Five boards said that LPN/VNs aren't taught to monitor blood transfusions in their basic programs so they must document further training in this area before they are allowed this responsibility. Another three boards say that LPN/VNs can administer blood transfusions when they provide evidence that they have had further training.

Questions 11, 12, 13, 14, 15, 16 and 18 all address intravenous (IV) responsibilities: Can LPN/VNs assess client's IV site and flow rate? Give a medication through a peripheral IV line by intravenous piggyback (IVPB) or IV? Provide medications by intravenous push (IVP)? Give IV fluid or IVPB/IVP medication through a central venous

say that the law is silent on that issue. One board of nursing said that this would be considered “counseling” and that is considered outside the scope of an LPN/VN. Another said that the RN could delegate this responsibility, though he or she would have to verify the competency of the LPN/VN.

Questions 26 a-f — Definitions for independent LPN/VN practice, LPN/VN decision making, assessment by

While 28 boards of nursing allowed their LPN/VNs to delegate, 33 allowed them to assign. Twelve boards of nursing responded that they do not allow delegation, while seven do not allow LPN/VNs to assign. Generally, the comments addressed to whom the LPN/VNs can delegate or assign, including LPN/VNs or assistive personnel (e.g., certified nurse assistants). One board said that they are requiring the LPN/VN programs to teach delegation information, with a focus on long-term care.

Questions 27 & 28 — Does your state have provisions for certification of LPN/VNs (i.e., LPN licensure designation)? If so, is that scope of practice different?

Only six boards of nursing have certification provisions, whereas 36 replied that they did not. Of those six who do have certification provisions, four allow a broader scope of practice. The specific certification addressed in the comments was IV certification.

Table 5 — Other LPN/VN Responsibilities Allowed by Boards of Nursing

Activity	Yes	No

Seago et al. also collected data from the boards of nursing that regulate LPN/VNs and they found substantial variation in the restrictiveness in the scopes of practice, as was found in the NCSBN survey. Further, after reviewing the board of nursing practice acts, they found some to be highly specific, while some were quite vague. Seago et al. (2004, p. 31) defined "restrictiveness" as "limiting the level of autonomy, flexibility or independence in the practice of LPNs." These authors then rated each board of nursing on restrictiveness in Appendix C of their publication, with 4 being the most restrictive and 1 being the least restrictive. They also, in the same appendix, rated each board of nursing as to specificity (4 most specific; 1 least specific), which they defined as "explicating defined parameters of practice of LPNs" (Seago et al., 2004, p. 31). Three principal investigators of the study categorized the practice acts of the boards of nursing and they had established criteria to denote agreement. On the restrictiveness scale, 15 boards of nursing were rated as 1 (least), 24 as 2, 11 as 3 and 2 as 4 (most). On the specificity scale, 14 boards were listed as 1 (least), 20 as 2, 6 as 3 and 12 as 4 (most). Their focus group data from Louisiana, Massachusetts, California and Iowa indicated that the employers restrict LPN/VN practice even more than the regulations require.

This publication has some very specific information about board of nursing requirements of LPN/VNs, such as the results of a board of nursing survey regarding IV medications, as well as an excellent table showing each state's specific scope of practice with certain functions (such as IVs, dressings and care planning), along with requirements of supervisors (such as cosigning documentation).

Again, these data point to wide variations across the country with LPN/VN regulations for scope of practice. Interestingly, in their conclusion, Seago et al. (2004) wonder if the expanded scope of practice of an LPN/VN leads to increased salary in the workplace. In their recommendations, they suggest that:

- States with the most restrictive scopes of practice should reduce those restrictions, unless it is clear that a restriction would negatively impact patient care.
- Workplaces create teams of LPN/VNs that share the workload.
- The RN and the LPN/VN should have a better understanding of the scope of practice and that the difference between the workplace scope of practice and the state board of nursing scope of practice should be clarified.
- Educational work toward standardization of LPN/VN educational preparation.
- States create articulation pathways between the LPN/VN and RN.
- While LPN/VNs cannot substitute for RNs, many tasks traditionally carried out by RNs can be carried out by the LPN/VN.
- While the LPN/VN could be used to augment the workforce during the current nursing shortage, this will depend on the ability of states to create a more flexible LPN/VN scope of practice.
- It is unlikely that the LPN/VN will substantially ease the RN shortage because LPN/VNs fall into the same worker pool.
- Employers should consider increasing wages when LPN/VNs receive additional training or education.
- Consider using the LPN/VN predominantly in long-term care, and not in acute care.
- Educate the public about the LPN/VN, both to give them recognition and to encourage people to pursue a career in practical nursing.

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- Employment status
- Spouse education
- LPN/VN license data
- Educational background
- Continuing education
- Employment settings
- Employment titles
- Hours and earnings
- Temporary employment services
- Status of those not employed
- Geographic mobility
- Change in employment status

"SCOPE OF LPN PRACTICE STUDY TO IDENTIFY CONGRUENCIES AND INCONGRUENCIES AMONG LPN REGULATIONS, EDUCATION AND PRACTICE, JANUARY 2005" MINNESOTA BOARD OF NURSING AND MINNESOTA COLLEAGUES IN CARING

McEvoy's (2005) Report to the Minnesota Board of Nursing outlined the purpose of the LPN Task Force, which was to:

- Identify congruencies and incongruencies among LPN regulations, education and practice.
- Make recommendations based on identification of incongruencies.

This group collected documents that reflect the education, practice and regulation of LPN/VNs in the state of Minnesota. The group was concerned that the practice of LPN/VNs in that state wasn't congruent with their education and the state regulations. Therefore, a random sample of LPNs in Minnesota according to practice area and geographic area were surveyed. They had a 64.3% response rate with this survey. Their significant findings included:

- Confusion with the terms "observation" and "assessment;" these terms lacked congruency across education, practice and regulation. Therefore, they recommended that the nature of observation and assessment needs to be clarified and differentiated 5(g)-0.2(ruenci6ue.1g(1TJ56.962 0 TD0 Tc0 Tw)]TJ5G Tf9 0 0 these ngr)89(/p67.6S7378.84 Tm0 Tc<0084>Tj/TT6 1 Tf9.4
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Appendix I

PN Focus Group Members

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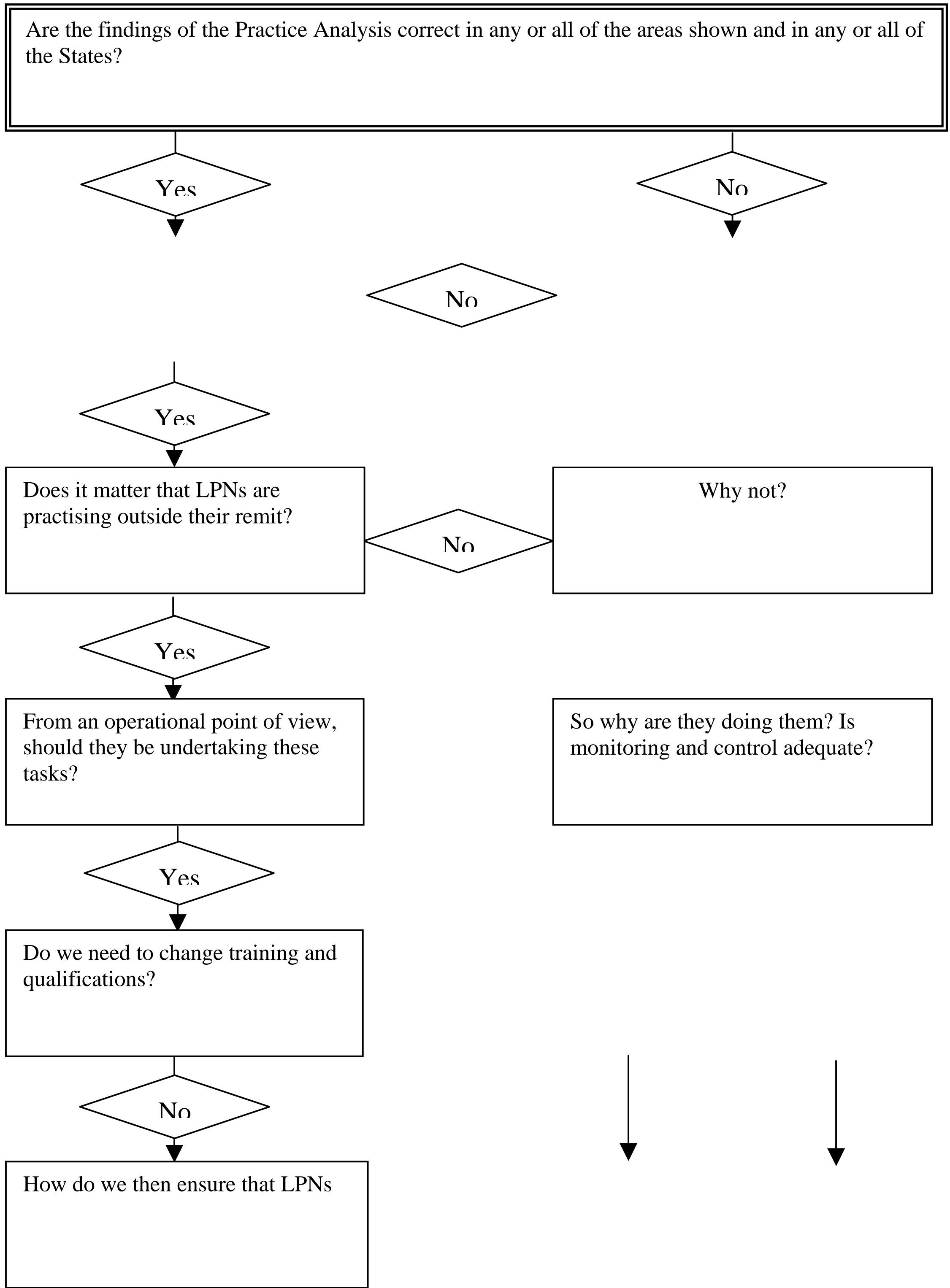
Appendix II
Algorithm for Discussion



Appendix iii

Now and/or Desired (Evolving)