CRNNL | College of **Registered Nurses** of Newfoundland & Labrador

COLLEGE OF LICENSED PRACTICAL NURSES OF NEWFOUNDLAND AND LABRADOR
LPNs - A Practical Approach to Quality Care

2009

Professional Responsibilities When Working with Institutionally Based Unregulated Care Providers

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Introduction/Purpose

The College of Licensed Practical Nurses of Newfoundland and Labrador (CLPNNL) and the Association of Registered Nurses of Newfoundland and Labrador (ARNNL) have the legislative authority to regulate, in the public interest, the practice of Licensed Practical Nurses and Registered Nurses in the province. This mandate grants the authority for ARNNL and CLPNNL to develop interpretive guidelines to identify RN and LPN accountabilities. The guidelines in this document clarify the roles and responsibilities of nurses when working with unregulated care providers (UCP) employed in institutional settings which includes; hospitals, health care centers and long term care facilities .[1] Throughout this document the term nurse will refer to RNs and LPNs. The term patient will refer also to resident.

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Evidence shows that higher professional staffing is linked with better patient outcomes and that the acuity and complexity of care needs are increasing in both acute and long term care facilities (ICN, 2006; CNA, 2003-2005b, 2006; CFNU, 2005). However, policy directions within the health care system indicate a move towards a greater utilization of unregulated assistive personnel. These changes, if implemented in a coordinated manner that ensures all team members are engaged in activities suited to their abilities, can be an important element of a more comprehensive solution to improving patient access to care and better utilization of existing health human resources (CNA, 2008). In 2008, a joint statement issued by six international organizations, including the International Council of Nurses, identified 12 components necessary to maximize effective decision-making in this area (see appendix A). Clarification of appropriate roles for UCPs in Newfoundland and Labrador can support RNs and LPNs to work to their full scope of practice, promote quality patient care, increase job satisfaction and enhance operational efficiency (ARNNL, 2006b).

Background

Prior to the 1980's the majority of patient care in institutional settings was provided by RNs and LPNs with supportive assistance provided by UCPs, such as, orderlies and porters. Changes to the Canadian health care system have resulted in the emergence of new models of care delivery. The use of the UCP has shifted from supportive role models, with the focus on the setting, to assistive roles, with a focus on patient care (CNA, 2006). More recently the term task shifting has been introduced internationally to identify this phenomenon and the relevant benefits and challenges. *Task shifting involves the rationale redistribution of tasks among health workforce teams. Specific tasks are moved, where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualifications in order to make more efficient use of the available human resources for health (ICM, ICN, IPF, WCPT, WDF, & WMA, 2008).*

Creating a common understanding of roles is important to inform the public, assist professionals working with unregulated workers and, for employers to establish staffing plans and develop appropriate standards of care to maximize the use of UCPs as part of the care team.

Over time there has been increasing diversity in the classification of UCPs. For example, at least 15 titles are listed to describe UCPs in Canada (CNA, 2006). The various titles have been primarily determined by employers, often linked to roles and or settings, such as care attendants or resident assistants. The lack of a standardized title, inconsistent training/educational programs, lack of standardized job descriptions, and concerns over scope of practice, liability, and job loss, can create

barriers to the effective use of UCPs (CNPS, 2000; Homecare Sector Study Corporation, 2003, CNA, 2008). Creating a common understanding of roles is important to inform the public, assist professionals working with unregulated workers and, for employers to establish staffing plans and develop appropriate standards of care to maximize the use of UCPs as part of the care team (HPRAC, 2006).

In NL the category of UCP most often utilized within institutional health care settings for direct patient care is titled personal care assistant, (PCA) or a variation, such as, resident care worker. The remainder of this document will therefore be directed towards the PCA role. However, if other UCP roles are in place or introduced that provide similar patient services, the principles outlined in this document should be considered or should guide role development.

Provincial Situation

The actual number of PCAs in NL is unknown as workers in this category often perform multiple roles and may be classified in different categories. The latest provincial human resource indicator report (1999-2003) identified that there were 412 personal care attendants employed in the regional health authorities in institutional settings (Health & Community Services Human Resource Planning Unit, 2005). Conversely, UCPs are reported to represent 70-80% of the home care workforce in Canada (Home Care Sector Study Corporation, 2003). In 2005 the Government of NL estimated that there were over 6000 home support workers in the province.

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Historically, training and educational programs for PCAs in NL ranged from on-the-job learning to formal courses with practical experience. Employing agencies traditionally provided an orientation which varied in length and content. Most employers did not require PCAs to have a formal educational background in the field. This has resulted in differences in the capabilities and skill set of PCAs within the province.

To address these issues the Government of Newfoundland and Labrador introduced a provincial title and position description for PCAs, a standardized educational curriculum, and a skills list to describe their scope of employment (Government of NL, 2006, 2007).

Title

Personal Care Attendant (PCA)
A member of the interdisciplinary team who is responsible for providing support to patients in all aspects of daily living through companionship, physical, spiritual, and psychosocial care. PCAs work in collaboration with the interdisciplinary team to achieve patient centered objectives. Duties are performed under the direction of a nurse (Government of NL, 2007).

Employing agencies have the responsibility to verify the credentials of all PCAs applying for positions or employed within their agency and address any identified gaps of deficiencies. See Appendix B.

Educational Program

In September 2006 a provincially approved 20 week PCA educational program was offered for the first time in a variety of private and public colleges in the province. Provincial standards were developed to guide curriculum development and implementation. Through the use of classroom, laboratory and supervised field

placements in a variety of settings, including patient's homes and long term care facilities, the program educates and equips graduates with the necessary skills to deliver appropriate, timely, and respectful patient focused care to the elderly, persons with disabilities, or those recovering from illness or injury and their families (Government of NL, 2006, p4).

Program content includes education related to performance of personal care, body mechanics, team work, and communication. Specific modules are offered on healthy aging, dementia and other cognitive disorders. Students are also prepared to demonstrate understanding of some basic nursing procedures but authorization to practice these nursing procedures is dependent upon employment. Graduates of this program will need to be brought to proficiency[2] in some skills upon employment.

Employing agencies have the responsibility to verify the credentials of all PCAs applying for positions or employed within their agency and address any identified gaps or deficiencies. A description of the roles and responsibilities of RNs, LPNs, PCAs and employing agencies are detailed in appendix B.

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Skills List

A comprehensive list of the skills and competencies expected of PCAs upon completion of the educational program and appropriate agency orientation is provided in appendix C.

The introduction of a Government approved title and description does not imply that PCAs are now a licensed or regulated profession in NL. To be a professional requires legislated authority and other essential regulatory components such as professional standards, a code of ethics and a process for conduct review with liability protection (CNA, 2007). However, having a provincial title and a standard curriculum will assist the effective and efficient use of PCAs as part of the health care team in institutional settings within the province.

PCA Role

The specific roles and activities performed by PCAs should be determined in collaboration with nursing staff and reflective of the context of practice. At no time should the use of PCAs place the patient at risk (CNA, 2005a, 2006; ARNNL, 2006b). Collaborative practice necessitates RNs, LPNs and PCAs working together, but utilizing PCAs has both benefits and challenges. It is therefore critical to have a staffing plan that promotes the use of the right person, with the right skills and education at the right time. The use of an evidence based framework, such as the *Evaluation Framework to Determine the Impact of Nursing Staff Skill Mix Decisions*, (CNA, 2005) can help achieve the desired skill mix outcome. In this model, assignment and delegation are important aspects of the RN and LPN role.

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The critical elements to consider when determining appropriate roles for PCAs are:

- Educational preparation
- Scope of employment
- Assignment
- Delegation

- Supervision
- Accountability

The role assumed by PCAs in patient care in institutional settings must also be in keeping with agency policy. Finally, decisions must always be based on the fundamental principle of providing quality nursing services and public protection and thus will always require nursing judgment.

Educational Preparation

In conjunction with the Regional Health Authorities, the Government of NL identified in 2006 that the standard educational preparation for employment as a PCA in institutional settings is the completion of the provincially approved 20 week PCA educational program, or equivalent. Consequently there remains diversity in the educational preparation of PCAs as those employed prior to 2006 may not have completed the 20 week program.

The specific roles and activities performed by PCAs should be determined in collaboration with nursing staff and reflective of the context of practice. At no time should the use of PCAs place the patient at risk.

PCAs that have not completed the provincial education program, or an equivalent program in another jurisdiction, will require additional education and support before they can assume the full scope of employment supported within the new title and skills list. The employer is responsible to identify the core tasks that are required and assess each PCA's learning needs as appropriate to their role. Together, the PCA and employer need to identify opportunities to obtain the required education to address any deficiencies.

Scope of Employment

In addition to the formal PCA educational program there is also a proposed provincial scope of employment[3] for PCAs. However, the setting and context of practice will impact the actual implementation of roles and interventions. Setting refers to the specific agency or authority; context is specific to level of care required for example, ambulatory dementia care or inpatient chronic care in a hospital. It is therefore possible that a PCA may be able to perform select roles in certain settings or contexts but not in others. The employer is responsible to ensure, and offer as necessary, any additional education or support required to assist the PCA to obtain and/or maintain competencies specific to the setting.

The fundamental role for PCAs in the provincial program and as currently implemented is most settings is the provision of basic personal care, to help patients accomplish activities of daily living (ADL).

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Activities of Daily Living – Means an activity that individuals normally perform on their own behalf to

[3] Scope of employment is different than scope of practice. Scope of practice is a term used to define the range of roles, responsibilities and functions of regulated health care professionals that are developed by a provincial and/or national authority, not the exclusive domain of an employer (ARNNL, 2006a).

maintain and promote their health and well being (CARNA, CLPNA, & CRPNA, 2003).

ADL includes but is not restricted to, personal hygiene, feeding, toileting, and mobilizing. It may also involve routine nursing procedures when the need for the procedure, the response to and the outcomes of performing the procedure have been established over time, and as a result are predictable. It should be a well established part of the patient's routine. For example, ostomy care, tube feeding, glucose meter monitoring, and vital signs could be considered ADL. The same procedure may be a routine activity of daily living in one circumstance and part of a therapeutic plan in another (CNO, 2004).

The fundamental role for PCAs in the provincial program and as currently implemented in most settings is the provision of basic personal care, to help patients accomplish activities of daily living (ADL).

Although there are a number of support roles that PCAs can safely perform independently there are also nursing tasks that could be assigned and/or delegated to a PCA that could cause significant harm. For example, the PCA may be responsible for bathing the feet of an elderly patient with diabetes. If not done properly this intervention could result in harm to the patient. Assessment of the situation, as outlined below, must be implemented so risks are mitigated (Anthony, Hertz, &Standing, 2000; HPRAC, 2006). Patient safety must always be a priority. Once the appropriate role is determined by the nurse the PCA can be assigned or delegated to implement these tasks.

Assignment

Shared skills refer to *the ability of different health care providers to perform similar activities* (ARNNL, 2006a). The activities within this category are within the skill set or scope of the involved care providers. The determination of who should perform a shared skill is the act of assignment.

Although there are a number of support roles that PCAs can safely perform independently, there are also nursing tasks that could be assigned and/or delegated to a PCA that could cause significant harm.

Assignment is defined as: *the selective designation of specific responsibilities for patient care within employer policies, legislated scopes of practice [identified scope of employment], competencies of providers, and environmental supports* (AARN, 2003). It is the determination of the most appropriate provider for the situation. Assignment is also based on staff complement and patient need. It is never acceptable to assign purely by physical layout of the institution.

Example: Bed baths are a shared skill of RNs, LPNs, and PCA. However, while all three groups have the ability to complete the bath, the knowledge and ability to assess patient needs and modify care appropriately during the bath may influence who should be assigned this role. The decision may change if the patient is one day versus 10 days post op with a new artificial hip. Another scenario where assignments for daily care require reflection, is a patient with dementia with unpredictable eating habits who has uncontrolled diabetes often requiring insulin dosage adjustment.

Framework for Assignment

Before patient care is assigned the nurse must be aware of and assess the following components. The assignment decision-making process, which is continuous, is described below and depicted in appendix D.

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nursing tasks that could be assigned and/ or delegated to a PCA that could cause significant harm

Step 1 Knowledge of Role

The nurse must have knowledge about the approved scope of employment of PCAs articulated in job descriptions and organizational policies.

Step 2 Assess the Circumstances

Patient - The nurse must be aware of the needs of each patient and where possible patient preference, have knowledge of the complexity of care required, and predictability of outcomes.

Care Provider - The nurse must inquire about the competency4 (theoretical and practical knowledge) and level of proficiency of each available care provider on the team.

Supports - The nurse must be aware of the available supports for example, supervision, mentorship or co-assignment, including consideration of potential negative patient outcomes and implications for other patients if care is or is not assigned (see supervision section).

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If the assessment of all of the above indicates it is appropriate the nurse should proceed with the assignment to the PCA.

Step 3 Assign the Care

The nurse must implement appropriate communication and supervision.

Step 4 Evaluate the outcomes

- The nurse to continue assignment if no problems noted.
- The nurse, as necessary, modify assignments or explore alternate options.
- The nurse to document relevant information.

If at any time in the process a concern is identified the nurse must **explore alternative assignments**. For example, if a PCA does not have the skill set required to practice in the particular setting or there is a change in the patient's health status, the nurse should notify his/her manager of the noted deficiency, obtain appropriate replacement, and advocate for opportunities for the PCA to obtain the necessary education.

In circumstances where the identified level of care required is not available, the nurse has the responsibility to prioritize patient care needs and:

- do the best she/he can in the circumstances,
- report and record the situation appropriately,
- adjust assignments to maximize patient safety, and
- monitor and trend patterns (ARNNL, 2007; CLPNNL, 2004).

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[4] Competency is defined as having the necessary knowledge, skills, attitude and judgment to provide the required patient care (ARNNL, 2006a). Proficiency is determined by the ability of the provider to perform the identified task independently.

For example, when modifying staffing plans due to shortages of personnel, available staff is reassigned appropriately and care needs are reviewed to meet the priorities of patient care and the unit specific situation.

If there are limited personnel for re-assignment then **explore alternate options**. In circumstances where a safe level of care cannot be provided with available staff, the nurse has a professional obligation to intervene on the patient's behalf (see Questionable Situations section).

Example: Tube feeding or assistance with medications are examples of nursing tasks which could be considered to be within the scope of employment of the PCA, if the PCA has successfully completed an educational program, agency policies support the assignment, and the patient's need for its performance meets the definition of ADL (Government of NL, 2006, 2007).

Note: A PCA is assisting with medications when they are caring for a patient who can independently direct their own care or who have family that assume responsible for the patient's overall care. Thus the patient's family monitors all the appropriate medication checks, e.g. the rights of medication administration [right medication, dose, route, time, patient, reason and documentation (ARNNL, 2003, 2005)].

Delegation may be required when there is an identified need for a PCA or group of PCAs to perform a nursing task that is not outlined in the provincial PCA educational program nor within their scope of employment.

Delegation

Delegation is defined as *the transferring of authority to perform a select task in a selected situation where the delegator retains accountability for the outcome* (CNPS, 2000). Delegation may be required when there is an identified need for a PCA or group of PCAs to perform a nursing task that is not outlined in the provincial PCA educational program nor within their scope of employment.

Delegation of nursing tasks to PCAs in institutional settings should not be a common occurrence as a variety of health care providers with different scopes of practice should be available in a team environment. There may however be select situations where delegation is required. This may occur in a particular agency or in limited circumstances on an individual basis. ARNNL and CLPNNL recognize that both RNs and LPNs can be involved in supervising PCA's implementation of a delegated task, as long as the specific nursing task is within the involved nurse's scope of practice and the role is supported by the agency (SALPN, 2006;SRNA, 2004).

Delegation may be required when there is an identified need for a PCA or group of PCAs to perform a nursing task that is not outlined in the provincial PCA educational program nor within their scope of employment.

Agency Delegation

The authority to delegate nursing tasks and the identification of what can be delegated to PCAs in institutional settings must be supported in agency policy. The practice of nursing cannot be delegated, that is, the overall assessment, care planning and evaluation of care outcomes (CNPS, 2000). These roles require advanced decision-making and critical thinking skills. Consequently these are activities that must be performed by an RN or, as appropriate within the CLPNNL approved scope of practice, by an LPN. The employer may determine that all PCAs employed in a particular context will be authorized to perform a specific nursing task that a specific patient needs for daily living, e.g., assist with the nursing care of a ventilated patient or a patient on peritoneal dialysis. Or, an employer may determine that all PCAs in a

specific setting will be authorized to perform a specific task for example, administration of topical medications. If the agency supports the delegation of a task it is also responsible to offer the appropriate theoretical and practical education to support the safe practice of the delegated tasks.

Delegated tasks are not transferrable...the authority to perform a specific delegated task is limited to a specific patient or specific setting or context.

Delegated tasks are not transferable, that is, the authority to perform a specific delegated task is limited to a specific patient or specific setting or context. It is not acceptable to sub delegate, re delegate or delegate to third parties. If the PCA is unable to complete a delegated task he/she must report this back to the nurse who delegated the task. The PCA cannot ask another PCA to perform the activity. Nor can the PCA perform the delegated task for another patient without specific direction from the nurse, or perform the task in another area of practice.

Employer and practitioner decisions related to PCA delegation must reflect consideration of the five rights of delegation:

Right Task
The task to be delegated is identified in employer policy.

Right Circumstances
Appropriate patient setting, available resources, and other relevant factors.

Right Person
Right person is delegating the right task, to the right person, to be performed on the right patient.

Right Communication
Clear, concise description of the task, including its objective, limitations and expectations.

Right Supervision
Appropriate monitoring, evaluation, and intervention as needed, and feedback (National Council of State Boards of Nursing, 1995, 1997)

Individual Delegation

Although limited, there may be situations when the nurse may urgently need to delegate to a PCA a nursing procedure that has not been identified within the provincial program or as an agency delegated task. In this circumstance the PCA may be required to perform an aspect of the task under direct supervision, for example, perform a step required to secure or replace a dislodged central line or feeding tube. There may also be situations, such as a snowstorm, where the nurse may need to temporarily delegate tasks to PCAs that can't be postponed or assigned to another professional. In both situations the nurse is ultimately responsible for the decision to delegate and must document and report accordingly. If such a situation becomes a routine occurrence then the need to have the task formally delegated to the PCA or group of PCAs should be explored by the agency.

Framework for Delegation

When participating in delegation of a nursing task to a PCA the nurse must ensure appropriate assessment, planning, implementation and evaluation (ARNNL, 2003). The delegation decision-making process, which is continuous, is described below and depicted in appendix E.

Step 1 Verify Authorization

- The nurse must be aware of the scope of employment of PCAs and agency policies on delegation.
- The nurse must be in a position whereby he/she is authorized to implement the delegated task within his/her organization.
- The nurse must assess his/her own knowledge and ability to implement the delegated task.

When participating in delegation of a nursing task to a PCA the nurse must ensure appropriate assessment, planning, implementation and evaluation.

Step 2 Assess Circumstances

Patient
Is the task considered to be a routine activity of daily living for this patient? Is the patient's care non-complex and the outcome of care predictable?

PCA Competency
Does the PCA have the appropriate education, skills and experience?

Situation
Is the process for supervision and monitoring satisfactory?
Is the process for addressing unexpected patient problems established?

If assessment of all of the above is supportive then the nurse should **proceed with the delegation** to the PCA.

Step 3 Delegate the Task

The nurse must identify expectations- who is doing what?
The nurse must establish lines of communication and supervision.

Step 5 Evaluate outcomes

The nurse must modify supervision if necessary and document relevant information.

Examples
Urinary catherization or oxygen therapy could be delegated to a PCA or group of PCAs if supported in agency policy, the PCA has completed the required education and practical experience to safely perform the task, and the nurse confirms that the situation is appropriate.

Supervision

The primary purpose of supervision is to maximize appropriate patient outcomes. Supervision can be either direct or indirect depending upon the circumstances.

Supervision is defined as the process of overseeing care. It involves the monitoring and directing of activities. It is a critical component of accountability and an expected element of both assignment and delegation. The primary purpose of supervision is to maximize appropriate patient outcomes. Supervision can be either direct or indirect depending upon the circumstances. Often the assigner/delegator also performs the supervisory role. It is up to the supervisor to determine which level of supervision is necessary for example, if it is a task that the PCA has performed recently, indirect supervision may be appropriate. Whereas, if it is a new task for the PCA, the nurse may decide to provide direct supervision.

Direct Supervision – The supervisor is physically present during the provision of care.

Indirect Supervision- The supervisor is not physically present, but monitors activities by having the caregiver report regularly to the supervisor or by periodically observing the caregivers activities (ARNNL, 2006a; CLPNNL, 2004).

Supervision can also involve co-assignment and mentorship. Co-assignment is the process whereby two or more providers with different professional designations are assigned the care of a particular patient or group of patients. This is done in order to ensure that all the patient care needs can be met, for example, a PCA is co-assigned with a LPN or RN. Mentorship may also be required on an ongoing basis. Mentorship is defined as an informal process of pairing health care providers for the purpose of continued learning, for example, an experienced LPN works alongside of a novice PCA during orientation period (ARNNL, 2006).

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Accountability

When assigning or delegating care to PCAs in institutional settings, the RN or LPN as appropriate within his/her scope of practice, retains accountability for the overall planning and supervision of care (ARNNL, 2000, 2007; CLPNNL, 2004). The PCA is responsible for identifying his/her level of competency and proficiency, competently completing the assigned or delegated task, and reporting outcomes and all related concerns (ANA, 2005). The employing agency is responsible for clear and comprehensive policy direction. A full description of the responsibilities for nurses, PCAs and agencies is provided as appendix B. Potential questions to explore when working with PCAs are included as appendix F. To maximize the quality of care and patient safety, each individual nurse working with PCAs is accountable to:

- Provide support and identify expectations;
- Monitor patient outcomes;
- Evaluate performance of delegated tasks and provide feedback;
- Intervene if necessary; and
- Reassess and adjust the overall plan of care or patient assignment/delegation as needed.

The employing agency is responsible for clear and comprehensive policy direction.

Questionable Situations

All RNs and LPNs have a professional obligation to promptly address situations if they become aware that the safety of patient care is in question (ARNNL, 2007; CLPNNL, 2004). This could include issues that involve; competency of the PCA, RN/LPN fulfilling supervisory role, and/or environmental challenges. If questionable situations occur the nurse has the responsibility to:

a) Clearly identify the problem with substantiating evidence.
b) If the task has not been assigned or delegated:
   - delay or refuse to assign or delegate task, and/or
   - request additional education or support for PCA and/or RN/LPN.
c) If the task has already been assigned or delegated:
   - intervene by assuming the role or stopping the practice, if imminent harm is anticipated, and/or

- implement appropriate interventions, such as; increased guidance, additional teaching & supervision, modification of the care plan, revision of assignment and/or revocation of the delegated task,
- document actions, rationale and planned measures, and
- report as necessary according to agency policies.

d) If the problem or situation remains unresolved the nurse has the responsibility to:
- intervene by assuming the role or stopping the practice,
- communicate concerns to nursing management,
- document situation, rationale and actions appropriately,
- advocate for appropriate changes/improvements, and
- seek advice from external resources, such as, ARNNL or CLPNNL as required.

Documentation

Documentation of patient care is a required profession responsibility (ARNNL, 2007; CLPNNL, 2004). The PCA should document the care she/he completed in accordance with agency policy, e.g., personal care administered and related patient response, completion of surveillance/assessment forms and/or other ADL flow sheets. The RN/LPN is responsible to document all care she/he provides, for example, assessment of the patients status and outcomes of care.

The PCA should document the care she/he completed in accordance with agency policy, e.g., personal care administered and related patient response, completion of surveillance/ assessment forms and/or other ADL flow sheets.

Care assignments should be recorded on the appropriate agency approved form/ process and updated or changed as necessary. These records are retained and used within the organization in accordance with quality assurance policies.

If an RN or LPN is involved in delegating a task to a PCA they may be required to record additional information such as, the necessary practical experience provided to the PCA to prepare them to competently perform a task. Educational preparation, supervision and/or determination of proficiency should be recorded by the appropriate person (e.g. educator, manager, team leader and/ or delegator) and retained in the PCAs file. Patient related information needs to be documented in the patient record.

Conclusion

The inter-relationships of a number of factors determine whether a patient's care needs fall within the clinical responsibilities for a specific category of care provider. The ability to assign, delegate, and supervise appropriately and knowing when and how to follow-up are key factors in quality patient outcomes (Anthony, Standing, & Hertz, 2000; CRNNS, 2004a). RNs and LPNs need to be aware of their role and related accountability when working with unregulated workers. Nurses also have a responsibility to work together to improve policies and practice settings to create quality professional practice environments.

References and Resources

Alberta Association of Registered Nurses. (AARN) (2003). Guidelines for Assignment of Patient/Client Care & Staffing Decisions. Edmonton: Author.

American Nurses Association. (ANA) (2005). Principles for Delegation. Washington,DC: American Nurses Publishing.

Anthony M. K., Hertz J. E., & Standing T. (2000). Factors Influencing out comes after Delegation to Unlicensed Assistive Personnel. Journal Of Nursing Administration 30, (10) 474-481. http// www.nursingcenter.com.

Association of Registered Nurses of Newfoundland & Labrador. (ARNNL) (2000).Guidelines Regarding Shared Scope of Practice with Licensed Practical Nurses. St. John's: Author.

Association of Registered Nurses of Newfoundland & Labrador. (ARNNL) (2003). Performance of Nursing Tasks by Support Workers in Community Settings. St. John's: Author.

Association of Registered Nurses of Newfoundland & Labrador. (ARNNL) (2005). Medication Standards. St. John's: Author.

Association of Registered Nurses of Newfoundland & Labrador. (ARNNL) (2007). Standards for Nursing Practice. St. John's: Author.

Association of Registered Nurses of Newfoundland & Labrador. (ARNNL) (2006a). Scope of Nursing Practice: Definition, Decision-Making & Delegation. St. John's: Author

Association of Registered Nurses of Newfoundland and Labrador. (ARNNL) (2006b). Quality Professional Practice Environment Standards. St. John's: Author.

Basford L. & Orr H. (2005). Mapping Competencies: LPN; RN; RPN on behalf of Calgary Health Region As Part of their: Systematic Approach to Maximizing Nursing Scopes of Practice Research Project. Calgary: University of Lethbridge.

Canadian Health Services Research Foundation. (CHSRF) (2005). Evaluation of Patient Safety and Nurse Staffing. Ottawa: Author.

Besner J., Doran D., McGillis-Hall L., Giovannetti P., Girard F., Hill W., Morrison J., and Watson L. (2005) A Systematic Approach to Maximizing Nursing Scopes of Practice. Calgary: Capital Health, Calgary Health Region, & Saskatoon Health Region.

Canadian Federation of Nurses Union. (CFNU) (2005). Enhancement of Patient Safety Through Formal Nurse-Patient Ratios: A Discussion Paper. Ottawa: Author.

Canadian Nurses Association. (CNA) (2003). Staffing decisions for the delivery of safe nursing care. Ottawa: Author.

Canadian Nurses Association. (CNA) (2005). Evaluation Framework to Determine the Impact of Nursing

Staff Mix Decisions. Ottawa: Author.

Canadian Nurses Association. (CNA) (2006). Unregulated Health Workers: A Canadian and Global Perspective. Ottawa: Author.

Canadian Nurses Association. (CNA) (2007). Nursing Now – Understanding Self-Regulation. Ottawa: Author.

Canadian Nurses Association. (CNA) (2008). Valuing Health-Care Team Members: Working with Unregulated Health Workers. Ottawa: Author.

Canadian Nurses Protective Society. (CNPS) (2000). Delegation to other Health Care Workers. Ottawa: Author.

College & Association of Registered Nurses of Alberta. (CARNA). College of Licensed Practical Nurses of Alberta (CLPNA), College of Registered Psychiatric Nurses of Alberta, (CRPNA) (2003). Decision-Making Standards for Nurses in the Supervision of Health Care Aides: Restricted Activities and Activities of Daily Living. Edmonton: Author.

College of Registered Nurses of Nova Scotia. (CRNNS) (2004a). Delegation Guidelines for Registered Nurses. Halifax: Author.

College of Registered Nurses of Nova Scotia. (CRNNS) (2004b). Entry Level Competencies for Registered Nurses, Licensed Practical Nurses, and Continuing Care Assistants in Nova Scotia. Halifax: Author.

Government of Newfoundland & Labrador. (2007). Position Description Form: Personal Care Attendant. St. John's: Author.

Government of Nova Scotia (2006). Principles and Guidelines: A Framework for Continuing Care Assistants in Acute Care. Halifax: Author.

College of Nurses of Ontario. (CNO) (2004). Working with Unregulated Care Providers. Toronto: Author.

College of Licensed Practical Nurses of British Columbia. (CLPNBC) (2005). Practice Expectation: Registered Nurses and Licensed Practical Nurses. Vancouver: Author.

Council for Licensed Practical Nurses of Newfoundland & Labrador. (CLPNNL) (2004). Scope of Practice, Standards of Practice, Entry Level Competencies, and Delegation of Function Process. St. John's: Author.

Government of Newfoundland & Labrador. (2006). Provincial Curriculum Standards for Training of Home Support Workers in Community Settings & Personal Care Attendants in Nursing Home Settings. St. John's: Author.

Health and Community Services Human Resource Planning Unit. (2005). Health Human Resource Indicator Report 1999-2003 Part 1 – Who's Who. St. John's: Author

Health Professions Regulatory Advisory Council. (HPRAC) (2006). Personal Support Workers in Ontario:

Discussion Guide. Toronto: Author.

Home Care Sector Study Corporation. (2003). Canadian Home Care Human Resources Study - Synthesis Report. Ottawa: Author.

International Confederation of Midwives (ICM), International Council of Nurses (ICN), International Pharmaceutical Federation (IPF), World Confederation of Physical Therapists (WCPT), World Dental Federation (WDF), World Medical Association (WMA). (February, 2008). Joint Health Professions Statements on Task Shifting: Author.

International Council of Nurses. (2006). Safe Staffing Saves Lives: Information and Action Took Kit. Geneva, Switzerland: Author.

National Council of State Boards of Nursing. (NCSBN) (1997). The Five Rights of Delegation. http://www.ncsbn.org/fiverights.pdf

National Council of State Boards of Nursing. (NCSBN) (1995). Concepts and Decision-Making Process. http://www.ncsbn.org/323htm

Saskatchewan Association of Licensed Practical Nurses. (SALPN) (2006). Assigning Care to Unregulated Care Providers. Regina: Author.

Saskatchewan Registered Nurses' Association. (SRNA) (2004). Practice of Nursing: RN Assignment & Delegation .Regina: Author.

Appendix A. Joint Health Professions Statement on Task Shifting

We, the representatives of more than 25 million health professionals, are committed to providing safe, accessible health care to the world's people. We understand all too well the impact of shortage of personnel, supplies and equipment on patients, families and providers. We witness the impact daily of not enough staff, not enough clean water, not enough drugs, not enough money to access services or to afford life's staples. We see health professionals mentally and physically exhausted daily. We struggle with the dilemma of resource restrictions and meeting the needs of everyone and the evidence that shows that better health outcomes occur when higher numbers of professionals are engaged in direct care.

We understand the need to address today's human resource crisis. At the same time we are concerned that that task shifting and adding new cadres of workers result in fragmented and inefficient service through reductionist and vertical approaches. We believe that for task shifting to be effective:

- Skill mix decisions should be country-specific and take account of local service delivery needs, quality and effectiveness factors, efficiency, the current configuration of health services and available resources, as well as production and training capacity, and include the health professions in decision-making.

- Roles and job descriptions should be described on the basis of the competencies required for service delivery and constitute part of a coherent, competency-based career framework that encourages progression through lifelong learning and recognition of existing and changing competence.

- There needs to be sufficient health professionals to provide the required selection, training, direction, supervision, and continuing education of auxiliary workers.

- Regulations for assistive personnel and task-shifting need to be set with the professions involved. It should be clearly stated who is responsible for supportive supervision to assistive personnel. In any case the curriculum development, the teaching supervision and assessment should always involve the health professionals from whom the task is being shifted.

- There must be adequate planning and monitoring to avoid the danger of generating a fragmented and disjointed system that fails to meet the total health needs of the patient, offers a series of disconnected and parallel services that are both inefficient and confusing, and may lead to de-motivation and high attrition rates.

Assistive personnel need compensation and benefits that equal a living wage, a safe workplace and adequate supplies to ensure their own safety and that of patients, At the same time they should be expected to work within the code of conduct of their employer.

- Deploying assistive personnel will increase demand on health professionals in a least three ways: (1) increased responsibilities as trainers and supervisors, taking scarce time away from other tasks; (2) higher numbers will be needed to take care of the new patients generated by successful task-shifting; and (3) health professionals will be faced with patients who have more complex health needs (the simpler cases will be covered by task-shifting) and thus require more sophisticated analytical, diagnostic, and treatment skills.

- There needs to be credible analysis of the economic benefit of task shifting to ensure equal or better benefit, i.e. health outcomes, cost effectiveness, productivity, etc. Ongoing evaluation, particularly in skill-mix changes and the introduction of new cadres and or new models or care, should systematically consider the impact on patient and health outcomes as well as on efficiency and effectiveness.
- When task shifting occurs in response to specific health issues such as HIV, regular assessment and monitoring should be conducted on the entire health system of the country concerned. In particular, quality assessment linked to overall health outcomes of the population is essential to ensure that programs are improving the health of patients across the health care system.
- Assistive workers should not be employed at the expense of unemployed and underemployed health professionals. Task-shifting should be complemented by fair and appropriate remuneration of health professionals and improvement of their working conditions.
- Where task shifting is meant as a long term strategy it needs to be sustainable. If meant as short term, there needs to be a clear exit strategy.
- Assistive workers need to be integrated into health care delivery systems and treated as part of the team.

Conclusion

In geographical areas facing a critical shortage of health professionals, efforts should be made and supported to increase professional training opportunities (undergraduate and graduate), and to provide incentives for the retention of health professionals. Whatever the strategy selected, task-shifting should not replace the development of sustainable, fully functioning health care systems. It is not the answer to ensuring comprehensive care, including secondary care, is accessible to all.

International Confederation of Midwives (ICM) International Council of Nurses (ICN) International Pharmaceutical Federation (IPF)
World Confederation of Physical Therapists (WCPT) World Dental Federation (WDF)
World Medical Association (WMA) February, 2008

Appendix B. Summary of Responsibilities

RN and LPN Responsibilities:

Nurses are responsible, as appropriate with their scope of practice for patient assessment.
Nurses are responsible for knowing what activities fall under the definition of and which nursing tasks have been approved by the agency for assignment/delegation to UCP.
Nurses are responsible at all times for their own practice and for making appropriate assignments/ delegating, and supervising of UCP.
Nurses are responsible to communicate with patients and UCPs to clarify roles and responsibilities.
Nurses are responsible, as appropriate within their scope of practice, for ongoing evaluation of care, re-assigning staff as needed and evaluation of outcomes.
Nurses are responsible to document care appropriately, assignments as appropriate, and as necessary any role they played with delegation.
Nurses are responsible to question and challenge all circumstances whereby the performance by UCP is deemed unsafe, intervene in unsafe situations, communicate concerns and participate in and advocate for effective solutions.
Nurses are expected to promote respectful team collaboration.

Agency Responsibilities:

Agencies are responsible to ensure that the UCPs they employ can function within the approved scope of employment in their agency i.e. have the necessary competency to perform the expected tasks. If they employ PCAs who have not completed the provincial educational program or equivalent, they are responsible to provide the necessary additional education and support required to bring the PCA to full scope of employment.
Agencies are responsible to provide clear and ongoing communication on unregulated workers with regulated nursing personnel e.g. information on scope of UCP employment.
Agencies are responsible to ensure policies are current and communicated to
Staff concerning the roles and responsibilities of nurses and UCP in providing patient care.
Agencies are responsible to provide educational support and/or opportunities
for nurses to develop expertise and confidence in safely assigning and delegating nursing tasks/functions to UCPs.
Agencies must be aware of staffing levels, skill mix and nursing care needs of patients when employing and allocating staff
Agencies are responsible to handle/address differences of opinion, evaluate practices, provide liability coverage, and clarify lines of accountability.
Agencies are responsible to ensure that practice environments have the necessary organizational and human supports systems necessary for safe competent and ethical nursing care, (QPPE, 2006).

UCP Responsibilities:

UCP are responsible to know their scope of employment, their own accountability and know individual limitations.
UCP are responsible for the care they provide, including acceptance of assignments and delegation and competent performance of all accepted roles.
UCP are responsible for communication with the nurse by reporting patient outcomes or changed circumstances accurately and in a timely manner, and seek guidance PRN. UCP are responsible for verifying authority to perform select procedures for which they are competent, with another patient or in

a different circumstance.
UCP are responsible to document care provided in accordance with employer practices.
UCP are responsible to participate in continuing education, in team discussions and advocate for improvements, policies etc.

Appendix C

Name: _____
Date: _____

SKILLS LIST - PERSONAL CARE ATTENDANT

A Personal Care Attendant (PCA) is a member of the interdisciplinary team who participates in the provision of basic care to clients, under the direction of the nurse or health care provider in charge of the organization. The following is a list of skills for which the PCA may be responsible to perform. You may not need to be proficient in all of these skills; it depends on the requirement in the area for which you are being hired. Please complete this skills list by initialing and dating the appropriate column, corresponding to each skill, identifying your level of achievement. This form must be completed prior to your interview as it will be reviewed with you at that time. You will be provided with a copy and the original copy will be retained with the Department of Human Resources on your employee file.

KEY:

No Knowledge: The skill has not been taught at the theory level.

Knowledge The skill has been taught at the theory level only and has not been performed in a laboratory or practice setting. Instruction and supervision in the performance of the skill is required.

Lab Demonstrated
The skill has been taught at the theory level and demonstrated in a simulated laboratory setting. An opportunity to practice the this skill in a lab setting was provided and supervision or testing may or may not have occurred.

Performed with Supervision
The skill has been taught at the theory, laboratory and clinical settings, but still requires direction or supervision of an RN or LPN in a designated role or setting.

Proficient Has demonstrated knowledge of the skill and can perform it independently in the practice setting, adapting it to clients in a variety of settings.

Skill	No Knowledge	Knowledge	Lab Demonstrated	Performed with Supervision	Proficient	Office Use Only
1. Personal Hygiene and Comfort 1.1 Ensures privacy when providing care						
1.2 Performs hand washing						
1.3 Assists with/completes bath (bed, tub, shower)						
1.4 Assists with/completes facial shave						
1.5 Assists with/completes skin care						
1.6 Assists with/completes eye, ear care						
1.7 Assists with/completes mouth care						
1.8 Assists with/completes perineal care						
1.9 Assists with/completes hair care/shampoo in bed						
1.10 Cares for the incontinent client						
1.11 Assist with/completes dressing/undressing						

Skill	No Knowledge	Knowledge	Lab Demonstrated	Performed with Supervision	Proficient	Office Use Only
1.12 Promotes relaxation and sleep						
1.13 Uses comfort devices						
1.14 Ensures cleanliness of wheelchairs, geriatric chairs, bedpans, urinals and commodes						
2. Assisting with Mobility, Positioning and Other Client Activities 2.1 Promotes independence by supporting client strengths to enable self-care						
2.2 Assists with range of motion exercises						
2.3 Assists clients to sit, stand and ambulate						
2.4 Positions client in bed, chair, maintaining body alignment						
2.5 Assists with use of ambulation devices						
2.6 Uses correct lifting, transfer and transport techniques including mechanical lifts						
2.7 Assists in planning and providing recreational activities and other client support activities such as reading, letter writing, music, pet therapy, socializing and providing companionship						
2.8 Porters to church services, recreational events and external appointments as requested						
3. Bed-making 3.1 Makes occupied bed						
3.2 Makes unoccupied bed (open and closed)						
3.3 Makes anesthetic/recovery bed						
3.4 Operates manual and electrical beds and bed attachments (side rails, bed boards, IV poles)						
4. Safety 4.1 Verifies client identification						
4.2 Ensures client accessibility to call system						
4.3 Participates in fire/evacuation drills						
4.4 Demonstrates appropriate body mechanics/injury prevention techniques						
4.5 Appropriately uses safety devices such as restraints, siderails						
4.6 Appropriately uses electronic surveillance devices/systems						
4.7 Provides constant surveillance of client						
4.8 Implements standard precautions and isolation procedures						

Skill	No Knowledge	Knowledge	Lab Demonstrated	Performed with Supervision	Proficient	Office Use Only
4.9 Promotes safety of self and others						
5. Nutrition 5.1 Prepares clients for meals						
5.2 Provides assistance in meal preparation and serves meals						
5.3 Assists clients to dining room						
5.4 Assists clients with feeding by mouth						
5.5 Distributes meal trays on unit						
5.6 Assists client with menu selection						
5.7 Assures appropriate food and fluid intake; assists in maintaining dietary and fluid restrictions						
5.8 Records intake						
6. Elimination 6.1 Assists client with use of bedpan						
6.2 Assists client with use of urinal						
6.3 Assists client with use of commode						
6.4 Assists client with toileting (including bowel and bladder training protocols)						
6.5 Provides catheter care						
6.6 Empties catheter bag						
6.7 Measures and records urinary output						
6.8 Administers Fleet enemas						
6.9 Provides ostomy care						
7. Communication 7.1 Refers to appropriate policies and procedures manuals						
7.2 Reports client information during, and at end of, shift						
7.3 Reports and records observations and changes in the client's condition promptly						
7.4 Records appropriate information as required on:						
7.4.1 Vital signs records						
7.4.2 Intake and Output records						
7.4.3 Surveillance records						
7.4.4 Interdisciplinary progress notes						
7.4.5 Flow sheets						
7.5 Maintains client confidentiality and privacy						

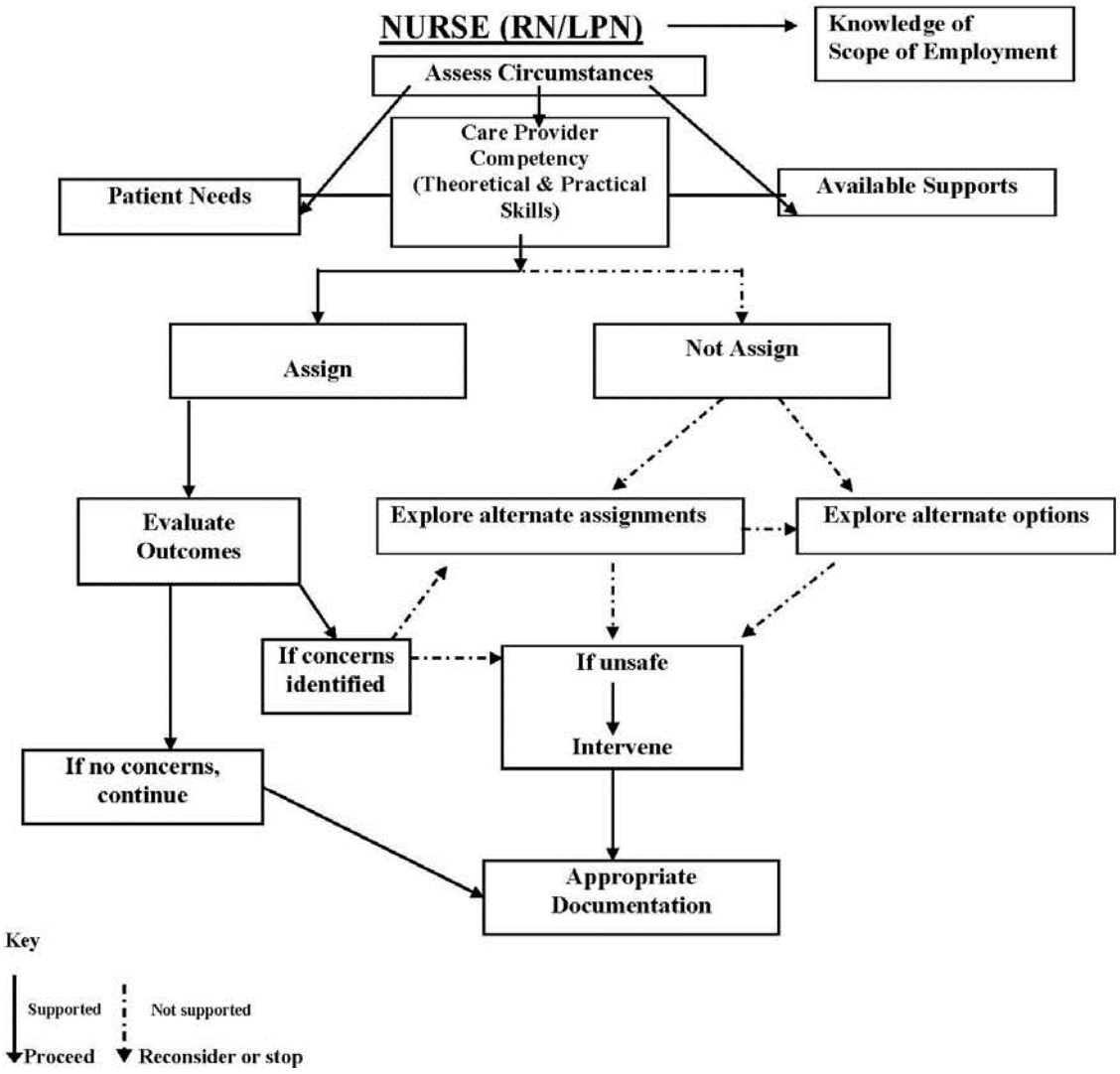
Skill	No Knowledge	Knowledge	Lab Demonstrated	Performed with Supervision	Proficient	Office Use Only
7.6 Establishes therapeutic communication with client (reading, letter writing, music therapy)						
7.7 Contributes to the orientation and learning experience of new colleagues, students, clients and families						
8. End of Life Care 8.1 Provides emotional support to clients						
8.2 Communicates with and provides support to family and loved ones						
8.3 Ensures client comfort and privacy is maintained						
8.4 Assists in post-mortem care						
8.5 Assists in transport of deceased client						
9. Admission, Transfer, Discharge of Client 9.1 Assists with the orientation of client and family to environment						
9.2 Assists with admission of client						
9.3 Assists with transfer of client						
9.4 Assists with discharge of client						
10. Vital Signs 10.1 Assesses and records height						
10.2 Assesses and records weight						
10.3 Assesses and record temperature (oral, tympanic, axilla, rectal)						
10.4 Assesses and records pulse						
10.5 Assesses and records respirations						
10.6 Assesses and records blood pressure						
11. Resident Environment 11.1 Performs unit duties, i.e., tidying, light cleaning and stocking client living areas, setting and clearing dining tables and mail delivery						
11.2 Maintains a clean and comfortable environment including linen changes and placement of clothing						
11.3 Responsible for checking the cleanliness, labeling and sorting of clients' personal clothes and checking to ensure clients wear clothing which are in good repair.						
12. Other 12.1 Documents using computer						
12.2 Completes unit inventory, requisitioning, distribution and storage of supplies						
12.3 Assists in collection of urine and stool specimens						

Skill	No Knowledge	Knowledge	Lab Demonstrated	Performed with Supervision	Proficient	Office Use Only
12.4 Assesses and records blood glucose using glucometer						
12.5 Administers basic cardiac life support						

NOTES:

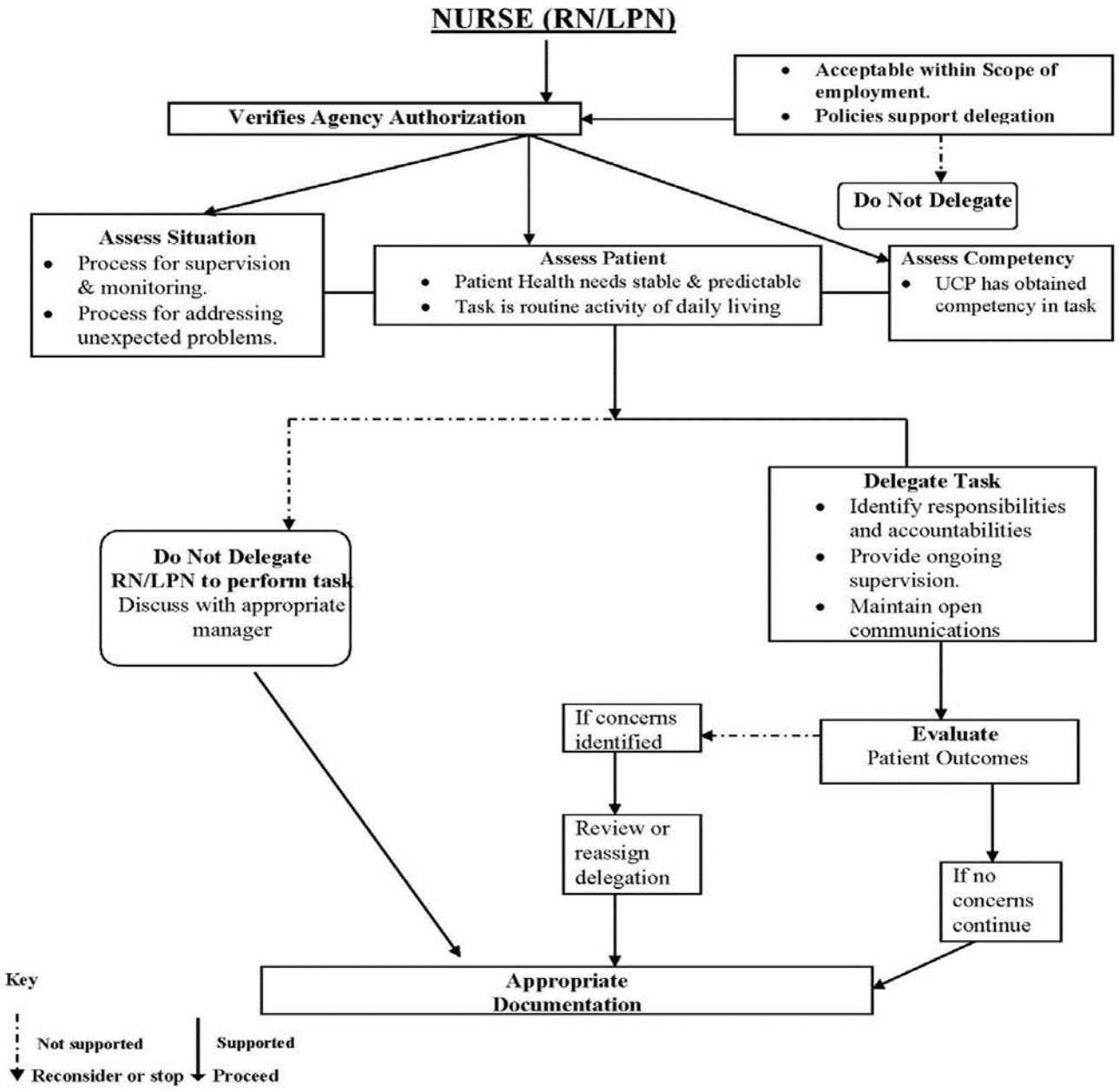
Appendix D

Framework for *Assignment* to Unregulated Care Providers



Appendix E

Framework for *Delegation* to Unregulated Care Providers



Potential Topics to Address Through Education

What is the difference between scope of employment of health care professionals and scope of employment for non-professional health care workers?

What is in the scope of employment for PCAs?

How are PCAs educated? For example how do they obtain competency?

How will PCAs hired before the availability of the provincial program, be prepared by employers to assume assignments and delegated tasks?

What if my employer expects me to teach/assign/or delegate a task to a PCA regard- less of the situation?

What happens if the PCA fails to perform the task appropriately or notify me of changes in the patient's status?

If a PCA is busy and can't perform a delegated task for a patient can she ask another PCA to do it?

Can LPNs delegate tasks to PCAs?

Does staffing shortage qualify as an urgent or emergent situation?

What if we don't have assignment sheets in our agency? How is assignment and delegation to be recorded?

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