Submission
on
Nursing Team Innovation

to the

Premiers' Health Care Innovation Working Group

Canadian Union of Public Employees

May 2012

Introduction and Summary

On the occasion of Nursing Week, and in light of Premiers exploring scope of practice through the Health Care Innovation Working Group, CUPE presents this report on nursing team innovation. We document some of the best examples of practical nurse and care aide full scope of practice, identify gaps, and propose ways for governments to advance this work.

Health care is changing, and CUPE members are meeting the challenge. The Canadian health care system faces budget pressures, worker shortages, and changing patient needs. CUPE members in all areas of health care are stepping up: upgrading their skills, taking on new roles, and embracing teamwork.

Unfortunately, nursing team innovation is uneven across and within provinces. Many of our members are blocked from opportunities to upgrade, work to full scope of practice, and take on specialty roles. Care aide education is a patchwork. The level of teamwork and other organizational practices that support full scope of practice varies between workplaces.

To advance nursing team innovation, CUPE recommends that provincial and territorial governments:

- Standardize care aide education programs; support continuing education for all team members; fund workers to meet new licensing requirements; promote full utilization, and; ensure working conditions that enable teamwork and full scope of practice.
- Work with the federal government to: collect labour force data on care aides; fund research on practical nurses and care aides, and; advance pan-Canadian education standards.

This paper focuses on licensed/registered practical nurses and care aides[1], but all of our health care members provide vital services and strive for better work environments and patient outcomes. For proposals to improve working conditions for the entire health care team, and by extension the quality and accessibility of public health care, see CUPE's recent submission to the federal government:

http://cupe.ca/health-care/health-care-offers-solutions

1. Innovation: the modern nursing team

The nursing team is evolving. In all provinces, though to varying degrees, team members' education, roles and interactions are changing.[2]

- New models of care are emerging, based on collaborative practice, new skill mixes and full scope of practice for all team members.[3]
- Education programs and regulatory frameworks have evolved for practical nurses and care aides, to support expanding scopes of practice.

Roles

In many parts of the country, practical nurses and care aides are working to their full scope of competencies, and some are taking on specialty roles or entering new practice settings.

Practical nurses in a number of places are working to their full scope of practice; for example:

- LPNs work to full scope of practice in all areas at Turtleford Hospital in Northern Saskatchewan, an integrated rural hub facility with 10 acute care beds and 22 LTC beds.[4]
- RPNs at Scarborough Hospital work in every department, including emergency and intensive care. Scarborough Hospital is a tertiary care hospital affiliated with the University of Toronto; it has the busiest emergency unit in the province.[5]
- Markham Hospital, a community hospital serving North York that has emergency and trauma units, also fully utilizes practical nurses.[6]
- At Queensway Carleton Hospital in Ottawa, RPNs have assumed a number of new responsibilities, including neonatal assessment and care, initiating IVs, changing central venous lines, monitoring/regulating blood transfusions, administering medications including narcotics and sublingual anticoagulants, and transcribing and writing doctors' orders.[7]
- In Nova Scotia, LPNs and care aides staff alternate level of care units.[8]

In addition to working to their full scope of practice in familiar areas, practical nurses are entering new settings, as Table 1 shows.

Table 1: Increase in practical nurses working in specialty areas, Canada-wide

Area of Responsibility	Increase in PN Workforce, 2006 - 2010
Operating Room/Recovery Room	152.1%
Emergency Care	128.5%
Community Health	59.0%
Paediatrics	40.5%
Home Care	49.1%
Maternity/Newborn	35.2%

Source: Canadian Institute for Health Information. 2011. *Regulated Nurses: Canadian Trends 2006-2010*. Table 29.

In 2006, BC health care unions, employers and government negotiated a policy process to explore issues and develop strategies regarding the effective utilization of LPNs and care aides. A follow-up report in 2010 noted several promising practices for LPN utilization:[9]

- Utilization of LPNs in the operating room in the Interior and Fraser Health Authorities.
- Training LPNs to be Flu Champions and administer staff immunizations in the Vancouver Island Health Authority.
- Utilization of LPNs to provide routine immunizations, with RN support, in the Northern Health Authority.
- Involvement of LPNs in decision-making bodies such as BC Cancer Agency nursing council.

In Nova Scotia, practical nurses are working in the emergency unit at Valley Region Hospital and Yarmouth Regional Hospital and on dialysis units in some hospitals; they are also being introduced to the operating room at Yarmouth Regional Hospital.[10]

There is increasing overlap between the competencies of registered and practical nurses.

- In Saskatchewan, 62 per cent of RNs have a two-year diploma; the practical nurse program in that province is two years.[11]
- In Ontario, RPNs' scope of practice has expanded in recent years, as recognized recently by the Ontario Nurses Association:

  "...A comparison of basic nursing competencies identified in the 2009 version of the CNO's Entry to Practice Competencies for Ontario Registered Practical Nurses and the 2005 version of the Entry to Practice Competencies for Ontario Registered Nurses, indicates that of the 119 nursing competencies assigned to RNs, 110 of these competencies are also assigned to RPNs, indicating a basic nursing skill overlap of roughly ninety-two per cent..."[12]

- Regulatory frameworks in several provinces recognize the autonomous practice of practical nurses.[13]

Care aides are also taking on new roles, for example:

- Care aides are working in acute care in Prince Edward Island, Nova Scotia and British Columbia.[14]
- In Ontario, personal support workers are increasingly providing assistance with activities of daily care (bathing, feeding, ambulation and toileting) in hospitals on medical/surgical, chronic care and rehabilitation units.[15]
- Care aides are developing their skills in leadership roles in some health authorities in BC, including coaching on safe patient handling/lifting techniques and preceptoring care aide students and colleagues.[16]
- Care aides have a new role in acute care mental health in British Columbia.[17]

Education

Practical nursing and care aide education programs have undergone major revisions to keep up with these role changes.

Education for care aides has evolved from on-the-job training to standardized post-secondary programs in many provinces.[18]

- Nova Scotia introduced a provincial curriculum in 2000.
- BC updated its provincial care aide curriculum in 2008.

- In 2005, the Saskatchewan Institute of Applied Science and Technology combined the Home Care and Special Care Aide programs to create the Continuing Care Aide Program and increased it to 760 hours.

Practical nursing education is increasing in length and complexity.

- LPN programs in Alberta, Ontario and New Brunswick are two years.
- LPN programs in Manitoba, Saskatchewan and Nova Scotia are 16 months, and BC will soon follow suit.
- In Nova Scotia, the pharmacology, IV therapies, and physical assessment modules are being updated, as has happened in other provinces.

The British Columbia Health Education Fund offers a good model of specialty education. The $2.5-million training fund was secured in 2010 by the Hospital Employees' Union (CUPE) through the BC Health Education Foundation, in partnership with BC health authorities. The fund has helped LPNs take on new roles in mental health, maternity, operating room, emergency, renal health, and leadership in residential long-term care. Care aides have used the fund for training in pain management, falls, communication and end-of-life care.[19] Care aides in four health authorities will soon take a new acute care course developed through the fund.[20]

Specialty education is available to LPNs in Saskatchewan in areas such as operating room technician, perioperative nursing, advanced foot care, immunizations, emergency triage and rapid primary assessment, interpretation of cardiac monitor and ECG. Between 2004 and 2010, over 1,500 LPNs took upgrading courses with help from the Provincial Employment Strategy Committee, with an investment of $1.9 million.[21]

Teamwork

Workers need good practice environments in order to contribute to the fullest extent of their abilities. Research shows that management and organizational practices of open communication, staff empowerment, and relationship-oriented leadership are associated with improved quality of care.[22] To take just some examples:

- A survey of LTC workers (care aides, LPNs, and RNs) from over 61 facilities in BC found that workers were better able to provide the individualized care if they were provided with support, and access to information, resources, and education.[23]
- Another BC study found that an engaged environment - one that supports teamwork, open and honest communication, full skill utilization, and management follow-up on problems – is key to helping front-line staff do their "best work".[24]

- In a study involving 156 LTC facilities in five US states, researchers found:
  - A lower incidence of pressure ulcers when care aides were given more opportunities — for example, access to advanced care aide positions, participation on committees, access to training, and orientation for new staff.[25]
  - More social engagement (residents spending more time with others, participating more in social, religious, occupational or other preferred activities) when care aides had more influence in resident care decisions.[26]
- A study of turnover in 164 Texas LTC facilities, which included a survey of 3,525 nurses and care aides, found that increased staff participation in decision-making, more open communication, and relationship-oriented leadership (e.g. that generates trust and helps staff resolve conflicts) was associated with better resident health outcomes.[27]

Effective change management is another major factor in the success of nursing team innovation. Change management is a planned approach to implementing new roles and/or skill mixes. It includes dedicated resources for the project, staff input on design and implementation, identified leadership, clear role definition (e.g. role documents, job descriptions, and job routines), education on roles and teamwork, and ongoing communication about changes.[28]

Above all, adequate staffing levels are necessary to realize the full benefits of teamwork and improve patient outcomes.[29]

2. Innovation gaps and barriers

Uneven Progress

Despite progress on education, utilization, and teamwork in many parts of the country, significant challenges remain. Practical nurses and care aides learn and apply different competencies depending on where they live and work, and teamwork also varies considerably.

In a 2010 survey in Saskatchewan[30] and a 2011 survey in Alberta,[31] only half of LPNs reported fully utilizing their knowledge, skills and clinical judgment in their work. Other research puts the level of full utilization far lower.[32]

For example, LPNs with dialysis training in the Regina Qu'Appelle Health Region are applying that knowledge and skill on the job; LPNs in the PA Parkland Health Region with the same training are not allowed to apply what they learned.

LPNs in the Prairie North Health Region took the same in-house emergency triage training as RNs, yet after years of competently doing triage work, LPNs are no longer assigned that work.

In some places, PNs and care aides have access to specialty education, but back on the job, they face barriers. In BC over the past few years, LPNs have expanded their competencies in palliative care, dementia care, teamwork and communications, perioperative, post-partum and newborn care, nephrology, and assessment and promotion of mental health. However, the uptake of LPNs into these news roles is slow.

Care aide utilization is also uneven. While some hospitals are introducing care aides to medical/surgical units, they are not staffing adequately. In residential care in BC and perhaps elsewhere, care aides are educated to take vitals, perform simple dressing changes and chart outcomes, but they are often not given enough time to perform these new duties.[33]

Care aide education is a patchwork. While BC and NS have provincial care aide curricula, and some other provinces are considering this, there is presently no pan-Canadian care aide education standard.[34]

Practical nurses and care aides face barriers in pursuing upgrading: cost of tuition and material, lack of time, and inaccessibility of courses. Governments should help experienced workers access upgrading for new responsibilities with subsidies for tuition and material, some work time study and leadership to make courses accessible to adult learners, many of whom have English or French as an additional language.

Need for change leadership

Health care is a hierarchical sector, and some decision-makers resist PN and care aide full scope of practice, specialty education, and full engagement in decision-making. The unit manager often decides to under-utilize nursing team members, despite commitment to full scope utilization at a higher level.[35] Sometimes, other health care professionals resist their co-workers' expanded roles.

Besner and colleagues describe the conflict as multi-dimensional:

> The inability to work as a team was described by RNs and RPNs as a barrier to full scope of practice....Negative attitudes about one another's capabilities and conflict among staff members were considered to limit nurses' ability to provide excellent care. Poor understanding of the roles of other healthcare professionals, role ambiguity within nursing and between nurses and other healthcare providers and "turf protection" were all identified as contributing to lack of collaboration among members of the team, limiting ability to work to full scope.[36]

Innovation in the nursing team requires leadership and a solid plan at all levels: federal, provincial, regional, and local. Williams notes of the experience in British Columbia that "on units where a change management approach was utilized and roles and accountabilities were clearly defined, collaboration has been a positive experience. Where there's been no change management process, there has been tension and lack of clarity of roles."[37] The same applies at higher levels of planning and decision-making: nursing team innovation must be resourced and democratic, with strong leadership and follow-through.

Knowledge gaps

Research on care team models - and on practical nurses and care aides within those teams - is inadequate and often biased. Where good research exists, findings are not adequately publicized.

- Practical nurses are under-represented in the nursing research literature,[38] and care aides are even less visible.[39] Most nursing research is conducted from the standpoint of registered nurses; often, it either ignores practical nurses or negatively interprets their role. Care aides are even more marginalized and have few 'advocates' among academic researchers.[40]
- Skill mix models are often not evaluated;[41] when they are, lessons are usually not widely shared.
- Neither governments (provincial or federal) nor the Canadian Institute for Health Information collect standardized data on the care aide occupation, one of the largest occupational groups in the health care sector.[42]

3. Conclusion and recommendations

We need strong leadership from federal, provincial and territorial governments in order to realize the potential of teamwork and full utilization of all team members.

To advance nursing team innovation, CUPE recommends that provincial and territorial governments:

- Standardize care aide education programs; support continuing education for all team members; fund workers to meet new licensing requirements; promote full utilization, and; ensure working conditions that enable teamwork and full scope of practice.
- Work with the federal government to: collect labour force data on care aides; fund research on practical nurses and care aides, and; advance pan-Canadian education standards.

sc/cope491

Notes

[1] Care aides have many different titles across the country, including "personal support worker", "continuing care assistant", and "préposés(es) aux beneficiaries". Practical nurses have two titles: registered practical nurse (RPN) and licensed practical nurse (LPN).

[2] This paper focuses on practical nurses and care aides because they make up the largest nursing team occupations in our membership and are relatively well documented in pan-Canadian research in these areas.

[3] For example, the 2008 Nova Scotia Collaborative Care Model aims to "...ensure the right people, processes, technology and information systems are in place" and to optimize the roles of LPNs, care aides, and support services staff: http://www.gov.ns.ca/health/mocins/; the PEI model of care announced in 2009: http://www.gov.pe.ca/news/getrelease.php3?number=6373; the goals of the December 2011 Saskatchewan10-year plan for Health Human resources are: "collaborative health care, optimizing the skills of all health professionals, and planning for future health workforce needs" http://www.health.gov.sk.ca/adx/aspx/adxGetMedia.aspx?DocID=5c66f3a8-899f-4d35-9456-72b5487caa4c&MediaID=5579&Filename=sask-health-human-resources-plan.pdf&l=English; East Toronto General Hospital in Ontario has developed a Coordinated Care Team model consisting of Registered Nurses (RNs) and Registered Practical Nurses (RPNs) working to their full scope of practice, and Patient Care Assistants (PCA) providing support services to patients and health care professionals: http://www.rnao.org/Storage/59/5322_CCT_evaluation_report.pdf.

[4] Interview with Deb Haftner, CUPE LPN, February 23, 2012.

[5] Interview with Gwen Hewitt, CUPE staff, March 12, 2012.

[6] Ibid.

[7] CUPE, Queensway Carleton Hospital RPN checklist, unpublished document.

[8] Interview with Carl Crouse and Wayne Thomas, CUPE staff, March 13, 2012.

[9] Janet Williams. 2010. *Effectively Utilizing BC LPNs and Care Aides: Follow-up Report*. Appendix 1 p.18.

[10] Interview with Carl Crouse and Wayne Thomas.

[11] CUPE Saskatchewan. 2012. *Full Utilization of Licensed Practical Nurses: A Practical Solution to the Nursing Shortage* http://www.cupe.sk.ca/updir/sk/ckfinder/files/FullUtilizationofLPNs(1).pdf p. 14

[12] ONA submission to the Labour Relations Board cited in Canadian Union of Public Employees. 2010. *Trillium Wage Arbitration Submission.* p. 15. CNO is the College of Nurses of Ontario, the regulatory body for registered nurses and registered practical nurses.

[13] Alberta, Manitoba, Saskatchewan, Ontario and Nova Scotia permit the autonomous practice of practical nurses. Janice Murphy. 2011. *LPN Scope of Practice: Comparison of Practical Nursing Education and Associated Restricted Activities*. Unpublished paper, p. 3.

[14] PEI Health Sector Council. 2011. Resident Care Workers Scan. http://peihsc.ca/members/news-events/resident-care-workers-environmental-scan-survey/; for BC, see Williams (2010); Nova Scotia. *Model of Care: What it Means for You* (October 2008). http://www.gov.ns.ca/health/MOCINS/MOCINS_What_it_Means_For_You.pdf

[15] Interview with Gwen Hewitt.

[16] Williams, p. 9.

[17] Hospital Employees' Union. 2009. *Caring for tomorrow … Leading today. Update: Professional Development.* http://www.heu.org/sites/default/files/uploads/MemberResources/fs3-professionaldevelopment.pdf

[18] In British Columbia, appreciable resources have also been allocated to skills development for care aides and rehabilitation assistants (as well as LPNs) to enhance their traditional roles. Hospital Employees' Union. 2009. *Promoting Promising Change: BC's LPNs and Care Aides*. http://www.heu.org/sites/default/files/uploads/2010%20Member%20Resources/2009_Jun12_IpncaNL%20vol1%20FN_2.pdf

[19] Hospital Employees' Union. 2012. *Training fund benefits LPNs*. http://www.heu.org/publications/training-fund-benefits-LPNs-more-courses-coming-online

[20] Email communication with Chris Kincaid, HEU Director of Policy and Research, March 2012.

[21] CUPE Saskatchewan, p. 14.

[22] Canadian Union of Public Employees. 2009. *Residential Long-Term Care in Canada: Our Vision for Better Seniors' Care*. Part 3: Staffing and quality of care. http://www.cupe.ca/long-term-care/our-vision

[23] Boothman, S. 2007. "The Influence of Care Provide Access to Structural Empowerment on Individualized Care in Long-term Care Facilities." MA Thesis. Simon Fraser University, School of Gerontology.

[24] Yassi, A., Cohen, M., Cvitkovich, Y., Park, I., Ratner, P.A., Ostry, A.S., Village, J. and Pollak, N. 2004. "Factors associated with staff injuries in Intermediate Care facilities in British Columbia, Canada." Nursing Research, 53(2): 1-12.

[25] Barry, T.T., Brannon, D. and Mor, V. 2005. "Nurse aide empowerment strategies and staff stability: Effects on nursing home resident outcomes." *Gerontologist,* 45(3): 309-317.

[26] Ibid.

[27] Anderson et al. (2003) cited in Janice M. Murphy. 2006. *Residential care quality: A review of the literature on nurse and personal care staffing and quality of care*. Prepared for the Nursing Directorate, BC Ministry of Health. November. www.heu.org/~DOCUMENTS/research_reports/November%202006%20CNAC%20report%20on%20residential%20care%20staffing%20and%20quality%20of%20care.pdf

[28] Williams, p. 5.

[29] Canadian Union of Public Employees, 2009. *Residential Long-Term Care in Canada: Our Vision for Better Seniors' Care*. Part 3: Staffing and quality of care. http://www.cupe.ca/long-term-care/our-vision

[30] CUPE Saskatchewan.

[31] College of Licensed Practical Nurses of Alberta. 2012. *When Do We Reach the Tipping Point?* http://blog.cLPNa.com/2012/04/when-do-we-reach-the-tipping-point/

[32] In a 2005 research study of nurses (registered, licensed practice and registered psychiatric nurses) in selected health authorities in Alberta and Saskatchewan, only 20% of PNs reported working to their full scope of practice. Jeanne Besner, Diane Doran, et al. 2005. *A Systematic Approach to Maximizing Nursing Scopes of Practice*. p. 13. http://www.calgaryhealthregion.ca/hswru/documents/reports/MNSOP_Final%20Report_Sept%202005.pdf

[33] Williams, p.5.

[34] The Association of Canadian Community Colleges has been funded by Health Canada to develop voluntary standards for care aide education programs.

[35] Interview with Deb Haftner, CUPE LPN.

[36] Besner, Jeanne et al. "Nursing Workforce Utilization: An Examination of Facilitators and Barriers on Scope of Practice," *Nursing Leadership* 2008. Volume 21 Number 1.

[37] In BC, "collaborative practice" is defined as "RNs, RPNs, LPNs and CAs working together as teams, each to their optimal scope". Williams, p. 10.

[38] "Evidence regarding LPNs remains limited and mixed (Needleman et al., 2002; Person et al., 2004; Unruh, 2000), given that few analyses have isolated LPNs as an individual group. Rather, LPNs tend to be studied as part of the 'licensed nurse' (RNs and LPNs) category (Kane et al., 2007)." Alexandra Harris and Linda McGillis Hall. 2012. *Evidence to Inform Staff Mix Decision-making: A Focused Literature Review Prepared for the Canadian Nurses Association.* p. 15

[39] Pat Armstrong, Hugh Armstrong and Krista Scott-Dixon. 2006. *Critical to Care: Women and Ancillary Work in Health Care.*

[40] A notable exception is Dr. Pat Armstrong and her research team in the Re-imagining Long Term Care project. http://reltc.apps01.yorku.ca/

[41] One major evaluation was done in Nova Scotia. Gail Tomblin Murphy, Rob Alder, Adrian MacKenzie, and Janet Rigby. 2010. *Model of Care Initiative in Nova Scotia (MOCINS): Final Evaluation Report.* p. 12 http://www.gov.ns.ca/health/MOCINS/docs/MOCINS-evaluation-report.pdf "The evaluation results indicate that MOCINS is making a difference for patients and their families, health care providers, and the health system. The evaluation data indicates that on units where care is more coordinated, the team climate is more positive and providers' various roles are clear, there are better outcomes. Such outcomes include shorter lengths of stay in the hospital and fewer repeat admissions for patients as well as fewer shifts missed due to injury among providers." The IWK Health Center's Family Newborn Adult Surgery Unit moved from total RN staffing to a mix of RNs and LPNs: http://www.gov.ns.ca/health/MOCINS/IWKs%20Family%20Newborn%20Adult%20Surgery.pdf

[42] By one estimate, there are 200,000 care aides in Canada. Dr. Carole Estabrooks, Aging in (what) place? 'Holding the line' in residential long term care. Presentation at CHSPR Boomerangst conference, February 2011. http://www.chspr.ubc.ca/files/conference/2011/Slides/Estabrooks_CHSPR_Vancouver_22Feb2011.pdf