POLICY

1. LPNs are accountable to self-assess competency and learning needs and may function within their level of education and competence once:
   1.1. the patient has been assessed by the Registered Nurse and
   1.2. the level of complexity and predictability has been established with a plan of care
   Note: If a patient becomes more complex or less predictable:
       • the LPN is to consult with the RN
       • the RN is to re-assess the patient, re-evaluate a plan of care to address the changes in care requirements and determine the appropriate care provider.

2. Based on the above assessment and ongoing evaluation of the patient, the LPN may engage in the psychomotor skills listed in the ‘DO’ and ‘Post-Entry Level Competency’ columns of Appendix A- LPN Skills List. (Also, refer to Post-Entry Level Competencies (Shared Competencies) CC 02-010)
   2.1. Psychomotor skills listed in the ‘DO NOT DO’ list are outside the legislated scope of practice of an LPN, carry an increased risk in performing, or apply to complex patients with unpredictable outcomes.

3. The LPN skills list is not exhaustive for all of the basic psychomotor skills (‘DO’ list) for which the LPN may perform, but rather represents those psychomotor skills which may lack clarity, particularly in light of the expanding scope of practice of the LPN. As with any practice, clinical and professional judgment must guide and direct decision-making.

4. Some of the skills listed in the ‘DO’ and ‘Post-Entry Level Competency’ columns may only be performed by designated LPNs following consultation with the Professional Practice Portfolio.
4.1. An assessment by Professional Practice is required to identify existing supports and competencies available to all nursing staff (LPN and RN) to ensure scope of practice is or can be optimized. This is inclusive of medication administration.

5. Capital Health is accountable for ensuring appropriate resources are available to assist LPNs in meeting their learning needs.

GUIDING PRINCIPLES AND VALUES

1. The level of complexity and predictability (Refer to Appendix B) is always determined through the RN’s assessment of the patient. The RN is solely accountable to establish this determination.

2. Complexity and predictability is made visible via an established plan of care.

3. The LPNs accountability for the outcomes of care and independence of practice are directly related to the predictability and complexity of the population.

4. Scope of practice is based on decisions around a task, not the task itself. All nurses (LPN and RN) should employ the “Can Do/Should Do” Analysis.

4.1. ‘Can Do’ refers to either basic or complex skills that are allowable within the legislated scope of practice.

4.2. ‘Should Do’ refers to skills that can be performed by the individual nurse based on their unique experiences, education and the context of care.

   Example – Venipuncture – while a skill allowable with the LPNs legislated scope of practice (i.e. ‘Can Do’) - is only performed by the LPN following completion of the learning module, necessary testing and observation of successful venipuncture (i.e. ‘Should Do’).

5. While the CLPNNS has established conditions wherein the LPN may undertake certain skills in the ‘DO NOT DO’ column, the consensus within Capital Health has determined the list of skills based upon the acuity of patients in Capital Health and the resources available to LPNs.

DEFINITIONS

Approved Practice Setting:

   Those areas where the role of the LPN has been optimized.

Basic Skill:

   Theory has been covered within the approved program. The LPN may not have had the opportunity to perform the practical skill while a student; however based on the theory received in the educational program and provided that the LPN is given the opportunity to perform the skill while being observed by the an employee of the organization, the expectation is that the LPN will be competent to perform the skill.

Complex (Unstable):

   Situations where patient status is fluctuating with atypical responses resulting in a complex plan of care. Care is determined by frequent assessments and intervention change often and patients responses to interventions are unknown or high risk (CNA, 2003)

Post-Entry Level Competency:

   Those skills or services that are beyond the entry-level competencies of a Health Discipline. They require additional education and assessment of competency prior to an individual being authorized to perform.
Predictable: Extent to which one can identify in advance a patient’s response on the basis of observation, experience, or scientific reason (Merriam-Webster Online Dictionary). Predictability involves assessment of how effectively a health condition is managed, the changes likely to occur, and whether the type and timing of change can be predicted (College of Nurses of Ontario, 1997, p.6).

Stable: The clients health status can be anticipated, the plan of care is readily established, and is managed with interventions that have predictable outcomes (The RN Exam Competency Project, CNA, 2003/CLPNNS Standards of Practice, 2005).

REFERENCES

Association of Registered Nurses of Prince Edward Island (ARNPEI), Licensed Practical Nurses Association of Prince Edward Island (LPNAPEI) and Prince Edward Island Health Sector (PEIHSC), Exemplary Care: Registered Nurses and Licensed Practical Nurses Working Together, 2008.

The Ottawa Hospital Model of Nursing Clinical Practice - RPN Skills List, Revised October 21, 2003.

College of Licensed Practical Nurses of Nova Scotia, Entry Level Competencies for Licensed Practical Nurses – Psychomotor Competencies, Approved February 14, 2002.


RELATED CAPITAL HEALTH DOCUMENTS

Policies

CC 02-010 Post-Entry Level Competencies
CC 02-006 Graduate Practical Nurse, Scope of Employment of

Appendixes

Appendix A - LPN Skills List
Appendix B – Complexity and Predictability

* * *
## APPENDIX A

### LPN SKILLS LIST

Some of the skills listed in the ‘DO’ and ‘Post-Entry Level Competency’ columns may only be performed by designated LPNs following consultation with the Professional Practice Portfolio. An assessment by Professional Practice is required to identify existing supports and competencies available to all nursing staff (LPN and RN) to ensure scope of practice is or can be optimized. This is inclusive of medication administration.

Note: This skill list is not exhaustive for all of the basic psychomotor skills (‘DO’ list) for which the LPN may perform, but rather represents those psychomotor skills which may lack clarity, particularly in light of the expanding scope of practice of the LPN. As with any practice, clinical and professional judgment must guide and direct decision-making.

<table>
<thead>
<tr>
<th>DO (Basic Skills)</th>
<th>Post-Entry Level Competencies¹</th>
<th>DO NOT DO</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHEST TUBES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Monitor and document amount of drainage</td>
<td>• Change chest tube dressing</td>
<td>• Change drainage system</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DOCUMENTATION</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Witness the signing of a consent</td>
<td>• Update the care plan</td>
<td>• Recopy medication administration record (MAR)</td>
</tr>
<tr>
<td>• Collects data and documents all components of the nursing process {assess, plan (in collaboration with the Interdisciplinary Health Care Team), implement, evaluate}</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Addendum to Documentation (Assess)**

An assessment consists of data collection and decision making. LPNs can complete assessments for patients who have new, changed or unknown challenges (new admissions, transfers). However the RN is accountable to verify and interpret the data collected by the LPN. Based on interpretation of the data collected, the RN may need to collect additional data, and/or perform further assessment to revise, change or develop the plan of care to ensure that it is complete and appropriate.

### ELIMINATION

| • Monitor intake and output (24° fluid balance, calorie count); inclusive of measuring drainage from all tubes and collection devices | • Peritoneal Dialysis | • Insert specialty urethral catheters (e.g. coude.) |
| • Administer enemas, suppositories, and rectal tubes | • Perform Continuous Ambulatory Peritoneal Dialysis (CAPD) therapy and on-going assessment of therapy | • Remove supra-pubic catheters |
| • Disimpaction | • Warm the dialysate | • Bladder irrigation with medicated solutions |
| • Set up oral suction equipment | • Change dressing on well healed exit sites (one week or more) | • Administer lactulose enemas in non-approved practice settings |
| • Care for colostomy, ileostomy and ureterostomy (empty, change pouch, irrigate colostomy, teach ostomy care) | • Peritoneal Dialysis | • Peritoneal Dialysis |
| • Urinary catheterization, indwelling and straight (male, female) | • Administer Intra-peritoneal medications | • Administer Heparin for maintenance of catheter patency |
| • Apply condom drainage | • Change dressing on well healed exit sites (one week or more) | • Change transfer sets |
**DO (Basic Skills)**

- Irrigate urinary catheter (intermittent or continuous – non-medicated)
- Remove indwelling catheters
- In approved practice settings – administer medicated enemas (E.g. lactulose)

**HEMODIALYSIS ACCESS**

- Care for Hemodialysis AV Fistula/Graft
- Care of Stable Tunneled Hemodialysis Central Venous Catheter (CVC)
  - Dressing change and Application of Prescribed Ointment to CVC exit site
  - Access CVC for hemodialysis treatment, blood sampling
  - Maintain CVC lumens(s) patency with instillation of heparin
  - Assisting the Physician in removal of the Tunneled CVC
- Removal of Venotomy Suture

**INFUSION THERAPY**

**PERIPHERAL**

- IV solution without additives:
  - Change non-medicated intravenous fluids
  - Change pre-mixed KCL (from the manufacturer) solution bags – Continuous infusion only.
  - Verify infusion orders
  - Monitor and regulate rate of flow (inclusive of infusion pumps)
  - Assess IV site and flow
  - Assess adverse reactions
  - Change IV tubing
  - Discontinue IV infusions/remove IV access device
- Blood/Blood Products Transfusion:
  - Monitor blood/blood products transfusion therapy
  - Obtain blood products from blood bank
  - Verify patient identity for blood administration

**DO NOT DO**

**HEMODIALYSIS ACCESS**

- Post-Entry Level Competencies

**INFUSION THERAPY**

**PERIPHERAL**

- Dressing change for peripherally inserted central catheters (PICCs) and tunneled external Central Venous Access Devices (CVAD) i.e. Hickman
  - Insert peripheral IV access device

**Addendum to Infusion Therapy**

- LPNs can only verify those physician orders which they can enact. This is limited to physician orders relating to Peripheral IV’s (Management of IV therapy via a central venous access device or PICC line is outside the legislated scope of practice of the LPN).
- Intermittent rate changes for the intent of delivery a large volume of fluid (greater than 200 mLs) over a short period of time (less

This is a CONTROLLED document for internal use only. Any documents appearing in paper form are not controlled and should be checked against the electronic file version prior to use.
### DO (Basic Skills) vs. Post-Entry Level Competencies

**DO**
- than 2 hours is considered a bolus and **NOT** a rate change

**DO NOT DO**
- Administer intravenous medication
- Initiate and administer continuous subcutaneous narcotic infusions
- Care for, monitor, or remove pleural/epidural catheters
- Receive and verify medication orders, and administer medications in practice settings not approved
- Hypodermoclysis

### MEDICATIONS

<table>
<thead>
<tr>
<th>DO (Basic Skills)</th>
<th>Post-Entry Level Competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transcribe orders</td>
<td>Administer vaccinations or inoculations</td>
</tr>
<tr>
<td>In approved practice settings:</td>
<td></td>
</tr>
<tr>
<td>Receive orders (written, verbal and telephone)</td>
<td></td>
</tr>
<tr>
<td>Verify medication orders</td>
<td></td>
</tr>
<tr>
<td>Administer medications</td>
<td></td>
</tr>
<tr>
<td>• Oral</td>
<td></td>
</tr>
<tr>
<td>• Subcutaneous</td>
<td></td>
</tr>
<tr>
<td>• Intramuscular</td>
<td></td>
</tr>
<tr>
<td>• Intradermal</td>
<td></td>
</tr>
<tr>
<td>• Topical (see below for additional information)</td>
<td></td>
</tr>
<tr>
<td>• Rectal</td>
<td></td>
</tr>
<tr>
<td>• Vaginal</td>
<td></td>
</tr>
<tr>
<td>• Aural</td>
<td></td>
</tr>
<tr>
<td>• Nasal</td>
<td></td>
</tr>
<tr>
<td>• Sublingual</td>
<td></td>
</tr>
<tr>
<td>• Ophthalmic</td>
<td></td>
</tr>
<tr>
<td>• Inhalation</td>
<td></td>
</tr>
<tr>
<td>• Nasogastric</td>
<td></td>
</tr>
<tr>
<td>• Gastrostomy</td>
<td></td>
</tr>
<tr>
<td>• Monitor, document and record medication administration and therapeutic and/or adverse effects</td>
<td></td>
</tr>
<tr>
<td>• Order from night cupboard</td>
<td></td>
</tr>
</tbody>
</table>

**Addendum to Medications**

Physician order transcription consists of 2 processes:

- **Transcription:**
  - Transcription is the process of writing/noting or documenting physician orders, including medications, to the appropriate place (Kardex, MAR). This process is **CLERICAL** in that it can be performed by any staff person with the appropriate transcription training. (RN, LPN, Clerk).

- **Verification:**
  - Verification is the process whereby the transcribed information is matched against the original order and compared for correctness and clinical appropriateness. This process is **CLINICAL** in that it requires clinical (RN or LPN) knowledge to ensure the transcription is correct and appropriate. LPNs can **only verify** orders in which they are legislated to enact.

**Topical Medication Administration**

- Application of dispensed or pharmacy compounded creams/ointments (only by physician prescription) may be applied by LPNs **holding a valid and current medication administration certificate in all** practice settings.
- Application of Over the Counter (OTC) creams/ointments (whether prescribed by a physician or not) may be applied by LPNs in any practice setting, **whether or not a valid and current medication administration certificate is held**

### MONITORING/ASSESSMENT

<table>
<thead>
<tr>
<th>MONITORING/ASSESSMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vital Signs (TPR, BP, Oxygen Saturation, skin colour, capillary refill, incentive spirometers)</td>
</tr>
<tr>
<td>Neuro-vital signs</td>
</tr>
<tr>
<td>Auscultate bowel sounds</td>
</tr>
<tr>
<td>Auscultate breath sounds</td>
</tr>
<tr>
<td>Obtain and monitor blood glucose levels with diagnostic devices</td>
</tr>
</tbody>
</table>

### NARCOTICS

*This is a CONTROLLED document for internal use only. Any documents appearing in paper form are not controlled and should be checked against the electronic file version prior to use.*
<table>
<thead>
<tr>
<th>DO (Basic Skills)</th>
<th>Post-Entry Level Competencies</th>
<th>DO NOT DO</th>
</tr>
</thead>
</table>
| • In approved practice settings: | • Administer narcotics by intramuscular, intermittent subcutaneous, transdermal (patch), oral, and rectal routes  
• Carry the narcotic key  
• Witness and sign for wastage  
• Participate in end of shift narcotic count | • Administer intravenous or epidural narcotics  
• Initiate and administer continuous subcutaneous narcotic infusions  
• In practice settings not approved:  
• Administer narcotics  
• Carry the narcotic key  
• Witness and sign for wastage  
• Participate in end of shift narcotic count |
| • In All Practice Settings  
• Pick up narcotics from pharmacy, or sign for narcotics delivered to the unit | | |

| NEUROLOGICAL SKILLS | | Remove halo vest  
• Care for lumbar drain (LD), Intraventricular Drain (IVD), and subdural drain (SDD), including changing the external drainage system (EDS) on lumbar and intraventricular drains.  
• Care for external VP shunt |
|---------------------|----------------|------------------|
| • Basic neurological vital signs  
• Apply and remove cervical collar on stable spinal patients | • Remove NG tubes (perform independently)  
• In approved practice settings - Insert small bore NG tubes (for feeding) | • Insert large bore NG tubes (decompression)  
• In practice settings not approved - Insert small bore NG tubes (for feeding)  
• Remove or replace gastrostomy tubes  
• Insert/remove trachio-oesophageal tubes |

<table>
<thead>
<tr>
<th>NUTRITION</th>
<th></th>
<th></th>
</tr>
</thead>
</table>
| • Administer feedings (bolus/intermittent or continuous) via nasogastric and gastrostomy tubes  
• Set-up and operate enteral feeding pumps  
• Assess feeding tube placement  
• Irrigate feeding tube  
• Assist with removal of NG tube | • Remove NG tubes (perform independently)  
• In approved practice settings - Insert small bore NG tubes (for feeding) | • Insert large bore NG tubes (decompression)  
• In practice settings not approved - Insert small bore NG tubes (for feeding)  
• Remove or replace gastrostomy tubes  
• Insert/remove trachio-oesophageal tubes |

<table>
<thead>
<tr>
<th>ORTHOPEDIC SKILLS</th>
<th></th>
<th>Apply/remove skeletal traction</th>
</tr>
</thead>
</table>
| • Perform pin site care  
• Assist with prosthetic devices  
• Assist with mobilizing devices (crutches, walkers, canes)  
• Apply and remove CPM machines (after appropriate settings established by the physiotherapists)  
• Care for patients in traction  
• Apply/remove skin traction (using foam splints and traction boots) | • Venipuncture (inclusive of blood cultures  
• Troponin testing (Point-of-care testing) | • Blood from central venous catheters, PICCs, or Hickman catheters. |

<table>
<thead>
<tr>
<th>SPECIMEN COLLECTION</th>
<th></th>
<th></th>
</tr>
</thead>
</table>
| • Assist with performing diagnostic tests  
• Collect and label:  
  • Sputum  
  • Stool  
  • Urine  
  • Swabs | • Venipuncture (inclusive of blood cultures  
• Troponin testing (Point-of-care testing) | • Blood from central venous catheters, PICCs, or Hickman catheters. |
## DO (Basic Skills)

- Test body fluids:
  - PH gastric contents
  - Blood sugar/glucose in blood
  - Urine and stool

## Post-Entry Level Competencies

- Insert and remove packing to surgical or deep wounds with established treatment regimes
- **VAC Therapy:**
  - On wounds with an established plan of care, change VAC dressing once the initial one has been done by the RN

## DO NOT DO

- Complex wound care where there is no established treatment regime.
- Debridement
- **VAC Therapy:**
  - Determine pressure settings for VAC Therapy

### WOUND CARE

- Assess wound, exudate, characteristics and pressure ulcer stage if applicable (p150)
- Apply bandages, binders, slings, tensors, teds
- Apply sterile dressings
- Clean and irrigate wounds
- Insert and remove superficial packing (2.5cm or less)
- Remove sutures and staples
- Shorten and remove penrose and hemovac drains
- Monitor wound healing
- Irrigate drains

### VENTILATION AND RESPIRATION

- BLS (including use of ambu bag)
- Oral and nasal suction
- Care of healed tracheal stomas
- Change trach ties
- Administer oxygen via cannula, mask, croupette, or humidifier

- Airway Management (FB aspiration, insertion of oral airway,)
- Mechanical Ventilation – TCU
- Tracheal stoma and inner cannula care
- Tracheal suction
- Laryngectomy stoma care and suction

- Remove and replace tracheostomy tubes (outer cannulas)
- Tracheal instillation
- Jet (mechanical) in-exsuflator
## Appendix B

### Complexity and Predictability

<table>
<thead>
<tr>
<th>High degree of complexity and low degree of predictability (COMPLEX):</th>
<th>RNs are solely accountable for the outcomes of care; LPN practice is DIRECTED by the RN in that the decisions of care are made by the RN. The LPN can enact all the skills within her/his skill set with this population; however the RN is ACCOUNTABLE to make the determination that the skills are required/appropriate for the patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients whose health challenge is not well known and frequently changes. Even though there is some degree of predictability by process, variations in care, patient needs (technical and/or psychosocial) are often significant. Patients whose health challenge is consistently variable requiring frequent assessments and changes in interventions.</td>
<td>RNs and LPNs share accountability for the outcomes of care; LPN practice is COLLABORATIVE with the RN in that decisions of care are made by the RN and LPN together. The LPN can enact all the skills within her/his skill set with this population; however the RN/LPN share ACCOUNTABILITY to make the determination that the skills are required/appropriate for the patient</td>
</tr>
<tr>
<td>Equal degrees of complexity and predictability (ACUTE):</td>
<td>RNs and LPNs share accountability for the outcomes of care; LPN practice is COLLABORATIVE with the RN in that decisions of care are made by the RN and LPN together. The LPN can enact all the skills within her/his skill set with this population; however the RN/LPN share ACCOUNTABILITY to make the determination that the skills are required/appropriate for the patient</td>
</tr>
<tr>
<td>Patients whose health challenge is not always well known and changes often, however has some degree of predictability by process, but variations often occur in individual patients.</td>
<td>RNs are solely accountable for the outcomes of care; LPN practice is INDEPENDENT of the RN. The LPN can enact all the skills within her/his skill set with this population, and is ACCOUNTABLE to make the determination that the skills are required/appropriate for the patient</td>
</tr>
<tr>
<td>High degree of predictability and low degree of complexity (PREDICTABLE):</td>
<td>LPNs are solely accountable for the outcomes of care; LPN practice is INDEPENDENT of the RN. The LPN can enact all the skills within her/his skill set with this population, and is ACCOUNTABLE to make the determination that the skills are required/appropriate for the patient.</td>
</tr>
<tr>
<td>Patients whose health challenge is known and trajectory of care/recovery has little variation from others with same health experience</td>
<td>---</td>
</tr>
</tbody>
</table>