Optimizing RN/RPN Skill Mix in Acute Care Settings
Tracey Kitchen-Clark RN, MHS:L
Dale Fraser, RN, B.Sc.N

Patsy Cho RN, MScN
Margaret Blastorah, RN, PhD

Questions? Email: tracey.kitchen-clark@sunnybrook.ca
Acknowledgement

• Skill mix project 2009
• Validating the skill mix tool 2008-2009
• Publication:
• Link to website and tools: www.sunnybrook.ca
  http://sunnybrook.ca/content/?page=Nursing_Practice
• Application of evidenced based research

Outcome:

• 3 General Internal Medicine units are now trialing one year of RPNs on days & evening shifts
Implementation of Pilot Project
November 2010-November 2011

• Education of Leaders and RNs of RPNs expanded scope of practice
• College of Nurses Ontario (CNO) 3 units = 90 RN’s educated over 5 sessions
• 5 sessions over 4 hours
• 90% of leaders and RNs 3 units
Implementation of Pilot Project  Continued

• Education from CNO: 3 Factor Framework
• Framework for decision making for assignments
• Leaders- change management on units
• RN accountability for making assignments in total patient care model
• Recruitment of RPNs
• Orientation
Implementation of Pilot Project Continued

Recruitment

• Development RPN Role profile, competencies & skill sets

• Interview panel composition: RN, PCM, HR & APN

• Candidate – new RPN education program 2005 or later
Three Factor Framework

**Nurse**
Knowledge, skill and judgment

**Environment**
Support tools
Consultation
Stability of the environment

**Client**
Acuity of care needs
Predictability of outcomes
Risk of negative outcomes

College of Nurses of Ontario

6/1/2011
Challenges with Recruitment

• >100 applications received, 62 interviews set up, 10 declined and 52 interviews held, 8 hires in total
• Challenging to stay with original criteria- graduated 2005 or later

Orientation

• 6 corporate education days, 3 GIM orientation days and buddy shifts ranging (10-20 days)
• same as RN competencies, except CVAD, (PICC only) different populations in 3 units
• Ongoing support with assignment making, RN accountability
Change Management
The 3 phases of Transition

1. Ending, Losing, Letting Go
2. The Neutral Zone
3. The New Beginning

W. Bridges (2003). Managing Transitions
Making the Most of Change.
http://www.wmbridges.com/images/model.gif

6/1/2011
**Change Management**

- Talking at unit staff meetings, daily huddles, one on one, orientation, email, D2 portal
- Time of ambiguity
- Meeting new Nurses, getting acquainted, trust building
- Nurses expressing need for a guideline

**Unit C4, D4, D2**

- Ending, Losing, Letting go
- Neutral Zone
- New beginning
Staff Concerns - Initially

- RN job loss? Loss of RN line?
- How will the Nurses and Doctors know what RPN’s can and can’t do?
- Will they be able to manage independently because it’s busy?
- Policy gap, long term care advanced nursing competencies (ANC) very limited scope of practice
- GIMAPN task to develop acute care ANC for RPNs
Change Management

Unit level Transitions:
Communication throughout process
Listening to concerns
Acting on concerns
Psychological realignment
Renewal
Using the Three Factor Framework for Making RPN Assignment

TL/Charge Nurse Accountability: Screen Patient’s Stability for RPN’s Assignment

“Stability is established by an RN” (College of Nurses of Ontario, Entry to Practice Competencies RPN, p.13, 2010)

RPN’s NOT Assigned to Patient’s with:
- Unstable vitals lying outside of normal parameters
- Initiation (first 24 hours) of remote telemetry
- Diagnosis of TIA, Stroke patients admitted under 4 days
- Transfers within 24 hours from ICU/ER

Autonomy for RPN Assignment:

PATIENT:  □ NOT complex  □ Moderately complex  □ Very complex

ENVIRONMENT:  □ Unstable  □ Moderately stable  □ Stable

NURSE:  □ Limited supports  □ Some supports  □ Many supports

LEVEL OF AUTONOMY:  □ Fully independent  □ Partial collaboration with RN  □ Full collaborative model

1. Nurse Knowledge, Skill and Judgement:

QUESTIONS TO CONSIDER:
- Is the nurse a novice, advanced beginner, competent, proficient, expert? (Benner, P. (1984).)
- What is the level of knowledge, skill and judgment?
- Is an advanced competency required?
- What is the level of critical thinking?

2. Patient Complexity:

QUESTIONS TO CONSIDER:
- What is the predictability of negative outcome? Changing condition?
- Patient’s vitals stable? Trach is mature or new? Chest tube – acute or chronic?
- CVAD for patient waiting long term care, remove device prior discharge?
- Blood transfusion for chronic anemia vs. acute GI bleed?
- Sub Q infusion with narcotics for patient with stable pain vs. unmanaged pain?
- Care plan in place for patient’s new diagnosis?

3. Environment:

QUESTIONS TO CONSIDER:
- What shift are we planning for?
- Is there a policy and procedure to support the care of this patient?
- Is there an established care plan?
- Is consultation available?

Developed by General Internal Medicine Advanced Practice Nurses, 2010
Accountability

TL/Charge Nurse Accountability: Screen Patient’s Stability for RPN’s Assignment

“Stability is established by an RN” (College of Nurses of Ontario, Entry to Practice Competencies RPN, 2010).
Guidelines

- RPN’s Not Assigned To: Patients with
  - Unstable vitals lying outside of normal parameters
  - Initiation (first 24 hrs) of remote telemetry
  - Diagnosis of TIA, Stroke patients admitted under 4 days
  - Transfers within 24 hours from ICU/ER
Autonomy for RPN Assignment

• **Patient**: NOT complex □ moderately complex □ or very complex □

• **Environment**: unstable □ moderately stable □ stable □

• **Nurse**: limited supports □ some supports □ many supports □

• **Level of Autonomy**: fully Independent □ partial collaboration with RN □ full collaborative model □

(if weekend or evenings shift consider changing assignment if using full collaborative model)
Nurse Knowledge, Skill and Judgement

Questions to consider:

• What is the level of knowledge, skill & judgment?
• Is an advanced competency required?
• What is the level of critical thinking?
Questions to consider:

• What shift are we planning for?
• Is there a policy & procedure to support the care of this pt?
• Is there an established care plan?
• Is consultation available?
Patient Complexity

Questions to consider:

• What is the predictability of negative outcome? Changing condition?
• Patient ‘s vitals stable? Trach is mature or new? Chest tube – acute or chronic?
• CVAD for patient waiting long term care, remove device prior discharge?
• Blood transfusion for chronic anemia vs. acute GI bleed?
• Sub Q infusion with narcotics for pt with stable pain vs. unmanaged pain?
• Care plan in place for patient’s new diagnosis?
Lessons Learned

• 3 factor framework is an excellent concept
• Challenging to apply in a fast pace environment
• Nurses preferred concrete guidelines
• Nursing care delivery model (primary care) challenges geographical assignments

• 2/8 RPN exited after orientation and a working period: 25% turn over
• Post exit interview revealed lack of educational prep/experience for acute care setting prior to hire

6/1/2011
Lessons Learned

• Challenged with recruiting RPNs graduating from the new education program 2005 or later

• 3 month delay from education to the staff on units to the time of orientation of new RPN hires

• Moral: RPNs experienced personal frustrations similar to being a new Nurse or a new hire when needing to ask other RNs for help
Evaluation in progress: Did Nurse sensitive outcomes stay the same or get worse: indicators of quality of care

• Pain management
• Pt satisfaction/nurse satisfaction
• Wound management, prevalence & incidence pressure ulcers
• Safety reports
• Falls
• Medication errors
• Restraint use
• Assignment changes during shifts (focus group)
Case Study #1

80 year old female, lives alone with no next of kin. Admitted with CVA off service to a renal floor. No care pathway available. Pt has mild cognitive deficits, is forgetful. Fallen once in hospital in BR, no injury.
Case Study #1 Continued

• Today the pt’s BP is elevated (systolic 220 mmHg). She has received one dose of an oral antihypertensive medication. Staffing on the unit includes a new RPN reassigned from outpatients department to cover the unit RPN who is on education leave. The RNs are regular unit staff and there are 3 students on the unit.

Do you assign the pt to an RN or an RPN?
Case Study #2

47 year old female admitted 3 days ago for an investigation of a lower GI bleed. She is scheduled for a possible colonoscopy and abdominal CT scan today. Her vital signs are stable; she is alert and can perform self care. She has a history of depression and is on oral anti-depressant medication. Her husband is present and her sister who is a Nurse.
Case Study #2 Continued

There are pt information brochures about colonoscopy and the abdominal CT scan. An additional RN has been reassigned to the unit from a unit with a reduced census.

• Do you assign the pt to an RN or an RPN?
**Case Study 1**

Nurse: New RPN, RNs have 3 students

Environment: No Pathway available, plan for preventing future falls? No mention of consultation available, no next of kin, admitted to wrong floor/bed spaced

Client: mild cognitive deficits, unstable blood pressure

RPN assignment

---

**Case Study #2**

Nurse: extra RN on unit

Environment: Sister and husband present, pt information brochures available

Client: self care, vitals stable, on medication for depression (not new), pt aware and can verbalize if condition changes

RPN assignment
Thank you!