Optimization of the RPN role within the Emergency Department Ambulatory Care Tract.

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Although the RPN role was an existing component of the Emergency Room interprofessional team, the role was underutilized.

- did not have a specific patient assignment, were primarily task orientated,
- had no clear accountability for patient care and
- limited interactions with the interprofessional team.

- This resulted in decreased RPN role satisfaction and role confusion between RNs and RPNs.
- Nursing need – fill the patient care need gaps
- Nursing shortage
Relevant Literature

Underutilization of Licensed Practical Nurses

Three themes:
1. Hospitals aren’t focusing on the available LPNs in the workforce to augment nursing care.
2. LPNs aren’t allowed to perform to their fullest and legal potential.
3. Differing attitudes of RNs and LPNs may be a barrier to implementing more responsibility and accountability to both nursing practices. (Livomese, 2012)
Emergency Department exists at three / seven sites that encompass the NHS/ ACT
• Welland Hospital Site
• Greater Niagara General Hospital
• St. Catharine's General Site

Urgent Care Centre located at the Ontario Street Site

Volumes
SCG ED and OSS combined saw a total of 71,856 visits last year.
NHS – Emergency Department

Patient volumes / CTAS categories

- CTAS 1 and 2: 12,675
- CTAS 3: 35,467
- CTAS 4 and 5: 23,714
Ambulatory Care Tract

Criteria for ACT Patients
Triaged by an RN as being CTAS 3-4-5
Registration completed
Consult with the Triage RN for appropriateness for ACT

ACT Patients:
Must be able to follow commands and be ambulatory (wheelchair must be minimal assist)
Children with stable vitals (>2 years)
No isolation – vomiting, gastro
No elderly with multiple complaints (dizzy or cardiac concerns)
No unstable vitals
One MD encounter

Patient must be within RPN scope of practice and RPN “comfort” level / current competency (e.g. novice to expert)
Collaborate with RN for medical directive initiation.
Decision Support Tools Used

- Less Complex, More predictable; Low risk for negative outcome
  - Autonomous Practice: RPN and RN
  - Increasing need for RN consultation and collaboration
- Highly Complex, Unpredictable; High risk for negative outcome
  - RN Practice

Client → Nurse → Environment

(College of Nurses of Ontario, 2011)
Patient Assessment

1. Resuscitations
   - Conditions that are a threat to life or limb requiring immediate aggressive interventions.

2. Emergent
   - Conditions that are a potential threat to life or limb requiring rapid medical interventions/delegated acts.

3. Urgent
   - Conditions that could potentially progress to a serious problem requiring emergency intervention.

4. Less Urgent
   - Conditions that are related to patient age, distress, or potential for deterioration or complications.

5. Non-urgent
   - Conditions that may be acute but non-urgent as well as conditions which may be part of a chronic problem.
Strategies for getting there

- **Process redesign**
  - Triage criteria for ACT
  - Focus on LOS for CTAS 3
  - Identification of “modifiers” – that would require consultation with RN

- **Practice**
  - Medical directives - initiated by RNs
  - Medication administration
  - IV initiation
  - Review of diagnostics and lab results

- **People**
  - RN
  - MD
  - Interprofessional Team
  - Union representatives (ONA, SEIU)
Patient presents @ ED

RN Triage

CTAS level

1. Resuscitations
2. Emergent
3. Urgent
4. Less Urgent
5. Non-urgent

Emergency

Ambulatory Care Tract

CTAS 3:
Collaboration b/t RN/RPN
Patient / RPN assignment / RPN competency (novice-expert)
“one MD encounter”
Resources and Supports

• Care delivery
• RN Float
• Access to MD
• Access to Regional Educator
• Culture: RN / MD acceptance?
• Change in client status – what happens
One RPN’s perspective

• Change in culture

• Pre – could not give meds; write on the secondary assessment sheet; no verbal/telephone orders; initially no patient assignment; all task focused

• Post - increased autonomy, responsibility, role satisfaction, working toward full scope of practice, and improved teamwork and collaboration.
One RPN’s perspective

- Impact on patients
- They are happy to get in faster
- Happy to get care fast and out
- Triage nurse happy to have less in waiting room
- ED MD –
  - Budget time for patient care in ACT; more efficient time spent in ER
  - Can easily go into ACT – consult with RPN – determine care needs; discharge
One RPN’s perspective

• I had to prove that I had the knowledge, skills and judgment / critical thinking

• I had to earn it!

• Have to fit with the “emergency nurse” personality
  o This is not for every RPN!
  o Not for the faint of heart!
Outcomes

• Satisfaction
  o RN – RPN – MD
  o Patients and Families

• Recruitment

• Retention

• Student placement requests
Gaps in the System

- Little formal educational opportunities for specialty areas for RPNs (College level; CNA certification)

- No current designated / budgeted “Education days for RPNs”
If starting from Scratch...

- You have to have the right players from the beginning
- Use the RPNs you have to build this
- Pick RPNs carefully!! - clear criteria for RPN applicants
  - Critical thinking
  - Clear understanding of scope
- Build in long orientation process (2-3 months)
- Engagement with RN / MDs
Quotes

Experienced ED RN
“it is great to have a team that works well together, with the RPN working to full scope in the department, the RN’s are freed up to care for the more acute patients. We have built up a trust and a collaborative relationship that enables the patient to flow through the department and receive great care.”

ED Physician Chief
"Evelyn not only is an integral part of our team, but also adds a wonderful dimension to it. It is just not the same without her."
"Evelyn is a breath of fresh air infused with all the caring in the world"
"It is a delight to come to work and find Evelyn on the team. She makes the day better"