Licensed Practical Nurses in the PACU

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Recommended staffing standards were developed by ASPAN to guide decisions for optimal outcomes and efficiency in a PACU. In the midst of a nursing shortage, providing optimal staffing can be challenging. Licensed practical nurses can be educated to meet evidence-based standards for optimal patient recovery. Determining critical skills and competencies and performing a thorough interview assists in selecting suitable licensed practical nurse candidates. Supplying a high-quality orientation contributes to team success. High-performing teams promote greater efficiency in patient care and consequently improve quality of care and staff morale. This article provides details of a model of care that includes licensed practical nurses in the nurse staff mix. Suitability qualities, orientation program, and scope of practice of licensed practical nurses will be discussed. Improved patient experience and efficiency can be successfully achieved with mixed registered and licensed practical nurse PACU staffing.

Keywords: *LPN, PACU, staffing, postanesthesia nursing caregivers, collaborative care.*

IN THE MIDST of a nursing shortage, staffing a PACU while meeting recommended staffing standards is a challenge. The PACU is a high-activity critical care environment where patients recover in the immediate postoperative period (also known as Phase I) after receiving anesthesia. An integral aspect to smooth PACU operations is optimal staffing. Lack of optimal staffing increases individual registered nurse (RN) workload and is associated with nurse burn-out and frustration. Teamwork, which is important for quality outcomes, is interrupted. High-level teamwork is associated with higher staff satisfaction, and higher employee satisfaction improves RN retention, with a resultant decrease in turnover.[1]

RN shortages prompt critical thinking about how to respond to retain optimal operations. Nurse retention is an important aspect of retaining optimal operations because nurses' ability to work to full scope of practice is related to job satisfaction that affects retention.[2] For example, heavy workload and ineffective teamwork affect retention.[2] To keep experienced nurses at the bedside, we analyzed the possibility of integrating licensed practical nurses (LPNs) into the PACU, but the question remained: Is the PACU an appropriate environment for LPNs based on education and skills, knowledge, and PACU standards of practice? After much analysis, we decided our PACU could be an appropriate environment for LPNs. Our objectives in hiring LPNs were to increase job satisfaction of RNs by alleviating the nursing shortage within the unit and to meet standards for postanesthesia care.

Standards of practice were developed by ASPAN to help guide staffing decisions on providing quality care to the specialized population of PACU patients.[3] In Resource 2 of the Standards of Perianesthesia Nursing Practice, prudent judgment will be used to establish appropriate staffing to accommodate patient acuity (Table 1).[3] Although based on expert opinion, ASPAN recommended staffing guidelines for nurse:patient ratios were found to result in safe, quality care.[4]

The Cleveland Clinic is a 1,000-plus–bed tertiary care, Magnet-designated hospital in Cleveland, Ohio. The main campus of the Cleveland Clinic performs approximately 34,000 surgeries per year, with 23,000 patients recovering in the Phase I PACU. The PACU also recovers patients who receive general anesthesia in procedural areas, such as the electrophysiology laboratory. The

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Table 1. Staffing Guidelines for Phase I Level of Postanesthesia Care

Two patients/nurse	a. One school-aged child or older patient (>8 years) who is unconscious but stable, without an artificial airway, *and* one patient who is conscious, stable, and without complications OR b. Two adults who are conscious, stable, and without complications OR c. Two children aged 8 years and under who are conscious, stable (without complications), and have family presence
One patient/nurse (with a second nurse available for backup, as needed)	a. When admitted to the PACU until report is accepted from Anesthesia OR b. Patients requiring mechanical life support and/or artificial airway OR c. An unconscious child (aged 8 years or under)
One patient/two nurses	One critically ill patient (child or adult) who is unstable, with complications or complex care needs

Data from ASPAN.[3]

PACU consists of 55 beds for adult patients and 10 additional beds for pediatric patients. The PACU is divided into clusters of beds with six, seven, or eight patient beds per cluster. One RN is assigned two bed spaces, with an unlicensed clinical technician (CT) assigned to the entire cluster to assist all RNs with admissions, discharges, and overall patient care.

A staffing challenge occurs when attempting to meet the recommended staffing guidelines in a cluster with an odd number of beds. If staffing is adequate on any given day, one RN is paired with another RN in a 3-bedspot assignment. On days with fewer staff, the RN will be in the 3-bedspot alone. Typically, less complex patients are assigned to the 3-bedspot; however, a daily hospital census of 92% to 95% has led to lengthier PACU stays, thereby decreasing bed availability in the PACU. When the PACU fills up quickly, there are limited choices on where to place incoming patients, which makes it difficult to keep lower-acuity patients in the 3-bedspot. A staffing strategy of one RN alone in the 3-bedspot minimizes provision of care based on recommended staffing standards. Therefore, our plan was to place an LPN in the 3-bedspot with an RN to provide safe, quality care and improve throughput of patients in the PACU.

The purposes of this article are to describe our strategy of staffing a Phase I PACU with a mix of RNs and LPNs, discuss the LPNs' scope of practice and orientation, and provide an overview of practice outcomes. In addition to a gap in evidence for PACU staffing ratios,[4] literature on LPNs in the PACU is sparse. One resource stated LPNs did not belong in a Phase I PACU because of the constant assessment needed for patients waking from anesthesia, but felt they could work in a Phase II PACU.[5] Literature on LPNs in an intensive care unit setting were all based on care delivery in the 1990s or earlier, when patient acuity was lower, surgical procedures were not as sophisticated, and postoperative management was less complex.

Scope of Practice

Before consideration of hiring an LPN into the PACU, it was important to understand the scope of practice for an LPN in general and specifically in our state. Contacting the State Board of Nursing was vital to gaining knowledge in LPN licensing and scope of practice. Assessing hospital policies for LPN caregivers ensured compliance with current practices, and a review of literature on scope of practice provided greater insight into potential strengths and barriers to adding LPNs in the model of care.

In general, scope of practice can be a challenging topic because RN and LPN caregivers have different and limited perceptions of their scope of practice. Scope of practice can be viewed as a legal base of practice or by clinical parameters of practice. In general, it should be viewed holistically and include competencies based on roles, responsibilities, and functions that are based on education.

LPNs tend to focus on tasks when describing their scope of practice and not on processes associated with health care delivery.[6,7] In a qualitative study, RNs and LPNs both viewed patient assessment as an essential element of scope of practice, but LPNs spoke about specific tasks (eg, vital signs, elimination, glucose level), whereas RNs used terms reflecting a systems review (eg, a respiratory or cardiovascular assessment).[6] LPNs did not view care coordination as part of scope of practice or had a task-oriented view (eg, completing tasks around other scheduled treatments or services), whereas RNs were more likely to be holistic and discuss coordination in terms of discharge planning, patient advocacy, and mediating