

Differentiating Scopes of Practice in Nursing Homes: Collaborating for Care

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Hospitalizations of nursing home residents are costly and adversely affect the health of already vulnerable residents, and reducing avoidable hospitalizations has been identified as a priority quality and safety outcome by the U.S. government. However, existing interventions to reduce hospitalizations do not account for differences in scopes of practice among licensed nursing staff. This article describes the development of an educational innovation for nursing home staff members to learn to collaborate in ways that differentiate registered nurse and licensed practical/vocational nurse scopes of practice and strengthen connections among licensed and unlicensed nurses to improve detection and management of conditions associated with avoidable hospitalizations. The innovation was developed using situated learning theory and facilitated unfolding case discussions, reflecting the actual care environment. Evaluation data indicated the feasibility of this approach to staff education.

Hospitalizations of nursing home residents are costly and adversely affect the health of already vulnerable residents. Annually, 25% of long- and short-stay nursing home residents are hospitalized at least once. Reducing avoidable hospitalizations is a priority quality and safety outcome of the U.S. government (U.S. Department of Health and Human Services [HHS], 2013a).

Although systems-level interventions are underway to reduce avoidable hospitalizations (Ouslander, Bonner, Herndon, & Shutes, 2014), these interventions are often implemented without addressing gaps in nursing practice, specifically the core elements of assessment, care planning, supervision, and delegation. For example, existing decision support tools designed to reduce avoidable hospitalizations do not meaningfully differentiate between the contributions of registered nurses (RNs) and licensed practical/vocational nurses (LPNs) in assessment and care planning, despite the fact Nurse Practice Acts indicate that only RNs are educated and licensed to conduct comprehensive assessments (Corazzini et al., 2013c). This lack of differentiation might reinforce using RNs and LPNs interchangeably, a common practice in nursing homes as suggested in a recent survey (Mueller, Anderson, McConnell, & Corazzini, 2012). Furthermore, research findings show that failure to differentiate between RN and LPN scopes of practice is related to poorer-quality nursing home care (Corazzini et al., 2013b; Corazzini et al., 2013c). Not surprisingly, a recent U.S. Office of the Inspector General report notes widespread problems in care planning and assessment in nursing homes: 37% of Medicare skilled nursing facility resident stays in a recent, nationally representative sample had care plans that did not meet regulations (HHS, 2013b).

Interventions that shape how scopes of practice are enacted, therefore, can transform the capacity of nursing home staff to imple-

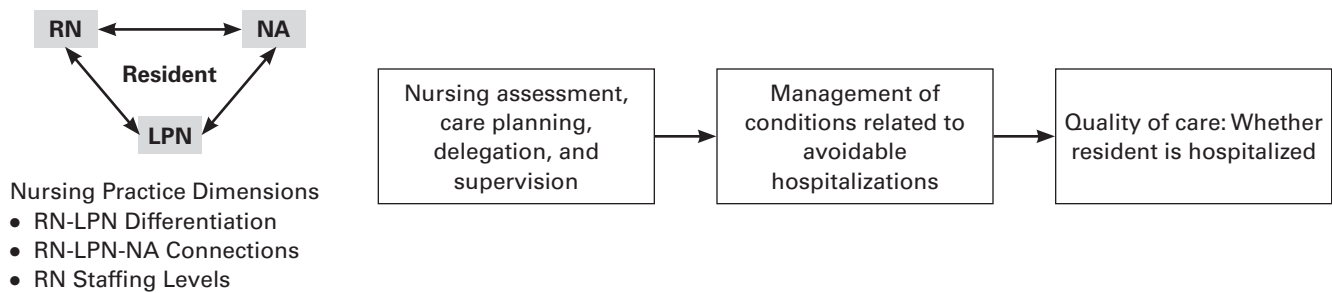
ment decision support tools and quality improvement programs designed to reduce residents' risk of hospitalization. Empirical evidence indicates that the manner in which nursing practice occurs in a nursing home affects the prevention of avoidable hospitalizations and the implementation of quality improvement programs in general (Graverholt, Forsetlund, & Jamtvedt, 2014; Masso, McCarthy, & Kitson, 2014; Ouslander et al., 2010). Additionally, research demonstrates variability in how nurse assessment, care planning, delegation, and supervision occur among RNs and LPNs, affecting a variety of resident outcomes, including medication safety, pain management, and Centers for Medicare & Medicaid Services (CMS) quality measures (Corazzini et al., 2013c; Corazzini et al., 2013d; Vogelsmeier, Scott-Cawiezell, & Pepper, 2011).

Studies focused on clinical microsystems (small groups of nursing home staff members that interact at the point of care) show these microsystems can differ significantly in quality and the differences are not fully captured in facility-level quality (Estabrooks et al., 2011; Mohr, Batalden, & Barach, 2004). This research suggests that efforts to improve quality and care outcomes should focus on these smaller clinical microsystems. Key members of the microsystem include unit-level teams of RNs, LPNs, and nursing assistants (NAs). Therefore, to reduce avoidable hospitalizations, we developed an educational innovation so these teams can learn to accomplish care in ways that more effectively use the scopes of practice of RNs and LPNs to achieve a higher capacity for quality. Drawing on our past empirical work (Corazzini et al., 2013b), we created the Practical nurse, Registered nurse, and Aide Collaborative Team In CarE (PRACTICE) intervention, an educational innovation designed to help RNs, LPNs, and NAs learn how to differentiate RN and LPN contributions to assessment and care planning and strengthen

FIGURE 1

Conceptual Model of Impact of Educational Innovation on Quality of Care

Clinical Microsystem of Care



Note. RN = registered nurse; NA = nursing assistant; LPN = licensed practical/vocational nurse.

the quality of connections among all nursing staff for assessing, care planning, delegating, and supervising. We focused on managing four common conditions related to avoidable hospitalizations: diabetes, congestive heart failure, urinary tract infections, and aspiration pneumonitis (HHS, 2013a). The purpose of this article is to describe the development of a theory-based educational innovation and its implementation in three nursing homes in North Carolina.

Conceptual and Theoretical Basis of the Innovation

Figure 1 depicts the conceptual model that supports the content and learning goals of the educational innovation. Nursing staff members providing care on units learn how to collaboratively assess, plan care, delegate, and supervise care of residents with diabetes, congestive heart failure, urinary tract infections, and aspiration pneumonitis, using behaviors consistent with our empirically derived model of enacted nursing practice associated with a capacity for higher quality care. The model's key components are differentiating between the roles of RNs and LPNs in practice, having multiple connections among all nursing staff members, and ensuring an adequate RN presence in the nursing home (Corazzini et al., 2013b).

Figure 2 depicts the theoretical framework for the innovation. We used situated learning theory (Lave & Wenger, 1991) to facilitate learning of these new behaviors. RNs, LPNs, and NAs were presented a detailed case of a resident, using an unfolding case study approach (Day, 2011). The facilitator divided a case describing a resident's care over time into a series of sequential snapshots, revealing one at a time and eliciting discussion between snapshots. At each time point, learners gained new or additional information or learned what was happening from a different staff member's perspective. This process allowed learners to imagine that they were in the role of the staff member, ask questions, determine which steps could next be taken, and consider potential outcomes of those steps. Learners expanded their understanding by sharing their knowledge or ideas with other group members, and they were guided by peers and the facilitator to explore new knowledge or behaviors that align

with the conceptual model of nursing practice. (See Figure 1.) Table 1 provides an excerpt from a case about a resident with a urinary tract infection and illustrates how the facilitator guided the discussion to practice congruent with the conceptual model and best practice.

This learning format shifts the traditional role of an instructor from simply transferring information to the role of a facilitator who builds on the learners' knowledge and ideas, positively reinforcing what matches the conceptual model and best practice and facilitating exploration of new ways of thinking or new knowledge for what does not. Rather than trying to fill learners with new information, the facilitator attempts to understand how participants are thinking and builds on the best of what they are already doing by helping them adjust their perceptions, sometimes only slightly, to see their practice in a new way. Ideally, at the end of an unfolding case study session, learners recognize that a different outcome can be created with modest changes in practice. By working through the case study in groups of RNs, LPNs, and NAs who normally work together, learners develop a new, shared understanding of how to accomplish new outcomes as a team with the capacity to begin to shift the practice narrative (Benner, Kyriakidis, & Stannard, 2011) and continue to share successful strategies with peers beyond the classroom.

Using case study narratives is an ideal way to meet the principles of situated learning theory (Lave & Wenger, 1991), whereby thinking and learning are dependent on the social contexts in which they occur. Drawing on pragmatism and phenomenology (Dewey, 1976; Heidegger, 2010; Lave, 1997; Lave & Wenger, 1991; Merleau-Ponty, 2012; Vygotsky, 1986; Wittgenstein, 1997), proponents of situated cognition hold that thinking is not an isolated function of an individual mind, but a process in which the mind is engaged with a social environment and involved in a particular context. Building on situated cognition, situated learning asserts that the most effective and sustained learning is the learning that happens in meaningful contexts (Lave, 1997; Lave & Wenger, 1991).

For Lave and Wenger (1991), social engagement is the primary source of learning, and the ease with which adults acquire and use knowledge improves when the learning environment reflects the social context in which they will use the knowledge. (Lave, 1988).

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