Colibri Healthcare

Podcast Transcript

Navigating Delegation - Balancing Responsibility and Collaboration

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Guest: Dr. James V. Stowe, JD, RN.

James is both a nurse and attorney, obtaining a nursing degree from Auburn University and a Juris Doctor from Samford University, Cumberland School of Law. He practiced in the legal field, concentrating in part on medical claims before returning to hospital administration. James is currently the Director of a large Emergency Department.

Host: Candace Pierce DNP, MSN, RN, CNE

Dr. Pierce is a nurse leader committed to ensuring nurses are well prepared and offered abundant opportunities and resources to enhance their skills acquisition and confidence at the bedside. With 15 years in nursing, she has worked at the bedside, in management, and in nursing education. She has demonstrated expertise and scholarship in innovation and design thinking in healthcare and education, and collaborative efforts within and outside of healthcare. Scholarship endeavors include funded grants, publications, and presentations. As a leader, Dr. Pierce strives to empower others to create and deploy ideas and embrace their professional roles as leaders, change agents, and problem solvers. In her position as the Sr. Course Development Manager for Elite, she works as a project engineer with subject matter experts to develop evidence-based best practices in continuing education for nurses and other healthcare professionals.

Episode 1: Navigating Delegation - Balancing Responsibility and Collaboration

Transcript

CANDACE PIERCE: This is Dr. Candace Pierce with Elite Learning by Colibri Healthcare, and you are listening to our Elite Learning podcast, where we share the most up-to-date education for Healthcare Professionals. Thank you for joining us for this podcast series Topic, “Navigating Delegation: Balancing Responsibility and Collaboration.” For this topic, I am joined by Dr. James Stowe, a registered nurse and a Juris doctor. I’m really looking forward to that legal and

that nursing-specific expertise that you're going to be able to bring to help us understand how to delegate appropriately and how to protect ourselves and our license. So, thank you so much for taking the time to be with us today.

JAY STOWE: Candace, It's great to be here. I appreciate it. Such high billing. I hope I can live up to that.

PIERCE: Oh, for sure. I know you can. So today, we're going to talk about delegation and really why that's so important to understand what we can delegate and what we can't delegate and the different roles that play into a healthcare team. And I know for me, teaching in nursing school and undergrad and, you know, I really didn't feel that when they came out of school that nursing students really understood the differences between the roles and what they could and could not delegate and who was responsible for what. So, can you help us understand why we need to understand what we can and can't delegate and the different roles of our healthcare team?

STOWE: So there's a couple of overarching reasons why this is important. Let's set aside the right thing for the right patient. Let's set aside that because that's always the most important thing that keeps the patient at the center of the care. Really, delegation boils down to a couple of things. One is licensure regulation, and two is legal malpractice, which is really known more as negligence. So, when you consider why delegation of duties is important one, the Joint Commission is the largest certifying body in the US for hospitals. There are others, ISO 9000. There are different things that you have to be certified. Basically, CMS or Centers for Medicare and Medicaid state that you have to be licensed by someone. Okay, so the Joint Commission just happens to be the biggest and the most talked about. The Joint Commission will survey for CMS; their surveyors are trained, and they'll come in and survey for that. So delegation-wise, if you get certain findings that are not outlined, requested, or approved by CMS, such as we will throw out there, LPNs are conducting the initial assessment or administering blood products, doing those two things well, CMS through Joint Commission, can find condition-level findings, and if they're egregious enough, then they can pull your license, right? They could pull your basically acceptance or approval to receive CMS funding, and that is, reimbursement for services to Medicare and Medicaid patients. Now, why is that impactful? Anywhere from 50% to 60% of our patients today receiving care have this insurance. They have Medicare or Medicaid, right? No entity, no business can afford to survive with 50% of your clientele don't pay for anything. Right? Think of it another way. You own a car dealership. 100 people come in there, and 50 of them drive off the lot with the car and don't pay for it. You go out of business. So, it's very impactful that way. The second way is legally, we as healthcare providers have a legal responsibility. We have a duty, a duty to care for the patients that we assign and train an educator to take care for. That duty can be breached. And if you breach that duty, which is for the RN, for example, you're responsible for performing the primary assessment and you're responsible for administering blood. The LPN, in turn, can do subsequent assessments on that patient to monitor that patient, take vital signs, assess for redness, particularly neck redness or anything of that nature, ringing of the ears, to monitor, see if there is a blood transfusion reaction occurring. They can't do the initial one. So, if we allow the LPN to do that, we have breached our duty, and if the patient has a poor outcome, then we can be liable for that. So, that liability can be extreme; it can be very expensive in court. So delegation of duty, while it seems a very simple thing and it's something in schools we are taught, oh, you're going to

have people that help you do these things right. We kind of leave it at that. We don't really go into defining what they can do or what they can't do.

PIERCE: I think it's what they see people delegate in clinical. It's not really this is what you can and can't do. It's more of like, oh, well, I see that they delegate their glucose, or I see that they delegate their vital signs. And so, it's kind of when they come out, they know that those are two of at least two of the things that I can delegate.

STOWE: Right. Right. And our systems that are out there right now are our certifying bodies. States and otherwise just aren't clear. They just aren't clear on this. And it just adds layers upon layers of complexity and, quite frankly, confusion.

PIERCE: Absolutely. I want to start from the top of leadership and work our way down as far as delegation. And one of the things that you will hear chief nursing officers, or sometimes they're called directors of nursing, but you know that top nurse in an organization, and you will say, they work under my license. Okay. Well, we all know that if you're an RN or an LPN, you have your own license, right. So, can you kind of help clarify what does that mean when you hear that head nurse? Right. They work under my license.

STOWE: So it kind of stems from a couple of things. Most importantly, it stems from we mentioned the certifying agencies, the Joint Commission and Centers for Medicare Medicaid. CMS has conditions of participation that you'll hear of. And there are thousands of things, and you will hear in the healthcare setting, Hey, Joint commission has a rule for this, and Joint commission has a rule for that. The Joint Commission has very few rules. Joint Commission has recommendations which say you need a policy. And we gave an example and I'll stick with the same example.

PIERCE: And you follow your policy.

STOWE: Joint Commission will say you have to have a policy governing the administration of blood because we feel that that's best practice, that you have a defined policy. They don't tell you what that policy is. The hospital then has to develop a policy, and then the hospital has to adhere to it. Of the big, big irony in the big surveys is Joint Commission will come in and say, "Can I see your policy, please?" And then they audit you for following your own policies to which many times you fail. Well, it's kind of a kick in the pants because you develop it, you educate to it, and you don't follow what you say you're going to do. So delegation is very, very similar to them. And while you have all this delegation, RNs, LPNs, what the Joint Commission really says is while you delegate and do all these things and there's these policies and procedures of practice, we need someone that can sign off on it. Who's saying this is best practice? This is what nursing should do. So, in short, all the nurses in your facility may have a dotted line all the way up to the CNO. They do. So, for example, if you're OR, it's very in vogue today that your surgery OR area reports to your COO from an operational standpoint versus directly to the CNO. So they don't report to the CNO, but all those nurses have a dotted line to the CNO because he or she is going to define quality best practice of nursing care with in the surgery department, even though it reports under an operational segment. So it's really a

reporting structure, and someone that is deemed the expert in that field helping to define what is allowed in that field.

PIERCE: So if a nurse makes a mistake, which license is the most at risk?

STOWE: So first and foremost, the nurse making the mistakes is at risk. They're the individual that messed up. Secondly, where it gets interesting is, that hospitals typically will support a nurse when there's legal action. Specifically or realistically, hospitals will support you so long as you followed hospital policy and procedure. If you do not follow the hospital policy and procedure, you acted on your own and away from what the CNO said you should do. So, you didn't follow the CNO's direction. So, the CNO typically

PIERCE: Which is your policy, right? So, the CNO directive, so they have delegated through a policy.

STOWE: Exactly, what you're going to do. And if you don't follow that, the CNO can't really be held responsible. She'll get some blame. But the true liability lies with that frontline staff member. And so you then have to go into all this, you know, how clear the policies. Are they intentionally vague? We have a habit of that. That's a whole other discussion that we can get into. But policies are very difficult to follow at times. And they very rarely, if at all, want to talk about delegation specifically because if I define specifically in a policy, RN does A, LPN does B, CNA does C, I get to court, and the LPN has kind of crept, and I call it creep, where your actions kind of go outside of what your purview, what your responsibility is, and they kind of creep over into somebody else's scope of practice. If you do that, well, you have carte blanche just violated that policy, right, because you have it outlined. So, for the most part, hospitals, even if the CNO wants to delineate that and make it very clear, risk management, legal team kind of step in and say, let's rethink this and make it a little more vague. Now you take that, and you're the frontline staff member, and go, wait a minute, this doesn't clear anything up.

PIERCE: Right.

STOWE: So, how much more confused are you now?

PIERCE: What did I do wrong? I don't understand. I try to follow. Okay, so we started at the top. So now we know that the big nurse, the chief nursing officer, they're going to set the delegation through policy, or I know in a facility I worked at, they kept changing all of our policies to guidelines. So, guidelines are also being used.

STOWE: You know, we say that's, it's a ploy. So when we talk about a ploy, attorneys historically will say in a legal action, give me all your policies and procedures that govern anything related to this. And hospitals have to turn those over. That is discoverable evidence that has to be turned over. They still use that verbiage. So hospitals are trying to say, hey, it's a guideline, and so they don't turn over those quote-unquote guidelines, which are policies and procedures. Now, that being said, we talked about how they're vague to begin with because we try to steer clear from defining things for legal action. Now, take it a second step, and now we've labeled it a guideline, which doesn't mean you have to adhere 100%.

PIERCE: Yes.

STOWE: Because it's just simply a guideline. It may be best practice, but you're not saying it's policy, and that's the way we expect it to happen. You're saying it's a guideline, and it should happen this way. That doesn't clear anything up for the front line.

PIERCE: Not at all. So now they're further confused.

STOWE: Yes.

PIERCE: Okay. So we started at the top. Now, let's move into your bedside staff and look at the roles that are set. We know these are the roles for the RN, the LPN, and the CNA.

STOWE: Absolutely. Very important roles. I think if you look back in history, these roles typically started with a nurse. We started with a nurse, and I think as things became more complicated, as we had more patients and more formal responsibilities, that we started adding layers of assistance to the nurse, keeping the nurse kind of the be-all-end-all bedside personnel. That's really represented in their roles. The role of the RN is kind of the patient coordinator of care. You can kind of think of them as a team leader. If you go back to nursing school and think of those old care plans, you have to think through all of the steps, right? You have to do the assessment, and a possible diagnosis is that you need to work under expected outcomes, interventions, and rationales and evaluating your ongoing assessments. So they do all of that. Then you think about LPNs, they're really more responsible for monitoring and assessing. They do have some kind of patient care tasks that they can do, specifically vital signs, some simple dressing changes, and things along those lines. But they're really the eyes and ears of the RN They're really the eyes and ears, ongoing assessment, so the RN can make kind of that coordination of care approach. The CNA really is more of a basic care provider case. CNAs, when I say basic care providers, don't misunderstand me, they're invaluable. There are they are CNAs that can assess patients way better than you think, and if you have good communication, a good relationship with them, and great teamwork, they can come and tell you, hey, this patient doing this, this, this, they weren't doing that yesterday, and they can give you the heads up to find stuff out. But they do things along the lines of, if you think, activities of daily living, right? Eating and bathing and getting dressed. They can do some range of motion exercises and some transferring folks. But really, your basic care, basic mobility, and function. So there are three different roles, and they all have to work in conjunction when you have them available. And it can be done, but you have to have clear communication and great teamwork.

PIERCE: So we have three different roles, but we also have three different levels of education, right?

STOWE: Correct. All three are very different. You know, you look at the RN, and you have two traditional pathways. You have a four-year degree a bachelor' of nursing degree. You have a two-year degree, which is an associate of nursing degree. And then you look at the LPN, and

that's traditionally a one-year degree, one year education. Both of them have to take the, and I get this wrong every time, the National Council licensure exam.

PIERCE: The NCLEX

STOWE: It's so much easier to say NCLEX

PIERCE: Yes, it is!

STOWE: But they both have to take that exam and pass.

PIERCE: Yes

STOWE: And that's the education part. They then have to submit their passage, which is done electronically, but you have to submit your passage, pay a little fee and all this kind of good stuff to get a license to practice nursing in the state that you practice. Every state is different. The fee for every state is different. The process for every state is different. But the nuts and bolts of is: pay a fee and submit your application. It's reviewed, and you get a license.

PIERCE: And I just think it's so important to kind of point this out. And I know that our main audience you are usually nurses, but sometimes physicians listen to our podcasts and CNAs, LPNs. You can also have therapists who listen to our podcast. And so, I want them to really understand the difference between each of these roles. But what's really important for nurses and for CNAs to know, let's get into that. And that is the first one I want to ask is who sets the scope of practice for each of these roles? And if you are a travel nurse, they have travel LPNs, travel RNs, we have travel CNAs. Who sets the standard and the practice for each of these roles.

STOWE: So that's the fun part. It varies greatly. You know, when you talk regulating bodies, determining who can do what. The easy one, RNs, LPNs, is your state board of nursing. That's your state board of nursing. But your state board of nursing is typically going to shy away. They're a little bit like the Joint Commission that we mentioned earlier. They're going to shy away from your specific you can do this, you can do that. State boards of nursing are really more concerned in the safe practice of care. They want to regulate the safe practice of care. They don't want to regulate how you actually practice it or provide the care. So then you get into who really regulates the practice, and that's going to be the institution in the hospital, the company that that you work for. They really set those things out. Now, when they set those out, who do they glean their, who they get their marching orders from, or who do they have to incorporate.

PIERCE: State Board.

STOWE: Shakes head no.

PIERCE: Joint Commission

STOWE: Joint Commission

PIERCE: Centers of Medicare. Am I getting it right?

STOWE: Yes, absolutely. You have your State departments of health that will weigh in. You had the DEA will weigh in on how you handle your medications. You'll even have your EPA come in. How do you how do you handle your waste? There's varying, I mean, that's just very topical. So you have all of these things to take into consideration of who regulates. When you talk about CNAs, that really is more varying state to state than nursing is, right? There's always a state board of nursing stereotypically. CNAs licenses, I live in Alabama, State Department of Health regulates ours. And Florida, it's the Board of Nursing. Just did a quick search, and in Georgia it's the Department of Community Health. So, they're all regulating bodies that have a healthcare component, but they're all different. So you just have to look that up. And then Georgia's, their practice, CNAs, same thing, all the same, same for Joint Commission. The CMS has all the other departments, all the three-letter people out there. So, when you mentioned traveling.

PIERCE: Yeah, I was going to say, so if I'm traveling, where do I look?

STOWE: I mean, it is incredibly difficult. It really is. And many times when you travel, you kind of operate on a wing and a prayer. The reason I say that is is you are deemed competent in your field of practice skills, evaluation-wise. But that doesn't mean you know the policies and procedures and the laws of the state that you're going into. And so, really and truly, the entity, a corporation that you go to really needs to be forthcoming and provide you with any nuances. Some hospital systems that have the manpower that have this delineated do a phenomenal job, right? That's few and far between. Most people don't have a plethora of personnel that can simply look up, oh, you happen to be coming from Massachusetts to come work down here in Alabama. What are the differences in that? That's a very difficult thing to figure out, nuance-wise.

PIERCEL: Right

STOWE: And so many, many times, it just doesn't happen. And that's where the healthcare personnel really have to speak up and say, hey, this is one of those hot, hot topics. This is one of the things that people talk a lot about. This is what I can do back home. What can you do here? And if you're able to do that, most of the time, you're okay. All right. You'll have people that can tell you. If you don't speak up.

PIERCEL: Yes

STOWE: Good luck.

PIERCEL: Wow, that seems very difficult. I want to take. So before I started nursing school, before I graduated, yeah, because I'm so much younger, just kidding. But at what time team nursing was gone. Team nursing was gone. I don't know if team nursing was still here when

you got out, but I remember whenever I was probably about two years into my nursing career, I was on a cardiac floor, and they had one LPN left on the floor. And I was told she was grandfathered in after they made the floor just RNs. It was a magnet facility.
I was in a cardiac floor, all RNs with one LPN left, but I remember it was not team nursing, and I actually did not look. I loved her as a person, but I did not enjoy working with the LPN part of it. And I'll explain why. I had my full load. She had her full load. There were just two of us, so I had to go assess all of her patients. If she got a new patient, I had to assess the new patient first. I had to sign off all of her orders, and being on a cardiac floor, there were certain medications she couldn't give. So, I would have to go assess that patient and give that medication. I would have to sign off on all of her assessments that she had done on patients. They always said RN, LPN, then the next shift, there would be another RN, And so they would do that. But if I put more work on me as an RN trying to take care of the same load that she was taking care of. So, I found that really difficult. But through Covid, I looked at team nursing, and it just makes more sense, team nursing does, and how does that look?

STOWE: You know, when we take a step back and look at what we traditionally have today, we have on most floors within hospitals, we have nursing, and we have CNAs or techs, and we have respiratory therapists. We have physical therapists come in, and pharmacists, and whether we believe it or not, that's team nursing, right? Because at the end of the day, we're taking care of patients. And I know we can get the semantics of its not nursing. It is therapy. But it's a team approach. Okay. And typically the only thing that's missing out of that today is the LPN.

PIERCE: Yeah.

STOWE: Versus the RN There was a big a big move away from LPN within the hospital system, and you kind of alluded to it earlier, when hospitals, after the eighties and nineties when there was high litigation and some rather large verdicts that came out. There was this move away from LPNs to the hospital because when they looked at outcomes and studies of facilities, those with more RNs per capita had better outcomes. And I don't think it's a stretch to think that if I've got a four-year degree if I've been studying nursing for four years versus one year, that I'm going to have more knowledge on the practice of nursing. I mean, I don't think that's a stretch. So I don't I don't think that is intended to insult anybody. I think that's just reality. If I practice skills for four years versus one, I expect to be better at those skills. If you're better at something, you have better outcomes. Okay. So, that's that arching band. And then you have this move based off of that research that says we can give you certain status, you know, certain awards. Magnet is one of those. And one of the original levels for Magnet was you had to be 80% RN. And then, they've kind of opted, and they've changed it from two-year to four-year and the percentages, and all that. But at the end of the day, Magnet is able to tout we have better outcomes. Okay. Well, it all comes back to the core training and core education. I believe you have more education and more training. Magnet also requires more ongoing training, right? So if you come out better prepared, and you have even further education and ongoing training, and furthering skills training where you can gain more knowledge, you're going to be better at your craft. I don't care if you're a mechanic. If that's the case, it's the same thing. A welder with six months experience, and a welder with six years' experience, which one's better? Stereotypically, the six years, right? So, we've moved to that direction. And it was a goal that, at the end of the day, better outcomes. Everybody wants that. I mean, everybody

does. It's just how you achieve them. It's been very difficult for many, many hospitals that are not in a university setting or associated in large cities because there are not enough actual RNs around to get to that total number that is required. So, while official team nursing wasn't out, it had been gone by the time I entered the workforce. Yes ma'am. Now, when you look at the number of nursing openings we have across this country, what we're projected to do, and the care that is needed down the road, that team nursing approach, whether it's hospital-wide or simply for certain areas, for example, just med-surg for example, maybe not in an ICU. It is becoming in vogue to look at that and to evaluate it and see if that is something we can do because at the end of the day, we have a responsibility to provide care. And if we don't have the individuals that can provide care, we're in trouble. We're in trouble as a society.

PIERCE: Absolutely. And I think it's so important to understand delegation, to understand how the team perspective works for nursing. It's the understanding of what you can do and your role versus what I can do in my role and how we help each other. I think that is the core piece of it. And when team nursing went away, it became just RNs. Back then, the nurse wasn't carrying all the hats they're carrying today. So not only did they get rid of the team approach that they had back then between nurses, but they added on all of these other hats. And they're still expecting the same outcome. As to the reason why, like you were saying, they got rid of team nursing because if they had more RNs, then they had higher patient outcomes. Well, you have more RNs, and I just wonder if we still have the same patient outcomes that they were going for.

STOWE: I dare say it's not improved. And I think one of the biggest issues that you have here is it's very rare that we sit back and evaluate the nurses' workflow at the bedside. Do you take the med surg nurse, which is, by far, there are more med surg nurses across the country than there are any other. I mean, there's a majority of units within a hospital. If you take the average med surg nurse, they have six patients. If they go through, and they make an assessment of six patients and document that every morning, it's a couple hours. If they're going to discharge three patients, so you've got to discharge, that's an hour apiece.
I'm in the ER. I am burning your phone up trying to get patients up because I've got another 50 in the lobby I'm trying to see. So you barely get somebody out the door before I've got one in the hallway waiting for environmental services to clean the room, to put in that room for you to get right back to work. And now you've got another hour of assessing them and documenting and doing a database, if not more, for each patient. You've got three med passes a day. That's assuming that no prn's are given. And all of a sudden, it's a 12 hour shift.
You haven't eaten. If you need to use a restroom, you haven't done that. You haven't made rounds with the doctor, and you haven't given any PRN medications. You haven't answered a single call light. And there's no time in the day. So what do you cut out? If you cut out, you've got to cut out something. What corner do you cut? And so, we talk about delegation and talk about these things, but if the staff isn't there, it is just RNs, the only thing that happens is we shortchange our service. The patient no longer is the center of care, and we don't answer a call line. We are slow at turning the patient. All of these things have potentially horrible side effects. But we, as hospitals, we instituted these no-pass zones.

You know, where we're going to do the right thing. And whether you're a dietary or security guard or environmental services, if somebody you see a call light, a light blinking in the hall, you go in that room and you help answer the call. Well, I'm Environmental Services, and I've

got 40 rooms to clean. Now, I'm supposed to take on the nurse's responsibility and go and stop and do that. It creates some really temperamental individuals doing this because everybody is stressed. And so, we have these great ideas. But at the end of the day, if we truly want to keep the patients at the center of care and have positive outcomes, we are going to have to consider team nursing. It's just inevitable. And the sooner we consider it, the sooner we implement it, the better patient outcomes are going to be. And I would daresay those patient outcomes are going to start rivaling some of the historical ones we've seen with just all nursing units.

PIERCE: Right. Well, and unfortunately, we have so much to talk about, but we've come to the end of our time for episode one. Please join us for episode two, where we're going to continue to talk about the art of delegation, the scope of practice strategies for effective team communication, as well as the critical elements of effective delegation. So, thank you so much, Jay, for joining us for episode one, and we'll get right into episode two.

Episode 2: Navigating Delegation - Balancing Responsibility and Collaboration

Transcript

PIERCE: Welcome back to our series on navigating delegation. To continue this discussion, we have Dr. James Stowe with us. In episode one, Jay walked us through why we need to understand the importance of proper delegation and the repercussions of improper delegation. So, through this episode, we're going to understand the scope of practice and really hit on the effect of what it looks like to effectively delegate and what those differences are between the roles of LPNs and CNAs. All right, Dr. Stowe, can you help us understand the legal and ethical obligations that are associated with each role: the LPN, the RN, and the CNA?

STOWE: Absolutely. When considering the legal obligations, they really are essentially the same. And I think the legal obligations are really impactful for the RN and the LPN. CAN, yes, there is, but not quite to the extent. Obviously, they're not doing the extent of work with a patient, not doing the invasive actions that the other two would. But legally, the obligation is when you've accepted that patient and are responsible for their care; you have a duty to provide care and do it correctly. And really, that duty is what actions, if you are a reasonable RN in the same situation, what would they do? LPN would be the same. You can always ask yourself what would a reasonable person in my same education licensure in this situation do? And so, for Alabama, it's where I am. There are roughly 60,000 nurses, 40,000 to 45,000 practicing. So, there's a pretty good sample of what a med surge RN would do. And so as long as you adhere to those duties and adhere to that practice, you are fine. If you breach that duty many times, you're still okay. But if you breached that duty, and that breach, which is breaking what you should do, and that break causes harm, then you could be in trouble. You could be legally in trouble. Ethical obligations: not only do you have the ethical responsibility to follow the laws, but ethically, you have the responsibility to follow the policies and procedures of the hospital. But more importantly, I would argue that you have the ethical responsibility of providing patient-centered care because that's our job, right? That's our fundamental belief and the fundamental reason that we've entered into healthcare. It may be because you need

to pay the light bill, but truthfully, you can pay the light bill a lot of places, but you wanted to do something other than that, or you typically wouldn't be there. And so ethically, that's a responsibility to do good and help the patient. But that is a bit more challenging. Ethically, there's not really an ethical policy. There's not really a guidepost for you or guideline that says, do these things, and you'll be ethically okay. It's really more of a personal guidepost. So, there's a lot of questions and a lot of leeway there, and that's what makes the practice of law and practice of medicine fun.

PIERCE: True. There is a lot of gray in both areas, but where there shouldn't be gray is in our communication when we delegate, especially who we're delegating it to and what we're trying to delegate. So, can you help us to understand the collaborative communication that needs to happen when we're delegating.

STOWE: So really, and truly, the most important thing, in my opinion, with delegation is clear communication. Now, that clear communication takes a number of different forms. It's not simply me as an RN telling the LPN, "Hey, I need you to do X, Y, and Z." It's not simply that. It is way more involved. Clear communication is, does the hospital have a clear policy communicating what each level of care or each licensure can do. I would challenge you, go ask your hospital. Go ask them what are the specific roles that a nurse, an LPN, and a CNA can do? If you get a response or policy that dictates that, I would be very, very shocked. I simply don't have that. There are legal repercussions for doing that. So, that clear piece of communication is most often missing.

PIERCE: And in education, we didn't teach that when you came in through orientation, that wasn't anything that we taught now that I think about it.

STOWE: No, we don't teach it. You know, when you're in nursing school, you come in there, and speaking only for a four-year degree, a bachelor's degree, they go in, and they tell you, "Oh, you're going to have help. You're going to have people that will do certain things for you. And they will do that." No one defined them, and no one defined what task they were going to do. You just had this belief because you were being told that, hey, I'm going to get help when I get out.

PIERCE: You saw it in clinical, like we said. You see it in clinicals.

STOWE: But what happens when you're now a nurse, and you are off orientation, and the techs all call out, and there are no LPNs on your unit. You are it, tag, and now what? Who do you rely on? You train a certain way, and then all of a sudden, they're out. So, it's a very difficult thing. We look for more clear communication from, say, the state, from other entities that can guide us. And I would tell you that the state, speaking rather the state of nursing, looking up, they don't have a list of you absolutely RN has to do this, RN can't do this, LPN has to do this, LPN can't do this. And the same for the CNA. CNAs are not even regulated by them, so they don't even mention them. So, when you look at that from RN to LPN, one of the big things is, okay, what can you delegate? Right? Surely, the regulating body is going to espouse that, and they don't. But you have to go in there and read certain things, certain decisions in other cases, certain appeals, certain rulings that they've had. And you can rule some things,

and they'll come out with things that say, for example, there was one that said, you know, you can't delegate anything that has nursing judgment involved with it. But that makes sense. I can't delegate to a CNA something that a nurse has to assess and judge what to do. You can't delegate invasive or sterile procedures. LPNs may not have been trained on those. So that that makes sense.

PIERCE: But then you have places where if an LPN gets further training, then they can do it. And I think one of those for the state of Alabama, correct me if I'm wrong, is IVs.

STOWE: It is. And it is interesting in this in this specific role. Just to backtrack just a second, they said that, well, finger sticks and peripheral venous phlebotomy while invasive, that's allowed. You can delegate that.

PIERCE: So, you can't do an invasive procedure.

STOWE: But we will allow these things.

PIERCE: Yeah.

STOWE: And you have to hunt and peck. It's not under a nice little tab, which can and can't do, and so yeah, it's just really convoluted. And then you add in, like you mentioned, these extraneous certifications after the fact. Well, okay, so you've got that. How is that communicated?

PIERCE: Oh, so how do I know when? So, for me, my background is in ICU, and you don't really have a lot of techs in ICU, first of all. You definitely didn't have LPNs in the ICU. And so, if I was pulled out to a med surg unit, I really wouldn't know what all a CNA could do, or an LPN could do unless somebody told me on that floor because where I am, I'm responsible for all that, even bathing the patient. I mean, yes, the tech would come in and help. But because of all the lines you had, the ventilator, you needed to be in there to ensure that the patient was okay if they were critical, so I wouldn't know where to start other than the known things like glucose and vital signs, because that's really all they did for us besides even our baths. Sometimes, two nurses would go. Even if we had a tech, it would be the two nurses going in there to give baths in the ICU.

STOWE: You know, we started this with clear communication, and I think that's where we will start and where we will probably end at the end of the day, is clear communication. You know, I have no problem, and I don't know why we're reticent as, kind of lumping myself into nursing leadership with posting what you can and can't do. I mean, it's in the break room, you know, you get nurses floated to you from all over. If the skills differentiate between LPNs, why isn't that listed?

PIERCE: Yeah, or maybe even a like something. They love badge buddies. Oh, you are an RN. Okay, what else is on it? There are so many things on a badge these days.

STOWE: Yeah.

PIERCE: Well, tell me that they can do IVs.

STOWE: If you look at some of the studies, this is across the board, and this is by no means scientific, but something I have read said you got to tell somebody something eight times before it really sinks in before they learn it. So, you get a nurse that floats from the ICU to the floor. Does she have time to listen to what can and can't be done, or who has what scope of practice eight times before she even gets her shift started? Because let's be honest, you report to your unit. You get there, and then you find out you float, and then you got to get to the new unit. You got to put your stuff up. Then you got to go get report. You're an hour behind. You're an hour behind, behind the eight ball, and you don't know that unit. You're not happy to be there because you're not comfortable. It's not just that you go every day.

PIERCE: It's not that we're unhappy to be there. We're uncomfortable. We are out of our comfort zone.

STOWE: You're unhappy because you're uncomfortable, because again, and I take that as a good thing. A lot of people call it an attitude problem. I call it a positive reaction because if you're uncomfortable, you have the desire to keep the patient at the center of care. And you know that for that unit, you don't know all the ins and outs like you do in your home unit, and there's a fear that that patient is going to lose the care that they need to get. And so, I'm not upset by that, as a nurse leader. What I need to do is have the responsibility, as so many do. We need to educate you on what you can do, what you can't do, and what is expected? I need to give you, one of the things I have done in the past is create a little pamphlet. I had them specifically designed where they would fit in the pockets of my scrubs. I'm a guy. I like the scrubs with the pockets on the pants.

Okay, so we made it that wide, it was a fold over, and you could flip it and say, this is what we do, when we do it, how we do it, yada, yada, yada. Almost like a cheat sheet for when you come out with a new EMR, a computer system. How do I enter an order, flip to page three. How do I delete this? And so, while it doesn't have all the answers, it gives that floating nurse something, that you can hold on to, you can grasp to. It adds a comfort level because the sooner you become more comfortable, the sooner you can calm down and think about what the patient needs and simply react and provide it because you know how to take care of them. It's just a different environment.

PIERCE: Right? So, we know that the scope of practice for LPNs and CNAs varies from state to state. Can you help us walk through the different tasks that LPNs versus CNAs, that the RN can? At the end of the day though, and if an RN delegates, the RN is still responsible for that task legally, correct?

STOWE: Correct. And now we get into some really interesting gray areas. When you take a step back, and you look at it. So, I think we all know that RNs are responsible for initial assessments and the more complex procedures, drawing blood. If the patient has a PICC line, I can draw blood out of the PICC line. I can assist with ventilation, a ventilator, triple lumens, foley catheters, and art lines. All these things that I have been trained and checked off to do are a

little more high-functioning. LPNs are not. Their scope is really vital signs, assessment, and education. They can administer some medications, but there are limitations on this. They can't administer paralytics, for example. And why is this? It's not a negative. They haven't been taught what are the side effects, what you do, what do you look for, when are the right situations, and the right times to do that. So, it's really a protective thing. So, they have a limited scope. And then the CNAs, really we mentioned them earlier, they're kind of a pretty big step down on their capabilities, you know, assisting with eating, bathing, brushing teeth, nail care, those type of things that are very important. You know, personal hygiene is unbelievably important in infection control and also positive self-image. I mean, you would be surprised how far that takes a patient. But when you think about the scope, and you look for kind of some guidance and some help in helping you chart that course, I looked up on the Alabama State Board of Nursing website, and specifically typed in delegation and all this kind of good stuff. They have put on there that the Alabama Board of Nursing released the "Alabama Board of Nursing Scope of Procedure Dash RN- LPN decision-making model." Oh great, that's wonderful, and the LPN and RN, presumptively, they're talking about delegating tasks, they're at the bedside, and this is an 11-step process before you perform tasks.

PIERCE: So, is that for the RN to use to determine if they can delegate.

STOWE: Both. RN to delegate and LPN to accept the delegation. It talks about what does the board says and what the Nurse Practice Act says. But it does go into what is the education and capabilities of the delegate, the LPN, in this case, what can they do? Well, how many RNs know what the LPNs have studied in school? What courses had they undergone? What was their orientation like? It is two different paths typically in orientation. For some, you have that commonality where everybody does, and then it kind of breaks off. LPNs go here, RNs go here, CNAs take a different path, different parts of the week. They start breaking off earlier or later. Who shares with each individual? Who shares with the nurses what the LPNs are checked off to do? Who shares with the nurses the education that the LPNs have undergone, and from the different schools to know when they get to the floor, hey I can delegate X, Y, and Z because they went to A, B, C school. We don't do that. That's part of the state's decision-making model, and at the very end of it, it says, even despite all of these actions, the last question says, are you prepared to accept the consequences of your actions?

PIERCE: I don't know. I'm not sure.

STOWE: I mean, talk about striking some fear, and I know that's a precautionary question designed to make you think, but if I'm already sitting on the fence and I don't know, I'm now completely scared, and I'm not doing anything.

PIERCE: I'm not delegating anything. I'm going to try to do all of it by myself.

STOWE: I'm not delegating.

PIERCE: I worked really hard for my license.

STOWE: Yeah, and if I'm the LPN, I'm not accepting it because I don't remember what was in school, because I was working three jobs, taking care of a family, just trying to make it through to get this position to get licensed. And I made it through. And while I knew it, I haven't practiced it. So, nothing gets delegated. And now, what happens to the patient? There's no patient-centered care at this point, right, when it comes to this task. So, we talk about clear communication and I circle back to it. That clear communication is absent, and I think we have to do a better job of while I know a tremendous amount of work went into this, and we want to consider all of these steps, we want to consider all this stuff, it's just not clear and concise. So, we've got to go back to the drawing board and come up with a methodology step by step, a much easier way to say, look, you can do this, you can't do that. And if you've got an exception where you can do something like an IV certification, your badge is a different color, your pen is different, or that's on there. You have a ribbon on there. We announce it every day, yada, yada, yada. Whoever you are assigned to, hey, by the way, you know that Sally Jo here has IV certification. This team, team B, your LPN does not, and the RNs have to do it. You know, we have to have more and better clear communication, delineation of duties or else we're going to freeze. We're going to paralyze ourselves, or we're going to have the worst thing, and that is creep, where we just assume people can do things. Their scope of practice starts creeping into the nursing practice, and we have bad outcomes. And so, at the end of the day, if we don't have that clear communication, those patient-centered approaches and patient-centered positive outcomes are going to be gone.

PIERCE: If you were a travel nurse today, what advice would you give to a travel nurse when it comes to effective delegation and safe delegation for their license?

STOWE: It's difficult. It's difficult because the first thing I would tell you as a travel nurse, both as a conscientious traveler nurse, just as a conscientious nurse wanting to do the right thing, but also legally, is I would ask the hospital you're going to work policies and procedures governing delegation, what is allowed, what isn't allowed. Now, when they're unable to give that to you, then what do you do? What's the second step? Contact the Risk Management department. Contact the CNO, her office, and see. Okay. And have something put down, put in writing. What can they do? What can't they do? What you're going to get is potentially down to the nurse director, manager, or maybe even a team lead in that area, and you can ask them, hey, what do LPNs do here. Write it down, email it to risk management, and say, hey, this is what I'm told. I need to confirm this before I delegate anything. Now, the hospital may not love that, right? Because you're putting them on the spot, to be honest.

PIERCE: You're going in and writing, black and white.

STOWE: You're making them make a decision, but it's your license. It is your license. And you have the choice to either comply with whatever they tell you or have some backup and say that that's okay. And then, when they give you the four things that you can delegate, stick to those four things. Don't creep. Don't say, hey, look, I'm going to be out of here in three months. You know, I'll roll the dice on this. Don't do that. Because, remember, it's patient-centered care. At the end of the day, if we allow individuals that haven't been properly trained to do things, we're not thinking of the patient first.

PIERCE: So, one of the things about delegation is that whoever does something should document it. So, if I delegate something appropriately, then I should not be the one that documents that it was done, other than maybe to say so-and-so did that. If you were in the room and you saw it happen. But what are the legal repercussions for choosing to document something you delegate as you did it, but you delegated it?

STOWE: So this is an interesting question because, we have this belief if it wasn't documented, it wasn't done. That's really not the case. That's really not true. That's not true under the eyes of the law. It's just really hard to prove that you did something if you didn't document it. I mean, let's just be honest. If it's three years later, and you're now in court, how do you prove it? How do you remember? How do you prove that you remember specifically what you did at the specific time and specifically should have written? It's kind of a hard thing to buy if you're on the jury, right. It's kind of reasonable. So, you really need to document those things. You have this area where if you're going to delegate something, so let's say you've got a critical value. Lab called with a critical lab value, right? The LPN takes the call,
and they tell you. It's a critical enough value to change cardiac rhythm. So, I might even as the RN go in and document, notified of the critical lab value, what it is, and say LPN instructed to call physician for verbal order. I'm not telling her to treat it because it's probably going to be something that they can't hang. It's an IV; it's a medication probably outside the scope, but I'm doing something that I can at least get the order. LPN needs to go and say, hey, called Dr. Smith. She gave me an order for X, Y, and Z at this rate, yada, yada, yada, and writes it all down. Okay, great. She communicates with the nurse. The nurse goes, gets it, and hangs it. If there is a delay in the LPN calling and getting an order, I now have a partial leg to stand on saying, hey, I recognize the issue. I delegated to try to address the issue, right. The hospital allows me to delegate this task. The hospital allowed this. That person didn't do it timely, bad outcome happened. Get on to the person that didn't do it timely, not me. So, this is not about placing blame, but it is about appropriately documenting step by step what did happen. And the LPN, when they call, they should put in there, hey received a note, put in an order, yada, yada, yada. They need to document that. The nurse also needs to come behind them and document their note, received this order did yada yada, x, y, z. Okay. Don't think that it's done just because the LPN's documentation is there. That may not be sufficient. Okay. They may have the knowledge or report the finding, but you better actually address the issue. That will get people a lot of time since they don't actually address the issue that they're reporting on.

PIERCE: And I will put a disclaimer on your example. First, when I say it's an example. The second is to make sure an LPN that you're working with can actually take orders because I have worked in areas where they were not allowed to take orders. Only RNs were allowed to take orders.

STOWE: So absolutely, again, look at your state laws, which you can and can't do. And then also what your hospital will allow them.

PIERCE: Right? Yes.

STOWE: Two different levels there. So, yeah, check, check, check.

PIERCE: It is hard. You know, I've worked in I've worked in a federal hospital over in Japan, and I've worked in a lot of different state hospitals. And so, I have seen firsthand the difference in trying to remember who can do what, where, when, and why. But at the end of the day, I'm responsible for the care of that patient. And so I can't assume that somebody is going to go take vital signs, that somebody is going to go take the glucose check on the patient. I can't assume that this is going to happen. I need to make sure that it happens.

STOWE: And as an RN, when you talk about that, brings up something, we talk about clear communication and almost over-communicating. As an RN, if you don't set your practice up to have that LPN tell you every time they get a value, whether it's a blood sugar, whether it's a vital sign, whatever it is to tell you, even if it's 100% normal, you're going to have skips, you're going to have misses because I want to know real-time and everything.

PIERCE: So set up that routine and that partnership between you of laying out what your expectations are and what their expectations are of you from the CNA and from that LPN so that you know how to work well together. And I know for me, a lot of times I will go in and check documentation because, if you get glucose and it's electronic, a lot of times it will roll over, and you can see it in real-time. Checking that, but just making sure that everything is done that is supposed to be done for that patient. At the end of the day, regardless of if you delegated or not, it's our responsibility as the nurse, as the registered nurse. So, it does make delegation for me difficult because it's sometimes easier to just do it yourself.

STOWE: You know, if you have OCD, a control freak, it's very difficult. It is very difficult. You do give up some responsibility there. I think team nursing, with different tasks, and different things that can be delegated, can be very successful on the floor. It can be somewhat successful on a telemetry unit. But if you get much more critical than that, I think there are challenges. That's from my own personal experiences. The education level, as far as what you're looking for, what you should report, and what you should act on immediately, becomes much more impactful when you're in a much more acute area than when you're in med surg. So, med surg, when I have floated before, like I've had an understanding with my CNAs, I knew I knew the hospital policy of anything less than 60, and the blood sugar was considered critical. That's just how the hospital defined it there. So my comments to them were, if it's less than 60, I need you to write down what it was, and I need you to go to the previous one that was taken, find it on the date and time it was taken, and what the value was. And then you tell me directly. Well, for me, you know, the CNA was like, I don't understand that, you're making me do more work. For me, now I have a trend, right? I can kind of see which direction we're going. Is it staying low or trending down? What's going on. But that helped me be able to react instantly as to what I needed to do with that patient. Once I was able to explain that and communicate that, the CNAs were now empowered to go and look. They would go back two or three and would say, "You know, Jay, I mean, this is all over the place, not really trending in one direction. What do you think it could be?" When you're CNA is evaluating those things from a tech level, a nursing assistant level, trying to have a medical conversation with you, it's phenomenal.

That means they're receptive to all these other things. So, clear communication. But I would agree that the higher acuity areas you have, the more difficult it is to rely on someone else, especially their assessments, because it's just that much more critical, that education

experience that you have that they don't really shows. So, I'm a big proponent for team nursing. I'm a big proponent for LPNs. But I would steer clear of them in the ICU, arguably some progressive care areas, I would steer clear of them. Step downs, we'd have to have some real clear defined roles there. But your med surg units, I think a lot of beneficial care could happen if we had a lot more LPNs in our med surg.

PIERCE: And I know you're saying steer clear. And I think that what you mean by that is you need more of the critical thinking that is taught to a registered nurse to ensure that the care of the patient, that the patient is receiving the care that they need to have in order to have a good outcome.

STOWE: Agreed. Agreed. You know, when you look at that, there's a reason that the ratios are 2:1 in most ICUs, maybe 3:1 depending on acuity. There is a reason. It's not for anything other than, if we keep the patient a center of care. They need the frequency of eyes on the frequency of assessment. They need the frequency of that skilled assessment, which the LPN, while very skilled, does not have the education or the assessment skills to the level of the RN, no fault of their own. That's the education path that they had. So, where can we properly place that level of skill that would work best for the patient? You hit the nail on the head there. The ICU, that's the reason that there's a ratio there. That's really the frequency of assessment that needs to occur by that skilled personnel.

PIERCE: Yes, there's a lot of titrating in there for medications. And absolutely, we're running out of time for this series. But I really loved what you said about empowerment. So, the art of delegation has that underlying piece of effective communication, but also the empowerment piece of that. And so, as we wrap this up and we come to the end of it, for those who are going to be walking away from this and go into the hospital to work, how can they roll that empowerment into effective communication?

STOWE: I would challenge you the next shift you work, the next couple of shifts. For one, think about them. Observe what your LPNs and CNAs are doing, and have conversations with them. When was the last time you told somebody when this surgical procedure happens? I look for these things. Have you told them the signs or symptoms you look for? They're going to be in the rooms. Why can't they help you assess? Why can't they help look for those things? Now, you still have to go do your assessment. You still have to go do things. But, if you're not planning on being in that patient's room for another two hours because you're doing something and they see dilated pupils, they see one that's dilate, they see this patient no longer can move his right foot, his leg. Wow. I mean, and they come and tell you. So, I think if you empower members of your team, I mean, imagine how quickly and how much better service and care we can provide our patients. You'd be surprised. You know, we oftentimes think of limitations like, oh, nurses have so much on them, or this person has so much on them. That's the very person I put in charge, right. To give them some authority and give them the ability to do more and they will rise to the occasion. I think you'd be very surprised of your LPNs and your CNAs. They deal with some pretty rough situations, right? They care for some pretty difficult patients. They want to be there. They want to help. Empower them. Let them help, let them do more, see more, and be more eyes and ears for you. You're always going to have that responsibility to go in there. You're always going to have that responsibility to go and oversee patient care. But hey, if you got some people that you can train to see more and

do more and help you take care of that patient better, you'll find that your workload becomes a whole lot easier and it will actually benefit you. And that really is the definition of team nursing that we kind of started with that was here 50 years ago. That's the team nursing that existed where everybody worked collaboratively for the patient, and that's what we've got with strayed away from it, right? And we've got to relearn that collaboration in order to have it successful today.

PIERCE: Absolutely. This has been very insightful, and this is such a grey area. And I know even as we come to the end of this, it's still probably pretty gray. But I hope that we've been able to give you some more places to go to find the answers, who to talk to, to find the answers, and most importantly, to protect yourself and your license. So, thank you so much for joining us today. Jay, you always bring so much insight to the discussion. I always love having you join us for these. To our listeners, I hope that you have gained insight into this topic and how to more effectively delegate and to safely delegate. And we encourage you to explore many of the other courses that we have available on elitelearning.com to help you grow in your careers and to earn CEs.