PNCC Meeting Minutes
03/18/2021
1430-1630

LOCATION: Video: Microsoft Office Teams

ATTENDANCE:

Present: Maureen Cooper-Gaine, Pam Bacon, Amy Gonzalez, Joy Choy, Lori Curtis, Ashley Bromley, Tiffany Eder

Guest Present: Susan Murtha, Mary Howard, Kristen O’Halloran, Emily Bennet, Corinne Schaefer 1430-1500

PNCC Meeting with Management

Management met with LPN- LPN had the following concerns:

- RN not keeping Plan of Care up to date
- Passing off complex patients
- LPN not receiving good direction
- Orders not entered

Contributing factors

- New higher productivity expectations (LPN and RN expected to see more patients per day)
- Case managers not making follow up visits due to:
  - Larger caseloads and territories
  - Frequent SOC visits resulting in case managers passing regular follow up visits to LPN
- Float nurses not comfortable to change POC
- Lack of oversite that care plans are complete
- RN case managers don’t have enough control over schedule.

PNCC to make recommendations:

PNCC Members discussion of LPN issue

Need clarification on

- Who is expected to supervise LPN and how is this done?
  - Are there productivity points involved in this?
- Who does LPN consult with when case manager is PTO or unavailable?
- If supervisors are a resource and/or supervising the LPN; who is their resource and/or supervising if supervisor is not an RN?

LPN Scope of Practice and How it Relates to the RN
A: A key scope of practice difference is that the RN has an independent nursing practice and the LPN has a dependent nursing practice. For example, the RN creates the comprehensive plan of care while the LPN contributes to the plan. The RN completes both comprehensive and focused assessments while the LPN completes focused assessments.

These differing scope of practice authorities are grounded in the type of nursing education program completed by the licensee and by the Nurse Practice Act (NPA).

At the RN level of licensure, the NPA makes no requirement for clinical direction or supervision of practice. Division 45 of the NPA grants the RN the authority to conduct an independent nursing assessment, develop a plan of care, and evaluate outcomes related to the plan. While a practice setting may enact supervision requirements related to the RN’s role within the setting, the RN remains independent in their nursing practice.

At the LPN level of licensure, the practice act does include requirements for clinical direction and supervision of practice. Division 45 of the NPA specifies that LPN practice may only occur under the clinical direction of a RN, or, under the clinical direction of a licensed independent practitioner (LIP) such as a physician or dentist.

Clinical direction of LPN practice means the communication from the RN to the LPN for the implementation of the RN’s established plan of care or the communication from the LIP to the LPN for the implementation of the LIP’s treatment plan. Any practice by an LPN that occurs outside of an established plan of care is not occurring within the scope of practice boundaries of LPN licensure.

Foundational to the LPN’s implementation of the established plan of care is the LPN’s completion of a nursing assessment. At the LPN level of licensure level this is a focused assessment. Focused assessment means recognizing the priority condition at the time of the intervention within the parameters of the established plan of care.

https://www.oregon.gov/osbn/Pages/FAQs_RN.aspx

PNCC Recommendations:

- LPN visits to be scheduled only after RN case manager has met with patient and reviewed plan of care.
- Team approach to LPN assignments (example: 2 RN & 1 LPN)
- Considering capping off number of SOC visits assigned to RN case manager to free up time to make follow up visit (example allow nurse 2 days a week without SOC visit).
- Develop a case-management, caseload guideline (to prevent caseloads becoming too big to manage).
- Consider developing a standardized practice, to make sure patients are receiving regular visits by RN Case manager.
  - Examples:
    - Wound care (2-3x week): RN case manager to see patient at least 1 time week
    - CVP/high risk (2-3week): RN case manager to see patient at least 1 time week.
    - CVP/ Medication education (1x week): RN case manager to see every other week

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SRDF
Situation: Report on current SRDFs

- SRDFs-From 2021 to present

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<th>Row Labels</th>
<th>Count of staffing conditions</th>
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<td>No Continuity of care</td>
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**Grand Total** 12

SRDF

- Compromise patient safety is most common issue
- Nurses are under reporting
  - Need to educate nurses
- Supervisors are receiving reports but response has been poor

PNCC BUSINESS

- Member selection
  - In past PNCC members would introduce potential replacement

- Number of members
  - 6 but approved increase to 7
  - Current: Maureen Cooper-Gaine, Amy Gonzalez, Joy Choy, Lori Curtis, Tiffany Eder
  - Contact Kathy Leendertse to confirm
Leaving: Carly Deweese, Jamie Aguilar, Pam Bacon

- Alternate, will ask:
  - Mary Dehning and Steve Lowry
- Request nurses to submit interest to join
- Attendance
  - Expected to attend every meeting or request alternate
  - 3 missed attendance without alternate- PNCC will seek replacement
- New PNCC Vice Chair

PRODUCTIVITY

- Nurse's feedback has been negative
- Survey to be sent out to nurses
  - Results to be forwarded to management
- Data supports new productivity grid is not achievable
  - Currently only <7% of nurses are meeting new productivity standards

To follow up during next meeting

- Grievance Mental Health Nurse:
  - Job description: Changes made to description without MHRN notification
  - Mental Health Clinical Oversight: Supervisor and/or consulting psychiatrist or Psychiatric Nurse Practitioner (PNP)
  - Status: POSSIBLE SUPERVISOR POSITION ANNOUNCED TO SHARE PALLIATIVE AND MH TEAM SUPERVISION

- Washington Rollout- clinical implications of low staff due to accepting alternate assignments

- Temporary territories COVID-19- Do we need to continue this???
  - Facilities require regular COVID-19 screening to visit residents.
  - Due to cost and limited supply following plan developed:
    - Nurses are divided in two groups: facility nurses requiring regular COVID-19 testing and non-facility nurses
- Consequences of new territory coverage (per nurses)
  - Territories have been enlarged
  - Larger and new case loads
- More driving
- Inconsistency with being titled Case Managers-Nurses with a Caseload that are not case managers.
- Extra time required while in facility and need for additional PPE
- Nurses feeling burnout
- Patient complaints related to no continuity of care and missed visits
- Nurses were under impression this was temporary

Next meeting April 22, 2021 via TEAMS 1430-1630