Licensed Practical Nurse Workforce in New Jersey as Described by LPNs and Employers

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Background: Licensed practical nurses (LPNs) are essential members of the nursing workforce in the United States. The growing aging population has led to an increased need for healthcare in settings where LPNs work. In many states, including New Jersey (NJ), the LPN roles and job functions in today's healthcare organizations have not been examined. **Purpose:** The purpose of this study is to gain an understanding of the current practice of LPNs in NJ by describing and comparing the perceptions of LPNs and LPN employers about their roles and job functions across settings. **Methods:** For this qualitative descriptive study, 10 LPN focus groups were held and 17 employers who hire LPNs were interviewed regarding their perspectives of the LPN role. **Results:** Two common themes emerged from the focus groups with LPNs and the interviews with LPN employers: (a) uncertainty exists regarding the future of LPNs and (b) LPNs need more hands-on experience. Additional themes from LPN focus groups were that (a) LPNs question what they should do, can do, and will do; (b) LPNs are stuck in their role; and (c) LPNs pray they make it through their shift. Themes that emerged from employer interviews were that (a) RNs and LPNs are pretty much interchangeable and (b) LPNs make economic "cents." **Conclusion:** Our findings reveal that LPNs in NJ have expanded their role, contributing to role confusion. Although state nurse practice acts and regulations should drive LPN practice, organizational policies often dictate how scope of practice is applied. To ensure a clear understanding of the LPN role and scope of practice, discussions regarding the nurse practice act should be conducted at the state level with the board of nursing and in practice settings.

Keywords: Licensed practical nurse, LPN scope of practice, qualitative descriptive, nursing practice, practical nurse

Today, the 920,655 licensed practical nurses (LPNs) in a variety of practice settings across the United States are caring for patients who have higher acuity levels than ever before (National Council of State Boards of Nursing, 2020). Although healthcare has evolved over the past decade, regulatory requirements and educational preparation, particularly for LPNs, have not been revised to meet these new demands. Additionally, differentiation between the role of registered nurses (RNs) and licensed practical nurses (LPNs) has historically been unclear to nurses, healthcare organizations, and consumers (Corazzini et al., 2013). The expansion of the LPN role to include skills and areas of practice that overlap with the RN role leads to further role confusion (Lankshear & Rush, 2016). Gray and White (2012) define role confusion as when information is lacking about one's ability to perform certain tasks or job functions. This role extension and confusion not only impacts LPNs' delivery of care but also blurs the understanding of what LPNs can do for other members of the healthcare team.

In the United States, state nurse practice acts and regulations define the LPN scope of practice. Scope of practice is influenced by nursing legislation, regulations, professional standards, position statements, organizational policies, nursing education, practice settings, and the needs of patients (Moore et al., 2019). In NJ, the board of nursing (BON) delineates the practice of nursing for LPNs as "performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a Registered Nurse or licensed or otherwise legally authorized physician or dentist" (NJ Stat. 45 §§ 11-23). As per the NJ BON administrative code 13:37-6.5 (2020), RNs shall not delegate assessment of the patient or the formulation and evaluation of the plan of nursing care.

In theory, state nurse practice acts and regulations should drive LPN practice; however, organizational settings, policies, and staffing models may dictate how scope of practice is applied for LPNs. For example, although LPNs can attain certification in intravenous therapy to maintain and remove short peripheral intravenous (IV) catheters and a state practice act may allow LPNs to do so, organizational leaders often determine whether the LPN can

perform this skill at their facility. This difference between organizational policy and scope of practice creates uncertainty regarding what an RN can do and what an LPN can do.

Considering the changing landscape of healthcare, it is necessary to examine current LPN roles and job functions across settings to ensure that there continues to be an adequate supply of appropriately prepared LPNs to care for the citizens of NJ. Furthermore, despite regulations set forth by state BONs, it is not clear whether LPNs are working within or to the full extent of their license. Healthcare has evolved since these licensure requirements have been enacted. It may be time to begin the discourse on the disparity between regulatory requirements and actual needs in the practice arena.

The Institute of Medicine (IOM, 2010) *Future of Nursing: Leading Change, Advancing Health r*eport recognized the unique contribution of LPNs in long-term care (LTC), including supervision of direct care workers and other nonlicensed individuals. As the National Academy of Medicine (formerly the IOM) expert committee develops the recommendations for the *Future of Nursing 2030 r*eport, it is essential that we explore current LPN roles and responsibilities to meet the higher acuity levels and evolving healthcare demands. It is imperative to also examine which settings are most appropriate for LPNs and the role that they will play in conjunction with RNs.

However, a current gap in the literature exists on LPN roles and job functions across settings, especially as it pertains to NJ. Considering the changing landscape of healthcare, the growing aging population throughout the country, and the influx of patients seeking the services in which LPNs are employed, information is needed to further understand their roles. Examining the current LPN roles and job functions across settings from a state with an average rate of demand for LPNs will begin to provide NJ and other similar states with a better understanding of this role (New Jersey Collaborating Center for Nursing [NJCCN], 2020). Additionally, since 2009, the NJ BON has had a moratorium on approving new practical nurse education programs in NJ. The findings from this study will provide the NJ BON with needed data on the current LPN role.

Our results can be used to inform NJ providers, administrators, and the state regulatory bodies about any incongruence between licensure and the actual practice as perceived by LPNs and employers. Furthermore, this study may provide evidence regarding the barriers to and facilitators for providing quality care to patients cared for in settings where LPNs work. Focusing solely on the perspective of the LPN ignores the important contribution of administrators who have LPNs in their settings. We recognize that these perspectives may differ; therefore, the purpose of this study is to examine the current practice of LPNs across settings in NJ by describing and comparing LPN roles and job functions from the LPN and LPN employer perspectives.

To guide this investigation, we considered the following two research questions:

1. What are LPNs' perspectives of their roles and job functions?
2. What are the employers' perceptions of the roles and job functions of LPNs?

Researchers who investigated the roles and responsibilities of LPNs in Illinois, North Carolina, and Minnesota found that LPNs working in nursing homes are unclear about the difference between the RN and the LPN roles (Corazzini et al., 2013; Dyck & Novotny, 2018; Mueller et al., 2012). In Illinois and North Carolina, LPNs reported performing activities that were not within their scope of practice (Dyck & Novotny, 2018; Parnell & Kring, 2012). While Corazzini et al. (2013), Dyck and Novotny (2018), and Mueller et al. (2012) examined the scope of practice, nursing activities, and roles and responsibilities of LPNs working in nursing homes, only Parnell et al. (2012) examined the practice of LPNs working in a variety of practice settings in North Carolina. Furthermore, although researchers have examined the perspectives of directors of nursing regarding the LPN role in nursing homes (Corazzini et al., 2013; Mueller et al., 2018), to our knowledge, no study has previously explored employers' perceptions of the LPN role and job functions across the varied settings where LPNs work.

Methods

A qualitative descriptive study (Sandelowski, 2000) was conducted to obtain a broad, comprehensive understanding of LPNs' and LPN employers' perspectives of the LPN role and job functions as well as to assess whether the LPNs were working within their scope of practice in a multitude of settings, including LTC, home care, and ambulatory care settings. Institutional Review Board approval was obtained from Rutgers, The State University of New Jersey.

LPNs Research Procedures

A purposeful sample of LPNs was obtained from the 20,807 LPNs in NJ who had an active NJ license and an email address listed with the NJ BON. The sampling strategy was to select an easy-access location for the in-person focus groups in the north, central, and southern regions of NJ and to invite LPNs who had a mailing address within 10 miles of one of these locations. Recruitment emails were sent to approximately 5,000 LPNs currently working in NJ to participate in a focus group near their home. The LPNs were asked to respond to the email if they were interested in participating or in learning more about this opportunity. The focus groups were offered on varied days of the week, at differing times of the day, and at convenient, well-known locations, such as a hospital conference room, a medical office building conference room, and a university conference room. When participants arrived for a focus group, they signed an informed consent form and completed a demographic data form. A semi-structured focus group discussion guide, which was developed by the researchers, was utilized to facilitate discussion. All proceedings were audio recorded. At the conclusion of the focus groups, the researchers gave each participant a $10 VISA gift card as a token of appreciation for their time.

To obtain a representative sample of NJ LPNs, we ensured that the practice settings of our LPN participants reflected the practice settings reported in the NJ and national LPN workforce data. In the 2018–2019 NJ license renewal survey, 21,373 LPNs responded, and the majority worked in LTC, subacute care, or an assisted living facility (44%) or home health/hospice (21%) (NJCCN, 2020). The 2017 National Nursing Workforce Survey revealed that the majority of LPNs work in LTC, subacute care, or an assisted living facility (37.3%) or home health/hospice (15.6%) (Smiley et al., 2018). The LPNs who participated in the focus groups represented the distribution of LPNs throughout NJ and nationally. For example, similar to the NJ and national LPN workforce data, the majority of focus group participants worked in LTC, subacute care, or an assisted living facility (42%) or home health/hospice (21%). Thus, the focus groups were conducted until data saturation was reached and no new themes emerged (Sandelowski, 1995).

LPN Employers Research Procedures

To recruit LPN employers, trade associations and organizations that represent facilities or organizations that hire LPNs, such as home care, hospice, LTC facilities, hospitals, and healthcare providers, were contacted. The trade associations and organizations sent emails to their members, inviting LPN employers who had direct impact on how the LPN functioned in their organization to respond to the email if they were interested in participating or learning more about this opportunity. The sampling strategy was to recruit LPN employers from varied settings, such as home care and LTC, and from the north, central, and southern regions of NJ. The one-time, in-depth telephone interviews were arranged at dates and times that were convenient for the participants. Before audio recording the interview, the researcher read the informed consent form. Participation in the interview served as consent to study participation. The interviews commenced with demographic questions followed by questions from the semi-structured interview guide that had been developed by the researchers. The LPN employer interviews continued until employers from varied settings were obtained and data saturation was reached.

Sample

Ten focus groups with no more than nine LPNs per group were conducted prior to the COVID-19 pandemic in eight of the 21 counties in the north, central, and southern regions of NJ to explore the LPNs' perspectives of their roles. The focus groups lasted an average of 59 minutes. Additionally, 17 employers who hire LPNs were interviewed by phone to understand their perspectives of the LPN role. The interviews were conducted prior to the COVID-19 pandemic, and the employers were from eight of the 21 counties that make up the different regions of NJ. The interviews lasted an average of 25 minutes.

Data Analysis

The focus group transcripts were analyzed for the LPNs' perspectives of their roles and job functions. The interview transcripts with the LPN employers were analyzed in a similar fashion, scrutinizing the texts for the employers' perspectives of the LPN role and its job functions. The audio recordings, which had been recorded by a digital recorder, were transcribed verbatim by paid transcriptionists and were checked for accuracy by a research team member. Transcripts and descriptive field notes were then read and reread individually by each researcher, beginning with the first focus group and interview and continuing throughout the rest of the study. In conducting the thematic analysis, the researchers used an iterative, constant comparative method to identify codes and themes (Graneheim & Lundman, 2004; Sandelowski, 2010).

The researchers first reviewed the data separately, creating codes and categories. Two members of the research team used NVivo 12 Pro (QSR International Pty Ltd) for data analysis, and the other two members used Microsoft Excel (Microsoft Corporation) for documenting quotations from the transcripts with the corresponding page numbers, categories, and codes. The code summary was exported from NVivo and transported into one Microsoft Excel spreadsheet that contained all team members' categories and codes. The research team held frequent meetings to compare the data for common codes, categories, and themes and to reach consensus. When analyzing the data, contrast tables were drawn and mapping was done to systematically display common patterns and themes (Graneheim & Lundman, 2004).

To enhance the validity of this research, trustworthiness was established with reflexivity, thick description, and respondent validation (member checks) (Morse, 2015; Squires & Dorsen, 2018). Thick description with in-depth details was used when writing the descriptive field notes after each interview and focus group. Reading and reflecting were utilized to thoroughly analyze the data from the interviews, focus groups, and field notes. The data were read, reread, contemplated, analyzed, and discussed by the research team to uncover and draw conclusions based on the deeper—not the superficial—meanings.

For credibility by using respondent validation, member checks were used in which a summary of the findings was sent to nine LPNs and nine LPN employer participants. Two LPNs responded, indicating the synopsis was accurate, particularly in regards to the LTC setting. Responses were also received from six LPN employers. Four employers agreed with the themes and subthemes, and two LPN employers agreed with the findings except for one theme and subtheme. One employer indicated the theme *RNs and LPNs are pretty much interchangeable* was not accurate at her setting and another employer indicated the subtheme *LPNs are running LTC* was not accurate at her setting. The researchers then rereviewed the transcripts. Regarding the LPN employer's concern about the theme *RNs and LPNs are pretty much interchangeable,* the researchers found the transcript supported this theme with the following: "very similar to what the RN does in long-term

care except they can't do assessments" and "orientation program for an RN and LPN is exactly the same except...different competency related to wound VAC [vacuum-assisted closure] and PICC [peripherally inserted central catheter] line." However, after reviewing the transcripts and discussing the other LPN employer's concern, the researchers revised the subtheme *LPNs are running LTC* to *LPNs are running LTC units.*

Results

A total of 43 LPNs participated in the 10 focus groups. The LPN participants were a mean age of 45.5 years and the mean years in their current position was 8.5 (Table 1). The majority obtained their practical nursing education at a vocational technical school (*n* = 34, 79%). The majority of LPN focus group participants worked full-time (*n* = 36 , 84%) and worked in LTC, subacute care, or assisted living facilities (*n* = 18, 42%). Additionally, 30% (*n* = 13) of the LPNs indicated they had two or more jobs.

A total of 17 LPN employers were interviewed, and the majority of LPN employers worked at LTC, subacute care, or assisted living facilities (*n* = 7, 41%) or home health settings (*n* = 6, 35%) (Table 2). The majority of those interviewed were directors or directors of nursing (*n* = 12, 71%), with others holding the titles of chief nursing officer or regional manager. The employers indicated LPNs were hired in full time, part time, and per diem positions, and the number of LPNs employed ranged from four at a Medicare-certified home health agency to 750 at a private duty home care agency.

Those who participated in the focus groups represented similar demographics in age, employment status, and employment setting to the overall NJ LPN workforce. For example, the LPN participants in this study and the LPN respondents in the 2018–2019 NJ license renewal survey were similar in age with a mean age of 45.5 years and 49 years, respectively, and 84% (*n* = 36) of LPNs in this study reported working full-time compared with 72% of LPNs in the 2018–2019 study (NJCCN, 2020). Additionally, the majority of LPNs and LPN employers worked in LTC, subacute care, an assisted living facility, or home health/hospice, which, as previously mentioned, was similar to the reported employment settings in the NJ LPN workforce data (NJCCN, 2020).

TABLE 1

Demographics of Focus Group Participants: Licensed Practical Nurses (*n* = 43)

Category	*M* (*SD*)
Age, y	45.51 (10.3)
Age range, y	29–62
Years in position	8.45 (9.7)
Years in position range	1–42
Gender	*n* (%)
Male	1 (2)
Female	42 (98)
Education	*n* (%)
Community college	7 (16)
Vocational technical school	34 (79)
Other	2 (5)
Employment Setting	*n* (%)
Long-term care/subacute/assisted living	18 (42)
Home health/hospice	9 (21)
Physician office/clinic	9 (21)
Hospital	3 (7)
Insurance company	2 (5)
Other	2 (4)
Shift Worked	*n* (%)
Day shift	28 (65)
Evening shift	3 (7)
Rotating shifts	12 (28)

Themes

Common Themes With LPNs and LPN Employers

Different themes from the LPNs and the LPN employers emerged; however, the two common themes that emerged from both the focus groups and the interviews (Table 3) were *uncertainty in the future of LPNs* and *LPNs need more hands-on experience.*

Uncertainty in the Future of LPNs. LPNs and LPN employers recognized the *uncertainty in the future of LPNs,* and this theme included three subthemes: (a) *There continues to be a demand for LPNs;* (b) *LPNs are running LTC units;* and (c) *LPNs believe they're going to die out.* According to the LPNs and employers, there is and will be a continued demand and need for LPNs in the home care and LTC settings. As stated by an LPN, "[There are] so many opportunities in nursing homes and LTC facilities and even in home care because you take on such responsibility. They're always hiring."

In addition, LPN employers explained the important roles that LPNs fulfill in their organizations: "The case manager role will always be an LPN role because you need to have somebody who has some clinical background. The cart nurse role, I think, there will always be a demand." When contemplating the future of the LPN role, employers recognized that LPNs are currently working at the "top of their license" or the "edge of their license." Furthermore, with the ever-increasing acuity of patients along with new technologies such as telehealth, employers have expanded LPN competencies, as explained by one employer:

> *With LTC, the doctors who we have here are not necessarily on in the evening hours, or, if they are, they're not easy to get ahold of. So, to prevent the patients from not being treated in a timely manner, we have a cart that has a screen on it—a large screen—and*

TABLE 2

Demographics of Interview Participants: Employers of Licensed Practical Nurses (*n* = 17)

Setting	*n* (%)
Long-term care/subacute care/assisted living	7 (41)
Home health/hospice	6 (35)
Continuing care community	1 (6)
State correctional facility	1 (6)
Insurance company	1 (6)
Psychiatric continuum of care	1 (6)

> *it's hooked up to a stethoscope and a blood pressure cuff, so the LPNs will take that to the room. As they're assessing the patient from head to toe to find out why the patient has a change in status, the doctor is live with them on the screen, and then they get orders immediately.*

The employers indicated that LPNs are not only running LTC units but are committed to a career in LTC. For example:

> *We couldn't function here without {LPNs}. . . . They are the backbone . . . everything that we need as far as documentation and overseeing the aides and running the units, they're there. They're doing everything. They're running the units, so without them, I wouldn't be able to run this building.*

Another LPN employer noted that "LPNs are more committed to staying in the subacute or LTC environment, whereas the RN population is looking to get their experience and branch out into the hospital world."

However, many LPNs are worried about their future and whether they will be needed, as one lamented, "We're going to die out, unfortunately." LPNs believed their role is being phased out because opportunities are only available in LTC and home care settings. As explained by one LPN, "I feel like associate [degrees] RNs are going to be the new LPNs because there are a lot of people who don't want to go back for their bachelor's degree. So, LPNs will be phased out."

LPNs Need More Hands-On Experience. Both LPNs and the employers identified the need for more hands-on experience for new graduate LPNs. The LPNs felt more hands-on experience is needed because, as one asserted, "You learn on the job. A lot of the skills that I have now, I learned completely on the job, including home care." One employer specified this educational need:

> *The barriers, when we're hiring LPNs, is the lack of training for skilled home care . . .. Having LPNs' clinical training in an LTC facility, learning how to take care of that specific population but not learning how to take care of the pediatric population. They don't ever see a child with a feeding tube or a child with a tracheostomy or a child on a ventilator.*

The employers have adapted to this lack in preparedness for the role by providing an extended orientation, and, at one organization, even a residency program for LPNs.

Focus Groups With LPNs

Three themes emerged from the focus group discussions: (a) *LPNs question what they should do, can do, and will do;* (b) *LPNs are stuck in their role;* and (c) *LPNs pray they make it through their shift* (Table 3).

LPNs Questions What They Should Do, Can Do, and Will Do. The primary theme from the focus groups was *LPNs question what they should do, can do, and will do,* illustrating the LPNs' collective perception of role confusion and meeting facility demands. An LPN explained this role confusion, which stems from working at different facilities and from being allowed or not allowed to perform certain procedures: "The scope of practice—it varies in each facility you work in and depends on what you can do and what you can't do." This role confusion, in which LPNs and RNs are viewed as having no difference between them, and in which the "a nurse is a nurse" view is typical, and in which LPNs are asked to work beyond their scope of practice, was pervasive. An LPN explained what happens when working with RNs who have much less experience:

> *A lot of the RNs whom I work with don't have as much experience. Even though I'm an LPN and they're an RN, a lot of times, they'll come to me for advice. They'll say to me, "Well, just do the care plan, and I'll just sign off on it as an RN." So, I find, sometimes, it's hard to stay within my scope of practice for things like that.*

This theme had two subthemes: (a) *RNs sign off on LPNs' work* and (b) *LPNs just do what they are told.* Whether working in home care or long-term care settings, RNs signed off on assessments completed by LPNs, which may be initial or ongoing assessments or may be referred to as body checks. An LPN explained, "If an admission comes in, I do the assessment but the RN has to sign off on it. What she's supposed to do is go and do the assessment herself." Role confusion for LPNs is further complicated when facility administrators outline what they should do, which may be different from what LPNs did at another facility or may differ from their interpretation of the nurse practice act. The LPNs concede, and, as they collectively relayed, "You just do what you're told." Two LPNs further explained this dilemma:

> *I am a little bit uncomfortable with doing the initial body assessment because where I've worked in the past as an LPN I wasn't allowed to do that. I could help with paperwork, but I couldn't do that initial assessment. I asked during orientation how they get away with that, and they explained it to me. I kind of don't under-*

TABLE 3

Themes From LPN Focus Groups and LPN Employers

Theme	Subtheme	Quotes
Common Themes Among LPNs and LPN Employers		
Uncertainty in the future of LPNs	There continues to be a demand for LPNs	"I definitely see [the LPN profession] continuing as long as there are LPNs who are skilled and available because it is a tremendous asset for the RN to do the admission, set up the plan of care, and have the LPN in there so that the RN can continue to admit other patients as they come home from acute care settings and [skilled nursing facility] settings. I see the demand absolutely continuing."
	LPNs are running long-term care units	"LPNs are helping run long-term care…They're so important to long-term care because RNs are few and far between."
	LPNs believe they're going to die out	"I think that we're going to die out…because no one really recognizes us and they [leaders] just want an RN in there and that's it."
LPNs need more hands-on experience		"We're finding that a lot of LPNs don't have the practical experience. You'd be amazed at how many haven't really given injections, haven't given certain types of medications, haven't done care for more than one or two patients at a time."
LPN Focus Group Themes		
LPNs question what they should do, can do, and will do	RNs sign off on LPNs' work	"This is the first place that I worked at that the LPN was allowed to do an admission. At the other place I worked, only the RN could do the admission…. If I do the entire admission, an RN is going to look at that entire packet and sign off on it."
	LPNs just do what they are told	"I can do the physical assessment, check their skin, and things like that, but the RN has to sign off on the actual assessment. It's what the law states, but at these facilities, you just do what you're told."
LPNs are stuck in their role	LPNs find it nearly impossible to go back to school	"When LPNs want to transition from LPN to RN, it's difficult because most of the programs are full time and a lot of us go into it with the hopes of one day transitioning, but once you're working full time, it's nearly impossible to go back to school, to have a family, to have a full-time job."
	LPNs are unable to advance in their role	"If I was an RN, I probably would have had even more opportunities. Sometimes [being an LPN] limits you, and you miss opportunities because of that."
LPNs pray they make it through their shift		"In the long-term care setting, it's very difficult. It's harder—there are a lot of medications, you're responsible for the CNAs—so you do what you have to do. You pray and you make it through the shift. And then you go home and you collapse."
LPN Employer Themes		
RNs and LPNs are pretty much interchangeable	Facility policies dictate practice	"The way our policies are written, LPNs are able to do the same activities as RNs, but there's always an RN on duty with them."
LPNs make economic "cents"		"With reimbursement going to a patient-driven grouping model, they're finding that the use of LPNs are going to be critical, obviously on a financial basis to assist the RN and to be part of the whole case management package with each client. We have to be savvy about what the government isn't giving us anymore in that respect …. It's financially critical."

Note. LPN = licensed practical nurse; RN = registered nurse; CNA = certified nursing assistant.

stand how they say the RN signs off on it is how they're allowed to do that.

I think that with the admissions that come in, where I'm working, the LPN is good enough to do an assessment but the RN signs off on it.

LPNs Are Stuck in Their Role. The theme *LPNs are stuck in their role* illustrates the conundrum for LPNs who believe it is "nearly impossible to go back to school," along with their belief that they are unable to advance in their role or position. This theme has two subthemes: (a) *LPNs find it nearly impossible to go back to school a*nd (b) *LPNs are unable to advance in their role.*

Many LPNs envisioned returning to school; however, they believe it is a costly venture that is complicated by family responsibilities and the need to continue to work full time. In addition, LPNs do not like the requirements of LPN to RN bridge programs, such as having to repeat courses and not receiving program credit for working as an LPN. An LPN explained, "It's a tough decision to make. I have children. I'm married. It's going to take me 2 years before I can even go to a bridge program." The LPNs expressed their inability to advance in their role, and as explained by an LPN, advancement beyond clinical positions is just not an option:

> *I work for a long-term skilled nursing rehabilitation center. Our need for LPNs is for direct patient care on the floors, but for the administrative clinical aspect, there isn't any need. You cannot get any of those clinical jobs—clinical reimbursement coordinators—or any of those other positions {as an LPN}. The only need is the direct hands-on care that is required on the floors. They {the clinical jobs} are not open to LPNs. You have to be an RN to apply.*

LPNs Pray They Make It Through Their Shift. *LPNs pray they make it through their shift* emerged as a theme from the focus groups and illustrates the challenges of working in LTC. An LPN provided an example of her angst with the heavy workload on an evening shift in LTC:

> *I had 34 patients from 3 to 11 p.m. in LTC with one patient transferred from subacute care and others who had dementia who really should have been in a locked unit. That used to be my full-time job, and I cried on my way to work every single day because I was so afraid that someone was going to die.*

Interviews With Employers

Two themes emerged from the interviews with employers who hire LPNs: (a) *RNs and LPNs are pretty much interchangeable* and (b) LPNs make *economic "cents"* (Table 3).

RNs and LPNs Are Pretty Much Interchangable. The primary theme was that *RNs and LPNs are pretty much interchangeable* in practice. Whether working as a staff nurse in LTC or in the field/patient's home, the employers collectively expressed the idea that "the RNs and LPNs are pretty much interchangeable in the field as far as providing skilled nursing care to our clients." One employer shared that, at their organization, "the orientation program for an RN and LPN is exactly the same" except that there was "different competency related to wound VAC and PICC line." Another employer recognized that "sometimes you can't tell the difference between the LPN and RN, and the LPNs are actually outperforming some of the RNs." One employer further explained the only difference was the license: "Nowadays, the way it has evolved with nursing, they really work exactly the same as an RN without the license for a RN." In this primary theme, *facility policies dictate practice* was a subtheme that emerged. According to the employers, as per national and/or state regulations, a nurse with an RN license is required, even though the LPNs are doing the work. An employer in the LTC setting elaborates:

> *I have to have RNs in the building. It's something that is warranted by the state now, so I have to have them . . . The LPNs are who are here, so they're doing everything.*

Meanwhile, an employer in the home health setting stated:

> *Our policies and procedures have specific guidelines that follow Medicare's criteria for when an RN needs to be in the home and then, for some of our patients for whom the plan of care is established, we have LPNs.*

And finally, another employer in the LTC setting explained:

> *We use the term evaluating because LPNs are not permitted to do assessment under the BON. But I'll be honest with you, it's similar to what the RNs do because we have RNs who are in staff nurse positions, and they're all doing the same thing. But in the LPN situation, they need to report their findings and get them signed off by an RN.*

The employers clearly stated that national and/or state regulations indicate that LPNs cannot do a comprehensive assessment. However, LPNs are evaluating, monitoring, and doing focused assessments, as one employer explained: "They're assessing for the wound and making sure it's not infected, but they are not allowed to do any of our comprehensive assessments that are required by Medicare, which is our OASIS {Outcome and Assessment Information Set}." The employers further explained that, although the RNs and LPNs are pretty much interchangeable, according to the state nurse practice act, there are some specific things that LPNs cannot do. One employer explained, "Obviously, we have a policy on this, and it kind of tells us what an LPN can and can't do … it clarifies it for the staff." Another employer provided an example of how the policy is followed and incorporated into practice:

> *It is in our policy, but a lot in our day-to-day practice of what we do. Same thing with IV medications. We have a nurse practitioner who does a lot of education with our nurses, and she also is aware of what our practice is and what the policy is. So, if she's going to order an IV push medicine, she will always say to the LPN, "Do you want me to do that, or are you going to get somebody to push that?"*

LPNs Make Economic "Cents." For the theme *LPNs make economic "cents,"* the employers explained—quite frankly—that, based on the reimbursement their organizations receive, it makes financial sense to hire LPNs who are paid at lower rates than RNs. As clarified by one employer, "Our budget can be very challenging.

We can have more nursing hours at the bedside if we have more LPNs than RNs, and we have our RNs in the managerial role. It makes financial sense." One home health employer explained that having LPNs "to assist the RN and to be part of the whole case management package with each client" is financially critical, especially with the Centers for Medicare and Medicaid Services change to the Patient-Driven Grouping Model (CMS, 2020). Another home health employer further elaborated:

> *The reason why LPNs work for us in home health is because we, unlike the acute care hospitals and rehabilitation centers, have a much lower reimbursement rate than those other facilities. The LPNs are good for us because they decrease our cost per visit because, obviously, we pay LPNs a lot less than RNs.*

Discussion

The findings from this study demonstrate that there is ambiguity in NJ regarding scope of practice for LPNs from the perspective of LPNs and LPN employers. Over time, the role of the LPN in caring for patients across settings has evolved, leading to role confusion for LPNs, RNs, and employers. LPNs as well as employers recognize that despite regulations, there are often patient situations that result in LPNs working beyond regulatory guidelines in order to deliver patient care. Regulation, education, and payment structure have not kept pace with the changes in the healthcare system. This ultimately can impact the quality and safety of care provided to patients and residents.

The NJ Nurse Practice Act (NPA) and regulations may be outdated or, at a minimum, misunderstood. The NJ NPA states that LPN practice is limited to "performing tasks and responsibilities within the framework of casefinding" and "reinforcing the patient and family teaching program… under the direction of a Registered Nurse or licensed or otherwise legally authorized physician or dentist" (NJ Stat. 45, §§ 11-23, p. 2). Yet, LPNs are being asked to take on more tasks and responsibilities that were previously identified for RNs to meet the patients' care needs. Furthermore, the NPA in NJ and in 13 other states dictates that LPNs cannot delegate (Corazzini et al., 2011), but in NJ LTC settings, only one RN is required to be present or on call for each shift (Standards for Licensure of Long-term Care Facilities, 2017), leaving LPNs with a demanding workload of caring for up to 34 patients per shift while not possessing the legal ability to delegate.

Role Confusion

Although RNs and LPNs in NJ have different scopes of practice, role confusion was a common theme identified by LPNs and LPN employers. This finding is similar to existing work. In Illinois, North Carolina, and Minnesota, LPNs working in nursing homes lacked clarity regarding the difference between the RN and the LPN roles (Corazzini et al., 2013; Dyck & Novotny, 2018; Mueller et al., 2012). Like the LPN employers identified in our study, directors of nursing from nursing homes in North Carolina and Minnesota also considered RNs and LPNs interchangeable in the staff nurse role (Mueller et al., 2018). For the LPNs in our study, role confusion emanated from facilities interpreting the LPN scope of practice differently, which resulted in the LPNs feeling that they were working beyond their scope of practice. This finding was also congruent with existing work that has found that LPNs working in Illinois nursing homes also reported that they performed nursing activities that were outside their scope of practice (Dyck & Novotny, 2018). The LPNs cope with this role confusion by having the RN sign off on their work and just doing what they are told. Furthermore, LPN employers recognized that LPNs are currently working at the "top of their license" or "edge of their license."

The findings from this study suggest that LPNs are working beyond their scope of practice to meet patient care demands. This is evidenced by the fact that the NJ scope of practice is very clear regarding assessment, stating, "A registered professional nurse shall not delegate the physical, psychological, and social assessment of the patient, which requires professional nursing judgment, intervention, referral, or modification of care" (NJ Admin. Code tit. 13 § 37-6.5, 2020). Interpretation of this regulation results in the employer deciding how they will enforce regulation and becomes a game of semantics for the LPN because the employer uses terms such as body check or evaluation instead of assessment. LPNs are uncertain if they can do any assessment or just a focused assessment, and they then resort to using terminology such as body check to describe their assessment of patients. LPNs explained that RNs sign off on their initial or ongoing assessments or body checks. Meanwhile, LPN employers were clear in indicating that LPNs cannot do a comprehensive assessment, yet they are permitted to evaluate, monitor, and perform focused assessments.

LTC Settings

In NJ, the majority of LPNs (44%) work in nursing homes, extended care, or assisted living facilities (NJCCN, 2020), which is comparable to the breakout of our LPN focus group participants. In NJ LTC settings, LPNs described providing the majority of care, possessing a high degree of self-reliance, and breaching their scope of practice to meet the needs of the facility. Additionally, LPNs working in LTC collectively "prayed they made it through the shift" because they are often the solo licensed nurse present and because they are caring for an increasing number of high-acuity patients, a situation that LPNs in Canada have described as "practicing in isolation" (Whitmore et al., 2019, p. 1278), which can lead to serious issues for the safety of LTC residents.

Our findings of LPNs practicing in isolation should be considered in the context of the current COVID-19 pandemic. This pandemic has recently brought to light the long-standing issues in LTC facilities that have led to recommendations for improving NJ's LTC system (Manatt, 2020). The recommendations focus on improving care to residents of LTC facilities by implementing new technology, designing and implementing minimum staffing ratios,

and requiring annual education programs (Manatt, 2020). In our study, one LPN employer utilized new technology, including telehealth, to ensure continuity of care to patients. More LTC facilitates should take advantage of telehealth and other new technology to foster timely assessment and treatment of patients. As previously mentioned, the current LTC staffing requirement only necessitates one RN on duty or on call (Standards for Licensure of Long-term Care Facilities, 2017), which leaves those with the least amount of education—LPNs and certified nursing assistants (CNAs)—overseeing the care of the residents.

Beginning in 2005, NJ has required LTC facilities to post staffing ratios. In a recent analysis of these ratios on the NJ Department of Health website, researchers found that RN and CNA staffing has remained stable from 2012 through 2019 (de Cordova et al., 2020). They also found that LPN staffing improved over time during the day, from 25 residents per LPN to 22 residents per LPN (de Cordova et al., 2020).

In addition to staffing, the issue of skill mix of nursing providers remains a concern. Recommendations to improve the overall work environment and skills of the nursing LTC workforce should be considered without interventions that are geared solely at increasing the number of staff working in these facilities. Research has demonstrated that nursing homes with better work environments have better quality outcomes and nurse retention (White et al., 2020). Thus, improving the overall LTC work environment, inclusive of staffing, should be the priority to foster quality care and patient safety.

As noted more than 15 years ago, the barriers to LPNs furthering their education remains unchanged and includes financial constraints, difficulty in getting into programs, and family commitments (Seago et al., 2004). Our findings are aligned with these barriers as evidenced by the theme *LPNs are stuck in their role,* which describes the difficulty LPNs have in advancing their education. An innovative LPN-BSN program was created in Massachusetts, which addressed some of these constraints by having a part-time option and accepting all college transfer course credits without time limits for LPNs who are currently working (Wallen et al., 2017). Considering NJ has only two LPN-BSN programs, this may be an opportune time to create a similar program with NJ universities (NJCCN, 2018).

Another educational limitation for current programs is that LPNs often lack the skills necessary to perform their duties upon graduation. Several employers included the option to extend orientation and one offered an LPN residency to counteract under preparation and the lack of hands-on experience. LPNs must care for patients with more complex health problems and fulfill leadership positions, neither of which are part of their scope of practice or education. There is an obvious dichotomy among education, regulation, and actual practice that requires rectification.

Economics

Payment structures such as those from the Centers for Medicare and Medicaid Services specifically dictate resource allocation in varied settings. Employers expressed that hiring LPNs made financial sense because LPNs provide more nursing hours for less money and because, in home care, LPNs decrease the cost per home visit. Quality care provided by a team of RNs, LPNs, and home health aides that prevents and mitigates health conditions in the community can keep patients out of hospitals.

Limitations

A limitation of this qualitative study was that the participants represented NJ and may not reflect the perspectives of LPNs working in other states. However, in a review of state NPAs, Georgia, Illinois, Michigan, and Wisconsin have regulations similar to NJ in that the NPAs restrict LPNs from delegation but do not address whether LPNs can supervise (Corazzini et al., 2011). Thus, the results of this study may be particularly helpful to leaders in those states, as they may uncover similar findings if they were to repeat this study in those states.

Additionally, although we used rigorous qualitative methods and obtained a sample of NJ LPNs that is similar to the NJ and national LPN workforce data, there is a possibility that the participants may not be representative of LPNs in NJ. This study also did not explore the LPN scope of practice in the context of the entire healthcare team, inclusive of CNAs, RNs, and nurse leaders. This should also be addressed at a national versus state level to ensure consistency and reduce role confusion.

Conclusion

This is important exploratory work for the state of NJ that will inform our future quantitative work examining LPN job function. LPNs are essential to the delivery of care in LTC facilities, home care, and physician office/clinic settings. In caring for patients across settings, LPNs have expanded their role, working beyond their scope of practice, which further contributes to their uncertainty in what they can do and what they should do as LPNs.

Leaders in settings that employ LPNs need to have knowledge regarding legislation, regulation, and standards of practice to ensure that they are competent in interpreting the scope of practice, and they must possess the skills needed to manage role ambiguity among their healthcare team. These leaders also need to define policies, job descriptions, and models of care that effectively integrate the healthcare team into various settings to meet both quality and financial challenges. Differentiating between tasks that expand the LPN's role and scope of practice needs to be clear as healthcare evolves. Formal workshops re-examining and discussing the nurse practice act should be conducted both through the BON at the state level and at the practice settings where LPNs work to help leaders and staff apply scope of practice

standards consistently. From these workshops, educational modules can be designed to provide clarity regarding the nurse practice act, scope of practice standards, and role implications for LPNs and RNs. Additionally, further discussions need to be held with LPN employers, facilitated through their trade associations and organizations, regarding the creation of structures and processes so that RNs are not just signing off on assessments completed by LPNs.

With LPNs as the mainstay in LTC who are carrying a demanding workload and with evidence linking the work environment to nurse and patient outcomes, recommendations include improving the LTC work environment. The American Nurses Credentialing Center (ANCC) (2020) has developed a roadmap to improve LTC environments. While organizations do not need to apply for the ANCC Pathway to Excellence® designation, a program that recognizes LTC organizations that create positive work environments for nurses, they can use these standards to assess and improve their work environment.

From an educational perspective for the next generation of LPNs, school administrators are encouraged to re-evaluate educational content and to consider integrating education for those new to practice on the difference between scope of practice and task expansion. This has the potential to prepare LPNs to understand their roles in varied settings. Also, program length and curricular content needs to be re-evaluated in relation to the new and expanded roles of LPNs.

This study underscores the important role that LPNs have in providing care to patients across settings. Academic and practice nurse leaders, RNs, and LPNs need to have clear understandings of the LPN scope of practice and should hold discussions with their state BON for guidance and clarification as needed. Ensuring that regulations and LPN education keep pace with the changes in the healthcare system will benefit patients, staff, and organizations.

References

American Nurses Credentialing Center. (2020). *2020 Pathway to Excellence® and Pathway to Excellence in Long-Term Care® application manual.* Author.

Corazzini, K. N., Anderson, R. A., Mueller, C., Hunt-McKinney, S., Day, L., & Porter, K. (2013). Understanding RN and LPN patterns of practice in nursing homes. *Journal of Nursing Regulation, 4(*1), 14–18. https://doi.org/10.1016/S2155-8256(15)30173-3

Corazzini, K. N., Anderson, R. A., Mueller, C., McConnell, E. S., Landerman, L. R., Thorpe, J. M., & Short, N. M. (2011). Regulation of LPN scope of practice in long-term care. *Journal of Nursing Regulation, 2(*2), 30–36. https://doi.org/10.1016/S2155-8256(15)30284-2

Centers for Medicare & Medicaid Services. (2020). Home health patient-driven groupings model. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/HH-PDGM

de Cordova, P.B., Johansen, M.L., Prado, J., Field, V., & Cadmus, E. (2020). *Public reporting nurse staffing legislation: Nursing home trend analysis 2012-2019* [Manuscript submitted for publication]. Rutgers, the State University of New Jersey.

Dyck, M. J., & Novotny, N. (2018). Exploring reported practice habits of registered nurses and licensed practical nurses at Illinois nursing homes. *Journal of Nursing Regulation, 9(*2), 18–30. https://doi.org/10.1016/S2155-8256(18)30114-5

Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today, 24(*2), 105–112. https://doi.org/10.1016/j.nedt.2003.10.001

Gray, F. C., & White, A. (2012). Concept analysis: Case management role confusion. *Nursing Forum, 47(*1), 3–8. https://doi.org/10.1111/j.1744-6198.2011.00244.x

Institute of Medicine. (2010). *The future of nursing: Leading change, advancing health.* The National Academies Press.

Lankshear, S., & Rush, J. (2016). Enhancing role clarity for the practical nurse: A leadership imperative. *Journal of Nursing Administration, 46(*6), 300–307. https://doi.org/10.1097/NNA.0000000000000349

Manatt. (2020, June 2). *Recommendations to strengthen the resilience of New Jersey's nursing homes in the wake of COVID-19.* https://www.manatt.com/Manatt/media/Documents/NJ-LTC-Report.pdf

Moore, J., Prentice, D., Crawford, J., Lankshear, S., Limoges, J., & Rhodes, K. (2019). Collaboration among registered nurses and practical nurses in acute care hospitals: A scoping review. *Nursing Forum, 54(*3), 376–385. https://doi.org/10.1111/nuf.12339

Morse, J. M. (2015). Critical analysis of strategies for determining rigor in qualitative inquiry. *Qualitative Health Research, 25(*9), 1212–1222. https://doi.org/10.1177/1049732315588501

Mueller, C., Anderson, R. A., McConnell, E. S., & Corazzini, K. (2012). Licensed nurse responsibilities in nursing homes: A scope-of-practice issue. *Journal of Nursing Regulation, 3(*1), 13–20. https://doi.org/10.1016/S2155-8256(15)30229-5

Mueller, C., Duan, Y., Vogelsmeier, A., Anderson, R., McConnell, E., & Corazzini, K. (2018). Interchangeability of licensed nurses in nursing homes: Perspectives of directors of nursing. *Nursing Outlook, 66(*6), 560–569. https://doi.org/10.1016/j.outlook.2018.09.004

National Council of State Boards of Nursing. (2020). NCSBN's environmental scan: A portrait of nursing and healthcare in 2020 and beyond. *Journal of Nursing Regulation,10(*4), S3–S35. https://doi.org/10.1016/S2155-8256(20)30022-3

NJ Admin. Code tit. 13 § 37-6.5 (2020, October 19). https://www.njconsumeraffairs.gov/regulations/Chapter-37-New-Jersey-Board-of-Nursing.pdf

NJ Stat. §§ 45:11-52 (1947 & amended 2019). https://www.njconsumeraffairs.gov/Statutes/nursinglaw.pdf

New Jersey Collaborating Center for Nursing. (2018). LPN bridge education programs in New Jersey. https://www.njccn.org/lpn-rn/

New Jersey Collaborating Center for Nursing. (2020). *Nursing data and analysis.* https://www.njccn.org/wp-content/uploads/2020/04/Nursing-Data-and-Analysis.pdf

Parnell, E. R., & Kring, D. L. (2012). Practice patterns of licensed practical nurses in North Carolina. *JONA's Healthcare Law, Ethics, and Regulation, 14(1)*, 14–18. https://doi.org/10.1097/NHL.0b013e31824768d0

Sandelowski, M. (1995). Sample size in qualitative research. *Research in Nursing & Health, 18(*2), 179–183. https://doi.org/ 10.1002/nur.4770180211

Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing and Health, 23(4), 334–340.*

Sandelowski, M. (2010). What's in a name? Qualitative description revisited. *Research in Nursing & Health, 33(*1), 77–84. https://doi.org/10.1002/nur.20362

Seago, J. A., Spetz, J., Chapman, S. A., & Dyer, W. (2004). *Supply, demand, and use of licensed practical nurses.* Health Resources and Services Administration.

Smiley, R. A., Lauer, P., Bienemy, C., Berg, J. G., Shireman, E., Reneau, K. A., & Alexander, M. (2018). The 2017 national nursing workforce survey. *Journal of Nursing Regulation, 9*(3 Suppl.), S1–S88. https://doi.org/10.1016/S2155-8256(18)30131-5

Squires, A., & Dorsen, C. (2018). Qualitative research in nursing and health professions regulation. *Journal of Nursing Regulation, 9*(3), 15–26. https://doi.org/10.1016/S2155-8256(18)30150-9

Standards for Licensure of Long-term Care Facilities, NJ Admin. Code tit. 8 § 39 (2017). http://www.pharmacareinc.com/files/201711_NJAC_8_39_Long-Term_Care_Facilities.pdf

Wallen, A., Mckay, L., Santos, E., LaFrance, H., & Veith, R. M. (2017). Actualization of a seamless nursing program: Licensed practical nurse to baccalaureate registered nurse. *Nurse Educator, 42*(5), 263–266. https://doi.org/10.1097/NNE.0000000000000360

White, E. M., Aiken, L. H., Sloane, D. M., & McHugh, M. D. (2020). Nursing home work environment, care quality, registered nurse burnout and job dissatisfaction. *Geriatric Nursing, 41*(2), 158–164. https://doi.org/10.1016/j.gerinurse.2019.08.007

Whitmore, C., Kaasalainen, S., Ploeg, J., & Baxter, P. (2019). Transitioning to practice in long-term care: New graduate nurses' experience of an accelerated transition to nurse leader. *Journal of Advanced Nursing, 75*(6), 1272–1283. https://doi.org/10.1111/jan.13945

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