Patients with cancer most often have complex care needs. Fitch and Mings (2003) reported that shortages in nursing, as in all professional disciplines, are having an impact on the delivery of cancer care and that oncology nurses have a major role to play in the delivery of optimum cancer care. In addition, oncology nursing, when adequately defined and supported, can benefit the cancer delivery system, patients, and families by playing an important role as part of the interdisciplinary team.

Although the role of the licensed practical nurse (LPN) often is discussed, particularly in consideration of the nursing shortage, the role of the LPN within a total care delivery model for patients with cancer, who have complex needs, is not. The following is a case study that led the author to question the ability of an LPN to function as a total care nurse for patients with cancer.

Case Study

Mr. Jones, a 63-year-old man with prostate cancer with bone metastasis, was admitted with uncontrolled pain. After complete evaluation and stabilization of his pain, Mr. Jones was discharged to hospice care. Mrs. Jones, a retired school teacher, was his primary caregiver. She was most often at his bedside during the hospitalization and participated in his care.

Mr. Jones was admitted to a 130-bed facility that has a cancer treatment center as well as a pain center. The facility explored different nursing models and has one unit that uses the total care nursing care delivery model with a patient-to-nurse ratio of four to one and no nursing assistants. All nursing staff on patient care units work 12-hour shifts. At this facility, LPNs are used only as flexpool staff, meaning they are assigned to certain units as needed. Two LPNs often work on the inpatient oncology unit. When they work on that unit, LPNs operate like everyone else, with the exception of state board limitations (IV pushes, etc.). The hospital policy requires an RN assessment every 24 hours. The assessment is completed every shift by an RN, but when an LPN is caring for a patient, an RN must work either the shift before or after so that the required assessments are completed. If a new admission is assigned to an LPN, another RN does the admission assessment. When an LPN is working, an RN or charge nurse is responsible for the LPN.

On the day of the incident, an RN was the assigned total care nurse for the 7 am–7 pm shift. Mrs. Jones stated that she was satisfied with the care the RN provided and that the nurse was available to the family to assist with repositioning and other care needs. At about 6:45 pm, Mr. Jones complained of pain. He was able to press the call button and communicate this to the person who answered. The respondent stated that she would let his nurse know (the call came in near the end of a shift). At about 7:15 pm, the oncoming nurse, an LPN, came in. She introduced herself and stated that she was going to measure vital signs. When Mrs. Jones noticed that the LPN did not have pain medication, she told the LPN that Mr. Jones had requested pain medication 30 minutes ago. The LPN said she would get Mr. Jones something after she checked on her other patients. She did not have a blood pressure cuff on the automatic blood pressure machine, so she left the room briefly to get one. When she returned, she said that he was scheduled for a dose of Oxycodone® (Purdue Pharma), an extended-release medication, soon. Mrs. Jones told the nurse that at home she sometimes would give Mr. Jones the oxycodone and his as-needed medication at the same time. In support of Mrs. Jones, the author, a friend of the family, told the nurse that patients receiving extended-release pain medication often need a breakthrough pain medication. The nurse left the room after completing the vital signs and said she would be back. The author remained with Mr. Jones and his wife for more than one hour; the nurse did not return. Fortunately, Mr. Jones fell asleep. Two days later, Mr. Jones was transferred to an inpatient hospice house; he died within 24 hours of admission.
Total Patient Care Nursing Delivery Model

Total patient care is considered the oldest model of patient care delivery (Marram, Barrett, & Bevis, 1979). According to Seago (n.d.) and the Agency for Health Care Research and Quality (AHRQ), the total patient care nursing model is defined as a model that generally uses an all-RN staff to provide all direct care and allows the RN to care for the same patient throughout the patient’s stay; unlicensed assistive personnel are not used, and unlicensed staff do not provide patient care. The nurse is responsible for direct care and also is able to decide to be patient-centered or task-centered in the delivery of care (Kron & Gray, 1987). Nurses working within the total care model usually provide a high quality of care because all activities are carried out by RNs who can focus their complete attention on the patient (Tiedeman & Lookinland, 2004). For quality care to be delivered, the skills and knowledge of the RN must be matched to the complexity of the patient’s needs.

Discussion

In a qualitative study to determine outstanding clinical oncology nurses, Kendall (1999) described the “star” nurse as being professional, committed, and caring; delivering excellent nursing care; being knowledgeable; having advanced communication skills; and establishing strong relationships with clients and peers. In addition, this study supports that outstanding nursing requires a variety of skills beyond psychosocial care, although an important aspect.

In the Oncology Nursing Society (ONS), 2006 position on cancer pain management, ONS mentions several important rights that should be incorporated into the care of patients and families with cancer. Those rights include that all people with cancer receive optimal pain relief, including culturally relevant and sensitive pain education, assessment, and management. In addition, ONS stated that all professionals caring for patients with cancer have an ethical responsibility to acquire and use current knowledge and skills and to implement evidence-based management guidelines.

For LPNs to be competent providers for patients with cancer, they need to be trained in the most common of the complex needs of this patient population. Those rights include that all professionals caring for patients with cancer have an ethical responsibility to acquire and use current knowledge and skills and to implement evidence-based management guidelines.

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Recommendations for Change

The issues addressed in the case presented are not unique to LPNs; RNs who specialize in other areas may not have the skills required to manage patients with cancer. Units that care for patients with cancer may want to reevaluate the use of staff, individual staff skills and competencies, and staffing patterns (Kelsey, 2006). In addition, unit managers should work toward developing environments that enhance staff support and collegiality. Support is particularly important for “float” staff, who play a valuable role in filling needs. Finally, regardless of level of education or training of the provider, the emphasis should always be providing optimal patient care. In the case of Mr. Jones, his request for pain medication was not addressed appropriately. Mr. Jones may have received breakthrough pain medication if the LPN had sought additional information about the administration of extended-release medication and breakthrough pain medication. Mrs. Jones was not persistent in the request for pain medication, particularly because Mr. Jones fell asleep. Her role as an advocate as well as a knowledgeable caregiver should have been supported and respected.

Author Contact: Coretta M. Jenerette, PhD, RN, AOCN®, can be reached at coretta.jenerette@ unc.edu, with copy to editor at CJONEditor@ ons.org.

References