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Purpose of this Document

This document describes the nurse's role in the development, implementation and evaluation of the [nursing care plan](#) (NCP).

What is a Nursing Care Plan?

The NCP is an individualized and comprehensive plan guiding the [nursing care](#) for a [client](#) in a systematic way. The purpose of the NCP is to enhance [communication](#) between care providers so care is provided consistently and client goals are achieved. The NCP includes:

- priority problems (nursing diagnosis);
- client goals;
- nursing interventions required to meet the identified goals; and,
- evaluation of the client's response to the plan or interventions within the plan.

The Nursing Act require nurses to ensure there is an appropriate NCP for every client. The NCP may be a discipline-specific stand-alone document or it may be one component of a broader interdisciplinary plan of care incorporating knowledge from nursing, health science and other disciplines.

NCPs are developed in [collaboration](#) with the client and reflect the client's priority needs on admission and throughout the duration of their care. The NCP evolves over time as the client's needs change. It is part of a legal medical record and may take on a variety of formats such as handwritten, electronic or pre-printed pathways. The employer is accountable to determine the format that fits the organizational context of practice. Additionally, the employer is also accountable for implementing policies or other processes to support the development and utilization of an NCP, whether it is nursing specific or interprofessional.

PREDICTABILITY AND COMPLEXITY OF THE CLIENT'S NEEDS

The client's level of predictability or complexity is established in the NCP. Initially, it is determined through the RN's or RPN's assessment or interpretation of assessment data (which can be collected by an RN, RPN or LPN) on the client and the client's response to [interventions](#). Client predictability or complexity are key factors for consideration when determining the most appropriate nurse to care for a client. It is important to recognize the level of predictability or complexity can change based on a client's response to an intervention or a change in their needs. While the RN or RPN is accountable to determine the initial level of predictability or complexity all nurses have a role in evaluating the client's ongoing needs.

The LPN, RN and RPN and the Nursing Care Plan

NURSING ROLES

LPNs, RNs and RPNs are autonomous practitioners with the professional authority to make independent care decisions. They are responsible for their practice and the decisions they make at all times. LPNs practice autonomously within collaborative relationships with other care providers, usually the RN and in some cases or settings the RPN.

While there is shared practice between the LPN, RN and RPN specific to the NCP, there are also practices unique to the RN and RPN. Unique practices are a result of the differences in the knowledge bases and professional scopes of practice of the LPN, RN and RPN. Unique RN and RPN practices include:

- Developing the initial NCP;
- Developing additional plans to address unexpected, new or worsened problems;
- Identifying and coordinating the initial care resources, referrals or care to support the client to achieve their care goals;
- Customizing nursing interventions to manage complex or high risk issues; and,

- Evaluating the overall effectiveness of the NCP.

LPNs are not authorized to engage in these practices independently and must do so with collaboration, guidance or direction from the RN or in some cases, the RPN.

Where the RN and RPN are autonomous in all practice contexts, the LPN's level of autonomous practice varies in relation to the needs of the client, supports in the practice environment and their professional authority. As the client's needs become more complex or supports in the practice environment diminish, the LPN's professional obligation to collaborate with the RN or RPN increases.

All nurses share accountability for determining and documenting collaboration and communication as required.

Although RNs and RPNs can create the nursing care plan and act as collaborators for LPNs, RNs and RPNs have different professional scopes of practice and therefore their role in the nursing care plan is dependent on their professional and individual scope of practice.

For more information on the differences in Scope of Practice of RNs and RPNs please refer to our [RPN FAQ](#) and [Scope of Practice Guidelines](#).

ASSESSMENT OF THE CLIENT

The client assessment is critical to the NCP. It creates both the foundation on which the plan is created and the benchmark to which the plan's effectiveness is measured. NCPs cannot adequately be developed or evaluated if there is no client assessment. Assessments have two functions: data collection and data interpretation.

LPNs, RNs and RPNs are authorized to perform client assessments. RNs and RPNs study for a longer period resulting in a more in-depth nursing knowledge base and a broader professional scope of practice than LPNs. Their broader scope of practice enables them to comprehensively analyze, interpret and independently act on the findings of the assessment. This is most important when clients' needs are not fully understood, variable or rapidly changing.

LPNs may perform an assessment on any client in any context. However, their professional capacity to analyze, interpret and independently act on the findings is limited to circumstances where there is already an established NCP in place as a benchmark and a guide for their analysis. When assessment findings are unexpected, variable or rapidly changing, the LPN's professional obligation to consult with the RN or RPN increases.

[Validation](#) is a collaborative process between the LPN and RN or in some cases RPN. The LPN is responsible to present the draft NCP based on initial assessment findings, pertinent clinical data, interventions and outcomes. The RN or RPN is responsible to review the plan, ask questions and/or suggest alternative assessments, interventions or outcomes. The plan is validated when both nurses are satisfied that the NCP is sufficient to meet the needs of the client and this is documented in the client's record. Regardless of process, the RN or RPN is responsible to analyze and interpret the initial assessment data and identify (or ensure identification of) priority problems.

DEVELOPMENT

Once the assessment is complete, the process of developing the NCP can begin. The roles specific to plan development vary for the LPN, RN and RPN, based on differences in their professional and individual scopes of practice. RNs and RPNs are authorized to independently develop initial NCPs. LPNs may only develop an initial NCP in collaboration with the RN or RPN as appropriate, or they may develop a draft NCP which gets validated by the RN or RPN (as appropriate).

The RN, RPN or other health care providers, including the LPN may collect client data. As part of their analysis of the data, the RN or RPN (as appropriate) is responsible to ensure it is valid, relevant and consistent with the clients overall presentation. If the validity of the data is in question, the RN or RPN should have the data recollected or recollect it themselves.

In contexts where the RN or RPN is not part of the care team, LPNs collaborate with the most appropriate care provider to contribute to the interprofessional plan of care. Health care professionals outside the nursing profession cannot validate a NCP.

IMPLEMENTATION

The roles of the LPN, RN and RPN can vary during implementation based on the context of practice. The RN and RPN can autonomously implement the NCP. The LPN may implement a newly developed or changed NCP in collaboration and communication with the RN or RPN (as appropriate). They may autonomously implement an ongoing NCP as long as the client is meeting their established outcomes. LPNs may autonomously revise an NCP as long as the revisions are because the client is achieving their intended outcomes. For example, a reduction in the frequency of an assessment parameter such as vital signs because the frequency of assessment is no longer warranted. They are obligated to communicate any revisions to the RN or RPN in a reasonable and timely fashion.

As the client's needs become more complex or variable, the LPN's professional obligation to collaborate increases because complex issues must be analyzed with the RN or RPN (as appropriate) to determine their relevance. Once issues are understood, the LPN and RN or RPN (as appropriate) may revise the NCP as required.

EVALUATION

The purpose of evaluating the NCP is to determine if the client is meeting their established goals. [Evaluation](#) involves comparing the findings of the comprehensive assessment of the client to the expected outcomes in the plan.

The roles specific to evaluation vary for the LPN, RN and RPN because of the differences in their professional scopes of practice. The LPN can autonomously evaluate the client's response to interventions included in the NCP. As stated above, as long as the responses are as expected, the LPN can independently move the NCP forward, however as the client's responses vary, the LPN's obligation to collaborate with the RN or RPN increases.

In addition to evaluating the client's response to interventions, the RN or RPN (as appropriate), is also accountable to evaluate the overall effectiveness of the NCP. They do this by reviewing each problem and associated interventions to ensure the issues are resolving as expected and the client is progressing towards the overall goals of the NCP. When a client is failing to meet goals, the RN or RPN (as appropriate) is responsible to analyze the situation and make the necessary changes in the plan or goals.

Pre-Printed Care Plans

Organizations are responsible to determine what type of NCP tool best meets the needs of their clients. Pre-printed care plans (e.g., care pathways, care maps, or standardized care plans) are appropriate for use in a variety of settings. Though a different format, the principles underpinning the role of the LPN, RN and RPN still apply:

- Either nurse may select a pre-printed care plan from a list of available care plans for a client, however, the RN or RPN (as appropriate), is responsible to make sure it is sufficient to meet the unique or individual needs of the client (validation process);
- LPNs may implement *standard*¹ interventions associated with a pre-printed care plan before it is validated, as long as the RN or RPN (as appropriate) is aware; and,
- The RN or RPN (as appropriate), or the LPN and RN or RPN (as appropriate) in collaboration, are responsible to customize standard interventions as needed.

¹ Standard interventions are those listed on the pre-printed care plan. Customization occurs when a standard intervention requires modification. For example, **Intervention A** is applicable to most clients in most situations; however, when a client also has **Co-Morbidity A**, the intervention requires customization to accommodate it. Customization does not apply to changes in frequency of an intervention unless it is because the client is failing to achieve expected outcomes. LPNs must collaborate with the RN whenever clients are failing to achieve intended outcomes.

Nursing Care Plan Versus a Service Plan

Nurses in all practice settings need to understand the differences between NCPs and service plans (SP) and the accountabilities of LPNs, RNs and RPNs in the development, implementation and evaluation of them.

A SP outlines standardized [activities of daily living \(ADL\)](#) or [instrumental activities of daily living \(IADL\)](#) that support clients living in their home. A SP is not a nursing plan of care. SPs are only appropriate for use in contexts where client needs are limited to home support care or retirement living.

All nurses are authorized to independently develop, evaluate, and modify SPs. Employers should have clear [authorizing mechanisms](#) in place that outline the steps that LPNs should take when the client's health needs change, and exceed their scope of practice, especially if an agency does not employ RNs or RPNs. In homecare for example, the LPN may communicate changes or concerns to the family or the client primary care provider.

Service Plans should be evaluated on a regular basis based on the organizational authorizing mechanism or when there has been a change in the client's health care needs. Nurses are accountable to collaborate appropriately, with the appropriate health care provider and/or according to organizational authorizing mechanism if the needs of the client have changed. A service plan needs to become a nursing care plan when a client's condition unexpectedly deteriorates requiring medical intervention and the focus of care changes from assistance with ADLs/IADLs to helping a client meet a health care need. The RN or RPN, (as appropriate) is accountable to ensure that the changes from an SP to an NCP are appropriate for the client. The LPN can participate in the change in collaboration with the RN or RPN or make draft changes which the RN or RPN must validate.

Conclusion

The development, implementation and evaluation of the NCP is a core function of nursing practice and helps to ensure clients receive safe, competent, ethical and compassionate care. It is essential all nurses understand the important role that they have regarding the NCP.

If you have additional questions, please contact a Practice Consultant at practice@nscn.ca.