NEWS BULLETIN

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LPN Regulations - RN/RPN Practice

What will the changes to the LPN regulations mean for Alberta's registered nurses and registered psychiatric nurses? That's the question that nurses across the province want answered as quickly as possible. Unfortunately, because of the way that the legislation is written, the answer won't be clear for a long time.

The provincial government began pursuing modifications of the LPN scope of practice in the late 1980s when LPNs expanded their practice to include, among other changes, oral medication administration. [Some would argue that the writing was on the wall when registered nursing assistants became licensed practical nurses.] An intense campaign of lobbying of the government by the Professional Council of Licensed Practical Nurses (the LPN equivalent to the AARN) successfully encouraged the provincial Cabinet to pass further changes blurring the scopes of practice of RNs/RPNs and LPNs at the end of May.

There are two spheres of concerns with the new regulations: the process utilized by the government in pursing the changes and the actual content of the legislation. The government made multiple promises to organizations representing registered nurses and registered psychiatric nurses to share information about the changes and to seek meaningful input from those organizations. One can speculate endlessly why the government then chose to do otherwise. In the end, the government's process has resulted in a piece of legislation that is certain to generate chaos and confusion within the health care system

Registered nurses and registered psychiatric nurses should be concerned about the content of the regulations which are confusing and open to a variety of interpretations. UNA obtained a preliminary legal opinion of the new wording and has now asked legal counsel for a more in-depth analysis surrounding the following areas:

- the definition of a *regulated health professional*
- the definition of *practical nurse services*
- the definition of *clinical nursing services*
- the defining line between *practical nurse* and *clinical nursing services*
- the definition of *delegation* of activities
- the meaning of *the direction to provide* versus *delegation*
- the guidelines of the Health Disciplines Board: How are they amended? Is there appropriate opportunity for input from registered nurses/registered psychiatric nurses?
- will LPNs be able to practice independently under the changes to the regulations?

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Welcome to UNA!

It's been twenty years since UNA began and it's still growing! UNA and UNA members welcome the registered nurses and registered psychiatric nurses at the Rosehaven Nursing Home in Camrose who voted overwhelmingly in favour of joining UNA in May. UNA Local #204 has already held elections for its local executive which will be busy over the summer preparing for negotiations for a new collective agreement.

Executive Board

Heather Smith, President
Home: 437-2477 • Work: 425-1025
Bev Dick, Vice-President
Home: 430-7093 • Work: 425-1025
Karen Craik, Secretary/Treasurer
Home: 720-6690 • Work: 425-1025

North District
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South
Diane Poynter (Chairperson), Sheila Bailey

Senior Staff
David Harrigan, Director of Labour Relations
Darlene Rathgeber, Director of Finance & Administrative Services
Florence Ross, Systems Coordinator

Provincial Office
900, 10611-98 Avenue
Edmonton, AB T5K 2P7
425-1025 •1-800-252-9394
Fax: 426-2093

Southern Regional Office
505, 700 - 6th Ave. S.W.
Calgary, AB T2P 0T8
237-2377 • 1-800-661-1802
Fax: 263-2908

e-mail: nurses@una.ab.ca
Web Site: http://www.ccinet.ab.ca/una/una.html

UNA members will be receiving 10 NewsBulletins each year. Any article, letter or comments for the NewsBulletins must be received by the Provincial Office no later than the 3rd of each month. Please include your name, Local number and phone number with the text. UNA reserves the right to edit any copy received and to make all final decisions on material published by the Union.

Melanie Chapman, Editor

900, 10611-98 Ave., Edmonton, AB•T5K 2P7•425-1025•1-800-252-9394

Hospital Closures by Province

British Columbia
1 facility closed

Alberta
7 (Elnora, Willingdon, Redwater, Charles Camsell, Calgary General Bow Valley, Salvation Army Grace, Holy Cross) plus numerous partial closures

Saskatchewan
3 rural hospitals converted to community health centres; 1 Regina hospital to close in 1998

Manitoba
no closures yet, one Winnipeg hospital is in process of becoming a community health centre

Ontario
24 closures announced thus far; hospital closure board touring province to determine which facilities will close

Quebec
7 hospitals to close by 1998

New Brunswick, Nova Scotia & PEI
no closures

Newfoundland
2 hospitals to close by 1999

(with information from Macleans Magazine, Globe and Mail)

"Health care is being converted from a social service to an economic commodity, sold in the marketplace and distributed on the basis of who can afford to pay for it."

-Arnold Relman

Office Closures

- The Southern Alberta Regional Office will be closed from July 28th - August 1st.
- Provincial Office will be closed from August 4th - 8th.

All membership services will be available through the open office during these closures.

Provincial Office: 1-800-252-9394 • SARO: 1-800-661-1802

UNA STAT

The UNA Stat is back! Watch for it on your UNA bulletin board.

(continued from p. 1)

- the responsibility of registered nurses when they 'delegate' or 'direct LPNs to provide' nursing care
- the responsibilities of the PCLPN, Health Disciplines Board, and the AARN for interpreting and administering the regulations.

Each UNA employer will be receiving a letter requesting information about how the employer intends to interpret and apply the new regulations. UNA's Staffing Committees, achieved so recently in negotiations, will be busy in upcoming months to ensure that employers do not abandon their responsibility to provide appropriate staffing and skill mix for their clients and patients. A few employers have already indicated that they intend to hire LPNs to replace RNs/RPNs. One regional health authority has taken down job postings for RNs [BScN preferred] and plans to hire LPNs to replace the nurses as a cost-savings measure (despite numerous studies which have shown that decreasing the level of skilled professionals results in higher costs from increased lengths of stay, increased readmissions, rising complication rates and higher levels of litigation). However, another employer, responding to the rise in patient acuity and complexity, has taken the opposite approach: eliminating LPN positions and substituting RNs.

Registered nurses and registered psychiatric nurses will have more opportunity for input into the shaping of the nursing profession for the next millennium. The LPN regulations and the Nursing Profession Act will change yet again in 1998. The government plans to introduce legislation that will move all health professions—including physicians, RNs, physiotherapists, pharmacists and LPNs— under one statute. The Health Professions Act will be the culmination of the workforce restructuring begun by the Health Workforce Rebalancing Committee and will result in all professions losing their exclusive scope of practice. Each professional group will be given a 'defined scopes of practice' and the government will establish an unknown number of 'restricted activities' that can be performed only by specified professions. It will be on this front that we must fight for both the quality of patient care and for our profession. In Alberta, "Nurses' work is never done; The fight goes on for what was won." Patient care quality—and not just the budget—must be the priority of each health care employer.

"The very first requirement in a hospital is that it should do the sick no harm."

-Florence Nightingale

Facilities Contract Off to Printer

The dispute between UNA and the Provincial Health Authorities about what would be contained in the multi-region health facilities (provincial hospitals) contract has been settled. The agreement has now been sent to the printer and copies of the "Red Book" will be available in the middle of July. Your employer is responsible for ensuring every registered nurse/registered psychiatric nurse receives a copy of the agreement. Contact your Local Executive if your employer has not given you a contract by the end of July.

UNA's Multi Region (Facilities) Negotiating Committee's Chairperson Marilyn Coady and PHAA's Chief Negotiator Jody Bauer sign the new Multi Region (Facilities) Contract

Health Care for Profit: part ii

Edited by Melanie Chapman from a report written by Trudy Richardson, Education Officer

Why are registered nurses and registered psychiatric nurses under attack by budget-fixated provincial governments and regional health authorities? Have nursing costs spiraled out of control? According to research, the governments and authorities are focusing on the wrong priorities when they cut budgets. Nursing care costs, it turns out, are not responsible for escalating health care costs. This month's look at the de-skilling of nursing shows that employers and governments would be well-advised to look at other areas when wielding their budget knives.

Nursing Costs

It is commonplace for health care bureaucrats to claim that nursing costs are too high and out of control. This belief is not just misleading—it is blatantly false.

Billion dollar health care budgets exist across North America. Canada and the USA have very different sets of priorities when it comes to health care budgets. In the US, large percentages of health care budgets are devoted to administration costs. Canada's single payer system means that huge bureaucracies are eliminated, leading to much smaller portions of health care budgets being consumed by administrative costs. More funds are thus released for patient care.

According to international data collected by the OECD, Canada ranks fifth out of seventeen countries on spending on nursing. In comparison, the US ranks 16th out of the 17 OECD countries on what it spends on nursing care. Unfortunately, as Canada falls under the spell of "in privatization we trust," more and more dollars are being siphoned out of direct patient care services such as nursing and into private sector, for-profit, administrative structures.

Recent publicity and media coverage implies that there is a shortage of funds in health care—that dollars are scarce and patient care services must be cut. A careful examination of the American system reveals that as patient care services have been cut, more and more funds have been diverted into non-patient care areas and not nursing services. So if it is not nurses who are causing the financial overspending, what is the source of the rising level of expenditures—the so-called "spiraling, out-of-control health care deficits" described by our Premier?

The place where out-of-control, cost-spiraling is happening is in the area of **administrative costs**. One astonishing statistic in health care budgets is the excessively high amounts of money paid to US health care corporate bureaucrats. A survey conducted in 1995 by *Hospitals & Health Networks*, the magazine of the American Hospital Association, found that the average total cash compensation for hospital CEOs was $188,500. In large hospitals the figure went up to $280,000, and in for-profit chains even higher. In 1995, at age forty-three, Richard Scott, the CEO of the Columbia/Healthcare Corporation, received a salary of $2,093,844. He also controlled shares in Columbia/HCA worth $359,500,000. In 1994, compensation for the CEOs of the seven largest for-profit health maintenance organizations averaged $7,000,000. In 1995, John Burry Jr., the chairman and CEO of Ohio Blue Cross and Blue Shield, was paid $1,600,000.

As provincial health care budgets have been slashed in Canada, almost all cuts have been applied to direct patient care services and not to the administrative component of health care. In Alberta, where massive downsizing in services and frontline staffing has occurred in the last few years, over two hundred Boards of Trustees were replaced with seventeen Regional Health Authorities. While looking as if administrative personnel had been reduced and bureaucracies eliminated, not only did the administrative costs not go down, they actually increased in many areas.

Nursing care costs are not responsible for escalating health care costs. A 1987 study by Donovan and Lewis showed nursing care costs between 1972 and 1985 declined as a percentage of health care costs—even as the number of nurses actually rose. In 1972 in Ontario, RNs comprised 36% of the health care workforce and accounted for 17.8% of the budget. By 1985, 94% of staff were RNs but nursing represented only 14.7% of the budget.

A 1993 study by Konrad Fassbender, an economic consultant in Edmonton, shows that nursing costs (wages, benefits and nursing supplies) as a percentage of total operating costs in Alberta health care expenditures declined from 32% in 1980 to 31% in 1990. Yet the Alberta government targeted nurses in its drive to reduce health care expenditures. Between March 1990 and March 1994, Alberta reduced its number of permanent full-time jobs for registered nurses by 19.8%. From 1994 to 1997, the reduction has continued. Unfortunately, we cannot get the exact figures because the government ceased its yearly study which profiled the health care workforce.

Numerous studies indicate that the cost of RN staffing is approximately 18% to 20% of a budget. The total percent of nursing costs has not been growing out of control and we have reduced the number of RNs and RPNs in the system. So if RN/RPN salaries and benefits do not constitute the primary reason for higher health care costs, it is time to ask: "If nursing does not cause the overspending problems, then why look to nurses' salaries and benefits to balance the budget? Why cut the numbers of skilled and experienced RNs and RPNs?"

A 1993 study by Newhouse argues that the main factor driving health care costs is **new technology**. A 1981 study by Feldstein indicated that from 1955 to 1975 non-labour costs (equipment, new technology, tests, drugs, capital expenditures) rose faster than labour costs.

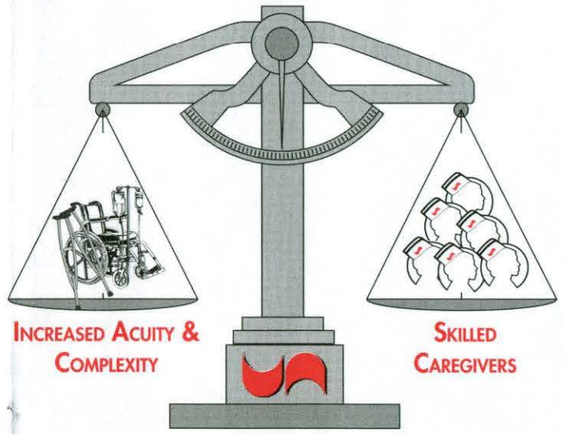
The Mulroney federal government passed legislation on **drug patent legislation** which increased drug costs by million dollar figures. Now that this legislation is up for review in 1997, perhaps the Chretien government which opposed the drug patent legislation when it was the opposition, should look to eliminating drug patent protection in order to save health care costs. Likewise, careful scrutiny needs to be applied to the increasing rates of intensity of medical services, procedures, new technologies and capital expenditures.

RNs and RPNs may be convenient targets for cost controls but nurses' salaries are not the culprit. Although hospital patient acuity has increased markedly over the past decade, research evidence reveals that **the actual cost of nursing care has declined**. Nursing is viewed as an easy target for cuts and restraint in a Canadian health care system that is becoming more vulnerable to domination by corporate interests. Nurses are viewed more and more as an expendable work force while health care is seen more and more as just another commodity. Patients are treated more and more as bargaining chips and profit has become the be-all and end-all. This is the US blueprint that Canada is fast adopting, a structure where administrative costs spiral out of control and patient care services are severely cut.

It is important that Canadian health care providers become knowledgeable about and conversant on factors that contribute to high quality care. In the next installment of our look at the de-skilling of nursing care, we will explore a Report Card developed by the American Nurses' Association to evaluate the quality of care provided by a hospital.

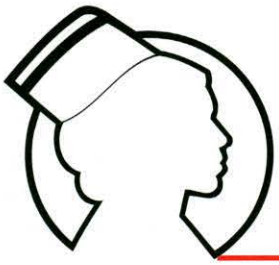
Fighting for Balance

Protecting Our Profession



"Nursing is a tapestry woven from countless threads into an intricate whole. At one moment a nurse may be involved in a sophisticated clinical procedure that demands advanced scientific and technologic education and judgment. The next moment, or even concurrently, the nurse may perform what many people would consider a trivial or menial task, such as making a bed, giving a bedbath, handling a bedpan, or feeding a patient. The fact that many of these tasks don't demand nurses' total attention allows them to spend time checking monitors and IV lines, assessing skin color and pulses, talking to patients, providing comfort, or teaching self-care activities. The seemingly menial tasks give nurses the opportunity to explore the mundane details of a patient's daily life, which often make the difference between safety and danger, illness and health, even life and death."

—Ellen Baer in *Money Managers Are Unraveling the Tapestry of Nursing*



From Both Sides

These poems were written by a woman who died in the geriatric ward of Ashludie Hospital near Dundee, Scotland and one of her nurses. They are so realistic, especially in today's climate, they were published in the Alberta Council on Aging's March/April newsletter. The woman's poem was found among her possessions and so impressed the staff that copies were made and distributed to every nurse in the Hospital.

To My Nurse

What do you see, nurse, what do you see?
Are you thinking when you look at me -
A crabbed old woman, not very wise,
Uncertain of habit with far away eyes,
Who dribbles her food and makes no reply
When you say in a loud voice "I do wish you'd try."
Who seems not to notice the things that you do
And forever is losing a stocking or shoes.
Who resisting or not, lets you do as you will
With bathing and feeding, the long day to fill.
Is that what you're thinking, is that what you see?
Then open your eyes, nurse. You're not looking at me.

I'll tell you who I am as I sit here so still.
As I move to your bidding, eat at your will,
I'm a small child of ten with a father and mother,
Brothers and sisters who love one another,
A young girl of sixteen with wings on her feet,
Dreaming that soon a love she'll meet.
A bride at twenty, my heart gives a leap,
Remembering the vows that I promised to keep;
At twenty-five now I have young of my own
Who need me to build a secure, happy home.

A woman of thirty, my young now grow fast,
Bound together with ties that should last.
At forty my young sons have grown up and gone,
But my man's beside me to see I don't mourn.
At fifty once more babies play around my knee -
Again we know children, my loved one and me.
Dark days are upon me, my husband is dead.
I look at the future, I shudder with dread.
For all my young folk are rearing young of their own,
And I think of the years and the Love that I've known.

I'm an old woman now and nature is cruel.
'Tis her jest to make old age look like a fool.
The body it crumbles, grace and vigour depart.
There is a stone where I once had a heart.
But inside this old carcass a young girl still dwells,
And now again my bittered heart swells.
I remember the joys, I remember the pain
And I'm loving and living life over again.
I think of the years, all too few, gone too fast,
And accept the fact that nothing can last.
So open your eyes, nurse, open and see
Not a crabbed old woman,
Look closer - see me!

A Nurse's Reply

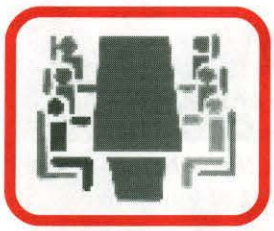
What do we see, you ask, what do we see
Yes, we are thinking when looking at thee!
We may seem to be hard when we worry and fuss,
But there's many of you and too few of us.

We would like far more time to sit by you and talk,
To bath you and feed you and help you to walk.
To hear of your lives and the things you have done;
Your childhood, your husband,
your daughter, your son.

But time is against us, there's too much to do -
Patients too many, and nurses too few.
We grieve when we see you so sad and alone,
With nobody near you, no friends of your own.
We all feel your pain, and know of your fear
That nobody cares for you now your end is so near.
But nurses are people with feelings as well,
And when we're together you'll often hear tell
Of the dearest old Gran in the very end bed,
And the lovely old Dad, and the things that he said.

We speak with compassion and love, and feel sad
When we think of your lives and
the joy that you've had.
When the time has arrived for you to depart,
You leave us behind with an ache in our heart.
When you sleep the long sleep, no more worry or care,
There are other old people, and we must be there.

So please understand if we hurry and fuss -
There are many of you and too few of us.



Negotiations Update

Edmonton Board of Health:

Negotiations for a new contract are still moving slowly with the employer insisting on rollbacks. The Board of Health wants massive changes in the hours of work and is refusing to return paid Named Holidays to the nurses. (The 1994 rollback taken by staff was taken in a mix of pay cuts and decreased paid Named Holidays.) UNA will be applying for formal mediation.

Long Term Care:

Long term care facility nurses have voted to accept their employer's last offer. The employers agreed to severance and wage parity with nurses covered by the multi-region facilities (provincial hospitals) agreement. The employer adamantly refused to address staffing issues and rejected having a registered nurse/registered psychiatric nurse in charge of the nursing care of long term care residents.

Community (Multi-Region Health Unit):

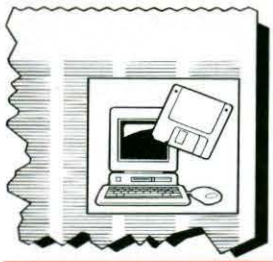
The employers' latest settlement offer (this is the second 'final' offer from the employers) contains rollbacks for nurses working in Alberta's health units. After presenting its package, the employers left the room and refused to explain their proposals to UNA's negotiating committee. The mediator then chased back and forth between the parties with the union's questions and the employers' replies.

Despite the employers' insistence (at least until March 26) that they wanted "equity" with the contract for hospital nurses, nearly every employee would face rollbacks under the employers' offer. In fact, the employer has proposed inferior provisions for overtime, on-call, layoff and recall, responsibility allowance, benefits, WCB, recognition of previous experience and shift differential!

In an attempt to create animosity between registered nurses with college preparation and those with university, the employers want to give all RNs a slight increase in basic rate of pay while decreasing the education allowance for nurses with either a BScN or a Masters degree. The net effect would be a decrease in the wages of university-prepared nurses until 1998. Nearly 60% of community nurses have BScNs.

After proposing that the 5-5-4 scheduling provisions continue unchanged, the employers have clarified their position and now say that they don't want to continue the 5-5-4 schedule (nurses work two weeks of 5 days with a third week of 4 days). For those employees currently not on 5-5-4, the employers want the ability to schedule nurses without any guarantees of weekends off and without any limits on the amount of evening shifts. The employers also want to assign nurses to work up to 49% of their time on night shift and to have complete control over changes to the daily hours of part-time employees. In addition, employers could schedule a part-time employee to work 4 hours per day for 365 days/year without ever receiving overtime. The employers agreed with the union that this was an absurd proposal but refused to change the wording.

New bargaining dates have been set for mid-July (after the employers claimed they wouldn't be able to meet until September). Fortunately, health unit nurses were the first health care workers in the province to receive a return of the 1994 rollbacks as a result of wording in their contract as it appears that their employers are somewhat less than eager to conclude a new agreement.



Found on the UNA Net

The following discussions are taken from UNA's latest communications tool, the UNA Net – a provincially linked network of computers. This is the forum for discussion of professional issues, a place to get feedback from fellow UNA members and a place to raise issues important to you and your facility. If you have a computer and modem and would like to be part of this network, contact Rena or Florence at Provincial Office.

Professional Responsibility

Patient Confidentiality

- I'm trying to get some statistics on patient confidentiality.

- Does your facility have name tags on the patient rooms?
- Do you find this affects patient confidentiality?
- Do you find the lack of name tags affects patient safety?

Thanks. Look forward to hearing the responses so I can present them to management!

- Our acute care hospital has no name tags on patient rooms but does have a locator board. Long term care does have name tags on the rooms. We find the locator board does affect confidentiality—without it only the people directly involved with the patient knows of his/her admission, not every busybody who walks into the hospital. It should not affect patient safety as patients should be wearing arm bands especially if they are unknown to staff or are mentally incompetent.
- Interesting questions. Yes, our unit does have name tags outside the room and over the bed. I work in a locked geriatric assessment unit and haven't noticed any loss of confidentiality because of this but I often feel just by virtue of being old the patient loses the right to confidentiality. If the patient has been found to be incompetent, everything seems to be discussed with everyone even if the patient has some ability to understand. The family often hears things before the patient does.
- The names are on the door at our facility. It doesn't seem to be a problem. If the patient doesn't want his/her name posted, we won't post it. [We don't ask patients; they have to notify us.]
- In our town, the nurses know everybody!! Seriously, there are no name tags on patient rooms. We do have armbands with names on patients' wrists so there is usually no problem with patient safety.
- Yes, we do have name tags on our patient's doors. We tried it with just first names and then with no names and neither one seemed to improve on any effort at increased confidentiality! Because we are in a small facility where people are known by everyone around, we just had more people peeking in each door to check the occupants instead of reading each name. This was several years ago that this was tried and I believe we even asked the patients and they didn't mind their names being on the doors!
- We don't have any names on the outside of the rooms (identification is by bracelets). The lack of outside names has not affected safety. Sometimes we do so many bed /patient moves in a day that the names would not accurately reflect who is really in that room anyway!

Professional Responsibility

LPNs

- Well, well... big surprise: the government passed the legislation without letting anyone know! The change in legislation that states "the direction to provide clinical nursing services" may only be given by an RN, etc. is certainly A LOT DIFFERENT than the old "under the direction of a Registered Nurse".

The new wording implies a RN does not have to be present on the units. The RN can give direction from an ivory tower of the upper admin. services. How different is clinical nursing services from practical nursing services?

Everyone, please call the AARN with your concerns.

- I had a long discussion with the AARN today. They're is not going to be taking any action regarding the LPN regulations. Their position is that the regulations are better then what was proposed, as they believe that LPN's will not be permitted to act independently. The terms "direction" and "clinical nursing services" are not defined, therefore the AARN sees this as an opportunity for the AARN to define those terms (I did ask how could the AARN enforce their definition of terms if employers chose to interpret them otherwise and got a less than satisfactory answer).

I asked, "What is the effect today of the regulations?" The answer—"RNs still own the direction of nursing care. LPNs can do more tasks where RNs believe it is appropriate for them to do so." I asked, "How close to the actual delivery of care must the RN direction be—can Sheila Weatherill, CEO of Region #10, say "LPNs in RHA 10 can do everything" and that be considered to be an RN directing nursing care? Answer: "The AARN would not support that interpretation of the regulations ...that there must be knowledge of the impact of the direction on patient outcomes."

- I need to chat with locals from Peace River and David Thompson. We are being told that these areas have implemented LPNs in community health specifically homecare. It would not be the first time we have been given misinformation by our RHA. Do you have LPNs in community nursing, and if so, could I get some information re: job descriptions, delegation of duties. etc. We are in a real fight here and I could use all the ammunition I can get.
- I do not work in home care but I know that home care in this region has many LPNs. All RNs who work there are out-of-scope and have to get their degrees in 5 years. Recently I heard that if one is working casual, they have 10 years to get their degree. I will get more information for you. We have both RNs and LPNs who work in the hospital and homecare .
- The AARN said that they are available to the membership to assist them in any way when they have questions about their practice. I would suggest that you contact one of the Nursing Practice Consultants at the AARN office and ask them for information about the use of LPNs in the homecare setting, when it is appropriate, what type of delegation and/or supervision is appropriate and any other questions or concerns you may have about the changes this move will make in your practice.
- Already done but thanks for the suggestion. There is a new document coming from the AARN (if passed at their meeting on Monday) re: delegation to LPNs. I have no doubt that there is a place for LPNs in homecare. For example, we have some very acute clients, such as those on home respirators, where it may be more appropriate to designate an LPN , instead of a home support aide, to do the personal care. But our region is talking laying off RNs in homecare and replacing them with LPNs. This is what I'm trying to fight. I disagree that a nurse supervisor in one end of the region would be able to appropriately delegate to an LPN at another end.