Section IV

Board of Nursing, Division 47 Rule
Nursing Delegation
Teaching for an Emergency
Sample Forms

- Delegation of Nursing Task to Unlicensed Staff
- Review of Delegated Task
- RN transfer of a Delegated Task
- Rescinding of a Delegated Task
- Teaching a Task for an Anticipated Emergency
- Review of Task for an Anticipated Emergency

Delegation and Teaching for Emergencies

Delegation (OAR 851- 47- 0000 through- 0040)

Nursing delegation means that a registered nurse authorizes an unlicensed caregiver to perform special tasks of nursing care under special circumstances and indicates that authorization in writing. “Special tasks” are those tasks, which require the education and training of a nurse to perform. Only registered nurses (RNs) are allowed to delegate nursing tasks.

Delegation Considerations:

Setting – Delegation applies only in settings where the site is not required by rule to have a regularly scheduled nurse. Delegation applies to community settings such as adult and child foster care, residential care facilities and schools. It does not apply to nursing care facilities or acute care facilities where nurses are regularly scheduled, nor does it apply to care given by immediate family members.

Tasks – A special task of nursing care can be delegated only after the RN has determined that the individual is stable and the unlicensed caregiver is competent and willing to perform the task. The RN must use his/her judgement to determine if the task can be performed accurately and safely.

Nursing Judgment – It is inappropriate for employers or others to require nurses to delegate a task when, in the nurse's professional judgement, delegation is unsafe and not in the individual’s best interest.

Nursing Process – The decision to delegate should be consistent with the nursing process (assessment, planning, implementation and evaluation). The RN who assesses the individual’s supports and plans nursing care should determine the tasks to be delegated and is accountable for that delegation.

Transferring Delegation – Nursing delegation may be transferred from one nurse to another, provided that there is documentation that the previous nurse has discussed the delegation(s) process with the new nurse. The new nurse must then document that he/she understands and accepts the delegations.

Rescinding Delegation – Delegation may be rescinded under the following conditions:

- The nurse feels that an individual's condition is not longer stable and predictable
- The nurse feels a caregiver is no longer capable of performing a task safely
- The nurse leaves the employment of an agency and is unable to transfer delegation. Rescinding documentation should be on record. When a nurse gives notice to leave employment, the agency has an obligation to replace the nurse with another, so that there is no lapse in nursing care.

Sharing Delegation – Two (or more) nurses may choose to complete the delegation process together, such as having one nurse providing the initial delegation and another nurse providing ongoing supervision. If the process is shared, all involved nurses have the responsibility to ensure that all delegation steps were followed. Careful, detailed communication is vital to ensure that steps are not overlooked and that documentation is complete. The nurses need to document the reason for separation of delegation and supervision from the standpoint of delivering effective care.

Regulation:
The Board of Nursing's authority is over the RN who delegates. The Board has no authority over the setting in which delegation occurs. If the setting is licensed, the authority over the setting belongs to the licensing agency.

Delegation Process Steps:
Assess
- Assess the situation and the person:
  - Identify the needs of the person
  - Consider the circumstances and setting
  - Assure the availability of adequate resources, including supervision
- Assess the person and determine that he/she is in a stable and predictable condition and requires minimal supervision. Individuals in hospice care are considered stable as the course of their illness is predictable.
- Consider and specify the nature of each task to be delegated, including the complexity of the task, risks involved in the performance of the task and the skill required to perform the task.
- Assure appropriate accountability:
  - As delegator, accept accountability for delegating each task
  - Verify that the caregiver accepts the delegation responsibility and accountability. If in the nurse's judgement, the caregiver is

unable to understand or perform the task, no delegation should occur.

Teach:

- Teach caregivers and observe them in their performance of the task. The caregiver is taught what signs and symptoms to watch for and when to contact the RN or health care professional. It is not expected that the caregivers always understand the meaning of the symptoms, but they do need to know when to call a health care professional about their observation.
- Leave clear, written instructions regarding the task. The instructions are to be specific to the person and should be clear and concise. The entire nursing process cannot be delegated

Supervise:

- Supervise the performance of the task periodically. Monitor performance of the task to assure compliance with OAR Division 47 rule.

Reassess:

- Reassess and evaluate the entire delegation process. Adjust the overall plan of care as needed. Determine and document the need and timeframe for future nursing assessments and supervisory visits. After the initial delegation, a supervisory visit must be done within the first 60 days and then can be done every 180 days (refer to rule).

Document:

- The task to be delegated
- The stability of the person's condition based on assessment
- The ability of the unlicensed caregiver to understand and perform the task safely.
- How the task was taught
- Teaching instructions and the outcome
- Evidence that the caregiver accepts responsibility for the task, knows the risks involved in performing the task and a written plan for dealing with the consequences
- Evidence that the caregiver knows that they cannot teach the task to another caregiver
- The frequency of the assessment/supervisory visits

Teaching a Task for an Anticipated Emergency (OAR 851- 047- 0040)

Is a process in which a nurse teaches a task that may be used for an anticipated emergency. These are tasks that cannot be practiced routinely

due to their emergent or infrequent nature and therefore, do not fall under delegation.

Process:

- The registered nurse must assess the probability that the caregiver will encounter an emergency situation with a given individual
- The RN teaches the emergency procedure
- The RN leaves step by step instructions
- The RN periodically evaluates the caregiver competence regarding the anticipated emergency situation
- The RN periodically reviews the client for changes in orders or condition

Documentation:

- Though the Board of Nursing does not spell out documentation requirements, they should include at a minimum:
    - The emergency task taught
    - Name of the unlicensed caregiver
    - Teaching methods and location of instruction material
    - Date and signature of unlicensed staff and nurse

Examples:

- Emergency injection to treat an acute allergic reaction
- Emergency injection to treat hypoglycemia
- Emergency rectal administration of diazepam (Diastat) to treat uncontrolled seizures

Teaching for an anticipated emergency can also be used in cases where an individual is mostly independent at performing a (usually delegated) task, such as blood glucose monitoring or insulin injections. The individual may need assistance from a caregiver with one step of the procedure, such as documentation or reading the meter correctly. The rest of the steps in the procedure the person can perform independently. However, caregivers need to know how to perform the task in its entirety in case the person becomes temporally incapacitated. If you have questions about an individual case, please call the Board of Nursing.

The following forms are samples only. They may be used as is or as templates for your own versions.

Section V

Nursing Documentation
Sample Forms
- Health Progress Notes
- Nursing Assessment
- Health Support Plan/Nursing Care Plan
- Review of Plan
- Health Needs Checklist

Nursing Documentation

Nurses working in community settings need to provide documentation that reflects the nursing process. A person's health record provides legal proof of the nature and quality of care the person receives.

Nursing documentation:

- ✓ Must adhere to standards, rules, regulations and laws of nursing practice.
- ✓ Should be written in language that is generally understood by caregivers. It is recommended that nurses not use abbreviations or technical medical terms.
- ✓ Needs to provide follow up on all health concerns/occurrences that are recorded/reported by caregivers and health care professionals. This should include interventions, monitoring of the person's response to interventions and eventual resolution of the problem(s).
- ✓ Should not be redundant. Double documentation should be avoided.
- ✓ Must remain at the person's residence so that it is accessible by caregivers at all times

When caring for an individual, the nurse is responsible for reviewing all documentation by caregivers and health care professionals. These include flow sheets (e.g. vital signs, intake/output, weight, menses, seizures, etc.), physician visit forms, consultation forms, medication administration records and any other documents that are pertinent to the person's care.

Documentation According to the 24-hour Rule
According to the 24-hour rule, the program must maintain records on each individual to aid others in understanding the person's health history.

Documentation must include:

- ✓ A list of known health conditions, medical diagnoses, allergies and immunizations
- ✓ A record of visits to licensed health care professionals that include documentation of the consultation and any therapy provided
- ✓ A record of known hospitalizations and surgeries

Document Organization
Because the 24-hour rule does not dictate how healthcare records are kept, organization will vary, depending on the setting and agency policy. The

nurse is often the most knowledgeable person about health care record standards and may be the best person to evaluate and resolve documentation issues. However, the nurse is only one member of the team and needs to explore all points of view in a respectful manner.

Potential Issues:

- ❖ Documentation that is inconsistent with nursing regulations and/or the 24-hour licensing rule.
- ❖ Poor documentation practices that persist because "things have always been done this way" or practices that have become sloppy over time because no one is doing quality assurance reviews.

Health Progress Notes

Day to day nursing documentation is usually found in the progress notes, which are often done in a narrative format and in a chronological order. These notes also often include entries from caregivers, managers and health care professionals. Occasionally, nursing entries may be written in a different section of the individual's file. There is no specific requirement for the frequency of entries. Entries are made as health issues arise. Most importantly, when someone identifies a health problem, the progress notes need to state the problem, what interventions are implemented and the eventual outcome. It is desirable that entries be kept in an individual's current record for at least six months.

When a nurse follows up on health concerns documented in the progress notes or passed on verbally by care-givers documentation should include:

- ✓ An assessment
- ✓ Interventions used or planned
- ✓ Ongoing monitoring if necessary
- ✓ A resolution of the problem

Telephone Communication

When working in the community, nurses often give guidance to caregivers over the phone. It is important that the agency and caregivers understand the parameters around these calls.

The agency policy, nurse contract or job description should clearly state the hours that the nurse can be called. This can range from only during working hours to being available twenty-four hours a day, seven days a week. It is essential that caregivers have clear guidelines on when the nurse should

be called and what to do if a health problem arises when the nurse is not available. These directions may be located in:

- Agency/program policy. The policy may have a specific list of circumstances under which the nurse is called
- ISP and/or Nursing Care Plan
- Nursing orders specific to an individual
- Protocols specific to an individual

Caregiver's instructions should be clear on how quickly the nurse must be notified, which can range from an immediate page or phone call to leaving a message for the nurse on the next business day.

When providing advice over the phone, the nurse needs to document the following:

- ✓ The contacting caregiver's name and title, the name of the person they are calling about, the date and time of call
- ✓ The reason for the call
- ✓ Additional information that is solicited
- ✓ Instructions given to the caller on how to intervene
- ✓ Instructions given to the caller regarding when and who to call if the suggested intervention fails
- ✓ The expected time for the nursing follow up
- ✓ The nurse's legal signature

We have included a sample telephone communication documentation form. Similar forms may also be purchased at an office supply store. The completed form should be filed in the person's health care record in a timely manner.

Nursing Orders

Within the scope of practice, as outlined by the Oregon Board of Nursing, is the ability of the registered nurse to write nursing orders, based upon the nurse's assessment and plan of care. These nursing interventions are written to maintain comfort, support human functions and responses, maintain an environment conducive to well being and to provide health teaching, counseling and advocacy of persons serviced.

This section is not intended to cover all examples of nursing orders. The Oregon State Board of Nursing can best answer questions regarding the appropriateness of a specific order. However, the following are some

common interventions that can be addressed by a registered nurse *without physician direction:*

Examples that clarify a physician's order:

- **Physician's order:** 1 to 2 Advil up to q 4 hours PRN
  - ✓ **Nurse's order:** Give John 2 Advil when he complains of headache or pain in his ankle. If he still is complaining 1 hour later, call the nurse for further direction. Only give a maximum of 8 tablets in 24 hours.
- **Physician's order:** Ducolax suppository PRN for constipation
  - ✓ **Nurse's order:** If Amy has had no BM that is at least medium-sized for two days, at bedtime of the second day, insert 1 Ducolax suppository rectally. Monitor for results and call the nurse if no results within 12 hours.

- **Orders that change the times medications are given, if the physician's order allows flexibility**:
  - **Physician's order:** Amoxicillin 250 mg every 8 hours t.i.d. for 10 days
  - **Nurse's order:** Give Amoxicillin 250 mg at 7:00 AM, 3:00 PM and 10:00 PM for 10 days
  - **Nurse's order:** Today, give Amoxicillin at 9:00 AM instead of 7:00 AM.

- **Preventive measures**:
  - Offer fluids every two hours
  - Minimal/maximum fluid requirements
  - Sunscreen
  - Barrier ointment (A & D, petroleum jelly, etc.)
  - Dandruff shampoo
  - Bran and prune juice
  - Exercise
  - Monitoring interventions with follow up instructions (vital signs, track fluid intake, etc.)

- **Physical management/comfort measures:**
  - Repositioning schedule
  - Keep home from work today
  - Elevate foot
  - Offer opportunity to go to the bathroom after breakfast for at least 15 minutes
  - Clear fluids for next 24 hours

Under the Oregon Administrative Rule that licenses residential sites, a physician's order is required for the following:

- Over the counter medications, other than topicals
- Treatments for illness or injury
  - Ice for a sprained ankle (beyond immediate first aid)
  - Tar shampoo for mild psoriasis
  - Topical ointment for groin rash

- Special diets
  - Modified consistency, such as chopped, pureed, thickened liquids to honey consistency, etc.
  - Calorie content, such as 1200 calorie ADA or 3000 calorie general diet
  - Food restrictions, such as no added sugar or no milk products

Conflicts

When writing nursing orders, the nurse needs to consider the values of integration, inclusion and empowerment of the person being served. At times these values may conflict with nursing best practices. For example; a person with a nursing order to only be in a wheelchair for a total of two hours at a time may wish to go to a movie that lasts three hours.

In addition, scopes of practices of various health professionals overlap. For example, both registered nurses and physical therapists may write orders concerning physical management. Clear communication with other disciplines will avoid conflicts.

When conflicts arise, the nurse should discuss the issue with his/her employer or contractor. Does the employer/contractor want the RN to write nursing orders or have all orders come from the physician? Who should decide if someone needs to stay home from work because of illness? What should the nurse do when nursing orders are given and not followed? At times it may be necessary to seek the assistance of the case manager, especially when a person's health and safety are a concern.

Nursing Assessment

Prior to providing direct nursing services for an individual, the nurse must perform and document a nursing assessment. There is a sample form in this manual; however, it is not mandatory and the nurse may use any form that contains assessment information. A nursing assessment is a "snapshot in time"; that is, it documents the person's health issues at the time when it is written.

A holistic nursing assessment may contain the following information:

- ✓ Name, date of birth, other identifying data such address and contact person(s)
- ✓ Current medications
- ✓ Allergies/adverse drug reactions
- ✓ Weight and height
- ✓ Current and past medical diagnoses
- ✓ Immunizations
- ✓ Adaptive equipment needs
- ✓ Communication style
- ✓ Nutritional status
- ✓ Pertinent laboratory tests and diagnostic studies
- ✓ Also included, may be cultural/spiritual/social needs, family history, and any other health/safety concerns

From the assessment information, the nurse is able to construct a plan of care. Direct nursing services that are limited in scope may require a less detailed assessment. For example, a person who has a fractured arm may require a nurse to assess a new cast for comfort and fit and the person for pain control.

Occasionally, a nurse will be hired to provide direct nursing services and will need to provide guidance and training to caregivers immediately. In these cases, the nurse will need to document a brief assessment that will ensure that any training done will be safe and effective. For example, the nurse is called in to see a person who has returned from the hospital following a laparoscopic cholecystectomy. The nurse will need to assess the person's medications, weight, diet, incisions, ability to communicate pain/discomfort, any behavioral issues that may affect healing and what happened during the person's hospital stay. From this information the nurse can construct a safe plan to care for the person overnight until a full care plan can be constructed the following day.

Nursing Care Plans/Health Support Plans

The nursing care plan is an important part of the nursing process. The essential parts of the plan are:

- ➢ List of health problems
- ➢ Desired outcomes/goals; should be measurable goals
- ➢ Interventions
- ➢ Ongoing review/updates with changes in condition/ circumstances

It is important that the nurse use language that is easily understood by the caregivers. Avoid using medical terms and abbreviations. While we have included a sample care plan form in this manual, it is not mandatory that this particular one be used.

It is important to routinely review the plan and update when the person's health supports change. The nursing care plan is a work in progress and must remain current. The frequency with which you make updates will vary depending on the setting and the individual's condition. Best practice dictates that changes are made as the person's health condition changes; this is best accomplished when the plan is reviewed on a routine basis.

Health Maintenance Tracking/Health Needs Checklist
Routine examinations and certain laboratory tests will need to be tracked to ensure that they are done on a timely basis.

Commonly tracked items:

- Dental exams
- Dietary evaluations
- Eye exams
- Periodic laboratory tests, such as drug blood levels
- Mammograms
- PAP smears
- Specialist appointments (neurology, orthopedist, ENT, etc,)
- Primary care appointments
- Therapist evaluations

Other data may be tracked, depending on the person's needs. The nurse may not be the person who is responsible for maintaining this record. The agency may assign a house manager or health manager to track this data but the nurse needs to be aware of all appointments/exams as they arise.

Section VI

Psychotropic Medication Use
Monitoring Side Effects (sample forms)
AIMS

Psychotropic Medication Use

The use of psychotropic medication in individuals with developmental disabilities has been the focus of legal debate and controversy for decades. A psychotropic medication is defined as a drug that has a prescribed intent to affect or alter thought processes, mood or behavior. This includes medications that are not typically classified as psychotropics, but may be used to affect or alter thought processes, mood or behavior.

> For example; Benadryl used at bedtime as a sleep aid or St. John's Wart used to improve mood.

A psychotropic medication is not considered a psychotropic medication when it is used to treat other health conditions or diagnoses.

> For example; Valium when used for spasticity or amitriptyline when used for migraine pain.

According to the 24-hour Rule:
When a person receives a psychotropic medication for a psychiatric diagnosis or behavior support, the medication must be:

- Prescribed by a physician or health care provider through a written order.
- Monitored by the prescribing physician, ISP team and program for desired responses and adverse consequences.
- When medication is first prescribed and annually thereafter, the provider must obtain a signed balancing test from the prescribing health care provider using the DHS Balancing Test Form.
- The provider must keep signed copies of these forms in the individual's medical records for seven years.
- ***Psychotropic medication cannot be prescribed on a PRN basis unless by variance.***

What is a Balancing Test?
The balancing test is a written statement from the prescribing health care provider stating that the risks of the psychiatric diagnosis or behavior outweigh the potential risks of the proposed psychotropic medication.

It is the responsibility of caregivers to:

- Collect a full and clear description of behavior or symptoms of the condition to be treated by the psychotropic medication.
- Collect data on frequency, intensity and circumstances around the targeted behavior(s) identified by the team and behavioral specialist through a functional analysis. You can expect short-term behavior fluctuations and should not react by favoring frequent medication changes.
- Define the expected goal(s) of treatment.
- Monitor and collect data on any medication side effects.
- Present all data to the prescribing health care professional in a understandable manner.
- Advocate for keeping drug regimes as simple as possible.

It is the responsibility of the health care provider to:

- Make a determination after reviewing the collected data that the harmful effects of the psychiatric illness or behavior outweigh the potentially harmful effects of the medication. ***The health care professional cannot make this determination without data collection and documentation from caregivers.***

Psychotropic medications cannot be used for:

- Punishment
- Convenience of caregivers
- As a substitute for a meaningful behavior plan
- In excessive amounts, thus interfering with the person's quality of life

Monitoring Forms:
If a psychotropic medication is used that has the potential of causing tardive dyskinesia (TD), a monitoring system may be put in place to track changes on a regular and systematic basis. If the drug is discontinued, monitor for withdrawal TD for approximately two months after the drug is stopped. The health care professional, the nurse, or a trained caregiver may complete the monitoring. See samples of MOSES and AIMS tools.

Abnormal Involuntary Movement Scale (AIMS)

An AIMS assessment is a useful tool when a person has involuntary movements that may be related to psychotropic medication use. These movements start insidiously and may go unrecognized by caregivers. If they do notice them, they may not understand the significance of what they observe. The following is a systematic process for evaluating involuntary movements with AIMS:

Examination Procedure:
Either before or after completing the examination procedure, observe the person unobtrusively, at rest (e.g. around the home). Having a caregiver present during the exam may be useful as the person may not be able to assist with the exam. If the person is unable to follow directions, information will come from caregiver and your observations.

The chair to be used in this exam should be a hard, firm one without arms.

- Have the person remove shoes and socks.
- Have the person remove any gum or candy from his/her mouth. Ask the person to open his/her mouth. Observe current condition of mouth. Do they wear dentures and if so do they fit properly? Have person open and close mouth twice. *Observe for tongue movement*.
- Observe if the person has any involuntary movements in mouth, face, hands or feet. If yes, do movements interfere with daily activities?
- Have the person sit in a chair with hands on knees, legs slightly apart and feet flat on floor.
    - ***Look for entire body for movements while in this position.***
- Have the person to sit with hands hanging unsupported. If male, between legs, if female and wearing a dress, hanging over knees.
    - ***Observe for hands and other body movements.***
- Have the person to tap thumb with each finger as rapidly as possible for 10 – 15 seconds; separately with right hand, then with left hand.
    - ***Observe for facial and leg movements.***
- Flex and extend the person's left and right arms one at a time.
    - ***Observe for rigidity.***
- Have the person stand up. Observe in profile all body areas again.
- Have the person extend both arms outstretched in front with palms down.
    - ***Observe trunk, legs and mouth.***
- Ask the person walk a few paces, turn and walk back to chair.
    - ***Observe hands and gait. Do this twice***