

Nursing Assessment & Delegation

Hawaii Department of Health
Developmental Disabilities Division
August 11, 2021

Agenda

- Overview & Recap of Nursing Assessment & Delegation
- 2021 Standards Breakdown
- T&C RN Process
- Recap of Nurse Assessment & Delegation
- Forms & How to Complete
- Closing



Changes in General Requirements

-

Section 1



Page	Section	Topic	Summary of Change
38	1.7.D	Nursing Assessment and Delegation	Added language about nursing assessment for participants whose health and safety needs include nursing tasks, performed during waiver service hours; revised language about nurse delegation

Nursing Assessment & Delegation Overview

Previous Standards	New Standards
<ul style="list-style-type: none">• Lack of RN autonomy during the delegation process• RNs not willing to delegate due to professional risk• Not enough hours of T&C RN to perform delegation to RN standards• Limited monitoring and standards of care for participant health and safety	<ul style="list-style-type: none">• Increased RN autonomy during assessment and delegation processes• Opportunity for enhanced communication between DDD and agency• Process improvements to authorization of hours• Modifications intended to improve health and safety by increased utilization of RN T&C service



Purpose of Training & Consultation (T&C)

- Provide training to caregivers, paid service supervisors and/or paid direct support workers in implementing participants' goals, objectives, and outcomes developed from the Individualized Service Plan (ISP).



T&C RN may be authorized for the following activities

- Provider Nursing Assessment
- Development of Nurse Delegation Plan(s) and/or protocols to address identified needs;
- Training and/or teaching;
- Oversight and monitoring of Nurse Delegation; and/or
- Revisions to Nurse Delegation plan(s) and/or protocols, as needed.

Limits of T&C

Time Limited

- the service is authorized for a specified time period in the ISP

Intermittent

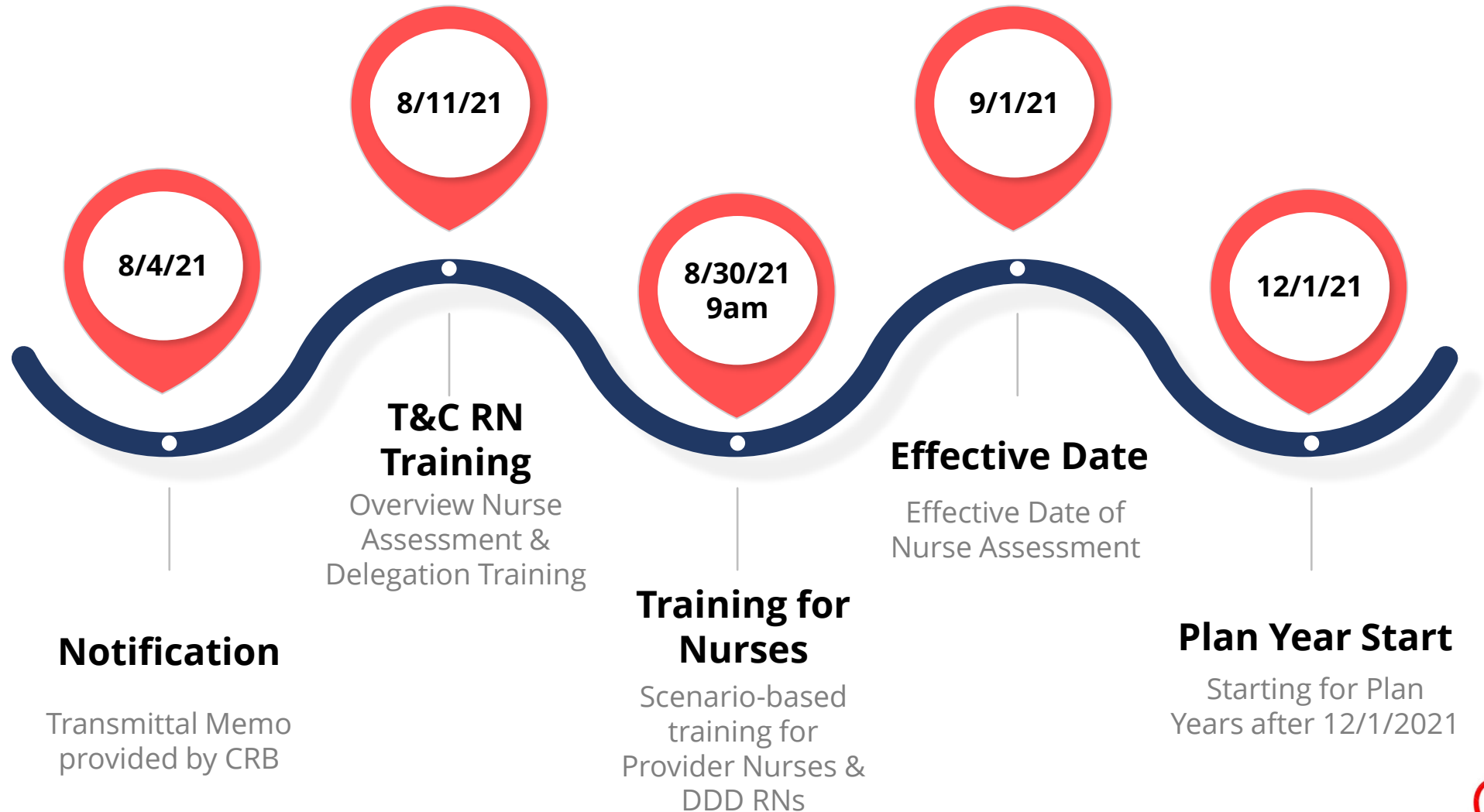
- that the service is delivered at intervals specified by the ISP that generally will be a block of time to complete assessments and training or at ongoing intervals such as ongoing monitoring

Consultative

- T&C provider delivers services in a manner that trains the workers, family and natural supports to build their capacity to provide the day-to-day supports to the participant.



Timeline of T&C RN



Identify Waiver Service/
Are there
Nursing Tasks?

✓ YES

CMs authorizes 2
hours of T&C for
Nursing Assessment
(for each provider)

Initial
Assessment –
2 hours
(Current Plan
Year)

Provider completes
& submits
Nursing Assessment

15
DAYS

Reviewed
& Approved by
DDD

10
DAYS

Mid Year Auth
(Current Plan
Year)

New Plan Year
Auth

✗ NO

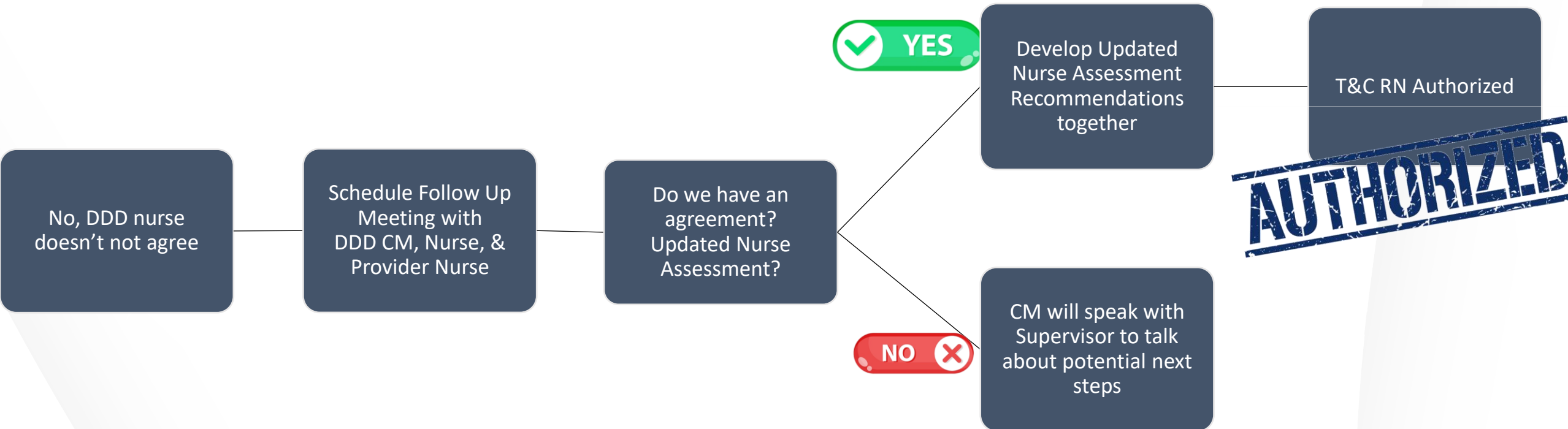
T&C RN not
needed

Overall Process for Case Managers Begins 9/1/2021

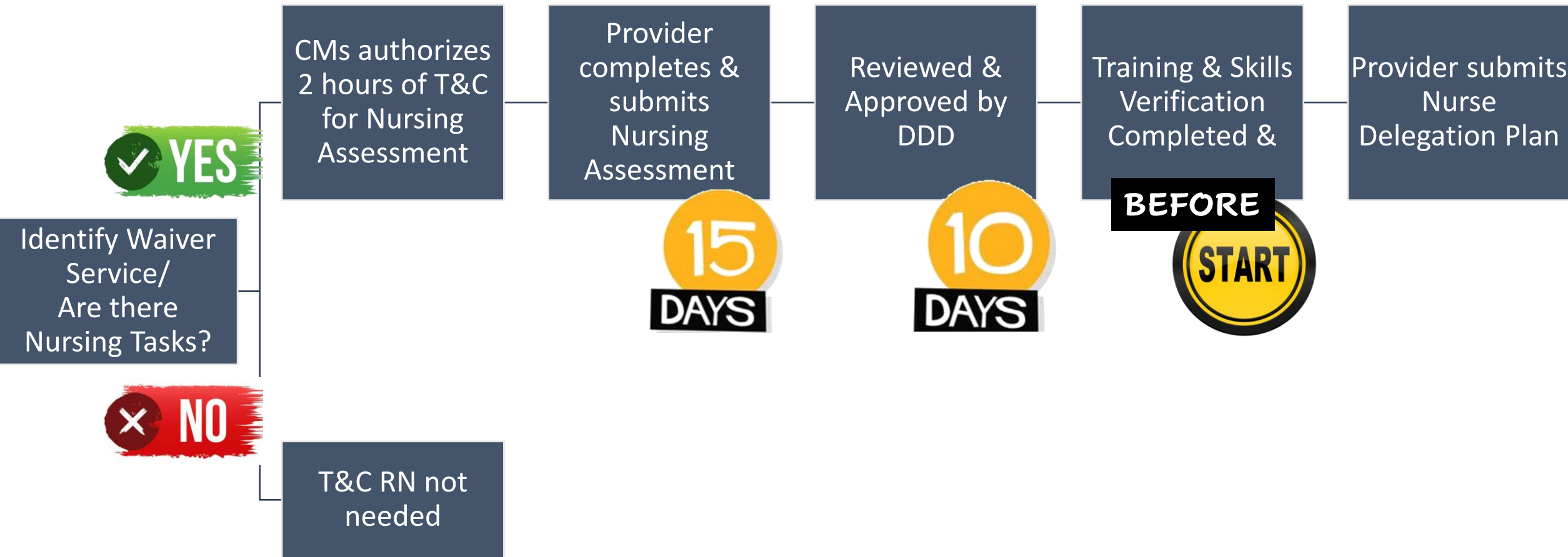


Do Not Agree with Assessment

10
DAYS



Overall Process for Providers



Nurse Assessment

Must include but not limited to:

Identification of tasks that may be delegated, based on the participant's needs and circumstance,

Assessment of the participant's circumstance,

Assessment of the person(s) that may perform the delegated task(s),

Supervision/monitoring requirements, and

Recommendation for hours needed to complete nurse delegation requirements

(recommended hours will be reviewed and considered for authorization by the DOH-DDD).



Nurse Assessment by Provider RN

Nurse assessment
required for
participants with:

- Nursing tasks
- Performed during waiver services hours

Completed by:

- Registered Nurse

RN will determine:

- Whether tasks can be delegated
- Who can perform those tasks under delegation



Tasks **Not** Delegable

If the RN determines that any person is unable to perform the task(s)

or that any task is not delegable (must be performed by a nurse),

the RN will NOT delegate;

The RN must submit documentation of the written notification with reason(s) to the CM.

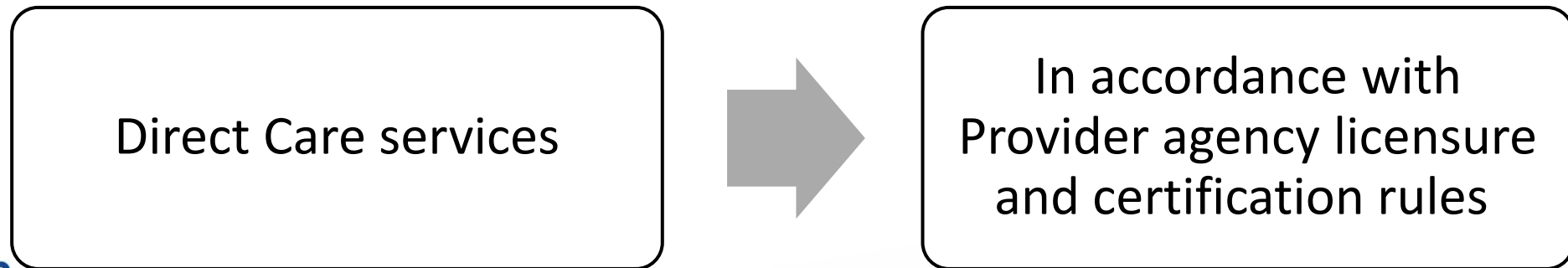
Nurse Delegation Best Practice & Guidelines



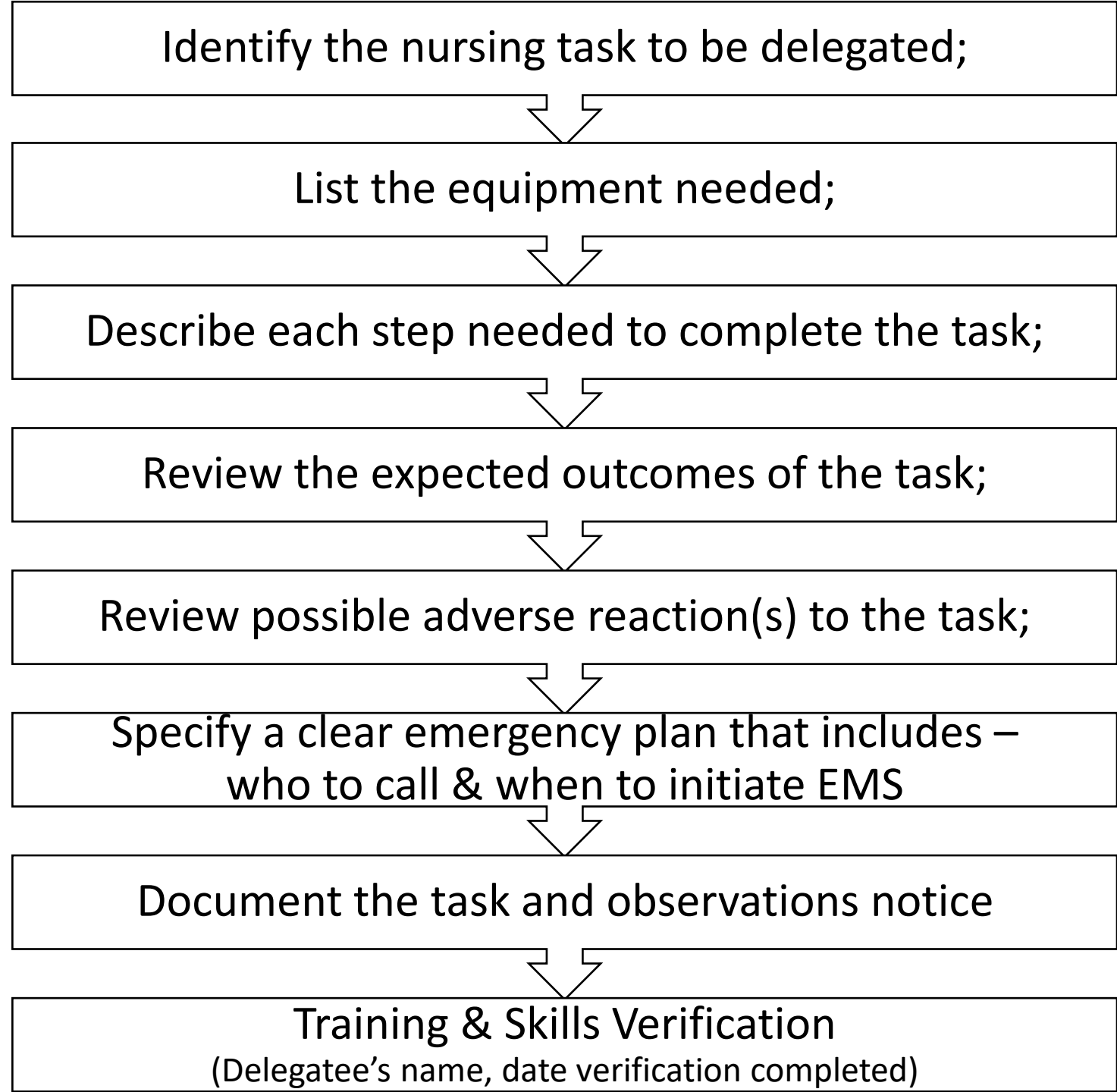
- All nurse assessment & nurse delegation activities must comply with the Hawaii Nurse Practice Act
 - HRS §457
 - HAR Chapter 89
 - http://cca.hawaii.gov/pvl/boards/nursing/statute_rules/
- Appendix of Waiver includes
 - American Nurses Association & National Council of State Boards of Nursing. (2019, April 29.) [National Guidelines for Nursing Delegation](#).
 - American Nurses Association & National Council of State Boards of Nursing. (2010). [Joint Statement on Delegation](#).

Nursing Delegation

- Must be delegated by RN, not LPN
- Nursing tasks can be delegated and performed by DSW or CD employee
- Plans must meet skills verification



Components of a Nurse Delegation Plan



Brand or generic (as applicable) name,

Identifying photo (if applicable)

Intended purpose

Potential adverse effects

Drug/food interactions

General information on recommended dosages
and the medications effect

Instructions for monitoring the participants
response to the medication

Training & Skills Verification
(Delegatee's name, date verification completed)

Nurse Delegation Plan for Medication Administration or Assistance

For each medication

Location of Nurse Delegation Plans

- Participants record at the service site
- Including Nurse Delegation plan(s) for any medication assistance or administrative tasks performed during waiver hours



Training & Skills Verification

Must be performed:

- Prior to the start of the person performing the task
- AND at least annually thereafter

Documentation & skills verification must include:

- Delegatee's name(s)
- Date(s) verification completed
- Nurse delegated tasks to be performed



Oversight and Monitoring of Nurse Delegation

- T&C RN must conduct:
 - At minimum, quarterly face-to-face visits with participant
 - With participant and delegatee(s)
 - Other supervision/monitoring tasks needed, based on Nursing Assessment
- Written Quarterly report provided to CM within 30 calendar days of the end of the quarter
- All documentation must be maintained in the T&C Provider's file

Oversight and Monitoring of Nurse Delegation, cont.

1

Review of the data to determine whether the delegatee(s) are performing tasks in accordance with the Nurse Delegation plan(s), for example, reviewing the Medication Administration Record (MAR) and other documents may identify medication errors that need the T&C RN to address with the delegatee;

2

Identification of any issues or concerns and recommendations for addressing;

3

Discuss any new delegatee training or re-training; and

4

Other requirements specified in the ISP

DDD Nurse Delegation Packet

**Provider Nursing
Assessment**

**Worksheet A
Activities**

**Worksheet B
Risk Guidance**



Provider Nursing Assessment

Worksheet A Activities

Worksheet B Risk Guidance

- 5 sections
 1. Background Information
 2. Identification of Nursing Tasks
 3. Assessment of Participant's Circumstance
 4. Supervision/Monitoring Requirements
 5. Provider RN Comments/Notes

2. Identification of Nursing Tasks & Person(s) Responsible		3. Assessment of Participant's Circumstance	
Nursing Task(s) <i>(See Worksheet A)</i>	List person(s) tasks are being delegated to & service(s) settings tasks are delegated in	<i>RN may consider the participant's medical stability, condition, and the situation, etc. when assessing the participant's circumstance.</i> Recommended Hours for T&C for Nurse Delegation <i>(Recommended hours will be reviewed and considered for authorization by the RN.)</i>	
PROVIDER NURSING ASSESSMENT 1. Background Information Date: _____ RN Provider Agency: _____ Participant Name: _____ Provider RN conducting the nurse assessment: _____ Date of Birth: _____ CMB Unit & CM: _____ Guardian (if applicable): _____ Residential Setting: _____ Health Plan: _____ Medical History: <i>(Include diagnoses)</i> _____ Medical Stability: <i>(Include all risk factors, precautions, hospitalizations, and AERs in the past year)</i> _____ Diet/Nutrition: _____ Durable Medical Equipment/Medical Supplies: _____ Medications /Allergies: <i>(Include medication name, indication, dose, route & ordering physician)</i> _____		RN authorization of task delegation <i>(If "No" provide reason such as skilled nursing activity only - must be performed by RN, other)</i> <input type="checkbox"/> Yes – task will be delegated. <input type="checkbox"/> No – Reason: _____ <input type="checkbox"/> Yes – task will be delegated. <input type="checkbox"/> No – Reason: _____ <input type="checkbox"/> Yes – task will be delegated. <input type="checkbox"/> No – Reason: _____ <input type="checkbox"/> Yes – task will be delegated. <input type="checkbox"/> No – Reason: _____ <input type="checkbox"/> Yes – task will be delegated. <input type="checkbox"/> No – Reason: _____	
		Participant and person being delegated to assessment. RN may assess if more frequent than Waiver Provider Standards Manual, details.) Recommendation. Please describe & rationale: _____ _____ _____	

Section 1 - Background Info

- Date
- Participant Name
- Date of Birth
- Guardian
- RN Provider Agency
- Provider RN
- CMB Unit & CM
- Residential Setting
- Health Plan

1. Background Information			
Date:		RN Provider Agency:	
Participant Name:		Provider RN conducting the nurse assessment:	
Date of Birth:		CMB Unit & CM:	
Guardian (if applicable):		Residential Setting:	
Health Plan:			

Section 2 - Identification of Nursing Tasks & Person(s) Responsible

2. Identification of Nursing Tasks & Person(s) Responsible			
Nursing Task(s) (See Worksheet A)	List person(s) tasks are being delegated to & service(s) settings tasks are delegated in	Assessment of person(s) (RN is responsible for ensuring person being delegated to possess the skills and knowledge to perform the activity)	RN authorization of task delegation (If "No" provide reason such as skilled nursing activity only - must be performed by RN, other)
Task #1:	Person(s) and Service(s):		<input type="checkbox"/> Yes – task will be delegated. <input type="checkbox"/> No – Reason:
Task #2:	Person(s) and Service(s):		<input type="checkbox"/> Yes – task will be delegated. <input type="checkbox"/> No – Reason:
Task #3:	Person(s) and Service(s):		<input type="checkbox"/> Yes – task will be delegated. <input type="checkbox"/> No – Reason:
Task #4:	Person(s) and Service(s):		<input type="checkbox"/> Yes – task will be delegated. <input type="checkbox"/> No – Reason:
Task #5:	Person(s) and Service(s):		<input type="checkbox"/> Yes – task will be delegated. <input type="checkbox"/> No – Reason:

Provider Nurse Assessment: Identification of Nursing Tasks & Person(s) Responsible



2. Identification of Nursing Tasks & Person(s) Responsible			
Nursing Task(s) (See Worksheet A)	List person(s) tasks are being delegated to & service(s) settings tasks are delegated in	Assessment of person(s) completing task(s) (RN is responsible for ensuring person being delegated to possess the skills and knowledge to perform the activity)	RN authorization of task delegation (If "No" provide reason such as skilled nursing activity only - must be performed by RN, other, etc.)
Task #1:	Person(s) and Service(s):	<input type="checkbox"/> RN determines the person(s) is able to perform task.	<input type="checkbox"/> Yes – task will be delegated.
What are the tasks?	Who's doing the tasks? Service task(s) is being delegated in	Does this person have knowledge and skills?	Will this task be delegated?

- *Additional Pages if necessary*

Section 3 - Assessment of Participant's Circumstance

- RN may consider the participant's medical stability, condition, and the situation, etc. when assessing the participant's circumstance.
- RN Assessor should use Worksheet B: Assessment of Risk Guidelines when determining Risk Category 1-4.

3. Assessment of Participant's Circumstance		
<i>RN may consider the participant's medical stability, condition, and the situation, etc. when assessing the participant's circumstance.</i>		
Category Risk Determination (Apply Criteria in Worksheet B)	Recommended Hours for T&C for Nurse Delegation (Recommended hours will be reviewed and considered for authorization by the DOH-DDD. Please enter the recommended hours.)	
	Authorization Hours (Per plan year)	Enter Provider RN's recommendation for hours needed to complete the nurse delegation requirements (Nurse Delegation Plan(s), training, skills verification, supervision/monitoring).
<input type="checkbox"/> Category 1 (Low Risk)	Up to 4 hours annually	
<input type="checkbox"/> Category 2 (Moderate Risk)	Up to 6 Hours annually	
<input type="checkbox"/> Category 3 (High Risk)	Up to 12 hours annually	
<input type="checkbox"/> Category 4 (Highest Risk)	Up to 24 hours annually	
RN Comments:		

Section 4 – Supervision/Monitoring Requirements

- Minimum requirement: Quarterly face-to-face
- Other frequency supervision/monitoring recommendation

4. Supervision/Monitoring Requirements	
<i>The RN must conduct, at a minimum, quarterly face-to-face visits with the participant and person being delegated to and other supervision/monitoring activities needed, based on the Nursing Assessment. RN may assess if more frequent supervision/monitoring requirements are needed based on RN assessment. (See Waiver Provider Standards Manual, Section 4.18 – Training & Consultation for more details.)</i>	
Supervision/Monitoring Requirements (based on Provider Nursing Assessment)	<input type="checkbox"/> Quarterly face-to-face visits sufficient <input type="checkbox"/> Other frequency supervision/monitoring recommendation. Please enter your recommended frequency for supervision/monitoring here:
RN Rationale/Comments	



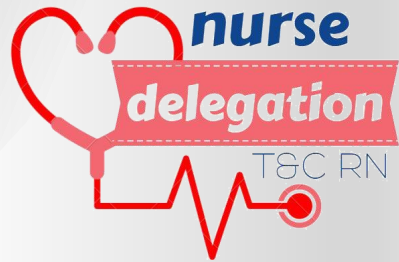
Section 5 – Provider RN Additional Comments/Notes

- RN may provide any additional relevant information

5. Provider RN Additional Comments/Notes	
Comments/Notes <i>(If applicable, RN may provide any additional relevant information)</i>	

DDD Internal Use only

- DDD RN Reviewer
 - Reviews assessment to approve authorized hours



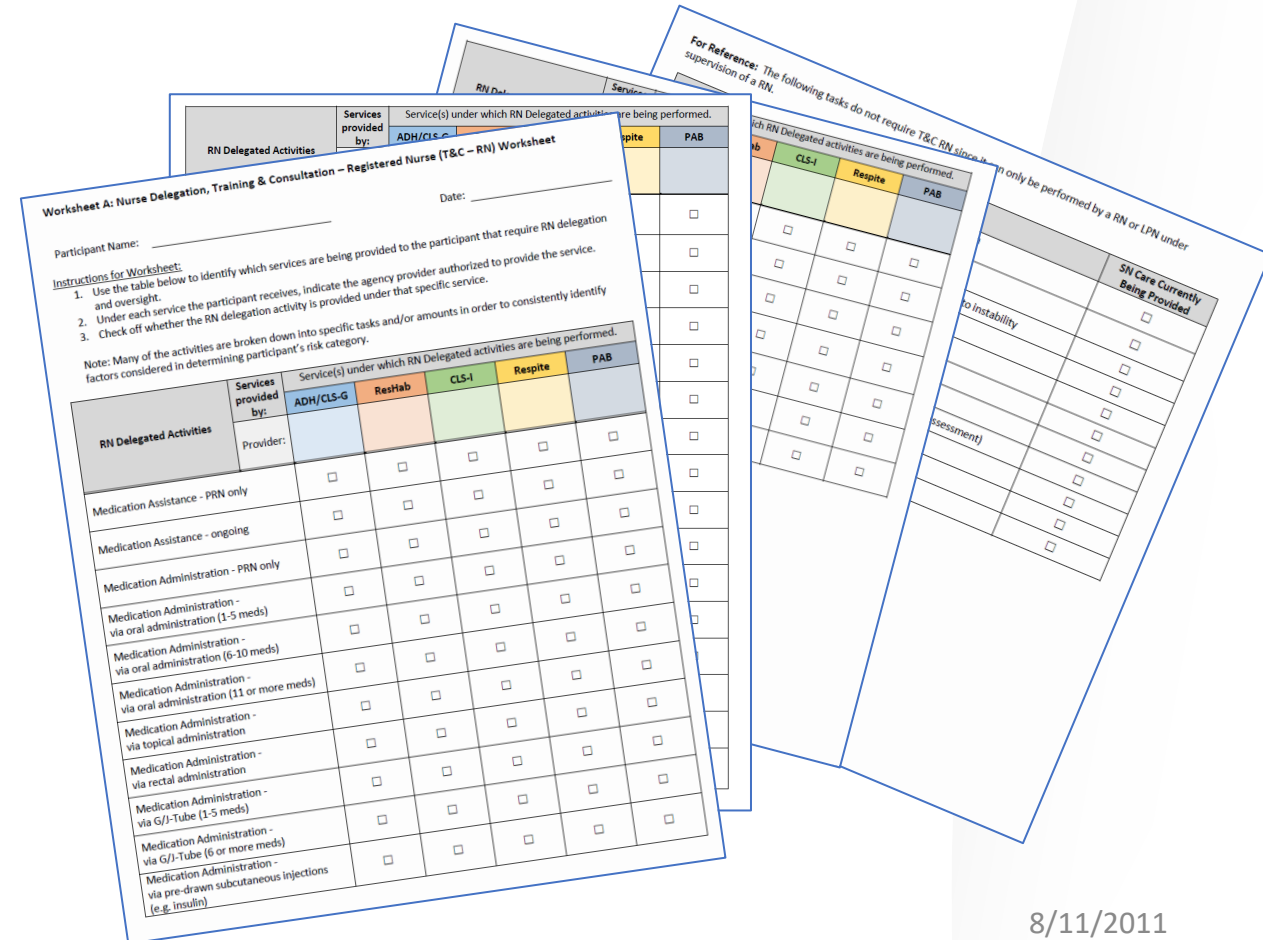
===== FOR DDD INTERNAL USE ONLY =====		
DDD RN REVIEWER		
AUTHORIZATION	<input type="checkbox"/> Yes	Approved Hours:
	<input type="checkbox"/> No	Recommended Hours:
Comments:		

Provider Nursing Assessment

Worksheet A Activities

Worksheet B Risk Guidance

- Worksheet A:
 - RN Delegated Activities
 - Skilled Nursing Activities (*cannot be delegated*)



List of Delegated Activities

- Medication Administration
- G/J Tube
- Cough Assist
- Suctioning
- Glucose
- Oxygen
- Catherization
- Apnea
- Tracheostomy
- Wound Care
- Etc...

Medication Administration - via topical administration	Apnea Care and Monitoring – BIPAP/CPAP <12 hours/day
Medication Administration - via rectal administration	Ileostomy/Colostomy care
Medication Administration - via G/J Tube (1-5 meds)	Wound Care
Medication Assistance - PRN only	Medication Administration - via pre-drawn intramuscular injection (e.g. epi-pen given as first aid)
Medication Assistance - ongoing	Medication Administration - via Nebulizer (inhalation therapy)
Medication Administration - PRN only	Cough Assist w/ Suctioning
Medication Administration - via oral administration (1-5 meds)	Chest Physiotherapy
Medication Administration - via oral administration (6-10 meds)	Suctioning – Oropharyngeal (when done separately from cough assist)
Medication Administration - via oral administration (11 or more meds)	G/J Tube – Bolus feeds
	G/J Tube – Continuous
	G/J Tube – site care
	Glucose Monitoring
	Oxygen Monitoring - Pulse Oximeter spot checks
	Oxygen Monitoring - Pulse Oximeter continuous monitoring
	Oxygen Therapy - Oxygen mask/cannula application
	Foley Urinary Catheterization
	Straight Urinary Catheterization
	Suprapubic Catheter Care
	Apnea Care and Monitoring – BIPAP/CPAP >12 hours/day

Skilled Nursing Activities (cannot be delegated)

- The following tasks do not require a nurse delegation plan since it can only be performed by a RN or LPN under supervision of a RN.
- Activities the Provider RN determines cannot be delegated

Skilled Nursing Activities (Activities cannot be delegated)	SN Care Currently Being Provided
Medication Administration - via non-prepared subcutaneous injection (drawing up of medications may NOT be delegated)	<input type="checkbox"/>
Medication Administration - via non-prepared intramuscular injection (drawing up of medications may NOT be delegated)	<input type="checkbox"/>
Oxygen Therapy requiring assessment and intervention by a nurse due to instability	<input type="checkbox"/>
Suctioning – Tracheostomy	<input type="checkbox"/>
Suctioning – Nasotracheal	<input type="checkbox"/>
Suctioning – Endotracheal	<input type="checkbox"/>
Tracheostomy Tube Change (stable trach)	<input type="checkbox"/>



Provider Nursing Assessment

Worksheet A Activities

Worksheet B Risk Guidance

- Worksheet B: Assessment of Risk Guidance
 - Indicators of Medical Instability
 - Risk Category Guidance

Risk Category Guidance	
Category 1	<p>Participant has maintained medical stability and has non-complex care needs.</p> <p><i>Examples:</i></p> <ul style="list-style-type: none"> • No changes to health condition reported over past year (excluding common cold, flu, or other seasonal illness) • Receives only annual medical check-ups with primary physician
	<p>Participant has complex care needs:</p> <p>primary physician medical specialists (e.g. neurologist, cardiologist, nephrologist, etc.)</p> <p>sporadic RN assessment if at all (e.g. daily vitamins)</p> <p>require sporadic RN assessment (e.g. Acetaminophen,</p>
	<p>Participant has complex care needs:</p> <p>primary physician medical specialists (e.g. neurologist, cardiologist, nephrologist, etc.)</p> <p>narcoctic analgesic orders which require verbal RN consult</p> <p>plexity of need requiring implementation of specific</p> <p>entia or Alzheimer's disease) but medical stability not</p>
	<p>Participant has complex care needs:</p> <p>primary physician or other medical specialists for reassessment (e.g. neurologist, cardiologist, nephrologist, etc.)</p> <p>al issue within the past six months (e.g. fall, pneumonia, etc.)</p> <p>ing implementation of specific precautions</p> <p>psychotropic medication AND required administration of the</p> <p>scale insulin or titration of medication</p> <p>nts; medications require regular MD and RN review (i.e. adjustment quarterly at minimum)</p> <p>medical stability or complexity of care (e.g. MRSA, VRS, age related conditions such as dementia or Alzheimer's)</p> <p>ng medical stability (e.g. medication refusal, refusal to eat, etc.)</p> <p>al admissions within past year)</p>
	<p>Participant has complex care needs, and is under review for transition of care:</p> <p>other medical specialists for reassessment (e.g. neurologist, cardiologist, nephrologist, etc.)</p> <p>/involved RN assessment</p> <p>ss</p> <p>failure requiring dialysis)</p> <p>vement of multiple systems for delivery of services and care</p> <p>ning off PDN to address long term support or will be in</p>

Worksheet B: Assessment of Risk Guidelines

Participants should be assigned to a risk category based on information from the Nursing Assessment, if applicable, and factors such as the participant's medical stability, complexity of care, and behavioral or other needs. Examples provided for each category below are intended to assist providers, CMs, unit RNs and unit supervisors, if applicable, with determining which category is most appropriate.

Participants do NOT have to meet all criteria in any given category and participants may fall into different categories depending on their assessed need(s) in different circumstances.

Indicators of Medical Instability (Used to support risk category determination)	Check all that apply
Frequent reassessment by medical professionals	<input type="checkbox"/>
Frequent medication changes or adjustments requiring regular MD and RN review	<input type="checkbox"/>
Inconsistent lab results (waxing/waning) requiring frequent medical follow up	<input type="checkbox"/>
Medical treatment for issue(s) requiring specific precautions	<input type="checkbox"/>
Administration of narcotic analgesic or psychotropic medication(s)	<input type="checkbox"/>
Unstable blood sugars requiring sliding scale insulin or titration of medication	<input type="checkbox"/>
Complicating factors negatively impacting health status	<input type="checkbox"/>
Challenging behaviors impacting medical stability	<input type="checkbox"/>
Frequent visits to urgent care or emergency room	<input type="checkbox"/>
Multiple hospitalizations (2 or more hospital admissions within past year)	<input type="checkbox"/>
Multiple AERs related to changes in health condition	<input type="checkbox"/>
Other (specify):	<input type="checkbox"/>
Other (specify):	<input type="checkbox"/>
Other (specify):	<input type="checkbox"/>
Other (specify):	<input type="checkbox"/>

Indicators of Medical Instability

- Used to support risk category determination

Indicators of Medical Instability <i>(Used to support risk category determination)</i>	Check all that apply
Frequent reassessment by medical professionals	<input type="checkbox"/>
Frequent medication changes or adjustments requiring regular MD and RN review	<input type="checkbox"/>
Inconsistent lab results (waxing/waning) requiring frequent medical follow up	<input type="checkbox"/>
Medical treatment for issue(s) requiring specific precautions	<input type="checkbox"/>
Administration of narcotic analgesic or psychotropic medication(s)	<input type="checkbox"/>
Unstable blood sugars requiring sliding scale insulin or titration of medication	<input type="checkbox"/>
Complicating factors negatively impacting health status	<input type="checkbox"/>
Challenging behaviors impacting medical stability	<input type="checkbox"/>
Frequent visits to urgent care or emergency room	<input type="checkbox"/>
Multiple hospitalizations (2 or more hospital admissions within past year)	<input type="checkbox"/>
Multiple AERs related to changes in health condition	<input type="checkbox"/>
Other (specify):	<input type="checkbox"/>

Risk Category Guidance

- **Category 1 (Low Risk):**
 - Maintained medical stability
 - Non-complex care needs
- **Category 2 (Moderate Risk):**
 - Maintained medical stability
 - Complex care needs
- **Category 3 (High Risk):**
 - Medically unstable
 - Complex care needs
- **Category 4 (Highest Risk):**
 - Medically Unstable
 - High acuity complex care needs

Risk Category Guidance	
Category 1 (Low Risk)	<p><u>Participant has maintained medical stability and has non-complex care needs.</u></p> <p><i>Examples:</i></p> <ul style="list-style-type: none"> • No changes to health condition reported over past year (excluding common cold, flu, or other seasonal illness) • Receives only annual medical check-ups with primary physician • May receive care from other medical specialists (e.g. neurologist, cardiologist, nephrologist, etc.) • Medications are well managed and require sporadic RN assessment if at all (e.g. daily vitamins) • Medications are taken on PRN basis and require sporadic RN assessment (e.g. Acetaminophen, Ibuprofen)

Stand Alone Sections for Providers

Section 1

PROVIDER NURSING ASSESSMENT			
1. Background Information			
Date:		RN Provider Agency:	
Participant Name:		Provider RN conducting the nurse assessment:	
Date of Birth:		CMB Unit & CM:	
Guardian (if applicable):		Residential Setting:	
Health Plan:			
Medical History: <i>(Include diagnoses)</i>			
Medical Stability: <i>(Include all risk factors, precautions, hospitalizations, and AERs in the past year)</i>			
Diet/Nutrition:			
Durable Medical Equipment/Medical Supplies:			
Medications /Allergies: <i>(Include medication name, indication, dose, route & ordering physician)</i>			

Provider Nursing Assessment | Updated 8/4/2021 Page 1

Section 4 & 5

4. Supervision/Monitoring Requirements	
<i>The RN must conduct, at a minimum, quarterly face-to-face visits with the participant and person being delegated to and other supervision/monitoring activities needed, based on the Nursing Assessment. RN may assess if more frequent supervision/monitoring requirements are needed based on RN assessment. (See Waiver Provider Standards Manual, Section 4.18 – Training & Consultation for more details.)</i>	
Supervision/Monitoring Requirements <i>(based on Provider Nursing Assessment)</i>	<input type="checkbox"/> Quarterly face-to-face visits sufficient
	<input type="checkbox"/> Other frequency supervision/monitoring recommendation. Please describe recommendation for supervision/monitoring & rationale:
RN Notes/Comments	
5. Provider RN Additional Comments/Notes	
Comments/Notes <i>(If applicable, RN may provide any additional relevant information)</i>	

Stand Alone Sections for DDD

Internal Use Only Section

===== FOR DDD INTERNAL USE ONLY =====		
DDD RN REVIEWER		
AUTHORIZATION	<input type="checkbox"/> Yes	Approved Hours:
	<input type="checkbox"/> No	Recommended Hours:
Comments:		

Supplemental Sections

Section 2 + Worksheet A

Section 3 + Worksheet B

2. Identification of Nursing Tasks & Person(s) Responsible			
Nursing Task(s) (See Worksheet A)	List person(s) tasks are being delegated to & service(s) settings tasks are delegated in	Assessment of person(s) completing task(s) (RN is responsible for ensuring person being delegated to possess the skills and knowledge to perform the activity)	RN authorization of task delegation (If "No" provide reason such as skilled nursing activity only - must be performed by RN, other, etc.)
Task #1:	Person(s) and Service(s):	<input type="checkbox"/> RN determines the person(s) is able to perform task. <input type="checkbox"/> RN determines that the person(s) is unable to perform task and will not delegate. Please specify the identified person(s) & reasons for not delegating:	<input type="checkbox"/> Yes - task will be delegated. <input type="checkbox"/> No - Reason:
Task #2:	Person(s) and Service(s):	<input type="checkbox"/> RN determines the person(s) is able to perform task. <input type="checkbox"/> RN determines that the person(s) is unable to perform task and will not delegate. Please specify the identified person(s) & reasons for not delegating:	<input type="checkbox"/> Yes - task will be delegated. <input type="checkbox"/> No - Reason:
Task #3:	Person(s) and Service(s):	<input type="checkbox"/> RN determines the person(s) is able to perform task. <input type="checkbox"/> RN determines that the person(s) is unable to perform task and will not delegate. Please specify the identified person(s) & reasons for not delegating:	<input type="checkbox"/> Yes - task will be delegated. <input type="checkbox"/> No - Reason:
Task #4:	Person(s) and Service(s):	<input type="checkbox"/> RN determines the person(s) is able to perform task. <input type="checkbox"/> RN determines that the person(s) is unable to perform task and will not delegate. Please specify the identified person(s) & reasons for not delegating:	<input type="checkbox"/> Yes - task will be delegated. <input type="checkbox"/> No - Reason:
Task #5:	Person(s) and Service(s):	<input type="checkbox"/> RN determines the person(s) is able to perform task. <input type="checkbox"/> RN determines that the person(s) is unable to perform task and will not delegate. Please specify the identified person(s) & reasons for not delegating:	<input type="checkbox"/> Yes - task will be delegated. <input type="checkbox"/> No - Reason:
Task #6:	Person(s) and Service(s):	<input type="checkbox"/> RN determines the person(s) is able to perform task. <input type="checkbox"/> RN determines that the person(s) is unable to perform task and will not delegate. Please specify the identified person(s) & reasons for not delegating:	<input type="checkbox"/> Yes - task will be delegated. <input type="checkbox"/> No - Reason:

RN Delegated Activities	Services provided by:	Service(s) under which RN Delegated activities are being performed.				
		ADH/CLS-G	ResHab	CLS-I	Respite	PAB
Apnea Care and Monitoring - BIPAP/CPAP	Provider:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication Administration - via pre-drawn intramuscular injection (e.g. epn given as first aid)	Provider:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Worksheet A: Nurse Delegation, Training & Consultation - Registered Nurse (T&C - RN) Worksheet

Participant Name: _____ Date: _____

Instructions for Worksheet:

- Use the table below to identify which services are being provided to the participant that require RN delegation and oversight.
- Under each service the participant receives, indicate the agency provider authorized to provide the service.
- Check off whether the RN delegation activity is provided under that specific service.

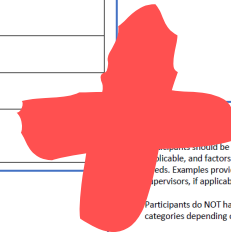
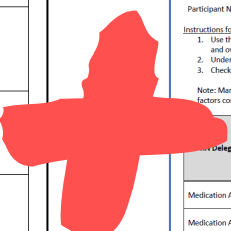
Note: Many of the activities are broken down into specific tasks and/or amounts in order to consistently identify factors considered in determining participant's risk category.

RN Delegated Activities	Services provided by:	Service(s) under which RN Delegated activities are being performed.				
		ADH/CLS-G	ResHab	CLS-I	Respite	PAB
Medication Assistance - PRN only	Provider:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication Assistance - ongoing	Provider:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication Administration - PRN only	Provider:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication Administration - via oral administration (1-5 meds)	Provider:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication Administration - via oral administration (6-30 meds)	Provider:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication Administration - via oral administration (11 or more meds)	Provider:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication Administration - via topical administration	Provider:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication Administration - via rectal administration	Provider:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication Administration - via G/I-Tube (1-5 meds)	Provider:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication Administration - via G/I-Tube (6 or more meds)	Provider:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication Administration - via pre-drawn subcutaneous injections (e.g. insulin)	Provider:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Assessment of Participant's Circumstance		
RN may consider the participant's medical stability, condition, and the situation, etc. when assessing the participant's circumstance.		
Category Risk Determination (Apply Criteria in Worksheet B)	Recommended Hours for T&C for Nurse Delegation (Recommended hours will be reviewed and considered for authorization by the DOH-DDD. Please enter the recommended hours.)	
	Authorization Hours (Per plan year)	Enter Provider RN's recommendation for hours needed to complete the nurse delegation requirements (Nurse Delegation Plan(s), training, skills verification, supervision/monitoring).
<input type="checkbox"/> Category 1 (Low Risk)	Up to 4 hours annually	
<input type="checkbox"/> Category 2 (Moderate Risk)	Up to 6 hours annually	
<input type="checkbox"/> Category 3 (High Risk)	Up to 12 hours annually	
<input type="checkbox"/> Category 4 (Highest Risk)	Up to 24 hours annually	
RN Comments:		

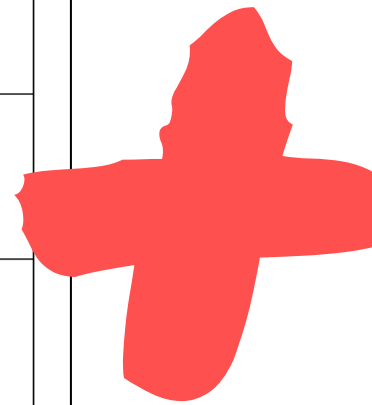
Risk Category Guidance	
Participant has maintained medical stability and has non-complex care needs.	
Examples:	
<ul style="list-style-type: none"> No changes to health condition reported over past year (excluding common cold, flu, or other seasonal illness) Receives only annual medical check-ups with primary physician May receive care from other medical specialists (e.g. neurologist, cardiologist, nephrologist, etc.) Medications are well managed and require sporadic RN assessment if at all (e.g. daily vitamins) Medications are taken on PRN basis and require sporadic RN assessment (e.g. Acetaminophen, Ibuprofen) 	
Category 1 (Low Risk)	

Worksheet B: Assessment of Risk Guidelines	
Indicators of Medical Instability (Used to support risk category determination)	Check all that apply
Frequent reassessment by medical professionals	<input type="checkbox"/>
Frequent medication changes or adjustments requiring regular MD and RN review	<input type="checkbox"/>
Inconsistent lab results (waxing/waning) requiring frequent medical follow up	<input type="checkbox"/>
Medical treatment for issue(s) requiring specific precautions	<input type="checkbox"/>
Administration of narcotic analgesic or psychotropic medication(s)	<input type="checkbox"/>
Unstable blood sugars requiring sliding scale insulin or titration of medication	<input type="checkbox"/>
Complicating factors negatively impacting health status	<input type="checkbox"/>
Challenging behaviors impacting medical stability	<input type="checkbox"/>
Frequent visits to urgent care or emergency room	<input type="checkbox"/>
Multiple hospitalizations (2 or more hospital admissions within past year)	<input type="checkbox"/>
Multiple AERs related to changes in health condition	<input type="checkbox"/>
Other (specify):	<input type="checkbox"/>
Other (specify):	<input type="checkbox"/>
Other (specify):	<input type="checkbox"/>
Other (specify):	<input type="checkbox"/>



Section 2 + Worksheet A

2. Identification of Nursing Tasks & Person(s) Responsible			
Nursing Task(s) (See Worksheet A)	List person(s) tasks are being delegated to & service(s) settings tasks are delegated in	Assessment of person(s) completing task(s) (RN is responsible for ensuring person being delegated to possess the skills and knowledge to perform the activity)	RN authorization of task delegation (If "No" provide reason such as skilled nursing activity only - must be performed by RN, other, etc.)
Task #1:	Person(s) and Service(s):	<input type="checkbox"/> RN determines the person(s) is able to perform task. <input type="checkbox"/> RN determines that the person(s) is unable to perform task and will not delegate. Please specify the identified person(s) & reasons for not delegating:	<input type="checkbox"/> Yes – task will be delegated. <input type="checkbox"/> No – Reason:
Task #2:	Person(s) and Service(s):	<input type="checkbox"/> RN determines the person(s) is able to perform task. <input type="checkbox"/> RN determines that the person(s) is unable to perform task and will not delegate. Please specify the identified person(s) & reasons for not delegating:	<input type="checkbox"/> Yes – task will be delegated. <input type="checkbox"/> No – Reason:
Task #3:	Person(s) and Service(s):	<input type="checkbox"/> RN determines the person(s) is able to perform task. <input type="checkbox"/> RN determines that the person(s) is unable to perform task and will not delegate. Please specify the identified person(s) & reasons for not delegating:	<input type="checkbox"/> Yes – task will be delegated. <input type="checkbox"/> No – Reason:
Task #4:	Person(s) and Service(s):	<input type="checkbox"/> RN determines the person(s) is able to perform task. <input type="checkbox"/> RN determines that the person(s) is unable to perform task and will not delegate. Please specify the identified person(s) & reasons for not delegating:	<input type="checkbox"/> Yes – task will be delegated. <input type="checkbox"/> No – Reason:
Task #5:	Person(s) and Service(s):	<input type="checkbox"/> RN determines the person(s) is able to perform task. <input type="checkbox"/> RN determines that the person(s) is unable to perform task and will not delegate. Please specify the identified person(s) & reasons for not delegating:	<input type="checkbox"/> Yes – task will be delegated. <input type="checkbox"/> No – Reason:
Task #6:	Person(s) and Service(s):	<input type="checkbox"/> RN determines the person(s) is able to perform task. <input type="checkbox"/> RN determines that the person(s) is unable to perform task and will not delegate. Please specify the identified person(s) & reasons for not delegating:	<input type="checkbox"/> Yes – task will be delegated. <input type="checkbox"/> No – Reason:



RN Delegated Activities	Services provided by: Provider:	Service(s) under which RN Delegated activities are being performed.				
		ADH/CLS-G	ResHab	CLS-I	Respite	PAB
Medication Assistance - PRN only		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication Assistance - ongoing		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication Administration - PRN only		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication Administration - via oral administration (1-5 meds)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication Administration - via oral administration (6-10 meds)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication Administration - via oral administration (11 or more meds)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication Administration - via topical administration		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication Administration - via rectal administration		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication Administration - via G/J-Tube (1-5 meds)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication Administration - via G/J-Tube (6 or more meds)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication Administration - via pre-drawn subcutaneous injections (e.g. insulin)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Participant Name: _____ Date: _____

Instructions for Worksheet:

- Use the table below to identify which services are being provided to the participant that require RN delegation and oversight.
- Under each service the participant receives, indicate the agency provider authorized to provide the service.
- Check off whether the RN delegation activity is provided under that specific service.

Note: Many of the activities are broken down into specific tasks and/or amounts in order to consistently identify factors considered in determining participant's risk category.

Section 3 + Worksheet B

3. Assessment of Participant's Circumstance

RN may consider the participant's medical stability, condition, and the situation, etc. when assessing the participant's circumstance.

Category Risk Determination (Apply Criteria in Worksheet B)	Recommended Hours for T&C for Nurse Delegation (Recommended hours will be reviewed and considered for authorization by the DOH-DDD. Please enter the recommended hours.)	
	Authorization Hours (Per plan year)	Enter Provider RN's recommendation for hours needed to complete the nurse delegation requirements (Nurse Delegation Plan(s), training, skills verification, supervision/monitoring).
<input type="checkbox"/> Category 1 (Low Risk)	Up to 4 hours annually	
<input type="checkbox"/> Category 2 (Moderate Risk)	Up to 6 Hours annually	
<input type="checkbox"/> Category 3 (High Risk)	Up to 12 hours annually	
<input type="checkbox"/> Category 4 (Highest Risk)	Up to 24 hours annually	

RN Comments:

Risk Category Guidance	
Category 1 (Low Risk)	<p>Participant has maintained medical stability and has non-complex care needs.</p> <p><i>Examples:</i></p> <ul style="list-style-type: none"> No changes to health condition reported over past year (excluding common cold, flu, or other seasonal illness) Receives only annual medical check-ups with primary physician May receive care from other medical specialists (e.g. neurologist, cardiologist, nephrologist, etc.) Medications are well managed and require sporadic RN assessment if at all (e.g. daily vitamins) Medications are taken on PRN basis and require sporadic RN assessment (e.g. Acetaminophen, Ibuprofen)
	<p>Participant has maintained medical stability but has complex care needs:</p> <p><i>Examples:</i></p>

Worksheet B: Assessment of Risk Guidelines

Participants should be assigned to a risk category based on information from the Nursing Assessment, if applicable, and factors such as the participant's medical stability, complexity of care, and behavioral or other needs. Examples provided for each category below are intended to assist providers, CMs, unit RNs and unit supervisors, if applicable, with determining which category is most appropriate.

Participants do NOT have to meet all criteria in any given category and participants may fall into different categories depending on their assessed need(s) in different circumstances.

Indicators of Medical Instability (Used to support risk category determination)	Check all that apply
Frequent reassessment by medical professionals	<input type="checkbox"/>
Frequent medication changes or adjustments requiring regular MD and RN review	<input type="checkbox"/>
Inconsistent lab results (waxing/waning) requiring frequent medical follow up	<input type="checkbox"/>
Medical treatment for issue(s) requiring specific precautions	<input type="checkbox"/>
Administration of narcotic analgesic or psychotropic medication(s)	<input type="checkbox"/>
Unstable blood sugars requiring sliding scale insulin or titration of medication	<input type="checkbox"/>
Complicating factors negatively impacting health status	<input type="checkbox"/>
Challenging behaviors impacting medical stability	<input type="checkbox"/>
Frequent visits to urgent care or emergency room	<input type="checkbox"/>
Multiple hospitalizations (2 or more hospital admissions within past year)	<input type="checkbox"/>
Multiple AERs related to changes in health condition	<input type="checkbox"/>
Other (specify):	<input type="checkbox"/>
Other (specify):	<input type="checkbox"/>
Other (specify):	<input type="checkbox"/>
Other (specify):	<input type="checkbox"/>

Participants should be assigned to a risk category based on information from the Nursing Assessment, if applicable, and factors such as the participant's medical stability, complexity of care, and behavioral or other needs. Examples provided for each category below are intended to assist providers, CMs, unit RNs and unit supervisors, if applicable, with determining which category is most appropriate.

Participants do NOT have to meet all criteria in any given category and participants may fall into different categories depending on their assessed need(s) in different circumstances.

Examples of complex care needs include: frequent reassessment by medical professionals; frequent medication changes or adjustments requiring regular MD and RN review; inconsistent lab results (waxing/waning) requiring frequent medical follow up; medical treatment for issue(s) requiring specific precautions; administration of narcotic analgesic or psychotropic medication(s); unstable blood sugars requiring sliding scale insulin or titration of medication; complicating factors negatively impacting health status; challenging behaviors impacting medical stability; frequent visits to urgent care or emergency room; multiple hospitalizations (2 or more hospital admissions within past year); multiple AERs related to changes in health condition; other (specify); other (specify); other (specify); other (specify).



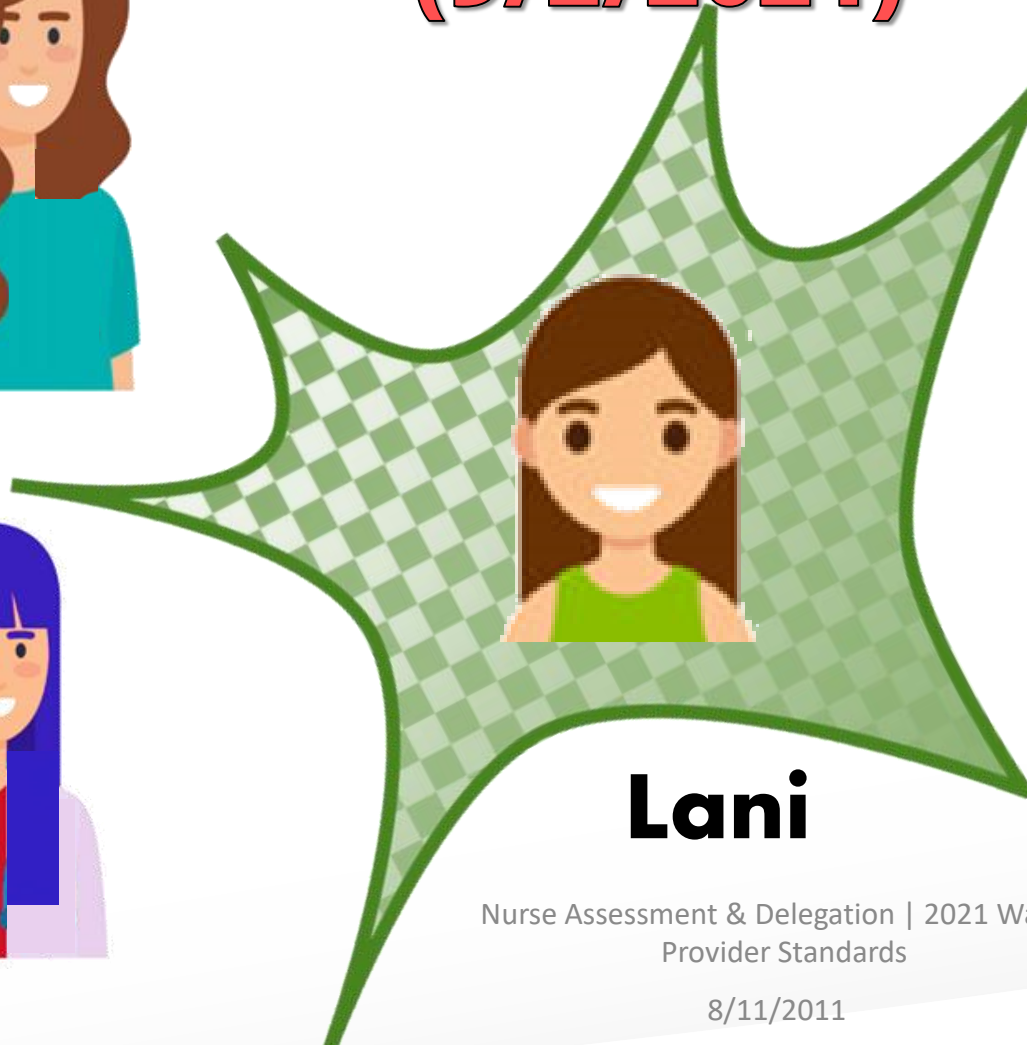
At the ISP (9/2/2021)



**Paula RN
Provider**



**Curt
Caregiver**



Lani

Nurse Assessment & Delegation | 2021 Waiver
Provider Standards

8/11/2011

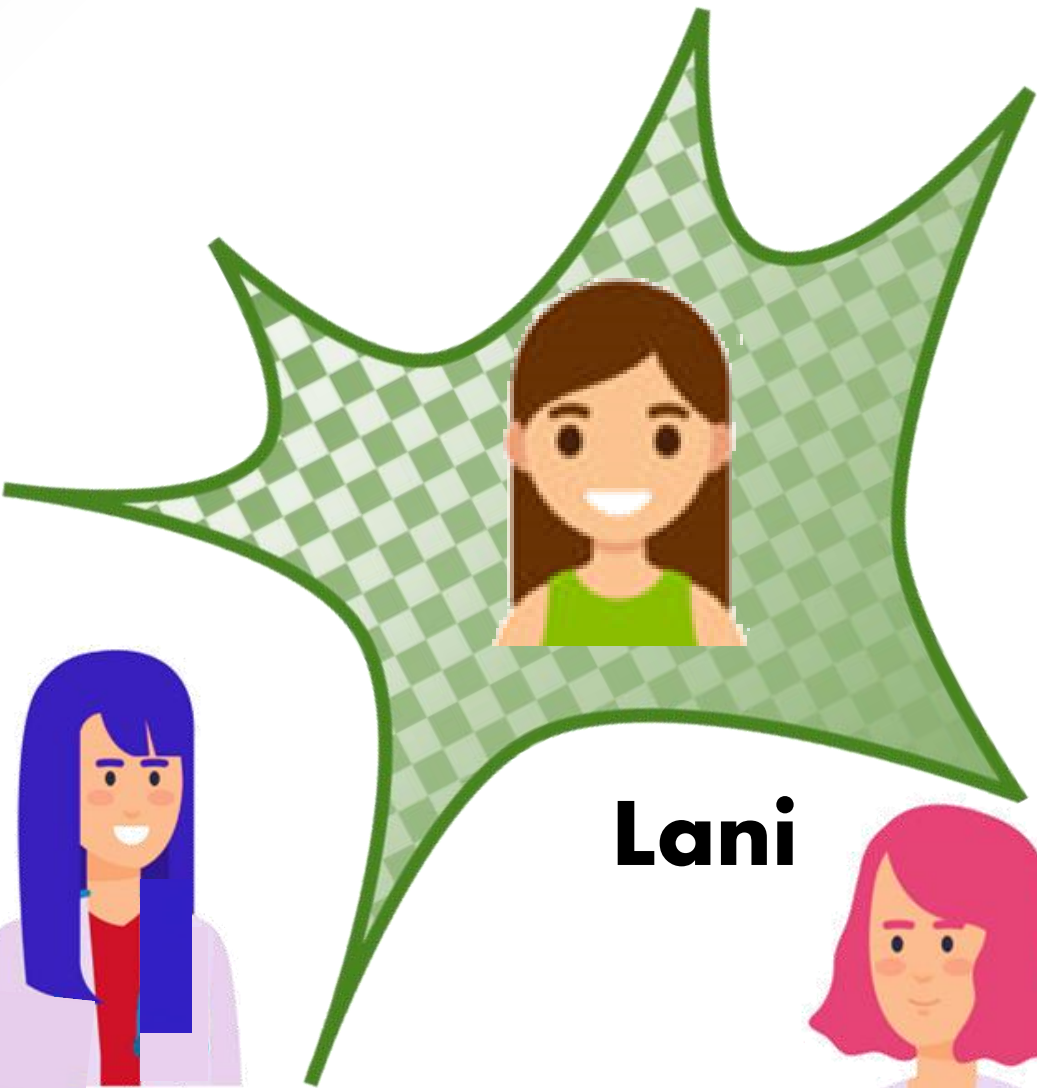


**Georgette
Guardian**



**Casey
Case-Manager**

RN Provider



Lani

Caregiver



Medication Administration - via oral administration (1-5 meds)

Nursing Task(s)
(See Worksheet A)

Guardian



Case Manager

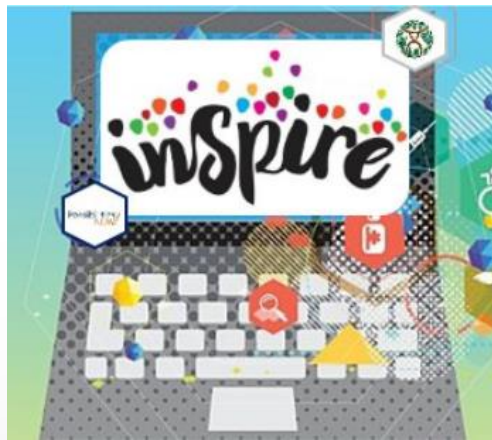


At the ISP



Nurse Assessment Authorization

- Nursing tasks were identified at ISP
- Create Working Action Plan at meeting
- CM authorizes T&C for Nurse Assessment
- 2 hours



Case Manager

Nurse Assessment

- Conducts assessment
- Completes Nursing Delegation Packet
- Submits to CM within 15 days



**RN
Provider**



Worksheet A: Nurse Delegation, Training & Consultation – Registered Nurse (T&C – RN) Worksheet

2. Identification of Nursing Tasks & Person(s) Responsible

Assessment of person(s)	RN authorization of task
PROVIDER NURSING ASSESSMENT	
1. Background Information	
Date: 7/22/2021	RN Provider Agency: ABC Agency
Participant Name: Lani Girl	Provider RN conducting the nurse assessment: Paula RN Provider
Date of Birth: 3/22/2002	CMB Unit & CM: Unit 16, Case Case-Manager
Guardian (if applicable): Georgette Guardian	Residential Setting: DDD AFH
Relevant Medical History: Lani is 19-year-old female with mild ID, Down Syndrome, and has a history of depression. She receives regular preventative care from her PCP annually and also sees a psychiatrist once every 3 months and therapist once a month to manage her mood disorder.	
Medical Stability: (include all risk factors, precautions, hospitalizations, and AERs in the past year) Lani has remained medically stable within the past year. She has been healthy the past year, with no hospitalizations/ER visits, no AERs. Her mood disorder has been well managed by through medication management by her psychiatrist and through sessions with her therapist. Lani had a prior history of taking PRN psychotropic medications about 2 years ago, but the psychiatrist has discontinued the use of PRN psychotropic medications, because the current medication regimen has been effective for a couple of years. Therapy and daily exercise have also been helpful and effective for Lani.	
Diet/Nutrition: Lani is on a regular diet with no nutrition restrictions and no modified food texture diet.	
Medical Equipment: Lani does not use any medical equipment. Lani is able to ambulate independently and currently does not require the use of medical supplies.	
Medications/Allergies: Lani does not have any known food or drug allergies. Her current medications include daily scheduled medication to manage her mood disorder is Citalopram (Celexa) 20 mg 1 tab PO QD.	

reason nursing must be N, other)

1

Page 2

Provider Nursing Assessment | DRAFT Updated 7/20/2021 Page 1



2. Identification of Nursing Tasks & Person(s) Responsible

PROVIDER NURSING ASSESSMENT

1. Background Information

Date:	7/22/2021	RN Provider Agency:	ABC Agency
Participant Name:	Lani Girl	Provider RN conducting the nurse assessment:	Paula RN Provider
Date of Birth:	3/22/2002	CMB Unit & CM:	Unit 16, Case Case-Manager
Guardian (if applicable):	Georgette Guardian	Residential Setting:	DDD AFH

Relevant Medical History:

Lani is 19-year-old female with mild ID, Down Syndrome, and has a history of depression. She receives regular preventative care from her PCP annually and also sees a psychiatrist once every 3 months and therapist once a month to manage her mood disorder.

Medical Stability: (include all risk factors, precautions, hospitalizations, and AERs in the past year)

Lani has remained medically stable within the past year. She has been healthy the past year, with no hospitalizations/ER visits, no AERs. Her mood disorder has been well managed by through medication management by her psychiatrist and through sessions with her therapist. Lani had a prior history of taking PRN psychotropic medications about 2 years ago, but the psychiatrist has discontinued the use of PRN psychotropic medications, because the current medication regimen has been effective for a couple of years. Therapy and daily exercise have also been helpful and effective for Lani.

Diet/Nutrition:

Lani is on a regular diet with no nutrition restrictions and no modified food texture diet.

Medical Equipment:

Lani does not use any medical equipment. Lani is able to ambulate independently and currently does not require the use of medical supplies.

Medications/Allergies:

Lani does not have any known food or drug allergies. Her current medications include daily scheduled medication to manage her mood disorder is Citalopram (Celexa) 20 mg 1 tab PO QD.



**DDD
Nurse**



**Case
Manager**

**10
DAYS**

- Reviews Provider RN Nurse Assessment
- May follow up with Provider RN for clarification
- 10 days

Provider RN Nurse Assessment
2 hours previously submitted

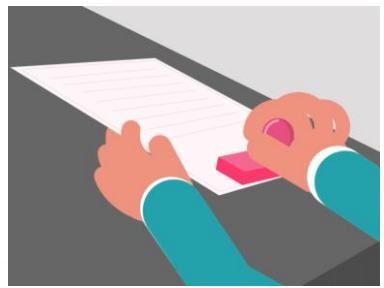


Mid Year Auth
(9/3/21 to 11/30/21)

Case Manager

T&C CURRENT PLAN YEAR	
	RN T&C Hours
Category 1 (Low Risk)	Up to 2 hours annually
Category 2 (Moderate Risk)	Up to 3 hours annually
Category 3 (High Risk)	Up to 4 hours annually
Category 4 (Highest Risk)	Up to 6 hours annually

T&C NEW PLAN YEAR	
	RN T&C Hours
Category 1 (Low Risk)	Up to 4 hours annually
Category 2 (Moderate Risk)	Up to 6 hours annually
Category 3 (High Risk)	Up to 12 hours annually
Category 4 (Highest Risk)	Up to 24 hours annually



Nurse Assessment & Delegation | 2021 Waiver Provider Standards

8/11/2011

Skills Verification

- Must be completed before Delegation performs nursing tasks
- Documented within Nurse Delegation Plan

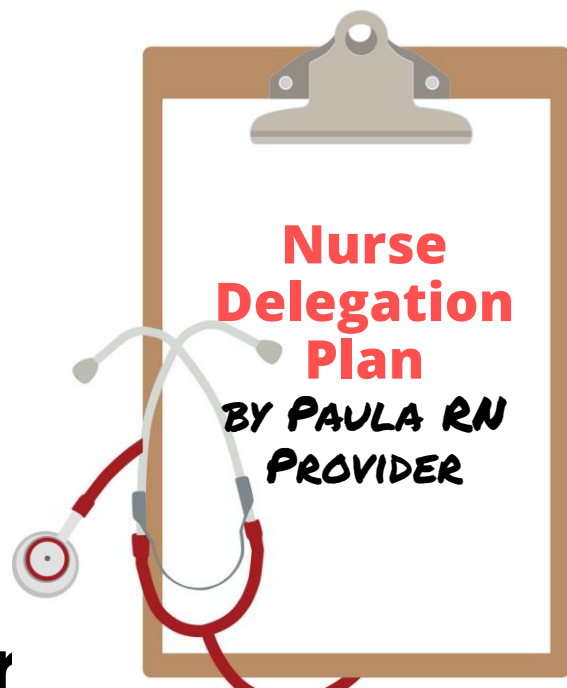
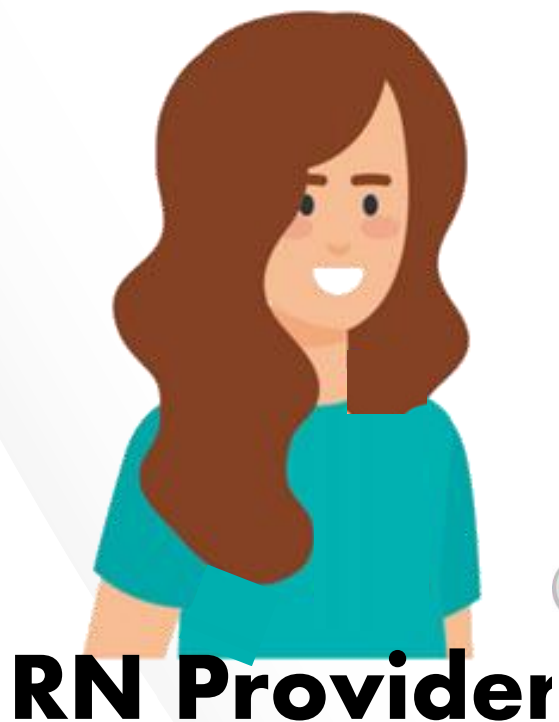
**RN
Provider**

Caregiver



Delegation Plan

- Creates and submits Nurse Delegation Plan
- Provides Nurse Delegation Plan



clipboard not needed



Case Manager



Quarterly Reports

RN Provider

- Quarterly visits must be documented including:
 - Date
 - Start/end time
 - Who was present
 - Observed nurse delegated tasks
- Provided to CM within 30 days of end of quarter
- Archived in T&C Provider file

Summary

- Revamped service to increase utilization of & support autonomy of Provider RN
- 2 components of T&C RN:
 1. Nurse Assessment
 2. Nurse Delegation
- Nurse Delegation Packet
- Standardized Nursing Assessment Form

Additional Questions?

Please email –

doh.dddcrb@doh.hawaii.gov



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<https://health.hawaii.gov/ddd>



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March 19, 2021
Community Presentations

COVID-19: Learn More About the Virus & Vaccines – Developmental Disabilities Division

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- Waiver Provider Trainings: DDD Policy
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- Waiver Provider Trainings: Presentations: Provider
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<https://health.hawaii.gov/ddd/waiver-providers/medicaid-idd-waiver-providers-archive-training-providers/>

Thank you

*thank
you!*

The cursive text "thank you!" is surrounded by ten short, orange, horizontal dashes arranged in a semi-circular pattern around the text.