DDD Provider Nurse Delegation Packet

Participants whose health and safety needs include nursing tasks, performed during waiver service hours, must receive a Nursing Assessment by a Provider Registered Nurse (RN) to help inform the person-centered planning process. The Nursing Assessment must be completed by a Registered Nurse who is licensed in the State of Hawai'i, in accordance with Chapter 89 of the HAR and HRS §457.

Training and Consultation-Registered Nurse (T&C RN) may be authorized for the following types of activities (refer to Waiver Standards, Section 4.18 for details):

- 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.

T&C RN may be authorized per Provider as nursing tasks may occur during multiple services the participant receives, and Providers are not obligated to delegate to workers outside of their agency.

T&C RN for Nursing Assessment:

- The CM may authorize up to two (2) hours for the Provider RN to complete the Provider Nurse Delegation Packet.

T&C RN for Nurse Delegation:

- The Provider RN will include their recommendation for the number of hours needed to complete the nurse delegation requirements (e.g. Nurse Delegation Plan(s), training, skills verification, supervision/monitoring).
- The Provider Nursing Assessment includes an Authorization Guide, based on the participant's identified risk category.
- The recommended hours will be reviewed and considered for authorization by the DOH-DDD.

Instructions:

Provider RN must complete the Nurse Delegation Packet and submit to the Developmental Disabilities Division (DDD) Case Manager (CM). The Nurse Delegation Packet includes the following:

1) Provider Nursing Assessment
2) Worksheet A: Nurse Delegation T&C RN Worksheet
3) Worksheet B: Assessment of Risk Guidelines

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: (*Include diagnoses)*

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

Diet/Nutrition:

Durable Medical Equipment/Medical Supplies:

Medications /Allergies: *(Include medication name, indication, dose, route & ordering physician)*

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):	☐ RN determines the person(s) is able to perform task. ☐ 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:	☐ Yes – task will be delegated. ☐ No – Reason:
Task #2:	Person(s) and Service(s):	☐ RN determines the person(s) is able to perform task. ☐ 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:	☐ Yes – task will be delegated. ☐ No – Reason:
Task #3:	Person(s) and Service(s):	☐ RN determines the person(s) is able to perform task. ☐ 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:	☐ Yes – task will be delegated. ☐ No – Reason:
Task #4:	Person(s) and Service(s):	☐ RN determines the person(s) is able to perform task. ☐ 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:	☐ Yes – task will be delegated. ☐ No – Reason:
Task #5:	Person(s) and Service(s):	☐ RN determines the person(s) is able to perform task. ☐ 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:	☐ Yes – task will be delegated. ☐ No – Reason:
Task #6:	Person(s) and Service(s):	☐ RN determines the person(s) is able to perform task. ☐ 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:	☐ Yes – task will be delegated. ☐ No – Reason:

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 #7:	Person(s) and Service(s):	☐ RN determines the person(s) is able to perform task. ☐ 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:	☐ Yes – task will be delegated. ☐ No – Reason:
Task #8:	Person(s) and Service(s):	☐ RN determines the person(s) is able to perform task. ☐ 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:	☐ Yes – task will be delegated. ☐ No – Reason:
Task #9:	Person(s) and Service(s):	☐ RN determines the person(s) is able to perform task. ☐ 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:	☐ Yes – task will be delegated. ☐ No – Reason:
Task #10:	Person(s) and Service(s):	☐ RN determines the person(s) is able to perform task. ☐ 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:	☐ Yes – task will be delegated. ☐ No – Reason:

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 Guide (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).
☐ **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*	

RN Comments:

4. Supervision/Monitoring Requirements

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.)

Supervision/Monitoring Requirements (*based on Provider Nursing Assessment*)	☐ Quarterly face-to-face visits sufficient ☐ Other frequency supervision/monitoring recommendation. Please enter your recommended frequency for supervision/monitoring here:
RN Rationale/Comments	

5. Provider RN Additional Comments/Notes

Comments/Notes *(If applicable, RN may provide any additional relevant information)*	

========== FOR DDD INTERNAL USE ONLY ==========		
DDD RN REVIEWER		
AUTHORIZATION	☐ Yes	Approved Hours:
	☐ No	Recommended Hours:
Comments:		

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

Participant Name: _____ Date: _____

Instructions for Worksheet:

1. Use the table below to identify which services are being provided to the participant that require RN delegation and oversight.
2. Under each service the participant receives, indicate the agency provider authorized to provide the service.
3. 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
	Provider:					
Medication Assistance - PRN only		☐	☐	☐	☐	☐
Medication Assistance - ongoing		☐	☐	☐	☐	☐
Medication Administration - PRN only		☐	☐	☐	☐	☐
Medication Administration - via oral administration (1-5 meds)		☐	☐	☐	☐	☐
Medication Administration - via oral administration (6-10 meds)		☐	☐	☐	☐	☐
Medication Administration - via oral administration (11 or more meds)		☐	☐	☐	☐	☐
Medication Administration - via topical administration		☐	☐	☐	☐	☐
Medication Administration - via rectal administration		☐	☐	☐	☐	☐
Medication Administration - via G/J-Tube (1-5 meds)		☐	☐	☐	☐	☐
Medication Administration - via G/J-Tube (6 or more meds)		☐	☐	☐	☐	☐
Medication Administration - via pre-drawn subcutaneous injections (e.g. insulin)		☐	☐	☐	☐	☐

RN Delegated Activities	Services provided by:	Service(s) under which RN Delegated activities are being performed.				
		ADH/CLS-G	ResHab	CLS-I	Respite	PAB
	Provider:					
Medication Administration - via pre-drawn intramuscular injection (e.g. epi-pen given as first aid)		☐	☐	☐	☐	☐
Medication Administration - via Nebulizer (inhalation therapy)		☐	☐	☐	☐	☐
Cough Assist w/ Suctioning		☐	☐	☐	☐	☐
Chest Physiotherapy		☐	☐	☐	☐	☐
Suctioning – Oropharyngeal (when done separately from cough assist)		☐	☐	☐	☐	☐
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		☐	☐	☐	☐	☐

RN Delegated Activities	Services provided by:	Service(s) under which RN Delegated activities are being performed.				
		ADH/CLS-G	ResHab	CLS-I	Respite	PAB
	Provider:					
Apnea Care and Monitoring – BIPAP/CPAP <12 hours/day		☐	☐	☐	☐	☐
Ileostomy/Colostomy care		☐	☐	☐	☐	☐
Tracheostomy Care		☐	☐	☐	☐	☐
Wound Care - Simple (for wounds, burns, ulcers using dry gauze and tape)		☐	☐	☐	☐	☐
Other (specify):		☐	☐	☐	☐	☐
Other (specify):		☐	☐	☐	☐	☐
Other (specify):		☐	☐	☐	☐	☐

For Reference: The following tasks do not require T&C RN since it can only be performed by a RN or LPN under supervision of a RN.

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)	☐
Medication Administration - via non-prepared intramuscular injection (drawing up of medications may NOT be delegated)	☐
Oxygen Therapy requiring assessment and intervention by a nurse due to instability	☐
Suctioning – Tracheostomy	☐
Suctioning – Nasotracheal	☐
Suctioning – Endotracheal	☐
Tracheostomy Tube Change (stable trach)	☐
Wound Care - Complex (requiring sterile dressing changes and RN wound assessment)	☐
Other (specify):	☐
Other (specify):	☐
Other (specify):	☐

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	☐
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):	☐

Risk Category Guidance	
Category 1 (Low Risk)	**<u>Participant has maintained medical stability and has non-complex care needs.</u>** *Examples:* • 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 2 (Moderate Risk)	**<u>Participant has maintained medical stability but has complex care needs:</u>** *Examples:* • Requires quarterly medical check-ups with primary physician • May require regular check-ups with other medical specialists (e.g. neurologist, cardiologist, nephrologist, etc.) • Medications include PRN psychotropic or narcotic analgesic orders which require verbal RN consult • Has therapeutic plans for care due to complexity of need requiring implementation of specific precautions (e.g. aspiration, falls) • Presence of complicating factors (e.g. dementia or Alzheimer's disease) but medical stability not compromised
Category 3 (High Risk)	**<u>Participant is medically unstable and has complex care needs:</u>** *Examples:* • Requires ongoing medical check-ups with primary physician or other medical specialists for reassessment (e.g. neurologist, cardiologist, nephrologist, pulmonologist, etc.) • Has required medical treatment for medical issue **within the past six months** (e.g. fall, pneumonia, bowel obstruction, sepsis, decubitus) requiring implementation of specific precautions • Has PRN order(s) for narcotic analgesic or psychotropic medication AND required administration of the medication **within the past six months** • Has unstable blood sugars requiring sliding scale insulin or titration of medication • Frequent medication changes or adjustments; medications require regular MD and RN review (i.e. medications require MD assessment or adjustment quarterly at minimum) • Presence of complicating factors affecting medical stability or complexity of care (e.g. MRSA, VRSA, dysphagia resulting in severe weight loss, age related conditions such as dementia or Alzheimer's) • Presence of challenging behaviors impacting medical stability (e.g. medication refusal, refusal to eat, pulling out tube, inability to follow fall risk protocols) • Multiple hospitalizations (2 or more hospital admissions within past year)
Category 4 (Highest Risk)	**<u>Participant is medically unstable, has high acuity complex care needs, and is under review for transition of care:</u>** *Examples:* • Requires frequent medical check-ups with other medical specialists for reassessment (e.g. neurologist, cardiologist, nephrologist, pulmonologist, etc.) • Has high risk care requiring ongoing, highly involved RN assessment • Progressive, degenerative, or terminal illness • Experienced organ failure (including renal failure requiring dialysis) • Acuity level of support needs requires involvement of multiple systems for delivery of services and care coordination Note: Participants in this level may be transitioning off PDN to address long term support or will be in transition to health plan.