

Professional Nursing and HCBS
Consumer access through nurse delegation
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Regional State Training on Olmstead Implementation, 2001

Elderly people and Olmstead

* Seniors = largest group in nursing homes

* Seniors = least likely to benefit from Olmstead

- conscious planning needed
- building senior constituency
- inspecting existing policies

Why the senior disadvantage?

- * Age inequities in state/waiver programs
- PAS for younger, agency for 65+
- * sheer numbers & \$ implications of change
- * ageism & protective instincts
- among providers, family, & seniors
- less disabled seniors served in HCBS
- * no constituency for reform
- * health needs: real & perceived
- * mixed agendas of seniors

Assisted living and HCBS

- * not all AL should count as HCBS
- counting in waiver not enough
- privacy & consumer control threshold
- some AL as institutional as NH
- some AL like private apartment
- * AL rules need inspection for:
- admission & retention requirements
- move-out rules
- environment rules

Strategies on behalf of seniors

- * build constituencies
- * education & dialogue
- providers, regulators, ombudsmen, citizen groups
- * review statutes, regs, & practices
- * make managed (negotiated) risk contracting operational
- * nurse delegation issues

Managed risk contracting

- * consumer knowingly accepts risk
- after information about risks & consequences
- * provider makes plan to mitigate risks
- * consumer cannot waive basic quality
- * all concerned parties sign written statement

Issues in managed risk

- * what risks count
- health, social, psychological
- * are risks of NH considered
- * how often are risks evaluated
- * who explains risks
- * proxy roles in risk assumption

Health care needs

- * routine help with medications
- oral, topical, suppository, injection, inhalator
- * routine nursing procedures
- * monitoring status when consumer cannot
- * when licensed personnel needed \$ é
- * self-care abilities may decline with age

- motor, visual, & memory problems
 - * BUT typically seniors have ADL/IADL help who could be delegated to do nursing
- Nurse delegation definitions
- . . . transfer of authority from a licensed health care provider to an individual not licensed to perform the delegated tasks within a specified situation (DHHS)
 - transferring to a competent individual the authority to perform a selected task in a selected situation, with the nurse retaining authority for delegation (MN)
 - the RN may delegate selected nursing tasks in the implementation of the nursing regimen to LPNs and ancillary nursing personnel. Ancillary personnel include but are not limited to: aides, attendants, and technicians [NJ]

Terminology

- * Delegation
- individualized delegation
- * Assignment
- delegates taught category of task & approved for that task (e.g. oral meds)
- * Exemption
- certain circumstances declared outside nurse practice
- sometimes family, domestic service, attendants

Delegation facts

- * Nurse practice acts build in delegation
- statutory change may not be needed
- * Clarifications may be needed
- * Provider license rules may be inconsistent with delegation
- * Types of delegation policies vary: need to know state

State policies

- * General delegation authority
- * List of what may be delegated
- * List of what may not be delegated
- * List of who may delegate & to whom by occupation
- * Specification of permissible settings for delegation

More state policy possibilities

- * Pre-training for nurse doing delegation
- * Pre-training for delegated person
- * Informed consent of consumer
- * Intervals for monitoring
- * Limited liability for nurse who delegates
- * if she teaches right, she is immune from bad performance of delegate

Nurse concerns about delegation

- * safety and quality
- * liability
- legal
- board of nursing license
- * control over own profession

Evaluation of delegation

- * Washington evaluation
- almost no negative effects (13 instances, none serious)
- in settings opting not to delegate, more nursing practice errors & more serious
- nurses in loop & more able to be helpful
- improved access for consumers
- task force recommended loosening policies
- * No bad outcomes in Oregon--doing it since early 1980's

Can physicians delegate?

- * Historically MD's instruct family & private-duty helpers
- * Possible end-run around nurses
- * May have negative impact in long-run
- ability to be systematic with MD's harder
- negative reactions among nurses
- nurses should be in loop sometimes

Strategies to make delegation work

- * statute or reg (changed practice
- * training & procedures useful
- * payment for nurse delegation an issue
- supervising delegation Medicare (skilled service
- state hiring nurse consultants

Specific stumbling blocks

- * PRN meds
- establish parameters
- * injections

Overview

- * nurse practice issues still halts reform
- * multifaceted opportunistic approach
- * nurse practice statutes & setting licenses
- regulatory clarification
- training & communication
- * payment sources
- * as needed, consider full range of delegation, assignment, and exemption
- * less prescriptive delegation rules best
- nurse retains discretion

Dealing with political obstacles

- * identify problem
- legislature? nursing board? providers? advocates?
- * get groups talking
- * get started with time-limited plan
- * build in evaluation
- * get quality surveyors on board