CHAPTER 1

EXECUTIVE SUMMARY

Long-term care legislation passed in 1995, Engrossed Second Substitute House Bill (E2SHB 1908), authorized registered nurses (RNs) to delegate specific tasks to registered or certified nursing assistants (NAs) in community residential programs for people with developmental disabilities, adult family homes and boarding homes with assisted living contracts. Prior to this legislation, nurses were authorized to delegate nursing care tasks to other persons except those tasks requiring "substantial skill or nursing judgment," the administration of medications, or piercing or severing of tissues. To distinguish between the two types of delegation, for the purposes of this report only, the new delegation authorized under E2SHB 1908 will be referred to as "specific" delegation and the previously authorized delegation will be referred to as "general" delegation.

E2SHB 1908 also required the Department of Health (DOH), in consultation with the Department of Social and Health Services (DSHS) and the Nursing Care Quality Assurance Commission (the Nursing Commission), to monitor the implementation of specific nurse delegation and provide a report back to the legislature with recommendations for improvements. As part of the monitoring process, DOH and DSHS, in consultation with the University of Washington School of Nursing, were also required to conduct a study of specific delegation in the authorized settings. This report incorporates results from both projects.

The *Nurse Delegation Study (The Study)* was conducted by a research team from the University of Washington School of Nursing using both quantitative and qualitative data sources, including existing data sources when possible. It is a descriptive study using a variety of methods including observation, interviews, surveys, and document review. A summary of *The Study* results appears in Chapter 2 of this report. A detailed report on *The Study* by the University of Washington School of Nursing is available on-line at www.doh.wa.gov.

Major findings of *The Study* included:

- Consumers prefer the least restrictive setting possible and value the ability to age in place.
- There was no evidence of significant harm or adverse outcomes for consumers receiving nurse delegation during *The Study* period.
- RN involvement in care planning has increased, communication has improved among the care team and with families and residents, and nursing assistants are better prepared to provide care under nurse delegation.
- Nurse delegation has brought unlicensed practice under the supervision of RNs.
- Rns exhibit professional judgment and discretion in determining what and to whom to delegate.

The *Implementation Project (The Project)* involved a work group that has been bringing forward issues and developing solutions over the past 3 years. The work group involved representation from providers, agencies and consumers. The involved agencies also held regional forums across the state in May 1998 to expand participation in *The Project* and receive a variety of perspectives on issues and solutions. The details about *The Project* are found in Chapter 3. Throughout this report, the term *work group members* refers to individuals who participated on the Nurse Delegation Work Group and/or participated in the regional forums.

The following recommendations have been separated into recommendations for legislative action and those for agency action. Recommendations include supporting rationale from *The Study* and *Project*. The recommendations for legislative action are incorporated in the attached draft legislation (Z-0094).

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RECOMMENDATIONS FOR LEGISLATIVE ACTION

<u>Recommendation #1:</u> Clarify in statute the differences between the specific delegation process that is allowed only in community-based care settings to registered or certified nursing assistants and general delegation which has been authorized for years in all care settings to licensed practical nurses (LPNs), NAs, and other personnel.

Rationale: The nurse practice act (RCW 18.79) has authorized general delegation for years. E2SHB 1908 authorized a pilot project requiring a more specific process for nurse delegation for specific tasks in specific settings. As changes are made to this statute, it is important to recognize that as this specific nurse delegation process is revised and expanded into other settings, it still does not negate the previously authorized delegation. *The Study* and *The Project* both found that a great deal of confusion existed about the nurse delegation process and when a RN is able to provide general vs. specific delegation. Reducing this confusion will enable nurses to more clearly define their practice, and will provide better patient care in all settings.

<u>Recommendation #2:</u> Place statutory requirements relevant to RNs' roles in both the general and specific delegation for community-based care settings in the nurse practice act (RCW 18.79) and those relevant to NAs' roles in the nursing assistant law (RCW 18.88A). Remove those references that are not relevant to RNs or NAs from those statutes.

Rationale: The general delegation that had been previously authorized was appropriately placed in the nurse practice act. The specific delegation authorized through E2SHB 1908 was placed in the nursing assistant law. Some of these details were specific to the role of the registered nurse. These provisions belong in the nurse practice act. This will also allow a clear connection and differentiation between what requirements apply to general delegation and the specific delegation for community-based care settings.

<u>Recommendation #3:</u> Remove the existing task list for the specific community-based care delegation from the statute. Authorize RNs to delegate nursing care tasks using their professional nursing judgment and standards of practice to registered or certified nursing assistants in community-based care settings. Tasks requiring nursing judgment shall not be delegated including administration of medications by the intravenous or intramuscular route, central line maintenance, and sterile procedures.

Rationale: For general delegation, nurses have always been expected to use professional judgment and discretion in decision making. *The Study* found that in the specific delegation authorized through E2SHB 1908, nurses exhibit professional judgment and discretion in determining what and to whom to delegate. Both *The Study* and *The Project* found that there was a need for tasks to be delegated in community-based care settings other than those on the task list. Leaving the determination to the RN of what tasks are appropriate will allow for more flexibility, make this specific delegation more consistent with general delegation, and respect the professional judgment of the nurse. However, there were some tasks that work group members and others thought should never be delegated. A list of tasks prohibited from delegation was included to address these concerns.

<u>Recommendation #4:</u> Expand specific delegation to all community-based care settings including: an individual's own home; community residential programs for the developmentally disabled certified by the department of social and health services under chapter 71A.12 RCW; adult family homes licensed under chapter 70.128 RCW; boarding homes licensed under chapter 18.20 RCW; and other community-based care settings as authorized by the Nursing Commission by rule. Clearly state that specific nurse delegation is not applicable to acute care or licensed nursing facilities.

Rationale: *The Study* found no evidence of significant harm or adverse outcomes for clients related to specific nurse delegation in the originally authorized community-based care settings. Instead, *the Study* found that: RN involvement in care planning has increased; nurse delegation has promoted better preparation for nursing assistants; there is better communication with the consumer and among the care team; there are improvements in quality of care -- with more training, flexibility and timeliness of care for clients. *The Study* also found that consumers and care providers prefer less restrictive environments and for consumer's quality of life, values include: aging in place, having continuity of care and not having to move from their preferred living situation. Expanding this specific nurse delegation to other community-based care settings will provide more choices to consumers and may bring the positive impacts on individual care and quality of life to these other settings.

<u>Recommendation #5:</u> Provide authority to the Nursing Commission to develop protocols for implementing all nurse delegation through the rule making process (see recommendations for agency action for more details). Remove the detailed protocols for specific delegation from the statute, retaining those necessary to protect the overall intent and quality of specific nurse delegation.

Rationale: The nursing process and health care environment are dynamic. Maintaining in statute only those requirements necessary to protect the overall intent and quality of nurse delegation will allow the Nursing Commission more flexibility to respond to this dynamic environment. *The Study* found that the paperwork associated with the statutory protocols was cumbersome, time consuming and a source of dissatisfaction among RNs, care providers and consumers. Using the rule making process, and its inherent public input, to improve the protocols is good management.

Recommendation #6: Remove the specific requirement for RNs to obtain written informed consent from the statute. Require the Nursing Commission to develop standards for providing information on specific nurse delegation and obtaining consumer consent. Assure that these standards are coordinated with requirements in the community-based care settings and that the consumer understands that tasks usually performed by licensed nurses can, through the delegation process, be performed by a nursing assistant at the direction of a RN.

Rationale: The intent behind the original requirement for written informed consent was to assure that consumers were notified that tasks usually performed by licensed nurses can, through the delegation process, be performed by a nursing assistant at the direction of a RN. *The Study* found that consumers were more concerned that care be delivered correctly, safely and conveniently by a trusted person and were less aware of the professional credentials of the caregiver. *The Study* and *Project* also found the paperwork associated with written informed consent to be cumbersome, time-consuming, disruptive to consumers, and a source of dissatisfaction with specific delegation. This change would still require that consumers be provided complete information about the delegation process and could allow for more flexibility, less paperwork, and better coordination with the settings' admission and care planning standards. Regardless of what standards the Nursing Commission develops, the requirement that the RN informs clients of their health status and changes to treatment is maintained.

Recommendation #7: Allow RNs, on a case by case basis, to delegate tasks to nursing assistants in community-based care settings prior to the nursing assistant completing the nurse delegation core training. The RN would provide all necessary one-on-one training specific to that task and consumer and would assure that the nursing assistant received the core delegation training within the first 60 days of the delegation process. Lack of completion of core training in the first 60 days of the delegation process will result in immediately rescinding the delegation process. No extensions would be permitted.

Rationale: *The Study* found that timing, availability and logistics of training remain challenging. Many work group members reported problems assuring ongoing quality care because of the high turnover rate of nursing assistants or changes in consumer needs, and the difficulty in finding core nurse delegation training options in a timely manner. Providers were often placed in a difficult situation when this happened. There were reports that in some cases it was taking months to get nursing assistants in training. This

change will recognize these realities and allow the nurse and providers greater flexibility in care delivery and help assure continuity of care for consumers.

Recommendation #8: Continue legislative work group discussions on self-directed care. Collaborate with consumer groups, DSHS, DOH, the Nursing Commission and other key stakeholders to develop a definition of self-directed care.

Rationale: *The Study* and *Project* found that consumers and providers, particularly those in the residential programs for people with disabilities, had numerous concerns about their inability to self-direct care and clearly articulated the conflict between current law and the desire of consumers to maintain control over their daily life.

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RECOMMENDATIONS FOR AGENCY ACTION

Recommendation #9: Request the Nursing Commission to address and evaluate the following issues when revising/developing rules to implement specific delegation:

(1) Requirements for supervision frequency;
(2) Situations when the use of restraints could be delegated;
(3) A system to allow a team of RNs to coordinate and supervise the delegation process;
(4) Appropriateness of allowing nurses to authorize exemptions to the specific nurse delegation process on a case-by-case basis;
(5) Protocols for use of oxygen in community care settings; and
(6) Simplification of documentation requirements.

Encourage the Nursing Commission to provide ongoing interpretation and technical assistance to DSHS and DOH on the nurse delegation rules and to recommend any additional legislative changes needed to address the above issues.

Rationale: There were many issues that work group members felt needed a closer evaluation but were too specific and detailed to be in the statute. The Nursing Commission will be revising and developing rules to implement the new legislation. They are the appropriate entity to continue discussion and develop any necessary requirements around these issues. Details on the list of issues can be found in Chapter 3 - Nurse Delegation Implementation Issues.

Recommendation #10: Encourage the Nursing Commission, DOH and DSHS to work collaboratively with the schools of nursing in Washington State to develop formal learning and technical assistance opportunities for nurses and create a plan for assuring ongoing communication and coordination among all entities involved in delegation.

Rationale: Specific nurse delegation authorized under E2SHB 1908 and the attached recommended changes represent a significant change in the delivery of nursing services

in community-based care settings. A certain amount of confusion was expected and will likely continue for some time. Continuing to develop and expand communication and education opportunities can only assist in assuring the successful implementation of the specific community-based delegation. It will also assist in differentiating between this delegation and the general delegation appropriate in other situations.

Recommendation #11: Refer issues regarding training access, availability, curriculum and costs to the DSHS work group required through 2SSB6544 to evaluate broader training issues.

Rationale: Training access, availability, curriculum and cost issues were reported through *The Study* and *The Project*. Many times these issues were seen as acting as a barrier to the successful implementation of the new specific nurse delegation. However, these issues apply to other issues in addition to nurse delegation. There are many training issues in community-based care that need to be addressed. A diverse work group was created through 2SSB6544 in the 1997 Legislative Session to evaluate these broader training issues. Having this group address the nurse delegation training issues will help assure a coordinated approach is taken.

Recommendation #12: Request DSHS, DOH and the Nursing Commission work together to revise regulatory language and develop interpretive guidelines so providers and surveyors/inspectors have a clear understanding and consistent interpretation of the rules. Ask those entities to develop a communication plan to disseminate information on the new legislative changes and on any regulatory changes or interpretive guidelines. Under the state's regulatory improvement initiatives and legislation, continue to regularly and systematically review nurse delegation rules.

Rationale: *The Study* found that nurse delegation had created tensions, confusions, fear and potential for different interpretations of the regulations. Information from the forums and work groups also indicate continued confusion, regulatory inconsistencies and misinterpretations about specific nurse delegation. Simpler regulatory language and interpretive guidelines will help allay some of these problems.

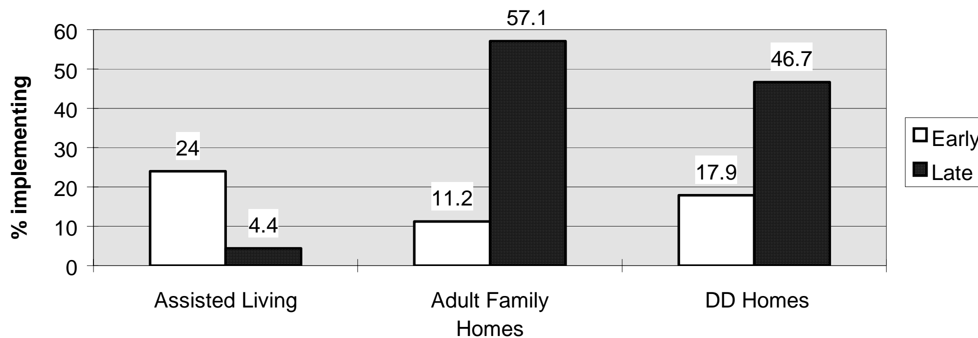
Chapter 2
Nurse Delegation Study
University of Washington School of Nursing

The Study was mandated by the 1995 Washington State Legislature in E2SHB 1908, Section 53. A study plan was approved by the Joint Legislative Task Force on Nurse Delegation on May 21, 1996. *The Study* was a descriptive study using a variety of methods including observation, interviews, surveys, and document review. E2SHB 1908 required that *The Study* consider eight variables. The eight variables are summarized with the appropriate measures and samples in Appendices 1 and 2. The following table summarizes the prevalence of nurse delegation in Washington State.

Percentage of Facilities Implementing Nurse Delegation
Early (December 1996 through April 1997) and
Late (April 1998 through July 1998)

Potential sample: 3,000 facilities in WA state, including all 3 settings (AL, AFH, DD)	Early sample size: 1781 facilities **% implementing**	Late sample size: 1501 facilities **% implementing**
Percentage implementing Nurse Delegation	12.1	52.2
Multiple tasks	2.0	10.6
Medications (oral)	9.8	52.2
Medications (eye/ear/nose drops)	4.2	15.8
Clean dressing change	1.2	3.9
Gastrostomy feeding	1.1	1.8
Enemas	1.2	1.9
Suppositories	1.7	3.7
Ostomy care	0.7	1.7
Clean catheterization	0.8	2.4
Blood glucose monitoring	2.0	7.2

Nurse Delegation Implementation



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A. GENERAL FINDINGS

The major findings of *The Study* can be grouped into four main areas: 1) The process of nurse delegation; 2) Consumer care and quality of life; 3) Regulatory aspects; and, 4) The scope of nursing practice. An overview of the findings follows.

1. The process of nurse delegation

- The process was cumbersome and confusing to start, but it became easier with experience
- Overall, all parties identify both benefits and concerns, yet most are satisfied
- Cost issues included paying for nursing assistant registration and the costs associated with staff turnover and repeated training
- Many implementation, protocol, reimbursement and statutory issues have been modified concurrently with *The Study*
- Training (timing, availability, and logistics) remain challenging for some
- The requirement for a 60 day re-evaluation of specific delegation situations is seen as too frequent in many cases by consumers, families, nurses, nursing assistants, and providers
- There was not evidence of coercion (i.e., being forced to participate in a task that would pose a safety risk), but there was evidence of tension around changing job descriptions and fear that the nursing assistant job might be lost if an employee refused categorically to perform delegated tasks.

2. Consumer care and quality of life

- There was no evidence of significant harm or adverse outcomes for consumers specifically related to nurse delegation
- RN involvement in care planning has increased
- Nurse delegation has promoted better preparation for nursing assistants
- There is better communication with the consumer and among the care team
- There are improvements in quality of care – with more training, flexibility and timeliness of care for consumers
- The quality of medication administration has improved with training and protocols ensuring appropriate methods of administration
- Consumers and care providers prefer less restrictive environments
- For consumers' quality of life, values include aging in place, having continuity of care and not having to move from their preferred living arrangement
- There are issues around self-care and consent in settings for persons with developmental disabilities, particularly for those who can direct their own care
- Prohibition of injection of insulin is a significant barrier to being able to place people in less restrictive environments

3. Regulatory aspects

- There is a general impression among case managers, nurses, and providers of increased access to less restrictive environments
- This type of regulation of care creates tensions, confusion, fear, and potential for different interpretations of the regulations. For example, "medication administration" was frequently cited as an area for different interpretations
- Change in one part of the system has implications for other sectors (such as home health and hospice)

4. The scope of nursing practice

- Nurse delegation brought unlicensed and unregulated practice under the supervision of registered nurses -- prior to nurse delegation, unlicensed and unregulated performance of tasks now delegated was widespread
- RN availability in certain communities, particularly rural areas, is a challenge
- Nurse delegation offers new practice opportunities for RNs
- Nurses exhibit professional judgment and discretion in determining what and to whom to delegate

B. DEPENDENT VARIABLES MANDATED BY E2SHB1908, Section 53

***1. Patient, nurse, and nursing assistant satisfaction*:** Information from consumers and families was gathered through in-depth interviews, forum comments, and field notes of comments and inquiries to department staff. Nurse satisfaction and nursing assistant satisfaction were ascertained in several ways, through questionnaires, in-depth interviews with expanded participation, review of comments made during training and implementation, field notes of comments and inquiries to department staff and review of comments made in public meetings such as the Regional Forums.

a. Patient (consumer) satisfaction: *Overall, consumers and families were satisfied with nurse delegation.*
Consumers and families focused primarily on the quality of care and the quality of relationships with caregivers, rather than on protocols for care delivery. Despite information and the consent process, consumers and families did not have a clear understanding of the technical aspects of delegation, but articulated that they were more concerned about care being delivered correctly and flexibly by a trusted person than by the professional credentials of the caregiver. Consumers and families identified the redundant paperwork and redundant training associated with the consent process and the 60-day re-evaluation as sources of dissatisfaction with nurse delegation. In settings for persons with developmental disabilities, there was a perception that nurse delegation reduced the status of the person receiving care, made home-like settings more institutional and clinical, and reduced the ability of the person to engage in self-care.

b. Nurse satisfaction: *Overall, registered nurses were moderately satisfied with nurse delegation.*

According to the Readiness to Implement and Satisfaction with Nurse Delegation Questionnaires, nurses who were involved with nurse delegation were moderately satisfied. In addition to responding to scaled items, RNs were asked to identify benefits and concerns about nurse delegation on questionnaires and in focused interviews. The major benefits identified were: Positive quality of care; cost savings; more freedom and time to provide care; improved placement availability; positive changes in RN role; bringing unlicensed and unregulated practice under RN supervision; improved communication and continuity of care; improved staff morale; and the benefits of trained staff. The major concerns identified were: Lack of confidence in the ability of nursing assistants to do the tasks; training and staffing limitations; redundancy and volume of paperwork; and regulatory aspects. At the time of the introductory training, liability and the potential for negative quality of care were major concerns; these had resolved at one year. At one year follow-up, RNs mentioned reimbursement more frequently.

c. Nursing assistant satisfaction*: Overall, nursing assistants reported moderate to high levels of satisfaction with nurse delegation.*

According to the Readiness to Implement and Satisfaction with Nurse Delegation Questionnaires, nursing assistants who were involved with nurse delegation showed moderate to high satisfaction. In addition to responding to scaled items, nursing assistants were asked to identify benefits and concerns about nurse delegation. The major benefits identified were: The opportunity for training; improved quality of care; improved knowledge of medication administration; the positive impact of new standards; improved self-confidence; convenience and time efficiency; improved consumer safety; pride in new responsibilities; having RN supervision; and cost savings. The major concerns identified were: Desiring more training; not feeling confident; liability; the time it takes; RN availability; understanding the protocol; communication; assuring adequate staffing; and feeling that it is the RN's role to do the tasks.

2. Medication errors, including those resulting in hospitalization: *This study did not identify any medication errors resulting in hospitalization in settings where nurse delegation was implemented.*

Because there is no centralized system for reporting medication errors, information was obtained during focused interviews and expanded participation, through forum comments and by auditing surveyor reports and Hot-line complaints. There were no errors reported to the Pharmacy Board during the period of *The Study*. Two delegated medication administration errors by nursing assistants were reported through the Hot-line and closed by the Nursing Commission as unsubstantiated. The most serious negative patient outcome found in the Hot-line and Nursing Commission complaint review was pain experienced by a consumer when a pain medication was inappropriately withheld by a nursing assistant. In this case the nursing assistant's registration was suspended for two years by the NCQAC due to this and related delegation protocol and scope of practice violations.

Isolated reports from registered nurses and surveyors suggest that the most common medication problems in the context of delegation are pharmacy errors (dispensing or documentation), staff filling Medi-sets (rather than a pharmacist), staff giving eye drops

or topical medications without delegation, and missed medications. Isolated incidents of right medication/wrong time, and wrong medication or wrong person were reported. In none of the error situations were adverse effects reported. In the incidents cited, the staff making the errors were either counseled and retrained, had delegation rescinded or were discharged/resigned from employment. According to multiple sources, medication administration has improved with training and protocols, as these have provided specific information about how to administer medications, side effects, and indications for particular consumers. Focused interviews and qualitative data on questionnaires included multiple reports of previous methods of administration that could cause harm, such as crushing time-release pills. The findings suggest that prior to the implementation of nurse delegation there was widespread unlicensed and unregulated medication administration occurring without supervision.

3. Compliance with required classroom training: *There was documentation supporting compliance with required classroom training, but there was some indication from interviews that the timing of training in relation to an admission (particularly if the admission occurs on a Friday afternoon), and in the case of staff turnover, can be difficult and there may be delays in obtaining the required classroom training for all staff.*

Training has been offered throughout Washington state and has resulted in over 7,000 nursing assistants receiving the mandatory classroom training, and 220 registered nurses attending the 2-day optional training. The dilemma of classroom training not being available in a timely manner is commonly solved in one of two ways: either qualified staff (licensed or delegated) cover the times when tasks must be completed, or non-delegated staff practice without the required training. This is viewed as the best alternative rather than going without or moving the client from their preferred living arrangement. RN availability in some communities (especially rural areas) can be a barrier to required training and appropriate delegation. The phone surveys to facilities confirmed the finding that training availability and the logistics of ensuring all delegated staff have completed the required training in time for care delivery continue to be challenges.

4. Compliance with nurse delegation protocols**:** *In general, nurse delegation protocols are being followed; initially, obtaining written consent and specifying potential outcomes were areas of weakness.*

The Care Plan audit revealed that the appropriate tasks are being delegated and there is RN involvement in the process. Areas of weakness in documentation and protocol included obtaining the written informed consent, individualizing the care plan, and providing specific potential outcomes and protocols. Some registered nurses were using pre-printed information (such as medication package inserts) as documentation for side effects, others were creating standardized care plans to facilitate the process. Focused interviews in the early stages of nurse delegation revealed that the written consent protocol was problematic and not consistently completed. The protocol for written consent was addressed in the last legislative session, alleviating much of the difficulty and irritation associated with obtaining separate consents for each staff member for each task. The RN maintains the professional responsibility to inform clients of their treatment and change of care plan.

Timing is an issue in implementing the nurse delegation protocols, particularly when an admission is rapid or occurs on a weekend when staff are less available to complete the care planning process. Confusion remains over certain protocol issues, such as the definition of medication administration and the perceived requirement for 24 hour on-call RN coverage. In addition, there is confusion over interpretive guidelines by regulators, who are not always consistent with the training that was provided to providers.

5. Incidence of harm to patients, including abuse and neglect*: There was no evidence of significant harm or adverse outcomes to patients among those receiving nurse delegation.*

Of 25,556 complaints called to the Abuse Hot-line and NCQAC (1996-7), eighty-eight (0.3%) cases were possibly related to nurse delegation and were reviewed in depth for incidence of harm, including abuse and neglect. Thirteen of the cases occurred in homes where nurse delegation protocols were being implemented. The most serious negative outcome identified through this review was unnecessary pain experienced by a consumer when a pain medication was inappropriately withheld by a nursing assistant. There were no hospitalizations, medical complications, injuries or deaths attributable to nurse delegation identified through this review. (See Appendix 3 for overview of complaint review).

Incidents of harm were also reported in some of the remaining 75 cases, in facilities where nurse delegation was not being attempted. In at least 24 of these cases unlicensed practices were alleged to be occurring. Unlicensed practices in addition to those that might have been allowed under nurse delegation protocols included insulin administration; medication administration through jejunostomy and gastrostomy tubes; and sterile urinary catheterization. Examples of harm noted in these unlicensed practice complaints and investigations included nausea, vomiting, potential choking and aspiration related to improper medication administration; abuse due to administration of benzodiazepines (chemical restraints) without a physician order; medication overdoses; insulin complications; and 3 hospitalizations. State agencies (DOH, DSHS, NCQAC) reviewed and/or did additional investigation in these cases resulting in citations and disciplinary actions. A potential benefit of nurse delegation is the education associated with medication administration and the correction of potentially harmful previous practices.

6. Impact on access to care: *There was a general impression from all perspectives (consumers and families, case managers, providers, RNs, and NAs) of improved access to less restrictive environments.*

Impact on access to care was ascertained in several ways, through questionnaires, in-depth interviews with expanded participation, field notes of comments and inquiries to department staff and review of comments made in public meetings such as the Regional Forums. Benefits of improved access included being able to age in place as functional condition declines; avoiding nursing home stays for certain condition changes; and being able to stay close to family and community as care needs increase. There has been a significant increase in the implementation of specific nurse delegation, from 12% in early

1997 to 52% in mid-1998, providing more options to consumers in community-based settings. According to DSHS Aging and Adult Administration (AASA) caseload trends, there has been a sizable shift since 1993 in the direction of growth in long-term care, with a marked reduction in nursing home consumers and a significant increase in community residential service options.

7. Impact on patient quality of life: *Consumers and family members value less restrictive environments and are willing to assume some risks to have the freedom and privacy afforded them in these settings. Nurse delegation was seen by some in the developmentally disabled community as reducing quality of life by taking away personal control.*

From the perspective of the consumer and his or her family members, the relationship with the caregiver is more important than the professional credential of the caregiver, when quality care is delivered. Consumers value flexibility, convenience, familiarity with the caregiver and the routine, and control over their situations. Consumers and family members want to be assured of safe conditions and high quality care.

Communication with the consumer and family and among the care team has improved with nurse delegation. The protocols requiring consent, care planning, and training have shifted the focus to the consumer receiving the care and have fostered individual care planning. Staff reported a greater appreciation of the individual needs of consumers and a better understanding of their health histories as a result of the improved care planning process. Training for nursing assistants has improved skills and instilled a sense of pride in their work, contributing to a more positive work environment and better quality of care, particularly around medication administration.

Persons with developmental disabilities and their caregivers articulated significant concerns with nurse delegation as it relates to the potential for self-directed care. Particularly among those whose developmental disabilities were physical, with intact cognitive ability, the idea of requiring a professional to direct care that the person him or herself could direct was offensive and demeaning. Nurse delegation brought about a change in the relationship between the nurse and the consumer in some DD settings, altering the role from one of a direct provider to a supervisor in some instances, and introducing the role as a new element in the care in some instances.

8. Incidence of coercion in the nurse-delegation process: *The Study found no instances of coercion, defined as the threat of losing one's job by refusing to perform an unsafe practice.*

There were, however, anecdotal reports of tension between nursing assistants and their supervisors as the job descriptions were renegotiated to include nurse delegation as an expectation of the role. This tension was illustrated by comments made at the regional forums and in the focused interviews by nursing assistants that they fear losing their jobs if they categorically refuse to accept any delegated task. There was also one Hot-line complaint from a nursing assistant who reported feeling the threat of job loss when he/she did not want to participate in nurse delegation training or delegated tasks as a personal preference.

In the questionnaires, registered nurses and nursing assistants were both directly asked whether they felt they had a choice in nurse delegation. Both groups indicated that they "moderately agree" with the statement that they have a choice in nurse delegation. In the early implementation phase, there were 6 calls and inquiries to the Nursing Commission alleging coercion. Three of these calls were from two staff members at the same boarding home. In addition to providing technical assistance, the Nursing Commission staff referred these complaints to DOH for licensing/survey follow-up and to DSHS for additional technical support. The remaining 3 calls were from anonymous callers refusing to identify themselves or the facility. In all three cases the NCQAC staff provided technical assistance. In one case, the caller was encouraged to submit a written complaint with names so the NCQAC could further investigate.

9. Additional finding: There was more RN involvement in care, and less unlicensed and unregulated practice. Rather than bringing higher risk tasks into the settings, Nurse delegation has actually enhanced the quality and intensity of supervision.

The most surprising and significant finding in this study was the extent to which nurse delegation brought unlicensed and unregulated practice under the supervision of the registered nurse. In considering the history of community residential services, developing as a community response to the needs of older and disabled members, rather than from an institutional template, it should not be surprising to find that practices reflect the philosophy of a home-like, low skill environment. Participants of all groups willingly shared their observations that the tasks that were delegated under E2SHB 1908 were already being done in the settings before the law addressed this area of practice.

C. IMPLICATIONS

This study of nurse delegation in the three settings (adult family homes, boarding homes with Assisted Living contracts, and community residences for persons with developmental disabilities) has several implications for nursing practice and community-base care.

1. Current protocols and regulations are confusing to those implementing nurse delegation. In addition, regulatory inconsistencies (such as the definition of medication administration) are a source of difficulty across practice settings. It would be helpful to focus on bringing greater clarity to regulatory language and interpretive guidelines and to provide the necessary training so that providers understand and surveyors/inspectors interpret regulations consistently.

2. *The Study* described considerable professional discretion and judgment of RNs in community-based settings. As an integral part of the nursing process, RNs were conducting assessments and developing plans of care that included supervision of nursing assistants and evaluation of the care. Delegating nurses showed professional judgment and discretion in selecting tasks to delegate and in selecting NAs to whom to delegate to, according to the condition of the consumer, their own assessment of the complexity of the task, and their confidence in the ability of the nursing assistant

to perform the task safely and correctly. This finding supports providing greater flexibility to RNs in the process of delegation, potentially in determining the time frame for re-evaluating, the tasks to be delegated, and the settings in which to delegate. Specifically, the 60 day re-evaluation is inconsistently completed due to RN scheduling and ability to meet with NAs in a timely fashion, and may not be necessary in some cases to ensure adequate supervision. Further clarity about expectations of the re-evaluation and possible extension of the re-evaluation period for consumers who have chronic, yet stable and predictable conditions could promote more appropriate supervision. Given the improved supervision and quality of care that came into being with nurse delegation, it would be reasonable to expand nurse delegation to other community-based settings where RNs can provide assessment and supervision. The inability to delegate insulin injections and other tasks, such as oxygen administration, creates a barrier to consumers desiring to remain in the least restrictive care environment. It would also be reasonable to re-examine which tasks are allowed to be delegated and to empower RNs to exercise their professional judgment in determining what and to whom to delegate.

3. The roles, responsibilities, and reimbursement of providers of skilled nursing services in community-based settings overlapped and were a source of potential conflict and miscommunication. The situation was further complicated when consumers had both acute and long-term care needs, requiring the involvement of multiple providers. In order to provide comprehensive and efficient care for consumers, it would be beneficial to improve collaboration among home health and hospice nurses providing Medicare services and nurses delegating nursing tasks.

4. Many participants in *The Study* noted the need to better prepare registered nurses to supervise and delegate to nursing assistants in community-based as well as other settings. This could be promoted if basic and continuing nursing education programs include and strengthen preparation for supervision and delegation roles of nurses in their curricula.

5. Consumers and providers of services to persons with developmental disabilities highlighted numerous concerns about self-directed care and clearly articulated the conflict between current law and the ability of consumers to maintain control over their daily life. It is to be expected with greater consumer awareness that this concern will become more prevalent in the aging community in the future. It is essential that professional groups, legislators, and the departments rethink the definition of self-directed care. Important elements to consider include: what it means to be disabled, and the relationship between physical disability without cognitive impairment and nurse delegation.

D. STUDY PARAMETERS

1. Methods were selected that incorporated multiple sources of data and several methodological approaches, offering the most effective and feasible design strategy for completing the evaluation mandated by E2SHB 1908, Section 53.

2. The subject of *The* Study was one about which there was little existing information, was highly contextual, and was being examined during a time when other changes in the health care system may also have effects on a patient's well-being, nursing practice, and provider issues.

3. At the time of the majority of qualitative data collection, only 12% of facilities were implementing nurse delegation. This study therefore reflects the experiences of those who implemented nurse delegation early on, and might be biased towards a heavier emphasis on logistical issues as all parties (those implementing, those administering, and those regulating) developed an understanding of the process.

4. Rather than conclusions that are "generalizable" to every situation, this study has provided in-depth knowledge about a range of findings based on the current context. By conducting the focused interviews in a variety of sites, the characteristics of each setting were documented, identifying factors that might influence the overall findings.

5. *The Study* findings reflect the perspectives of those who were willing to participate. Every attempt was made to include as many participants as possible, and some data sets are more comprehensively sampled than others. For example, all nurses who attended the voluntary training participated in *The Study* by completing questionnaires at least once. In calling all the facilities in the state (potential number of 3,000), 1781 agreed to participate in the simple phone screen that determined the prevalence of nurse delegation. This represents a 60% response rate, which is a statistically respectable level of participation, yet nothing is known about those who refused to be a part of *The Study*. In an effort to overcome simple refusals to participate, multiple opportunities to provide input were made available, including review of all calls to complaint or inquiry hot-lines, inclusion of all comments made in writing to the department, and inclusion of all comments made in public meetings. By using multiple methods and data sets, the design addressed the limitation of participation.

6. In conclusion, the findings provided detailed information from a variety of sources that can be used as a basis for evaluating policy and will serve as a foundation for further, more extensive evaluation if deemed necessary. The prevalence of nurse delegation has increased dramatically over the past year. As this practice becomes more widespread, ongoing evaluation of the outcomes of interest will be important, particularly determining whether nurse delegation has indeed met the goals of E2SHB 1908 to improve access and quality of care in more cost-effective ways.

Appendix 1: Variables and Measures

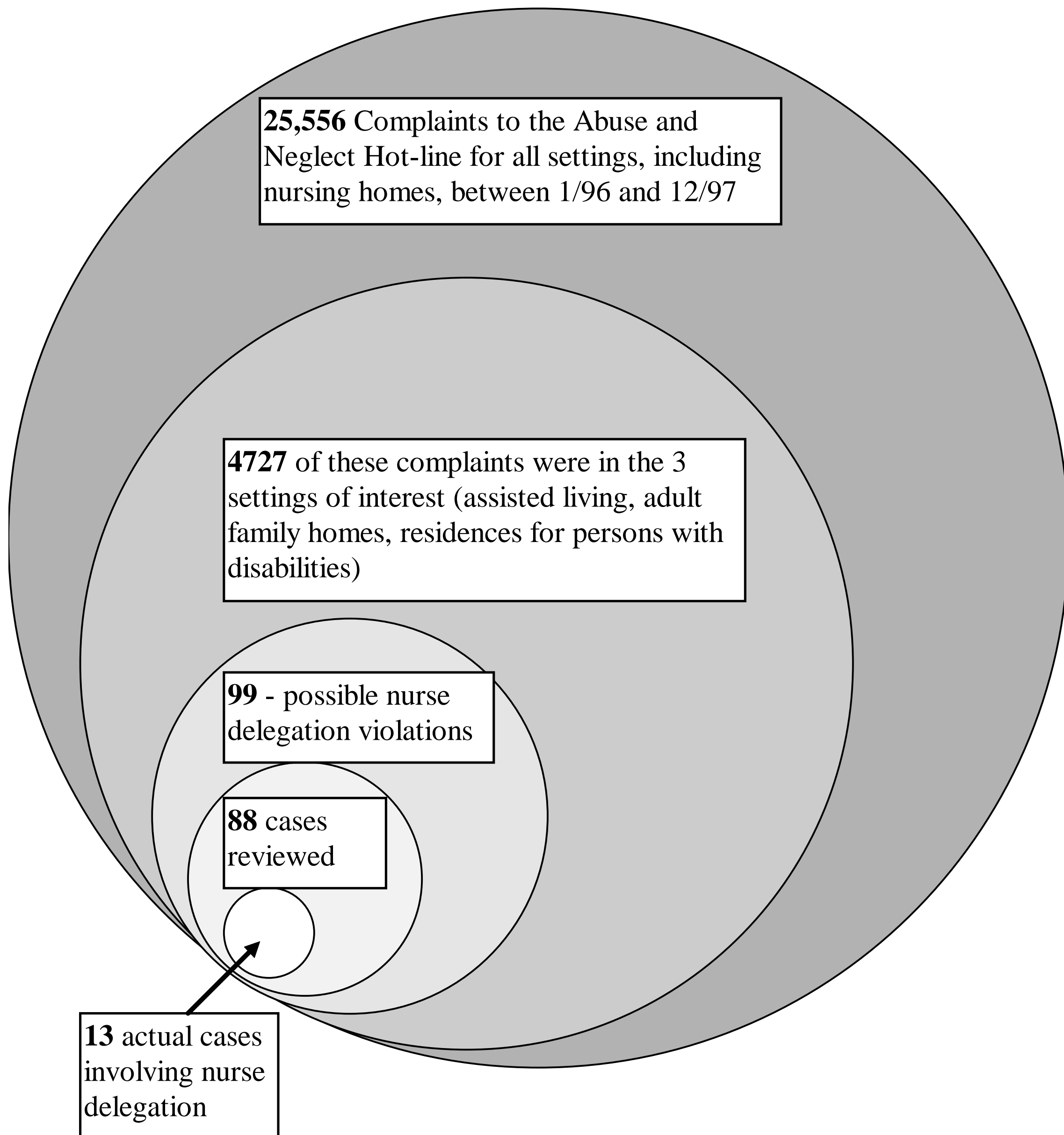
Study Aim	Methods/Measures
1) Patient, nurse, and nursing assistant satisfaction	Readiness to Implement/Satisfaction Questionnaire Focused interviews Forum comments Field notes and inquiries to Departments
2) Medication errors, including those	Incident reports/Hot-line complaints

resulting in hospitalization	Survey findings Rescinding delegation Focused interviews
3) Compliance with required training	Certificates of Completion Delegation of Nursing Care Task Form
4) Compliance with nurse delegation protocols	Delegation of Nursing Care Task Form Checklist for the Delegation of Specific Nursing Tasks Nursing Care Task follow-up Evaluation Form Nursing Care Task: Rescinding Delegation Form Focused interviews
5) Incidence of harm to patients, including abuse and neglect	Nursing Care Task: Rescinding Delegation Form Complaints received at Hot-Line Survey findings Uniform Disciplinary Act findings Focused interviews
6) Impact on access to care	Focused interviews Readiness to Implement/Satisfaction Questionnaire Field notes and inquiries to Departments Forum comments
7) Impact on patient quality of life	Focused interviews Forum comments
8) Incidence of coercion in the nurse-delegation process	Readiness to Implement/Satisfaction Questionnaire Focused interviews Forum comments Complaints received at Hot-Line Field notes and inquiries to Departments

Appendix 2. Data Sets

Data Set	**Sample and sample sizes**
Focused interviews	78 in-depth interviews (27 AFH, 20 AL, 31 DD settings) with 16 consumers/family members, 17 RNs, 18 nursing assistants, 19 Providers, 8 Case Managers
Readiness to Implement/Satisfaction Questionnaires *(administered at pre and post training and at 1 year to RNs and NAs, one time to surveyors)*	Staff/Pre training/Post training/1 yr. Registered nurse/220/202/42 Nursing assistant/1382/1335/187 Surveyors/58
Telephone Screening	12/96-4/97: 1781 facilities (75 AL, 1588 AFH, 117 DD settings) 4/98-7/98: 1501 facilities (135 AL, 1211 AFH, 150 DD settings)
Surveyor/inspector observation	DD: Audit of all inspections from 10/97 - 5/98 DSHS: Audit of all inspections from 1/97 to 6/98
Minutes/training and field notes	420 comments and inquiries
Incident reports	25,556 Complaints, of which 99 were possible nurse delegation violations, 88 cases warranted review, 13 actual cases involving nurse delegation
Nurse Delegation Form Audit	Care plan audit: 47 records Rescinding Delegation: 58 records Medication Change Form: 18 records

Appendix 3: Review of Complaints/Reports to the Abuse and Neglect Hot-line and the Nursing Care Quality Assurance Commission



CHAPTER 3

IMPLEMENTATION PROJECT ISSUE SUMMARY

ISSUE: PROTOCOLS

BACKGROUND

The current statute outlines nurse delegation protocols in great detail (RCW 18.88A.210 (6)). As nurse delegation was implemented, some of the protocols did not allow the flexibility for nurses to make decisions based on individual situations. The nurse delegation work group discussed the specific problematic areas and forwarded legislation in the 1998 legislative session that addressed these issues. The work group did not want to forward any major changes until *The Study* was completed but acknowledged that the nursing process is dynamic and having such prescriptive protocols in statute could continue to inhibit flexibility. *The study* found that the paperwork associated with the protocols was cumbersome, time consuming, and a source of dissatisfaction among RNs, care providers, and consumers. Using the rule making process, and its inherent public input, to improve the protocols is good management.

DISCUSSION

The majority of comments about protocols saw the protocols in statute as too prescriptive. Many participants thought the statute should rely more on the nurse practice act that regulates the RN's scope of practice and establishes standards to guide how the delegation process is carried out. Many thought there did need to be some minimum standards in statute to protect the overall intent and quality of nurse delegation such as maintaining total RN discretion and allowing delegation only for residents with a stable and predictable condition. Allowing the Nursing Commission to develop needed protocols was suggested as the best way to be able to respond to an ever-changing health care environment.

RECOMMENDATION

Provide authority to the Nursing Commission to develop protocols for implementing all nurse delegation through the rule making process. Remove the detailed protocols from statute, retaining those necessary to protect the overall intent and quality of specific nurse delegation. (See Executive Summary, recommendation #5 & #10)

* * * * * * * *

ISSUE: APPROPRIATE TASKS

BACKGROUND

The current statute specifies which tasks can be delegated in the specific community-based settings (RCW 18.88A.210(4)). These tasks include: oral and topical medications and ointments; nose, ear, eye drops, and ointments; dressing changes and catheterization using clean techniques; suppositories, enemas, and ostomy care; blood glucose monitoring; and gastrostomy feedings in established and healed conditions. For general delegation, nurses have always been expected to use professional judgment and discretion in decision making. The *Nurse Delegation Study* found that RNs are comfortable exhibiting discretion and are making decisions within the current parameters about which settings, residents, nursing assistants and tasks are appropriate for delegation based on individual assessments and judgments. *The Study* also found that there was a need for tasks to be delegated in community-based care settings other than those on the task list.

DISCUSSION

The majority of written and verbal comments supported RNs being given the professional discretion to decide what tasks to delegate. This was seen as allowing RNs greater flexibility to use their skills in determining when delegation is appropriate and potentially providing more options for community-based care. Many participants stated a need for specific additional tasks to be available in community-based settings through nurse delegation. Subcutaneous injection of insulin was the main task mentioned along with foley catheter irrigation, oxygen administration, jejunostomy tube management, complex wound care, and others.

Concerns about expanding the task list or leaving the tasks to be delegated to the discretion of the RN focused on concerns for assuring quality of care. There were comments that nursing assessment and judgment would have to be maintained and/or strengthened if there were more tasks being delegated. Having a list that defined what tasks could never be delegated was presented as a method for controlling quality. Participants found it critical that if the task list was removed, it was imperative that the tasks appropriate for delegation shall be at the discretion of the RN. It was also seen as important that each case be decided on an individual basis and based on a comprehensive nursing assessment of the individual resident, the specific setting and the ability of the caregiver(s) involved.

RECOMMENDATION

Remove the existing task list for the specific community-based care delegation from the statute. Authorize RNs to delegate nursing care tasks using their professional nursing judgment and standards of practice to registered or certified nursing assistants in community-based care settings. Tasks requiring nursing judgment shall not be delegated including: administration of medications by the intravenous

or intramuscular route; central line maintenance; and sterile procedures. (See Executive Summary, recommendation #3)

ISSUE: APPROPRIATE SETTINGS

BACKGROUND

Currently, specific delegation is only allowed in: community residential programs for people with disabilities certified by DSHS under RCW 71A.12; adult family homes licensed under RCW 70.128; and boarding homes licensed under RCW 18.20 contracting with DSHS to provide assisted living services pursuant to RCW 74.39A.010.

The findings of *the study* revealed no significant negative outcomes or harm to residents from the current delegation system that exists for the three community-based long term care settings. Instead, *The Study* noted issues jeopardizing client care and safety were more prevalent in those settings that were not using nurse delegation. According to *The Study*, nurse delegation, in most cases, enhanced quality by increasing the availability of nursing assessments, improving communication and bringing unlicensed practice under the appropriate supervision of RNs. *The study* also confirmed residents' and families' preference to say in the least restrictive environment for care.

The focus of the legislation authorizing nurse delegation (E2SHB 1908) was to expand access to community-based services. *The Study* and *Project* authorized through this legislation did not evaluate the use of nurse delegation in the acute care setting where nurses are regularly involved.

DISCUSSION

The majority of verbal and written comments supported expanding nurse delegation into other community-based care settings. The two most mentioned settings were licensed boarding homes without assisted living contracts and individuals' own homes. Other settings mentioned included: the school for the blind, free-standing hospice, retirement centers, children's foster care, adult day health, and acute care settings.

There was some concern raised about expanding into less-regulated settings, especially the in-home setting. Most of these concerns focused on how to assure quality and appropriate oversight. The majority of participants felt that expansion into other settings is only appropriate with specific safeguards. These include: maintaining total RN discretion and thorough nursing assessment of the resident, nursing assistant, specific setting, and tasks to be delegated; allowing nurse delegation only for stable and predictable residents; and assuring adequate training, teaching and supervision of nursing assistants performing delegated tasks. (Related training issues are discussed in other sections of this document).

Some participants felt there shouldn't be a need for nurse delegation in the home setting because of the belief that no professional board or other entity should have the right to regulate what happens in private homes.

RECOMMENDATION

Expand specific delegation to all community-based care settings including: an individual's own home; community residential programs for the developmentally disabled certified by the department of social and health services under chapter 71A.12 RCW; adult family homes licensed under chapter 70.128 RCW; boarding homes licensed under chapter 18.20 RCW; and other community-based care settings as authorized by the Nursing Commission by rule. Clearly state that specific nurse delegation is not applicable to acute care or licensed nursing facilities.

(See Executive Summary, recommendation #4)

ISSUE: TRANSFER OF TASKS

BACKGROUND

The original nurse delegation legislation required RNs to directly observe nursing assistants performing each task on the specific resident who would be receiving that task prior to determining that nursing assistants competency to perform the task. This process was seen as time consuming, inflexible and unnecessary. Some work group participants requested a process that would allow nursing assistants to be able to "transfer tasks" from one resident to another when the nurse determined it was appropriate. Instead of altering the one-to-one intent of the original nurse delegation legislation, the problem was addressed by recognizing training and competency. The legislature enacted legislation forwarded by the work group in the 1998 session that allows nurses to determine the appropriate means for determining the competency of each nursing assistant (RCW 18.88.210 (6)(g). This allows a nurse, on a case-by-case, basis to recognize previous training and allow the "transfer" of that learning to another resident. This maintains the requirement for the RN to give instructions unique to the individual case, but does not require a NA to be "taught" how to administer a medication if they have already demonstrated competency.

DISCUSSION

The legislation enacted in the 1998 session addressed the majority of the issues raised by the work group. Since the work group is recommending that these types of detailed protocols be removed from statute, the authority for making any additional changes to the process will now rest with the Nursing Commission. Most work group members expressed the need to maintain the integrity of the new protocols maintaining nurse discretion as to when previous training was appropriate to a new situation and allowing RNs to permit nursing assistants to perform a previously taught task on a new patient.

The RN utilizes nursing judgment and discretion on a case by case basis and assesses the particular resident and nursing assistant.

Concerns did arise related to the practicality of the RN having to verbally relay a medication change to every nursing assistant in the setting. Participants thought it would be reasonable to have the Nursing Commission evaluate when it would be appropriate for one nursing assistant to relay the message to other nursing assistants if the RN also provided systems for written exchange of information.

RECOMMENDATION

Authorize the Nursing Commission to be the body that develops protocols around nurse delegation. Request the Nursing Commission to use the existing language in (RCW 18.88.210 (6)(g) as a model for allowing "transfer of tasks" to other residents. (See Executive Summary, recommendation #5 & #10)

ISSUE: SUPERVISION

BACKGROUND

Currently, RNs are required to supervise nursing assistants under the specific delegation system at least every 60 days. *The Study* found that the current 60-day supervision requirement was not always appropriate and needed to be reevaluated. *The Study* suggests that the re-evaluation period be at the discretion of the delegating nurse, potentially extending the re-evaluation period for those consumers with chronic, yet stable and predictable conditions, and allowing for more frequent re-evaluation if the consumer's condition warrants closer supervision.

DISCUSSION

Many work group members thought more flexibility needed to be incorporated in the current requirements for 60-day RN supervision of the nursing assistants. Many RN delegators found the 60-day requirement to be too frequent in some situations and wanted to maintain the flexibility to do more frequent supervision in others. Concerns were raised about the unnecessary costs associated with RNs doing unneeded 60 day visits and the time it was taking away from the RN to provide other needed nursing services. Suggestions for providing more flexibility included: leaving the appropriate time period for supervision to the discretion of the RN; placing a longer term minimum in statute with the RN having discretion to determine when more supervision was needed; and having the Nursing Commission evaluate the need for minimum supervision requirements. Work group members did think it was critical for the RN to continue to have the discretion in deciding the appropriate amount of supervision for each specific case even if there is a minimum in statute or rule.

Some concern was raised that removing the protocol requiring 60 day nurse supervision of the nursing assistant from statute could lead to funding issues if a nurse still

determines she/he needs to supervise the nursing assistant every 60 days or more frequently. Most participants felt that authorizing the Nursing Commission to develop any needed supervision requirements would address these concerns.

RECOMMENDATION

Provide authorization to the Nursing Commission to develop nurse delegation protocols. Request the Nursing Commission to evaluate the need for requirements for supervision frequency. (See Executive Summary, recommendation #5 and #10)

ISSUE: DOCUMENTATION

BACKGROUND

The existing specific nurse delegation statute contains very specific protocols about the nurse delegation process, including details on written consent and documentation. Additionally, DSHS required any nurse delegator contracting with them to use model forms developed by the Nursing Commission. These forms were very detailed to meet the requirements of the statute but also to gather specific information for *The Study*. The work group agreed to not change documentation requirements until after *The Study* had been completed.

DISCUSSION

Work group members found the current requirements for documentation to be time consuming and inflexible. Simplification was seen as necessary, with some participants wanting simpler standardized forms, some wanting no required forms and some wanting standardized protocols detailing the documentation requirements.

Some specific suggestions for reducing paperwork included: allowing the RN to refer to understandable and accessible reference materials instead of having to include all documentation in the client file to save time currently spent duplicating information that already exists; allowing providers to use existing charting mechanisms to document delegation requirements; and developing optional sample forms to provide direction to settings not accustomed to clinical documentation.

Work group members did want to assure that written instructions would be appropriate to the level of care, based on the previous training of the unlicensed person and at the discretion of the RN. Work group members also wanted to assure that any materials referenced to in the written instructions would need to be accessible in the setting where delegation occurs and understandable to that particular nursing assistant.

RECOMMENDATION

Provide authorization to the Nursing Commission to develop nurse delegation protocols. Request the Nursing Commission to evaluate simplifying current documentation requirements. (See Executive Summary, recommendation #5 & #10)

ISSUE: INFORMED CONSENT

BACKGROUND

The nurse practice act requires that the RN who delegates a task of nursing care be responsible for explaining the process and any ongoing changes to the client's care needs. Clients or their decision-makers will always have the right to refuse care anywhere in the delegation process. These requirements apply for both the general and specific nurse delegation.

The original nurse delegation statute required the RN to "assure that the delegations of nursing tasks …have the written informed consent of the patient…". The original intent of this language was to assure that nurses informed patients that through this new delegation process tasks usually performed by licensed nurses could be performed by a nursing assistant at the direction of a RN. However, because the language referred to "delegations of nursing tasks", the language was being interpreted to mean that *written* informed consent was required for every task and for every change in task, nurse, or nursing assistant. This was often disruptive to the resident and/or difficult with respect to time and the client's need for care, particularly when a guardian/power of attorney was needed to sign the consent.

The work group forwarded legislation in the 1998 session to make the language consistent with the original intent without making any substantive changes while *The Study* was underway. The new language reads: "Assure that the initial delegating nurse obtain written consent to the nurse delegation process from the patient or a person authorized under RCW 7.70.065. Written consent is only necessary at the initial use of the nurse delegation process for each patient and is not necessary for task additions or changes or if a different nurse or nursing assistant will be participating in the process."

The study found that overall consumers and families were satisfied with delegation. The redundant paperwork associated with the consent process was found to be a frequent source of consumer, family, RN and provider dissatisfaction with nurse delegation. Additionally, *The Study* found that consumers were more concerned that care be delivered correctly, safely, and conveniently by a trusted person and were less aware of the professional credentials of the caregiver. There was no evidence of significant harm or adverse outcomes to consumers receiving nurse delegation

DISCUSSION

The recent legislative changes addressed the concerns over having to obtain written consent for every task and/or change in the delegation process. The majority of participants felt that having the nurse obtain written informed consent at the onset of delegation was important while *The Study* was underway to be able to evaluate resident, nurse and nursing assistant satisfaction with the process and to assure complete information was provided to residents.

After reviewing *The Study* findings, the majority of participants were in favor of obtaining the *written* informed consent at the time a resident is admitted to a particular setting or as it is determined nurse delegation is needed. This would assure complete information is provided to residents prior to entering the setting and gives them the ability to decide whether to enter a particular setting based on the care delivery system available in that setting. Nurses would follow the nurse practice act requirements for communication when initiating or changing delegation for a particular resident.

RECOMMENDATION

Remove the specific requirement for RNs to obtain written informed consent from the statute. Require the Nursing Commission to develop standards for providing information on specific nurse delegation and obtaining consumer consent. Assure that these standards are coordinated with requirements in the community-based care settings and that the consumer understands that tasks usually performed by licensed nurses can, through the delegation process, be performed by a nursing assistant at the direction of a RN. (See Executive Summary, recommendation #6)

ISSUE: NURSING ASSISTANT TURNOVER & TRAINING AVAILABILITY

BACKGROUND

Currently, nursing assistants are required to attend core nurse delegation classroom training prior to participating in specific nurse delegation. An average of 1, 150 new nursing assistant registrations and certifications are processed every month. Nursing assistants have historically had a high turnover rate, as evidenced by a consistently high ratio of lapsed registrations and certifications. Of the 118,858 total registrations and certifications issued since 1989, 43, 304 were active in October, 1998. *The study* noted the difficulty managing new admissions with the immediate delegation training requirement.

DISCUSSION

Many participants reported problems assuring ongoing quality care because of the high turnover rate of nursing assistants and the difficulty in finding core nurse delegation training options in a timely manner. Providers were often placed in a difficult situation when needing to have staff trained in response to turnover issues or changes in resident

needs. There were reports that in some cases it was taking months to get nursing assistants into training. Providers either needed to provide care outside the nurse delegation protocols, bring in a nurse to provide the care (which was often impractical and costly), or move the resident to another setting. Suggestions were made to address turnover by supporting the DSHS budget request increasing wages for nursing assistants providing nurse delegated tasks to recognize the increased responsibilities when participating in delegation. *The Study* and work group members confirmed that in most cases the added responsibility provided to the nursing assistants has improved job satisfaction, skills and communication for the nursing assistants. Work group members reported nurse delegation to have already had a positive impact on reducing nursing assistant turnover. Recognizing this increased responsibility with increased wages should also help decrease turnover and provide more continuity of care.

Suggestions were also made to address the training issues including providing the RN the flexibility to delegate to a nursing assistant prior to that nursing assistant receiving the core delegation classroom training. This was seen as a way to provide greater flexibility in care delivery and assure continuity and quality of care for residents. Important safeguards suggested included: total RN discretion in deciding when to initiate the delegation process based on one on one instruction of nursing assistant; the RN providing all necessary one on one training specific to that task and resident; and assurance that the nursing assistant received the core delegation classroom training within the first 60 days of the delegation process with no extensions permitted.

RECOMMENDATION

Allow RNs, on a case by case basis, to delegate tasks to nursing assistants in community-based care settings prior to the nursing assistant completing the nurse delegation core classroom training. The RN would provide all necessary one-on-one training specific to that task and consumer and would assure that the nursing assistant received the core delegation training within the first 60 days of the delegation process. Lack of completion of core training in the first 60 days of the delegation process will result in immediately rescinding the delegation process. No extensions would be permitted. (See Executive Summary, recommendation #7)

Refer issues regarding training access and availability of classes to the DSHS work group required through 2SSB 6544 to evaluate broader training issues. (See Executive Summary, recommendation #12)

ISSUE: TRAINING CURRICULUM AND COSTS

BACKGROUND

The original nurse delegation legislation (E2SHB 1908) required DSHS, the Nursing Commission, professional nursing organizations, and appropriate consumer and association representatives to develop a core nurse delegation training curriculum. Nursing assistants are required to receive this training prior to participating in delegation.

In the 1998 session, 2SSB 6544 established a work group involving representatives from DSHS, the Nursing Commission, DOH and other interested parties to evaluate broader training quality and availability issues.

DISCUSSION

A variety of ideas were presented by work group members regarding revisions to training curriculums including: increasing hands-on training opportunities; increasing required training hours; and removing the requirements on a set number of hours and focusing instead on course content. (Many comments also addressed costs of training as a barrier to the implementation of delegation. Refer to section on cost and reimbursement issues.)

Tying these discussions in with the broader review of training standards in community-based settings will assure a coordinated approach to training and reduce duplication of curriculum.

RECOMMENDATION

Refer issues about the nurse delegation training curriculum and costs to the DSHS work group required through 2SSB6544 to evaluate broader training standard issues. (See Executive Summary, recommendation #12)

"TEAM APPROACH" TO DELEGATION

BACKGROUND

When the specific nurse delegation process was being implemented, the process of one RN being solely responsible was seen as a barrier in some situations, particularly for home health agencies. Concerns focused on how delegating RNs and providers can assure that residents receive delegated tasks appropriately when they are needed without requiring individual RNs to be on call 24 hours a day, 7 days per week

The delegation process requires the development of an effective contingency plan as part of the client's overall care plan to provide direction to caregivers when the client's condition changes. Extensive technical assistance has been provided during implementation (and at the forums) to clarify that RNs are not required to be available 24 hours per day, 7 days per week for the delegation process. Further education is still needed within the community to understand the nurse delegation process.

A current process does exist for one RN to "assume" the delegation process of another RN. This process, however, does not suggest shared responsibility.

DISCUSSION

A process to allow multiple RNs to be involved in the delegation process for a particular resident, nursing assistant, and setting was suggested as a means to address the coverage

issues further. Implementing a “team approach” is seen as a method to assure better continuity of care for residents by providing another option for addressing client changes, vacation planning, and staffing needs. The key to this approach would be that the original delegating or supervising RN retains the responsibility and utilizes professional nursing judgment for the delegation and supervision process.

RECOMMENDATION

Request the Nursing Commission to consider developing a system to allow a team of RNs to coordinate and supervise the delegation process. (See Executive Summary, recommendation #10)

ISSUE: COST & REIMBURSEMENT ISSUES

BACKGROUND

DSHS AASA and Division of Developmental Disabilities (DDD) are the license/contract holders and set cost and reimbursement structures based on budget appropriations. In the current biennium (July 1997 -June 1998), DSHS AASA has expended a total of $683,238.80 to implement nurse delegation. These expenditures include:

RN services @ $30 per hour	$173,050.00
RN Consultation, Monitoring and Technical Assistance	$102,590.41
Assisted livingcontract costs	$214,405.03
Adult family home contract costs	$120,460.87
Nurse Delegation Study costs and training	$ 72,312.51

In the current biennium (July 1997 - June 1998) DSHS DDD has expended a total of $421,462. These expenditures include:

RN services @ $30 per hour	$271,149
Core training class time	$ 92,883
Core training tuition	$ 41,329
Transportation	$ 16,101

The Nursing Commission currently charges an application fee of $10.00 for nursing assistant registrations and certifications, with a late fee of $20.00. The Nursing Commission cannot increase these fees without specific statutory authority. DOH, DSHS and the Nursing Commission have no authority to regulate private health care industry fees.

DISCUSSION

Work group members raised cost and reimbursement issues for both state and private pay clients. There were concerns raised about the credentialing costs for the registered and certified nursing assistants being prohibitive. RN-operated adult family home providers

reported an inequity of policies due to their inability to be reimbursed for nurse delegation. Participants reported that private entities or individual RNs were charging excessive fees for private pay delegation services.

RECOMMENDATIONS

Support DSHS policy (MB-AASA-HCS-98-21) for nurse delegation in RN-Operated Adult Family Homes.

Forward all reimbursement and cost issues to the responsible agency related to state paid clients or to the Nursing Commission for credentialing issues.
Encourage DSHS and DOH to continue to evaluate nurse delegation cost and reimbursement policies.

ISSUE: ROLE OF SURVEYORS, INSPECTORS AND EVALUATORS

BACKGROUND

The specific nurse delegation legislation required DSHS to "impose a civil fine of not less than two hundred fifty dollars nor more than one thousand dollars" on the community-based settings eligible to participate in delegation that "knowingly permits an employee to perform a nursing task except as delegated by a nurse". Many providers saw the inspectors as too punitive and thought offering technical assistance to providers would be more beneficial to both the providers and consumers. The work group forwarded legislation enacted last session that gives DSHS inspectors more flexibility in determining when to issue fines. This gives inspectors the ability to provide technical assistance and education when appropriate.

The Study findings indicate continued confusion around the state and reflect regulatory inconsistencies and misinterpretations about nurse delegation requirements generated through the licensing and inspection process.

DISCUSSION

Many work group members continue to question the role of the surveyors, inspectors and evaluators in the nurse delegation process. There were comments that the inspectors were inconsistent in their interpretations of the nurse delegation requirements, approached providers in a punitive manner and didn't seem to understand delegation. Many providers were hesitant to participate in delegation because of these concerns.

Other concerns dealt with the difficulty to be in constant compliance with the nurse delegation protocols due to staff turnover, difficulty in finding timely training opportunities and other issues that have been discussed in previous sections. A strong desire was represented for more consistency of interpretation between surveyors.

RECOMMENDATION

Request DSHS, DOH and the Nursing Commission work together to revise regulatory language and develop interpretive guidelines so providers and surveyors/inspectors have a clear understanding and consistent interpretation of the rules. Have those entities develop a communication plan to disseminate information on the new legislative changes and on any regulatory changes or interpretive guidelines.

ISSUE: COMMUNITY EDUCATION

BACKGROUND

The specific nurse delegation represented a significant change in the delivery of nursing services in community-based care settings. A certain amount of confusion was expected. With new changes, will come additional challenges to educate all involved.

The study found that there continues to be confusion about nurse delegation. The roles, responsibilities and reimbursement of skilled nursing services in community-based settings overlapped and were a source of potential conflict and miscommunication. *The study* also noted that many participants in *The Study* saw the need to better prepare RNs to supervise and delegate to NAs in community-based care as well as other settings.

DISCUSSION

Many work group members reported confusion and misinterpretations about nurse delegation in the community. There were comments regarding a lack of understanding of nurse delegation by physicians, home health agencies, educators, case managers, and others involved in the delegation process. Many coordination issues have also arisen between the various caregivers involved in nurse delegation (e.g. delegating nurses, home health nurses, DSHS oversight nurses, and case managers). There were varying levels of comfort with RNs' understanding of nurse delegation and a need was seen for standardized training opportunities for RNs on delegation.

RECOMMENDATION

Encourage the Nursing Commission, DOH and DSHS to work collaboratively with the schools of nursing in Washington State to develop formal learning and technical assistance opportunities for nurses and create a plan for assuring ongoing communication and coordination among all entities involved in delegation.

ISSUE: SELF-DIRECTED CARE

BACKGROUND

The Study reports that consumers and providers highlighted numerous concerns about self-directed care and clearly articulated the conflict between current law and the ability of consumers to maintain control over daily life. Particularly in community residential programs for people with disabilities, nurse delegation was seen as interfering with the ability to self-direct care.

During the summer of 1997, the Nursing Commission led a series of meetings with interested stakeholders to explore issues related to self-directed care, many of which had come to light because of specific nurse delegation. A consensus definition of self directed care was developed by this group and was subsequently adopted into law during the 1998 legislative session at the request of several advocacy groups and the Governors Office on Disabilities. An interim study of self directed care was authorized by the 1998 legislature, which culminated in a descriptive presentation to the legislature in September, 1998. The work group and interested stakeholders are continuing dialogue about the issue.

DISCUSSION

Work group members confirmed that there is a great desire for self-directed care options in the community. It was clear that the prohibition of self-directed care in the community is limiting options and has contributed to a reduction in choices for consumers. There was strong consensus that a system needs to be developed to allow self-directed care across community-based care settings. Consensus was not reached on details such as how self-directed care would be defined or how the process would be initiated.

RECOMMENDATION

Continue legislative work group discussions on self-directed care. Collaborate with consumer groups, DSHS, DOH, the Nursing Commission and other key stakeholders to further discuss the definition of self-directed care and possible legislative and program proposals. (See Executive Summary, recommendation #9)

ISSUE: RESTRAINT USE AS A DELEGATABLE TASK

BACKGROUND

The long-term care resident rights statute (RCW 70.129) states that residents have a right to be free from physical or chemical restraint. Rules regulating the use of restraints (WAC 388-76) prohibit using any and all forms of physical restraint that are used for the purposed of discipline or convenience and are not required to treat the resident's medical symptoms. Treatment of such medical symptoms must be applied by and immediately

supervised on-site by a RN, LPN or a physician. Immediate supervision means the RN, LPN or physician is in the home and quickly and easily available.

DISCUSSION

The suggestion was made to add restraint use to the list of tasks that nurses could delegate to registered or certified nursing assistants. Since the work group decided to eliminate the task list from the statute and leave the decision making about what tasks are appropriate up to the discretion of the registered nurse, it did not seem appropriate to address restraint use in the statute. Additionally, the majority of stakeholders felt that it was important to retain the direct involvement and supervision of RNs, LPNs and physicians when restraints are used. However, it was felt that discussion about the appropriateness of delegating restraint use should continue.

RECOMMENDATION

Continue to require direct supervision by a RN, LPN or physician of the use of restraints. Request the Nursing Commission to evaluate, in consultation with DSHS, DOH and consumer groups, any situations when the use of restraints could be safely delegated. (See Executive Summary, recommendation #10)

ISSUE: OXYGEN ADMINISTRATION

BACKGROUND

Questions arose during the implementation of nurse delegation as to whether oxygen administration was a delegatable task. The Board of Pharmacy has stated that under Washington state law, oxygen is not classified as a medication. However, a prescription is required for its use, no matter what the setting. Providers and regulators have asked for clarification, technical assistance, and standardized guidelines related to oxygen.

DISCUSSION

Since there was agreement that the task list should be removed from the statute, it did not seem appropriate to specify whether oxygen should or should not be delegated in the statute. All parties involved agreed it would be best to develop protocols or clinical practice guidelines for the use of oxygen to assure safe care of residents.

RECOMMENDATION

Request the Nursing Commission to develop guidelines for the delegation of and use of oxygen in community-based care settings. (See Executive Summary, recommendation #10)

ISSUE: EXEMPTIONS TO NURSE DELEGATION

BACKGROUND

When nurse delegation was first being implemented, many concerns were raise about the process being time consuming and cumbersome. There were concerns that providers would either not accept residents who needed delegated tasks or would partake in unlicensed practice to provide care to their residents. The legislative changes forwarded last session addressed these concerns to a great extent. The recommendations included in this document would serve to streamline the process even more, add flexibility and enhance nurse discretion in decision making.

DISCUSSION

Due to the concerns with how time consuming and cumbersome the specific delegation process was initially, allowing nurses to exempt the nurse delegation process in specific situations was seen as a potential method for allaying the concerns. Since the changes being forwarded should address many of the concerns, it was not seen as necessary to develop a system in statute to allow exemptions to the process. However, providing the Nursing Commission with the ability to develop rules to implement delegation allows this discussion to continue as the new changes are implemented.

RECOMMENDATION

Request the Nursing Commission to evaluate the appropriateness of allowing nurses to authorize exemptions to the specific nurse delegation process on a case-by-case basis. (See Executive Summary, recommendation #10)