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Oregon's Nurse Practice Policies for Home and Community Living

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Oregon's Nurse Practice Policies for Home and Community Living

Summary

State policymakers and consumer activists who are promoting community living for all people, regardless of age or disability, confront many challenges in reversing this country's bias toward institutionalizing individuals who have ongoing needs for care and support. One major challenge is the extent to which a state's nurse practice laws and regulations permit workers who are not registered nurses to help consumers with their health maintenance activities, like taking medications or managing bladder catheters, among many other long term, daily care tasks. Few states have crafted nurse practice policies that specifically address how unlicensed workers, consumers and nurses can work together to manage these health maintenance tasks.[1]

This *State Policy in Practice* brief is the second in a series of reports on how states are addressing laws that regulate nursing practice to be more responsive to consumers' preferences to live in their own communities. The first brief summarized a national study of State Boards of Nursing (BON) and their executive staff's interpretation of how their policies affect consumers' desires to live at home and manage their ongoing care needs.[2] This second brief focuses on Oregon's policies for how nurses may collaborate with consumers in managing health maintenance activities. The purpose is to provide enough detail on how these policies have been implemented over time to stimulate interest in exploring policy options for other states. Subsequent issue briefs will focus on other state examples.

Major points

- State policymakers from Oregon's State Board of Nursing and the Oregon Department of Human Services have worked together for more than two decades to synchronize their policies to better serve people of all ages with disabilities who live in the community.

- State policy continues to evolve, with 2004 changes permitting unlicensed workers to administer intravenous medication under certain circumstances.

- Oregon's distinction between "teaching" and "delegating" care tasks is significant.

- Oregon's rules regarding "teaching" and "delegating" are specific to settings where a registered nurse is not regularly scheduled and not available to provide direct supervision.

- There is a tight relationship between nurses and workers, with nurses providing all of the training for those who will be performing the tasks that the nurse will be delegating. There are no formal courses or certification requirements for these "lay workers."

- There are 150 "Contract Registered Nurses" hired by the state as independent contractors to assess, teach, delegate and monitor care provided to people receiving publicly funded community based care.

- Contract Registered Nurses are required to learn how to delegate care task to workers.

- Nurses who follow the regulations are not subject to an action for civil damages for the performance of the worker, unless the worker is acting upon the nurse's specific instructions, or no instructions were given when they should have been provided.

Background

Oregon is a pioneer in the area of home and community-based services (HCBS), spending more of its public funding on HCBS than on institutional care.[3] For more than two decades, the state has been offering people who require "nursing home level of care" equal access to HCBS, including home care, adult foster care, assisted living, and many other options. Most of this care is delivered by "lay providers" in local communities. About half of all long term care services in Oregon's publicly funded programs are provided in the home,[4] and less than 2% of home care in Oregon is delivered through home care agencies.[5] Most consumers hire workers, known as "Client Employed Providers". They usually know these providers (family members, neighbors, friends), who often work exclusively for that one consumer. Indeed, only 2,000 of the 13,000 client employed providers work for more than one consumer at a time. There are more than 8,000 beds available in commercial adult foster homes and 2,000 beds in relatives' adult foster homes. The commercial adult foster homes have an occupancy rate of 85%-90% living with lay people in their own homes with up to four other clients. Approximately 60% of the consumers living in commercial adult foster homes pay privately for their care and the remainder are supported by the state. All consumers residing in relative foster homes are supported by Medicaid.

It is important to understand Oregon's HCBS context and the state's mission to support community living for older adults and people with disabilities in "normalized," non-institutional settings. This mission is operationalized through many state policies. One critical and continually evolving set of laws and regulations provides a framework for permitting lay caregivers to help individuals with personal care and health maintenance needs with consultation from registered nurses.

The framework that supports this nurse-consumer-worker collaboration began in 1979 when the Oregon State Board of Nursing (OSBN) first implemented its policy to permit registered nurses (nurses) to "delegate" the administration of non-injectable medications to unlicensed workers in certain circumstances.[6] As the state became more deliberate about helping people who need ongoing care and support to remain in their communities, stakeholders sought major changes in statutes, regulations, and financing methods. The consolidation of all policy, budgetary, and programmatic authority for senior services into one state department through a 1981 statute (Senate Bill 955) helped to spearhead many other changes needed to make HCBS a viable choice for Oregonians, including policies that support nurses' participation in the community. The Seniors and People with Disabilities (SPD) Division within the Oregon Department of Human Services (ODHS) is the state agency charged with developing the infrastructure needed to support community living.[7]

Part of that infrastructure development has been the continual evolution of the regulation of HCBS governed by the SPD, regulation of nursing practice governed by OSBN, and the intersection between the two sets of regulations. Partly through the urging of consumers and legislators, policymakers from both state agencies have worked

together over the years to synchronize their policies so that nurses can support consumers' desire for both independence and quality services.

Amendments to Oregon's Nurse Practice Act in 1987 permitted nurses to delegate tasks formerly performed only by nurses to unlicensed persons.[8] The following year, OSBN adopted regulations that gave more specificity to nurse delegation.[9] The policy goal of nurse delegation was two-fold. First, policymakers wanted to remove barriers to HCBS and believed that it was not necessary (or possible) to have a nurse perform daily, health-related activities. Second, knowing that many people living in communities have unmet nursing needs, leaders from both state agencies wanted to shape policies that would bring more nurses into situations where unlicensed personnel were already providing these services, without the benefit of nursing consultation or regulatory oversight. Oregon has amended its Nurse Practice Act several times since 1987, most recently in 2004.[10]

Creating the policy framework for nurse delegation was a fundamental contribution by the OSBN. Based on the OSBN rules, the SPD/ODHS developed a mechanism to maximize the use of nurse delegation for publicly funded programs. In the late 1980s, this agency created the Contract Registered Nurse (CRN) Service comprised of registered nurses that work as independent contractors for the state. Currently, SPD has contracts with 150 nurses.[11] Because these nurses work with consumers who receive Medicaid-funded services to support community living, the state appropriately claims the customary 75% federal Medicaid administrative match rate. After undergoing an orientation developed as part of the contract standards, these nurses implement a sophisticated model of community nursing. They teach and delegate care tasks to unlicensed workers, training these lay caregivers to perform needed health-related activities on a group (teaching) or individual (delegation) basis, and providing ongoing monitoring.

Oregon has had 25 years of experience in nurse delegation, and continues to make changes based on experience and dialogue with stakeholders, including consumers, legislators, and nurses. This state's implementation of policy into practice offers many lessons for other states.

Program Practices

Some details about how nurse delegation occurs in Oregon can help stakeholders in other states consider policy options. Answers to common questions posed are offered here to stimulate discussion.

Can nurses delegate nursing tasks in any setting?

Nurse delegation in Oregon is well developed, although continually evolving. **Delegation rules apply only to settings where a registered nurse (RN) is not regularly scheduled and not available to provide direct supervision.** That means that nurses can delegate to lay caregivers who have no course training or certification, but

only in community based settings, such as private homes, public schools, adult and child foster homes, assisted living and other 24-hour residential care settings, detoxification centers, and correction and detention facilities.

Nurses do supervise trained and certified medication technicians in nursing homes. However, Oregon views this nursing role as supervision of credentialed personnel, rather than delegation to non-certified lay caregivers.

What tasks can nurses delegate?

Within this broad parameter, nurses are given much discretion in what they can teach and delegate. The OSBN and the SPD/ODHS make an important distinction between these activities.

Nurses can teach groups of unlicensed workers how to assist a group of consumers with activities of daily living, like bathing, toileting, and transferring. Nurses can also teach the administration of non-injectible medications (e.g., oral, topical, eye drops). They must give the worker written instructions, including risks, side effects, and whom to contact to report any problems.

In addition to teaching tasks, the nurse can delegate more complex tasks to a specific worker for a specific client. This one-to-one delegation model is required for injectible medications, most often subcutaneous insulin injections. The worker cannot "transfer" this delegation to another consumer.

It is interesting to note that nurses are not allowed to delegate intramuscular injections, but the 2004 amendments permit nurses to delegate intravenous medications and fluids in certain circumstances. The nurse must be employed by a home health agency, home infusion agency or hospice, and must be available 24 hours a day. The bags of fluid and doses of medication need to be pre-measured by a health care professional and the nurse needs to be responsible for initiating or discontinuing this type of medication. Delegated tasks in these circumstances are limited to flushing the line with routine, measured flushing solutions, adding pre-measured medications, administering a bolus of medication by pushing a button on a pre-programmed pump, and changing bags of pre-measured fluids.[12]

Who decides what tasks can be taught and/or delegated?

The nurse is solely responsible for deciding to delegate nursing activities to specific unlicensed workers, and can rescind that delegation. In practice, this decision is based on discussions with the consumer, worker, and other involved parties where appropriate (e.g., assisted living administrator, family caregiver). The nurse can only delegate tasks to the number of workers who can be safely supervised by the nurse. The nurse also has the right to refuse to delegate tasks of nursing care if there is a concern about the safety of delegating or the ability to provide adequate supervision. The nurse may delegate if the following conditions are evident:

- the client's condition is stable and predictable;
- the client's situation or living environment is such that the delegation of a nursing care task could be safely performed; and,
- the unlicensed person(s) have been taught the nursing care task and are capable of and willing to safely perform this task. [13]

The teaching and/or delegation process begins with assessing a client's situation to determine whether the nursing task can be safely performed. This decision is based on the specific circumstances for a specific client and worker in a specific setting. For example, the consumer who has a full understanding of his condition and the care tasks that need to be carried out routinely can self-direct a worker and the nurse acts as a consultant to the consumer. An individual with moderate dementia who is residing in an assisted living setting with several workers is in a different situation. The nurse uses judgement about the stability of the person's condition, and the complexity of the task(s) that would be taught or delegated in relation to the risks involved and the skills necessary to safely perform the task. The nurse needs to decide if the unlicensed worker can safely perform the task without the continual presence of a supervising nurse. The nurse must also determine how often the client's condition needs to be reassessed to assure that continued delegation is appropriate for this client, worker, and the task. The state requires that the nurse completes the first evaluation when training the unlicensed aide and then re-evaluates the situation within 60 days, with subsequent evaluations taking place no more than 180 days apart.[14]

What training do the workers get to perform care tasks?

Since Oregon's community-based care system was founded on home care with client-employed providers, adult foster homes and other residential settings (including assisted living), the state views HCBS workers as "lay providers" who are taught any health-related tasks they need to know by nurses and doctors. This is a "home care" model of training caregivers in how to offer care and support to those who seek their help.

The OSBN and SPD have guidelines for nurses to provide: (1) group training to teach workers how to give help with activities of daily living (ADLs) and administer non-injectible medications; and (2) one-on-one training when delegating a specific tasks (like Insulin injections) to a specific worker for a specific client. The nurse is responsible for writing the parameters of the nursing care tasks, and making sure these instructions are available for the worker. The written instructions need to include specific outlines of the step-by-step administration of the task, signs and symptoms to be observed, and guidelines for what to do if signs and symptoms do occur.

Teaching the administration of non-injectible medications includes:

- the proper methods for administering the non-injectable medications;
- the reasons for the medication;
- the potential side effects of the medication;
- observation of the client's response;
- expected actions if side effects are observed; and,
- documentation of the medication administration.

Workers are permitted to only administer medication that they have been trained to provide. It should be noted that the state does not require a nurse to train workers in administering oral medications. Community based care settings may or may not require nurse consultation or the involvement of a licensed nurse. Frequently, physicians provide initial guidance on medications.[15]

The same steps are followed in one-to-one training of a worker who will be performing delegated tasks, such as giving a specific consumer an insulin injection. The nurse must observe the worker perform this task to ensure accuracy and safety. In this case, the trained worker can only administer that medication for a specific consumer. If that worker cares for another consumer who receives the same type of injection, the nurse would need to provide one-on-one training again to specifically delegate the administration of that injection for the other consumer as well.

What documentation and supervision does the state require?

The nurse must document the assessment of the client's condition, the rationale for deciding that a specific task could be safely delegated to the worker, and the skills and willingness of the worker. Furthermore, the nurse needs to document that the care task was taught to the worker and record what written instructions were left for the worker, including the schedule of reassessments for the specific client, worker, and task.[16]

Once the worker is performing the tasks, the nurse is responsible for supervising and reassessing the status of the worker, the client, and the care situation. The nurse again assesses the stability of the client's status and observes the competence and willingness of the worker to perform the delegated task(s). The process can be done in person or by use of technology that allows the nurse to visualize the client and the worker. Finally, the nurse needs to determine if the schedule for supervision and assessment can remain the same or if it needs to be performed more frequently.

Who is accountable?

The nurse is accountable for following the guidelines, for teaching and delegation. According to the Nurse Practice Act and implementing regulations, nurses who follow

the regulations are not subject to an action for civil damages for the performance of the worker, unless the worker is acting upon the nurse's specific instructions, or no instructions were given when they should have been provided. The nurse retains the responsibility for determining the appropriateness of teaching or delegating nursing tasks to workers.

Adhering to the OSBN's process for delegation, the nurse must also report unsafe practices to the appropriate state agency(ies) and the owner or administrator of the care setting (adult foster care, assisted living, etc.) as appropriate.[17]

Lessons Learned

Oregon made reform of the Nurse Practice Act and regulations a core part of the strategy to promote home and community based care. The OSBN worked closely with the state agency that is responsible for regulating the care settings (SPD). Each state agency's authority became clear, and both were charged with helping to implement the statewide mission to promote independence, dignity and choice for Oregonians who need long term care and supportive services.

This collaboration took several years to evolve. Early dialogue between the SPD and the OSBN seems to have been similar to what most other states experience today. The Board of Nursing was concerned about the safety of delegating tasks like medication administration. However, continued discussion with the SPD, consumers, and other key stakeholders led to the refinement of nurses' teaching role, with guidelines and training for nurses to strengthen their teaching and delegation skills.

Distinguishing teaching from delegation and limiting this teaching and delegating scope of practice to settings where a nurse is not regularly scheduled and available to provide direct supervision are important policy parameters for other states to consider. Some state BONs struggle with delegation issues setting by setting, and spend years trying to define "acute care" and "long term care" in an attempt to prevent "delegation creep." Rather than attempt to define specific settings, which will change and emerge over time, Oregon officials started with the premise that they wanted to bring more nursing expertise into settings where nurses were not present round the clock, and never would be. The goal was not to make community settings more like institutional or "medical model" settings. They did not want to create certified nursing assistants, or another category of health care provider with a specific number of hours of training and a written competency evaluation. Instead, they chose a flexible model of nurses training workers in the homes and residential settings where they would be giving care.[18]

Oregon's model of hiring nurses as independent contractors to assess, teach, delegate and monitor care tasks is a strategic method for promoting HCBS and monitoring quality. State officials consider their "Nursing Support Services" to be one of their most important HCBS services. While the OSBN rules permit all nurses to delegate, the state's Certified Contract Nurses receive special orientation to the delegation policies and processes, including how to train and monitor unlicensed workers. They provide a

comprehensive, holistic assessment of the person with chronic, maintenance care needs in that person's unique living environment. The state relies on their professional judgement to decide when to delegate and how often to monitor, beyond minimum standards.

State officials in Oregon believe their policies are noteworthy because they respect consumers' autonomy and expand the field of nursing, rather than limit it. A state that designs and implements nurse delegation policies to support people in the settings in which they choose to live is emphasizing the value of including the nurse as a teacher and consultant in community care settings. In contrast, a state that exempts community-based care (e.g., personal care attendant programs) or settings (e.g., group homes) from the Nurse Practice Act removes the opportunity for nurses to provide this teaching and consultation. Consumer activists seek more autonomy in directing their care. They do not reject the option for nurse consultation but do reject restrictive state policies that prevent them from managing health maintenance tasks in community settings. They seek nurses who are familiar with person-centered planning led by the consumer, not the nurse.

Finally, Oregon state officials have historically engaged all stakeholders in policy development and implementation processes. State officials believe that continued communication is the most important element to the continually evolving policies that support nurses and consumers in the home and community-based settings. They have continually adapted their policies to best suit the concerns of nurses and the needs of consumers.

Conclusion

For a quarter of a century, Oregon has been a model for states that want to promote community living for people of all ages and disabilities. Consumer and policymakers in other states are seeking ways to change their infrastructure to do the same. States' Nurse Practice Acts and regulations must be addressed in this discussion of infrastructure reform. Oregon offers one time-tested model. Subsequent *State Policy in Practice* Briefs will feature other state models.

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[3] Justice, D. & Heestand, A. (2003). Promising Practices in Long Term Care Systems Reform: Oregon's Home and Community Based Services System. Washington, D.C.: Medstat

[4] Cindy Hannum, SPD/ODHS, Presentation to the Summit of Thought leaders on Nurse-Consumer Collaboration, Office of the Assistant Secretary of Planning and Evaluation (ASPE), Washington, DC, April7, 2004.

[5] Justice, D. & Heestand, A. (2003). Promising Practices in Long Term Care Systems Reform: Oregon's Home and Community Based Services System. Washington, D.C.: Medstat.

[6] 1979 Oregon Revised Statue (ORS) 678.

[7] This agency was originally named the Senior Services Division in 1981.

[8] 1987 Oregon Revised Statute (ORS) 678.

[9] 1988 Oregon State Board of Nursing (OSBN), Oregon Administrative Rules (OARS) Division 45.

[10] In 1992, the OSBN moved the delegation rule to Division 47 *Standards for Registered Nurse Delegation and Assignment of Nursing Tasks to Unlicensed Persons.* These rules were amended again in 1998 and 2004.

[11] Cindy Hannum, SPD/ODHS, Presentation to the Summit of Thought leaders on Nurse-Consumer Collaboration, Office of the Assistant Secretary of Planning and Evaluation (ASPE), Washington, DC, April7, 2004.

[12] Margaret Murphy Carley, OSBN, Presentation to the Summit of Thought leaders on Nurse-Consumer Collaboration, Office of the Assistant Secretary of Planning and Evaluation (ASPE), Washington, DC, April7, 2004.

[13] Oregon Secretary of State. (2004). The Oregon administrative rules contain OARs filed through March 15, 2004. Division 47: Standards for Registered Nurse delegation and assignment of nursing care tasks to unlicensed persons. Available as of April 5, 2004 at http://arcweb.sos.state.or.us/rules/OARS_800/OAR_851/851_047.html

[14] Ibid

[15] Margaret Murphy Carley, OSBN, Presentation to the Summit of Thought leaders on Nurse-Consumer Collaboration, Office of the Assistant Secretary of Planning and Evaluation (ASPE), Washington, DC, April7, 2004

[16] Oregon Secretary Of State (2004).

[17] Oregon Board of Nursing. (2004). Division 47: Nurse delegation. Power point presentation provided by OR BON, April 8th, 2004, at a National Summit on Nurses Collaborating with Consumers. Washington, DC.

[18] Cindy Hannum, SPD/ODHS, Presentation to the Summit of Thought leaders on Nurse-Consumer Collaboration, Office of the Assistant Secretary of Planning and Evaluation (ASPE), Washington, DC, April7, 2004.

The Oregon Administrative Rules contain OARs filed through December 15, 2004

BOARD OF NURSING

DIVISION 47

STANDARDS FOR REGISTERED NURSE DELEGATION AND ASSIGNMENT OF NURSING CARE TASKS TO UNLICENSED PERSONS

851-047-0000

Rule Summary, Statement of Purpose and Intent

These rules provide standards and guidance for nurses to delegate specific tasks of nursing care and teach administration of noninjectable medications to unlicensed persons. Registered Nurses have a broad scope of practice in teaching and delegating tasks of nursing care to unlicensed persons and providing periodic supervision. Licensed Practical Nurses' scope of practice includes teaching and supervision of unlicensed persons at the discretion and under the direction of the Registered Nurse. It is the responsibility of the Registered Nurse to decide when, how and if it is appropriate for unlicensed persons to be delegated tasks of nursing care. The Registered Nurse, when delegating to an unlicensed person, is authorizing that person to perform a task of nursing care normally within the Registered Nurse's scope of practice. Prior to agreeing to delegate tasks of nursing care, the Registered Nurse has the responsibility to understand these rules for delegating tasks of nursing care and achieve the competence to delegate and supervise. This may be accomplished by attending a class on delegation, obtaining one to one instruction or using other methods to understand delegation. These rules describe the type of settings in which delegation may occur, define delegation of tasks of nursing care, who may delegate, describe the process for delegation and describe the process for teaching the administration of noninjectable medications.

(1) These rules apply only in settings where a Registered Nurse is not regularly scheduled and not available to provide direct supervision. These are home and community-based settings as described in OAR 851-047-0010(6) and local corrections, lockups, juvenile detention, youth corrections, detoxification facilities, adult foster care and residential care, training and treatment facilities as described in ORS 678.150(9).

(2) These rules have no application in acute care or long-term care facilities or any setting where the regularly scheduled presence of a registered nurse is required by statute or administrative rule.

(3) The purpose of these rules is to govern nurses (Registered Nurses, Licensed Practical Nurses, Clinical Nurse Specialists, Certified Registered Nurse Anesthetists and Nurse Practitioners) who practice in settings where delegation may occur. These rules are not intended to govern the setting itself. The Board recognizes that some settings do not provide nursing services. The Board believes that

settings which provide nursing services or advertise that they provide nursing services should have consistent nursing practice standards in place that the public may rely on, including the delegation of nursing care tasks consistent with the provisions of these administrative rules.

(4) Pursuant to ORS 678.036, a Registered Nurse who delegates tasks of nursing care to an unlicensed person shall not be held responsible for civil damages for the actions of the unlicensed person in performing a task of nursing care unless:

(a) The unlicensed person is acting on specific instructions from the nurse; or

(b) The nurse fails to leave instructions when the nurse should have done so.

(5) The Registered Nurse is responsible for:

(a) Assessing a client situation to determine whether or not delegation of a task of nursing care could be safely done;

(b) Safely implementing the delegation process;

(c) Following the Board's process for delegation as described in these rules; and

(d) Reporting unsafe practices to the facility owner, administrator and/or the appropriate state agency (ies).

(6) Failure to follow the provisions of these rules may subject the nurse to disciplinary sanctions by the Board.

Stat. Auth.: ORS 678.150

Stats. Implemented: ORS 678.150
Hist.: NB 2-1988, f. & cert. ef. 6-24-88; NB 7-1989(Temp), f. & cert. ef. 10-4-89; NB 2-1990, f. & cert. ef. 4-2-90; NB 8-1992, f. & cert. ef. 7-27-92; Renumbered from 851-045-0011; BN 3-1998, f. & cert. ef. 3-13-98; Administrative Correction 5-12-98; BN 2-1999, f. & cert. ef. 3-16-99; BN 5-2004, f. & cert. ef. 2-26-04

851-047-0010

Definitions

For the purpose of rules in this division, the following definitions apply:

(1) "Activities of Daily Living" means those self-care activities which a person performs independently, when able, to sustain personal needs and/or to participate in society. Activities of daily living include activities such as bathing, dressing, eating, drinking, ambulating, and toileting.

(2) "Administration of Medications" means removal of an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with the physician's or nurse practitioner's order, giving the individual dose to the proper client at the proper time by the proper route and promptly recording the time and dose given.

(3) "Assisting with Administration of Medications" means helping the client with one or more steps in the process of taking medications, but does not mean "administration of medications" as defined in these rules. Examples of "assisting" include, but are not limited to, opening the medication container,

reminding the client of the proper time to take the medication, helping the client to self-administer their own medication, assisting the client with one or more steps of medication administration at the client's direction and setting up medications for future administration by another person.

(4) "Certified Nursing Assistant (CNA)" means a person who holds a current Oregon CNA certificate by meeting the requirements specified in Division 61; whose name is listed on the CNA Registry; and who assists licensed nursing personnel in the provision of nursing care. The phrase Certified Nursing Assistant and the acronym CNA are generic and may refer to CNA 1, CNA 2 or all CNAs.

(5) "Client-Directed Care" means that a person requiring care fully self-directs or manages his/her own care even though he/she is not physically able to perform the care. The care that may be client directed includes activities of daily living, administration of noninjectable medications and tasks of nursing care.

(6) "Community Based Care" means a setting that does not exist primarily for the purpose of providing nursing/medical care, but where nursing care is incidental to the setting. These settings include adult foster homes, assisted living facilities, child foster homes, private homes, public schools and twenty-four hour residential care facilities.

(7) "Delegation" means that a registered nurse authorizes an unlicensed person to perform tasks of nursing care in selected situations and indicates that authorization in writing. The delegation process includes nursing assessment of a client in a specific situation, evaluation of the ability of the unlicensed persons, teaching the task, ensuring supervision of the unlicensed persons and re-evaluating the task at regular intervals. For the purpose of these rules, the unlicensed person, caregiver or certified nursing assistant performs tasks of nursing care under the Registered Nurse's delegated authority.

(8) "Initial Direction for Administration of Noninjectable Medications" means giving explicit instructions regarding administration of noninjectable medications.

(9) "Initial Direction for a Task of Nursing Care" means that the Registered Nurse gives explicit instructions regarding the provision of the task of nursing care.

(10) "Injectable Medications," for the purpose of Division 47, means any medication administered by intravenous or subcutaneous routes.

(11) "Noninjectable Medication" means any medication, including controlled substances, which is not administered by the arterial, intradermal, subcutaneous, intramuscular, intraosseous, epidural, intrathecal or intravenous route.

(12) "Nursing Assessment" means the systematic collection of data about an individual client for the purpose of judging that person's health/illness status and actual or potential health care needs. Nursing assessment involves collecting information about the whole person including the physical, psychological, social, cultural and spiritual aspects of the person. Nursing assessment includes taking a nursing history and an appraisal of the person's health/illness through interview, physical examination and information from family/significant others and pertinent information from the person's past health/medical record. The data collected during the nursing assessment process provides the basis for a diagnosis(es), plan for intervention and evaluation.

(13) "Nursing Process" means a systematic problem-solving method licensed nurses use when they provide nursing care. The nursing process includes the steps of assessing, making a nursing diagnosis, establishing a plan of care, carrying out the plan of care by completing client/nursing care procedures and evaluating the effectiveness of the plan of care.

(14) "Periodic Inspection, Supervision and Evaluation of the Administration of Noninjectable Medications" means that either a physician or Registered Nurse determines the frequency at which

review of medication administration practices should occur within a setting in accordance with the rules and policies of that setting.

(15) "Periodic Inspection, Supervision and Evaluation of a Task of Nursing Care" means that the Registered Nurse, at regular intervals, assesses and evaluates the condition of the client for whom a task of nursing care has been delegated, reviews the procedures and directions established for the provision of the nursing care and reviews the competence of the care-giver(s).

(16) "Rescind" means to cancel or take back.

(17) "P.R.N. (pro re nata) medications and treatments" means those medications and treatments which have been ordered to be given as needed.

(18) "Procedural Guidance" means written instructions that the Registered Nurse leaves as a specific outline of how the task of nursing care or administration of medications is to be performed.

(19) "Regularly Scheduled" means that the presence of a licensed nurse is required by statute and administrative rule 24 hours each day in a setting where client care is being continuously delivered.

(20) "Stable/Predictable Condition" means a situation where the client's clinical and behavioral state is known, not characterized by rapid changes, and does not require frequent reassessment and evaluation. This includes clients whose deteriorating condition is predictable.

(21) "Supervision of Unlicensed Persons" means that the Registered Nurse periodically monitors by direct observation on-site or by use of technology that enables the Registered Nurse to visualize the unlicensed person's skill and ability to perform a task, reassesses the client and assesses the need for continued supervision.

(22) "Tasks of Nursing Care" means procedures that require nursing education and a license as a Registered Nurse or Licensed Practical Nurse to perform.

(23) "Teaching," for the purpose of Division 47, means providing instructions for the proper way to administer noninjectable medications and/or perform a task of nursing care. Teaching may include presentation of information in a classroom setting or informally to a group, discussion of written material and/or demonstration of a technique/procedure.

(24) "Unlicensed Person," for the purpose of Division 47, means an individual who is not licensed to practice nursing, medicine, or any other health occupation requiring a license in Oregon, but who provides tasks of nursing care or is taught to administer noninjectable medications. A certified nursing assistant, as defined by these rules, is an unlicensed person. For the purpose of these delegation rules, unlicensed persons do not include members of the client's immediate family. Family members may perform tasks of nursing care without specific delegation from a Registered Nurse. The terms "unlicensed person" and "caregiver" may be used interchangeably.

(25) "Unstable Condition" means a situation where the client's clinical and behavioral status is of a serious nature, critical, fluctuating, expected to rapidly change, and in need of the continuous reassessment and evaluation of a licensed nurse.

(26) "Written Parameters" means directions that are so specific that the unlicensed caregivers use no discretion in administering p.r.n. medications or treatments.

Stat. Auth.: ORS 678.150
Stats. Implemented: ORS 678.150

Hist.: NB 2-1988, f. & cert. ef. 6-24-88; NB 7-1989(Temp), f. & cert. ef. 10-4-89; NB 2-1990, f. & cert. ef. 4-2-90; NB 8-1992, f. & cert. ef. 7-27-92; Renumbered from 851-045-0011; BN 3-1998, f. & cert. ef. 3-13-98; Administrative Correction 5-12-98; BN 5-2004, f. & cert. ef. 2-26-04

851-047-0020

Assignment of Basic Tasks of Nursing Care, Including Noninjectable Medications

These rules for teaching administration of noninjectable medications apply only when a Registered Nurse is designated by the facility or client to provide training and consultation. Unlicensed persons administer noninjectable medications in community-based care settings. Many of these settings are regulated and the unlicensed persons who function in them are regulated from the standpoint of training requirements for them to be caregivers. Training to administer noninjectable medications may or may not be part of the caregiver's orientation program and the training is not required to be done by a Registered Nurse. Community-based care settings may or may not require nurse consultation or the involvement of a licensed nurse. In these settings, the nurse is encouraged to review the facility license requirements that reference the duties of a licensed nurse.

(1) A physician may provide the initial direction for administration of noninjectable medications.

(2) A Registered Nurse, or Licensed Practical Nurse at the direction of a Registered Nurse, may provide the initial direction for administration of noninjectable medications. When a Registered Nurse provides initial direction for the administration of noninjectable medications, the Registered Nurse must ensure that procedural guidance for administration of noninjectable medications is available to caregivers who administer medications. Initial direction shall include the following:

(a) The proper methods for administration of noninjectable medications;

(b) The reasons for the medications;

(c) The potential side-effects of the medications;

(d) Observation of the client's response;

(e) Expected actions if side-effects are observed;

(f) Documentation of the administration of the medications; and

(g) Verification of the physician's or nurse practitioner's order and accurately transcribing the order onto the medication administration record.

(3) Administration of noninjectable medication may or may not be periodically inspected, at the discretion of the Registered Nurse, and must be in accordance with the regulations for the setting in which the medications are administered. Individual clients within the setting may require more frequent review as determined by the judgment of the Registered Nurse. Factors to consider in determining more frequent review include:

(a) The client's condition and medical diagnoses;

(b) The number of medications prescribed and their potential for interaction;

(c) The type and amount of medication administered;

(d) The potential side-effects of the medications; and

(e) The client's history of medication side-effects.

(4) Assisting with the administration of medications does not include administration of noninjectable medications and is not subject to the requirements of OAR 851-047-0020.

(5) Administration of noninjectable p.r.n. medications and treatments may be taught to unlicensed caregivers by a Registered Nurse or a Licensed Practical Nurse at the direction of a Registered Nurse and in accordance with the regulations of the setting in which medications are administered, provided:

(a) Initial direction for administration of noninjectable medications as described in OAR 851-047-0020 (2) is provided for the p.r.n. medications;

(b) The Registered Nurse writes parameters to clarify the physician's or nurse practitioner's p.r.n. order;

(c) The Registered Nurse or Licensed Practical Nurse leaves written parameters for the unlicensed caregiver(s) who administer medications; and

(d) The Registered Nurse or Licensed Practical Nurse leaves information for the caregivers who administer medications about the medications/treatments to be administered, including the purpose of the medications/treatments, their side effects and instructions for action if side effects are observed.

(6) The Registered Nurse and Licensed Practical Nurse have the responsibility to report unsafe practices that come to their attention related to administration of noninjectable medications to the proper person or agency even though the nurse may not have the primary responsibility for review of medication administration practices or supervision of the caregivers who administer noninjectable medications.

Stat. Auth.: ORS 678.150
Stats. Implemented: ORS 678.150
Hist.: NB 2-1988, f. & cert. ef. 6-24-88; NB 7-1989(Temp), f. & cert. ef. 10-4-89; NB 2-1990, f. & cert. ef. 4-2-90; NB 8-1992, f. & cert. ef. 7-27-92; Renumbered from 851-045-0011; BN 3-1998, f. & cert. ef. 3-13-98; Administrative Correction 5-12-98; BN 5-2004, f. & cert. ef. 2-26-04

851-047-0030

Delegation of Special Tasks of Client/Nursing Care

These rules for delegation of tasks of nursing care, in particular the process for initial direction described in OAR 851-047-0030(3)(g), the first supervisory visit within at least 60 days described in OAR 851-047-0030(4)(d) and the documentation requirements described in OAR 851-047-0030(3)(k), apply only to those tasks of nursing care delegated after the date these rules are adopted and in effect. Any new delegation of a task of nursing care undertaken after the effective date of these rules shall be in accordance with OAR 851-047-0030(2) and (3). After the effective date of these rules, the next scheduled periodic inspection, supervision and re-evaluation shall be in accordance with OAR 851-047-0030(4).

(1) The Registered Nurse may delegate tasks of nursing care, including the administration of subcutaneous injectable medications.

(a) Under no circumstance may the Registered Nurse delegate the nursing process in its entirety to an unlicensed person.

(b) The responsibility, accountability and authority for teaching and delegation of tasks of nursing care to unlicensed persons shall remain with the Registered Nurse.

(c) The Registered Nurse may delegate a task of nursing care only to the number of unlicensed persons who will remain competent in performing the task and can be safely supervised by the Registered Nurse.

(d) The decision whether or not to delegate a task of nursing care, to transfer delegation and/or to rescind delegation is the sole responsibility of the Registered Nurse based on professional judgment.

(e) The Registered Nurse has the right to refuse to delegate tasks of nursing care to unlicensed person if the Registered Nurse believes it would be unsafe to delegate or is unable to provide adequate supervision.

(2) The Registered Nurse may delegate a task of nursing care to unlicensed persons, specific to one client, under the following conditions:

(a) The client's condition is stable and predictable.

(b) The client's situation or living environment is such that delegation of a task of nursing care could be safely done.

(c) The selected caregiver(s) have been taught the task of nursing care and are capable of and willing to safely perform the task of nursing care.

(3) The Registered Nurse shall use the following process to delegate a task of nursing care:

(a) Perform a nursing assessment of the client's condition;

(b) Determine that the client's condition is stable and predictable prior to deciding to delegate;

(c) Consider the nature of the task, its complexity, the risks involved and the skills necessary to safely perform the task;

(d) Determine whether or not an unlicensed person can perform the task safely without the direct supervision of a Registered Nurse;

(e) Determine how often the client's condition needs to be reassessed to determine the appropriateness of continued delegation of the task to the unlicensed persons; and

(f) Evaluate the skills, ability and willingness of the unlicensed persons.

(g) Provide initial direction by teaching the task of nursing care, including:

(A) The proper procedure/technique;

(B) Why the task of nursing care is necessary;

(C) The risks associated with;

(D) Anticipated side effects;

(E) The appropriate response to untoward or side effects;

(F) Observation of the client's response; and

(G) Documentation of the task of nursing care.

(h) Observe the unlicensed persons performing the task to ensure that they perform the task safely and accurately.

(i) Leave procedural guidance for performance of the task for the unlicensed persons to use as a reference. These written instructions shall be appropriate to the level of care, based on the previous training of the unlicensed persons and shall include:

(A) A specific outline of how the task of nursing care is to be performed, step by step;

(B) Signs and symptoms to be observed; and

(C) Guidelines for what to do if signs and symptoms occur.

(j) Instruct the unlicensed persons that the task being taught and delegated is specific to this client only and is not transferable to other clients or taught to other care providers.

(k) Document the following:

(A) The nursing assessment and condition of the client;

(B) Rationale for deciding that this task of nursing care can be safely delegated to unlicensed persons;

(C) The skills, ability and willingness of the unlicensed persons;

(D) That the task of nursing care was taught to the unlicensed persons and that they are competent to safely perform the task of nursing care;

(E) The written instructions left for the unlicensed persons, including risks, side effects, the appropriate response and that the unlicensed persons are knowledgeable of the risk factors/side effects and know to whom they are to report the same;

(F) Evidence that the unlicensed person(s) were instructed that the task is client specific and not transferable to other clients or providers;

(G) How frequently the client should be reassessed by the registered nurse regarding continued delegation of the task to the unlicensed persons, including rationale for the frequency based on the client's needs;

(H) How frequently the unlicensed persons should be supervised and reevaluated, including rationale for the frequency based on the competency of the caregiver(s); and

(I) That the Registered Nurse takes responsibility for delegating the task to the unlicensed persons, and ensures that supervision will occur for as long as the Registered Nurse is supervising the performance of the delegated task.

(4) The Registered Nurse shall provide periodic inspection, supervision and re-evaluation of a delegated task of nursing care by using the following process and under the following conditions:

(a) Assess the condition of the client and determine that it remains stable and predictable; and

(b) Observe the competence of the caregiver(s) and determine that they remain capable and willing to safely perform the delegated task of nursing care.

(c) Assessment and observation may be on-site or by use of technology that enables the Registered Nurse to visualize both the client and the caregiver.

(d) Evaluate whether or not to continue delegation of the task of nursing care based on the Registered Nurse's assessment of the caregiver and the condition of the client within at least 60 days from the initial date of delegation.

(e) The Registered Nurse may elect to re-evaluate at a more frequent interval until satisfied with the skill of the caregiver and condition of the client.

(f) The subsequent intervals for assessing the client and observing the competence of the caregiver(s) shall be based on the following factors:

(A) The task of nursing care being performed;

(B) Whether the Registered Nurse has taught the same task to the caregiver for a previous client;

(C) The length of time the Registered Nurse has worked with each caregiver;

(D) The stability of the client's condition and assessment for potential to change;

(E) The skill of the caregiver(s) and their individual demonstration of competence in performing the task;

(F) The Registered Nurse's experience regarding the ability of the caregiver(s) to recognize and report change in client condition; and

(G) The presence of other health care professionals who can provide support and backup to the delegated caregiver(s).

(g) The less likely the client's condition will change and/or the greater the skill of the caregiver(s), the greater the interval between assessment/supervisory visits may be. In any case, the interval between assessment/supervisory visits may be no greater than every 180 days.

(5) It is expected that the Registered Nurse who delegates tasks of nursing care to unlicensed persons will also supervise the unlicensed person(s). However, supervision may also be provided by another Registered Nurse who was not the delegator provided the supervising nurse is familiar with the client, the skills of the unlicensed person and the plan of care. The acts of delegation and supervision are of equal importance for ensuring the safety of nursing care for clients. If the delegating and supervising nurses are two different individuals, the following shall occur:

(a) The reasons for separation of delegation and supervision shall be justified from the standpoint of delivering effective client care;

(b) The justification shall be documented in writing;

(c) The supervising nurse agrees, in writing, to perform the supervision; and

(d) The supervising nurse is either present during teaching and delegation or is fully informed of the instruction, approves of the plan for teaching and agrees that the unlicensed person who is taught the

task of nursing care is competent to perform the task.

(6) The Registered Nurse may transfer delegation and supervision to another Registered Nurse by using the following process. Transfer of delegation and supervision to another Registered Nurse, if it can be done safely, is preferable to rescinding delegation to ensure that the client continues to receive care:

(a) Review the client's condition, teaching plan, competence of the unlicensed person, the written instructions and the plan for supervision;

(b) Redo any parts of the delegation process which needs to be changed as a result of the transfer;

(c) Document the transfer and acceptance of the delegation/supervision responsibility, the reason for the transfer and the effective date of the transfer, signed by both Registered Nurses; and

(d) Communicate the transfer to the persons who need to know of the transfer.

(7) The Registered Nurse has the authority to rescind delegation. The decision to rescind delegation is the responsibility of the Registered Nurse who originally delegated the task of nursing care. The following are examples of, but not limited to, situations where rescinding delegation is appropriate:

(a) The unlicensed person demonstrates an inability to perform the task of nursing care safely;

(b) The condition of the client has changed to a level where delegation to an unlicensed person is no longer safe;

(c) The Registered Nurse determines that delegation and periodic supervision of the task and the unlicensed person is no longer necessary due to a change in client condition or because the task has been discontinued;

(d) The Registered Nurse is no longer able to provide periodic supervision of the unlicensed person, in which case the registered nurse has the responsibility to pursue obtaining supervision with the appropriate person or agency;

(e) The skill of the unlicensed person, the longevity of the relationship and the client's condition in combination make delegation no longer necessary.

(8) The Registered Nurse may delegate the administration of medications by the intravenous route to unlicensed person(s), specific to one client, provided the following conditions are met:

(a) The delegation is done by a Registered Nurse who is an employee of a licensed home health, home infusion or hospice provider.

(b) The tasks related to administration of medications which may be delegated are limited to flushing the line with routine, pre-measured flushing solutions, adding medications, and changing bags of fluid. Bags of fluid and doses of medications must be pre-measured and must be reviewed by a licensed health care professional whose scope of practice includes these functions.

(c) A Registered Nurse is designated and available on call for consultation, available for on-site intervention 24 hours each day and regularly monitors the intravenous site.

(d) The agency has clear written policies regarding the circumstances for and supervision of the delegated tasks.

(e) Delegation does not include initiating or discontinuing the intravenous line.

(9) A Registered Nurse who is an employee of a licensed home health, home infusion or hospice provider may delegate the administration of a bolus of medication by using a preprogrammed delivery device. This applies to any route of intravenous administration.

(10) The Registered Nurse may not delegate medications by the intravenous route other than described in subsections (8) and (9) of this rule.

(11) The Registered Nurse may not delegate the administration of medications by the intramuscular route, except as provided in ORS 433.800 - 433.830, Programs to Treat Allergens and Hypoglycemia.

(12) The Registered Nurse has the right to refuse to delegate administration of medications by the intravenous route if the Registered Nurse believes it would be unsafe to delegate or is unable to provide the level and frequency of supervision required by these rules.

Stat. Auth.: ORS 678.150
Stats. Implemented: ORS 678.150
Hist.: NB 2-1988, f. & cert. ef. 6-24-88; NB 7-1989(Temp), f. & cert. ef. 10-4-89; NB 2-1990, f. & cert. ef. 4-2-90; NB 8-1992, f. & cert. ef. 7-27-92; Renumbered from 851-045-0011; BN 3-1998, f. & cert. ef. 3-13-98; Administrative Correction 5-12-98; BN 5-2004, f. & cert. ef. 2-26-04

851-047-0040

Teaching the Performance of Tasks for an Anticipated Emergency

The Registered Nurse may teach tasks to unlicensed persons which prepare the persons to deal with an anticipated emergency under the following conditions:

(1) The Registered Nurse assesses the probability that the unlicensed persons will encounter an emergency situation. Teaching for an anticipated emergency should be limited to those who are likely to encounter such an emergency situation.

(2) The Registered Nurse teaches the emergency procedure.

(3) The Registered Nurse leaves detailed step-by-step instructions how to respond to the anticipated emergency.

(4) Preparation for an anticipation of an emergency includes the administration of injectable medications by the intramuscular route as provided in ORS 433.800 - 433.830, Programs to Treat Allergens and Hypoglycemia.

(5) The Registered Nurse periodically evaluates the unlicensed persons' competence regarding the anticipated emergency situation.

(6) The responsibility, accountability and authority to teach for an anticipated emergency remains with the Registered Nurse.

Stat. Auth.: ORS 678.150
Stats. Implemented: ORS 678.150
Hist.: BN 3-1998, f. & cert. ef. 3-13-98; Administrative Correction 5-12-98; BN 5-2004, f. & cert. ef. 2-26-04

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BOARD OF NURSING

DIVISION 48

STANDARDS FOR PROVISION OF NURSING CARE

BY A DESIGNATED CARE-GIVER

851-048-0010

Statement of Intent

(1) These rules are to be used only in situations where a person who requires nursing care in a private home or home-like setting designates a person who is like a family member as a care-giver. The designated care-giver is not paid or compensated in any way for the nursing care that he/she provides. Examples of designated care-givers are persons who live in the same household as the person requiring nursing care such as a significant other; or persons who live outside the household of the person requiring nursing care but who have a significant relationship with the person such as a neighbor, friend or relative who is not a member of the immediate family.

(2) Prior to providing the nursing care, the care-giver is taught by a licensed nurse who has expertise related to the person's care needs and is practicing within his/her scope of practice.

Stat. Auth.: ORS 678.150
Stats. Implemented: ORS 678.010
Hist.: BN 2-1998, f. & cert. ef. 1-26-98; BN 8-2001, f. & cert. ef. 7-9-01

851-048-0020

Statement of Purpose

(1) The Board believes that consumers of nursing care have the right to designate family and family-like individuals to participate in the provision of their health care.

(2) The Board recognizes that there are situations where immediate family members are not available to provide nursing care for persons requiring such care.

(3) The Board believes that persons who are "like a family" to a person needing nursing care, and who have a significant, caring relationship with that person, can provide safe care in the best interest of the patient as would a member of the immediate family who is enabled to provide care by exclusion from

the statutory definition of the practice of nursing.

Stat. Auth.: ORS 678.150 & HB 2779, 1997
Stats. Implemented: ORS 678.010
Hist.: BN 2-1998, f. & cert. ef. 1-26-98

851-048-0030

Applicability of the Rules

(1) These rules apply in situations where a person requires nursing care and designates a care-giver who is able and willing to provide the necessary nursing care. Examples include but are not limited to situations where members of the immediate family are not readily available or able to provide care, or the person needing the nursing care prefers to designate someone other than members of the immediate family to provide his or her nursing care.

(2) These rules apply in situations where a person requires nursing care, the person cannot provide his/her own care, and someone who has the authority to act on behalf of the person needing care designates a care-giver who is able and willing to provide the necessary nursing care.

(3) These rules apply in settings of a private home or home-like environment where a person requires nursing care and that care is provided by a designated care-giver without monetary or other compensation.

(4) These rules do not apply to licensed health care facilities which provide nursing services or general supervision over activities of daily living and where the presence of licensed nurses and/or trained/certified care-givers is required. The settings where these rules do not apply include but are not limited to:

(a) Acute care facilities;

(b) Long term care facilities;

(c) Adult foster homes;

(d) Assisted living facilities;

(e) Residential care facilities.

(5) These rules do not prohibit the delegation of nursing care to paid care-givers under the provisions of Division 047 (OAR 851-047-0000 through 0030).

Stat. Auth.: ORS 678.150 & HB 2779, 1997
Stats. Implemented: ORS 678.010
Hist.: BN 2-1998, f. & cert. ef. 1-26-98

851-048-0040

Definitions

(1) "Designated Care-Giver" means a person who is not a member of the immediate family and who has been selected by the person needing care or by an individual authorized to act on behalf of the person needing nursing care, to provide nursing care. The designated care-giver shall not be compensated,

either directly or indirectly, for the nursing care he/she provides. Examples of designated care-givers include, but are not limited to: persons who live in the same household as the person requiring nursing care such as a significant other; or persons who live outside the household of the person requiring nursing care but who have a significant relationship with the person such as a neighbor, friend or relative who is not a member of the immediate family.

(2) "Licensed Nurse" means a Registered Nurse or Licensed Practical Nurse licensed by the Oregon State Board of Nursing.

(3) "Members of the Immediate Family" mean father, mother, grandfather, grandmother, husband, wife, son, daughter, sister, brother or other persons related to the person needing nursing care by blood, by marriage or through legal adoption.

(4) "Teaching" means that the Licensed Nurse instructs the designated care-giver in the correct method of performing a selected task of nursing care or the provision of nursing care.

Stat. Auth.: ORS 678.150 & HB 2779, 1997
Stats. Implemented: ORS 678.010
Hist.: BN 2-1998, f. & cert. ef. 1-26-98; BN 8-2001, f. & cert. ef. 7-9-01

851-048-0050

Responsibilities of the Care-Giver

The designated care-giver shall not:

(1) Accept monetary or other compensation, either directly or indirectly, for providing the specific tasks of nursing care;

(2) Transfer the authority of nursing care to other persons or other care-givers. Only the person needing nursing care, or a person who has the authority to act on behalf of the person needing nursing care, has the authority to designate another care-giver to provide nursing care.

Stat. Auth.: ORS 678.150 & HB 2779, 1997
Stats. Implemented: ORS 678.010
Hist.: BN 2-1998, f. & cert. ef. 1-26-98

851-048-0060

Responsibilities of the Licensed Nurse in Working with the Designated Care-Giver

The Licensed Nurse whose responsibility it is to teach the designated care-giver the provisions of nursing care shall:

(1) Determine that the person who is to be taught the tasks of nursing care meets the definition of a designated care-giver as stated in OAR 851-048-0030;

(2) View the designated care-giver as they would a member of the immediate family.

(3) Teach the designated care-giver as they would a member of the immediate family.

(4) Teach the designated care-giver any task of nursing care necessary for the person to receive care.

Stat. Auth.: ORS 678.150
Stats. Implemented: ORS 678.010
Hist.: BN 2-1998, f. & cert. ef. 1-26-98; BN 8-2001, f. & cert. ef. 7-9-01

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