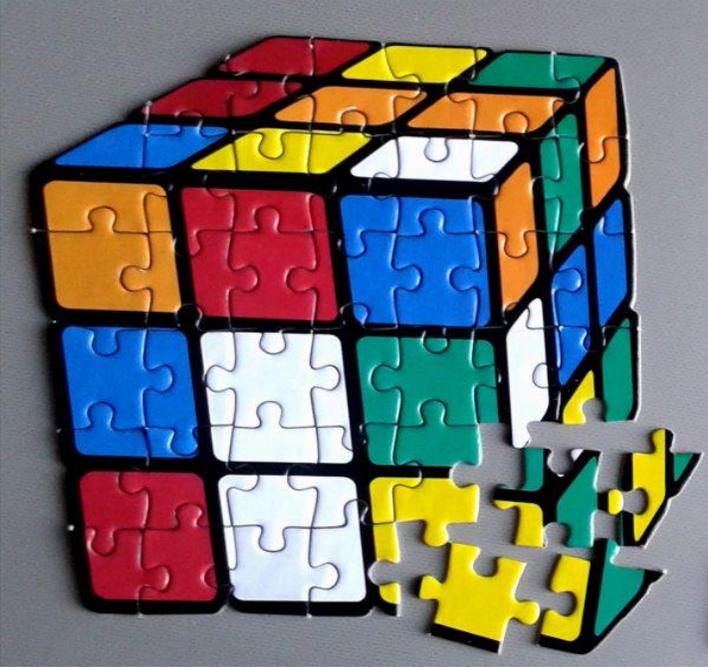


MONITORING OF NURSING SUPPORTS



WHAT DOES MEDICAL COMPLEXITY MEAN TO YOU?



WHY IS THIS IMPORTANT?

Health and Safety

Recurrent Hospitalizations

Care Coordination

PURPOSE OF MONITORING

For you personally,
what is the purpose of
monitoring of nursing
plans, protocols, and
supports?

ODDS Purpose

TYPES OF NURSING SUPPORTS AND SERVICES

- LTCCN – A set of community nursing services that focus on a child or adults chronic and ongoing health and activity of daily living needs. This is NOT shift care nursing.
- DNS – These are shift nursing services for individuals 21 years and older who have complex medical needs.
- PDN – These are shift nursing services for individuals 20 years and younger who have complex medical needs.
- 24hr Residential Nursing- Nursing services in a 24 hour residential setting based on the medical supports identified in a Nursing Care Plan & ISP
- Nursing in Child Welfare- These are Nursing Delegation Service provided by Child Welfare

NURSING SUPPORT MONITORING EXPECTATIONS

- If the case manager determines services are not being delivered as agreed in the ISP or that the service needs of an individual have changed since the last review, initiate at least one of the following actions:
 - Update the ISP of the individual.
 - Provide or refer technical assistance
- If there are concerns regarding the ability of a provider to provide services, the CME must determine the need for technical assistance or other follow-up activities

NURSING SUPPORT MONITORING EXPECTATIONS

What documents should I be looking at when monitoring nursing supports?

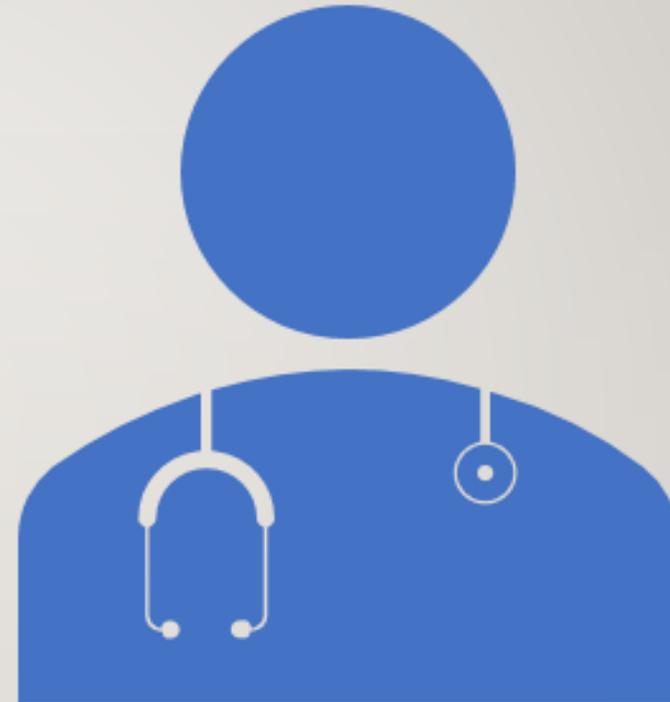
- Nursing Care Plan
- History and Physical
- MAR
- Nursing Progress Notes

SO WHAT IS A NURSING CARE PLAN

The definition of Nursing Care Plan OAR 851-045-0035(23):

- "Plan of Care" means the comprehensive outline authored by the RN that communicates the client's identified problems or risks, identifies measurable client outcomes, and identifies nursing interventions chosen to mitigate the identified problems or risks.

WHAT SHOULD A NURSING PLAN INCLUDE?





I'M NOT A NURSE....

UNDERSTANDING RN CARE PLANS

A nursing care plan should be:

- Written in plain language
- From head to toe
- Individual specific

UNDERSTANDING MEDICAL TERMINOLOGY WHEN IN DOUBT ...

- Ask the Registered Nurse or Agency who wrote the Nursing Care Plan and Assessment
- Ask the individuals physician, specialists or contact the doctors office
- Check with parents or providers. For In-home situations oftentimes parents who have been taking care of the child or adult have received a lifetime of education/experience with procedures, conditions and treatments.
- Check with others in your office who may have experience working with others with medical complex children, individuals or families
- Use the resources found online-medical sites, medical dictionaries, search engines
- OSBN Nursing presentations

DIRECT NURSING- PROVIDER EXPECTATIONS

- Each Nurse (RN) must write a Nursing Service plan following the standards outlined in the Oregon State Board of Nursing.
- The Nurse (RN) must complete Nursing Service Plan (sometimes called Nursing Care Plan) within 7 days after initiating services.
- The Nurse (RN) must submit the NSP to the Case Management Entity every 6 months or after a significant change in condition



DIRECT NURSING- PROVIDER EXPECTATIONS

- Continuous assessment and reassessment of the medical condition
- Skilled nursing tasks
- Nursing interventions
- Implementation of treatment and therapies
- Data collection
- Documentation
- Written and oral communication with individuals, physicians and other health professionals, other caregivers, case management entities, ISP teams, foster care providers and agency providers
- Other nursing responsibilities under OSBN Scope of practice approved by the department

DIRECT NURSING- PROVIDER DOCUMENTATION EXPECTATIONS

- Documentation must be written in an accurate, timely, thorough and clear manner
- Documentation must comply with OSBN OAR's and must include
- Name of individual on each page of documentation
- The date of service
- Time of start and end of delivery by each provider
- Anything unusual from the standard plan of care expanded in the narrative
- Interventions
- Outcomes, including the response of the individual to services delivered
- Nursing assessment of the status of the individual and any changes in that status per each working shift
- Full signature
- Documentation of services must be sent to the Case Management entity upon per request or as outlined in the ISP and maintained in the home, foster home, or the place of business of the provider of services

LTCCN- PROVIDER DOCUMENTATION EXPECTATIONS

- INITIAL ASSESSMENT. The RN must perform a face-to-face comprehensive nursing assessment as defined in OAR 85 I-045-0030 within 10 business days following the acceptance of the individual's referral.
- (a) The RN must conduct and document the comprehensive nursing assessment as specified in OAR chapter 85 I, division 045.

LTCCN- PROVIDER DOCUMENTATION EXPECTATIONS

- NURSING SERVICE PLAN. Based on the initial assessment or reassessment, the RN must develop or update the individual's Nursing Service Plan.
- (a) The Nursing Service Plan must describe the needs of the individual and the individual's caregiver and the specific interventions the RN intends to provide to meet those needs including scope, duration, and frequency.
- (b) An RN must complete and document Nursing Service Plans on the Department approved form and provide the Nursing Service Plan to an individual's case manager within 10 business days of the date that an initial assessment or a reassessment is initiated.
- (c) An RN must attend a minimum of two Nursing Service Plan review meetings each year with a case manager. The RN and the case manager may agree to conduct the Nursing Service Plan review meeting by phone.

LTCCN- PROVIDER DOCUMENTATION EXPECTATIONS

- **TEACHING.** An RN must follow the standards and documentation requirements for teaching health promotion as described in OAR 851-045-0060.
- (a) In an overall teaching plan, the RN must describe and document the reason the teaching is needed and the specific goals for the individual or the individual's caregiver.
- **MONITORING.** An RN must provide home based monitoring visits as needed to oversee and implement an individual's Nursing Service Plan.
- (a) The RN must document the projected frequency of monitoring visits in an individual's Nursing Service Plan and may adjust the frequency based on the complexity of the Nursing Service Plan and the individual's needs.

LTCCN- PROVIDER DOCUMENTATION EXPECTATIONS

- CARE COORDINATION. An RN provides care coordination in order to advocate for health care services that an individual needs and to gather the information that is needed in the assessment or reassessment process, medication review, or Nursing Service Plan implementation. An RN uses care coordination to provide updated information to people involved in an individual's health care via phone calls, faxes, electronic mediums, or meetings. Care coordination is provided but not limited to case managers, RNs who provide acute care community nursing services, health care providers, and non-caregiving family members or legal representatives.

LTCCN- PROVIDER DOCUMENTATION EXPECTATIONS

- DELEGATION. An RN must follow the standards and documentation requirements for delegation of nursing tasks as required by OAR chapter 85 I, division 047 (Standards for Community Based Care Registered RN Delegation).
- (a) The RN alone, based on professional judgment and regulation, makes the determination to delegate or not delegate a nursing task, or to rescind a delegation.
- (b) The RN must provide the case manager with an estimate of the number of hours of delegation the individual needs on the Nursing Service Plan and keep the case manager informed of ongoing delegation activities on the Service Summary form.
- (c) The RN must keep the adult foster home provider informed of the delegation decisions and activities provided to caregivers in their home.

OREGON STATE BOARD OF NURSING & DELEGATION OAR 851-047

- (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.

OREGON STATE BOARD OF NURSING DELEGATION - CONTINUED

- "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.

OREGON STATE BOARD OF NURSING

Oregon Administrative Rules Chapter 85 I Division 45 covers the STANDARDS AND SCOPE OF PRACTICE FOR THE LICENSED PRACTICAL NURSE AND THE REGISTERED NURSE

- It covers the requirement for LPN supervision by an RN OAR 85 I-045-0040(I)(a) & OAR 85 I-045-0050(I)

(I) Standards related to the licensee's responsibility for safe nursing practice. The licensee shall:

(a) Practice within the laws and rules governing the practice of nursing at the level the nurse is licensed;

(I) The Board recognizes that the LPN has a supervised practice that occurs at the clinical direction and under the clinical supervision of the RN or LIP who have authority to make changes in the plan of care, and encompasses a variety of roles.

HOW CAN THESE RULES HELP ME MONITOR?

- The OSBN rules apply to EVERY service setting and every nurse is responsible for understanding and adhering to the OSBN rules
- The rules can guide you on who can do what- RN vs LPN
- The OSBN rules can guide you on what to do if you have concerns about care or the nurse providing services



GOING FORWARD

NEXT STEPS...

What Tools or
Resources Would Be
Helpful?

How Can Nursing
Services Monitoring
expectations be
more clearly defined
or simplified?

THANKS FOR ATTENDING!

- Myles Maxey- Home & Community Monitoring Specialist

Myles.Maxey@state.or.us 503-302-7547

- Ken Ralph- Policy Analyst

Ken.J.Ralph@state.or.us 503-947-5191

- Rachel Olson- PASRR-II Coordinator & Health Management Specialist

Rachel.Olson@state.or.us 503-269-5602