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Consumer Directed Care and Nurse Practice Acts

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Executive Summary

Older adults and people who have disabilities want to live as independently as possible in their homes and communities. Across the country, these consumers are seeking more choices for long-term care and more control in managing the services they need. This "consumer directed care" includes greater autonomy in directing care received from unlicensed assistive personnel (UAPs) like "personal care assistants." State regulations that govern the practice of registered professional nurses often affect the extent to which consumer autonomy is permitted by the state boards of nursing, which are charged with the responsibility to protect the public's safety.

This paper examines the current state nurse practice acts and their implementing regulations to determine the extent to which they permit more consumer direction in home and community based services. This review focuses on several key issues that might affect consumer-directed care state policy and practice. First is the analysis of the statutory and regulatory language that pertains to delegation, including who may delegate, tasks (especially medication administration) that may be delegated, in what setting, and with what supervision and training requirements. These variables help clarify how prescriptive a state may be in its delegation policy, from broad authority to narrow authority that limits delegation to a laundry list of tasks or to certain settings. Second is the examination of exemptions that permit nursing tasks to be performed by persons who are not nurses. Explicit consumer-directed care provisions in both the statute and regulations are highlighted. Finally, the liability sections are studied to determine nurses' "accountability" for delegation.

The most detailed analysis of both nurse practice acts and regulations in relation to consumer-directed care conducted to date, this 50-state report provides substantial detail for more in-depth, state-specific research, policy analysis, and action. The findings document multiple approaches that can support consumer-directed care with varying degrees of flexibility. A handful of states have made substantial progress in developing nurse practice policies that specifically address consumer direction. Consumers in these states have been active in the policy debate, although the emphasis has often been on independent living settings and personal assistance programs more than the full range of home and community-based care, such as assisted living. Even in states that have made substantial progress in resolving the issue of nursing regulation and consumer-directed care, there is a need to educate nurses, consumers, and policymakers in how to put the policies into practice. It may also be helpful to bring together a core group of stakeholders in targeted states to discuss consumer direction, policy options to balance consumer protection and independence, internal consistency in state practice regulations, consistency across state departments, and potential demonstrations with evaluation research as needed. Consumers, policymakers, and providers need to come together, ideally with similar representatives from model states that can share their policies, practices, and lessons learned.

CONSUMER DIRECTED CARE AND NURSE PRACTICE ACTS

Introduction

The drive to increase consumer choice, flexibility, and control of services to support independent living in the community is accelerating. To implement this model, states throughout the country must balance two policy goals. One goal is to promote independence, dignity, and choice for consumers. The other goal is to protect them. Persons with disabilities are seeking more autonomy and less "protection." Under consumer-directed care policies, persons with disabilities have more autonomy in directing the care they receive from unlicensed assistive personnel (UAPs), such as "personal care assistants." However, state regulations that govern the practice of registered professional nurses often affect the extent to which this consumer autonomy is permitted by the state boards of nursing, which are charged with the responsibility to protect the public's safety.

This paper examines the current state nurse practice acts and their implementing regulations to determine the extent to which they permit more consumer direction in home and community based services. This analysis may be helpful to consumers and states that are seeking ways to better balance state policies to support consumer-directed care.

Background

The movement toward consumer-directed care is fueled by several factors. More people need assistance with personal care, and more people would prefer that that assistance be provided in their homes or other home-like settings. The aging of the population is well underway, with more frail older adults seeking alternatives to nursing home placement. There are also more younger adults with physical disabilities because more young people survive disabling conditions and live longer life spans. State governments, the payers of much of this care, are struggling with how to manage costs. Consumer-directed care in community-based settings may be one option. In addition, recent court decisions, including the Supreme Court's Olmstead decision, reinforce the drive to care for people outside of institutions whenever possible (Fox-Grage, Folkemer, & Horahan, 2001). These decisions are consistent with the Independent Living Movement that holds as one of its central tenants the right of persons with disabilities to be "people first" and not patients (Eustis, 2000).

The consumer-directed care model derived from this Independent Living Movement holds that the person with a disability is knowledgeable about his or her own needs and can direct others to help meet those needs. There is actually a range of consumer-directed and consumer choice models, with the unifying principle that "individuals have the primary authority to make choices that work best for them…regardless of the nature or extent of their disability or the source of payment for services" (National Institute on Consumer-Directed Long-Term Care Services, 1996).

The literature supporting the consumer directed care model is growing (Bass, 1996; Benjamin, Matthias, & Franke, 2000; Dautel & Frieden, 1999; Doty, Benjamin, Matthias, & Franke, 1999; NASUA, 1998; Racino & Heumann, 1992). This is true for the younger disabled population as well as the application of consumer-directed concepts to the older adult population (Glickman, Stocker, & Caro, 1997; Simon-Rusinowitz, 1999; Tilly & Weiner, 2001). However, systematic analysis of the relationship between this model and state nurse practice acts is limited. The most relevant work was reported six years ago.

Sabatino and Litvak (1995) provide a comprehensive review of liability issues affecting consumer-directed services, including an analysis of the nurse practice acts in all states. They describe two broad policy approaches that are also summarized by Flanagan and Green (1997) and Wagner and her colleagues (Wagner, Nash, & Sabatino, 1997). The first is "delegation" or the transfer to a competent (unlicensed) individual the authority to perform a selected nursing task in a selected situation (National Council of State Boards of Nursing, 1995; Burbach, 1997). The second is an "exemption" approach that specifically exempts certain individuals (like family members or domestic servants) or programs (like personal care assistance programs) from the regulations governing delegation.

These two approaches are not mutually exclusive, but the important distinction is where authority and responsibility rests in each. In the exemption approach, which is taken by New York State for one of its programs, the consumer who is directing his or her own care is responsible for that care, not the nurse. The nurse can educate the consumer and the assistant, and monitor the services over time, but that nurse is not held responsible for the actual provision of the care. Under the delegation approach, the nurse maintains responsibility for authorizing the delegation. A few states make nurses responsible for the delegation of the task, but not responsible for the actual performance of the delegated task (Wagner et al, 1997). In other words, the nurse is responsible for determining that the task is appropriate to transfer to an unlicensed person who is capable of performing that task (direct liability for the delegation process only). The nurse is not held responsible if that aide negligently harms the consumer (vicarious liability for the delegation outcome).

Given these differences in how states define delegation, Rosalie Kane and her colleagues (Kane, O'Connor, & Baker, 1995) conducted case studies of nurse delegation in 20 states that were selected because they were actively promoting more community-based long-term care. Since it was also believed that the nurse practice acts in these states permitted substantial delegation, it is likely that the other 30 states lagged behind these 20 states. Yet, the findings documented that even among the most advanced states, there was considerable ambiguity, confusion, and interstate variation. Although most of these states permitted delegation of the kinds of tasks that would permit more persons with disabilities to remain in their homes or in group situations like assisted living, few states had implemented these policies broadly, and none had data systems to track problems (if any).

The national review of nursing statutes provided by Sabatino and Litvak, and the 20-state targeted analysis conducted by Kane and her colleagues, provide an important foundation for understanding many of the actual and perceived state regulatory barriers to implementing consumer-directed care. However, some progress has been made in the past six years. A current understanding of the regulatory status in each state is fundamental to removing barriers to consumer-directed models of community living. Significant change embraced by selected state boards of nursing can influence their peers.

Method of Analysis

This review of nurse practice acts and regulations in all 50 states focuses on several key issues that might affect consumer-directed care state policy and practice. First is the analysis of the statutory and regulatory language that pertains to delegation, including who may delegate, tasks that may be delegated (especially medication administration since this is a common need as Dautel and Frieden indicated in their 1999 report of the National Blue Ribbon Panel on Personal Assistance Services), in what setting, and with what supervision and training requirements. These

variables help clarify how prescriptive a state may be in its delegation policy, from broad authority to narrow authority that limits delegation to a laundry list of tasks or to certain settings. Second is the examination of exemptions that permit nursing tasks to be performed by persons who are not nurses. Since most nurse practice acts include numerous exemptions to permit nursing students to practice and others to provide emergency care, this study focuses on those exemptions most applicable to consumer-directed care. In particular, any explicit consumer-directed care provisions in both the statute and regulations are highlighted. Finally, the liability sections are studied to determine nurses' "accountability" for delegation.

Limitations

All statutes and regulations reviewed are current as of the year 2000, with many current as of May 2001 (verified by dates in the statutes and regulations). Many are accessible through websites, but in several states, access was difficult for the research staff that obtained these legal documents only after persistent direct communication with states' staff. Given this rigorous effort to obtain the most recent laws governing nurse practice acts, we are confident that this review is extensive and current through 2000. However, we also know that states frequently revise statutes, rules, and regulations and that some may have done so in the first half of 2001. Some states, like Maryland, North Carolina, West Virginia, and New Jersey, indicated that the regulations are currently under review and will be updated. Thus, this analysis should be considered a snapshot of state activity in nurse practice regulation in relation to consumer-directed care. We will be following up this legal analysis with a national survey of the executive directors of state boards of nursing, and selected telephone interviews with a sample of these state policy administrators to explore a more in-depth understanding of nurse practice regulation and consumer-directed care. The underlying trends, issues, and policy options reported here will guide this further study.

This analysis of nurse practice regulation and consumer-directed care does not include statutes and regulations outside of those governed by state boards of nursing. In some cases, the state nurse practice act and/or regulations reference additional laws and in other cases, we are aware of additional laws not referenced in the nurse practice documents. Further study is needed to collect and analyze state (and federal) laws that may affect consumer-directed care in relation to nursing practice in any given state. For example, the federal Fair Housing Act may be broadly interpreted by a state attorney general to mean that a board of nursing that allows delegation in one kind of housing (assisted living) must consider other forms of housing.

Findings

The most detailed analysis of both nurse practice acts and regulations in relation to consumer-directed care conducted to date, this report provides substantial detail for more in-depth, state-specific research, policy analysis, and action. Table 1summarizes this analysis and guides the discussion.

Delegation

Most states have explicit language in either the Nurse Practice Act (NPA) or the implementing regulations, or both, to make it possible for nurses to legally delegate to others. Three states (California, Missouri, and Tennessee) provide language to support delegation only in the NPA, and three states (Alabama, New Jersey, and Rhode island) provide only regulatory language. Connecticut only provides guidelines on delegation that do not have the force of regulation. New York

and Pennsylvania are unusual because they are silent on delegation in both their statute and implementing regulations.

Most states (41) provide both statutory and regulatory delegation language, with most of the detail found in the regulations. At minimum, these delegation provisions provide for nursing supervision of unlicensed assistive personnel (UAPs) in hospitals and nursing homes. However, many states also offer an explicit opportunity for nurses to delegate in home and community-based settings, or have language that is broad enough to support this delegation if consumers, nurses, providers, and policymakers seek such interpretations.

As noted in previous analyses of nurse practice acts, there is much variation across the states. Those that have made changes in the last six or seven years are often more supportive of consumer direction, but they continue to take idiosyncratic approaches to this issue and other aspects of nursing practice.

Broad Language

Eleven states (Alabama, Illinois, Indiana, Iowa, Kansas, Minnesota, Mississippi, Missouri, Tennessee, Vermont, and West Virginia) have very **broad language** that does not limit delegation by setting or task. Alabama's regulations are typical for this group of states, simply stating that nursing care must be delegated to others in accordance with the education and demonstrated competence of the person to whom the task is delegated; there are no other requirements regarding delegation.

Requirements with Discretion

Fifteen states (Alaska, Florida, Georgia, Kentucky, Louisiana, Maine, Michigan, Nebraska, New Hampshire, New Jersey, North Carolina, North Dakota, Texas, Utah, and Wisconsin) have a framework for delegation with **requirements that offer nurses much discretion** in delegating tasks to unlicensed assistive personnel, with no limits placed on settings or tasks. These states use language like New Jersey, which requires the nurse to delegate only to those who have "verifiable training" and can demonstrate their adequacy, skill and competency to perform the task being delegated. "Verifiable training" is left up to the nurse to verify. In addition, the nurse cannot delegate any task that requires the "specialized skill, judgment, and knowledge of a registered nurse"—again left up to the nurse to decide. Others (Sabatino & Litvak, 1995) have noted the tautological nature of this provision. However, the individually licensed nurse is permitted to make this decision, which at least in theory, permits a great deal of situational flexibility, regardless of setting or task.

Intermediate Approach

Fifteen states (Arizona, Arkansas, Colorado, Delaware, Hawaii, Idaho, Maryland, Massachusetts, Nevada, New Mexico, Ohio, Oregon, South Dakota, Virginia, and Washington) fall in an **intermediate position**, providing fairly broad language on delegation, but limiting it by setting, tasks, or training requirements for the person to whom the task is delegated. Connecticut also falls into this category, although its guidelines do not have the force of law. These states are similar to those above that provide requirements that offer nurses discretion, but have more detailed requirements and limits. For example, Arizona, Arkansas, Colorado, Delaware, and Nevada do not permit delegation of medications to an unlicensed person. Idaho, Maryland, Massachusetts, New Mexico, Ohio and Virginia only permit delegation of medications if certain require-

ments are met.

Oregon takes an innovative approach, with a decade of experience in implementing this policy framework in the field. Led by Oregon's Department of Human Services' Division of Senior and Disabled Services (DSDS), the state amended its nurse practice act in 1987 to allow nurses to delegate in home and community-based settings that are regulated by DSDS, and no regularly scheduled nurse is employed. It took almost two years of deliberations to promulgate the 1989 implementing regulations with the final decision to permit as much discretion as possible for the registered nurse working in these particular settings. Although nurses sought a "laundry list" of what they could and could not delegate, the Oregon Board of Nursing chose not to limit tasks through a list. Two years later, the board convened a task force to further operationalize delegation policy and detail what is known as "assignment." Whereas delegation refers to tasks delegated to a specific person caring for a specific consumer, assignment allows nurses to delegate tasks categorically. For example, the nurse can assign the operator of an adult foster care home the administration of prescribed oral medications for all consumers in his or her care. The nurse can assign oral medication administration, but must delegate subcutaneous injections (like insulin), and cannot assign or delegate intramuscular injections (with rare exceptions).

Hawaii has also given much thought to this issue and has taken an intermediate approach. Although the state allows registered nurses to delegate in any setting at any time that direct supervision is possible, regulations provide more guidance for those delegating in settings where a nurse is not regularly scheduled and not available to provide direct supervision. These settings include supervised group living, independent living, or assisted living settings, as well as schools and day care centers. The nurse is responsible for training the unlicensed assistive personnel if needed and must be available for consultation. Within these guidelines, there is a great deal of individual discretion left up to the nurse.

Finally, Washington has changed its NPA twice in the last few years, making progress in expanding the delegatory authority of nurses to support more home and community-based care. The first legislative change in 1995 permitted registered nurses to delegate specific (laundry list) tasks in three settings (adult family homes, residences for persons with developmental disabilities, and assisted living boarding homes with Medicaid contracts). The client had to provide written informed consent for this delegation. It also required the University of Washington School of Nursing to evaluate the consequences of delegation, including the safety of consumers affected (Sikma & Young, 2001). The study reported no evidence of significant harm or adverse outcomes for consumers and recommended expansion of delegation to all community based settings, without a laundry list of tasks and written informed consent (Young et al, 1998). A second law (with regulations effective July 2000) codified these recommendations, permitting delegation for individuals who have a "stable and predictable" condition and the nursing assistant has completed core training. Even within this more intermediate approach, Washington nurses may not delegate injectible medications, including insulin injections.

Narrow Approach

Those with the most restrictive language limit delegation to a few settings, few specific tasks, or highly regulated training requirements that leave little discretion for the nurse. Six states take this **narrow approach** (California, Montana, Oklahoma, Rhode Island, South Carolina, and Wyoming). For example, South Carolina specifies only a few tasks that can be delegated. Further, since these tasks are specific in the statute itself, it is difficult to make changes consistent with technological and social change. Until last year, Washington fell into this category.

Summary of Delegation Approaches

To some extent these four categories overlap at the margins, so that a fairer representation would offer a continuum of how much discretion and guidance states provide in their NPAs and implementing regulations. Further survey of the state boards of nursing and selected interviews will lead to more precise determinations. However, for the purposes of this overview, these analytic categories can help shed some light on how the states are debating and deciding on delegation as a way to enable or limit consumer-directed care.

From a practical standpoint, there is disagreement about how useful it is to have broad language versus more specific guidance on delegation. On one hand, broad language permits the greatest discretion for the nurse in delegating tasks, and allows the nurse to use judgment in determining the ability of the assistants to perform tasks like wound care or the administration of medications. On the macro level, this kind of policy framework permits consumer direction of services with nurses included as consultants to consumers and their assistants. On the other hand, the absence of detailed requirements or guidance for delegation leaves room for varied interpretations. Program administrators and nurses themselves often seek more detail to protect themselves from charges of "violating the nurse practice act." In the absence of detailed language, they frequently call their state board of nursing for "permission" to delegate specific tasks in specific circumstances.

The presence of very broad language for delegation could mean that the legislature and/or the state board of nursing gave considerable thought to delegation policy and decided to provide an "enlightened" approach to allow ultimate discretion. Alternatively, this very broad language could mean that state policymakers simply have not thoughtfully debated and addressed delegation policy. The difference is important because it affects the regulatory climate and the confidence of nurses and program administrators to "stretch the envelope." Without direct communication with the policymakers in these states, it is difficult to make a specific determination about how receptive that state is to allowing the broad language to support consumer-directed care when that care includes typical nursing procedures like medication administration, would care, complex catheter care, and similar tasks.

It would appear that states that fall into the other three categories have given thought to delegation policy. States in the "narrow" classification" have limited delegation in specific ways. For example, California limits delegation to mental health or developmental disability institutions and Montana has restricted delegation by settings that include community-based residential settings, but never allows delegation in acute or long-term care facilities. Both of these states are examples of those that appear to have deliberately considered delegation policy and decided to limit its scope. Yet, both of these states also provide alternative means to support consumer-directed care. For example, California's In-Home Supportive Services program operates largely through physician delegation (Sabatino & Litvak, 1995) and also offers a broad statutory exemption n the NPA that states that any person who performs duties for the physical care of a patient is exempt from the NPA as long as that person does not claim to be a nurse. Similarly, Montana details a statutory exemption for personal assistants performing health maintenance activities that include urinary systems management, bowel treatments, administration, and wound care—if that person is acting on the direction of person with a disability and the physician or other health professional determines the procedure could be safely performed in the home.

Both of these exaçples illustrate the importance of examining both the delegation and exemption provisions of nurse practice acts in relation to consumer-directed care. Nonetheless, they also demonstrate the narrower policy platform for home and community-based care more generally. For example, neither of these exemptions would be supportive of nurse delegation of medications in assisted living. Further analysis of these exemptions is discussed below.

States that provide some requirements for delegation but much discretion, and those that are more intermediate in their approach, have considered delegation policy. In the former case, states attempt to guide nurses and programs with language that leaves the delegation decision in the hands of the nurse based on his or her assessment of the situation—how complex the task is, how well prepared the delegatee is, and how much supervision is required. For example, Alaska permits the nurse to certify the ability of the unlicensed person to perform the task, which permits much discretion and flexibility in this frontier state. States that take a more intermediate approach provide the same kind of guidelines, but then limit discretion in some way. For example, Hawaii and Oregon limit this discretion to settings in which the nurse is not regularly scheduled to permit the most discretion in home and community-based settings. This approach was carved out by the other state agencies that are responsible for promoting home and community-based care, in negotiation with their state boards of nursing. Others, like Arizona and Colorado, provide a discretionary framework for nursing, but omit certain tasks from that discretion, notably the administration of medications, or they require specified training/certification for the delegatee (see Idaho as one example). To some extent these states overlap, and their designation may be debatable. What they share in common is the evidence that they have considered delegation policy questions in some detail and they have made decisions at this point in terms of where they fall. They may be the states that are most open to expansion of consumer-directed care policies.

Exemption

Most states include either a statutory or regulatory exemption from the provisions of the NPA, some of which are at least arguably related to consumer-directed care. Sabatino and Litvak (1995) and Flanagan and Green (1997) have documented many of these provisions based on their reviews of the nursing regulatory climate several years ago. Much of what they summarized remains true today, but there have been some significant changes since this area is continually evolving.

Proponents of consumer direction often believe that the exemption approach is best, since it can carve out consumer-directed/personal care assistance programs. Technically, an exemption from the NPA removes personal care from nursing regulation and makes delegation mute. This approach is consistent with the independent living movement's philosophy that consumers know what they need and can direct their own assistants, without the "medical model" oversight of nursing or medical supervision. Others (Kane et al, 1995) have argued that a well-designed framework for delegation that supports a consultative model for health professionals to assist consumers in their direction of assistants can be more helpful than an outright exemption. In a practical sense, even in a state like New York that clearly falls within a strong exemption model for consumer-directed care, actual practice and other regulations pertaining to personal care assistance programs call for involvement of nurses and/or physicians to assess the situation. The professionals certify that the consumer is able to direct his or her own health maintenance care needs.

In many cases, the exemption provisions in NPAs are confusing. The tasks, or category of persons, or setting is exempted from regulation and then the act or the regulations proceed to regulate that exemption. As one example, Florida exempts patient-selected assistants providing hemodialyis, but then regulates that that provider must be trained and have telephone access to a nurse. In addition, the exemption sections sometimes detail the requirements for delegation, as seen in Tennessee. In addition, some exemptions that are carved out in other regulations or memorandum

of understandings pertaining to consumer-directed care are included in the NPA itself or the regulations (as in the case of New York).

The most common exemption that is applicable to consumer directed care is gratuitous (unpaid) care by family and friends (21 states). In addition, eight states exempt family care, without specifying "gratuitous" leaving the door open for paid family care (Alaska, Idaho, Missouri, Nebraska, North Dakota, Ohio, Pennsylvania, and Wisconsin). Idaho exempts all family care and gratuitous care by non-family members, which would imply paid family care is exempt but paid care by friends is not exempt. Nebraska, Pennsylvania, and Wisconsin require that the family members or friends not hold themselves out to be a nurse. Another five states exempt "incidental care" or "domestic care" by family or friends without mentioning compensation (Delaware, Illinois, New York, North Carolina, and Wyoming). Finally, Florida exempts incidental care by "surrogate family."

Surprisingly, many states do not explicitly exempt care by family and friends. It is possible that historically, states presumed that family and friends would not be considered to be violating the nurse practice act when they assist with care, and that this care is generally given for free as "informal" care. However, the proviso in the majority of states that do exempt "gratuitous" care may be a problem for consumer-directed care programs that want to permit payment to family members.

A related frequent exemption is one that permits care by a "domestic servant" or person employed primarily as a housekeeper. This exemption takes various forms, sometimes including "companions", "nursemaids", "attendants", or "household aide of any type", sometimes referencing "incidental care" by these persons, sometimes stipulating that the person "not be initially employed in the nursing capacity" or provide care that constitutes the practice of nursing, and often requiring the person not claim to be a nurse (see table for specific language in each state). As Sabatino and Litvak (1995) noted, these exemptions might be used to support consumer-directed care, but they are vague with some notable exceptions. For example, Illinois exempts "attendants in private homes" as a separate category from incidental care by family and domestic servants or housekeepers. Similarly, Ohio exempts the activities of persons employed as attendants in private homes. A few states are more specific in exempting the activities of personal care attendants, as discussed in the following section.

Consumer-Directed Care Provisions

Reviewing the nurse practice acts and implementing regulations with an eye toward consumer-directed care offers some provocative findings. It is clear that some states have discussed consumer-directed care and independent living. Whether in the NPA or the regulations, several states have language that should support consumer-directed care. Since these findings emerge even without examining laws, regulations, memoranda or agreements, and attorney general decisions that are not cited in the nurse practice acts or regulations, they may understate the extent to which states have a legal framework that can support consumer-directed care. Further examination of these other sources of law and policy guidance would be helpful to better understand a given state's regulatory climate, as well as overall national trends.

Hawaii's statute specifies independent living settings as an appropriate setting for nurse delegation. Oregon's delegation rules for home and community-based care are designed to cover consumer-directed care. Maryland permits delegation of medications in certain settings, including

independent living.

A few states have broad exemptions or other language that could be used to support consumer-directed care. California and Montana have already been noted. Illinois and Ohio exempt attendants in private homes. Maine's unusual statutory language defines nursing in part as "teaching activities of daily living to care providers designated by the patient and family." North Carolina exempts caretakers who provide personal care to individuals whose health care needs are "incidental to the personal care required," a definition that many people with chronic health maintenance needs would embrace. Alaska allows broad discretion caring for person with "routine, repetitive needs" and provides examples that are consistent with the needs of persons who seek consumer-directed care (urinary catheterizations, suctioning, and gastrostomy tube feedings).

Specific consumer-directed care exemptions are found in nine states (Connecticut, Florida, Kansas, Nebraska, New York, New Mexico, South Dakota, Texas, and Vermont). The different approaches these states take are interesting, and might guide other states that are considering revisions to guide home and community-based care, particularly the consumer-directed model.

Connecticut is a unique state, since it has no regulations at all, but does have a "Memorandum of Decision" (April 1995) that does not have the force of regulation but is intended to provide guidance to nurses. This memorandum of decision interprets the exemption provisions contained in the NPA to exempt consumer-directed care of personal care attendants when a client is able to engage in decisions relating to his or her own care and is merely directing someone else to assist in implementing that plan of care.

New York is also an unusual state since it silent on nurse delegation, but exempts persons who are under the instruction of a patient, family, or household member determined by the nurse to be self-directing and capable of providing such instruction. In practice, nurses are involved early in the situation to confirm that consumers are knowledgeable about their self-care needs (including complex procedures), are proficient in the processes involved, and capable of instructing and supervising unlicensed personal assistants in performing specific tasks. The nurse is viewed as a consultant to the consumer, and is not delegating to the assistant.

Some states use specific language in their exemptions that reflect discussion about personal care attendant programs and consumer direction. For example, Vermont exempts the work and duties of attendants in attendant care services programs. Nebraska takes an even more sophisticated approach by exempting "health maintenance activities" by a designated care aide for a competent adult, "at the direction" of such adult or at the direction of a caretaker for a minor child or incompetent adult.

Other states specifically address consumer direction, but take a narrowly defined approach. For example, Florida's exemption only applies to a patient-selected assistant providing dialysis in the home. New Mexico exempts personal care providers in non-institutional settings for bowel and bladder assistance if a health care provider certifies that the person is stable, not in need of medical care, and is able to communicate his own needs. South Dakota allows bowel and bladder care, but not insertion or removal of catheters. The Kansas statute goes farther in exempting attendant, in-home services. A laundry list of tasks is enumerated in another section of state public health law (65-6201) that defines "health maintenance activities" including but not limited to medication administration, wound care, catheter irrigation, and enemas—and requires the opinion of a physician or nurse to determine if such activities can be performed safely.

Texas regulations for nurse delegation in independent living environments begins with the stated purpose that the board of nursing "believes that it is essential that the registered nurse who works with the client in an independent living environment with stable and predictable health care needs, and the ability to participate in the management of the delegated task, understand the

delegation rules" (section 218.8). The purpose statement includes the philosophy that the public prefers a "greater opportunity for clients to share with the registered nurse in choice and control for the delivery of services in the community-based settings." *Together with the client*, the nurse verifies the training and competency of the unlicensed person to perform a wide range of complex tasks, including medication administration, tube feedings, and intermittent catheterization.

Given the different approaches that these states use to specifically provide for consumer-directed care, it would be helpful to understand the processes they used to make the decisions they made. Case studies of the participants, process, alternative policy approaches considered, and final outcomes could be helpful to other states. Sharing statutory and/or regulatory language across the states could focus discussions and clarify policy options for any given state.

Liability

When consumer-directed care is exempted from the nurse practice act, the care falls outside of the purview of the nurse. Many personal care assistant programs still involve nurses in at least a "consultative role" with the consumer to determine his or her ability to direct others in assisting with health maintenance activities. However, the nurse acting in the consultative role is not "transferring the authority" for providing care to another person and should not be held accountable for the outcomes of care performed by the attendant who is directed by the consumer.

The nurse who is delegating care activities to unlicensed assistive personnel is technically in a different position. One of the biggest concerns for delegating nurses is the extent to which they will be held liable for the actions of those to whom they delegate. In the parlance of nurses, the concern is that these delegates are "acting on my license."

This liability concern is interesting and often open to interpretation. To what extent has a particular state made it clear that the nurse is accountable for the process of delegation, the outcomes of that delegation, or both?

Silent and Vague States

Thirteen (California, Florida, Kansas, Maine, Minnesota, Missouri, New Hampshire, New York, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Wisconsin) are silent in liability. Liability is not addressed in either the statute or regulations. Most states (18) do have some language, but it is vague and therefore open to interpretation. These states include: Arizona, Arkansas, Georgia, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maryland, New Jersey, North Carolina, Ohio, South Dakota, Tennessee, Utah, Vermont, Virginia, and West Virginia. Iowa's language is an example—"the nurse retains accountability for nursing care when delegating nursing interventions." Kentucky provides another example—"the delegator is responsible for assuring that the delegated task is performed in a competent manner by the delegatee."

Strict Liability

Fourteen states have clearer language that might be construed as a "strict" view of liability for the nurse who delegates—the nurse retains accountability for the outcome of the delegation.[1] Strict liability states include: Alabama, Alaska, Colorado, Connecticut, Delaware, Idaho, Massachusetts, Michigan, Mississippi, Nebraska, Nevada, New Mexico, Texas, and Wyoming. For example, the delegating Massachusetts nurse bears "full and ultimate responsibility" for the outcomes of the delegation, language that might make nurses very reluctant to delegate. Similar

language in Michigan gives the nurse "ultimate responsibility for the performance of nursing acts, functions, or tasks performed by the delegatee." Alabama is another example of strict liability in which the delegator is "responsible and accountable for the quality and quantity of nursing care given to patients by nursing personnel" under the nurse's supervision. Idaho is also strict because the nurse must "retain responsibility for the delegated acts and the consequences of delegation," although the unlicensed person is "personally accountable and responsible for all actions taken in carrying out the activities delegated to them."

Specific Language

A few states (Hawaii, Montana, North Dakota, Oregon, and Washington) are interesting because they have attempted to address the liability with more specific language without holding the nurse legally responsible for all actions of the delegatee. These states hold the nurse accountable for the process of delegation, for following the guidelines.[2] For example, Montana's regulations regarding liability can be interpreted as limiting liability for the act of delegating (process) rather than the outcome—"the delegating nurse will be liable for the act of delegating and for the supervision provided." Some other interesting examples include:

- Oregon's statute states that a delegating nurse "shall not be subject to an action for civil damages for the performance of a person to whom nursing care is delegated unless the person is acting pursuant to specific instructions from the nurse or the nurse fails to leave instructions when the nurse should have done so."

- Washington's statute stipulates "nurses acting within the protocols of their delegation authority are immune from liability for any action performed in the course of their delegation duties." The regulations hold the nurse and the assistant accountable for their own individual actions.

- Hawaii states "the nurse shall be accountable for the adequacy of nursing care to the client, provided the UAP performed the special task as instructed and directed by the delegating nurse."

- North Dakota holds the nurse accountable for individual delegation decisions and the *evaluation* of the outcomes, not the outcomes themselves.

The progressive liability provisions in these states should be shared with other states that are attempting to reduce barriers to consumer direction.

Discussion

There have been important changes in the nurse practice regulatory climate in the last several years that could affect support for consumer-directed care. First, the National Council of State Boards of Nursing (NCSBN, 1995) issued delegation guidelines. Developed mainly to address the issue of working with unlicensed assistive personnel in acute care settings, many states have incorporated these guidelines into their regulatory frameworks. On the one hand, this regulatory dissemination of the NCSBN guidelines has helped move the field forward, because more state

boards of nursing are thinking about delegation. On the other hand, since the guidelines have internally inconsistent messages about liability, states may be adopting flawed guidelines that might impede the expansion of delegation to support consumer-directed care.

Second, states' proclivity to alter their nurse practice acts is growing. Twenty years ago, state boards of nursing were afraid to "open the nurse practice act" because they were afraid that many undesirable amendments from physician groups and others would be added during the legislative process. But in 2000, 30 bills to change some aspect of state nurse practice acts were introduced in 17 states, often at the request of nursing groups (Reinhard, 2001). While much of this state legislative and regulatory activity has been focused on advanced practice nursing like nurse practitioners, there is also considerable discussion about unlicensed assistive personnel. State boards of nursing are poised for discussion about consumer-directed care, especially outside the acute care model. Of course, most board members come from the acute care arena, particularly hospitals, and have little experience in home and community-based care. Many of them are sensitive to the political pressure of nurse unions who claim that broad delegation policies will allow employers to force nurses to delegate and "patient care" will suffer. Until more board members become comfortable with the philosophy of consumer-directed care, state-by-state progress will be slow. Consumers appointed to the board as "public members" may become the leaders for change.

Third, the past few years have demonstrated that there are different approaches that can support consumer-directed care with varying degrees of flexibility. While the exemption approach offers a way to "carve out" consumer-directed care programs from the authority of the state boards of nursing, it can also restrict the expansion of the consumer-directed care philosophy beyond the bounds of a particular program named in the exemption language. For example, New York's consumer-directed program is exempt but its personal care assistance program is not, leaving state administrators frustrated (Simone, 2001). In addition, many programs exempt from the state's NPA nonetheless require a nursing assessment and periodic follow-up, leaving nurses confused about the liability of their actions.

Delegation policies can support consumer-directed care, as long as they provide either much discretion or very specific language that is consistent with consumer direction. For example, Alaska's delegation guidelines allow much discretion regardless of setting. In settings where the nurse is not regularly scheduled and the consumer has stable, predictable needs, the nurse can delegate a wide range of complex care, including gastrostomy tube feedings and suctioning of a long-term tracheostomy. Oregonian nurses can use much discretion in home and community-based settings, which should include consumers in independent living environments. Texas very clearly addresses consumers in such environments, providing specific delegation regulations for nurse delegation in "independent living environments."

States like Texas and Kansas have made substantial progress in developing nurse practice policies that specifically address consumer direction. Consumers in these states—and others—have been active in the policy debate, although the emphasis has often been on independent living settings and personal assistance programs more than the full range of home and community-based care, such as assisted living. Frequently, the intent of new regulations or guidelines is to establish a process for certifying consumers to be able to direct and supervise personal assistants in the performance of routine personal care tasks that have formerly been considered nursing tasks. It is not unusual to find the specific policy guidance in regulations that fall outside of the state boards of nursing, although these regulations are usually referenced (see New York and Kansas as examples). It is not clear how well regulations from different state agencies articulate in actual practice.

Finally, there is one statewide study that reports there are no adverse consequences of nurse delegation to unlicensed assistive personnel who are caring for some of the most vulnerable persons in community-based settings (Young et al., 1998). Although more studies are needed in

other states and settings, the findings are encouraging other state boards of nursing to consider policies that are more consistent with community-based care (Payseno, 2001).

While assuring that state policies will support changing the way care is provided in communities, restrictive policies are not the only barrier. Indeed, this review confirms what Kane and her colleagues (1995) noted—that most states have broad enough language to support delegation, if not exemption. However, even in those states like Oregon that have a decade of experience in permitting delegation, nurses continue to be confused about what can and cannot be delegated. As one board of nursing executive director described the situation, nurses continually call her office to ask the proverbial question, "Mother, may I? (Polansky, 2001). In addition, the acute care focus of most board members, and pressure from nurse unions who generally represent the concerns of nurses practicing in hospitals, reinforce the drive for detailed lists of what can and cannot be delegated, rather than broad guidelines that offer the kind of flexibility needed for home and community-based care, particularly consumer direction. Nurses' fear of liability and concern that employers will coerce them to delegate are additional barriers.

Several actions are needed to address these barriers. A multi-pronged effort in research, policy development, and education would be most effective.

Research

This analysis of NPAs and regulations should be enhanced with a concurrent analysis of personal assistance programs conducted by Batavia (2001). This cross-fertilization of research efforts would help determine the gaps between regulations governing these consumer-oriented programs and regulations governing nursing practice. Progress in one area in any given state should help fuel change in the other area of regulation. Furthermore, a better understanding of which states are developing consistent policies to support consumer-directed care would inform policy development in other states. The climate for this research-based dialogue is enhanced by the current focus on implementing the Olmstead decision, which supports community-based care for persons with disabilities across all age groups and challenges.

To confirm and further the results of this analysis of NPAs and regulations, the research team intends to share these results with the individual state boards of nursing, and survey the executive directors on potential changes they forsee in delegation and exemption policies. This national survey will lay the foundation for interviews with selected executive directors, and a presentation of the research findings before the National Council on State Boards of Nursing in August 2002.

The findings will also help identify progressive states and those who are currently considering policy options. Case studies of both kinds of states would be useful to describe the change processes these states have found effective, and their decision frameworks for selecting certain policy approaches. The case studies should include focused interviews with consumers, policymakers, state agency administrators, nurses, and other providers. Examples of innovative policies and stakeholder involvement should be widely disseminated to those who can stimulate sound and creative policy development in their states.

Finally, although the Washington study on outcomes of delegation is helpful, further research on the relationship between nurse practice regulation and client outcomes would provide a more substantive basis for enlightened and futuristic policy-making.

Policy Development

Findings from research should help drive policy changes at the state level. The legal mandate to state boards of nursing is to protect the public, not promote consumer direction. Given this mandate, it is important to bring together a core group of stakeholders in targeted states to discuss consumer direction, policy options to balance consumer protection and independence, internal consistency in state practice regulations, consistency across state departments, and potential demonstrations with evaluation research as needed. Consumers, policymakers, and providers need to come together, ideally with similar representatives from model states that can share their policies, practices, and lessons learned.

Criteria for targeting states to convene these kinds of policy summits should include evidence that they are open to change. This evidence should emerge from the national survey and case studies described above. Once a critical mass of these states is identified, more inter-state discussions can occur to stimulate more national support for change.

Education

Even in states that have made substantial progress in resolving the issue of nursing regulation and consumer-directed care, there is a need to educate nurses, consumers, and policymakers. Oregon has begun to develop curricula and regional training of nurses to help them understand the policies of their state and how to delegate effectively. Continuing education courses for practicing nurses are needed. Curriculum development for undergraduate and graduate nursing programs is also needed, with clinical experiences designed for students to work with consumers in a more consultative framework. Of course, their nursing faculty has to learn first.

Summary

The movement toward home and community-based care, with substantial consumer direction, is growing. Nurse practice regulations in each state can help or thwart that movement. Further research should be designed with the intent to inform state policy development and education of both consumers and providers.

Table 1: Summary of Key Provisions of State Nurse Practice Acts and Regulations Affecting Consumer-Directed Care

State	Delegation	Exemption	Consumer-Directed Care	Liability	Other/Notes
Alabama	R-Broad	Yes – statute Attendants but nurse supervision required; Gratuitous care by friends and family	No	R-Strict	
Alaska	S and R – Requirements/ Discretion	Yes – regulations Members of immediate family or guardians; caretakers who provide personal care to individuals whose health care needs are incidental to the personal care required	Yes – regulations Delegation to "providers" (UAPs) caring for clients with routine, repetitive needs. Broad discretion with examples provided, such as assistance with urinary catheterizations, medication administration (including insulin), and oxygen therapy; "under safe conditions" nurse may also delegate suctioning (oral and tracheostomy) and gastrostomy tube feedings	R-Strict Accountability for the performance of the activity remains with the licensed nurse Also clarifies responsibility of UAP to perform the delegated activities correctly	Nurse must certify person's ability to perform the task based on nurse's assessment of UAP's abilities and client client's condition Specific delegation rules for assisted living settings

State	Delegation	Exemption	Consumer-Directed Care	Liability	Other/Notes
Arizona	S and R – Intermediate Delegation of medication administration not permitted	Yes – statute Incidental care by domestic servant or person employed primarily as a housekeeper, if no claim to be a nurse; Gratuitous care by friends and family	No	S and R – Vague Nurse retains accountability for the delegation; responsible for the care provided by others under the nurse's supervision	
Arkansas	S and R Intermediate Nurse can delegate what a reasonable and prudent nurse would delegate. Yet tasks that can and cannot be delegated enumerated, but no restrictions on settings, no specific training requirements, and supervision may be by phone at nurse's discretion. Examples of what may not be delegated include administration of medications.	Yes – regulations Gratuitous care by friends and family	No	R-Vague Nurse "retains accountability for the total nursing care of the individual"	

State	Delegation	Exemption	Consumer-Directed Care	Liability	Other/Notes
California	S-Narrow Permitted in Mental Health or Developmental Disability institutions Specifies no delegation of medications, tube feedings, suctioning, inserting nasogastric tubes or catheters (but see exemptions)	Yes-statute Any person can perform duties required for physical care of a "patient" and or carrying out medical orders prescribed by a licensed physician if no claim to be a nurse (very broad exemption); Incidental care by domestic servant or person employed primarily as a housekeeper, if no claim to be a nurse; Gratuitous care by friends and family	No, but broad statutory exemption should provide for CDC Physician delegation clearly stated	Not addressed	Delegation language is confusing in the statute, but broad exemption should provide for nurse delegation related to CDC Physician delegation provision is used for CDC programs in this state

State	Delegation	Exemption	Consumer-Directed Care	Liability	Other/Notes
Colorado	S and R Intermediate (but conflicting language in S and R) Medication selection may not be delegated (but provisions for certain facilities made elsewhere); Nurse is solely responsible for determining competency of delegatee and degree of supervision with no limits on setting	Yes-statute Incidental care by domestic servant, housekeeper, companion, or household aide of any type—whether employed regularly or because of an emergency illness, if no claim to be a nurse; Gratuitous care by friends and family	No	R-Strict Delegator is responsible for the decision to delegate and the quality of care provided by others through delegation	Statue and regulations conflict; exemption language regarding household employees and companions broader than those in most other states
Connecticut	Not addressed in statute and no regulations exist from board (Dept. of public health can issue regulations). 1995 Memorandum of Decision offers an intermediate approach. Cannot delegate medication administration; nurse must be available for phone consultation in non-institutional settings	Yes Statute exempts hospitals with supervision; domestic servants, housekeepers, nursemaids, companions, attendants, or household aides of any kind if not initially employed in the nursing capacity	Yes (through Memorandum and guidelines) Specifies a "Personal Care Attendant" provision when a client is able to engage in decisions relating to his or her own care and is merely directing someone else to assist in implementing that plan of care	Strict in guidelines Nurse responsible for outcomes of delegation in all situations	Only state that has no nurse practice regulations; does have guidelines that address delegation and CDC (but no force of regulation); Personal Care Attendant provision in guidelines is very broad and respects client's decision-making capacity and ability to self-direct attendants

State	Delegation	Exemption	Consumer-Directed Care	Liability	Other/Notes
Delaware	S and R Intermediate No setting limitation, no training requirements, supervision by phone Cannot delegate medication administration	Yes- statute Incidental care by family, friends, domestic workers, or housekeepers; "auxiliary care services" that do not require nursing judgment and are performed by attendants directed and supervised by a nurse, physician, dentist, or podiatrist; medication administration by designated, trained providers in certain settings.	No	R-Strict "Legally liable for actions and decisions; responsible for the "delivery of safe and competent care."	

State	Delegation	Exemption	Consumer-Directed Care	Liability	Other/Notes
Florida	S and R Requirements/ Discretion No limits on setting and nurse determines competence of delegatee and supervision required	Yes-statute Incidental care by domestic servant or surrogate family; Gratuitous care by friends and family; Nursing assistants under the supervision of a nurse; patient-selected assistant providing hemodialysis treatments in the home, if trained and has immediate telephone access to a nurse	Yes (for hemodialysis only)	Not addressed	Hemodialysis exemption provides interesting precedent for broader CDC provision
Georgia	S and R Requirements/ Discretion	Yes—S and R Incidental care by domestic servant or person employed primarily as a housekeeper, if such care does not constitute the practice of nursing; auxiliary services if they do not require nursing knowledge and skill and are performed under the direction of a nurse.	No	R-Vague	Exemption language is very limited

State	Delegation	Exemption	Consumer-Directed Care	Liability	Other/Notes
Hawaii	S and R Intermediate Permits the nurse to delegate in any setting at any time, provided that when the nurse is not regularly scheduled and not available to provide direct supervision, the nurse shall provide indirect supervision (available for consultation). Regulations designed to address settings where a nurse is not regularly required, including independent living settings, assisted living, supervised group living, supervised or sheltered work settings, schools and day care. Requirements for delegation of medication administration in those settings.	No	Yes R-Independent Living Settings included in the statute with nursing delegation and consultation required	R-Specific Nurse is accountable for the decision to delegate and is "accountable for the adequacy of the nursing care to the client, provided that the unlicensed assistive person performed the task as instructed and delegated by the delegating nurse."	Unusual provisions, with some similarities to Oregon to provide for more discretion in community-based settings, including independent living and assisted living Specifies that the delegation of tasks be the "exception rather than the rule unless the registered nurse can justify the need for delegation"

State	Delegation	Exemption	Consumer-Directed Care	Liability	Other/Notes
Idaho	S and R Intermediate Board-approved training for UAPs required for certain tasks, including assistance with medications Delegation allowed in all settings. Nurse determines the degree of supervision.	Yes-regulations Family members; gratuitous care by non-family members on a temporary basis to provide respite to family members; incidental care by live-in domestics, housekeepers and companions, if no claim to be a nurse	No	R-Strict Nurse responsible for "consequences of delegation" and UAP personally accountable and responsible for all actions in carrying out activities delegated to them.	Exemption can support live-in CDC attendants
Illinois	S and R Broad	Yes- Statute Attendants in private homes; incidental care by family, domestic servants, housekeepers, spiritual treatment; staff in mental health and developmental disability facilities	No, but broad exemption	R-Vague	Broad exemption for attendants in private homes should support CDC, but Task Force examining need to regulate persons in private homes (report unavailable at this time, but no changes seen in regulations as of May 2001)
Indiana	S and R Broad	No	No	R-Vague	
Iowa	S and R Broad	No	No	R-Vague	Provides a "Delegation Decision-making Grid" adapted from the National Council of State Boards of Nursing

State	Delegation	Exemption	Consumer-Directed Care	Liability	Other/Notes
Kansas	S and R Broad Degree of supervision determined by nurse. Regulations only address delegation in school settings.	Yes-Statute Performance of attendant care services directed by or on behalf of an individual who needs in-home care defined under 65-6201 (not part of NPA); delegated nursing tasks with supervision of a nurse (also specifies delegation in school settings); gratuitous care by family and friends; auxiliary patients care services in medical care facilities, including adult care homes if supervised by RN or LPN; administration of medications by trained person in adult care or hospital long-term care units	Yes—provided in statutory exemption	Not addressed	Regulations contained in 65-6201 (not part of NPA) detail CDC provisions NPA confuses delegation and exemption
Kentucky	S and R Requirements/ Discretion	No	No	R-Vague	

State	Delegation	Exemption	Consumer-Directed Care	Liability	Other/Notes
Louisiana	S and R Requirements/ Discretion	Yes-statute Gratuitous care by family and friends; incidental care by those primarily employed as domestic workers	No	R-Vague	
Maine	S and R Requirements/ Discretion Statue defines nursing in part as "teaching activities of daily living to care providers designated by the patient and family" Nurse determines competency of delegatee	No	Yes- statute appears to permit consumer directed care but somewhat vague	Not addressed	Unusual statutory language regarding teaching providers designated by the "patient" and family
Maryland	S and R Intermediate Medication administration limited to certain types of medications in certain settings, including independent living	Yes-S and R Gratuitous care by self, family or friends; care supervised by nurse, physician or dentist in the area of that professional's responsibility	Yes-"Independent Living Centers" in regulations	R-Vague	Regulations being reviewed and revised Broad exemptions provided but then regulated under delegation

State	Delegation	Exemption	Consumer-Directed Care	Liability	Other/Notes
Massachusetts	S and R Intermediate Cannot delegate medication administration except in certain circumstances	Yes-statute Gratuitous care by family, friend, or person employed primarily as a companion, housekeeper, domestic servant, or nursemaid; care in a rest home, convalescent hoe, or nursing home if supervised by a nurse	No	R-Strict Nurse bears full and ultimate responsibility for the outcomes of delegation	Medication administration permitted by M.G.L., c. 94C (not included in NPA)
Michigan	S and R Requirements/ Discretion	No	No	R-Strict	
Minnesota	S and R Broad	Yes-statute Delegated nursing tasks when supervised by RN or LPN	No	Not addressed	Exemption simply refers to delegation Regulations outside of NPA refer to assisted living and administration of medications
Mississippi	S and R Broad	Yes-statute Gratuitous care by family and friends	No	R-strict	Regulations somewhat confusing since uses the term "assign" rather than delegation—not clarified as in Oregon

State	Delegation	Exemption	Consumer-Directed Care	Liability	Other/Notes
Missouri	S Broad	Yes-statute Medication administration (except injectables other than insulin) in licensed long-term care facilities; providing of care by family or friends (does not address compensation); incidental care by domestic servants or persons primarily employed as housekeepers.	No	Not addressed	Payment for care by family and friends appears permissible and exempt

State	Delegation	Exemption	Consumer-Directed Care	Liability	Other/Notes
Montana	S and R Narrow Restricted by setting, which includes community-based residential settings, including community-based residential settings and personal care homes, but "never appropriate" in acute care or long-term care facilities Delegation must be for a "specific task for a specific patient to a specific unlicensed delegatee in the specific setting" Nurse determines the degree of supervision and must be available by telecommunication Cannot delegate injections, sterile procedures or invasive procedures	Yes-Statute Personal assistants performing health maintenance activities (includes urinary systems management, bowel treatments, administration of medications, wound care) and acting on the direction of a person with a disability—if the physician or other health professional (including a social worker) determines the procedure could be safely performed in the home. Also provides for gratuitous care by family and friends, incidental care by domestic servants or persons primarily employed as housekeepers, and nursing tasks delegated by licensed nurses.	Yes-Statutory exemption	Specific Delegating nurse will be liable for the act of delegating and for the supervision provided. Does not appear to hold the nurse strictly accountable for the outcome.	CDC language is noteworthy Delegation language unusual since it describes settings in which delegation is "never appropriate." Certain aspects of medication administration and gastrostomy tube feedings specified Clearly much discussion about delegation, exemption, and CDC

State	Delegation	Exemption	Consumer-Directed Care	Liability	Other/Notes
Nebraska	S and R Requirements/ Discretion No setting restrictions, degree of supervision left up to the nurse Clearly states that nursing—and delegation—cannot be reduced to a list of tasks	Yes-statute Health maintenance activities by a designated care aide for a competent adult at the direction of such adult or at the direction of a caretaker for a minor child or incompetent adults (71-1,132.30) Home care provided by parents, foster parents, family or friends, if they do not hold themselves out to be a nurse; delegated "auxiliary patient care services"	Yes	S and R- strict; conflicting	Statutory and regulatory language is conflicting but overall, appears to hold nurse accountable for delegation outcomes in the regulations CDC provision defines **health maintenance activities** as specialized procedures, beyond activities of daily living, which the MD or RN determines can be safely performed in the home and community by the designated care aide as directed by a competent adult or caretaker

State	Delegation	Exemption	Consumer-Directed Care	Liability	Other/Notes
Nevada	S and R Intermediate	Yes-statute Incidental care by domestic servant or person employed primarily as a housekeeper, if such care does not constitute professional nursing; Gratuitous care by friends and family	No	R-Strict	
New Hampshire	S and R Requirements/ Discretion	Yes-statute Administration of medications in mental health or developmental disability settings, and hospice care	No (although Medicaid provisions may apply but not specified in NPA)	Not addressed	Personal care services under Medicaid addressed (no provisions obtained)
New Jersey	R Requirements/ Discretion Nurse determines competency of delegatee and degree of supervision No limit by setting. Guidelines for making delegation decisions provided	Yes – statute Incidental care by domestic servant or person employed primarily as a housekeeper, if such care does not constitute professional nursing, and no claim to be a nurse; Gratuitous care by friends and family	No	R-Vague	Regulations under revision; Board opinion permits CDC Delegation of medication in assisted living and adult foster care specified in regulation under the Department of Health and Senior Services

State	Delegation	Exemption	Consumer-Directed Care	Liability	Other/Notes
New Mexico	S and R Intermediate Delegation of medications not permitted except to certified medication aides Nurse verifies delegatee's knowledge and skill and determines level of supervision required. No limits by setting.	Yes-statute Personal care provider in non-institutional settings for bowel and bladder assistance if a health care provider certifies the person is stable, not in need of medical care, and is able to communicate and assess his own needs; home health aide, nursing aide, or orderly, unless performing acts defined as professional nursing; certified medication aides serving developmentally disabled persons in licensed facilities or through a Medicaid waiver	Yes- regulations, but limited to bowel and bladder assistance	R-Strict	Limited CDC provision

State	Delegation	Exemption	Consumer-Directed Care	Liability	Other/Notes
New York	Not addressed	Yes-statute Domestic care by family, friend, household member, or person employed primarily in domestic capacity, if person does not hold himself/herself out to be a nurse; person (who does not hold himself out to be a nurse) under the instruction of a patient, family or household member determined by the nurse to be self-directing and capable of providing such instruction, and any renumeration is provided under S3622 (public health) or S365f (social service) laws.	Yes in statute as an exemption with references to 2 other state laws	Not addressed	Delegation language absent, but specific exemption for CDC references other laws that define CDC Broad exemption by others appears to allow paid care if not held out to be nursing care

State	Delegation	Exemption	Consumer-Directed Care	Liability	Other/Notes
North Carolina	S and R Requirements/ Discretion Delegation decision-making tools included. No limits by setting. Nurse determines delegatee's competency and level of supervision required. Nurse must be "continuously available" –"onsite when necessary"	Yes-S and R Clients, families, significant others, or caretakers who provide personal care to individuals whose health care needs are incidental to the personal care required. Physician delegation noted in statute for services that are "routine, repetitive, limited in scope" and do not require nursing judgment.	Yes—broad regulatory exemption for "personal care" if "health care needs are incidental"	R-Vague	Broad CDC exemption, depending on definition of "incidental health care needs" Proposed changes in progress

State	Delegation	Exemption	Consumer-Directed Care	Liability	Other/Notes
North Dakota	S and R Requirements/ Discretion No limit on settings. Nurse determines supervision. Medication administration to aides who have met requirements—but also discretion allowed when the "nurse specifically delegates to a specific nurse assistant the administration of a specific medication for a specific client"	Yes-statute Person who performs tasks for a family member; medication administration in certain circumstances	No	Specific Nurse accountability for individual delegation decisions and evaluation of outcomes	

State	Delegation	Exemption	Consumer-Directed Care	Liability	Other/Notes
Ohio	S and R Intermediate All settings. Minimum training requirements for UAP with written skills checklist but can be done by nurse one on one or for a group, leaving situational flexibility. Limited delegation of medication administration; nurse must supervise at all times, but through telecommunications if appropriate.	Yes-statute Activities of persons employed as nurses aides, attendants, orderlies, or other auxiliary workers in patient homes; provision of nursing services to family members	Yes—broad statutory exemption for attendants in homes	R-Vague	Broad exemption would appear to cover CDC Board provides guides on nursing delegation
Oklahoma	S and R Narrow Refers to delegation to "an advanced unlicensed assistive person" who has completed a "certified training program"	Yes-statute Gratuitous care by family and friends	No	Not addressed	Unclear if nurses are permitted to delegate only to "advanced unlicensed assistive personnel"

State	Delegation	Exemption	Consumer-Directed Care	Liability	Other/Notes
Oregon	S and R Intermediate Delegation rules apply only to settings where a RN is not regularly scheduled, and have no application to acute, long-term care, or any other settings where the regularly scheduled presence of an RN is required; distinguishes between" assignment" and "delegation"	No	Yes-Division 48 of regulations set forth specific rules regarding CDC	S and R-Specific Nurse who follows the regulations is not subject to an action for civil damages for the performance of the UAP, unless the UAP is acting upon the nurse's specific instructions, or no instructions are given when they should have been provided; nurse retains the responsibility for determining the appropriateness of assigning or delegating nursing tasks to UAPs.	Liability language noteworthy Detailed regulations for home and community-based settings provide much discretion and CDC, but nursing presence is required at some level Assignment and delegation is clearly defined
Pennsylvania	Not addressed	Yes-statute Home care by family, friends, domestic servants, nursemaids, companions, or household aides of any type, if do not hold out as nurses	No	Not addressed	Inconsistencies between RN and LPN act

State	Delegation	Exemption	Consumer-Directed Care	Liability	Other/Notes
Rhode Island	R Narrow, only delegation to registered or licensed nurses or nursing assistants	Yes-statute Gratuitous care by family and friends; care by domestic servants, housekeepers, nursemaids, companions, or household aides of any type, employed primarily in a domestic capacity and do not hold themselves out as nurses; persons employed in settings regulated as hospitals, nursing homes, etc.	No	Not addressed	
South Carolina	S and R Narrow No limit by setting, but Enumerates tasks (few) that can be delegated	Yes-statute Gratuitous care by family and friends; incidental care by domestic servants or persons primarily employed as housekeepers, as long as they do not practice nursing.	No	Not addressed	

State	Delegation	Exemption	Consumer-Directed Care	Liability	Other/Notes
South Dakota	S and R Intermediate Enumerates specific tasks that can and cannot be delegated as routine, with specific guidelines for distinguishing what can be delegated under what circumstances. Does not permit delegation of medication administration (except in certain settings, which includes among others community support services programs certified by the Department of Human Services); never injections. Nurse can instruct delegatee and provide supervision through telecommunications.	Yes-statute Personal attendant when acting under the direction of a person with a disability; assistance with bowel and bladder care (except insertion or removal of suprapubic and foley catheters) by domestic servants, housekeepers, companions, or household aides, at the direction of the person needing such care who resides independently; gratuitous care by family and friends; care by domestic servants, housekeepers, companions or household aides who do not assume to practice nursing; administration of medications by staff in certain settings	Yes—two statutory exemptions clearly apply	R-Vague	CDC regulations outside of Nurse Practice Act/regulations

State	Delegation	Exemption	Consumer-Directed Care	Liability	Other/Notes
Tennessee	S Broad in statute	Yes-S and R Care of persons in their homes by attendants, domestic servants, housekeepers, or household aides of any types if not initially employed in a nursing capacity; staff in physician or dentist offices and institutions with supervision; assistance with self-administration of medications in mental health and developmental disability programs	No	R-Vague	CDC could be permitted under first statutory exemption cited Contradictory for NPA to exempt UAPs in certain settings, but then adopt regulations limiting tasks

State	Delegation	Exemption	Consumer-Directed Care	Liability	Other/Notes
Texas	S and R Requirements/ Discretion All settings, with additional guidance in Rule 218.8 for delegation in independent living environments—allo ws medication administration, tube feedings, intermittent catheterizations, and other tasks RN discretion in assessing delegatee's capacity and need for supervision	Yes-statute Gratuitous care by family and friends	Yes—Rule 218.8	R-Strict	Guidelines for delegation in independent living environments is noteworthy
Utah	S and R Requirements/ Discretion	Yes-statute Gratuitous care by family, friends, foster parents, or legal guardians	No	R-Vague	

State	Delegation	Exemption	Consumer-Directed Care	Liability	Other/Notes
Vermont	S and R Broad	Yes-statute Work and duties of attendants in attendant care services programs; care by domestic help of any type if person is employed primarily in a domestic capacity	Yes—statutory exemption	R-Vague	CDC statutory exemption is fairly broad for those in "attendant care programs"
Virginia	S and R Intermediate No limits on settings. Nurse assesses delegatee's competency and need for supervision. Administration of medications limited.	Yes-statute General care of sick provided by nursing assistants, companions or domestic servants that does not constitute the practice of nursing	No	R-Vague	Broad statutory exemption may permit CDC, but open to interpretation

State	Delegation	Exemption	Consumer-Directed Care	Liability	Other/Notes
Washington	S and R Intermediate Distinguishes between "general delegation" in all settings and "specific delegation in community-based settings (community residential programs for developmentally disabled, adult family homes, and boarding homes, including assisted living). Medication administration only to certified assistants in community-based settings (injectible medications, sterile procedures, and central line maintenance may never be delegated; aides must complete core nursing delegation training	Yes-statute Gratuitous care by anyone if not holding out a nurse; nursing assistants providing delegated tasks	No	Specific Nurses acting within the protocols of their delegation authority are immune from liability for any action performed in the course of their delegation duties; RN and nursing assistant are accountable for their own individual actions in the delegation process.	Noteworthy liability language Legislation called for an evaluation of delegation, with more recent changes to broaden delegation. Perhaps due to continual changes in the statue and regulations, the NPA and regulations appear to conflict with the NPA appearing to allow delegation in all settings, but the regulations allowing delegation only in "community-based settings. Formerly informed consent of each delegated act was required

State	Delegation	Exemption	Consumer-Directed Care	Liability	Other/Notes
West Virginia	S and R Broad	No	No	R-Vague	Provides guidelines for determining acts that may be delegated, but do not have the force of law New regulations imminent
Wisconsin	S and R Requirements/ Discretion	Yes-statute Care by family or friends, if not held out as a nurse	No	Not addressed	
Wyoming	S and R Narrow Detailed list of tasks that may be delegated to certified aides only. No limit by setting	Yes-statute Incidental care by family or friends	No	R-Strict Nurse retains accountability for "the overall outcome" although delegatee "retains the burden for performing the delegated tasks or activities and keeping the delegator informed"	

KEY

Throughout table: S = appears in statute; R = appears in regulations

Abbreviations used:

NPA = Nurse Practice Act

UAP = Unlicensed assistive personnel (includes personal care attendants)

RN = Registered nurse

LPN = Licensed practical nurse

MD = medical doctor (physician)

Delegation: Broad = broad language with no requirements specified; Requirements/discretion = Requirements specified but provide considerable discretion in delegation (no limits by setting, tasks); Intermediate = detailed requirements that permit discretion in certain circumstances, such as home and community-based care; Narrow = prescriptive requirements that limit delegation by setting, tasks, on-site supervision by the nurse, or other details.

Not addressed = no language in either statue or regulations

Exemption: Yes = exemptions applicable to consumer-directed care; No = No exemptions applicable to consumer-directed care

Consumer-Directed Care (CDC): Yes = specific reference to personal care attendant or similar language

Liability: Vague = Vague or open to interpretation; Strict = makes nurse accountable for the outcome of delegation; Conflicting = conflicting language; Specific = specific language clarifies liability to hold the nurse accountable for the process of delegation;

Not addressed = no language pertaining to liability in either statue or regulations

Other: indicates matters of particular interest

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