



Rutgers Center for
State Health Policy

NATIONAL ACADEMY
for STATE HEALTH POLICY

December 2004

State Policy in Practice

Community Living Exchange

Funded by Centers for Medicare & Medicaid Services (CMS) and
the Office of the Assistant Secretary for Planning & Evaluation (ASPE)

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The Community Living Exchange at Rutgers/NASHP provides technical assistance to the Real Choice Systems Change grantees funded by the Centers for Medicare & Medicaid Services.

We collaborate with multiple technical assistance partners, including ILRU, Muskie School of Public Service, National Disability Institute, Auerbach Consulting Inc., and many others around the nation.

This document was prepared under Grant No. P-91512/2. for the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services and the Office of the Assistant Secretary for Planning & Evaluation. However, these contents do not necessarily represent the policy of the U.S. Department of Health and Human Services, and you should not assume endorsement by the Federal government. Please include this disclaimer whenever copying or using all or any of this document in dissemination activities.

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Summary

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

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

Major points

- State policymakers from Oregon's State Board of Nursing and the Oregon Department of Human Services have worked together for more than two decades to synchronize their policies to better serve people of all ages with disabilities who live in the community.
- State policy continues to evolve, with 2004 changes permitting unlicensed workers to administer intravenous medication under certain circumstances.

- Oregon’s distinction between “teaching” and “delegating” care tasks is significant.
- Oregon’s rules regarding “teaching” and “delegating” are specific to settings where a registered nurse is not regularly scheduled and not available to provide direct supervision.
- There is a tight relationship between nurses and workers, with nurses providing all of the training for those who will be performing the tasks that the nurse will be delegating. There are no formal courses or certification requirements for these “lay workers.”
- There are 150 “Contract Registered Nurses” hired by the state as independent contractors to assess, teach, delegate and monitor care provided to people receiving publicly funded community based care.
- Contract Registered Nurses are required to learn how to delegate care tasks to workers.
- Nurses who follow the regulations are not subject to an action for civil damages for the performance of the worker, unless the worker is acting upon the nurse’s specific instructions, or no instructions were given when they should have been provided.

Background

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

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

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

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

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

Amendments to Oregon's Nurse Practice Act in 1987 permitted nurses to delegate tasks formerly performed only by nurses to unlicensed persons.⁸ The following year, OSBN adopted regulations that gave more specificity to nurse delegation.⁹ The policy goal of nurse delegation was two-fold. First, policymakers wanted to remove barriers to HCBS and believed that it was not necessary (or possible) to have a nurse perform daily, health-related activities. Second, knowing that many people living in communities have unmet nursing needs, leaders from both state agencies wanted to shape policies that would bring more nurses into situations where unlicensed personnel were already providing these services, without the benefit of nursing consultation or regulatory oversight. Oregon has amended its Nurse Practice Act several times since 1987, most recently in 2004.¹⁰

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

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

Program Practices

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

Can nurses delegate nursing tasks in any setting?

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

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

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

What tasks can nurses delegate?

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

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

In addition to teaching tasks, the nurse can delegate more complex tasks to a specific worker for a specific client. This one-to-one delegation model is required for injectible medications, most often subcutaneous insulin injections. The worker cannot “transfer” this delegation to another consumer. In other words, the worker cannot administer the same delegated task to another consumer unless they are specifically trained to do so by a nurse.

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

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

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

delegating or the ability to provide adequate supervision. The nurse may delegate if the following conditions are evident:

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

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

What training do the workers get to perform care tasks?

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

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

Teaching the administration of non-injectible medications includes:

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

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

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

What documentation and supervision does the state require?

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

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

Who is accountable?

The nurse is accountable for following the guidelines, for teaching and delegation. According to the Nurse Practice Act and implementing regulations, nurses who follow the regulations are not subject to an action for civil damages for the performance of the worker, unless the worker is acting upon the nurse's specific instructions, or no instructions were given when they should have been provided. The nurse retains the responsibility for determining the appropriateness of teaching or delegating nursing tasks to workers.

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

Lessons Learned

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

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

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

Oregon's model of hiring nurses as independent contractors to assess, teach, delegate and monitor care tasks is a strategic method for promoting HCBS and monitoring quality. State officials consider their "Nursing Support Services" to be one of their most important HCBS services. While the OSBN rules permit all nurses to delegate,

the state's Certified Contract Nurses receive special orientation to the delegation policies and processes, including how to train and monitor unlicensed workers. They provide a comprehensive, holistic assessment of the person with chronic, maintenance care needs in that person's unique living environment. The state relies on the nurses' professional judgment to decide when to delegate and how often to monitor, beyond minimum standards.

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

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

Conclusion

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

Acknowledgements

The authors express their gratitude to the following key people from Oregon and elsewhere who participated in several discussions and meetings regarding the topic of nurses collaborating with consumers: Cindy Hannum of Oregon's Department of Human Services, Megan Hornby of Oregon's Department of Human Services, Joan Bouchard Executive Director of Oregon's Board of Nursing, Mary Amdahl Thompson of Oregon's Board of Nursing, Kathy Apple, Executive Director of the National Association of State Boards of Nursing, Rosalie Kane of the University of Minnesota, Andrea Augenbaugh of New Jersey's State Nurses' Association, Noreen D'Angelo of New Jersey's Department of Health and Senior Services and New Jersey's Board of Nursing, William Ditto of the

Office of Disability Services at the New Jersey Department of Human Services, and Bob Kafka of ADAPT.

This document was prepared under Grant No. P-91512/2-01 for the U. S. Department of Health and Human Services's Centers for Medicare & Medicaid Services, and the Assistant Secretary for Planning and Evaluation. However, these contents do not necessarily represent the policy of the U. S Department of Health and Human Services, and you should not assume endorsement by the Federal government. Please include this disclaimer whenever copying or using all or any of this document in dissemination activities.

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- ⁶ 1979 Oregon Revised Statute (ORS) 678.
- ⁷ This agency was originally named the Senior Services Division in 1981.
- ⁸ 1987 Oregon Revised Statute (ORS) 678.
- ⁹ 1988 Oregon State Board of Nursing (OSBN), Oregon Administrative Rules (OARS) Division 45.
- ¹⁰ In 1992, the OSBN moved the delegation rule to Division 47 *Standards for Registered Nurse Delegation and Assignment of Nursing Tasks to Unlicensed Persons*. These rules were amended again in 1998 and 2004.
- ¹¹ Cindy Hannum, SPD/ODHS, Presentation to the Summit of Thought leaders on Nurse-Consumer Collaboration, Office of the Assistant Secretary of Planning and Evaluation (ASPE), Washington, DC, April 7, 2004.
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