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Washington's Nurse Practice Policies for Home and Community Living

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Summary

Promoting community living for all people, regardless of age or disability, often challenges conventional thinking and policymaking. One major state policy area that requires new thinking and potential action is the extent to which a state's nurse practice laws 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 ongoing needs for care and support.

This *State Policy in Practice* brief is the third 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) about interpretations of how their policies affect consumers' desires to live at home and manage their ongoing care needs.[1] The second brief focused on Oregon's policies for how nurses may collaborate with consumers to manage health maintenance activities.[2] This third brief examines Washington's activities in this area. 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

- Nurse delegation is reserved for those who do not wish to direct their own attendants, or for those living in congregate settings, such as assisted living.

- Washington has taken a deliberate, evolving approach to changing long-term care policy, including nurse delegation.

- Washington is the only state that mandated a statewide study of nurse delegation in home and community-based settings.

- **In addition to delegation, Washington also allows persons with disabilities to hire and direct independent providers for personal and health care. A**

[1] Reinhard & Quinn (2004a).
[2] Reinhard & Quinn (2004b).

person who can direct his or her own care does not need to rely on nurse delegation to a nursing assistant.

- Policy development on nurse delegation has evolved in the past ten years in response to many forces for change, including consumer advocates, state executive branch leaders, nursing leaders, legislators, and providers.

- Current law permits registered nurses to delegate specific tasks to specific unlicensed workers (registered or certified nursing assistants), including oral medications, but does not allow delegation of any injections.

- In community-based settings, registered nurses may only delegate to nursing assistants (registered or certified) who have completed an additional nine hours of basic delegation training.[3]

- Contrary to expectations that nurse delegation would result in job loss for licensed staff, this policy increased the level of nurse oversight and involvement in these settings.

- The study revealed that consumers desire to live in the least restrictive setting possible, that they desire timely, convenient and safe care, and they are willing to take risks to meet these goals; there was no evidence of significant harm or adverse outcomes for consumers receiving nurse delegation during the two-year study period.

- The limitation of delegating injections is a barrier for some consumers with diabetes who may have to leave their community-based settings when unable to self-administer their insulin.

Background

More than ten years ago, the state of Washington began to make significant policy changes to promote home and community-based services (HCBS). Success can be measured in many ways, but notably Washington is spending about 48% of its long-term care spending budget on non-institutional care, making this state one of a handful that can claim this achievement.[4] This means that the state offers people who require "nursing home level of care" equal access to HCBS, including home care, adult foster care, assisted living, and many consumer-directed options. Notably, nursing facility beds have decreased from 25,797 in 2001 to 24,096 in 2004. The shift from nursing facility care to more home and community-based services is reflected in a 9% growth in adult family home beds, an increase from 93 to 117 adult day care centers and the establishment of 74

[3] This requirement is different than the Oregon model of delegation in which nurses can delegate to "lay caregivers" who are not certified nursing assistants.
[4] Hendrickson & Reinhard (2004).

new home care agencies in Washington between 2001 and 2004.[5] Washington's Community Options Program Entry System (COPES) waiver offers a variety of services to over 30,000 people with disabilities, including older people, and has an annual budget of over $3250 million. Washington's Nursing Facility Case Management system is the state's program that employs case managers who work with nursing facility staff to assist residents in learning about and accessing HCBS services.[6]

Many of those who prefer to live in their homes and communities need some assistance to manage daily tasks, such as taking medication or managing tube feedings or catheters. These tasks are traditionally performed by registered nurses (RNs) or licensed practical nurses (LPNs) in institutional settings. To reconsider how these tasks may be completed outside of institutions, consumer advocates and policy makers from Washington's Aging and Disabilities Services Administration looked to their sister state of Oregon, which had been making policy changes to promote HCBS since the 1980s.[7] Since most home-based care in Oregon is delivered by "lay providers" in local communities,[8] Washington was eager to replicate their model as much as possible.

Many state policies now support Washington's mission to support community living for older adults and people with disabilities in non-institutional settings. One critical set of laws and regulations provides a framework for permitting registered nurses to delegate a broad range of care tasks to others who help individuals with personal care and health maintenance needs.

In 1995, the Washington State House of Representatives voted for House Bill 1908, a comprehensive bill that sought transformation of the long-term care system to promote home and community-based care in less costly settings that consumers preferred.[9] This law was highly controversial with multiple stakeholders, and it included an effort to optimize the skill mix of providers. In this first legislative change, nurses would have limited authority to delegate certain tasks to unlicensed staff in three settings: adult family homes (AFHs); residences for persons with developmental disabilities (DDs); and, assisted living boarding homes (AL) that had contracts to serve Medicaid beneficiaries. Nurses could delegate the administration of oral medications, eye/ear/nose drops, and suppositories, but no injectable medications. They could also delegate feedings through gastrostomy tubes in patients in an established and healed condition, "clean"[10] dressing changes, "clean" urinary catheterizations, the administration of enemas, and monitoring of blood glucose.[11] These tasks could be delegated by a specific nurse to a specific worker for a specific client. The worker had to complete a nine-hour "core training" program in delegation provided by the state before the nurse could train

[5] Washington Department of Social and Health Services, Aging and Disability Services Administration (2006).
[6] The MEDSTAT Group (2004).
[7] Justice & Heestand (2003).
[8] Reinhard & Quinn (2004c).
[9] Sikma & Young (2001).
[10] The term "clean" refers to the need for careful hand washing rather than the use of "sterile' gloves and equipment.
[11] The lay term for "blood glucose" is "blood sugar," which people with diabetes must check regularly.

the worker in any specific task.[12] The client had to be in a stable and predictable condition and had to give informed consent for each task and each nursing assistant before the nurse could delegate tasks to a worker.

This 1995 law that gave nurses limited authority to delegate tasks to workers in three settings, also provided for a statewide study of nurse delegation, a unique legislative mandate. It required the University of Washington School of Nursing to study:

- Consumer, nurse and worker satisfaction;
- Medication errors;
- Incidence of harm, abuse and neglect;
- Impact on access to care and consumer quality of life;
- Incidence of coercion in the process; and,
- Compliance with training and nurse delegation protocols.

The study was conducted in collaboration with state agency personnel, the Washington Board of Nursing, and a 40-member workgroup that helped design and implement the study. It included phone surveys, questionnaires, document reviews and focused in-depth interviews with residents, family members, workers, nurses, administrators and case managers.[13] Initially, stakeholders were polarized and the process was contentious. In the course of the research process, diverse opinions were aired and with deeper dialogue and growing evidence, stakeholders evolved to a more unified view of the benefits and risks of the policy.[14]

The major findings of this two-year study helped shape further changes in the Washington Nurse Practice Act. The study found that:[15]

- Consumers preferred the least restrictive setting possible and value the ability to age in place;
- There was no evidence of significant harm or adverse outcomes for consumers receiving nurse delegation during the two-year study period;
- RN involvement in care planning increased, communication improved among the care team and with families and residents, and nursing assistants were better prepared to provide care under nurse delegation;

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[12] This nine-hour course is an addition to the required training to become a registered or certified nursing assistant.
[13] Sikma & Young (2001).
[14] Sikma & Young (2003).
[15] Young & Skima (1998).

- Nurse delegation brought unlicensed practice under the supervision of RNs; and,
- RNs exhibited professional judgment and discretion in determining what and to whom to delegate.

Based on these findings, the Washington legislature made two major changes to the statute. First, the list of tasks that could be delegated was removed. Instead, nurse delegation was left to the professional discretion of the registered nurse with certain exclusions (i.e., sterile procedures, central line care, and injectible medications). The detailed protocols were removed from the statute, and authority was provided to the Nursing Care Quality Assurance Commission (the state's Board of Nursing) to develop protocols for nurse delegation through the rule making process. The revisions determine that the consumer no longer has to give informed consent for every delegated task, but does have to provide consent when delegation is initiated.

Nurse delegation is now permitted in home and community-based settings,[16] regardless of payer, and is not limited to specific tasks. A few notable exceptions remain. First, nurses cannot delegate sterile procedures such as complex wound care or insertion of indwelling catheters, nor can they delegate maintenance of central lines (i.e., intravenous catheters inserted in large blood vessels).

Perhaps most important, nurses cannot delegate any injections, including pre-filled insulin injections. However, most consumers can direct their workers to administer injections through the provisions of a different law (see below). In cases where they cannot self-direct, the state will pay for a registered nurse to administer the injections as an ancillary service for people who are served under Medicaid.[17]

It should be noted that in addition to nurse delegation of tasks provided through House Bill 1908, Washington enacted House Bill 1880 in 1998 to permit individuals with disabilities the right to hire and direct independent providers for personal and health care.[18] This legislation established that family members could serve in the role of independent providers. Unlike nurse delegation, there are no restrictions on what the consumer can direct. For example, consumers can direct their attendants to administer medications, including insulin and other injections, insert catheters, give gastrostomy tube feedings, suction, administer enemas and provide ostomy care. The only criterion is that the person with the disability must be able to self-direct. Registered nurses can be authorized by the state at the request of the consumer to "teach" the person with disabilities and the caregiver how to do a task, but the task must remain under the direction of the consumer. Again a study was mandated and the most significant findings of this evaluation included:

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[16] Nurse delegation was recently expanded to the in-home population.
[17] Black (2005).
[18] Young & Sikma (2003).

- There were no negative outcomes attributable to self-directed care. Benefits included improvements in quality of life and quality of care for consumers;

- There was high satisfaction with self-directed care and strong endorsement for the program;

- People value staying at home and want to have control over their lives and care. Self-directed care supported autonomy and choice;

- Self-directed care offered another alternative in the array of options for persons with functional and health needs;

- Both consumers and case managers believe that this program has prevented utilization of more expensive services (e.g., nursing homes, emergency rooms for routine care);

- The self-directed care program was well implemented, with minimal logistical issues and few barriers to ongoing service; and,

- The biggest challenge to implementation was assuring adequate staffing, a reflection of a broader labor issue affecting consumers in all long-term care settings.

Program Practices

Washington has had almost ten years of experience in nurse delegation, and the dialogue continues with stakeholders, including consumers, legislators, and nurses. This state's implementation of policy into practice offers some important lessons for other states.

Some details about how nurse delegation occurs in Washington can help interested parties in other states who are considering policy options. Answers to commonly posed questions are offered here to stimulate discussion.

Can nurses delegate nursing tasks in any setting?

Nurse delegation in Washington can delegate specific tasks to specific workers for specific clients in community-based settings, such as consumers' homes, adult foster homes (adult family homes), assisted living and certified residences for persons with disabilities. This one-to-one delegation model is required for all tasks. The worker cannot "transfer" this delegation to another consumer.

Nurses do not supervise trained and certified medication technicians in nursing homes.

How is nurse delegation different from self-direction?

Nurse delegation is restricted to community-based settings and involves nursing assessment of the client, determination of appropriateness of delegation, as well as training and supervision of nursing assistants executing delegated tasks. Self-direction is enacted by the consumer who directly hires, trains, and supervises the unlicensed worker (not required to be a nursing assistant). This worker is known as an "independent provider." Nurses may be reimbursed for teaching the consumer and the independent provider how to do a task, but they do not assume supervisory responsibility.

What tasks can nurses delegate?

The tasks are determined at the discretion of the registered nurse, depending on the client's condition, the abilities of the nursing assistant, and the complexity of the task. There are notable exceptions: sterile procedures, injections, and central line maintenance. The nurses are responsible for providing hands-on training with return demonstration, and for giving the worker written instructions, including risks, side effects, and whom to contact to report any problems.

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

The registered nurse decides in the context of the client's condition, the capacity of the nursing assistant(s), and the complexity of the task.

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 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 nursing assistant(s) have been taught the nursing care task and are capable of and willing to safely perform this task.

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. 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.

What training do the workers get to perform care tasks?

The nursing assistant must first be trained as a registered or certified nursing assistant (basic caregiver training), and then complete additional training in delegation (core delegation training). Both the "Fundamentals of Caregiving" (Edition 2, July 2005) and the "Nurse Delegation Training for Nursing Assistants" curricula are available on DVD through Washington's Aging & Disability Services Administration (ADSA). It covers the provisions of the law, responsibilities of the nurse and the person receiving the delegation, and focuses on key areas, such as medication administration.[19] ADSA issues a "certificate of completion" to the nursing assistant once the core nurse delegation training is complete. In addition, the registered nurse delegator must identify and facilitate any additional training of the nursing assistant that may be needed for complex tasks.

What documentation and supervision does the state require?

The nurse must document the rationale for delegating or not delegating tasks and provide specific, written delegation instructions to the nursing assistant with a copy maintained in the consumer's record. The nurse instructs the assistant in how to document the task in the consumer's record. The nurse must supervise and evaluate the performance of the nursing assistant, and re-evaluate at least every 90 days.

Who is accountable?

The nurse is accountable for following the guidelines, for teaching and delegation.

WAC 246-840-970 Accountability, liability, and coercion. (1) The registered nurse delegator and nursing assistant are accountable for their own individual actions in the delegation process. The delegated task becomes the responsibility of the person to whom it is delegated but the registered nurse delegator retains overall accountability for the nursing care of the patient, including nursing assessment, evaluation, and assuring documentation is completed.

(2) Under RCW 18.79.260 (3)(d)(iv), delegating nurses acting within the protocols of their delegation authority shall be immune from liability for any action performed in the course of their delegation duties.

[19] Acedo (2005).

(3) Under RCW 18.88A.230(1), nursing assistants following written delegation instructions from registered nurse delegators for delegated tasks shall be immune from liability.

(4) Complaints regarding delegation of nursing tasks may be reported to the aging and adult services administration of the department of social and health services or via a toll-free telephone number.

(5) All complaints related to nurse delegation shall be referred to the nursing care quality assurance commission.

(6) Under RCW 18.79.260 (3)(c), no person may coerce the registered nurse delegator into compromising patient safety by requiring the nurse to delegate if the registered nurse delegator determines it is inappropriate to do so. Registered nurse delegators shall not be subject to any employer reprisal or disciplinary action by the Washington nursing care quality assurance commission for refusing to delegate tasks or refusing to provide the required training for delegation if the nurse determines delegation may compromise patient safety.

(7) Under RCW 18.88A.230(2), nursing assistants shall not be subject to any employer reprisal or disciplinary action by the secretary for refusing to accept delegation of a nursing task based on patient safety issues.

Lessons Learned

Like Oregon, Washington made reform of the Nurse Practice Act and regulations a core part of the strategy to promote home and community-based care.[20] Unlike any other state, Washington's incremental policy changes have been the focus on statewide research.

It is important to note that Washington's approach to nurse delegation differs from that of Oregon. Only those workers who are already registered and certified to be nursing assistants—and undergo additional training in delegation—can perform delegated tasks. For 20 years, Oregon has permitted delegation to "lay caregivers" or workers who are not already certified as nursing assistants.

It is also crucial to distinguish between nurse delegation and consumer direction. In Washington, consumers who can direct their own "independent providers" can direct them to administer medications and perform all other care tasks needed to maintain daily living in the community. Nurse delegation is reserved for those who do not wish to direct their own attendants, or for those living in congregate settings, such as assisted living.

[20] Reed (2005).

Conclusion

For more than a decade, Washington has been a model for states that want to promote community living for people of all ages and disabilities. Consumer and policy makers 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. Washington offers one research-based model. Subsequent *State Policy in Practice* Briefs will feature other state models.

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