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Meeting Summary

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Invitational Forum:
Advancing Consumer Choice
Through Better Understanding of
Nurse Delegation

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Invitational Forum: Advancing Consumer Choice Through Better Understanding of Nurse Delegation

Meeting Summary

**Susan Reinhard
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Summary

The Nurse Delegation Invitational Forum, convened by Rutgers Center for State Health Policy (CSHP), was held May 31 through June 2, 2006 in Portland, Oregon. It brought together 28 participants from seven states to discuss the involvement of unlicensed assistive personnel (UAP) in the provision of health care tasks to long-term care consumers through nurse delegation and consumer direction. The Oregon long-term care system served as the forum centerpiece, with presentations by staff from state programs, the board of nursing, practicing nurses who delegate and visits to several sites in the Portland area. Other states also discussed recent policy changes and emerging issues in their states.

This forum is the latest in a series of research reports, State Policy in Practice briefs, and invitational summits sponsored by CSHP to describe and analyze policy options for nurse delegation.¹ Please refer to these reports for technical definitions of nurse delegation. This invitational forum and its summary build on this foundational work to advance dialogue and policy development.

This meeting summary describes the meeting objectives and participants' goals, provides an overview of the presentations made at the meeting, and concludes with a summary of the themes that emerged from meeting discussions. The appendix contains the handouts and presentations from the forum. Below are the major points that emerged from the meeting.

Major Points

- Practicing nurses in Oregon contend that nursing delegation helps to keep long-term care consumers out of emergency rooms and nursing homes.

¹ The first was: Reinhard, S.C. (2001). *Consumer Directed Care and Nurse Practice Acts*. New Brunswick, NJ: Rutgers CSHP. Available at: <http://www.cshp.rutgers.edu/PDF/consdirmurspract.PDF> . For others, see the section on CSHP Publications of Interest on page 25.

- Research in Washington finds that delegation has expanded rather than contracted the nurse's role, and that nurses use their judgment to decline to delegate if the assistant is not capable of performing the task.²
- The consumer perspective, in addition to that of occupational and industry groups, should be central to the design of regulations.
- Federal law requires that consumers of long-term care services have the opportunity to live in the most integrated community setting possible. Where nurse practice regulations are restrictive, consumers may face the choice of unwanted institutionalization or receiving unlicensed/unregulated services in the community. Regulatory agencies struggle to balance consumer choice with safety.
- Regulators must think carefully about what they are responsible for regulating and what they can reasonably regulate, and not step over those bounds. Having a defined philosophy or mission can help guide this process.
- Regulatory agencies must cooperate with one another when designing and interpreting rules.
- When deciding how to create and define roles or regulations, all stakeholders should be involved in the discussion.
- It is important to take the time to define terms in stakeholder discussions, to make sure that people are all on the same page.
- Sometimes interpretation of regulations, rather than the regulations themselves, are creating a perceived barrier.
- It is important to define the roles of all involved when licensed nurses are working with unlicensed assistive personnel.
- Education and professional support are necessary for licensed nurses who delegate, and should be improved.
- Research can be used to measure outcomes and evaluate policy.

Learning Across the States

To foster learning across the states with respect to nurse delegation, CSHP invited the participation of leaders involved in the regulation of the nursing profession or of health care

² Sikma, S., Young, H. (2001). Balancing freedom with risks: the experience of nursing task delegation in community-based residential care settings. *Nursing Outlook*, 49:193-201. Also stated by conference participant (see quote from P. Black on page 9).

settings from seven states: Arkansas, New Jersey, North Carolina, North Dakota, Ohio, Oregon and Washington (see a list of attendees in Appendix A). The overall technical assistance goal of the event was to advance consumer choice through better understanding of nurse delegation.

The specific objectives of this technical assistance event were to:

- Summarize research findings on nurse delegation.
- Observe and discuss the Oregon model for community nursing (nurse delegation in home and community-based settings)
- Discuss other states' models, policy issues and future plans
- Participate in a free exchange of ideas about how to successfully implement nurse delegation in home and community-based settings. Planned topics included the following:
 - Training of nurses and unlicensed assistive personnel (UAP)—what is needed for nurses to feel safe/competent to delegate?
 - Consumer direction of UAP—policy options for states
 - Medication administration
 - Civil liability—how to structure laws and practice to keep nurses and UAP accountable without discouraging delegation where appropriate

Participants' Goals for the Forum

Prior to the forum, CSHP asked participants about what they would most like to take away from the conference. Their requests fell into the following categories:

- Defining delegation
 - Several states expressed an interest in comparing definitions and rules of delegation, including exploring the differences between delegation and teaching, delegation and consumer direction, and delegation and exemption.³ Some felt that more consistency in the use of terms and standards across the country would be an improvement.
- Nurse role—there were several elements, including desires to learn more about:
 - How to better educate nurses about delegation
 - How to provide ongoing professional support to nurses who are delegating
 - How to make sure that nurses are involved in client care, not just “doing” delegation or teaching for self-directed care and then moving on
 - Liability protection for delegating nurses

³ See Reinhard, S.C. & Quinn, W.V. (2004). *Consumer-Directed Care and States' Nurse Practice Policies*. New Brunswick, NJ: Rutgers CSHP. Available at: <http://www.cshp.rutgers.edu/cle/products/QuinnConsumerDirectedCare.pdf>

- UAP role
 - States were interested in hearing how other states dealt with UAP—for example, do nurses delegate to them, or are they assigned a role? Is their training standardized and codified, or more situational?
- Education/Training
 - Four states expressed an interest in improving education for nurses to increase nurses' comfort level with delegation. These states were interested in tools and models for teaching and reinforcing what was learned.
 - States were also interested in exploring training for UAP.
- Evaluation
 - Several states expressed an interest in discussing how to measure the safety/efficacy of delegation rules.
 - One state was interested in discussing others' experiences with piloting new programs before a full rollout.
- Medications
 - There is great demand for assistance with medications, and states were interested to explore how other states combined licensed nurses with unlicensed personnel to carry out this assistance.

Summary of Forum Presentations

The appendix contains the forum agenda and a participant list. Susan Reinhard and Heather Young previewed research results of their study of medication administration by unlicensed personnel in assisted living (see presentation in Appendix). Their main finding was that errors made by UAP were lower than those made by licensed nurses in hospitals and comparable to the error rate in nursing homes.⁴

Participants discussed how nurse delegation and consumer direction work in their states (see Appendix for summaries from each state).

Oregon participants gave several presentations on the development of nurse delegation and consumer direction, and discussed how these practices are currently carried out in Oregon (see Appendix for copies of presentations). Cindy Hannum, who directs the state's Office of Licensing and Quality of Care in the Department of Human Services, discussed the history and vision behind Oregon's development of community-based care, how it was implemented, and how the state's nurse delegation policy was an essential part of this vision.

A vision of community-based care

Beginning in 1981, Oregon began to move toward a model of community-based long-term care. This was influenced by consumer preferences as well as cost considerations.

⁴ The majority of errors were found in administering medications more than two hours late.

- Putting the consumer first, and the role of advocates: *“I can remember... that we had advocates and consumers at the table at the Oregon legislature and literally one or two pounding the table to say “We have a right to live at home! We have a right! How dare you force us into nursing homes?” and that still holds today. If you look at consumers as the focus, if you look at yourself as a consumer, if you look at your parents as a consumer, what is your right, and your right should be able to live where you want to live. Long-term care is not about treatment and diagnosis, it is about the 24 hour day and where you want to live, and how we bring those services to support that.”*⁵
- Cost considerations: *“... all states struggle with ... how to use public dollars in the most efficient and meaningful way, and Oregon has had some very rough financial times But there was also a focus not just on public dollars but private pay people. We have an obligation, all of us who work in public policy, to think about people who have to buy these things themselves, and where are they going to get the money? So, we had a mission to try to keep the cost down for everybody.”*⁶

Implementing community-based care

- The importance of leadership: *“We ... had a sterling leader. Those of you who work in long-term care nationally know the name of Dick Ladd... I like to refer to him as our General Patton because he had very strong focus, mobilization ... that’s what you need. That’s how public policy changes ... you have champions, you have vision, and you work together to make it so.”*⁷
- Collaboration with local governments, agencies and provider organizations: *“we used Area Agencies on Aging heavily in the state to serve as a resource point to help case manage if Medicaid ... was involved. We created through legislative action a single state agency to administer Medicaid long-term care, Older Americans Act and OPI [Oregon Project Independence] programs ... (a state general fund supported program, no federal dollars for persons aged 60 and over for a little bit of home care help. ... for those people who need some help who can’t really afford to buy it completely by themselves but are not Medicaid eligible). We were very much into partnership with local government. Oregon is a grassroots state, and the local focus is very important, and we also emphasized development of community-based care programs.”*⁸
- Supporting consumer-directed care: *“From the very beginning, we assumed that we were going to pay for informal caregivers to help people in their home—we were going to pay neighbors. We would pay family members, we would pay anybody who was interested in doing it [providing services] that the client wanted to have, as long as they were minimally capable of doing it. We never did put a lot of constraints on this—never.*

⁵ C. Hannum, 6/1/06.

⁶ C. Hannum, 6/1/06.

⁷ C. Hannum, 6/1/06.

⁸ C. Hannum, 6/1/06.

...Oregon was as far out on this as you could possibly get. It was an assumption that ... [it] was the client's right, and as long as we could make sure that the care was adequate, fine. We did require criminal record checks. For those situations where we felt guidance was needed, we would use our contract nursing program ... but there was never any question from day one that they could do this—there was never any question from day one that they could administer meds. It was never thought otherwise.”⁹

- Developing capacity: *“It’s not enough in public policy to allow it to happen, if you want it to happen you have to create it as well, and that’s part of the challenge.... We ... worked hand in hand with the private provider community and encouraged them to develop models that we thought would be good.”¹⁰*

With adult foster homes, *“Oregon made a conscious effort within the state Medicaid, the state agency, to encourage the development of these, and I vividly remember ... I would say to Dick¹¹ ...we keep licensing and developing these foster homes, and then they only take privates—that’s not helping our Medicaid clients. And he’d say, ‘Let them do it. You’re doing a good job. It’s good public policy to develop these, and eventually you’ll get more capacity for Medicaid eligible people, but we’re not in the business to just develop for Medicaid.’”¹²* They now have a capacity of about 8,000 adult foster care slots, of which about one-third are taken by Medicaid clients.

- The necessity of case management: *“We do have a strong case management system. If you’re going to run a statewide Medicaid home and community-based care program, you need to have a case management system in place whether you use all state staff or area agencies, whether you have other partners in that effort, but there needs to be a way both for proper utilization and authorization but also monitoring for quality purposes”¹³*

Nurse delegation regulations in Oregon

Mary Amdall Thompson, past Program Executive for Professional Services for the Oregon Board of Nursing and current president of the Community Based Care Nurses Association, discussed the history of nurse delegation in Oregon. Marilyn Hudson, Nursing Practice Consultant with the Oregon Board of Nursing, discussed how the rules are implemented.

Delegation by physicians or nurses to unlicensed personnel in detention facilities, residential care and other facilities listed in the statute, was first allowed in 1979. Delegation of nursing tasks was first authorized in 1987 by the legislature, and the Board of Nursing developed regulations a little more than a year later. Of the initial set of regulations and the revisions that followed a few years later, Thompson says: *“the first rules ... really, nobody could find them, nobody could make any sense of them. So in 1992 they were moved to their own division. And, with this move came what I call a lot of warning labels. There were things in the initial rules*

⁹ C. Hannum, 6/1/06.

¹⁰ C. Hannum, 6/1/06.

¹¹ Dick Ladd, see discussion in text preceding footnote 7.

¹² C. Hannum, 6/1/06.

¹³ C. Hannum, 6/1/06.

*that said things like you'd better not delegate unless you've considered every other possible means to have this client get the care they need, and we're going to hold you strictly accountable for the fact that you delegated. Well, do you think nurses wanted to delegate? No, they were afraid of delegating. But that was I think a way of the board saying we take this delegation thing very seriously and you better too."*¹⁴ Thompson noted that she was initially skeptical about delegation: *"when the delegation act was first passed in 1987, I said to myself, this is never going to work, and it took awhile to convince me. I'm surprised how well it does work, actually."*¹⁵

The rules were revised again in 1998 to allow for some work with intravenous administration, and teaching for an anticipated emergency. They were revised and extensively restructured in 2004, lengthening the limit for periodic re-inspection of delegated tasks to 180 days (from 120, after an initial post-inspection delegation period of 60 days), and adding some additional intravenous tasks.¹⁶

Thompson noted that a lot of cooperation between state agencies was necessary to make delegation work, and that there can be problems with delegation when nurses move from an acute care setting to a community-based setting and do not understand the process. These points were a major point of discussion and will be elaborated on below.

With respect to implementing the rules, Marilyn Hudson noted that the rules are useful for nurses because *"there is a very structured format that RNs use in providing delegation and ... it is very much spelled out so that it's really clear if you look at it, and read through it, what you can and can't do."* However, she also notes: *"With that said, I think that in the general nursing population, it's hard for someone to just pick up these rules, read through it and go apply them."* In other words, the rules are a good reference for someone who has already been educated about delegation and how the rules are interpreted by the board. *"[A] lesson learned,"* she says, *"is really figuring out from the start a better mechanism to educate nurses on delegation and what it really means."*¹⁷

In addition to education, Hudson also noted that it would be useful to have measurements for safety and efficacy to evaluate rules from their inception: *"it's important to define and establish mechanisms to ensure safety, efficacy of the rules ... it's helpful to have outcome measures in place ... from the start of rule adoption."*¹⁸ The Oregon Board of Nursing is still in dialogue with other stakeholders regarding defining outcomes and gathering data on the delegation rules.

¹⁴ M. Thompson, 6/1/06.

¹⁵ M. Thompson, 6/1/06.

¹⁶ See the appendix summary regarding Oregon and the following for a more detailed discussion: Reinhard, S.C. & Quinn, W.V. (2004). *Oregon's Nurse Practice Policies for Home and Community Living*. New Brunswick, NJ: Rutgers CSHP. Available at: <http://www.cshp.rutgers.edu/cle/products/QuinnOregon.pdf>

¹⁷ M. Hudson, 6/1/06.

¹⁸ M. Hudson, 6/1/06.

Complexities of the community practice setting

Hudson also noted some particular complexities with the community-based setting, given the lack of nursing education for community-based settings and the fact that they are not health care settings.

Autonomous practice. For nurses going into community practice, she says *“I don’t think that the level of autonomy of practice that is really required is always understood, and so sometimes there are nurses who think it’s going to be an easy... thing, because...they don’t have to do everything they did in acute care, and they don’t really understand ... what it means to provide that level of oversight over a group of clients, and so you sometimes get folks who just don’t get what they’re getting themselves into—get in over their heads, or a new nurse who doesn’t realize that really this is really a role... that requires everything of you that you’ve collected over time as a nurse—pulling it all together and being able to assess, and seeing those nuances.”*¹⁹

Fewer resources to understand rules governing setting. *“In a hospital or other traditional health care setting, nurses have ... managers ... that can integrate all of the rules ... regarding how hospitals have to be run.... Well, when they’re in a community-based care setting ... not only your assisted livings and residential care ... but also schools ... corrections nurses and so forth, it becomes really important for that nurse to also understand the rules that govern those facilities.... I try to be very clear about ... what the board rules, what we have authority over, writing rules that govern nursing practice, but if they’re going to work in a community-based care practice setting they also must have an understanding of the rules that govern that practice, and it is their responsibility as a nurse who is in that role to be the empowered person to pull that all together and be the nursing authority ... that can be pulling together and integrating all of those rules that govern that practice so that nursing is practiced safely and successfully.”*²⁰

Lack of others’ understanding of the nurse’s role. *“The other thing ... in addition to lack of clarity within the nursing community ... is the lack of understanding about the role of the nurse in community-based care settings ...because it is not a traditional health care setting.... we probably need to find better mechanisms for providing education for [managers of community-based settings] so that there is a better understanding about how we can all mesh and ... what nursing has to offer.”*²¹

These items, together with fiscal pressures and without an assertive nurse, can mean that nurses are underutilized: *“I get the impression, not only amongst nurses but also amongst some of the folks that are in charge [of community practice settings], that nurses are there to do delegations. Nursing becomes kind of dumbed down ... to the person who can come in to do this particular task...and if a nurse isn’t very strong.... the richness that the RN can bring to community-based care ... is undervalued.”*²² This underscores the importance of professional support for nurses, a topic that was heavily discussed during the forum.

¹⁹ M. Hudson, 6/1/06.

²⁰ M. Hudson, 6/1/06.

²¹ M. Hudson, 6/1/06.

²² M. Hudson, 6/1/06.

Washington has found that delegation has expanded rather than contracted the nurse's role: "I would have to say that in Washington there have been no horror stories, and what has actually happened ... we have brought many more nurses in to care situations than were there before, especially in the in-home settings. So I would say that with nurse delegation we have much more safety and involvement of licensed personnel than we did before.... nurses ... became very comfortable with their role about making decisions and they make decisions that decline nurse delegation. If the caregiver is not able to perform certain tasks, they [nurses] are not reluctant to say this is inappropriate." ²³ This participant also felt that the role of nurses in managing and overseeing nurse delegation in Washington was key: "The nurse delegation program in Washington is managed by nurses. ... it's really improved the quality of in-home care, so we've seen the importance of having nurses manage those programs." ²⁴

Delegation in practice

Megan Hornby and Gretchen Koch-Thompson from the Office of Licensing and Quality of Care discussed Oregon's contract nurse program. Alison Pfeffer, a contract nurse, discussed the role she plays in long-term care. Linda Bifano, a Gerontological Nurse Specialist at an assisted living facility, discussed her role as a delegating nurse (a role she has largely designed).

Oregon has had a contract nurse service for about 12 years. The service involves registered nurses who work as independent contractors for the Oregon Department of Human Services, Seniors and People with Disabilities. Contract nurses work with consumers with long-term, chronic health care needs who are living in the community. These independent nurse contractors assess consumers, teach health care tasks to consumers and their caregivers, delegate tasks to caregivers in some cases, and monitor consumers' condition over time. The nurses work closely with case managers who coordinate services for consumers. The contract nurse role is more that of an educator, consultant and manager rather than as a direct provider of health care tasks. ²⁵ As the quotes below indicate, the program works well when nurses are able to adapt to this role. However, their nursing training does not adequately prepare them for the role, and they can feel isolated. Also, the state cannot pay for continuing nursing education for these contract nurses—they can only pay for services and for attending meetings relevant specifically to the contract program. The preparation and professional support for delegating nurses was a large topic of discussion at the forum and will be discussed in more detail below.

²³ P. Black, 6/1/06. For discussions of nurse delegation in Washington, see: Reinhard, S.C. & Young, H. (2006). *Washington's Nurse Practice Policies for Home and Community Living*. New Brunswick, NJ: Rutgers CSHP. Available at: <http://www.cshp.rutgers.edu/cle/Products/WashNursePracPolicyWEB.pdf> ; Sikma, S., Young, H. (2001). Balancing freedom with risks: the experience of nursing task delegation in community-based residential care settings. *Nursing Outlook*.49:193-201; Young H.M., Sikma S.K., Eyres S.J., et al. (1998). *Nurse Delegation Study Final Report*. Seattle, WA: University of Washington. Available at: <http://www.doh.wa.gov/hsqa/uwstudy.doc>

²⁴ P. Black, 6/1/06.

²⁵ See contract nurse policy in appendix (page 81) and Reinhard, S.C. & Quinn, W.V. (2004). *Oregon's Nurse Practice Policies for Home and Community Living*. New Brunswick, NJ: Rutgers CSHP. Available at: <http://www.cshp.rutgers.edu/cle/products/QuinnOregon.pdf>

Successes and Challenges of the Contract Nurse Program	
Success	Challenge
<p><i>“the caregivers and providers really like this consulting model. It’s dramatically increased the quality, safety, and... access ... to home and community-based care services. We can place much more acute clients in home and community-based care settings when we know we can add a nursing component to their package of services.”</i>²⁶</p>	<p><i>“we have had trouble keeping our RNs ... this is ... a very autonomous practice—these nurses are really out there on their own and often times they are working with case managers and area agencies on aging who, some of them ... are mistrustful of nurses. They ... need a lot of support and mentoring from experienced community nurses nursing training ... does not mesh well with consumer self-directed care”</i>²⁷</p>

The contract nurse perspective. Alison Pfeffer has worked as a contract nurse for about four years, and described the complexity of her role in terms of assessing not only clients themselves, but also their caregivers and the environment in which health care tasks are to be carried out. She notes, *“We need to be creative, we have limited resources and sometimes you have to make the best of what you have—I always joke that one of my best tools is my leatherman, I use that some days more than I do my stethoscope.”*²⁸ Prior to her move to contract nursing, Alison was an intensive care unit (ICU) nurse for 15 years. She noted that her move to community-based care nursing involved giving up some control over the environment of care, but says *“for me it was a relief. I liked giving up some of that control.”* She notes that most of the contract nurses have about 15 years of experience, in a variety of practice settings.

She describes her role as assessor, advocate, liason and coach on a client centered team: *“I do everything with a client centered approach ... it is paramount, the client is the leader of the team, and one of my biggest roles is to keep all the members of the team mindful of the client’s goals. We have... a ... saying ... that the client has the right to make poor choices. We have to repeat this over and over and over again sometimes and be mindful of it.”*²⁹

She describes her overall role: *“I help keep elderly and disabled [people] out of a nursing home. And I think about conversations I’ve had with these people over the years and that really is their biggest fear, is having to give up their independence and go into a facility.... one of the things that the contract registered nurses are most proud of is the fact that we keep people out of the emergency room.... And then also we help link members of the care team with those within the client’s social and community support network.”*³⁰

The consulting/delegating nurse perspective. Linda Bifano began her career as a hospital nurse in Michigan but moved to Oregon in 1982, where she became a community health nurse

²⁶ M. Hornby, 6/1/06.

²⁷ M. Hornby, 6/1/06.

²⁸ A. Pfeffer, 6/1/06.

²⁹ A. Pfeffer, 6/1/06.

³⁰ A. Pfeffer, 6/1/06.

and got involved with the nursing task force on nurse delegation issues. She has remained involved with nursing governance over time: *“I’ve ... been on every task force from a practice perspective, bringing practice issues to the task force ... I also was representative from the Oregon Nurses Association at one time to that task force [on delegation].... I’m also on the rule revision committee ... again, a nurse in practice, sort of representing nursing issues as we sit and negotiate the new rules that are now combining residential care and assisted living care.”*³¹

Bifano spent some time as an independent contractor to facilities and now has a role as a consulting nurse full-time in one assisted living facility. She described some challenges she faced as an independent contractor when facilities were reluctant to pay for enough time for her to do a proper assessment of both client and caregiver in order to determine whether delegation was appropriate. She summed it up as follows: *“administrators weren’t understanding that nurse delegation is not just a piece of paper.”*³² Bifano had to walk away from the job: *“I did inform the facility I can no longer consult unless you provide the following things so that I can delegate.”*³³ Bifano, a mandated reporter of unsafe conditions, had to report the facility for things she had observed. The facility reported Bifano to the Board of Nursing for refusal to delegate. The board supported Bifano’s right to refuse to delegate. Bifano’s experience provides a concrete illustration of the general concern outlined by Marilyn Hudson earlier, that in the complex community-based setting, the nurse’s expertise may be underutilized.

Her experiences as an independent contractor and her subsequent full-time consulting position at one facility led Bifano to see her role as a manager of systems: *“at that point I had collected some experience now in trying to do independent contracting and experiencing similar situations in several different facilities ... the hiring practices, who they’re hiring, how they’re training, who’s responsible for training, and I saw a systems issue.... I thought, well, why should I reinvent the wheel wherever I go as one single nurse, when I can’t do that? So, when I went to work full time for Rose Schnitzer Manor ... they wanted me to develop a training system ... I knew that I couldn’t do that alone, so we went out and got a grant, and developed a training program for a concept that ... does incorporate the unlicensed, noncertified personnel.”*³⁴

Bifano worked with the Oregon Department of Community Colleges and Workforce Development on the curriculum,³⁵ and has continued to work with them on another grant that will update the curriculum and provide certification for UAP who complete it.³⁶

While Bifano is a manager of systems, she is not a direct manager of personnel. Bifano describes how the administration of the facility sees her role: *“he explained that the nurse was not hired to provide direct nursing services, that the nurse is an advisor and a consultant and helps to train and oversee the procedures by which services are carried out on behalf of the resident.”*³⁷ Bifano does not hesitate to pull together outside resources to support nursing

³¹ L. Bifano, 6/1/06.

³² L. Bifano, 6/1/06.

³³ L. Bifano, 6/1/06.

³⁴ L. Bifano, 6/1/06.

³⁵ The curriculum is available at: http://www.workforcepartners.org/display_one.cfm?ID=194

³⁶ Email communication with L. Bifano, 8/22/06. Information about the latest grant can be found at: <http://www.rwjf.org/applications/solicited/cfp.jsp?ID=19526>

³⁷ L. Bifano, 6/1/06.

services: *“I use a lot of resources. I don’t look at my practice as I have to do everything.... I often will ask for referrals to home health agencies, for nurses to come out and help manage the care, in particular situations where I cannot provide enough oversight for the care of that individual—hospice is a good example of that, but also some wound care ... I don’t consider myself to be competent in every area of nursing practice, and in recognizing that, I ... say, I need some help here.”*³⁸

Meeting Outcome

Much of the forum consisted of discussion among participants. The following themes emerged from these discussions.

Putting the Consumer First

The consumer perspective emerged at many points in the discussion. One Board of Nursing director, discussing a consumer who is in dialogue with the board about nurse delegation issues in her state, said: *“It’s really given us a better understanding of the consumer perspective. We hear from the nurses all the time, we hear from the facilities, but we weren’t hearing from the actual consumer and I think that’s made a difference in terms of our perspectives.”*³⁹

Oregon’s philosophy revolves around putting the consumer first, as illustrated by quotations above from Cindy Hannum and Alison Pfeffer.⁴⁰ The Oregon Department of Human Services has had to do some education with its community-based care nurses regarding how to work collaboratively with clients in community settings: *“we’ve started to try to do some training ... about home care nursing and client-directed care. ... I remember one discussion with a nurse where we were talking about keeping their nursing notes available for the clients to read and they were horrified at that idea—that they would keep their record at the home of the client—“well, the client might read it.” Well, the client should read it. “Well, what if I’ve written about the client’s obesity?” Well, the client needs to know what you think about their obesity, and it came down to some of the documentation was not very professional, it was not very helpful, it was derogatory and it wasn’t supportive.”*⁴¹

Balancing Consumer Choice with Safety

Consumers generally want flexibility in terms of the choices they have to manage their health care (some are more willing to defer to outside opinions than others). How is it decided if a consumer has the capacity to make choices for himself or herself? Who decides what is an acceptable level of risk? What is defined as a bad outcome, and who is held responsible for it? If a nurse is involved with a consumer, what is the nurse’s responsibility to that consumer? These are the types of questions that consumers, health care providers and health care regulators struggle over. The following quote illustrates the philosophy of flexibility in Oregon’s system: *“we have consumers that aren’t the best at self-direction and we try to give them some support*

³⁸ L. Bifano, 6/1/06.

³⁹ C. Kalanek, 5/31/06.

⁴⁰ See notes 5, 9 and 29.

⁴¹ M. Hornby, 6/1/06.

*to help them. It isn't -- there's no magical line here. There's no, okay, you can do it all yourself, you're on your own, or no, we have to oversee it. It is a continuum and we use the case managers to make that judgment, but the goal is make it work. ... we have some very interesting home care situations, we have some very interesting providers, we have some things that you and I would probably not tolerate, but it's their lifestyle, it's their life, and they want their neighbor to do it so we're going to try and help the neighbor to do it."*⁴²

The third party between consumers and health care providers

It was noted several times in the forum that when consumers are paying privately, they have the freedom to contract for whatever services they want, and unless a complaint of practicing nursing without a license is brought, the Board of Nursing is unlikely to know about it. However, the market for health care services is influenced greatly by the practices of third party payers (generally public or private insurance). There was concern that if third party payers refuse to pay unlicensed personnel for health care tasks that could be delegated or directed by the consumer, the consumer might be forced to forgo needed care, or enter an institution to get the care they need. However, there was also concern that if Boards of Nursing were too liberal about what unlicensed personnel could do, it might lead to refusal by third parties to pay for nursing services, thereby undermining safety.

Board of Nursing Perspectives on Third-Party Involvement	
1—Lack of flexibility can hurt consumers when payers refuse to reimburse qualified unlicensed personnel	2—Too much regulatory flexibility can hurt consumers if payers use it to refuse nursing services
<i>"the issue arises when payments are reduced by a third party. Allowable services change, and consumers grapple with sorting out how to fill gaps in care. They question ... if this person could do this yesterday and they're not licensed and I know that Suzy can do this for my son, why can't she do that independently or why can't I pay, it's less than a nurse. So, those kinds of things really challenge consumers."</i> ⁴³	<i>" there was an agency that was denying skilled nursing care to clients because it could be delegated to an unlicensed person. So, we had to deal with that particular agency, that you cannot refuse ... they were basing it on our school nurse guidelines that we had developed. ... [denied services were for] people who wanted respite care--that they wouldn't pay for a nurse to come in and provide that service because it could be delegated to an unlicensed person, but they weren't looking at the whole picture and making sure the client met all the criteria and that there was someone who was trained and competent that could come in and do that."</i> ⁴⁴

⁴² C. Hannum, 6/1/06.

⁴³ J. George, 5/31/06.

⁴⁴ D. Jones, 5/31/06. A similar situation can be found in a declaratory ruling from 1999 by Iowa's Board of Nursing. See http://www.state.ia.us/nursing/pdf_files/declaratory_ruling_102.pdf

This underscores the importance of preserving a deciding role for licensed nurses in deciding what to delegate and when. There will probably always be some payers that look for an excuse to refuse payment for services, and the argument that a more highly paid nurse is not required could be one of them. However, it is not in anyone's ultimate interest, including the payer's, for the consumer to receive inadequate services.

Setting Regulatory Boundaries

Figuring out which institutions govern which settings or practices, as well as what can reasonably be regulated, presents an enormous challenge. In general, participants agreed that boards of nursing regulate the practice of nursing for licensed nurses, and that agencies that license facilities govern those settings. There is some overlap, given that licensed professions work in licensed settings, creating a need for cooperation (discussed below). Because of this need for cooperation, the boundaries become at times unclear. The number of regulated settings has grown quite a bit in recent years, as the box quote above indicates, which creates more need for regulations, boundaries and cooperation.

“Health care settings...used to be a hospital, and a nursing home, and a home health agency, and that’s what we licensed. I get a headache every day, because we’re licensing so many ... what I would not consider health care settings coming before us and saying we need a license because we need third party reimbursement ... the point is, this health care setting thing is really rubber bandish.” N. D’Angelo, 5/31/06.

Fundamentally, regulatory boundaries, as well as the regulations subsequently enacted, reflect allocations of responsibility. Understandably, professional groups such as nurses do not want to be held responsible for processes they do not control. This can lead to professional groups seeking to control the settings in which they practice. As settings become more community-based (up to and including private homes), this becomes more problematic. Americans are resistant to the idea of being told what they can do in their private home. In addition to professional groups, providers of services and/or payers of services (in any setting) generally require some ground rules to provide the predictability that a formal organization needs—to obtain a license, insurance, financing, and so on. Payers want assurance that providers will provide the service for which the payer is paying; providers want to know that they will be paid, and reasonable assurance that they will not be sued. Wherever licensed professional boundaries overlap imperfectly with licensed settings, and wherever formal organizations such as home health agencies operate within informal settings such as private homes, there will likely be some conflicts.

If the various parties can agree on a common vision or common values in order to set boundaries, this makes regulating cooperatively easier. Is consumer choice most important? Is safety most important? How will those things be defined and what happens if they are in conflict? This can help define the threshold of regulation, or the absolute level. From there, the relative levels (who regulates what) can be discussed.

Philosophical Regulatory Statements	
Lower Threshold—Bad outcomes will be apparent to all	Higher Threshold—Monitoring needed
<p><i>" When you talk about what we regulators know about what goes on in home settings where people are privately paid, we know very little ... there are probably very few bad outcomes, because when there's a bad outcome they're going to send a complaint or you're going to hear about it.it is a challenge for regulators to consider stepping back a bit and allowing consumers to direct care. It's also challenging for us to find ways to support nurses working with consumer choice in home health care, so we have a ways to go..."</i>⁴⁵</p>	<p><i>"[our state] is expanding its home and community-based options with a pilot ... [in a] region of our state ... [that is] very poor, people live very far apart... [and] can't find workers. So our ... program is allowing you to hire any member of your family except your spouse to provide the care you need. So who is supervising any of that, or who is delegating, or who is even monitoring to see what is happening? So, that is a concern for us ... started down there because of the lack of help, but we still have to provide some safety there."</i>⁴⁶</p>

Consumer Freedom to Select Worker	
Lower Threshold—The consumer may decide	Higher Threshold—The state has a responsibility to help consumers decide
<p>In response to a question about whether officials would know if a potential consumer-directed caregiver had a criminal background: <i>"we regulate the profession of nursing, we don't regulate home care, and so we had to get to a new mindset that we couldn't regulate it. We felt like we had in place the policies and the regulations that would allow consumers to direct their own care... when the disability community finally got us to see the light Helping ... guide us to the place that we're in-- to see that we can let that go, and the consumers can train and direct their own care."</i>⁴⁷</p>	<p><i>"it comes to those health maintenance workers, are we serving our mission of public safety with those health maintenance workers. This particular individual has two people now that have applied to be on the registry whose criminal background is very questionable. So, it will be a learning experience for all of us in the next six months while we're working with our current law ... to see if they can qualify to be a health maintenance worker—and the consumer believes they can."</i>⁴⁸</p>

Boards of nursing have differing rules on what is defined as the exclusive practice of nursing. Some rules define tasks, such as injections, as something that only a nurse may do.⁴⁹ One board executive director says: *"I can't imagine in my rules that there's anything that's absolutely sacred, and only a nurse may do, period. It's really difficult, if there's not a nursing framework in a setting, whether it's in the community, the home, the correctional system, if there*

⁴⁵ J. George, 6/1/06.

⁴⁶ M. Kearns, 5/31/06.

⁴⁷ F. Fields, 6/1/06.

⁴⁸ C. Kalanek, 6/1/06.

⁴⁹ Practice statement, 2001, available at:

http://mt.gov/dli/bsd/license/bsd_boards/nur_board/pdf/practice_statements.pdf (no one from this state was at the conference)

is not a nursing framework there, and there's not a licensed nurse there, then we as a board cannot tell those settings what they have to do.”⁵⁰

Regulation Through Cooperation

Participants generally agreed that regulators should involve one another in the regulatory development process, given the overlap of professionals licensed by one agency working in settings licensed by another agency:

“when there are rules being developed for, whether it's hospitals, long-term care, assisted living etc. ...we collaborate with them. I've sat on many of those task forces ... to assure that when those rules are put in place there's nothing ... that would place a ... licensed nurse in violation of his or her own practice act, nor any others, and I think you'd always find that across the board, that basically the agency

licensure requirements recognize that one's practice is consistent with their occupational licensure requirements.... We can't operate in isolation, we have to be sure that they fit but that no law puts a licensed individual in jeopardy of their own practice.”⁵¹

“Public policy ... is not the domain of the state agency—it's all of us working together—you have to work really hard at that, but I would suggest to you it is a responsibility, it is not an option, and that whether you're a Board of Nursing or you're the Medicaid agency, whether you're the long-term care regulatory agency, you have a responsibility to get everybody at the table and attempt to hold hands and move public policy forward, and that requires everyone to be practical and requires everyone to go back to the vision, and what is the vision? The vision has to have values of supporting the consumer where they want to live in a cost-effective manner.” C. Hannum 6/1/06.

At times there may be conflict, which requires a willingness to work through differences. The following is an exchange between Mary Amdall Thompson and Cindy Hannum regarding a difference they had in the past:

Mary: *“I think it's really important ... because we know that there will be philosophical differences, if you have the willingness and the ability to hammer those things out—to debate, to argue, to do all those things that have to happen, to come to some kind of negotiated settlement about whatever the issue is....Another discussion I remember we had was about PRN medications. Cindy said, well, a medication is a medication, so what's the big deal? I said well, PRN medications require nursing judgment to give them, and we had this discussion, it was sort of a mutual exchange and it worked out well for both of us but we had a pretty hot argument about that as I remember.”*

Cindy: *“You know, it's good to fight, it's healthy to fight.”*

Mary: *“Yes, it is.”*

As their experience shows, conflict will happen, but can be managed if all sides come into the process willing to negotiate. As the box quote above suggests, it is easier to manage conflict if

⁵⁰ P. Johnson, 6/1/06.

⁵¹ P. Johnson, 6/1/06.

the parties can return to a common vision or goal. At a minimum, it is usually possible to agree that all care deeply about the issue at hand.

Involving Stakeholders

Representatives of all stakeholder groups must be at the table before this cooperative process can be effective. A small, unrepresentative group of people may be able to agree more quickly and “get something done,” but that something will not ultimately be effective unless stakeholders go along. Unfortunately, involving stakeholders can result in a slow process. Several participants

“That curriculum was developed by the state and stakeholders, and it was a horribly laborious, miserable process, because everybody had their axe to grind, and we only had funding for—at the time, it was 26 hours and now it’s up to almost 29 [of training]. It took two years to develop the elements of the curriculum, but then the stakeholders did not trust the state, and rightly so, to develop a test, because we’re not experienced in doing this, so we contracted with a testing organization that developed the test, validated the test against the curriculum and now ... everybody is relatively happy” P. Black. 6/1/06

described it as a painful process, but a necessary one. Patience and flexibility are necessary. As one participant noted about a task force on an issue in her state, “We invited a number of people of people that we knew wanted to be involved and then every time we had a meeting we had additional people from different organizations—it was a growing group. Each time we got a bigger room ...”⁵²

Long-term collaboration

As the quote box above indicates, lack of trust, in addition to disagreements to work out, can be an issue. Long-term collaboration over time can help build trust and deal with issues as they arise: “you need to constantly work with your stakeholders, the providers, the nurses, the Board of Nursing, the long-term care agencies, because no matter how much you work on setting these things in stone, the next wave of perception comes along and you’re back up against the wall and trying to determine policy”⁵³

Defining terms for discussion

Several participants noted that often misunderstandings about what was being discussed led to unnecessary conflict, and suggested taking time to define common terms before proceeding.

“I can remember fights we got into ... that could have been totally avoided if we had taken the time to define what we think our terms mean” P. Black 6/1/06

At times terms can be controversial or trigger unintended reactions. In Oregon they realized discussions could be more productive if they created a new term that better reflected what they wanted to talk about, even though it meant moving away from the way things were framed at the national level: “[We] worked very hard to get the social-medical model language out of the equation because it’s too divisive and it’s too either- or, and the chronic care model

⁵² D. Jones, 5/31/06.

⁵³ M. Hornby, 6/1/06.

and the person-centered care model is a concept where everybody fits in and the focus is the client, and the client's health care conditions and what everybody's roles are to support that client's needs."⁵⁴

Interpreting Regulations

Several participants noted that in many cases it was not the regulations themselves but the way in which they were interpreted that led nurses or others to think that unlicensed persons could not do certain tasks or that nurses could not delegate. Participants suggested that nurses and others need education and guidance on how to interpret rules.

"My eyes were opened when we had a consumer knocking at our door saying your rules are a barrier to me getting the care that I need, where they were not, it was how they were being interpreted by the nurses themselves, so I think education is a big point." L. Emrich, 5/31/06.

Regulators struggle with how much detail to put into regulations. More detail can make processes clearer, but can also make future changes difficult. Where processes are vague, people may be afraid to act. For example, one state's chapter on delegation contains a sentence in its introductory section stating that nurses are "responsible for all nursing care that a client receives under their direction."⁵⁵ Some nurses have expressed concerns to the board about whether they are then liable for mistakes made by an unlicensed person to whom they have delegated a task. While cautioning nurses that they do not have control over civil liability, the Board of Nursing position is that nurses are accountable for *"Following the steps for delegating appropriately, and as long as they can provide us with evidence that ... it was appropriate for them to delegate the task to the person that they did, then the board of nursing does not hold them responsible for errors that the individual makes."*⁵⁶

Mary Amdall Thompson noted that nurses in Oregon were initially hesitant to delegate because of warnings that the board put in its regulations (see note 14 and surrounding text). This was despite statutory language that delegating nurses "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."⁵⁷

The director of education and practice for one state board of nursing noted that nurses may interpret the same regulations differently in different settings: *"In hospitals, it seems that nurses need to know when to pull back or restrict delegation when it's not appropriate. In contrast, in community settings nurses need the skill to know when delegation is appropriate, as it's not always as well-defined. Even though you have a decision tree to guide delegation, people... go back to those task lists of what nurse aides were taught and see those tasks as a "scope" of practice for the nurse aide....rather than seeing the task list as merely a framework of their education and understanding that nurses must determine how and when to delegate."*⁵⁸

⁵⁴ M. Horby, 6/1/06.

⁵⁵ See appendix, page 30.

⁵⁶ D. Jones, 6/1/06.

⁵⁷ ORS §678.036, available at: <http://www.oregon.gov/OSBN/pdfs/npa/ORS.pdf>

⁵⁸ J. George, 6/1/06.

Role Definition for Nurses, UAP and Consumers

What is the relationship of the nurse and the unlicensed assistive person (UAP)? Is the nurse teaching the UAP a task, or delegating a task to him or her?

Alternatively, is the UAP a certified assistant with his or her own “scope of practice?” Is the nurse in a supervisory role with the UAP? What is the role of the consumer? Is the consumer directing the UAP, or is the nurse directing the UAP? What responsibility does the nurse have for care provided by the UAP? What is the nurse’s responsibility, if any, for long-term monitoring? These are the kinds of questions that can arise.

“Biggest issues [for medication administration in assisted living] are lack of supervision of the aides and the noninvolvement of the registered nurse ... trying to educate the nurse what delegation is and how to do it, and when nurses come into the facilities and they see aides administering the meds, they sort of say, oh that’s their task, I don’t have to worry about it, not realizing that they really need to have strong supervision over that.” N. D’Angelo 6/1/06

It is important for everyone to understand his or her role as well as the roles of others involved. These roles can be defined in statute, rule, organizational procedure, or to some degree worked out among the participants themselves (particularly with consumer direction). However, licensed nurses will always be subject to professional regulation, and will need guidance from the Board of Nursing as to what is allowable for them. States such as Oregon and Washington that rely heavily on community-based care have fairly extensive rules regarding delegation processes, and have forms for nurses to use when delegating, as well as training for things like how to write parameters for unlicensed persons, with samples (see appendix for references).

If delegation is allowed but processes are not defined in some way, nurses may be reluctant to delegate. For example, most delegation rules require the nurse to verify the competency of the unlicensed person in some way. Even if the nurse is not liable for care provided by the unlicensed person, the nurse may wonder what would be considered adequate verification of competency. How would the nurse show that he or she had observed the unlicensed person performing the task if asked at a later time by an enforcement entity? Probably some type of written documentation would be best, but what should this include? Without some type of guidance from an authoritative source, the nurse may decide that the uncertainty is too great a risk.

“our rules ... for delegation—they’re just not well utilized, and the nursing community is questioning how much participation they can have. ... nurses are concerned about the delegation process, but they’re also concerned about the overall assessment process. Once they’ve delegated out that task, what is their responsibility two or three weeks down the way if that person’s status changes dramatically, where do they go from there and what is their liability once that status changes?” C. Kalanek, 5/31/06

Oregon draws a distinction between teaching and delegation in its rules.⁵⁹ Other participants agreed with this distinction, as shown by the following statement from a Board of

⁵⁹ See appendix or OAR 851-047-0010(7) and (23), available at <http://www.oregon.gov/OSBN/adminrules.shtml>.

Nursing executive from a different state: “[We need to] *try to get clearer on delegation versus teaching, particularly in self directed care, or even in a number of other settings ... I can teach someone to do something--I am not delegating that to them. ... I think that that’s another area that’s ... difficult to tease apart.*”⁶⁰

The consultative role for nurses

In many community-based settings, the nurse is more of a consultant or manager than a direct care worker.⁶¹ Participants generally agreed that nursing education does not prepare nurses for this type of role.⁶² Below is a quote describing a policy that the Oregon Department of Human Services, Seniors and People with Disabilities worked on together with the Board of Nursing to address some questions that nurses had about their role working with clients regarding self-administration of medication in the clients’ homes.⁶³ Critical to this model is that Oregon reimburses nurses for the consultative work they do in coordinating care for clients—and not just for their direct client work:

“The nurses ... were very worried about doing medication setups for people whose competency wasn’t clear and that their risk and their liability when they would do a med setup, do some teaching, walk out for two weeks and then come back and find that the pill box with—clearly the person hadn’t been taking the medications the way they were instructed. So, this was a policy that we developed and worked on with some core group of nurses and it’s been very successful. I think it really helped the nurses understand some of the critical issues.

We had to work with them to understand the difference between capacity, competency, and choice—that there were people who had capacity to make decisions, that was a very fluid thing—that capacity is your mental ability to ... make informed judgments, understand risk, understand consequences. Your choice is something that everybody’s got in terms of preferences and desires, and then competence, at least in Oregon, is a very legal term, as to whether or not you can make decisions for yourself. The vast majority of our clients are deemed competent—they don’t have guardians. They may have fluctuating capacity, good days, bad days, they may make poor choices or different choices, but they are legally competent.

So, it was a lot of work with nurses to understand that their role as a nurse was to teach people the risks and consequences of making decision such as not to take their pills every day, or to split pills when they shouldn’t be splitting them, and then if they were really concerned, to look at who else to pull into the case, who else to inform, that they could share the risk, in terms of risk management, we said to them, you don’t have to do this solo—if you are concerned that somebody is cutting their pills because they can’t afford medications, or they’re doubling up on pills because their short-term memory is so bad, you’ve got a case manager, you’ve got a physician, you’ve got protective service, you’ve got us at the state, you know, pull other people into this case if you’ve got concerns about the safety in this home. You’re not a solo agent here,

⁶⁰ P. Johnson, 5/31/06.

⁶¹ See discussion by Linda Bifano of her role on pages 10-12. See Reinhard, S.C. & Reinhard, T. (2006). Scanning the Field: Nursing Leadership in Long-Term Care (available at: http://www.futureofaging.org/PublicationFiles/Full_Report_Scanning_the_Field.pdf), for a recent summary of leadership/management training programs for nurses.

⁶² See text preceding note 27.

⁶³ See policy in appendix, page 83.

and I think that was a very important lesson for nurses to hear, that they are not the only guardian of safety out there in the world. And that if they documented that they had pulled in these other people, that they had shared their concerns, that that was what the board, that that was within their scope, that was adequate.

What we didn't want happening was people to say this situation is so unsafe I'm out of here, that we did feel that the nurse's role--it was very important that that nurse continue to come in and continue to advocate for that client. I wasn't sure that this policy would work, but it really helped an awful lot, and it actually—along with paying them for the care coordination, so that if they get on the phone and they start calling all—doing the old Dorothea Dix school of nursing where you are sort of nurse social worker, where they get on the phone, they start calling everybody they think they can think of to pull in and say, hey your daughter living in Ohio, your mom's really having some trouble here, I think you need to come out, we need to talk about her moving to a facility. You know, sometimes even doing that kind of social work is within their scope and we will pay them if they end up having to do that.”⁶⁴

Training for unlicensed assistive personnel

There were differing opinions expressed about the amount and type of training that should, in general, be required for unlicensed assistants. For some, the primary concern is maximizing flexibility for the consumer. Others have concerns that a concentration on costs (or profits) may create an incentive for organizations to push unlicensed people beyond their level of knowledge and ability. Both concerns are legitimate. The goal for everyone is to construct a system in which consumers have the flexibility to choose their services without compromising safety.

One approach is to require training for all caregivers before they can be reimbursed: *“Washington developed standardized caregiver training that's transferable between settings, so if you're a boarding home, assisted living, adult family home caregiver or in-home caregiver that core caregiving curriculum is the same. People are tested for competency, and they are all required to attend the same delegation training.”⁶⁵*

Not everyone is happy with standardized training—particularly consumers: *“when we were having our meetings with the stakeholders, one of the things that they did not want us to put into the rules was that they have to complete a specific course or a specific number of hours of course, and their thinking was that...if I don't need someone to put in a Foley catheter ... then why should I have to wait for someone to go through this 120 hour course or 75 hour course, to learn that. ...I will teach them exactly what I need them to be able to do, and I will make sure that they are competent to do that.”⁶⁶* This state has an exception in its Nurse Practice Act for consumer directed care. They require that a physician or nurse determine that the activity can be performed in a community setting, and that the unlicensed assistant demonstrate that he or she can perform the task. There is no required training.

⁶⁴ M Hornby, 6/1/06.

⁶⁵ P. Black, 6/1/06.

⁶⁶ D. Jones, 6/1/06.

The fundamental struggle and the ultimate question that must be answered was summed up very well by one participant: *“I think the struggle is philosophically what do we want these people to do. ... do we want them to be mini-nurses, or do we want them to take on simply the technical tasks. And I think that’s what we struggle with, in terms of how much training does somebody need. And nursing has been acculturated to medication administration meaning everything from the time the order is written, including deciding whether it was an appropriate order or not ... making what in some people’s minds might be a medical judgment, to the whole ball of wax—i.e., considering appropriateness of the drug for the specific client, preparing, administering, and monitoring the client’s response. It’s a really difficult thing for nurses to pull away from that mindset when being asked to train someone to perform the task of giving a pill to a client. So we do see really long training programs, but when you try to go out and ‘sell’ such a training package to a social model system ... they’re just not going to buy that.”*⁶⁷

Linda Bifano, who worked with training professionals to design a curriculum for unlicensed workers in assisted living facilities, suggests that a lot of work must go into identifying what the personnel need to know: *“what do you need to know about this client, what do you need to know about this task, what do you need to do in case something untoward happens, and how do you predict that, in an otherwise stable and predictable situation.”*

Education/Professional Support for Delegating Nurses

All participants agreed that nursing education currently does not do enough to prepare nurses for delegation in community-based practice. As discussed previously, nurses in community-based settings have to work very autonomously and are often managing systems, teaching, coaching and coordinating the work of others as opposed to performing direct health care tasks themselves.⁶⁸

Knowledge of content and interpretation of laws and rules

Most participants felt that in many cases nurses do not know what the rules are about delegation. Even if nurses are educated about the rules themselves, they may not be confident that their interpretation of what is safe to delegate will be shared by an enforcement body if something goes wrong, so they will likely need some guidance as to how the Board of Nursing will interpret rules. In other words, in addition to teaching nurses that delegation is a process, nurses will likely need some reassurance that they are carrying out that process correctly before they will feel comfortable doing it. One participant pointed out, and others agreed, that nursing training instills in nurses that *“you were responsible for everything that went bad ... and that you should anticipate anything that might go bad.”*⁶⁹ She went on to note that this attitude poses particular problems with respect to working with a long-term care population, because in many cases *“people will get worse no matter what you do.”*

“I think most all states struggle with ... the fact that nurses themselves really do not understand delegation. ... they’ll call and say ‘can I do this and can I do that’ and what they really need to understand is that delegation is a process and not a list of activities. ... that’s why all the algorithms, and we all have them... try to help folks with that.” P. Johnson 5/31/06

⁶⁷ P. Johnson, 6/1/06.

⁶⁸ See discussion on pages 8-12 and 20-21.

⁶⁹ M. Hornby, 6/1/06.

Self-confidence to supervise, coordinate, and refuse to delegate if necessary

Confidence and good judgment are required to delegate tasks and supervise others. One participant noted that national studies show that new nurses have difficulty taking on delegation.⁷⁰ Nursing education does not necessarily include training in management, leadership, or working in teams with non-medical personnel, so nurses may be unprepared to face these demands.⁷¹ As discussed earlier with Linda Bifano's story, nurses may have to stand up to pressure to delegate when they do not feel it is appropriate. Bifano has also volunteered to be a practice site for student nurses, but has found in the two rotations of students that have come through that, "*the clinical instructors don't understand the practice site—there's a shortage so ... you do the best you can. But ... when they show up they want to have shots to do ... it's still based on ... got to get experience with the task.*" This task-centered approach does not reflect what Bifano does as a consultative nurse, and does not allow her to impart to the students the work that she actually does.

Teaching skills

Nurses may need help to understand how to teach health care tasks to unlicensed personnel: Mary Amdall Thompson from Oregon notes, "*we've discovered that RNs need a lot of help in writing parameters because RNs think automatically about what they need to consider and they have to be able to reduce it in steps so that an unlicensed person can look at the steps or the conditions and say oh, this is what I have to do. I was talking to a group of hospice nurses—this is a couple of years ago, and they said, "PRN parameters, well, I would just write, give when there's pain" well, how much pain, where is the pain, how, you know, all those things need to be considered.*"⁷² The training that Washington state requires for all caregivers contains written procedures for several types of tasks, including the administration of eye, ear, nose, oral medications and enemas.⁷³

Access to colleagues

As several participants noted, community-based care nursing is a very autonomous practice (at least in Oregon) and nurses can feel isolated. Though there are national associations for gerontological and public health nurses, this doesn't necessarily fit for nurses doing community-based work with clients who have chronic health conditions. Nurses in Oregon have founded the Community Based Care Nurses Association to try and fill this void and create professional support for nurses in this type of practice setting.⁷⁴ The Department of Human Services has begun putting out a newsletter for those interested in community-based care

⁷⁰ P. Johnson 5/31/06 and 6/1/06, referring to practice analyses done by the National Council of State Boards of Nursing.

⁷¹ See Reinhard, S.C. & Reinhard, T. (2006). Scanning the Field: Nursing Leadership in Long-Term Care (available at: http://www.futureofaging.org/PublicationFiles/Full_Report_Scanning_the_Field.pdf), for a recent summary of leadership/management training programs for nurses.

⁷² M. Thompson, 6/1/06.

⁷³ See the instructions at <http://www.aasa.dshs.wa.gov/professional/nursedel/documents/ProceduresCOMM BASED CG.doc> and a link to the entire training at <http://www.aasa.dshs.wa.gov/professional/nursedel/TOC.htm>

⁷⁴ See web site: <http://www.cbcna.org>

nursing.⁷⁵ Several participants indicated that nursing education is beginning to recognize community-based practice as important to teach, but that there is still some resistance from some students and faculty in terms of seeing that as “real” nursing as compared with the hospital nursing model.

Research—Measuring Outcomes, Evaluating Policy

Most participants agreed that research on outcomes could inform policy. However, the question of how to define good versus bad outcomes was more difficult. A participant from Oregon suggested consumer satisfaction as an indicator of outcome: *“the measures may be satisfaction surveys from the clients themselves ... because usually, people—they may not know exactly how to describe what’s not right, but usually they know when they’re not happy with their care....the true bad outcomes—we’d eventually get that information, but what do you do with it ... because that can ... happen in a ... hospital system.”*⁷⁶

Other participants suggested measuring hospitalizations. Alison Pfeffer, the Oregon contract nurse, mentioned reduced emergency room visits as an outcome contract nurses are proud of achieving for their clients.⁷⁷

Regarding using hospitalization as an outcomes measure *“I think that’s a great idea but I just want to give another caution. If you’re a managed health care organization, and you have the wrong incentives, it might be a very good outcome for you to keep people in nursing homes because you know there’s nurses there and you’re going to avoid hospitalization. That is not a good outcome. That is a health care measure that has not a whit to do with quality of life. So ... I again challenge us to go back to the consumer. ... People get to decide, and risk is a part of living ... people are going to go to the hospital, you know, people get sick in the hospital”* C. Hannum 6/1/06.

Washington has implemented a quality assurance program for nurse delegation. When delegation was first implemented, there was a requirement that nurse delegation be rigorously evaluated to make sure there were no bad outcomes.⁷⁸ The current quality assurance program involves *“state employees who look at the work of delegating nurses and they look at all aspects of that—the documentation, quality of the documentation, and their decisions not to delegate or to delegate maybe in a situation where they shouldn’t have, and also to look at their paperwork kinds of things that they do so they are more accountable. That’s been very good—it’s helped the state develop training programs both for nurses and for caregivers.”*⁷⁹

⁷⁵ To be added to the email list for the newsletter, contact Gretchen Koch Thompson at Gretchen.L.Thompson@State.or.us

⁷⁶ D. Cateora, 6/1/06.

⁷⁷ See text preceding footnote 30.

⁷⁸ See Young H.M., Sikma S.K., Eyres S.J., et al. (1998). *Nurse Delegation Study Final Report*. Seattle, WA: University of Washington. Available at: <http://www.doh.wa.gov/hsqa/uwstudy.doc>

⁷⁹ P. Black, 6/1/06.

Conclusions

Participants indicated that they enjoyed the exchange of perspectives at the forum. Many found it thought-provoking and useful to be challenged to think differently about their conceptual framework for nurse delegation and consumer direction. The concrete information about what other states were doing in these areas was particularly helpful, since many participants were actively engaged in these policy discussions in their own states. For the future, they were interested in getting feedback as they drafted regulatory language, considered statutory reforms, or designed educational programs.

CSHP Publications of Interest

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Other Publications of Interest

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http://www.ncsbn.org/regulation/uap_delegation_documents.asp
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