Pennsylvania Developmental Disabilities Nurses' Network [PADDNN]

Guidance on Delegation

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INTRODUCTION

The framework of the developmental disability system in the Commonwealth of Pennsylvania is based on the philosophy of community integration of developmentally disabled individuals to the greatest extent possible. Central to that philosophy is that most adults are competent and that competent adults are able to manage their own healthcare needs and select their own healthcare providers. Because the population of developmentally disabled individuals has increased due to general improvements in healthcare, advances in neonatal technology, and increasing recognition of and care for genetic and congenital syndromes, greater numbers of individuals with intellectual/developmental disabilities [I/DD] are being challenged by the same problems of aging as the larger population.

Fiscal and human resources are struggling to meet the growing population and the increased needs of individuals with I/DD. A shortage of nurses throughout Pennsylvania also exists. Accordingly, care that was formerly within the exclusive aegis of the nursing professions is steadily being undertaken by nonlicensed staff, commonly known as unlicensed assistive personnel (UAP)/direct support professionals (DSP). Tasks formerly thought of as exclusive nursing activities, such as nutritional feedings by enteral tubes, for example, are being undertaken by UAP/DSP in growing numbers which is a concern to nurses practicing in the field of I/DD. To address this concern, the Pennsylvania Developmental Disabilities Nurses' Network [PADDNN] convened a committee to examine the issue of assumption by UAP's/DSP's of an increasingly dominant role in the healthcare of individuals with I/DD that impacts the varied roles of nurses [RN and LPNs] who care for the same individuals. The PADDNN and the Committee on Delegation recognize that the issue of nursing delegation as it applies to developmental disabilities nursing is a major concern of nurses in this field.

The Pennsylvania Department of Public Welfare (DPW), Office of Developmental Programs [ODP], provides for several different models of care for individuals with I/DD, which range from family care, supported living of adult individuals, small community homes [formerly known as community living arrangements or CLA], and intermediate care facilities [ICF-MR]. Care is also provided at day program settings. Through the DPW and ODP, each model of care setting is governed by regulation through licensing inspection instruments.

ODP regulation of community homes is through the "Licensing Inspection Instrument For Community Homes For Individuals With Mental Retardation Regulations Chapter 6400" [*6400 regulations*]. The 6400 Regulations are silent on the involvement of nurses with individuals who live in community homes. Only the ICF setting has a regulatory requirement [*Chapter 2400, 2900*] for the provision of nursing services. There is no requirement that a provider operator of community homes employ a nurse to help manage the care of residents in community homes. In fact, many providers of care in community homes under the 6400 Regulations throughout the Commonwealth of Pennsylvania do not employ any registered or licensed practical nurses, while a provider that operates both ICF and community homes/CLA settings may employ nurses to work in the ICF settings but not in the community homes/CLAs.

In large ICFs, where nurses are present for care management by State regulation, models of delegation may have been established where UAP/DSP are supervised by and accountable

to nurses with onsite presence. However, in small community homes (formerly CLA) settings, nurses may have a limited role, or may not be present if the provider has not chosen to employ a nurse. Where a nurse is absent or has minimal presence, a provider may manage healthcare needs of the individuals it supports with UAP/DSP. While the majority of developmentally disabled adults live in community home settings, placement of individuals does not depend solely on the complexity of individual healthcare needs. Relatively healthy adults may live in ICF-MRs; individuals with complex medical conditions may reside in community homes [*e.g. CLAs, Family Living, Life Sharing, and Support for Independent Living Programs*] where the healthcare of residents may be managed and/or provided by UAP/DSP. UAP/DSP working in community homes perform a wide variety of tasks and functions whether or not the provider employs a nurse.

Moreover, where nurses, both registered nurses [RNs] and licensed practical nurses [LPNs], are employed to work with individuals living in community homes/CLAs, the contractual arrangements and job descriptions for nurses may differ significantly from provider to provider. Hours worked may vary from a few hours a week to full-time with on-call responsibilities. Job duties may range from full management of individual care, including accompaniment to all medical appointments, to limited or no contact with individual residents. Because of the special circumstances of a nurse working in the various community home settings in Pennsylvania, where the role of the nurse is controlled by the provider, the relationship of the registered nurse, licensed practical nurse, and UAP/DSP generally lacks clarity and uniformity. The provider/employer generally controls the relationship of UAP/DSP and nurses, and therefore controls the element of accountability from UAP/DSP to the registered nurse.

Nursing is an outcome driven, knowledge-based, process discipline that is context dependent and requires critical thinking. Nursing cannot be reduced solely to a list of tasks. The RN's specialized education, professional judgment and discretion are essential for competent, quality nursing care.[*NCSBN, 1997*] Therefore, the delegation of nursing tasks to UAP/DSP must be designated to the RN because of the specialized skills, knowledge, critical thinking competencies and judgment required in the RN professional practice role.

Accordingly, any discussion of the rights and obligations attendant upon the I/DD nurse working in various I/DD settings must carefully distinguish between the meaning of the terms "assignment", "delegation", and "supervision". "Assignment" may mean the distribution of work to individual staff members during a given work period, a downward or lateral transfer of both the responsibility and accountability of an activity from one individual to another, or the designation of nonprofessional healthcare tasks to an unlicensed individual trained and competent to perform them. "Assignment" does not connote the employment of nursing judgment. "Supervision" is the provision of guidance by a qualified nurse for the accomplishment of an appropriately delegated nursing task or activity with initial direction of the task or activity and periodic inspection of the actual act of accomplishing the task or activity [*DDNA Position Statement on Delegation*]. A nurse may or may not supervise depending on the specific responsibilities assigned by his/her employer.

"Delegation" as a term of act within the context of nursing practice means that a nurse transfers authority for performance of a nursing task to a competent individual, while the nurse

retains accountability for the transfer. Delegation cannot be implied; it must be an intentional and deliberate act of judgment and assessment of the competency of the delegatee, the health status of the individual to whom care is being provided, and the nature of the task to be delegated. The delegating registered nurse must be competent, adequately informed, and free of controlling influences. The retention of accountability requires that the registered nurse must have the opportunity to supervise and evaluate the delegated task and the condition of the individual cared for. It should be manifestly clear that in the circumstances when a registered nurse is employed in an I/DD setting, "delegation" cannot occur when the registered nurse has neither right or opportunity to assess the competency of the delegatee, or the ability to transfer authority beyond what the employer/provider may prescribe.

Neither the Pennsylvania Board of Nursing or the ODP have issued any guidance about the nursing delegation process in general, including its effect on registered or licensed practical nurses working in I/DD care settings in this State. Therefore, the Nursing Issues Committee of the Pennsylvania Developmental Disabilities Nurses' Network has identified the need to inform and educate all persons working in this field about the process of appropriate nursing delegation. The guidelines on the delegation of nursing presented in this document are based on recommendations of the National Council of State Boards of Nursing, the Developmental Disabilities Nurses Association, and the American Nurses Association. Delegation in Pennsylvania I/DD care settings include the following "residential" and "non-residential" programs:

Residential Programs:

- Personal Care Home Licensing (PCH) (*55 PA Code Ch. 2620*)
- Child Residential and Day Treatment Facilities (CRDTF) (*55 PA Code Ch. 3800*)
- Community Homes For Individuals with Mental Retardation (CH) (*55 PA Code Ch. 6400*)
- Family Living (FL) (*55 PA Code Ch. 6500*)
- Intermediate Care Facility for the Mentally Retarded (ICF/MR) (*55 PA Code Ch. 6600*)
- Support for Independent Living (*Not a licensed program*)

Non-residential Programs:

- Older Adult Daily Living Centers (OADLC) (*6 PA Code Ch. 11*)
- Adult Training Facilities (ATF) (55 PA Code Ch. 2380)
- Vocational Facilities (VOC) (55 PA Code Ch. 2390)
- Early Intervention – Center-based (EI) (*55 PA Code Ch. 4226*)
- Early Intervention – Home-based (EI) (*Not a licensed program*)
- Family Support Services (FSS) (55 PA Code Ch. 6350)

In order to provide safe, effective healthcare for individuals with I/DD, it is our recommendation that provider agencies in conjunction with nurses develop and implement consistent policies and procedures that actively support nurses' responsibilities, as defined in the Nurse Practice Acts and regulations of the Pennsylvania State Board of Nursing. These policies and procedures shall be cognizant of the distinction between registered nurses and licensed practical nurses. Until such time that these are developed only general guidance regarding delegation in I/DD settings can be promulgated by this committee, however, we provide the following resources in helping to understand the delegation process as it exists in the wider nursing community.

THE FIVE (5) RIGHTS OF DELEGATION

The Five (5) Rights of Delegation serve to clarify the critical elements of the nursing delegation decision-making process: right task, right circumstances, right person, right direction/communication, and right supervision/evaluation. The chief nursing officer/administrator, where one exists, is accountable for establishing a systematic nursing delegation process that ensures safe, effective, and appropriate execution of health-related care activities. Some questions to consider are:

- Which activities and/or tasks frequently occur in the daily care of the individual with I/DD or group of individuals with I/DD?
- Which activities and/or tasks do not require the UAP/DSP to exercise "nursing judgment"?
- Which activities and/or tasks do not require application of the nursing process?
- Which activities and/or tasks have predictable results and minimal risks?

For additional information regarding The Five (5) Rights of Delegation, please refer to Appendix VI.

RECOMMENDED BEST PRACTICES

Organizations/agencies that provide nursing and health-related care/services for individuals with I/DD should have both a working knowledge of as well as compliance with those regulations under which their residential programs operate.

Best practices would include:

- Developing and maintaining competency-based job descriptions for all licensed staff [*RNs & LPNs*] and all unlicensed direct care workers [*e.g. UAP, CNA, DSP*] in their employ.

- Designing nursing and health-related care/services delivery system(s) that meet the health care needs of all individuals with I/DD.

- Ensure the safety, health, welfare, dignity and rights of all individuals who are the recipients of I/DD nursing and health-related care/services.

- Evaluating the intensity and complexity of nursing and health-related care/service activities.

- Ensuring the provision of safe, appropriate and efficient staffing and resource utilization

- Conducting systematic evaluation of the appropriateness and effectiveness of agency health-related care and I/DD nursing care/services delivery systems.

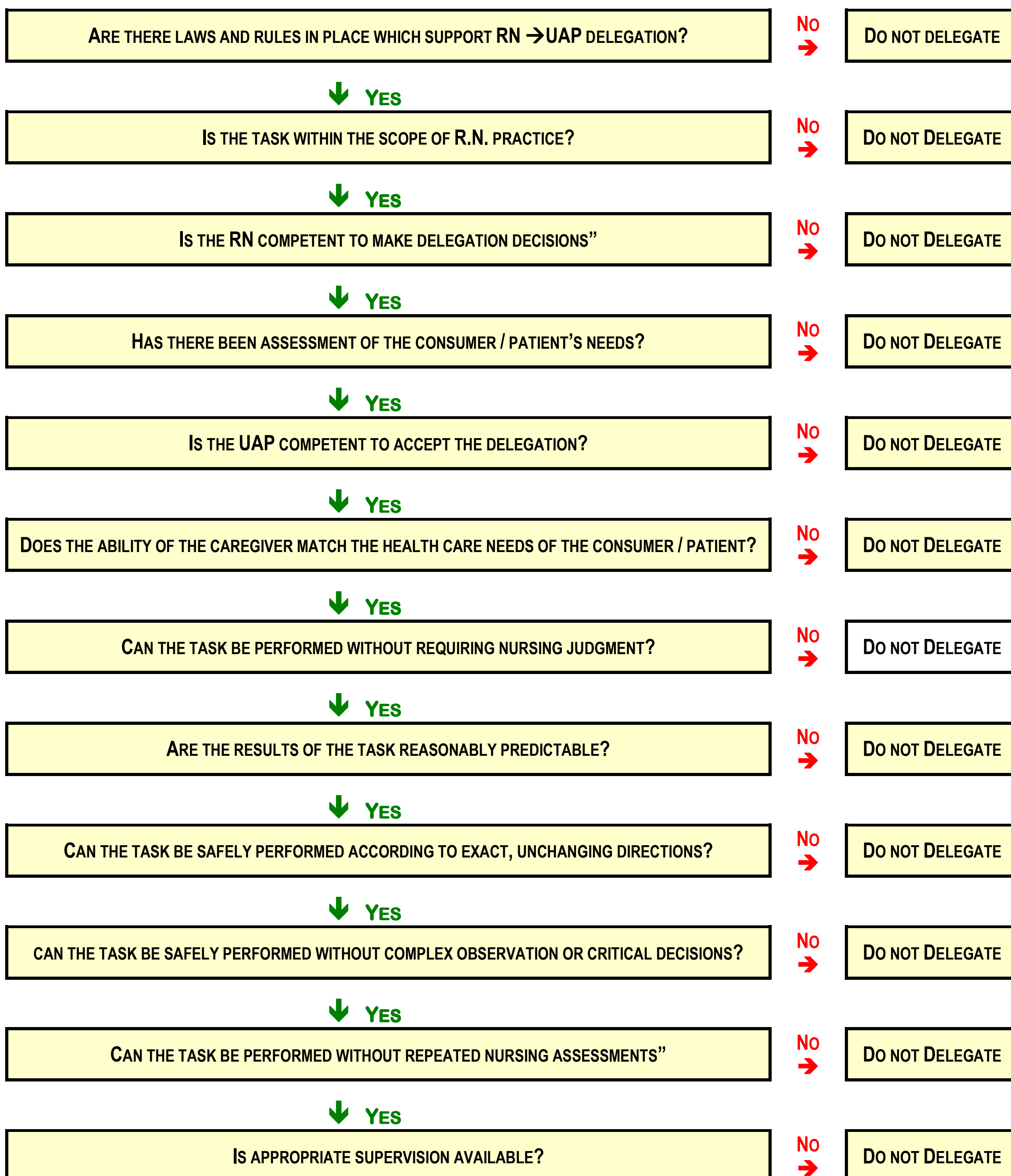
- Employing qualified individuals and validating entry-level competencies.

- Providing appropriate competency-based educational programs and training activities.

- Conducting ongoing competency-based evaluation of all agency health care staff and taking corrective action as needed.

Decision-Making Tree

A standard instrument frequently utilized for making delegation decisions is provided below:



APPENDIX I
DEFINITIONS AND TERMINOLOGY

- **Accountability**…………"being responsible and answerable for actions or inactions of self or others in the context of delegation". *Kelly-Heidenthal, P. & Marthaler, M.T. Delegation of Nursing Care, 2005, p.163.*

- **Active Treatment**……….is an aggressive and organized effort to assist each client attain their highest possible functional capacity through the development and implementation of an integrated and individually tailored program of services directed to achieve developmental objectives specified in measurable terms.

- **Assignment**………."The distribution of work that each staff member is responsible for during a given work period." *ANA Principles for Delegation, September 2005, p.4.*

  …………"The downward or lateral transfer of both the responsibility and accountability of an activity from one individual to another". *Hansten, R.I. & Jackson, M. Clinical Delegation Skills: A Handbook for Professional Practice, 3rd Ed., 2004, p. 163.*

  ………."Designation of nonprofessional health care tasks to an unlicensed individual trained and competent to perform them." *NYSNA & NYONE. "The Guidelines", 2nd Ed., 7/9/01, p. 4...*

- **Authority**……….The right to act or to command the action of others. *Hansten, R.I. & Jackson, M. Clinical Delegation Skills: A Handbook for Professional Practice, 3rd Ed., 2004, p. 163.*

- **Baseline Competency of Unlicensed Staff**………..Nursing Assistive Personnel [NAP] and Unlicensed Assistive Personnel [UAP] are presumed to have baseline competencies if they are certified as a Certified Nursing Assistant or Home Health Aide, or if documentation exists validating their competency for specific activities/tasks. Newly hired unlicensed staff, not holding board approved certification or documented competencies in specific skills, are presumed to have baseline competency only after satisfactory completion of a new employee orientation program and after validation of competencies identified in the UAP/NAP job description.

  Task-specific Competency……..unlicensed staff shall be considered competent only after written proof/documentation of satisfactory completion of training specific to the task being delegated is presented. Satisfactory completion of training must include demonstration of required skills as well as understanding of basic knowledge required to safely perform the delegated task.

- **Critical thinking**……….A rational reasoning process that involves applying knowledge, skills, attitudes and professional nursing values for the purpose of making a decision that affects patient care. Critical thinking uses clinical and professional judgment in each phase of the nursing process. *ANA Principles for Delegation, September 2005, p .4.*

- **Delegation**…………"Transferring to a competent individual authority to perform a selected nursing task in a selected situation". *Hansten, R.I. & Jackson, M. Clinical Delegation Skills: A Handbook for Professional Practice, 3rd Ed., 2004, p. 1.*

  ………."The transfer of responsibility for the performance of an activity from one individual to another while retaining accountability for the outcome". *Kelly-Heidenthal, P. & Marthaler, M.T. Delegation of Nursing Care, 2005, p.163 and ANA Principles for Delegation, September 2005, p. 7.*

- **Direct Support Professional (DSP)**………. person who assists an individual with an intellectual/developmental disability to lead a self-directed life, contribute to the community, be of assistance with healthcare requirements and ADLs as needed, and encourages attitudes and behaviors that enhance community inclusion. A DSP may provide supports to a person with a disability at home, work, school, church, and other community places. A DSP also acts as an advocate for the disabled individual, in communicating their needs, self expression and goals. They must possess the knowledge, skills, and abilities to provide consistent and high quality services to meet consumer needs.

- **Health-related activities** …………<u>are activities that are **NOT** within the legally protected scope of nursing practice</u> and can be assigned to unlicensed assistive personnel <u>who have demonstrated their competency</u>. Health-related activities may include, but are not limited to ADLs [*e.g. feeding, drinking, ambulating, turning, grooming, toileting, dressing*]; vital signs [*temperature, blood pressure, heart rate, respiratory rate*]; basic intake & output; oral suctioning and mouth care; nail, hair and skin care; external catheter care; one-on-one observation; and non-nursing functions [*e.g. transporting, cleaning, clerical work, answering the telephone*]. *NYSNA & NYONE. "The Guidelines", 2nd Ed., 7/9/01.*

- **Nursing assistive personnel [NAP]**……………."Individuals who are trained to function in an assistive role to the licensed registered nurse [RN] in providing patient care activities as delegated by the RN regardless of the title of the individual to whom nursing tasks are delegated. The term includes, but is not limited to nurses' aides, medication aides, orderlies, attendants, or technicians." *ANA Principles for Delegation, September 2005, p. 4.*

- **Nursing judgment**…………"The process by which nurses come to understand the problems, issues, or concerns of clients, to attend to salient information, and to respond to client problems in concerned and involved ways." *Kelly-Heidenthal, P. & Marthaler, M.T. Delegation of Nursing Care, 2005, p.164*

- **Nursing process**…………"The professional, systematic approach to ensuring complete care. The process consists of various steps including assessing, diagnosing, planning, implementing and evaluating the care provided." *ANA Principles for Delegation, September 2005, p. 4.*

- **Practical Nursing [LPN]**………….. "The **'Practice of Practical Nursing'** means the performance of selected nursing acts in the care of the ill, injured or infirm under the direction of a licensed professional nurse, a licensed physician or a licensed dentist which do not require the specialized skill, judgment and knowledge required in professional nursing." *The Practical Nurse Law (one amended Dec. 20, 1985, P.L.423, No.110), Commonwealth of Pennsylvania.*

- **Registered professional nurse [RN]**………… "The **'Practice of Professional Nursing'** means diagnosing and **'treating'** human responses to actual or potential health problems through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well-being, and executing medical regimens as prescribed by a licensed physician or dentist. The foregoing shall not be deemed to include acts of medical diagnosis or prescription of medical therapeutic or corrective measures, except as may be authorized by rules and regulations jointly promulgated by the State Board of Medicine and the Board, which rules and regulations shall be implemented by the Board." *The Professional Nursing Law (one amended Dec. 20, 1985, P.L.409, No.109), Commonwealth of Pennsylvania.*

  In addition, the RN has both legal and ethical obligations to society of rendering safe and competent care. Based on the ethical principles of respect, beneficence, fidelity, and justice, the RN is expected to abide by the ***ANA Code of Ethics for Nurses***.

- **Responsibility**………….”Obligations involved when one accepts an assignment." *Kelly-Heidenthal, P. & Marthaler, M.T. Delegation of Nursing Care, 2005, p.163*

- **Supervision**………the active process of directing, guiding, and influencing the outcome of an individual's performance of a task. Individuals engaging in supervision of patient care should **NOT** be construed to be managerial supervisors on behalf of the employer. *ANA Principles for Delegation, September 2005, p. 4.*

  ……Providing initial direction and periodic inspection of the task / activity through completion. *Hansten, R..I. & Jackson, M. Clinical Delegation Skills: A Handbook for Professional Practice, 3rd Ed., 2004, p. 7.*

  ……The provision of guidance or direction, evaluation and follow-up by the licensed professional nurse for accomplishment of a nursing task delegated to unlicensed personnel. *Hansten, R.I. & Jackson, M. Clinical Delegation Skills: A Handbook for Professional Practice, 3rd Ed., 2004, p. 7.*

- **Unlicensed assistive personnel [UAP]**………”individuals who are trained to function in an assistive role to the registered professional nurse [RN] in the provision of patient/client care activities as delegated by and under the supervision of the registered nurse." *ANA.*

  <u>In practice, a UAP may include</u>: certified nurses aide, clinical assistant, home health aide, nursing assistant, personal care assistant, orderlies, or attendants, certified phlebotomist. *The American Association of Nurse Attorneys [TAANA], Recommendations Regarding Unlicensed Assistive Personnel, 2004, pp. 1-2.*

APPENDIX II
PROFESSIONAL REFERENCES THAT GUIDE DELEGATION PRACTICE

The Pennsylvania State Board of Nursing [PASBN] and the American Nurses' Association [ANA] recognize that there is a clear distinction between the "practice of professional nursing" [RN] and the "practice of practical nursing" [LPN/LVN].

RNs are accountable to the public for providing culturally competent, safe and effective nursing care for patients in a variety of settings across the continuum of health care. *ANA Principles for Delegation, September 2005, p. 3.* Protection of the health, safety and welfare of the public/consumers must be the central focus of all decisions regarding the delegation of nursing tasks and functions to nursing assistive personnel. *NCSBN, 1997.*

The RN must assign or delegate nursing tasks/functions/activities based on the needs and condition of the consumer/patient, potential for harm, stability of the patient's condition, complexity of the task, the predictability of the outcome, and the availability of resources to meet those needs. *Nursing Scope and Standards of Practice, ANA, 2003 and NCSBN, 1997.*

The professional nursing [RN] functions of assessment, diagnosis, planning, evaluation and nursing judgment cannot be delegated. *NCSBN, 1997.* However, selected aspects of the "intervention" component of the "nursing process" may be delegated, but nursing supervision is required. RNs may solicit "input" from UAP/DSP regarding the assessment, planning, intervention and evaluation components, but not for the "diagnosis" component of the nursing process. *Nursing Scope and Standards of Practice, ANA, 2003 and ANA Principles for Delegation, September 2005, p. 14.*

Each organization must be accountable for and supportive of sound nursing task delegation [*i.e. care provided for the defined population is within the approved scope(s) of practice*] by providing the necessary and appropriate resources, including staffing levels and staff skill mix; policies, procedures and job descriptions; employee-focused staff development, training and continuing education programs; and lastly, creating a client-centered environment that insures sound, cost-sensitive, optimal utilization of all available resources while rewarding collaboration and team work. *ANA Principles for Delegation, September 2005, pp. 1, 5 and NYSNA & NYONE. "The Guidelines," 2nd Ed., 7/9/01.*

Each organization must be accountable for validating the competencies of all newly hired staff [*i.e. nurses and unlicensed assistive personnel*] during their orientation and through ongoing annual competency-based evaluation thereafter [*including corrective action for substandard performance*]. In addition, each organization must ensure that the RN has access to documented competency verification information for all unlicensed assistive personnel for whom the RN is responsible and accountable for delegating nursing tasks. *NCSBN, 1997 and ANA Principles for Delegation, September 2005, p. 7 and NYSNA & NYONE. "The Guidelines," 2nd Ed., 7/9/01.*

APPENDIX III
DEVELOPMENTAL DISABILITIES NURSES ASSOCIATION
POSITION STATEMENT ON DELEGATION

As developmental disabilities nurses we must work to ensure that adequate and sensitive services and flexible resources are, to the greatest extent possible,

- cost-effective
- least intrusive
- most normative
- provided by qualified, trained personnel
- meet individual needs and preferences.

The professional developmental disabilities nurse who provides care for the consumer determines if, when, what, and to whom to delegate tasks.

It is the purpose of unlicensed assistive personnel (UAPs) to enable the professional developmental disabilities nurse to provide nursing care for the consumer, and it is the nursing profession that defines and supervises the education, training, and utilization for any unlicensed assistant roles involved in providing delegated nursing tasks.

The professional developmental disabilities nurse must consider the following factors for any delegation decision:

State Nurse Practice Act and Other Applicable State/Agency Regulations

Since delegation is not defined by law or regulation in all states and is often defined differently in different states, professional nurses in each state must know the legal scope of nursing practice according to their own state's nurse practice act and any other regulations that are applicable. The differences among state nurse practice acts may be broken down according to the following questions:

- **Program Limitations** – Is nurse delegation limited to only certain programs providing home and community-based services or only institutional settings?
- **Personnel Limitations** – Who, by title, may be the delegate to whom authority to perform designated nursing tasks has been transferred?
- **Task Limitations** – Does the law identify: (a) specific tasks that can be delegated, (b) tasks that are permitted without delegation (i.e., assignment), and/or tasks that cannot be delegated at all?
- **Required Procedures for Delegation** – Are specific procedures or process standards included in the law or regulation?
- **Consumer Limitations** – Must consumers have the capacity to self-direct their care or are surrogates for consumers of impaired mental capacity permitted to oversee services?
- **Consumer Role** – What substantive or procedural rights of consumers are granted or specifically recognized? These rights could touch upon consent, or control over decisions, access to service, or rights to notice and information.
- **State Board's Position** – Has the state board responsible for nursing practice standards in your state issued a ruling or other similar recommendations regarding standards for

delegation of nursing tasks to UAPs?

Standards of Nursing Practice

As nurses with a specialized area of practice, we are professionally and ethically obligated to promote and support standards of practice in our specialty. These standards define our professional accountability to the public and the individual outcomes for which we are responsible. They also provide a direction and framework for the evaluation of our practice.

Capacity of the Consumer

Capacity does not equal competency. Most consumers are capable of at least some informed decisions; some consumers may be capable of directing their own care. This capacity may vary over time and may vary across different decisions. Therefore, except for those who are most profoundly impaired, the evaluation for capacity needs to be decision-specific.

Condition/Stability of the Consumer

The professional nurse should assess the consumer's condition/stability to determine what nursing procedures could safely be performed by UAPs. Tasks should not be delegated to a UAP when the consumer's condition can no longer be classified as chronic or stable and for whom the performance of the assigned task could not be termed routine. A UAP should be assigned only minimal health-related tasks for consumers with unstable health conditions.

Complexity of the Procedure

The professional nurse may delegate to unlicensed personnel selected nursing tasks that help implement the registered nurse's directed plan of care. These nursing tasks should not require the nursing process components of assessment, planning, and evaluation during implementation. Nursing procedures that require an understanding of nursing process or nursing assessment and judgment during implementation are licensed activities. Nursing activities of health counseling, teaching, case finding and referral may not be delegated. The nurse retains the responsibility for the total process and for its outcomes in all situations in which delegation has occurred.

Abilities of the Unlicensed Personnel

The UAPs should possess skill in core areas such as:

- basic reading, writing and communications skills;
- a basic understanding of consumers' rights, including confidentiality, the right to privacy, the right to refuse care and the right to be treated with dignity;
- culturally sensitive interpersonal communications;
- role clarification;
- principles of consumer safety, including infection control and standard precautions; and feel competent that they can perform the activities.

Amount and Type of Training Required

Teaching is an essential part of delegation. To effectively train UAPs, professional nurses should possess the knowledge and specialized skills needed to perform and teach specific nursing tasks; and, based on the education and experience of the UAPs, nurses should determine the amount and type of training required for each UAP to perform delegated nursing

tasks. Nurses need to be qualified to assess care plans, perform procedures, teach individuals form a variety of backgrounds and educational levels in a variety of environments, and consider the overall context of care. The education and training of UAPs to perform delegated nursing tasks may only be performed by a professional nurse.

Amount and Type of Supervision Required

Supervision is the provision of guidance by a qualified nurse for the accomplishment of a nursing task or activity with initial direction of the task or activity and periodic inspection of the actual act of accomplishing the task or activity. It is the responsibility of the professional involved to exercise his/her judgment as to the amount and type of supervision required depending on:

- the services to be performed;
- the skill and experience of the persons involved; and
- the individual consumer nursing diagnosis(es).

Documentation

For each task delegated, the professional nurse should document the following:

- the specific task that was delegated;
- the circumstances under which the task may be performed;
- the person(s) to whom and for whom the task was delegated;
- the appropriate direction and communication needed;
- the amount and type of supervision required; and
- the outcome of the delegated task.

Liability Issues

A violation of the scope of duty under a nurse practice act is not enough in itself to create liability. If no one is hurt, there is no liability. Or if someone is hurt, but it was a result of something other than the nurse's violation of duty, there is no liability.

To be liable for any injuries to consumers caused by the acts of a nurse-delegate, negligence would have to be proven. Negligence requires four elements generally:

1. the party allegedly at fault must have had a duty – an ascertainable standard of care;
2. the party must have breached that duty;
3. there must be an injury to another; and
4. the violation of duty must be the proximate cause of that injury.

If any one of these elements is missing, there is no liability. There may still be a lawsuit, because almost anyone can assert negligence in a personal injury suit, but it will not be successful unless all four elements are proven by a preponderance of evidence.

The nurse remains ultimately responsible for the care provided, but the scope of this responsibility should be made clear because being responsible for the task of delegation is not the same as being responsible for the actual performance of the delegated task.

APPENDIX IV
THE I/DD SELF-CARE DEFICIT MODEL

Orem's Self-Care Deficit Model has been modified and adapted to the I/DD specialty area in order to demonstrate the interface between the registered nurse [RN or DDRN] and persons who are intellectually impaired and developmentally disabled. The RN-to-person/consumer relationship is based, in part, on the extent to which the individual with I/DD is able to: [1] physically function independently, in the provision of their own nursing and health-related care, and [2] intellectually make sound choices and decisions with regard to his or her own nursing and/or health-related care.
Adaptation from NCSBN, 1998, p. 2.

The individual with I/DD's ability to: [1] make sound self-care decisions and choices, and [2] physically meet his or her own health care needs directly interfaces with the RN's role of encouraging person/consumer "choice," "self-determination," "independence," "collaboration" and "active participation" in the planning, provision and evaluation of all nursing and health-related care/services, including those aspects of care that are "delegated" to LPNs and UAP/DSP. The "I/DD Self-Care Deficit Model" serves to demonstrate and to guide an ongoing reciprocal relationship between the individual with I/DD [*their family, legal representative and/or advocate*] and the RN/DDRN, LPN and UAP/DSP.

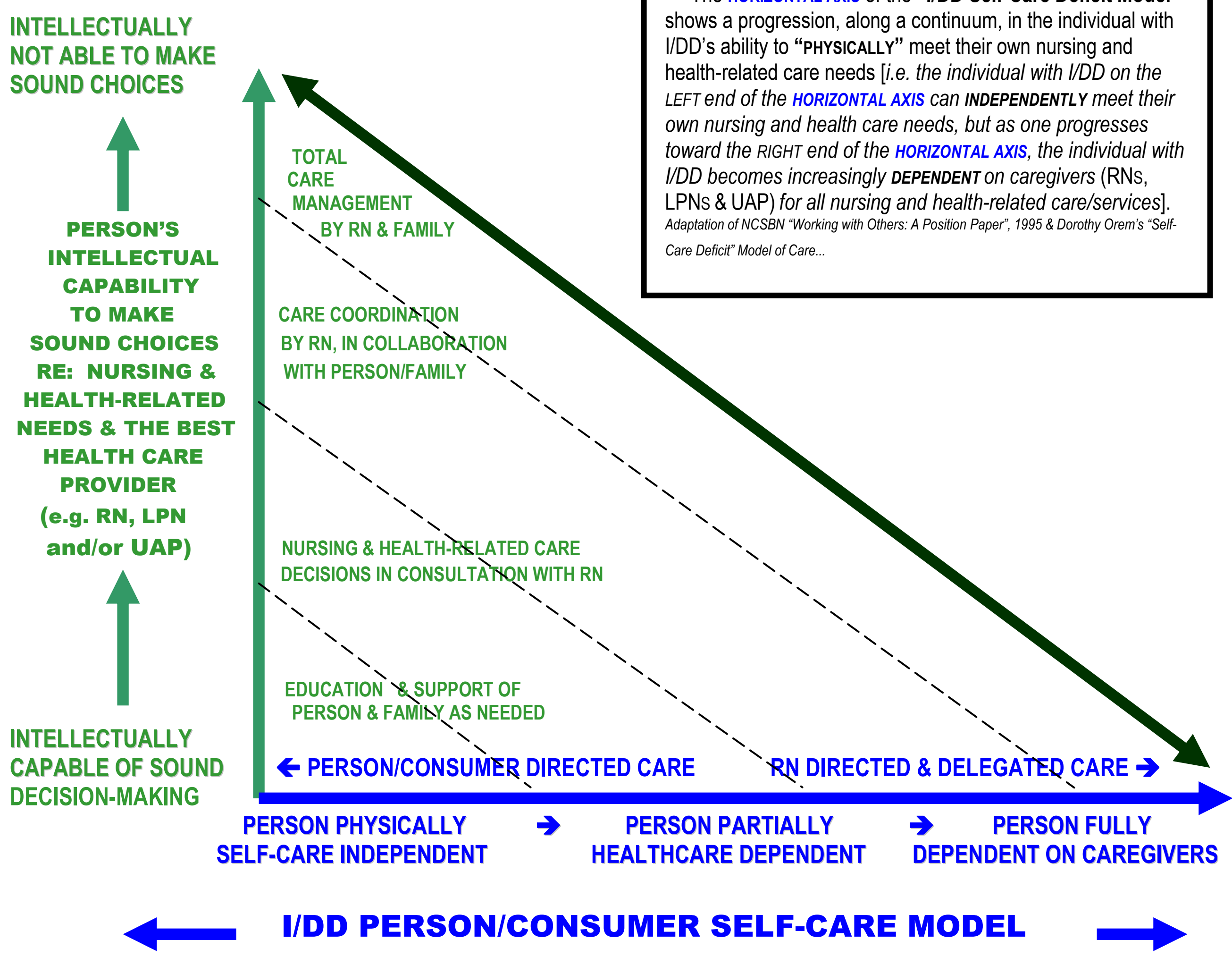
The "I/DD Self-Care Deficit" Model shows the interrelationships between the health status of individuals with I/DD along a continuum of developmental disabilities and the various roles of the professional nurse (DDRN) working in non-traditional residential and non-residential health care settings [*i.e. Child Residential and Day Treatment Facilities* (CRDTF), *Community Homes for Individuals with Mental Retardation* (CH), *Family Living* (FL), *Intermediate Care Facilities for the Mentally Retarded* (ICF/MR), *Adult Training Facilities* (ATF), *etc.*]
Based on Dorothy Orem's Self-Care Deficit Theory of Nursing, 1994.

Please see next page

The VERTICAL AXIS of the **"I/DD Self-Care Deficit Model"** shows a progression, along a continuum, in the individual with I/DD's ability to **"INTELLECTUALLY"** make sound choices and decisions with regard to their nursing and health-related care needs [*i.e. at the bottom of the VERTICAL AXIS, the individual with I/DD is fully capable of making sound choices and decisions, but at the top of the VERTICAL AXIS, the individual with I/DD is no longer able to make intellectually sound nursing and health care choices and decisions*].

The HORIZONTAL AXIS of the **"I/DD Self-Care Deficit Model"** shows a progression, along a continuum, in the individual with I/DD's ability to **"PHYSICALLY"** meet their own nursing and health-related care needs [*i.e. the individual with I/DD on the* LEFT *end of the HORIZONTAL AXIS can* **INDEPENDENTLY** *meet their own nursing and health care needs, but as one progresses toward the* RIGHT *end of the HORIZONTAL AXIS, the individual with I/DD becomes increasingly* **DEPENDENT** *on caregivers* (RNs, LPNs & UAP) *for all nursing and health-related care/services*].

Adaptation of NCSBN "Working with Others: A Position Paper", 1995 & Dorothy Orem's "Self-Care Deficit" Model of Care...



The "VERTICAL AXIS" of the **"I/DD Self-Care Deficit" Model** shows, along a continuum, the individual with I/DD's intellectual capability/competence to choose the appropriate level of nursing and/or health-related care / services needed as well as the most appropriate provider [*RN, LPN and/or UAP*] of needed nursing and/or health-related care/services. The relationship between the RN who has the knowledge and competencies needed to assess, plan, implement, coordinate, and evaluate nursing and health-related care needs/services of intellectually impaired and developmentally disabled persons and the individual with I/DD who needs nursing and/or health-related care, is guided by each individual's ability to choose the appropriate **"LEVEL"** [*i.e. knowledge and skill level of the provider of nursing and health-related care*], **"MIX"** [*i.e. the best "mix" of caregiver* ([RN, LPN and/or UAP) *competencies needed to insure safe, appropriate, yet efficient use of limited health care resources*], and **"INTENSITY"** [*i.e. the number of nursing and/or health-related care provider hours needed each day/week/month*] to safely, effectively, and efficiently meet the individual with I/DD's nursing and health-related care needs.

The **“VERTICAL AXIS”** continuum, beginning at the bottom of the axis, shows the individual with I/DD who is “competent” to make sound decisions regarding their own nursing and health-related care needs. As one moves from the bottom to the top of the vertical axis, the upward progression along the axis shows declining intellectual capability to make sound and appropriate choices and decisions by individuals with I/DD regarding their own nursing and health-related care requirements, and an increasing necessity for the person’s family/legal guardian and RN to participate in supporting and assisting the individual with I/DD to make the “best” decisions regarding their own nursing and/or health-related care needs [*i.e. supporting and assisting each person’s ability to choose and make **“competent”** decisions regarding “what,” “where,” “how,” by “whom,” and “when” their own nursing and/or health-related care requirements will be met*].

More specifically, the bottom of the **“VERTICAL AXIS”** shows the individual with I/DD who is independently **“competent”** to decide how their nursing and/or health-related care needs shall be met. Only consumer **“education and support”** in the provision of nursing and/or health-related care is needed at this point on the **“VERTICAL AXIS”.** As the individual with I/DD declines in their ability to intellectually make sound, independent choices—i.e. determine their own nursing and health-related care needs, there is an increased need for the individual with I/DD to **“consult with the RN”** regarding the assessment, planning, implementation, coordination, and evaluation of needed nursing and/or health-related care/services. When the individual with I/DD is no longer competent to make independent decisions, the family / legal guardian need to consult with an **“RN to assess, plan, manage, and evaluate all aspects of the person/consumer’s nursing and health-related care/services”.**

The **“HORIZONTAL AXIS”** continuum shows a progression in the individual with I/DD’s ability, from self-care [*i.e. for nursing and/or health-related care*] “independence” to an increasing “dependence” upon caregivers [*e.g. RNs, LPNs and/or UAP*] to meet their nursing and/or health-related care needs. Movement along the **HORIZONTAL AXIS**, from the left-to-the-right [**L→R**], shows a self-care continuum that progresses from **“TOTAL INDEPENDENCE”** to **“PARTIAL DEPENDENCE,”** then, **“TOTAL DEPENDENCE”** of the individual with I/DD upon caregivers [*e.g. RNs, LPNs and/or UAP*] to meet their physical nursing and/or health-related care needs.

APPENDIX V
THE I/DD CONTINUUM OF CARE FRAMEWORK

THE I/DD CONTINUUM OF CARE FRAMEWORK

[*An adaptation of NCSBN 1998 Model & Orem Self-Care Deficit Model, 1994*]

<table>
<tr><th>CONSUMER HEALTH STATUS</th><th colspan="2">INDEPENDENT</th><th colspan="2">PARTIALLY DEPENDENT</th><th>FULLY DEPENDENT</th></tr>
<tr><td>Health status of individual with I/DD addresses both physical functional abilities and cognitive capabilities of the person</td><td>Individual with I/DD with no identified health impairment or self-care deficit [i.e. individual can provide self care as well as initiate, accept and direct health-related interventions]</td><td>Individual with I/DD with identified health impairment or self-care deficit [i.e. individual can provide self care as well as initiate, accept and direct health-related interventions]</td><td>Individual with I/DD has a self-care deficit.

Assistance is needed in ADLs and/or health maintenance activities.

Individual maintains most self-care responsibilities</td><td>Individual with I/DD has a sufficient degree of self-care deficit that requires frequent monitoring & direct interventions by health care professionals.

Individual maintains some self-care responsibilities</td><td>Responsibility for care is transferred to the licensed professional nurse [RN] within a specific health care delivery system [e.g. PA MR/DD Service Delivery System]</td></tr>
<tr><td>PRIMARY ROLE OF THE PROFESSIONAL DEVELOPMENTAL DISABILITIES NURSE [RN] IN THE COMMONWEALTH OF PENNSYLVANIA</td><td><u>General Education & Support</u>:

To promote wellness, health maintenance, and disease prevention as requested by individual with I/DD or Legal Representative.

Support, maintain, and encourage individual with I/DD's independence, choice, & self-determination.

Individual with I/DD or Legal Representative initiates health care</td><td><u>Care Consultation</u>:

Related to health impairment, includes education & support to maintain maximum level of health, function, independence and choice.

Individual with I/DD or Legal Representative initiates health care & nursing care</td><td><u>Care Coordination—Health Care & Nursing Care Activities Include</u>:

• Consultation
• Needs assessment
• Teaching care provider to perform care activities
• Provision of education, support & other direct care
• Monitoring client health status
• Ongoing evaluation of care provision

Individual with I/DD or RN initiates & directs health care & nursing care</td><td><u>Care Coordination—Health Care & Nursing Care Activities includes all previous health care activities plus</u>:

• Directing nursing care
• Assignment of nursing care
• Care is provided by both licensed nurses [RNs & LPNs] and UAP [delegated health care activities

Nurse [RN] coordinates & directs health care & nursing care provided</td><td><u>Total Care Management</u>:

• RN provides direct nursing care
• RN directs nursing care provision
• RN assigns health care activities
• Delegation responsibilities within the health care system
• Care is provided by both licensed nurses [RNs & LPNs] and UAP [delegated health care activities]

Nurse [RN] directs health & nursing care provided</td></tr>
<tr><td>UNLICENSED ASSISTIVE PERSONNEL [UAP]/DIRECT SUPPORT PROFESSIONAL(DSP) ROLE</td><td colspan="2">May participate in individual requested and directed care.

Care activities are NOT delegated nursing activities.

UA/DSP is accountable to the Client/Resident</td><td>UAP/DSP may be directed by individual with I/DD and/or authorized to perform health care activities through the "nursing delegation process"

UAP accountable to individual and/or RN</td><td>UAP/DSP is authorized to perform health care activities through the "nursing delegation process"

UAP/DSP is accountable to the RN</td><td>UAP/DSP is authorized to perform health care activities through the "nursing delegation process"

UA/DSP is accountable to the RN</td></tr>
<tr><td>TYPES OF SETTINGS FOR CARE</td><td colspan="2">Independent Living, MR/DD Homes, Community Living Arrangement [CLA], ICF/MR Residential Facility, Schools, Vocational Training Programs</td><td colspan="2">Home, Community Living Arrangement [CLA], Assisted Living, ICF/MR Residential Facility, MH Residential Care Facility, MR/DD Homes, Schools, Vocational Training Programs</td><td>ICF/MR Residential Facilities, Long Term Care Facilities [LTC] , SNFs, CLAs, MR/DD Homes</td></tr>
</table>

APPENDIX VI

THIS APPLIES TO INSTITUTIONAL AND LARGE ICF-MR SETTINGS

AN OVERVIEW OF THE "PRINCIPLES THAT DELINEATE NURSING ACCOUNTABILITY: THE FIVE (5) RIGHTS OF DELEGATION"

American Nurses Association & National Council of State Boards of Nursing

RIGHT TASK	
CHIEF NURSING OFFICER/ADMINISTRATOR	**REGISTERED PROFESSIONAL STAFF NURSE [RN]**
Appropriate activities for consideration in delegation decisions are identified in the UAP job description/role delineation.	Appropriate delegation activities are identified for specific clients/patients/consumers
Organizational policies, procedures and standards describe expectations of and limits to delegated activities/tasks	Appropriate activities/tasks are identified for specific UAP.
RIGHT CIRCUMSTANCES	
CHIEF NURSING OFFICER/ADMINISTRATOR	**REGISTERED PROFESSIONAL STAFF NURSE [RN]**
Assess the health status of the client community/patient population, analyze the data and identify collective nursing care needs, priorities, and necessary resources	Assess the health status of individual clients/patients, analyze the data and identify client/patient specific goals and nursing care needs
Provide appropriate staffing and skill mix, identify clear lines of authority and reporting, and provide sufficient equipment and supplies to meet the collective nursing care needs	Match the complexity of the activity with the UAP competency and with the level of supervision available
Provide appropriate preparation/education/training in management techniques to deliver and delegate care	Provide for appropriate monitoring and guiding for the combination of client/patient, activity and personnel
RIGHT PERSON	
CHIEF NURSING OFFICER/ADMINISTRATOR	**REGISTERED PROFESSIONAL STAFF NURSE [RN]**
Establish organizational standards and competency-based job descriptions consistent with applicable law and rules which identify educational and training requirements and competency measurements of nurses [RNs & LPNs] and UAP	Instruct and/or assess, verify and identify the UAP's competency on an individual and client/patient specific basis
Incorporate competence standards into institutional policies; assess RN, LPN and UAP performance; perform competency-based evaluations based upon standards; and take steps to remedy failure to meet standards, including reporting nurses who fail to meet standards to the board of nursing	Implement facility/organization professional development activities based on assessed needs; assess UAP performance; perform evaluation of UAP based upon competency-based job descriptions/ standards; and take steps to remedy failure to meet standards

RIGHT DIRECTION / COMMUNICATION	
CHIEF NURSING OFFICER/ADMINISTRATOR	**REGISTERED PROFESSIONAL STAFF NURSE [RN]**
Communicate acceptable activities for delegation, UAP competencies and qualifications, and the supervision plan through a description of a nursing service delivery model, standards of care, job & role descriptions and policies and procedures	Communicate delegation decision on a client specific and UAP-specific basis. The detail and method [oral and/or written vary with the specific circumstances
	Situation specific communication includes: • Specific data to be collected and method and timeliness for reporting, • Specific activities to be performed and any client-specific instruction and limitation, and • The expected results or potential complication and time lines for communicating such information

RIGHT SUPERVISION / EVALUATION	
CHIEF NURSING OFFICER/ADMINISTRATOR	**REGISTERED PROFESSIONAL STAFF NURSE [RN]**
Assure adequate human resources, including sufficient time, to provide for sufficient supervision to assure that nursing care is adequate and meets the needs of the client/patient	**Supervise performance of specific nursing activities:** Supervision may be provided by the delegating RN or by other licensed nurses designated by the chief nursing office or the delegating nurse. The supervising nurse must know the expected method of supervision [*direct or indirect*], the competencies, & qualification of UAP, the nature of the activities that have been delegated, the stability of the client/patient condition and predictability of the client/patient expected outcome.
Identify the licensed nurses responsible to provide supervision by position, title, job description and role delineation	**Provide directions and clear expectations of how the health-related activity is to be performed**: • Monitor performance, • Obtain and provide feedback, • Intervene if necessary, and • Ensure proper documentation.
Evaluate outcomes of client community/patient population and use information to develop quality improvement activities and contribute to risk management plans	**Evaluate the entire delegation process:** • Evaluate the client/patient, and • Evaluate the performance of the health-related task/activity

APPENDIX VII

A DECISION-MAKING GRID TO BE USED WHERE RNS HAVE THE AUTHORITY TO DELEGATE

AACCN & National Council of State Boards of Nursing, 1997

- The "Delegation Decision-making Grid" was developed by the American Association of Critical Care Nurses as a tool to assist nurses in making sound delegation decisions.
- The tool provides a scoring system for seven (7) elements that should be considered when making delegation decisions.
- The tool builds on the assumption that the health-related activity/task being performed is within the RNs scope of practice and that the Nurse Practice Acts support RN delegation.
- The proposed delegation must be consistent with organizational/facility policy.
- When used in conjunction with the "Five Rights of Delegation" Table, the "Decision-making Grid" Provides a framework for assessing the client/patient's needs, the skills of the UAP, the skills of the delegating RN, the health-related activity/task, and the potential harm in delegating an activity/task.
- A LOW SCORE [e.g. 0-1] indicates that the activity/task could be safely delegated
- A HIGH SCORE [e.g. 3-4] cautions against delegation.
- Each organization/facility must establish a policy regarding the level of score deemed acceptable for delegation

DELEGATION DECISION-MAKING GRID

ELEMENTS FOR REVIEW	↓ PARAMENTS TO BE SCORED ↓	CLIENT A	CLIENT B	CLIENT C	CLIENT D
ACTIVITY/TASK	Describe health-related activity/task to be delegated:				
LEVEL OF CLIENT/ PATIENT STABILITY	SCORE THE CONSUMER / PATIENT'S LEVEL OF STABILITY: 0. Client condition is chronic / stable / predictable 1. Client condition has minimal potential for change 2. Client condition has moderate potential for change 3. Client condition is unstable / acute /strong potential for change				
LEVEL OF UAP COMPETENCE	SCORE THE UAP COMPETENCE IN COMPLETING DELEGATED NURSING CARE ACTIVITIES IN THE DEFINED CONSUMER / PATIENT POPULATION: 0. UAP is expert in activities to be delegated, in defined consumer/patient population 1. UAP is experienced in activities to be delegated, in defined patient population 2. UAP is experienced in activities but not in defined patient population 3. UAP is a novice in performing activities and in defined patient population				
LEVEL OF RN COMPETENCE	SCORE THE RN'S COMPETENC IN RELATION TO BOTH KNOWLEDGE OF PROVIDING NURSING CARE TO A DEFINED POPULATION AND COMPETENCE IN IMPLEMENTATION OF THE DELEGATION PROCESS: 0. Expert in the knowledge of nursing needs / activities of defined client / patient population and Expert in the delegation process 1. Either expert in knowledge of needs / activities of defined consumer/patient population and competent in delegation or experience in the needs / activities of defined client population and expert in the delegation process. 2. Experienced in the knowledge of needs / activities of defined consumer/patient population and competent in the delegation process. 3. Either experienced in the knowledge of needs / activities of defined consumer/patient population or competent in the delegation process 4. Novice in knowledge of defined population and novice in delegation.				

DELEGATION DECISION-MAKING GRID (*continued*)					
ELEMENTS FOR REVIEW	**➜ PARAMENTS TO BE SCORED ➜**	**CLIENT A**	**CLIENT B**	**CLIENT C**	**CLIENT D**
POTENTIAL FOR HARM	**SCORE THE POTENTIAL LEVEL OF RISK THE NURSING CARE ACTIVITY HAS FOR THE CONSUMER/ PATIENT [*i.e. risk is probability of suffering harm*]:** 0. None 1. Low 2. Medium 3. High				
FREQUENCY	**SCORE BASED ON HOW OFTEN THE UAP HAS PERFORMED THE SPECIFIC NURSING CARE ACTIVITY:** 0. Performed at least daily 1. Performed at least weekly 2. Performed at least monthly 3. Performed less than monthly 4. Never performed				
LEVEL OF DECISION-MAKING	**SCORE THE DECISION-MAKING NEEDED, RELATED TO THE SPECIFIC NURSING CARE ACITVITY, CONSUMER/PATIENT [*both cognitive and physical status*] AND CLIENT SITUATION:** 0. Does not require decision making 1. Minimal level of decision making 2. Moderate level of decision making 3. High level of decision making				
ABILITY FOR SELF-CARE	**SCORE THE CONSUMER / PATIENT'S LEVEL OF ASSISTANCE NEEDED FOR SELF-CARE ACTIVITIES:** 0. No assistance 1. Limited assistance 2. Extensive assistance 3. Total care or constant attendance or monitoring required				
TOTAL SCORE =					

ACKNOWLEDGEMENTS

It has been the goal of the Nursing Issues Committee of the Pennsylvania Developmental Disabilities Nurses' Network (PADDNN) to support developmental disabilities nurses as they strive to provide safe and effective care for individuals diagnosed with I/DD, while recognizing the many challenges faced daily in this specialized field of nursing. The following members of this committee contributed many hours to the creation of this document.

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