

**MBON – OHCQ Panel Discussion Summary
Spring 2013**

At each of the DDA Regional Quarterly Nurses Meetings in the Spring of 2013, pre-submitted questions were answered by A'lise Williams, Director of Nursing Practice at the MBON, and by Jennifer Baker, Director of the DD Unit at the OHCQ. The following is a summary of the presentations. This summary has been read and the content approved by both A'lise Williams and Jennifer Baker.

CNA CONCERNS:

1. **What happened to the proposal by the MBON to make it mandatory for all direct care staff/CMTs to be CNAs?**
 - a. The recommendation for all direct care staff/CMTs to be CNAs came from the CMT Sub-Committee. The recommendation was approved twice by the MBON. Subsequently, there was push back from the community – specifically the DDA community – and the MBON rescinded their approval of the recommendation.

2. **What are the specific criteria being used to determine if CNAs should be recommended to provide care?**
 - a. The unlicensed/non-CNA caregiver is appropriate to provide “assistance” with ADL care. Assistance with ADL care is just that – assistance. It does not mean performing the care for the individual.
 - b. The individual’s clinical status dictates the level of training the caregiver needs to provide safe care. The clinical status is determined by the RN CM/DN when the comprehensive assessment is performed. If the assessment indicates that the individual only needs assistance with ADLs and health tasks, then a UAP (unlicensed/non-CNA) may be appropriate. The RN CM/DN must determine if someone without training or with minimal training can meet the needs of the individual. If the individual needs the caregiver to perform those ADL and health tasks described in CNA duties for them, the RN then should consider the skill level and recommend the appropriate base of training required of the caregiver to perform functions needed by the individual.

3. **What is the difference between ADL assistance from unlicensed persons to those requiring care to be done for them? (e.g., CNA vs. UAP)**
 - a. Assistance is lending a “helping hand” to the individual and would be appropriate for the UAP role. When the caregiver must “do/complete” the ADL and health tasks for the individual, the appropriate caregiver would be the CNA.

4. **When a CNA is recommended/indicated:**
 - a. Where should this recommendation be documented?
 - i. Most importantly, it must be documented somewhere!

- ii. OHCQ expects to see the recommendation documented in the Nursing Assessment, IP and NCP. (COMAR 10.22.05.02 A & B) OHCQ expects the IP to reflect discussion by the team of the RN recommendation with a determination made as to the status of the recommendation. This could include providing the staffing immediately, determining interim measures to be done until the increased level of staffing is requested, funded, and hired, or a decision by the team that the increased level of care is not justified (with written discussion supporting this decision.
 - iii. MBON, per COMAR 10.27.11, expects the staffing training expectation to be determined after completion of the comprehensive nursing assessment performed by the RN/CM/DN.
- b. What is the time frame for implementation of the RN recommendation?
 - i. There is no rigid time frame for implementation but there must be a reasonable/ prudent plan by the agency to implement the staffing plan. There should be documentation in the nursing notes/assessments and the IP. The nurse should be requesting an interim IP, as necessary. An interim IP meeting should be held within no more than a month of the nurse's recommendation.
 - ii. The general "rule of thumb" would be to have the plan implemented within 3-6 months of the team decision. The individual's needs will determine the speed with which the RN recommendation and team decision should be implemented.
- c. If the individual is new to the agency, then the Service Funding Plan (SFP) should address the needs of the individual. OHCQ recommends that the RN CM/DN be involved in the development of the SFP so that health care needs are appropriately addressed.
- d. If an individual's needs change and care originally provided by an UAP is no longer appropriate and a CNA is now recommended by the RN CM/DN, then the RN must make a recommendation to the team. The nurse should request an interim IP, as necessary. As in a.ii. above, the team must discuss the recommendation and plan for implementation or indicate why the RN recommendation will not be pursued. The general "rule of thumb" would be to have the plan implemented within 3-6 months.
- e. Many individuals receive safe care from non-CNA staff. The caveat is that the RN CM/DN determines the skill set needed to provide the individual's care. The RN must compare the skill set of the trained CNA, with the skill set of the UAP. If through training, the UAP is assessed as competent to provide the care required, then the RN CM/DN may delegate that care to the UAP. If the RN assesses that the UAP is competent to perform the needed tasks and agrees to delegate those tasks, then the training and competency of the staff must be documented by the RN. Training curricula must be documented and easily retrievable. The training curricula must be developed or obtained by the RN. After providing initial training, the RN may identify and approve a LPN to provide the training and complete the initial competency checklist. Ongoing supervision is the responsibility of the RN.

- f. The CNA core clinical skill set is available on the MBON website. There are 25 skills. There are also examples of Skills Competency Checklists.
 - g. There was much emphasis placed on the fact that the CMT is only certified to administer medications, not to provide personal care. Personal care needs must be assessed by the RN and recommendations made to the team/agency for the appropriate level of training of staff.
5. **If the RN CM/DN recommends CNA staff and the team and agency disagree and do not put in place, what does the RN need to do to protect herself?**
- a. The RN CM/DN must train the current staff. The RN may allow the UAP to perform some personal care tasks with appropriate training. However, if staff are not competent then the RN CM/DN may not delegate to those specific staff. OHCQ looks at individual specific staff training documentation. Training curricula must be documented and easily retrievable.
 - i. There is role confusion in the DDA community. CMTs are hired under the assumption that they administer medications as well as provide personal care. This is not the case. The CMT is only trained and certified to administer oral and topical medications. The CNA is trained and certified in the skill set required to provide personal care. The regulations governing the practice of the CNA, CMT and CMA are found in COMAR 10.39.
 - ii. If disciplinary issues are reported to the MBON concerning a UAP (e.g., CMT, CMA, CNA), the RN CM/DN will be contacted by the MBON as part of the investigation.
 - iii. As the healthcare case manager, the RN CM/DN must look at cost effectiveness with the agency administration. Which is more fiscally responsible: to train UAPs in the skill set(s) needed or to hire CNAs?
 - iv. Note: The MBON regulates the certified/licensed caregiver; the OHCQ regulates facilities. The MBON and OHCQ recognize that the RN is not responsible to run the facility/agency. However, the RN is responsible to assess the needs of the individual and to make recommendations to the team for the level of caregiver needed. The RN must do the assessment and document recommendations with rationale.
 - b. Should/can the RN train on all skills needed and continue to make recommendations? What are the risks?
 - i. OHCQ looks at individual specific staff training documentation.
 - ii. OHCQ will look for the RN CM/DN's documentation of recommendations.
 - iii. The RN CM/DN is required to train and to continue to make recommendations.
 - iv. The RN cannot be forced to delegate to staff that s/he has determined not to be competent in the skill/task performance.

v. If the RN CM/DN cannot or will not delegate to certain staff either due to staff or task issues, this should be documented. If delegation is withdrawn, the RN CM/DN must notify the MBON

TRAINING CONCERNS:

1. **Can an agency develop a personal care training program? What is the difference between personal care training and CNA training? Who can train personal care attendants? Who governs personal care attendants?**
 - a. The MBON does **NOT** recognize a Personal Care Attendant. Personal Care Attendants are UAPs and hold no certificate from the MBON.
 - b. Personal Care Attendant courses were developed in arenas of practice when the needed skill set of the caregiver was more than the UAP but a CNA was not available to provide care.
 - c. Only RNs teach CNA courses. However, individual specific skills may be assigned to the LPN to teach once approved by the RN to do so.
 - d. Nurses delegate ADL care.

2. **Who can train on ADLs? Must it be an RN?**
 - a. ADLs are self-care tasks that include: bathing, toileting, dressing, eating (chewing and swallowing), feeding (food set up and self-feeding), functional mobility, and personal hygiene/grooming.
 - b. If ADL training is needed, the RN is responsible for ADL training and curriculum development. However, the LPN may be assigned to provide this training once they are approved by the RN.
 - c. Training of new staff by having them mentor with experienced staff is not appropriate training and cannot replace training by the RN CM/DN or approved LPN.
 - d. In case of an emergency, can the supervisor train new staff to cover the shift? Agencies must have plans in place to train new staff. COMAR 10.22.01.11 C states that staff must be trained in the care needs of the individual prior to being assigned independent duty. Emergencies related to training should be rare. The RN is responsible for health care related training.
 - e. When training on specific equipment is required (e.g., Hoyer lift), the company providing the equipment may provide training directly to staff and identify an agency trainer (can be someone other than the RN). Additionally, the RN can train and identify a trainer for adaptive equipment. PT or OT could also provide training.
 - f. Diet training can be done by the nurse, dietician, or nutritionist. RNs can teach texture diets based on DDA's Choking and Dysphagia Training program. Specific diets (e.g., 1800 cal ADA, 2 gm Na) must be developed and written by a dietician. Once developed by the trained specialist, the RN can teach the diet plan.

3. **How many ADL tasks can a nurse train on before it is considered teaching an “unsanctioned” CNA class?**
 - a. There is no clear answer to this question as it would be based on the RN’s judgment. However, consider the number of skills required to be taught, staff turnover, and designated training time. From a fiscal standpoint, at what point does it become fiscally irresponsible and/or too burdensome for the RN to provide training on each needed skill for each staff person?

4. **What type of training documentation is needed to prove that appropriate training has been done?**
 - a. Training documentation should verify, by the trainer, the course topic, staff taking the training and that each specific staff person has or has not successfully completed the course objectives and demonstrated competency in any skill/task, and the date on which the course completion occurred.
 - b. If using electronic documentation system, there must be controlled access.
 - c. Consider that the adaptive equipment company could provide training and identify a trainer(s) within the agency. The RN is not required to be the trainer on adaptive equipment.
 - d. In some circumstances (e.g., day program, CSLA, etc) medication administration is not required but ADL care is provided. Health care needs must be identified (consider using the HRST) and a NCP developed to direct ADL care. Since no medications are being administered, the RN would **not** have to perform 45 day supervisory visits but the RN would have to determine and document the frequency with which supervisory visits would be performed (e.g., every 90 days).
 - e. In a day program, if the individual is residing at home with family, can family train staff?
 - i. The RN must determine what training is needed, evaluate the complexity of the task to be taught and the risk involved in having the family provide the training. The decision would be up to the RN CM/DN.
 - f. When a new RN is hired, the RN must perform competency checks on all caregivers on all tasks being performed.
 - g. If staff need to be trained in transporting of individuals, there is no requirement that this is done by the RN.

5. **What about day programs where ADL care is being done and there is no delegating nurse, who is responsible for training?**
 - a. All programs must have a plan for screening participants for health care needs and providing the needed services/training. RNs are responsible for training staff and in delegating ADL care.
 - b. If a participant is living with family and attending a day program, the RN can look at the complexity of the task and the relative risk and make a determination if it is appropriate for the family to train.

- c. A new RN CM/DN must determine competency of staff performing medication administration and ADL care.
 - d. Many training curricula are available in Chapter 7 of the MTTP. If not found in Chapter 7, the RN must obtain or develop the needed curriculum.
 - e. If medication administration or treatments are being delegated, the RN must perform supervisory visits and assessments minimally every 45 day (10.27.11).
 - f. The frequency of RN supervision of ADL care is at the discretion of the RN but must be done more frequently than annually.
 - g. Documentation of staff training must be in the staff's personnel file.
 - h. RNs must perform their own assessments and competency checks.
- 6. How best can the CMT be trained to assist the individuals we serve (e.g., monitoring and reporting critical health issues dealing with a decline or elevated vital signs to the nurse)?**
- a. Utilize the NCP to determine the training needs of staff.
 - b. Staff training is specific to meet the needs of the individual.
 - c. Training must be documented both for the NCP and for any specific tasks associated with the NCP. (e.g., If the NCP directs that the person should be turned and positioned every 2 hours, there must be training in not only the directions of the care plan but also in the skill involved. In this case, the staff must have documented training and competency checks in how to turn and position an individual.)
 - d. How best can training be documented? How can the RN avoid staff saying "I was not taught to do this"?
 - i. Consider having staff sign off on training documentation where there is a statement saying: "My signature below indicates that I have been taught the content necessary for me to safely perform the indicated task and that I understand my responsibilities in providing this care. I understand that if questions/concerns should arise, I am to contact the RN CM/DN for clarification/direction."
 - ii. Having staff read and sign off on a NCP is not adequate training, per MBON and OHCQ.
 - iii. The RN must regularly evaluate/supervise the performance of tasks required to provide care and document the oversight of staff skill performance (competency checks).
- 7. Will the monitoring/measuring of vital signs be included in the proposed MTTP Core Curriculum?**
- a. Yes. Training in the monitoring/measuring of vital signs will be included in the MTTP core curriculum.
- 8. Can the CMA work in the DD community setting?**
- a. Yes. The CMA may work in the DD community setting administering oral and topical medications. However, in order to recertify as a CMA, they must meet the work hours

requirement through working in a nursing home. Their work hours in a DD community agency do not qualify them to recertify as a CMA. These staff must either meet the recertification requirements for a CMA or take the MTTP and become certified as a CMT.

DELEGATION/SUPERVISION:

- 1. If no medications/treatments are being delegated, how often must the RN supervise staff in the performance of ADL care?**
 - a. If no medications/treatments are being delegated, but the staff is doing ADL care as either a UAP or CNA, the RN determines the frequency of supervision. It must be more frequent than annually.

- 2. Can LPNs supervise and delegate ADL care as per 10.27.10 and 10.27.11?**
 - a. LPNs work under the supervision of the RN and may delegate ADL care at the direction of the RN.
 - b. LPN supervision does not replace RN supervision.
 - c. LPNs may not delegate medication administration, perform triage responsibilities, perform case management responsibilities, nor perform comprehensive assessments.

- 3. What are the differences in responsibilities between the RN CM/DN in the residential setting vs. the RN CM/DN in the day program setting?**
 - a. The responsibilities of the RN CM/DN do not change with the setting.
 - b. When should the RN CM/DN in the day program be responsible for notifying the doctor?
 - i. The RN onsite triages and makes the determination for immediate care of the individual, i.e., calling 911, non-911 transport to the ER, and/or notifying the doctor.
 - ii. Communication between the day program and the residential program is paramount at all times, not just when emergencies arise
 - iii. The program should have policy and procedures in place to clarify the program's responsibility in notifying the doctor or in triaging and sending the participant out to the ER. These procedures should address individuals supported residentially by other agencies, living with family, or living independently
 - iv. Non-911 transport to the ER is the responsibility of the day program during work hours.

- 4. What is OHCQ's suggestion regarding how the RN should report/document remediation or withdrawal of delegation? Consider that the RN does not hire, fire, nor schedule staff.**

- a. Remediation or withdrawal of delegation should be documented by the RN CM/DN in a nursing note and in a memo to the agency. Suggest citing the 10.27 regulation on withdrawal of delegation.
 - b. What should the RN do when staff for whom delegation has been withdrawn are working in the home?
 - i. Staff may continue to work but they may not perform the withdrawn task.
 - ii. If medication administration is withdrawn, it is the RN's responsibility to notify the MBON. The DDA Regional Nurse should also be notified.
 - iii. If staff continue to perform the task for which delegation has been withdrawn, the RN must notify the agency. OHCQ and DDA must be notified if the issue is not resolved via submission of a complaint
5. **If the nurse assesses that the individual is NOT "chronic, stable, routine, predictable, and uncomplicated," can delegation continue?**
- a. Yes, delegation can continue but, per 10.27.11.04 D, RN supervision must be done minimally every 2 weeks.
 - b. RN must re-evaluate the needs of the individual to determine if the current staffing is appropriate.

DOCUMENTATION/MARs/PMOFs/IPs

1. **Related to medical diagnoses as documented on the PMOF, MAR and/or IP: If the medical diagnoses are not current, but kept on the PMOF/MAR to maintain an easily accessible health history (e.g., h/o leg fx), do these diagnoses need to be reflected in the IP and health care plan?**
 - a. There should be a place in the health record where all health history is captured.
 - b. If it is determined that a diagnosis has been entered in error or the diagnosis is no longer relevant, the responsible HCP should remove the diagnosis.
 - c. Chronic health care needs of the individual should be identified and included in the NCP.
 - d. In surveying, OHCQ looks for all "relevant" diagnoses.
 - e. NCP should address all health concerns being addressed with active treatment/nursing interventions.
2. **What medical/health information does the MBON/OHCQ require agencies to have available (e.g., health database, emergency contact sheet)?**
 - a. Residential Programs (e.g., GH, ALU, CSLA, IFC): everything
 - b. Day Programs (when delegation occurs vs. when delegation does not occur): required information would be pertinent to the care being provided. There should minimally be annual documentation from the HCP or the RN CM/DN.
 - c. When the individual or family is providing care vs paid staff: required information would be pertinent to the care that is being provided.

- d. Though not a regulation, it is helpful to identify the model of Care being used (e.g., RN Delegation/Case Management, RN Case Management, or RN Consultation). This will prevent confusion at the time of an OHCQ survey regarding the type and frequency of the RN documentation. This identification can be documented in a nursing assessment and/or the IP.
 - e. Individuals should be assessed for self-medication readiness and the level of medication support needed determined by the RN. The level of medication support (i.e., Level One: Cooperative Participation in Medication Administration Management/all medications administered by CMTs; Level Two: Capable of Self Administration with Supervision/Training Phase; or, Level Three: Independent Self Administration of Medications) should be documented in the IP and the nursing assessments. The Level Three/Self-Medicator should be re-evaluated minimally annually.
 - f. What if the RN recommends a medical appointment but the guardian refuses?
 - i. The RN should document his/her recommendation and the rationale. The concern should be brought to the Team's attention for their resolution. If the team is concerned that the legal guardian is not acting responsibly then the team can follow through.
 - g. How much data should be kept in the current healthcare record?
 - i. OHCQ is looking for 12 -18 months of data plus the last evaluation if it occurred longer than 18 months ago.
 - ii. Regulations require that 5 years of data be kept, however, HIPAA and Medicare statute require 6 years for record retention.
 - h. If a family is not providing you with requested information, document your efforts to obtain the information, including efforts to get health care information from the HCP and present concerns to the Team for resolution.
- 3. How do we stay in compliance with regulation requiring medication review/renewal every 90 days minimally?**
- a. Concerns: HCPs do not want to sign without an office visit. HCPs do not want to see individuals every 90 days. HCPs do not want to sign for meds prescribed by subspecialist and subspecialist may only want to see individuals annually. The nurse should collaborate with the HCP and update PMOF's prior to the 90 day renewal to ensure orders are correct and accurate. There is no requirement that the HCP needs to see the individual unless requested. Note: This concern is under review to determine if change in regulation/MTTP is needed.
 - b. What if staff don't follow through with getting orders updated? This is a delegation issue as there would be no current order authorizing the medication. It is not enough to document that the staff didn't get the renewal. RN must take action and either get the renewal his/herself or stop delegation. The agency policy should be reviewed. This is a systems issue within the agency. The RN CM/DN may need to collaborate with the pharmacy representative.

4. **Are computer generated printouts and electronic orders acceptable?**
 - a. Yes, computer generated printouts and electronic orders are acceptable with either physical or protected electronic signature and if dated. The electronic orders must be accessible/available for the CMT to perform the 3-way check.
 - b. A computer generated print out from the HCP that lists medications as part of the appointment record is acceptable as the “medication review/renewal” for the 90 day requirement as long as there is the dated signature of the HCP.
 - c. The nurse may use electronic signature if it is protected.

5. **Can nurses use pre-printed name and date stamps to stamp the MARs at the end of the month instead of signing each MAR by hand?**
 - a. No. Name and date stamps are not protected and may not be used.

CMT QUESTIONS:

1. **Is there somewhere on the MBON website that specifically states when a CMT must stop practicing if their renewal has not appeared in the certification database? No.**
 - a. **Initial Applications:** Once the applicant has satisfied all requirements of the MTTP and an initial application is submitted to the MBON via the online process, the applicant may work for no more than 180 days while the application is processed and the certification posted to the website. Careful monitoring of the MBON website for the posting of the CMT is critical. If posting has not occurred within 4 weeks of submission of the application, the MBON should be contacted. If certification is not posted by 180 days, the applicant must cease administering medications/treatments and contact Board staff regarding the status of the application.

 - b. **Renewal Applications:** The CMT certificate expires on the 28th day of the CMT’s birth month in odd or even years (correlates with whether the CMT was born in an odd or even year). The certificate holder may complete the requirements for certification (successful completion of the Four Hour Clinical Update and the Clinical Practicum) renewal beginning 90 days prior to the certificate’s expiration date and up to 30 days after the expiration date. If the renewal application has been submitted within this 120 day period and prior to the end of the 30 days after the expiration date, the CMT may continue to work as a CMT as the MBON has 180 days to process the renewal and post the renewal information to the website. If the posting to the website has not occurred within four weeks of submission of the renewal application, the MBON should be contacted. If certification renewal is not posted by 180 days, the applicant must cease administering medications/treatments and contact Board staff regarding the status of the renewal application.

 - c. **Lapsed Certifications:** If the renewal application is not submitted by the end of the 30 days after the expiration date, the CMT is considered Non-Renewed and may **not** work

as a CMT. The MBON will send a “Non-Renewed Status” post card to the CMT. The postcard will advise that they cannot work as a CMT. To reactivate their certification status, the CMT must retake the entire MTTP and submit a “paper” renewal application. The applicant will need to qualify to take the course by taking and passing the math and reading test. When all requirements for the 20 hour MTTP are met and the “paper” renewal application submitted to the MBON by the MTTP Trainer, the applicant may work as a CMT for up to 180 days while awaiting updated posting to the MBON website. If the posting to the website has not occurred within four weeks of submission, the MBON should be contacted. If certification renewal is not posted by 180 days, the applicant must cease administering medications/treatments and contact Board staff regarding the status of the renewal application.

- d. If there are issues affecting the application (e.g., tax issues), the MBON cannot divulge this information to the agency. Only the applicant can obtain this information from the MBON.
 - e. Maryland legislation passed a bill that will expire/sunset in April 2014 that allows the 180 days of practice while awaiting posting to the MBON website.
 - f. MBON IT questions should be directed to Michele Molesworth at michele.molesworth@maryland.gov.
2. **There continue to be problems with the posting of individuals to the MBON website – despite the online application process. What can the RN do to expedite the process?**
- a. Many of the delays were attributed to faulty data entry (especially, errors in entering the SSN) or lack of data entry on the application. The online process should alleviate many of these issues as the applicant will not be able to advance screens unless the information requested has been submitted. Care should be taken to ensure accurate data entry.
 - b. If problems, contact: kia.alexander-canty@maryland.gov ; jaray.jarvis@maryland.gov ; or, kirby.graham@maryland.gov. The IT Department contact is michele.molesworth@maryland.gov.
3. **When is the CMT required to go to the MBON to get a paper application?**
- a. Paper applications must be used for the recertification process if the current certification has lapsed and is in “Non-Renewed Status” or if the renewal applicant has had new disciplinary action since their last renewal cycle. If the initial applicant answers yes to the disciplinary question, they still submit an application online and, after being contacted by the MBON Discipline Department, will be required to submit requested paperwork.
4. **What are the training differences among the different arenas of practice utilizing the CMT?**
- a. There are major differences in the different arenas of practice related to the specific population served.

- b. The development of a MTTP core curriculum will standardize the core training and allow the applicant to become certified as a CMT. The CMT seeking employment will be provided arena of practice specific training by the employing agency. DDA will develop the DD practice specific training.
- c. The MTTP Core Training will be offered through the Community College system and at MBON approved facilities. MBON may require the facility to have a skills lab. MBON will approve the facility as well as the faculty. The requirements to become approved training faculty will be determined by the MBON. The MBON hosts monthly meetings where the MTTP curriculum is being developed. These meetings are open and all nurses are invited to attend.
- d. How the renewal/recertification process will work has yet to be determined. Of note, Maryland is an active practice renewal state for other licenses and certificates. Only the CMT is required to take a clinical update class in addition to meeting the minimum number of practice hours.
- e. Currently, when a CMT trained in another arena of practice seeks employment with a DDA agency, the DDA agency must train the CMT on the DD specific information in the MTTP.
- f. The MBON website does identify the arena of practice in which the CMT was originally trained.

5. How does the MBON/OHCQ see the role of our agencies' policies related to medication errors?

- a. While not required, it is best practice for the agency policy and procedure related to medication errors to be developed by the agency collaboratively with the RN. The agency policy must be followed. The policy does not replace prudent nursing judgment.
- b. What is the responsibility of the agency RN when s/he withdraws delegation? The RN must notify the MBON and the agency. In addition, the RN should notify the DDA Regional Nurse.
- c. What is the agency responsibility when the CMT is fired or is being investigated by the agency for non-medication issues like theft, fraud, abuse, neglect, abandonment, etc? What regulations address this? The agency is required to notify the MBON as per 10.39.07 as these issues are ethical issues. Reporting is also addressed in health Occupations Article 8:6A-10 Violations, Items 15 and 29.
- d. Will there be a statewide/national abuse database? CMS is looking at a national background check system for specific settings. OHCQ is involved in the development of the national background check.

6. How should RNs approach and document competency evaluations?

- a. Competency evaluations with documentation are done at the time of training and regularly thereafter. Regular supervision should occur at the time of the nursing visit. Per the MBON, annual competency checks are not appropriate. Competency evaluations should be documented and filed in the personnel record.

7. **How should RNs approach and document training on the individualized care plan?**
 - a. Documentation should follow agency specific policy/procedure. Documentation should minimally include: topic, name of staff trained, name of trainer, date of training, competency evaluation, and certification by the trainer of successful completion.
 - b. The NCP is part of the IP and the individualized plan.
 - c. Retraining on the NCP is at the discretion of the RN.

8. **Need suggestions regarding how to accomplish this in high staff turnover environment, for multiple shifts, diverse work schedules, part-time nurses, respite, etc.**
 - a. Hire the properly trained staff for the job. If a CNA is needed, hire a CNA. Though competency evaluations will need to be done, there should be minimal training required in the ADL skills as that is part of the CNA curriculum.
 - b. Need to discuss with agency administration strategies for staff retention.

9. **What is the status of the Modular/Accelerated CMT to CNA training program?**
 - a. The program was developed based on the recommendation to the MBON that all CMTs be CNAs. Since that recommendation has been voted down by the MBON due to community push back, the program, while developed, is on hold at this time.

HOSPICE:

1. **What is the role of the CMT in providing nursing care of the hospice patient?**
 - a. This is an example of role confusion. The CMT is **NOT** certified to provide nursing care; the CMT is only certified to administer medications.
 - b. The UAP can be trained in specific delegatable nursing tasks.
 - c. In Hospice, delegation will require increased oversight.... Minimally every 2 weeks.
 - d. The RN CM/DN must collaborate with the Hospice nurse in determining the plan of care.
 - e. The RN CM/DN must consider the number and types of skills required to provide care, determine if those skills are delegatable, and train staff in care needs as the RN CM/DN retains all responsibilities as the delegating nurse.

2. **What documentation is required in this setting to meet regulations/good practice?**
 - a. The documentation requirements do not change under Hospice.
 - b. RN CM/DN in collaboration with Hospice nurse should develop protocols (e.g., for administration of MSO₄/monitoring tool/parameters for RN notification.
 - c. Communication between the Hospice nurse and the RN CM/DN is critical to coordinating care.

3. **Does delegation or the criteria for delegation change when the individual is receiving Hospice care?**

- a. The regulations governing delegation remain the same.
- b. The DD RN CM/DN is still the team leader and takes the lead in coordinating care, in determining what can be delegated and in training staff.
- c. The previously issued Hospice Memo allows for prn psychotropic drugs for treating anxiety.

NURSING:

1. **Are criteria and expectations related to delegation different when an individual is receiving respite services?**
 - a. The regulations and expectations related to delegation **do not** change in respite services.
 - b. Are we obligated to the exact same regulations (INA, NCP, training, HCP orders, pharmacy labels, blister packs, appointment records, etc.) as in a residential setting?
 - i. Yes, the regulations are the same. Individuals should arrive with the needed paperwork/ HCP orders.
2. **What is the RN's responsibility for coordinating reconciliation amongst orders from multiple subspecialists? (e.g., diet orders from HCP – Nutritionist – subspecialists, etc.)**
 - a. As the RN CM/DN, it is the RN's responsibility.
3. **If an HCP order is detailed in its instructions as written does the NCP need to repeat the same directions?**
 - a. The RN CM/DN can refer to the order in the NCP. Consider attaching a copy of the order for ease of clarification.
 - b. The NCP should be the complete "blueprint" for care.
4. **What should the RN do when a non-nurse gives healthcare directions to CMTs/staff? (e.g., directs triage, PRN meds, etc.) What is the best way to handle Administrative persons who make healthcare related phone calls about consumers without initially notifying and /or collaborating with the nurse?**
 - a. Non-Nurses may not direct healthcare.
 - b. This is an agency issue as the regulations are clear. There needs to be education regarding role delineation, role of the delegating nurse, and applicable regulations. If issue not resolved, may need to report to MBON, OHCQ, and DDA.
 - c. Communication and role delineation is critical.
5. **What if care needs exceed what can be safely provided in the current situation? What if assessment reveals that the skill cannot be delegated or that the environment is not safe for delegation?**

- a. If care that is needed cannot be provided, RN CM/DN must contact the agency administration and work with them in identifying where the person can go.
- b. As the license holder, the RN makes assessments, identifies level of care, and communicates level of care needs. Care needs that cannot be met should be identified early and communicated to the agency, to resource coordination, and to DDA.
- c. It is the RN CM/DN's responsibility to identify the level of training of the appropriate caregiver.