POLICY:

1. Governing Bodies, Regulatory Requirements and Quality Standards

All procedures and practices contained within this manual are implemented in order to meet the regulations and quality standards of governing bodies as indicated by the State of Colorado.

Innovations is required to operate according to the rules, program guidelines, standards and policies of the Colorado Department of Human Services, Division of Developmental Disabilities and the Volume of Developmental Disabilities Services (2 CCR 503-1).

Such guidelines apply to all community centered boards, service agencies and regional centers receiving funds – Medicaid and otherwise - administered by the Colorado Department of Human Services.

Imagine! is a Community Centered Board (CCB) that operates as a private not-for-profit corporation providing case management services, eligibility determination, authorized services and supports to such persons either directly or by purchasing such from Services Agencies/Service Provider Agencies based on consumer needs.

Innovations is a Service Provider Agency that specializes in and provides Comprehensive Habilitation Services to adults and qualifying children with Developmental Disabilities by way of contract with Imagine! or privately contracting with families in need.

Comprehensive Habilitation Services is defined as habilitative services and supports that provide:

- Full day (24 hour) implementation to ensure the health, safety and welfare of the individual
- Provide training and habilitation services or,
- A combination of training and supports in the areas of personal, physical, mental and social development and,
- To promote interdependence, self-sufficiency and community inclusion.
- Services include residential supports, day program supports and transportation.

Nursing Services is a specialized department within Innovations and is required to follow and maintain regulatory compliance with rules and regulations described by the Colorado Department of Health Care Policy and Financing (HCPF) Medical Assistance Manual (Section 8.5000/10 CCR 2505-10):

- IRSS (Individual Residential Services and Supports – Host Homes, Personal Care Alternatives)
- GRSS (Group Residential Services and Supports – Group Homes)
Group Facilities are additionally required to follow regulations determined by the Health Facilities Division of the Colorado Department of Public Health and Environment (CDPHE) Chapter VIII – Part 5 (i.e., “Health Department” or “DOH”)

All Innovations Nursing Services Staff are required to be well versed in IRSS, GRSS and CDPHE quality standards and to educate, implement and ensure quality standard compliance at all times.

As a Service Agency, Innovations is required to maintain written procedures relevant to the provision of authorized services according to its governing bodies, their regulatory requirements and quality standards. This manual is intended to meet this requirement as regards both Skilled Nursing Interventions and Administrative procedures.

Whereas Innovations Nursing Services provides the majority of its services within the Adult Comprehensive Services Waiver, it’s mission to provide community based specialized supports to individuals with developmental and cognitive disabilities is not limited to this demographic alone. Innovations Nursing Services also provides Skilled Nursing interventions and training to consumers and staff within the Supported Living Waiver, Children’s Extensive Services Waiver, to other Service Agencies, and to families on a contractual basis. Regulations are followed accordingly.
II. DECISION TREE FOR NURSE DELEGATION

This decision tree is to assist Registered Nurses in determining if it is appropriate to delegate a particular nursing task in a particular setting to an Unlicensed Assistive Personnel (UAP) using these Delegation Guidelines.

It is assumed that a nurse has assessed the consumer and situation completely in order to answer the questions in this decision tree.

1. Is the task within the registered nurse's scope of practice?
   - No → Do not delegate
   - Yes

2. Are there any specific laws, rules or institutional/agency policies prohibiting the delegation?
   - No → Next question
   - Yes → Do not delegate

3. Can the task be performed without observations or critical decision-making that requires nursing knowledge, skills and judgment?
   - No → Do not delegate
   - Yes

4. Can the task be safely performed according to clear, unchanging directions?
   - No → Do not delegate
   - Yes

5. Are the outcomes of the task reasonably predictable?
   - No → Do not delegate
   - Yes

Task itself is generally appropriate for nurse delegation/ Follow the Delegation Guideline and agency policies.
III. Nursing Documentation: Definitions

Approved OTC/PRN List - Annual
A generic list of over-the-counter/as needed medications is assigned to each consumer on entrance into Innovations Nursing Services; the list is individualized over time by the Nurse Case Manager or Medical Coordinator based on consumer needs and interventions; the list is reviewed no less than annually before sending via fax to the Primary Care Physician for review, edit, signature and date.

Department of Health Check List – No less than Quarterly/Monthly until all variances are resolved
Summary of CDPHE medically based regulations utilized in the Group Homes to ensure ongoing compliance with Colorado Department of Health quality standards.

Health and Medical Education Tool – Continuous for all Health and Medical
Utilized by the unlicensed Medical Coordinator to document caregiver contact, education, supports, advocacy and case management tasks.

Health Care Documentation Form (HCDF) - Continuous
Documentation tool utilized by care giving staff during health and therapeutic office visits in order to ensure clarity of orders, interventions performed, and follow up recommendations and in order that IRSS/GRSS quality standards are met; HCDF’s are reviewed by Nurse Case Managers and Medical Site Supervisors routinely including notation of follow up, Med Support updates, scanning into the Questys data base and filing into the Medical Home Book.

Health Support Manual (HSM) - Resource
Comprehensive reference tool and overview of health and medical practices and procedures utilized by direct care staff and contractors, Nurse Case Managers, Medical Site Supervisors, Program Managers and Program Site Supervisors in the community based setting.

This Manual is available to all staff for use in the home and provided to all community based residential settings.

Staff and contractors are asked to review the Table of Contents and have become generally familiar with its content within the first three months of employ.

The Health Support Manual is reviewed during the PCA/Group Home 40 hours orientation training and also introduced briefly at the conclusion of Medication Administration II

Incident Reports (IR’s)
Required for health and medical events meeting but not limited to the following criteria: injury; medical emergencies; hospitalizations; medication or charting errors; death; allegations of abuse, neglect, mistreatment, exploitation; health and medical incidents that are unusual or require review/reporting.

Informed Consent for Psychotropic Medications – Update annually or as parameters for consent change
All medications ordered and administered for a psychiatric diagnosis and intended to modify behavior require the completion of an Informed Consent with signature from the guardian or consumer. To include: Fair explanation of procedures to be followed as indicated; potential discomforts and risks;
benefits expected; disclosure of appropriate and possible alternatives; an offer to answer questions; instruction that consent can be withdrawn; a statement that withdrawal of consent shall not prejudice future provision of appropriate supports and services

Medical/Nursing Case Review – Annual and with New Admissions (NCR/MCR)
Summary of the last IP year’s health and medical goals/interventions including identifying information, medical appointment summary and narrative summary with medical goals for the next IP year. See Appendices.

Medical Home Book
The Medical Home Book is a compilation of all health and medical interventions and supporting documentation. It is a legal document and reviewed during IRSS, GRSS, CDPHE, and internal Imagine! surveys to determine regulatory compliance.

Medication Error Tool – Continuous as Incident Reports occur
Completed by the Nurse Case Manager or Medical Coordinator as integral to Incident Reports and follow up indicated

Medication Reminder Box Qualified Manager
Forms Utilized: MRB Policy; MRB Consent.
Unlicensed staff deemed Qualified Managers must first review all MRB regulations and obtain signature of consent from the agency director. Materials must be filed into the Qualified Manager’s personnel file and updated as necessary.

Medication Reminder Boxes
All staff that complete Medication Administration are expected to sign the MRB disclosure form and are not allowed to fill an MRB unless trained by licensed personnel or a Qualified Manager. In order that competency is established for filling an MRB, the staff person must review the regulations and Innovations policy, complete the Quiz and be observed in filling a consumer specific MRB no less than 2x. Training must be repeated in the event consumer specific medication regimes change.

Nursing Check List – Optional
Abbreviated Quality Assurance Tool utilized by Nurse Case Managers and Medical Site Supervisors to support ongoing quality standard compliance

Nursing Services Orientation Tool – All care giving staff and contractors on hire
Orients the direct caregiver or contracted provider to Nursing Services policies, practices and procedures

This tool is introduced at the conclusion of Medication Administration II by the course instructor

Subsequently, this tool is thoroughly reviewed with the Host Home Provider prior to placement of a consumer in the home (emergency placements excepted) by the Nurse Case Manager or Medical Coordinator

For PCA and Group Home staff, this tool is subsequently and thoroughly reviewed in the 40 hour caregiver orientation
Protocol – Annual or as need indicates
A protocol is a diagnosis specific set of actions, supports and documentation criteria for caregivers to follow in order to support the health and safety of consumers while ensuring physician’s orders.

Nurse Case Managers are responsible for training and documenting staff/consumer education on the protocol and for reviewing and updating as indicated.

Completed/updated annually in follow up to the IP meeting or as a change in consumer status indicates

Examples: G-Tube; Swallow; Seizure; Bowel; GERD; Special/Therapeutic Diet; CPAP/Oxygen (or other respiratory supplies), Blood Pressure; etc.

Quality Assurance Tool (QA) – Routine Completion (see below)
Summary of medical IRSS/GRSS/CDPHE medical regulations utilized by the Nurse Case Manager and Site Supervisors to ensure ongoing regulatory compliance according to quality standards as established by the governing bodies

Bi Annual Reviews of Medication and Therapeutic Diet
Updates automatically in Med Support when medication and diet changes are made via the back office; reviewed no less than quarterly by the Nurse Case Manager or Medical Coordinator prior to fax request for review, signature and date by the prescribing physician

Self-Medication Independence Assessment Tool – No less than Quarterly
Utilized by the Nurse Case Manager or Site Supervisor to assess and document independence skills in the consumer who self-administers medications?

Skilled Nursing Documentation (SKN) – Continuous for all Skilled Nursing Intervention
Utilized by licensed Nursing Professionals to document training, education, regulation review, assessments, advocacy, case management, etc.

Completed daily/weekly as Skilled Nursing Intervention/education is provided to consumers and staff.

Supervision
All Nursing Services staff are required to meet with their direct supervisor no less than monthly.

All Nursing Services staff are required to maintain currency with all Imagine! training modules and live classes as indicated per job description

Licensed Personnel are required to maintain licensure and CEU’s for specialized credentials as indicated
VI. Nurse Case Manager/Medical Coordinator Procedures

Annual Individualized Planning (IP) Meeting/Service Plan

Preparation
Review of previous year’s Case Review, Nursing Care Plan and Protocols (as indicated)
   - Change dates, contact information, vitals, etc.
   - Re-name all with IP year and save to G:drive/Consumer Chart
   - Print and bring Emergency Information Sheet to IP Meeting

Review Informed Consents (Medication and Authorizations for Release of Confidential Information)
   - Update as indicated
   - Save to Consumer Chart (Medication Informed Consents)
   - Print for IP Meeting

Review Medical Records for orders, appointment status, recall compliance, care implementation, outstanding medical needs and topics

IP Meeting
   - Update team on medical topics; appointment status; advocate for health and safety as indicated
   - Obtain signature for Informed Consents/Consents for the release of Medical Records as indicated

Post IP Meeting (30 day deadline)
   - Review IP/Service Plan for Accuracy re: health and medical topics
   - Complete NCR, Protocols, Self-Medication Assessments (as indicated), Save to Consumer Chart/G:drive
   - Sign and Date hard copy
     - Submit to Nursing Administrative Assistant for Scanning/routing
   - Submit Protocols to DON or Prescribing Physician as indicated (to Admin. Assistance once signed/approved for scanning/routing)
     - Complete staff training in Care Plans, Protocols, Medications, and Therapeutic Interventions as indicated
     - Sign and Date
     - Route for scanning and staff training records

Home Visitation

These are basic guidelines.

PCA’s: 1 time per week and as needed

Group Homes: 2 times per week and as needed

Medical Paperwork Review
Health Care Documentation Forms (HCDF’s) are to be picked up at staffed houses or delivered to the Nurse Case Manager’s mailbox at the administrative offices.

Nurse Case Managers and Medical Site Supervisors review HCDF’s within one week of receipt while concurrently updating Med Support data base with diagnoses information, special diets, therapies, allergies, immunizations, medical contacts and medication regimes.

Record updates/follow through at the bottom of the HCDF; sign, date and route to Administrative Assistant

Nurses and Medical Site Supervisors follow up with direct care staff as necessary and document education as indicated regarding diagnoses, medication, diet, therapies, assistive equipment, etc.

Nurse Case Managers and Medical Site Supervisors make request via fax for all specialized testing, review, notate, sign, date and route once received.

Route all hard copy Nursing/Medical intervention documentation to administrative Assistant through Questys for filing in medical home book.

**Medication Administration In-Home Support**

Each PCA and Group Home Caregiver is required to pass a home medication administration practicum; competency is determined by the Nurse Case Manager.

Site Supervisors are notified that new staff have passed Medication Administration and earned QMAP status. Staffs are required to contact the Nurse to schedule medication/diagnoses training.

Once completed, Nurses and Medical Site Supervisors render caregivers as ACTIVE on the Med Support system.

All consumer specific/caregiver specific training is documented and routed.

**Home Medication Side Effect Reference**

*Each Nurse Case Manager and Site Supervisor will maintain a side effect reference tool for each Group Home, The format of this tool will be developed by the medical supervisor and reflect the needs of the individual site.*

The Side Effect Reference Tools will be reviewed and updated quarterly/or monthly.

**Medication Administration Error Tracking**

Each medication administration error will be tracked via an incident report with an accompanying Medication Administration Error Reporting/Follow up Tool.
Medical and Health Services Policy

The Medication Administration Error Reporting/Follow up Form will be completed by the Nurse Case Manager or Medical Coordinator as integral to Incident Report Review and Follow Up documentation.

The completed form is submitted to the Nursing Administrative Assistant for database updates and filing into the Med Error notebook.

Administrative Assistant tracks Med Errors per care giving staff and provides status/reminders to the Nurse Case Manager or Medical Coordinator.

**Staff Education, Documentation and Monitoring Requirements (including but not limited to)**
- Nursing Care Plans
- Diagnoses
- Medications
- Protocols (G-Tube, Ostomy Equipment, Seizure, Bowel, Swallow, GERD, Medication Independence, Wound Care, Adaptive Equipment Maintenance, Oxygen and Respiratory Supplies, etc.)
- Special Diets
- Therapies (Physical, Occupational, Speech)
- Psycho-social factors
- Medication Reminder Boxes
- Health Advocacy
- Medical Records Maintenance
- Nursing Services Policies and Procedures

**Quality Assurance Review of Medical Records**

Nurse Case Managers and Medical Site Supervisors are responsible for ensuring that all quality standards pursuant to GRSS and Colorado Department of Health regulations are met.

Nurses will complete random Quality Assurance Reviews of home Medical Books.

Group Homes: No less than 2 thorough reviews of charts are required on a monthly basis.

QA Process:
Chart reviews are conducted in the home using the Nursing Services Quality Assurance Tool
Follow up to deficiencies and variances are completed within 30 days of the chart review.

**New Admissions**
- Review RFP (and any records available)
- Attend community based visits for consumer assessment and/or IDT meetings to orient to the potential new consumer
- Complete Admissions Form
- Complete and obtain signature for Authorization for Release of Confidential Information
- Obtain Medical Records
- Advocate to team re: health and medical needs/placement issues (i.e. home modifications, bathing needs, DME, etc.)
- Support establishment of community based care/medical providers
Prior to entry, update Med Support with medical information/medication regime
Attend placement IP; complete all Nursing IP requirements
Educate/orient staff; document and route training

**New Consumer OTC/Med & Diet Reviews (“Quarterlies”)**
Process:
Nurses and Medical Site Supervisors enter OTC and Quarterly Review Information
Ensure the dates on the forms coincide with the current quarter/annual year
Fax to prescribing physician
Update and route as above

**Medical Appointments**
Nurse Case Managers will attend consumer specific medical office visits based on their own discretion.

**Incident Reporting**
See above for IR parameters.

**Investigations**
Nurse Case Managers and Medical Site Supervisors may be required to participate in or provide documentation to support the administrative record of an investigation.

Documentation may include but is not limited to:
IR follow up documentation/evidence thereof

Documentary evidence: Log notes; Skilled Nursing Documentation; Staff or Consumer Training Records/documentation; MAR review; consumer assessments; plans of care; physician or health professional orders; vitals tracking and review, etc.

Emails; phone logs; faxes

Any notes or documentation at all related to the event under investigation

Any physical evidence

All documentation must be signed and dated including employee title and/or credentials

**PRN’s/OTC’s - Group Home Specific**
DOH requires that PRN’s are stored in the home if on the signed OTC list
All labels on PRN’s provided from Goose Creek must be removed or re-labeled to meet DOH requirements
If the label is expired, but not the medication – do not throw out (remove label or have re-labeled by the pharmacy)
If the pharmacy label is removed, record the individual consumer name on the PRN container using a Sharpe marker without obstructing information regarding the PRN and without obstructing the expiration date.
Include the First and Last name
Medical and Health Services Policy

Review PRN’s against the approved OTC list no less than Quarterly

**Medical Supply and Medication Ordering Oversight**

The Nurse Case Manager or Site Supervisor will support the acquisition of medical supply (medications and DME) as regards cost effectiveness.

For DME, this includes support to direct care staff and program Site Supervisors in obtaining orders, diagnoses/vitals information as indicated

For Medications, this includes implementation of Step Therapy or PAR approval from the prescribing physician

**Medication & Therapeutic Diet Reviews/Annual OTC lists**

Administrative Assistant sends email reminder to review entire caseload’s every 6 months or annual OTC lists.
A deadline will be noted on the email.
Two weeks are allotted for review
Make all additions and add notes to the med & diet sheets (via the DETAILS window in the back office) and or the OTC’s in Med Support.
A reminder email will go out one week before the due date.
Documents are printed in bulk, organized and faxed to PCPs.
All in-coming faxes will be remitted to the appropriate Nurse or Medical Coordinator, who review, make updates to Med Support, sign, date and give to the Admin Assistant.