Adult Nursing
Overview of the Nurse’s role in the DD Waiver and larger health care system
General Nursing Services Requirements
Licensing and Supervision
Electronic Nursing Assessment and Planning Process
  Timelines
Collaboration
Electronic Comprehensive Health Assessment Tool (e-CHAT)
Aspiration Risk Management Screening tool (ARST)
Medication Administration Assessment Tool (MAAT)
Overview of MAAT Categories
  Self-Administration of Medication
  Self-Administration of Medication with Physical Assistance by Staff
  Assistance with Medication Delivery by Staff (AWMD)
  Medication Administration by Licensed/Certified Personnel
Health care plans (HCP)
  Medical Emergency Response Plan (MERP)
  Training and Implementation of Plans
Medication Delivery
  Monitoring and Oversight
Nurse Delegation:
  Health Related Documentation: In all settings
ADULT NURSING SERVICES
SCOPE OF SERVICE
  Nursing Assessment and Consultation Services
  Ongoing Adult Nursing Services
Healthcare Planning and Coordination:
  Aspiration Risk Management (ARM)
  Medication Oversight
  Nurse Delegation
  Medication Administration by Licensed Nurse
  Coordination of Complex Condition(s) (Required in host surrogate families)
Service Limitations
SERVICE REQUIREMENTS
For Individuals Receiving Ongoing Nursing Services for Health Care Plans and MERPs: 26
For Individuals Receiving Any Ongoing Nursing Services: ................................. 28
Documentation Requirements for All Adult Nursing Services: .......................... 29
Collaboration with IDT, Clinicians and Others As Needed: ................................. 30
For Individuals Receiving Ongoing Nursing Services for Medication Oversight or Medication Administration: ............................................................... 30
Discharge Summary: ......................................................................................... 31
Change of Providers: ......................................................................................... 32
AGENCY REQUIREMENTS .................................................................................. 33
REFERENCES ...................................................................................................... 33

Adult Nursing
This chapter contains standards for the delivery of nursing services that support the health and safety of individuals on the DD Waiver. It is divided into two sections:

Part I addresses General Nursing Services requirements that are applicable for nurses in Family Living (FL), Supported Living (SL) and Intensive Medical Living Services (IMLS), Customized Community Supports – Group (CCS-G).

Nursing Services are bundled into the reimbursement rate in in Supported Living (SL) and Intensive Medical Living Services (IMLS) and Customized Community Supports – Group (CCS-G). Nursing Services are not bundled into the reimbursement rate in Family Living (FL). Instead, every Family Living provider must also be an Adult Nursing Services Provider. Adult Nursing Services provider deliver and bill specific types of nursing services based on the individuals needs and desires.

Part II of this Chapter addresses Adult Nursing Services (ANS) requirements for all ANS providers including Family Living Services. The ANS section of this chapter includes requirements regarding where ANS is required and optional.

Refer to the Health Chapter for information regarding a variety of other Health related issues including Aspiration Risk Management and Health Care Coordination.

Overview of the Nurse’s role in the DD Waiver and larger health care system
Health care services are accessed through the individual’s Medicaid State Plan benefits through Fee for Service or Managed Care and through Medicare and/or private insurance for individuals who have these additional types of insurance coverage. DD Waiver health related services are specifically designed to support the individual in the community setting and will compliment but may not duplicate health related services provided by the Medicaid State Plan or other insurance systems.

Nurses play a pivotal role in supporting individuals and their guardians within the DD Waiver system and are a key link with the larger Health Care system in New Mexico. DD Waiver Nurses identify and support the individual’s preferences regarding health decisions; support health awareness and self-management of their medications or health condition(s); and; assess, plan, monitor and manage health related issues; provide education, support and share information among the IDT including Direct Support Staff (DSP) in a variety of settings.
Nurses also respond proactively to chronic and acute health changes and concerns, facilitating access to appropriate healthcare services. This involves communication and coordination both within and beyond the DD Waiver system and typically includes contact and collaboration with the individual, guardian and IDT members; Primary Care Practitioners (physicians, nurse practitioners or physician assistants); Specialists; Dentists and the Medicaid Managed Care Organization (MCO) Care Coordinator. The MCO Care Coordinator is a critical link to access the larger system of needed health care services for the individual. Refer to the Health Care Coordination section of the Health Chapter for additional details.

**General Nursing Services Requirements:**
The following general requirements are applicable for RNs and LPNs in Supported Living, Intensive Medical Living Services, Family Living, Customized Community Supports- Group and Adult Nursing Services. If there are specific nursing requirements in a Living Support or in Adult Nursing, it will be noted below.

**Licensing and Supervision**
1. All DD Waiver Nursing services must be provided by a Registered Nurse (RN) or licensed practical nurse (LPN) with a current New Mexico license in good standing.
2. Nurses must comply with all aspects of the New Mexico Nursing Practice Act.
3. The RN must provide face-to-face supervision and oversight required by the New Mexico Nurse Practice Act and these DDSD standards for LPNs, Certified Medication Aides (CMAs) and Direct Support Personnel (DSP) who have been delegated nursing tasks.
4. An LPN or CMA may not work without the routine oversight of an RN.
5. Refer to the Delegation section for more information regarding delegated nursing tasks.

**Electronic Nursing Assessment and Planning Process**
**Tools:** The nursing assessment process includes several DDSD mandated tools: the electronic Comprehensive Nursing Assessment Tool (e-CHAT), the Aspiration Risk Screening Tool (ARST) and the Medication Administration Assessment Tool (MAAT). LPNs may complete the ARST and MAAT and may contribute to the eCHAT. No portion of this process may be delegated to a non-nurse.

**Hierarchy:** The following hierarchy is used to determine which provider agency nurse is responsible for completion of the assessment and related subsequent planning and training. Note that additional communication and collaboration for planning specific to community inclusion services may be needed. Refer to Health Care Planning section for more detail regarding communication and collaboration responsibilities between two providers.

1. Community living services: Supported Living, Intensive Medial Living Services or Family Living (via Adult Nursing Services)
2. Customized Community Supports- Group
   a. if not receiving any residential services
3. Adult Nursing Services
   a. for persons in Community Inclusion with health-related needs OR
b. if no residential services are budgeted but assessment is desired and health needs may exist.

4. Collaboration:

DD Waiver nursing is a community nursing service. Nurses in various service settings must routinely and professionally communicate and collaborate with one another for the benefit of the individual’s health and safety.

a. When individuals are served in multiple settings, the Nurses will share assessment information and care plans. Each nurse is responsible for completing and training plans pertinent to their setting.

b. When collaborating with home based Hospice services, the nurse will assure that all plans for DDW nurses and DSP are updated to reflect the individual’s current desired services, health status and pain management needs.

Timelines:

Timely completion, entry and approval of an e-CHAT, ARST and MAAT in Therap must be:

1. within no more than 3 business days of admission or transfer to a new provider agency, or two weeks following the initial ISP or transition meeting, whichever comes first.

2. at least 14 calendar days but no more than 45 calendar days prior to the annual ISP meeting. In order to reflect the individual’s current condition,

3. within 3 business days of a significant change of health status (change of condition) and upon return from any out of home placement including hospitalization, long term care, rehab/sub-acute admission or incarceration.

4. LPNs may complete the ARST and MAAT and may contribute to the eCHAT. The eCHAT must be reviewed, edited as needed and must be approved by an RN within 3 business days.

5. Non-nurses may only enter data into the e-CHAT from a paper version of the e-CHAT that has been completed, signed and dated by an RN. The data entry must occur within 1 business day of completion by the RN. The RN must review and electronically approve the e-CHAT after data entry within 3 business days. The original signed and dated paper version must be retained in the agency file. Non-nurses may not complete or approve the e-CHAT.

6. All electronic signatures must contain the nurse’s name and credentials (RN or LPN).

Collaboration:

DD Waiver nursing is a community nursing service. Nurses in various service settings must routinely and professionally communicate and collaborate with one another. Nurses will share based on professional and Timely completion, entry and approval of an e-CHAT, ARST and MAAT in Therap must be:

Electronic Comprehensive Health Assessment Tool (e-CHAT)

1. The e-CHAT is a nursing assessment and, in accordance with the New Mexico Nurse Practice Act and these Standards, may not be delegated by a licensed nurse to a non-licensed person.
2. The nurse must see the individual face to face to complete a nursing assessment. Additional information may be gathered from other sources.

3. An e-CHAT must be completed for individuals in Family Living, Supported Living, Intensive Medical Living and Customized Community Supports-group (CCS-G).
   a. All other DDW recipients may obtain an e-CHAT if needed or desired by adding Adult Nursing Services hours for assessment and consultation to their budget.

4. When completing the eCHAT, the nurse must review, update the electronic record as needed and consider the diagnoses, medications, treatments and overall status of the individual. Discussion with others may be needed to obtain critical information.

5. The nurse must fully complete all the e-CHAT assessment questions and is required to document additional pertinent information in all comment sections that are clinically appropriate. No question section may be skipped.

6. LPNs may contribute to the eCHAT. If this occurs, the eCHAT must be reviewed, edited as needed and must be approved by an RN within 3 business days.

7. Non-nurses may only enter data into the e-CHAT from a paper version of the e-CHAT that has been completed, signed and dated by an RN. The data must be entered within 3 business days after the RN completes the paper version. The RN must review and electronically approve the e-CHAT after data entry within 3 business days. The original signed and dated paper version must be retained in the agency file.

8. Non-nurses may not complete or approve the e-CHAT.

9. The final comment section must contain additional narrative notes regarding any health-related issues that were not captured in the e-CHAT and reflect the nurse’s complete clinical assessment of the individual’s current health status, needs and a synopsis of progress toward care planned goals for individuals with established plans.

10. Information about the nurse’s actions and decisions regarding Health Care Plans (HCP) or Medical Emergency Response Plans (MERP) are to be noted in the narrative section at the bottom of the e-CHAT Summary Sheet.

11. Dates for HCP and MERPs must be noted on the e-CHAT Summary Sheet and updated as plans are created or revised. Plans must be reviewed, revised as needed and re-dated at least annually or as needed with revisions.

12. HCPs (including CARMP) and MERPs must be linked into the Therap system.

13. The CARMP is the HCP for Aspiration Risk Management. Refer to the Nursing portion of the ARM Standards for details.

14. When Individuals, or guardians of individuals, who reside with Biological Family Living providers to opt out of ongoing Adult Nursing Services, the decision must be noted in the narrative section at the bottom of the e-CHAT Summary Sheet. These notes will indicate the reason why the nurse did not proceed with plans that were required or were to be considered. Refer to Section II: the Adult Nursing Services section of this chapter for details.
Aspiration Risk Management Screening tool (ARST)
1. LPNs may complete the Aspiration Risk Management Screening tool (ARST)
2. Refer to the Aspiration Risk Management section of the Health Chapter for details regarding actions to be taken once this tool is completed.

Medication Administration Assessment Tool (MAAT)
1. A licensed nurse will complete the DDSD Medication Administration Assessment Tool (MAAT) based on the timelines listed above.
2. In addition to the frequency stated in the introduction to this section, the MAAT must be completed by a licensed nurse and may not be assigned or delegated to a non-nurse.
3. After completion of the MAAT, the nurse will identify any needed primary care practitioner (PCP) orders, determine the need for consents and any additional needed information or forms and present his/her recommendations regarding the level of assistance with medication delivery to the IDT. A copy of the MAAT will be sent to all the team members two weeks before the annual ISP meeting and the original MAAT will be retained in the provider agency records.
4. In order to promote an individual's maximum independence and community integration, decisions about medication delivery:
   a. Shall be made by the individual’s IDT by consensus regarding which criteria the person meets considering results of the MAAT and the nursing recommendations and shall be documented in the ISP.
   b. Shall be based on the individual’s best match to criteria for the following:
      i. Self-administration
      ii. Self-administration with physical assistance by staff
      iii. Assistance with medication delivery by staff
      iv. Medication administration by licensed/certified personnel (licensed nurses and certified medication aides).
   c. In situations where consensus cannot be reached, the guardian will determine the level of medication delivery.
5. After the IDT determines which criteria the individual best meets, the agency nurse will obtain needed PCP orders and the Case Manager will obtain needed consents.

Overview of MAAT Categories
Self-Administration of Medication
1. All individuals who self-administer medications must have a current PCP order to self-administer medication and a current written consent must be obtained from the individual/guardian/surrogate health decision maker for self-administration of medication. Individuals receiving Customized In-home Supports -Independent Living and Living with family and Friends are not required to have a PCP order or consent to self-administer medications.
2. If the individual has the potential to self-administer medications and only needs additional training and support, the team (including the nurse) should coordinate, plan and provide this training and support.
   a. The team should consider the use of Assistive or Personal Support Technology to support independence with self-administration.
   b. During the time the individual is receiving additional training and support for self-administration of medications, the medication assistance level will be based upon the current MAAT results, the nurse’s recommendation and the level of delivery agreed upon by the IDT.
   c. After any needed training is completed, the nurse will complete another MAAT to determine needed level of support.
   d. Individuals should receive added training or new AT or PST supports as needed to continually promote their independence.

Self-Administration of Medication with Physical Assistance by Staff
1. Individuals with physical challenges that prevent them from completing the process of taking medication independently, but who otherwise meet all criteria for independent self-administration, may receive support in the form of physical assistance from staff. Specific ordered medications may need to be delivered by licensed/certified personnel per the MAAT.
2. All individuals (including those in CIHS) must have a current written consent, obtained from the individual or guardian/surrogate health decision maker for provision of self-administration of medication with physical assistance.
3. All individuals must have a current PCP order to self-administer medications with physical assistance by staff.

Assistance with Medication Delivery by Staff (AWMD)
1. For individuals who do not meet the criteria to self-administer medications independently or with physical assistance, trained staff may assist with medication delivery if:
   a. Criteria in the MAAT are met.
   b. Current written consent must be obtained from the individual/guardian/surrogate health decision maker for assistance with medication delivery by staff.
   c. All individuals must have a current PCP order to receive assistance with medication delivery by staff.
   d. Only AWMD staff in good standing may support the individual with this service.
   e. Refer to the Assistance with Medication Delivery Section of the Health Chapter for more detail about AWMD.
Medication Administration by Licensed/Certified Personnel

1. A Registered Nurse (RN) or Licensed Practical Nurse (LPN) must administer a medication if it is delivered by any of the following medication routes:
   a. Intramuscular (IM), subcutaneous (SQ), or intravenous (IV) injection
   b. Naso-gastric (NG) tube
   c. Nebulizer, if the medication is not pre-mixed

2. In all settings with required nursing services except Related Family Living, a licensed nurse (RN or LPN) must administer any new medication that has been prescribed which requires a routine ordered assessment with the delivery of each dose until such time as:
   a. The nurse determines the individual’s condition is stable and
   b. An MERP is in place if deemed necessary by the nurse. and
   c. Direct care staff, including CMAs, are adequately trained and demonstrate competence on the MERP related to the individual’s condition; the desired effects of the medication utilized and the routine ordered assessment with the delivery of each dose.

3. A CMA Level I or II may administer medications through all routes included in the Certified Medication Aide chapter of the Nurse Practice Act. CMAs must be supervised/directed by an RN, work for an agency that is a current BON approved provider and function in accordance with all New Mexico BON Rules.

Health care plans (HCP)

1. At the nurse’s discretion, based on prudent nursing practice, interim healthcare plans may be developed to address issues that must be implemented immediately after admission, readmission or change of medical condition to provide safe services prior to completion of the e-CHAT and formal care planning process. This includes interim aspiration risk management plans in those newly identified at moderate or high risk for aspiration. All interim plans must be removed if the plan is no longer needed or when final HCP including CARMPs are in place in order to avoid duplication of plans.

2. The agency nurse must create, with input from the interdisciplinary team, a HCP for each individual that addresses all areas identified as required in the most current e-CHAT summary report, as indicated by “R” in the healthcare plan column. At the nurse’s sole discretion, based on prudent nursing practice, healthcare plans may be combined where clinically appropriate and may also include any or all of the areas indicated for consideration for inclusion, as indicated by “C” on the e-CHAT summary report or any other areas the nurse decides are warranted.

3. Each healthcare plan must be clearly developed or revised within 5 business days of admission, readmission or change of medical condition.

4. HCPs must include a statement of the individual’s problems or health needs and list measurable goals to be achieved through implementation of the healthcare plan. Needs statements may be based upon supports needed for the individual to maintain a current strength, ability or skill related to their health, prevention measures, and/or supports needed to remediate, minimize or manage existing health conditions. Goals must be measurable and may have an achievement, maintenance or palliative focus. Steps to take
that may prevent a medical emergency situation must be addressed in the health care plan in order to support the actions steps identified corresponding MERPs.

5. HCP and goals should be revised when an individual’s needs have changed; the goal has been met; there is potential to attain a new or additional goal; a maintenance or palliative goal is appropriate or the individual no longer requires supports to maintain the goal.

6. Interventions/strategies described in the plan should be individualized to reflect the individual’s unique needs, provide guidance to the DSP and designed to support successful interactions. Some interventions may be carried out by DSP, family or other team members; other interventions may be carried out exclusively by an agency nurse. Persons responsible for each intervention/strategy must be specified in the plan by discipline/title. Interventions or strategies must be written in language easily understood by the person responsible for implementation.

7. Include the individual’s name and date of birth on each page. The healthcare plan must be signed by the author. Plans authored by an LPN must have RN review and approval as indicated by review date and signature.

8. The healthcare plan must be reviewed semi-annually to determine its effectiveness and must be revised as needed (e.g. as goals are achieved, circumstances change or new issues or strategies are identified). This review must be documented.

9. After the annual ISP meeting, healthcare plans may need to be developed or revised.

10. Dates for HCP and MERPs must be noted on the e-CHAT Summary Sheet and updated as plans are created or revised.

11. Plans must be reviewed, revised as needed and re-dated at least annually or as needed with revisions.

12. HCPs (including CARMP) and MERPs must be linked into the Therap system.

13. The CARMP is the HCP for Aspiration Risk Management. Refer to the Nursing portion of the ARM Standards for details.

14. Revisions authored by an LPN must have RN review and approval as indicated by review date and signature.

Medical Emergency Response Plan (MERP);

1. Medical Emergency Response Plans (MERPs) are required for individuals who have one or more conditions or illnesses that present a likely potential to exacerbate into a life-threatening situation when indicated as stated below.

   a. The nurse develops a MERP for all conditions the electronic Comprehensive Health Assessment Tool (e-CHAT) indicates that Medical Emergency Response Plan(s) (MERP) are required, shown as "R" in the e-CHAT summary report. After reviewing conditions for which the e-CHAT indicates that a MERP should be considered, (shown as "C" in the e-CHAT summary report), the agency nurse, based upon clinical judgment and input from the Interdisciplinary Team (IDT), identifies the need for additional (MERP) for any individual who has one or more known medical conditions.
which, under certain circumstances, have the likely potential to exacerbate into a life-threatening situation requiring emergency treatment. Examples include but are not limited to:

i. Seizure disorder/epilepsy creating risk for prolonged seizures or status epilepticus;
ii. Neurological disorders requiring devices or implants such as shunts or Vagal Nerve Stimulator that may have specific directions for use or may malfunction;
iii. Cardiac conditions creating risk for heart attack or cardiac failure;
iv. Asthma or other respiratory disease creating risk for respiratory distress or failure;
v. Diabetes mellitus creating risk for diabetic coma from very high or very low blood sugar;
vi. Risk for sepsis due to use of high dose steroids, cancer therapy, removal of spleen, certain immune disorders, indwelling urinary or IV catheters;
vii. Risk for aspiration creating risk for aspiration pneumonia; acute respiratory distress or sepsis
viii. Gastrointestinal disorders with history of severe constipation, impaction, bowel obstruction or gastric bleeding;
ix. Feeding tubes, to address risk for tube displacement or becoming plugged;
x. Severe allergies that are known to result in anaphylactic shock or other severe, life threatening reaction;
xi. Bleeding risk related to diseases, disorders or anticoagulant therapy.

b. The MERP cannot be combined with or replace the Healthcare Plan.
d. Authors of the MERP should encourage family members/guardians to provide input regarding the situations under which the medical emergency has the potential to occur, the action steps to be taken in such medical emergency, and to receive training on its implementation

e. The MERP must be written in clear, jargon free language and include at a minimum the following information:

i. A brief, simple description of the condition or illness with the most likely life-threatening complications that might occur.
ii. What those complications may look like to an observer.
iii. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to intervene in the emergency, including criteria for when to call 911.
iv. Emergency contacts with phone numbers.
v. Reference to whether the individual has advance directives or not, and if so, where the advance directives are located if pertinent to the MERP.
f. The IDT determines whether natural supports need to be included in training on the content of the individual’s MERP based upon the role of the natural support(s) in the individual’s life, and include those individuals in the Individual Specific Training section of the ISP.
g. The MERP must be quickly and easily accessible for review and use by DSP in all service delivery settings, or any other setting under DSP supervision.
h. Agency nurses are responsible for ensuring that all MERPs they develop are given to all relevant service delivery sites. Nurses are also responsible for providing training on the MERP to DSP working with the individual as well as any other individuals listed in the Individual Specific Training section of the ISP. The nurse may designate an alternate, competent trainer to provide education about the MERP.
i. Provider agencies are responsible for ensuring the MERP document is present in all needed settings and arranging and ensuring that DSP are trained on the contents of the MERP prior to staff working alone with the individual. Provider agencies must have a procedure in place for notifying the agency nurse or MER author when a change of personnel occurs. Refer to Adult Nursing Services Section for specific information.
   i. Family Living provider subcontractors who are related by affinity or by consanguinity who have arranged for MERPs to be developed by the primary care practitioner or a physician specialist are responsible for working with the author to obtain reviews and any needed revisions no later than two weeks prior to the annual ISP meeting.
   ii. A MERP is not required for persons in respite services. In this setting, families are responsible for sharing a copy of any and all instructions regarding medical emergency response with respite providers at their discretion.
   iii. Refer to the Adult Nursing Services for more information.
j. At least annually, the agency nurse will review the frequency and outcome of medical emergencies, and, based upon this analysis, the nurse may identify the need to revise the individual’s healthcare plan or the MERP.
k. The MERP must be reviewed by the agency nurse or other author for needed revisions no later than two weeks prior to the annual ISP meeting.
l. During the annual meeting, the IDT discusses the continued need for each condition listed in the MERPs and whether the current plan(s) need(s) to be modified or eliminated.
m. If the emergency response involves delivery of a PRN medication, the prior consultation with the agency nurse requirements of the Medication Delivery
section of these standards as it relates to use of PRN medication shall be adhered to.

i. The only exception to prior consultation with the agency nurse is the use of Epi-pens and DisStat. The nurse must be contacted as soon as possible after an Epi-pen or DiaStat are used.

n. Dates for MERPs must be noted on the e-CHAT Summary Sheet and updated as plans are created or revised.

o. MERPs must be linked into the Therap system.

p. Revisions authored by an LPN must have RN review and approval as indicated by review date and signature.

Training and Implementation of Plans

1. RNs and LPNs must provide Individual Specific Training regarding HCPs and MERPs
2. The agency nurse must deliver and document training for DSP regarding the healthcare interventions/strategies and Medical Emergency Response Plans that the DSP are responsible to implement, clearly indicating level of competency achieved by each trainee such as; awareness, knowledge, or skill as defined in the Training Chapter.
3. Training must be offered at least annually to those routinely supporting the individual.
4. If such healthcare strategies are not delegated nursing tasks, at the nurse’s discretion, a designated trainer may be identified by the nurse who is then authorized to train DSP.
5. The training roster will indicate the Plans by name and the content covered. The plans should be attached to the roster, in addition to being made available in the specifically needed settings.
6. RNs and LPNs must provide Individual Specific Training regarding HCPs and MERPs
7. The agency nurse must deliver and document training for DSP regarding the healthcare interventions/strategies and Medical Emergency Response Plans that the DSP are responsible to implement, clearly indicating level of competency achieved by each trainee such as; awareness, knowledge, or skill as defined in the Training Chapter.
8. Training must be offered at least annually to those routinely supporting the individual.
9. For delegated nursing tasks or nursing functions, the delegating nurse must provide training and monitoring for continued competence consistent with the New Mexico Nurse Practice Act, prudent nursing practice, the agency policies on delegation, and related DDSD standards. Delegation may not be mandated, may not be transferred and must be rescinded at any time the nurse has any concerns with quality of delivery of the delegated task. See the Delegation Section of this chapter for more information.
10. If healthcare approaches or strategies are not delegated nursing tasks, at the nurse’s discretion, a designated trainer may be identified by the nurse who is then authorized to train DSP.
11. Nurses will monitor the implementation of plans during routine visits and will retrain as needed to support proper delivery of care.
12. Nurses will communicate any concerns with DSP implementation of plans to the Living or Community Inclusion agencies for resolution of issues.

**Medication Delivery**

1. Nurses must:
   a. Be aware of the Provider Agency’s written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with these Standards, the New Mexico Nurse Practice Act, and Board of Pharmacy standards and regulations.
   b. Communicate with the PCP and relevant specialists regarding medications and attend condition specific medical appointments as needed;
   c. Educate the individual, guardian, family, and IDT regarding the use and implications of medications as needed;
   d. Administer medications when required, such as medications by IV, specific injections or NG tube, non-premixed nebulizer treatments, or new prescriptions that have an ordered assessment for each dose until the individual is stable;
   e. Assure that the Medication Administration Record (MAR) is updated for any changes or existing orders or new medication or treatment orders from Primary Care Practitioners, Specialists of other clinicians.
   f. Nurses must monitor the MAR or treatment records at least monthly to monitor for accuracy, PRN use and errors.
   g. Per the DDSD Medication Assessment and Delivery Training, respond to calls requesting delivery of PRNs from Assist with Medication Delivery (AWMD) trained DSP and non-related (surrogate or host) Family Living providers.
   h. Assure that orders for PRN medications or treatments have clear instructions for use that includes observable signs/symptoms or circumstances in which the medication is to be used, and documentation of the effectiveness of the PRN medication administered.
   i. When PRN medications are used, there must be clear documentation that the DSP contacted the agency nurse prior to assisting with the medication and the nurse will clearly document their instructions and their follow up regarding the results of the PRN.
   j. When the nurse delivers the PRN medication, the nurse must document the reasons why the medications were given and the individual’s response to the medication.
   k. Deliver medications or treatments via routes that are not appropriate under the AWMD Training program.
   l. Monitor and document the individual’s response and the effectiveness of medication in routine documentation as warranted and as part of the eCHAT. This includes contacting the ordering practitioners as needed to address any concerns related to medications or treatments.
   m. Nurses must document any observed or reported signs of allergic reaction or adverse medication effects and provide needed follow up and supports including accessing appropriate medical treatment and communicating with
the ordering practitioner.

n. Nurses must be aware of the location of medication information from the prescribing pharmacy regarding medications that are kept in the home and community inclusion service locations and must support the DSPs awareness of the expected desired outcomes of administrating the medication.

o. Support the individual’s increased independence with self-administration of medication by collaborating with IDT as needed for using assistive technology (AT) and providing training that supports independence with self-administration of medication when possible and desired by the individual.

p. Collaborate with agency supervisors to investigate and correct medication errors; and follow up on pharmacy consultant reports as needed.

q. Where CMAs are used, the Registered Nurse (RN) must assure compliance with New Mexico Board of Nursing requirements, including training and ongoing monitoring of CMA skill level and performance and response to CMA requests to deliver PRN medication.

r. Refer to the Delegation section for information related to delegation of medications and treatments.

s. Refer to the Adult Nursing Services Chapter for information related to medication requirements in that service.

Monitoring and Oversight:

1. Routine Visits by nurses in the individual’s home:
   a. The following is the minimum, face to face home visit schedule based on the individual’s acuity level that is required in all service settings except in IMLS and for Jackson Class members.
      i. Low acuity – at least annually
      ii. Moderate acuity – at least two times a year (semiannually)
      iii. High Acuity – at least once per quarter
   b. Nurses must visit more often if, based on prudent nursing practice, there are clinical issues that require a face to face nursing visit to assess the status of the individual. These visits may occur at the home or other settings. They may not be delegated to a non-nurse.
   c. In IMLS:
      i. A daily, face to face nursing visit must be made by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) in order to deliver required direct nursing care, monitor each individual’s status, and oversee DSP delivery of health-related care and interventions. Face to face nursing visits may not be delegated to non-licensed staff.
      ii. Although a nurse may be present in the home for extended periods of time based on individual(s) needs, a nurse is not required to be present in the home during periods of time when direct nursing services are not needed.

NM DOH – 2017 DDSD Service Standards-DRAFT
Proposed Effective Date: January 1, 2018
CHAPTER- Nursing
Page 14 of 34
ii. Weekly RN oversight visits are required.
   - A supervising RN must perform an RN oversight visit at least weekly. The RN oversight visit may not be delegated to an LPN or a non-licensed person.
   - The supervising RN’s oversight visit is performed in order to monitor the clinical status and needs of the individual and the delivery of planned care and services, to provide consultation and serve as a resource, and to provide oversight of the licensed nurses and DSP;
   - The frequency of the RN oversight visit may vary and must be based on the individual’s condition, the skill level of the DSP, and prudent nursing practice. It is up to the judgment of the supervising RN to determine if a weekly RN oversight visit is adequate or if there is a need to visit more frequently; and
   - RN oversight visit(s) may replace one or more of the daily nursing visits during each week if all ordered nursing tasks are completed during the RN visit.

d. For Jackson Class Members: to be added

e. In Family Living with a related provider: Refer to the Adult Nursing Services section of this chapter.

2. On-Call nursing services: The following Standards are applicable to all settings. IMLS exceptions are noted below. Refer to the Adult Nursing Services section of this chapter.
   a. An on-call nurse must be available to DSP during periods when a nurse is not present.
      i. In all settings except IMLS: The on-call nurse must be able to make an on-site visit when information provided by DSP over the phone indicates, in the nurse’s professional judgment, that there is a need for a face to face assessment to determine appropriate action
      ii. In IMLS: The on-call nurse must be available within the hour to make an on-site visit when, based on available information and the nurse’s professional judgment, there is a need for a face to face assessment to determine appropriate action;
   b. The on-call nurse is not obligated to make an onsite visit if, based on prudent nursing practice, they determine it is most prudent to advise immediate access to ER via ambulance or transport by car or ambulance to Urgent care services.
   c. An LPN on duty or on-call must have access to their RN supervisor by phone in case consultation is required; and
   d. It is expected that no single nurse carries the full burden of on call duties for the agency covering on call shifts.
   e. Nurses on-call are required to document the calls they receive, the actions
thy have taken or directed; to communicate with their agency peers and to follow up as needed on the individual’s status.

3. Change of condition:
   a. If the nurse identifies or is notified of a significant change of condition, the nurse may (based on prudent nursing practice) determine to make a home visit and complete an assessment; may work with the CM to coordinate an IDT meeting or may refer to immediate emergency care. All actions will be documented.
   b. Refer to Electronic Nursing Assessment activities after hospitalization or change of condition.

Nurse Delegation:
1. Nurses must follow the Provider agency’s internal policies and procedures regarding delegation that are in accord with these DDSD Standards and the New Mexico Nurse Practice Act.
2. Delegation is a unique relationship between the RN and a DSP. Delegation is entirely up to the nurse and, when delegation of specific nursing functions has been granted, the nurse, must ensure:
   a. Train each DSP to skill level competency.
   b. Monitor ongoing staff performance, skill level and the individual’s health status.
   c. Rescind delegation immediately at any time the nurse determines that the DSP is unwilling or unable to safely perform the delegated task.
   d. All activities related to delegation must be documented by the delegating nurse and retained in a separate staff file at the agency office.
   e. Delegation is a unique relationship between a nurse and a DSP that cannot be mandated by the agency and cannot be transferred between nurses or between direct support staff.
   f. If a staff nurse or DSP is no longer employed by the agency, the delegation relationship is nullified.
   g. For delegated nursing tasks, training and monitoring for continued competence can only be provided by the delegating nurse.

Health Related Documentation: In all settings:
1. The nurse must complete legible and signed progress notes with date and time indicated that describe all interventions or interactions conducted with individuals served as well as all interactions with other healthcare providers serving the individual. Documentation may be electronic or on paper.
2. All notes must have the nurse’s signature and credentials.
3. All interactions must be documented whether they occur by phone or in person.
4. Dr Orders:
   a. Nurses must ensure that practitioner orders are carried out until discontinued. If orders cannot be implemented as directed, the ordering practitioner must
be notified as soon as possible and no later than within three (3) business days.

b. If an order cannot be implemented due to individual or guardian refusal, the nurse must immediately contact the Case manager to initiate the Decision Consultation Form must be completed in consultation with the practitioner. Based on the final decision the order must be reinstated, altered or discontinued. RN’s may determine, based on prudent nursing practice, to hold a practitioner order but must document the circumstances and rationale and notify that practitioner by the next business day.

c. Practitioner recommendations must be considered by the individual and their guardian/health decision maker in consultation with the IDT and implemented unless a DDSD Decision Consultation Form is completed indicating an informed decision not to implement the recommendation.

5. Nursing assessments or on-site visits conducted to determine current health status or to evaluate a change in clinical condition must be documented in a signed progress note that includes time and date as well as subjective information, including the individual’s complaints, signs, and symptoms noted by nurse, DSP, family members, or other team members; objective information, including vital signs, physical examination, weight, and other pertinent data for the given situation; assessment of the clinical status, and plan of action addressing relevant aspects of all active health problems; and follow up on any recommendations of medical consultants.

6. Semi-annual reports: Nurses will provide the IDT with semiannual reports indicating the person’s current health status; significant changes to date and progress towards planned health related goals. At least annually, the nurse will also include a review of the number of episodes that an MERP had to be implemented in order to determine what MERPs are currently needed to be developed and trained.

7. Discharge Planning: The nurse will collaborate with the Case Manager to support well planned discharges from hospitals or other out of home placements in order to support the wishes of the individual or their guardian.

8. Discharge Summary: Upon discharge or transfer:

   a. The nurse prepares a discharge summary report and provide it to the case manager and receiving provider on the day of discharge, regardless of length of stay;
   b. The summary must contain a synopsis of the individual’s stay and reflect current health status and needs at time of discharge;
   c. The nurse must collaborate with other agency nurses as needed to facilitate a smooth transition of care;
   d. Any impact to the individual’s Level of Care due to health or functional status changes must be discussed with the case manager prior to the discharge; and
e. When an individual changes providers, it is the responsibility of both the existing and new provider to ensure that safe and appropriate planning takes place. For persons with health related issues, nurses must attend or participate by phone in IDT meetings to develop a transition plan shall be held to address exchange of health-related information, individual preferences and required documentation, training of staff, and moving logistics.

ADULT NURSING SERVICES

Adult Nursing Services are designed to meet a variety of health conditions experienced by adults receiving services on the Developmental Disabilities Waiver (DDW) Program. These services are intended to support the highest practicable level of health, functioning and independence for individuals, age twenty-one (21) and older who:

1. reside in a Family Living setting;
2. receive Customized In-Home Supports;
3. require ANS but who do not receive Living Supports; or
4. require ANS during participation in Customized Community Supports and/or

Adult Nursing Services are also available for young adults, age 18 through 20, who are at aspiration risk and who desire to have Aspiration Risk Management (ARM) services.

There are two categories of Adult Nursing Service, which are described in detail in the Scope of Services.

The first category is Nursing Assessment and Consultation Services. This core nursing service provides an initial and annual comprehensive health assessment and subsequent consultation from the nurse to the individual, health decision maker/guardian and, as requested, with the team. This activity is required for all participants in Family Living, including young adults from age 18 through 20, and is available to all individuals in the service settings listed above.

The second category, Ongoing Adult Nursing Services, provides focused nursing supports that are based on the needs identified in the comprehensive health assessment. Ongoing Adult Nursing requires prior authorization and is an optional service that can be selected by individuals, their health decision maker or guardians. Several elements of ongoing Adult Nursing Services are required for certain individuals when health related supports are delivered by non-related direct support personnel in settings other than Supported Living or Intensive Medical Living services in order to comply with nursing oversight required by the New Mexico Nurse Practice Act.

Adult Nursing Services support the delivery of professional nursing services in compliance with the New Mexico Nurse Practice Act and in accordance with professional standards of practice. Adult Nursing Services are a model of nursing intended to support the individual and their family.
towards a goal of maximum practicable independence and access to the general health care system, while providing a framework of ongoing DDW nursing supports as needed.

With the exception of ARM services and Assessment and Consultation listed above, children and young adults up to the age of twenty-one (21) receive all other medically necessary nursing services through the Medicaid State Plan Early Periodic Screening Diagnosis and Treatment (EPSDT) program.

SCOPE OF SERVICE
The Non-billable Services section lists: 13. Time associated with h) Review of Relevant Records as being non-billable. This should not apply to Adult Nursing Services. Also, nursing non-billable items should be listed separately. Review of medical records is an integral part of completing the nursing assessments. The Provider is not always an accurate historian in terms of the health information that needs to be included in the assessments. The nurse extensively reviews the medical appointments and medical records of the clients to ensure that all information is captured. The records review is also essential to ensuring the health and safety of the individuals. Follow up appointments would often be overlooked without a nurse reviewing medical appointments. This is also something that DHI holds agencies responsible for - follow up appointments as recommended by a physician. All of this time spent reviewing records should be able to be billed!

Nursing Assessment and Consultation Services:
1. Individuals who receive Individual Customized Community Supports and/or Community Integrated Employment and those who receive Customized In-Home Supports have the option to select Nursing Consultation and Assessment Services. Nursing Assessment and Consultation is required if the individual receives health related supports from non-related direct support personnel that require training and oversight by nursing. If selected, they are eligible for up to twelve (12) hours or forty-eight (48) units of services as listed below.

2. All Adults on the DDW, who reside in a Family Living setting, are eligible for up to twelve (12) hours or forty-eight (48) units of Nursing Assessment and Consultation Service. This is a required service and includes the following:
   a. Completion of an initial and annual Electronic Comprehensive Health Assessment Tool (e-CHAT), Aspiration Risk Management (ARM) Screening, Medication Administration Assessment Tool (MAAT) and any other assessments identified as relevant per prudent nurse practice. Review of the Ongoing Adult Nursing eligibility parameters and identify any Ongoing Adult Nursing Services for which the individual may qualify;
   b. Consultation with the individual, guardian, case manager and, as requested, with their Interdisciplinary Team (IDT), regarding the results of the above assessment and resulting recommendations including a discussion of plans that are required or could be considered and any indicated need for Ongoing Adult Nursing Services:
i. If the individual receives Family Living from a family member related by affinity or consanguinity, and the individual and/or health decision maker/guardian determine that ongoing Adult Nursing Services as described in Section B of these standards are not desired, the family will provide any needed health supports or interventions based on guidance from the Primary Care Provider (PCP) or specialists. The family is responsible for sharing all information with substitute care providers. If a substitute care provider is a surrogate (not related by affinity or consanguinity) pertinent Ongoing Adult Nursing Services must be added.

ii. Individuals in Family Living with surrogate or host families must access required components of Ongoing Adult Nursing as stated in this standard.

c. Provision of limited consultation regarding health related issues, as requested by the individual, family/guardian or team; If Ongoing Adult Nursing is not selected, such consultation shall not exceed the remaining balance of twelve (12) hours budgeted for initial/annual Nursing Assessment and Consultation Services;

d. Development of any urgently needed interim Healthcare Plan, PRN Psychotropic Medication Plan, or Medical Emergency Response Plan (MERP) per policy, pending authorization of Ongoing Nursing Services as indicated by health status and individual/guardian choice. Conduct training with family/Direct Support Personnel (DSP) as needed on these interim MERPs or interim Healthcare Plans. Nurses may combine any clinically appropriate topics into the interim Health Care plans based on prudent nursing practice; and

e. Documentation of all nursing activities in contact logs or progress notes. Nurses will document the results of the Consultation meeting in a nursing progress note and will summarize the individual and/or health decision maker/guardian decision to either pursue prior authorization for Ongoing Adult Nursing Services or to decline these services on the e-CHAT summary sheet. A Decision Consultation form is not needed if this benefit is declined.

3. If the individual is hospitalized or experiences a significant change of condition, the nurse may request the Case Manager to budget an additional eight (8) hours or thirty-two (32) units. These additional hours are used to:

   a. Update assessments; care plans or MERPs to reflect the individual’s changed health status;
   b. Create any needed interim plans;
   c. Complete the Ongoing Adult Nursing eligibility parameters if indicated;
d. Conduct training with family/DSP on these changes as needed;
e. Attend hospital discharge meetings or related IDT meetings;
f. For individuals receiving Ongoing Adult Nursing Services, the nurse must ensure that discharge orders after hospitalization or a stay in a nursing home or rehabilitation center are implemented within twenty-four (24) hours and reflected via revision of the Healthcare Plan(s), PRN Psychotropic Medication Plan(s) and/or MERPs if needed, within five (5) business days following discharge. Interim Healthcare Plans shall be put in place by the next business day for urgent issues while updating or creating Healthcare Plans, PRN Psychotropic Medication Plans and/or MERPs to reflect discharge orders. For individuals who decline Ongoing Adult Nursing Services despite the change of condition, the individual/family is responsible for implementation of discharge orders in coordination with their healthcare practitioners; and

g. Any further additional nursing hours must receive prior authorization under Ongoing Adult Nursing as outlined below.

Ongoing Adult Nursing Services

Are an array of services that are available singly or in combination to adults who require supports for specific chronic or acute health conditions. Ongoing Adult Nursing Services may only begin after the Nursing Assessment and Consultation has been completed and Prior Authorization has been approved. The services must be agreed upon by the individual and/or health decision maker/guardian and must receive prior authorization for one or more of the categories outlined in this standard. Several elements of Ongoing Adult Nursing services are required if the individual resides with surrogate or host Family Living providers or receives health related supports that require training and oversight by nursing in Customized Community Supports; Community Integrated Employment or Customized In Home supports. The nurse from the Adult Nursing Services Provider agency will complete the designated Ongoing Adult Nursing eligibility parameters in the format provided by DDSD. This shall include any additional required information that supports the need for Ongoing Adult Nursing Services, identification of the specific nursing service(s) proposed, and the anticipated number of hours required to carry out the proposed nursing services. The following services are included:

Healthcare Planning and Coordination:

1. Provision of Healthcare Planning and Coordination is required in Family Living with surrogate families and is optional for all other eligible individuals. In addition:
   a. If the individual resides with their biological family (by affinity or consanguinity) and it is determined that Healthcare Planning and Coordination is not a desired service, the family will provide any needed health supports or interventions based on guidance from the PCP or specialists.
   b. Participation in Customized Community Supports, Customized In-Home Supports and Community Integrated Employment may be dependent upon provision of this service in cases in which the individual has a need for health
related supports from direct support personnel that require training and oversight by a nurse.

2. Development, training, monitoring, and revision as needed, of Healthcare Plans which are labeled as “required” in the e-CHAT and additional Healthcare Plans labeled as “consider” in the e-CHAT and which the nurse recommends.
   a. If the individual or guardian objects to particular Healthcare Plans or aspects of Healthcare Plans, these concerns shall be discussed with the individual and guardian. The nurse will work with the team to initiate the Decision Consultation process and the Healthcare Plan(s) in question deleted or modified to reflect the individual’s/guardian’s final decision.
   b. The frequency of monitoring will be based on the individual’s needs, assessed risk, and prudent nursing practice.

3. Development, training, monitoring, and revision as needed, of MERPs labeled as “required” in the e-CHAT and additional MERPs labeled as “consider” in the e-CHAT and which the nurse recommends. The Decision Consultation process and form may be used to resolve individual/guardian concerns about MERPs;

4. Participation in annual ISP meeting and other IDT meetings where health issues are on the agenda;

5. Provision of response/consultation, as needed, for unanticipated health related events. The nurse will rely on prudent nursing practice to determine if a face to face assessment is warranted or if urgent or emergent care is needed;

6. Provision of a semi-annual nursing report to the IDT and, at least two (2) weeks prior to the annual ISP meeting, complete and distribute an electronic or paper nursing report regarding the individual’s status and outcomes of Healthcare Plans and MERPs implemented during the year; and

7. Document all related nursing activities.

Aspiration Risk Management (ARM):
ARM is required in Family Living for surrogate/host families and Jackson class members and is optional in Customized In-Home Supports.

1. Biological Family Living providers who are the Guardian for individuals at moderate or high risk, may opt out of ARM services, after the CARMP has been developed and presented to the individual and Guardian per the ARM Policy and Procedure;

2. If the individual resides with their biological family (by affinity or consanguinity) and it is determined that ARM is not a desired service, the family will continue to provide any needed health supports or interventions based on guidance from the Primary Care Provider (PCP) or specialists. However, if the individual/biological family is receiving ARM-related therapy services, and therefore have a Comprehensive Aspiration Risk Management Plan (CARMP), they must also budget this component of Ongoing Adult Nursing services and comply with the ARM Policy and Procedure;

3. The nurse will carry out nurse related responsibilities described in the DDSD ARM Policy and Procedure, including:
a. Communicating with the PCP and relevant specialists;
b. Developing an interim ARM plan for individuals newly identified at risk;
c. Participating in collaborative assessments and annual reassessments with relevant therapy and Behavior Support Consultation (BSC) providers;
d. Attending IDT meetings related to aspiration risk management;
e. Developing, training, monitoring, and revising, as needed, nurse sections of the CARMP;
f. Developing, training, monitoring and revising as needed a MERP related to the individual’s Aspiration Risk;
g. Responding as needed to reports of aspiration signs and symptoms; and
h. Documenting all related nursing activities.

Medication Oversight:
1. Medication Oversight is required in Family Living for surrogate/host families. The nurse is responsible for:
   a. Communicating with the PCP and relevant specialists regarding medications and attend condition specific medical appointments as needed;
   b. Monitoring and documenting the individual’s response and the effectiveness of medication;
   c. Educating individual, guardian, family, and IDT regarding the use and implications of medications as needed;
   d. Monitoring Medication Administration Records (MARs) for accuracy, PRN use and errors;
   e. Responding per the DDSD Medication Assessment and Delivery Policy and Procedure, to calls requesting delivery of PRNs from Assist with Medication Delivery (AWMD) trained DSP; surrogate or host Family Living providers and Certified Medication Aides (CMAs). Family Living providers related by affinity or consanguinity are not required to contact the nurse;
   f. Collaborating with agency supervisors to investigate and correct medication errors; and follow up on pharmacy consultant reports; and
   g. Where CMAs are used, the Registered Nurse (RN) must assure compliance with New Mexico Board of Nursing requirements, including training and ongoing monitoring of CMA skill level and performance and response to CMA requests to deliver PRN medication.
2. Medication Oversight is optional if the individual lives independently and can self-administer their medication or resides with their biological family (by affinity or consanguinity). If it is determined that Medication Oversight is not a desired service, the family will continue to provide any needed health supports or interventions based on guidance from the PCP or specialists. If Medication Oversight is not selected as an Ongoing Nursing Service, all elements of medication administration and oversight are the sole responsibility of the individual and their biological family. In addition, for
Family Living participants the biological family must:

a. Communicate at least annually, and as needed, for significant change of condition with the agency nurse regarding the current medications and the individual’s response to medications for purpose of accurately completing required nursing assessments.

b. The agency is not responsible for providing a monthly MAR unless the family requests it and continually communicates all medication changes to the provider agency in a timely manner to insure accuracy of the MAR.

c. Medication oversight is not optional if substitute care is provided by a person who is not related by affinity or consanguinity. A MAR is required for the substitute care provider and biological families are encouraged but not required to use the MAR.

d. Medication oversight is not optional if AWMD supports are provided in Community Integrated setting.

2. As per the DDSD Medication Assessment and Delivery Policy and Procedure, paid DSP who are not related by affinity or consanguinity to the individual may not assist with the delivery of medications to the individual unless they have completed Assisting with Medication Delivery (AWMD) training. DSP may also be under a delegation relationship with a DDW agency nurse or be a CMA. Where CMAs are used, the agency is responsible for maintaining compliance with New Mexico Board of Nursing requirements.

Nurse Delegation:

1. Nurse delegation shall be a budgeted service in Family Living with surrogate/host families or in any Community Integrated or Customized in Home supports, substitute care, or other settings where Adult Nursing is delivered if delegation relationships exist or should be utilized. If the individual resides with their biological family (by affinity or consanguinity), delegation of nursing tasks is only relevant if the individual receives services from persons who are not related by affinity or consanguinity and the individual requires specific nursing functions that may be delegated by a licensed nurse during those services.

2. Nurses must ensure compliance with the New Mexico Nurse Practice Act, DDSD Policies Standards and relevant agency policies and procedures when delegation of specific nursing functions has been granted, including:

a. Assessing the skill level of the DSP and provision of training to a competent skill level for each delegated task;

b. Monitoring and observing staff performance, skill level, and the individual’s health status;

c. Rescinding delegation at any time the nurse determines that the DSP is unwilling or unable to safely perform the delegated task;

d. Responding as needed to report of changing condition or needs; and
e. Documenting all delegation related activities.

Medication Administration by Licensed Nurse:
Medication administration by a licensed nurse is allowed under the following circumstances:

1. Routine administration of medication when required by DDSD Medication Assessment and Delivery Policy and Procedure, including documentation and oversight of individual’s response to those medications;
2. As a result of discussion with the PCP, as needed, and as follow-up to pharmacy consultant reports;
3. To respond as needed to reports of changing condition or needs;
4. To document all related nursing activities;
5. In addition to completion of the required designated Ongoing Adult Nursing eligibility parameters, detailed justification for administration of medication by a nurse must be submitted, indicating why medication delivery must be carried out by a nurse rather than by a CMA, DSP trained in “Assisting With Medication Delivery”, family member, or natural support trained by the family; and
6. This service is required in Family Living with surrogate/host families.

Coordination of Complex Condition(s) (Required in host surrogate families):
In addition to typical Healthcare Planning and Coordination described above, the nurse will provide ongoing support and resources to the individual, family and team as evidenced by:

1. Frequent and ongoing assessment, coordination of health related services and monitoring of the individual’s complex medical conditions;
2. Communicating with the PCP and relevant specialists as needed;
3. Analyzing the response to and the effectiveness of interventions and adjustment of the care plan(s), PRN Psychotropic Medication Plan(s), and MERPs as needed;
4. Educating the individual, guardian, family, and team regarding the implications of the complex condition;
5. Attending condition specific medical appointments, as needed;
6. Performing nursing tasks consistent with practitioner orders for interventions or treatments which the nurse is not electing to delegate;
7. Responding as needed to reports of changing condition or needs;
8. Serving as a resource for accessing information or supports; and
9. Documenting all related nursing activities.

Service Limitations:
1. Adult Nursing Services beyond Nursing Assessment and Consultation must meet eligibility criteria and prior authorization;
2. Individuals cannot receive Adult Nursing Services during Supported Living or Intensive Medical Living Services since nursing is fully bundled into those services;
3. For Medication Administration prior authorized under 1.B.6 in Scope of Services, such administration may only be billed at the LPN rate, regardless of whether the medication was administered by a RN, LPN or CMA. Customized Community Supports- Group
agency nurses are expected to administer such medication if needed during that service and so administration in that setting is not eligible for this Adult Nursing service; and

4. Any individual who operates or is an employee of the Adult Nursing Services provider shall not serve as guardian for that individual, except when related by affinity or consanguinity [45-5-31(1) A NMSA(1978)]. Affinity which stems solely from the caregiver relationship is not sufficient to satisfy this requirement.

SERVICE REQUIREMENTS

1. **Adult Nursing Services:** Adult Nursing Services are provided by RNs or LPNs that are licensed to practice in the state of New Mexico. LPNs may only work under the supervision of a RN as required by the New Mexico Nurse Practice Act.

2. **Individuals Receiving Living Supports- Family Living Services:** For individuals receiving Family Living Services, the following requirements apply:
   a. Nursing Assessment and Consultation Services, listed in Nursing Assessment and Consultation Services, shall be budgeted and provided for all recipients of Family Living.
   b. Healthcare Planning and Coordination is required in Family Living with surrogate/host families. Individuals/health decision makers/guardians may utilize the Decision Consultation process as needed.
   c. For individuals receiving Family Living Services from a surrogate family and who take routine or PRN medication, Ongoing Nursing Services for Medication Oversight shall be budgeted and provided. The nurse may choose to delegate medication delivery per the DDSD Medication Assessment and Delivery Policy and Procedure and the New Mexico Nurse Practice Act.
   d. For individuals receiving Family Living Services who reside with a surrogate/host family and/or that are Jackson class members and are at moderate or high risk of aspiration, Ongoing Nursing Services for ARM shall be budgeted and provided.
   e. For individuals receiving Family Living Services from a surrogate/host family, Nurse Delegation must be requested for those individuals whose Family Living staff is currently in a delegation relationship under DDSD policy and procedures or who require specific nursing functions that, per the nurses’ discretion, need to be delivered under a delegation relationship. If the nurse is not comfortable with a delegation relationship, then Medication Delivery by a Licensed Nurse must be budgeted.

For Individuals Receiving Ongoing Nursing Services for Health Care Plans and MERPs:

1. The agency nurse shall create Healthcare Plans for each individual that address all areas identified as “required” as a result of the most current e-CHAT, indicated by an “R” on
the e-CHAT summary report and in compliance with the Electronic Comprehensive Health Assessment Tool Policy. At the nurse’s sole discretion, based on prudent nursing practice, Healthcare Plans may also be developed for any or all of the areas that should be “considered” for care planning, indicated by “C” on the e-CHAT summary report. In addition, the agency nurse may develop any other Healthcare Plans that they determine are warranted. Nurses may combine issues into related Healthcare Plans as clinically appropriate. Each Healthcare Plan must:

a. Include a statement of the individual’s healthcare needs and list measurable goal(s) to be achieved through implementation of the Healthcare Plan. Needs statements may be based upon supports needed for the individual to maintain a current strength, ability or skill related to their health, prevention measures, and/or supports needed to remediate, minimize, or manage existing health conditions;

b. Contain goals that are measurable. Goals should be revised when an individual has met the goal and has the potential to attain additional goals. Goals may be achievement, maintenance, or palliative in nature;

c. Have interventions/strategies described in the plan that are individualized to reflect the individual’s unique needs, subtle signs and symptoms if applicable, and to provide guidance to the DSP, and are designed to support successful interactions. Some interventions may be carried out by DSP, family, or other team members; other interventions may be carried out exclusively by the nurse. Persons responsible for each intervention/strategy shall be specified in the plan by discipline/title, and, therefore, interventions/strategies shall be written in language easily understood by the person responsible for implementation;

d. Include the individual’s name and date of birth on each page. Each Healthcare Plan shall be signed and dated by the registered nurse author or by the RN supervisor for an LPN authored plans and in case of the CARMP by members of the collaborative team;

e. Health care plans must be created/updated within 5 business days of admission, annual assessment, admission, readmissions or significant change in health status;

f. Ensure that for individuals at moderate or high acuity receiving Adult Nursing Services, each Healthcare Plan or CARMP must be reviewed at least every six (6) months to determine its effectiveness and revised as needed (e.g., as goals are achieved, circumstances changes or new strategies are identified). Such review and revisions must be documented;

g. Ensure DSP are trained prior to working alone on a shift and at least annually regarding when and how to implement the HCP; such training shall be documented, clearly indicating resulting competency level (awareness, knowledge, or skill) for each trainee. Retraining will occur as
needed based on the nurse’s judgment and performance by the DSP;

h. Require that if the HCP is revised, the nurse shall assure that DSP are trained and the revised copy is replaced at the service delivery site with the new date indicated and the old version is removed from the service delivery site;

i. Provide that the nurse may designate a competent person to train all or part of a plan that they have authored. The nurse must use prudent nursing practice to determine which sections of a plan may be trained by a designee. A designee may not train any portion of a plan that is a delegated nursing function;

j. Ensure that a summary report of the individual’s current health status, including comments about the care plan review and the individual’s progress towards planned goals, shall be provided to the IDT on at least a semi-annual basis and quarterly for Jackson Class members; and

k. Ensure that Healthcare Plans are updated within five (5) business days after hospitalization or significant change of condition. This includes incorporation of any additional required areas identified in the updated e-CHAT. Interim Healthcare Plans shall be put in place by the next business day for urgent issues while updating to reflect discharge orders.

2. For recipients of Ongoing Adult Nursing Services who have a chronic condition with the potential to exacerbate into a life-threatening situation, a MERP must be written by the nurse or other appropriately designated health professional consistent with the DDSD Medical Emergency Response Plan Policy and Procedures. DSP must be trained prior to working alone on a shift and at least annually regarding when and how to implement the MERP; such training shall be documented, clearly indicating resulting competency level for each trainee. The following requirements shall be met:

   a. The MERP shall include the individual’s name and date of birth on each page and the MERP shall be signed by the author;
   b. On at least a semi-annual basis, the nurse shall review the MERP to determine how many times it was implemented and whether the MERP needs to be revised.

   Such review shall be documented; and

   c. If the MERP is revised, the nurse shall assure that DSP are trained and the revised copy is replaced at the service delivery site with the new date indicated and the old version is removed from the service delivery site.

For Individuals Receiving Any Ongoing Nursing Services.

1. The nurse shall ensure for individuals receiving any Ongoing Nursing services that:

   a. Each individual has a licensed PCP, and receives an annual physical examination and specialty medical care as needed, including an annual dental checkup by a licensed dentist for those with teeth or dentures;
b. All practitioner orders are carried out until discontinued. If orders cannot be implemented as directed, the ordering practitioner must be notified within three

c. (3) business days. (If the reason an order cannot be implemented is due to individual or guardian refusal, a Decision Consultation Form must be completed in consultation with the practitioner. Based on the final decision the order shall be reinstated, altered or discontinued);

d. If an RN determines, based on prudent nursing practice, to hold a practitioner order they must document the circumstances and rationale and notify that practitioner by the next business day; and

e. Practitioner recommendations shall be considered by the individual and their guardian/health decision maker in consultation with the IDT and implemented unless a DDSD Decision Consultation Form is completed indicating an informed decision not to implement the recommendation.

2. Based on the individual’s needs, diagnosis, health care plan and prudent nursing practice, nurses will deliver such direct services necessary to address the individual’s clinical needs, and support health and safety;

3. The nurse may attend physician, specialist visits or other medical appointments as indicated to provide support and planning for complex needs;

4. Oversight and monitoring of the individuals and DSP staff training will be done in accordance with orders, Healthcare Plans and prudent nursing practice;

5. Nurses will provide such education and guidance as necessary, based on the individual’s health needs, diagnosis, health care plan and prudent nursing practice; and

6. Nurses will deliver and document these efforts in designated documents or in progress notes according to DDSD policy.

Documentation Requirements for All Adult Nursing Services:

1. Documentation of all professional nursing activities in an accurate manner in accordance with established standards and State and Agency policies and procedures. This includes assessments, plans, progress notes and reports;

2. For individuals receiving Ongoing Adult Nursing services, nurses will provide teams with a semi-annual nursing report that discusses the services provided and the status of the individual over the last six (6) months. This may be provided in an electronic or paper format to the team no later than two (2) weeks prior to the ISP and semi-annually;

3. Nursing visits conducted to monitor health status or to evaluate a change of clinical condition must be documented in a signed progress note that includes time and date as well as subjective information including the individual’s complaints, observations reported or noted by DSP, family, or other team members; objective information including apparent signs/symptoms; vital signs, physical examination, weight and other pertinent data for the given situation (e.g. frequency of seizures, method by which
temperature was taken); assessment of the clinical status and plan of action addressing relevant aspects of all active health problems; and follow up on any recommendations of medical consultants;

4. The nurse must complete legible, signed progress notes or logs with date and time indicated that describe all interventions or interactions conducted with individuals served, as well as all interactions with other healthcare providers serving the individual. All interactions shall be documented whether they occur by phone or in person. Any phone interactions with DSP which occur between visits must also be documented by the nurse in a signed progress note/log indicating time, date, reason for the call including complaints reported by the individual or observations reported by the DSP and any instructions given;

5. Documentation may be handwritten, typed and printed or in an electronic format; and

6. Out of sequence charting will be noted according to standard documentation practices.

Collaboration with IDT, Clinicians and Others As Needed:

1. When Nursing Assessment and Consultation Services or Ongoing Adult Nursing Services includes attendance at an IDT meeting, the nurse shall attend in person or by phone. If, due to unavoidable scheduling conflict, the nurse cannot attend in person or by phone, the nurse must arrange to have critical health related information provided to the IDT in advance and then follow up with the case manager afterward to identify needed follow up activities;

2. The nurse will collaborate with other clinical service providers such as nurses from Customized Community Supports, Home Health, or Hospice agencies as needed. This collaboration with other agencies requires timely and professional communication and planning to assure maximum consistency across settings;

3. When Hospice services are utilized, DDW agency nurses must develop new or edit existing Healthcare plans and MERP’s to reflect the individuals condition and end of life decisions made by the individual or health decision maker/guardian in order to provide guidance to the DSP regarding hospice or palliative care efforts. The DDW agency nurse is responsible for training the DDW DSP;

4. The nurse will collaborate with other clinicians including those on the IDT, physicians, dentists, and other specialists; and

5. The nurse may attend medical or other appointments as warranted per professional nursing judgment.

For Individuals Receiving Ongoing Nursing Services for Medication Oversight or Medication Administration:

1. Nurses will follow the DDSD Medication Administration Assessment Policy and Procedure;
2. Nurses will administer medications when required by DDSD policy such as medications by IV, injection or NG tube, non-premixed nebulizer treatments, or new prescriptions that have an ordered assessment for each dose until the individual is stable;

3. Nurses will be contacted prior to the delivery of PRN medications by DSP, including surrogate Family Living providers, who are not related by affinity or consanguinity that have successfully completed AWMD or CMA training. Nurses will determine whether to approve the delivery of the PRN medication based on prudent nursing judgment;

4. Nurses must complete or oversee the development of the monthly MAR and will review the MAR monthly for accuracy of transcription of orders for the upcoming month, and to be aware of changes to the MAR:
   a. Nurses must also review MARs to identify patterns of medication errors; Nurses may periodically observe delivery of medication by DSP in order to determine accuracy and quality of delivery. The need for and frequency of this observation is up to the individual nurse;
   b. Nurses shall collaborate with agency supervisors to investigate and correct any identified patterns of medication errors. Nurses will periodically review the utilization of PRN medications, looking for appropriate documentation for the response to the medication, resolution of problems, patterns of use, and possible relationships or links with underlying illnesses, conditions or occurrences;
   c. Participate in following up on issues identified in the Pharmacy consultant reports as needed; and
   d. MARs are not required for individuals served by their biological family if they have opted out of Ongoing Adult Nursing services related to Medication oversight.

5. Nurses will address the individual’s response to their medication regime in the e-CHAT at least annually and more frequently as needed, indicating the delivery method, significant medication changes, and noting presence or absence of positive or negative responses, known interactions or allergies;

6. Nurses will communicate as needed with the pharmacy consultant regarding any actions needed to address findings in the pharmacy report. Nurses may participate in delivery of AWMD training and monitoring; and

7. Nurses must assure compliance with New Mexico Board of Nursing requirements for Supervision of CMAs in agencies where CMA’s are utilized.

Discharge Summary:
When Ongoing Nursing Services are no longer needed, the nurse shall compose a nursing discharge summary and provide it to the case manager within ten (10) business days of the decision for discharge. The report may be electronic or paper format. The report must note an overview of the individuals stay in service and their overall health status at time of discharge.
Change of Providers:
When an individual changes providers, or waiver programs, it is the responsibility of both the existing and new provider to ensure that safe and appropriate planning takes place. An IDT meeting to develop a transition plan shall be held to address exchange of health-related information, individual preferences and required documentation, training of staff, and moving logistics.

AGENCY REQUIREMENTS

1. Adult Nursing Service Providers are accountable for the appropriate delivery of nursing services identified in the Scope of Service and Service Requirement sections of this standard in order to assure the individual’s health and safety.

2. All providers of Adult Nursing Services must offer and deliver these services in accordance with pertinent sections of the New Mexico Administrative Code, the New Mexico Nurse Practice Act, and DDSD policies and procedures.

3. Adult Nursing Services must be offered and provided by all Family Living providers.

4. All providers of Adult Nursing Services must assure that nurses providing this service hold a current RN or LPN license with the New Mexico State Board of Nursing. LPNs must be supervised by an RN per the New Mexico Nurse Practice Act.

5. All providers of Adult Nursing Services must ensure that nurses working for the agency complete the following training upon hire or assignment to these services within timeframes listed below:

   a. DSDD Nurse Orientation and Healthcare Planning modules within ninety (90) calendar days;

   b. Observation of the full two (2)-day “Assisting with Medication Delivery” course to gain awareness of expectations for the DSP that assists with medication delivery within one hundred eighty (180) calendar days; and

   c. Within twelve (12) months of hire complete training for ARM; Effective Individual Specific Training, and Person Centered Planning.

6. All providers of Adult Nursing Services must designate an RN who is the head nurse for the agency and who is responsible for ongoing supervision of the nursing department. The DDSD Regional Office must be given contact information and notified when turnover occurs. A RN will supervise those services delivered by LPNs and CMAs as required by the New Mexico Nurse Practice Act. Such supervision must include periodic face to face interaction and observation.

7. The RN who is the head nurse for the agency must hold a current New Mexico license; must reside in New Mexico or if residing in a neighboring state must not live more than one (1) hour away from the New Mexico border.

8. Agencies that contract for nursing services must ensure that the nurse contractor is available, aware of and in compliance with all nursing standards.

9. Adult Nursing Providers must assure twenty-four (24) hour access to an on call nurse to
provide support, consultation or direction to individuals and DSP. An LPN may take call but must have an RN backup for consultation as needed. It is expected that no single nurse carry the full burden of on call duties for the agency.

10. Compliance With New Mexico Nurse Practice Act and DDSD Standards Regarding Delegation of Specific Nursing Functions:
   a. Provider agencies must develop and implement policies and procedures regarding delegation which must comply with relevant DDSD Standards and the New Mexico Nurse Practice Act that is described in the Scope of Service section in this standard. Agencies must ensure that all nurses they employ are knowledgeable of all these requirements;
   b. All activities related to delegation must be documented by the delegating nurse and retained in a separate staff file at the agency office;
   c. Delegation is a unique relationship between a nurse and a DSP that cannot be mandated and cannot be transferred between nurses or between DSP. If a staff nurse or DSP is no longer employed by the agency, the delegation relationship is nullified; and
   d. Delegation is not necessary if the DSP or Family Living Provider is related to the individual by affinity or consanguinity.

11. Nursing Home Drug Control (NMAC 16.19.11) Requirements: Home Health Agencies or Independent Nursing Providers must be aware of and support the NMAC 16.19.11 in appropriate settings. All other Adult Nursing providers must be in compliance NMAC 16.19.11 Nursing Home Drug Control to be licensed by the Board of Pharmacy per current NMAC regulations for twenty-four (24)-hour residential homes serving two (2) or more unrelated individuals (defined as a Licensed Custodial Care Facility) and meet all applicable standards including:
   a. The organization of pharmaceutical services;
   b. Policies and procedures;
   c. Ordering, administration, maintenance and disposal of drugs;
   d. Pharmacy license requirements for residences; and
   e. Pharmacist Inspection reports for the home.

12. Adult Nursing Services providers must have written policy and procedures that assure compliance with all nursing documentation requirements listed in this standard.

13. Adult Nursing Services providers must have written policy and procedures regarding medication delivery and tracking and reporting of medication errors consistent with the DDSD Medication Administration Assessment Policy and Procedures, relevant Board of Nursing Rules, and Pharmacy Board standards and regulations.

REFERENCES

DDSD Medication Delivery Policy & Procedures
7NMAC 26.5 Individual Service Plan regulations
ARM Policy and Procedure 2015
eCHAT Policy and Procedure
MERP Policy and Procedure 2010
Health Care Planning Policy and Procedure
Medication Assessment and Administration Policy and Procedure 2006