State of Connecticut
Department of Developmental Services

NURSING STANDARD

NURSING PROCESS # NS 09.1

(Replaces 96.1 Nursing Process and 96-2 Nursing Process Components)

Date of Issue: March 2009 (Revised 9/20/13) **Effective Date:** October 1, 2013

Purpose: To identify the best practice standards of the Department of Developmental Services (DDS) for the delivery of nursing care by licensed nurses providing care/support to persons served by the department.

Applicability: This protocol shall apply to registered nurses employed or contracted by DDS or private agencies licensed or funded by DDS who provide or coordinate care to persons in residential and respite programs, or to persons receiving individual supports or residing in Community Companion Homes.

Definitions:

Nursing Assessment: A " systematic, dynamic process by which the nurse, through interaction with the client, significant others, and health care providers, collects and analyzes data about the client. Assessment is broader than observing and data gathering. It includes the application of processes such as critical thinking and professional judgments used in prioritizing, identifying immediate and anticipated need, analyzing medical and nursing interventions aimed at appropriate outcomes, and providing for holistic continuum of care" (ANA, Nursing Scope and Standards of Practice). Nursing assessment is limited in Connecticut to RN scope of practice only.

Nursing Process: An evolving procedure consisting of five components by which a person's health status and needs are identified (assessment and diagnosis), plans are developed (planning), care is delivered (implementation), and outcomes are evaluated (evaluation) as the physical, social, and emotional problems of the person are resolved and/or new problems are identified.

Nursing Review: The reporting and evaluation by an RN of the person's response to a prescribed plan of treatment and to nursing and/or health care interventions which occurred during the review period.

Responsible RN: The registered nurse that has been identified to be accountable for the health care of persons at a particular site or being supported by a particular program.

Responsible covering RN: The registered nurse (i.e., Nursing supervisor, co-worker of responsible nurse) that has been identified to cover during business hours, another RN's caseload during their vacation, illness, etc.)

RN On-Call: As defined in DDS Procedure- A regional communication system that identifies one or more registered nurses, who are responsible for responding to calls within a specified area, of the region, that are made outside of business hours and that necessitate oversight, intervention and documentation by a registered nurse.

Introduction:

The standards for delivery of nursing care in Connecticut are identified in the Nurse Practice Act and the rulings of the Board of Examiners for Nursing (BOEN). Licensed nurses hired or contracted to provide nursing care/support to persons served by the department are expected to provide that care/support within the scope of practice identified for the license they hold. RNs are responsible for the implementation of all phases of the nursing process. Licensed Practical Nurses (LPNs) are permitted to participate in the nursing process only within the specific parameters identified in the BOEN Declaratory Ruling on LPN scope of practice. The LPN is required to perform their responsibilities under the direction of a registered nurse. In community-based settings, an RN who is "proximately available for on-site visits and available can provide this direction by telephone". (Refer to References section of this document for link to the Declaratory Ruling).

Implementation of the nursing process as identified in this Nursing Standard should allow for the delivery of quality nursing care within a systematic, goal-directed framework and a reasonable assurance that the individual's course along the health/illness continuum is predictable and progressive. An oversight or omission in any of the steps of this process may lead to less than optimal nursing care.

DDS Standard: Nursing interventions shall take place within the context of the components of the nursing process and include the considerations identified in this standard.

A. Components of the nursing process and expectations for the delivery of nursing care

1. Assessment and data collection

   a) The purpose of the assessment component of the Nursing process as performed by the RN is to:
      - Determine the physical condition of the person by observation or report
      - Deliberately and systematically collect data about the person's condition and needs by observation or report
      - Determine the person's current health status and the potential for change to that status
      - Evaluate the person's past and present coping pattern
      - Analyze data collected, identify problems, and recommend interventions

   b) The assessment process shall include consideration of the following five factors:
      - Biophysical conditions (i.e., medical diagnoses and treatment plan)
      - Psychosocial environmental concerns
      - Self Care skills/deficits
      - Educational/ training needs of the person and those who provide support to that person
      - Transition planning as appropriate

   c) The LPN is permitted to support the assessment process through the collection of data, reporting of pertinent observations, and suggestion of nursing intervention modifications based upon the person's response.

   d) Nursing assessments support the planning process for individuals. For this reason, the responsible RN or responsible covering RN shall complete an assessment of a person in their care according to the following guidelines:

      - Prior to acceptance or within 2 working days of admission of the person to Community Living Arrangements (CLA) or Campus based homes. RN/RN on Call must be immediately notified when the person is admitted so orders can be reviewed and direction for care provided until

assessment is completed. Nurse may direct trained staff to complete a body check to document presence of bruising or obvious skin alteration as well as vital signs upon admission.

- Prior to admission or as identified by the individual's planning process for services provided in a Community Training Home (CTH), or Individual Supports/Own Home (formerly supported living)
- In conjunction with the discharge of the person from another care facility (i.e., hospital, LTC) back to their home either within 24 hours prior to discharge or within 2 working days following discharge. The RN/RN On Call must be called immediately upon the person's return to the facility orders can be reviewed and direction for care provided.
- Prior to the initial admission to a DDS Respite Center and as necessary to update information prior to visits
- At the frequency identified in regulation (i.e., ICF/MR, DDS Licensing) and to support the planning and support process of the department (i.e., annually, semi-annually, and/or quarterly).
- Whenever there is a change in the person's needs or health status.
- Prior to the planned discharge of a person from one home to another.

e) Generally, nursing assessments involve the visual inspection of the person being assessed. Some assessments however, may be conducted as part of an identified communication/On-Call process in which information is obtained from a caller according to the specified DDS RN On-Call procedure. The RN using nursing judgment, collects all necessary data to determine the acuity of the situation, and decides the action to be taken to ensure the health and safety of the person. The RN maintains the option to visit the person's home or to direct that the person have timely medical care at the appropriate facility.

2. Nursing Diagnosis

The purpose of the Nursing Diagnosis as a component of the Nursing Process is to reflect the nurse's clinical judgment about the person's response to actual or potential health conditions or needs (i.e., A person in pain may demonstrate the potential for poor nutrition, anxiety, and/or decreased mobility).

3. Planning

a) The purpose of the Planning component of the Nursing process is to develop the care plan that specifies the goals and interventions that will be provided to the person to promote, maintain, or restore their health, prevent illness and affect habilitation.

b) The RN shall develop the plan following collaboration with the person and others who support the person. This plan shall be reflected in the individual's plan of support.

c) The LPN can assist the RN in the development of the plan by providing data, contributing to the identification of priorities, and contributing to the identification of realistic and measurable goals.

d) During the planning phase the RN shall consider the training requirements of the person, family/guardian, and/or support staff, and the time frame that is necessary to implement this training.

e) The RN shall revise the plan when the needs of the person significantly change (i.e., new diagnoses, new medications, changes in condition). This revision shall be reflected in nursing documentation.

f) For the purpose of completion of the Level of Need tool, and the development of the Individual Plan, the health care plan shall be revised at a minimum, on an annual basis by the RN. A review of the plan and the person's response shall be completed by the nurse on a semi-annual, and/or quarterly basis as required by regulation.

4. Implementation

a) The purpose of the Implementation component of the Nursing Process is for the RN and/or the LPN under the direction of the RN, is to execute the elements of the identified plan.

b) The RN or LPN under the direction of the RN may delegate all or portions of the implementation of the health plan to appropriately trained non-licensed personnel per the DDS Nursing Standard on Delegation to Non-licensed personnel.

c) The RN is responsible for the total plan which includes awareness of all aspects of the implementation of the plan and the person's response to it.

d) The RN is responsible to transfer information regarding the care plan when the person is transferred or discharged to another facility.

e) The LPN is responsible to keep the RN advised about all aspects of the implementation of the plan, the person's response to the plan, and changes in prescribed treatments that may impact the plan.

5. Evaluation

a) The purpose of the Evaluation component of the Nursing Process is to determine the person's progress toward achievement of the identified goals and/or the revision of the care plan as new problems are identified.

b) The RN's evaluation of care can lead to changes in the elements of the plan and/or implementation of those elements as the person's status and needs change. This evaluation process is reflected in nursing documentation such as focus nursing notes and in the completion of periodic Nursing/Health Care reviews at the frequency identified in regulation.

c) The LPN supports the RN's evaluation through communication of observations, data, and the person's response to treatment.

d) The RN is also supported in this component of the process through communication with others who provide care, support, and/or information. (i.e., health care providers, family/guardian, staff).

B. Documentation of the Nursing Process – DDS nurses shall utilize the Community Health and Safety Assessment Form – Attachment A

Utilization of the nursing process shall be evident in review of the completed Community Health and Safety assessment (Attachment A) for all admissions, transfers, long term care stays, and significant changes in condition. The Community Health and safety form has an optional Health information checklist (Attachment B) which shall be used to gather system information from an individual, family, or team. It is recommended that the Health Information checklist be completed on all new admissions. The shorter Nursing assessment form (Attachment C) shall be utilized by the nurse to document body checks, minor injuries, or returns from short hospitalizations with minor changes in condition. The short nursing assessment form has an area to document a focus nursing note detailing the nursing intervention.

References:

CGS, Chapter 378, 20-87a (a)-(e) Nurse Practice Act
http://www.cga.ct.gov/2007/pub/Chap378.htm

Connecticut Board of Examiners for Nursing Declaratory Ruling – Licensed Practical Nurses
http://www.dph.state.ct.us/Public_Health_Hearing_Office/hearing_office/Nursing_Board/Guidelines/LPN Declaratory Ruling.pdf

Connecticut Board of Examiners for Nursing Declaratory Ruling- Delegation by Licensed Nurses to Unlicensed Assistive Personnel
http://www.dph.state.ct.us/Public_Health_Hearing_Office/hearing_office/Nursing_Board/Guidelines/unlicensed_ap_dec_rul.pdf

ANA Nursing World, The Nursing Process: A Common Thread Amongst All Nurses, copyright January 2008, American Nurses Association
http://www.nursingworld.org/EspeciallyForYou/StudentNurses/Thenursingprocess.aspx

Aspirational Standards of Developmental Disabilities Nursing Practice, Developmental Disabilities Nurses Association, 2008.

Attachments:

- Community Health and Safety Assessment – Attachment A
- Health Information Checklist – Attachment B
- Nursing Assessment Short Form – Attachment C