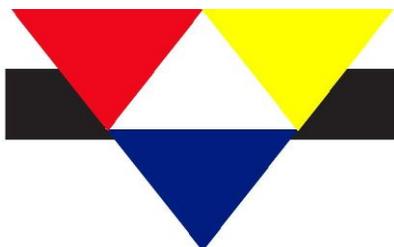


MISSOURI DEPARTMENT OF

MENTAL
HEALTH



**Division of Mental Retardation and
Developmental
Disabilities**

**Community RN Program
2006 Revision**





COMMUNITY RN PROGRAM

2006 REVISION

**Missouri Department of Mental Health
Division of Mental Retardation
And Developmental Disabilities**

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Jefferson City, MO
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Acknowledgments

The following individuals participated through review and or comment in the 2003 development of this training manual.

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The DMRDD RN workgroup would like to acknowledge Dr. Rita Tadych, MO State Board of Nursing, and Poplar Bluff Regional Center RN's for their assistance with resources for the development of this training package.

Additional Acknowledgments for the 2006 Revised Edition

Bryson, Jo, RN, DMRDD State Quality Assurance Team

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INTRODUCTION

The DMRDD Community RN Program was funded in February 2003 to assist residential providers in meeting compliance with the Missouri Nursing Practice Act (Chapter 335 RSMo). This program is a basic oversight service for all individuals receiving DMRDD funded residential services.

The purpose of the program is to provide RN monitoring for the health and safety of individuals with mental retardation and developmental disabilities; provide appropriate delegation and/or supervision of Unlicensed Assistive Personnel (UAP) and Licensed Practical Nurses (LPN) who perform such duties as medication administration and other nursing tasks when applicable.

The following orientation manual developed by the Division will be used for orientation training of all nurses serving in the Community RN position and contracted residential providers. This training should be completed within 90 days of the Community RN's hire and will be offered at least quarterly by the Regional Centers.



Section I

**ABOUT
DMH / DMRDD**

MISSOURI DEPARTMENT OF MENTAL HEALTH

At a Glance

More than 170,000 Missourians are served by the Missouri Department of Mental Health through programs that recognize the dignity of the individual, their families, and their communities.

- The Division of Comprehensive Psychiatric Services (CPS) helps people who suffer from mental illnesses.
- The Division of Mental Retardation and Developmental Disabilities (MRDD) helps people who have long-term delays or disabilities in physical or mental development.
- The Division of Alcohol and Drug Abuse (ADA) helps people with substance-abuse and compulsive-gambling problems.

The department is dedicated to combating stigma associated with mental illness, developmental disabilities, and substance addiction.

Missourians must know that:

Mental illness is a treatable disease;

Persons with substance-abuse or compulsive-gambling problems can triumph over their addictions;

Persons with developmental disabilities can be productive employees and good neighbors in our communities.

The Operating Divisions

The Division of Comprehensive Psychiatric Services

One in four families in Missouri is affected by mental illness. While many persons with mental illnesses seek and obtain treatment from private health-care providers, more than 70,000 people each year turn to the Department of Mental Health's Division of Comprehensive Psychiatric Services.

- ▼ Schizophrenia and depression are two of the most common forms of mental illness.
- ▼ The causes of mental illnesses vary: physical changes in the brain, genetic factors present since birth, or outside factors.
- ▼ Most mental illnesses can be treated successfully and the individuals treated returned to productive lives.
- ▼ In recent years, the focus of services has shifted from large institutions to community-based programs.

The goals of the division follow:
*Accessible community-based services,
Quality residential services,
Available and affordable housing,
Family-focused children's services.*

- ▼ The division operates 11 facilities, supports 25 administrative agents, and contracts with more than 500 community residential facilities.

The Division of Mental Retardation and Developmental Disabilities

A developmental disability is a long-term condition, occurring before age 22, that delays/limits mental or physical development and interferes with basic life activities.

- ▼ An estimated 35,000 Missourians with such developmental disabilities as mental retardation, cerebral palsy, and autism receive services from the division each year.
- ▼ Many of these individuals, because of their disabilities, face barriers to the basic opportunities of education, employment, and community life.
- ▼ The Division of MRDD is committed to helping people with developmental disabilities live as independently and productively as possible in a safe and healthy environment.

Services can include the following:
Therapy - occupational, physical, speech and behavioral therapy;
Family Support - respite care, counseling, home support services, parent training, and early intervention for infants and toddlers.
Training - programs are designed to help each individual reach their potential.
Residential Services - services may include specialized housing.

- ▼ Eleven regional centers serve as entry points into the MRDD system.
- ▼ Six habilitation centers provide specialized residential services.

The Division of Alcohol and Drug Abuse

An estimated 462,000 Missouri adults over age 18 need alcohol or drug abuse treatment, and 39,000 adolescents ages 12-17 need intervention or treatment. A network of division-funded programs provides substance abuse services to approximately 70,000 persons each year.

- ▼ Alcohol and nicotine are the most commonly abused substances.
- ▼ Other abused substances include prescription and over-the-counter medicines as well as illicit drugs, such as cocaine and marijuana.

Treatment services include:
*Detoxification
Substance Abuse Treatment
Compulsive gambling treatment*

CSTAR - Comprehensive Substance Treatment and Rehabilitation Programs offer a flexible combination of clinical services and living arrangements that are individually tailored for each client.

Prevention Programs include:
Community 2000 - Approximately 200 Missouri communities are working to combat drug abuse on the local level.

Missouri SPIRIT - a comprehensive, evidence-based, school-based prevention initiative.

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REV. 12/03



Vision

Lives Beyond Limitations

Missourians shall be free to live their lives and pursue their dreams beyond the limitations of mental illness, developmental disabilities, and alcohol and other drug abuse.

Mission

Working side by side with individuals, families, agencies and diverse communities, the Department of Mental Health establishes philosophy, policies, standards and quality outcomes for prevention, education, habilitation, rehabilitation and treatment for Missourians challenged by mental illness, substance abuse/addiction and developmental disabilities.

Values



All people are accepted and included in the educational, employment, housing, and social opportunities and choices of their communities.



All people can easily access coordinated and affordable services of their choice in their own communities.



All people design their own services and supports to enhance their lives and achieve their personal visions.



All people are valued for and receive services that reflect and respect their race, culture, and ethnicity.



All people are treated with respect and dignity and their rights are ensured by persons providing them with services and supports.



All people live their lives free of, or are less affected by, mental or physical disabilities as a result of our emphasis on prevention and early intervention.



All people determine the excellence of their services and supports based on the outcomes they experience.



All people who provide services and supports are our organizations' most important resources.



All people receive services delivered by staff who are competent in dealing with culture, race, age, lifestyles, gender, sexual orientation, religious practice, and ethnicity.

August 1996

Department History

Before 1921, each mental health facility was managed by an independent board of trustees who appealed separately to the legislature for appropriations.

The department was originally called the “State Eleemosynary Board”. It was created in 1921 to provide “humane and safe treatment, to secure the highest degree of individual development for the wards of the state, to secure systematic and uniform management, to attain the highest degree of economy consistent with the standards to be maintained, and finally, to promote the study of mental, physical and moral defect with a view to cure or prevention.”

The Department of Mental Health was created as one of the 13 separate state departments under the Omnibus Reorganization Act of 1974, which implemented constitutional provisions passed in 1973 reorganizing state government. This Reorganization Act also created the Division of Mental Retardation and Development Disabilities within the department. The Division of Mental Retardation and Development Disabilities supervises the operations of habilitation centers and regional centers. The division also oversees a purchase-of-service and placement program for people who have mental retardation or other developmental disabilities.

In 1980, the Division of Alcohol and Drug Abuse and the Division of Comprehensive Psychiatric Services were created. The Division of Alcohol and Drug Abuse oversees and administers purchase-of-service programs without providing direct services. The Division of Comprehensive Psychiatric Services supervises the operation of facilities, including a state hospital, psychiatric rehabilitation centers, mental health centers, children’s psychiatric programs and one children’s residential treatment center. The division also oversees community-based psychiatric services.

Division of Mental Retardation and Developmental Disabilities (MRDD)

OVERVIEW

The Division of Mental Retardation and Developmental disabilities serves person who have been diagnosed with mental retardation, cerebral palsy, epilepsy, head injury, autism, or a learning disability related to a brain dysfunction. These mental or physical impairments must be manifested before the age of 22, be likely to continue indefinitely, and result in substantial functional limitations. The division's primary mission is to support persons with developmental disabilities through programs and services that enable those persons to live independently and productively, given their individual needs and capabilities. Services and supports the division funds or provides include case management, evaluation, habilitation, and rehabilitation services. The Division provides case management services through eleven (11) regional centers around the state, and multiple county-based boards, funded with Senate Bill 40 dollars on a county basis. Additionally, the Division has contractual arrangements and oversight responsibilities with programs and facilities funded, licensed, or certified by the Department of mental health. In addition, the division has six habilitation centers where person with severe developmental disabilities reside.

People of all ages who have developmental disabilities are eligible for Division services. Eligibility is determined by the Division's 11 regional centers, which evaluate an individual's situation in light of state law. (Sec. 630.005, RSMO.)

The cost of services is determined by a Standard Means Test (SMT), a tool used to determine if the individual or family (in the case of a minor child) is financially able to pay a portion of the costs. Charges are determined using a table that evaluates family size, income and the type of service. However many other resources, especially third-party payments, also must be used to cover costs. Some Medicaid services also may have a co-payment.

STATE FACILITIES

Regional Centers – Based in 11 principal sites and supported by numerous satellite locations, the regional centers are the entry point into the service system. Each center serves from three to 15 counties. Staffed by case managers and support personnel, the centers perform intake activities which help to determine if an individual is eligible for services. When a person is found eligible for services, in accordance with state law and regulation, the individual and family, in partnership with the case manager, works to identify needed services or supports. These services and supports are documented in a person-centered plan that describes what is needed, how the service / support will be obtained, and the method by which the effectiveness of the service or support will be measured.

When developing and implementing person centered plans, the Division strives to meet an individual's needs in the most appropriate environment, typically in or near the individual's home. The 11 regional centers serve approximately 26,507 people annually with a total budget of approximately \$30.8 million.

Habilitation Centers – The primary mission of the division's sic habilitation centers is to provide residential services, direct care support and treatment services to people who cannot be supported in other residential settings in the community. Each resident of the habilitation center has an individual plan that identifies services and supports needed to live successfully in the habilitation center or to return to the community.

The Division operates Southeast Missouri Residential Services in Poplar Bluff and Sikeston; Bellefontaine Habilitation Center and St. Louis Developmental Disabilities Treatment Centers, both in St. Louis and habilitation centers in Nevada, Higginsville and Marshall. These facilities are certified as intermediate care facilities for person with mental retardation (ICFs-MR) and receive federal Medicaid matching funds. The six habilitation centers are receiving approximately \$92.7 million in FY 2006. In FY 2005, approximately 1,200 individuals were served in habilitation centers.

Regional Center	Contact	Phone	Address	Email
Albany	Michelle Smith QM RN III	800-560-8774 660-726-5246 Fax: 660-726-5612	809 North 13th St. Albany MO 64402	michelle.smith@dmh.mo.gov
Central MO	Barb Schaefer QM RN III	573-882-9835 X 241 Fax: 573-884-4294	1500 Vandiver Dr., Suite 100 Columbia MO 65202	barb.schaefer@dmh.mo.gov
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Hannibal	Lori Charlton QM RN III	573-248-2400 Fax: 573-248-2406	805 Clinic Rd., PO Box 1108 Hannibal MO 63401	lori.charlton@dmh.mo.gov
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Poplar Bluff	Linda Goldschmidt QM RN III	573-840-9300 Fax: 573-840-9311	2351 Kanell Blvd. Poplar Bluff MO 63902	linda.goldschmidt@dmh.mo.gov
Rolla	Kathy Skyles QM RN III	573-368-2200 or 573-368-2581 Fax: 573-368-2206	105 Fairgrounds Rd, PO Box 1098 Rolla MO 65402	kathy.skyles@dmh.mo.gov

Regional Center	Contact	Phone	Address	Email
Sikeston	Jane LeGrand QM RN III	573-472-5300 or 573-472-6551 Fax: 573-472-5308	112 Plaza Dr, PO Box 966 Sikeston MO 63801	jane.legrand@dmh.mo.gov
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Missouri Revised Statutes
Chapter 630
Department of Mental Health
Section 630.005

August 28, 2005

Definitions.

630.005. As used in this chapter and chapters 631, 632, and 633, RSMo, unless the context clearly requires otherwise, the following terms shall mean:

(1) "Administrative entity", a provider of specialized services other than transportation to clients of the department on behalf of a division of the department;

(2) "Alcohol abuse", the use of any alcoholic beverage, which use results in intoxication or in a psychological or physiological dependency from continued use, which dependency induces a mental, emotional or physical impairment and which causes socially dysfunctional behavior;

(3) "Chemical restraint", medication administered with the primary intent of restraining a patient who presents a likelihood of serious physical injury to himself or others, and not prescribed to treat a person's medical condition;

(4) "Client", any person who is placed by the department in a facility or program licensed and funded by the department or who is a recipient of services from a regional center, as defined in section 633.005, RSMo;

(5) "Commission", the state mental health commission;

(6) "Consumer", a person:

(a) Who qualifies to receive department services; or

(b) Who is a parent, child or sibling of a person who receives department services; or

(c) Who has a personal interest in services provided by the department. A person who provides services to persons affected by mental retardation, developmental disabilities, mental disorders, mental illness, or alcohol or drug abuse shall not be considered a consumer;

(7) "Day program", a place conducted or maintained by any person who advertises or holds himself out as providing prevention, evaluation, treatment, habilitation or rehabilitation for persons affected by mental disorders, mental illness, mental retardation, developmental disabilities or alcohol or drug abuse for less than the full twenty-four hours comprising each daily period;

(8) "Department", the department of mental health of the state of Missouri;

(9) "Developmental disability", a disability:

(a) Which is attributable to:

a. Mental retardation, cerebral palsy, epilepsy, head injury or autism, or a learning disability related to a brain dysfunction; or

b. Any other mental or physical impairment or combination of mental or physical impairments; and

(b) Is manifested before the person attains age twenty-two; and

(c) Is likely to continue indefinitely; and

(d) Results in substantial functional limitations in two or more of the following areas of major life activities:

a. Self-care;

b. Receptive and expressive language development and use;

c. Learning;

d. Self-direction;

e. Capacity for independent living or economic self-sufficiency;

f. Mobility; and

(e) Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, habilitation or other services which may be of lifelong or extended duration and are individually planned and coordinated;

(10) "Director", the director of the department of mental health, or his designee;

(11) "Domiciled in Missouri", a permanent connection between an individual and the state of Missouri, which is more than mere residence in the state; it may be established by the individual being physically present in Missouri with the intention to abandon his previous domicile and to remain in Missouri permanently or indefinitely;

(12) "Drug abuse", the use of any drug without compelling medical reason, which use results in a temporary mental, emotional or physical impairment and causes socially dysfunctional behavior, or in psychological or physiological dependency

resulting from continued use, which dependency induces a mental, emotional or physical impairment and causes socially dysfunctional behavior;

(13) "Habilitation", a process of treatment, training, care or specialized attention which seeks to enhance and maximize the mentally retarded or developmentally disabled person's abilities to cope with the environment and to live as normally as possible;

(14) "Habilitation center", a residential facility operated by the department and serving only persons who are mentally retarded, including developmentally disabled;

(15) "Head of the facility", the chief administrative officer, or his designee, of any residential facility;

(16) "Head of the program", the chief administrative officer, or his designee, of any day program;

(17) "Individualized habilitation plan", a document which sets forth habilitation goals and objectives for mentally retarded or developmentally disabled residents and clients, and which details the habilitation program as required by law, rules and funding sources;

(18) "Individualized rehabilitation plan", a document which sets forth the care, treatment and rehabilitation goals and objectives for patients and clients affected by alcohol or drug abuse, and which details the rehabilitation program as required by law, rules and funding sources;

(19) "Individualized treatment plan", a document which sets forth the care, treatment and rehabilitation goals and objectives for mentally disordered or mentally ill patients and clients, and which details the treatment program as required by law, rules and funding sources;

(20) "Investigator", an employee or contract agent of the department of mental health who is performing an investigation regarding an allegation of abuse or neglect or an investigation at the request of the director of the department of mental health or his designee;

(21) "Least restrictive environment", a reasonably available setting or mental health program where care, treatment, habilitation or rehabilitation is particularly suited to the level and quality of services necessary to implement a person's individualized treatment, habilitation or rehabilitation plan and to enable the person to maximize his functioning potential to participate as freely as feasible in normal living activities, giving due consideration to potentially harmful effects on the person and the safety of other facility or program clients and public safety. For some mentally disordered or mentally retarded persons, the least restrictive environment may be a facility operated by the department, a private facility, a supported community living situation, or an alternative community program designed for persons who are civilly detained for outpatient treatment or who are conditionally released pursuant to chapter 632, RSMo;

(22) "Mental disorder", any organic, mental or emotional impairment which has substantial adverse effects on a person's cognitive, volitional or emotional function and which constitutes a substantial impairment in a person's ability to participate in activities of normal living;

(23) "Mental illness", a state of impaired mental processes, which impairment results in a distortion of a person's capacity to recognize reality due to hallucinations, delusions, faulty perceptions or alterations of mood, and interferes with an individual's ability to reason, understand or exercise conscious control over his actions. The term "mental illness" does not include the following conditions unless they are accompanied by a mental illness as otherwise defined in this subdivision:

(a) Mental retardation, developmental disability or narcolepsy;

(b) Simple intoxication caused by substances such as alcohol or drugs;

(c) Dependence upon or addiction to any substances such as alcohol or drugs;

(d) Any other disorders such as senility, which are not of an actively psychotic nature;

(24) "Mental retardation", significantly subaverage general intellectual functioning which:

- (a) Originates before age eighteen; and
 - (b) Is associated with a significant impairment in adaptive behavior;
- (25) "Minor", any person under the age of eighteen years;
- (26) "Patient", an individual under observation, care, treatment or rehabilitation by any hospital or other mental health facility or mental health program pursuant to the provisions of chapter 632, RSMo;
- (27) "Psychosurgery",
- (a) Surgery on the normal brain tissue of an individual not suffering from physical disease for the purpose of changing or controlling behavior; or
 - (b) Surgery on diseased brain tissue of an individual if the sole object of the surgery is to control, change or affect behavioral disturbances, except seizure disorders;
- (28) "Rehabilitation", a process of restoration of a person's ability to attain or maintain normal or optimum health or constructive activity through care, treatment, training, counseling or specialized attention;
- (29) "Residence", the place where the patient has last generally lodged prior to admission or, in case of a minor, where his family has so lodged; except, that admission or detention in any facility of the department shall not be deemed an absence from the place of residence and shall not constitute a change in residence;
- (30) "Resident", a person receiving residential services from a facility, other than mental health facility, operated, funded or licensed by the department;
- (31) "Residential facility", any premises where residential prevention, evaluation, care, treatment, habilitation or rehabilitation is provided for persons affected by mental disorders, mental illness, mental retardation, developmental disabilities or alcohol or drug abuse; except the person's dwelling;
- (32) "Specialized service", an entity which provides prevention, evaluation, transportation, care, treatment, habilitation or rehabilitation services to persons affected by mental disorders, mental illness, mental retardation, developmental disabilities or alcohol or drug abuse;
- (33) "Vendor", a person or entity under contract with the department, other than as a department employee, who provides services to patients, residents or clients.
- (L. 1980 H.B. 1724, A.L. 1981 H.B. 399, A.L. 1982 H.B. 1565, A.L. 1990 H.B. 1383, S.B. 808 & 672, A.L. 1993 S.B. 388, A.L. 1995 H.B. 574, A.L. 1996 S.B. 884 & 841)

*Individual Rights of Persons
Receiving Services from the
Division of Mental Retardation and
Developmental Disabilities*



It is important for every person to know his or her rights. These are your rights if you receive services from a regional center or a habilitation center. No one can take them away from you.

Individual Rights

1. A person receiving Division services shall be entitled to the following rights without limitation:
 - To be treated with respect and dignity as a human being;
 - To have the same legal rights and responsibilities as any other person unless otherwise limited by law;
 - To have the right to due process review when any limitation to rights is proposed or is alleged to have taken place;
 - To receive services regardless of gender, race, creed, marital status, national origin, disability or age;
 - To be free from physical, verbal, mental and sexual abuse and neglect;
 - To receive appropriate humane and high quality services and supports as determined by the person's support team, which may include, but not be limited to, the person, parents, guardian or authorized representative;
 - To receive these services and supports in the most integrated setting appropriate for the person's particular needs;
 - To have access to Division rules, policies and procedures pertaining to services and supports;
 - To have access to personal records;
 - To have personal records maintained confidentially; and
 - To have services, supports and personal records explained so that they are easily understood.
2. A person receiving services and/or the person's parents, guardian or authorized representative shall be informed of the person's rights in language that is easily understood.
 - At the time of enrollment and whenever changes are made to the description of individual rights, the Division shall provide to the person and/or the person's parents, guardian or legal representative a written description of the person's rights and how to exercise them.
 - A representative of the Division shall read and explain the description of rights to people who require assistance because they are unable to read or unable to understand the written description.

3. If a person receiving services has complaints of abuse, neglect or violation or limitation of rights, the person, the person's parents, guardian or authorized representative may contact the regional center or habilitation center representative, or they may contact the Department's clients rights monitor at 800-364-9687 or TT 573-526-1201 for assistance.
4. The Division shall have policies and procedures that enhance and protect the human, civil and statutory rights of all persons receiving services.
5. The Division and each service provider shall have policies and procedures for providing positive supports to persons receiving services. Those policies and procedures shall be consistent with the enhancement and protection of human rights.
6. The Division shall report abuse and neglect as mandated by law. Any violation of rights shall constitute, at a minimum, inadequate care and treatment.

The following is an explanation of your rights in people first language.

Due Process

- When you apply for services, the regional center or habilitation center must give you, your parents, your guardian, or any other person you choose a written copy of your rights. If any changes in your services are made, you will receive a new copy of your rights.
- Regional centers, habilitation centers and provider agencies that have staff who work with you have rules to provide you good help. They have rules to make sure you learn and understand your rights, and that no one takes your rights away before you have a chance to speak for yourself or have someone you choose speak for you. This is called due process.
- Someone from the regional center or habilitation center will read and explain your rights to you in a way you understand them.
- You have the same legal rights and responsibilities as any other person unless the court says you do not. For example, if you have a guardian, you do not have the same legal rights as people without a guardian.
- You have the right to be treated with respect and dignity as a human being.
- You have the right to get help. You cannot be denied help because of your race, your religion, your disability or your age. It does not matter if you are a man or woman, married or single.
- Before your rights or services can be limited or taken away, you have the right to be heard or to have someone you choose speak for you. This is called due process.

Services and Supports

- You have the right to get your services and supports in the most integrated setting and in a way that best meets your needs. To determine those services, these people may be involved: you, your parents, your guardian or any other person of your choice.
- You have the right to know what the regional center and habilitation center rules are for the services and supports you receive.
- You have the right to have your services, supports and personal records explained to you so you understand them.
- You have the right to receive and read your personal records.
- You have the right to receive and sign a copy of your personal plan.
- You have the right to have your records kept private.

Abuse and Neglect

- You have the right not to be abused or neglected. Abuse can be physical, verbal, mental, sexual or financial. Neglect is not getting the things you need to be healthy and safe.
- If you think you are being abused, neglected, or your rights taken away, you, your parents, your guardian, or any other person you choose can contact your regional center or habilitation center for help. You can also call the clients rights monitor in Jefferson City at 1-800-364-9687 or TT: 573-526-1201 for help.
- People who work for the regional center or habilitation center must report any abuse or neglect that they see or that people report to them.

Missouri Department of Mental Health
Division of Mental Retardation and Developmental Disabilities
P.O. Box 687
Jefferson City, MO 65102
Phone: 573-751-4054
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Toll Free: 800-207-9329
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Revised 2/01

People First Language: Disability Etiquette

***The difference between the right word and the almost right word
is the difference between lightening and the lightening bug.***

--Mark Twain

What is People First Language?

People First Language describes what the person HAS, not what the person IS. People First Language puts the person BEFORE the disability. Make reference to the person first, then the disability. Say "a person with a disability", rather than "a disabled person". (More examples are included at the end of this section). People First Language also means avoiding the use of words or phrases that evoke pity or fear, or that have a negative connotation. Avoid words such as abnormal, birth defect, burden, deformed, disfigured, invalid, imbecile, idiot, moron, palsied, spastic, tragic, victim, suffers from, or stricken with.

Why?

If people with disabilities are to be included in all aspects of our communities--in the ordinary, wonderful, and typical activities most people take for granted--we must talk about them, and they must talk about themselves, in the ordinary, wonderful, typical language others use about themselves.

Language is powerful. When we misuse words, we reinforce the barriers created by negative and stereotypical attitudes. When we refer to people with disabilities by medical diagnoses, we devalue and disrespect them as members of the human race. For too long, labels have been used to define the value and potential of people who are labeled. Often, when someone hears a person's diagnosis, they automatically make assumptions. Assumptions about the person's potential, what they can or can't do, whether they can learn, be employed, or live in the community. We must believe all people with disabilities are real people with unlimited potential, just like all people. People will live up (or down) to our expectations. If we expect people with disabilities to succeed, we cannot let labels stand in their way. A person's self image is strongly tied to the words used to describe the person. We must not let labels destroy the hopes and dreams of people with disabilities and their families. *The only label people really need to use is their name.*

History

Certain words used to describe people with disabilities have a historic, and often very derogatory origin. For example, the word "handicapped" has a historic origin which refers to a person with a disability having to beg on the street with "cap in hand". People with disabilities do not want to be the recipients of charity or pity. They want to participate equally with the rest of the community. A disability is a functional limitation that interferes with a person's ability to walk, hear, talk, learn, etc. ONLY use "handicap" to describe a situation or barrier imposed by society or the environment.

Even in our casual language, we use words that have historic origin in the world of disability. For example, words such as moron, imbecile, and idiot, were once used as technical terms to describe and categorize people with disabilities. When we use this language in our everyday lives, it is insulting and degrading to people who have disabilities.

Language is often corrupted in our society. What is the worst insult nowadays that a child can sling at another child? "Retard". When people use the word retard or retarded in casual conversations, it is insulting and degrading to those who happen to have that label.

Examples of People First Language:

SAY...

people with disabilities

he has a cognitive disability

she has autism

he has Down syndrome

she has a learning disability

he has a physical disability

she's of short stature

he has an emotional disability

she uses a wheelchair or mobility chair

he receives special ed services

typical kids – kids without disabilities

congenital disability

he has a brain injury

accessible parking

she needs - or she uses...

INSTEAD OF...

the handicapped or disabled

he's mentally retarded

she's autistic

he's Downs

she's learning disabled

he's quadriplegic/crippled

she's a dwarf (or midget)

he's emotionally disturbed

she's wheelchair bound or
confined to a wheelchair

he's in special ed

normal or healthy kids

birth defect

he's brain damaged

handicapped parking

she has a problem with.

Common Courtesies

- If the disability isn't germane to the conversation, don't mention it.
- Remember, a person with a disability is not necessarily chronically sick or unhealthy.
- Don't automatically assume a person with disabilities in public needs your assistance. Offer assistance, but wait until your offer is accepted before you help. Listen to any instructions the person may give.
- A wheelchair is part of one's personal body space. Leaning or hanging on it, or pushing it unasked, is annoying and rude.
- When speaking to a person who uses a wheelchair for more than a few minutes, place yourself at eye level with that person. This will spare both of you a sore neck.
- Share the same social courtesies with everyone. If you shake hands with people you meet, offer your hand to everyone, regardless of disability.
- When planning events which involve people with disabilities, consider their needs when choosing a location.
- When speaking about people with disabilities, emphasize achievements, abilities and individual qualities. Portray them as they are in real life: sons, daughters, parents, employees, etc.
- When talking to a person who has a disability, speak directly to that person, not through a companion. For people who use sign language, speak to them, not to the interpreter.

REMEMBER, the disability community is the largest minority group in our nation, and it's all-inclusive. It includes people of both genders and of all ages, as well as individuals from all religions, ethnic backgrounds, and socio-economic levels. About the only things people with disabilities have in common with one another is 1) having a body part that is different and 2) facing prejudice and discrimination. The disability community is the only minority group that *anyone* can join, perhaps in the split second of an accident, or perhaps through aging. Many people who do not have a disability now will have one in the future. Others will have a family member or friend who acquires a disability. If and when it happens to you, will you have more in common with others with disabilities or with your family, friends, and coworkers? How will you want to be treated? How will you want to be described?

Adapted from Kathie Snow's "Disability is Natural"

***A List of Commonly-Used
MRDD Abbreviations and Terms***

ADA	Division of Alcohol and Drug Abuse
CARF	Commission on Accreditation of Rehabilitation Facilities, a national accreditation agency
Certification	A process which is designed to assure the health, safety, and human and legal rights for individuals participating in the Medicaid Waiver program and which is intended to enhance the quality of life for those individuals.
CI	Community Integration
CM	Case Manager (same as Service Coordinator)
CMMS	Centers for Medicare and Medicaid Services (Formerly HCFA)
CME	Certified Medication Employee (Utilized in Habilitation Centers)
CMT	Certified Medical Technician
CO	Central Office
CPS	Division of Comprehensive Psychiatric Services
DHSS	Department of Health and Senior Services (Formerly Division of Aging, now a combination of Department of Health and Division of Aging)
DMH	Department of Mental Health
DOR	Department Operating Regulation
DSM IV	Diagnostic and Statistical Manual-Fourth Edition, used by the department professional staff to diagnose clients served
FLA	Family Living Arrangement
ICF/MR	Intermediate care facility for the mentally retarded, a program certified under the federal Medicaid program (Title XIX)
IEP	Individual Education Plan required for school-aged clients of the department
ISL	Individualized Supported Living

Level I Medication Aide DHSS (Medication Aide certification and title issued by the Department of Health and Senior Services)

Licensure A process by which a non-Medicaid Waiver provider of residential or day program services can be determined to meet the licensing requirements relative to admission criteria, care, treatment, and habilitation or rehabilitation needs of residents or consumers.

Medication Aide MR/DD (Medication Aide certification and title issued by the Department of Mental Health Division of MR/DD)

Medicaid Waiver Program A funding source for various programs including, but not exclusive of, placement, etc.

Monthly Review/Quarterly Review (Process for review and update of individual's plan, progress, and needs completed by Service Coordinators)

DMR/DD Division of Mental Retardation and Developmental Disabilities

OSHA Occupational Safety & Health Administration

POC Plan of Care (CMMS Term)

POS The Department's Purchase of Service program

PCP Person Centered Plan

QA Quality Assurance

QAS Quality Assurance Specialist

QM-RN III Quality Management RN for the Regional Centers

QMRP Qualified Mental Retardation Professional

RC Regional Center

RCF Residential Care Facilities

SB 40 Board County property tax board which administers funds for services to people with MR/DD

SC Service Coordinator

SNF Skilled Nursing Facility (Nursing Home)

SSI	Supplemental Social Security Income benefits under Title XVI of the Social Security Act
The Council	The Council on Quality and Leadership in Support for People with Disabilities (accreditation body)
Title XVII	The Medicare program under the Federal Social Security Act
Title XIX	The Medicaid program under the Federal Social Security Act
Title XX	The Social Services program under the Federal Social Security Act.
UAP	Unlicensed assistive personnel

DMRDD Person Centered Planning Process

Each individual who receives DMRDD services funded through the division will have a Person Centered Plan (PCP) in place. The PCP is the authorizing document that drives **all** services specific to the individual and must be updated at least every 365 calendar days. The PCP can be amended anytime during the calendar year.

The PCP contains information and outcomes vital to the overall well-being and chosen outcomes of the individual to include but not limited to health/safety issues, daily activities, relationships, communication and finances. A copy of the current PCP should be maintained in the individual's record at their residence. It is important for the Community RN to be familiar with the content of the PCP. The Community RN's role in the Person Centered Planning Process will vary based on the amount of nursing supports needed by the individual.

Each individual has a treatment planning team consisting of the individual, guardian, family members, friends, provider agency staff and service coordinator. Other advocates who may be involved in this process may include the Regional Center Quality Management RN, Community RN, therapist, physicians etc...

Each individual has a PCP planning meeting prior to the PCP implementation date, the Community RN as well as other advocates may participate in the planning process through written report and/or attendance. The Community RN is not required to attend all PCP meetings however any pertinent medical/health information and outcomes should be included in the current PCP.

The progress towards the PCP outcomes are monitored through the service coordinator's monthly review process. This process will include a review of the Community RN's Monthly Health Summary which would have been submitted to the agency QMRP for attachment to their monthly summary.

Prior to the PCP planning date a Health Inventory will be completed by designated Regional Center staff. The Health Inventory is a statewide tool which identifies health issues through a series of indicators which are scored based on level of acuity. Those individuals meeting a score threshold of 30 or above will receive a Nursing Review completed by the Regional Center Quality Management RN. Information from the review will be provided to the PCP planning team for utilization in the PCP planning process. This quality assurance function (Health Inventory and Nursing Review) is referred to as the Health Identification and Planning System (HIPS).



Section II
Community
RN
Program

Job Functions for the Community RN Position

I. Monitor the health and safety of the individuals receiving residential services.

The Community RN will be responsible for:

- completing a monthly face to face assessment of the individual consumer and record any findings.
- reviewing the individual consumer record monthly to include physician orders and the medication administration record.
- maintaining communication with agency management and habilitation teams including reporting and documenting of all changes in the individual's health status, needs, and identified deficiencies in the standard of care provided to consumers.

II. Provide appropriate delegation and supervision of Unlicensed Assistive Personnel (UAP) or Licensed Practical Nurse (LPN) who perform such duties as medication administration and other nursing tasks when applicable, and document those activities. (Nursing Practices Act Chapter 335 RSMo.)

The Community RN will be responsible for:

- identifying needs for staff supervision /delegation or specialized instruction and any follow-up or plan of action that may result.
- oversight of all functions of medication administration by medication aides certified through DHSS or DMRDD, to include but not limited to the review of physician orders, medication administration record and staff documentation. This would also include periodic inspection of technique and skill of certified aides delegated to pass medications.
- identifying nursing supports individualized to specific consumer needs.
- identifying the support staff who are competent to receive specialized instruction and delegation to perform specific tasks.
- ensuring that specialized instruction regarding identified tasks is provided and documented on the designated form.
- ensuring through periodic oversight/supervision that the identified staff are able to perform the specific task as delegated.

III. Accountability for Activities

The Community RN will be responsible to:

- account for their time dedicated to the functions of the Community RN Program each month. This will be accomplished by completion of the Monthly Service Log.
- ensure the total hours available for each month are accounted for and do not carry over to the next month.
- ensure the Monthly Service Log is completed accurately each month and submitted to their employer for review and maintenance of the document.

Community RN Program Overview

1. Job Functions

- II. Monitor the health and safety of the individuals receiving residential services.
- II. Provide appropriate delegation and supervision of Unlicensed Assistive Personnel (UAP) or Licensed Practical Nurse (LPN) who perform such duties as medication administration and other nursing tasks when applicable, and document those activities. (Nursing Practices Act Chapter 335 RSMo).
- III. Accountability for Activities.

2. Community RN Orientation & Training:

- Community RN's should participate in the Community RN Orientation Training within 90 days of hire or contract. This training is offered by regional centers at least quarterly.
- New Provider's should receive the Community RN orientation with their new provider training offered through the Regional Centers.
- Community RN's should receive the same required training as other new employees except for Medication Aide Certification and First Aide as their license waives the need for this. Community RN's should be current in CPR certification and expect to receive training on abuse and neglect, positive behavior supports, and confidentiality. The employer should maintain a copy of the Community RN's current license and background check.
- Regional Community RN informational meetings will be hosted at least annually by each Regional Center for all Community RNs. Regional meetings will be an informational and provide an opportunity for connecting but would not be mandatory.
- Training that effects the statewide Community RN Program or are statewide training needs identified through quality assurance will be mandatory and may count towards the funded program hours. Community RN's and provider's would be notified of such.

3. Monthly Service Log & Community RN Authorized Hours:

- Each individual in MRDD funded residential services receives 1.25 hours/month for Community RN service. This is a baseline nursing oversight service for all persons in MRDD community placement.
- The hours provided for the Community RN Program services should remain distinct and separate from any other hours the same nurse may contract or be employed for with the agency
- Community RN hours does not include travel or course instruction such as instruction for CPR or for Medication Aide Certification etc.
- The Community RN will complete a monthly service log reflecting the hours of service provided in this capacity. The log will be available in a "form" format on the computer so that consumer names and other consistent information can be completed and printed each month.
- To accommodate individual needs, some flexibility is allowed in the distribution of the consumer's monthly hours. As long as the RN provides at minimum, a monthly face to face assessment and review of each consumer, the hours may be combined and distributed based on needs within each provider agency.
- Total hours should be provided in full each month and should not be carried over into the next month.
- Completed Service Logs should be maintained by the agency and made available for review upon request.

4. Community RN Monthly Health Summary

- The Community RN Monthly Health Summary is a required form utilized for communication of the nurse's assessment, review, and findings. If you prefer to adapt your current documentation tool, you must utilize the same title "Community RN Monthly Health

Summary” and assure the same components on this form are covered in the content of your form.

- The Community RN will complete the Monthly Health Summary each month and submit to the agency’s QMRP. The RN will communicate to appropriate staff what activities need to occur from their evaluation.
- The QMRP will review and attach the Monthly Health Summary to the monthly review for the corresponding month. The QMRP will assure appropriate follow up. This process will support consistent communication of findings, integration of appropriate information into the personal plan and assure follow up is completed.
- The Service Coordinator will review the Monthly Health Summary during the individual’s monthly review to assure necessary action is completed and necessary information is integrated into the personal plan. If there is no monthly health summary, the service coordinator should investigate the reason why and report to QA if the position is vacant or there are other problems in obtaining this report monthly.
- The Monthly Health Summary will be kept in the consumer file in the home as part of the monthly review.
- The Monthly Health Summary should be part of the consumer’s monthly review not later than April 15, 2006.

5. Delegation

- Community RN’s will be provided with a form “Delegation of Specified Nursing Tasks” to document non-licensed staff training, competency and delegation of specific tasks for individuals. The form is consumer and staff specific. It is not required for delegation of medication administration that is covered within the scope of their medication administration training and certification. For example, it would be required to administer medications through a tube since this is not part of basic medication aide training.
- This same form may be used to document rescinded delegation for staff. However, specific personnel details should be documented in the personnel record.
- This form will be kept in the consumer’s record in the home, indicating all staff who have been trained and who are delegated this specific task.
- When there is a change in community RN, it is the new RN’s responsibility to assure there is documentation that staff were trained and persons are deemed competent to continue performing that task.
- To support the nurse’s role in supervision, the provider should assure their Community RN has access to the agencies event reports for medication errors and injuries.

6. Quality Management

- Fiscal Audits will be completed at least every 2 years and as needed in accordance with the fiscal monitoring directive.
- Clinical Audits will be completed through data collected during the Health Identification and Planning System (HIPS) Nursing Review. The analysis of APTS data from nurse reviews will be completed at least annually and as needed.
- During the absence of a Community RN in an agency, the provider agency will be requested to submit a plan for nursing coverage for review by the Regional Center Director and QM RN. The Quality Management Team will incorporate necessary action into the provider’s quality management plan. This may include increased monitoring of the stability of consumer’s overall health status of the consumers and could include funding reimbursement. New staff hired during the absence of a RN should not perform nursing tasks including medication administration without benefit of nursing delegation and supervision.

Created on 1/25/2006 4:36:00 PM



DMRDD Community RN Monthly Service Log

1. Provider Agency Name: Quality Care Inc. 2. Month/Year: March/2007 3. Total Authorized Hours Per Month: 10 Per Agency or Community RN (circle one)

4. Date	5. Individual's Name	6. Facility Name	7. Face to Face Assessment	8. Labs	9. Review of Physician orders	10. Review of Medication(s)	11. Review of Record	12. Delegation/ Specialized Training/ Supervision	13. Other (Specify)
3-15-07	Monday Smith	Canyon Street Group Home	X		X	X	X		
3-15-07	Tuesday Jones	Canyon Street Group Home	X	X	X	X	X		
3-08-07	Wednesday Johnson	Canyon Street Group Home	X		X	X	X	X	
3-08-07	Thursday Baker	Canyon Street Group Home	X		X	X	X		
3-08-07	Friday Adams	Bluffs St. ISL							Phone contact with dietician. See Note
3-26-07	Saturday Cooper	Bluffs St. ISL	X	X	X	X	X		
3-26-07	Sunday Daniels	Ridgeway Lane ISL	X		X	X	X		
3-11-07	April Evans	Ridgeway Lane ISL	X		X	X	X		
3-26-07	Friday Adams	Bluffs St. ISL	X		X	X	X		
3-19-07	April Evans	Ridgeway Lane ISL						X	
EXAMPLE									

| 14. Total amount of time per date |
|-----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|
| <u>3/8/07</u> | <u>3/11/07</u> | <u>3/15/07</u> | <u>3/19/07</u> | <u>3/26/07</u> | | | | | | | |
| 4 hours | 1 hours 15 min. | 1 hour 15 min | 2 hour 15 min | 1 hour 15 min | | | | | | | |

15. Total Time Per Month: 10 hours 16. Community RN Signature: Shea Nurse RN 17. Community RN Name (Printed): Shea Nurse RN 18. Date: 3-31-07

Missouri Department of mental Health
Division of Mental Retardation and Developmental Disabilities
Community RN Monthly Service Log Operational Instructions

Purpose: The RN Service Log will serve as an auditing tool for both the Provider Agency and MRDD to account for the Community RN services and monthly hours.

Process:

- The Community RN will be responsible to account for their time dedicated to the functions of the Community RN Program each month. This will be accomplished by the completion of the service.
- The Community RN will need to sign and date the service log monthly.
- Total hours should be fulfilled each month and not carried over.
- The Community RN will be responsible for ensuring that the form is completed accurately each month and submitted to their employer for review and maintenance of the document.

Directions:

1. **Provider Agency Name:** Name of the company which is providing the contracted Community RN service
2. **Month/Year:** The month and year service is provided
3. **Total Authorized Hours Per Month:** The formula used to establish a rate per contract was 1.25 hours per person however, to accommodate flexibility based on individual needs, as long as the Community RN provides at minimum a monthly evaluation of each individual and oversight of delegated tasks, the hours may be distributed based on individual needs within the provider agency. The hours cannot carry over from one month to the next. The RN needs to circle if the total number of hours listed are per agency or based on 1 Community RN's hours for providing service for that agency.
4. **Date:** Current date of service to include month and day
5. **Individual Name:** Full name of the individual who is receiving the Community RN service.
6. **Facility Name:** Name of the individual's specific residence.
- 7-16 choose all that apply
7. **Assessment:** Face to face evaluation with the individual and staff in the home including assessment of individual's specific issues
8. **Labs:** Review, analyze and interpret lab results. Ensure that the agency has a protocol established for necessary labs and follow-up.
9. **Review of Physician Orders:** The monthly review of physician's orders for physician signature, accuracy and staff compliance. To include the signature/date of the Community RN identifying the review of any new orders.
10. **Review of Medication(s):** To include monthly review of the medication administration record (MAR) for accuracy (compare to orders) and staff compliance, medication labels, monitor for side effects (including Tardive Dyskinesia), effectiveness, frequency of PRN use, drug storage of routine and PRN medications, and check for supporting diagnosis.
11. **Review of Records:** To include wt, immunization records, bowel, vitals, blood sugar, dietary, fluids, seizure, menses, skin, range of motion, consultation reports, event reports for falls, injuries, psychotropic meds and medication errors ,hospitalization, ER reports and significant change in behavior etc.)
12. **Delegated Nursing Tasks/Specialized Instruction/Supervision:** Which include but are not limited to those tasks listed in the MRDD Health Reference Manual and /or specialized instruction and supervision of tasks based on the individualized needs of the individual (*does not include med administration, CPR and first aid courses*).
13. **Other:** Any additional services not specified on this form i.e. direct nursing care, nursing directives pertinent to health monitoring processes etc.
14. **Total Number of Hours for Date:** Total amount of time provided for Group Home, Residential Care Facility or ISL for that date
15. **Total Time Per Month:** Total amount of time provided for all services for the month
16. **Community RN Signature:** Full signature of the Community RN providing the logged service.
17. **Community RN Name Printed:** Printed name of Community RN providing the logged service.
18. **Date:** Date of RN signature.

Community RN Delegation Of Specified Nursing Task

Individuals Name: _____

ID Number: _____

Provider Agency Name: _____

Facility Name: _____

Delegated Task: _____

Purpose of Task: _____

The following agency employees have been trained by a licensed person, demonstrate competency in all instructed procedures and are being delegated the task indicated above. This delegation and individualized instruction is specific to this individual and may not be transferred to other individuals with similar needs within this or other agencies.

Date of Delegation	Name/Title	Staff Signature	Initials
1. _____	1. _____	_____	<input type="checkbox"/> Rescinded Date: _____
2. _____	2. _____	_____	<input type="checkbox"/> Rescinded Date: _____
3. _____	3. _____	_____	<input type="checkbox"/> Rescinded Date: _____
4. _____	4. _____	_____	<input type="checkbox"/> Rescinded Date: _____
5. _____	5. _____	_____	<input type="checkbox"/> Rescinded Date: _____
6. _____	6. _____	_____	<input type="checkbox"/> Rescinded Date: _____
7. _____	7. _____	_____	<input type="checkbox"/> Rescinded Date: _____
8. _____	8. _____	_____	<input type="checkbox"/> Rescinded Date: _____
9. _____	9. _____	_____	<input type="checkbox"/> Rescinded Date: _____
10. _____	10. _____	_____	<input type="checkbox"/> Rescinded Date: _____
11. _____	11. _____	_____	<input type="checkbox"/> Rescinded Date: _____
12. _____	12. _____	_____	<input type="checkbox"/> Rescinded Date: _____

The delegating RN is responsible for the provision of guidance and ongoing evaluation for the delegated nursing task including periodic inspection based at intervals determined by the delegating RN. The delegating RN maintains authority to require corrective action or rescind delegation of this task.

Task Rescinded: Change in Health Status Other: _____

Delegating RN: _____ Date: _____
Signature & Title

_____ of _____ Pages

SPECIALIZED INSTRUCTION FOR DELEGATION

PROCEDURES/Steps to follow to perform the task

What to OBSERVE for and REPORT, what to DO, and WHOM to CONTACT.

***Attach any additional instructional documentation**

Instructional Licensed Medical Professional:

Signature and Title

Date: _____ Contact# _____

Delegating RN if different than Instructing Medical Professional:

Signature and Title

Date: _____ Contact# _____

**Missouri Department of Mental Health
Division of Mental Retardation and Developmental Disabilities**

**Community RN Delegation of Specified Nursing Task
Operational Instructions**

Purpose: The RN Delegation of Task form will serve as tool for the Community RN to record any training / specialized instruction specific to the individual.

Process:

- The Community RN will be responsible for identifying what nursing supports a specific individual needs.
- Once the specific supports are identified the Community RN will then identify what support staff will be able to receive specialized instruction and delegation to perform the task.
- The Community RN will then ensure that specialized instruction regarding identified task is provided and document information on the Delegation of Task form.
- The Community RN will be responsible for ensuring through periodic oversight/supervision that identified staff are able to perform the specific task as delegated.

Directions:

1. The Community RN will identify any nursing supports that require nursing delegation.
2. The individual date column will identify the specific date of specialized instruction and delegation.
3. Each identified support/task will be documented on a separate Specialized Instruction for Delegation Form, listing any and all procedures to follow to perform the specified task as well as what to observe for and report, what to do and whom to contact.
4. The Specialized Instruction for Delegation section will be signed and dated by the Instructional Licensed Medical Professional providing the information i.e. Home Health nurse, physician etc....
5. The Specialized Instruction for Delegation section will be signed and dated by the delegating RN if different than the Instructing medical professional.
6. The specialized instruction including any clinical instruction and observation will be provided to identified support staff and will be identified on the RN Delegation for Specified Nursing Task form to include the staff's name and title and staff signature. Delegating RN will also sign and date the form.
7. In the event that the individual no longer requires the specified delegated task the RN Delegation for Specified Nursing Task Form can be rescinded by the delegating RN.
8. In the event that a specific staff is no longer identified as being able to perform the specified delegated task, the Community RN can identify on the RN Delegation for Specified Nursing Task form by checking the staff's name dating, and initialing in the identified box.

A copy of the RN Delegation for Specified Nursing Task Form and any specialized instructions shall be kept in the individual's record in their home.

Missouri Revised Statutes

Chapter 335 Nurses Section 335.016

August 28, 2005

Definitions.

335.016. As used in this chapter, unless the context clearly requires otherwise, the following words and terms mean:

- (1) "Accredited", the official authorization or status granted by an agency for a program through a voluntary process;
- (2) "Advanced practice nurse", a nurse who has had education beyond the basic nursing education and is certified by a nationally recognized professional organization as having a nursing specialty, or who meets criteria for advanced practice nurses established by the board of nursing. The board of nursing may promulgate rules specifying which professional nursing organization certifications are to be recognized as advanced practice nurses, and may set standards for education, training and experience required for those without such specialty certification to become advanced practice nurses. Advanced practice nurses and only such individuals may use the title "Advanced Practice Registered Nurse" and the abbreviation "APRN";
- (3) "Approval", official recognition of nursing education programs which meet standards established by the board of nursing;
- (4) "Board" or "state board", the state board of nursing;
- (5) "Executive director", a qualified individual employed by the board as executive secretary or otherwise to administer the provisions of this chapter under the board's direction. Such person employed as executive director shall not be a member of the board;
- (6) "Inactive nurse", as defined by rule pursuant to section 335.061;
- (7) A "licensed practical nurse" or "practical nurse", a person licensed pursuant to the provisions of this chapter to engage in the practice of practical nursing;
- (8) "Licensure", the issuing of a license to practice professional or practical nursing to candidates who have met the specified requirements and the recording of the names of those persons as holders of a license to practice professional or practical nursing;
- (9) "Practical nursing", the performance for compensation of selected acts for the promotion of health and in the care of persons who are ill, injured, or experiencing alterations in normal health processes. Such performance requires substantial specialized skill, judgment and knowledge. All such nursing care shall be given under the direction of a person licensed by a state regulatory board to prescribe medications and treatments or under the direction of a registered professional nurse. For the purposes of this chapter, the term "direction" shall mean

guidance or supervision provided by a person licensed by a state regulatory board to prescribe medications and treatments or a registered professional nurse, including, but not

limited to, oral, written, or otherwise communicated orders or directives for patient care. When practical nursing care is delivered pursuant to the direction of a person licensed by a state regulatory board to prescribe medications and treatments or under the direction of a registered professional nurse, such care may be delivered by a licensed practical nurse without direct physical oversight;

(10) "Professional nursing", the performance for compensation of any act which requires substantial specialized education, judgment and skill based on knowledge and application of principles derived from the biological, physical, social and nursing sciences, including, but not limited to:

(a) Responsibility for the teaching of health care and the prevention of illness to the patient and his or her family;

(b) Assessment, nursing diagnosis, nursing care, and counsel of persons who are ill, injured or experiencing alterations in normal health processes;

(c) The administration of medications and treatments as prescribed by a person licensed by a state regulatory board to prescribe medications and treatments;

(d) The coordination and assistance in the delivery of a plan of health care with all members of a health team;

(e) The teaching and supervision of other persons in the performance of any of the foregoing;

(11) A "registered professional nurse" or "registered nurse", a person licensed pursuant to the provisions of this chapter to engage in the practice of professional nursing.

(L. 1975 S.B. 108 § 2, A.L. 1993 H.B. 564, A.L. 1995 S.B. 452, A.L. 1999 H.B. 343, A.L. 2002 H.B. 1600, A.L. 2004 S.B. 1122)

(1993) It is the public policy of Missouri that registered nurses licensed in this state have an obligation to faithfully serve the best interests of their patients. The Nurses Practices Act and regulations thereunder set forth a clear mandate of public policy that a nurse not "stay out" of a dying patient's improper treatment. Grant of summary judgment based on finding that there was no public-policy exception to employment-at-will doctrine was not proper. *Kirk v. Mercy Hospital Tri-County*, 851 S.W.2d 617 (Mo. App. S.D.).

RN Scope of Practice

Pursuant to the Nursing Practice Act (1999), registered professional nurses [statute, 335.016(10), RSMo] are able to independently perform nursing acts including, but not limited to, the entries under (a) through (e) of the statute, 335.016 (10), RSMo, as long as they defensibly have the requisite specialized education, judgement, and skill and an authorized prescriber's order to administer medications and treatments when indicated [335.016(10)(c), RSMo]. Registered professional nurses may perform nursing acts without physician oversight [see also Missouri Supreme Court case, Sermchief v. Gonzales, 660 S.W.2d 683 (Mo.banc 1983)].

If registered professional nurses (RNs) are to perform acts "prescribed by a person licensed by a state regulatory board to prescribe medications and treatments" [335.016 (10)(c), RSMo] as part of a patient's care, an authorized prescriber-registered professional nurse relationship must clearly be in place and verbal or written orders from and cosigned by the authorized prescriber delegating the acts would be needed by registered professional nurses. The acts being delegated must be within the scope of practice of the authorized prescriber and the registered professional nurses must have the ability to perform the delegated acts defensibly, safely and competently.

For example, a physician-registered professional nurse contractual relationship may be established for the performance of medically delegated acts by a registered professional nurse in at least two (2) ways:

First, a professional relationship between a physician and a RN can be established and exercised through the traditional means of specific, and later cosigned, verbal orders from a physician or written orders, possibly in the form of protocols or standing orders, generated and signed by a physician and carried out by a RN. In this case, the relationship is not based on a jointly agreed upon practice arrangement and, therefore, would not constitute a collaborative practice arrangement.

Second, a registered professional nurse who is not recognized by the Missouri State Board of Nursing as an advanced practice nurse within a specific clinical nursing specialty area and role may enter into a written collaborative practice arrangement with a physician pursuant to the statute, 334.104.1, RSMo, and rule, 4 CSR 200-4.200 Collaborative Practice. Through a written agreement, jointly agreed upon written protocols, or written standing orders for the delivery of health care services, a physician may delegate to a RN who is not an advanced practice nurse the authority to administer or dispense drugs and provide treatment within the RN's scope of practice and consistent with the RN's skill, training, and competence.

(This information is from the MO State Board of Nursing Website)

LPN SCOPE OF PRACTICE

Pursuant to the Nursing Practice Act (1999), licensed practical nurses [statute, 335.016 (9), RSMo] are able to perform nursing acts that they defensibly have the requisite specialized skill, judgment, and knowledge to perform only "under the direction of a person licensed by a state regulatory board to prescribe medication and treatments or under the direction of a registered professional nurse" [see also statute, 335.016 (10) (e), RSMo, and rule, 4 CSR 200-5.010 Definitions (i.e., proper supervision)]. Licensed practical nurses, by statutory law, are not authorized to independently perform nursing care/acts. It is essential, therefore, for licensed practical nurses to have ongoing defensibility with respect to under whose specific direction (i.e., supervision) they are working at any given time. Furthermore, it is important for licensed practical nurses to have immediate access, at all times, to the individual (e.g., physician, registered professional nurse) under whose direction they are working when, for example:

- (a) patients' care needs exceed their legal scope of practice;
- (b) patients' care needs surpass their knowledge, education, skills, training, or experience; or
- (c) patients' conditions indicate pressing importance of consultation or imminent referral consideration.

If licensed practical nurses (LPNs) are to perform acts prescribed by "a person licensed by a state regulatory board to prescribe medications and treatments" [335.016(9), RSMo] as part of a patient's care, an authorized prescriber-licensed practical nurse relationship must clearly be in place and verbal or written orders from and cosigned by the authorized prescriber delegating the acts would be needed by licensed practical nurses. The acts being delegated must be within the scope of practice of the authorized prescriber and licensed practical nurses must ensure that appropriate oversight is in place (see rule, 4 CSR 200-5.010) and that they possess the ability to perform the delegated acts defensibly, safely, and competently.

For example, a physician-licensed practical nurse relationship may be established for the performance of physician-delegated acts that are associated with prescribed medications and treatments: (a) through specific, and later cosigned, verbal orders from a physician; (b) through specific written orders from a physician; or (c) through written orders, possibly in the form of protocols or standing orders, generated and signed by a physician. The acts being delegated must be within the scope of practice of the prescribing physician and the licensed practical nurse must ensure that appropriate oversight is in place (e.g., physician, registered professional nurse) and that she/he possesses the ability to perform the delegated acts defensibly, safely, and competently. Licensed practical nurses must keep in mind that merely having physicians' orders for patients, however, does not mean that they also have physician oversight for their practice.

(This information is from the MO State Board of Nursing Website)

Delegation to and Supervision of Unlicensed Assistive Personnel

The American Nurses Association (1993) and the National Council of State Boards of Nursing (1995) defined unlicensed assistive personnel (UAP) as unlicensed individuals, regardless of title, trained to function in an assistive role to licensed nurses in the provision of patient/client care activities. When properly utilized, unlicensed assistive personnel can enhance efficiency and quality of care in hospitals (Kreplick, 1995) and other health care environments. Generally speaking, however, determining the boundaries of what constitutes 'proper utilization' of unlicensed assistive personnel seems an elusive process to licensed nurses.

Two essential behaviors imbedded within the process of properly utilizing unlicensed assistive personnel are delegation and supervision by registered professional nurses (American Nurses Association, 1993; National Council of State Boards of Nursing, 1995).

Delegation

The National Council of State Boards of Nursing (1995) defined delegation:

An authorized delegator transferring to a competent individual (delegatee) the authority to perform a selected nursing task in a selected situation. The licensed nurse delegator retains accountability for the delegation.

Pursuant to the statute, 335.010 (10) (e), RSMo (Missouri Nursing Practice Act 1999), registered professional nurses may teach and supervise "other persons in the performance of any of the" nursing acts specified in subsections (a) through (d). In subsections (a) through (d), however, there is no laundry list of selected nursing care or tasks that can and cannot be delegated by registered professional nurses to licensed practical nurses [335.016 (9), RSMo, 1999] and unlicensed assistive personnel. Even the statute, 335.081 (2), RSMo, which provides an exemption from the Missouri Nursing Practice Act for services rendered by unlicensed individuals trained and employed in public or private hospital and licensed long-term care facilities, does not specify particular nursing tasks that can and cannot be delegated to these unlicensed personnel by registered professional nurses. Licensed nurses employed in such facilities would need to also examine the statutes and rules applicable to these licensed facilities for further guidance, as well as review facility policies and procedures.

The lack of statutory specificity regarding what particular nursing care or tasks can and cannot be delegated by registered professional nurses to licensed practical nurses and unlicensed assistive personnel increases the importance of being able to render reasonable, prudent, and defensible delegative decisions. The delegating registered professional nurse is responsible and answerable for actions or inactions of one's self or others in the context of delegation (National Council of State Boards of Nursing, 1995). Licensed practical nurses and unlicensed assistive personnel remain accountable for their own actions and inactions (Missouri State Board of Nursing, 1999).

Through its Practice Committee, the Missouri State Board of Nursing assists individuals or facilities regarding specific practice matters. When a specific scope of practice question is addressed in writing to the Board, the Missouri State Board of Nursing responds with a specific written opinion or decision. Sometimes licensed nurses will use the resources of the Board to assist them in making reasonable and prudent decisions in particular instances.

Professional literature may also provide some assistance in decision making. Kreplick (1995), for example, described the most frequently delegated nursing tasks:

Basic care [morning/evening care; monitoring body mechanics and skin integrity; application of cold and heat; post-mortem care (Crawley, 1993)] Vital signs and measurements (height; weight; intake and output)
Nutritional support (to assist with meals; take calorie counts; maintain gravity tube feedings)
Elimination (catheter care; enema administration; application and monitoring of condom catheters)
Uncomplicated respiratory care (breathing exercises; monitoring incentive spirometer use; application of oxygen by nasal cannula or mask; suctioning)
Specimen collection (stool; sputum; urine)
Documentation (flow charts; intake and output recordings; vital sign records; diabetic records; other nursing tasks performed).

The National Council of State Boards of Nursing (1995), in its paper, "Delegation: Concepts and Decision-Making Process" (http://www.ncsbn.org/regulation/uap_delegation_documents_delegation.asp), and the American Nurses Association (1995), in its pamphlet, "The ANA Basic Guide to Safe Delegation" (<http://www.nursingworld.org>), provide further assistance to registered professional nurses on how to safely and appropriately maximize the utilization of other licensed and unlicensed health care providers. The essence of professional practice, however, is never delegated according to Barter, 1999 – such as formulating the entire nursing process, making nursing diagnoses, developing the plan of care or setting patient goals, evaluating patient progress in relation to the plan of care, and so forth.

Exploring these and other professional articles, along with examining various specialty area position statements, on the topic of delegation or utilization of assistive personnel is important for the ongoing development of licensed nurses' critical thinking. With this proactive approach, licensed nurses may, when faced with an immediate delegative decision-making situation, more likely make a state-of-the-art, reasonable, prudent, and defensible judgment.

It is inappropriate for employers or others to require licensed nurses to delegate when, in the nurse's professional judgment, delegation is unsafe and not in the patient's best interests. If licensed nurses determine that delegation should not take place, but nevertheless elect to delegate as directed by an employer, the nurses increase their liability risk and may also be subject to discipline by the Board of Nursing (National Council of State Boards of Nursing, 1995).

Given their responsibilities and accountabilities, licensed nurses at all levels of management and practice need to involve themselves in the ongoing development, implementation, maintenance, and evaluation of assistive role policies within their facilities. Being part of these ongoing processes within a facility can increase knowledge and understanding of how to properly train and successfully utilize unlicensed assistive personnel within the facility, safeguard the health and wellbeing of the patients cared for, and lessen liability risks.

Supervision

The National Council of State Boards of Nursing (1995) defined supervision:
The provision of guidance or direction, evaluation and follow-up by the licensed nurse for accomplishment of a nursing task delegated to unlicensed assistive personnel.

Pursuant to the Missouri State Board of Nursing rule, 4 CSR 200-5.010 Definitions, proper supervision is defined:
Proper supervision means the general overseeing and the

authorizing to direct in any given situation. This includes orientation, initial and ongoing direction, procedural guidance and periodic inspection and evaluations.

Regardless of appropriate training and competency verification of assistive personnel and reasonable and prudent delegative decisions, there is no guarantee of flawless performance by a delegatee. Patient care cannot be merely assigned or simply 'turned over' as if the patient's care is now an independent activity of the delegatee. Once an appropriate delegation is made, registered professional nurses must adequately monitor and supervise the activities delegated to licensed practical nurses and unlicensed assistive personnel and evaluate their performance on the basis of whether quality patient outcomes, including accurate and complete care documentation, have been achieved. Determining the particular type of supervision to utilize must be based on a case by case analysis of pertinent variables.

Understanding Your Risks

According to several authors, liability and professional responsibility risks occur in several areas that are related to delegation and supervision:

Delegation to an individual lacking sufficient education or experience to perform the nursing task

Delegation of nursing tasks and responsibilities contrary to the state nurse practice act

Delegation that poses substantial risk or harm to the patient or results in patient injury

Inadequate supervision of the individual to whom the nursing tasks has been delegated.

The reality of risk does not mean a licensed nurse should not delegate. In fact, not delegating when it may be timely and appropriate to do so can obviously create another list of risks. Knowledge and understanding of risks associated with delegation and supervision does mean that licensed nurses should develop reasonable, prudent, and defensible professional boundaries within which appropriate and effective delegative decisions are made and proper supervision is implemented. (1999)

(This information is from the MO State Board of Nursing Website)

Frequently Asked Questions

Originally published Nov, Dec, 1999, Jan 2000 BON Newsletter

A Few Perspectives on Unlicensed Assistive Personnel

With the Board's revision of its position statement on unlicensed assistive personnel at its March 1999 Full Board meeting, I developed an interest in researching the question, "Who are they, really, in Missouri?" I have chosen to share my seminal thoughts with you in the hope of beginning a clarifying examination of the matter.

Establishing boundaries for membership within the unlicensed assistive personnel category may be a challenge not only for the general public but for licensed professionals as well. Although possessing no license from a state regulatory body would seem like fairly clear criteria, the growing number of health care provider "accredited" program options, title designations, certificate awards, certification or registration conferment's, garment attributions, and so forth currently available to individuals convey official credibility to the degree that one may inaccurately surmise statutory/regulatory underpinnings, including licensure.

A cursory review of literature on and off the Internet elicited the following labels, which by no means are exhaustive, that could possibly fall into the unlicensed health care personnel category unless licensed and regulated by state laws: medical assistant, nursing assistant, nurse assistant, clinical affiliate, patient care technician, patient care giver, health care technician, medication aide, medication technician, nurse aide, health unit coordinator, allied health professional, para-professional and, of course, unlicensed assistive personnel (UAP). Some of these labels are preceded by terms such as "certified" or "registered". Whether these special, added designations are grounded within state law would also require further scrutiny. Additionally, information concerning the certifying entity itself may be relevant.

Given numerous health-related settings in which unlicensed health care providers may be employed, trained, and titled in various ways, I have elected to circumscribe my examination as follows.

"Nurse Assistant" Training Programs in Missouri

Division of Aging. The statute, 335.081 (2), RSMo, provides an exemption from the Nursing Practice Act for unlicensed persons "trained and employed in" licensed long-term care facilities as long as the persons do not represent or hold themselves out as nurses. Pursuant to the rule, 13 CSR 15-13.010 Nurse Assistant Training Program, the Missouri Department of Social Services, Division of Aging (DOA), provides a nurse assistant training program through more than seven hundred (700) approved training agencies in a variety of entities in Missouri. Examples of DOA-approved training agencies include specific public high schools, community colleges, vocational technical schools, private schools, hospitals, and long term care facilities. These approved training agencies must use the DOA-approved manual and DOA-approved instructors who are registered professional nurses who must have two (2) years of nursing experience and at least one (1) year of long term care experience.

Individuals enrolled in the program:

- ◆ complete seventy-five (75) classroom hours of training,
- ◆ complete one hundred (100) hours of supervised on-the-job clinical practice training.
- ◆ complete written and practicum examinations:
 - ◆ written, fifty (50) multiple choice question DOA-approved examination (must be passed at 80% to proceed to practicum examination) under the direction of a DOA-approved examiner, and
 - ◆ practicum examination that includes nine (9) procedures. The nine (9) procedures shall always include a type of bath, vital signs (T, P, R, BP), transfer techniques, feeding techniques, dressing and grooming, skin care, active or passive ROM to upper and lower extremities, and hand washing and gloving from the standardized

DOA-approved curriculum. The remainder shall be selected according to the resident's care needs at the time of day that testing occurs. The evaluation of the student shall include communication and interaction with the resident, provision of privacy, work habits, appearance, conduct, and reporting and recording skills (practicum must be passed at 100%).

If individuals successfully complete the examinations and clinical training, one (1) of seven (7) long-term care associations or other DOA-approved entities in Missouri issues a wall certificate, wallet card with photo, and pin to the person. These specifically named long-term care associations or other DOA-approved entities are referred to as "certifying agencies" in the rule. I think this rule definition relates, then, to the individuals being designated as and using the title, certified nurse assistant.

A critical feature of the DOA-approved Nurse Assistant Training Program is stated in the rule as follows:

(2) The purpose of the Nurse Assistant Training Program shall be to prepare individuals for employment in an LTC facility. The program shall be designed to teach skills in resident care which will qualify students to perform uncomplicated nursing procedures and to assist licensed practical nurses or registered professional nurses in direct resident care. (Note: LTC means a long-term care facility)

In other words, the title, certified nurse assistant (CNA), that individuals use after successful completion of the DOA-approved Nurse Assistant Training Program is setting and client population specific. My impression, however, is that, over time, this course content and clinical practice specificity has been overshadowed by a trend toward using completion of this training program and issuance of title designation, certified nurse assistant (CNA), as if the content and title are authorized as generalizable to other settings and client populations.

The Division of Aging also has other unlicensed assistive personnel training programs: certified medication technician training program, level I medication aide training program, and insulin administration training program. As mentioned above, the course content and clinical practice in each of these programs is also setting and client population specific.

Persons who want to verify whether an individual has successfully completed nurse assistant training through the DOA and is in good standing (i.e., does not have a federal disqualification mark) can call the automated voice response telephone number: 573-526-5686.

To verify the status of a nurse assistant, medication technician, or level I medication aide with respect to the employee disqualification list, call 573-526-3633.

Hospitals. Unlicensed assistive personnel may also receive nurse aide or technician training in Missouri hospitals. The statute, 335.081 (2), RSMo, provides an exemption from the Nursing Practice Act for unlicensed persons "trained and employed in public or private hospitals" as long as the persons do not represent or hold themselves out as nurses. The training provided facilitates individuals in satisfactorily performing their assigned job classification duties and responsibilities within a particular hospital setting. The training may vary in content, quality, duration, and competency measurement from hospital to hospital. Titles assigned to unlicensed assistive personnel working in hospitals may also vary from one facility to another.

Other. Unlicensed individuals may come to Missouri from other states where they completed either state approved or other health care training programs. There are no state reciprocity options available in Missouri. Unlicensed individuals who have been certified as a

nurse assistant by another state's administrative body, however, may challenge the program offered through DOA.

“Medical Assistant” Training

Based on a brief exploration of the medical assistant label, I found a variety of resources that I have only started to digest. What I have learned so far I will share with you, but please know that these perspectives are initial understandings in an area replete with information.

It appears that various sectors have, over the years, developed formal structures intended to afford legitimacy to medical assistant training programs and subsequent titling designation. To my knowledge, there is no statutory title protection for medical assistants, licensure, or regulatory oversight for their practice in Missouri.

The Healthcare Career Resource Center <http://library.thinkquest.org/15569/car1bmd3.html> describes the duties and responsibilities of medical assistants as follows:

Nursing aides work under the direction of other health care professionals, usually in nursing homes or hospitals. Their duties include taking the blood pressure, temperature, and pulse of patients. They help patients get in and out of bed, take baths, and dress. They also serve meals and perform housekeeping chores like making beds and cleaning rooms

The American Association of Medical Assistants (AAMA), the association for “medical assistant professionals”, <http://www.aama-ntl.org> discusses the nature of the work of medical assistants more expansively following a lead-in of “Clinical duties vary according to state law and include...” Graduates from a medical assisting program accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP), established as a non-profit agency in 1994 <http://www.caahep.org>, are eligible to take the AAMA certification examination. Upon successful completion of the certification examination, individuals are awarded the “certified medical assistant (CMA) credential by the AAMA. Recertification, met through re-examination or continuing education, is every five (5) years. The mission of the AAMA, established in 1955, is stated as: “...to promote the professional identity and stature of its members and the medical assisting profession through education and credentialing.” “The mission of CAAHEP is to provide public recognition for quality allied health education programs in the CAAHEP system.” By its report, CAAHEP, recognized by the Council for Higher Education Accreditation (CHEA), accredits nearly 2000 allied health educational programs in eighteen (18) disciplines.

According to information posted on the AAMA Internet Home Page on June 12, 1999, there are five (5) state chapters of the Missouri State Society of Medical Assistants.

The Accrediting Bureau of Health Education Schools (ABHES) also recognized by CHEA and listed as a nationally recognized accrediting agency by the U.S. Department of Education, appears to be another entity that accredits “specialized programs for medical assistant in the private sector” at <http://www.abhes.org/> Accreditation is voluntary.

There is another medical assistant certification examination available through American Medical Technologists (AMT) at <http://www.amt1.com/>. Once applicants have successfully completed the AMT certification examination, they are able to refer to themselves as a “registered medical assistant” (RMA). The RMA is certified for life and remains current as long as payment of dues is current. Continuing education is recommended, not mandatory. Only CAAHEP-accredited educational program graduates may take the AAMA certification examination.

Missouri State Board of Nursing Position on UAPs

The Missouri State Board of Nursing's position statement on the "Utilization of Unlicensed Health Care Personnel" states:

Unlicensed health care personnel who perform specific nursing care tasks without benefit of instruction, delegation, and supervision by licensed nurses may be engaged in the practice of nursing without a license. Such actions by unlicensed health care personnel are a violation of the Missouri Nursing Practice Act [335.066(10), RSMo]. Unlicensed health care personnel remain personally accountable for their own actions.

Use of the Term, "Nurse", by UAPs

Some time ago I reviewed the Missouri Nursing Practice Act and found the following statutory references that will be assistive if you need to address the matter of unlicensed assistive personnel (UAP) using the term, "nurse", in reference to themselves or that an employer is using "nurse" as part of a UAP's job title and responsibilities:

- ◆ 335.076.1. - 3., RSMo
- ◆ 335.086(4), RSMo
- ◆ 335.096, RSMo

Go to the Missouri State Board of Nursing Home Page at <http://pr.mo.gov/nursing.asp> and click on "Rules and Statutes (Nursing Practice Act)" for a complete text of these statutes.

For more information concerning class A misdemeanors, the penalty for violation of the above provisions, see the statutes, 556.016.3, RSMo, and 557.021.3(2)(a), RSMo via entry at <http://www.moga.state.mo.us/STATUTES/STATUTES.HTM>. Click on XXXVIII. Crimes and Punishment.

I trust this article on unlicensed assistive personnel has begun to address the question, "Who are they, really, in Missouri?" and, of course, is helpful to readership. Future articles will continue to examine the unlicensed assistive personnel area. If I have inadvertently missed or misunderstood any pertinent facts, please feel free to contact me at the Board office address (see [Newsletter](#) cover page); fax 573-751-0075; office 573-751-0073; or e-mail nursing@pr.mo.gov. (1999)

Frequently Asked Questions

Originally published Aug Sept Oct 1999 BON Newsletter

Updated websites and email addresses 8/2005

(This information is from the MO State Board of Nursing Website)

GENERAL DOCUMENTATION GUIDELINES

1. The consumer's chart is a legal document which means that it is a court of law as evidence of truth. The chart must conform to certain legal standards and shall meet all regulatory, accrediting, and professional organization standards.
2. Use black permanent ink for entries.
3. Date, time and sign all entries. Use first initial, last name and title. Full signature and title must be on file in agency.
4. Entries are to be legible with no blank spaces left on a line or in any area of the documentation. If a space is left on a line, draw a line through the space to the end of the line. For large areas not used on a form or page, use diagonal lines to mark through the area.
5. For errors, draw a line through the error, write error, initial and date the line. Do not attempt to erase, obliterate or "white out" the error.
6. Entries are to be factual, complete, accurate, contain observations, clinical signs and symptoms, consumer quotes when applicable, nursing interventions, and consumer reactions. Do **not** give opinions, make assumptions, or enter vague, meaningless statements (e.g., "adequate fluids"). Be specific.
7. Use correct grammar, spelling, and punctuation.
8. Write consumer's name and other identifying information on each page of the chart.
9. Be sure to use only those abbreviations approved by your agency/facility.
10. Documentation should occur as soon after the care given as possible. Note problems as they occur, resolutions used and consumer's status. Do **not** chart in advance.
11. Chart an omission as a new entry. Do not backdate or add to previously written entries.
12. Record only your own observations and/or actions. If you receive information from another caregiver, state the source of the information.
13. When leaving messages, document time, name, and title of person taking message and telephone number you called.
14. Record the date, time and content of all telephone consumer related communications.
15. Record consumer assessment before and after you administer medications or other treatments.
16. Document any discussion of questionable medical order, and the directions the doctor gave. Include the time and date of discussion and your actions as a result of the discussion and consequent directions given.
17. When an unusual incident occurs, document the incident on the Community Event Form. Do **not** write "incident report filed in the medical record". Do write what happened to the consumer and actions taken to assure the consumer's well-being in the medical record, but record on event report..

18. Never document for someone else or sign another staff's name in any portion of the record.

19. REMEMBER, if you didn't document it, it didn't occur.

REFERENCES

Public Health Nursing Manual (Revised August 2004).

Brent, Nancy. (1997). Nurses and the Law. W.B. Saunders Company.

Kopf, Randi. Are Your Medical Records a Legal Asset or Liability? Legal Documentation Guidelines. Journal of Nursing Law. 1, (1)

Other Resources:

Missouri State Board of Nursing (1996). Documentation /Charting Information Packet.

Missouri State Board of Nursing

The mission of the Missouri State Board of Nursing is to protect the public by development and enforcement state laws governing the safe practice of nursing.

The profession of nursing is a dynamic discipline. Practice potentials change and develop in response to health care needs of society, technical advancements, and the expansion of scientific knowledge. All licensed nurses share a common base of responsibility and accountability defined as the practice of nursing. However, competency based practice scopes of individual nurses may vary according to the type of basic licensure preparation, practice experiences, and professional development activities.

The parameters of the practice scopes are defined by basic licensure preparation and advanced education. Within this scope of practice, all nurses should remain current and increase their expertise and skill in a variety of ways, e.g., practice experience, in-service education, and continuing education. Practice responsibility, accountability, and relative levels of independence are also expanded in this way.

The licensed nurse is responsible and accountable, both professionally and legally, for determining his/her personal scope of nursing practice. Since the role and responsibilities of nurses, and consequently the scope of nursing practice, is ever changing and increasing in complexity, it is important that the nurse makes decisions regarding his/her own scope of practice.

THE PRACTICE OF NURSING

The Practice of Professional (Registered) Nursing:

The performance for compensation of any act which requires substantial specialized education, judgment and skill based on knowledge and application of principles derived from the biological, physical, social and nursing sciences, including, but not limited to:

- Responsibility for the teaching of health care and the prevention of illness to the patient and his or her family;
- Assessment, nursing diagnosis, nursing care, and counsel of persons who are ill, injured or experiencing alterations in normal health processes;
- The administration of medications and treatments as prescribed by a person licensed by a state regulatory body to prescribe medications and treatments;
- The coordination and assistance in the delivery of a plan of health care with all members of a health team;
- The teaching and supervision of other persons in the performance of any of the foregoing.

335.016.(10), RSMo 2000

The Practice of Advanced Practice Nursing:

A nurse who has had education beyond the basic nursing education and is certified by a nationally recognized professional organization as having a nursing specialty, or who meets criteria for advanced practice nurses established by the board of nursing. 335.016.(2), RSMo 2000.

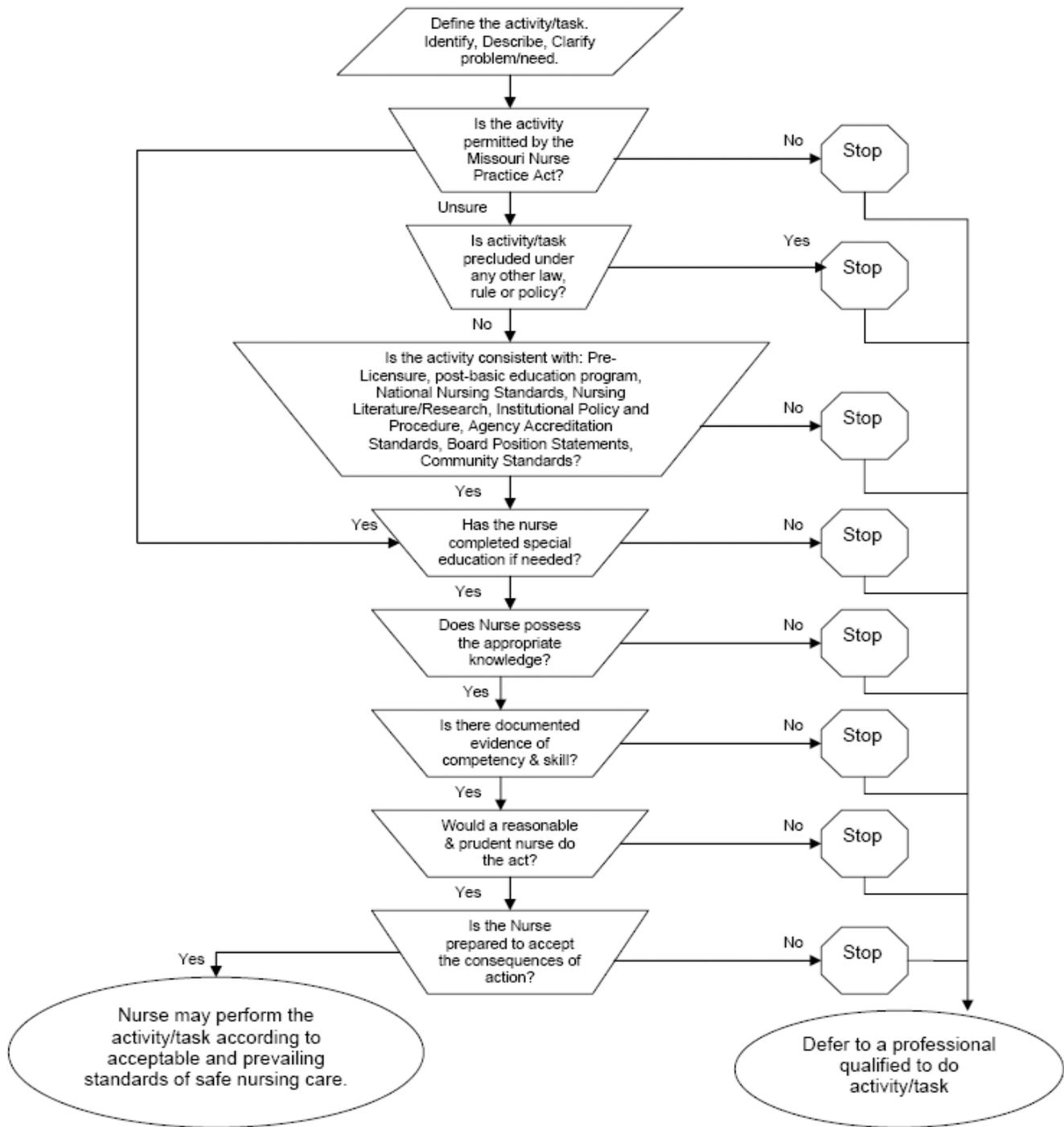
Advanced practice nurses shall function clinically within the professional scope and standards of their advanced practice nursing clinical specialty area and consistent with their formal advanced nursing education and national certification, if applicable, or within their education, training, knowledge, judgment, skill, and competence as a registered professional nurse. **4 CSR 200-4.100(5).**

The Practice of Practical Nursing:

The performance for compensation of selected acts for the promotion of health and in the care of persons who are ill, injured, or experiencing alterations in normal health processes. Such performance requires substantial specialized skill, judgment and knowledge. All such nursing care shall be given under the direction of a person licensed by a state regulatory board to prescribe medications and treatments or under the direction of a registered professional nurse. For the purposed of this chapter, "direction" shall mean guidance or supervision provided by a person licensed by a state regulatory board to prescribe medications and treatments or a registered professional nurse, including, but not limited to, oral, written, or otherwise communicated orders or directives for patient care. When practical nursing care is delivered pursuant to the direction of a person licensed by a state regulatory board to prescribe medications and treatments or under the direction of a registered professional nurse, such care may be delivered by a licensed practical nurse without direct physical oversight.

335.016.(9), RSMo 2000

Scope of Practice Decision Making Model



Decision Making Process

1. Define the Activity/Task:

Clarify what is the problem or need?

Who are the people involved in the decision?

What is the decision to be made and where (what setting or organization) will it take place?

Why is the question being raised now?

Has it been discussed previously?

2. Is the activity permitted by Missouri Nurse Practice Act?

NO – Stop. Defer the activity/task to a professional qualified to do the activity/task.

Yes – Go to Question # 5 – Special education needed?

Unsure -- Go to Question # 3 – Precluded by other law, rule, or policy?

3. Is activity/task precluded under any other law, rule or policy?

No – Go to Question # 4 – Consistent with....

Yes -- Stop. Defer the activity/task to a professional qualified to do the activity/task.

4. Is the activity consistent with:

Pre-licensure/post-basic education program

National Nursing Standards

Nursing Literature/Research

Institutional policies and procedures

Agency Accreditation Standards

Board Position Statements

Community Standards?

No -- Stop. Defer the activity/task to a professional qualified to do the activity/task.

Yes – Go to Question # 5 – Special education needs?

5. Has the nurse completed special education if needed?

No -- Stop. Defer the activity/task to a professional qualified to do the activity/task.

Yes – Go to Question # 6 – Possess appropriate knowledge?

6. Does nurse possess appropriate knowledge?

No -- Stop. Defer the activity/task to a professional qualified to do the activity/task.

Yes – Go to Question #7—Documented competency?

7. Is there documented evidence of competency & skill?

No -- Stop. Defer the activity/task to a professional qualified to do the activity/task.

Yes – Go to Question #8 – Reasonable & prudent nurse?

8. Would a reasonable & prudent nurse perform the act?

No -- Stop. Defer the activity/task to a professional qualified to do the activity/task.

Yes – Go to Question #9 – Prepared to accept consequences?

9. Is nurse prepared to accept the consequences of action?

No -- Stop. Defer the activity/task to a professional qualified to do the activity/.

Yes – Nurse may perform the activity/task according to acceptable and prevailing standards of nursing care.

Guidelines for Decision Making

The nurse is constantly involved in the decision-making and problem solving process, whether as a staff nurse or a manager, regardless of the practice setting. Although their perspectives are different the process is the same. The following steps are basic to the process.

Clarify: What is the problem or need?

Who are the people involved in the decision?

What is the decision to be made and where (what setting or organization) will it take place?

Why is the question being raised now?

Has it been discussed previously?

Assess:

What are your resources?

What are your strengths?

What skills and knowledge are required?

What or who is available to assist you?

Identify

What are possible solutions?

Options:

What are the characteristics of an ideal solution?

Is it feasible?

What are the risks?

What are the costs?

Are they feasible?

What are the implications of your decision?

How serious are the consequences?

Point of Decision:

What is the best decision?

When should it be done?

By whom?

What are the implications or consequences of your decision?

How will you judge the effectiveness of your decision?



SECTION III

**NURSING
DELEGATION
RESOURCES**

Please refer to the following resources on Nursing Delegation:

<http://www.ncsbn.org/regulation/uap.asp>

<http://www.nursingworld.org/readroom/position/uap/uaprned.htm>

<http://www.nursingworld.org/readroom/position/uap/uapuse.htm>

<http://www.ddna.org>

Use of Ready Web References Document

Using the Ready Web References, you may want to consider the following statutes and rules:

- ◆ Go to 'Focus on Practice' button for clarification of registered professional nurse and licensed practical nurse authorities:
 - √ Registered professional nurses have statutory authorities for practice specified in 335.016 (10)(a) through (e), RSMo. Included in 335.016 (10)(e), RSMo, for example, is the authority to teach, delegate, and supervise others in the performance of "any of the foregoing" (a) through (d) provisions. Registered professional nurses remain accountable and responsible for their teaching, delegation, and supervision decisions. Others (e.g., licensed practical nurses; unlicensed assistive personnel) who perform nursing care or nursing care tasks delegated by registered professional nurses also remain accountable and responsible for their actions or inactions. You may want to review the unlicensed assistive personnel information at the 'Focus on Practice' button, particularly the Board's position statement regarding their utilization. Unlicensed assistive personnel cannot perform nursing care tasks independently.
 - √ Licensed practical nurses, pursuant to the statute, 335.016 (9), RSMo (NOTE: This statutory, legal definition changed in 1999), are authorized to perform all nursing care under the direction of a supervising registered professional nurse or supervising "person licensed by a state regulatory board to prescribe medications and treatments" (e.g., physician). Licensed practical nurses cannot perform nursing care independently. It is important for licensed practical nurses to know which registered professional nurse or "person licensed by a state regulatory board to prescribe medications and treatments" is functioning as their delegator and supervisor. Sometimes written supervisory agreements are used to document the supervisory relationship. It is also important for licensed practical nurses to stay communicatively connected to their supervising registered professional nurse or "person licensed by a state regulatory board to prescribe medications and treatments" for purposes of ongoing problem-solving and decision-making in the best interests of a patients' health, welfare, and safety or to secure coverage for care outside the authority of their license.
- ◆ Other important considerations that may influence health care provider practice include, but are not limited to:
 - √ Federal laws applicable to the employing entity and the practice activities of licensees.
 - √ The licensing rules/regulations applicable to the employing entity, if the entity is required to have a license in Missouri. For example, hospital regulations may be found in the Code of State Regulations at 19 CSR 30-20.021 Organization and Management for Hospitals.
 - √ The entity's accreditation body standards. For example, the accreditation body for hospitals is the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) at <http://www.jcaho.org>.
 - √ The written policies and procedures of the employing entity, with the assumption that they are supportable by law and current, reputable literature. If there are no written policies on a matter, pursuit of such might very well be warranted. In regard to existing policies and procedures, any subsequent changes in practice that are equally defensible should be reflected in policy/procedure revisions. (2001)

(Information from MO State Board of Nursing website)

Frequently Asked Questions

Originally published May, June, July 2001 BON Newsletter

READY WEB REFERENCES

For assistance now and in the future with negotiating the State of Missouri environment of statutes (RSMo); current and proposed rules (SOS); Missouri State Board of Nursing (MSBN) website; other licensees' web pages and laws (PR); other government entities (Missouri State Government); legislation (Missouri State Government); and so forth, use this document, "Ready Web References".

❖ REVISED STATUTES OF MISSOURI (RSMo)

<http://www.moga.state.mo.us/STATUTES/STATUTES.HTM>

PROVIDES ACCESS TO CURRENT STATUTORY LAWS

❖ SECRETARY OF STATE OFFICE (SOS)

<http://www.sos.mo.gov/adrules/csr/current/4csr/4csr.asp#4-200>

PROVIDES ACCESS TO CURRENT (CODE OF STATE REGULATIONS -- CSR) AND PROPOSED (MISSOURI REGISTER) RULES/REGULATIONS

❖ MISSOURI STATE GOVERNMENT

<http://www.state.mo.us>

PROVIDES ACCESS TO EXECUTIVE, LEGISLATIVE, JUDICIAL, AND STATE DEPARTMENT INFORMATION

❖ OFFICE OF THE MISSOURI STATE GOVERNOR

<http://www.gov.state.mo.us>

PROVIDES GUBERNATORIAL INFORMATION AND PERTINENT LINKS

❖ PROFESSIONAL REGISTRATION (PR)

<http://pr.mo.gov>

PROVIDES ACCESS TO ALL REGULATED PROFESSIONS IN DIVISION OF PROFESSIONAL REGISTRATION AND INCLUDES DOWNLOADABLE DIRECTORIES — e.g., RN, LPN, APN

❖ MISSOURI STATE BOARD OF NURSING (MSBN)

<http://pr.mo.gov/nursing.asp>

INCLUDES LINKS TO "FOCUS ON PRACTICE" AND "ADVANCED PRACTICE", ALONG WITH NURSE PRACTICE ACT AND OTHER PERTINENT INFORMATION

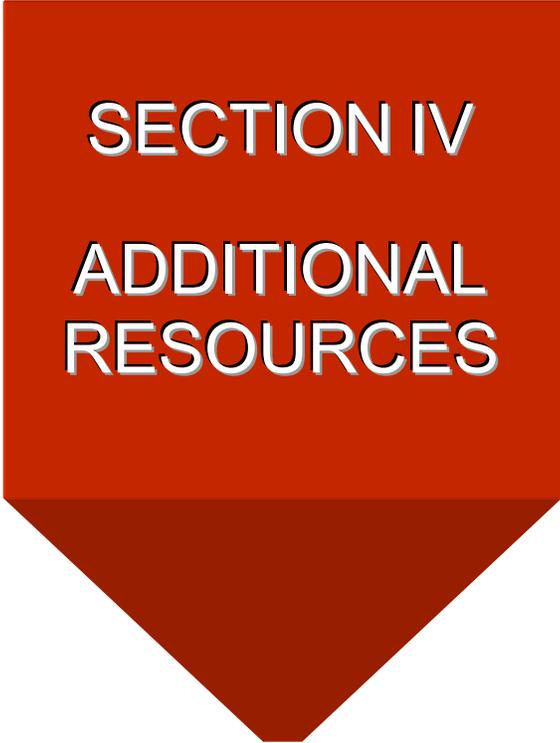
❖ NATIONAL COUNCIL OF STATE BOARDS OF NURSING (NCSBN)

<http://www.ncsbn.org>

PROVIDES INFORMATION ON OTHER STATE BOARDS OF NURSING AND HAS PERTINENT INFORMATION ON TOPICS IMPORTANT TO NURSING AND NURSING PRACTICE

(Information from MO State Board of Nursing website)

9/2000 Revised 7/2001, 5/2002, 6/2002, 8/2005

A red shield-shaped graphic with a white border, containing the text "SECTION IV" and "ADDITIONAL RESOURCES".

SECTION IV
**ADDITIONAL
RESOURCES**

www.dmh.mo.gov/mrdd/nurses/rnhome.htm



Or Go to DMH on line, click on Division of MRDD, and look for the Health and Safety on the left hand side.

Resource Information

American Association on Mental Retardation

<http://www.aamr.org/index.shtml>

American Cancer Society

<http://www.cancer.org>

American Diabetes Association

<http://www.diabetes.org>

American Heart Association

<http://www.americanheart.org>

American Hyperlexia Association

<http://www.hyperlexia.org>

Asperger's Syndrome

<http://www.wpi.edu/~trek/aspergers.html>

Autism Society of America

<http://www.autism-society.org>

Brain Injury Association of Missouri

(800) 674-0362

(314) 423-6442

Centers for Disease Control

<http://www.cdc.gov>

Developmental Disabilities Nurses Association

<http://www.ddna.org>

Direct Support Professionals Website

<http://rtc.umn.edu/dsp/>

Directory of Drug Company Assistance Programs

<http://www.phrma.org/patients>

Down Syndrome Association of Greater St. Louis

(314) 961-2504

Down Syndrome Society (National)

<http://www.ndss.org>

Dr. Koop

<http://www.drkoop.com>

Drugs.Com

<http://www.drugs.com>

Drug Information

<http://www.druginfonet.com>

Drug Interactions

<http://www.onemedicine.com>

Epilepsy Foundation of America

<http://www.epilepsyfoundation.org>

Family Village

<http://www.familyvillage.wisc.edu/index.html>

Fragile X Resource Center of Missouri

(314) 997-0431

Healthfinder

<http://www.healthfinder.gov>

Health Square.Com

<http://www.healthsquare.com>

Leukemia Society of America

(800) 264-2873

Mayo Clinic

<http://www.mayoclinic.com>

McGowan Publications (Publications for serving the MRDD population such as Healthcare Protocols for DD Nurses, Health and Wellness Reference Guide etc.)

Voice: (678) 817-0077

E-Mail: mcgons@pipeline.com

<http://www.mcgowanpubs.com>

Medline

<http://www.medlineplus.gov>

MedWatch

<http://www.fda.gov/medwatch/SAFETY>

Missouri Coalition of Alliance for the Mentally Ill

(573) 634-7727

Missouri DD Resource Center

<http://www.moddrc.com>

Missouri Department of Health and Senior Services

<http://www.health.state.mo>

Missouri Department of Mental Health

<http://www.modmh.state.mo.us>

Missouri Head Injury Advisory Council

(573) 751-9003

Missouri State Board of Nursing

<http://www.ded.state.mo.us>

National Cancer Institute

<http://cancer.gov>

National Council for State Board of Nursing

<http://www.ncsbn.org>

National Council on Disabilities

<http://www.ncd.gov>

National Down Syndrome Society

<http://www.ndss.org>

National Fragile X Foundation

<http://www.fragilex.org>

National Institutes of Health

<http://www.nih.gov>

National Library of Medicine Medlineplus Health Information

<http://medlineplus.gov>

National Neurofibromatosis Foundation-Missouri Chapter

(314) 435-6877

NORD-National Organization of Rare Disorders

<http://www.NORD-RDB.com/orphan>

OSHA-Occupational Safety and Health Administration

<http://www.osha.gov>

Pharmacy Information

<http://new.health-center.com>

Prader-Willi Association

<http://www.pwsausa.org/MO/>

United Cerebral Palsy Association

(800) 872-5827

Web MD

<http://www.webmd.com>

Title 9--DEPARTMENT OF MENTAL HEALTH
Division 10--Director, Department of
Chapter 5--General Program Procedures

9 CSR 10-5.200 Report of Complaints of Abuse, Neglect and Misuse of Funds/Property.

PURPOSE: This rule prescribes procedures for reporting and investigating complaints of abuse, neglect and misuse of funds/property in a residential facility, day program or specialized service that is licensed, certified or funded by the Department of Mental Health (department) as required by sections 630.135, 630.167, 630.168, 630.655 and 630.710, RSMo. The rule also sets forth due process procedures for persons who have been accused of abuse, neglect and misuse of funds/property.

(1) The following words and terms, as used in this rule, mean:

(A) Class I neglect, failure of an employee to provide reasonable or necessary services to maintain the physical and mental health of any consumer when that failure presents either imminent danger to the health, safety or welfare of a consumer, or a substantial probability that death or physical injury would result;

(B) Class II neglect, failure of an employee to provide reasonable or necessary services to a consumer according to the individualized treatment or habilitation plan, if feasible, or according to acceptable standards of care. This includes action or behavior which may cause psychological harm to a consumer due to intimidating, causing fear or otherwise creating undue anxiety;

(C) Consumer, individual (client, resident, patient) receiving services directly from any program or facility contracted, licensed, certified or funded by the department;

(D) Medications

1. "Medication Error", a mistake in prescribing, dispensing, or administering medications. A medication error occurs if a consumer receives an incorrect drug, drug dose, dosage form, quantity, route, concentration, or rate of administration. This includes failing to administer the drug or administering the drug on an incorrect schedule. Levels of medication errors are:

A. "Minimal", medication error is one in which the consumer experiences no or minimal adverse consequences and receives no treatment or intervention other than monitoring or observation is required;

B. "Moderate", medication error is one in which the consumer experiences short-term reversible adverse consequences and receives treatment and or intervention in addition to monitoring or observation; and

C. "Serious", medication error is one in which the consumer experiences life-threatening and/or permanent adverse consequences or results in hospitalization or an emergency room episode of care.

2. "Serious" medication errors may be considered abuse or neglect and shall be subject to investigation by the Department of Mental Health.

(E) Misuse of funds/property, the misappropriation or conversion for any purpose of a consumer's funds or property by an employee or employees with or without the consent of the consumer;

(F) Physical abuse—

1. An employee purposefully beating, striking, wounding or injuring any consumer; or

2. In any manner whatsoever, an employee mistreating or maltreating a consumer in a brutal or inhumane manner. Physical abuse includes handling a consumer with any more force than is reasonable for a consumer's proper control, treatment or management;

(G) Sexual abuse, any touching, directly or through clothing, of a consumer by an employee for sexual purpose or in a sexual manner. This includes but is not limited to:

1. Kissing;
2. Touching of the genitals, buttocks or breasts;
3. Causing a consumer to touch the employee for sexual purposes;
4. Promoting or observing for sexual purpose any activity or performance involving consumers including any play, motion picture, photography, dance, or other visual or written representation;
5. Failing to intervene or attempt to stop, or encouraging inappropriate sexual activity or performance between consumers; and

(H) Verbal abuse, an employee using profanity or speaking in a demeaning, nontherapeutic, undignified, threatening or derogatory manner to a consumer or about a consumer in the presence of a consumer.

(2) This section applies to any director, supervisor or employee of any residential facility, day program or specialized service, that is licensed, certified or funded by the Department of Mental Health. Facilities, programs and services that are operated by the department are regulated by the department's operating regulations and are not included in this definition.

(A) Any such person shall immediately file a written or verbal complaint if that person has reasonable cause to believe that a consumer has been subjected to any of the following misconducts while under the care of a residential facility, day program or specialized service:

1. Physical abuse;
2. Sexual abuse;
3. Misuse of funds/property;
4. Class I neglect;
5. Class II neglect;
6. Verbal abuse;
7. Serious medication error; or
8. Diversion of medication from intended use by the consumer for whom it was prescribed.

(B) A complaint under subsection (A) above shall be made to the head of the facility, day program or specialized service, and to the department's regional center, supported community living placement office or district administrator office.

(C) The head of the facility, day program or specialized service shall forward the complaint to—

1. The Children's Division if the alleged victim is under the age of eighteen (18);
or

2. The Division of Senior Services and Regulation if the alleged victim is a resident or client of a facility licensed by the Division of Senior Services and Regulation or receiving services from an entity under contract with the Division of Senior Services and Regulation.

(D) Failure to report shall be cause for disciplinary action, criminal prosecution, or both.

(3) The head of the facility, day program or specialized service that is licensed, certified or funded by the department shall immediately report to the local law enforcement official any alleged or suspected—

- (A) Sexual abuse; or
- (B) Abuse or neglect which results in physical injury; or
- (C) Abuse, neglect or misuse of funds/property which may result in a criminal charge.

(4) If a complaint has been made under this rule, the head of the facility or program and all employees of the facility, program or service shall fully cooperate with law enforcement authorities and with department employees or employees from other agencies authorized to investigate the complaint. Failure to cooperate may result in contract termination or dismissal of the employee.

(5) A department investigator shall gather facts and conduct an investigation regarding the alleged abuse or neglect. The investigation shall be conducted in accordance with the procedures and time frames established under the department's operating regulations. Upon completion of the investigation, the investigator shall present written findings of facts to the head of the supervising facility.

(6) Within ten (10) working days of receiving the final report from the investigator, if there is a preliminary determination of abuse, neglect or misuse of funds/property, the head of the supervising facility or department designee shall send to the alleged perpetrator a summary of the allegations and findings which are the basis for the alleged abuse/neglect/misuse of funds or property; the provider will be copied. The summary shall comply with the constraints regarding confidentiality contained in section 630.167, RSMo and shall be sent by regular and certified mail.

(A) The alleged perpetrator may meet with the head of the supervising facility or department designee, submit comments or present evidence; the provider may be present and present comments or evidence in support of the alleged perpetrator. If the alleged perpetrator wishes to have this meeting, s/he must notify the head of the supervising facility or department designee within ten (10) working days of receiving the summary.

(B) This meeting shall take place within ten (10) working days of notification, unless the parties mutually agree upon an extension.

(C) Within ten (10) working days of the meeting, or if no request for a meeting is received within ten (10) working days of the alleged perpetrator's receipt of the summary, the head of the supervising facility or department designee shall make a final determination as to whether abuse/neglect/misuse of funds or property took place. The perpetrator shall be notified of this decision by regular and certified mail; the provider will be copied. If the charges do not meet the criteria in paragraphs (11) & (12), the decision of the head of the supervising facility or department designee shall be the final decision of the department.

(D) If the charges meet the criteria in paragraphs (11) & (12), the letter shall advise the perpetrator that they have ten (10) working days following receipt of the letter to contact the department's hearings administrator if they wish to appeal a finding of abuse, neglect or misuse of funds/property.

(E) If there is no appeal, the decision of the head of the supervising facility or department designee shall be the final decision of the department.

(F) The department's effort to notify the alleged perpetrator at his/her last known address by regular and certified mail shall serve as proper notice. The alleged perpetrator's refusal to receive certified mail does not limit the department's ability to make a final determination. Evidence of the alleged perpetrator's refusal to receive certified mail shall be sufficient notice of the department's determination.

(7) If an appeal is requested, the hearings administrator shall schedule the hearing to take place within thirty (30) working days of the request, but may delay the hearing for good cause shown. At the hearing, the head of the supervising facility or designee, or other department designee shall present evidence supporting its findings of abuse, neglect, misuse of funds/property, or all. The provider or perpetrator may submit comments or present evidence to show why the decision of the head of the supervising facility or department designee should be modified or overruled. The hearings administrator may obtain additional information from department employees as s/he deems necessary.

(8) The decision of the hearings administrator shall be the final decision of the department. The hearings administrator shall notify the perpetrator, and the head of the supervising facility or department designee by certified mail of the decision within fourteen (14) working days of the appeal hearing; the provider will be copied.

(9) The opportunities described in sections (6), (7) and (8) of this rule regarding a meeting with the head of the supervising facility and an appeal before the department's hearings administrator apply also to providers and alleged perpetrators in an investigation of misuse of funds/property.

(10) For those charges in paragraphs (11) & (12), an alleged perpetrator does not forfeit his/her right to an appeal with the department's hearings administrator when s/he declines to meet with the head of the supervising facility under subsections (6)(A) and (B) of this rule.

(11) If the department substantiates that a person has perpetrated physical abuse, sexual abuse, class I neglect, or misuse of funds/property, the perpetrator shall not be employed by the department, nor be licensed, employed or provide services by contract or agreement at a residential facility, day program or specialized service that is licensed, certified or funded by the department. The perpetrator's name shall be placed on the department Disqualification Registry pursuant to section 630.170, RSMo. Persons who have been disqualified from employment may request an exception by using the procedures described in 9 CSR 10-5.210 Exception Committee Procedures.

(12) If the department substantiates that a person has perpetrated two (2) counts of verbal abuse, or two (2) counts of class II neglect, or one (1) count of verbal abuse and one (1) count of class II neglect, within a twelve (12)-month period, the perpetrator shall not be employed by the department, nor be licensed, employed or provide services by contract or agreement at a residential facility, day program or specialized service that is licensed, certified or funded by the department. The perpetrator's name shall be placed on the department Disqualification Registry pursuant to section 630.170, RSMo.

(13) In accordance with 9 CSR 10-5.190, no person convicted of specified crimes may serve in facilities or programs licensed, certified or funded by the department.

(14) No director, supervisor or employee of a residential facility, day program or specialized service shall evict, harass, dismiss or retaliate against a consumer or employee because he or she or any member of his or her family has made a report of any violation or suspected violation of consumer abuse, neglect or misuse of funds/property. Penalties for retaliation may be imposed up to and including cancellation of agency contracts and/or dismissal of such person.

AUTHORITY: sections 630.050, 630.135, 630.165, 630.167, 630.168, 630.655 and 630.705, RSMo 2000 and 630.170, RSMo Supp. 2003. Original rule filed Oct. 29, 1998, effective May 30, 1999. Emergency amendment filed March 29, 2002, effective May 2, 2002, terminated Oct. 30, 2002. Amended: Filed March 29, 2002, effective Oct. 30, 2002. Amended: Filed May 5, 2003, effective Dec. 30, 2003. Emergency amendment filed August 11, 2005, effective September 16, 2005, expires February 28, 2006. Amended: Filed August 11, 2005.*

Title 9--DEPARTMENT OF MENTAL HEALTH
Division 45--Division of Mental Retardation and Developmental Disabilities
Chapter 3--Care and Habilitation

9 CSR 45-3.070 Certification of Level I Medication Aides Serving Persons with Developmental Disabilities

PURPOSE: Individuals who administer medications or supervise self-administration of medications in any residential setting or day program funded, licensed or certified by the Department of Mental Health to provide services to persons who are mentally retarded or developmentally disabled, are required to be either a physician, a licensed nurse, a certified medication technician, a certified medication employee, a level I medication aide or Department of Mental Health medication aide. The provisions of the rule do not apply to family-living arrangements unless they are receiving reimbursement through the Medicaid Home and Community-Based Waiver for persons with developmental disabilities. This rule sets forth the requirements for approval of a Medication Aide Training Program designating the required course curriculum content, outlining the qualifications required of students and instructors, designating approved training facilities and outlining the testing and certification requirements.

PUBLISHER'S NOTE: The publication of the full text of the material that the adopting agency has incorporated by reference in this rule would be unduly cumbersome or expensive. Therefore, the full text of that material will be made available to any interested person at both the Office of the Secretary of State and the office of the adopting agency, pursuant to section 536.031.4, RSMo. Such material will be provided at the cost established by state law.

(1) The purpose of the Medication Aide Training Program shall be to prepare individuals for employment as medication aides in any residential setting or day program funded, licensed or certified by the Department of Mental Health to provide services to persons with mental retardation or developmental disabilities. The training program does not prepare individuals for the parenteral administration of medications such as insulin or the administration of medications or other fluids via enteral feeding tubes.

(2) All aspects of the Medication Aide Training Program included in this rule shall be met in order for a program to be considered approved.

(3) The objectives of the Medication Aide Training Program shall be to ensure that the medication aide will be able to—

- (A) Define the role of a medication aide;
- (B) Prepare, administer and chart medications by nonparenteral routes;
- (C) Observe, report and record unusual responses to medications;
- (D) Identify responsibilities associated with control and storage of medications; and
- (E) Utilize appropriate drug reference materials.

(4) The course shall be a minimum of sixteen (16) hours of integrated formal instruction and practice sessions supervised by an approved instructor.

(5) The curriculum content shall include procedures and instructions in the following areas: basic human needs and relationships; drug classifications and their implications; assessing drug reactions; techniques of drug administration; documentation; medication storage and control; drug reference resources; and infection control.

(6) The approved course curriculum shall be the manual entitled *Level I Medication Aide* (IE 64-1), developed by the Department of Elementary and Secondary Education, Department of Mental Health and the Division of Aging and produced by the Instructional Materials Laboratory, University of Missouri-Columbia. This manual is incorporated by reference in this rule. Students and instructors each shall have a copy of this manual.

(7) A student shall not administer medications without the instructor present until s/he successfully completes the course and obtains a certificate.

(8) Student Qualifications.

(A) Any individual employable in a residential setting or day program funded, licensed or certified by the Department of Mental Health to provide services to persons who are mentally retarded or developmentally disabled, and who meet the requirements of 9 CSR 10-5.190, shall be eligible to enroll as a student in this course or to challenge the final examination.

(B) An individual may qualify as a medication aide by successfully challenging the final examination if that individual has successfully completed a medication administration course and is currently employed to perform medication administration tasks in a residential setting or day program operated, funded, licensed or certified by the Department of Mental Health to provide services to persons who are mentally retarded or developmentally disabled.

(C) Certain persons may be deemed certified under paragraph (13)(B)4. of this rule.

(9) Those persons wanting to challenge the final examination shall submit a request in writing to the Missouri Division of Mental Retardation and Developmental Disabilities enclosing applicable documentation. If approved to challenge the examination, the Division of Mental Retardation and Developmental Disabilities will send the applicant a letter to present to an approved instructor so arrangements can be made for testing.

(10) Instructor Qualifications.

(A) An instructor shall be currently licensed to practice as either a registered nurse or practical nurse in Missouri or shall hold a current temporary permit from the Missouri State Board of Nursing. The licensee shall not be subject to current disciplinary action such as censure probation, suspension or revocation. If the individual is a licensed practical nurse, the following additional requirements shall be met:

1. Shall not be waived: the instructor has a valid Missouri license or a temporary permit from the Missouri State Board of Nursing; and

2. Shall be a graduate of an accredited program, which has pharmacology in the curriculum.

(B) In order to be qualified as an instructor, the individual shall—

1. Have attended a “Train the Trainer” workshop to implement the Level I Medication Aide Training Program conducted by a Missouri registered nurse presenter approved by the Missouri Division of Aging.

2. Meet at least one (1) of the following criteria:

A. Have had one (1) year’s experience working in a long-term care (LTC) facility licensed by the Division of Aging or in a residential facility or day program operated, funded, licensed or certified by the Department of Mental Health within the past five (5) years; or

B. Be currently employed in a LTC facility licensed by the Department of Mental Health and shall have been employed by that facility for at least six (6) months; or

C. Shall be an instructor in a Health Occupations Education Program.

(11) Sponsoring Agencies.

(A) The Medication Aide Training Program may be sponsored by providers of residential or day programs operated, funded, licensed or certified by the Department of Mental Health, Division of Mental Retardation and Developmental Disabilities

(B) The sponsoring agency is responsible for obtaining an approved instructor, determining the number of manuals needed for a given program, ordering the manuals for the students and presenting a class schedule for approval by the local regional center. The sponsoring agency shall maintain the following documentation: the name of the approved instructor; the instructor’s Social Security number, current address and telephone number; the number of students enrolled; the name, address, telephone number, Social Security number and age of each student; the name and address of the facility that employs the student, if applicable; the date and location of each class to be held; and the date and location of the final examination. If there is a change in the date and location of the training, the sponsoring agency shall notify the local regional center.

(C) Classrooms used for training shall contain sufficient space, equipment and teaching aids to meet the course objectives as determined by the Division of Mental Retardation and Developmental Disabilities.

(D) If the instructor is not directly employed by the agency, there shall be a signed written agreement between the sponsoring agency and the instructor which shall specify the role, responsibilities and liabilities of each party.

(12) Testing.

(A) The final examination shall consist of a written and a practicum examination administered by the instructor.

1. The written examination shall include questions based on the course objectives developed by the Division of Mental Retardation and Developmental Disabilities.

2. The practicum examination shall be conducted in a residential setting or day program operated, funded, licensed or certified by the Department of Mental Health, Division of Mental Retardation and Developmental Disabilities or an LTC facility which shall include the preparation and administration by nonparenteral routes and recording of medications administered to consumers under the direct supervision of the instructor and the person responsible for medication administration in the facility. When it is not feasible and/or possible to conduct the practicum examination in an approved residential or day program, the instructor may request a waiver from the local regional center to conduct the practicum examination in an approved simulated classroom situation.

(B) A score of eighty percent (80%) is required for passing the final written examination and one hundred percent (100%) accuracy in the performance of the steps of procedure in the practicum examination.

(C) The final examination, if not successfully passed, may be retaken within ninety (90) days one (1) time without repeating the course, however, those challenging the final examination must complete the course if the examination is not passed in the challenge process.

(D) The instructor shall complete final records and shall submit these and all test booklets to the sponsoring agency.

(13) Records and Certification.

(A) Records.

1. The sponsoring agency shall maintain records of all individuals who have been enrolled in the Medication Aide Training Program and shall submit to the local regional center all test booklets, a copy of the score sheets and a complete class roster.

2. A copy of the final record shall be provided to any individual enrolled in the course.

3. A final record may be released only with written permission from the student in accordance with the provisions of the Privacy Act—PL 900-247.

(B) Certification.

1. The regional center shall issue a Department of Mental Health, Division of Mental Retardation and Developmental Disabilities, Medication Aide Certificate to employable individuals successfully completing the course upon receiving the required final records and test booklets from the sponsoring agency.

2. The regional center shall enter the names of all individuals receiving a Medication Aide Certificate in the Division of Mental Retardation and Developmental Disabilities Medication Aide Registry.

3. Medication aides who do not currently meet certification requirements must successfully pass the Level I Medication Aide course or challenge the final examination, if eligible, and obtain a Division of Mental Retardation and Developmental Disabilities Medication Aide Certificate within eighteen (18) months from the effective date of this regulation. Individuals who fail to comply shall not be allowed to administer medications.

4. Individuals who hold a Medication Aide Certificate issued by a regional center or a Division of Aging Level I Medication Aide Certificate, and have completed bi-annual training as required in section (14), will meet the requirements of this rule.

(14) Bi-Annual Training Program.

(A) Level I medication aides shall participate in a minimum of four (4) hours of medication administration training every two (2) years in order to administer medications in a residential setting or day program funded, certified or licensed by the Department of Mental Health to provide services to persons who are mentally retarded or developmentally disabled. The training shall be taken in two (2) two (2)-hour blocks or a four (4)-hour block and must be completed by the anniversary date of the medication aide's initial level I medication aide certificate. The training shall be—

1. Offered by a qualified instructor as outlined in section (10) of this rule; and
2. Documented on the Level I Medication Aide Bi-Annual Training form MO 650-8730 and kept in the employee's personnel file. This form is incorporated by reference in this rule.

(B) The training shall address at the least the following:

1. Medication ordering and storage;
2. Medication administration;
 - A. Use of generic drugs;
 - B. How to pour, chart, administer and document;
 - C. Information and techniques specific to the following: inhalers, eye drops, topical medications and suppositories;
 - D. Infection control;
 - E. Side effects and adverse reactions;
 - F. New medications and/or new procedures;
 - G. Medication errors;
3. Individual rights, and refusal of medications and treatments;
4. Issues specific to the facility/program as indicated by the needs of the consumers, and the medications and treatments currently being administered; and
5. Corrective actions based on problems identified by the staff, the trainees or issues identified by regulatory and accrediting bodies, professional consultants or by any other authoritative source.

(C) The Department of Mental Health regional centers will routinely monitor the quality of medication administration. When quality assurance monitoring documents that a medication aide is not administering medications within training guidelines, the regional center may require the aide to take additional training in order to continue passing medications in the residential setting or day program.

(15) Revocation of Certification.

If the Department of Mental Health upon completion of an investigation, finds that a medication aide has stolen or diverted drugs from a consumer or facility or has had his/her name added to the Department of Mental Health Employee Disqualification Registry or Division of Aging Employee Disqualification Registry, the Department of Mental Health shall render the medication aide's certificate invalid.

*AUTHORITY: sections 630.050 and 633.190, RSMo 2000. * Original rule filed Jan. 10, 2001, effective Aug. 30, 2001.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995; 633.190, RSMo 1993, amended 1995*



STATE OF MISSOURI
 DEPARTMENT OF MENTAL HEALTH
 MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES
MEDICATION AIDE 2 YEAR UPDATE TRAINING

NAME		DATE OF BIRTH / /	SOCIAL SECURITY NUMBER - -
ADDRESS		MEDICATION CERTIFICATE CERTIFICATE # _____ DATE ISSUED ____/____/____ SOURCE: (CHECK ONE): <input type="checkbox"/> DHSS (Formally DOA) <input type="checkbox"/> MRDD TYPE: (check one): <input type="checkbox"/> MEDICATION AIDE <input type="checkbox"/> CERTIFIED MEDICATION TECHNICIAN (CMT) <input type="checkbox"/> CERTIFIED MEDICATION EMPLOYEE (CME)	
EMPLOYER NAME			
EMPLOYER ADDRESS			
A. Training shall address at least the following		DATE OF TRAINING ____/____/____ HOURS COMPLETED _____	DATE OF TRAINING ____/____/____ HOURS COMPLETED _____
1. Medication ordering and storage			
2. Medication administration			
<input type="checkbox"/> Use of generic drugs			
<input type="checkbox"/> How to pour, chart, administer and document			
<input type="checkbox"/> Information and techniques specific to the following: inhaler, eye drops, topical medications and suppositories			
<input type="checkbox"/> Infection Control			
<input type="checkbox"/> Side effects and adverse reactions			
<input type="checkbox"/> Medication errors			
3. Individual rights, and refusal of medications and treatments;			
4. Issues specific to the facility/program as indicated by the needs of the residents/clients, and the medications and treatments currently being administered			
5. Corrective actions based on problems identified by the staff, the trainees or issues identified by regulatory and accrediting bodies, professional consultants or by any other authoritative source; and			
Other specify:			
The training shall be taken in two (2) two (2) hour blocks or a four (4) hour block. Medication aides who do not participate in at least 4 hours of medication administration training every two years will not be allowed to administer medication in accordance with 9CSR 45-3.060. A signed copy of this form denotes compliance with the training requirement. The form must be included in the employee's personnel file and copied to the regional center. It is the responsibility of the agency to offer and the employee to participate in the required training.			
RN/LPN SIGNATURE (INSTRUCTOR)		LICENSE NUMBER	DATE
EMPLOYEE SIGNATURE			DATE

Rules of Interest to Nurses

Advance Practice Nurse	4 CSR 200-4100
Collaborative Practice:	
Nursing	4 CSR 200-4-200
Healing Arts	4 CSR 150-5.100
Department of Mental Health:	
Mental Health Programs	9 CSR 30-4010-4.190
Alcohol and Drug Abuse Programs	9 CSR 30-3.010.3.970
Division of Aging:	
Intermediate Care and Long-Term Care Facilities:	
Nurse Assistant Training	13 CSR 15-13.010
Medication Technician Training	13 CSR 15-13.020
Administration and Resident Care Requirements	13 CSR 15-14.042
Residential Care Facilities:	
Administrative, Personnel and Resident Care Requirements	13 CSR 15-15.042
n-Home Service Standards	13 CSR 15-7.021
Division of Medical Services:	
Hospice Services Program	12 CSR 70-50.010
Medicaid Benefits for Nurse Midwife Services	13 CSR 70-55.010
Home Health Care Services	13 CSR 70-90.010
Personal Care Program	13 CSR 70-91.010
Private Duty Nursing Care Under Healthy Children and Youth Program	13 CSR 70-95.010
Generic Drug Formulary:	4CSR 220-3.011
Hospital Regulations:	
Definitions	19 CSR 30-20.011
Administration of Program	19 CSR 30-20.021
Organization and Management	19 CSR 30-20.021
Non-pharmacy Dispensing	4 CSR 150-5.020
Prescription Requirements	4CSR 220-2.018

(Information from MO State Board of Nursing webs)

SECTION V

REQUIRED PROGRAM FORMS

**Missouri Department of Mental Health
Division of Mental Retardation and Developmental Disabilities**

Community RN Monthly Service Log Operation Instructions

Purpose: The RN Service Log will serve as an auditing tool for both the Provider Agency and MRDD to account for the Community RN services and monthly hours.

Process:

- The Community RN will be responsible to account for their time dedicated to the functions of the Community RN Program each month. This will be accomplished by the completion of the service.
- The Community RN will need to sign and date the service log monthly.
- Total hours should be fulfilled each month and not carried over.
- The Community RN will be responsible for ensuring that the form is completed accurately each month and submitted to their employer for review and maintenance of the document.

Directions:

1. **Provider Agency Name:** Name of the company which is providing the contracted Community RN service.
2. **Month/Year:** The month and year service is provided.
3. **Total Authorized Hours Per Month:** The formula used to establish a rate per contract was 1.25 hours per person however, to accommodate flexibility based on individual needs, as long as the Community RN provides at minimum a monthly evaluation of each individual and oversight of delegated tasks, the hours may be distributed based on individual needs within the provider agency. The hours **cannot** carry over from one month to the next. The RN needs to circle if the total number of hours listed are per agency or based on 1 Community RN's hours for providing service for that agency.
4. **Date:** Current date of service to include month and day.
5. **Individual Name:** Full name of the individual who is receiving the Community RN service.
6. **Facility Name:** Name of the individual's specific residence.
- 7-16 choose all that apply**
7. **Assessment:** Face to face evaluation with the individual and staff in the home including assessment of individual's specific issues.
8. **Labs:** Review, analyze and interpret lab results. Ensure that the agency has a protocol established for necessary labs and follow-up.
9. **Review of Physician Orders:** The monthly review of physician's orders for physician signature, accuracy and staff compliance. To include the signature/date of the Community RN identifying the review of any new orders.
10. **Review of Medication(s):** To include monthly review of the medication administration record (MAR) for accuracy (compare to orders) and staff compliance, medication labels, monitor for side effects (including Tardive Dyskinesia), effectiveness, frequency of PRN use, drug storage of routine and PRN medications, and check for supporting diagnosis.
11. **Review of Records:** To include wt, immunization records, bowel, vitals, blood sugar, dietary, fluids, seizure, menses, skin, range of motion, consultation reports, event reports for falls, injuries, psychotropic meds and medication errors, hospitalization, ER reports and significant change in behavior etc.
12. **Delegated Nursing Tasks/Specialized Instruction/Supervision:** Which include but are not limited to those tasks listed in the MRDD Health Reference Manual and /or specialized instruction and supervision of tasks based on the individualized needs of the individual (*does not include medication administration, CPR and first aid courses*).
13. **Other:** Any additional services not specified on this form i.e. direct nursing care, nursing directives pertinent to health monitoring processes etc.
14. **Total Number of Hours for Date:** Total amount of time provided for Group Home, Residential Care Facility or ISL for that date.
15. **Total Time Per Month:** Total amount of time provided for all services for the month.
16. **Community RN Signature:** Full signature of the Community RN providing the logged service.
17. **Community RN Name Printed:** Printed name of Community RN providing the logged service.
18. **Date:** Date of RN signature.

Community RN Delegation Of Specified Nursing Task

Individual's Name: _____ ID Number: _____

Provider Agency Name: _____ Facility Name: _____

Delegated Task: _____

Purpose of Task: _____

The following agency employees have been trained by a licensed person, demonstrate competency in all instructed procedures and are being delegated the task indicated above. This delegation and individualized instruction is specific to this individual and may not be transferred to other individuals with similar needs within this or other agencies.

	Name/Title	Staff Signature	Initials
1.	_____	_____	<input type="checkbox"/> Rescinded Date _____
2.	_____	_____	<input type="checkbox"/> Rescinded Date _____
3.	_____	_____	<input type="checkbox"/> Rescinded Date _____
4.	_____	_____	<input type="checkbox"/> Rescinded Date _____
5.	_____	_____	<input type="checkbox"/> Rescinded Date _____
6.	_____	_____	<input type="checkbox"/> Rescinded Date _____
7.	_____	_____	<input type="checkbox"/> Rescinded Date _____
8.	_____	_____	<input type="checkbox"/> Rescinded Date _____
9.	_____	_____	<input type="checkbox"/> Rescinded Date _____
10.	_____	_____	<input type="checkbox"/> Rescinded Date _____
11.	_____	_____	<input type="checkbox"/> Rescinded Date _____
12.	_____	_____	<input type="checkbox"/> Rescinded Date _____

The delegating RN is responsible for the provision of guidance and ongoing evaluation for the delegated nursing task including periodic inspection based at intervals determined by the delegating RN. The delegating RN maintains authority to require corrective action or rescind delegation of this task.

Task Rescinded: Change in Health Status Other _____

Delegating RN: _____ Date: _____
Signature & Title

SPECIALIZED INSTRUCTION FOR DELEGATION

PROCEDURES/Steps to follow to perform the task	What to OBSERVE for and REPORT, What to DO, and WHOM to CONTACT.

***Attach any additional instructional documentation**

Instructional Licensed Medical Professional: _____
Signature and Title

Date: _____ **Contact #** _____

Delegating RN if different than Instructing Medical Professional: _____
Signature and Title

Date: _____ **Contact #** _____

Community RN Delegation of Specified Nursing Task Operational Instructions

Purpose: The RN Delegation of Task form will serve as tool for the Community RN to record any Training / specialized instruction specific to the individuals.

Process:

- The Community RN will be responsible for identifying what nursing supports a specific individual needs.
- Once the specific supports are identified the Community RN will then identify what support staff will be able to receive specialized instruction and delegation to perform the task.
- The Community RN will then ensure that specialized instruction regarding identified task is provided and document information on the Delegation of Task form.
- The Community RN will be responsible for ensuring through periodic oversight/supervision that identified staff are able to perform the specific task as delegated.

Directions:

1. The Community RN will identify any nursing supports that require Nursing delegation.
2. Each identified support/task will be documented on a separate Specialized Instruction for Delegation Form, listing any and all procedures to follow to perform the specified task as well as what to observe for and report, what to do and whom to contact.
3. The Specialized Instruction for Delegation Form will be signed and dated by the Instructional Licensed Medical Professional providing the information i.e. Home Health nurse, physician etc....
4. The Specialized Instruction for Delegation Form will be signed and dated by the Delegating RN if different than the Instructing Medical Professional.
5. The Specialized Instruction including any clinical instruction and observation will be provided to identified support staff and will be identified on the RN Delegation for Specified Nursing Task form to include the staff's name and title and staff signature. Delegating RN will also sign and date the form.
6. In the event that the individual no longer requires the specified delegated task the RN Delegation for Specified Nursing Task Form can be rescinded by the delegating RN.
7. In the event that a specific staff is no longer identified as being able to perform the specified delegated task, the Community RN can identify on the RN Delegation for Specified Nursing Task form by checking the staff's name and documenting in the identified box the date rescinded.
8. A copy of the Specialized Instruction for Delegation Form and RN Delegation for Specified Nursing Task Form shall be kept on record at the individual's home.

iiTS #

DMH Use Only
7/14/05

All events must be reported to the regional center immediately, unless otherwise specified on this form. The written event report form must be submitted the next working day, unless requested sooner by

Department of Mental Health

iiTS- Community Event Report Form-MRDD

EVENT CATEGORY (CHECK ONE)		1. <input type="checkbox"/> INCIDENT		<input type="checkbox"/> MEDICATION ERROR		<input type="checkbox"/> DEATH	
PROGRAM CATEGORY (CHECK ONE)		2. <input type="checkbox"/> COMMUNITY PLACEMENT		<input type="checkbox"/> PURCHASE OF SERVICE (POS)		<input type="checkbox"/> CASE MANAGEMENT	
3. Event Date & Time ____/____/____ : ____AM ____PM Month Day Year				4. Discovery Date & Time ____/____/____ : ____AM ____PM (Complete this section only if different than event date/time)			
INVOLVED							
5. Consumer Name (Last) (First) (MI)			6. DOB ____/____/____		7. <input type="checkbox"/> Male <input type="checkbox"/> Female	8. Consumer ID	
9. Address/Home Telephone Number ()				10. DMH/County Board Service Coordinator Name			
11. Event Location or where discovered (Name of agency or location)				12. Name of Provider Agency/Organization involved in event & VENDOR NUMBER			
13. Persons who witnessed or have direct knowledge of the event				Relationship (CHOOSE FROM LIST BELOW)		Telephone Number	
Last Name		First Name					
*Relationship to Consumer-consumer, parent/guardian, staff, visitor, volunteer, complainant, perpetrator, reporter, victim, witness, other -specify)							
14. NOTIFIED: Persons /Agencies (CHECK ALL THAT APPLY)		Name of Person Contacted		DATE		TIME	
<input type="checkbox"/> DMH Regional Center						____:____AM ____PM	
<input type="checkbox"/> Family or Guardian						____:____AM ____PM	
<input type="checkbox"/> Physician						____:____AM ____PM	
<input type="checkbox"/> Law Enforcement						____:____AM ____PM	
<input type="checkbox"/> DSS Children's Division						____:____AM ____PM	
<input type="checkbox"/> Division of Senior Services						____:____AM ____PM	
<input type="checkbox"/> 911						____:____AM ____PM	
<input type="checkbox"/> Other						____:____AM ____PM	
15. EVENT DESCRIPTION: Describe what happened and interventions used by staff: - Refer to instruction sheet for items to be included in this section.							

Attach additional pages if necessary

Consumer Name _____

Event Date _____

16. MEDICATION ERROR CATEGORY (SELECT ONE) <input type="checkbox"/> Failure to Administer Reason _____ <input type="checkbox"/> No Physician Order <input type="checkbox"/> Wrong Dose <input type="checkbox"/> Wrong Form <input type="checkbox"/> Wrong Medication <input type="checkbox"/> Wrong Person <input type="checkbox"/> Wrong Route <input type="checkbox"/> Wrong Time	17. MEDICATION ERROR SEVERITY RATING (SELECT ONE) <input type="checkbox"/> Minimal: No treatment or intervention other than monitoring or observation Notification and written report to regional center within five (5) working days of discovery unless a suspicion or allegation of neglect <input type="checkbox"/> Moderate: Treatment and/or interventions in addition to monitoring or observation <input type="checkbox"/> Serious: Life threatening and/or permanent adverse consequences																																												
18. EVENT/ INCIDENT TYPE (SELECT ONE) ** emergency medical intervention or hospitalization of consumer																																													
<input type="checkbox"/> Choking with ** <input type="checkbox"/> Violation of Client Rights in RSMo 630.110 & 630.115 <input type="checkbox"/> Consumer struck object resulting in injury <input type="checkbox"/> Elopement/Unauthorized absence when absence raises reasonable concern for the safety of consumer or others, or concern the consumer will not return <input type="checkbox"/> Fall with ** <input type="checkbox"/> Fire <input type="checkbox"/> Inappropriate language by staff toward consumer (Verbal Abuse-9 CSR 10-5.200) <input type="checkbox"/> Ingestion of non-food item <input type="checkbox"/> Medical emergency	<input type="checkbox"/> Misuse of consumer funds/property-(9 CSR 10-5.200) <input type="checkbox"/> Physical altercation-consumer & consumer <input type="checkbox"/> Physical altercation-consumer & non-staff <input type="checkbox"/> Physical altercation-consumer & staff <input type="checkbox"/> Possession of weapon <input type="checkbox"/> Property loss/destruction <input type="checkbox"/> Sexual conduct-consumer/non-consensual <input type="checkbox"/> Sexual conduct-consumer & staff <input type="checkbox"/> Suicide attempt <input type="checkbox"/> Theft by consumer <input type="checkbox"/> Vehicular accident Report any of the following three incidents <input type="checkbox"/> Consumer self harm <input type="checkbox"/> Graphic threat of harm <input type="checkbox"/> Seizures only if: <ul style="list-style-type: none"> • unusual and not being addressed in the personal plan; • there is an injury; or • there is an allegation/suspicion of neglect. 																																												
19. DID THE EVENT RESULT IN Check all that apply <input type="checkbox"/> Injury to consumer <input type="checkbox"/> Use of physical restraint <input type="checkbox"/> Administration of PRN psychotropic medication <input type="checkbox"/> Hospitalization/non-injury <input type="checkbox"/> None of the above If injury complete 20, 21 22, 23																																													
20. INJURY TYPE (SELECT ONE) <input type="checkbox"/> Accident <input type="checkbox"/> Consumer Inflicted <input type="checkbox"/> Other Inflicted <input type="checkbox"/> Self Inflicted <input type="checkbox"/> Staff inflicted <input type="checkbox"/> Unknown																																													
21. INJURY SEVERITY: (SELECT ONE) <input type="checkbox"/> Medical Intervention <input type="checkbox"/> Hospitalization <input type="checkbox"/> Death																																													
22. INJURY DESCRIPTION (CHECK ALL THAT APPLY) <input type="checkbox"/> Abrasion <input type="checkbox"/> Bite <input type="checkbox"/> Bruise <input type="checkbox"/> Burn <input type="checkbox"/> Complaint of Pain <input type="checkbox"/> Cut <input type="checkbox"/> Concussion <input type="checkbox"/> Dislocation <input type="checkbox"/> Fracture/Break <input type="checkbox"/> Frostbite <input type="checkbox"/> Heat related illness <input type="checkbox"/> Poisoning <input type="checkbox"/> Puncture <input type="checkbox"/> Scratches <input type="checkbox"/> Strain/Sprain <input type="checkbox"/> Swelling <input type="checkbox"/> Other (specify) _____	23. INJURED BODY PARTS (CHECK ALL THAT APPLY) <table style="width:100%; border: none;"> <tr> <td style="width:25%; border: none;"><input type="checkbox"/> Head</td> <td style="width:25%; border: none;"><input type="checkbox"/> Shoulder</td> <td style="width:25%; border: none;"><input type="checkbox"/> Upper Back</td> <td style="width:25%; border: none;"><input type="checkbox"/> Knee</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Face</td> <td style="border: none;"><input type="checkbox"/> Upper Arm</td> <td style="border: none;"><input type="checkbox"/> Lower Back</td> <td style="border: none;"><input type="checkbox"/> Calf</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Eye</td> <td style="border: none;"><input type="checkbox"/> Elbow</td> <td style="border: none;"><input type="checkbox"/> Abdomen</td> <td style="border: none;"><input type="checkbox"/> Shin</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Ear</td> <td style="border: none;"><input type="checkbox"/> Forearm</td> <td style="border: none;"><input type="checkbox"/> Waist</td> <td style="border: none;"><input type="checkbox"/> Ankle</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Nose</td> <td style="border: none;"><input type="checkbox"/> Wrist</td> <td style="border: none;"><input type="checkbox"/> Hip</td> <td style="border: none;"><input type="checkbox"/> Foot</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Mouth</td> <td style="border: none;"><input type="checkbox"/> Hand</td> <td style="border: none;"><input type="checkbox"/> Genitals</td> <td></td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Teeth</td> <td style="border: none;"><input type="checkbox"/> Chest</td> <td style="border: none;"><input type="checkbox"/> Buttock</td> <td></td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Neck</td> <td></td> <td style="border: none;"><input type="checkbox"/> Thigh</td> <td></td> </tr> </table> <table style="width:100%; border: none; margin-top: 10px;"> <tr> <td style="width:50%; border: none;">FINGERS</td> <td style="width:50%; border: none;">TOES</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Thumb</td> <td style="border: none;"><input type="checkbox"/> Big</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Index</td> <td style="border: none;"><input type="checkbox"/> 2nd</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Middle</td> <td style="border: none;"><input type="checkbox"/> 3rd</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Ring</td> <td style="border: none;"><input type="checkbox"/> 4th</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Little</td> <td style="border: none;"><input type="checkbox"/> Little</td> </tr> </table>	<input type="checkbox"/> Head	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Upper Back	<input type="checkbox"/> Knee	<input type="checkbox"/> Face	<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Lower Back	<input type="checkbox"/> Calf	<input type="checkbox"/> Eye	<input type="checkbox"/> Elbow	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Shin	<input type="checkbox"/> Ear	<input type="checkbox"/> Forearm	<input type="checkbox"/> Waist	<input type="checkbox"/> Ankle	<input type="checkbox"/> Nose	<input type="checkbox"/> Wrist	<input type="checkbox"/> Hip	<input type="checkbox"/> Foot	<input type="checkbox"/> Mouth	<input type="checkbox"/> Hand	<input type="checkbox"/> Genitals		<input type="checkbox"/> Teeth	<input type="checkbox"/> Chest	<input type="checkbox"/> Buttock		<input type="checkbox"/> Neck		<input type="checkbox"/> Thigh		FINGERS	TOES	<input type="checkbox"/> Thumb	<input type="checkbox"/> Big	<input type="checkbox"/> Index	<input type="checkbox"/> 2 nd	<input type="checkbox"/> Middle	<input type="checkbox"/> 3 rd	<input type="checkbox"/> Ring	<input type="checkbox"/> 4 th	<input type="checkbox"/> Little	<input type="checkbox"/> Little
<input type="checkbox"/> Head	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Upper Back	<input type="checkbox"/> Knee																																										
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<input type="checkbox"/> Ring	<input type="checkbox"/> 4 th																																												
<input type="checkbox"/> Little	<input type="checkbox"/> Little																																												
24. IMMEDIATE ACTION TAKEN BY AGENCY AND ACTION STEPS TO PREVENT REOCCURENCE (To be completed by agency management) 																																													
25. Signature-Reporter	Phone Number ()	Date ___/___/___ :___:___ <input type="checkbox"/> AM <input type="checkbox"/> PM																																											
26. Signature-Agency Management/Supervisor		Date																																											
27. Signature-Service Coordinator		Date																																											
28. Signature-Other DMH Staff		Date																																											
29. ACTION/ COMMENTS (To be completed by DMH) 																																													
Suspicion or Allegation of Abuse, Neglect or Misuse of Consumer Funds/Property? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, must be entered into iiTS within 24 hours Suspected Manner of Death <input type="checkbox"/> ACCIDENT <input type="checkbox"/> HOMICIDE <input type="checkbox"/> NATURAL <input type="checkbox"/> SUICIDE <input type="checkbox"/> UNDETERMINED																																													

**Instruction Sheet for the Community Event Report Form
9/30/05**

1	Event Type: Check the event type being reported -Incident , Medication Error or Death - (Check one)	
2	Program Category: Check the primary service the consumer was receiving at the time of event –(Check one)	
3	Event date/Time: Date and time the event began/occurred or is believed to have begun/occurred.	
4	Discovery date/Time: Date and time the event was discovered. For example, a bruise on a consumer is discovered but the date of injury is unknown.	
5	Name of consumer involved in the event	
6	Consumer's date of birth – month, day, year	
7	Consumer's gender- male or female	
8	Consumer's ID number- the local/case number that appears on the consumer's personal plan	
9	Consumer's address or the name of the group home or facility where the consumer resides	
10	Name of Consumer's Service Coordinator	
11	Event Location or where discovered: Agency name or location where the event occurred	
12	Name of Provider Agency/ Organization involved in event & Vendor Number: The organization that may be responsible for the event. This is usually where the event occurred or if not at an organization, the organization with primary oversight responsibility for the individual.	
13	Name, relationship and contact number of person(s) who witnessed or has direct knowledge of the event	
	Relationships	
	Consumer.....	Any individual receiving services from the Department of Mental Health
	Parent/guardian.....	Individual who is legally responsible for the care and custody of the consumer
	Staff.....	Agency worker/employee
	Visitor.....	Individual coming to see a person or spending time in a place, whether for social, business or professional reasons.
	Volunteer.....	Individual providing services, of his own free will, and receiving no compensation.
	Complainant.....	Individual making the complaint or allegation
	Perpetrator.....	Individual that appears to be responsible for the event; the one who commits an unacceptable act.
	Reporter.....	Individual responsible for completing the event reporting form.
	Victim.....	Person harmed by or made to suffer from an act, circumstance, agency, or condition.
	Witness.....	Individual that observed /heard the event.
	Other.....	If other, please specify
14	Notified- Check persons/agencies notified, along with the person's name and date and time of notification. <i>Note: Department of Mental Health notification required.</i>	
15	Narrative- Describe what happened and interventions used by staff. If there was a medication error, indicate the name(s) of medications involved, including times, dosage, and reason for error.	
16	Medication Errors- (Check all that apply)	
	Failure to administer...	One or more doses of prescribed medication were not distributed, dispensed or administered as prescribed by the physician.
	Reason	Add the reason that the medication was not administered.
	No Physician Order.....	One or more doses of medication were distributed, dispensed or administered without the authorization of a physician.
	Wrong dose.....	More or less of the prescribed amount of medication was distributed, dispensed or administered to the consumer.
	Wrong form.....	The medication was administered in a form other than ordered, e.g. tablet instead of concentrate, ointment instead of cream.
	Wrong medication.....	A different medication than the one prescribed was distributed, dispensed or administered to the consumer
	Wrong person.....	One or more doses of medication were distributed, dispensed or administered to a person for whom the medication was not prescribed.
	Wrong route.....	The medication was distributed, dispensed, or administered to a person by the wrong route, i.e. by mouth, in ear, in eye, injection, topical, etc.
	Wrong time.....	The medication was not distributed, dispensed, or administered at the prescribed time. Current standard of practice is that medication should be administered within 60 minutes prior to or following the prescribed time. As an example, if a medication is prescribed for 8:00 p.m. or the h.s. medication rounds time for a facility is 8:00 p.m., then the acceptable window would allow medications to be administered as early as 7:00 p.m. or as late as 9:00 p.m.

17	Medication Error Severity Rating: Must be completed if there was a medication error. Check the box that describes the severity level. (DMH staff will review and confirm the severity level checked.)							
18	<p>Event/Incident Type – Check the event that occurred-</p> <p>Choking: (Required if medical intervention or hospitalization occurred.) When food or an object has obstructed the airway and the Heimlich maneuver or other medical intervention is required to save the life of an individual.</p> <p>Consumer rights: Any suspected violation of consumer rights as established by RSMO 630.110 or where there is a suspicion or allegation of abuse or neglect.</p> <p>Consumer struck object: Any physical force inflicted upon an object by a consumer.</p> <p>Elopement/Unauthorized Absence: The consumer has not been accounted for when expected to be present and has not been found on the grounds of the facility/home; or has left the grounds of the facility/home without permission.</p> <p>Fall: (Required if medical intervention or hospitalization occurred.) Sudden loss of an upright or erect position of the body. The fall did not result from any forcible physical actions of another person.</p> <p>Fire: Starting a fire whether intentional or due to impaired cognition or judgment.</p> <p>Inappropriate language-staff to consumer: Staff using profanity or speaking in a demeaning, non-therapeutic, undignified, threatening or derogatory manner in a consumer's presence.</p> <p>Ingestion of non-food item: Ingestion of an item that is not food, water, medication or other commonly ingestible item that may constitute a hazard to health.</p> <p>Medical emergency-consumer: A medical emergency occurs while a consumer is receiving active services in a facility, program or in the community with staff. The consumer is sent to a hospital or emergency care clinic in an urgent situation and receives medical treatment. This is used only when another incident type does not first describe the incident.</p> <p>Misuse of consumer funds/property: Staff is suspected to have misappropriated or converted a consumer's funds or property for their own benefit.</p> <p>Physical altercation consumer & consumer: Any physical force inflicted upon a consumer by a consumer</p> <p>Physical altercation consumer & non staff: Any physical force inflicted upon non-staff by a consumer.</p> <p>Physical altercation- consumer & staff: Any physical force inflicted upon the other when an altercation occurs between a staff and consumer.</p> <p>Possession of weapon: Having on one's person or in one's room an instrument or an object manufactured or altered to have potential to cause injury to oneself or to another individual. This includes a lighter or matches where/when not allowed.</p> <p>Property loss/destruction: Significant or notable destruction of property.</p> <p>Sexual conduct-consumer-non-consensual: Any sexual act involving a consumer when it is suspected or alleged that one of the parties was not a willing participant. This includes those incapable of giving consent due to guardianship or other reasons.</p> <p>Sexual conduct- consumer & staff: Any suspected or alleged sexual conduct between staff and consumer including but not limited to the definition of sexual abuse.</p> <p>Suicide attempt: Any action(s) taken by an individual with the intent to kill oneself but he/she is not successful.</p> <p>Theft by consumer: The act or an instance of stealing committed by a consumer</p> <p>Vehicular accident: Consumer was involved in the collision of a vehicle with another object.</p> <p>Blank line – Specify any incident not described above.</p> <p>Report the following incidents only if 1) unusual and not being addressed in the personal plan; 2) there is an injury; or 3)there is an allegation/suspicion of neglect.</p> <p>Consumer self-harm: Any physical force inflicted by a consumer on self.</p> <p>Graphic threat of Harm: Any threat, verbal or non verbal, which conveys a significant risk of imminent harm or injury and results in reasonable concern that such harm will actually be inflicted.</p> <p>Seizure – A convulsion or attack of Epilepsy</p>							
19	<p>Check if event resulted in (Check all that apply)</p> <table border="1" data-bbox="142 1669 1549 1919"> <tr> <td data-bbox="142 1669 503 1732">Injury.....</td> <td data-bbox="503 1669 1549 1732">Any physical harm or damage. This does not include naturally occurring physical illnesses or death from natural causes.</td> </tr> <tr> <td data-bbox="142 1732 503 1827">Physical restraint.....</td> <td data-bbox="503 1732 1549 1827">Any physical intervention technique used to restrict a consumer's movement. Specific division definitions may be found in the applicable Code of State Regulation 9 CSR 40-1.015</td> </tr> <tr> <td data-bbox="142 1827 503 1919">Administered PRN Psychotropic Medication...</td> <td data-bbox="503 1827 1549 1919">Any administration of a medication (pharmacologic agent) that affects a person's mental status that is prescribed but given according to circumstances and not a scheduled time.</td> </tr> </table>		Injury.....	Any physical harm or damage. This does not include naturally occurring physical illnesses or death from natural causes.	Physical restraint.....	Any physical intervention technique used to restrict a consumer's movement. Specific division definitions may be found in the applicable Code of State Regulation 9 CSR 40-1.015	Administered PRN Psychotropic Medication...	Any administration of a medication (pharmacologic agent) that affects a person's mental status that is prescribed but given according to circumstances and not a scheduled time.
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Administered PRN Psychotropic Medication...	Any administration of a medication (pharmacologic agent) that affects a person's mental status that is prescribed but given according to circumstances and not a scheduled time.							

	Hospitalization- Non-Injury Not applicable.....	The incident was not a result of an injury; however, the incident did require that the consumer be admitted as an inpatient to a hospital and assigned to a bed on a unit outside the emergency room. The event did not result in one of the above.
20	Injury Type- (Check one)	
	Accident..... Self-inflicted..... Consumer-inflicted..... Staff-inflicted..... Other-inflicted..... Unknown.....	Unexpected or unintentional occurrence such as slipping on an icy surface or injuries sustained during a seizure. Deliberate action by the person that results in self-harm, such as punching a wall or lacerating the wrists. A consumer inflicts physical harm on another person Staff intentionally or unintentionally inflicts physical harm on a person A person that is not staff or consumer, or an animal inflicts physical harm on a person The cause of the injury is not apparent or evident.
21	Injury Severity- Must be completed if an injury- (Check one)	
	Medical Intervention..... Hospitalization..... Death	Injury is severe enough to require the treatment of the individual by a licensed physician, osteopath, podiatrist, dentist, physician assistant or nurse practitioner but not serious enough to warrant or require hospitalization. The treatment received may be provided within the facility or provided outside the facility where it may range from treatment at a doctor's private office through treatment at the emergency room of a general acute care hospital. Injury is so severe that it requires medical intervention and treatment as well as care of the injured individual at a general acute care hospital. Regardless of the length of stay, this severity level requires that the injured individual be formally admitted as an inpatient to the hospital and assigned to a bed on a unit outside the emergency room. The injury received, or complications from the injury, was so severe that it resulted in the termination of the life of the injured individual.
22	Injury Descriptions - (Check all that apply)	
23	Injured Body Parts- (Check all that apply)	
24	Immediate Action taken: Describe the immediate by agency management as a result of the event. Include disciplinary and/or follow-up action taken to prevent reoccurrence of such events in the future.	
25	Signature Reporter: Name and telephone of Individual providing the initial information to the department which results in completion of an event report. Report Date/Time: Date and time event report completed	
26	Signature of Agency Management/Supervisor: Indicates that report was reviewed before sent to DMH	
27	Signature of Service Coordinator: Indicates the date the Service Coordinator reviewed the report.	
28	Signature of other DMH Staff: This could include Quality Assurance, Supervisors, Director, Abuse & Neglect, or Behavioral Resource Technicians.	
29	DMH Comments: Indicates action taken by DMH staff upon notification and indicate if there is suspicion/allegation of abuse, neglect, misuse of consumer funds, and if death the suspected manner of death.	

SECTION VI

EXAMPLE FORMS



STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH
CONSULTATION REPORT AND REQUEST

DATE

Name

BIRTHDATE

SEX

MALE

FEMALE

ID No.

REQUEST FOR CONSULATION TO (PHYSICIAN OR SERVICE)

REASON FOR REQUEST

BILL:

MEDICAID NO.

MEDICARE NO.

INDIVIDUAL'S FUND

CASEMANAGER

CENTER DIRECTOR

REPORT OF CONSULATION – DIAGNOSIS, FINDINGS AND RECOMMENDATIONS

REQUEST RECEIVED _____

DATE

CONSULTANT

IMMUNIZATION RECORD

NAME	CASE NUMBER	DATE
------	-------------	------

TETANUS-DIPHTHERIA (If the client has already been vaccinated, indicate the date of the DPT or Td Series was completed under "primary".)					
PRIMARY		2 MONTHS		4 MONTHS	
DOSAGE	DATE	DOSAGE	DATE	DOSAGE	DATE

TETANUS BOOSTER (A Tetanus Booster will be given at least once every ten years)					
DOSAGE	DATE	DOSAGE	DATE	DOSAGE	DATE

MEASLES, MUMPS, RUBELLA (If the client has history of disease or has already been vaccinated, please indicate the date/dates.)					
DOSAGE	DATE	DOSAGE	DATE	DOSAGE	DATE

HEPATITIS B (The primary dosage should be given as soon as the results of the screening are available. If the vaccination is not necessary, indicate the date and result of the screening under "primary".)					
PRIMARY		1 MONTH		6 MONTHS	
DOSAGE	DATE	DOSAGE	DATE	DOSAGE	DATE

INFLUENZA					
DOSAGE	DATE	DOSAGE	DATE	DOSAGE	DATE

PNEUMOVAX (This vaccination is given only once to clients who, in the physician's opinion, are a high risk for Pneumonia.)					
DOSAGE	DATE	DOSAGE	DATE	DOSAGE	DATE

TUBERCULIN TESTING RECORD

Clients will be tested yearly for Tuberculosis using the Mantoux Method. Clients who have a positive PPD will be followed up with a Chest X-Ray and then be X-rayed on a yearly basis.

PPD			
DATE	READING	DATE	READING

MENSES RECORD

Name: _____					
January:	Date Started _____			Date Ended _____	
	Flow: Discomfort:	Scant Headache	Light Cramps	Moderate Backache	Heavy Nausea
February:	Date Started _____			Date Ended _____	
	Flow: Discomfort:	Scant Headache	Light Cramps	Moderate Backache	Heavy Nausea
March:	Date Started _____			Date Ended _____	
	Flow: Discomfort:	Scant Headache	Light Cramps	Moderate Backache	Heavy Nausea
April:	Date Started _____			Date Ended _____	
	Flow: Discomfort:	Scant Headache	Light Cramps	Moderate Backache	Heavy Nausea
May:	Date Started _____			Date Ended _____	
	Flow: Discomfort:	Scant Headache	Light Cramps	Moderate Backache	Heavy Nausea
June:	Date Started _____			Date Ended _____	
	Flow: Discomfort:	Scant Headache	Light Cramps	Moderate Backache	Heavy Nausea

Comments:

MENSES RECORD

Name: _____					
July:	Date Started _____			Date Ended _____	
	Flow:	Scant	Light	Moderate	Heavy
	Discomfort:	Headache	Cramps	Backache	Nausea
August:	Date Started _____			Date Ended _____	
	Flow:	Scant	Light	Moderate	Heavy
	Discomfort:	Headache	Cramps	Backache	Nausea
September:	Date Started _____			Date Ended _____	
	Flow:	Scant	Light	Moderate	Heavy
	Discomfort:	Headache	Cramps	Backache	Nausea
October:	Date Started _____			Date Ended _____	
	Flow:	Scant	Light	Moderate	Heavy
	Discomfort:	Headache	Cramps	Backache	Nausea
November:	Date Started _____			Date Ended _____	
	Flow:	Scant	Light	Moderate	Heavy
	Discomfort:	Headache	Cramps	Backache	Nausea
December:	Date Started _____			Date Ended _____	
	Flow:	Scant	Light	Moderate	Heavy
	Discomfort:	Headache	Cramps	Backache	Nausea

Comments:

SEIZURE RECORD

Name: _____

Type	Name	Seizure Description
1.		
2.		
3.		

Date	Type	Start Time	Duration	Variation from Type	*Staff
			S		

***Use a name key with initials.**

Sample Seizure Record

Name: *John J. Consumer*

Type	Name	Seizure Description
1.	<i>tonic-clonic</i>	<i>Shout/cry - loss of contact - limb stiffening/shaking - 2 minutes - recovery over 8 hours.</i>
2.	<i>myoclonic</i>	<i>Forceful limb/body jerks - single or multiple - 5 minutes</i>
3.		

Date	Type	Start Time	Duration	Variation from Type	*Staff
<i>June 1, 1998</i>	<i>1</i>	<i>8:20 am</i>	<i>90 seconds</i>		<i>SAA</i>
	<i>1</i>	<i>10:30 am</i>	<i>2 min</i>		<i>RCO</i>
<i>June 22</i>	<i>2</i>	<i>4:50 pm</i>	<i>15 min</i>	<i>longer than usual, but recovered quickly</i>	<i>RCO</i>
<i>June 31</i>	<i>1</i>	<i>2 am</i>	<i>30 seconds</i>	<i>incontinence</i>	<i>SAA</i>
<i>7/4/05</i>	<i>1</i>	<i>11:15 am</i>	<i>2 min</i>		<i>BBS</i>
<i>7/17/05</i>	<i>1</i>	<i>4:45</i>	<i>2 min</i>	<i>cyanosis</i>	<i>BBS</i>

*Use a name key with initials.

TARDIVE DYSKINESIA

What is Tardive Dyskinesia?

Tardive Dyskinesia, or TD, is one of the muscular side effects of anti-psychotic drugs, especially the older generation like haloperidol. TD does not occur until after many months or years of taking antipsychotic drugs, unlike akathisia (restlessness), dystonia (sudden and painful muscle stiffness) and Parkinsonism (tremors and slowing down of all body muscles), which can occur within hours to days of taking an antipsychotic drug. TD is primarily characterized by random movements in the tongue, lips or jaw as well as facial grimacing, movements of arms, legs, fingers and toes, or even swaying movements of the trunk or hips. TD can be quite embarrassing to the affected patient when in public. The movements disappear during sleep. They can be mild, moderate or severe.

How does an individual get TD?

Essentially, prolonged exposure to antipsychotic treatment (which is necessary for many persons who have chronic schizophrenia) is the major reason that TD occurs in an individual. Some persons get it sooner than others. The risk factors that increase the chances of developing TD are a) duration of exposure to antipsychotics (especially the older generation), b) older age, c) post-menopausal females, d) alcoholism and substance abuse, e) mental retardation and f) experiencing a lot of EPS in the acute stage of antipsychotic therapy.

The mechanism of TD is still unknown despite extensive research. However, it is generally believed that long-term blocking of dopamine D₂ receptors (which is what all antipsychotics on the market do) causes an increase in the number of D₂ receptors in the striated region of the brain (which controls muscle coordination). This "up-regulation" of D₂ receptors may cause spontaneous and random muscle contractions or movements throughout the body, but particularly in the peri-oral and facial muscles.

How many individuals currently have TD?

It is not known how many individuals currently have TD. No large scale epidemiological prevalence survey has been done. It would also change because TD can be transient or persistent, and it can be more common in some persons with risk factors than others.

However, there have been several follow-up studies of individuals who start taking antipsychotics in order to measure the annual occurrence (incidence) of TD. Eight studies in young individuals (average age 29 years) receiving the older antipsychotics showed practically the same rate of 5% of those persons develop TD every year, year after year, until eventually almost 50-60% develop TD over their lifetime. The incidence of TD is higher in older individuals (average age 65 years) where our studies have shown that TD occurs in 26% after only one year of exposure to haloperidol, which increases to 52% after two years and up to 60% after three years.

Do the newer generation atypical antipsychotics pose a lower risk of TD?

Yes, the newer atypical antipsychotics are much safer than the older generation when it comes to TD. The first year incidence of TD with risperidone, olanzapine, quetiapine, and ziprasidone in young persons about 0.5%, which is ten-fold lower than with haloperidol. Similarly, the incidence of TD with atypical antipsychotics in the first year in geriatric patients is 2.5%, which is also ten-fold lower than with haloperidol. There is also growing evidence that the incidence is even lower in subsequent years of exposure to atypicals. The problem of TD has been significantly reduced with the advent and wide-spread use of atypical antipsychotics.

What are the symptoms of TD and is TD reversible?

As described above, the main symptoms of TD are continuous and random muscular movements in the tongue, mouth and face, but sometimes the limbs and trunks are affected as well. Rarely, the respiration muscles may be affected resulting in grunts and even breathing difficulties. Sometimes, the legs can be so severely affected that walking becomes difficult.

It must be noted that there are many other conditions that resemble TD and must be ruled out before a diagnosis of TD is made. For example, several neurodegenerative brain diseases may cause movement disorders. Very old persons may also develop mouth and facial movements with age that may be mistaken for TD. Blepharospasm is another condition that may be mistaken for TD. It should be emphasized that a history of several months or years of antipsychotic intake must be documented before TD is even considered.

TD is often mild and reversible. The percentage of patients who develop severe or irreversible TD is quite low as a proportion of those receiving long-term antipsychotic therapy.

What should you do if you notice symptoms of TD in yourself or in a family member?

Consult a psychiatrist with an established experience in using antipsychotic drugs or a neurologist who specializes in movement disorders. That physician will take a detailed history and conduct an examination and decide whether you have TD or something else, and will recommend the appropriate management.

The pattern and severity of TD is usually measured on a rating scale called "The Abnormal Involuntary Movement Scale", (AIMS for short). Psychiatrists generally assess patients receiving long-term antipsychotic medication for TD symptoms at least annually using the AIMS.

Are there effective treatments for TD?

There has never been a definitive, validated and widely accepted treatment for TD. Dozens of drugs have been tested over the past 30 years with mixed results at best. The atypical antipsychotic clozapine has been reported to reverse persistent TD after 6-12 months, possibly through gradual "down-regulation" of supersensitive dopamine D₂ receptors. Some preliminary reports suggest that other atypical antipsychotics may also help reverse TD.

However, given that a large majority of persons who need antipsychotic treatment are now receiving the new atypicals and given the drastically lower incidence of TD with atypical antipsychotics, the issue of developing a treatment for TD may have become a moot one. Preventing the occurrence of TD is much more preferable to treating TD.

Reviewed by Henry A. Nasrallah, MD September 2003

http://www.nami.org/Content/ContentGroups/HelpLine1/Tardive_Dyskinesia.htm

Commonly Prescribed Psychotropic Medications

Antipsychotics <i>(used in the treatment of schizophrenia and mania)</i>	Anti-depressants	Anti-obsessive Agents
Typical Antipsychotics	Tricyclics	
Haldol (haloperidol)	*Anafranil (clomipramine)	Anafranil (clomipramine)
Loxitane (loxapine)	Asendin (amoxapine)	Luvox (fluvoxamine)
Mellaril (thioridazine)	Elavil (amitriptyline)	Paxil (paroxetine)
Moban (molindone)	Norpramin (desipramine)	Prozac (fluoxetine)
Navane (thiothixene)	Pamelor (nortriptyline)	Zoloft (sertraline)
Prolixin (fluphenazine)	Sinequan (doxepin)	
Serentil (mesoridazine)	Surmontil (trimipramine)	Antianxiety Agents
Stelazine (trifluoperazine)	Tofranil (imipramine)	Ativan (lorazepam)
Thorazine (chlorpromazine)	Vivactil (protriptyline)	BuSpar (buspirone)
Trilafon (perphenazine)		Centrax (prazepam)
	SSRIs	*Inderal (propranolol)
Atypical Antipsychotics	Celexa (citalopram)	*Klonopin (clonazepam)
Abilify (aripiprazole)	Lexapro (escitalopram)	Lexapro (escitalopram)
Clozaril (clozapine)	*Luvox (fluvoxamine)	Librium (chlordiazepoxide)
Risperdal (risperidone)	Paxil (paroxetine)	Serax (oxazepam)
Seroquel (quetiapine)	Prozac (fluoxetine)	*Tenormin (atenolol)
Zyprexa (olanzapine)	Zoloft (sertraline)	Tranxene (clorazepate)
	MAOIs	Valium (diazepam)
Mood Stabilizers <i>(used in the treatment of bipolar disorder)</i>	Nardil (phenelzine)	Xanax (alprazolam)
Depakene (valproic acid)	Parnate (tranylcypromine)	* <i>Antidepressants, especially SSRIs, are also used in the treatment of anxiety.</i>
Depakote	Others	Stimulants
Eskalith	Desyrel (trazadone)	(used in the treatment of ADHD)
Lithobid (lithium)	Effexor (venlafaxine)	Adderall (amphetamine and dextroamphetamine)
Lithonate	Remeron (mirtazapine)	Cylert (<i>pemoline</i>)
Lithotabs	Serzone (nefazodone)	Dexedrine
*Lamictal (lamotrigine)	Wellbutrin (bupropion)	(dextroamphetamine)
*Neurontin (gabapentin)	Anti-Panic Agents	Ritalin (methylphenidate)
*Tegretol (carbamazepine)	Klonopin (clonazepam)	* <i>Antidepressants with stimulant properties, such as Norpramin and Wellbutrin, are also used in the treatment of ADHD</i>
*Topamax (topiramate)	Paxil (paroxetine)	
	Xanax (alprazolam)	
	Zoloft (sertraline)	
	* <i>Antidepressants are also used in treatment of panic disorder.</i>	

**Although this medication has been approved by the FDA for the treatment of other disorders, it has not been approved for this particular use. Some evidence of this medication's efficacy for such use does exist however. This type of medication use is referred to as "off label."*

Remember, always consult your doctor or pharmacist with any specific medication questions

*The chart below provides cross-referencing by generic name. ** Indicates medication may be associated with Tardive Dyskinesia, this is not an exhausted list. Other medications that have been associated with Tardive Dyskinesia include Gastrointestinal Medications and Bowel Medications.*

Generic Name	Brand Name	Current Uses
alprazolam	Xanax	anxiety, panic
** amitriptyline	Elavil, Endep	depression (tricyclic)
** amoxapine	Asendin	psychotic depression
amphetamine	Adderall	ADD
aripiprazole	Abilify	schizophrenia (atypical)
bupropion	Wellbutrin	depression, ADD
bupirone	BuSpar	anxiety
** carbamazepine	Tegretol	bipolar disorder
chloriazepoxide	Librium	anxiety
** chlorpromazine	Thorazine	schizophrenia (typical)
citalopram hydrobromide	Celexa	depression (SSRI)
clomipramine	Anafranil	OCD, depression (tricyclic)
** clonazepam	Klonopin	anxiety
clorazepate	Tranxene	anxiety
**clozapine	Clorazil	schizophrenia (atypical)
**desipramine	Norpramin	depression (tricyclic), ADD
dextroamphetamine	Adderall, Dexedrine	ADD
diazepam	Valium	anxiety
**divalproex sodium	Depakote	bipolar disorder
** doxepin	Adapin, Sinequan	depression (tricyclic)
escitalopram	Lexapro	depression (SSRI), anxiety
fluoxetine	Prozac	depression (SSRI), OCD, panic
** fluphenazine	Prolixin, Prolixin Decanoate	schizophrenia (typical)
fluvoxamine	Luvox	OCD, depression (SSRI)
** haloperidol	Haldol, Haldol Decanoate	schizophrenia (typical)
** imipramine	Tofranil	depression (tricyclic), panic
lithium carbonate	Eskalith, Lithobid	bipolar disorder
lithium citrate	Cibalith S	bipolar disorder
** lorazepam	Ativan	anxiety
**loxapine	Loxitane	schizophrenia (typical)
maprotiline	Ludiomil	depression (tricyclic)
** mesoridazine	Serentil	schizophrenia (typical)
** methylphenidate	Ritalin	ADD
mirtazapine	Remeron	depression
** molindone	Moban	schizophrenia (typical)

nefazodone	Serzone	depression
** nortriptyline	Pamelor	depression (tricyclic)
** olanzapine	Zyprexa	schizophrenia (atypical)
oxazepam	Serax	anxiety
paroxetine	Paxil	depression (SSRI), OCD, panic
** pemoline	Cylert	ADD
** perphenazine	Trilafon	schizophrenia (typical)
phenelzine	Nardil	depression (MAOI)
prazepam	Centrax	anxiety
** prochlorperazine	Compazine	schizophrenia (typical)
protriptyline	Vivactil	depression (tricyclic)
quetiapine	Seroquel	schizophrenia (atypical)
** risperidone	Risperdal	schizophrenia (atypical)
sertraline	Zoloft	depression (SSRI), ODC, panic
** thioridazine	Mellaril	schizophrenia (typical)
** thiothixene	Navane	schizophrenia (typical)
tranylcypromine sulfate	Prarnate	depression (MAOI)
trazodone	Desyrel	depression (tricyclic)
** trifluoperazine	Stelazine, Vesprin	schizophrenia (typical)
trimipramine	Surmontil	depression (tricyclic)
** valproic acid	Depakene	bipolar disorder
venlafaxine	Effexor	depression

Abnormal Involuntary Movement Scale (AIMS)

Definition

The Abnormal Involuntary Movement Scale (AIMS) is a rating scale that was designed in the 1970s to measure involuntary movements known as tardive dyskinesia (TD). TD is a disorder that sometimes develops as a side effect of long-term treatment with neuroleptic (antipsychotic) medications.

Purpose

Tardive dyskinesia is a syndrome characterized by abnormal involuntary movements of the patient's face, mouth, trunk, or limbs, which affects 20%–30% of patients who have been treated for months or years with neuroleptic medications. Patients who are older, are heavy smokers, or have diabetes mellitus are at higher risk of developing TD. The movements of the patient's limbs and trunk are sometimes called choreathetoid, which means a dance-like movement that repeats itself and has no rhythm. The AIMS test is used not only to detect tardive dyskinesia but also to follow the severity of a patient's TD over time. It is a valuable tool for clinicians who are monitoring the effects of long-term treatment with neuroleptic medications and also for researchers studying the effects of these drugs. The AIMS test is given every three to six months to monitor the patient for the development of TD. For most patients, TD develops three months after the initiation of neuroleptic therapy; in elderly patients, however, TD can develop after as little as one month.

Precautions

The AIMS test was originally developed for administration by trained clinicians. People who are not health care professionals, however, can also be taught to administer the test by completing a training seminar.

Description

The entire test can be completed in about 10 minutes. The AIMS test has a total of twelve items rating involuntary movements of various areas of the patient's body. These items are rated on a five-point scale of severity from 0–4. The scale is rated from 0 (none), 1 (minimal), 2 (mild), 3 (moderate), 4 (severe). Two of the 12 items refer to dental care. The patient must be calm and sitting in a firm chair that doesn't have arms, and the patient cannot have anything in his or her mouth. The clinician asks the patient about the condition of his or her teeth and dentures, or if he or she is having any pain or discomfort from dentures.

The remaining 10 items refer to body movements themselves. In this section of the test, the clinician or rater asks the patient about body movements. The rater also looks at the patient in order to note any unusual movements first-hand. The patient is asked if he or she has noticed any unusual movements of the mouth, face, hands or feet. If the patient says yes, the clinician then asks if the movements annoy the patient or interfere with daily activities. Next, the patient is observed for any movements while sitting in the chair with feet flat on the floor, knees separated slightly with the hands on the knees. The patient is asked to open his or her mouth and stick out the tongue twice while the rater watches. The patient is then asked to tap his or her thumb with each finger very rapidly for 10–15 seconds, the right hand first and then the left hand. Again the rater observes the patient's face and legs for any abnormal movements.

After the face and hands have been tested, the patient is then asked to flex (bend) and extend one arm at a time. The patient is then asked to stand up so that the rater can observe the entire body for movements. Next, the patient is asked to extend both arms in front of the body with the palms facing downward. The trunk, legs and mouth are again observed for signs of TD. The patient then walks a few paces, while his or her gait and hands are observed by the rater twice.

Results

The total score on the AIMS test is not reported to the patient. A rating of 2 or higher on the AIMS scale, however, is evidence of tardive dyskinesia. If the patient has mild TD in two areas or moderate movements in one area, then he or she should be given a diagnosis of TD. The AIMS test is considered extremely reliable when it is given by experienced raters.

If the patient's score on the AIMS test suggests the diagnosis of TD, the clinician must consider whether the patient still needs to be on an antipsychotic medication. This question should be discussed with the patient and his or her family. If the patient requires ongoing treatment with antipsychotic drugs, the dose can often be lowered. A lower dosage should result in a lower level of TD symptoms. Another option is to place the patient on a trial dosage of clozapine (Clozaril), a newer antipsychotic medication that has fewer side effects than the older neuroleptics.

Examination Procedure

Either before or after completing the examination procedure, observe the patient unobtrusively at rest (e.g., in the waiting room).

The chair to be used in this examination should be a hard, firm one without arms. Have the person remove their shoes and socks.

1. Ask the patient whether there is anything in his or her mouth (such as gum or candy) and, if so, to remove it.
2. Ask about the *current* condition of the patient's teeth. Ask if he or she wears dentures. Ask whether teeth or dentures bother the patient *now*.
3. Ask whether the patient notices any movements in his or her mouth, face, hands, or feet. If yes, ask the patient to describe them and to indicate to what extent they *currently* bother the patient or interfere with activities.
4. Have the patient sit in chair with hands on knees, legs slightly apart, and feet flat on floor. (Look at the entire body for movements while the patient is in this position.)
5. Ask the patient to sit with hands hanging unsupported -- if male, between his legs, if female and wearing a dress, hanging over her knees. (Observe hands and other body areas).
6. Ask the patient to open his or her mouth. (Observe the tongue at rest within the mouth.) Do this twice.
7. Ask the patient to protrude his or her tongue. (Observe abnormalities of tongue movement.) Do this twice.
8. Ask the patient to tap his or her thumb with each finger as rapidly as possible for 10 to 15 seconds, first with right hand, then with left hand. (Observe facial and leg movements.) [±activated]

9. Flex and extend the patient's left and right arms, one at a time.
10. Ask the patient to stand up. (Observe the patient in profile. Observe all body areas again, hips included.)
11. Ask the patient to extend both arms out in front, palms down. (Observe trunk, legs, and mouth.) activated
12. Have the patient walk a few paces, turn, and walk back to the chair. (Observe hands and gait.) Do this twice. activated

ABNORMAL INVOLUNTARY MOVEMENT SCALE (AIMS)

Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration
National Institute of Mental Health

NAME: _____
DATE: _____
Prescribing Practitioner: _____

CODE 0=None
1=Minimal, may be extreme normal
2=Mild
3=Moderate
4=Severe

INSTRUCTIONS:

Complete Examination procedure (attachment d.)
Before making ratings

MOVEMENT RATINGS: Rate highest severity observed. Rate movements that occur upon activation one less than those observed spontaneously. Circle movement as well as code number that applies.		RATER	RATER	RATER	RATER
		Date	Date	Date	Date
Facial and Oral Movements	1. Muscles of Facial Expression e.g. movements of forehead, eyebrows, periorbital area, cheeks, including frowning, blinking, smiling, grimacing	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	2. Lips and Perioral Area e.g., puckering, pouting, smacking	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	3. Jaw e.g. biting, clenching, chewing, mouth opening, lateral movement	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	4. Tongue Rate only increases in movement both in and out of mouth. NOT inability to sustain movement. Darting in and out of mouth.	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Extremity Movements	5. Upper (arms, wrists,, hands, fingers) Include choreic movements (i.e., rapid, objectively purposeless, irregular, spontaneous) athetoid movements (i.e., slow, irregular, complex, serpentine). DO NOT INCLUDE TREMOR (i.e., repetitive, regular, rhythmic)	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	6. Lower (legs, knees, ankles, toes) e.g., lateral knee movement, foot tapping, heel dropping, foot squirming, inversion and eversion of foot.	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Trunk Movements	7. Neck, shoulders, hips e.g., rocking, twisting, squirming, pelvic gyrations	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Global Judgments	8. Severity of abnormal movements overall	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	9. Incapacitation due to abnormal movements	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	10. Patient's awareness of abnormal movements Rate only patient's report No awareness 0 Aware, no distress 1 Aware, mild distress 2 Aware, moderate distress 3 Aware, severe distress 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Dental Status	11. Current problems with teeth and/or dentures?	No Yes	No Yes	No Yes	No Yes
	12. Are dentures usually worn?	No Yes	No Yes	No Yes	No Yes
	13. Edentia?	No Yes	No Yes	No Yes	No Yes
	14. Do movements disappear in sleep?	No Yes	No Yes	No Yes	No Yes

Final: 9/2000

SECTION VII

FAQ'S

Frequently Asked Questions
MRDD Community RN Program
January 2006

❖ **Can an LPN meet the need for contracting with a nurse?**

Only a Registered Nurse (RN) can fulfill the requirements of the DMRDD Community RN Program via contract.

❖ **Can providers contract with “nursing agencies” to access an RN for this program instead of contracting directly or hiring an RN?**

Temporary or rotating agency nurses could not fulfill the functions of this position on a permanent basis as rotating nurses would not provide the continuity of care expected with this program. They may serve to fill nursing needs during the absence of a RN employee. If a nurse agency agreed to assign a primary nurse to each facility and would integrate the job functions into their job description, it may be possible that they could meet the job expectations. They would also have to attend the required training. The agency would still be accountable to see that the contracting agency / nurse fulfilled the job functions as defined. A temporary or rotating nurse could be used to meet a consumer health care need or provide coverage short term while hiring a RN for the position.

❖ **Does the RN have to spend exactly 1.25 hours per consumer?**

The formula used to establish a rate was 1.25 hours per consumer. However, to accommodate individual needs, some flexibility is allowed in the distribution of those hours. As long as the RN provides at minimum, a monthly face to face assessment of each consumer, the hours may be combined and distributed based on needs and distributed **within each provider agency**. Total authorized hours should be provided each month and not be carried over into another month. Service logs will be maintained by the RN to account for their time. These documents are maintained by the provider agency and will be used for program audit purposes.

❖ **Will the RN be required to spend 1.25 hours per month with each consumer even if they take no medications and have no acute health concerns at the moment?**

If delegation and supervision of medication administration or other nursing tasks are not needed at the moment, the RN will still complete a monthly health inventory summary and can spend the monthly 1.25 hours per consumer or (for a portion of this time) on activities that will assist in the monitoring and promotion of consumer’s health and education. The RN should use their clinical judgment to determine needs and supports that would enhance their health or the health care delivery for each consumer. This may include preventative care and instruction for their diagnosis or other persons of similar age and gender. The flexibility to distribute the total nursing hours based on consumer needs will also allow the nurse to spend more or less time with each consumer as appropriate as long as each person is evaluated from month to month.

❖ **Can the RN’s travel time be included in the 1.25 hours/consumer/month?**

No. Travel is excluded from the acceptable activities of the nurse within the 1.25 hour formula.

❖ **Can the RN instruct a Medication Administration Course within the allowed 1.25 hours/consumer/month?**

No. Course instruction is not an acceptable activity within the 1.25 hour formula. The RN may provide instruction for the purpose of delegation or enhancement of consumer care but should be done so on an individualized basis and not a course non-specific to a consumer.

❖ **What if the RN determines she/he can not delegate an activity?**

The decision to delegate is up to the RN and reasons for not delegating must be evaluated on an individual basis. For example, if an RN feels he/she can not delegate an activity because the staff person is not competent to carry out the task, he/she should not delegate but should communicate the reasons to agency management to determine the appropriate course of action. Possible interventions may be addressing employee training or making a staff available who may have or can learn the necessary skills. If the RN determines a task is not to be delegated to a non-licensed person, they should not delegate the task but complete the task themselves and communicate to agency management the reason. The provider and Regional Center may then need to meet to determine the appropriate course of action to sustain the person's needs if it is more than the RN can support at 1.25 hours/month. All actions taken should be documented.

❖ **What if the RN determines their health support needs are not adequately reflected in a person's personal plan?**

The RN should inform agency management and the Regional Center Service Coordinator or Quality Management RN for appropriate follow up. The RN's job expectations do not include regular attendance at the Personal Planning meeting however, if occasional attendance is necessary to address a specific client need it would be an acceptable planning activity.

❖ **What about coverage for twenty four hour on-call emergencies?**

On-call services are not an expectation of this RN position in relation to the allocated funding. If a provider negotiates this service for additional funding, it is their option but this service should not come out of the allotted 1.25 formula. Emergencies should continue to be handled through the same avenues that were available prior to this program or as new policy directs.

❖ **Explain why there is a requirement for monthly face to face visits to every consumer by the RN.**

A thorough evaluation of a person's status can not be completed accurately by paperwork review alone. It is expected that the RN will meet and assess the consumer each month as part of their professional evaluation process. The RN should get to know each consumer, providing continuity in their care and their evaluation. In addition to achieving compliance with the MO Nursing Practice Act, the Division expects this program to reduce the incidents of negative outcomes to the individuals by providing funding for a nursing professional to routinely evaluate the consumer's status and oversee direct care staff in the delivery of nursing care.

❖ **Can the monthly assessment be delegated to a LPN?**

The RN may delegate any task that is within the scope of practice for a LPN if the proper components are present. If part of the physical assessment or other data collection is delegated to the LPN, the RN still needs to see each consumer monthly as part of their professional evaluation and determination of further assessment needs. The consumer is the focus of the evaluation and the focus of service delivery for which this program is funded. Professional evaluation should not occur without assessing, evaluating progress and updating his/her support needs. The depth of each assessment will depend on the consumer's needs as identified by the RN but will be in person each month.