LICENSED VOCATIONAL NURSE ON CALL PILOT PROGRAM – FINAL REPORT

Center for Policy and Innovation

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TABLE OF CONTENTS

Executive Summary	1
Introduction	3
Scope of Report	3
Background	3
Advisory Committee	4
Training/Protocol Development	4
Pilot Participation	4
Data Collection and Evaluation	5
Challenges	8
Lessons Learned	8
Recommendations	9
Appendix A – MOU	10
Appendix B – Training	13
Appendix C – Advisory Committee Composition	14
Appendix D – Documents associated with pilot	15
Appendix E – Participating and Non-participating Provider Survey Questions	36
Appendix F – Random sample/deaths chart review evaluation questions	45

Executive Summary

Senate Bill (S.B.) 1857, 82nd Legislature, Regular Session, 2011, amended the Texas Human Resources Code relating to the administration of medications for persons with intellectual and developmental disabilities (IDD). It directed the Texas Department of Aging and Disability Services (DADS) and the Texas Board of Nursing (BON) to develop and conduct a pilot program to evaluate licensed vocational nurses (LVNs) providing on-call services by telephone to individuals receiving services in the Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Medicaid waivers and in intermediate care facilities for individuals with an intellectual disability or related condition (ICFs/IID) with 13 or fewer beds. This report covers the time period following the interim report on the pilot published in December 2012 and offers a final evaluation of the pilot which ended August 31, 2015.

Milestones Achieved

- DADS conducted advisory committee meetings on a regular basis to keep the committee apprised of findings and issues.
- DADS and BON conducted surveys of participating and non-participating providers in the pilot.
- DADS and BON developed a system to evaluate the pilot with input from the advisory committee based on a random sample of chart reviews and reviews of all deaths.
- In response to input from the advisory committee, DADS and BON modified operational and communication protocols.
- DADS provided training in response to issues identified during evaluation of the pilot, in partnership with BON.
- BON and DADS increased communication among staff regarding nursing practice in pilot settings.
- DADS led development of an LVN Educator Toolkit aimed to assist in preparing new LVNs for practice in community and long term care settings.

For a list of milestones achieved prior to December 2012, see the interim report.

Challenges

- Providers were often non-responsive to DADS requests for records.
- The lack of documentation by both nursing and direct care staff when an incident occurred made it difficult to evaluate if a nurse followed communication and operational protocols correctly.
- Processes for DADS to obtain and review records and for DADS and BON to conduct mortality reviews are labor intensive.
- Turnover of personnel at DADS and BON led to gaps in pilot management.

- Turnover of personnel at provider organizations led to potential gaps in training in pilot protocols.
- Understanding of the LVN's scope of practice varied among providers
- LVNs who participated in the pilot may be unaware the pilot ended.
- Providers have difficulty recruiting, hiring and retaining RNs as reported by advisory committee provider members.
- Training in management of a critical incident or death varied from provider to provider.
- No funding was appropriated to administer the pilot.

Lessons Learned

- Nurses and providers were unaware of continuing education and certification for nurses who care for individuals with IDD is available through the Developmental Disabilities Nurses Association.
- Direct and frequent communication among direct care providers and the nurse on-call is essential for safe care of individuals.
- Providers employing nurses must understand scope of practice for RNs and LVNs.
- Based on a survey of providers, the most frequently cited reason for not participating in the pilot was the need to have an RN available to the LVN for consultation while taking calls.

Recommendations

- BON does not recommend expansion of the LVN scope of practice in the community setting of HCS/TxHmL and ICF/IID, including the provision of on-call services by telephone.
- The state should convene a workgroup consisting of DADS, BON, and IDD stakeholders to identify and resolve issues involving nursing scope of practice in community settings.
- The state should develop training to improve the ability of direct care staff to recognize deterioration in status in individuals who have chronic medical diagnosis.
- Direct care staff should contact nursing staff directly to communicate client health care needs and status changes as opposed to through a third party such as a house administrator.
- Nursing orientation at a provider level should include training on documentation in the IDD care setting.
- BON should continue educational offerings aimed to teach LVN scope of practice.

S.B. 1857, 82nd Legislature, Regular Session, 2011, required the Texas Board of Nursing (BON) and the Texas Department of Aging and Disability Services (DADS) to conduct a pilot program to evaluate an expansion of licensed vocational nurses' (LVNs) scope of practice to include on-call services by telephone to individuals receiving services in the Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Medicaid waiver programs and in intermediate care facilities for individuals with an intellectual disability or related conditions (ICFs/IID) with 13 or fewer beds. The provision of on-call telephone services means: providing telephone services any time of the day or night, to handle non-urgent, urgent, and emergent conditions an individual may experience; making a telephone assessment; providing instructions to an unlicensed person over the phone regarding that condition; and reporting those instructions to a registered nurse (RN) clinical supervisor. The LVN On-Call Pilot Program was developed to determine the impact of allowing LVNs to function with an expanded scope of practice on the quality of care provided to individuals served in the designated intellectual and developmental disability (IDD) programs. The pilot began September 1, 2011, and concluded August 31, 2015.

Scope of Report

This report, in addition to the interim report issued December 2012, outlines findings of the pilot and provides recommendations based on those findings. It focuses on the time period after the interim report was published up to the conclusion of the pilot. The report describes details of the pilot (e.g., data collection) and evaluation, challenges encountered and lessons learned.

Background

BON rules in Title 22, Texas Administrative Code (TAC) Section 217.11 (2) and (3) indicate that on-call services provided by telephone are within the scope of practice of the RN but not within the scope of practice of the LVN. The RN scope of practice and the LVN scope of practice, while different, are based upon the educational preparation in the RN or LVN programs of study. The Texas Occupations Code, Chapter 301 (Nursing Practice Act), Section 301.353 (Supervision of Vocational Nurse) and 22 TAC, 217.11(2) states that the LVN practice is a directed scope of practice and must be supervised by an RN, physician, physician assistant, dentist or podiatrist.

There is a growing need for nursing services to individuals with IDD who are living in the community and an insufficient number of RNs who choose to work in this setting. Because of the difficulty in employing RNs, some LVNs informally began performing certain functions outside their legal scope of practice, including telephone on-call services. The purpose of this pilot was to formally test the concept of allowing LVNs to perform on-call services provided by telephone without negatively affecting quality of care.

S.B. 1857 required BON and DADS to conduct the pilot. Both agencies entered into a memorandum of understanding establishing the pilot on July 6, 2011 (See Appendix A).

Advisory Committee

S.B. 1857 required that the pilot be developed in coordination with public and private providers and RNs and LVNs employed by ICFs/IID with 13 or fewer beds and HCS/TxHmL waiver program providers. BON and DADS formed an advisory committee to function in this capacity (see Appendix C for Advisory Committee membership). Regular meetings were held to keep the advisory committee informed of the results of evaluations of the pilot and challenges encountered. Adjustments to the operational and communication protocols were discussed in the meetings. The advisory committee was given opportunity to review and to provide input on DADS communications to the provider community regarding the pilot.

Training/Protocol Development

Initial training was conducted in the fall of 2011 based on the operational and communications protocol. Additional training was then conducted during the pilot to educate participants on issues that surfaced during the evaluation (See Appendix B).

An operational protocol was developed as a framework for the pilot to include essential requirements necessary to provide support and safety to individuals receiving services. The operational protocol described the goal, purpose, data collection, documentation, outcome measures, participation requirements and evaluation criteria that were used in the pilot program. The operational protocol was revised throughout the pilot to accommodate feedback from the advisory committee and providers (See Appendix D).

The communication protocol described how the LVN would provide on-call telephone services and when to communicate with the RN clinical supervisor. In the absence of any existing standardized and validated protocols for LVNs providing on-call services in these care settings, the communication protocol was developed using current standards of practice and evidence-based references with input from the advisory committee. The communication protocol identified a new model to define the collaborative relationship between the LVN and the RN. This new model was intended to maximize communication between the LVN and the RN to develop a team approach for meeting the ongoing and emergent needs of individuals in these programs (See Appendix D).

Pilot Participation Requirements

Providers who utilized LVNs for telephone on-call services were required to participate in the statewide pilot; those who chose not to participate in the statewide pilot were required to use RNs to provide on-call services. Each participating provider and its nursing staff (RNs and LVNs) were required to sign an agreement with DADS that indicated full understanding and intent to comply with the terms of the pilot. Participating providers were required to attend a DADS-sponsored training or complete the computer based training posted on the DADS website. Because of nursing personnel turnover, it was difficult to track the number of nurses

participating in the pilot at a given time. The contracts listed refer to a single provider location rather than a corporate entity, which could hold multiple contracts.

	Total number of contracts participating as of December 2012	Total number of contracts participating as of August 2015	Total number of contracts with DADS as of June 2015 (active billing)
ICF/IID Contracts	376	326	812
HCS Contracts	94	63	827
TxHmL Contracts	44	33	411
Total	514	422	2,050

In August and September 2013, DADS asked both non-participating providers and participating providers to complete a survey of their reasons for not participating or their experiences with the pilot, respectively (See Appendix E).

Of the 35 nurse participants who responded:

- 43% reported that communication between LVN and RN improved when the required communication protocol was followed;
- 74% of nurses worked between 8-40 hours per week on-call and 50% of those did not receive compensation;
- 78% reported they have not completed the required training (i.e., annual face to face or computer-based training);
- 9% reported they did not meet the minimum number of years of experience required to participate in pilot; and
- Respondents offered comments that were both positive (e.g., "I believe everyone feels we are more of a team because we are more knowledgeable about our clients") and negative (e.g., "The pilot is cumbersome and time consuming and has not improved the quality of care that I provide").

Responses to the non-participating provider and nurse version of the survey indicated more than half of the 100 respondents reported it was more cost-effective to hire RNs for on-call telephone services than to participate in the pilot study.

Data Collection and Evaluation

The December 2012 interim report discussed the data collection method used to gather information about each on-call encounter and subsequent evaluation that was completed by an LVN. Due to limitations in DADS automated reporting infrastructure and stakeholder input about the process, the decision was made to discontinue this aspect of the pilot. DADS notified providers through an alert dated June 10, 2013.

DADS subsequently issued Provider Letter 2013-21 Random Sampling and Deceased Individual Information Needed for the Licensed Vocational Nurse (LVN) On-Call Pilot Program and

Information Letter 2013-47 Random Sampling for the Licensed Vocational Nurse (LVN) On-Call Pilot Program, in August 2013. These were used to inform providers participating in the pilot of the new method of evaluation. Form letters with the required documents for review were created and reviewed by the advisory committee. Using the list of participating providers and the individuals under their care, a random sample was generated for each month and the records for those individuals were requested. After the records were received, they were sent to registered nurses in the DADS Quality Monitoring Program to review and enter into a database. BON was responsible for collection and analysis of the data. Data was collected from October 2013 to June 2015.

In addition, the charts for all individuals under the care of participating providers who died while in their care were reviewed using the same data collection elements (See Appendix F).

The following table depicts the ongoing cumulative results of the mortality and random record reviews. Noteworthy trends of both samples include:

- Ongoing noncompliance with following the operational and communication protocols; and
- Lack of documentation to reflect care provided, notification of, and follow-up with the RN as required in the pilot protocols.

LVN On-Call Pilot Program
SB 1857

Mortality Review Data					
	FY'14	FY'15	FY'15	FY'15	FY'15
Measure Description	7/31/14	11/4/14	2nd Quarter	3rd Quarter	4th Quarter
Number of reviews	31	61	78	90	110
ICF records include the Nurses Notes*	100%	100%	100%	100%	100%
ICF records include the Comprehensive Ns Assessment*	100%	100%	93%	93%	93%
ICF records include the Nursing Service Plan*	91%	92%	86%	87%	77%
HCS records include the Nurses Notes*	71%	80%	83%	85%	88%
HCS records include the Comprehensive Ns Assessment*	94%	91%	90%	90%	89%
HCS records include the Nursing Service Plan*	82%	82%	80%	76%	73%
Up-to-date RN Comprehensive Ns Assessments*	90%	90%	84%	85%	82%
Up-to-date RN Nursing Service Plans*	83%	83%	79%	77%	77%
Records indicate LVN notified RN of initial call*	50%	55%	41%	43%	39%
Records indicate LVN followed-up with RN within 24/hours of call*	50%	45%	29%	33%	32%
Records indicate the LVN followed the Communication Protocol*	27%	23%	17%	17%	15%
Records indicate the LVN did not document adequately to demonstrate that Communication Protocol was followed*	47%	50%	43%	48%	53%
NOTE: All data are cummulative					

Random Sample Review Data					
	FY'14	FY'15	FY'15	FY'15	FY'15
Measure Description	7/31/14	11/4/14	2nd Quarter	3rd Quarter	4th Quarter
Number of reviews	517	613	750	888	982
ICF records include the Nurses Notes*	84%	84%	85%	83%	83%
ICF records include the Comprehensive Ns Assessment*	96%	95%	95%	96%	96%
ICF records include the Nursing Service Plan*	72%	71%	73%	72%	73%
HCS records include the Nurses Notes*	68%	69%	70%	72%	71%
HCS records include the Comprehensive Ns Assessment*	86%	88%	89%	90%	89%
HCS records include the Nursing Service Plan*	76%	77%	77%	78%	77%
Up-to-date RN Comprehensive Ns Assessments*	85%	86%	87%	88%	88%
Up-to-date RN Nursing Service Plans*	74%	74%	75%	75%	75%
Records indicate LVN notified RN of initial call*	42%	42%	43%	38%	39%
Records indicate LVN followed-up with RN within 24/hours of call*	39%	41%	40%	39%	41%
Records indicate the LVN followed the Communication Protocol*	16%	15%	15%	15%	15%
Records indicate the LVN did not document adequately to demonstrate that Communication Protocol was followed*	73%	74%	74%	75%	76%

* Indicates requirement for pilot participation
NOTE: All data are cummulative

Challenges Encountered

- Difficulty obtaining records from providers for random sample: DADS administrative staff was responsible for obtaining records from providers. The providers did not always send records in a timely manner which delayed completion of record review by DADS nursing staff.
- Lack of documentation by both nursing and direct care staff: When an incident occurred, it was difficult to evaluate if a nurse acted correctly. Early in the record review process, it was identified by DADS nurses that, although all the records had been sent as requested, it was difficult to evaluate the incident with the client. Direct staff did not always complete a note when they called a nurse. The nurse did not always document the telephonic evaluation. The LVN infrequently charted when or if a call was placed to the RN to report an incident and whether the incident was resolved as required by the communication protocol.
- Labor intensive for DADS staff to obtain records: After the gap in time with providers sending back records was identified, a process was put into place to send follow-up letters and to terminate the provider contract from the pilot if the provider did not submit the requested information.
- Turnover of personnel at DADS and BON: The project manager for the pilot implementation changed once, and key personnel at DADS and BON who implemented the training and initiated the pilot resigned from their positions. This left both new and remaining staff without historical information to make the most informed adjustments to achieve optimal implementation.
- Understanding of the LVN scope of practice varied between providers: Despite training during the pilot, BON and DADS continued to receive inquiries from nurses and providers as to what an LVN could or could not do.
- Turnover at provider organizations: Nursing and administrative personnel turnover in the provider organizations similarly challenged implementation. While the computer based training on the DADS website provides useful and detailed information, that forum can never replace face-to-face training which offers the opportunity for in-person discussion. As a result, it was difficult to ensure that all providers and nursing staff have received the same level of information and understanding.
- LVNs who participated in the pilot may be unaware the pilot ended. Although DADS has sent communications to the distribution lists of all potential providers, it is uncertain if that information has been passed from provider to staff because DADS does not have a way to communicate directly with nursing staff.
- Providers have difficulty recruiting, hiring and retaining RNs as reported by advisory committee provider members. In the quarterly advisory committee meetings, the provider associations brought up the issue of difficulty with RN hiring. The inability to hire RNs to supervise the LVNs on staff was a limiting factor in participation in the pilot.

- Training in management of a critical incident or death varied from provider to provider. Review of submitted patient documentation showed variation in what steps the direct care staff and nursing staff took in critical incident. No funding was appropriated to administer the pilot.

Lessons Learned

- Need for improved training in management of a critical incident or death: Record reviews revealed inconsistency among providers in documentation of a critical incident, including a death. In some cases, an incident form was filled out; in others, direct care or nursing staff, or both, filled out a progress note. In some instances, staff was empowered to call emergency services prior to supervisors, but in other documentation stated that the supervisor was called first and then instructed staff to call.
- The survey of providers not participating in the pilot indicated the most common reason was the need to have an RN available to the LVN for consultation while taking calls: At the time of legislative approval, it was thought by some stakeholders that the pilot would enable LVNs to take telephone calls unsupervised by RNs. When the operational and communication protocols were established that emphasized the RN supervisory relationship with the LVN, the interest in participating in the pilot decreased.
- There is a need for providers employing nurses to understand LVN and RN scope of practice. At the onset of the pilot, there was a lack of understanding of the differences between what an LVN and an RN could do in their clinical practice among some of the participating providers. The BON and DADS collaborated to provide educational resources to clarify the distinction.
- Increase information sharing about existing educational materials: DADS and BON in partnership with provider associations should increase efforts to inform nurses and providers about continuing education and certification for nurses who care for individuals with IDD that is available through the Developmental Disabilities Nurses Association.
- Direct and frequent communication among direct care providers and the nurse on-call is essential for safe care of individuals. The review of patient documentation from the providers had instances where the staff noted an issue but did not communicate with the nurse on-call in a timely manner.

Recommendations

- BON does not recommend expansion of the LVN scope of practice in the community setting of HCS, TxHmL and ICFs/IID to include providing on-call services by telephone.
    - Results of chart reviews do not support the safety or efficiency of expanding the LVN scope of practice to provide on-call telephone services in this setting.
    - Reviews demonstrated the need for continued training in documentation of nurses in community settings.

- The state should establish a workgroup composed of DADS, BON and IDD stakeholders to identify and resolve issues involving nursing scope of practice in community settings.
- Training should be developed to improve the ability of direct care staff to recognize deterioration in status in individuals who have chronic medical diagnosis.
- Providers should require direct care staff to contact nursing staff directly to communicate client health care needs and status changes as opposed to a third party such as a house administrator.
- Provider nursing orientation should include training for nurses on appropriate documentation in the IDD care setting.
- BON should continue educational offerings aimed to teach LVN scope of practice.

APPENDIX A

MEMORANDUM OF UNDERSTANDING

Memorandum of Understanding Between the Texas Department of Aging and Disability Services and the Texas Board of Nursing

STATE OF TEXAS

COUNTY OF TRAVIS

Article I.

This Memorandum of Understanding (MOU) is entered into between the TEXAS DEPARTMENT OF AGING AND DISABILITY SERVICES (DADS) and the TEXAS BOARD OF NURSING (Board), agencies of the State of Texas, as parties.

Article II.
Background and Purpose.

The purpose of this MOU is to outline the requirements that will apply to a state-wide pilot program implemented by DADS, and how the program relates to when telephone on-call services may be provided by a Licensed Vocational Nurse (LVN).

Article III.
Definitions

A. "Individual" means a person with an intellectual and developmental disability receiving services in a facility or program licensed and/or certified under Section C of this article, as a "Pilot Site".

B. "Unlicensed assistive person" or "UAP" means an individual, not licensed as a health care provider, who provides services in a facility or program licensed and/or certified under Section C of this article as a "Pilot Site" and who:

i. is monetarily compensated to provide certain health related tasks and functions in a complementary or assistive role to the licensed nurse in providing direct client care or carrying out common nursing functions;
ii. is providing those tasks and functions as a volunteer but does not qualify as a friend providing gratuitous care for the sick under Section 301.004(1), Occupations Code;
iii. is a professional nursing student, not licensed as a nurse, providing care for monetary compensation and not as part of their formal education program; or
iv. includes, but is not limited to, nurse aides, orderlies, assistants, attendants, technicians, home health aides, medication aides permitted by a state agency, and other individuals providing personal care/assistance with health related services.

C. "Pilot Site" means:

i. A small facility with one to eight beds or a medium facility with nine to thirteen beds that is licensed or certified under Chapter 252, Health and Safety Code; or
ii. One of the following Section 1915(c) waiver programs administered by DADS, including:
   a. Home and Community-based Services (HCS) waiver; ~~or~~
   b. Texas Home Living (TXHmL) waiver or,.
   c. Any other Section 1915(c) program not specifically identified, which is approved by DADS, in consultation with the Board and the Advisory Committee, prior to participation in the pilot program.

D. "Operational Protocol" means a comprehensive plan detailing all aspects of the pilot program that will be the working document to guide the pilot program described under this MOU.

Article IV.
Advisory Committee

DADS and the BON will convene an Advisory Committee to:

a. Advise in the overall implementation of the pilot program described in Article II;
b. Advise in the development of the Operation Protocol;
c. Assist in the development of the goals and measurable outcomes as referenced under Article VI;
d. Review outcomes of the pilot and advise DADS and the BON of future actions;
e. Make recommendations for corrective actions when data indicate unsafe or ineffective nursing care resulting from the pilot program;
f. Identify best practices that can be replicated without increasing costs; and
g. Advise in the development of the Legislative report detailed under Article VI.

The Advisory Committee will include representatives from DADS, the BON, public and private providers, registered and licensed vocational nurses employed in the programs described in Article III.C., and, individuals receiving services in those programs.

Article V.
Operational Protocol

An Operational Protocol will be developed by DADS and the BON in consultation with the Advisory Committee to detail the:

- Specifics of implementing the pilot program referenced in Article II;
- Requirements for conducting the LVN on call pilot program;
- Requirements for data collection and evaluation for the pilot program; and
- Actions to be taken when data indicate that adverse consequences are occurring because of the implementation of the pilot program.

Article VI.
Terms of Pilot Programs

A. The pilot program will allow LVNs to perform on call services for individuals in the pilot sites.

B. The LVN on-call pilot program permits an exception to 22 TAC, §217.11 (2) under which LVNs may perform telephone on-call services for individuals in their care. The requirements for the LVN will be detailed in the Operational Protocol.

C. Data Collection

Measurable outcomes for evaluating of the pilot program will be developed in consultation with the Advisory Committee. The data collected during the pilot program must allow for the Board and DADS to determine if practices related to LVNs performing telephone on-call services in the pilot settings provide safe, efficacious nursing care. Data will be based on current data available to DADS or the BON upon the signing of this MOU or additional data that DADS or the BON may be required to collect as the result of direction by the 82nd Legislature (2011). This section does not prevent DADS, the BON, or the Advisory Committee from collecting or reviewing additional data that may become available and relevant to pilot review.

If information collected demonstrates that the pilot program results in unsafe or ineffective nursing care, the Board and DADS, in consultation with the Advisory Committee shall create a corrective action plan to be implemented by DADS immediately. If the pilot program continues to result in unsafe or ineffective nursing care following the implementation of the corrective action plan, the BON and DADS will have the authority to terminate this MOU and the pilot program.

D. Length of the Pilot Program

The pilot program will commence as soon as possible but no later than September 1, 2011 and will last at least four years. DADS and the BON will submit a status report regarding the pilot programs to the Senate Committee on Health and Human Services and the House Committee on Public Health no later than December 1, 2012. The report will:

- Review and analyze data collected by DADS
- Assess the impact of the pilot on the delivery of services
- Assess the impact of the pilot on assuring the health and safety of the individuals served in the programs under Article III, Section C
- Make recommendations for statutory and funding changes to support the successful practices piloted in the study.

The Advisory Committee will advise DADS and the Board in the development of the report to the above mentioned legislative committees.

E. Training

All DADS surveyors, providers and nurses listed in programs referenced in Article III, Section C, must be adequately trained about the terms of the MOU and the pilot program prior to their commencement. DADS and the BON, with consultation by the Advisory Committee, will develop the content for training the surveyors, nurses and providers.

This MOU and Pilot Program do not exempt anyone from complying with Texas Occupations Code Chapter 301, Subchapter I; and Chapter 303 pertaining to reporting violations and peer review.

Katherine A. Thomas, MN, RN
Executive Director
Texas Board of Nursing

6/6/11
Date Signed

Chris Traylor
Commissioner
Texas Department of Aging and Disability Services

7-6-11
Date Signed

APPENDIX B

TRAINING

Texas Board of Nursing Sponsored:

BON: LVN Scope of Practice Workshop – Houston – April 30, 2014

BON: LVN Scope of Practice Workshop – Arlington – September 10, 2014

BON: LVN Scope of Practice Workshop – Austin – November 13, 2014

BON: Documentation Webinar – June 18, 2014*

BON: LVN Scope of Practice Webinar – December 18, 2014

BON: LVN Scope of Practice Webinar – May 21, 2015

BON Presentation to Providers Alliance for Community Services in Texas on Nursing Scope of Practice and the LVN On-Call Pilot Program – September 18, 2014 San Marcos

BON Presentation to Texas Association of Vocational Nurse Educators on LVN On-Call Pilot Update – October 30, 2014

BON Presentation to Private Providers Association of Texas on Nursing Scope of Practice and the LVN On-Call Pilot Program – November 13, 2014 Austin

BON maintained LVN On-Call Pilot Program resource email address

Texas Department of Aging and Disability Services Sponsored:

BON Presentation at DADS Webinar Series Part I Nursing in Community IDD Programs - Texas Board of Nursing: Requirements for Documentation and BON rules – January 28, 2015

BON Presentation at DADS Webinar Series, Part II Nursing in Community IDD Programs, Part II - Texas Board of Nursing: Requirements for Delegation and BON rules – February 26, 2015

BON Participation in DADS Webinar Series, Part III Nursing Practice related to ICF/IID Policies and Regulations – April 22, 2015

BON Participation in DADS Webinar Series, Part IV *Nursing and HCS and TxHmL Policies and Regulations* – April 27, 2015

**A recording of this webinar has been made available to pilot participants asynchronously since August 2014*

APPENDIX C

ADVISORY COMMITTEE COMPOSITION

The advisory committee included staff from:

- Private Providers Association of Texas (PPAT)
- Texas Board of Nursing (BON)
- Texas Nurses Association (TNA)
- The Arc of Texas
- Texas Department of Aging and Disability Services (DADS)
- Texas Council of Community Centers
- Texas Council for Developmental Disabilities (TCDD)
- Provider Alliance for Community Services of Texas (PACSTX)
- Vocational Nursing Education

APPENDIX D

DOCUMENTS ASSOCIATED WITH PILOT

HCS/TxHmL Frequently Asked Questions

• ICFs/IID Frequently Asked Questions

• LVN On-Call Pilot Program Operational Protocol

• LVN On-Call Communications Protocol

• Online Training for LVN On-Call Pilot Program computer-based training

• Forms and Sample Templates

o Form 8496 Nursing On-Call Services Log (discontinued)

o Form 8584 Nursing Comprehensive Assessment

o Form 8590 Agreement for Licensed Vocational Nurses On-Call Services Pilot Program (discontinued)

o Form 8591 Verification of Eligibility to Participate in Licensed Vocational Nurses On-Call Services Pilot program (discontinued)

• Provider/ Information Letters

- IL 13-47 Random Sampling for the Licensed Vocational Nurse on call pilot
- PL 13-21 Random Sampling and Deceased Individual Information needed for the LVN on call pilot
- PL 13-22/IL 13-46 Licensed Vocational Nurse On Call Pilot Participation Survey
- IL 14-46/PL 14-03 Licensed Vocational Nurse On Call Pilot Program Requirements
- IL 15-24/PL 15-05 LVN On Call Pilot Program Ends September 1, 2015

LVN On-Call Communication Protocols

Revised June 23, 2014

Topic	Page
Communication Protocols: General Guidance	1
Behavioral or Psychiatric Conditions	2
Cardiovascular Conditions	3
Ear, Eye, Nose, and Throat Conditions	4
Gastrointestinal Conditions	5
General Health Changes	5
Genitourinary Conditions	6
Hospice Managing Terminal Condition	6
Injury-Related Conditions	6
Medication or Diagnosis Changes or Concerns	7
Metabolic Conditions	7
Neurological Conditions	8-9
Pregnancy Related Conditions	10
Respiratory Conditions	10
Skin Conditions	11

LVN On-Call Communication Protocols - Revised June 23, 2014

Emergency Conditions and Communication Protocols *** Call 911 *** *- Notify RN Immediately -*	*Urgent Conditions and Communication Protocols* *- Notify RN within 1 hour -*	*Non-Urgent Conditions and Communication Protocols* *- Notify RN within 12 hours -*
Communication Protocols: General Guidance		
This list is not inclusive of all the emergency situations that may arise. The LVN and RN at any point are required to activate EMS if an individual is in a life-threatening situation.	*This list is not inclusive of all urgent conditions that may arise. The LVN and RN at any point are required to activate EMS if they believe an individual is in a life-threatening situation.*	*This list is not inclusive of all non-urgent conditions that may arise. The LVN and RN at any point are required to activate EMS if they believe an individual is in a life-threatening situation.*
LVNs must be permitted to speak directly with direct support staff who are with an individual. At no time should anyone intercept or relay on-call information between the direct support staff and the LVN concerning an individual's condition. When calls are received by the LVN from Direct Support Providers (DSP) for these emergency conditions, the LVN must direct the DSP to notify EMS immediately. The LVN must then immediately call the RN clinical supervisor after each of the following events: • An individual requires evaluation or transport by EMS (9-1-1); or • An individual is evaluated in an emergency room or urgent care treatment center; or • An individual is admitted to an acute care facility	LVNs must be permitted to speak directly with direct support staff who are with an individual. At no time should anyone intercept or relay on-call information between the direct support staff and the LVN concerning an individual's condition. Calls received by the LVN from Direct Support Providers (DSP) for urgent conditions require the LVN to notify a RN clinical supervisor within one hour of the call or sooner if indicated. For these urgent conditions, the LVN should apply interventions from the Nursing Service Plan (NSP) or principles of first aid and notify the RN clinical supervisor within one hour of the call or sooner. Notify a RN clinical supervisor within one hour of the call if the individual requires an in person (face-to-face) focused assessment as the result of a call. *Notify the RN clinical supervisor within one hour if DSP calls two or more times in one hour regarding an individual's condition/symptoms.	LVNs must be permitted to speak directly with direct support staff who are with an individual. At no time should anyone intercept or relay on-call information between the direct support staff and the LVN concerning an individual's condition. Calls received by the LVN from Direct Support Providers (DSP) for non-urgent conditions require the LVN to notify a RN clinical supervisor within 12 hours of the call or sooner if indicated. For non-urgent conditions, the LVN should apply interventions from the Nursing Service Plan (NSP) or principles of first aid and notify the RN clinical supervisor within 12 hours of the call or sooner. If any non-urgent conditions are not addressed in the NSP, the LVN should apply basic nursing principles and first aid and notify the RN clinical supervisor no more than 12 hours after the initial call. *Notify the RN clinical supervisor within one hour if DSP calls two or more times in one hour regarding an individual's condition/symptoms.

Emergency Conditions and Communication Protocols *** Call 911 *** *- Notify RN Immediately -*	*Urgent Conditions and Communication Protocols* *- Notify RN within 1 hour -*	*Non-Urgent Conditions and Communication Protocols* *- Notify RN within 12 hours -*
Communication Protocols: General Guidance		
The LVN must assure that EMS has been activated in these situations and then immediately call the RN clinical supervisor to report the emergency. The RN must follow-up on the individual's emergency condition. If after an in person (face-to-face) focused assessment, the LVN determines an emergency condition exists, the LVN should instruct the DSP to call 911 and notify the RN clinical supervisor immediately.	The LVN must follow-up with the individual within twenty-four hours of the initial urgent call to evaluate the status of the individual's condition (outcome). If the condition that generated the original call is unresolved, the supervising RN must be contacted to assume the management of the individual's care; unless the RN determines the LVN can continue to safely manage the individual's care and documents the decision.	The LVN must follow-up with the individual within twenty-four hours of the initial non-urgent call to evaluate the status of the individual's condition (outcome). If the condition that generated the original call is unresolved, the supervising RN must be contacted to assume the management of the individual's care; unless the RN determines the LVN can continue to safely manage the individual's care and documents the decision.

Emergency Conditions and Communication Protocols *** Call 911 *** *- Notify RN Immediately -*	*Urgent Conditions and Communication Protocols* *- Notify RN within 1 hour -*	*Non-Urgent Conditions and Communication Protocols* *- Notify RN within 12 hours -*
Behavioral or Psychiatric Conditions		
• For life threatening injuries see emergency conditions • Suicidal ideation with plan and means to carry out plan	• Physical aggression that results in physical harm to self or others • Self-injurious behavior not typical for the individual and/or not addressed in the Behavioral Management Plan, such as biting or head banging • Physical aggression or self-injurious behavior requiring personal physical restraint • Suicidal ideation not typical for the individual and/or not addressed in the Behavior Management Plan	• Other behavioral changes/outbursts • For non-urgent conditions, the LVN should apply interventions from the Nursing Service Plan (NSP) or principles of first aid and notify the RN clinical supervisor within 12 hours of the call or sooner.
	Notification of emergency restraints • The LVN must call the RN immediately if authorizing the use of a chemical restraint • The use of a prn chemical restraint must be addressed in the behavior management plan and referenced in the NSP	

Emergency Conditions and Communication Protocols *** Call 911 *** *- Notify RN Immediately -*	*Urgent Conditions and Communication Protocols* *- Notify RN within 1 hour -*	*Non-Urgent Conditions and Communication Protocols* *- Notify RN within 12 hours -*
Cardiovascular Conditions		
Chest Pain – with: • Left-sided pain; and/or • Pain radiating to jaw; and/or • Chest Pressure; and/or • Shortness of Breath; and/or • Sweating; and/or • Nausea; and/or • Dizziness; and/or • Changes in vital signs; and/or • Pain is unrelieved after 10 minutes	**Chest Pain** • Relieved immediately with rest, with • Stable vital signs • And without other signs/symptoms	• For non-urgent conditions, the LVN should apply interventions from the Nursing Service Plan (NSP) or principles of first aid and notify the RN clinical supervisor within 12 hours of the call or sooner.

Other Cardiac Signs/Symptoms
• Systolic blood pressure over 180; or
• Diastolic blood pressure over 110; or
• Elevated blood pressure with
  • Chest pain; or
  • Shortness of breath; or
  • Severe headache, blurred vision, drowsiness, confusion; or
  • Severe weakness, dizziness, lightheadedness;
  • Persistent nosebleed; or
  • Pink frothy or blood tinged sputum
	Other Cardiac Signs/Symptoms
	• Shortness of breath with activity; and/or
	• Significant edema of extremities; and/or
	• Excessive fatigue; and/or
	• Dizziness; and/or
	• Blood Pressure above 160/100
		Other Cardiac Signs/Symptoms
		• Minimal edema of extremities; or
		• Fatigue; or
		• Blood pressure over 150/90; or
		• Sustained blood pressure over 140/90; or
		• For other non-urgent conditions, the LVN should apply interventions from the Nursing Service Plan (NSP) or principles of first aid.

Emergency Conditions and Communication Protocols *** Call 911 *** *- Notify RN Immediately -*	*Urgent Conditions and Communication Protocols* *- Notify RN within 1 hour -*	*Non-Urgent Conditions and Communication Protocols* *- Notify RN within 12 hours -*
Ear, Eye, Nose, and Throat Conditions		
Ears • Severe pain; and/ or • Severe itching; and/or • Severe swelling; and/or • Bleeding from ear	**Ears** • Change or loss in hearing; and/or • Pain; and/or • Itching; and/or • Red; and/or • Swelling	• For non-urgent conditions, the LVN should apply interventions from the Nursing Service Plan (NSP) or principles of first aid.

Eyes
• Chemical splash in eye; or
• Object stuck in eye; or
• Hit in the eye
  o with loss of vision; or
  o with clear jelly like
  o discharge; or
  o persistent or severe pain
	Eyes
	• Red, crusty or draining eyes; and/or
	• Eyelids stuck together; and/or
	• Excessive discharge or tears; or
	• Sty interfering with vision with redness spreading to entire lid
		• For non-urgent conditions, the LVN should apply interventions from the Nursing Service Plan (NSP) or principles of first aid.

For emergency conditions related to the nose see Neurologic Conditions - Head Injury	**Nose** • Nosebleed – unable to stop	• Change in the color of nasal mucous; o Yellow or green mucous • For non-urgent conditions, the LVN should apply interventions from the Nursing Service Plan (NSP) or principles of first aid.
Throat • Difficulty breathing; or • Swelling of throat	**Throat** • Swollen neck glands; and/or • Redness with or without pustules; and/or • White tongue; and/or • Difficulty swallowing; and/or • Cough with yellow or green phlegm	• For non-urgent conditions, the LVN should apply interventions from the Nursing Service Plan (NSP) or principles of first aid.

Emergency Conditions and Communication Protocols *** Call 911 *** *- Notify RN Immediately -*	*Urgent Conditions and Communication Protocols* *- Notify RN within 1 hour -*	*Non-Urgent Conditions and Communication Protocols* *- Notify RN within 12 hours -*
Gastrointestinal Conditions		
Abdominal Pain – with: • Severe pain; or • Vomiting bright red blood or dark, "coffee-grounds" emesis; or • Vomiting with dehydration • Frequent "black, tarry" stools; or • Large amount of bright blood in the stool; or • Passing "blood clots" in stool	**Abdominal Pain – with:** • Persistent vomiting; and/or • Fecal-odor of breath or emesis; and/or • Fever with elevated temperature above 101° F; and/or • No bowel movement in 3 days; and/or • Acute onset of mild abdominal pain	**Abdominal Pain – with:** • Minor discomfort; and/or • Episodic nausea, vomiting; and/or • Stomach pain after eating, drinking, or taking certain medications; and/or • Diarrhea; and/or • Constipation unrelieved by prescribed laxative; and/or • Change in individual's bowel pattern; or • For other non-urgent conditions, the LVN should apply interventions from the Nursing Service Plan (NSP) or principles of first aid.
General Health Changes		

Change in health condition:
• Bleeding
  o Unable to stop or control; or
  o Large amount
	Change in health condition:
	• Not eating or drinking; or
	• Lethargy
	• Fever – with elevated temperature above 101°F
	• Signs of dehydration – i.e. dry mucous membranes, dry mouth, poor skin turgor, etc.
		Change in health condition:
		• Change in or loss of appetite; and/or
		• Moderately high fever – with temperature above 100.2°F; or
		• For other non-urgent conditions, the LVN should apply interventions from the Nursing Service Plan (NSP) or principles of first aid.

Emergency Conditions and Communication Protocols *** Call 911 *** *- Notify RN Immediately -*	*Urgent Conditions and Communication Protocols* *- Notify RN within 1 hour -*	*Non-Urgent Conditions and Communication Protocols* *- Notify RN within 12 hours -*
Genitourinary Conditions		
Changes in Urinary Function • Unable to void	**Changes in Urinary Function** • Difficulty urinating; and/or • Decrease in urine output; and/or • No urine output for 6-8 hours; and/or • Pain or burning on urination; and/or • Foul smelling; and/or • Dark or cloudy in color; and/or • Frequency or urgency; and/or • Blood in urine	• For non-urgent conditions, the LVN should apply interventions from the Nursing Service Plan (NSP) or principles of first aid.
Changes in Reproductive System • Acute/severe testicular pain and/or swelling • Persistent painful erection	**Changes in Reproductive System** • Mild testicular pain and/or swelling	
Hospice Managing Terminal Condition		
		The LVN should apply interventions from the Nursing Service Plan (NSP) developed by the hospice RN and provider's RN for the terminal condition.
Injury-Related Conditions		
Accidental injuries, such as slips, trips or falls that result in: o Exposed bones; or o New body/bone deformity; or o Skin is pale, cold or numb	**Accidental injuries, such as slips, trips or falls that result in abrasions or bruising; with** • Swelling of injured area; or • Limited movement due to pain • Injuries of unknown origin or that are suspicious in nature	• Accidental injuries, such as slips, trips or falls that result in abrasions or bruising <u>but without change in or loss of mobility/function</u> • For non-urgent conditions, the LVN should apply interventions from the Nursing Service Plan (NSP) or principles of first aid.
Life-threatening abuse or neglect situations: • Reported to local law enforcement immediately; and/or • Reported to the Department of Family and Protective Services at 1-800-252-5400. This Abuse Hotline is toll-free 24 hours a day, 7 days a week, nationwide. • Reports can also be made via a secure website at <u>www.txabusehotline.org</u> For other life-threatening injuries see all Emergency Conditions	**Allegations of abuse or neglect** Also Assure: • Reported to local law enforcement immediately; and/or • Reported to the Department of Family and Protective Services at 1-800-252-5400. This Abuse Hotline is toll-free 24 hours a day, 7 days a week, nationwide. • Reports can also be made via a secure website at www.txabusehotline.org	

Emergency Conditions and Communication Protocols *** Call 911 *** *- Notify RN Immediately -*	*Urgent Conditions and Communication Protocols* *- Notify RN within 1 hour -*	*Non-Urgent Conditions and Communication Protocols* *- Notify RN within 12 hours -*
Medication or Diagnosis Changes or Concerns		
	• Reports of new medical diagnoses requiring significant change to NSP or current nursing interventions • Reports of medication or treatment errors. In addition, the LVN must notify the ordering practitioner of medication or treatment errors. • Reports that prescribed medication is not available • Requests to administer initial doses of new medications • Requests to administer PRN medications not addressed in the individual's NSP	• Reports of new medical diagnoses not requiring significant change to the NSP **Use of all other PRN medications and/or treatments** • For non-urgent conditions, the LVN should apply interventions from the Nursing Service Plan (NSP) or principles of first aid. • Request to refill routine medications
Metabolic Conditions		
High Blood sugar • Above normal range o Unconscious; or has an o Altered mental state; and/or o Deep and rapid breathing; and/or o Fruity smell to breath; and o Persistent vomiting	**High Blood sugar** • Above normal range o If blood sugar exceeds upper limits of individual's sliding scale, or o Upper range of sliding scale with associated symptoms; or o Persistent vomiting for greater than 12 hours; or o Unable to keep medication down	• For non-urgent conditions, the LVN should apply interventions from the Nursing Service Plan (NSP) or principles of first aid.
Low Blood sugar • Below normal range o Unable to take oral glucose; or o Unresponsive to oral glucose; or o Unconscious; or has an o Altered mental state; or o Persistent vomiting	**Low Blood sugar** • If blood sugar is less than 80 and unresponsive to measures to raise blood sugar	• For non-urgent conditions, the LVN should apply interventions from the Nursing Service Plan (NSP) or principles of first aid.

Emergency Conditions and Communication Protocols *** Call 911 *** *- Notify RN Immediately -*	*Urgent Conditions and Communication Protocols* *- Notify RN within 1 hour -*	*Non-Urgent Conditions and Communication Protocols* *- Notify RN within 12 hours -*
Neurological Conditions		
• Possible neck injury; or • Unconsciousness – or Loss Consciousness	**Change in Level of Consciousness:** • Minor confusion i.e. does not remember date/day of week but level of consciousness & orientation otherwise normal for individual;and/or • Unsteady gait or movements; • With vital signs stable and • Without other signs of distress	• For non-urgent conditions, the LVN should apply interventions from the Nursing Service Plan (NSP) or principles of first aid.
Changes in Condition: • Decreased level of consciousness; and/or • Sudden weakness/paralysis on one side; and/or • New facial droop; and/or • New speaking difficulty; and/or • Sudden vision loss or significant change in vision; and/or • Very high fever – temperature above 104° F *(continued on next page)*	**Changes in Condition:** • Dizziness, uncoordinated movements, unsteady gait; and/or • New onset of tremor; and/or • Headache unrelieved by PRN analgesic; and/or • Recurrent headache; and/or • Unexplained sedation, decrease in energy; and/or • High fever – temperature above 102° F - unrelated to known infection/illness *(continued on next page)*	**Changes in Condition:** • Headache, minor; and/or • Moderately high fever – temperature above 100.2° F; or • For other non-urgent conditions, the LVN should apply interventions from the Nursing Service Plan (NSP) or principles of first aid. *(continued on next page)*

Emergency Conditions and Communication Protocols *** Call 911 *** *- Notify RN Immediately -*	*Urgent Conditions and Communication Protocols* *- Notify RN within 1 hour -*	*Non-Urgent Conditions and Communication Protocols* *- Notify RN within 12 hours -*
Neurological Conditions (continued)		
Head Injury – with: • Loss of consciousness or changes in consciousness; or • Blurred vision; or • Disorientation; or • Dizziness, uncoordinated movements, frequent falls; or • Sedation or diminished response to stimuli • Nausea & vomiting; or • Bleeding from ears; or • Changes in vital signs; or • Headache – severe or increasing	**Head Injury – with:** • Open laceration; and/or • Headache requiring analgesic	**Head Injury – minor – with:** • Stable vital signs; and/or • Local contusion or abrasion at point of impact; and/or • No visible evidence of injury; and/or • No signs of distress; or • For other non-urgent conditions, the LVN should apply interventions from the Nursing Service Plan (NSP) or principles of first aid.
Seizures • Tonic-Clonic seizure lasting longer than 5 minutes; or • First seizure with no prior history; or • Repeated Tonic-Clonic seizures; or • Changes in vital signs or other signs of distress	**Seizures** • Not called to EMS; but • Lasting more than 4 minutes; or • Occurring more frequently; or • Clusters of non-convulsive seizures; or • Atypical seizure activity for an individual with a known seizure disorder • Use of magnet to activate vagus nerve stimulator	**Seizures** • Not called to EMS; and • Lasting less than 4 minutes; and • Without change in vital signs or other signs of distress; and • Seizure activity consistent with the individual's history; or • For other non-urgent conditions, the LVN should apply interventions from the Nursing Service Plan (NSP) or principles of first aid

Emergency Conditions and Communication Protocols *** Call 911 *** *- Notify RN Immediately -*	*Urgent Conditions and Communication Protocols* *- Notify RN within 1 hour -*	*Non-Urgent Conditions and Communication Protocols* *- Notify RN within 12 hours -*
Pregnancy Related Conditions		
• Vaginal bleeding Significant amount; or • Rupture of membranes without meconium staining, blood or prolapsed umbilical cord; or • Injury or blow to abdomen with vaginal bleeding or severe abdominal pain	• Severe pain in abdomen; or • Severe headache; or • Absence or decrease in fetal movements; or • Rupture of membranes without meconium staining, blood or prolapsed umbilical cord; or • Injury or blow to abdomen without abdominal pain/vaginal bleeding • Onset of uterine contractions/labor pain/discomfort • Elevated blood pressure – above 140/90 • Significant edema	• For non-urgent conditions, the LVN should apply interventions from the Nursing Service Plan (NSP) or principles of first aid.
Respiratory Conditions		
NO Breathing – or Difficulty Breathing – <u>with</u> • Cyanosis – blue lips and/or skin; and/or • Chest Pain; and/or • Pink frothy or blood tinged sputum; and/or • Worsens with deep breath; and/or • Severe wheezing unrelieved by inhaled medications; and/or • Accompanied by allergy signs/symptoms: Face/Airway swelling, itching, flushing, hives	**Respiratory Changes:** • Cough or congestion <u>with</u> • Elevated Temperature above 101° F; and/or • Wheezing which requires increased use of prescribed inhaled medication	**Respiratory Changes:** • Cough or congestion <u>with</u> • Minor wheezing which resolves with use of prescribed inhaled medication; or • For other non-urgent conditions, the LVN should apply interventions from the Nursing Service Plan (NSP) or principles of first aid.
Choking/airway obstruction unresolved with abdominal thrusts	Choking/airway obstruction that required abdominal thrusts to clear	Minor choking episode cleared by the individual through an effective cough

Emergency Conditions and Communication Protocols *** Call 911 *** *- Notify RN Immediately -*	*Urgent Conditions and Communication Protocols* *- Notify RN within 1 hour -*	*Non-Urgent Conditions and Communication Protocols* *- Notify RN within 12 hours -*
Skin Conditions		
• Skin burned and is blistered, red, white or charred in appearance with severe pain; or • Laceration and unable to stop bleeding • Sudden onset of severe hives and rash with difficulty breathing, chest tightness, or swelling in back of throat or tongue	• Any new burn, not called to 911 with blisters or charred appearance or larger than 2 inches in diameter; or • Painful blisters; or • Red streaks extending from an existing wound; or • Existing or healing wound begins to have redness, swelling, pain, drainage; or • Severe bruising • Laceration not evaluated in ER but requiring "tension" bandage or similar intervention to approximate/close wound • Dirt or debris embedded in a scrape that cannot be removed with gentle cleansing • Persistent and/or extensive rash; or • Painful rash and/or rash and itching interfering with sleep; or • Multiple grouping of painful blisters	• New bruise, abrasion, cut, scrape, rash; and/or • Minor burn with redness only and less than 2 inches in diameter • More than 5 years since last tetanus shot; and/or • For other non-urgent conditions, the LVN should apply interventions from the Nursing Service Plan (NSP) or principles of first aid.

References:

American Red Cross. (2006). *First aid and emergency preparedness: Quick reference guide*. China: The American Red Cross.

Briggs, J. K. (2007). *Telephone triage protocols for nursing*. Philadelphia: Wolters Kluwer – Lippincott Williams & Wilkins.

MHMR of Tarrant County. (2011). *Nursing decision tree*.

HealthSoft Inc. (2003). *Healthcare protocols guidelines*. Retrieved from http://www.healthsoftinc.com/index.html

LVN On-Call Pilot

Operational Protocol

Goal of LVN On-Call Pilot

The goal of the pilot is to evaluate licensed vocational nurses providing On-Call nursing services by telephone to individuals receiving services in the HCS and TxHmL programs and to individuals residing in small and medium ICFs/IID to determine if the licensed vocational nurse (LVN) can safely provide On-Call services to these individuals. The definition of on-call telephone services for purposes of the LVN On-Call Pilot is providing telephone services anytime of the day to handle non-urgent, urgent and emergent conditions an individual may experience; making a telephone assessment, providing instructions to an unlicensed person over the phone regarding that condition and reporting those instructions to a RN clinical supervisor. LVNs must be permitted to speak directly with direct support staff that is with an individual. At no time should anyone intercept or relay information between the direct support staff and the LVN concerning an individual's condition.

Purpose of Operational Protocol

The purpose of the Operational Protocol is to identify and document the requirements that apply to the implementation of SB 1857, 82nd Legislature, Regular Session/Chapter 161, Subchapter D, Human Resources Code. The legislation requires implementation of a statewide pilot by DADS in collaboration with the Texas Board of Nursing (BON) that expands the scope of practice of the LVN to include telephone On-Call services when acting under the supervision of a RN for persons residing in small and medium ICFs/IID and for persons receiving HCS and TxHmL services. The operational protocol will identify conditions in which the LVN notifies the RN and when the LVN will immediately initiate emergency medical services (EMS). The operational protocol identifies a new model to define the collaborative relationship between the LVN and the RN. This new model will maximize communications between the LVN and the RN in order to develop a team approach for meeting the on-going and emergent needs of individuals in these programs.

Outcome Measures

Information and data collected during the pilot will inform future policy regarding On-Call services provided by LVNs.

DADS and BON

Define an Operational Protocol that directs the LVN On-Call Pilot

Define a process for communication protocol between the LVN providing On-Call services and the RN clinical supervisor that promotes patient safety in HCS and TxHmL programs and small and medium ICFs/IID.

1/11/12 Updated 8/10/12, 1/7/13, 5/31/13, 5/2014, 8/2014

Identify the criteria necessary for RNs to safely supervise LVNs who provide On-Call services.

Determine the training standards regarding the LVN On-Call Communication Protocols.

Identify recommendations for other DADS programs.

DADS will collect data related to whether:

Is it safe for LVNs to provide On-Call services using the defined process for communication?

BON will collect data to:

• Identify recommendations for vocational nursing education curriculums.

• Analyze BON complaints and investigatory files received that pertain to the LVN On-Call Pilot to determine safety and efficacy.

Pilot Participation

Providers must receive updates that relate to the HCS/TxHmL/ICF/IID programs by registering at https://public.govdelivery.com/accounts/TXHHSC/subscriber/new?qsp=307

• Providers of HCS and TxHmL services and providers of ICF/IID services in small and medium facilities that use LVNs for telephone On-Call services must participate in the statewide pilot program.

• Providers of HCS and TxHmL services and providers of ICF/IID services, who choose not to participate in the statewide pilot program, must use RNs for providing On-Call services. This is in accordance with 22 TAC 217.11 (2), (3) and BON policy.

• Those providers who exclusively use RNs for On-Call services may decide not to participate in the pilot.

• Each participating provider and their nursing staff (RNs and LVNs) must sign an agreement with DADS that indicates full understanding and intent to comply with the terms of the pilot agreement prior to participating.

• The pilot agreements must be submitted to DADS Waiver Survey and Certification at Mail Code E-348, P.O. Box 149030, Austin, TX 78714-9030 prior to participating in the pilot.

• If, at any time during the pilot, a participating provider or staff nurse decides to discontinue participation in the pilot, notification must be sent to DADS Waiver Survey and Certification at Mail Code E-348, P.O. Box 149030, Austin, TX 78714-9030 in order to document this decision.

• DADS will maintain a list of all providers, RNs and LVNs who are participating in the On-Call Pilot Project.

1/11/12 Updated 8/10/12, 1/7/13, 5/31/13, 5/2014, 8/2014

• AT least two representatives from each provider contracted to deliver ICF/IID services in small or medium facilities or HCS/TxHmL services (especially the RNs and LVNs they employ/contract), and DADS ICF/IID surveyors and HCS/TxHmL reviewers must attend a DADS sponsored training on the pilot. Training will be provided throughout Texas from October 5 – November 10, 2011 and will be available on the DADS website as a computer-based training (CBT) at the conclusion of the kick-off training sessions to use on an "as needed" basis.

Participation Requirements

In order to ensure each individual's safety, LVNs participating in the pilot must:

• Have a RN clinical supervisor. Clinical supervision includes monitoring for changes in health needs of the individual, overseeing the nursing care provided and offering clinical guidance as indicated, to ensure that nursing care is safe and effective and provided in accordance with the NSP for the individual;

• Have been determined competent by the RN clinical supervisor; and

• Have:

1. A minimum of 1 year of full time employment providing hands-on, direct patient care in a structured acute care, long-term care, or outpatient setting such as a hospital, nursing home, rehabilitation center, skilled nursing facility, private physician's office or health care clinic. This experience providing hands-on, direct patient care must be in a structured setting in which the LVN received direct and on-site supervision from experienced RNs, APRNs, physicians, or physician's assistants who were readily available to validate findings and offer input regarding the LVN's practice; AND a minimum of 1 year of full time employment providing hands-on, direct nursing services to individuals who have intellectual and developmental disabilities.

OR

2. A minimum of 3 years of full time employment providing hands-on, direct nursing services in a community-based setting with at least one of those years providing hands-on, direct nursing services to individuals who have intellectual and developmental disabilities .

• Train direct support providers on the importance of communicating changes in condition and any occurrence of the emergency and urgent conditions listed in the communication protocol;

• strictly adhere to the Operational Protocol, Emergency Conditions and Communication Protocols and the Urgent Conditions and Communication Protocols attachments, unless directed otherwise by their RN clinical supervisor;

1/11/12 Updated 8/10/12, 1/7/13, 5/31/13, 5/2014, 8/2014

1/11/12 Updated 8/10/12, 1/7/13, 5/31/13, 5/2014, 8/2014

LVN On-Call Communication Protocol

The LVN must communicate with the RN clinical supervisor to ensure the safety of the individual at any point during the On-Call Communication Protocols if the individual's condition or situation exceeds the LVN's level of competency. The LVN must collaborate with the RN to assist in the implementation of the NSP, when providing On-Call services and following up with individuals. However, emergency and urgent situations may arise at any time in which the LVN must provide On-Call and follow-up services.

1) For **Non-emergency and Non-urgent Conditions** addressed in the NSP, the LVN must utilize the NSP and or principles of first aid for appropriate interventions and must:

a. Notify the RN clinical supervisor not more than twelve hours after a non-emergent call (or sooner based on the individual's condition).

b. When situations are not addressed in the NSP the LVN must call the RN not more than 12 hours after the initial call.

2) For **Urgent Conditions see Communication Protocols.** Calls received by the LVN for urgent conditions must notify a RN clinical supervisor within one hour of the call or sooner;

3) For **Emergency Conditions see Communication Protocols.** Calls received by the LVN for emergency conditions must direct the caller to activate 911 immediately. The LVN must then immediately call the RN clinical supervisor after each of the following events:

a. Directing a caller to activate a 911 call; or

b. An individual is evaluated in an emergency room or urgent care treatment center; or

c. An individual is admitted to an inpatient facility.

4) Notify a RN clinical supervisor within one hour of the call if the individual requires an in person (face to face) focused nursing assessment as the result of a call.

5) The LVN must notify the RN immediately if authorizing the administration of a PRN chemical restraint. Note: use of PRN chemical restraints must be addressed in the behavior management plan and referenced in the NSP.

6) The LVN must follow-up with the individual within twenty-four hours of the initial call to evaluate the status of the individual's condition (outcome). If the condition that generated the original call is unresolved, the supervising RN must be contacted to assume the management of the individual's care; unless the RN determines the LVN can continue to safely manage the individual's care and documents the decision.

1/11/12 Updated 8/10/12, 1/7/13, 5/31/13, 5/2014, 8/2014

• Have an established nursing relationship with the individual who is the subject of the call, as evidenced by at least one face-to-face contact and knowledge of the individual's current health issues and the NSP for the individual. The NSP may be considered the nursing care plan and directs the LVN in appropriate interventions while providing On-Call services;

• provide On-Call services for no more than 100 individuals at one time;

• Prior to the start of the On-Call period, the LVN, with guidance from the RN supervisor, will assure he/she has ready access to an On-Call Reference Resource (either electronic or hard copy) that includes the Emergency and Urgent Condition Communication Protocols, the current NSP, list of medications, and a list of medical diagnoses for each individual in the LVN's On-Call caseload;

• Prior to providing On-Call services, successfully complete the following web-based courses* thru membership with the Developmental Disabilities Nurses Association (DDNA) available at http://ddna.org

o Syndromes and Conditions 1

o Syndromes and Conditions 2

o A Care Approach to Seizure Care

o Promoting Understanding of Neurological Assessment

o A Caring Approach to Behavioral Issues

• Prior to providing On-Call services, complete a CPR course for health professionals and a first aid course and maintain certification.

• Maintain certificates of successful course completion and have available upon request. These certificates are available to the LVN upon successful completion of a course.

• Complete the LVN On-Call Training. LVNs may choose to take either the face to face joint training by DADS and the BON or a CBT if unable to attend the training in person. (Face to face training not available after Fall 2011)

• Complete the DADS computer-based training (CBT) training annually that will include, at a minimum, information regarding the pilot operational protocols, the communication protocols and required documentation of the On-Call services provided. In addition, the LVN must obtain a minimum score of 80 out of a possible 100 on a written exam that will be developed by DADS.

- Document in web-based database on DADS website completion dates of annual training, CPR/first aid and web based courses from DDNA
- On quarterly basis, document continued participation in LVN on call pilot and update RN supervisor

Documentation When Using On-Call Communication Protocols

Accurate, legible and complete documentation is essential and a minimum standard of nursing practice for LVNs and RNs [See 22 TAC Rule 217.11(1) (D)]. Documentation of the On-Call services provided must be maintained in the individual's record. Documentation must be in English.

The RN Clinical Supervisor must:

• Develop the NSP and provide clinical supervision to the LVN, who will be providing On-Call services through the NSP,

• Determine if the LVN is competent to provide On-Call services;

• Train direct support providers on the importance of communicating changes in condition and any occurrence of the emergency and urgent conditions listed in the communication protocol;

• Determine and document for which individuals the LVN may provide On-Call services;

• Determine the LVN's On-Call caseload by taking into consideration the acuity of the individuals and the setting in which the individuals are supported.

• Guide the LVN in the development of the On-Call Reference Resource;

• Depending on the nature of the call, be available telephonically or physically, to the LVN who is providing On-Call services;

• Provide adequate clinical supervision and oversight of nursing care during the On-Call period to ensure nursing care provided by the LVN is effective and safe;

• Assume management of the individual's care if the condition that generated the initial call is unresolved within 24 hours; unless the RN determines the LVN can continue to safely manage the individual's care and documents the decision;

• Document calls received from LVNs who provide On-Call services and any recommendations or directions given to LVNs in a nursing progress note;

• Use the book titled, **Telephone Triage Protocols for Nurses** by Julie K. Briggs as a resource when providing telephone triage services to individuals.

1/11/12 Updated 8/10/12, 1/7/13, 5/31/13, 5/2014, 8/2014

Data Collection and Evaluation

All HCS and TxHmL providers and ICFs/IID with a Capacity of 13 or fewer beds, must document data related to on-call services. DADS and the BON will conduct random sampling of a provider's documentation regarding the provision of LVNs providing On-Call services. The data collected and submitted by providers during the pilot program will allow the BON and DADS to determine if LVNs performing telephone On-Call services in the programs outlined in the legislation provide safe, efficacious nursing care. Results of the pilot program will provide information that will inform future public policy.

Data that will be analyzed includes: pre and post training and pilot program surveys of participating RNs, LVNs, providers, and surveyors/reviewers. Data that will be analyzed includes: number of deaths by fiscal year; and results of mortality reviews. Currently required critical incident data and mortality review information submitted to DADS by providers will also be analyzed. BON staff will continue to track and trend complaint data submitted to the BON for nursing incidents related to the pilot.

If information collected demonstrates that the pilot program results in unsafe or ineffective nursing care, the BON will work collaboratively with DADS and the advisory committee to develop a corrective action plan that will be implemented immediately. If the pilot program continues to result in unsafe or ineffective nursing care following the implementation of the corrective action plan, the BON retains the authority to terminate the pilot program 30 days after written notice to DADS. *Providers and nurses may report any concerns regarding unsafe or ineffective nursing care directly to sb1857@bon.texas.gov.*

Communication regarding updates or changes to the LVN On-Call Pilot Project will be posted on the DADS website.

The Pilot Program will begin on September 1, 2011 and will continue through September 1, 2015. Pilot data will be evaluated and a final report will be submitted to the Senate Committee on Health and Human Services and the House Committee on Public Health at the conclusion of the pilot. The BON/DADS MOU and Pilot Program do not exempt anyone from complying with Texas Occupations Code Chapter 301, subchapter I. and Chapter 303 pertaining to reporting violations and peer review.

RN/LVN Liability

LVNs are not licensed to practice independently. A LVN must ensure that he or she has a RN clinical supervisor in order to perform On-Call services. The proximity of a RN supervisor depends on the skills and competency of the LVN, patient conditions and practice setting. Direct, on-site supervision may not always be necessary depending on the LVN's skill and competence and should be determined by the RN clinical supervisor on a case-by-case basis while taking the practice setting laws into consideration. The RN clinical supervisor must provide timely and readily available supervision and may have to be physically present to assist LVNs should emergent situations occur. 1/11/12 Updated 8/10/12, 1/7/13, 5/31/13, 5/2014, 8/2014

APPENDIX E

PARTICIPATING AND NON-PARTICIPATING SURVEY QUESTIONS

LVN On-Call Pilot Participation Survey

Your responses are voluntary and anonymous. The information collected will be used to improve the LVN On-Call Pilot Program.

1. Are you an LVN, RN, or APRN?

- ☐ LVN
- ☐ RN
- ☐ APRN

2. How long have you participated in the LVN On-Call Pilot Program?

- ○ 1-6 months
- ○ 7-11 months
- ○ 1-2 years
- ○ Over 2 years

3. How many years of experience do you have working with individuals with intellectual and developmental disabilities?

- ○ Less than one year
- ○ 1-2 years
- ○ 3-4 years
- ○ 5-10 years
- ○ Over 10 years

4. What program type are you providing On-Call Telephone Services? Please check all that apply.

- ☐ HCS
- ☐ ICF
- ☐ TxHmL

Page 1

LVN On-Call Pilot Participation Survey

5. Have you participated in a training related to the LVN On-Call Pilot? Please check all that apply.

- ☐ In person training
- ☐ Computer-based training
- ☐ On the job training
- ☐ Webinar
- ☐ I have not attended a training

6. What type of training opportunities would help you provide On-Call Telephone Services to the individuals you work with? Please explain below.

7. How is the Communication Protocol useful in your work with the LVN On-Call Pilot Program? Please explain below.

8. Do you have any suggestions for additional topics to be added, or any changes that should be made, to the Communication Protocol? Please explain below.

LVN On-Call Pilot Participation Survey

9. What benefits have you experienced with your work in the LVN On-Call Pilot Program? Please explain below.

10. What obstacles have you experienced with your work in the LVN On-Call Pilot Program? Please explain below.

11. Does your role in the LVN On-Call Pilot contribute to your job satisfaction? Please explain below.

12. Does the Communication Protocol improve your communication with either the LVN you supervise or the RN who is your clinical supervisor? Please explain below.

LVN On-Call Pilot Participation Survey

13. How many calls do you receive a week from individuals, direct service providers, or administrators on call related to an individual's health condition?

- ◯ 0-10
- ◯ 11-20
- ◯ 21-30
- ◯ 31-40
- ◯ 41-50
- ◯ Over 50

14. If you are a LVN, how many individuals do you provide On-Call Telephone Services for?

- ◯ 1-25
- ◯ 26-50
- ◯ 51-75
- ◯ 76-100
- ◯ Over 100

15. How many hours are you scheduled to work in a typical week?

- ◯ 8-24
- ◯ 25-32
- ◯ 33-40
- ◯ Over 40
- ◯ Only when called (contract work)

16. What are your regular work hours? Please specify (e.g. 8 a.m. to 5 p.m. or specific shift).

LVN On-Call Pilot Participation Survey

17. How many hours a week do you provide On-Call Telephone Services outside of regular business hours or regularly scheduled shift?

- ◯ 8-24
- ◯ 25-32
- ◯ 33-40
- ◯ Over 40
- ◯ Only when called (contract work)

18. Are you financially compensated to provide On-Call Telephone Services outside of regular business hours or regularly scheduled shift?

- ◯ Yes
- ◯ No
- ◯ Other (please specify)

NON-PARTICIPANT SURVEY - LVN ON-CALL PILOT

Your responses are voluntary and anonymous. The information collected will be used to improve the LVN On-Call Pilot Program.

1. What program type are you employed or provide? Please check all that apply.

- ☐ HCS
- ☐ ICF/IID
- ☐ TxHmL

2. Are you a LVN, RN, or an APRN?

- ○ LVN
- ○ RN
- ○ APRN
- ○ No

3. If you have a dual role at your place of employment, please choose the option that best describes it:

- ○ LVN/Administrator/CEO
- ○ LVN/Owner
- ○ RN/Administrator/CEO
- ○ RN/Owner
- ○ APRN/Administrator/CEO
- ○ APRN/Owner
- ○ I do not have a dual role

NON-PARTICIPANT SURVEY - LVN ON-CALL PILOT

4. If you are NOT a LVN, RN, or an APRN, which position best describes the position you hold?

- ◯ Administrator/CEO
- ◯ Owner
- ◯ Other (please specify)

5. Does the company/facility where you are employed, participate in the LVN On-Call Pilot?

- ◯ Yes
- ◯ No

6. Even though the company/facility where you are employed is participating in the LVN On-Call Pilot, what was the most significant reason you decided not to participate?

- ◯ No financial compensation for providing On-Call Telephone Services
- ◯ Do not meet the work experience requirements for providing On-Call Telephone Services
- ◯ I am a LVN and I did not want to complete the required trainings
- ◯ I am a LVN and I did not want the responsibility for providing On-Call Telephone Services
- ◯ I am a RN and I did not want the responsibility for the supervision of LVNs providing On-Call Telephone Services
- ◯ Other (please specify)

NON-PARTICIPANT SURVEY - LVN ON-CALL PILOT

7. As a LVN, RN, or APRN, what do you believe was the most significant reason your employer decided not to participate in the LVN On-Call Pilot?

- ◯ It was more cost effective to have RN(s) provide On-Call Telephone Services because the RN must still be available to the LVN when the LVN provides these services
- ◯ Unable to meet the LVN experience requirements for the LVN On-Call Pilot
- ◯ The LVN(s) and/or RN(s) did not wish to participate in the LVN On-Call Pilot
- ◯ The LVN(s) are clinically supervised by a physician
- ◯ We did not wish to collect and record the necessary data for the LVN On-Call Pilot
- ◯ Other (please specify)

8. Does the company/facility where you are employed or own participate in the LVN On-Call Pilot?

- ◯ Yes
- ◯ No

9. Even though the company/facility is participating in the LVN On-Call Pilot, do you employ LVN(s) and/or RN(s) that declined to sign an agreement to participate?

- ◯ Yes
- ◯ No

NON-PARTICIPANT SURVEY - LVN ON-CALL PILOT

10. As the Administrator/CEO/Owner, what do you believe was the most significant reason the LVN(s) and/or RN(s) declined to sign an agreement to participate?

- ◯ No financial compensation for providing On-Call Telephone Services
- ◯ LVN(s) did not meet the work experience requirements for providing On-Call Telephone Services
- ◯ The LVN(s) and/or RN(s) did not want to complete the required trainings
- ◯ The LVN(s) did not want the responsibility for providing On-Call Telephone Services
- ◯ The RN(s) did not want the responsibility for the supervision of the LVN(s) providing On-Call Telephone Services
- ◯ Other (please specify)

11. As the Administrator/CEO/Owner, what was the most significant reason for deciding not to participate in the LVN On-Call Pilot?

- ◯ Unable to meet the LVN experience requirements for the LVN On-Call Pilot
- ◯ The LVN(s) and RN(s) we employ did not wish to participate in the LVN On-Call Pilot
- ◯ Our LVN(s) are clinically supervised by a physician
- ◯ We did not wish to collect and record the necessary data for the LVN On-Call Pilot
- ◯ It was more cost effective to have RN(s) provide On-Call Telephone Services because the RN must still be available to the LVN when the LVN provides these services
- ◯ Other (please specify)

Thank You

This now completes the survey. Thank you for participating.

APPENDIX F

RANDOM SAMPLE/DEATH CHART REVIEW EVALUATION QUESTIONS

LVN On-Call Pilot Data Collection Tool

Purpose

The purpose of this data collection is to evaluate if LVNs are providing On-Call Telephone Services safely and effectively for individuals living in small or medium ICFs or receiving HCS and TxHmL services. Accurate and complete data collection is necessary for this evaluation.

Page 1

LVN On-Call Pilot Data Collection Tool

Instructions

It is very important to follow the instructions below with accurate and complete information.

This data collection tool (survey) is used to record information for ONLY one condition/incident in which an unlicensed person initially called and reported a change in condition/incident to the LVN. There may be multiple calls documented that are related to the initial call regarding the condition/incident received by the LVN. All the information that is related to the initial call must be recorded in this document.

If you find that an unlicensed person called and reported a different condition/incident to the LVN, you must document this in a separate data collection tool (survey). Each change in condition/incident must be recorded in separate surveys. For example, an unlicensed person calls the LVN and reports that the individual is out of Tegretol and will not have any for the nighttime dose. Two weeks later, an unlicensed person calls the LVN and reports that the individual vomited after dinner. These two condition/incidents must be recorded in separate data collection tools because each represents two separate changes in condition/incident.

Each question marked with an asterisk (*) in front of the number requires an answer and you will not be allowed to proceed to the next question without answering that question. Some questions will only allow you to select one answer. Some questions must be answered by checking all that apply. If there is not an answer that applies, please select "Other" and provide a specific explanation. Some of the questions will take you to the next appropriate question depending on your answer.

In order to progress through this survey, please use the following navigation links:

* Click the < Next > button to continue to the next page.

* Click the < Prev > button to return to the previous page.

* Click the < Submit > button to submit your survey.

LVN On-Call Pilot Data Collection Tool

General Information

***1. Individual's CARE ID number**

***2. Provider ID number**

***3. Enter the dates (quarter) of the documents reviewed.**

	Quarter Reviewed
Document Dates	

***4. Program Type**

- ◯ ICF
- ◯ HCS
- ◯ TxHmL

LVN On-Call Pilot Data Collection Tool

5. HCS/TxHmL documents reviewed for this audit: (Check all that apply)

- [ ] Nurses Notes
- [ ] Comprehensive Nursing Assessment
- [ ] Nursing Service Plan
- [ ] Behavior Support Plan
- [ ] Service Delivery Notes for services identified on ISP
- [ ] Physician Orders
- [ ] Medication Administration Records
- [ ] Laboratory/X-ray Reports
- [ ] Medical Consults
- [ ] Behavioral Incident Reports
- [ ] Critical Incident Reports

Other (please specify)

LVN On-Call Pilot Data Collection Tool

6. ICF documents reviewed for this audit: (Check all that apply)

- [ ] Nursing Notes
- [ ] Comprehensive Nursing Assessment
- [ ] Nursing Sevice Plan
- [ ] Quarterly Nursing Physical Exam/MD Physical Exam
- [ ] Behavior Management Program/Behavior Support Plan
- [ ] Direct Care Staff Progress Notes
- [ ] Physician Orders
- [ ] Medication Administration Records
- [ ] Laboratory/X-Ray Reports
- [ ] Behavioral Incident Reports
- [ ] Incident Reports
- [ ] Medical Consults
- [ ] Physician Progress Notes

Other (please specify)

***7. Did the RN complete or update the RN comprehensive assessment and nursing service plan within the last year?**

- ◯ Yes
- ◯ No
- ◯ No assessment/nursing service plan available

LVN On-Call Pilot Data Collection Tool

Nature of the Call

***8. Do records indicate that a LVN received a call regarding an individual's health condition?**

- ◯ Yes
- ◯ No

LVN On-Call Pilot Data Collection Tool

*9. What was the date of the call?

LVN On-Call Pilot Data Collection Tool

***10. How many calls were made to the LVN regarding this condition?**

- ◯ 1-2
- ◯ 3-4
- ◯ 5 or more

***11. What was the nature of the condition communicated to the LVN?**

- ◯ Emergent Condition
- ◯ Urgent Condition
- ◯ Non-Urgent Condition

***12. What action did the LVN take in response to the initial call?**

	LVN Action	LVN Instructed staff to:
LVN's Action		

Other (please specify)

13. Was the nursing service plan followed if the interventions in the plan addressed the individual's change in condition?

- ◯ Yes
- ◯ No
- ◯ Condition warranted interventions not addressed in the nursing plan. Please specify.

Other (please specify)

***14. Did the LVN notify the RN clinical supervisor regarding this call?**

- ◯ Yes
- ◯ No

LVN On-Call Pilot Data Collection Tool

***15. When did the LVN notify the clinical supervisor?**

- ◯ Immediately
- ◯ Within one hour of the initial call
- ◯ Within 12 hours of the initial call
- ◯ More than 12 hours after the initial call
- ◯ Date and/or time not documented

***16. Was the individual's condition that triggered the initial call resolved?**

- ◯ Yes
- ◯ No
- ◯ No documentation of resolution

***17. When did the LVN follow-up on the individual's condition?**

- ◯ Within 24 hours of the initial call
- ◯ More than 24 hours after the initial call
- ◯ LVN did not follow-up on the initial call
- ◯ LVN did not follow-up on the initial call but communicated to another nurse that follow-up was required
- ◯ Other (please specify)

18. If unresolved, did the LVN notify the RN clinical supervisor?

- ◯ Yes, within one hour
- ◯ Yes, but greater than one hour later
- ◯ No, the RN clinical supervisor was not notified

***19. What was the final outcome of the incident that triggered the initial call?**

	Outcome of Individual's Condition
Final Outcome:	

Other (please specify)

Page 9

LVN On-Call Pilot Data Collection Tool

***20. Did the LVN follow the Communication Protocol?**

- ◯ Yes
- ◯ No

LVN On-Call Pilot Data Collection Tool

***21. Please enter the first and last name of the LVN receiving the initial call.**

***22. Please enter the first and last name of the RN clinical supervisor involved in the call.**

***23. Enter the completion date of this audit.**