



COMMISSIONER  
Jon Weizenbaum

September 4, 2015

To: Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions

Subject: **Provider Letter 15-23** – Medication Administration by an Unlicensed Person and Clarification of the Texas Board of Nursing (BON) Registered Nurse (RN) Delegation Rules (**Replaces Provider Letter 12-12**)

The Department of Aging and Disability Services (DADS) is issuing this provider letter to remove references to the Licensed Vocational Nurse On-Call Pilot related to Senate Bill (SB) 1857, 82<sup>nd</sup> Texas Legislature, Regular Session, 2011. SB 1857 added §§161.091 – 161.096 to the Texas Human Resource Code (HRC) to allow an unlicensed person to administer medications in ICFs/IID that have 13 or fewer beds without the requirement that the RN delegate or oversee each dose of medication.

### **Medication Administration by an Unlicensed Person in all ICFs/IID with a Capacity of 13 or Fewer Beds**

An unlicensed person may provide administration of medication to an individual without the requirement that a registered nurse (RN) delegate or oversee each administration of the medication **if** the following conditions are met:

- Each individual who has medications administered by an unlicensed person is assessed by an RN to identify the individual's needs and abilities regarding the individual's medication.
- The administration of medication is performed in such a manner as to ensure the greatest degree of independence as possible (including the use of adaptive equipment).
- The medication administered by an unlicensed person is an oral medication, a topical medication or a metered dose inhaler.
- The medication is administered for a stable or predictable condition.
- An RN has personally assessed the individual:
  - (a) prior to initiation of an unlicensed person administering medications,
  - (b) in response to significant changes in health status, and
  - (c) to determine that the individual's health status permits the administration of medication by an unlicensed person.
- The unlicensed person has been:
  - (a) trained by an RN or licensed vocational nurse (LVN) under the direction of an RN regarding proper administration of medication, or
  - (b) determined to be competent by an RN or LVN under the direction of an RN regarding proper administration of medication, including through a demonstration of proper technique by the unlicensed person.
- The facility has policies to ensure that the determination of whether an unlicensed person may provide administration of medication to an individual may be made only by an RN.

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The administration of medication other than an oral medication, a topical medication or a metered dose inhaler is subject to the BON rules regarding the delegation of nursing tasks.

DADS has initiated a rule change at Texas Administrative Code, Title 40, Part 1, Chapter 90, Subchapter C, §90.43 **Standards for Facilities Serving Persons with Mental Retardation or Related Conditions**, to implement §§161.091 – 161.096 of the Human Resource Code as established by SB 1857.

Although an unlicensed person may administer medications to certain individuals in all ICFs/IID with a capacity of 13 or fewer beds, an ICF/IID must still comply with the Code of Federal Regulations (CFR) regarding medication administration, including but not limited to:

- drug administration (42 CFR §483.460(k), W367 through W376);
- drug storage and recordkeeping (42 CFR §483.460(l), W377 - W387); and
- drug labeling (42 CFR §483.460(l), W388 -W392).

42 CFR §483.460(k)(3) (W370) states, “Unlicensed personnel are allowed to administer drugs only if State law permits.”

In the Texas ICF/IID program, unlicensed personnel can only administer medications via the delegation process by a registered nurse (RN) or through the Human Resource Code §§161.091 – 161.096 (as established by SB 1857). If the conditions outlined in HRC §§161.091 – 161.096 **are not met**, the RN will have to make a decision about whether to delegate the administration of medication to unlicensed staff. If the RN chooses not to delegate the administration of medication to unlicensed staff (i.e., supervise the self-administration medication (SAM) training program), then the RN or LVN will have to administer the medication (i.e., supervise the SAM training program).

In addition, the following Centers for Medicare & Medicaid Services [Appendix Q - Guidelines for Determining Immediate Jeopardy](#) triggers still apply:

1. administration of medication to an individual with a known history of allergic reaction to that medication;
2. lack of monitoring and identification of potential serious drug interaction, side effects, and adverse reactions;
3. administration of contraindicated medications;
4. pattern of repeated medication errors without intervention;
5. lack of diabetic monitoring resulting or likely to result in serious hypoglycemic or hyperglycemic reaction; or
6. lack of timely and appropriate monitoring required for drug titration.

In training an unlicensed person to administer medications in accordance with HRC §§161.091 – 161.096, DADS encourages providers to utilize the “Six Rights of Medication Administration,” which include giving the *right medication* to the *right person* in the *right dosage* at the *right time* by the *right route of administration* and *recording the dosage and time that the medication was given*.

### **Nurse Accountability**

In accordance with Texas Human Resources Code, §161.095, an RN performing an individual assessment or an RN or LVN training an unlicensed person or determining whether an unlicensed person is competent to perform administration of medication may be held accountable or civilly liable only in relation to whether the nurse properly performed the assessment, conducted the training, and determined whether the unlicensed person is competent to provide administration of medication to individuals.

Section 161.095(c) provides that an RN or LVN may not be held accountable or civilly liable for the acts or omissions of an unlicensed person performing administration of medication if the assessment and training were properly performed.

### **Texas BON RN Delegation Rules**

An RN working in an ICF/IID may delegate tasks other than medication administration if the situation and task delegated meet all the requirements for delegation under the BON's rules at Texas Administrative Code, Title 22, Part 11, Chapter 224 and Chapter 225. 22 TAC §[225.9\(c\)](#) states that "if the RN is employed, the employing entity must have a written policy acknowledging that the final decision to delegate shall be made by the RN in consultation with the individual or client's responsible adult."

FAQs regarding the BON and RN delegation are included in the attachment to this provider letter.

If you have questions regarding this letter, please contact an ICF/IID policy specialist in the Policy, Rules and Curriculum Development unit at (512) 438-3161.

Sincerely,

Mary T. Henderson  
Assistant Commissioner  
Regulatory Services

MTH:cg

Attachment

Frequently Asked Questions (FAQs) Regarding the Texas Board of Nursing (BON) and Registered Nurse (RN) Delegation

**Provider Letter 15-23 Attachment: Frequently Asked Questions (FAQs) Regarding the Texas Board of Nursing (BON) and Registered Nurse (RN) Delegation**

*In response to the addition of the Texas Human Resource Code (HRC) §§161.091 – 161.096 to the Texas Human Resource Code, the Department of Aging and Disability Services (DADS) has prepared answers to assist Intermediate Care Facility for Persons with Intellectual Disability (ICF/ID) providers with FAQs regarding the BON and RN Delegation. The answers provided below are consistent with the BON’s rules at Texas Administrative Code (TAC), Title 22, Part 11, [Chapter 217](#) and [Chapter 225](#). The BON’s rules are available at <http://www.bon.texas.gov/>.*

**1. What is the criteria for a nurse using 22 TAC Chapter 225 (Registered Nurse (RN) Delegation to Unlicensed Personnel and Tasks Not Requiring Delegation In Independent Living Environments For Clients With Stable or Predictable Conditions)?**

According to the BON’s rules at 22 TAC §225.1(a)(1)-(3), an RN may only use 22 TAC Chapter 225 when:

1. an individual is in an independent living environment;
2. the individual, if 16 or older, or the client’s responsible adult is willing and able to participate in decisions about the overall management of the individual’s healthcare; and
3. the task is for a stable, predictable condition as defined by §225.4 (relating to Definitions)

In addition, 22 TAC §225.1(b) states if the situation does not meet the criteria in §225.1(a)(1)-(3) listed above, any delegation of nursing tasks by the RN to an unlicensed person must then comply with 22 TAC [Chapter 224](#) (Delegation of Tasks Relating to Acute Conditions or Settings Other Than Independent Living Environments).

The rules at 22 TAC §225.1(c) further state, “Should the client develop an acute condition that is unstable or unpredictable, this chapter may still be applicable to tasks that relate solely to the client’s stable and predictable condition(s) and not to the acute condition(s).”

**2. Who can be the client’s responsible adult (CRA) and, together with the RN, make decisions about the overall management of the individual’s health care (including the RN’s delegation decisions and the RN’s training of an unlicensed person to perform a delegated task)?**

According to 22 TAC §225.4(5) a CRA is “an individual, 18 or older, normally chosen by the individual, who is willing and able to participate in decisions about the overall management of the individual’s health care and to fulfill any other responsibilities required under this chapter for the care of the individual. The term includes but is not limited to parent, foster parent, family member, significant other, or legal guardian.”

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In the ICF/ID program, the CRA will be the individual, the individual's legally authorized representative (if applicable) and the interdisciplinary team (IDT).

40 TAC §90.3(27) defines a legally authorized representative as “a person authorized by law to act on behalf of a person with regard to a matter described in this chapter, and may include a parent, guardian, or managing conservator of a minor, or the guardian of an adult.”

The RN begins the delegation process (which includes an assessment) and then collaborates with the IDT on decisions related to the delegation, training and supervision of tasks to unlicensed staff. ICF/ID providers must have written policies acknowledging that the final decision to delegate shall be made by the RN in consultation with the individual and the CRA.

**3. Does the CRA have to give consent before an RN may delegate a task to an unlicensed person?**

The CRA's consent for an RN to delegate a nursing task is not required. However, after the RN completes the comprehensive nursing assessment, the RN and the CRA (the client, the client's legally authorized representative and/or IDT) review the decision to delegate a nursing task to an unlicensed person. Although the IDT does a review with the RN, the RN makes the final decision whether to delegate a nursing task to an unlicensed person.

**4. Does the Provider Advocate Committee (PAC) apply to ICF/ID?**

The PAC applies only in the Home and Community-based Services (HCS) and Texas Home Living (TxHmL) waiver programs. The PAC does not apply to the ICF/ID program.

The PAC was created for HCS and TxHmL because those programs do not have an IDT. The PAC and the IDT perform the same function (each one reviews a RN's delegation decision with the RN).

**5. Does the Surrogate Consent Committee have any role in the implementation of HRC §§161.091 – 161.096?**

The Surrogate Consent Committee provides consent for treatment decisions. This role *does not* include a decision about how treatment is delivered, such as an RN delegating a task to an unlicensed person or the use of HRC §§161.091 – 161.096 provisions that let an unlicensed person administer certain medications under certain conditions.

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**6. What is the difference between a comprehensive and focused assessment? When is a comprehensive assessment required?**

RNs conduct comprehensive assessments. According to the BON's rules at 22 TAC §217.11(3)(A)(i), Standards Specific to Registered Nurses and Position Statement [15.28](#), comprehensive assessment is defined as “an extensive data collection (initial and on-going) for individuals, families, groups and communities addressing anticipated changes in an individual's condition as well as emergent changes in an individual's health status; recognizing alterations to previous conditions; synthesizing the biological, psychological, spiritual and social aspects of the individual's condition; and using this broad and complete analysis to make independent decisions and nursing diagnoses; plan nursing interventions, evaluate need for different interventions, and the need to communicate and consult with other health team members.”

Within this assessment, the RN determines if the care includes tasks for delegation to unlicensed personnel. The comprehensive assessment cannot be performed by an LVN. The comprehensive assessment provides more information than is available from a self-administration of medication assessment and may allow the RN to determine if any tasks may be delegated. The RN comprehensive assessment must be updated when there is a significant change in condition. These assessments (annual or change in condition) must include at least an updated physical assessment of the individual. An example of a change in condition would be when an individual is discharged from the hospital. The RN would perform an assessment and revise the nursing service plan as needed to address this change.

LVNs may only conduct focused assessments. According to the BON's rules at 22 TAC §217.11(2)(A)(i) and Position Statement [15.27](#) the “focused assessment is an appraisal of an individual client's status and situation at hand [what is occurring at that moment], contributing to the comprehensive assessment by the RN, supporting on-going data collection, and deciding who needs to be informed of the information and when to inform.”

In order for an RN to use 22 TAC, Chapter 225 for delegation, the RN must perform an assessment in consultation with the individual to determine if the care qualifies as an activity of daily living (ADL) or HMA not requiring delegation, or can be delegated to an unlicensed person, or should not be delegated, as outlined in 22 TAC §225.6(a)-(c).

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**7. Must the comprehensive nursing assessment for a new admission meet a timeline?**

1. describes how, who, when and what nursing care/supports will be provided to the individual served. **Who can develop the NSP?**

The RN must develop the plan for the nursing services that are needed by the individual. LVNs cannot develop the NSP. LVNs may participate and contribute information but cannot develop a plan [22 TAC §217.11(2)(A)(ii)-(iii)]. A NSP must be developed from the RN's comprehensive assessment for ICF/ID individuals who receive health care services. The NSP is also required in situations where the RN has determined that delegation does not apply. The RN would then serve as a resource, consultant or educator and should intervene when necessary to ensure safe and effective care (22 TAC §225.6(a)(3)). The NSP must be current and updated when there is a change in condition or at least annually.

**8. What is the difference between a medical care plan and a nursing care plan?**

A "medical care plan" is familiar terminology for ICF/ID providers. A physician may place an individual on a medical care plan when the individual's illness requires 24-hour licensed nursing care. According to 42 CFR §483.460(a)(2) (W320), the need for a medical care plan is determined by the physician.

In contrast, the nursing care plan (also called the nursing service plan [NSP]) is terminology that is specific to the profession of nursing and is not specifically mentioned in the ICF/ID federal regulations. In order to develop the NSP, the RN first conducts the comprehensive nursing assessment to determine the individual's healthcare needs. This determination is the basis for the plan, goals, interventions and evaluation that will guide nurses and unlicensed staff when they provide support services to individuals in ICFs/ID. The NSP becomes part of the individual program plan.

Although there are no ICF/ID federal regulation or DADS rule that requires the NSP to be a formal document, there are BON rules that require RNs to perform comprehensive nursing assessments, make nursing diagnoses, develop plans of care, provide interventions, and then evaluate those services (22 TAC §217.11(3)). In addition, RNs are required to accurately and completely report and document their actions (22 TAC §217.11(1)(D)).

RNs in all practice settings are required to develop a nursing care plan. In the ICF/ID setting, a nursing care plan is equivalent to a NSP. A nursing care plan is an organizational tool that lets RNs systematically assess, plan, implement, and evaluate the healthcare needs of an individual. A standard of practice for nurses is documentation. Documentation of the NSP will direct the RN and all other staff.

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**9. What are the definitions of an ADL and an HMA?**

According to 22 TAC §225.4(1), an ADL is defined as bathing, dressing, grooming, routine hair and skin care, meal preparation, feeding, exercising, toileting, transfer/ambulation, positioning, range of motion, and assistance with self-administered medications. The term does not include more specific tasks defined as HMAs.

According to 22 TAC §225.4(8)(A)-(E), HMAs are limited to the following tasks that enable the individual to remain in an independent living environment and that go beyond ADLs because of the higher skill level required to perform:

- administering oral medications that are normally self-administered, including administration through a permanently placed feeding tube with irrigation;
- the administering of a bowel and bladder program, including suppositories, enemas, manual evacuation, intermittent catheterization, digital stimulation associated with a bowel program, tasks related to external stoma care including but not limited to pouch changes, measuring intake and output, and skin care surrounding the stoma area;
- routine care of a Stage 1 decubitus; and
- feeding and irrigation through a permanently placed feeding tube inserted in a surgically created orifice or stoma.

**10. Do ADLs have to be delegated when an individual is considered independent?**

ADLs may be provided by an unlicensed person under the direction of an independent individual. However, many individuals in the ICF/ID program are not truly independent and, because of their intellectual disabilities, cannot direct their own care. Even though a person may have an intellectual disability, the person's ADLs may be excluded from delegation in independent living environments when requirements of 22 TAC §225.7 are met.

ADLs include but are not limited to bathing, dressing, grooming, routine hair and skin care, meal preparation, feeding, exercising, toileting, transfer and ambulation, positioning, and range of motion. These may or may not be listed as an objective in the individual program plan (IPP), depending upon the individual's needs. If an RN determines that an ADL requires delegation, the RN should discuss this need with the IDT to ensure that the delegated tasks are part of the individual's IPP and that the written training program specifies the training methods to be used, the training schedule, the person responsible for implementing the training and type and frequency of data collected from the training to assess the individual's progress [42 CFR §483.440(c)(5)-(iv) (W234-W237)].

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**11. What nursing tasks can be excluded from delegation and designated as HMAs?**

Based on the comprehensive nursing assessment (22 TAC §225.6), the RN may determine that an allowable HMA may be performed by a paid unlicensed person without being delegated because it does not fall within the practice of professional nursing. In making this determination, ALL the following criteria must be met (22 TAC §225.8):

- The task will be performed for an individual with a functional disability.
- The individual would perform the task(s) but for his/her functional disability.
- The task(s) can be directed by the individual or LAR to be performed by a paid unlicensed person(s) without RN supervision.
- The individual or LAR is able, and has agreed in writing, to participate in directing the paid unlicensed person's actions in carrying out the HMA and either:
  - ✓ the individual or LAR is willing and capable of training the paid unlicensed person(s) in the proper performance of the task, and
  - ✓ will be present when the task is performed, or
  - ✓ *if not present, will have observed the paid unlicensed person(s) perform the task at least once to assure he/she can competently perform the task and will be immediately accessible in person or by telecommunications to the paid unlicensed person(s) when the task is performed.*

The RN may exempt allowable HMAs (22 TAC §225.4(8)(A)-(D)) from delegation if all the criteria are met at 22 TAC §225.8. **The ONLY tasks that may be exempted from delegation as HMAs are:**

- Administering oral medications that are normally self-administered, including administration through a permanently placed feeding tube with irrigation
- Administering of a bowel and bladder program, including suppositories, enemas, manual evacuation, intermittent catheterization, digital stimulation associated with a bowel program, tasks related to external stoma care including but not limited to pouch changes, measuring intake and output, and skin care surrounding the stoma area
- Routine care of a Stage I decubitus (skin redness that blanches or disappears on fingertip pressure; the skin and underlying tissues are still soft)
- Feeding and irrigation through a permanently placed feeding tube inserted in a surgically created orifice or stoma

The delegation criteria in 22 TAC Chapter 224 and Chapter 225 requires that the RN verify the paid unlicensed person's training and level of competency. The RN must also develop a schedule to verify that the paid unlicensed staff remains proficient in safely carrying out the task(s) that have been exempted from delegation. In some settings, an RN, through the delegation process may decide to delegate or exempt from delegation the HMAs listed in the definition 22 TAC §225.4(8)(A)-(E). However, DADS and the BON have agreed that HMAs may not be exempt from delegation in the ICF/ID setting. The need for multiple rotating staff makes performance of HMAs by unlicensed staff without delegation

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unsafe for the individual. Therefore, HMAs will always require delegation in the ICF/ID setting.

**12. What tasks CANNOT be designated as HMAs but MAY be delegated?**

The following tasks are considered nursing tasks that may be delegated by an RN or must be performed by a licensed nurse. Unless otherwise noted, they **cannot** be exempt from delegation. Reference: 22 TAC §225.10 and Human Resources Code, Chapter 161, Subchapter D.

- An activity of daily living the RN has determined requires delegation\*
- An HMA (22 TAC §225.4(8)) the RN has determined requires delegation under §225.8 (relating to HMAs Not Requiring Delegation)
- Non-invasive and non-sterile treatments with low risk of infection
- Collecting, reporting, and documentation of data including, but not limited to:
  - ✓ vital signs, height, weight, intake and output, capillary blood test and urine test for sugar and hematest results;
  - ✓ environmental situations/living conditions that affect the client's health status;
  - ✓ client or significant other's comments relating to the client's health status; and
  - ✓ behaviors related to the plan of care
- Reinforcement of health teaching provided by the RN
- Inserting tubes in a body cavity or instilling or inserting substances into an indwelling tube limited to the following:
  - ✓ insertion and/or irrigation of urinary catheters for the purpose of intermittent catheterization (Note: may not require delegation if the criteria is met at 22 TAC §225.8); and
  - ✓ irrigation of an indwelling tube such as a urinary catheter or permanently placed tube (Note: irrigation of an indwelling catheter must be delegated but the irrigation of a permanently placed feeding tube may not require delegation if the criteria is met at 22 TAC §225.8)
- Tracheostomy (trach) care including instilling normal saline and suctioning of a trach with routine supplemental oxygen administration
- Care of broken skin with low risk of infection
- Sterile procedures involving a wound or an anatomical site that could potentially become infected
- Administration of medications:
  - ✓ orally or by permanently placed feeding tube inserted in a surgically created orifice or stoma (Note: this is also an HMA at 22 TAC §225.4(8)(A) that may not require delegation if all the criteria is met 22 TAC §225.8);
  - ✓ sublingually;
  - ✓ topically;
  - ✓ Via eye, ear drops and sprays; or
  - ✓ Via vaginal or rectal suppositories (that are not part of bowel or bladder program at 22 TAC §225.4(8)(B))

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- Unit dose medication administration by inhalation for prophylaxis and/or maintenance
- Oxygen administration for the purpose of non-acute respiratory maintenance
- Administration of oral unit dose medications from the client's daily pill reminder container
- Administration of insulin SQ, nasally, or by insulin pump

*\* An example of an ADL that may need to be delegated is transferring an individual in a Hoyer lift. Safely operating this type of lift requires additional training.*

**13. Does the BON allow an RN to delegate medication administration to an unlicensed staff in ICFs/ID with a capacity of 13 or fewer beds?**

Yes. The BON RN delegation rules in 22 TAC Chapter 225 permit RNs to either delegate or exempt from delegation certain medication administration tasks to paid unlicensed staff.

In addition, HRC §§161.091 – 161.096 permits the unlicensed caregiver to administer specified types of medication under certain situations. Please refer to PL 12-12 that accompanies this attachment.

**14. Are breathing or nebulizer treatments included in HRC §§161.091 – 161.096 (SB 1857) or can a RN decide to delegate these tasks? Also, can a RN delegate the use of a hand-held magnet to activate a vagus nerve stimulator (VNS)?**

Per an interpretation from BON staff, when an individual in an independent living environment (such as a home or school) has a diagnosis that requires a prescription for the administration of Glucagon, Diastat, an Epipen, or a Metered Dose Inhaler (MDIs), an RN may determine if it is safe and appropriate to delegate the administration of these medications to an unlicensed person, according to the list at 22 TAC Chapter 224, Delegation of Nursing Tasks by Registered Professional Nurses to Unlicensed Personnel for Clients with Acute Conditions or in Acute Care Environments. Breathing or nebulizer treatments and the use of a hand-held magnet to activate a vagal nerve stimulator (VNS) will be added to this list as of January 9, 2012.

A breathing or nebulizer treatment is not a metered dose inhaler and is not a route of medication administration that an unlicensed person could administer, according to HRC §§161.091 – 161.096 (SB 1857). However, as of January 9, 2012, an RN may determine through the delegation process if it is safe and appropriate to delegate to an unlicensed person the administration of medication (administered through a breathing or nebulizer treatment) for the relief of acute respiratory symptoms, according to 22 TAC Chapter 224. In non-acute situations, RNs may still delegate a unit dose medication by way of inhalation for prophylaxis and or maintenance, according to 22 TAC §225.10(10)(F).

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As of January 9, 2012, an RN may also determine if it is safe and appropriate to delegate the use of a hand held magnet to activate a VNS (to prevent or control seizure activity) to an unlicensed person, according to 22 TAC Chapter 224. When emergencies occur in community settings, such as homes and schools, RNs must use their nursing judgment when they decide to delegate Glucagon, Epipens, Diastat, MDIs, nebulizer treatments and the use of a hand-held magnet to activate a VNS. They must consider the delegation rules in Chapter 224. While all the delegation criteria in §224.6 are important, the RN must consider how he or she will meet the supervisory standards as delegation decisions are made. An RN must provide adequate supervision while an unlicensed person is performing a task, particularly in emergency situations. Therefore, the RN must consider his or her geographical distance to the individual that is experiencing an emergency. In rural or remote parts of Texas, or in situations where an RN is far from the individual, it may be reasonable and prudent to delegate these types of life-saving measures to unlicensed personnel while the RN or another person is activating the Emergency Medical System (EMS) or calling 9-1-1. RNs would also be responsible for timely follow-up, which may include a face-to-face assessment depending on the emergency situation and how far the RN is from the individual.

**15. What are the definitions of an oral medication, a topical medication and a metered dose inhaler?**

To implement SB 1857, DADS proposed the following definitions in a rule revision to 40 TAC Chapter 90. DADS anticipates that these rules will be effective in June 1, 2012.

- Oral medication—Medication administered by way or through the mouth and does not include sublingual or buccal.
- Topical medication—Medication applied to the skin but does not include medication administered in the eyes.
- Metered dose inhaler—A device that delivers a measured amount of medication as a mist that can be inhaled.

**16. Is nasal spray considered to be a “metered dose inhaler” in HRC §§161.091 – 161.096?**

Nasal spray is not considered to be a metered dose inhaler because the route of medication absorption is through the nasal tissue. The medication is not inhaled through the lungs. An example of a metered dose inhaler is a Proventil inhaler used to treat the acute symptoms of asthma. An RN could choose to delegate the administration of nasal spray to an unlicensed person according to 22 TAC §225.10(10)(D). However, because nasal spray is not part of HRC §§161.091 – 161.096, the RN would be accountable for how the unlicensed person administered the nasal spray.

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**17. What are the requirements for using pill reminder boxes?**

42 CFR §483.460(k) (W367) states that the facility must have an organized system for drug administration that identifies each drug up to the point of administration. The system must assure that:

- all drugs are administered according to the physician's orders (42 CFR §483.460(k)(1) (W368)); and
- all drugs, including those that are self-administered, are administered without error (42 CFR §483.460(k)(2) (W369)).

22 TAC §225.11(a)(1)-(5) lets RNs determine through the delegation process whether it is safe and appropriate to delegate the administration of medication from pill reminder containers. The rule also states that an RN must do the following when he or she delegates the administration of oral unit dose medications from the client's daily pill reminder container:

- 1) The RN must ensure that the medications are placed in the client's daily reminder pill container, from properly dispensed prescription bottle(s), by the RN or a person mutually agreed upon by the RN and the client (or the CRA) who has demonstrated the ability to complete the task properly.
- 2) The RN must instruct the client (or the CRA) and the unlicensed person involved in such delegation activity about each medication placed in a pill reminder container. The RN must point out the distinguishing characteristics of each medication and the proper time, dose, route and adverse effects that may be associated with each medication.
- 3) The RN must tell the client (and CRA if applicable) and the unlicensed person(s) to contact the RN before a medication is administered when there are questions concerning the medication or changes in the client's status related to the medication being given. An example is when the medications appear to be rearranged or a medication is missing.
- 4) The RN must make supervisory visits if there are changes in the client's status related to the medication being given and determine the frequency of supervisory visits in consultation with the client (or the CRA) to ensure that safe and effective services are being provided.
- 5) The RN must ensure the client (or client's CRA) acknowledges in writing that the administration of medication(s) under this section will be delegated to an unlicensed person.

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**18. What knowledge does the individual need to have in order to self-administer his or her medications?**

According to W373 (42 CFR §483.460(k)(6)), no individual self-administers medication until he or she demonstrates the competency to do so. The W369 (42 CFR §483.460(k)(2)) Guidelines state that “self-administered means administration of medications by the individual, independent of a staff person obtaining, selecting, and preparing the medications for the individual. This includes all usage forms (oral, injections and suppositories). The individual should be trained until he/she can perform this function without error.”

The W373 Guidelines state: “Do not expect individuals served to be more knowledgeable than members of the general public in order to self-administer medication. There is no requirement for the individual to be able to state both the generic and brand names of the medication being taken, nor is it expected that the individual be able to list all potential side effects of the medication. The test of competency to self-administer is whether the individual can take the correct medication, in the correct dosage, at the correct time.”

**19. What are surveyors’ expectations regarding monitoring of medications and medication administration records (MARs)?**

A surveyor will expect to see medications monitored and documented on the MAR as indicated by the CFR and 40 TAC §[90.43](#).

Monitoring also includes the licensed nurse’s interview with a paid unlicensed staff about medication administration. For example, any side effects, changes, or concerns can be identified and discussed through the interview process. The licensed nurse should periodically visit the home and assess the knowledge of the paid unlicensed person(s) regarding medications being administered as well as what medications are actually being given compared to what is prescribed.

The use of pro re nata (PRN) medications should also be monitored by the licensed nurse. If an individual is receiving an increased number of PRN medications, the individual’s health status should be assessed by a nurse. An increase in the use of PRN medications may be an indication of an underlying medical condition that requires follow-up.

Although paid unlicensed personnel may now administer medications under certain conditions, the expectation of compliance with federal regulations and state rules has not changed.

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**20. Can PRN medications be delegated?**

The RN may decide to delegate certain PRN medications provided an appropriate (initial/annual) assessment and a nursing service plan (NSP) (which includes protocols) have been completed. The NSP must also include emergency plans should untoward reactions occur and any necessary follow-up that is needed. Over-the-counter (OTC) medication such as Tylenol *may* be delegated if it has been taken by the individual with no adverse reactions IF very specific written instructions are provided. A provider is not prohibited from developing a policy/procedure that requires the unlicensed staff to call the RN prior to administering a PRN medication. The RN must document the conversation and instructions given in the individual's record.

**21. Can the initial dose of a medication be delegated to a paid unlicensed person?**

According to 22 TAC §225.12(5)(E), the administration of the initial dose of a medication that has not been previously administered to the individual cannot be delegated *unless* the RN documents in the individual's medical record the rationale for authorizing the paid unlicensed person to administer the initial dose of prescribed or over-the-counter (OTC) medication. BON staff recommends the RN base this decision on sound nursing judgment. The RN would be expected to consider the possibility of allergic reactions, interactions with other medications the individual is taking, the potential side effects, and the individual's medical diagnosis that could possibly be affected by the new medication. For example, the initial dose of an OTC decongestant may not be safe to authorize an unlicensed person to administer if the individual has a history of high blood pressure or other risk factors. It is advisable that the RN document side effects from a reliable drug reference book in the medical record in addition to reviewing this information with the paid unlicensed person administering the medication.

*If an individual self-administers his/her medications, then he/she can self-administer the initial dose.*

If the unlicensed person is a medication aide permit holder functioning as a medication aide in an unlicensed ICF/ID, DADS rules do not allow a medication aide to administer the initial dose of a medication that has not been previously administered to a resident (40 TAC §[95.105](#)(b)(4)).

**22. Can an LVN train and supervise the paid unlicensed person performing delegated tasks through RN delegation?**

Training and supervising task(s) delegated to paid unlicensed personnel is the RN's responsibility. An LVN may *assist* in the training and supervision; however, the RN retains the overall accountability and responsibility for delegation. On-site supervisory visits must be conducted and documented for each paid unlicensed person that performs delegated tasks. BON staff does not recommend conducting training or supervision over the telephone. The LVN may be in the home more

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often than the RN and may encounter a problem with the paid unlicensed personnel performing a task. The LVN is then expected to intervene on behalf of the individual, which may require the LVN to stop the paid unlicensed staff from performing the task and immediately report this to the RN. The RN is then expected to follow-up with a supervisory visit to evaluate the competency of the paid unlicensed person. The RN may need to re-train the paid unlicensed person or may determine that the paid unlicensed person is not competent to perform the task. The RN must document these situations.

Information provided in 22 TAC Chapter 225 is specific to the practice of RNs. The LVN's contributions are important to the healthcare team and provide valuable assistance to the RN in delivering safe and effective nursing care. However, an LVN cannot make decisions regarding delegation and cannot take the place of the RN in making supervisory visits. The LVN may ONLY assist the RN in the supervision, teaching, training, and education of the individual and paid unlicensed personnel. The RN retains the overall responsibility and accountability for teaching and health counseling.

When a new nurse is hired, providers are advised to have a skills self-assessment or checklist that is completed during orientation to identify areas of strength and those that require additional training. Not all nurses have the same training and experience. For example, if the LVN assists in training unlicensed personnel on trach care, then the supervising RN needs to ensure that the LVN is competent to perform and train others in this task.

**23. What is the RN's responsibility when another licensed practitioner has delegated tasks to a paid unlicensed person?**

If an RN practices in a collegial relationship with another licensed practitioner who has delegated tasks to a paid unlicensed person, the RN must:

- verify the training of the unlicensed person;
- verify the unlicensed person can properly and adequately perform the task;
- adequately supervise the unlicensed person; and
- if the RN cannot verify the unlicensed person's capability, communicate this fact to the licensee who delegated the task (22 TAC §225.13).

**\*\*The RN on duty is responsible for the supervision of paid unlicensed staff performing nursing functions. In determining the LVN's caseload, the RN supervisor must consider the acuity of the individuals and the setting in which the individuals are supported.**

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**24. What kind of emergency procedures can be performed by paid unlicensed staff?**

Unlicensed personnel may be trained to perform life-saving procedures such as cardio-pulmonary resuscitation and the Heimlich maneuver. These interventions do not require delegation. Unlicensed personnel may also be *trained* to administer Epic-pens, Glucagon, Diastat, or metered dosed inhalers in an emergency. However, these life-saving procedures **CANNOT** be delegated by an RN under 22 TAC Chapter 225 (stable and predictable conditions) but may be delegated under 22 TAC Chapter 224 (acute conditions). The unlicensed person may take any action that a reasonable and prudent non-health care professional would take in an emergency and then call 911.

**25. Are ICF/ID program providers required to have a Nursing Peer Review Committee?**

The Texas Occupations Code (TOC), §[303.0015](#) (Nursing Peer Review) and 22 TAC §217.19(c) lists the requirements for employers regarding nursing peer review. Employers of 10 or more nurses must have a Nursing Peer Review Committee. A nurse may *NOT* serve on the committee when a nurse he/she supervises is being reviewed.

**26. What are RNs and LVNs required to document in the individual's record?**

Nurses must accurately and completely report and document as outlined in 22 TAC §217.11(1)(D)(i)-(vi), which states: “Accurately and completely report and document: (i) the client’s status including signs and symptoms; (ii) nursing care rendered; (iii) physician, dentist or podiatrist orders; (iv) administration of medications and treatments; (v) client response(s); (vi) contacts with other health care team members concerning significant events regarding client’s status.”

This standard applies in all situations whether or not the people providing supports meet the BON definition of an “unlicensed person.”

**27. Is an electronic signature by the physician acceptable, such as a signature on a prescription that is securely generated?**

Yes, a signature generated electronically with security measures is acceptable.

**28. What is a newly hired RN's responsibility regarding the prior delegation to paid unlicensed personnel by an RN formerly employed by the company?**

The newly hired RN is now accountable for the care of the individuals. The RN should make reasonable progress in conducting supervisory visits of the paid unlicensed personnel to verify the appropriateness of the delegation and continued competency of the paid unlicensed personnel performing the delegated tasks. The RN should consider the type of task(s) being performed and the medical issues of the individual when planning the timeline to accomplish the supervisory visits.

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**29. What is the RN's responsibility when the paid unlicensed staff at the day habilitation or workshop is performing medication administration for an individual?**

The same requirements apply regardless of whether the day habilitation staff are direct employees of the program provider or employees of another agency with which the program provider contracts. The ICF/ID program provider is responsible to ensure that all services for which they receive reimbursement comply with all applicable laws, statute and program rules.

**30. Can an individual choose not to receive medications?**

Yes, an individual may choose not to receive medications. However, 42 CFR §483.440(b)(1) (W198) states that, an individual who is admitted by the facility must be in need of and receiving active treatment services.

Training an individual in the self-administration of medication (SAM) is one area of active treatment. 42 CFR §483.460(k)(4) (W371) states that individuals must be taught to administer their own medications if the IDT determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise.

42 CFR §483.440(c)(1) (W206) states that each individual must have an individual program plan (IPP) developed by an IDT that represents the professions, disciplines or service areas that are relevant to identifying the individual's needs, as described by the comprehensive functional assessment (CFA) and designing programs that meet the individual's needs.

Therefore, surveyors will expect to see a SAM assessment as part of the CFA and a SAM training objective on the IPP if the IDT determines that a SAM training objective is appropriate.

The Guidelines for 42 CFR §483.420(a)(2) (W124) state, "An individual who refuses a particular treatment (e.g., a behavior control, seizure control medication or a particular intervention strategy) must be offered information about acceptable alternatives to the treatment being refused, if acceptable alternatives are available. The individual's preference about alternatives should be elicited and considered in deciding on the course of treatment. If the individual also refuses the alternative treatment, or if no alternative exists to the treatment refused, the facility must consider the effect this refusal may have on other individuals, the individual himself or herself and the facility, and if it can continue to treat the individual consistent with these regulations. Thus, every effort must be made to assist the individual to understand and cooperate in the legitimate exercise of the IPP."

Since surveyors will assess a facility's compliance with the federal regulations, the facility must address a situation where an individual has chosen not to take a medication.

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**31. In a licensed ICF/ID, can a medication aide permit holder be used as both a direct care staff and a medication aide?**

Since the definition of a “facility” in 40 TAC §[95.101](#)(b)(6) does not include a licensed ICF/ID, DADS does not recognize a medication aide permit in a licensed ICF/ID. DADS considers a medication aide who is in a direct care staff position at a licensed ICF/ID to function only as a direct care staff. Medication aides cannot function solely as a medication aide in licensed ICFs/ID.

However, HRC §§161.091 – 161.096 does permit the direct care staff, as an unlicensed person, to administer specified types of medication under certain situations. Please refer to PL 12-12 that accompanies this attachment.

**32. Does HRC §§161.091 – 161.096 override the medication aide rules for unlicensed ICFs/ID with a capacity of 13 or fewer beds?**

Human Resource Code (HRC) §161.093(a)(1)(A)-(B) states, “Notwithstanding other law, an unlicensed person may provide administration of medication to an individual without the requirement that a registered nurse delegate or oversee each administration if the medication is: an oral medication; a topical medication; or a metered dose inhaler”.

HRC§161.096 also states, “This subchapter controls to the extent of a conflict with other law.”

According to 40 TAC §95.105(b)(2) and (10), a medication aide with a permit must not:

- “administer medication used for intermittent positive pressure breathing (IPPB) treatments or any form of medication inhalation treatments”; or
- “apply topical medications that involve the treatment of skin that is broken or blistered or when a specified aseptic technique is ordered by the attending physician.”

When HRC §§161.091 – 161.096 comes into conflict with §95.105(b)(2) and (10), HRC §§161.091 – 161.096 prevails and a medication aide working in a community unlicensed ICF/ID could administer a metered dose inhaler and apply topical medications to the skin if all the conditions of HRC §§161.091 – 161.096 are met. However, if all the conditions of HRC §§161.091 – 161.096 are not met, the medication aide would again be operating under 40 TAC Chapter [95](#) rules and, therefore, could not administer a metered dose inhaler or apply topical medication to compromised skin.

Per 22 TAC §225.10(8), when skin is broken with low risk of infection, a RN has to decide whether to delegate or to administer the topical medication. When infection is a possibility, an RN may decide it is not safe to delegate topical medications that are applied during sterile procedures.

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**33. Will HRC §§161.091 – 161.096 ever be applied to ICFs/ID with a bed capacity of 14 or more beds or Community Living Assistance and Support Services (CLASS)?**

The provisions of HRC §§161.091 – 161.096 *do not* include ICFs/ID with a capacity of 14 or more beds or CLASS. Thus, there is no a mechanism to apply the provisions of HRC §§161.091 – 161.096 to large ICFs/ID. However, RNs in large ICFs/ID may delegate nursing tasks to unlicensed persons as long as delegation is done in accordance with the BON’s RN delegation rules.

**34. What are the requirements when an individual returns from the hospital?**

When there has been a change in the individual’s condition, such as a change that required a hospital admission, an RN must update the comprehensive assessment and NSP to reflect the change in condition. The updates must include at least an updated physical assessment of the individual and review of current medications. The RN will need to use his or her professional judgment to determine the time frame for conducting the reassessment in response to the change in condition.

**35. What responsibility does an ICF/ID RN have for delegation to staff at a day habilitation center?**

42 CFR §483.410(d)(1) (W117) states that if a service required under this subpart is not provided directly, the facility must have a written agreement with an outside program, resource or service to furnish the necessary service, including emergency and other health care. The agreement must:

- contain the responsibilities, functions, objectives, and other terms agreed to by both parties (42 CFR §483.410(d)(2)(i); W118); and
- provide that the facility is responsible for assuring that the outside services meet the standards for quality of services contained in this subpart (42 CFR §483.410(d)(2)(ii); W119).

42 CFR §483.410(d)(3) (W120) states that the facility must assure that outside services meet the needs of each individual.

W120 Facility Practices states that outside service providers meet the needs of each individual as identified by the IDT. Programs and services are coordinated/integrated and consistent with those provided by the facility.

W120 Guidelines state that “assure” means that the facility’s staff actively participate with staff of outside programs in the assessment process and in development of objectives and intervention strategies.

The facility’s written agreement with the day habilitation center (assuming the facility does not own or operate the day habilitation center and the center supervises the individuals while at the center) should specify how RN delegation to day habilitation staff should occur (e.g., how training on the delegated task is delivered, how the staff’s competency is assessed, how the day habilitation center

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will ensure that the delegated tasks are performed correctly, etc.) The notion that RN delegation is not allowed in an ICF/ID is a misconception. Now that this misconception has been dispelled, an ICF/ID may need to renegotiate its written contract with the day habilitation center. According to the ICF/ID federal regulations, the facility is responsible for ensuring that the emergency and other healthcare services provided by the staff of a day habilitation staff (including medication administration or any other nursing task) meet the individual's needs.

Although not always feasible due to the nature of the nursing task, another option an ICF/ID has if the contracted day habilitation center does not properly perform a delegated task, is to see what can be done to have the task performed at the ICF/ID by facility staff. For example, an ICF/ID could request that the physician adjust the medication dosing schedule so that medications are given in the morning and at night at the ICF/ID and not at the day habilitation center.

If an RN makes the decision to delegate a nursing task to the day habilitation staff, the RN would be responsible for how the day habilitation staff performed that task.

22 TAC §225.5(a)-(d), RN Accountability, states:

- a) The RN is responsible for proper performance of the assessment required by §225.6 of this title (relating to RN Assessment of the Client) and for the RN's decisions made as a result of that assessment including determining that performance of a particular ADL or HMA for a particular client qualifies as not requiring delegation.
- b) The RN is not accountable for an unlicensed person's actual performance of ADLs or HMAs not requiring delegation.
- c) The RN's accountability to the BNE with respect to its taking disciplinary action against the RN's license is met when the RN can verify compliance with this chapter.
- d) This chapter does not change a RN's civil liability.

**36. Can an RN delegate a CPAP or BiPAP procedure to an unlicensed staff person?**

In January of 2012, the BON approved noninvasive ventilation (NIV), such as continuous positive airway pressure (CPAP) and bilevel positive airway pressure (BiPAP) therapy as additional tasks that RNs may determine are safe and appropriate to delegate in accordance with Chapter 225, RN Delegation to Unlicensed Personnel and Tasks not Requiring Delegation in Independent Living Environments for Clients with Stable and Predictable Conditions. The tasks RNs may decide to delegate are listed in Rule 225.10 and specifically, Rule 225.10 (13) now permits RNs to delegate NIV procedures to unlicensed personnel.

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The BON is aware that NIV is used increasingly in independent living environments for the treatment of numerous chronic respiratory disorders, such as chronic obstructive pulmonary disease, asthma, sleep apnea and cystic fibrosis. In order for clients to achieve optimal health benefits in the least restrictive environments as possible, RNs may use the delegation process in collaboration with the individual or individual's LAR/IDT to decide if NIV procedures are safe to delegate in home settings.

RNs are responsible for adequately and accurately assessing the needs of clients in order to ensure their safety in these settings. The delegation process can assist RNs to make decisions as to how unlicensed personnel will be utilized to accomplish safe and effective supportive services and care.