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REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

When an antihypertensive medication is being administered and the order contains instructions to withhold the medication if the blood pressure readings are not within the specified parameters, does the nurse have to initial, circle the block and explain why the medication was withheld in the nurses' notes, if the blood pressure readings are documented directly on the MAR?

No. If the documentation indicates that the drug was withheld and the reason for the omission is self-explanatory on the MAR (e.g., blood pressure reading), then it is not necessary that the nurse document any further explanation regarding the omission of the drug.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

When PRNs, especially laxatives, are administered at the end of a shift and insufficient time has elapsed for the medication to be effective, how should the offgoing nurse handle the documentation of the results? Many times the documentation is left for the oncoming nurse and is frequently forgotten.

The nursing report to the oncoming shift staff must include instructions for follow-up nursing activity from the past shift. If done properly, responsibility for assessment and charting of the effects of the PRN medication is passed to the staff on the next shift. In other words, the staff on the shift in which results are observed should do the charting.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

On what basis is a facility cited when a small number of the residents are not out of bed during the hours the surveyors are in the building?

Deficiencies are based on individual residents' needs and choices and are not related to the number of residents in bed at a specific time. A review of medical records, resident care plans, flow sheets, interviews with staff, residents, and families will help determine if a resident's individual needs are being met.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

Is there a requirement that residents with purulent drainage from a pressure ulcer need to have daily charting?

No. There is no regulation regarding the frequency of documentation for pressure ulcers. Facility policy may address specific charting guidelines. If the purulent drainage constitutes an acute condition (fever or other evidence of an inflammatory/infectious process; sudden onset) or there is a significant change in the drainage (e.g., odor or color) then daily assessment and documentation are usually warranted; otherwise, the drainage may be chronic in nature. Only the nurse(s) directly involved in the ongoing care of the resident can make this judgment.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

Can "hi-lighters" be used in nurses' notes?

There are no regulations that address this question.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

Page Reserved.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

Is it required that intake and output records be maintained on all residents with urinary catheters?

No. There is no regulation that requires that intake and output (I&O) records be maintained on all residents with urinary catheters. I&Os should be recorded if the physician orders it or resident's condition warrants it or facility policy requires it.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

Measuring contractures - are nurses supposed to be doing this as part of assessment?

No. Measurement of contractures is not a routine part of nursing protocol. A complete nursing assessment and progress notes must include a description of any and all contractures in order to implement necessary interventions. Assessment models (e.g., mild, moderate, severe) should be described in facility policies. Physical therapists and occupational therapists are trained and licensed to measure contractures.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

Do injection sites have to be recorded (i.e., Vitamin B_{12})?

Yes. A complete or thorough nursing assessment for residents receiving injections include the documentation of the injection sites. This applies to all types of injections and for ones prescribed as needed, as well as those given on a routine basis (i.e., every day). Documentation of injection sites is beneficial for evaluating if a resident has an adverse reaction and for rotating sites.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

Could you clarify the accepted procedure for administration of eye drops?

According to the interpretive guidance at §483.25(m) for medication errors, the administration of eye drops must achieve the following critical objectives:

o "Eye Contact: The eye drop, but not the dropper, must make full contact with the conjunctival sac and then be washed over the eye when the resident closes the eyelid; and

o Sufficient Contact Time: The eye drop must contact the eye for a sufficient period of time before the next eye drop is instilled. The time for optimal eye drop absorption is approximately 3 to 5 minutes".

It is always important to follow manufacturer's instructions.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

Is a physician's order necessary for bowel and bladder retraining or restorative feeding program?

No. Specific orders may be needed for a laxative or medication if part of the protocol or when speech/occupational therapy are involved (for reimbursement purposes). Facility administration may choose to require orders for these programs, but that is at the facility's discretion.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

If a nurse aide gives a supplemental feeding, can a nurse chart it?

Yes. It is acceptable for a nurse to chart the supplemental feeding, if the nurse verified it with the aide.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

Please clarify the definition of "days" in the requirements about time frames for completion of resident assessments and care plans - "working" days or "calendar" days.

OBRA '90 amended the original 4-working day requirement for completion of the resident assessment, which was found in OBRA '87. The current requirements are: that the resident assessment be completed within 14 calendar days of admission, that the care plan be completed within 7 calendar days of the completion of the resident assessment, and that the assessment may be amended through day 21 of residency.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

What is an acceptable length of time in which to "answer" a call bell?

Regulations do not specify a length of time, however, staff should acknowledge a call bell as soon as possible to determine the urgency of the resident's needs.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

On the intake and output records of residents requiring tube feedings, are facilities supposed to record both the amount of formula and water given, or can these be combined in the intake records?

The facility has to document compliance with the physician's orders that prescribe the amount of formula, water, and/or other fluids the resident is to receive. The facility also has to document total fluid intake for the resident in each 24 hour period. The record of the tube feeding having been administered by the nurse (which is usually kept on the MAR) should show that the prescribed amounts of each fluid were administered. The intake record records the total amount of fluid consumed overall.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

What constitutes an acceptable rehabilitative feeding program?

The regulations do not prescribe how to structure a restorative feeding program. Licensure and certification require resident assessment to determine feeding, skills, and the implementation of interventions to meet the resident's needs.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

Clarification for interpretive guidelines, Tag F328 Injections -

1. Do nursing notes indicate, as appropriate, the resident's response to treatment (e.g., side effects, adverse reactions, problems at the injection site, relief of pain)?

2. Does this mean every resident receiving insulin or other routinely administered injection have responses documented in nursing notes or on the MAR? If so, please give an example of a response.

1. Yes. Adverse reactions, side effects, problems at injection sites would require documentation and follow up in the medical record. This documentation could be entered in the nurses' notes.

2. No. If a person receiving routine injections has no problem at any given time relative to the injection, then documentation regarding response to the medication is not needed. However, if a problem does occur, assessment and follow up should be recorded.

REGULATORY FOCUS BULLETIN
FOR YOUR INFORMATION

FILE TOPIC: Nursing Services

NOTE: FYI is an informational and educational service of the Regulatory Focus Committee to assist you in finding the resources for answers to questions regarding issues not regulated by the Division of Health Service Regulation. The source of the information is included for your reference.

May nurses use signature stamps?

"The North Carolina Board of Nursing has taken the position that the only "signature" which qualifies on any official record or document, including a medical record, must be an original signature. Thus, a signature stamp would not be permitted."

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

The quarterly summary form for RAI Version 2.0 now has the potential to elicit responses to items that would trigger a RAP if entered as a part of an annual assessment. Computer software and certain forms printed by independent vendors will indicate a RAP has been triggered when entering data during a quarterly assessment. Are RAPs a part of every quarterly assessment?

No. Only if the quarterly assessment indicates a significant change in condition has occurred and a significant change assessment is required. If a significant change occurred, a complete reassessment including trigger RAPs would be required. However, members of the interdisciplinary team may use the RAP guideline to aid in the review and revision of care plans quarterly if desired. The regulation requires a quarterly assessment utilizing the RAI Medicare Payment Assessment Form (MPAF) form.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

The guidance to surveyors for F314 states "The staging system presented below is one method..." Would it therefore be acceptable to stage wounds according to the new recommendations of wound care experts, i.e., "healing Stage III" for an area that currently "presents" as a Stage I or II, but was a Stage III? Is it agreed that a Stage III despite current appearances, is always a Stage III and may later break back down quickly to a Stage III?

Yes. The guidelines to surveyors for F314 is appropriate for defining maximum depth of tissue involvement when assessing pressure ulcers prior to the beginning of healing. The guidelines do not address the description of an improved ulcer (reverse staging or staging down).

The fourth National Conference of the National Ulcer Advisory Panel published the following position on the practice of reverse staging of pressure ulcers in *Advances in Wound Care Journal*, Volume 8 #4, July/August 1996.

> Reverse staging should never be used to describe the healing of a pressure ulcer.
>
> Healing of pressure ulcers should be documented by objective parameters such as: size, depth, amount of necrotic tissue, amount of exudate, presence of granulation tissue, etc.

The rationale for these statements is that using pressure ulcer staging systems to describe healing must assume that full thickness pressure ulcers heal by replacing the same structured layers as body tissue that was lost. Clinical studies have shown that is not the way the ulcer heals.

Please Note: For the purpose of coding the MDS and Quarterly Review ulcers of all types must be coded by stage. The RAI version 2.0 does not provide for any other type of assessment on this form. CMS is continuing to study this issue.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

It is written that there be documentation of meal intake and supplemental feedings and snacks. However, it does not specify if this documentation must be in the resident's medical record or if a multi-resident form would suffice. Please clarify. Is daily documentation of food intake required for all residents?

Licensure rule 10 NCAC 13D .2701(d)(5) states: "The dietitian shall spend sufficient time in the facility to assure the following parameters of nutrition have been addressed and that recommended successful interventions have been met:...(5) The amount of meal and supplement consumed to meet nutritional needs."

The facility must have a mechanism for documenting; in the record of each individual resident receiving an in between meal nourishment as a component of a specifically ordered therapeutic diet, whether the resident consumed or refused the nourishment.

The facility must have a mechanism for assessing the resident's food intake in order to record this information in the individual resident's progress notes.

Unless the resident has specially ordered therapeutic supplemental feedings or has nutritional problems or risks addressed in the care plan, there is no requirement for meal by meal documentation of intake.

Please note that the RAI requires intake be assessed for the first 14 days.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

Can a treatment ordered daily or BID be initialed by the nurse when completed as a 7-3 or 3-11 treatment on treatment record rather than a specific time like 11:00 am or 5:00 pm?

The treatment must be recorded and initialed upon completion, however, unless the physician orders the treatment to be done at a specific time, it is acceptable, but not prudent, for the treatment record to reflect a daily or BID treatment as 7-3 or 3-11, rather than an actual time. It would be beneficial for the resident to have times indicated on the treatment record to allow sufficient time to elapse between treatments to ensure the effectiveness of the treatment. The nurse for that shift should initial the treatment as being done for that specific shift or the specified time.

REGULATORY FOCUS BULLETIN
FOR YOUR INFORMATION

FILE TOPIC: Nursing Services
DATE: October 1996

Note: FYI is an informational and educational service of the Regulatory Focus Committee to assist you in finding the resources for answers to questions regarding issues not regulated by the Division of Health Service Regulation. The source of the information is included for your reference.

What is the time period that is acceptable/permissible for nurses (or other staff) administering medications and/or treatments to sign off (document) administration when it is not done immediately after the act? In other words, how long before blanks or omissions can be filled by staff? Is circling initials with an explanation on back that entry is late, acceptable?

The North Carolina Board of Nursing has provided the following answer to this question:

"Documentation of medications and treatments should be completed immediately after the procedure is done by the nurse. If the nurse fails to document the procedure, but at a later date, that nurse recalls that it was indeed carried out, he/she can enter the documentation in the medical record consistent with facility policy and procedure for late entry. At a minimum, the late entry needs to include the date the information is entered into the medical record and clearly identify the earlier date when the nursing intervention occurred. The exact procedure to follow, such as circling initials with an explanation elsewhere, should be detailed in the facility policy and procedure for late-entry documentation."

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services
DATE: August 1999

Who must supervise a nurse aide who has successfully completed all course requirements including return demonstrations of clinical skills while they are waiting to take the final competency testing within 120 days?

All students in a Nurse Aide Training Competency Evaluation Program (NATCEP) must be under the general supervision of a licensed or registered nurse when they are performing services for residents. Please refer to the attached letter.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

When the M.D. orders continuous oxygen administration must the nurse document this every shift on the treatment MAR or nurse's notes?

There are no requirements for a nurse to document the use of continuous oxygen every shift on the treatment MAR or nurse's notes. For Medicare reimbursement purposes, refer to the Medicare Provider Reimbursement Manual.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services
DATE: August 2006

May a Nurse Practitioner serve as Director of Nurses and practice in the facility as well?

No. A nurse practitioner may not serve simultaneously in a dual role as DON and nurse practitioner. The DON is responsible for administering nursing services on a full time basis. The role of the nurse practitioner is as a physician extender in both licensure rule and federal requirement.

Federal regulation 483.30(b)(2) says, “Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis”. North Carolina does not have a history of receiving requests or granting waivers for the RN requirement and/or the 24-hour licensed nurse requirement.

483.30(b)(3) says, “The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents”.

Full time is defined as 35 hours per week. Registered nurses may share the role of DON. (Licensure does not permit sharing the role of DON. Therefore, this rule takes precedence.)

The licensure rule is more restrictive than the federal regulation.
The licensure rule 10A NCAC 13D .2302 NURSING SERVICES says,
(a) The facility shall designate a registered nurse to serve as the director of nursing on a full-time basis. (35 hours per week)
(b) The director of nursing shall be responsible for the administering of nursing services.
(c) The director of nursing may serve also as nurse-in-charge, only if the average daily occupancy is less than 60.
(d) The director of nursing shall not serve as administrator, assistant administrator or acting administrator during an employment vacancy in the administrator position.

The clinical services of a nurse practitioner are outlined in section .2500 under physician services in the licensure rule and at 483.40(e) Physician Delegation of Tasks in SNFs in the federal regulation.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Service
DATE: August 2006

What is the regulatory definition of "elopement" versus "wandering" used to determine compliance?

There are no definitions that "determine" compliance. Administrative law judges have supported citations at 483.25(h)(2) related to failure to provide supervision to residents at a level adequate to prevent accidents, as evidenced by repeated elopements and resident-to-resident altercations, often involving severely cognitively-impaired residents and, in some cases, resulting in serious injury. See http://www.hhs.gov/dab/decisions/dab1726.html.

According to the interpretive guidance at 483.25(h)(2), "Wandering is random or repetitive locomotion. This movement may be goal-directed (e.g., the person appears to be searching for something such as an exit) or may be non-goal-directed or aimless. Non-goal-directed wandering requires a response in a manner that addresses both safety issues and an evaluation to identify root causes to the degree possible. Moving about the facility aimlessly may indicate that the resident is frustrated, anxious, bored, hungry, or depressed. Unsafe wandering and elopement can be associated with falls and related injuries. Unsafe wandering may occur when the resident at risk enters an area that is physically hazardous or that contains potential safety hazards (e.g., chemicals, tools, and equipment, etc.). Entering into another resident's room may lead to an altercation or contact with hazardous items. While alarms can help to monitor a resident's activities, staff must be vigilant in order to respond to them in a timely manner. Alarms do not replace necessary supervision. Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. A resident who leaves a safe area may be at risk of (or has the potential to experience) heat or cold exposure, dehydration and/or other medical
complications, drowning, or being struck by a motor vehicle. Facility policies that clearly define the mechanisms and procedures for monitoring and managing residents at risk for elopement can help to minimize the risk of a resident leaving a safe area without authorization and/or appropriate supervision. In addition, the resident at risk should have interventions in their comprehensive plan of care to address the potential for elopement. Furthermore, a facility's disaster and emergency preparedness plan should include a plan to locate a missing resident."

FILE TOPIC: Nursing Service

May a Director of Nursing be the instructor for Medication Assistants in a facility?

A Director of Nursing can be faculty for the Medication Assistant course but may not teach the basic Nurse Aide course, i.e., Nurse Aide Training and Competency Evaluation (NATCEP).