

## Family Care Registered Nurse

### Section 2.7

The Family Care Registered Nurse (RN) is responsible for oversight of health care provided to individuals receiving Family Care services. The RN coordinates each individual's health care in partnership with the Family Care Provider (FCP). The RN is responsible for the completion of a nursing assessment and the development and monitoring of plans of care to address the individual's health care needs. The RN must be able to:

- a. Effectively communicate and coordinate with other caregivers including day program providers and other healthcare providers
- b. Participate in the assessment of the FCP's skills and abilities relative to addressing the needs of the individual
- c. Provide training and education to the FCP and the individual receiving services regarding health care issues and preventative healthcare strategies
- d. Participate in the development of recommendations for home modifications and adaptive equipment, as appropriate, to meet the needs of the individual receiving services

Prior to the placement of an individual in Family Care, the RN must:

- a. Participate in the planning process by assessing the health care status of the individual and assisting the team to determine whether the individual's needs can be safely and adequately met in the Family Care Home (FCH)
- b. Review health care documentation to establish that necessary examinations, immunizations, and/or assessments are completed or scheduled and to determine if there is a need for additional assessments or evaluations. These include but are not limited to:
  - i. Physical and dental examinations
  - ii. Specialty medical consults
  - iii. Behavior Support Plan and Informed Consent, if applicable
  - iv. Smoking Cessation, if applicable
  - v. Assessment for falls, bedrails, etc.
  - vi. Immunizations/screenings
  - vii. Medical Immobilization/Protective Stabilization Plan (MIPS), if applicable
  - viii. Medical and contact information on the individual for medical appointments and urgent or emergent medical care
  - ix. Health Care Proxy and/or Advanced Directives

### **After Admission to Family Care**

Within 30 days of permanent placement, the RN will collaborate with the individual, the individual's advocate, the FCP, and members of the interdisciplinary team to complete the individual's nursing assessment.

### Nursing Assessment

The Family Care RN must complete a nursing assessment for each individual receiving Family Care services that includes, but is not limited to:

- a. Demographic information
- b. All medical conditions and diagnoses
- c. Relevant family history
- d. Allergies or sensitivities
- e. Medications and reason for each medication
- f. Adaptive equipment required, if applicable

### **Plans of Nursing Services (PONS) and Training for Family Care Providers**

The Family Care RN must ensure the FCP has received training and direction to address the medical needs of the individual receiving services and on any tasks delegated by the RN. It is recommended that the PONS be used to provide this instruction and direction to the FCP. The RN must ensure the FCP demonstrates the skills and competence to provide needed care and any delegated nursing services. Documentation of training must be maintained by the sponsoring Agency.

### **Nursing Oversight Activities**

The RN, in consultation with the Family Care team, will determine the frequency of nursing visits to a FCH based on the needs of the individual(s) served. However, in no case will the RN visit the FCH less than once every 90 days. Nursing visits must occur in the FCH at a time when the individuals can be present for at least a portion of the visit.

Every 90 days, at least one face-to-face nursing visit with the individual and FCP must occur. The RN will review the following with the FCP:

- a. Medication Administration Records (MARs)
- b. Medication storage practices to ensure safe storage in accordance with the safety needs of the individual and any others in the home
- c. Monitoring/counting of controlled substances
- d. Verification of medication orders
- e. Bowel Management, Seizure, Menses, Vital Signs, Blood Sugar, and other charts, as applicable
- f. Physician/Practitioner Orders
- g. Pertinent medical information for medical appointments and urgent or emergent medical care, including the Ready to Go Form and Ready to Go Packet and, for Willowbrook Class Members, the Ready to Go Checklist
- h. Medical appointment reports to ensure follow up on health care provider instructions including diagnostic procedures, laboratory work, specialty referrals, and dental care
- i. Consult notes and evaluation of follow-up
- j. Nursing assessment and training to the FCP including review of instructions when there is a change in the individual's healthcare needs
- k. Review of the PONS, if in use, to ensure the PONS is updated and consistent with individual's needs
- l. Observation of the individual and discussion of the individual's overall health, noting any changes and/or concerns
- m. Review of changes and concerns related to:

- i. The safety of the home environment
- ii. The FCP skills and abilities
- iii. The health and well-being of the individual
- iv. Any areas in which the FCP may need additional training or retraining
- n. Other areas as the RN deems appropriate

### Documentation of Visits

During every 90-day visit, nursing documentation should address nursing oversight activities completed, including but not limited to following:

- a. Face to face contact with individuals present at the time of the visit
- b. Documentation of specific trainings that were provided to the FCP
- c. Review of appointments and practitioner visits completed since the last 90-day review
- d. Notation of follow-up activities completed or to be completed
- e. Review of nursing assessment and PONS for any updates or changes
- f. Identification of concerns related to the FCP or the home, along with a plan to address the concern(s). Notification to the Family Care Home Liaison is required for concerns related to the FCP, such as changes in the condition of the home or the FCP abilities
- g. Count of controlled substances, where applicable

If an individual receives a visit more than once every 90 days from the RN, it is required that the RN keep documentation of each visit so it is clear what was monitored or addressed during each contact.

### **Additional Nursing Activities**

The Family Care RN is also responsible for the following:

- a. A Self Administration of Medication Evaluation annually and as needed
- b. An immunization record review to include a specific emphasis on tetanus, influenza, and pneumovax
- c. A Tardive Dyskinesia Evaluation (such as the Abnormal Involuntary Movement Scale or Dyskinesia Identification System-Condensed User Scale) at least every six months, if indicated and if not completed by the prescriber
- d. A Medication Regimen Review to be completed at least every six months, with more frequent review for contraindications of newly introduced medications, unless either has been done by a pharmacist or physician
- e. Assistance to obtain Informed Consent, as needed or requested
- f. Training for the FCP and Substitute Provider on medication administration, PONS, and other areas, as necessary
- g. Assessment of the FCP's and Substitute Provider's ability to properly administer medication through observed medication pours to be conducted at initial certification and any time the RN and/or treatment team deems additional support or monitoring is necessary (e.g., medication errors)
- h. Monitoring of controlled substances consistent with the Sponsoring Agency's policy and procedures and New York State Controlled Substances regulations.

This will include at a minimum counting the controlled substances at every 90-day visit. This count will be documented as part of every 90-day visit.

### **Ready to Go Packet/Form**

It is the responsibility of the FCP to ensure that important medical information accompanies an individual to the hospital or other health care facility for routine, urgent, or emergent care. This information can be found on the Ready to Go Form. This form, completed by the RN and FCP, is a valuable tool which provides current medical information based on the specific needs of the individual who will be receiving care. This form accompanies a packet of information known as the Ready to Go Packet (usually kept in a folder or binder) to ensure practitioners are provided sufficient information when an individual goes to a hospital or other health care facility.

If an individual receiving Family Care services is also a Willowbrook Class member, the RN and FCP must complete the Ready to Go Checklist in conjunction with the Ready to Go Form.

The Ready to Go Form and checklist are available on the Office for People With Developmental Disabilities (OPWDD) website.

### **Admissions to Hospitals/Other Sub-Acute Health Care Facilities:**

The FCP must notify the Sponsoring Agency's RN and Family Care Home Liaison when an individual is hospitalized or evaluated in an Emergency Room or urgent care facility.

If an individual is admitted to the hospital, the RN is responsible for:

- a. Establishing and maintaining contact with appropriate hospital personnel to review the individual's health and safety needs, medication regimen, and other needs specific to the individual.
- b. Making the initial contact with hospital personnel within 24 hours (or next business day) of receiving notification that the individual has been hospitalized.
- c. Conducting visits to the hospital at least once a week; frequency of visits may increase when deemed appropriate, or at the request of the hospital.
- d. Contacting the hospital's discharge planning staff to request participation in discharge planning activities and notification to the Sponsoring Agency of discharge planning activities.
- e. Assessing the individual prior to discharge, to determine, in conjunction with the team, if the healthcare needs of the individual can continue to be adequately addressed in the FCH.

Once an individual has been temporarily admitted to a sub-acute facility (e.g., nursing home or rehabilitation), the RN is responsible for:

- a. Conducting visits consistent with the individual's needs, as long as the discharge plan is for the individual to return to the FCH.
- b. Ensuring that required services, adaptive equipment, and/or environmental modifications to the FCH that are necessary for health and safety are in place prior to the individual's discharge home.

- c. Contacting the FCP within 24 hours (or next business day) of discharge to review the individual's healthcare status and ask the FCP about any supports or assistance that may be needed to facilitate a smooth transition.
- d. Reviewing the discharge instructions, cross referencing medications to ensure all medications are in order, ensuring prescriptions and medications are available upon discharge, and ensuring diet orders are correct.
- e. Ensuring follow up or specialty appointments are made.