
Basic Training 2009

Licensed Health Professional Support

Developed by:

Adult Care Licensure Section

Division of Health Service Regulation

Licensed Health Professional Support (LHPS)

TRAINING OBJECTIVES after completing this training session the participant will have a better understanding of:

- **the knowledge of the rules pertaining to licensed health professional support (LHPS)**
 - **observation, interview, and record review to assess the quality of LHPS services provided to residents.**
 - **effective interventions to improve the quality of LHPS services (QA)**
-

TRAINING OBJECTIVES cont.:

- the knowledge of the rules pertaining to licensed health professional support (LHPS)
 - observation, interview, and record review to assess the quality of LHPS services provided to residents.
 - effective interventions to improve the quality of LHPS services (QA)
-

History

- LHPS was originally adopted as a temporary rule under the authority of S.B. 864 (1996 session of the GA)
- DHSR in consultation with DMA and the Board of Nursing, drafted the rule to allow unlicensed personnel to perform specific heavy care tasks with RN oversight.

Fundamental Licensed Health Professional Support Rules

- **10A NCAC 13F/G .0903**

On-site review and evaluation of the residents' health status, care plan and care provided

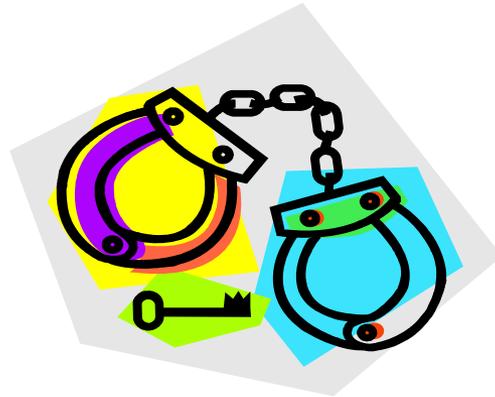
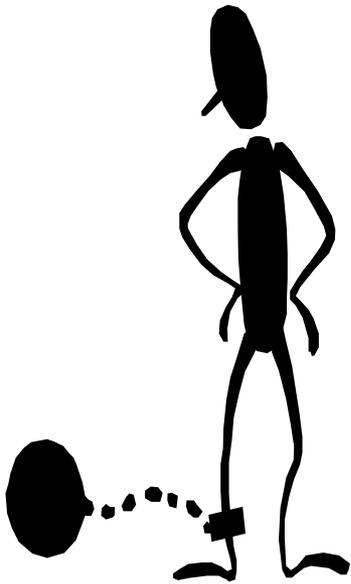
- **10A NCAC 13F/G .0504**

Training and skill validation of staff to ensure they are competent to perform the tasks

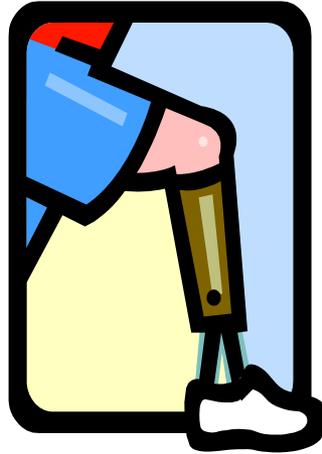
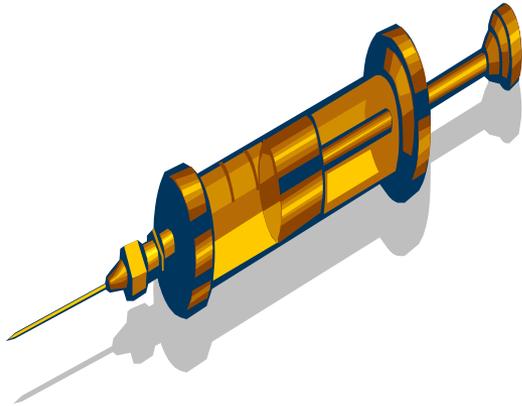
10A NCAC 13F/G .0903

What task(s) require(s) LHPS Reviews?

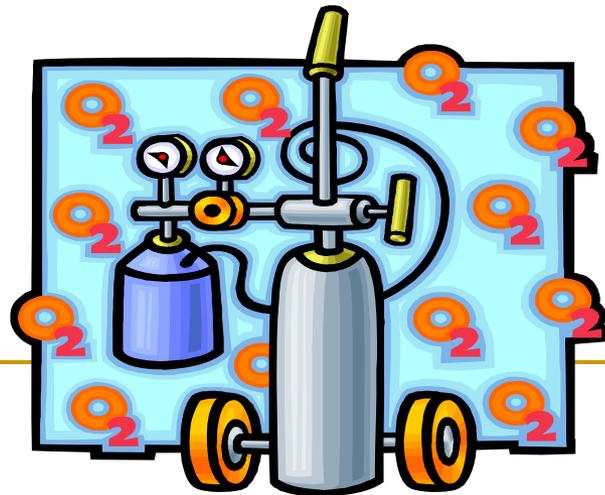
Restraints, Range of Motion Exercises



Injections, oxygen, prosthesis



Prosthesis



Applying/Removing splints, braces.
bandages, clean dressing changes



Assistance with transfers: semi/non-ambulatory residents, ambulation with assistive devices and physical help



What Is G.S. 131D - 2 (A1)?

- **Adult care homes shall not care for individuals with**
 - **Ventilator dependency**
 - **The need for continuous nursing care**
 - **MD certification that placement is no longer appropriate for the resident**
 - **A determination by the facility that it can not meet the residents' needs**
 - **Other medical and functional care needs as determined by the Medical Care Commission**
-

Rule Update

10A NCAC 13F/G 0504 (C)

- A physician may certify that staff perform tasks beyond those listed in the rule for a specific resident on a **TEMPORARY** basis.
 - This change in the rule is to prevent the unnecessary relocation of a resident.
-

Who Can Perform LHPS Reviews?

10A NCAC .0903(C)

- ❑ RN
 - ❑ Occupational & Physical Therapist
 - Heat therapy
 - Prosthetic devices
 - Ambulation w/ assistive devices
 - ROM exercises
 - Transfers and any other prescribed PT or OT
-

When are Reviews to be Completed?

- The review and evaluation are to be conducted:
 - Within the first 30 days of admission
 - Within 30 days from the date the resident develops the need for the task
 - At least QUARTERLY thereafter
-

Where?

10A NCAC 13F/G .0903(C)

- The review is to be conducted on site
 - The reviews are to be maintained in the facility and readily available
-

The LHPS Review Includes:

- ❑ A physical assessment of the resident as related to the diagnosis or current condition requiring 1 or more of the previously listed 28 task(s)
 - ❑ Observation and evaluation of care provided & resident's response
 - ❑ Recommended changes in the care as needed based on the physical assessment and evaluation of the progress
 - ❑ Documentation of above
-

LHPS Recommendations

- Documentation of facility response
 - Notification of Physician or appropriate health professional
-

10A NCAC 13F/G .0504

Who Can Validate LHPS Skills?

■ Skill Validation

□ RN

□ PT & OT

■ heat therapy

■ ambulation w/assistive devices

■ ROM

■ Transfers and other prescribed PT & OT

□ Pharmacist

■ fingerstick blood test

□ Respiratory Therapist

■ chest physiotherapy

■ med. by inhalation

■ oxygen

■ oral suctioning

■ tracheotomy care

Competency Validation

- ❑ Unlicensed staff must be trained and validated in the specific tasks outlined in paragraphs (a) and (b) of the rule
 - ❑ Training must be provided on the care of residents with diabetes prior to staff administering insulin to the resident.
 - ❑ Ongoing competency must be assured.
-

When Are Competency Validations Performed?

10A NCAC 13F/G .0504 (a)

- **Competency Validation must:**
 - occur PRIOR to the performance of the task
 - be documented and available in the facility for review
-

Orienting the LHPS

- Give them a rule book
 - Talk about the LHPS rules
 - Give them the name and phone number of AHS
 - Give them the name and phone number of DHSR
-

Review Residents' and Staffs' Needs

- Identify residents that need to be reviewed by the RN and the due date (tracking system)
 - Identify staff that need training and competency validation
-

Monitoring tips

- **Random Review of Residents' Records**
(new orders, new admissions, new task(s) FL-2/subsequent orders/LHPS reviews/care plan/Pharmacy reviews. Routine inspection of Residents' Records for documentation of LHPS tasks.
- **Random observations of resident vs the care plan vs the LHPS review. Random observations of new staff**
- **Interview Residents/staff/family members/physician/RN/pharmacist**

Monitoring tips

- Are competency validations done prior to staff performing the task?
 - Are return demonstrations done?
 - Are staff comfortable performing the tasks?
 - Are staff performing tasks with proficiency?
-

Monitoring LHPS

- Observations
What have you seen?
 - Record Review
What have you read?
 - Interview
What have you heard?
 - Analysis?
 - Is there a problem?
 - What is causing the problem?
 - What is the impact on residents?
-

Monitoring Tips

- **Did the RN's documentation include the following?**
 - **Indication of staff competency**
 - **Physical assessment r/t diagnosis & current condition**
 - **Response to care being provided**
 - **Recommendations for changes in care if necessary**
-

Conclusion

- Is there a system to assure safety and accountability
 - Use your available resources
 - Ask questions!!!
-

OPTIONAL

This check list has been developed as a tool to evaluate and monitor areas pertaining to Licensed Health Professional Support in Adult Care and Family Care Homes. Licensure regulations for adult and family care homes have been referenced for the items that are specifically rule based. Items on the checklist that are recommendations may prevent problems from developing but do not have a licensure regulation referenced.

10A NCAC 13F/G .0903 Licensed Health Professional Support

	<u>Yes</u>	<u>No</u>	<u>Comments</u>
<p>1. The facility has an appropriate LHPS that participates in the on-site review and evaluation of resident's health status, care plan and care provided requiring one or more of the 28 personal care task(s) outlined in rule 10 A NCAC 13 F/G .0903 (a)(b)</p>			
<p>2. The evaluation is on site and hands on 10A NCAC 13F/G .0903 (c)</p>			
<p>3. The evaluation is completed within the first 30 days of admission or within 30 days of developing the task 10A NCAC 13F/G .0903(c)</p>			
<p>4. The evaluation is performed at least quarterly thereafter 10A NCAC 13 F/G .0903 (c)</p>			
<p>5. The evaluation contains the following: 10A NCAC 13F/G .0903 (c)(1)(2)(3)(4)</p> <ul style="list-style-type: none"> • Performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of the Rule 			

OPTIONAL

	<u>Yes</u>	<u>No</u>	<u>Comments</u>
<ul style="list-style-type: none"> • Evaluating the resident’s progress to care being provided • Recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and • Documenting the activities in Subparagraphs (1) through (3) outlined above. 			
6. Action is taken in response to the LHPS review 10A NCAC 13F/G .0903 (d)			
7. Documentation of the facility response to the recommendation is available for review 10A NCAC 13F/G .0903 (d)			
8. The physician or appropriate health profession is informed of the recommendations when necessary 10A NCAC 13F/G .0903 (d)			
9. There is a system in place to identify residents’ requiring the LHPS review			
10. There is a system in place to notify the LHPS nurse of the new task or a new admission with a task			
11. There is a system in place to assure the reviews are completed timely.			
12. There is a system in place to assure the reviews contained the required information			

OPTIONAL

	<i><u>Yes</u></i>	<i><u>No</u></i>	<i><u>COMMENTS</u></i>
13. There is a system in place to ensure the LHPS nurse has a copy of the rules and understand the requirements.			
14. System to verify license of RN performing LHPS			

OPTIONAL

LICENSED HEALTH PROFESSIONAL SUPPORT 10A NCAC 13 F/G .0903

LHPS reviews for the following tasks may include, but are not limited to the following:

1. Applying and removing ace bandages, ted hose, binders, and braces and splints
 - a. Assessment
 - i. Site of application of ace bandages, binders, braces and splints (note any swelling)
 - ii. Ted Hose smooth and not wrinkled, time applied, time removed?
 - iii. Condition of skin under splints, TEDS, braces, and binders(note irritation/blisters/reddened/painful areas)
 - iv. If splint, note circulation in extremities
 - v. Appliance clean/condition
 - b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b, and c.
2. Feeding Techniques for residents with swallowing problems
 - a. Assessment
 - i. Type of technique identified (e.g. chin tuck, double swallow, etc.)
 - ii. Lung sounds
 - iii. Appetite
 - iv. Staff assisting with feeding?
 - v. Diet served as ordered (e.g. puree, thickened liquids) medication served with thickened liquids?
 - vi. Alternate foods and fluids frequently?
 - vii. Feeding with tip of spoon?
 - viii. Spoon only half filled?
 - ix. Straw use or non-use?
 - x. Weight
 - b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b, and c.
3. Bowel or Bladder training programs to regain continence
 - a. Assessment
 - i. How often and amount fluids offered
 - ii. How often toileted
 - iii. How often incontinent
 - iv. If bowel program,
 1. Response to suppositories, enemas, etc.
 2. How often incontinent?
 3. Dietary recommendations (e.g. encourage fluids)
 - v. Condition of skin under briefs?

OPTIONAL

- b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b and c
4. Enemas, suppositories, break-up and removal of fecal impactions and vaginal douches
- a. Assessment
 - i. Why enemas, suppositories given?
 - ii. Results of enemas, suppositories, and frequency given
 - iii. How often fecal impactions removed?
 - iv. Resident tolerance of procedure
 - v. Vaginal douches—why given, effectiveness, and resident tolerance
 - vi. Observations of vaginal discharge, perineal skin or anal condition
 - b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b, and c
5. Positioning and emptying of urinary catheter bag and cleaning around the urinary catheter
- a. Assessment
 - i. When catheter last changed?
 - ii. Description of urine in bag and tubing (color, amount, exudates?)
 - iii. Leakage around catheter?
 - iv. Frequency of staff cleaning
 - v. Positioning of drainage bag
 - vi. Any treatments for UTI's?
 - b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b, and c.
6. Chest physiotherapy or postural drainage
- a. Assessment
 - i. Lung sounds
 - ii. Description of secretions and amount
 - iii. Coughing/Shortness of breath?
 - iv. Frequency of procedure
 - v. Resident assessment of effectiveness of procedure
 - vi. Hospitalizations or infections?
 - b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b, and c.

OPTIONAL

7. Clean dressing changes, excluding packing wound and application of prescribed enzymatic debriding agents
 - a. Assessment
 - i. Site and type of dressing
 - ii. Frequency of change
 - iii. Description of wound
 - iv. Positioning of resident required?
 - v. Pressure reducing devices used?
 - vi. Home Health involved?
 - b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b, and c.

8. Collecting and testing of finger stick blood samples.
 - a. Assessment
 - i. Blood sugar ranges
 - ii. Skin assessment (open or irritated areas/ circulation in feet)
 - iii. Nail assessment (particularly toenails)
 - iv. Dietary compliance
 - v. Resident understanding of disease
 - vi. Dental problems?
 - vii. Visual problems?
 - viii. Frequency of sliding scale administration if indicated
 - ix. Complaints of peripheral neuropathy?
 - b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b, and c.

9. Care of well established colostomy or ileostomy (having a healed surgical site without sutures or drainage)
 - a. Assessment
 - i. Description of stoma
 - ii. Description of skin around stoma
 - iii. Description of fecal material in bag
 - iv. Frequency of appliance change
 - b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b, and c.

10. Care for pressure ulcers up to and including a Stage II pressure ulcer which is a superficial ulcer presenting as an abrasion, blister or shallow crater
 - a. Assessment

OPTIONAL

- i. Site of ulcer
- ii. When first discovered?
- iii. Description of ulcer
- iv. Home health involvement?
- v. Dressings and/or frequency of change
- vi. Pressure reducing devices?
- vii. Positioning and turning requirement?
- viii. Resident response to treatments
- b. Evaluate the resident's progress to the care provided
- c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
- d. Documentation of a, b, and c.

11. Inhalation by machine

- a. Assessment
 - i. Assessment of Lungs
 - ii. Frequency of Nebulizer treatments
 - iii. Resident response to the treatments
 - iv. Equipment clean and in good working order?
- b. Evaluate the resident's progress to the care provided
- c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
- d. Documentation of a, b, and c.

12. Forcing and restricting fluids

- a. Assessment
 - i. Required amount of fluids to be forced or restricted
 - ii. Resident compliance with order?
 - iii. Recorded amounts forced or restricted?
 - iv. Weights if indicated
- b. Evaluate the resident's progress to the care provided
- c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
- d. Documentation of a, b, and c

13. Maintaining accurate intake and output records

- a. Assessment
 - i. Reason for measuring intake and output (e.g. dialysis, CHF)
 - ii. Review of intake and output record
 - iii. Diet compliance if indicated(e.g. NAS)
 - iv. Resident understanding and compliance with measuring intake and output?
 - v. Weights if indicated
- b. Evaluate the resident's progress to the care provided
- c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident

OPTIONAL

- d. Documentation of a, b, and c.
14. Medication administration through a well-established gastrostomy feeding tube (having a healed surgical site without sutures or drainage and through which a feeding regimen has been successfully established)
- a. Assessment
 - i. Assessment of skin around tube placement
 - ii. Abdominal assessment to include bowel sounds
 - iii. Resident tolerance of procedure
 - iv. Frequency of medication administration (if applicable)
 - v. Amount of water used to flush tubing
 - b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b, and c.
15. Medication administration through injection (Note: Unlicensed staff may only administer subcutaneous injections, excluding anticoagulants such as heparin)
- a. Assessment
 - i. Assessment of injection sites
 - ii. Frequency of injections
 - iii. Response to injection (e.g. Haldol injection---resident behaviors)
 - b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b and c.
16. Oxygen administration and monitoring
- a. Assessment
 - i. Type of oxygen delivery (e.g. tank, concentrator, portable tank, or combinations)
 - ii. Rate of oxygen flow (as ordered)
 - iii. Frequency of administration (self-administration/staff?)
 - iv. Lung assessment
 - v. Resident's response (i.e. able to ambulate to and from DR without SOB)
 - vi. Resident compliant with treatment?
 - vii. Condition/maintenance of equipment
 - b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b, and c.

OPTIONAL

17. The care of residents who are physically restrained and the use of care practices as alternatives to restraints
 - a. Assessment
 - i. Date of restraint order
 - ii. Type of restraint used (least restrictive)
 - iii. Frequency of use
 - iv. Applied correctly?
 - v. How often checked and released
 - vi. Reason for restraint
 - vii. Skin assessment
 - viii. Resident response to restraint
 - b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b, and c.

18. Oral suctioning
 - a. Assessment
 - i. Reason for suctioning
 - ii. Frequency of suctioning
 - iii. Lung assessment
 - iv. Assessment of mouth
 - v. Resident response to suctioning
 - b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b, and c.

19. Care of well-established tracheostomy, not to include endotracheal suctioning
 - a. Assessment
 - i. Assessment of stoma and skin surrounding stoma
 - ii. Description and frequency of care involved
 - iii. Assessment of secretions
 - iv. Lung assessment
 - b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b, and c.

20. Administering and monitoring of tube feedings through a well-established gastrostomy tube
 - a. Assessment
 - i. Assessment of site and skin around site
 - ii. Abdominal assessment

OPTIONAL

- iii. Residuals noted?
 - iv. Lung assessment
 - v. Description of type of tube feeding (e.g. Bolus or continuous and type of formula used)
 - vi. Mouth care provided and assessment of oral mucosa
 - vii. Resident response to procedure
 - viii. Weights
 - b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b, and c.
21. The monitoring of continuous positive air pressure devices (CPAP and BIPAP)
- a. Assessment
 - i. Type of device used (CPAP or BIPAP)
 - ii. Self administer or staff assisted?
 - iii. Resident compliance with order?
 - iv. Resident response to treatment
 - v. Equipment clean and in good working order?
 - b. Evaluate the resident's progress to the care provide
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b, and c.
22. Application of prescribed heat therapy
- a. Assessment
 - i. Type and frequency of application
 - ii. Site of application
 - iii. Assessment of skin after prescribed heat therapy
 - iv. Resident response to treatment
 - b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b, and c.
23. Application and removal of prosthetic devices except as used in early post-operative treatment for shaping of the extremity
- a. Assessment
 - i. Type of prosthetic
 - ii. Resident compliant with use of prosthetic?
 - iii. Assessment of stump
 - iv. Length of time worn
 - v. Any problems with prosthesis?
 - b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident

OPTIONAL

- d. Documentation of a, b, and c.
24. Ambulation using assistive devices that requires physical assistance
- a. Assessment
 - i. Type of assistive device required (slide board, walker, waist belt)
 - ii. Type of help required in use of assistive device (e.g. 1 person stand by assist)
 - iii. Frequency of staff assistance required
 - iv. Resident response to ambulation (e.g. resident able to ambulate approximately 500 feet with 1 person stand by assist)
 - b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b, and c.
25. Range of motion exercises
- a. Assessment
 - i. Frequency of ROM exercises
 - ii. Active, Assistive or Passive ROM
 - iii. What extremities involved?
 - iv. Evaluation of movement of affected area
 - v. Assessment of any contracture
 - vi. Response to ROM exercises
 - b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b and c.
26. Any prescribed physical or occupation therapy
- a. Assessment
 - i. Type of therapy prescribed
 - ii. Frequency of therapy
 - iii. Therapy provided by PT or OT?
 - iv. Resident response to therapy (e.g. able to ambulate to DR with stand by assist only)
 - b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b, and c.
27. Transferring semi-ambulatory or non-ambulatory residents
- a. Assessment
 - i. Type of transfer (e.g. Hoyer lift, bed to chair, etc.)
 - ii. Number of people required for transfer
 - iii. Resident tolerance, response to transfers
 - b. Evaluate the resident's progress to the care provided

OPTIONAL

- c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
- d. Documentation of a, b, and c.

28. Nurse aide II tasks according to the scope of practice as established in the Nursing Practice Act and rules promulgated under that act in 21 NCAC 36.

- a. www.ncbon.com/

Optional Form
LICENSED HEALTH PROFESSIONAL SUPPORT
INITIAL EVALUATION & QUARTERLY REVIEW OF RESIDENTS

RESIDENT: _____ **DATE OF BIRTH:** _____ **ROOM:** _____

DATE OF EVALUATION: _____ **DATE OF LAST EVALUATION:** _____

PRIMARY DIAGNOIS: _____ **OTHER Dx.:** _____

HEIGHT: ____ **WEIGHT:** ____ **PULSE RATE:** ____ **TEMP.:** ____ **RESPIRATION:** ____ **BP:** ____

Personal care tasks currently present: (check all that apply)

<input type="checkbox"/> Applying and removing ace bandages, ted hose, binders, and braces and splints	<input type="checkbox"/> Feeding techniques for residents with swallowing problems	<input type="checkbox"/> Bowel or bladder training programs to regain continence	<input type="checkbox"/> Enemas, suppositories and vaginal douches
<input type="checkbox"/> Positioning and emptying of the urinary catheter bag & cleaning around the urinary catheter	<input type="checkbox"/> Chest physiotherapy or postural drainage	<input type="checkbox"/> Clean dressing changes excluding packing wounds & application of prescribed enzymatic debriding agents	<input type="checkbox"/> Collecting and testing of fingerstick blood samples
<input type="checkbox"/> Care of well-established colostomy or ileostomy	<input type="checkbox"/> Care for pressure ulcers up to and including a Stage II pressure ulcer	<input type="checkbox"/> Inhalation medication by machine	<input type="checkbox"/> Forcing and restricting fluids
<input type="checkbox"/> Maintaining accurate intake and output data	<input type="checkbox"/> Medication administration through a well established gastrostomy feeding tube	<input type="checkbox"/> Medication administration through injections	<input type="checkbox"/> Oxygen administration and monitoring
<input type="checkbox"/> Care of residents who are physically restrained and the use of care practices as alternatives to restraints	<input type="checkbox"/> Care of well-established tracheostomy	<input type="checkbox"/> Administering and monitoring of tube feedings through a well-established gastrostomy tube	<input type="checkbox"/> Monitoring of continuous positive air pressure devices (CPAP and BIPAP)
<input type="checkbox"/> Application and removal of prosthetic devices	<input type="checkbox"/> Ambulation using assistive devices that requires physical assistance	<input type="checkbox"/> Range of motion exercises	<input type="checkbox"/> Any other prescribed physical or occupational therapy
<input type="checkbox"/> Transferring semi-ambulatory or non-ambulatory residents	<input type="checkbox"/> Application of prescribed heat therapy	<input type="checkbox"/> Tasks performed by a nurse aide II according to the scope of practice as established in the Nursing Practice Act and rules promulgated under the act in 21 NCAC 36	<input type="checkbox"/> Oral Suctioning

Review of health status and care provided, physical assessment as related to diagnoses/current condition, progress to care provided and recommended changes in care:

Changes and follow up recommended to meet the Resident's Needs:

LHPS Personal Care Task Provided

Staff Competency Validated

yes _____ no _____
 yes _____ no _____
 yes _____ no _____
 yes _____ no _____

Signature/Title _____

Date: _____

Note: The facility shall assure that an appropriate licensed health professional, participates in the on-site review and evaluation of the residents' health status, care plan and care provided for residents requiring, but not limited to, one or more of the above tasks.

EXAMPLE: paranoid schizophrenia NIDDM

LICENSED HEALTH PROFESSIONAL SUPPORT
REVIEW AND EVALUATION OF RESIDENT

Resident's Name _____ Date of Evaluation 4/05/06
Mr. Very Pleasant Resident Date of Last Evaluation 12/14/05

Review of Health Status and Care Provided--Physical Assessment as related to
Diagnoses/Current condition

Receives Risperdol Consta 37.5mg. injections every 2 weeks. Dosage was increased from 25mg. last month. Shots given by ACT team nurse. Resident compliant with injection appointments and lab work. even though he states he does not believe he needs these injections. Resident is alert and oriented X3. Resident still has delusions about his deceased mother visiting him. Reports the frequency of the voices is decreasing. Resident is easily re-directed when he becomes agitated. No outbursts observed by staff this quarter.
Resident has gained 3 lbs this quarter (April, May, June 2006) Weight today 223 lbs. Resident and staff report non-compliant with NCS diet.

Recommended Changes in Caring for the Resident to meet the Resident's Needs:

Continue to encourage compliance with NCS diet, healthy snacking. Monitor for additional weight gain. Report changes in behavior and additional weight gain to MD.

<u>LHPS Personal Care Task Provided</u>	<u>Staff Competency Validated</u>	
<u>Injection</u>	<u>YES X</u>	<u>NO</u>

Signature/title Mrs. Good Nurse RN

An on-site review and evaluation is to be completed within the first 30 days of admission for new residents or within 30 days from the date the resident develops the need for one or more of the LHPS personal care task. Reviews and evaluations are to be completed at least quarterly thereafter.

EXAMPLE: Resident with diagnosis of diabetes and lung disease

LICENSED HEALTH PROFESSIONAL SUPPORT
REVIEW AND EVALUATION OF RESIDENT

Resident's Name _____ Date of Evaluation 4/05/06
Mr. Pleasant Resident _____ Date of Last Evaluation 12/14/05

Review of Health Status and Care Provided--Physical Assessment as related to
Diagnoses/Current condition

Finger sticks ordered BID and recorded on the March 2006 MAR at -
7:30am and 4:30pm. FSBS range from 98-150. No skin problems noted,
good circulation in feet, nails clean and trimmed. Insulin injection daily
controls blood sugar. Staff and Resident reveal compliance with NCS
diet. No visual or dental complaints.

No complaints of shortness of breath, lungs clear, no wheezes noted.
Nail beds pink, gets Nebulizer treatment at 8:00am and 8:00pm
Resident is not using prn inhalers.

Recommended Changes in Caring for the Resident to meet the Resident's Needs:

Continue FSBS checks as ordered

LHPS Personal Care Task Provided	Staff Competency Validated	
FSBS	YES X	NO
Injection	YES X	NO
Nebulizer	YES X	NO

Signature/title Mrs. Good Nurse RN

An on-site review and evaluation is to be completed within the first 30 days of admission for new residents or within 30 days from the date the resident develops the need for one or more of the LHPS personal care task. Reviews and evaluations are to be completed at least quarterly thereafter.

**Skills/Competency Evaluation
(Licensed Health Professional Support)**

Optional Form

Skill/ Competency	Perf. Date	Satisfactory Completion Date	Inst. Initials/ Signature	Needs Training	Inst. Initials/ Signature
1. Applying and removing ace bandages, Ted hose, binders, and braces, and splints					
2. Feeding techniques for residents with swallowing problems					
3. Bowel or bladder training programs to regain continence					
4. Enemas, suppositories, breaking up of fecal impactions and vaginal douches					
5. Positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter					
6. Chest physiotherapy or postural drainage					
7. Clean dressing changes, excluding packing wounds and application of prescribed enzymatic debriding agents					
8. Collecting and testing of fingerstick blood samples					
9. Care of well established colostomy or ileostomy (having a healed surgical site without sutures or drainage)					
10. Care for pressure ulcers up to and including a Stage II pressure ulcer which is a superficial ulcer presenting as an abrasion, blister or shallow crater					
11. Inhalation medication by machine					
12. Forcing and restricting fluids					
13. Maintaining accurate intake and output date					
14. Medication administration through a well established gastrostomy feeding tube (having a healed surgical site without sutures or drainage and through which a feeding regimen has been successfully established.)					
15. Medication administration through injection (sub q only)					
16. Oxygen administration and monitoring					
17. The care of residents who are physically restrained and the use of care practices as alternatives to restraints					
18. Oral suctioning					
19. Care of well established tracheostomy, not to include indo-tracheal suctioning					

Skill/ Competency	Perf. Date	Satisfactory Completion Date	Inst. Initials/ Signature	Needs Training	Inst. Initials/ Signature
20. Administering and monitoring of tube feedings through a well established gastrostomy tube (see description in Subparagraph (14))					
21. The monitoring of continuous positive air pressure devices (CPAP and BIPAP)					
22. Application of prescribed heat therapy					
23. Application and removal of prosthetic devices except as used in early postoperative treatment for shaping of the extremity					
24. Ambulation using assistive devices that requires physical assistance					
25. Range of motion exercises					
26. Any other prescribed physical or occupational therapy					
27. Transferring semi-ambulatory or non-ambulatory residents					
28. Nurse aide II tasks according to the scope of practice as established in the Nursing Practice Act and rules promulgated under that act in 21 NCAC 36					

Additional Tasks List Below					

Instructor's Initials _____ **Name & Title** _____ **Instructor's Initials** _____ **Name & Title** _____

EMPLOYEE SIGNATURE _____ **DATE:** _____

SUPERVISOR'S SIGNATURE: _____ **DATE:** _____

OPTIONAL

Tracking Tool

(Administrator/designee's use)

10A NCAC 13F/G .0903 Licensed Health Professional Support

- (a) An adult care home shall assure that an appropriate licensed health professional participates in the on-site review and evaluation of the residents' health status, care plan and care provided for residents requiring one or more of the following
- (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the onsite review and evaluation of the residents' health status, care plan and care provided as required in Paragraph(a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter

FACILITY: _____

RESIDENT: _____

Administrator/Designated Staff

Signature (completing check sheet) _____ **Date:** _____

Date referred to RN: _____ **Date referred to OT or PT:** _____

Name of RN: _____ **Name of PT/OT:** _____

CHECK ALL TASKS REQUIRED

- applying and removing ace bandages, ted hose, binders, braces and splints
- feeding techniques for residents with swallowing difficulties
- bowel or bladder training programs to regain continence
- enemas, suppositories, break-up and removal of fecal impactions, and vaginal douches
- positioning & emptying of the urinary catheter bag and cleaning around the urinary catheter
- chest physiotherapy or postural drainage
- clean dressing changes, excluding packing wounds and application of prescribed enzymatic debriding agents
- collecting and testing of fingerstick blood samples
- care of well-established colostomy or ileostomy
- care for pressure ulcers up to and including Stage II pressure ulcer
- inhalation medication by machine
- forcing and restricting fluids
- maintaining accurate intake and output data
- medication administration through gastrostomy feeding tube
- medication administration through injections (subcutaneous, excluding anticoagulants)
- oxygen administration and monitoring
- restraints
- oral suctioning
- tracheostomy care (not to include endotracheal suctioning)
- tube feedings through established gastrostomy tube
- CPAP or BiPap
- heat therapy
- application or removal of prosthetic devices
- ambulation using assistive devices that require physical assistance
- transferring semi-ambulatory or non-ambulatory residents

TEMPORARY LICENSED HEALTH PROFESSIONAL SUPPORT TASK
PHYSICIAN'S CERTIFICATION

Resident's Name _____

Facility _____

I certify that the **NON-LICENSED** facility staff may be competency validated by an appropriate licensed health professional, according to Rule 10A NCAC 13F .0504 or 13G .0504, to perform (*please specify task below*)

on a **temporary** basis for: _____ one day

_____ up to seven days

_____ up to thirty days

MD Signature _____ Date _____

MEDICATION ADMINISTRATION RECORD

Medications	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31			
Prolixin Decanoate 25 mg. IM every 3 weeks. 02/21/07																																			
		To Be administered at MHC																																	
Glucophage 850 mg. by mouth twice daily with meals 02/21/07		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31			
	8 AM	B	C	B	B	B	C	A	A	A	A	A	B	B	C	B	B	B	C	A	A	A	A	A	B	B	C	B	B	B	C	A	A		
	8 PM	T	T	R	R	R	J	J	J	T	T	T	T	T	R	R	R	J	J	J	J	J	J	J	R	T	T	T	R	R	R	J	J		
HCTZ 12.5 mg. by mouth twice daily 02/21/07		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31			
	8 AM	B	C	B	B	B	C	A	A	A	A	A	B	B	C	B	B	B	C	A	A	A	A	A	B	B	C	B	B	B	C	A	A		
	8 PM	T	T	R	R	R	J	J	J	T	T	T	T	T	R	R	R	J	J	J	J	J	J	J	R	T	T	T	R	R	R	J	J		
Tylenol 325mg 1-2 tablets every 6 hours as needed for pain or T > 100°F 02/21/07		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31			
												A																							
					R																														
Cogentin 1 mg. by mouth twice daily 02/21/07		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31			
	8 AM	B	C	B	B	B	C	A	A	A	A	A	B	B	C	B	B	B	C	A	A	A	A	A	B	B	C	B	B	B	C	A	A		
	8 PM	T	T	R	R	R	J	J	J	T	T	T	T	T	R	R	R	J	J	J	J	J	J	J	R	T	T	T	R	R	R	J	J		
Fingerstick blood sugars Check daily before breakfast 02/21/07		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31			
	7 AM	91	117	160	107	183	123	170	181	155	140	165	177	86	145	191	180	160	170	180	160	140	160	140	150	117	150	140	160	170	180				
		B	C	B	B	B	C	A	A	A	A	A	B	B	B	B	C	A	A	A	A	B	B	B	C	A	A	A	B	C	B	B			
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31				

Charting for the month of: April 1-30, 2007		
Physician: Dr. Olivia Bruton	Telephone # 555-1212	Medical Record #:
Alt. Physician:	Alt. Physician Telephone #:	
Allergies: Codeine	Rehabilitation Potential:	
Diagnosis: Paranoid Schizophrenia, HTN, NIDDM, COPD	Admission Date: 02/21/07	
Resident's Name: Garrett Clayton	Room and bed #: 12A	

