

NURSING SERVICES IN THE ICF/IID

NURSING ROLES AND ASSESSMENTS

Topics Covered

Nursing services as they apply to Federal Regulations in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).



- ✓ Nursing roles
- ✓ The Inter-disciplinary team approach.
- ✓ Nursing scope of practice.
- ✓ Nursing Assessments
- ✓ The relationship and role with the QIDP

NURSING ROLES

Nursing takes on many roles¹ in the ICF/ID including:

- Liaison between the individual and health care providers
- Direct service provider
- Interdisciplinary Team (IDT) member
- Advocate
- Educator

NURSING ROLES - LIAISON

W338:

Health status reviews must result in necessary actions.

“The nursing staff document that referrals are made in a timely manner, if indicated, for any concerns identified. Nurses must ensure all concerns they identify are communicated and addressed appropriately, including:

- Need is fully identified in assessment;
- Appropriate referrals are made;
- Revisions are made to IPP/Medical care plan; and
- Follow-up occurs to the new plan.”²

NURSING ROLES – DIRECT SERVICE PROVIDER

W331:

“The facility must provide clients with nursing services in accordance with their needs.”²

W344:

Licensed nursing services should be sufficient to care for each clients’ health needs.²

NURSING ROLES – IDT MEMBER

W332:

Nursing should participate in the development and update of individuals' program plans as appropriate.²

Medical and health concerns that can impact active treatment and objectives need to be addressed with the IDT.



Collaboration is key!

NURSING ROLES - ADVOCATE

W339:

Health and wellness are actively promoted, problems are promptly attended to, and steps are taken to prevent recurrence of problems.²

NURSING ROLES - EDUCATOR

W340, W341, W342:²

Nursing provides training to individuals and staff as needed in appropriate health and hygiene methods.

Nursing provides instructions in methods of infection control.

Nursing trains staff in detecting signs and symptoms of illness, first aid, and basic skills needed to meet individuals' health needs.

SCOPE OF PRACTICE

W345, W346:

The facility must adhere to State board of Nursing regulations³ that govern allowed nursing activities. In the state of Idaho, RN and LPN functions are clearly delineated. The facility must have arrangements with a registered nurse for consultation when LPNs are utilized.

SCOPE OF PRACTICE

The RN may:

- Complete comprehensive assessments.
- Identify nursing diagnoses.
- Identify objectives and develop a nursing plan of care.
- Analyze data collected and revise the nursing plan of care.
- Develop education plan for staff and individuals.
- Delegate tasks, as allowed by the State Board of Nursing, and train staff for delegable tasks.

SCOPE OF PRACTICE

The LPN may:

- Collect data for assessments.
- Participate in identifying health issues.
- Participate in identifying objectives and developing the nursing plan of care.
- Complete specific nursing tasks as assigned.
- Collect and report data and nursing observations.
- Educate staff and individuals in accordance with the nursing plan of care.

NURSING ASSESSMENT

W334:

The assessment must be completed by direct physical examination and is an integral part of the nursing process that includes:

- Assessment
- Nursing diagnosis
- Plan
- Implement
- Reassess for effectiveness



NURSING ASSESSMENT

The components of a nursing assessment remain unchanged from assessments in other clinical settings (clinics, hospitals, etc.).

However, the nurse may need to modify the approach taken with individuals in an ICF/ID.

NURSING ASSESSMENT

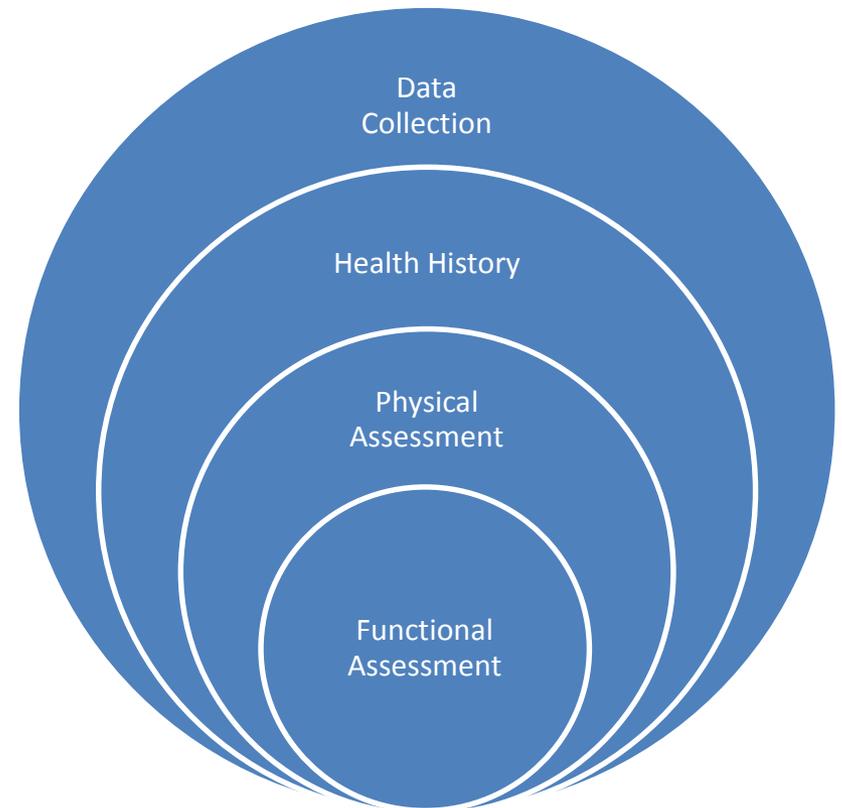
Factors that need to be considered during assessment are:

- Cognitive limitations
- Communication limitations
- Mental health concerns
- Anxiety or fear
- Tactile defensiveness

NURSING ASSESSMENT

The assessment process includes four components:

- Data collection
- Health history
- Physical assessment
- Functional assessment



NURSING ASSESSMENT

When conducting an assessment, consider its purpose and extent.

There are two types of nursing assessments.

- Comprehensive assessments include all body systems and psychosocial issues.
- Focused assessments are limited in nature and directed at a specific issue or problem.

NURSING ASSESSMENT

W336:

Assessments are to be completed at least quarterly (approximately 90 days apart) or more frequently if needed.²

W337, W338:

Assessments are recorded and result in necessary actions.²

NURSING ASSESSMENT

Focused assessments may be completed on a daily or emergent basis:

- Daily assessments are completed to monitor chronic conditions. These might include treatments, medications, or diets.
- Emergent assessments are completed when there is a change in health status such as injury, illness, hospitalization, ER visit, or behavioral changes.

DATA COLLECTION

Two types of data can be collected during an assessment.

- Objective – tangible data such as vital signs, weight, height, current medications and treatments.
- Subjective – non-tangible information that is reported to you by the individual or by staff, such as descriptions of pain or symptoms.

DATA COLLECTION

Age, history, life style and habits are important data to collect.

Current lab values and diagnostic test results are also important pieces of information to include.

All data collected should be validated for accuracy and documented.

*Validating data by ensuring it was collected in a manner to avoid false readings and comparing values with history and patient condition to fit the overall clinical picture.

PHYSICAL ASSESSMENT

Actual physical assessment can be accomplished using either a “head to toe” approach or a “review of body systems” approach.

A head to toe assessment is a visual and manual inspection of each body part starting at the head and scalp and continuing downward to the feet and toes. Any observed or functional concerns are noted.

PHYSICAL ASSESSMENT

Techniques used for evaluation during assessment should include:

Inspection – what you can see.

Palpation – what you can feel.

Percussion – what you can hear by tapping.

Auscultation – what you can hear with the aid of a stethoscope.

PHYSICAL ASSESSMENT

The body system approach includes a visual and manual inspection of the major systems of the body. Any observed or functional concerns are noted.

ASSESSMENT OF SYSTEMS

Neurological – assesses level of consciousness, gait, balance, cognition, and affect.

Cardiovascular – includes the collection of vital signs and listening to heart tones.

Pulmonary – includes respiratory rate and listening to lung sounds.

ASSESSMENT OF SYSTEMS

Gastrointestinal – includes the size and shape of the abdomen, any palpable masses, and listening to bowel sounds. Subjective data collection may include reports such as abnormal bowel movements, nausea, changes in appetite, etc.

Genitourinary – includes visual inspection and collection of subjective data (urine pattern, individual or staff reported abnormalities) to determine the need for a more extensive screening.

Musculoskeletal – includes bony and soft tissue development and function.

ASSESSMENT OF SYSTEMS

Integumentary – includes skin appearance, hydration status, and wounds or open areas. This assessment can be done at the same time other systems are being assessed.

Metabolic – includes the person's general appearance such as swelling, bruising and nutrition status. Lab values can also be used in evaluating metabolic function.

FUNCTIONAL ASSESSMENT

The purpose is to evaluate a person's ability to perform activities of daily living and to meet their own health needs. This includes his/her ability and means of expressing pain.

This is an excellent opportunity to look at maladaptive behaviors as well as cognitive limitations and decline.

HEALTH HISTORY

A complete health history should include the individual's information about medications used, treatments performed, surgical interventions, comparative lab values and diagnostic test results, and family history that might indicate genetic predisposition to certain conditions.

- ❖ Collaboration with the IDT is imperative to consider how health status may effect active treatment.

PLAN OF CARE

W320:

A medical care plan is required for clients that need 24 hour licensed nursing care.

W321:

The medical care plan must be integrated into the individual program plan.

The QIDP and Nursing

W159:

The QIDP orchestrates all facets of the active treatment program, including effectively coordinating and monitoring aspects that contribute to active treatment.

- Health concerns that may impact active treatment need to be monitored and addressed by the QIDP to ensure needs are met.

Collaboration is key!

References

¹ First Things First: Nursing Assessments in the ICF/MR. Retrieved from https://webinar.cms.hhs.gov/naicfmr_archived/

² *State Operations Manual Appendix J - Guidance to Surveyors: Intermediate Care Facilities for Individuals with Intellectual Disabilities*. Retrieved from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_j_intermcare.pdf

³ *IDAPA 23 Board of Nursing*. Retrieved from <https://adminrules.idaho.gov/rules/2011/23/0101.pdf>

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