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

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**10A NCAC 13F/G .0903**
What task(s) require(s) LHPS Reviews?
Restraints, Range of Motion Exercises
Injections, oxygen, 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 (Al)?

- 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
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!!!
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**

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<th>Yes</th>
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<tr>
<td>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 <strong>10 A NCAC 13 F/G .0903 (a)(b)</strong></td>
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<td>2. The evaluation is on site and hands on <strong>10A NCAC 13F/G .0903 (c)</strong></td>
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<td>3. The evaluation is completed within the first 30 days of admission or within 30 days of developing the task <strong>10A NCAC 13F/G .0903(c)</strong></td>
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<td>4. The evaluation is performed at least quarterly thereafter <strong>10A NCAC 13 F/G .0903 (c)</strong></td>
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<td>5. The evaluation contains the following: <strong>10A NCAC 13F/G .0903 (c)(1)(2)(3)(4)</strong></td>
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<td>• 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</td>
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- 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
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<td>13. There is a system in place to ensure the LHPS nurse has a copy of the rules and understand the requirements.</td>
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<td>14. System to verify license of RN performing LHPS</td>
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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?
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.
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
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
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.
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
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 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.

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
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
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/
Resident’s Name: ______________________ Date of Evaluation ____________

Facility Name: ______________________ Date of Last Evaluation ____________

Review of Health Status and Care Provided—Physical Assessment as related to Diagnoses/Current Condition and Progress to Care Provided:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

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

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

LHPS Personal Care Task Provided   Staff Competency   Validated
________________________________________________________________________
yes___   no___
________________________________________________________________________
yes___   no___
________________________________________________________________________
yes___   no___
________________________________________________________________________
yes___   no___

Signature/title ____________________________

As 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.
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 DIAGNOSIS: ___________ OTHER Dx.: ___________

HEIGHT: _____ WEIGHT: _____ PULSE RATE: _____ TEMP.: _____ RESPIRATION: _____ BP: _____

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

☐ Applying and removing ace bandages, ted hose, binders, and braces and splints
☐ Feeding techniques for residents with swallowing problems
☐ Bowel or bladder training programs to regain continence
☐ Enemas, suppositories and vaginal douches

☐ Positioning and emptying of the urinary catheter bag & cleaning around the urinary catheter
☐ Chest physiotherapy or postural drainage
☐ Clean dressing changes excluding packing wounds & 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 a Stage II pressure ulcer
☐ Inhalation medication by machine
☐ Forcing and restricting fluids

☐ Maintaining accurate intake and output data
☐ Medication administration through a well-established gastrostomy feeding tube
☐ Medication administration through injections
☐ Oxygen administration and monitoring

☐ Care of residents who are physically restrained and the use of care practices as alternatives to restraints
☐ Care of well-established tracheostomy
☐ Administering and monitoring of tube feedings through a well-established gastrostomy tube
☐ Monitoring of continuous positive air pressure devices (CPAP and BIPAP)

☐ Application and removal of prosthetic devices
☐ Ambulation using assistive devices that requires physical assistance
☐ Range of motion exercises
☐ Any other prescribed physical or occupational therapy

☐ Transferring semi-ambulatory or non-ambulatory residents
☐ Application of prescribed heat therapy
☐ 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
☐ 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:

______________________________________________________________________________________
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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.

DHSR/AC 4619 (Rev. 9/06) NCDHHS
EXAMPLE: paranoid schizophrenia NIDDM

LICENSED HEALTH PROFESSIONAL SUPPORT
REVIEW AND EVALUATION OF RESIDENT

Resident’s Name                                                Date of Evaluation       4/05/12
Mr. Very Pleasant Resident _____ Date of Last Evaluation       12/14/11

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

Recieves 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 (Jan, Feb, Mar 2012 ) 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.

LHPS Personal Care Task Provided            Staff Competency Validated
Injection                                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.
Resident’s Name: Mr. Pleasant Resident
Date of Evaluation: 4/05/12
Date of Last Evaluation: 12/14/11

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.
OPTIONAL
LHPS Review Tracking
YEAR __________

1. LHPS on-site review and evaluation of resident’s health status, care plan and care provided is required within 30 days admission or order for task & quarterly thereafter for the following residents’
2. Check for new admissions and new care order that require LHPS review

<table>
<thead>
<tr>
<th>Resident Name</th>
<th>Date Adm or Task Ordered</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sept</th>
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<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
</table>
**Licensed Health Professional Support (LHPS) Quality Assurance Tool**

<table>
<thead>
<tr>
<th>Resident Name</th>
<th>LHPS task(s)</th>
<th>Assigned Care Givers</th>
<th>Care Giver Skill Validation</th>
<th>LHPS Review quarterly</th>
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</thead>
<tbody>
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### Optional Form

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

<table>
<thead>
<tr>
<th>Skill/Competency</th>
<th>Perf. Date</th>
<th>Satisfactory Completion Date</th>
<th>Inst. Initials/Signature</th>
<th>Needs Training</th>
<th>Inst. Initials/Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Applying and removing ace bandages, Ted hose, binders, and braces, and splints</td>
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<tr>
<td>2. Feeding techniques for residents with swallowing problems</td>
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<tr>
<td>3. Bowel or bladder training programs to regain continence</td>
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<td>4. Enemas, suppositories, breaking up of fecal impactions and vaginal douches</td>
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<tr>
<td>5. Positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter</td>
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<td>6. Chest physiotherapy or postural drainage</td>
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<tr>
<td>7. Clean dressing changes, excluding packing wounds and application of prescribed enzymatic debriding agents</td>
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<td>8. Collecting and testing of fingerstick blood samples</td>
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<tr>
<td>9. Care of well established colostomy or ileostomy (having a healed surgical site without sutures or drainage)</td>
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<tr>
<td>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</td>
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<td>11. Inhalation medication by machine</td>
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<td>12. Forcing and restricting fluids</td>
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<td>13. Maintaining accurate intake and output date</td>
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<tr>
<td>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.)</td>
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<tr>
<td>15. Medication administration through injection (sub q only)</td>
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<td>16. Oxygen administration and monitoring</td>
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<td>17. The care of residents who are physically restrained and the use of care practices as alternatives to restraints</td>
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<td>18. Oral suctioning</td>
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<tr>
<td>19. Care of well established tracheostomy, not to include intratracheal suctioning</td>
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<tr>
<td>Skill/Competency</td>
<td>Perf. Date</td>
<td>Satisfactory Completion Date</td>
<td>Inst. Initials/Signature</td>
<td>Needs Training</td>
<td>Inst. Initials/Signature</td>
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<tr>
<td>20. Administering and monitoring of tube feedings through a well established gastrostomy tube (see description in Subparagraph (14))</td>
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<td>21. The monitoring of continuous positive air pressure devices (CPAP and BIPAP)</td>
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<td>22. Application of prescribed heat therapy</td>
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<td>23. Application and removal of prosthetic devices except as used in early postoperative treatment for shaping of the extremity</td>
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<td>24. Ambulation using assistive devices that requires physical assistance</td>
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<td>25. Range of motion exercises</td>
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<td>26. Any other prescribed physical or occupational therapy</td>
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<td>27. Transferring semi-ambulatory or non-ambulatory residents</td>
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<tr>
<td>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</td>
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</table>

Additional Tasks List Below

- 
- 
- 

Instructor’s Initials  Name & Title  Instructor’s Initials  Name & Title

____________________________________________________________  ______________________________________  ______________________________________  ______________________________________

EMPLOYEE SIGNATURE ______________________________________  DATE: ______________________

SUPERVISOR’S SIGNATURE: __________________________________  DATE: ______________________
10A NCAC 13F/G .0903 Licensed Health Professional Support

(a) An adult care home shall assure than 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

DFS/ACLS 2006
### Staff Validation by LHPS Tracking Tool

**YEAR __________**

1. LHPSs must validate the competencies of LPNs and non-licensed personnel for tasks listed on the *Residents Identified for Licensed Health Professional Support* form prior to the staff providing the care.

2. Check for new staff and new care orders that require staff validation by LHPS before the staff can perform the task.

<table>
<thead>
<tr>
<th>Task Number</th>
<th>1</th>
<th>2</th>
<th>3</th>
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</table>
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 ________________________
<table>
<thead>
<tr>
<th>Medications</th>
<th>Hour</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prolixin Decanoate 25 mg. IM every 3 weeks.</strong> 02/21/07</td>
<td>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</td>
</tr>
<tr>
<td>Glucophage 850 mg. by mouth twice daily with meals 02/21/07</td>
<td>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 C A A A A A B B C B B C A</td>
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<td>8 PM: T T R R J J J J T T T T T T R R J J J J R T T T R R J J</td>
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<tr>
<td>HCTZ 12.5 mg. by mouth twice daily 02/21/07</td>
<td>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 C A</td>
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<td>8 PM: T T R R J J J J T T T T T T R R J J J J R T T T R R J J</td>
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<tr>
<td>Tylenol 325mg 1-2 tablets every 6 hours as needed for pain or T &gt; 100°F 02/21/07</td>
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<tr>
<td>Cogentin 1 mg. by mouth twice daily 02/21/07</td>
<td>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 C A</td>
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<td>8 PM: T T R R J J J J T T T T T T R R J J J J R T T T R R J J</td>
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Charting for the month of: **April 1 - 30, 2007**

<table>
<thead>
<tr>
<th>Information</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>Dr. Olivia Bruton</td>
</tr>
<tr>
<td>Telephone #</td>
<td>555-1212</td>
</tr>
<tr>
<td>Medical Record #</td>
<td></td>
</tr>
<tr>
<td>Alt. Physician</td>
<td></td>
</tr>
<tr>
<td>Alt. Physician Telephone #</td>
<td></td>
</tr>
<tr>
<td>Allergies</td>
<td>Codeine</td>
</tr>
<tr>
<td>Rehabilitation Potential</td>
<td></td>
</tr>
<tr>
<td>Admission Date</td>
<td>02/21/07</td>
</tr>
<tr>
<td>Room and bed #</td>
<td>12A</td>
</tr>
</tbody>
</table>

Resident's Name: **Garrett Clayton**
### NURSE’S MEDICATION NOTES

|   | 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 |
|---|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| Temperature |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Respiration |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Pulse      |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Blood Pressure |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |

<table>
<thead>
<tr>
<th>Initials</th>
<th>Nurse’s Signature</th>
<th>Initials</th>
<th>Nurse’s Signature</th>
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<tbody>
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### Charting Codes:
- **A.** Chart error
- **B.** Drug unavailable
- **C.** Resident refused
- **D.** Drug held
- **E.** Dose contaminated
- **F.** Out of facility
- **G.** See notes
- **H.** Drug holiday

### Instructions:
- **A.** Put initials in appropriate box when medication given.
- **B.** Circle initials when medication refused.
- **C.** State reason for refusal on Nurse’s Notes.
- **D.** PRN medication: Reason given should be noted on Nurse’s Notes.
- **E.** Indicate injection site (code).

### Result Codes:
- 1. Effective
- 2. Ineffective
- 3. Slightly Effective
- 4. No Effect Observed

### Injection/Patch Site Codes:
- 1-Right dorsal gluteus
- 2-Left dorsal gluteus
- 3-Right upper chest
- 4-Left upper chest
- 5-Right lateral thigh
- 6-Left lateral thigh
- 7-Right deltoid
- 8-Left deltoid
- 9-Right upper arm
- 10-Left upper arm
- 11-Upper back left
- 12-Upper back right