Title

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Journal

Journal of Gerontological Nursing, 42(9)

ISSN

0098-9134

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Publication Date

2016-09-01

DOI

10.3928/00989134-20160811-04

Peer reviewed

Nurse Delegation in Home Care

Research Guiding Policy Change

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ABSTRACT

The current study evaluated nurse delegation in home care, a pilot program introduced in 2007 in New Jersey to promote home care options for consumers needing assistance with medical/nursing tasks. Findings on readiness for the program, barriers and facilitating factors, experience with the program, and recommendations are summarized and presented. Methods included surveys and interviews with participants in nurse delegation, observations of planning and implementation meetings, and review meeting minutes. Major findings were no negative outcomes for consumers, improvements in quality of life and quality of care for consumers, high readiness and increasing satisfaction with experience in delegation, perception of nurse delegation in home care as a valued option, and the challenges of ensuring adequate staffing. Subsequent changes in regulation in New Jersey are underway, translating this research into policy. [*Journal of Gerontological Nursing*, *42*(9), 7-15.]

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The authors have disclosed no potential conflicts of interest, financial or otherwise. This study was funded by the New Jersey Department of Human Services, Division of Disability Services under a grant from the Robert Wood Johnson Foundation. The authors acknowledge the following individuals for their assistance: Susan Brennan-McDermott, William A.B. Ditto, and Audrey Nicastro of the New Jersey Department of Human Services, Division of Disability Services; members of the pilot advisory council; Lilian Chung, Alison Goodrich, Nirvana Petlick, and Bram Poquette from Rutgers Center for State Health Policy; Thomas F. Reinhard from The Juncture Group Consulting; and Vanessa Santillan from UC Davis.

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doi:10.3928/00989134-20160811-04

A growing number of older adults and younger individuals with disabilities prefer to live at home in the community and need assistance with routine health maintenance tasks, such as medication administration, managing catheters, and wound care (Caffrey et al., 2012). Over the past two decades, community-based long-term care options have grown as a result of the Olmstead Decision by the U.S. Supreme Court affirming that public entities must provide community-based services to individuals with disabilities (United States Department of Justice Civil Rights Division, 1999) and in response to consumer preference for less institutionalized settings and expectations to play a more active role in their own health care. At the same time, the feasibility of RNs providing this care is limited due to workforce shortages and the high cost of delivery in the home (Young & Siegel, 2016). The lack of availability of appropriate services can force institutionalization upon consumers, a choice that is undesirable and costly. Leaders in long-term care policy and practice are actively seeking alternatives that meet the needs of older adults and individuals with disabilities in the least restrictive environment possible and involve collaboration among consumers, nurses, and direct care workers to provide affordable and high-quality care.

One approach to increasing access to care at home is nurse delegation, an approach that can facilitate delivery of nursing care in a variety of settings. Nurse delegation is a long-standing feature of most nurse practice acts (Kane, O'Connor, & Baker, 1995) and a legal mechanism to advance person-centered care in community-based settings. The National Council of State Boards of Nursing (NCSBN; 2005) defines *delegation* as the "the process for a nurse to direct another person to perform nursing tasks and activities" (p. 1). States vary in their implementation of nurse delegation, with different patterns of adoption, interpretation of RN role and accountability, and expectations for training (Reinhard, Young, Kane, & Quinn, 2006; Young & Siegel, 2016). To enhance policy development across states, the NCSBN with the American Nurses Association (ANA) in 2009 issued a joint declaration on delegation. The National Academy of Medicine report on caring for older adults further reinforces this approach in its recommendation to deploy all long-term care workers as efficiently and flexibly as possible and at their highest capability (Institute of Medicine [IOM], 2008). Nurse delegation is a force multiplier by enhancing community capacity for long-term care services and supports.

The lack of availability of appropriate services can force institutionalization upon consumers, a choice that is undesirable and costly.

The only systematic evaluation of nurse delegation published to date occurred in the context of assisted living, adult family homes, and residences for individuals with disabilities (Sikma & Young, 2003; Young & Sikma, 1999). In 1995, Washington State led the nation in advancing a model of reimbursed nurse delegation in community-based long-term care settings as part of an initiative to reduce costs by expanding alternatives to nursing homes for individuals needing assistance with a variety of health care tasks. The study concluded that formalizing and reimbursing nurse delegation increased the presence and influence of RNs in assisted living and brought unlicensed staff practice under RN supervision. This evaluation established the safety and effectiveness of nurse delegation in these settings, with improved communications among the team with the consumer and family and greater satisfaction for all stakeholders. The highest priority for consumers was their choice regarding living situation and how and when care is delivered, reinforcing the notion of person-centered care.

Home care has long provided essential services that support aging in place, with limited direct care by nurses and education/support for families who provide care. However, many older adults and individuals with disabilities do not have access to full-time family care, and many family caregivers face competing demands from employment (National Alliance for Caregiving & AARP, 2015). Nurse delegation has the potential to further improve quality and access to care in the home for individuals who live alone, and it can also increase capacity of family caregivers by augmenting the supports they provide with hired home care workers (Reinhard et al., 2014). Federal and state policymakers are expected to support the aims of the Americans with Disability Act and the Olmstead Decision in cost-effective and person-centered ways. However, research is lacking on the feasibility of nurse delegation in home health.

PILOT DEMONSTRATION

The current article highlights evaluation findings of a pilot demonstration of nurse delegation in home care and describes subsequent policy changes. New Jersey has a long history of innovative reimbursement and regulatory programs to enhance community-based care, leading with the Community Choice Counseling program

in the 1990s to facilitate return to the community from nursing homes (Howell-White, 2003). In 1998, New Jersey became one of the original Cash and Counseling pilot states, allowing consumer direction of health maintenance tasks in community settings. However, the situation was not clear for individuals receiving services outside of the consumer-directed model (Reinhard, 2010). The New Jersey Nurse Practice Act (NJNPA) was amended in the early 1990s to permit RNs to use broad discretion in delegating tasks to unlicensed assistive personnel, with no laundry list of tasks or limits by setting. But further amendments several years later precluded certified home health aides from administering medications (yet permitting delegation of other tasks at the discretion of the RN).

As state leaders and advocates continued to press for more home- and community-based services instead of automatic institutional care, the disconnect between long-term care policy and nursing policy became more pronounced. In 2006, New Jersey legislation established the Independence, Dignity, and Choice in Long-Term Care Act, with the intent to "ensure that, in the case of Medicaid-funded long-term care services, 'the money follows the person' to allow maximum flexibility between nursing homes and home and community-based settings..." (para. i.). Shortly thereafter, New Jersey implemented the Money Follows the Person Demonstration Project (Centers for Medicare & Medicaid Services, 2007). Because New Jersey recognized the importance of developing alternatives in home health, the Board of Nursing (NJBON), the New Jersey Division of Disability Services of the New Jersey Department of Human Services (NJDHS), and the New Jersey Department of Health and Senior Services (NJDHSS) considered ways to align their policies to better support consumer demand. They recognized two major barriers. First, the NJBON needed evidence to change their regulation that precluded the delegation of medication administration in home settings. Second, although delegation of other health maintenance tasks was legally permitted in New Jersey, some nurses and their employing agencies were unwilling to delegate tasks because they were unfamiliar with the Nursing Practice Act's delegation scope and fearful of liability outcomes. As a consequence, nurse delegation was rarely being used in home care, despite its potential for improving access and quality of care.

To advance the option of nurse delegation in home care and encourage nursing home discharge to homes, the regulatory bodies collaborated on a pilot demonstration that would address both of these barriers (Reinhard, 2010). The pilot focused on nurse delegation of health maintenance tasks, including medication administration, to unlicensed assistive personnel employed by selected home care agencies, coupled with an evaluation conducted by the authors to inform subsequent policy making (Reinhard & Farnham, 2006).

METHOD

Collaborative Design Process

The study was designed and implemented in collaboration with representatives from the NJBON, NJDHS, and NJDHSS and the investigators. A stakeholder work group provided input for the design and conduct of the study. Members included representatives from state agencies and representatives of certified home health agencies. At the end of the study, the work group reconvened to review and discuss preliminary results and implications, achieving confirmation of findings and clarification of issues important to stakeholders. Approval was obtained from the Human Subjects Research Review Board at Rutgers University.

Sample

The target population included consumers enrolled in the pilot, nurses oriented to the pilot, home health aides, agency administrators, and policy makers. Nurses were resurveyed after 1 year of delegation. For nurses, initial surveys were distributed at orientation to the program and follow-up surveys were available by mail, phone, or online. Surveys were distributed through the agencies to aides, consumers, and home care agency administrators. In addition, consumers were invited through the state registry of enrollees. A Spanish interpreter translated survey materials and conducted telephone outreach. An online survey option was also available for consumers and aides. State administrators and policy makers were contacted through outreach and attendance at advisory meetings. A summary of the demographic characteristics of the sample is included in **Table 1**.

On average, consumer participants needed help with three activities of daily living (ADLs) and seven instrumental ADLs. More than one half of consumers lived with family and approximately one third lived alone. To select cases of delegation for in-depth interviews, the following criteria were used: regions (North, Central, South, and the rural Northwest) and for-profit and nonprofit agencies. Once a case was selected, all stakeholders were contacted and invited for an interview, starting with the consumer, and including the aide, a family member, the nurse, and program administrators associated with the case.

Measures

The pre- and post-implementation design deployed surveys, in-depth semistructured interviews, document review, and observations of relevant policy and practice deliberations and work group meetings. Data collection began in 2008 and ended in early 2011,

TABLE 1

SURVEY PARTICIPANT DEMOGRAPHICS

	n (%)			
Variable	**RNs (*n* = 176)**	**Aides (*n* = 49)**	**Administrators (*n* = 54)**	**Consumers (*n* = 44)**
Age (years)				
18 to 25	1 (1)	0	0	3 (7)
>25 to 35	24 (14)	9 (18)	0	5 (11)
>35 to 45	51 (29)	9 (18)	12 (22)	7 (16)
>45 to 55	43 (24)	17 (35)	17 (32)	6 (14)
>55 to 65	45 (25)	10 (20)	20 (37)	5 (11)
>65 to 75	10 (6)	3 (6)	0	9 (21)
>75 to 85	1 (1)	1 (2)	1 (2)	6 (14)
>85	1 (1)	0	0	3 (7)
Gender (female)	162 (93)	45 (92)	46 (85)	34 (77)
Ethnicity (Hispanic/Latino)	41 (24)	10 (22)	3 (6)	6 (14)
Race				
Pacific Island/Hawaiian	6 (4)	0	0	0
White	121 (71)	16 (35)	41 (76)	19 (44)
Asian	8 (5)	2 (4)	4 (7)	1 (2)
Black/African American	19 (11)	23 (50)	6 (11)	16 (37)
Other	17 (10)	5 (11)	0	7 (16)
Education				
Some high school	0	4 (8)	0	12 (31)
High school	0	26 (53)	0	14 (36)
Some college	7 (4)	13 (26)	4 (7)	4 (10)
Associate degree	61 (35)	2 (4)	11 (20)	3 (8)
Diploma in nursing	23 (13)	2 (4)	2 (4)	3 (8)
Bachelor degree	66 (38)	2 (4)	19 (35)	3 (8)
Master degree	18 (10)	0	15 (28)	0
Professional certification	165 (97)	46 (94)	44 (81)	N/A

capturing early implementation and follow up.

Demographic information included age, gender, education, race/ethnicity, and income. For staff, additional questions included educational preparation in the field, employment tenure, previous experience, and current role. For consumers, additional questions included a screen for ADLs and information about their current living situation.

The Readiness to Implement Nurse Delegation Scale. This scale measures perceptions of readiness, including satisfaction with the proposed program, willingness to implement, perceived preparation and capability of the unlicensed staff to perform delegated tasks, and perceptions of outcomes: quality, access, cost, and safety. The tool is answered using a Likert scale ranging from 1 (*very positive*) to 5 (*very negative*) with anchors worded to relate to the question (*very willing*, *very prepared*). Versions were developed to assess perspectives from multiple parties (i.e., RN, aide, consumer, and administrator). This is a well-established instrument, modified from previous work evaluating nurs delegation (Sikma & Young, 2003). Cronbach's alpha for the scale in th current sample was 0.93. Descriptiv statistics included mean and standar deviation for each item by informa group, and normative average score

across informants were calculated by summing the items and dividing by the total number. Paired *t* tests examined differences between Time 1 and Time 2, and independent two-tailed *t* tests examined differences between nurses with and without experience delegating.

In addition to the scale items, the survey included several open-ended questions to identify perceived concerns, benefits, and effects of delegation. Content analysis was used to summarize the open-ended questions from the survey (Krippendorff, 2004).

Focused Interviews, Observations, and Document Review. Semistructured focused interviews elicited data about understanding of nurse delegation, experiences, perceptions regarding quality of care and risk for consumers, and general satisfaction with nurse delegation from multiple perspectives (e.g., consumer, nurse, aide, administrator) around the same instance of delegated task. Interviewing all involved in nurse delegation around a selected task allows explorations of multiple perspectives on the same task and situation. The interviewer used structured interview guides to ensure that the same set of questions was asked for each category of participant. Interviews were conducted in private at the location of the participant's choice, audiorecorded, and transcribed. Observation field notes and meeting minutes throughout the study period were collected and included in the qualitative data set.

Data Analysis

Data were analyzed using constant comparative analysis, a useful approach for organizational and policy-related research (Strauss & Corbin, 1998). Theoretical sampling drove sampling decisions to include incidents of nurse delegation, region, and agency type. Constant comparative analysis incorporated multiple data sources (e.g., transcribed interviews, field notes) and systematic guidelines for coding the data from simple codes to relational codes. Data were entered into NVivo software (version 9.0) to facilitate text analysis. More than 400 initial codes were generated; ideas were categorized and organized to determine common themes and relationships among ideas. Contributing factors or results of a given idea category were identified. The results of the focused interviews were reported in the form of the major themes and relationships that were evident.

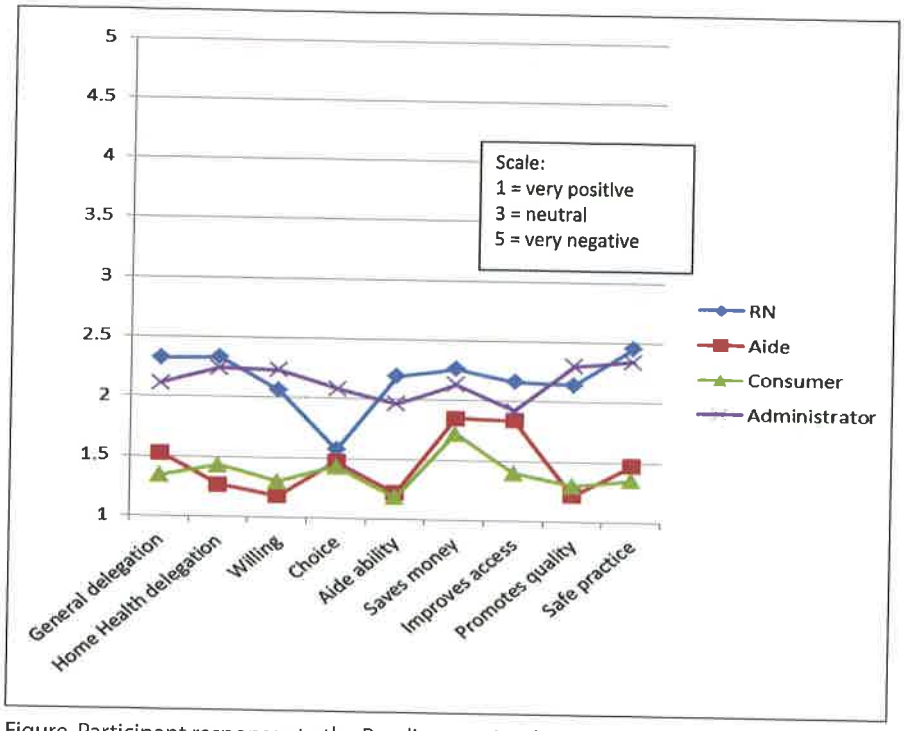

Figure. Participant responses to the Readiness to Implement Nurse Delegation Scale. Note. Scale responses range from 1 = *very positive* to 5 = *very negative*.

RESULTS

Survey Responses

A total of 323 respondents participated in the survey: 44 consumers or their caregivers, 49 aides, 54 administrators/policymakers (17 provider administrators and 37 state administrators/policy makers), and 176 nurses. All groups were positive about delegation on all items in the Readiness to Implement Nurse Delegation Scale, with responses ranging from 1.22 to 2.45 on a 5-point scale, with 1 representing *very positive* and 3 representing *neutral*. As can be seen in the **Figure**, although all stakeholders were positive, aides and consumers were more positive about nurse delegation and their confidence in its implementation and outcomes than RNs and administrators. Overall mean normalized scale scores demonstrated a pattern of consumers and aides being the most enthusiastic about nurse delegation as a care option: RN = 2.16 (*SD* = 0.61), administrator = 2.11 (*SD* = 0.6), aide = 1.44 (*SD* = 0.45), and consumer = 1.37 (*SD* = 0.39).

In the follow-up survey of nurses, perceptions were significantly more positive for general satisfaction with nurse delegation, confidence in the ability of aides to perform the tasks, improving quality, and safety of nurse delegation (**Table 2**). Fifty-two of 95 nurses who responded to the follow-up survey reported that they had actually delegated tasks. There were no significant differences between delegating and nondelegating nurses

TABLE 2

COMPARISON OF RN RESPONSES TO THE READINESS TO IMPLEMENT THE NURSE DELEGATION SCALE PRE- AND POST-IMPLEMENTATION

	Time 1	Time 2		
Scale Item	**All RNs (*N* = 95)**	**All RNs (*N* = 95)**	**Experience With Delegating (*n* = 52)**	**No Experience With Delegating (*n* = 38)**
In general, what do you think of nurse delegation?	2.34 (0.86)	1.97 (0.96)**	1.63 (0.69)	2.39 (1.0)†
What do you think of nurse delegation for you/your clients?	2.33 (0.80)	1.98 (1.1)**	1.63 (0.79)	2.46 (1.1)†
How willing are you to allow delegation?	2.06 (0.90)	1.93 (0.99)	1.65 (0.68)	2.34 (1.2)†
Do you have choice in deciding about delegation?	1.57 (0.78)	1.44 (0.78)	1.37 (0.66)	1.61 (0.95)
How capable do you believe aides are of doing the delegated tasks after proper training?	2.19 (0.88)	1.93 (0.93)*	1.62 (0.69)	2.37 (1.1)†
Nurse delegation saves money.	2.26 (0.96)	2.19 (1.2)	2.06 (1.1)	2.39 (1.3)
Nurse delegation improves access for consumers.	2.16 (0.83)	2.00 (1.1)	1.88 (0.94)	2.24 (1.2)
Nurse delegation promotes quality of care and services.	2.14 (0.94)	1.84 (1)*	1.56 (0.73)	2.3 (1.2)†
Nurse delegation is a safe practice.	2.45 (0.94)	2.08 (1.1)**	1.72 (0.81)	2.58 (1.2)†

Note. Scale responses range from 1 = very positive *to 5 =* very negative. *Comparison between RNs at Time 1 and 2: Paired* t *tests,* *p < 0.05; **p < 0.01; ***p < 0.001. *Comparison between RNs with experience delegating versus RNs with no experience delegating at Time 2: Independent* t *tests,* †p < 0.001.

in terms of reported caseloads, y
of home care experience, educat
or experience as a nursing assist
However, those who had experi
with delegation had a significant
more positive response regard-
ing their general satisfaction wit
delegation, willingness to delega
confidence in the capability of a
and perceptions of quality and
safety (**Table 2**).

In response to open-ended questions, most commonly offe
concerns related to quality/safet
and program operations. Most f
quently identified benefits inclu
improved quality, lower cost, an
improved access to care. Consu
identified personal benefits of n
delegation, including greater tim
ness of medication administratio
and treatments, family respite, p
of mind, improved health, and n
independence.

Interviews and Observations

Cases from seven agencies we
included in semistructured inter
views and involved seven aides,
nurses, two consumers, three fa
members/caregivers, and the pr
gram manager. Two cases were f
nonprofit and five from for-prof
agencies, with at least one case fi
each region of the state. Consun
at the center of the cases ranged
age from mid-20s to approximat
90, were mostly women, and ha
multiple chronic health conditio
including diabetes, chronic ob-
structive pulmonary disease, hea
disease, seizure disorders, and se
brain damage. Delegated tasks
included medication administrat
(i.e., oral, suppository, topical, i
jectable, and through a feeding t
as well as glucometer readings, c
eterization, and wound care. On
consumer was previously a nurs
home resident and three consum
ers did not have informal suppo
systems. Task delegation was at
the discretion of the nurses. Task
reported in the focused intervie
included: medication administra

TABLE 3

MAJOR THEMES FROM FOCUSED INTERVIEWS

Theme	Most Prevalent Ideas
How care was delivered before nurse delegation	• Family meeting demand • Family struggling to balance care with employment (i.e., having to leave work during the day to give medications) • Clients waiting for care or taking medications at times other than ordered due to family availability • Aides providing care out of their scope, including catheterization, medication administration, and blood glucose tests
Facilitating factors	• Marketing in nursing homes to case managers • Board of Nursing waivers, delegating algorithm, and protocol to determine client eligibility • Communication among family members, consumers, nurses, and aides • Adequate identification and training of aides • Sense of pride in ability to deliver the care (aides)
Barriers/concerns	• Availability of qualified and motivated aides • Managing the requirement of one-nurse-one-aide-one-client in the case of unexpected coverage needs • Willingness to support the program among a few nurses due to liability concerns or reluctance related to workload • Time involved in orientation and documentation • Logistical issues in nursing home discharge, such as housing • Reluctance of nursing homes to discharge due to census • Developing new communication norms with the new role • No additional compensation for nurses or aides • Sustainability of the program
Recommendations	• Formalize role of state program manager to assure quality in implementation • Changes in Nurse Practice Act to allow delegation of medication administration and nursing tasks in home health agencies • Payment codes for teaching and supervising aides • Communication with nursing homes to identify clients who could be discharged home with delegation • Compensation for aides • Develop a pool/team of delegating nurses and qualified aides • Reduce paperwork • Teaching tools for nurses to use

blood glucose testing, tube feedings, nebulizer treatments, insulin injection, wound care, and straight catheterization. The most common was medication administration. Aides provided family support by supplementing the care provided by family members. In addition, investigators attended meetings and reviewed meeting minutes reflecting state and agency discussions during the period of implementation.

Results include feedback about the program and overall impressions of its impact for consumers. **Table 3** summarizes how care was delivered before nurse delegation, facilitating factors, barriers, and recommendations.

Overall Impressions

Overall, participants were highly satisfied with the program. Many nurses commented that aides should be able to do what family members have been doing, sharing the responsibility of care with the family. Nurses stated they were supportive of the program continuing, as expressed by one nurse:

> The nurse delegation project prevents a lot of visits to the ER [emergency room], a lot of hospitalizations, a lot of people having to end up in institutions where their needs aren't fully met. This allows them to stay home where they feel more comfortable, where they can still remain independent in their own homes... surrounded by the people and things they love.

Aides were eager to learn and comfortable performing the tasks they were delegated. Some liked having the additional responsibility and being able to better assist with their clients' well-being. Although some expected more compensation for additional responsibility, most did not.

One aide described her experience:

> The nurse was great because she came here; she said, "I'll come every day as long as you need me to come." So they showed me everything one step at a time...she was right here

every day probably like 9 to 10 days straight she came here to make sure I felt confident.

Consumers were very satisfied with the care they received, as one stated in her interview:

> Through the nurse delegation program, I could get care daily. It worked to my advantage because it kept me out of the hospital. It prevented more infection from happening and it saved my foot...their care and compassion was just more helpful than I got from community hospital. It helped me mentally and physically.

Family members of consumers also expressed high satisfaction with the program. The father of a consumer needing tube feedings and medication administration stated:

> Having somebody like her aide, it takes a weight off of you, the caregiver. I can do what I want to do for a few hours, which I didn't have before because the aides would come to do all that but I had to be here to feed her.

Culture Change

Participants described initial reluctance about the program among their peers, and commented that the program represents a change in culture. A few nurses in the orientation program were initially not supportive of the idea of delegation, but the trainers observed that after training, the views of these nurses changed and they were able to identify that some of their clients might benefit from the program. One nurse stated:

> I think that the promise of increasing people not to be in institutions is really, really exciting. Because we see with the geriatric population so many are put in institutions simply because they can't do their medications anymore, such a simple thing.

DISCUSSION

No adverse outcomes to clients were identified in the course of the study, nor any cases in which participants were forced to partake in delegation, supporting the safety of the program. The voluntary nature of the program and ability of nurses to choose when and to whom they delegate are important. As with any new program, multiple stakeholders require information about the program, its potential benefits, and how issues would be addressed.

Consumers reported better quality of life and positive effects on their health, and caregivers experienced increased peace of mind and respite.

The pattern of responses to the readiness survey was similar to previous studies in Washington State (Sikma & Young, 2003), where consumers and aides were the most positive about the pilot, and nurses and administrators initially were less positive. However, with experience delegating, nurses demonstrated significant change toward a more positive evaluation of the program. Fears about liability and lack of confidence abate once nurses implement the program and see the positive results for clients. This program depends on a ready and willing workforce, suggesting that recruitment and retention of qualified nurses and aides is an important focus for home health agencies implementing this program.

All groups participating (i.e., nurses, aides, consumers, and administrators/policymakers) expressed satisfaction with delegation as proposed and implemented. Consumers reported better quality of life and positive effects on their health, and caregivers experienced increased peace of mind and respit Being cared for at home made the client feel independent and comfor able.

In approximately one of five cases, the delegated task was not performed at all prior to the implementation of delegation, and in other cases, consumers or their families were having trouble completing the tasks on a regular basis. In some cases, it was reporte that aides were already performing tasks prior to the implementation of delegation. This nondelegated task performance is consistent wit earlier research, which found that nurse delegation brought nursing supervision to "underground" practices (Sikma & Young, 2001). The current study supported the a sertion that delegation offers timel consistent, quality delivery of care at home, providing a mechanism for clients to leave or avert nursing homes, and a means to augment an support family caregivers.

SUBSEQUENT POLICY CHANG

Upon completion of the pilot, t state agencies reviewed the results this evaluation in conjunction with the final report from the New Jers Division of Disability Services (Mc Dermott, 2011) and with an independent review of the costs of the program conducted by Mathemati Policy Research and funded by the Assistant Secretary for Planning ar Evaluation in the U.S. Department of Health and Human Services. Th independent review examined Med icaid claims data and found that th cost of nurse delegation per benefi ciary year was slightly less than th cost of 4 days in a nursing facility (approximately $550 in 2010), and found no evidence of adverse events (Dale & Brown, 2010). The determined that the NJBON shou amend their regulations to permit nurses to use their discretion to delegate tasks, including medicatio administration. This amendment was essentially a return to the nurs

ing policy established in the early 1990s, but with more clarity for nurses, employers, and regulators. That clarity is essential for further policy, program, and payment developments to support consumer demand for independence, dignity, and choice in long-term care.

After several hearings and public comment, the new NJBON (2016) regulations were adopted in early 2016. The evidence from the current study was a critical factor in achieving this policy change. Plans are underway for establishing methods to educate nurses and employers to understand the new rules.

New Jersey is at the forefront of creating policies to optimize home care. As consumer demand increases for home-based services and cost pressures drive higher value in long-term care, such advances are likely to be adopted more widely across the nation. This offers an opportunity for nurses to elevate their practice to serve older adults within new models of care, in collaboration with unlicensed colleagues, and achieve the goals outlined in the IOM (2008) report on caring for older Americans. Gerontological nurses can play a vital role at the state level in advocating for care delivery policies that support the values and preferences of older adults.

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