**Instructions**

**for**

**Skilled Nursing Services**

**and**

**Skilled Nursing Services requiring “Under the Direction of”**

**Skilled Nursing Services must be provided by:**

* **NYS Licensed Registered Nurse** qualified in accordance with the requirements at 42 CFR 440.60(a) and other applicable state and federal laws and regulations acting within his or her scope of practice.
* **NYS Licensed Practical Nurse** qualified in accordance with 42 CFR 440.60(a) and

other applicable state and federal law or regulations acting within his or her scope of practice **“under the direction of”** a **Licensed Registered Nurse,** a **Physician,** or other licensed health care provider authorized under the Nurse Practice Act.

**A.** Please attach a copy of the prescription and detailed treatment plan to your first months

report. All skilled nursing services must be provided in accordance with the Nurse

Practice Act. Providers must request a new prescription each year.

**Services are NOT to be provided without a prescription.**

**B. Skilled nursing services** may include health assessments, medical treatments

and procedures, administering and/or monitoring medication needed by the child

during school hours and consultation with licensed physicians and parents regarding

the effects of medication.

**C. An individualized Health Care Plan** should be maintained, when appropriate, for the student receiving the Nursing Services signed by a Registered Nurse (RN). Nursing

notes should be prepared in accordance with the Nurse Practice Act.

Medication/treatment log must be maintained and signed by Nurse providing services.

* Health History must be on file
* Medication Log must be maintained
* Written protocols for each procedure should be available when appropriate
* Recorded documentation of Nursing services delivered, and dates of service signed and dated by RN

**D. “Under the Direction of”** means that the **Licensed Registered Nurse, Physician** or

other **Licensed Health Care Provider** authorized under the Nurse Practice Act sees the child at the beginning of and periodically during the course of treatment.

* The Supervising RN must co-sign all Nursing reports, daily treatment logs and quarterly progress notes. In accordance with 42CFR 440.110(b) and applicable state and federal laws and regulations.
* The **Supervisor** ensures that the **LPN** working under his or her direction has contact information to permit him or her direct contact with the **Supervisor** as necessary during course of treatment and keeps supporting documentation.

* The **Supervisor** is familiar with the treatment plan as recommended by the referring Physician or other Licensed Practitioner practicing under state law.
* The **Supervisor** has continued involvement in the care provided and reviews the need for continued services throughout treatment.
* The **Supervisor** assumes professional responsibility for the services provided under his or her direction and spends as much time as necessary directly supervising services to ensure child is receiving services in a safe and efficient manner in accordance with accepted standards of practice and maintains documentation supporting the supervision of services and ongoing involvement in treatment.
* The **Supervisor** must complete a Certification of “Under the Direction of”

(UDO) for each LPN being supervised. An “Under the Direction of” (UDO) Log

must be used to record direct supervision of the LPN. Note that it is child specific

and must be prepared for each child. Keep all written documentation of such

supervision, including Certification and UDO Log. (See attached sample form

and instructions.)

**CERTIFICATION**

**OF**

**SKILLED NURSING SERVICES**

## UNDER THE DIRECTION AND ACCESSIBILITY

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, **Licensed Registered Nurse (RN)**, with current license number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ certify that I am providing "Under the Direction of" services to the following Licensed Practical Nurse (LPN) for the \_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_ school year:

**Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

#### Name of LPN License # and NPI #

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I am providing accessibility to the Licensed Practical Nurse in the following manner:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I will keep the appropriate records documenting that the **"Under the Direction of”** activities have occurred (i.e. telephone logs, minutes of meetings, minutes of observations, **initial and subsequent periodic face to face contacts with each student,** **etc**.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

# Signature of Supervisor and Title Date

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Skilled Nursing Services "Under the Direction of" LOG** | | | | |
|  |  |  |  |  |
| CHILD NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | SCHOOL YEAR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
|  |  |  |  |  |
| SKILLED NURSING SERVICES MANDATED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |  |
|  |  |  |  |  |
| ASSIGNED LPN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LICENSE # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
|  |  |  |  |  |
| SUPERVISOR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TITLE & LICENSE # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
|  |  |  |  |  |
| ACTIVITY | Meeting Date | Type of Meeting (Group, Individual, Telephone, Etc.) | Services / Evaluation Recommended | SUPERVISOR SIGNATURE |
| IEP REVIEW |  |  |  |  |
| *INITIAL OBSERVATION - Face to Face with Child* |  |  |  |  |
| FIRST QTR REVIEW |  |  |  |  |
| Meeting |  |  |  |  |
| Meeting |  |  |  |  |
| Meeting |  |  |  |  |
| *2nd OBSERVATION - Face to Face with Child* |  |  |  |  |
| SECOND QTR REVIEW |  |  |  |  |
| Meeting |  |  |  |  |
| Meeting |  |  |  |  |
| Meeting |  |  |  |  |
| *3rd OBSERVATION - Face to Face with Child* |  |  |  |  |
| THIRD QTR REVIEW |  |  |  |  |
| Meeting |  |  |  |  |
| Meeting |  |  |  |  |
| Meeting |  |  |  |  |
| *4th OBSERVATION - Face to Face with Child* |  |  |  |  |
| FOURTH QTR REVIEW |  |  |  |  |
| Meeting |  |  |  |  |
| Meeting |  |  |  |  |
| Meeting |  |  |  |  |
| **NOTE:** The Supervisor **MUST** provide an initial (within first 2 weeks) and subsequent periodic face to face contact for each student being serviced by an **LPN** "under the direction of". The Supervisor **MUST** have on file the manner in which he/she has provided supervision to the **LPN** for each child being serviced. | | | | |