Nurse Delegation (ND) Contract Monitoring Chart Audit

Program Manager Use Only

NAME OF REGISTERED NURSE DELEGATE (RND)	PROVIDER ID NUMBER	CLIENT'S NAME

ND START DATE	D/C OF ND (DATE)	NUMBER LTCW DELEGATED	ADULT FAMILY HOME NAME
			SUPPORTED LIVING AGENCY NAME

TASK(S) DELEGATED

A. Referral Process	Yes	No	N/A	Term Care Manual / Contract
1. Provide Pages 1 and 2 of the Referral and Communications forms (DSHS 01-212)	☐	☐	☐	
2. Provide Consent for Delegation Process form (DSHS 13-678 Page 1)	☐	☐	☐	
3. Provide HCS / AAA Nursing Services Referral form (DSHS 13-776)	☐	☐	☐	
4. Documentation of how and when referral made	☐	☐	☐	
5. SOP assessment within 48 hours of referral	☐	☐	☐	
B. RND Assessment of Client				**WAC 246-840-930(12)(h)(i)(j)**
1. Initial physical / systems assessment documented and provided	☐	☐	☐	
2. Assessment completed within three working days of referral	☐	☐	☐	
3. SOP documentation returned to Case Manager	☐	☐	☐	
C. Delegation Process / Consent				**WAC 246-840-930(10)(b)**
1. Evidence of timely consent to delegation process? Date – verbal: _____ Date – written / electronic: _____	☐	☐	☐	
2. Evidence of RND communication with collateral contacts (C/RM/SW, MD, PA, etc.)	☐	☐	☐	
D. Long Term Care Workers Credentials / Training (Sample)				**WAC 246-840-930(8) and WAC 246-841-405(2)(a)(d)**
1. Registered Nurse License current and without restriction	☐	☐	☐	
2. Completed Credentials and Training Verification form (DSHS 10-217) for each LTCW	☐	☐	☐	
E. Instructions for ND Task				**WAC 246-840-930(12)(13)**
1. Instructions for Nursing Task form (DSHS 13-678 Page 2) showing step by step instructions for performing each task	☐	☐	☐	
2. Specific parameters for giving PRN medication located on form DSHS 13-678 Page 2	☐	☐	☐	
3. List specific side effects, unexpected outcome, or changes and when to notify RND, physician, or emergency services	☐	☐	☐	
4. Change in Medical / Treatment Orders form (DSHS 13-681)	☐	☐	☐	

F. Supervision and Client Changes				WAC 246-840-930(18,19) and WAC 246-840-950(1)(a) / Contract
1. Provide all completed Nursing Visit forms (DSHS 14-484)	☐	☐	☐	
2. Client assessment documented at least every 90 days?	☐	☐	☐	
3. If insulin delegated must have four (4) visits documented seven (7) day intervals	☐	☐	☐	
4. Documentation of how medication(s) verified and documented (if delegating meds)?	☐	☐	☐	
5. Listing of documented medication on an approved PRN Medication form (DSHS 13-678A)	☐	☐	☐	
G. Assume / Rescind RN Delegation Duties				**WAC 246-840-960(3)**
1. Assumption of Delegation form (DSHS 13-678B) for this client?	☐	☐	☐	
2. Rescinding Delegation form (DSHS 13-680) date documented?	☐	☐	☐	
3. Case / Resource Manager notified of assumption / rescinding	☐	☐	☐	
H. Billing / Administrative				**Provider One Requirements**
1. Records justify time billed in RND tracking?	☐	☐	☐	
2. Request for Additional Units form (DSHS 13-893) submitted greater than100 units in the month?	☐	☐	☐	
I. Caregiver Interview: Provide contact information where LTCW or AFH Provider or House Manager can be reached (for example, Client home)				
1. Has your Registered Nurse Delegator been to the client's home within the last 90 days?	☐	☐	☐	
2. Can the Registered Nurse Delegator be reached easily when there are questions and/or concerns with the delegated tasks?	☐	☐	☐	
REVIEWED BY: PRINTED NAME	TITLE			DATE

Changes are required for all "NO" answers.

RND Response (RND to sign, date and return with this section completed).

1) Indicate the changes you will incorporate into your future ND practice for all NO answers. Attach additional sheets to this form when returned. If you already have documents that support changing a NO answer to a YES, please submit.

RND SIGNATURE | DATE | PRINTED NAME

2) Please mail your response to the Nurse Delegation Program Manager at PO Box 45600, Olympia WA 98504-5600.

3) You will receive a final notice within 30 working days that the ND Program Managers have accepted your changes.

ND PM Response to RND

☐ We have reviewed and accepted your changes.

☐ Additional action is necessary, which may include further training, technical assistance or corrective action. The specific action required is outlined in the attached letter.

NDPM SIGNATURE | DATE | PRINTED NAME