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| Transforming Lives | AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  HOME AND COMMUNITY SERVICES (HCS)  **Private Duty Nursing Contract Monitoring Tool** | | | | | |
| **Purpose**: This tool is intended to aid in the contract monitoring process but is not the only means of contract monitoring performed for the Private Duty Nursing Program.  **Process:** Each PDN contract will be monitored using this tool on a yearly basis. One client file will be selected at random to be monitored. If contract monitoring results are not met, the PDN program manager may choose to review other client files. Contract monitoring results will be recorded and reviewed for yearly trends. to year trends will aid in determining the risk level at which your contract is monitored. If a contractor consistently does not meet contract requirements, their contract could be at risk for termination.  **Monitoring References:** Each measure is followed by a reference. Each measure is based on contract requirements found in the General Terms and Conditions (GTC) or Special Terms and Conditions (STC) of the PDN contract. Some measures are also referenced with the corresponding Washington Administrative Code (WAC). | | | | | | |
| NAME OF PDN / CONTRACTED AGENCY | | | | | | PROVIDER ID NUMBER |
| CLIENT’S NAME | | CONTRACT NUMBER | | | CONTRACT START DATE | CONTRACT END DATE |
| **A. Contact Information** | | **Met** | **Not Met** | **N/A** | **Comments** | |
| 1. Current address on file – STC 2a | |  |  |  |  | |
| 1. Current phone number on file – STC 2a | |  |  |  |  | |
| **B. Licensure** | | **Met** | **Not Met** | **N/A** | **Comments** | |
| 1. Current RN / LPN license and without restriction – STC 2b(1) | |  |  |  |  | |
| 1. LPNs have RN oversight letter on file – STC 2b(2) | |  |  |  |  | |
| 1. Proof of current business license – STC 2a | |  |  |  |  | |
| 1. Current background check every two years – STC14 | |  |  |  |  | |
| 1. Nurse does not exceed 16 hours in a single day –STC3h | |  |  |  |  | |
| **C. Insurance Coverage** | | **Met** | **Not Met** | **N/A** | **Comments** | |
| 1. Proof of industrial insurance coverage – GTC 22 | |  |  |  |  | |
| 1. Proof that general liability insurance was maintained with each occurrence $1million; General aggregate $2million or supplemental liability insurance or workplace liability insurance if contractor has less than three contracts – STC 20a | |  |  |  |  | |
| 1. Proof that professional liability insurance or errors and omissions insurance was maintained – STC 20e | |  |  |  |  | |
| 1. Insurance carrier is a State of WA carrier and has a rating of B++, Class VII or better. Surplus lines insurance companies will have A - STC 20g | |  |  |  |  | |
| **D. Client Documentation** | | **Met** | **Not Met** | **N/A** | **Comments** | |
| 1. Care plan signed by PCP and submitted to Care Manager and updated at least every six months – STC 3a | |  |  |  |  | |
| 1. CARE assessment found on client file and updated at least every six months – STC 3d | |  |  |  |  | |
| 1. Skilled Nursing Task Log is found on file and updated at least every six months – STC 3f, WAC 388-106-1040(10) | |  |  |  |  | |
| 1. Limited English Proficiency, deaf, deaf-blind or hard of hearing clients have access to certified interpreter – STC 8a, STC 8b | |  |  |  |  | |
| 1. Significant change in client’s condition are reported to case manager within 24 hours – STC 10 | |  |  |  |  | |
| 1. Verbal communication of clients death was reported within one hour upon notification of death and written communication follow up within one business day of death – STC 11 | |  |  |  |  | |
| 1. Sufficient disaster response plan in place that covers the type of individuals that are being cared for – STC 6 | |  |  |  |  | |
| **Contract Monitoring Results**  Number of requirements NOT MET: Number of requirements MET: | | | | | | |
| SIGNATURE OF INDIVIDUAL COMPLETING MONITORING TOOL DATE PRINTED NAME | | | | | | |
| **PDN Response** (PDN to sign, date, and return with this section completed)   1. Attach additional sheets to this form that indicate the changes you will incorporate into your future PDN practice for all areas marked “Not Met.” If you have documents that support changing a “Not Met” to a “Met”, please submit. | | | | | | |
| PDN’S SIGNATURE DATE PRINTED NAME | | | | | | |
| 1. Please mail this signed form and any supporting documentation to the Private Duty Nursing Program Manager at: PO Box 45600, Olympia WA 98504-5600. 2. You will receive a final notice within 30 business days that the PDN Program Manager has accepted your changes. | | | | | | |
| **PDN PM Response to PDN**  Reviewed additional documentation and/or proposed practice changes and changes are accepted.  Additional action is necessary, which may include further training, technical assistance or corrective action. The specific action required is outlined in the attached letter. | | | | | | |
| PDN SIGNATURE DATE PRINTED NAME | | | | | | |