Transforming Lives

Understanding Community Based Nurse Delegation 2019

Presented by: Nurse Delegation Program Managers

Welcome

- House keeping notes…
- Introductions
- Thank you for coming

Agenda

- History of Nurse Delegation
- ND and the Nursing Process
- Forms and Documentation
- Contracting with DSHS
- Billing
- Responsibilities
- Program Evaluation

Nurse Delegation Program Managers

Nurses who contract with Aging and Long Term Supports Administers (ALTSA) are supported by:

HCS

Marlo Moss RN

360-725-2450

mossm@dshs.wa.gov

DDA

Doris Barret, RN

360-407-1504

barreda@dshs.wa.gov


START

Purpose

This training is:

- Required for all Registered Nurses (RN's) who would like to contract with DSHS and be paid for Nurse Delegation services
- Offered for RN's who wish to delegate in other circumstances
- Intended to clarify rules for community based Nurse Delegation

Today's training is not a certification course

Important to Know

Attendees will earn seven (7) contact hours of continued education hours:

- To receive full credit for the course
  - The attendee must:
    - Sign the attendance sheet
    - Stay for the entire training
    - Complete the evaluation form

Knowledge Check

Pre-Work

1. What do you know about Community Based Nurse Delegation?

2. What do you hope to take away from today?

3. Parking Lot questions.

Did You Know?

Common confusion…

Community Based Nurse Delegation- Describes certain nursing tasks which can be taught to long term care workers under a certain set of rules and circumstances.

The rules apply only to community-based settings.

The rules for Community Based Nurse Delegation are defined within the Nurse Practice Act

Accountability:

- RN is responsible for delegating the nursing task
- LTCW is responsible for performing the nursing task as instructed
  - Based on written instructions

WAC 246-840-910 thru 970

Laws & Rules

What laws and rules govern the program?

Revised Code of Washington (RCW) is the law of Washington State

18.79A.260(3)(e)

Washington Administrative Code (WAC) are the rules of Washington State

246-840-910 thru 970

Nurse Delegation Impact

Give me the facts!

- The Nurse Delegation program serves approximately 8,600 clients
- The average cost is $186 per month/client

What do you think is the average cost for a Skilled Nursing Facility per month?

Who's Involved

Who's involved with community based nurse delegation

- Client
- Long Term Care Worker (LTCW)
- Registered Nurse (RN)
- Case Manager (CM)/ Case Resource Manager (CRM-DDA)
- Program Manager (PM)

Long Term Care Worker Types

Nursing Assistant-Registered (NAR)	Home Care Aide-Certified (HCA-C)	Nursing Assistant-Certified (NAC)
		
• Registered through DOH • $65 registration fee to DOH • Take 7 hour HIV/AIDS course • No CE requirement • Must be renewed annually on birthday	• Completes 75 hours of training • Certified through DOH • $85 application fee to DOH • Take 4 hour HIV/AIDS course • 12 hours of CE due each year • Must be renewed annual on birthday	• Completes 85 hours of training (7 hour HIV/AIDS included) • Certified through DOH • $65 application fee to DOH • No CE requirements • Must be renewed annual on birthday

Key Takeaways

Purpose of Nurse Delegation rules

- Rules create a consistent standard of practice
- Support the authority of the RN to make independent and professional decisions
- Enhance client choices
- Protect the public in community-based and in-home settings

Program Description

The RN will:

- Assess a client to determine stability and predictability
- Teach the long term care work the nursing task
- Evaluate the performance of the long term care worker
- Provide ongoing supervision of the client's condition
- Provide ongoing supervision and evaluation of the long term care workers performance of the nursing task

Client Type

Who do the rules apply to?

- Clients receiving services in their private homes
- Clients receiving services in Community Residential Settings (SL, GTH, CH)
- Clients receiving services in Adult Family Homes (AFH)
- Clients receiving services in Assisted Living Facilities (ALF)
  - *Formerly known as Boarding Homes*

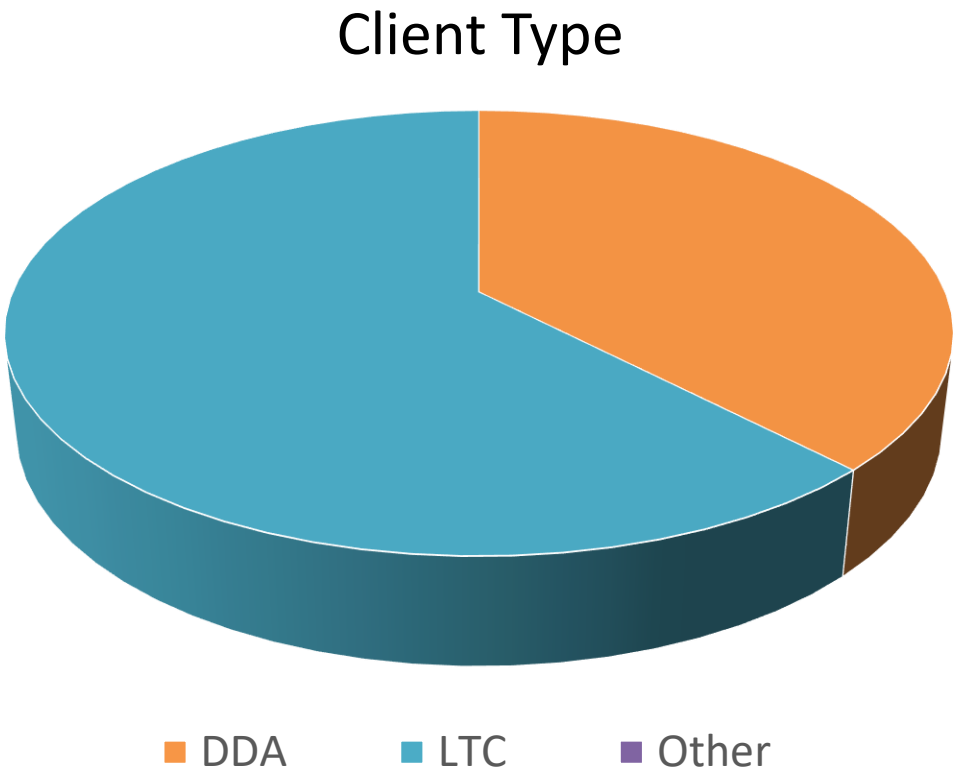
Nurse Delegation History

1996-97	• **Nurse Delegation Rules established through DOH**
	• **Task list created**
	• **Three settings identified**
	  • **Assisted Living (AL)**
	  • **Adult Family Home (AFH)**
	  • **Supported Living (SL)**

2000	• Task list eliminated • In home setting added to approved settings
2009	• Law change to include insulin injects and blood glucose monitoring as delegatable tasks • Prohibited list created
2017	• Rule clarification to include non-insulin injections, used to treat DM as delegatable tasks • Examples include: Byetta, Victoza, Toujeo

2018	• Collaborate with Nursing Commission and stakeholders to expand nurse delegation services:
	  • INR testing
	  • Other subcutaneous injects
	  • Define nurses role in medical marijuana “administration”
	  • Epinephrine injections

Nurse Delegation



The Targeted Population

Who are long term care (LTC) clients?

- Client 18 years or older
- Often times referred to as “aging” clients
- Live in a community- based setting
- Have case managers who work for Home and Community Services (HCS) or an Area Agency on Aging (AAA) office.

The Targeted Population Cont.

Who are developmental disability (DD) clients?

- Diagnosed prior to the age of 18
- May be an adult or child
- Referred to as “developmentally disabled”
- Live in a community-based setting
- Have case resource managers through Developmentally Disabled Administration (DDA)
- Referrals managed through a regional nurse delegation coordinator

Nurse Delegation

DDA Coordinators:

Region	Name	Phone number	Email address
Region I	Gail Blegen-Frost	(509) 374-2124	blegegd@dshs.wa.gov
Region II South	Aaron Peterson	(253) 372-5850	PeterAN@dshs.wa.gov
Region II North	Claire Brown-Riker	(206) 568-5773	brownCA2@dshs.wa.gov
Region III	Brian Wood	(253) 725-4282	woodsbp@dshs.wa.gov

Different Populations

LTC clients	DDA clients
• Chronic conditions • Diabetes • Arthritis • Mental health diagnoses – Alzheimer's – Dementia • Congestive heart failure • Lung disease • Obesity	• Developmental Delays • Autism • Mood disorders • Bipolar • Major Depressive Disorder • Schizophrenia • Cerebral Palsy • Epilepsy or seizure disorders
WAC 388-106	*WAC 388-825*

Additional Variables

So what's the difference?

DDA client may have:

- Unique or complex medical needs
- Behaviors managed through a positive behavioral support plan (PBSP)
- Frequent medication changes
- High staff turn over

Skin Observation Protocol (SOP)

Specific protocol for DSHS clients

- Case manager will refer a client to you if:
  - Their annual CARE assessment triggers SOP
- RN must follow specific protocol to assess skin
  - Specific forms
  - Specific documentation criteria
    - Document on triggered referral
- Timeline must be followed without exception.

Skin Observation Protocol (SOP) Cont.

Skin Observation Protocol (SOP)

HCS	DDA
Referral sent by CM	Referral sent by CM
RN has 48 hours to accept or deny referral	RN has 48 hours to accept or deny referral
5 days to contact client, assess client, document clients skin assessment, and return documentation to the CM	5 days to contact client, assess client, document clients skin assessment, and return documentation to the CM
	If the client can not be assessed after two attempts or the client declines the assessment APS or CPS and the CM must be notified.

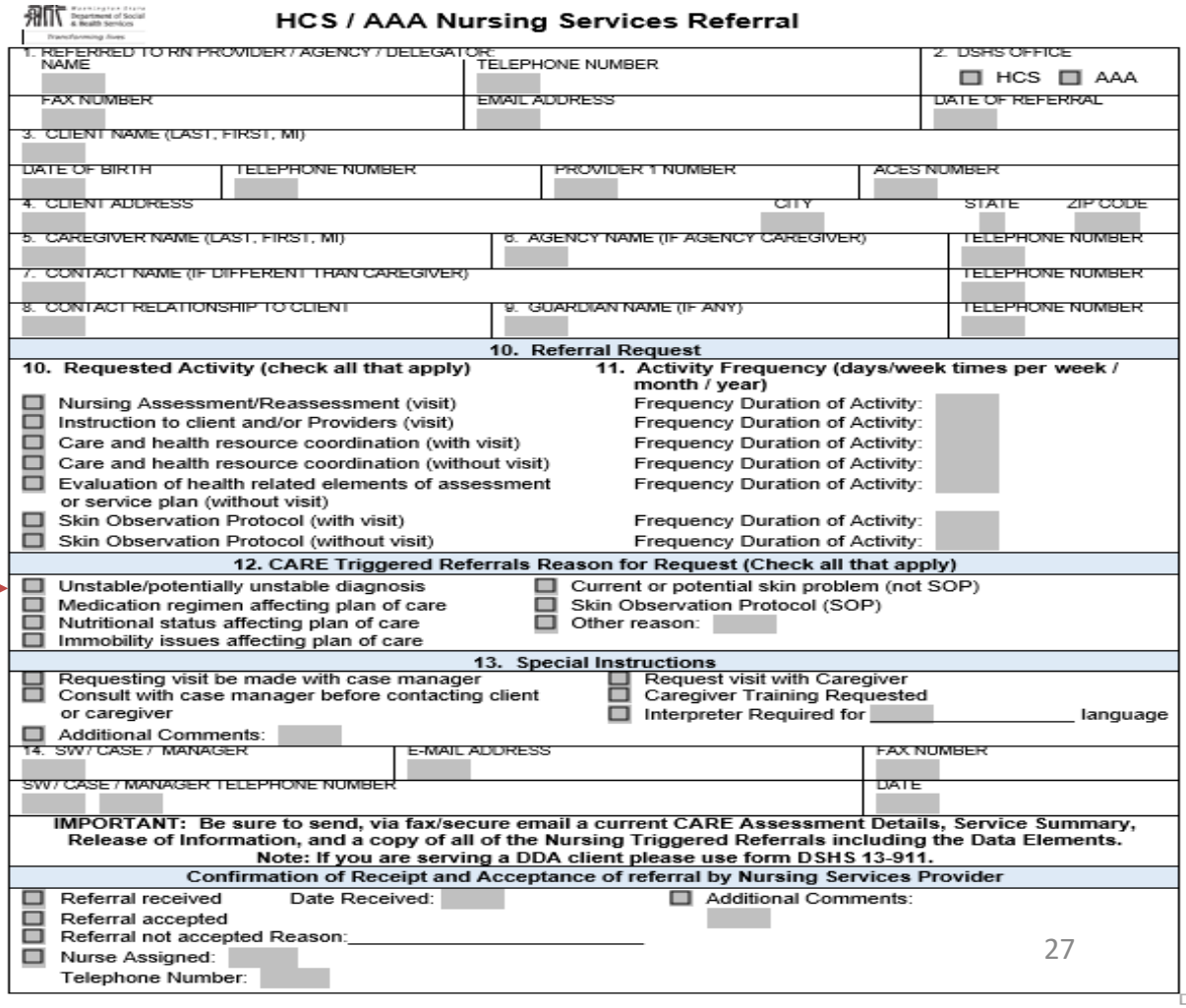
Skin Observation Protocol (SOP) cont.

Forms to be used when SOP is triggered:

- Nursing Service Referral:
  - HCS
  - DDA
- Basic Skin Assessment
- Pressure Ulcer Assessment
  - Only complete if there is a pressure injury
    - Complete a pressure ulcer assessment for each Pressure injury

HCS Nursing Service Referral Form

HCS Nursing Service Referral form (13-776)



HCS / AAA Nursing Services Referral

1. REFERRED TO RN PROVIDER / AGENCY / DELEGATOR: NAME | TELEPHONE NUMBER | 2. DSHS OFFICE ☐ HCS ☐ AAA
FAX NUMBER | EMAIL ADDRESS | DATE OF REFERRAL
3. CLIENT NAME (LAST, FIRST, MI)
DATE OF BIRTH | TELEPHONE NUMBER | PROVIDER 1 NUMBER | ACES NUMBER
4. CLIENT ADDRESS | CITY | STATE | ZIP CODE
5. CAREGIVER NAME (LAST, FIRST, MI) | 6. AGENCY NAME (IF AGENCY CAREGIVER) | TELEPHONE NUMBER
7. CONTACT NAME (IF DIFFERENT THAN CAREGIVER) | TELEPHONE NUMBER
8. CONTACT RELATIONSHIP TO CLIENT | 9. GUARDIAN NAME (IF ANY) | TELEPHONE NUMBER

10. Referral Request

10. Requested Activity (check all that apply)	11. Activity Frequency (days/week times per week / month / year)
☐ Nursing Assessment/Reassessment (visit)	Frequency Duration of Activity:
☐ Instruction to client and/or Providers (visit)	Frequency Duration of Activity:
☐ Care and health resource coordination (with visit)	Frequency Duration of Activity:
☐ Care and health resource coordination (without visit)	Frequency Duration of Activity:
☐ Evaluation of health related elements of assessment or service plan (without visit)	Frequency Duration of Activity:
☐ Skin Observation Protocol (with visit)	Frequency Duration of Activity:
☐ Skin Observation Protocol (without visit)	Frequency Duration of Activity:

12. CARE Triggered Referrals Reason for Request (Check all that apply)

☐ Unstable/potentially unstable diagnosis	☐ Current or potential skin problem (not SOP)
☐ Medication regimen affecting plan of care	☐ Skin Observation Protocol (SOP)
☐ Nutritional status affecting plan of care	☐ Other reason:
☐ Immobility issues affecting plan of care	

13. Special Instructions

☐ Requesting visit be made with case manager	☐ Request visit with Caregiver
☐ Consult with case manager before contacting client or caregiver	☐ Caregiver Training Requested
	☐ Interpreter Required for _____ language
☐ Additional Comments:	

14. SW / CASE / MANAGER | E-MAIL ADDRESS | FAX NUMBER
SW / CASE / MANAGER TELEPHONE NUMBER | DATE

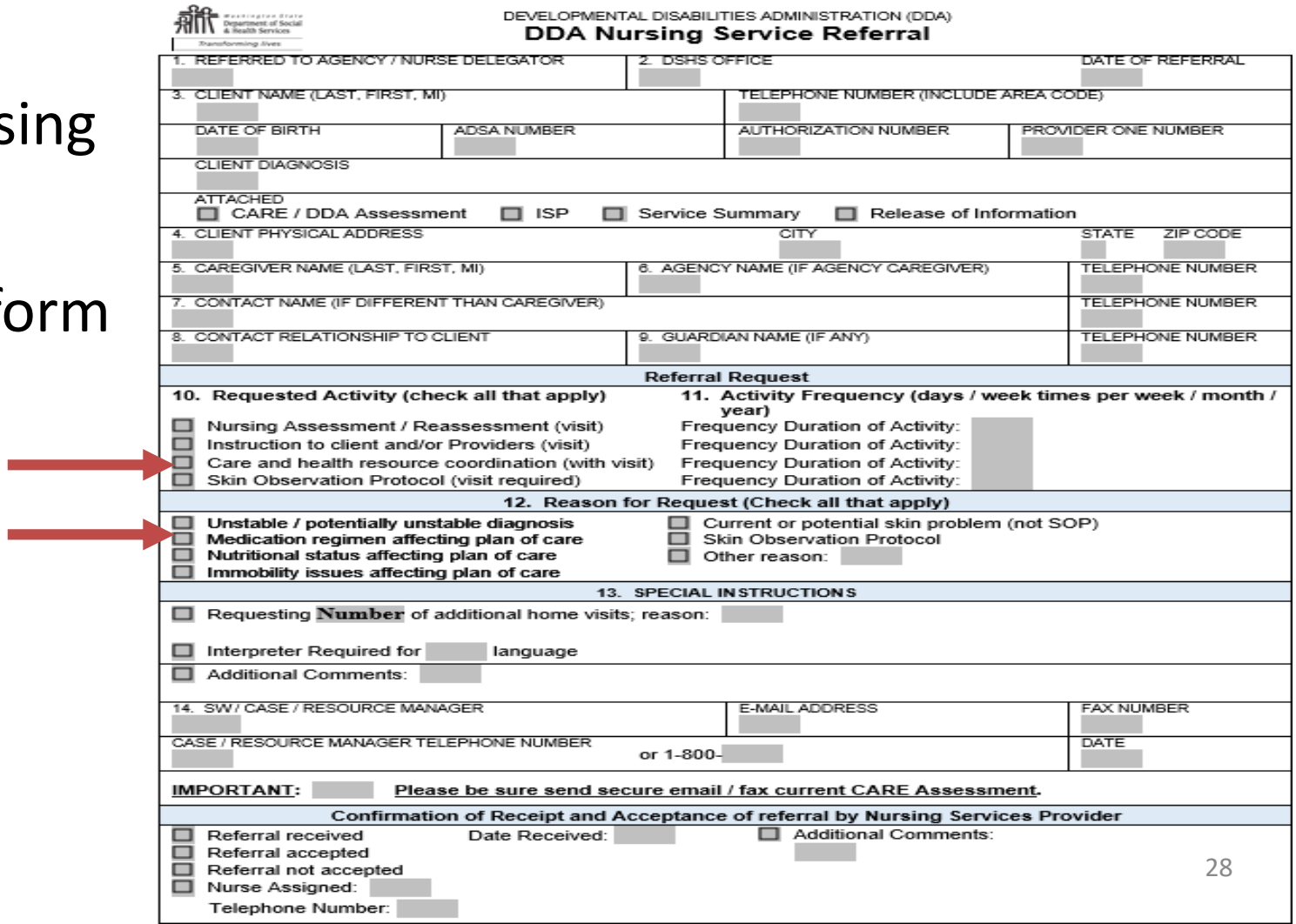
IMPORTANT: Be sure to send, via fax/secure email a current CARE Assessment Details, Service Summary, Release of Information, and a copy of all of the Nursing Triggered Referrals including the Data Elements.
Note: If you are serving a DDA client please use form DSHS 13-911.

Confirmation of Receipt and Acceptance of referral by Nursing Services Provider

☐ Referral received Date Received: ☐ Additional Comments:
☐ Referral accepted
☐ Referral not accepted Reason:_____
☐ Nurse Assigned:
Telephone Number:

DDA Nursing Service Referral Form

DDA Nursing Service Referral form (13-911)



DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

DDA Nursing Service Referral

1. REFERRED TO AGENCY / NURSE DELEGATOR | 2. DSHS OFFICE | DATE OF REFERRAL

3. CLIENT NAME (LAST, FIRST, MI) | TELEPHONE NUMBER (INCLUDE AREA CODE)

DATE OF BIRTH | ADSA NUMBER | AUTHORIZATION NUMBER | PROVIDER ONE NUMBER

CLIENT DIAGNOSIS

ATTACHED
☐ CARE / DDA Assessment ☐ ISP ☐ Service Summary ☐ Release of Information

4. CLIENT PHYSICAL ADDRESS | CITY | STATE | ZIP CODE

5. CAREGIVER NAME (LAST, FIRST, MI) | 6. AGENCY NAME (IF AGENCY CAREGIVER) | TELEPHONE NUMBER

7. CONTACT NAME (IF DIFFERENT THAN CAREGIVER) | TELEPHONE NUMBER

8. CONTACT RELATIONSHIP TO CLIENT | 9. GUARDIAN NAME (IF ANY) | TELEPHONE NUMBER

Referral Request

10. Requested Activity (check all that apply) | **11. Activity Frequency (days / week times per week / month / year)**

☐ Nursing Assessment / Reassessment (visit) — Frequency Duration of Activity:
☐ Instruction to client and/or Providers (visit) — Frequency Duration of Activity:
☐ Care and health resource coordination (with visit) — Frequency Duration of Activity:
☐ Skin Observation Protocol (visit required) — Frequency Duration of Activity:

12. Reason for Request (Check all that apply)

☐ **Unstable / potentially unstable diagnosis**
☐ **Medication regimen affecting plan of care**
☐ **Nutritional status affecting plan of care**
☐ **Immobility issues affecting plan of care**
☐ Current or potential skin problem (not SOP)
☐ Skin Observation Protocol
☐ Other reason:

13. SPECIAL INSTRUCTIONS

☐ Requesting **Number** of additional home visits; reason:

☐ Interpreter Required for language

☐ Additional Comments:

14. SW / CASE / RESOURCE MANAGER | E-MAIL ADDRESS | FAX NUMBER

CASE / RESOURCE MANAGER TELEPHONE NUMBER or 1-800- | DATE

IMPORTANT: **Please be sure send secure email / fax current CARE Assessment.**

Confirmation of Receipt and Acceptance of referral by Nursing Services Provider

☐ Referral received — Date Received: ☐ Additional Comments:
☐ Referral accepted
☐ Referral not accepted
☐ Nurse Assigned:
Telephone Number:

Basic Skin Assessment Form

Basic Skin Assessment (13-780) Page 1

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)

Nursing Services Basic Skin Assessment (Integumentary System – Skin, Hair, Nail)

DATE OF SERVICE

CM / RN NAME

REFERRING RN NAME

CLIENT NAME	DATE OF BIRTH	CLIENT ACES ID	CLIENT PROVIDER ONE ID

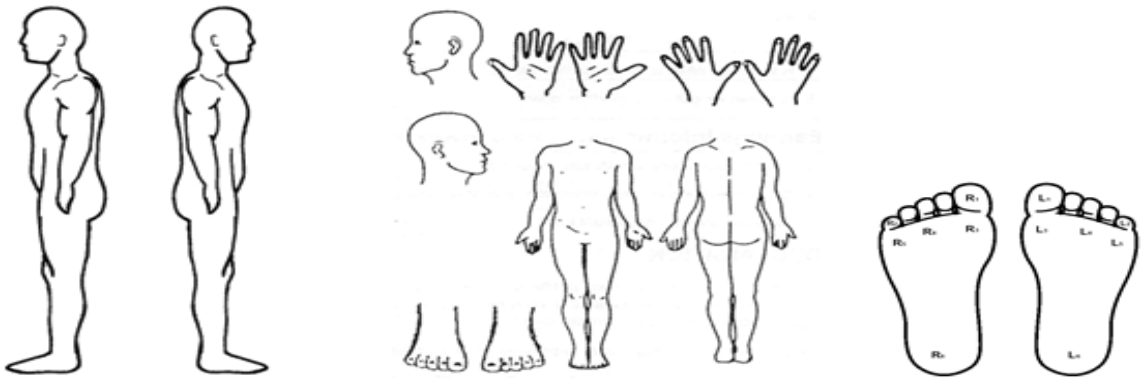
REQUEST RELATED TO (REQUESTOR COMPLETES): CHECK ALL THAT APPLY

- ☐ Skin Observation
- ☐ Other referral type (describe):

Documentation to be sent back to: By: ☐ Fax ☐ Email ☐ Hard Copy

Injuries Assessment Section

Beginning with any pressure injuries, number all integumentary issues consecutively, starting with #1, #2, #3, etc. (Skin, Hair and Nails)



Skin Issues

Specify all types below as numbered / designated above: The number, skin issue type and comments.

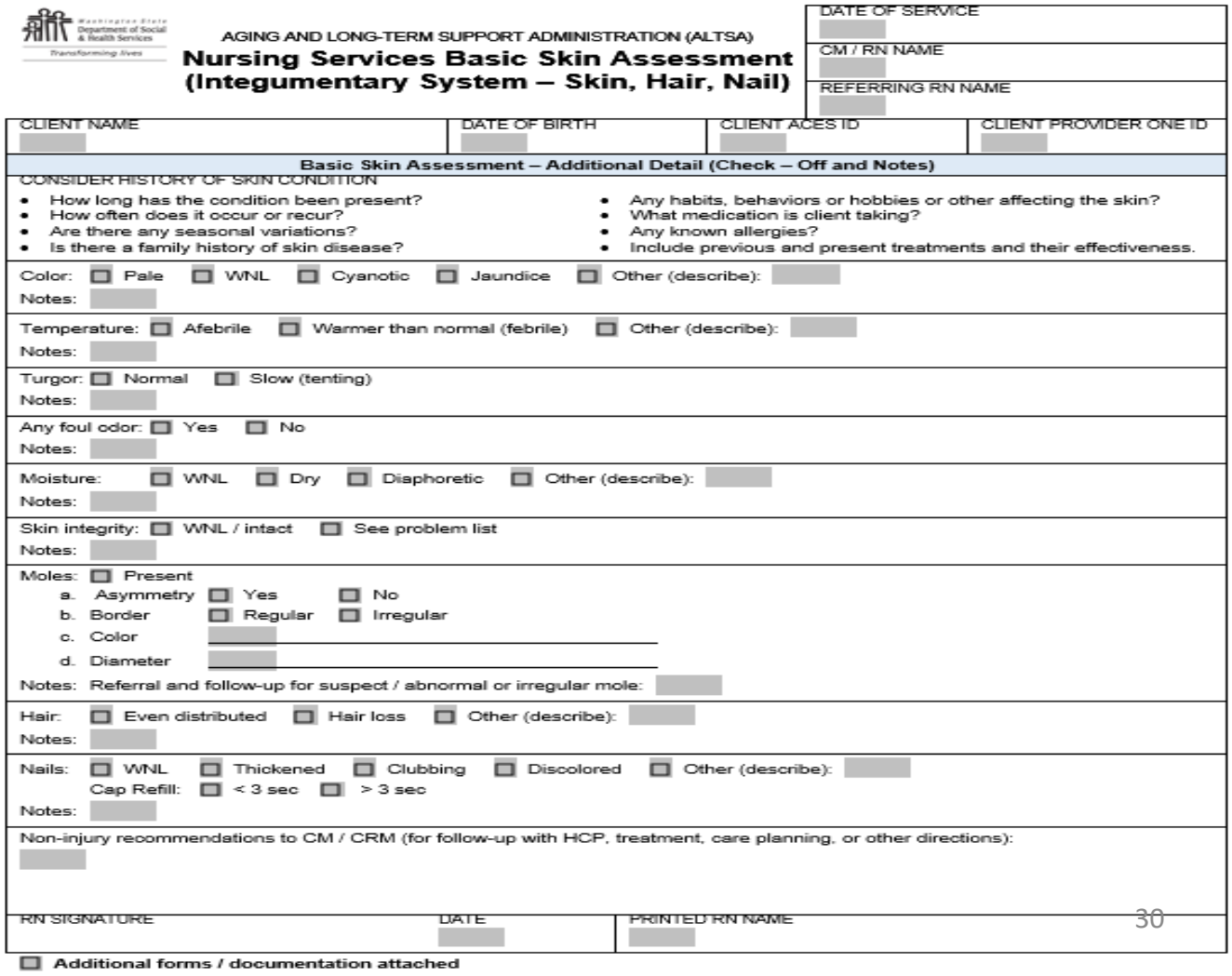
Examples of possible types of skin issues from CARE include pressure injuries, abrasions, acne / persistent redness, boils, bruises, burns, canker sore, diabetic ulcer, dry skin, hives, open lesions, rashes, skin desensitized to pain / pressure, skin folds / perineal rash, skin growths / moles, stasis ulcers, sun sensitivity, and surgical wounds. Please note there are many other skin issues not mentioned here such as irregular skin area such as boggy or mushy skin area, discoloration area(s).

Please note: Any current pressure injuries require further detailed documentation on Pressure Ulcer Assessment and Documentation, form DSHS 13-783.

NUMBER	SKIN ISSUE TYPE AND LOCATION	COMMENTS (PROVIDE FURTHER (NON-PRESSURE INJURY) DOCUMENATION IN ADDITIONAL NOTES SECTION. FURTHER PRESSURE INJURY DOCUMENTATION REQUIRES FORM DSHS 13-783.)

Basic Skin Assessment Form Cont.

Basic Skin Assessment (13-780) Page 2



AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)

Nursing Services Basic Skin Assessment (Integumentary System – Skin, Hair, Nail)

DATE OF SERVICE

CM / RN NAME

REFERRING RN NAME

CLIENT NAME | DATE OF BIRTH | CLIENT ACES ID | CLIENT PROVIDER ONE ID

Basic Skin Assessment – Additional Detail (Check – Off and Notes)

CONSIDER HISTORY OF SKIN CONDITION

- How long has the condition been present?
- How often does it occur or recur?
- Are there any seasonal variations?
- Is there a family history of skin disease?
- Any habits, behaviors or hobbies or other affecting the skin?
- What medication is client taking?
- Any known allergies?
- Include previous and present treatments and their effectiveness.

Color: ☐ Pale ☐ WNL ☐ Cyanotic ☐ Jaundice ☐ Other (describe):
Notes:

Temperature: ☐ Afebrile ☐ Warmer than normal (febrile) ☐ Other (describe):
Notes:

Turgor: ☐ Normal ☐ Slow (tenting)
Notes:

Any foul odor: ☐ Yes ☐ No
Notes:

Moisture: ☐ WNL ☐ Dry ☐ Diaphoretic ☐ Other (describe):
Notes:

Skin integrity: ☐ WNL / intact ☐ See problem list
Notes:

Moles: ☐ Present
a. Asymmetry ☐ Yes ☐ No
b. Border ☐ Regular ☐ Irregular
c. Color
d. Diameter
Notes: Referral and follow-up for suspect / abnormal or irregular mole:

Hair: ☐ Even distributed ☐ Hair loss ☐ Other (describe):
Notes:

Nails: ☐ WNL ☐ Thickened ☐ Clubbing ☐ Discolored ☐ Other (describe):
Cap Refill: ☐ < 3 sec ☐ > 3 sec
Notes:

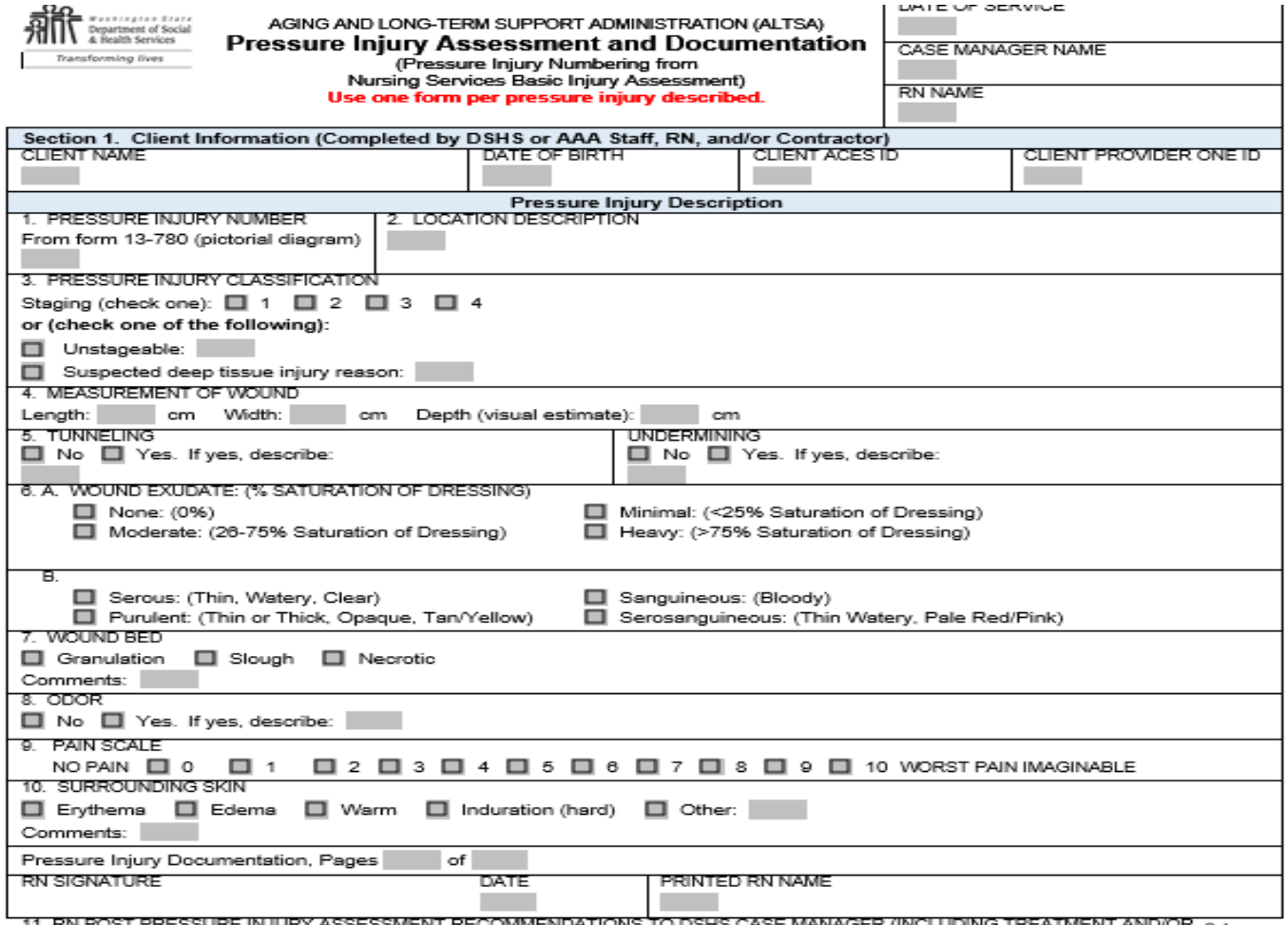
Non-injury recommendations to CM / CRM (for follow-up with HCP, treatment, care planning, or other directions):

RN SIGNATURE | DATE | PRINTED RN NAME

☐ Additional forms / documentation attached

Pressure Injury Assessment Form

Pressure injury Assessment Form (13-783)



Washington State Department of Social & Health Services
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AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
Pressure Injury Assessment and Documentation
(Pressure Injury Numbering from Nursing Services Basic Injury Assessment)
Use one form per pressure injury described.

DATE OF SERVICE
CASE MANAGER NAME
RN NAME

Section 1. Client Information (Completed by DSHS or AAA Staff, RN, and/or Contractor)

CLIENT NAME | DATE OF BIRTH | CLIENT ACES ID | CLIENT PROVIDER ONE ID

Pressure Injury Description

1. PRESSURE INJURY NUMBER From form 13-780 (pictorial diagram)
2. LOCATION DESCRIPTION

3. PRESSURE INJURY CLASSIFICATION
Staging (check one): ☐ 1 ☐ 2 ☐ 3 ☐ 4
or (check one of the following):
☐ Unstageable:
☐ Suspected deep tissue injury reason:

4. MEASUREMENT OF WOUND
Length: cm Width: cm Depth (visual estimate): cm

5. TUNNELING
☐ No ☐ Yes. If yes, describe:

UNDERMINING
☐ No ☐ Yes. If yes, describe:

6. A. WOUND EXUDATE: (% SATURATION OF DRESSING)
☐ None: (0%)
☐ Minimal: (<25% Saturation of Dressing)
☐ Moderate: (26-75% Saturation of Dressing)
☐ Heavy: (>75% Saturation of Dressing)

B.
☐ Serous: (Thin, Watery, Clear)
☐ Sanguineous: (Bloody)
☐ Purulent: (Thin or Thick, Opaque, Tan/Yellow)
☐ Serosanguineous: (Thin Watery, Pale Red/Pink)

7. WOUND BED
☐ Granulation ☐ Slough ☐ Necrotic
Comments:

8. ODOR
☐ No ☐ Yes. If yes, describe:

9. PAIN SCALE
NO PAIN ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 WORST PAIN IMAGINABLE

10. SURROUNDING SKIN
☐ Erythema ☐ Edema ☐ Warm ☐ Induration (hard) ☐ Other:
Comments:

Pressure Injury Documentation, Pages of

RN SIGNATURE | DATE | PRINTED RN NAME

11. RN POST PRESSURE INJURY ASSESSMENT RECOMMENDATIONS TO DSHS CASE MANAGER (INCLUDING TREATMENT AND/OR RECOMMENDATIONS FOR HCP FOLLOW-UP, ADDITIONAL TREATMENT OR CARE NEEDS AND/OR RECOMMENDED CHANGES TO

Nurse Delegation

Skin Observation Protocol (SOP)

Forms and Power Point can be found on ND website or:

https://www.dshs.wa.gov/altsa/residential-care-services/skin-observation-protocol-sop-resources

In Summary

Rewind…

- The rules for Community Based Nurse Delegation are defined in the Nurse Practice Act.
- Any RN in the state of Washington can delegate
- There is no certification course to delegate in the state of Washington
- Only contracted RN's with DSHS may receive a referral and be paid for delegated services for Medicaid clients
- The assessed client must be stable and predictable for delegation
- The LTCW's could not perform the nursing tasks without the supervisor and evaluation of the RN delegating

Nurse Delegation

Trusted Process

Nurse Delegation is based on the Nursing Process:

- Assess
- Plan
- Implement
- Evaluate

HCS Settings

Approved HCS Settings:

Adult Family Home (AFH)	Assisted Living Facility (ALF)	In-Home
• 2-6 clients • No nurse required • Regulated by RCS. • Contracted RND paid to delegate to clients.	• 6 or greater clients • Often times a nurse on staff during the week. • Regulated by RCS • Contracted nurses are NOT paid to provide delegation in ALF.	• Clients live in their private homes. • May be cared for by an IP or AP • No oversight, unless agency provider • Contracted RND paid to delegate to client.

DDA Settings

Approved DDA Settings:

Supported Living	Group Training Homes	Companion Home
• Clients may live in their own home, or share a home with up to three others • Clients are cared for by a state contracted agency • No nurse required • Contracted RND paid to delegate to clients.	• Group settings, clients may live in a facility with which serves two or more adults. • Clients are cared for by facility staff. • No nurse is required • Contracted RND paid to delegate to clients.	• Clients reside in their home • Clients are cared for through an agency • No nurse is required • Contracted RND paid to delegation to clients

Where We Are Not

Delegation does not occur in the following settings:

- Hospitals
- Jails
- Schools
- Other community programs (adult day, senior centers, etc.)

Assess

- Setting
- Client
- Nursing Task
- Long term care workers (LTCW's)

Assess Cont.

Assess

Assess the client:

- Full system- head to toe assessment
  - Completed within 3 working days of accepting the referral
- Is the clients condition **stable and predictable**

Assess Cont.

Not a standardized form

Head-to-Toe Assessment
Assessment conducted by _____

Date:_____
Time:_____

LOC
☐Alert ☐Drowsy ☐Lethargic ☐Stuporous☐Coma
Orientation
☐ Person _____
☐ Place _____
☐ Time _____
☐ Situation _____
Vitals
☐ Temp _____ ☐ R _____
☐ BP _____ Pulse Ox _____
Head
☐ Hair _____
☐ PERLA _____ mm
☐ Nose _____
☐ Ears _____
☐ Mouth _____
- Midline tongue _____
- Moist _____
- Lesions _____
- Dentition _____

Neck
☐ Carotid pulse ___ ☐ JVD + ☐Trachea midline
Chest
☐ Apical Pulse _____☐Muffled ☐Arrhythmia
☐ Breath Sounds - Anterior_____
Posterior _____Lateral_____
☐ Chest Symmetry _____
☐ Skin Turgor (clavicle) _____
Abdomen
☐ Inspection _____
☐ Ausculation
- LUQ (active / hyper / absent)
- RUQ (active / hyper / absent)
- LLQ (active / hyper / absent)
- RLQ (active / hyper / absent)

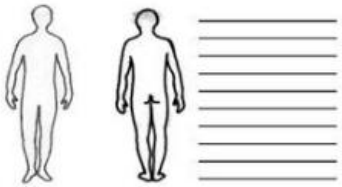
☐ Palpation _____

Upper Extremities
☐ Radial pulses equal, +2
- Other: _____

☐ Temp vs. trunk (warm / cool)
☐ Grip equal and strong _____
☐ Capillary refill <3 sec
☐ Vein filling rapid

Lower Extremities
☐ Hair present
☐ Edema _____
☐ Foot strength
☐ Homain's (+ / -) Claudication (+ / -)
☐ Temp vs. Trunk (warm / cool)
☐ Nails ☐ Yellowed ☐ Thickened ☐ Ingrown
☐ Pedal pulse R(palp / doppler) L(palp / doppler)
ROM / Strength
☐ Upper R _____ ☐ Upper R _____
☐ Upper L _____ ☐ Upper L _____
☐ Lower R _____ ☐ Lower R _____
☐ Lower L _____ ☐ Lower L _____
☐ Sensation _____

General Assessment
☐ Weight/Height _____
☐ BM _____
Pain Assessment
☐ Acute/Chronic ☐ Intensity (0-10) _____
☐ Location _____
☐ Duration _____
☐ Characteristics _____
☐ Precipitation _____
☐ Frequency _____
☐ Non-verbals _____
☐ Relief factors _____
☐ Sleep _____
Skin Assessment
☐ Description: _____



Courtesy of http://nursing.arizela.com

Assess Cont.

Assess

What does stable and predictable mean?

- The RN determines the clients clinical and behavioral status is non-fluctuating and consistent.
- The client does not require frequent nursing presence
- The client does not require frequent evaluation by an RN

Client's with **terminal conditions** and those who are on **sliding scale insulin** are stable and predictable

WAC 246-840-920 (15)

Assess Cont.

Assess

Assess the nursing task to be delegated:

- Does the nursing task fall within your skill set?
- Is the nursing task on the prohibited list
- Do you need additional assistance to determine delegation
  - Consult the decision tree
    - WAC 246-840-940
- If task determined for delegation is different from the original request, discuss findings with the referring case manager on page two of the referral form.

Assess Cont.

Assess

Prohibited nursing tasks:

- Sterile Procedures or processes
- Injectable medications
  - **Except insulin and non-insulin injections for DM**
- Central line of IV maintenance
- Acts that require nursing judgement

Assess Cont.

Assess

Examples of nursing tasks

Previous Task List developed in 1996	New "nursing tasks"
Oral/topical medication	Clean suctioning- oral/tracheal
Ointments	Vagal nerve stimulator (VNS)
Drops- eye, ear, and nose	Bladder irrigations
Clean (non-sterile) dressing changes	Insulin injections
Gastrostomy (G-tube) feedings	Nasal versed for seizure control
Ostomy care	Non-insulin injections
In-and-out catheterizations	Blood glucose monitoring

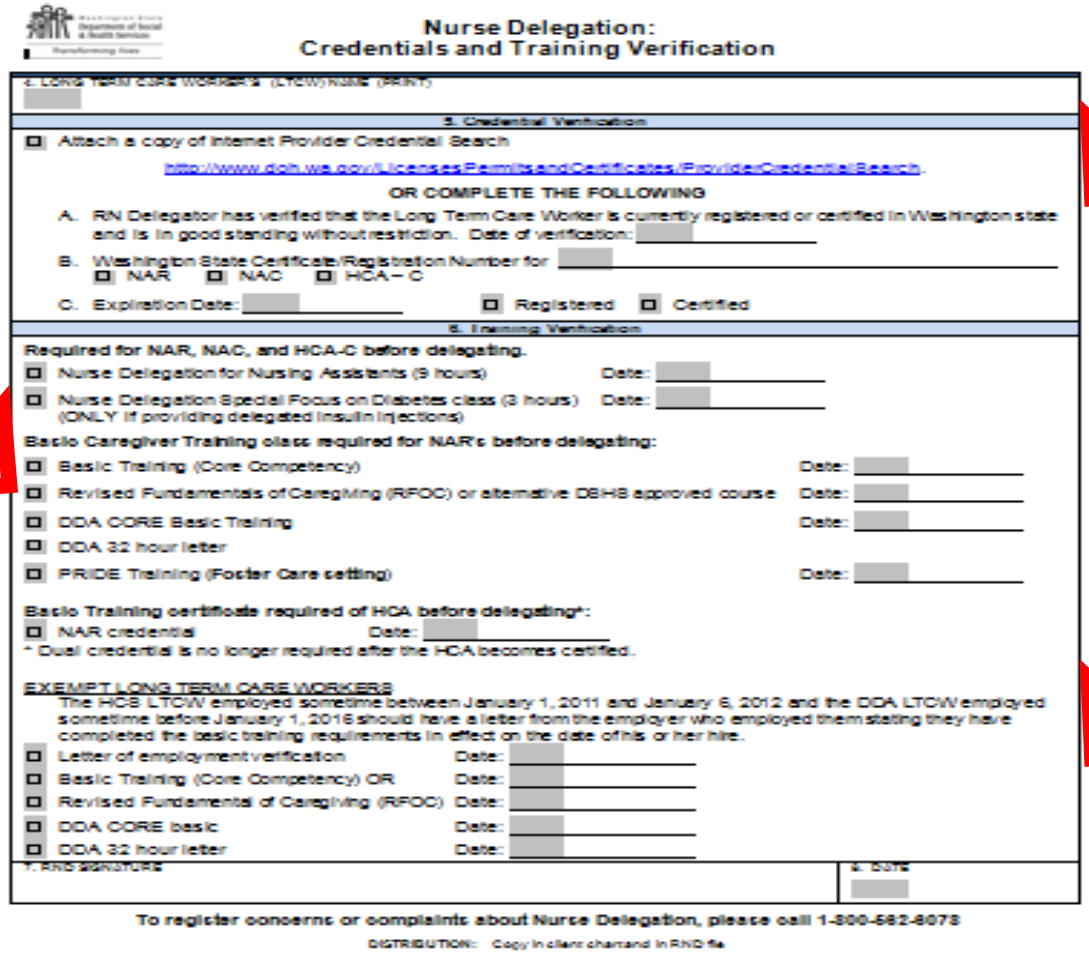
Assess Cont.

Assess

Assess the LTCW:

- Does the LTCW have the appropriate training and credentials to perform the nursing task
- Assess the competency of the LTCW performing the nursing task
- Identify additional training needs for the LTCW to properly and safely perform the nursing task
- Consider language and cultural diversity which may affect delegation
- Is the LTCW **willing and able** to perform the nursing task

Credentials and Training



Nurse Delegation:
Credentials and Training Verification

4. LONG TERM CARE WORKER'S (LTCW) NAME (PRINT)

5. Credential Verification

☐ Attach a copy of Internet Provider Credential Search

http://www.doh.wa.gov/Licenses/Permits/Certificates/ProviderCredentialSearch

OR COMPLETE THE FOLLOWING

A. RN Delegator has verified that the Long Term Care Worker is currently registered or certified in Washington state and is in good standing without restriction. Date of verification: _____

B. Washington State Certificate/Registration Number for _____
☐ NAR ☐ NAC ☐ HCA – C

C. Expiration Date: _____ ☐ Registered ☐ Certified

6. Training Verification

Required for NAR, NAC, and HCA-C before delegating.

☐ Nurse Delegation for Nursing Assistants (9 hours) Date: _____

☐ Nurse Delegation Special Focus on Diabetes class (3 hours) Date: _____
(ONLY if providing delegated insulin injections)

Basic Caregiver Training class required for NAR's before delegating:

☐ Basic Training (Core Competency) Date: _____

☐ Revised Fundamentals of Caregiving (RFOC) or alternative DSHS approved course Date: _____

☐ DDA CORE Basic Training Date: _____

☐ DDA 32 hour letter

☐ PRIDE Training (Foster Care setting) Date: _____

Basic Training certificate required of HCA before delegating*:

☐ NAR credential Date: _____

* Dual credential is no longer required after the HCA becomes certified.

EXEMPT LONG TERM CARE WORKERS

The HCS LTCW employed sometime between January 1, 2011 and January 6, 2012 and the DDA LTCW employed sometime before January 1, 2016 should have a letter from the employer who employed them stating they have completed the basic training requirements in effect on the date of his or her hire.

☐ Letter of employment verification Date: _____

☐ Basic Training (Core Competency) OR Date: _____

☐ Revised Fundamental of Caregiving (RFOC) Date: _____

☐ DDA CORE basic Date: _____

☐ DDA 32 hour letter Date: _____

7. RND SIGNATURE 8. DATE

To register concerns or complaints about Nurse Delegation, please call 1-800-562-6078

DISTRIBUTION: Copy in client chart and in RND file

NURSE DELEGATION: CREDENTIALS AND TRAINING VERIFICATION
DSHS 10-217 (REV. 03/2016)

Training classes

Credential type, expiration date, and original issue date

Exempt LTCW letter of employment verification

Does Not Apply

Who's exempt from the Home Care Aide training?

- NA-R working with a aging client, who worked one day from January 1, 2011-January 6, 2012.
  - The NAR must provide a letter of employment verification showing dates of employment.
- NA-R working with a DDA client, who worked prior to 2016.
  - The NA-R must provide a letter of employment verification showing days of employment (the DDA 32 hour letter will work).
- HCA-C
- NA-C
- LPN

https://fortress.wa.gov/doh/providercredentialsearch/SearchCriteria.aspx

Home Care Aid Training

What's included in the Home Care Aide training?

75 hours "Home Care Aid" training

- 40 hours "basic training"
- 30 hours "population specific"
  - Mental health
  - Dementia
- 5 hours orientation and safety

Training **must** be completed within 200 days of hire
WAC 246-980

Credentials

Assess HCS LTCW credentials:

NAR	HCA-C	NAC
Non-exempt (**after** 2012) 1. Verify current NAR credential 2. Verify 9 hour Nurse Delegation for Nursing Assistants 3. If delegated insulin, verify 3 hour SFOD 4. Verify completion of 40 hour Basic Training Exempt (**January 1, 2011-January 6, 2012**) 1. Verify NAR credential 2. Verify 9 hour Nurse Delegation for Nursing Assistants 3. If delegated insulin, verify 3 hour SFOD 4. Verify completion of basic training: 1. FOC 2. RFOC 5. Obtain a letter of employment verification-stating dates of employment	1. Verify current HCA-C (HM) credential 2. Verify 9 hour Nurse Delegation for Nursing Assistants 3. If delegated insulin, verify 3 hour SFOD	1. Verify current CNA credential 2. Verify 9 hour Nurse Delegation for Nursing Assistants 3. If delegated insulin, verify 3 hour SFOD

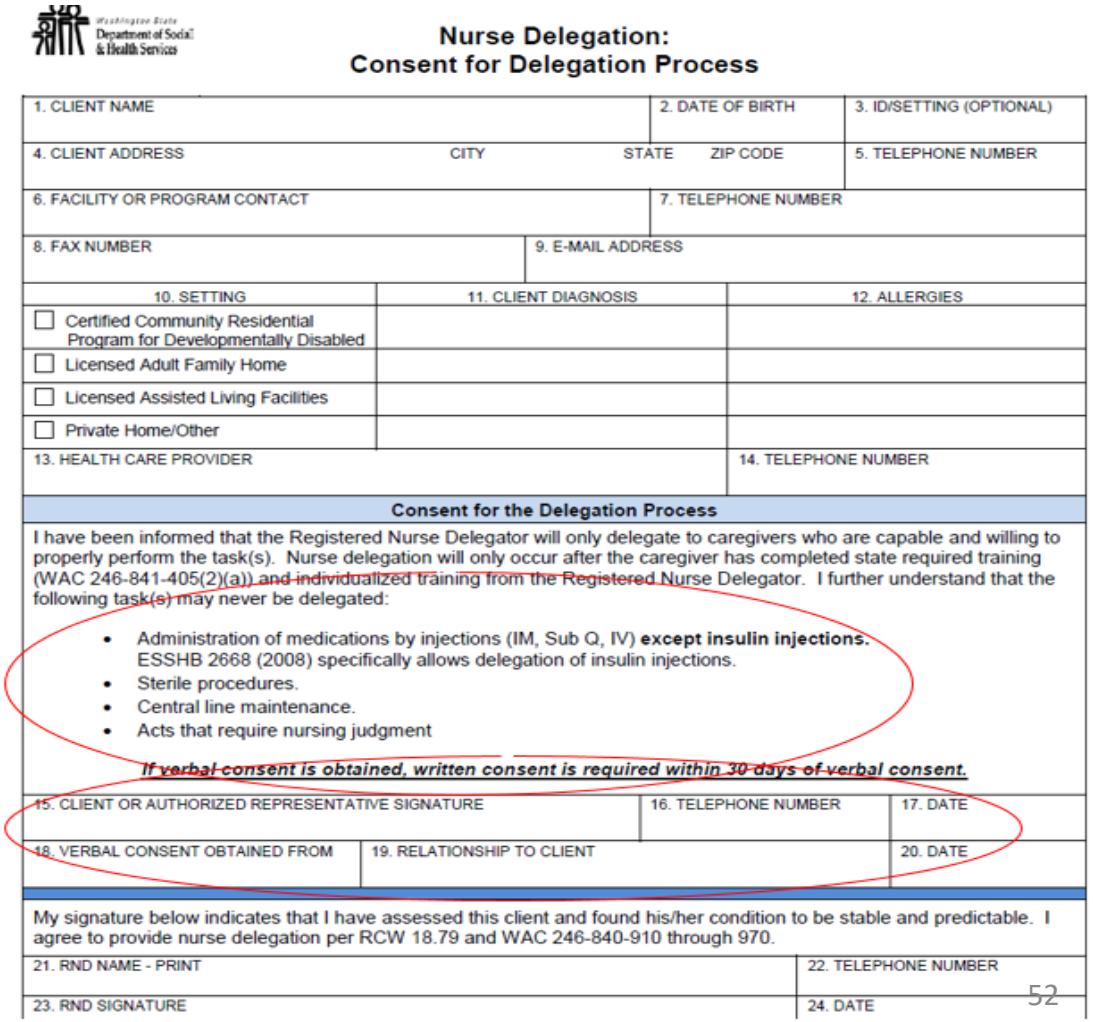
Credentials

Assess DDA LTCW credentials:

NAR	NAC
Non-exempt (**after 2016**) 1. Verify current NAR credential 2. Verify 9 hour Nurse Delegation for Nursing Assistants 3. If delegated insulin, verify 3 hour SFOD 4. Verify completion of 40 hour CORE Basic Training Exempt (**prior to 2016**) 1. Verify NAR credential 2. Verify 9 hour Nurse Delegation for Nursing Assistants 3. If delegated insulin, verify 3 hour SFOD 4. Verify completion of basic training; 32 hour letter 5. Obtain a letter of employment verification- stating dates of employment	1. Verify current CNA credential 2. Verify 9 hour Nurse Delegation for Nursing Assistants 3. If delegated insulin, verify 3 hour SFOD

Consent Process

Consent form (13-678)



Nurse Delegation:
Consent for Delegation Process

1. CLIENT NAME			2. DATE OF BIRTH	3. ID/SETTING (OPTIONAL)
4. CLIENT ADDRESS	CITY	STATE ZIP CODE		5. TELEPHONE NUMBER
6. FACILITY OR PROGRAM CONTACT			7. TELEPHONE NUMBER	
8. FAX NUMBER		9. E-MAIL ADDRESS		

10. SETTING	11. CLIENT DIAGNOSIS	12. ALLERGIES
☐ Certified Community Residential Program for Developmentally Disabled		
☐ Licensed Adult Family Home		
☐ Licensed Assisted Living Facilities		
☐ Private Home/Other		
13. HEALTH CARE PROVIDER		14. TELEPHONE NUMBER

Consent for the Delegation Process

I have been informed that the Registered Nurse Delegator will only delegate to caregivers who are capable and willing to properly perform the task(s). Nurse delegation will only occur after the caregiver has completed state required training (WAC 246-841-405(2)(a)) and individualized training from the Registered Nurse Delegator. I further understand that the following task(s) may never be delegated:

- Administration of medications by injections (IM, Sub Q, IV) **except insulin injections.** ESSHB 2668 (2008) specifically allows delegation of insulin injections.
- Sterile procedures.
- Central line maintenance.
- Acts that require nursing judgment

If verbal consent is obtained, written consent is required within 30 days of verbal consent.

15. CLIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE	16. TELEPHONE NUMBER	17. DATE
18. VERBAL CONSENT OBTAINED FROM	19. RELATIONSHIP TO CLIENT	20. DATE

My signature below indicates that I have assessed this client and found his/her condition to be stable and predictable. I agree to provide nurse delegation per RCW 18.79 and WAC 246-840-910 through 970.

21. RND NAME - PRINT	22. TELEPHONE NUMBER
23. RND SIGNATURE	24. DATE

Assess Cont.

Assess

Consent for delegation:

- Discuss the process of delegation with the client or the client's authorized representative
- Obtain consent
  - Verbal consent acceptable for first 30 days
  - Written consent **must** be obtained after the first 30 days
    - Scanned, emailed, or faxed consents are acceptable
- Consent is only needed for initial delegation
  - No need to get new consent when nursing task changes
  - **Must** get new consent if the authorized representative changes

Nurse Delegation

Nurse Delegation is based on the Nursing Process:

- Assess
- Plan/Implement
- Evaluate

Instructions for Nursing Task

Instructions for Nursing Task (Form 13-678)

Washington State Department of Social & Health Services
Transforming lives

Nurse Delegation:
Instructions for Nursing Task

1. CLIENT NAME	2. DATE OF BIRTH	3. ID / SETTING (OPTIONAL)	4. DATE TASK DELEGATED
5. DELEGATED TASK AND EXPECTED OUTCOME			
Complete 6 and 7 only if medication(s) delegated:			
6. LIST SPECIFIC MEDICATION(S), DOSAGES AND FREQUENCY OF MEDICATIONS DELEGATED ON THIS DATE (☐ CHECK HERE IF ADDITIONAL FORM ATTACHED.)	VERIFICATION OF DELEGATED MEDICATION DATE NAME / TITLE METHOD OF VERIFICATION		
8. STEPS TO PERFORM THE TASK: ☐ Check here if additional teaching aide(s) attached.			
Report Side Effects or Unexpected Outcomes To:			
9. RND NAME (PRINT)			10. TELEPHONE NUMBER
11. WHAT TO REPORT TO RND			
12. HEALTH CARE PROVIDER NAME			13. TELEPHONE NUMBER
14. WHAT TO REPORT TO HEALTH CARE PROVIDER			
EMERGENCY SERVICES, 911			
15. WHAT TO REPORT TO 911			

Plan/Implement Cont.

Plan/Implementation

- Written instructions
  - Steps to follow when performing nursing task
  - Predicted outcome
  - Specific side effects of medications
  - To whom do LTCW's report side effects
- Teach LTCW how to perform the nursing task
  - Based on the written instructions
- Determine caregiver competency
  - Return demonstration
  - Verbal description
  - Record review
- Delegation of a nursing task is at the discretion of the RN assessing and delegating; including the delegation of insulin

Plan/Implement Cont.

Plan

Instructions:

- Rationale for delegation- the “why”
- Specific to the client and their condition
  - Not transferable to another client or LTCW
- Clear description or nursing task with step by step instructions
- Expected outcomes of delegated nursing task
- Possible side effects of medications prescribed
  - To whom do LTCW’s report AND when
- How to document the nursing task as completed or omitted.

Plan/Implement Cont.

Plan

If the nursing task is medication administration:

- Verify what medications are prescribed
  - Pharmacy list
  - MAR's
  - Conversation with Health Care Provider
- Verify medication changes AND how they were verified
- Determine if there is a need to retrain the LTCW on the task
- Update delegation paperwork
- Update instructions and task sheet

Plan/Implement Cont.

Plan

Insulin delegation:

- Teach proper usage of insulin
- Instruct and demonstrate safe insulin injection technique
- Determine competency of LTCW in performing safe insulin administration
  - Drawing up the insulin in a syringe
  - Dialing the dose of insulin on the prefilled syringe
  - Administering the insulin
- Competency:
- Must verify LTCW once a week for the first four weeks of insulin delegation
  - The first visit MUST be in person
  - Each subsequent visit may be verified through
    - Observation or demonstration of the task
    - Verbal communication
    - Record review

Plan/Implement Cont.

Plan

In private homes RN must set up the clients chart, which includes all of the following:

- Nurse delegation forms
- Medication orders
- Medication administration records (MAR's)
- Credentials for all delegated LTCW's
- Progress notes

Plan/Implement Cont.

Plan

In the process of writing your plan, you may need help determining if the nursing task is appropriate for delegation.

Review the decision tree located in the nurse practice act:

WAC 246-840-940

(1)	Does the patient reside in one of the following settings? A community-based care setting as defined by RCW 18.79.260 (3)(e)(i) or an in-home care setting as defined by RCW 18.79.260 (3)(e)(ii).	No ->	Do not delegate
	Yes ↓		
(2)	Has the patient or authorized representative given consent to the delegation?	No ->	Obtain the written, informed consent
	Yes ↓		
(3)	Is RN assessment of patient's nursing care needs completed?	No ->	Do assessment, then proceed with a consideration of delegation
	Yes ↓		
(4)	Does the patient have a stable and predictable condition?	No ->	Do not delegate
	Yes ↓		

Evaluate

Nurse Delegation is based on the Nursing Process:

- Assess
- Plan/Implement
- Evaluate

Evaluate Cont.

Evaluate

Evaluation of delegation occurs every 90 days.
There is no exception

Supervisory visits have 2 components:

1. RN evaluates the client:
   - Head to toe assessment
   - Assess client to determine if the client status continues to be “stable and predictable”
   - Evaluate the clients response to the delegated nursing task
     - Modify tasks if needed
     - Retrain LTCW’s if needed

Evaluate Cont.

Evaluate

2. RN evaluates the continued competency of each delegated LTCW:

- Evaluation can be direct or indirect
  - Observation or demonstration
  - Record review
  - Verbal description
- Assess care provided
- Documentation submitted in last 90 days
- Validate current credentials

Evaluate Cont.

Evaluate

Modifications to tasks:

- Update Instructions and Task form
- Retrain LTCW's on updated tasks
- Rescind LTCW's who are no longer delegated to client
- Rescind entire caseload
- Assumption of caseload

Nurse Delegation

Evaluate

Update instructions and task form if:

- Nursing task has changed
  - Added, discontinued, or modified
    - RN verifies the new orders with the health care provider
    - Determines if the task can be delegated
    - Determines if delegation can occur immediately or if a site visit is required.
      - If the task can not be completed immediately the RN initiates and participates in developing an alternative plan to meet the needs of the client.

Evaluate Cont.

Evaluate

RN role in rescinding:

- RN initiates and participates in a safe transition plan with case managers, family member's, and the client.
- RN documents the reason for rescinding and the plan for continuing the nursing task
  - Who will provide the service in lieu of delegation

Evaluate Cont.

Evaluate

Rescind delegation if:

- Client safety is compromised
- Client is no longer stable and predictable
- Staff turnover makes delegation difficult
- Staff unwilling or unable to perform nursing task
  - Task performed incorrectly
  - Client requests new staff
  - When any license lapse
    - Facility
    - LTCW
    - RN

Evaluate Cont.

Evaluate

Transferring delegation to an assuming RN:

- The RN may transfer their case to another RN willing to assume.
- The assuming RN will:
  - Assess the patient
  - Assess the nursing tasks as being delegatable and within his/her skill set
  - Assess the LTCW's competency
  - Assess the written instructions and task sheet

Once the care has been assumed, the assuming nurse must document:

- Reason for assumption
- Notification to client and LTCW's

Evaluate Cont.

Evaluate

- Document the entire Nurse Delegation process
  - Including
    - Assessment
    - Written plan
    - Training and credentials
    - Verification of competency

In Summary

Nurse Delegation is based on the Nursing Process

- Assess
- Plan
- Implement
- Evaluate

- Only occurs in four community settings
  - Not hospitals, jails, or skilled nursing facilities
- The client must be stable and predictable
- Select nursing tasks can only be delegated
  - Prohibited list
  - No other list available
- LTCW must have appropriate training and credentials
- There must be an individualized written plan available

Summary Cont.

Summary

- Frequency of insulin delegation
- How to access the decision tree and when
- Evaluation of nurse delegation occurs every 90 days
  - Not every 3 months
- When to update nurse delegation documents
- When to provide additional training
- How to rescind a caseload of LTCW

Nurse Delegation

Group Activity

Training and Credentials

- Breakout into small groups: 3-5 people
- Each group will be assigned a scenario
- Take 5-10 minutes to review the scenario, determine what training and credentials are required and complete the required training and credentials form
- Present your findings to the entire class

Activity Role Descriptions

1. A Licensed Practice Nurse who works in an Adult Family Home providing suctioning to a client.

2. An NA-R working for a Supported Living agency, in April of 2012 administering insulin.

3. An NA-C worked in an Adult Family Home in 2013, applying a fentanyl patch.

Activity Role Descriptions

4. A HCA-C is working in an Assisted Living Facility giving insulin since. The HCA-C has worked for the same ALF since February of 2012.

5. An NA-R is working with a client in their private home. The client requires insulin injections and wound care daily. The LTCW was hired before January 7, 2012.

6. An NA-R is currently working for a Supported Living agency. The NA-R has been asked to give insulin to a client. The NA-R previously worked for a Home Care Agency in 2011. It is now February 2014.

Activity Role Descriptions

7. A NA-R was just hired in an Adult Family Home, on January 15, 2017 and is asked to administer insulin to a client. The NA-R did not work in 2011.

8. A HCA-C is working in an Adult Family Home administering oral medications, it is February of 2013.

9. The NA-R is working in Supported Living, after January 1, 2016, administering insulin injections.

Nurse Delegation

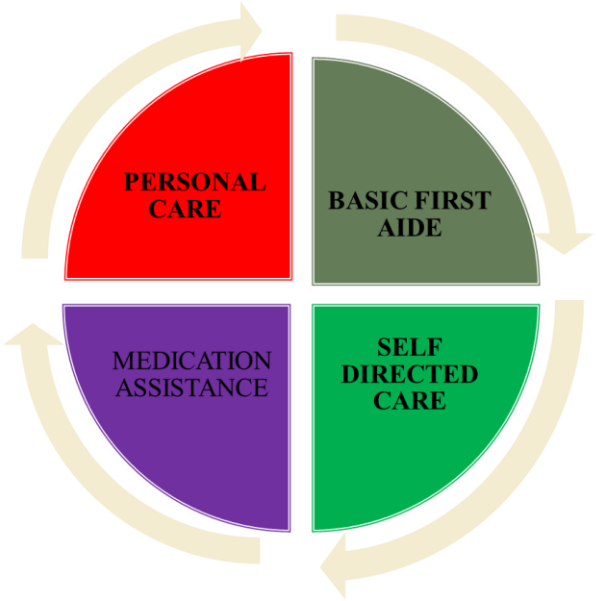
When To Delegate?

Decisions

To delegate or not…

When delegation may not be needed

- Personal care
- Basic first aid
- Self directed care
- Medication assistance



Personal Care

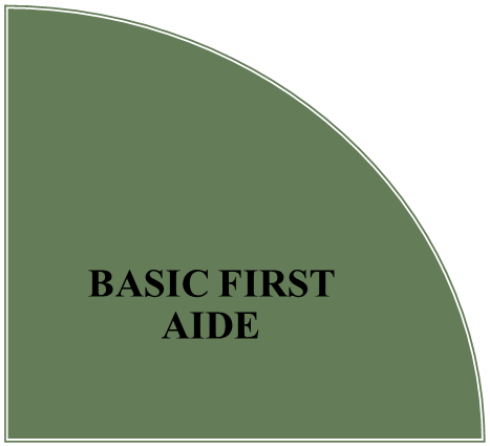
Personal care tasks

- Medicated shampoos
- Chlorohexidine mouth rinse
- Topical lotions
- Indwelling catheter care
- Antiembolism stockings (TED)
- Emptying a colostomy bag
- Peri care
- Filing nails

Basic First Aid

Basic First Aid

- Applying a bandage to a cut
- Reinforcing a bandage
- Administering epinephrine under the
  - "Good Samaritan Law"
    - RCW 4.24.300



Self Directed Care

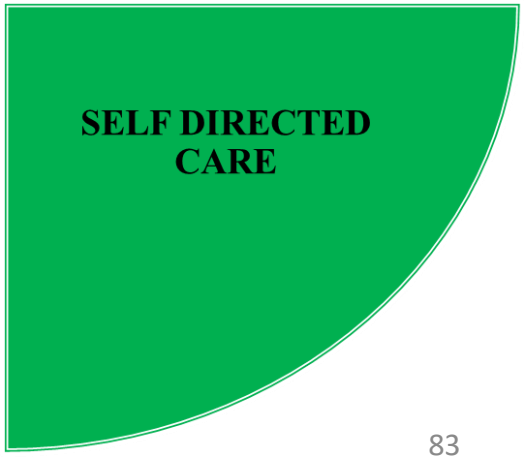
Self Directed Care

- Nursing care provided to a client who resides in their private home by an Individual Provider (IP).
  - Only occurs in private homes
  - Only if an Individual Provider is providing care
  - Client trains and supervises the Individual Provider on their completion and competency level
  - Client must be cognitively aware
    - As determined by the case manager in her assessment
  - The clients physician must be aware the client is self directing their care

The IP can provide any nursing task an able bodied person could do for themselves.

WAC: 388-825-400

RCW: 74.39



Medication Assistance

Medication Assistance

- Rules written by the Board of Pharmacy
- Describes ways to help an individual take their medications
  - Remind
  - Coach
  - Open
  - Pour
  - Crush
  - Dissolve
  - Use of an enabler
  - Mix with food or liquids (client must be aware the medication is in the food or liquid)
- Medication assistance can be performed by anyone
- Client must be in a community setting

WAC 246-888-020

Medication Assistance Cont.

Medication Assistance

- If medications are crushed or dissolved it must be noted on a physician or pharmacy order
- Examples enablers:
  - Cups
  - Bowls
  - Spools
  - Straws
  - Adaptive devices
- Hand over hand is never allowed as an assistance
- Client maintains the right to refuse medications at any time.

Medication Assistance Cont.

Components of Medication Assistance

In order for medication assistance to take place, the client must meet both:

- **Functionally ability:** able to get the medication to where it needs to go
  - Medication to mouth
  - Ointment on back

AND

- **Cognitively aware:** he/she is receiving medications
  - Doesn't need to know the name of the medication
  - Intended side effect

If client is not functionally able to take medications and cognitively aware he/she is receiving medications, the **medication must be administered by a person authorized to do so**.

Delegation is appropriate

Medication Assistance Cont.

Medication Assistance

Assisted Living Exception Rule:

- Clients who reside in an assisted living facility who are unable to independently self-administer their medications may receive medication assistance as follows:
  - If the client is physically unable to self-administer medication they can accurately direct others to do so.

This is not self directed care

Medication Assistance Cont.

Medication Assistance

So what is covered under medication assistance?

- Oral medication administration
- Topical medication administration
- Ophthalmic medication administration
- Insulin pen set up
- Medications via G-Tubes

Nurse Delegation

Medication Assistance

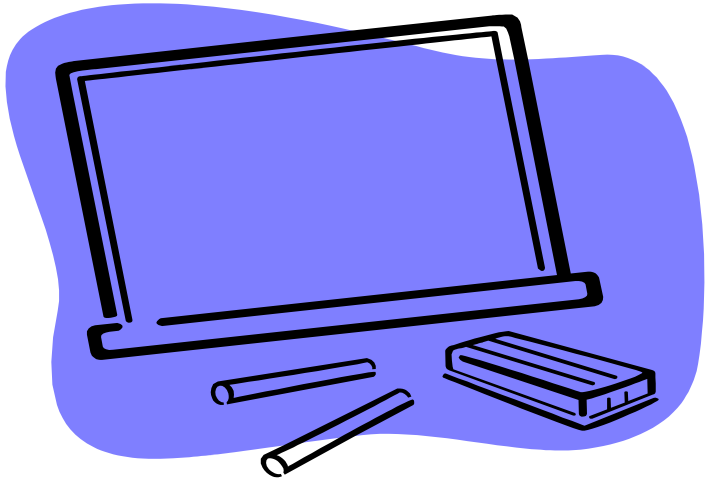
What is not covered under medication assistance:

- Injectable medication
- Intravenous medications
- Oxygen administration

Nurse Delegation

Blue Board Exercise

Review nursing takes which may need delegation, may not need delegation, or are strictly prohibited from delegation



Nurse Delegation

Forms Review

Delegation Forms Review

FORMS:

- Referral
- Consent
- Credentials and verification
- Head to toe assessment
- Instructions and nursing task
- Nursing visit
- PRN
- Change in medication or treatment
- Rescinding
- Assumption
- SOP documents
- Billing tracker

Review sample chart:

Nurse Delegation

Step by step process for delegation
Forms review

Initial delegation:

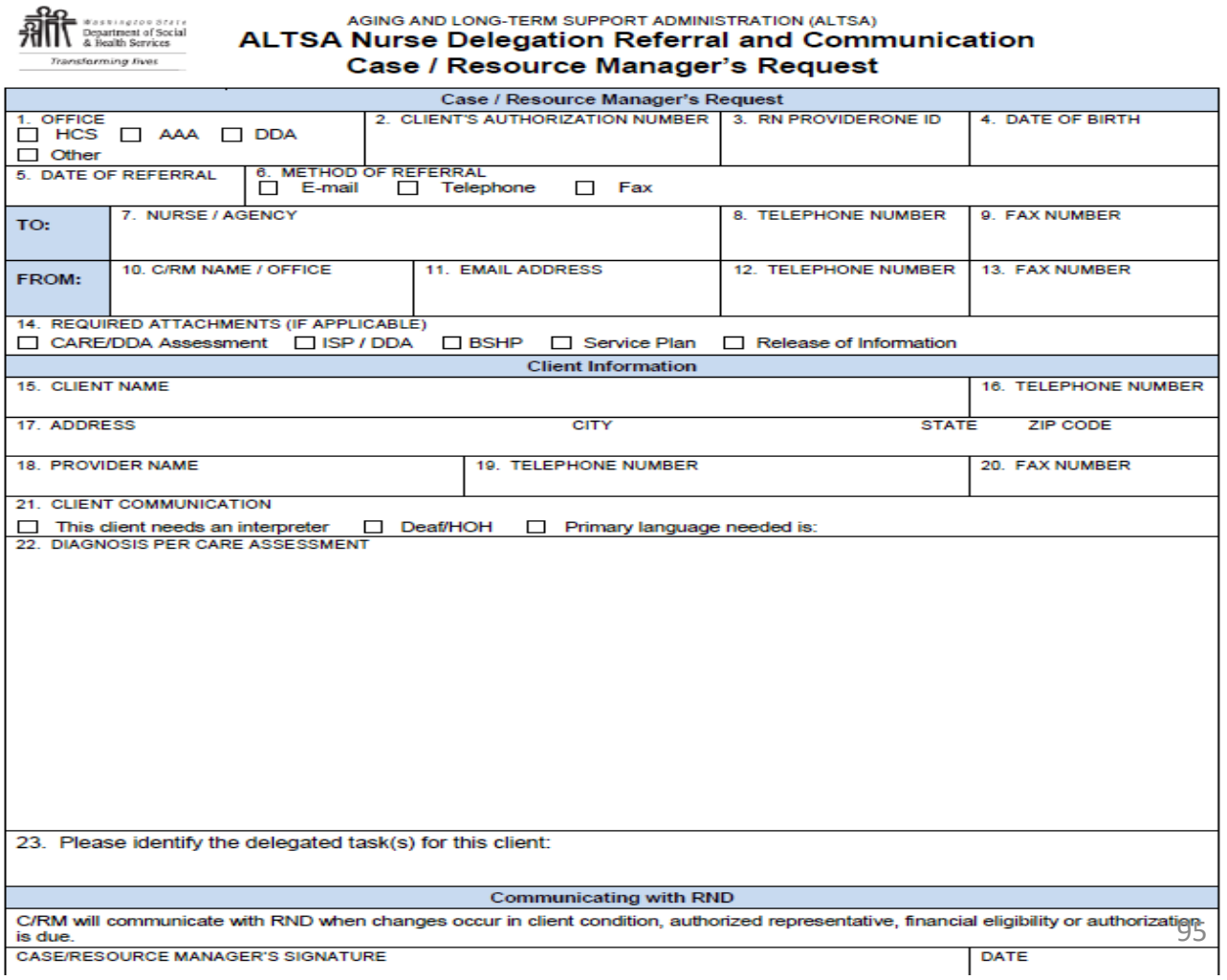
- Referral
  - Case Manager will scan, email, or fax if a state client
- Attached to the referral:
  - Copy of most recent CARE assessment
    - Including behavior support plans
  - Release of information
  - Authorization number
  - Date of birth
- Assessment of client must be completed within three days from the date of accepting referral.
  - If unable to meet this deadline, discuss with case manager

Nurse Delegation Referral Form

Referral form

(01-212)

Page 1



AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)

ALTSA Nurse Delegation Referral and Communication
Case / Resource Manager's Request

Case / Resource Manager's Request

1. OFFICE ☐ HCS ☐ AAA ☐ DDA ☐ Other	2. CLIENT'S AUTHORIZATION NUMBER	3. RN PROVIDERONE ID	4. DATE OF BIRTH
5. DATE OF REFERRAL	6. METHOD OF REFERRAL ☐ E-mail ☐ Telephone ☐ Fax		
TO:	7. NURSE / AGENCY	8. TELEPHONE NUMBER	9. FAX NUMBER
FROM:	10. C/RM NAME / OFFICE / 11. EMAIL ADDRESS	12. TELEPHONE NUMBER	13. FAX NUMBER

14. REQUIRED ATTACHMENTS (IF APPLICABLE)
☐ CARE/DDA Assessment ☐ ISP / DDA ☐ BSHP ☐ Service Plan ☐ Release of Information

Client Information

15. CLIENT NAME			16. TELEPHONE NUMBER
17. ADDRESS	CITY	STATE	ZIP CODE
18. PROVIDER NAME	19. TELEPHONE NUMBER		20. FAX NUMBER

21. CLIENT COMMUNICATION
☐ This client needs an interpreter ☐ Deaf/HOH ☐ Primary language needed is:

22. DIAGNOSIS PER CARE ASSESSMENT

23. Please identify the delegated task(s) for this client:

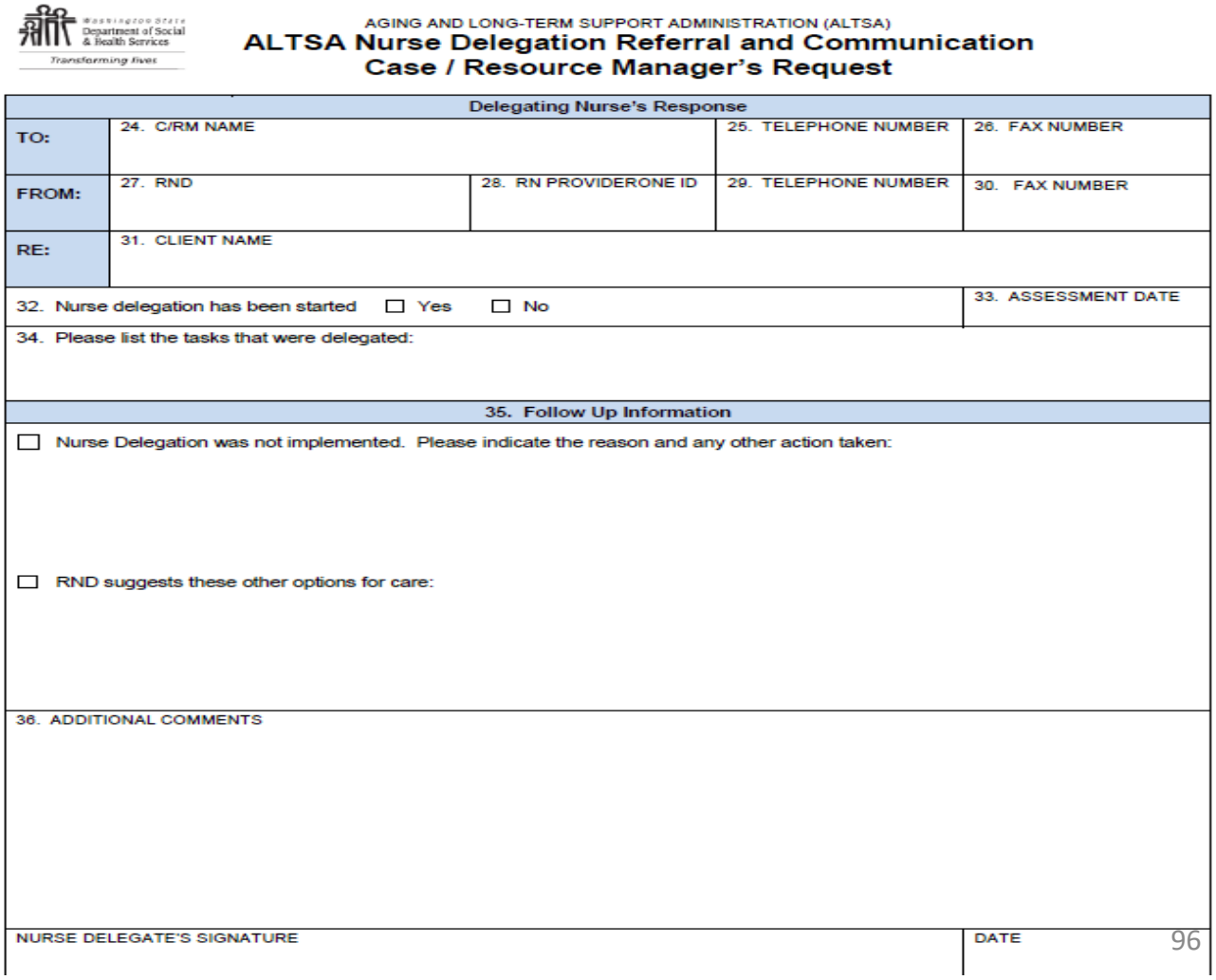
Communicating with RND

C/RM will communicate with RND when changes occur in client condition, authorized representative, financial eligibility or authorization is due.

CASE/RESOURCE MANAGER'S SIGNATURE	DATE

Nurse Delegation Referral Form Cont.

Referral form (01-212) Page 2



Washington State Department of Social & Health Services
Transforming lives

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)

ALTSA Nurse Delegation Referral and Communication Case / Resource Manager's Request

Delegating Nurse's Response				
TO:	24. C/RM NAME		25. TELEPHONE NUMBER	26. FAX NUMBER
FROM:	27. RND	28. RN PROVIDERONE ID	29. TELEPHONE NUMBER	30. FAX NUMBER
RE:	31. CLIENT NAME			
32. Nurse delegation has been started ☐ Yes ☐ No				33. ASSESSMENT DATE
34. Please list the tasks that were delegated:				
35. Follow Up Information				
☐ Nurse Delegation was not implemented. Please indicate the reason and any other action taken:				
☐ RND suggests these other options for care:				
36. ADDITIONAL COMMENTS				
NURSE DELEGATE'S SIGNATURE				DATE

Consent for Delegation

Consent for delegation

Obtain client or the clients authorized representative consent for delegation.

- Obtain prior to initiating delegation
- Verbal consent is good for 30 days
  - After 30 days you must have a signed consent form.
- Consent only needs to be gathered one time, at the start of delegation
  - If the client authorized representative changes
  - If assuming a case and the new RN wants to explain the delegation process

Consent for Delegation Form

Consent form (13-678)

Washington State Department of Social & Health Services

Nurse Delegation:
Consent for Delegation Process

1. CLIENT NAME			2. DATE OF BIRTH	3. ID/SETTING (OPTIONAL)
4. CLIENT ADDRESS	CITY	STATE ZIP CODE		5. TELEPHONE NUMBER
6. FACILITY OR PROGRAM CONTACT			7. TELEPHONE NUMBER	
8. FAX NUMBER		9. E-MAIL ADDRESS		

10. SETTING	11. CLIENT DIAGNOSIS	12. ALLERGIES
☐ Certified Community Residential Program for Developmentally Disabled		
☐ Licensed Adult Family Home		
☐ Licensed Assisted Living Facilities		
☐ Private Home/Other		
13. HEALTH CARE PROVIDER		14. TELEPHONE NUMBER

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- Acts that require nursing judgment

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My signature below indicates that I have assessed this client and found his/her condition to be stable and predictable. I agree to provide nurse delegation per RCW 18.79 and WAC 246-840-910 through 970.

21. RND NAME - PRINT	22. TELEPHONE NUMBER
23. RND SIGNATURE	24. DATE

Credentials and Verification Form

Credentials and verification form

- Check credentials for all delegated LTCW's
- Complete training and credentials form or print copies of training and credentials
- Document verification of all training and credentials
- Verification of exempt LTCW letter of employment

Credentials and Verification Form

Credentials And Training Verification (10-217)

Nurse Delegation:
Credentials and Training Verification

4. LONG TERM CARE WORKER'S (LTCW) NAME (PRINT)

5. Credential Verification

☐ Attach a copy of internet Provider Credential Search

http://www.doh.wa.gov/LicensesPermitsandCertificates/ProviderCredentialSearch.

OR COMPLETE THE FOLLOWING

A. RN Delegator has verified that the Long Term Care Worker is currently registered or certified in Washington state and is in good standing without restriction. Date of verification: _____

B. Washington State Certificate/Registration Number for _____
☐ NAR ☐ NAC ☐ HCA – C

C. Expiration Date: _____ ☐ Registered ☐ Certified

6. Training Verification

Required for NAR, NAC, and HCA-C before delegating.

☐ Nurse Delegation for Nursing Assistants (9 hours) Date: _____

☐ Nurse Delegation Special Focus on Diabetes class (3 hours) Date: _____
(ONLY if providing delegated insulin injections)

Basic Caregiver Training class required for NAR's before delegating:

☐ Basic Training (Core Competency) Date: _____

☐ Revised Fundamentals of Caregiving (RFOC) or alternative DSHS approved course Date: _____

☐ DDA CORE Basic Training Date: _____

☐ DDA 32 hour letter

☐ PRIDE Training (Foster Care setting) Date: _____

Basic Training certificate required of HCA before delegating*:

☐ NAR credential Date: _____

* Dual credential is no longer required after the HCA becomes certified.

EXEMPT LONG TERM CARE WORKERS

The HCS LTCW employed sometime between January 1, 2011 and January 6, 2012 and the DDA LTCW employed sometime before January 1, 2016 should have a letter from the employer who employed them stating they have completed the basic training requirements in effect on the date of his or her hire.

☐ Letter of employment verification Date: _____

☐ Basic Training (Core Competency) OR Date: _____

☐ Revised Fundamental of Caregiving (RFOC) Date: _____

☐ DDA CORE basic Date: _____

☐ DDA 32 hour letter Date: _____

7. RND SIGNATURE	8. DATE

Physical Assessment

Head to Toe Assessment

- Full systems nursing assessment
  - Currently no standardized form required
  - Must be completed at each supervisory visit
    - RN may chart per exception after the initial assessment.

Physical Assessment Form

Head to toe assessment

Head-to-Toe Assessment
Assessment conducted by _____

Date:_____
Time:_____

LOC
☐Alert ☐Drowsy ☐Lethargic ☐Stuporous☐Coma
Orientation
☐ Person _____
☐ Place _____
☐ Time _____
☐ Situation _____
Vitals
☐ Temp _____ ☐ R _____
☐ BP _____ Pulse Ox _____
Head
☐ Hair _____
☐ PERLA _____ mm
☐ Nose _____
☐ Ears _____
☐ Mouth _____
- Midline tongue _____
- Moist _____
- Lesions _____
- Dentition _____

Neck
☐ Carotid pulse ____ ☐ JVD + ☐Trachea midline
Chest
☐ Apical Pulse _____☐Muffled ☐Arrhythmia
☐ Breath Sounds - Anterior_____
Posterior _____Lateral_____
☐ Chest Symmetry _____
☐ Skin Turgor (clavicle) _____
Abdomen
☐ Inspection _____
☐ Auscultation
- LUQ (active / hyper / absent)
- RUQ (active / hyper / absent)
- LLQ (active / hyper / absent)
- RLQ (active / hyper / absent)

☐ Palpation _____

Upper Extremities
☐ Radial pulses equal, +2
- Other: _____

☐ Temp vs. trunk (warm / cool)
☐ Grip equal and strong _____
☐ Capillary refill <3 sec
☐ Vein filling rapid

Lower Extremities
☐ Hair present
☐ Edema _____
☐ Foot strength
☐ Homan's (+ / -) Claudication (+ / -)
☐ Temp vs. Trunk (warm / cool)
☐ Nails ☐ Yellowed ☐ Thickened ☐ Ingrown

☐ Pedal pulse R(palp / doppler) L(palp / doppler)
ROM / **Strength**
☐ Upper R _____ ☐ Upper R _____
☐ Upper L _____ ☐ Upper L _____
☐ Lower R _____ ☐ Lower R _____
☐ Lower L _____ ☐ Lower L _____
☐ Sensation _____

General Assessment
☐ Weight/Height _____
☐ BM _____
Pain Assessment
☐ Acute/Chronic ☐ Intensity (0-10) _____
☐ Location _____
☐ Duration _____
☐ Characteristics _____
☐ Precipitation _____
☐ Frequency _____
☐ Non-verbals _____
☐ Relief factors _____
☐ Sleep _____
Skin Assessment
☐ Description: _____


Courtesy of http://nursing.arizela.com

Instructions and Task Sheet

Instructions and Task Sheet

- Complete instructions and task sheet for each delegated task
  - Oral medications
  - Topical medications
  - Wound care
- List medications delegated
  - Method of verification
    - MD order
    - MAR review
    - Pharmacy
- Step by step task analysis to complete nursing task

Instructions and Task Sheet

Instructions and Task Sheet

- Expected side effects
- When to notify the RN
  - Provide contact information
- When to notify MD
  - Provide contact information
- When to notify 911

Be specific when giving examples of side effects. Remember, side effects and steps to perform task are specific to the client

Instructions and Task Sheet

Instructions

And task

Form

(13-678)

Washington State Department of Social & Health Services
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Nurse Delegation:
Instructions for Nursing Task

1. CLIENT NAME	2. DATE OF BIRTH	3. ID / SETTING (OPTIONAL)	4. DATE TASK DELEGATED
5. DELEGATED TASK AND EXPECTED OUTCOME			
Complete 6 and 7 only if medication(s) delegated:			
6. LIST SPECIFIC MEDICATION(S), DOSAGES AND FREQUENCY OF MEDICATIONS DELEGATED ON THIS DATE (☐ CHECK HERE IF ADDITIONAL FORM ATTACHED.)	VERIFICATION OF DELEGATED MEDICATION DATE NAME / TITLE METHOD OF VERIFICATION		
8. STEPS TO PERFORM THE TASK: ☐ Check here if additional teaching aide(s) attached.			
Report Side Effects or Unexpected Outcomes To:			
9. RND NAME (PRINT)			10. TELEPHONE NUMBER
11. WHAT TO REPORT TO RND			
12. HEALTH CARE PROVIDER NAME			13. TELEPHONE NUMBER
14. WHAT TO REPORT TO HEALTH CARE PROVIDER			
EMERGENCY SERVICES, 911			
15. WHAT TO REPORT TO 911			

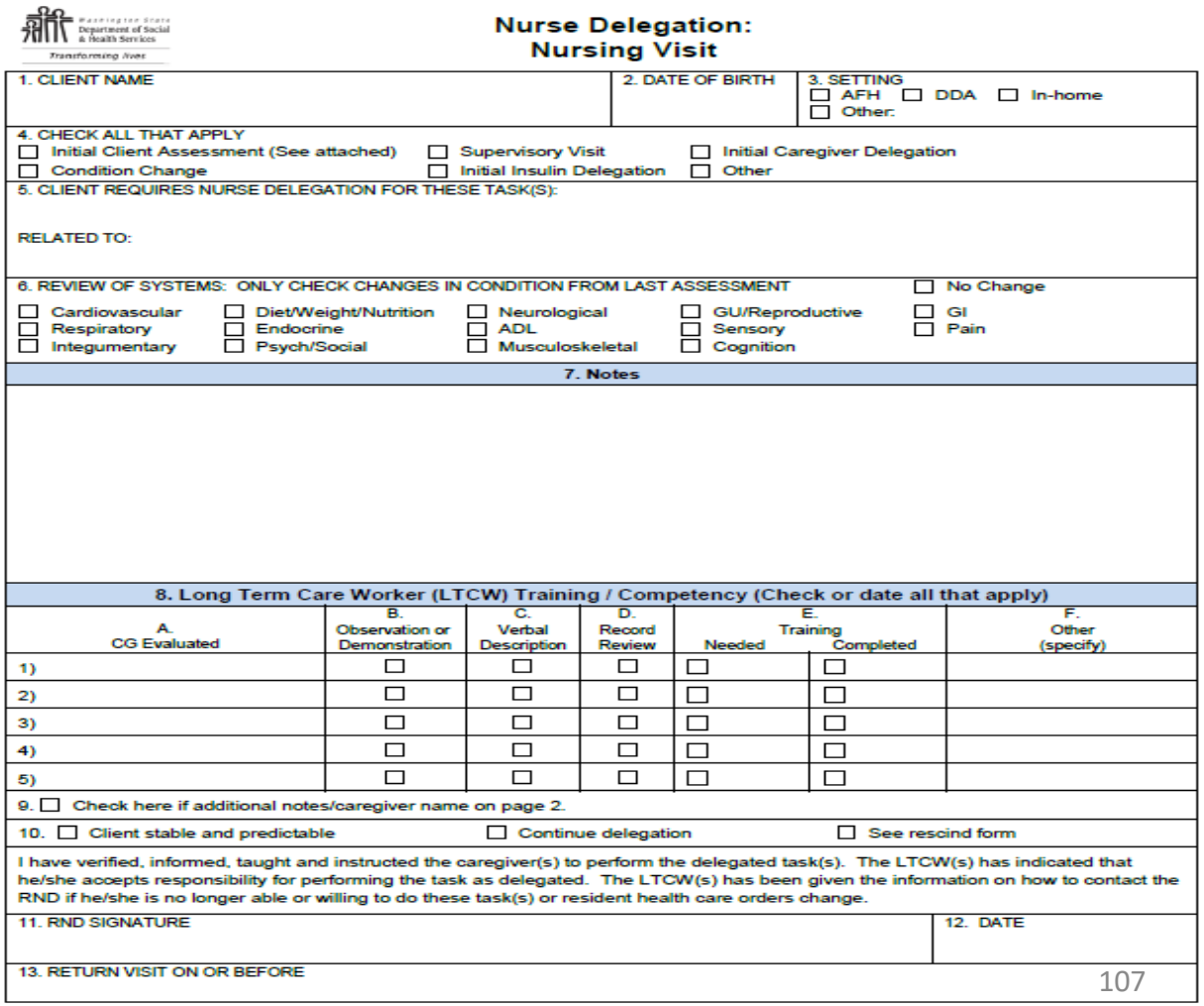
Nursing Visit Form

Nursing Visit Form

- The nursing visit form is the most widely used form
  - Initial assessment
  - Supervisory (90 day) visits
  - Change in condition
  - Change in delegated task
  - Rescinding of LTCW
  - Delegation to new LTCW
  - other

Nursing Visit Form

Nurse visit form (14-484)



Nurse Delegation:
Nursing Visit

1. CLIENT NAME | 2. DATE OF BIRTH | 3. SETTING ☐ AFH ☐ DDA ☐ In-home ☐ Other:

4. CHECK ALL THAT APPLY
☐ Initial Client Assessment (See attached) ☐ Supervisory Visit ☐ Initial Caregiver Delegation
☐ Condition Change ☐ Initial Insulin Delegation ☐ Other

5. CLIENT REQUIRES NURSE DELEGATION FOR THESE TASK(S):

RELATED TO:

6. REVIEW OF SYSTEMS: ONLY CHECK CHANGES IN CONDITION FROM LAST ASSESSMENT ☐ No Change

☐ Cardiovascular	☐ Diet/Weight/Nutrition	☐ Neurological	☐ GU/Reproductive	☐ GI
☐ Respiratory	☐ Endocrine	☐ ADL	☐ Sensory	☐ Pain
☐ Integumentary	☐ Psych/Social	☐ Musculoskeletal	☐ Cognition	

7. Notes

8. Long Term Care Worker (LTCW) Training / Competency (Check or date all that apply)

A. CG Evaluated	B. Observation or Demonstration	C. Verbal Description	D. Record Review	E. Training Needed	E. Training Completed	F. Other (specify)
1)	☐	☐	☐	☐	☐	
2)	☐	☐	☐	☐	☐	
3)	☐	☐	☐	☐	☐	
4)	☐	☐	☐	☐	☐	
5)	☐	☐	☐	☐	☐	

9. ☐ Check here if additional notes/caregiver name on page 2.

10. ☐ Client stable and predictable ☐ Continue delegation ☐ See rescind form

I have verified, informed, taught and instructed the caregiver(s) to perform the delegated task(s). The LTCW(s) has indicated that he/she accepts responsibility for performing the task as delegated. The LTCW(s) has been given the information on how to contact the RND if he/she is no longer able or willing to do these task(s) or resident health care orders change.

11. RND SIGNATURE | 12. DATE

13. RETURN VISIT ON OR BEFORE

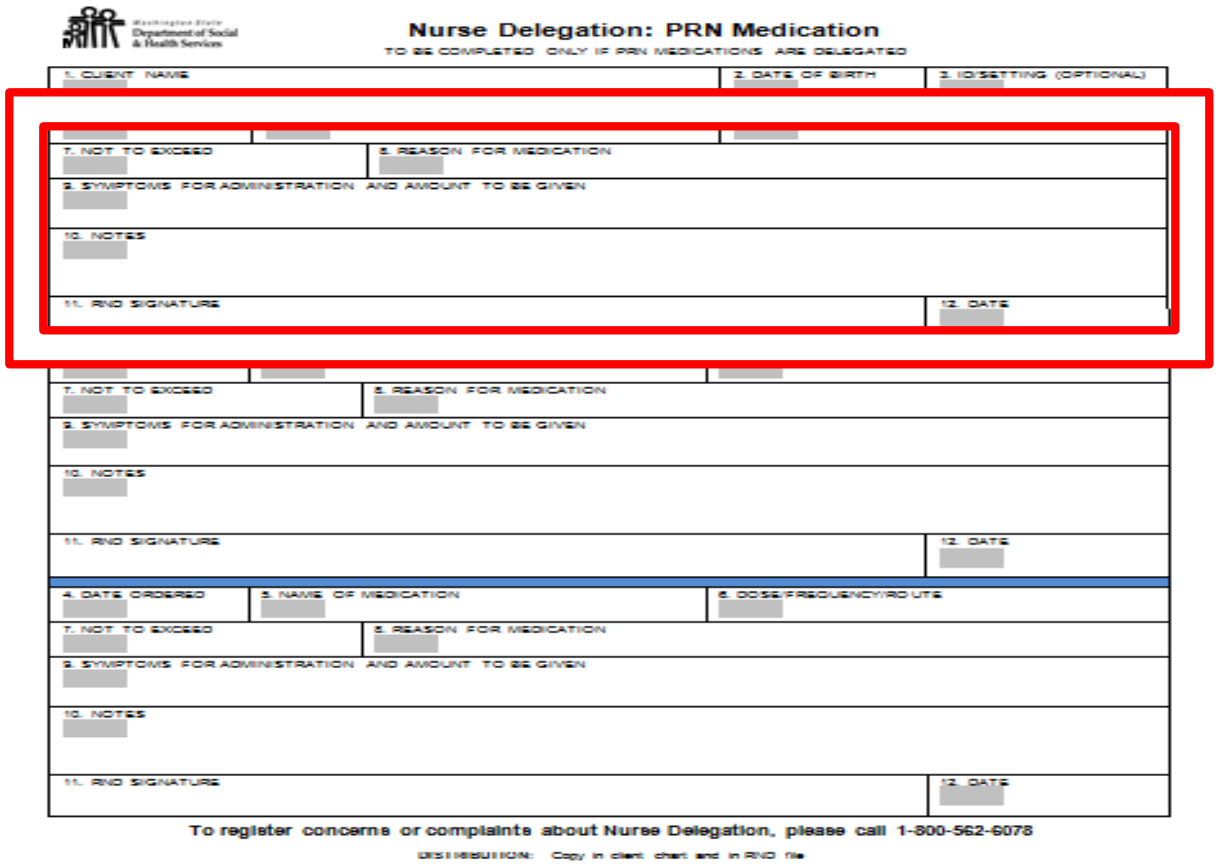
Supplementary Forms

The following forms are not required, but can be used:

- PRN
- Change in medical orders
- Assumption
- Rescinding

PRN Medication Form

There is room for multiple PRN medications to be listed



Nurse Delegation: PRN Medication

TO BE COMPLETED ONLY IF PRN MEDICATIONS ARE DELEGATED

1. CLIENT NAME | 2. DATE OF BIRTH | 3. ID/SETTING (OPTIONAL)

4. DATE ORDERED | 5. NAME OF MEDICATION | 6. DOSE/FREQUENCY/ROUTE

7. NOT TO EXCEED | 8. REASON FOR MEDICATION

9. SYMPTOMS FOR ADMINISTRATION AND AMOUNT TO BE GIVEN

10. NOTES

11. RND SIGNATURE | 12. DATE

(Duplicate blank rows)

To register concerns or complaints about Nurse Delegation, please call 1-800-562-6078

DISTRIBUTION: Copy in client chart and in RND file

Nurse Delegation

4. DATE ORDERED	5. NAME OF MEDICATION	6. DOSE/FREQUENCY/ROUTE
01/03/2014	Ativan	2-4 mg every 4-6 hrs as needed
7. NOT TO EXCEED: 8 mg/24 hrs	8. REASON FOR MEDICATION: Agitation	
9. SYMPTOMS FOR ADMINISTRATION AND AMOUNT TO BE GIVEN: Pacing in hallway; striking out;		
10. NOTES: Can repeat dose as needed		
11. RND SIGNATURE: IMA NURSE RN		12. DATE: 01/03/2014

Not an acceptable order due to ranges

4. DATE ORDERED	5. NAME OF MEDICATION	6. DOSE/FREQUENCY/ROUTE
01/03/2014	Ativan	2mg every 4 hrs PRN for agitation
7. NOT TO EXCEED: 8 mg/24 hours	8. REASON FOR MEDICATION: Agitation	
9. SYMPTOMS FOR ADMINISTRATION AND AMOUNT TO BE GIVEN: with pacing in hallway and/or striking out. Client yells when she is agitated usually.		
10. NOTES: See second page for possible 2nd dosing when no relief in agitation after 1 hour.		
11. RND SIGNATURE: IMA NURSE RN		12. DATE: 01/03/2014

To register concerns or complaints about Nurse Delegation, please call 1-800-562-6078

DISTRIBUTION: Copy in client chart and in RND file

PRN Medication Form Cont.

Washington State Department of Social & Health Services

Nurse Delegation: PRN Medication

TO BE COMPLETED ONLY IF PRN MEDICATIONS ARE DELEGATED

1. CLIENT NAME	2. DATE OF BIRTH	3. ID/SETTING (OPTIONAL)
MABEL SMITH	05/16/1932	AFH

4. DATE ORDERED	5. NAME OF MEDICATION	6. DOSE/FREQUENCY/ROUTE
01/03/2014	Ativan	May repeat 2mg by mouth in 1 hr. PRN

7. NOT TO EXCEED	8. REASON FOR MEDICATION
8mg/24 hours	agitation

9. SYMPTOMS FOR ADMINISTRATION AND AMOUNT TO BE GIVEN

with pacing in hallway and/or striking out. Client yells when she is agitated usually

10. NOTES

This order is for repeat dose of Ativan when no relief within 1 hour.

11. RND SIGNATURE	12. DATE
IMA NURSE RN	01/03/2014

Acceptable order for delegation

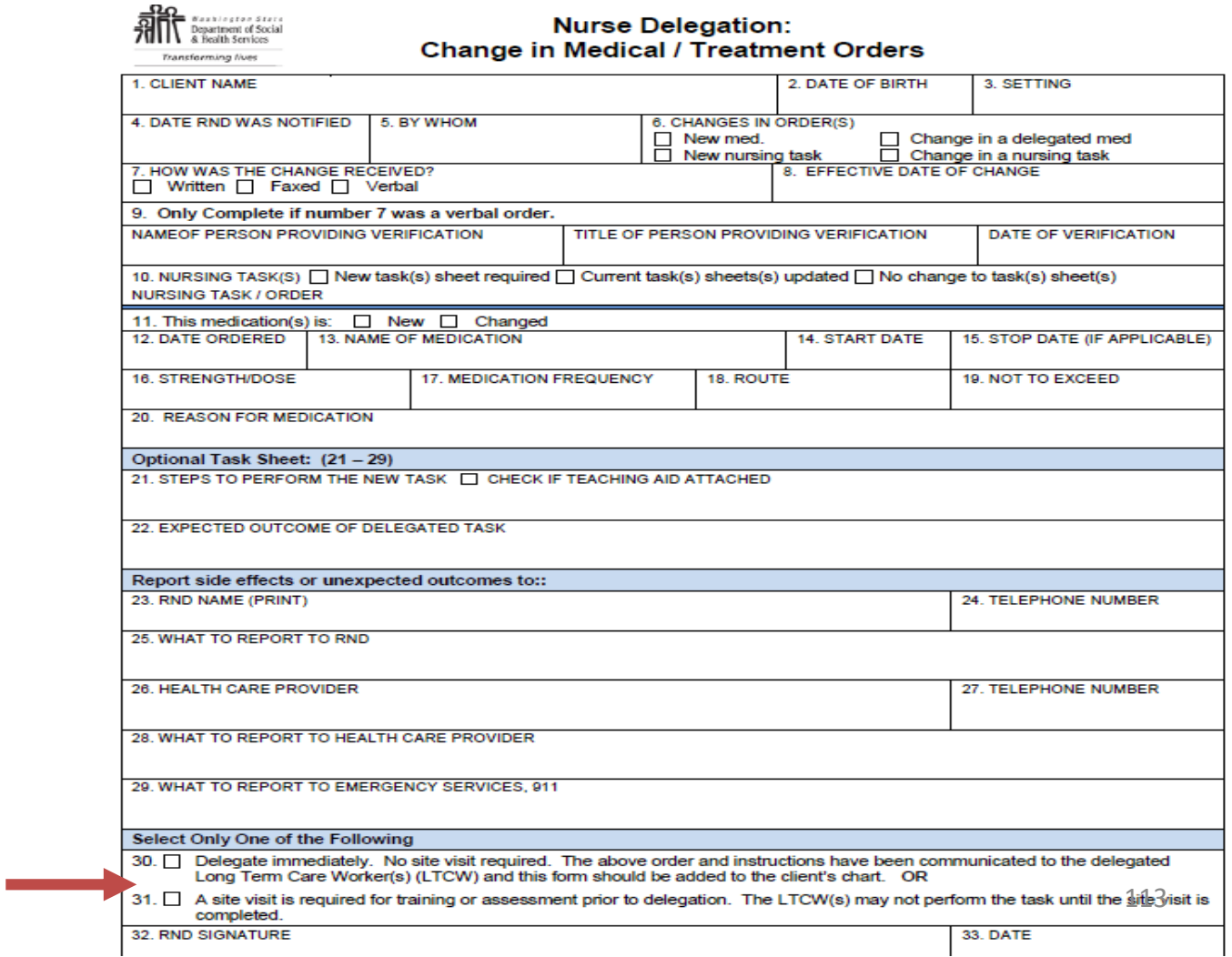
Change in Medical Orders Form

- If there is a change in medications mid review cycle
- Change in dosage
- Addition of short term medication
  - 10 day course of antibiotic ointment
- Change in a nursing task

The change in medical orders form is similar to the instructions and task form

Change in Medical Orders Form Cont.

Change in Medications Or treatment (13-681)



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Nurse Delegation:
Change in Medical / Treatment Orders

1. CLIENT NAME	2. DATE OF BIRTH	3. SETTING
4. DATE RND WAS NOTIFIED / 5. BY WHOM	6. CHANGES IN ORDER(S) ☐ New med. ☐ Change in a delegated med ☐ New nursing task ☐ Change in a nursing task	
7. HOW WAS THE CHANGE RECEIVED? ☐ Written ☐ Faxed ☐ Verbal	8. EFFECTIVE DATE OF CHANGE	
9. **Only Complete if number 7 was a verbal order.**		
NAMEOF PERSON PROVIDING VERIFICATION	TITLE OF PERSON PROVIDING VERIFICATION	DATE OF VERIFICATION
10. NURSING TASK(S) ☐ New task(s) sheet required ☐ Current task(s) sheets(s) updated ☐ No change to task(s) sheet(s) NURSING TASK / ORDER		
11. This medication(s) is: ☐ New ☐ Changed		
12. DATE ORDERED	13. NAME OF MEDICATION	14. START DATE / 15. STOP DATE (IF APPLICABLE)
16. STRENGTH/DOSE	17. MEDICATION FREQUENCY / 18. ROUTE / 19. NOT TO EXCEED	
20. REASON FOR MEDICATION		
Optional Task Sheet: (21 – 29)		
21. STEPS TO PERFORM THE NEW TASK ☐ CHECK IF TEACHING AID ATTACHED		
22. EXPECTED OUTCOME OF DELEGATED TASK		
Report side effects or unexpected outcomes to::		
23. RND NAME (PRINT)	24. TELEPHONE NUMBER	
25. WHAT TO REPORT TO RND		
26. HEALTH CARE PROVIDER	27. TELEPHONE NUMBER	
28. WHAT TO REPORT TO HEALTH CARE PROVIDER		
29. WHAT TO REPORT TO EMERGENCY SERVICES, 911		
Select Only One of the Following		
30. ☐ Delegate immediately. No site visit required. The above order and instructions have been communicated to the delegated Long Term Care Worker(s) (LTCW) and this form should be added to the client's chart. OR		
31. ☐ A site visit is required for training or assessment prior to delegation. The LTCW(s) may not perform the task until the site visit is completed.		
32. RND SIGNATURE	33. DATE	

Change in Medical Orders Form Cont

Optional Task Sheet: (21 – 29)

21. STEPS TO PERFORM THE NEW TASK(S)
See: 1. Instructions for administering PO meds 2. See attached Pharmacy Sheet highlights for possible side effects

22. EXPECTED OUTCOME OF DELEGATED TASK(S)
Resolution of infection with normal breath sounds

Report side effects or unexpected outcomes to::

23. RND NAME (PRINT)	24. TELEPHONE NUMBER
Ima Nurse RN	**(206) 000-0000**

25. WHAT TO REPORT TO RND
Rash; Increase in cough or deep yellow/gold, green or bloody sputum

26. HEALTH CARE PROVIDER	27. TELEPHONE NUMBER
Dr. Welby	**(206) 777-1212**

28. WHAT TO REPORT TO HEALTH CARE PROVIDER
Rash, difficulty swallowing, increased difficulty with breathing

29. WHAT TO REPORT TO EMERGENCY SERVICES, 911
Non responsive

Select Only One of the Following

30. ☐ Delegate immediately. No site visit required. The above order and instructions have been communicated to the delegated caregiver(s) and this form should be added to the client's chart. **OR**

31. ☒ A site visit required for training or assessment prior to delegation. The caregiver may not perform the task until the site visit is completed.

32. RND SIGNATURE	33. DATE
Ima Nurse RN	**2/4/2014**

To register concerns or complaints about Nurse Delegation, please call 1-800-562-6078

nd in RND file

RN can make the decision to delegate immediately or require a site visit

Rescinding Form

- Document date rescinded
- Who you rescinded
- Why you rescinded

Rescinding Form Cont.

Rescinding Form (13-680)

Washington State Department of Social & Health Services
Transforming lives

Nurse Delegation: Rescinding Delegation

1. CLIENT NAME	2. DATE OF BIRTH	3. SETTING
4. FACILITY OR PROGRAM NAME		5. TELEPHONE NUMBER

6. Reason for Rescinding: (Check all that apply)

- ☐ A. Client died
- ☐ B. Client's condition is no longer stable and predictable
- ☐ C. Frequent staff turnover
- ☐ D. Client / authorized representative requested
- ☐ E. NA not competent
- ☐ R. NA not willing
- ☐ G. NA credential expired
- ☐ H. NA No longer working with client
- ☐ I. Client safety compromised
- ☐ J. Rescinding facility including clients and nurse assistant
- ☐ K. Other (specify)

7. NAMES OF CAREGIVERS	8. MEDICATIONS AND TREATMENTS RESCINDED	9. NOTES
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		
9)		
10)		

10. NAME OF CASE MANAGER NOTIFIED	11. METHOD OF NOTIFICATION ☐ Telephone ☐ Email	12. DATE

13. ALTERNATIVE PLAN FOR CONTINUING THE TASK

14. RND SIGNATURE	15. DATE

Assumption Form

- If you are assuming a case complete the assumption form to verify date assumed
- This is the date you will begin assuming liability
- Document the reason why assumption occurred.

Assumption Form Cont.

Assumption Form (13-678B)

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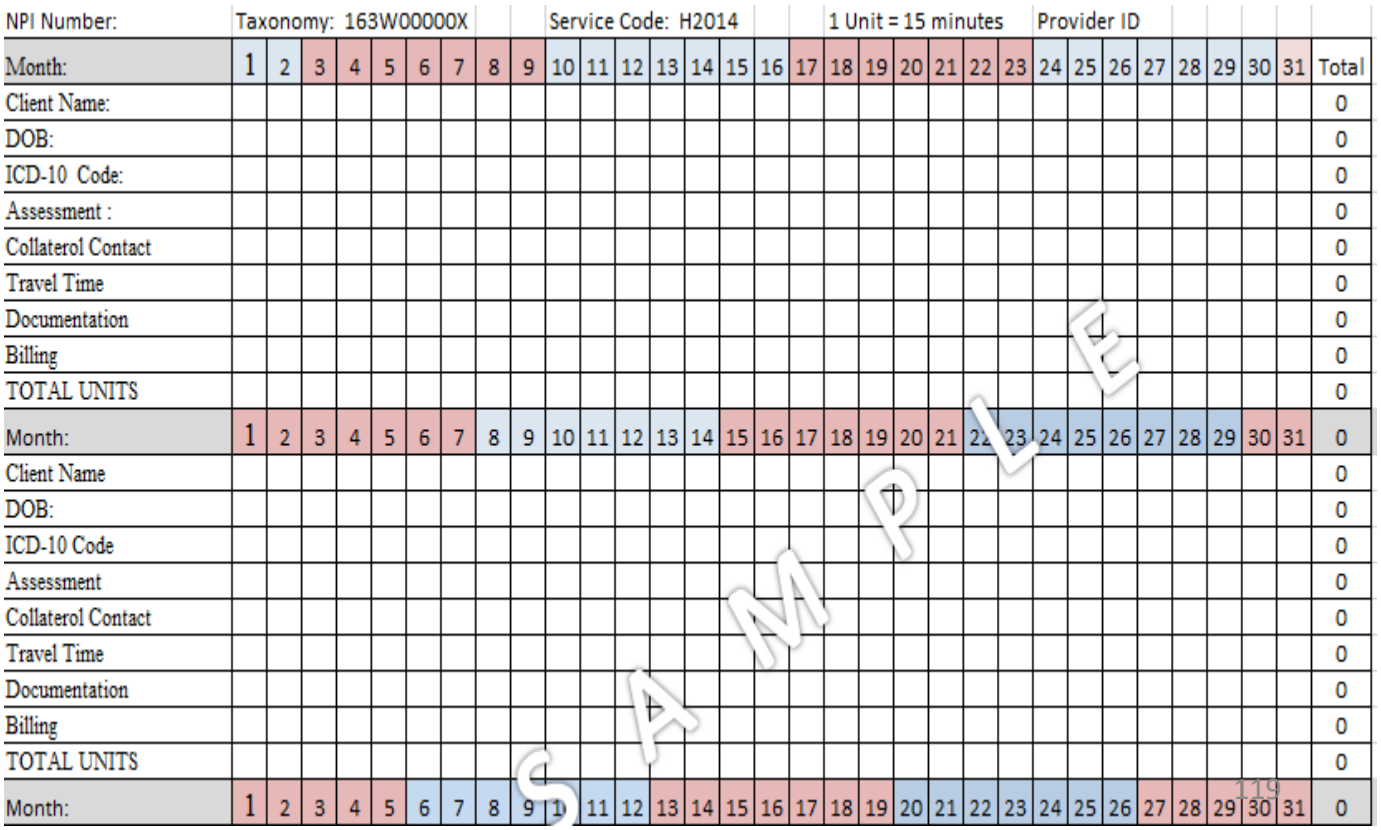
Nurse Delegation: Assumption of Delegation

1. CLIENT NAME	2. DATE OF BIRTH	3. SETTING
4. FACILITY OR PROGRAM NAME		5. TELEPHONE NUMBER
6. REASON FOR ASSUMING DELEGATION		
I agree that I know the client through my assessment, the plan of care, the skills of the Long Term Care Worker(s) (LTCW), and the delegated task(s). I agree to assume responsibility and accountability for the delegated task(s) and to perform the nursing supervision. I have informed the client and/or authorized representative of this change. I have informed the LTCW, case manager, and client of this change.		
7. RND SIGNATURE		8. DATE

Additional Billing Tracker

Additional Billing tracker



NPI Number:	Taxonomy: 163W00000X									Service Code: H2014								1 Unit = 15 minutes							Provider ID							
Month:	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	Total
Client Name:																																0
DOB:																																0
ICD-10 Code:																																0
Assessment :																																0
Collaterol Contact																																0
Travel Time																																0
Documentation																																0
Billing																																0
TOTAL UNITS																																0
Month:	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	0
Client Name																																0
DOB:																																0
ICD-10 Code																																0
Assessment																																0
Collaterol Contact																																0
Travel Time																																0
Documentation																																0
Billing																																0
TOTAL UNITS																																0
Month:	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	0

Nurse Delegation

Group Activity

Background:

On 11/20/2016 at 10:15am you receive a call from Judy a Case Manager in your local Home and Community Services office, she is looking for a nurse delegator to evaluate a client to determine if delegation is appropriate. He currently has informal support at home however has enlisted the help of three caregivers to help complete his care needs.

Group Activity Cont.

Break out into groups of 5

Take 10 minutes to work through the following scenario. Answer questions as a group, on slide 111.

Be prepared to talk about your response.

Client History:

Alfonso Green a 66 year old male with a history of insulin dependent diabetes, diabetic foot ulcers, hypertension, congestive heart failure, immobility, and rheumatoid arthritis.

Group Activity Cont.

From Scenario

Medications and Treatments:

- Novolog
- Lantus
- Lasix
- Metoprolol
- Methotrexate
- Weekly dressing changes to foot ulcers

Group Activity Cont.

Forms Scenario

Current Caregivers:

- Lisa- CNA (9 hour nurse delegation course completed and 3 special focus on diabetes completed)
- Rachel- NAR completed on Feb. 11th 2010 and has worked at the same long-term care facility since acquiring NAR.
- David HCA-C- (9 hour nurse delegation course completed)

Group Activity Cont.

- What form and attachments will you need from the case manager before you complete your assessment?
- Is there specific information you need on that form to complete an accurate assessment?
- Are the caregivers prepared for delegation (Use the Credential and Verification form to help you)?
- What do you need to complete and send back to the case manager?
- What would your delegation process look like, from start to finish?
  - What information do you need
  - Who would you contact
  - What forms would you use
  - At what frequency would you return to Alfonso's home to assess him and his LTCW's


CONTRACTING

Contracting with DSHS

Contracting with DSHS for Nurse Delegation

RN's interested in being paid to delegate for Medicaid clients, in the following settings must be contracted:

- Adult Family Homes
- DDA Supported Living
- Private homes

Contracting with DSHS

What services can I provide with a DSHS contract?

- Nurse Delegation for both DDA and HCS clients
- Skin Observation Protocol for existing clients
- One time skilled nursing task
  - For DDA clients ONLY

Requirements for Contracting with ALTSA

- RN must attend 8 hour Nurse Delegation Orientation
- WA state RN license without restrictions
- 1 years RN experience or equivalent experience, determined by ND program managers
- Professional liability insurance
  - 1 million incident/ 2 million aggregate
- Pass a criminal background check
- Have a National Provider Index (NPI) number
- Complete a Core Provider Agreement (CPA)
- Have a business license

Contract Requirements

- Resume or letter of interest
- Copy of your certificate from this class
- Copy of Drivers License
- Copy of RN license
- Copy of business license
- Copy of professional liability insurance
- Completed background check
- Completed W-9
  - Private business owner

Nurse Delegation Application Process

1. Return completed packet to ND Program
2. ND Program Manager
3. ALTSA Contract Unit
4. CPA to Health Care Authority (HCA)
5. HCA to ALTSA Contracts Unit
6. ALTSA Contract Unit to RN
7. RN to Contracts Unit
8. Contracts Units to RN Program Managers

What Can I Bill For?

- Assessments
- Documentation
- Collateral contacts
- Travel time
- Billing time

Payment

- RN delegators must track time billed
- Billed in units
  - 1 unit= 15 minutes
  - 4 units= 1 hour
- Current rate is $11.33 per unit
  - $45.32 an hours
  - Rate set by Legislation

Nurse Delegation

Billing

- HCS clients are authorized:
  - 36 units per month x 12 months
- DDA clients are authorized:
  - 100 units per month x 12 month

If additional units are needed RN must complete an "additional unit request form" outlining rationale

HCS Additional Units Request Form

HCS Addition Unit Request form (13-893)

AGING AND LONG-TERM SUPPORT ADMINISTRATION

Nurse Delegation: Request For Additional Units

To be completed by Delegating Nurse

1. RN'S NAME	2. RN'S TELEPHONE NUMBER	3. RN'S E-MAIL ADDRESS
4. CLIENT'S NAME		5. CLIENT'S DATE OF BIRTH
6. CASE MANAGER'S NAME	7. CASE MANAGER'S TELEPHONE NUMBER	8. CASE MANAGER'S E-MAIL

9. I will need _____ more units in addition to the 36 units already authorized for the month of _____.
This will allow me to bill for a total of _____ units for the month.

10. Reason Additional Units Needed:

A. **For Insulin,** complete the section below (no additional narrative required).
- ☐ Initial visit; _____ units needed.
- ☐ Supervisory visit; _____ units needed.
- ☐ New support providers / caregivers; _____ units needed.

Total number of caregivers delegated insulin: _____

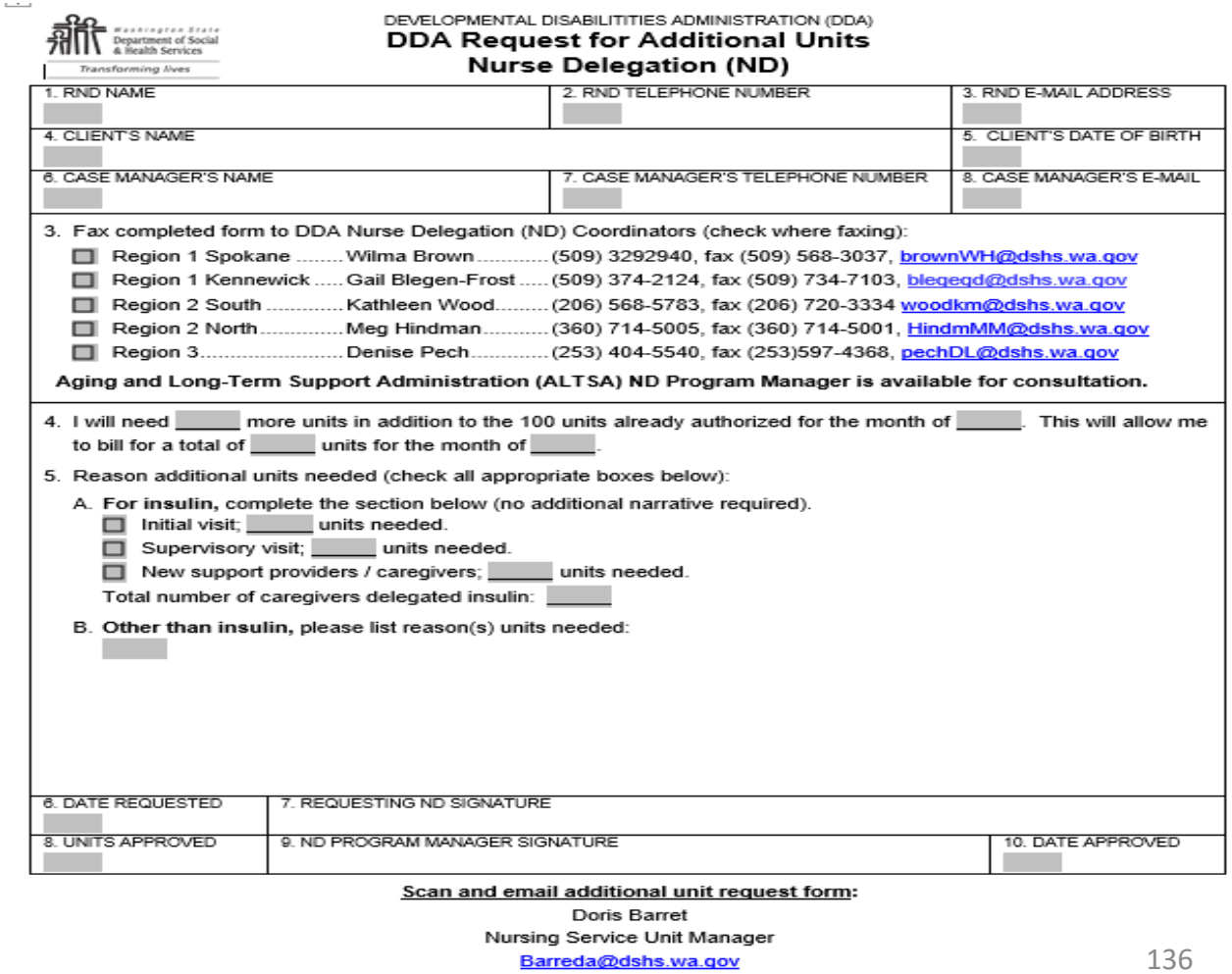
B. **Other than Insulin** please list reasons units needed:

11. DATE REQUESTED	12. REQUESTING RN SIGNATURE	
13. UNITS APPROVED	14. RN PROGRAM MANAGER SIGNATURE	15. DATE APPROVED

Scan and email additional unit request form:
Erika Parada
Nurse Delegation Program Manager
ParadE@dshs.wa.gov

DDA Additional Units Request Form

DDA Additional Request Form (13-903)



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DEVELOPMENTAL DISABILITITIES ADMINISTRATION (DDA)

DDA Request for Additional Units
Nurse Delegation (ND)

1. RND NAME	2. RND TELEPHONE NUMBER	3. RND E-MAIL ADDRESS
4. CLIENT'S NAME		5. CLIENT'S DATE OF BIRTH
6. CASE MANAGER'S NAME	7. CASE MANAGER'S TELEPHONE NUMBER	8. CASE MANAGER'S E-MAIL

3. Fax completed form to DDA Nurse Delegation (ND) Coordinators (check where faxing):
- ☐ Region 1 Spokane ..... Wilma Brown ..... (509) 3292940, fax (509) 568-3037, brownWH@dshs.wa.gov
- ☐ Region 1 Kennewick ..... Gail Blegen-Frost ..... (509) 374-2124, fax (509) 734-7103, bleqeqd@dshs.wa.gov
- ☐ Region 2 South ..... Kathleen Wood ..... (206) 568-5783, fax (206) 720-3334 woodkm@dshs.wa.gov
- ☐ Region 2 North ..... Meg Hindman ..... (360) 714-5005, fax (360) 714-5001, HindmMM@dshs.wa.gov
- ☐ Region 3 ..... Denise Pech ..... (253) 404-5540, fax (253)597-4368, pechDL@dshs.wa.gov

Aging and Long-Term Support Administration (ALTSA) ND Program Manager is available for consultation.

4. I will need _____ more units in addition to the 100 units already authorized for the month of _____. This will allow me to bill for a total of _____ units for the month of _____.

5. Reason additional units needed (check all appropriate boxes below):

A. **For insulin,** complete the section below (no additional narrative required).
- ☐ Initial visit; _____ units needed.
- ☐ Supervisory visit; _____ units needed.
- ☐ New support providers / caregivers; _____ units needed.

Total number of caregivers delegated insulin: _____

B. **Other than insulin,** please list reason(s) units needed:

6. DATE REQUESTED	7. REQUESTING ND SIGNATURE	
8. UNITS APPROVED	9. ND PROGRAM MANAGER SIGNATURE	10. DATE APPROVED

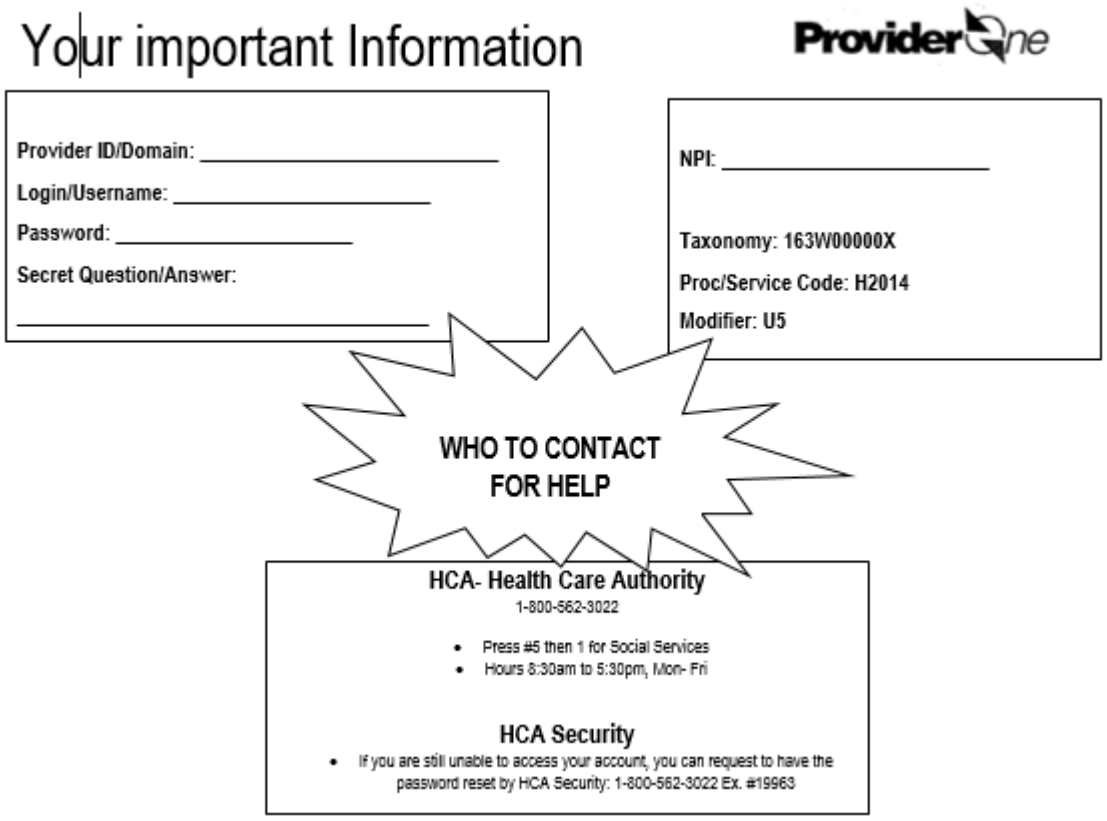
Scan and email additional unit request form:
Doris Barret
Nursing Service Unit Manager
Barreda@dshs.wa.gov

How Do I Bill?

Billing is completed through the Health Care Authority (HCA)

- You must complete a CPA in order to get access to ProviderOne for billing
- Once you have access you will:
  - Receive a welcome letter via US mail
  - Receive your domain and user name via email
  - Receive a second email with a temporary password

Rolodex Sheet



Group Activity

Group work:
Billing Scenarios

Use provided scenario to track units used from the initial date of your referral until the time you billed.

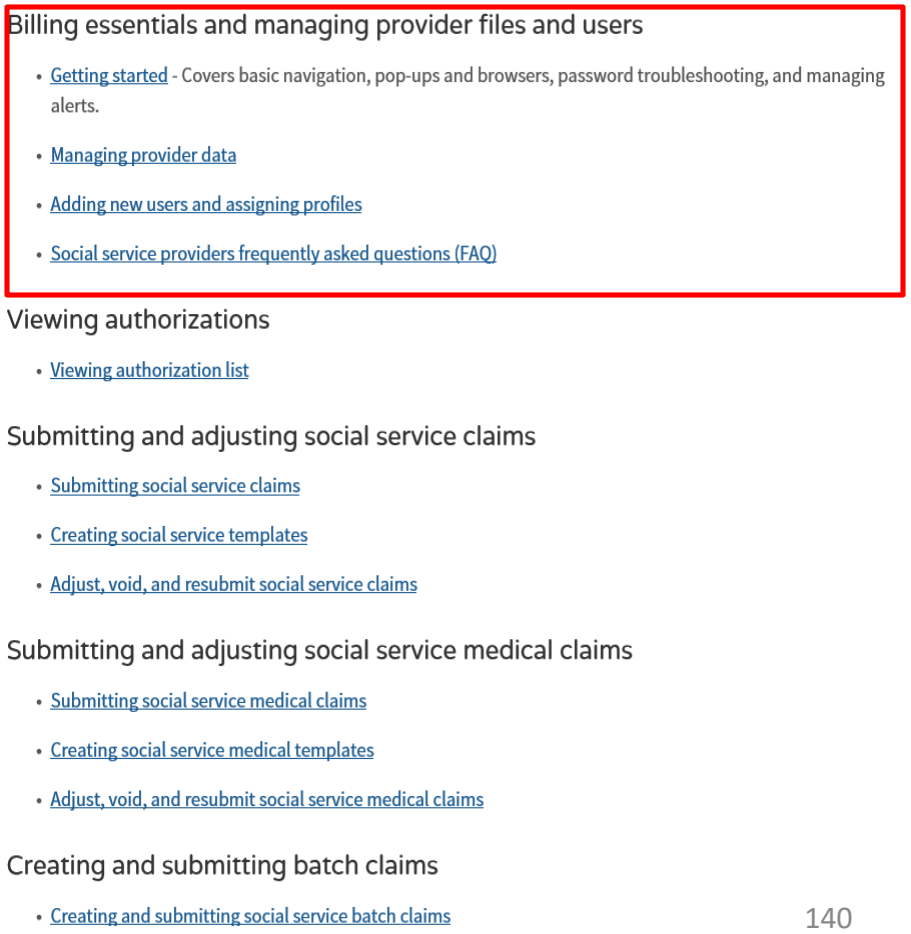
This may include:

- Conversation regarding referral
- Assessment of client
- Task analysis
- Training caregivers
- Returning documentation
- Billing

Activity

Health Care Authority

ProviderOne self study billing: https://www.hca.wa.gov/billers-providers/providerone/providerone-social-services



Billing essentials and managing provider files and users

- Getting started - Covers basic navigation, pop-ups and browsers, password troubleshooting, and managing alerts.
- Managing provider data
- Adding new users and assigning profiles
- Social service providers frequently asked questions (FAQ)

Viewing authorizations

- Viewing authorization list

Submitting and adjusting social service claims

- Submitting social service claims
- Creating social service templates
- Adjust, void, and resubmit social service claims

Submitting and adjusting social service medical claims

- Submitting social service medical claims
- Creating social service medical templates
- Adjust, void, and resubmit social service medical claims

Creating and submitting batch claims

- Creating and submitting social service batch claims

Activity

Billing practice:

- Take 5-10 minutes to walk through purple billing scenario
- Complete sample billing chart
  - Track units in category (there is no right or wrong category)
  - Add units up based on your billing schedule (weekly, every two weeks, monthly…)

NPI Number:	Taxonomy: 163W00000X									Service Code: H2014								1 Unit = 15 minutes							Provider ID							
Month:	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	Total
Client Name:																																0
DOB:																																0
ICD-10 Code:																																0
Assessment :																																0
Collaterol Contact																																0
Travel Time																																0
Documentation																																0
Billing																																0
TOTAL UNITS																																0
Month:	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	0
Client Name																																0
DOB:																																0
ICD-10 Code																																0
Assessment																																0
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Travel Time																																0
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Billing																																0
TOTAL UNITS																																0
Month:	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	0

Nurse Delegation

Other DSHS Contract

- Community instructor contract
  - Train LTCW for 9 hour ND for NA
  - Train LTCW for 3 hour SFOD
- HCS
  - Contact Training Unit at (360) 725-2548
- DDA
  - Contact Doris Barret: (360) 407-1504

Nurse Delegation

Other DSHS Contracts

- Skilled Nursing Waiver Contract
  - Provide skilled nursing task
  - Similar to Home Health
    - Wound care
    - Indwelling catheter insertion
    - Injections
  - Contact local Area Agency on Aging (AAA) office

Nurse Delegation

Other DSHS Contracts

- Private Duty Nursing
  - Provide 1:1 care
  - Client must require four hours of continued nursing services
    - Vent
    - Trach
  - Contact Jevahly Wark (360) 725-1737

Setting Up Your Business

You must market your business and yourself

- Contact CM's
- Develop marketing materials
  - Business cards
  - Flyers
  - Website
- Contact other RN delegators in y our community
- Attend quarterly meetings

Nurse Delegation

Responsibilities

- Contracted RN responsibilities
- Case manager responsibilities
- ND program manager responsibilities

Contracted RN

- Document when, how, and from who referral was received
- If necessary arrange interpreter services with CM
- Assess client within 3 working days of receiving the referral
- Provide SOP documentation to CM within five days
- Return page two of referral to case manager
- Notify CM if there is a change in client condition or nursing task delegated
- Notify CM if rescinding or assuming a caseload

Contracted RN Cont.

- Maintain duplicate copies of all ND files for six years
- Send client files to case managers as requested
- Send client files to program managers if requested
- If client resides in a private home, set up client chart
- Teach LTCW how to safely perform the nursing task
- Maintain a current RN license, business license, and liability insurance
- Report suspected abuse or neglect

Case Manager

- Send referral to RN
- Send current CARE assessment
- Send positive behavior support plan
- Send release of information
- Authorize payment for 12 months
- Communicate changes in client eligibility
- If client referred is in their private home, the case manager will verify LTCW credentials prior to referring

Program Manager

- Resource for all contracted RN's
- Resource for RN's in the state of WA
- Resource for all CM's in the state of WA
- Provide follow up and investigations on all delegation complaints, with contracted nurses
- Maintain contracted RN records
- Contract Monitoring on all contracted RN's
- Train statewide

Summary of Delegation

- RCW's and WAC's are the same for all clients receiving delegation
- Nurse delegation is based on the nursing process
- Communication is key to having a successful business
- Program managers are available for support

Nurse Delegation

Program Evaluation

- Complete orientation evaluation
- Submit evaluation to Program Managers for certificate of completion

Transforming Lives

Program Managers

Marlo Moss RN
HCS
mossm@dshs.wa.gov

Doris Barret, RN
DDA
360-407-1504
barreda@dshs.wa.gov

Washington State Department of Social & Health Services
Transforming lives