Nurse Delegation 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 OF NA'S DELEGATED	ADULT FAMILY HOME"S NAME
			SUPPORTED LIVING AGENCY'S NAME

TASK(S) DELEGATED

A. Referral Process	Yes	No	N/A	Term Care Manual / Contract
Documentation of how and when referral made?	☐	☐	☐	
SOP assessment within 48 hours of referral	☐	☐	☐	
B. RND Assessment of Client				**WAC 246-840-930(12)(h)(i)(j)**
Initial physical / systems assessment documented?	☐	☐	☐	
Assessment completed within three working days of referral	☐	☐	☐	
SOP documentation returned in five (5) working days?	☐	☐	☐	
C. Delegation Process / Consent				**WAC 246-840-930(10)(b)**
Evidence of timely consent to delegation process? Date – verbal: _____ Date – written: _____	☐	☐	☐	
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)**
Registered Nurse License current and without restriction?	☐	☐	☐	
Certificates, transcripts or Credential and Training verification form for training?	☐	☐	☐	
NA-R's completed basic caregiver training (FOC, Basic - Core Competency, DDA basic, DDA CORE basic, Foster Parent PRIDE)	☐	☐	☐	☐ DOH Web Check ☐ DOH Telephone Check
Completed 9-hour Core Delegation training	☐	☐	☐	
Completed 3-hour Special Focus on Diabetes	☐	☐	☐	
HomeCare Aide-Certified verified	☐	☐	☐	
Exempt Long Term Care Worker verification by letter of employment, and training	☐	☐	☐	
E. Instructions for ND Task				**WAC 246-840-930(12)(13)**
Instruction for each nursing task?	☐	☐	☐	
Specific parameters for giving PRN medication?	☐	☐	☐	
Identify S/E unexpected outcomes or changes and when to notify RND, physician or emergency services?	☐	☐	☐	
F. Supervision and Client Changes				**WAC 246-840-930(18,19) and WAC 246-840-950(1)(a) / Contract**
Nurse Visit Form used for 90 day visit documentation	☐	☐	☐	

Client assessment documented at least every 90 days?	☐	☐	☐	
If insulin delegated must have four (4) visits documented seven (7) day intervals	☐	☐	☐	
Documentation of how medication(s) verified and documented (if delegating meds)?	☐	☐	☐	
Listing of documented medication on an approved ND form:	☐	☐	☐	
G. Assume / Rescind RN Delegation Duties				**WAC 246-840-960(3)**
Assumption / rescinding on this client?	☐	☐	☐	
Assumption / rescinding date documented?	☐	☐	☐	
Case / Resource Manager notified of assumption/rescinding	☐	☐	☐	
H. Billing / Administrative				**Provider One Requirements**
Records justify time billed on RND tracking form?	☐	☐	☐	
Additional units form submitted for units needed >36 or 100 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)				
Has your Registered Nurse Delegator been to the client's home within the last 90 days?	☐	☐	☐	
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

Thank you for your response!

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