I Care
Nursing Services

NURSE DELEGATION INFORMATION & CONTRACT

This packet is intended to inform you of what nursing delegation is and why a patient may need it. To complete the forms electronically click on or copy and paste this link in your web browser. https://pdf.ac/9Ey6x

Nurse delegation is required when a patient needs a licensed caregiver to put medication in or on the patient's body, or when a caregiver has to perform a medical task for a patient. It is also required when a patient can put the medication in or on their own body, but they do not understand they are taking medication. This is known as the Washington State rule (WAC 246-840-910 to 920). This includes both over the counter and prescription medications.

In instances where a medical professional deems that a person is suffering from cognitive impairment or is frail such that medication administration must occur, medications must be under nurse delegation. Washington law is written to protect older adults who may not have the mental capacity or physical functionality to know what medications they are taking or may not be able to consume the medication without assistance. This requires specific written orders from the primary care provider

Nurse Delegation enables an individual who requires nursing care to remain living in an AFH, ALF, or at home instead of being placed in a nursing home. For example, an individual requires medical care from a Registered Nurse (RN) daily, such as assistance with medications and medication management, wound care, tube feedings or insulin injections. Previously, persons had the choice of moving into a nursing home or paying privately for daily visits from a Registered Nurse. Under the Nurse Delegation Program, an RN teaches the appointed non-medically trained caregiver in the proper technique(s) for managing the patient.

The caregiver must be licensed with the state as a nursing assistant. Once competent at handling nurse delegated tasks, daily visits from a nurse or extended stays at a nursing home are no longer required, thereby significantly reducing one's care costs. It is important to note that not all nursing skills can be delegated.

Only a Registered Nurse can delegate a qualified caregiver. Furthermore, the nurse must be a delegating nurse and assume formal delegation responsibility for the client. For instance, a home health nurse who is an RN cannot delegate a caregiver if not the RN delegator. An LPN CANNOT delegate. Nursing delegation means an RN transfers the performance of a specific task for an individual client to a qualified Nursing Assistant working in a community setting.

Registered Nurses delegating tasks are accountable to the Washington State Nursing Care Quality Assurance Commission. The registered nurse delegator and nursing assistant are accountable for their own individual actions in the delegation process. No person may coerce an RN into compromising patient safety by requiring the RN to delegate.

Not all licensed caregivers qualify to be delegated to assist with these tasks. A caregiver must be a CNA, HCA, HCA-C, or NAR and have a current unrestricted license. They must have taken the 9-hour nurse delegation class and have a certificate. If the client needs insulin, then the caregiver has to have an additional 3-hour certificate for Diabetes training. They must also have 40 hrs. completed of the 75 hr. basic training or be exempt from having this with proof. Please refer to the cheat sheet at the end of this packet for more details.

Nurse delegation occurs in a community setting.

- Certified community residential programs for the Developmentally Disabled
- Licensed Adult Family Homes
- Licensed boarding homes
- In the client's own personal home

Family members are not required to have nursing delegation. Many family members choose to have medication education; however, this is not called delegation. It is a great way to learn about your loved one's care and keep them safe, however again not a state rule.

There are 4 tasks that CANNOT be delegated at this current time.

- Injections other than insulin
- Sterile procedures
- Maintenance of central lines
- Anything that requires nursing judgement/assessment

The State of Washington requires that a patient is "stable and predictable" prior to receiving nurse delegation services. When an I Care nurse arrives to perform delegation they will do a brief head to toe assessment of the client. If the client has had any changes from their last full comprehensive nursing assessment on file, then they will need to have a new nursing assessment done prior to delegation. You will need to have signed physician orders for the medications/tasks you would like to be delegated.

The state requires that each and every caregiver performing delegated tasks be delegated and continue to have oversight. It is a misconception that delegation is only due every 90 days. That is a minimum however there are other situations that may trigger a visit earlier than every 90 days. If there is a new medication prescribed, a new task, a new caregiver, and or if the caregivers need further training for delegated tasks.

An I Care nurse will perform an initial comprehensive visit. If a client is getting caregivers delegated for diabetes the visits will be a minimum of weekly for the first 4 weeks. For other tasks the visits will be a minimum of the initial visit and every 90 days or sooner. If there are any changes in medications or client condition, then a visit will be made. If a new caregiver begins to work with the client, a visit will be made. If a caregiver has concerns or questions and this cannot be addressed via phone, a visit will be made. *PLEASE have all signed orders ready and available for the nurse when they arrive. * The state requires that each and every caregiver performing delegated tasks be delegated for each and every client's specific needs.

If a hospice or home health nurse is involved in care, please remember to call them for refills on medications. Remember the sole role of the delegator is that to be the delegator. Other providers who are involved are still responsible for their roles in care, however, always call the delegator with any concerns, side effects, or change in patient condition.

If at any time, you wish to stop nurse delegation or go with another provider, 72 hrs. notice must be given to I Care. Notice must be given in two forms e.g. via phone, fax, email. During the time this contract is enforced there shall be no other providers delegating the client.

If you are on an annual payment plan, with a certificate of service, refunds will not be given after you have received 90 days of service. If you cancel within 90 days a pro-rated amount will be refunded to you based on the set-up fee, full nursing visit fee, and or charges for all nursing services and visits. This contract is good for 1 year and after 1 year the set-up fee does not apply to the next years plan.

If you wish to have another provider temporarily see the client notice must be given to I Care, to allow for the proper documentation to be completed. If your I Care nurse goes on vacation or has an extended leave of absence; you will be given the covering nurses information. The proper documentation will be placed in the client's profile prior to the leave.

If in doubt call I Care!!! We are here to help and make sure our caregivers feel confident and supported. We work with you as a team to ensure the safety of our clients. Navigating the laws of Nurse Delegation in the State of Washington can be overwhelming. Rely on the experts to help guide you.

Please keep the next page posted on the wall where the caregivers can see it easily!!!

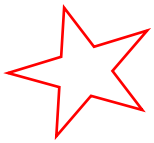
KEY TIPS TO REMEMBER

Emergencies Call 911

<u>If in doubt call I Care!!!</u> Never hesitate to ask a question. I Care loves to help and our nurses are happy to answer any questions. If it is extremely important, please call 2 x back to back and the first time leave a message.

<u>Please call I Care promptly as it is your RESPONSIBILITY to notify us if there is,</u>

- A change in client condition
- Side effects
- Client hospital visits, treatment facility or SNF
- New medications and treatments (even if it is not a delegated task or med)
- If a patient begins new treatment e.g. hospice, home health, PT
- There is a new caregiver
- There is a new task to be delegated
- Clients condition physical or mental changes to where they now need delegation
- New doctor's orders
- If you have difficulty or are unable to perform a task
- If a client has a new wound
- Change of DPOA
- Client moves
- Client dies



6 CLIENT RIGHTS

1. Right Client
2. Right Time
3. Right Dose
4. Right Route
5. Right Medication
6. Right Documentation

- Refer to task tab in delegation folder for instructions on a task
- If a fax comes from I Care, please put it in the back of the patient's folder it belongs to.
- Please save all I Care documentation
- Remember to keep I Care folders where they can easily be located. If you make a copy of a document in a folder put it back where you got it, please.
- To rescind nurse delegation, 72 hours of notice must be given. Documentation must be completed prior to another nurse delegator seeing a client under I Care Services.

I CARE CONTACT INFORMATION

Bus Ph: **(650) GO-NURSE** *Cell/Text:* **(206) 291-0937**

1st E-Fax: **(206) 508-2334** *2nd Fax:* **(206) 588-2108**

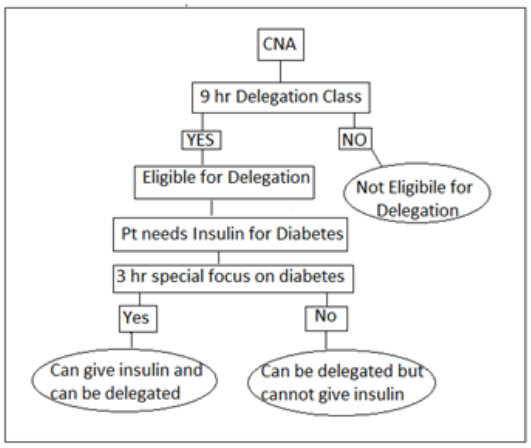
Email: Kindra.Andreas@ICARENURSES.com

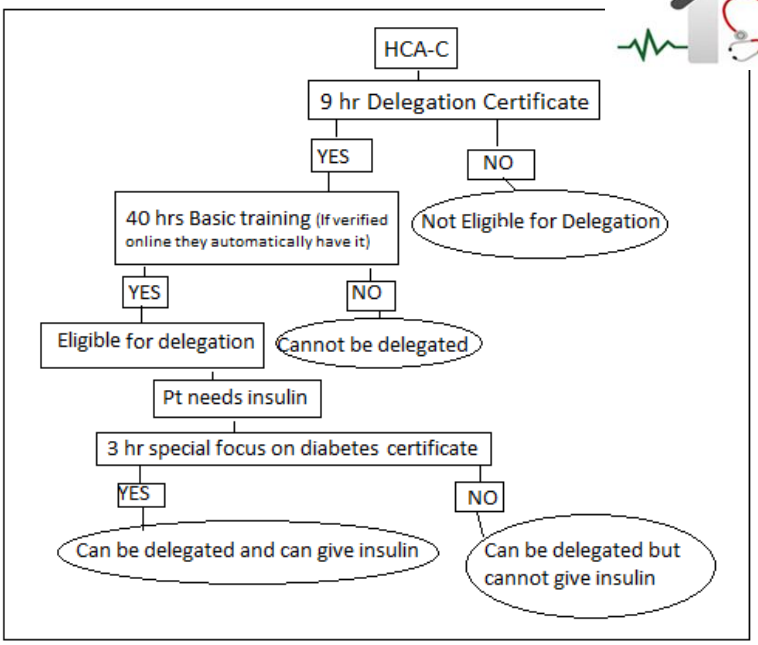
Website: **icarenurses.com**

I Care
Nursing Services

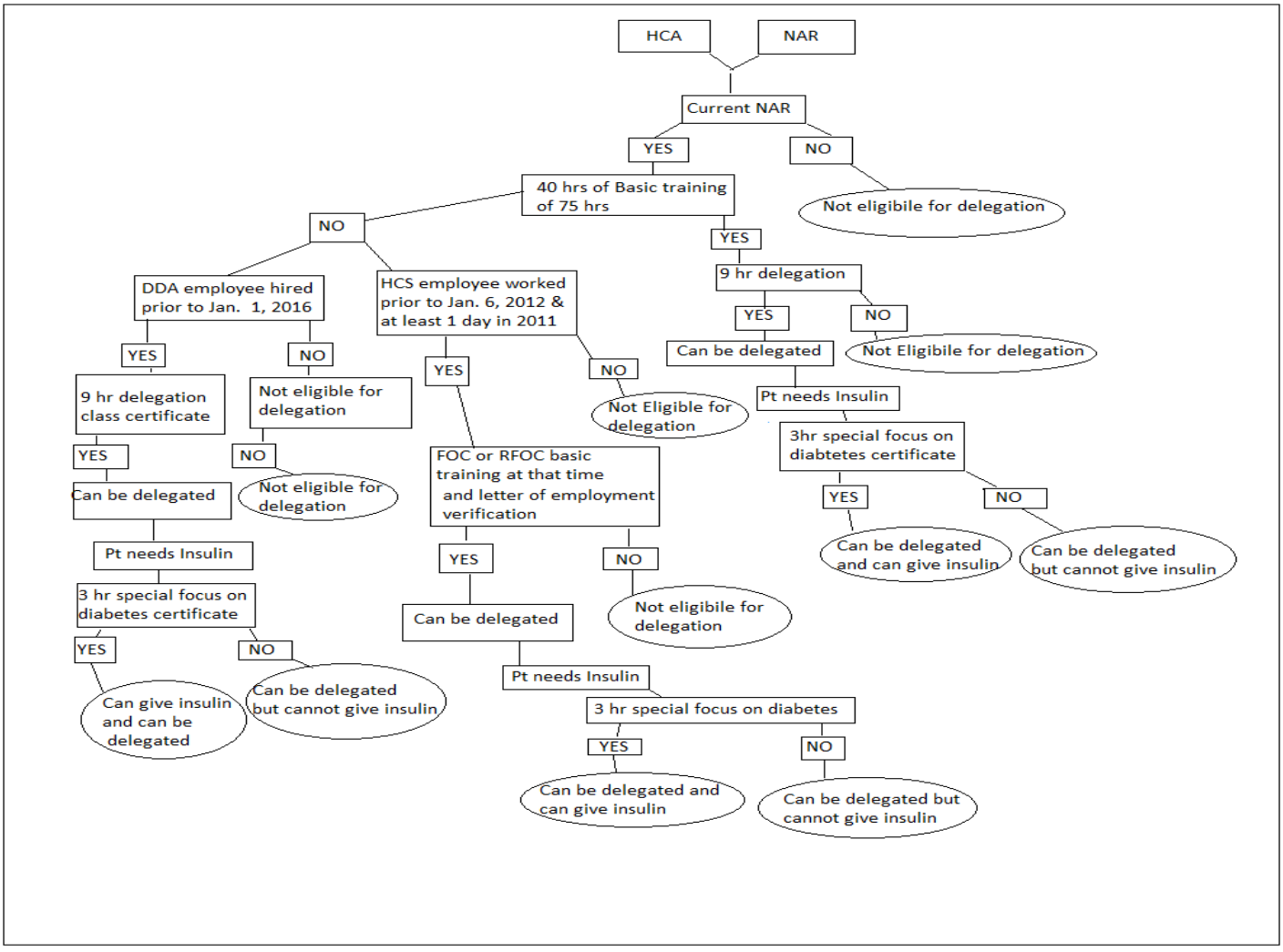
"Because you should have a choice,
Bringing healthcare home"

Caregiver Verification Tree





All caregivers licenses must be current and without any restrictions. These are verified on the Washington State website: http://www.doh.wa.gov/LicensesPermitsandCertificates/ProviderCredentialSearch Copies of certificates and or letters will need to be provided prior to authorizing delegation. Delegation is specific to caregiver and patient. Each new patient and or caregiver will need to be delegated specific to that task and patient. At any time a caregiver has a restriction against their license, loses their license or does not renew their license delegation will be rescinded.



I Care
Nursing Services

Contract Agreement

I Care nursing services is not affiliated with any other agency. Nursing delegation is a separate service that is not covered under a client's current living arrangement fees. If a client is on Medicaid, not Medicare and delegation services are covered by Medicaid, then this fee schedule does not apply to you or your loved one. If there is a secondary billing source, I Care will be happy to bill them first. If they do not cover the costs the responsible party will be required to pay.

It is a required service for community living clients that need a licensed caregiver to put medication in or on the patient's body. It is also required when a patient can put the medication in or on their own body but they do not understand they are taking medication. This is known as the Washington State rule (WAC 246-840-910 to 920). This includes both over the counter and prescription medications. This also includes several caregiving tasks.

Currently I Care processes all payments electronically unless prior arrangements are made and only in special circumstances. You can pay with credit, debit, and or electronic check and there is no additional charge to use credit or debit. Please fill out and return the AFT form attached. If you have difficulty filling out this form or would like to set up payment over the phone, please call I Care for assistance. Invoices will vary depending on the needs and how frequent visits are necessary. Clients with diabetes have more frequent visits and tend to have larger invoices. Clients with wound care may require more frequent visits.

Initial Nurse Delegation Set-up, the 1st visit and I Care Club Delegation annual plan must be paid prior to delegation. If the client is not on an annual plan then future visit invoices will be sent promptly after services are rendered and automatically deducted from the account on file. If other arrangements have been made invoices must be paid within 14 days of service. Payments made after the 14th day will incur a late fee of $20 per day. If I Care has to take legal action to collect payment the client will be responsible to pay all legal fees. If the client lives in an AFH the provider has the option to pay the invoice and bill you later if they wish. If the provider opts out for this option services will be terminated with a provider given one week notice to find another Delegation service.

All full head to toe yearly comprehensive assessments will be collected prior to performing the assessment. This is a very detailed assessment and requires the undivided attention of a nurse for an entire day. This is required by state rule annually and if there is a change in client condition. I Care will do its best to give you as much notice as possible when this assessment becomes due.

**Any concerns with billing or delegation services please address this with I Care directly as the AFH or community living setting is not responsible for discrepancies. **

I Care Nursing Services
10420 19th Avenue South
Seattle, WA 98168
Ph. 650-GONURSE | Cl. 206-291-0937 | Fx. 206-588-2108
Email. Kindra.Andreas@ICarenurses.com
Web. ICARENURSES.COM

CONTRACT FEE SCHEDULE

RN Assessments	**$450.00-$750.00**
Delegation Set-Up Fee	**$275.00**
RN Visits	**$275.00**
Hourly Rate	**$110.00**
Telephone Calls	**Prorated every 15 min at hourly rate**
Additional Caregivers	**$100.00 Per Caregiver if present at delegation set-up**
Bed Rail/Assistive Device Assessments	**$275.00**
Comfort Kit Delegation	**$375.00**
Diabetes Delegation visits	**$1,250.00**
Any task outside of medication management.	**$175.00-$375.00 Per Visit**

RESIDENT NAME	SIGNATURE	DATE
GUARDIAN/DPOA NAME	**SIGNATURE**	**DATE**
AFH PROVIDER NAME	**SIGNATURE**	**DATE**
RN NURSE DELEGATOR	**SIGNATURE**	**DATE**

I UNDERSTAND AND AGREE TO ALL TERMS IN THIS CONTRACT. I AM SIGNING WITH MY OWN FREE WILL AND AM NOT BEING COHERCED TO SIGN BY ANY OTHER PARTY.

I Care Club Delegation Fee $__$2,475.00-$5,980.00_____, **Start Date** _____

(Includes all delegation visits for 12 months. Including quarterly visits, new caregiver visits, change of med visits, change of task visits, unlimited telephone calls. Does not include the annual assessment and or any DME assessments. If a patient passes away, moves out or separates from the AFH within 90 days a refund will be given within 30 days minus the full cost of contracted rate per visit and services rendered)

RELEASE OF INFORMATION AND CONSENT FORM

It is important that healthcare providers work together. As such, I Care Nursing Services would like your permission to communicate, when necessary, with your medical providers.

PT NAME: _____ **DOB:** _____ **SSN:** _____

ADDRESS: _____ **CITY:** _____

STATE: _____ **ZIP:** _____

I _____, herby authorize the release and exchange of information specified below between:

NAME/TITLE _____ **ORGANIZATION NAME:** _____

ORGANIZATION ADDRESS: _____ **CITY:** _____

STATE: _____ **ZIP:** _____

PHONE: _____ **FAX:** _____

and

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Seattle, WA 98168
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Web. ICARENURSES.COM

The release of information shall be limited to the following specific types of information:

- ☐ Diagnosis
- ☐ Psychosocial Evaluation
- ☐ Psychological Evaluation
- ☐ Psychiatric Evaluation
- ☐ Discharge/Transfer
- ☐ Continuing Care Plan
- ☐ Medication Management Info
- ☐ Presence/Participation in Treatment
- ☐ Nursing/Medical Progress Notes
- ☐ Toxicological Reports/Drug Screens
- ☐ Demographic Information
- ☐ Treatment Notes
- ☐ Other _____

The purpose of this disclosure is to improve assessment, treatment planning, share information relevant to treatment, and coordinate treatment services. Any other purpose as specified _____

This authorization is made with informed consent and without coercion. Consent is subject to revocation by written instruction of the undersigned at any time by sending notification to I Care Nursing. The information is confidential and any re-disclosure by the recipient is prohibited unless expressly permitted by the patient or an authorized representative. I understand that this authorization is for the release of all medical records including Psychiatric, Alcohol, Drug Abuse, Sexually Transmitted Diseases, and HIV/AIDS.

Client Name (Printed) _____ Client Signature _____ Date _____

CUSTOMER PAYMENT AGREEMENT

Automatic Funds Transfer (AFT)

I Care
Nursing Services
10420 19th Ave S.
Seattle, WA 98168
(206) 291-0937

CLIENT NAME (PLEASE PRINT)			**DATE OF BIRTH**
HOME ADDRESS (NOT P.O. BOX)**: STREET**			
CITY	STATE	ZIP	COUNTY
MAILING ADDRESS (IF DIFFERENT THAN HOME ADDRESS)**: STREET**			
CITY	STATE	ZIP	COUNTY
PHONE NUMBER (HOME/CELL):		**PHONE NUMBER (WORK):**	

AUTOMATIC FUNDS TRANSFER AUTHORIZATION ☐ **CHECKING** ☐ **SAVINGS**

I have selected the monthly AFT payment option and I hereby authorize I Care Nursing Services to initiate funds transfer from the bank or depository institution account indicated below. I authorize my financial institution to honor these transfers.

Financial Institution or Bank Name:			
Account Holders Name (print):			
CITY		STATE	ZIP
ACCOUNT NUMBER		ROUTING NUMBER	

CREDIT/DEBIT AUTHORIZATION

NAME AS IT APPEARS ON CARD			
CREDIT CARD #	__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __		
EXPIRATION DATE	__ __ / __ __	**CODE ON THE BACK OF THE CARD**	__ __ __ __
BILLING ADDRESS			
PHONE # ASSOCIATED WITH THE ACCOUNT	(__ __ __) - __ __ __ - __ __ __ __		

ADDITIONAL TERMS AND CONDITIONS:

- Funds are to be transferred within 14 days of service or as soon thereafter as practical.
- It may take up to __10__ days to setup an AFT. You may receive an invoice in the mean time.
- I understand that this AFT will remain in effect until I Care Nursing Services has received notice from me that it should be cancelled. To ensure prompt cancellation of my AFT, this notice must be submitted at least 20 days prior to my next scheduled transfer. I have the right to stop payment of a specific transfer from my depository financial institution at least 3 days before the next scheduled withdrawal date.

PLEASE ENCOLSE VOIDED CHECK (FOR CHECKING ACCOUNT) OR DEPOSIT SLIP (FOR SAVINGS ACCOUNT) FROM THE ACCOUNT TO BE DEDUCTED.

Account Holders Signature: _____ Date (MM/DD/YYYY): _____/_____/_____

Washington State Department of Social & Health Services

Nurse Delegation:
Consent for Delegation Process

I Care Nursing Services

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
Kindra Andreas	**206-291-0937**
23. RND SIGNATURE	24. DATE

DISTRIBUTION: Copy in client chart and in RND file

I Care
Nursing Services

PHOTO AUTHORIZATION FORM

Patient Name (print name)	*Date of Birth*	*Phone #*
Address		*Email Address*

**** Complete the following only if the person authorizing the use or disclosure is not the patient:***

Name	*Relationship to Patient*	
Representative's Address	*Phone #*	*Email Address*

By signing this form, I authorize the following:

The following protected health information may be disclosed: (*Check all that apply)*

☐ Photographs taken during a health care encounter
☐ Accounts, summaries, narratives describing a health care encounter
☐ Photographs taken to help improve teaching
☐ Photographs taken to help promote wellness and healing
☐ Photographs taken to document concerns of abuse or neglect
☐ Photographs taken to document skin concern
☐ Photographs taken to be sent electronically via email
☐ Photographs taken to identify me on my face sheet and/or medication record
☐ Other (*describe)* _____

Description of Protected Health Information Disclosed in Photos or Images:

I understand that the following identifiable information may be included in the photos, narratives, and/or images: my facial and/or other body images and verbal descriptions about my medical condition including my prognosis as well as other related descriptions and information about the care or my treatment. I understand that my first name may be used. I further understand that no other identifiable information will be made available such as my address, medical record or other identifying numbers, etc. I consent for medical imaging to be made of me (or for person whom I am legal representative). I understand that the information may be in my medical record.

By signing this Authorization, I am giving permission for the use or disclosure of the information described above for the purpose(s) described. I hereby release I Care Nursing and its agents and employees from any and all liability that may arise from the release of information as I have directed.

- I have the right to receive a copy of this Authorization.
- I will not receive any compensation for my images
- I understand that I have the right to revoke this Authorization at any time, if I do so in writing, and address it to I Care Nursing. The revocation will not apply to any information already released as a result of this Authorization.
- I understand that I may refuse to sign this Authorization, and that I Care Nursing cannot deny or refuse to provide services if I refuse to sign.
- I understand that information disclosed pursuant to this Authorization may no longer be protected by the federal health information privacy law and could be re-disclosed by the person or agency that receives it.

*_____ *(Please place Initials)* I agree that this Authorization will remain in effect until I revoke it in writing.

Signature of Patient or Legal Representative: _____ *Date:* _____

RESIDENT INTAKE CARD

BACKGROUND INFO

RESIDENT NAME	NICK NAME	DATE

AGE	DATE OF BIRTH	GENDER	SSN	LANGUAGE	ETHNICITY

MEDICAL CONTACTS

PRIMARY CARE PHYSICIAN	ADDRESS	PHONE	FAX

SPECIALIST	ADDRESS	PHONE	FAX

SPECIALIST	ADDRESS	PHONE	FAX

PHARMACY NAME	PHONE	FAX

CONTACT INFO

SUBSTITUTE DECISION MAKER/PAYEE 1 SPECIFY RELATIONSHIP:	EMAIL ADDRESS	PHONE NUMBERS HOME: OFFICE: CELL:
ADDRESS		

SUBSTITUTE DECISION MAKER/PAYEE 2 SPECIFY RELATIONSHIP:	EMAIL ADDRESS	PHONE NUMBERS HOME: OFFICE: CELL:
ADDRESS		

BASELINE MEDICAL INFO

HEIGHT:

WEIGHT:

ALLERGIES:

OTHER INFO I MIGHT NEED TO KNOW: