Oregon Department of Human Services
OFFICE OF DEVELOPMENTAL DISABILITIES SERVICES

Self-Auditing Checklist

For Direct Nursing Services (DNS) and Private Duty Nursing (PDN) in Oregon's Intellectual and Developmental Disabilities (I/DD) sector

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Self-auditing checklist

Navigating Nursing in I/DD: your pathway to a nursing career in Oregon's intellectual and developmental disabilities sector.

DISCOVER UNDERSTAND THRIVE

General guidelines

- Documentation of DNS or PDN care must be written in an accurate, timely, thorough, and clear manner.
- Documentation must comply with OAR chapter 851, which are Board of Nursing standards, and other applicable, current OARs (see References).
- This checklist is intended for reference purposes only and does not supersede the rules and regulations established by the Oregon State Board of Nursing. The Registered Nurse (RN) is responsible for adhering to all applicable rules.

Main documentation

A. The **initial assessment** will ensure completion and documentation of a comprehensive assessment of the client's capabilities and needs for nursing services.

B. The **service plan**, or care plan, will describe the medical, nursing, and psychosocial needs of the client and how the nurse will actively coordinate and facilitate meeting those needs. This description of needs shall include risks and problems, interventions, measurable objectives, goals, and time frames in which the goals and objectives will be met and by whom.

C. **Daily documentation –** Ensure your flow sheets and charting notes reflect your authorized nursing service interventions and care that includes:

- ☐ Continuous assessment and reassessment of the medical condition, as part of each shift.
- ☐ Skilled nursing tasks.
- ☐ Nursing interventions.
- ☐ Implementation of treatment and therapies.
- ☐ Data collection, including ventilator, medication, or seizure logs.
- ☐ Documentation, including shift notes and flow sheets.
- ☐ Written and oral communication with individuals, physicians and other health professionals, other caregivers, case management entities, ISP teams, foster care providers, and agency providers.
- ☐ Other nursing responsibilities under OAR 851-045-0040 (Scope of Practice Standards for All Licensed Nurses) approved by the Department.

Initial documentation

- ☐ Schedule face-to-face nursing assessment and Service Plan meeting within 7 business days of start of services.
- ☐ Assessment and Service Plan
  - ☐ Gather data from client, family, community, other healthcare providers, including:
    - ☐ Subjective data
    - ☐ Objective data (measurable; collected thorough examination)
    - ☐ Verifying orders
  - ☐ Retain copy of orders
- ☐ Send copies of Initial Nursing Assessment and Service Plan to Case Manager (CM) within 7 business days of start of services.

Initial and daily documentation requirements

- ☐ The name of the individual on each page of documentation.
- ☐ The date of service.
- ☐ Time of start and end of service delivery by each provider.
- ☐ Full signature of the provider.

Daily documentation specific

- ☐ Anything unusual from the standard plan of care expanded in the narrative.
- ☐ Interventions.
- ☐ Outcomes, including the response of the individual to services delivered.
- ☐ Nursing assessment of the status of the individual and any changes in that status per each working shift.

Update the Assessment and Service Plan

The RN must review, update, and resubmit the Nursing Service Plan to the CM entity and the Department in the following instances:

- Every 6 months for DNS clients.
- Every 60 days for PDN clients.
- Within 7 business days of a change of an RN (a change from one RN to another).
- With any request for authorization of an increase in hours of service.
- After any significant change of condition, such as hospitalization, emergency visits, or significant change in the health status of the
- Individual.
- Remember to send Service Plan and Reassessment to CM when updated, or upon request.

Retention of documentation

Providers must retain the following documentation:

- Billing forms, timesheets, and financial records for at least 5 years from the date of service, and
- Clinical record documentation of provided services for at least seven years from the date of service.

Developing a Nursing Service Plan or Care Plan

Nursing care plans include the initial client assessment and diagnosis, the desired outcomes and how to achieve them and an evaluation of the client's outcomes.

Nursing plans should be holistic and take account of nonclinical needs where possible, such as needs for social interaction and mental health support.

Fundamental components of nursing care plans

- **Assessment**
  RN collects relevant data and information relative to the client's health and home environment. They use a systematic method to collect and analyze client data. The assessment includes physiological data, as well as psychological, sociocultural, spiritual, economic, and lifestyle data. For example, if a PDN's assessment finds the client has a history of seizures, their assessment would include the history of the diagnosis, how the seizures manifest and the effect(s) to the client, and what interventions are in the home, or are needed.

- **Diagnosis**
  The RN analyzes the assessment data to find the actual or potential diagnoses, problems, and issues. A nursing diagnosis is the nurse's clinical judgment about the client's response to actual or potential health conditions or needs. Nursing diagnoses are the backbone for the nurse's care plan. Using the example of the

client who has a history of seizures, relevant nursing diagnoses can be risk for injury, risk for ineffective airway and aspiration, and deficient knowledge, and noncompliance.

- **Outcomes identification**
  The RN identifies expected outcomes for a plan personalized to the client and/or the situation. Collaborating with the client and/or family, the nurse sets measurable and achievable short- and long-term goals and specific outcomes founded on their assessment data and nursing diagnoses. Examples for a seizure diagnosis include: “The client will verbalize the need for assistance to prevent accidents or injuries,” and “The family will adhere to the ordered drug regimen.”

- **Planning**
  The RN develops a collaborative plan outlining strategies to achieve expected outcomes. Using assessment data, expected outcomes, and nursing interventions, evidence-based nursing interventions are customized to each client’s needs and concerns. Goals, expected outcomes, and nursing interventions are documented in the client’s nursing care plan. The plan is utilized by the nurse and team members for continuity of care.

- **Implementation**
  The RN implements the identified plan. Nursing interventions are implemented or delegated (with supervision when indicated) as outlined in the care plan to promote continuity of care across multiple nurses and team members caring for the client. Progress, goal attainment, and interventions are documented in the client’s medical record.

- ☐ **Evaluation**
  The RN evaluates progress toward attainment of goals and outcomes. During this phase, the nurse assesses the client and compares the results and conclusions against the initial assessment to determine the effectiveness of the interventions and overall nursing care plan. The client's status and the effectiveness of the nursing care needs to be continuously evaluated and modified when indicated and as needed.

Checklist for prior authorization and payment

Prior authorization

- ☐ The Individual Care Plan must be up to date as per required schedule (see documentation checklist)
- ☐ Confirm client's monthly hours determined by ODDS nursing criteria assessment, which is updated at these milestones:
  - ☐ Initial eligibility.
  - ☐ At least annually for DNS and every 6 months for PDN.
  - ☐ After any significant change, such as hospitalization, emergency visits, or significant changes in the health status of the individual, reported by the CM entity or provider.
- ☐ Estimate service hours/units needed during the service period in MMIS
  - ☐ Discuss with individual, family, provider, and/or legal representative the hours to be worked.
  - ☐ Be sure to compare schedules with other nurses and/or care workers in the home to confirm you won't go over hours/are within nursing criteria assessment hour limits.

        - Enter time in hours into MMIS no later than 25th of the month prior to anticipated service month.
- Send an email request to appropriate administrative email(s), requesting to pend the authorization. The request must include:
    - Individual's initials
    - Number of hours requested
    - Prior authorization number
- CME will then pend the PA and provide confirmation by email. This authorizes the nurse to provide services.

Payment

- After the full month of delivered services, invoices/timesheets must be signed by the DNS/PDN provider, and then by the individual, family, provider, and/or guardian.
- Submit invoice/timesheets to the case management entity via secure email (contact varies depending on program).
    - Include the client initials and PA number in the email.
    - Proper billing documentation must be legible and should include:
        - PA number
        - Provider name and credential level
        - Client name on every page
        - Month of service and dates for each shift
        - In/Out times for each shift (in military time or including AM/PM)
        - Total hours for each day
        - Total hours and units for the month
    - If all documentation is correct and services are within authorized limits, CME will change the status of PA to "approved" in MMIS.
    - The provider may then file the claim in MMIS for payment.

References and applicable rules

- OAR 410-120-1360
- OAR 410-132
- OAR 411-300
- OAR 411-380
- OAR 851-006
- OAR 851-045