Investigative Plan

Respondent Name Case Number

Summary of the Complaint:

Possible Violations as identified by the Complainant:

Evidence needed

Medical Records (Week of incident only, to include H&P, PO, NN, MAR, NAR or Pyxis, flowsheets as applicable):

Facility Policy and Procedures:

Reports/Documents from other agencies/facilities:

Witness Statements:

Nursing Care Quality Assurance Commission
INVESTIGATIVE REQUEST CHECKLIST

File #_____ Respondent: _____

- ☐ DSHS Report
- ☐ Law Enforcement Report
- ☐ Court Records
  - ◆ Affidavit of Probable Cause
  - ◆ Criminal Informatory (charging doc)
  - ◆ Judgment & Sentencing
  - ◆ Plea of Guilty (if applicable)
- ☐ Provider/Facility Letter of Cooperation

Address To: _____
_____
_____
_____
_____

INVESTIGATE

- ☐ Diversion/Substance Use/Abuse
- ☐ Standard of Care
- ☐ Documentation/Medication Order
- ☐ Beyond Scope
- ☐ Sexual Misconduct
- ☐ Criminal
- ☐ Theft
- ☐ Abuse

PATIENT RECORDS

Name(s)	Date of Records
1._____	_____
2._____	_____
3._____	_____
4._____	_____
5._____	_____

- ☐ History and Physical
- ☐ Care Plan
- ☐ Physician Orders
- ☐ Nursing Chart Notes
- ☐ Flow Sheets _____
- ☐ Lab Reports _____
- ☐ Medication Administration Records
- ☐ Narcotic Withdrawal Log
- ☐ Pyxis/Omnicell Log
- ☐ Narcotic Wastage Log
- ☐ Admission and Discharge Summary
- ☐ Other _____
  _____

FACILITY INVESTIGATIVE DOCUMENTS

- ☐ Internal Investigation Including All Statements
- ☐ Pharmacy Audit
- ☐ Description of Behavior(s)
- ☐ Full Panel Drug Screen
- ☐ Breathalyzer test results or Blood Alcohol test(s) results
- ☐ Other _____
  _____

FACILITY POLICES AND PROCEDURES

- ☐ Medication Administration & Documentation
- ☐ IV Medication Administration
- ☐ Pyxis/Omnicell Use
- ☐ Fitness for Duty/Testing for Cause
- ☐ Physician Notification
- ☐ Change in Patient Condition
- ☐ Assessment and Documentation
- ☐ Abuse/Neglect of Residents/Patients
- ☐ Delegation
- ☐ Narcotic Wastage Documentation
- ☐ Nurse/Patient/Family Relationships
- ☐ Other _____
  _____

RESPONDENT:

DATE	MEMO	ILRS	TIME	ACTIVITY

CONTACTS

RESPONDENT: _____

NCQAC MEDICATION ADMINISTRATION DOCUMENTATION WORKSHEET

Patient: Respondent: File No.

Date	Medication	Provider Order	Amount Withdrawn	Time Withdrawn	Amount Given	Time Given	Waste	Documentation of Administration	Discrepancy	Pages

WASHINGTON STATE
DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION

CONFIDENTIAL INVESTIGATION REPORT

****

CASE #

RESPONDENT:

****

TABLE OF CONTENTS

Investigator
Health Care Investigator
Phone number:

APPROVED BY _____ DATE _____

APPENDIX A

PRINCIPAL PARTICIPANTS

Respondent

Name:
Address:
Telephone/email:
DOB:
License number:
First issue date:
Expiration date:
Method of Licensure:
Current place of employment:

Additional Credentials:

Out of State License(s):

Respondent Attorney:

Complainant:

Patient(s):

APPENDIX B

GENERAL SUMMARY

Complaint Summary

Summary

APPENDIX C

EVIDENCE/EXHIBITS

Page #'s	Description

APPENDIX D

CONTACT LIST

(Other than principals)

Healthcare Investigator
Department of Health
PO Box 47864
Olympia, WA 98504-7864
Phone

APPENDIX E

PREVIOUS CASES

APPENDIX F

MEDICATION ADMINISTRATION DOCUMENTION

Weekly Report

1. **Name**
   - complaint
   - Obtain Facility records
   - Prepare letter of allegations
   - Prepare report.

2. **Name**
   - complaint
   - Obtain Facility records
   - Prepare letter of allegations
   - Prepare report.

3. **Name**
   - complaint
   - Obtain Facility records
   - Prepare letter of allegations
   - Prepare report.

4. **Name**
   - complaint
   - Obtain Facility records
   - Prepare letter of allegations
   - Prepare report.

5. **Name**
   - complaint
   - Obtain Facility records
   - Prepare letter of allegations
   - Prepare report.

6. **Name**
   - complaint
   - Obtain Facility records
   - Prepare letter of allegations
   - Prepare report.

7. **Name**
   - complaint
   - Obtain Facility records
   - Prepare letter of allegations
   - Prepare report.

WA State Department of Health Nursing Care Quality Assurance Commission														
Priority	Number	Name	Date Assigned	Case Due Date	Complainant	Patient	Attorney	LOC	LOC Due	Complete ?	LOA	LOA Due	Received	Remarks
LEGEND														
LOC = Letters of Cooperation to all Principles														
LOA = Letter of Allegation to Respondent														

Remarks