Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

Nursing Care Consultant Transition Tool

CLIENT NAME	
PROVIDERONE / ADSA ID	

LOCATION OF MOVE	PROPOSED MOVE DATE	INSURANCE COVERAGE

Purpose: This is a required document intended to facilitate and track Nursing Care Consultant (NCC) activities towards the individuals move. The NCC will track all nursing activities on this tool, highlighting individual needs and readiness towards the transition. A copy may be provided to DDA staff, client, authorized representative, and residential provider upon request. This tool will be saved to the clients DDA CARE file upon transition.

MOST RECENT PLAN OF CARE RECEIVED ☐ Yes ☐ No
RECEIVED BY:
DATE OF PLAN

NOTES

DIAGNOSIS

CODE STATUS
POLST form: ☐ Yes ☐ No

HISTORY

ED VISITS / HOSPITALIZATION IN THE LAST 12 MONTHS

Is there a change to plan of care? ☐ Yes ☐ No

DATE OF BIRTH AGE	HEIGHT	WEIGHT CURRENT: GOAL:	BMI

DIET
☐ Oral ☐ G/J Tube ☐ G/J Tube ☐ Central Line
☐ Other:

EATING ASSISTANCE
☐ Independent ☐ Partial Assistance
☐ Full Assistance

DIET TEXTURE
Fluid: ☐ Regular ☐ Nectar ☐ Honey ☐ Pudding
Food: ☐ Regular ☐ Chopped / cut ☐ Pureed

ADLs
☐ Independent
☐ Partial Assistance
☐ Full Assistance

MOBILITY NOTES

MEDICATION ADMINISTRATION
☐ Independent
☐ Assistance
☐ Must be administered

SKIN ASSESSMENT COMPLETED
Wound: ☐ Yes ☐ No
Acute / chronic:

CONTINENCY OF:
Bowel: ☐ Yes ☐ No
Bladder: ☐ Yes ☐ No

METHOD OF COMMUNICATION
☐ Verbal ☐ Nonverbal
☐ Assistive devices:

CURRENT EQUIPMENT NEEDS
☐ Up to date
☐ Repairs needed

BEHAVIOR / MENTAL HEALTH TRANSITIONAL CLINICAL TEAM REFERRAL MADE
☐ Yes ☐ No

REGIONAL CLINICAL TEAM REFERRAL MADE
☐ Yes ☐ No

PAIN
Acute / chronic: ☐ Yes ☐ No
Location:
Treatment:
Is treatment effective? ☐ Yes ☐ No

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IMMUNIZATION HISTORY

Allergies:

Medications / Dose / Route / Purpose:

Scheduled:

PRN:

ROUTINE LABS	ABNORMAL LAB VALUES IN THE PAST 12 MONTHS	CURRENT LABORATORY

Transition Team

Title	Name, contact information, and organization	Role in transition	Notes and status
Individual			
Authorized representative (NSA / Guardian)			If guardianship is in place, are orders current: ☐ Yes ☐ No
MCO Representative			
DDA Case Manager			
DDA Clinical Team Psych / ARNP			
Current residential provider			
Receiving residential provider			

Medical Providers

Title	Name, contact information, and organization	Role in transition	Notes and status
Current Primary Care			
Assuming Primary Care			
Current Dental Provider			
Assuming Dental Provider			
Specialists			
Therapy (PT / OT / SLP)			
Current Pharmacy			
Assuming pharmacy			
Current laboratory			
Assuming laboratory			
Other:			

Upcoming / Scheduled Appointments		
Appointment Type	**Date**	**Outcome**

Transition Preparation				
Activity	**To be completed by:**	**Target Date**	**Notes**	**Date completed**
Review existing supports				
Discuss preferred living arrangements / settings			Will the setting of choice be able to meet nursing needs?	
Review CARE to determine accuracy of nursing supports				
Review referral packet for medical needs, if needed			Are nursing supports added to the referral packet?	
Consent form signed, to allow collaboration with health care team				
Meet proposed provider and tour residential placement			If no, why?	
Safety / environmental modifications recommended				
Medical equipment needed or recommended				
Client agrees to allow residential provider to provide identified nursing supports				
Residential provider agrees to provide identified nursing supports				
Active Coordination of Transition (ACT)				
Activity	**To be completed by:**	**Target Date**	**Notes**	**Date completed**
Nurse Delegation assessment completed / staff training plan (if needed)				
Transportation available to and from medical appointments				

Nursing plans / protocols in place: ☐ Fall risk ☐ Risk for skin breakdown ☐ Repositioning program ☐ Bowel movement monitoring ☐ Seizure plan ☐ Diet plan (food textures) ☐ Fluid goal ☐ Nutrition monitoring ☐ Weight tracking ☐ Other:			Recommended plans / protocols:	
Staff trained on plans / protocols: ☐ Fall risk ☐ Risk for skin breakdown ☐ Repositioning program ☐ Bowel movement monitoring ☐ Seizure plan ☐ Diet plan (food textures) ☐ Fluid goal ☐ Nutrition monitoring ☐ Weight tracking ☐ Other:				
Exception to Rule or Policy in place			Who approved the ETR / ETP:	
Staff trained in ETR / ETP				
Referral needed: ☐ Nurse Delegator ☐ Home Health ☐ Wound care clinic ☐ Therapy ☐ Psychiatrist ☐ Psychologist ☐ Podiatry ☐ Other:				

Post Move and Stabilization

The NCC will contact the client and the receiving provider within **seven** (**7) working days** of the client's move, to ensure staff are trained on all plans and protocols are in place and address remaining nursing needs.

The NCC will complete an **on-sight visit within 14 working days** of the client's move, which may serve as the initial contact post move, if within seven (7) working days. If possible, the NCC will complete the on-sight visit with the DDA case manager.

Activity	Resolved	Notes

Clear discharge instructions from discharging provider and needed protocols in place: ☐ Yes ☐ No		
Receiving provider has Medication Administration Records		
Receiving provider has medications / prescriptions		**Day's until refill needed:**
Receiving provider received medical equipment and supplies		
Nurse Delegation in place and training completed		
Confirm that plans / protocols are in place and receiving entity is trained		
Safety / environmental modifications completed		
ETR / ETP in place		
Assuming medical provider(s) in place		
Assuming pharmacy in place		
Receiving provider understands how to order medications and supplies		
Problems with medication administration		
Problems with nutrition		Height: Weight: Goal:
Problems with hydration		
Other:		

Client happy with the move: ☐ Yes ☐ No

Comments:

Receiving provider has tools and resources in place, to continue providing care: ☐ Yes ☐ No

Comments:

Date of two-week post move transition meeting:

NCC Transition Summary:

NCC recommends continue nursing follow up: ☐ Yes ☐ No

If yes, why:

SIGNATURE DATE