

Nurse Delegation: Rescinding Delegation

1. CLIENT NAME	2. ACES CLIENT ID NUMBER	3. DATE OF BIRTH	4. SETTING															
5. FACILITY OR PROGRAM NAME			6. TELEPHONE NUMBER															
7. Reason for Rescinding: (Check all that apply) <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> A. Client died</td> <td><input type="checkbox"/> E. NA not competent</td> <td><input type="checkbox"/> J. Rescinding facility including clients and nurse assistant</td> </tr> <tr> <td><input type="checkbox"/> B. Client's condition is no longer stable and predictable</td> <td><input type="checkbox"/> R. NA not willing</td> <td><input type="checkbox"/> K. Other (specify)</td> </tr> <tr> <td><input type="checkbox"/> C. Frequent staff turnover</td> <td><input type="checkbox"/> G. NA credential expired</td> <td></td> </tr> <tr> <td><input type="checkbox"/> D. Client / authorized representative requested</td> <td><input type="checkbox"/> H. NA No longer working with client</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> I. Client safety compromised</td> <td></td> </tr> </table>				<input type="checkbox"/> A. Client died	<input type="checkbox"/> E. NA not competent	<input type="checkbox"/> J. Rescinding facility including clients and nurse assistant	<input type="checkbox"/> B. Client's condition is no longer stable and predictable	<input type="checkbox"/> R. NA not willing	<input type="checkbox"/> K. Other (specify)	<input type="checkbox"/> C. Frequent staff turnover	<input type="checkbox"/> G. NA credential expired		<input type="checkbox"/> D. Client / authorized representative requested	<input type="checkbox"/> H. NA No longer working with client			<input type="checkbox"/> I. Client safety compromised	
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8. NAMES OF CAREGIVERS	9. MEDICATIONS AND TREATMENTS RESCINDED	10. NOTES																
1)																		
2)																		
3)																		
4)																		
5)																		
6)																		
7)																		
8)																		
9)																		
10)																		
11. NAME OF CASE MANAGER NOTIFIED		12. METHOD OF NOTIFICATION <input type="checkbox"/> Telephone <input type="checkbox"/> Email	13. DATE															
14. ALTERNATIVE PLAN FOR CONTINUING THE TASK																		
15. RND SIGNATURE			16. DATE															

To register concerns or complaints about Nurse Delegation, please call 1-800-562-6078

DISTRIBUTION: Copy in client chart and in RND file

Instructions for Completing Nurse Delegation: Rescinding Delegation

All fields are required unless indicated “**OPTIONAL**”.

1. Client Name: Enter ND client’s name (last name, first name).
2. ACES Client ID Number: Enter the client’s ACES ID number.
3. Date of Birth: Enter ND client’s date of birth (month, day, and year).
4. Setting: Enter client’s setting “AFH”, “ALF”, DDA Program, or “In-home”.
5. Facility or Program Name: Enter name of facility/program contact.
6. Telephone Number: Enter telephone number of facility/program contact including area code.
7. Reason for Rescinding: Mark the boxes next to the reason for rescinding. Mark all that apply.
8. Names of Caregivers: Enter name of individual caregiver rescinded.
9. Medications and treatments rescinded: Enter name of individual medication or treatment.
10. Notes: List notes related to rescinded tasks
11. Name of Case Manager Notified: Enter case manager name, if notified.
12. Method of notification: Identify method of notification to case manager.
13. Date: Enter date the case manager was notified.
14. Alternative Plan for Continuing the Task: Describe how client’s needs will continue to be met.
15. and 16. RND Signature and Date: Sign and date your signature. The date the form is signed is the date of rescinding.

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