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| Transforming Lives | **Nurse Delegation:**  **Nursing Visit** | | | |
| 1. CLIENT NAME | | 2. ACES ID NUMBER | 3. DATE OF BIRTH | 4. SETTING  AFH  DDA  In-home  Other: |
| 5. CHECK ALL THAT APPLY  Client Assessment (See attached)  Supervisory Visit  Initial Caregiver Delegation  Condition Change  Initial Insulin Delegation  Other: | | | | |
| 6. CLIENT REQUIRES NURSE DELEGATION FOR THESE TASK(S):    RELATED TO: | | | | |
| 7. REVIEW OF SYSTEMS: Only check changes in condition from last assessment (see attached, if applicable)  No Change  Cardiovascular  Diet / Weight / Nutrition  Neurological  GU / Reproductive  GI  Respiratory  Endocrine  ADL  Sensory  Pain  Integumentary  Psych / Social  Musculoskeletal  Cognition  Other: | | | | |
| **8. Notes** | | | | |

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| **9. Long Term Care Worker (LTCW) Training / Competency (Check or date all that apply)** | | | | | | | | |
| A.  LTCW Evaluated | B.  Observation or  Demonstration | C.  Verbal  Description | D.  Record  Review | E.  Training  Needed Completed | | F.  Other  (specify) | | G.  Active Credential |
| 1) |  |  |  |  |  |  | | Yes  No |
| 2) |  |  |  |  |  |  | | Yes  No |
| 3) |  |  |  |  |  |  | | Yes  No |
| 4) |  |  |  |  |  |  | | Yes  No |
| 5) |  |  |  |  |  |  | | Yes  No |
| 10.  Check here if additional notes / LTCW name on page 2. | | | | | | | | |
| 11.  Client stable and predictable  Continue delegation  See rescind form | | | | | | | | |
| I have verified, informed, taught and instructed the LTCW(s) to perform the delegated task(s). The LTCW(s) verified responsibility for performing the listed task as delegated. The LTCW(s) has been given the information on how to contact the delegating RN if they are no longer able or willing to do the listed task(s), client’s health care orders change, and/or client’s condition changes. | | | | | | | | |
| 12. RND SIGNATURE | | | | | | | 13. DATE | |

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| 14. RETURN VISIT ON OR BEFORE |

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| Transforming Lives | **Nurse Delegation:**  **Nursing Visit – Page 2** | | |
| 15. CLIENT NAME | | 16. DATE OF BIRTH | 17. SETTING  AFH  DDA  In-home  Other: |
| **18. NOTES** | | | |

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| **19. Long Term Care Worker (LTCW) Training / Competency (Check or date all that apply)** | | | | | | | | |
| A.  LTCW Evaluated | B.  Observation or  Demonstration | C.  Verbal  Description | D.  Record  Review | E.  Training  Needed Completed | | F.  Other  (specify) | | G.  Active Credential |
| 1) |  |  |  |  |  |  | | Yes  No |
| 2) |  |  |  |  |  |  | | Yes  No |
| 3) |  |  |  |  |  |  | | Yes  No |
| 4) |  |  |  |  |  |  | | Yes  No |
| 5) |  |  |  |  |  |  | | Yes  No |
| 6) |  |  |  |  |  |  | | Yes  No |
| 7) |  |  |  |  |  |  | | Yes  No |
| 8 |  |  |  |  |  |  | | Yes  No |
| 9) |  |  |  |  |  |  | | Yes  No |
| I have verified, informed, taught and instructed the LTCW(s) to perform the delegated task(s). The LTCW (s) verified responsibility for performing the listed task as delegated. The LTCW(s) has been given information on how to contact the delegating RN if they are no longer able or willing to do the listed task(s), client’s health care orders change, and/or client’s condition changes. | | | | | | | | |
| 20. RND SIGNATURE | | | | | | | 21. DATE | |

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| 22. RETURN VISIT ON OR BEFORE |

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| **Instructions for Completing Nurse Delegation: Nursing Visit**  All fields are required unless marked **“OPTIONAL”.**  1. Client Name: Enter ND client’s name (last name, first name).  2. ACES ID Number: Enter ND client’s ACES ID Number.  3. Date of Birth: Enter ND client’s date of birth (month, date, year).  4. Setting: Enter settings “AFH”, ALF, “DDA Program”, “In-home”.  5. Check the box or boxes that apply to how you are using this form. Assessment must be completed and attached.  6. Client Requires Nurse Delegation For These Delegated Task(s): List the task(s) you are delegating and the reason why the client needs to have the task(s) delegated.  7. Review Of Systems: Check the box for “No change” if client’s condition is unchanged from your last client assessment. If client’s condition is changed from your last assessment, check the appropriate category box. If a category box is checked, complete a note in Box 8 below.  8. Notes: Describe change in client’s condition in this box. If a category box (other than “No change”) is checked above, attach assessment documentation. Section may also be utilized as a “progress note” section.  9. LTCW Training Competency:  A. List the name of each LTCW evaluated at this visit.  B. – D. Check the appropriate box.  E. Check box or insert the date for training needed or completed.  F. OPTIONAL – In this column, enter any other method of determining competency not already listed or additional information you deem necessary.  G. Active Credential: Verify the LTCW has a current active credential. If needed, update Credentials and Training Verification form, DSHS 10-217.  10. OPTIONAL – Check this box if a second page is used for additional notes / LTCW names.  11. Check all boxes that apply. If “Rescinding delegation” box is checked, you must complete “Rescinding Delegation form,  DSHS 13-680.  12. and 13. RND Signature and Date: Sign and date. Please make legible.  14. Return Visit On Or Before: Enter a date you will return for next supervisory visit or date of visit(s) before the 90 day time frame requirement.  15. See number 1. above.  16. See number 2. above.  17. See number 3. above.  18. See number 8. above.  19. See number 9. above.  20. and 21. See number 12. and 13. above.  22. See number 14. above.  **Be sure to sign and date both pages if a second page is used.** |