

NURSE DELEGATION: RESCINDING DELEGATION

1. CLIENT NAME		2. DATE OF BIRTH		3. ID/SETTING (OPTIONAL)		
4. FACILITY OR PROGRAM NAME (OPTIONAL)				5. TELEPHONE NUMBER		
6. Reason for Rescinding: (Check all that apply)						
<input type="checkbox"/> A. Client died <input type="checkbox"/> B. Client's condition changed <input type="checkbox"/> C. Frequent staff turnover <input type="checkbox"/> D. Client/authorized representative requested		<input type="checkbox"/> E. Task not performed correctly <input type="checkbox"/> F. NA not competent <input type="checkbox"/> G. NA not willing <input type="checkbox"/> H. NA credential expired <input type="checkbox"/> I. NA No longer working with client		<input type="checkbox"/> J. Client safety compromised <input type="checkbox"/> K. Rescinding facility including clients and nurse assistant <input type="checkbox"/> L. Other (specify)		
7. TASK RESCINDED						
8. NAMES OF CAREGIVERS	9. ALL TASKS	10. MEDICATIONS			11. BLOOD SUGAR	12. OTHER/SPECIFY
		ORAL	TOPICAL	DROPS		
1)						
2)						
3)						
4)						
5)						
6)						
7)						
8)						
9)						
10)						
13. <input type="checkbox"/> Case Manager Notified (When appropriate)		14. NAME OF CASE MANAGER NOTIFIED			15. DATE	
16. ALTERNATIVE PLAN FOR CONTINUING THE TASK						
17. RND SIGNATURE					18. DATE	

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

COPIES IN CHART AND RND FILE

INSTRUCTIONS – NURSE DELEGATION: RESCINDING DELEGATION

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

1. Client Name: Enter ND client’s name (last name, first name).
2. Date of Birth: Enter ND client’s date of birth (month, day, year).
3. ID Setting: OPTIONAL – Enter client’s ID number as assigned by your business OR enter settings “AFH”, “BH”, DDD Program, “In-home”.
4. Facility or Program Name: OPTIONAL – Enter name of facility/program contact.
5. Telephone Number: OPTIONAL – Enter telephone number of facility/program contact including area code.
6. Reason for Rescinding: Mark the boxes next to the reason for rescinding. Mark all that apply.
7. Task Rescinded: Enter name of task rescinded. If medication, list name. This applies to all caregivers delegated for this task.
8. Names of Caregivers: Enter name of individual caregiver rescinded. If all, enter “ALL”.
9. All Tasks: Enter “X” under all tasks next to name of appropriate caregiver(s).
10. Medications: Enter name of individual medication if appropriate. If all, enter “ALL”.
11. Blood Sugar: Enter “X” if blood sugar rescinded.
12. Other/Specify: OPTIONAL – List other tasks rescinded or list date if appropriate.
13. OPTIONAL – Check the box if appropriate. Case Manager must be notified if ALL tasks (client condition has changed) are rescinded or ALL caregivers (client unable to receive needed services).
14. Name of Case Manager Notified: Enter case manager name, if notified.
15. Date: Enter date the case manager was notified.
16. Alternative Plan for Continuing the Task: Describe how client’s needs will continue to be met.
17. & 18. RND Signature and Date: Sign and date your signature. The date the form is signed is the date of rescinding, unless otherwise noted in #7.