Washington State Department of Social & Health Services
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

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	E. TRAINING 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

14. RETURN VISIT ON OR BEFORE

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

DISTRIBUTION: Copy in client chart and in RND file

Washington State Department of Social & Health Services
Transforming lives

Nurse Delegation: Nursing Visit – Page 2

15. CLIENT NAME	16. DATE OF BIRTH	17. SETTING ☐ AFH ☐ DDA ☐ In-home ☐ Other:

18. NOTES

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	E. TRAINING 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

22. RETURN VISIT ON OR BEFORE

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: 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.

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

DISTRIBUTION: Copy in client chart and in RND file