

## Nurse Delegation: Rescinding Delegation

1. CLIENT NAME		2. DATE OF BIRTH	3. SETTING															
4. FACILITY OR PROGRAM NAME			5. TELEPHONE NUMBER															
6. 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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	<input type="checkbox"/> I. Client safety compromised																	
7. NAMES OF CAREGIVERS	8. MEDICATIONS AND TREATMENTS RESCINDED	9. NOTES																
1)																		
2)																		
3)																		
4)																		
5)																		
6)																		
7)																		
8)																		
9)																		
10)																		
10. NAME OF CASE MANAGER NOTIFIED		11. METHOD OF NOTIFICATION <input type="checkbox"/> Telephone <input type="checkbox"/> Email	12. DATE															
13. ALTERNATIVE PLAN FOR CONTINUING THE TASK																		
14. RND SIGNATURE			15. 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. Date of Birth: Enter ND client’s date of birth (month, day, and year).
3. Setting: Enter client’s setting “AFH”, “ALF”, DDA Program, or “In-home”.
4. Facility or Program Name: Enter name of facility/program contact.
5. Telephone Number: 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. Names of Caregivers: Enter name of individual caregiver rescinded.
8. Medications and treatments rescinded: Enter name of individual medication or treatment.
9. Notes: List notes related to rescinded tasks
10. Name of Case Manager Notified: Enter case manager name, if notified.
11. Method of notification: Identify method of notification to case manager.
12. Date: Enter date the case manager was notified.
13. Alternative Plan for Continuing the Task: Describe how client’s needs will continue to be met.
14. and 15. RND Signature and Date: Sign and date your signature. The date the form is signed is the date of rescinding.

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