Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

Nursing Care Consultant Transition Tool

CLIENT NAME AND PREFFERED PRONOUNS
PROVIDERONE / ADSA ID

LOCATION OF MOVE	PROPOSED MOVE DATE	INSURANCE COVERAGE

Purpose: This is a required document intended to facilitate and track Nursing Care Consultant (NCC) activities towards the individuals move. The NCC will track all nursing activities on this tool, highlighting individual needs and readiness towards the transition. A copy may be provided to DDA staff, client, authorized representative, and residential provider upon request. This tool will be saved to the clients DDA CARE file upon transition.

MOST RECENT PLAN OF CARE RECEIVED ☐ Yes ☐ No	RECEIVED BY:	DATE OF PLAN

NOTES

DIAGNOSIS

CODE STATUS

POLST form: ☐ Yes ☐ No

NOTES:

HISTORY

Emergency Care and Reason Within the Last 12 Months

911 calls	Date: Reason: Outcome:
Emergency Department Visits	Date: Reason: Outcome:
Urgent Care Visits	Date: Reason: Outcome:
Hospitalizations	Date: Reason: Outcome:

NOTES

DATE OF BIRTH AGE	GENDER ☐ Male ☐ Female ☐ Other	HEIGHT	WEIGHT CURRENT: GOAL:	BMI

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PROVIDERONE / ADSA ID

DIET
☐ Oral ☐ Tube Fed ☐ Central Line
☐ Other:
NOTES:

EATING ASSISTANCE
☐ Independent ☐ Partial Assistance
☐ Full Assistance
NOTES:

DIET TEXTURE
Fluid: ☐ Regular ☐ Nectar ☐ Honey ☐ Pudding
NOTES:

Food: ☐ Regular ☐ Chopped / cut ☐ Pureed
NOTES:

ADLs
☐ Independent
☐ Partial Assistance
☐ Full Assistance
NOTES:

MEDICATION ADMINISTRATION
☐ Independent
☐ Assistance
☐ Must be administered
NOTES:

SKIN ASSESSMENT COMPLETED
Wound: ☐ Yes ☐ No
NOTES:

CONTINENCY OF:
Bowel: ☐ Yes ☐ No
Bladder: ☐ Yes ☐ No
NOTES:

METHOD OF COMMUNICATION
☐ Verbal ☐ Nonverbal
☐ Assistive devices:
NOTES:

CURRENT EQUIPMENT NEEDS
☐ Up to date
☐ Repairs needed
NOTES:

BEHAVIOR / MENTAL HEALTH TRANSITIONAL CLINICAL TEAM REFERRAL MADE
☐ Yes ☐ No
REGIONAL CLINICAL TEAM REFERRAL MADE
☐ Yes ☐ No
NOTES:

Pain: ☐ Yes ☐ No
Location:
Treatment:
Is treatment effective? ☐ Yes ☐ No
NOTES:

IMMUNIZATION HISTORY

Allergies:

Current Medications

Medication	Dose / Route	Time

PRN usage in the last 30 days:

Changes to medications in the last six months:
NOTES:

ROUTINE LABS	ABNORMAL LAB VALUES IN THE PAST 12 MONTHS

Transition Team

Title	Name, contact information, and organization	Notes and status
Individual		
Authorized representative (NSA / Guardian)		If guardianship is in place, are orders current: ☐ Yes ☐ No
MCO Representative		
DDA Case Manager		
DDA Clinical Team Psych / ARNP		
Current provider		
Receiving provider		

Medical Providers

Title	Name, contact information, and organization	Notes and status
Current Primary Care		
Assuming Primary Care		
Current Dental Provider		
Assuming Dental Provider		
Specialists		
Therapy (PT / OT / SLP)		
Current Pharmacy		
Assuming pharmacy		
Current laboratory		
Assuming laboratory		
Other:		

Upcoming / Scheduled Appointments

Appointment Type	Date	Notes

Transition Preparation

Activity	Notes	Date completed
Review existing nursing supports		

Review CARE assessment		
Review referral packet for medical needs	Are nursing supports added to the referral packet?	
Consent form signed, to allow collaboration with health care team		
Is a tour of the residential placement needed prior to move?	☐ Yes ☐ No	
Safety / environmental modifications recommended	☐ Yes ☐ No	
Medical equipment needed or recommended	☐ Yes ☐ No	
Will the setting of client's choice meet the client's needs?	☐ Yes ☐ No	
NOTES:		

Active Coordination of Transition (ACT)

Activity	Notes	Date
Nurse Delegation referral initiated	☐ Yes ☐ No	
Discharge orders received	☐ Yes ☐ No	
Safety / environmental modifications recommendations		
Transportation needed to and from medical appointments	☐ Yes ☐ No	
Nursing plans / protocols in place: ☐ Fall risk ☐ Risk for skin breakdown ☐ Repositioning program ☐ Bowel movement monitoring ☐ Seizure plan ☐ Diet plan (food textures) ☐ Fluid goal ☐ Nutrition monitoring ☐ Weight tracking ☐ Other:	Recommended plans / protocols:	
Staff trained on plans / protocols: ☐ Fall risk ☐ Risk for skin breakdown ☐ Repositioning program ☐ Bowel movement monitoring ☐ Seizure plan ☐ Diet plan (food textures) ☐ Fluid goal ☐ Nutrition monitoring		

☐ Weight tracking ☐ Other:		
Exception to Rule in place	☐ Yes ☐ No	
Exception to Policy in place	☐ Yes ☐ No	
Staff trained on ETP	☐ Yes ☐ No	
Referral needed: ☐ Nurse Delegator ☐ Home Health ☐ Wound Care Clinic ☐ Therapy ☐ Psychiatrist ☐ Psychologist ☐ Podiatry ☐ Other:		

Post Move and Stabilization

The NCC will contact the client and the receiving provider within **seven (7) working days** of the client's move, to review staff training on plans and protocols, and address remaining nursing needs.

The NCC will complete an **on-sight visit within 14 working days** of the client's move, which may serve as the initial contact post move, if within seven (7) working days. If possible, the NCC will complete the on-sight visit with the DDA case manager.

Activity	Notes
Discharged orders received ☐ Yes ☐ No	
Plans or protocols in place ☐ Yes ☐ No	
Medication Administration Records in place ☐ Yes ☐ No	
Medications are available and onsite ☐ Yes ☐ No	**Days until refill needed:**
Receiving provider received medical equipment and supplies ☐ Yes ☐ No	
Nurse Delegation in place and training completed (if needed) ☐ Yes ☐ No	
Safety / environmental modifications completed (if needed) ☐ Yes ☐ No	
Assuming medical provider(s) in place ☐ Yes ☐ No	
Assuming pharmacy in place ☐ Yes ☐ No	
Receiving provider understands how to order medications and supplies ☐ Yes ☐ No	
Concerns with medication administration	

☐ Yes ☐ No	
Concerns with nutrition ☐ Yes ☐ No	NOTES: Height: Weight: Goal:
Concerns with skin integrity ☐ Yes ☐ No	
Other:	

Client happy with the move: ☐ Yes ☐ No

Comments:

Was the 7-day and 14-day meeting completed at the same time? ☐ Yes ☐ No

Date of 7-day post move check in .

Date of 14-day post move transition meeting .

NCC Transition Summary:

Date of two-week post move transition meeting:

NCC Transition Summary:

NCC recommends continue nursing follow up: ☐ Yes ☐ No

If yes, why:

SIGNATURE DATE