Nurse Delegation: Assumption of Delegation

<table>
<thead>
<tr>
<th>1. CLIENT NAME</th>
<th>2. ACES ID</th>
<th>3. DATE OF BIRTH</th>
<th>4. SETTING</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. FACILITY OR PROGRAM NAME</td>
<td>6. TELEPHONE NUMBER</td>
<td></td>
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7. REASON FOR ASSUMING DELEGATION

I agree that I know the client through my assessment, the plan of care, the skills of the Long Term Care Worker(s) (LTCW), and the delegated task(s). I agree to assume responsibility and accountability for the delegated task(s) and to perform the nursing supervision. I have informed the client and/or authorized representative of this change. I have informed the LTCW, case manager, and client of this change.

8. RND SIGNATURE

9. DATE

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

DISTRIBUTION: Copy in client chart and in RND file

NURSE DELEGATION: ASSUMPTION OF DELEGATION
DSHS 13-678B (REV. 09/2021)

Instructions for Completing Nurse Delegation: Assumption of Delegation

All fields are required unless indicated “OPTIONAL”.

1. **Client Name**: Enter ND client’s name (last name, first name).
2. **ACES ID**: Enter client’s ACES Identification number.
3. **Date of Birth**: Enter ND client’s date of birth (month, day, year).
4. **ID Setting**: OPTIONAL – Enter client’s ID number as assigned by your business OR enter settings “AFH”, “ALF”, DDA Program, “In-home”.
5. **Facility or Program Name**: OPTIONAL – Enter name of facility/program contact.
6. **Telephone Number**: OPTIONAL – Enter telephone number of facility/program contact including area code.
7. **Reason/Dates for Another RND to Assume Delegation**: Enter reason other RND rescinded and the date you assume responsibility for delegation.
8. and 9. **Assuming RND Signature and Date**: Sign and date your signature.