Washington State
Department of Social & Health Services
Transforming lives

Nurse Delegation:
Change in Medical / Treatment Orders

1. CLIENT NAME	2. ACES ID NUMBER	3. DATE OF BIRTH	4. SETTING

5. DATE RND WAS NOTIFIED	6. BY WHOM	7. CHANGES IN ORDER(S)
		☐ New med.　　☐ Change in a delegated med ☐ New nursing task　☐ Change in a nursing task

8. HOW WAS THE CHANGE RECEIVED? ☐ Written　☐ Faxed　☐ Verbal	9. EFFECTIVE DATE OF CHANGE

10. Only Complete if number 7 was a verbal order.

NAME OF PERSON PROVIDING VERIFICATION	TITLE OF PERSON PROVIDING VERIFICATION	DATE OF VERIFICATION

11. NURSING TASK(S) ☐ New task(s) sheet required ☐ Current task(s) sheets(s) updated ☐ No change to task(s) sheet(s)
NURSING TASK / ORDER

12. This medication(s) is:　☐ New　☐ Changed

13. DATE ORDERED	14. NAME OF MEDICATION		15. START DATE	16. STOP DATE (IF APPLICABLE)

17. STRENGTH/DOSE	18. MEDICATION FREQUENCY	19. ROUTE	20. NOT TO EXCEED

21. REASON FOR MEDICATION

Optional Task Sheet: (21 – 29)

22. STEPS TO PERFORM THE NEW TASK ☐ CHECK IF TEACHING AID ATTACHED

23. EXPECTED OUTCOME OF DELEGATED TASK

Report side effects or unexpected outcomes to::

24. RND NAME (PRINT)	25. TELEPHONE NUMBER

26. WHAT TO REPORT TO RND

27. HEALTH CARE PROVIDER	28. TELEPHONE NUMBER

29. WHAT TO REPORT TO HEALTH CARE PROVIDER

30. WHAT TO REPORT TO EMERGENCY SERVICES, 911

Select Only One of the Following

31. ☐ Delegate immediately. No site visit required. The above order and instructions have been communicated to the delegated Long Term Care Worker(s) (LTCW) and this form should be added to the client's chart. **OR**

32. ☐ A site visit is required for training or assessment prior to delegation. The LTCW(s) may not perform the task until the site visit is completed.

33. RND SIGNATURE	34. 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: Change in Medical / Treatment Orders

All fields are required unless indicated **"OPTIONAL".**

1. Client Name: Enter ND client's name (last name, first name).

2. ACES ID Number: Enter Client's ACES ID 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", DDD Program, "In- home".

5. Date RND Was Notified: Enter date you were notified of change.

6. By Whom: List name and title of individual who notified delegating nurse of change/new task or medication.

7. Change in Orders: Check appropriate box to indicate a change or a new task/medication.

8. How Was the Change Received: Select the method used by the health care provider to communicate the change.

9. Effective Date of Change: Enter date the change was ordered by health care provider.

10. If Verbal was selected in #7 above: Insert the name, title (MD, ARNP, PA) and date the order was verified.

11. Nursing Task/Orders: What was the order, and does it require a new task sheet or a change to the current instructions.

12. This Medication Was: OPTIONAL – Complete 11-20 **only** if a medication was involved. Indicate whether the medication was changed or new. Complete all boxes (11-20) for **each** medication changed or ordered new.

13. Date Ordered: Enter the date this change was ordered.

14. Name of Medication(s): Enter name of medication(s) ordered.

15. Start Date: Enter the date the new/changed medication was first administered.

16. Stop Date: Enter, if applicable, last date to administer this medication.

17. Strength/Dose: Enter strength of medication and dose to be administered.

18. Medication Frequency: Enter how often medication is to be administered.

19. Route: Enter route for medication to be administered. *Examples: PO, Supp, Topical, Drops, etc.*

20. Not to Exceed: Enter maximum number of doses in a specified time period, if applicable.

21. Reason for Medication: Enter the reason the client takes this medication.

    Repeat #11 – 20 for **each** new or changed medication.

22. - 23. Steps to Perform New Task/Medication: OPTIONAL – Complete 21 & 22 only if using this form for a task sheet.

    Enter results expected by providing this task/medication.

24. – 25. RND Name and Telephone Number: Print your name and telephone number including area code.

26. What to Report to RND: Enter symptoms or side effects for all tasks, medications on this sheet to be reported to you.

27. – 28. Health Care Provider Name and Telephone Number: Enter health care provider name and telephone number including area code.

29. What to Report to Health Care Provider: Enter symptoms or side effects for all tasks, medications on this sheet to report to health care provider.

30. What to Report to Emergency Services, 9-1-1: Enter symptoms or side effects for all tasks, medications on this sheet to report to emergency services (911)

31. – 32. Delegate Immediately OR Site Visit Required: Choose **only one** (#30 **OR** #31) to indicate whether caregiver(s) may provide the new task/medication immediately or whether a training visit (on site) is necessary prior to delegation. IN EITHER CASE, THE DOCUMENTATION IN THE CLIENT FILE MUST REFLECT WHEN DELEGATION FOR THE NEW TASK/MEDICATION BEGAN.

33. – 34. RND Signature and Date: Sign and date your signature.

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