| Text  Description automatically generated | | 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 |
| 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** | | |
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| 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: |  | |  |

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| **Upcoming / Scheduled Appointments** | | |
| **Appointment Type** | **Date** | **Notes** |
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| **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 completed** |
| 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 | | Height:  Weight: | | NOTES: | | |
| 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 | | | | | | |