| Text  Description automatically generated | DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)**Nursing Care ConsultantTransition 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 STATUSPOLST 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 | WEIGHTCURRENT:  GOAL:  | BMI |
| DIET[ ]  Oral [ ]  Tube Fed [ ]  Central Line[ ]  Other: NOTES: | EATING ASSISTANCE[ ]  Independent [ ]  Partial Assistance[ ]  Full AssistanceNOTES: |
| DIET TEXTUREFluid: [ ]  Regular [ ]  Nectar [ ]  Honey [ ]  PuddingNOTES: | Food: [ ]  Regular [ ]  Chopped / cut [ ]  PureedNOTES: |
| ADLs[ ]  Independent[ ]  Partial Assistance[ ]  Full Assistance | NOTES: |
| MEDICATION ADMINISTRATION[ ]  Independent[ ]  Assistance[ ]  Must be administeredNOTES: | SKIN ASSESSMENT COMPLETEDWound: [ ]  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 neededNOTES: | BEHAVIOR / MENTAL HEALTH TRANSITIONAL CLINICAL TEAM REFERRAL MADE[ ]  Yes [ ]  NoREGIONAL CLINICAL TEAM REFERRAL MADE[ ]  Yes [ ]  NoNOTES: |
| Pain: [ ]  Yes [ ]  NoLocation: Treatment: Is treatment effective? [ ]  Yes [ ]  No NOTES: |
| IMMUNIZATION HISTORYAllergies:  |
| **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 TeamPsych / 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 [ ]  NoComments:   |
| Was the 7-day and 14-day meeting completed at the same time? [ ]  Yes [ ]  NoDate 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 [ ]  NoIf yes, why:  |
| SIGNATURE DATE  |