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| Transforming Lives | **Nurse Delegation: Assumption of Delegation** | | | |
| 1. CLIENT NAME | | 2. ACES ID | 3. DATE OF BIRTH | 4. SETTING |
| 5. FACILITY OR PROGRAM NAME | | | | 6. TELEPHONE NUMBER |
| 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 |

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| **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 Reason/Dates for Another RND to Assume Delegation: Enter reason other RND rescinded and the date you assume responsibility for delegation.  8.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.  **NURSE DELEGATION: ASSUMPTION OF DELEGATION**  **DSHS 13-678B (REV. 09/2021)** |