|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Transforming Lives | **Nurse Delegation: Rescinding Delegation** | | | | | | | | | | |
| 1. CLIENT NAME | | | | 2. ACES CLIENT ID NUMBER | | 3. DATE OF BIRTH | | | 4. SETTING | | |
| 5. FACILITY OR PROGRAM NAME | | | | | | | | | 6. TELEPHONE NUMBER | | |
| 7. Reason for Rescinding: (Check all that apply) | | | | | | | | | | | |
| A. Client died  B. Client’s condition is no longer stable and predictable  C. Frequent staff turnover  D. Client / authorized representative requested | | | E. NA not competent  R. NA not willing  G. NA credential expired  H. NA No longer working with client  I. Client safety compromised | | | | J. Rescinding facility including clients and nurse assistant  K. Other (specify) | | | | |
| 8. NAMES OF CAREGIVERS | | 9. MEDICATIONS AND TREATMENTS RESCINDED | | | | | | 10. NOTES | | | |
| 1) | |  | | | | | |  | | | |
| 2) | |  | | | | | |  | | | |
| 3) | |  | | | | | |  | | | |
| 4) | |  | | | | | |  | | | |
| 5) | |  | | | | | |  | | | |
| 6) | |  | | | | | |  | | | |
| 7) | |  | | | | | |  | | | |
| 8) | |  | | | | | |  | | | |
| 9) | |  | | | | | |  | | | |
| 10) | |  | | | | | |  | | | |
| 11. NAME OF CASE MANAGER NOTIFIED | | | | | 12. METHOD OF NOTIFICATION  Telephone  Email | | | | | | 13. DATE |
| 14. ALTERNATIVE PLAN FOR CONTINUING THE TASK | | | | | | | | | | | |
| 15. RND SIGNATURE | | | | | | | | | | 16. DATE | |

|  |  |
| --- | --- |
|  |  |

|  |
| --- |
| **Instructions for Completing Nurse Delegation: Rescinding Delegation**  All fields are required unless indicated **“OPTIONAL”.**   1. Client Name: Enter ND client’s name (last name, first name). 2. ACES Client ID Number: Enter the client’s ACES ID number.   3. Date of Birth: Enter ND client’s date of birth (month, day, and year).  4. Setting: Enter client’s setting “AFH”, “ALF”, DDA Program, or “In-home”.  5. Facility or Program Name: Enter name of facility/program contact.  6. Telephone Number: Enter telephone number of facility/program contact including area code.  7. Reason for Rescinding: Mark the boxes next to the reason for rescinding. Mark all that apply.  8. Names of Caregivers: Enter name of individual caregiver rescinded.  9. Medications and treatments rescinded: Enter name of individual medication or treatment.  10. Notes: List notes related to rescinded tasks  11. Name of Case Manager Notified: Enter case manager name, if notified.  12. Method of notification: Identify method of notification to case manager.  13. Date: Enter date the case manager was notified.  14. Alternative Plan for Continuing the Task: Describe how client’s needs will continue to be met.  15. and 16. RND Signature and Date: Sign and date your signature. The date the form is signed is the date of rescinding. |