DDD RN Delegation Plan

To accompany RN Assessment

Demographic Information:

Participant (Name): _____ RN Delegating Tasks (Name): _____

Setting (for delegating tasks): _____ Physician's Orders Attached: ☐ Yes ☐ No

ISP Plan Year: _____

All Current DDD Waiver Services: (Please list)

Service	Agency Provider	RN Delegated Tasks
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

Service	Agency Provider	RN Delegated Tasks
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

Rationale: (Please describe the reason and intent of the RN delegation.)

Clinical Notes: (Please include what the order is, the medical provider, and clear parameters if needed for each delegated task.)

Order and Parameters	Potential Risks and Safety Plan

Skill: (Please describe clearly and concisely each task the delegatee will need to complete – broken down step-by-step, if applicable.)

No.	Skill (Describe task, broken down step-by-step)	Rationale (What tasks will be delegated & why)	Equipment & Supplies	Competency Validation: Delegatee (Initials)	Delegator (Initials)
1					
2					
3					
4					
5					
6					

No.	Skill (Describe task, broken down step-by-step)	Rationale (What tasks will be delegated & why)	Equipment & Supplies	Competency Validation: Delegatee (Initials)	Delegator (Initials)
7					
8					
9					
10					
11					
12					

Acknowledgement of Understanding of Nursing Delegation Protocol:

Disclaimer:

This Nurse Delegation Form is intended to authorize a qualified delegatee to perform specific nursing tasks under the delegation and supervision of a licensed nurse, in accordance with applicable laws and regulations.

By signing this form, all parties acknowledge and agree with the following:

1. **Scope of Delegation**: The tasks delegated are appropriate to the *delegatee*'s level of training and competence and have been assessed and approved by the delegating nurse.
2. **Limitations**: Delegated tasks do not include those that require nursing judgment, assessment, or clinical decision-making and may not be re-delegated to another individual.
3. **Responsibility**: The delegating nurse retains accountability for the decision to delegate and the overall outcomes, but the *delegatee* is responsible for performing the delegated tasks safely and correctly, as instructed.
4. **Training and Supervision**: The *delegatee* has received appropriate training and demonstrated competence in the delegated task(s) and understands the conditions under which the delegation may be withdrawn or modified.
5. **Revocation**: This delegation may be revoked at any time by the delegating nurse if the caregiver fails to perform the task safely, the patient's condition changes, or any concerns arise that affect the safety or appropriateness of the delegated task.
6. **Legal Compliance**: This form and the delegation of tasks comply with all applicable local, state, and federal laws and professional practice standards.

This form does not replace medical advice, treatment plans, or clinical supervision. It is the responsibility of the parties involved to ensure they understand their roles and limitations under this agreement.

Delegatee: _____ **Date:** _____
(Print / Signature)

Provider RN: _____ **Date:** _____
(Signature)

Service Supervisor: _____ **Date:** _____
(Signature)

Follow-Up Recommendations:

Retraining Log:

Date	Task	Reason	Initials