

ATTENTION: \_\_\_\_\_

RE: PERSONAL ASSISTANCE GUIDELINES FOR: **DELEGATED OCCUPATIONAL THERAPY TASKS**

Was the 'Decision to Delegate' tool used to determine if it is safe and suitable to delegate this task? ☐ Yes ☐ No

Is this Delegated Task a:	<input type="checkbox"/> New Task	<input type="checkbox"/> Change to Task	<input type="checkbox"/> Review
---------------------------	-----------------------------------	---	---------------------------------

PARIS ID: \_\_\_\_\_

Client: \_\_\_\_\_ Phone #: \_\_\_\_\_ Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Client is able to direct own care? ☐ Yes ☐ No

Family or Client's Key Caregiver: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Phone #: \_\_\_\_\_

This is to confirm home support has agreed to accept the task of **ASSISTING WITH:**

- ☐ Prosthetics / Orthotics / Splints ☐ Re-Training Client's Functional Capability  
☐ Other: \_\_\_\_\_

VCH Community staff will continue to monitor the client's condition. They should be contacted as soon as possible by Home Support staff if there are any concerns about the task(s) or a change in client's condition.

VCH Community Contact:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_

**TASK GUIDELINES:**

The Unregulated Care Provider is to:
1.
2.
3.
4.
Additional Information:

**TASK COMPETENCY: (Complete if applicable)**

Persons Trained:	Name	Date	Competence Demonstrated (Y/N)
------------------	------	------	-------------------------------

Agency Supervisor:

Unregulated Care  
Provider(s):**REFER TO THE DETAILED: (X All that apply)**

- ☐ Written Instructions
- ☐ Diagrams
- ☐ Photographs
- ☐ Other

This is not a task that can be transferred to another UCP or client. If one of the above UCP's leaves or there is a change in the client's status it is the responsibility of the agency supervisor to contact the delegating HCP.

The referring HCP is available for ongoing consultation and /or teaching. The client's Home Care file will remain active in order to provide monitoring service for the above delegation. Community staff should be contacted as soon as possible if there are any concerns about the task(s) or a change in client's condition.

**PAG AFTER HOURS BACK-UP PLAN**

**When the trained Unregulated Care Provider is not able to complete the task contact the home support Supervisor or the home support on call Supervisor;**

**Then Either: (X 1 option)**

- ☐ The client family/contact will be required to do the task

*Designated Back-up contact: Name: \_\_\_\_\_ Phone: \_\_\_\_\_; **or***

- ☐ Refer to Care Plan (***Include Detailed PAG After Hours Back-up Plan***); **or**
- ☐ Other \_\_\_\_\_

<b>Copied to:</b>	<input type="checkbox"/> Client	<input type="checkbox"/> HCN	<input type="checkbox"/> PT	<input type="checkbox"/> OT	<input type="checkbox"/> CM	<input type="checkbox"/> Physician
-------------------	---------------------------------	------------------------------	-----------------------------	-----------------------------	-----------------------------	------------------------------------