
Working with Others: A Position Paper

Executive Summary

KEY CONCEPTS

1. Boards of Nursing regulate nursing practice.
2. State Nurse Practice Acts determine what level of licensed nurse is authorized to delegate.
3. Delegation is a skill requiring clinical judgment and final accountability for client care. Nursing education should include delegation theory and opportunities for case studies and simulated exercises. However, the application of delegation theory to practice must occur in a practice setting, where the nurse has clinical experience to support decision-making and the authority to enforce the delegation.
4. There is both individual accountability and organizational accountability for delegation. Organizational accountability relates to providing sufficient resources, staffing, appropriate staff mix, implementation of policies and role descriptions, opportunity for continuing staff development and creating an environment conducive to teamwork, collaboration and client-centered care.
5. To delegate is to transfer authority to a competent individual for completing selected nursing tasks/activities/functions. To assign is to direct an individual to do activities within an authorized scope of practice. Assignment (noun) describes the distribution of work that each staff member is to accomplish in a given work period.
6. The practice pervasive functions of assessment, planning, evaluation and nursing judgment cannot be delegated.
7. The steps of the delegation process include assessment of the client, the staff and the context of the situation; communication to provide direction and opportunity for interaction during the completion of the delegated task; surveillance and monitoring to assure compliance with standards of practice, policies and procedures; and evaluation to consider the effectiveness of the delegation and whether the desired client outcome was attained.
8. The variation in the preparation, regulation and use of nursing assistive personnel presents a challenge to nurses and assistants alike. Consistent education and training requirements that prepare nursing assistive personnel to perform a range of functions will allow delegating nurses to know the preparation and skill level of assistive personnel, and will prepare nursing assistants to do this work.
9. Delegation is one type of interface between nurses and other health care personnel. There are other types of interfaces, and nurses need to assess other types of interactions to identify the nursing role and the responsibility for the particular type of interface.

THE POSITION OF NCSBN

- State Boards of Nursing should regulate nursing assistive personnel across multiple settings.
- There are other types of interfaces with health care providers and workers in settings where there is not a structured nursing organization. In some settings, health care plays a secondary role. Nurses need to assess other types of interactions to identify the nursing role and responsibility for the particular type of interface.
- Delegation is the act of transferring to a competent individual the authority to perform a selected nursing task in a selected situation, the process for doing the work. Assignment describes the distribution of work that each staff member is to accomplish in a given time period.

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- Nursing assistive personnel, regardless of title, should receive adequate basic training as well as training customized to the specific work setting. Basic education should include how the nursing assistant functions as part of the health care team, with an emphasis on receiving delegation. Individuals who successfully complete comprehensive educational and training requirements, including passing a competency examination, will be certified as nursing assistive personnel.

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But in both [hospitals and private houses], let whoever is in charge keep this simple question in her head, (not, how can I always do this right thing myself, but) how can I provide for this right thing to be always done?

- Florence Nightingale

I. Introduction

The importance of working with and through others and the abilities to delegate, assign, manage and supervise have never been as critical and challenging as in the complex and complicated world of 21st century health care. Recent decades have seen an upheaval in health care triggered by an escalation of new knowledge and technology. There has never been a greater demand for nursing. At the same time, the number of nurses is not keeping pace with the growing needs for nursing services.

Nurses are present most continuously with clients and hold a tradition of using a variety of nursing assistive personnel in order to meet the needs of more clients than one nurse can care for alone. Today the world is facing a critical nursing shortage. Unlike the cyclic shortages that occurred periodically throughout the 20th century, this shortage is compounded by an aging nurse population, an increased need for nursing services due to changing demographics (e.g., the increased survival rate of people with chronic diseases as well as people generally living longer), more nursing care being delivered in nonhealth care settings, and a “war for talent” with other health and service professions. The profession of nursing **must** determine how to continue providing safe, effective nursing care with decreased numbers of nurses caring for increased numbers of clients.

Working with others has always been a fundamental aspect of nursing, and traditionally the major type of interaction has been the nurse delegating to competent others. This Paper provides an analysis of the complex concepts related to delegation, and is intended as a resource for boards of nursing in the regulation of nursing. It provides nurses and employers with information that will assist them in making informed decisions about using nursing assistive personnel to provide safe, competent nursing care. The Paper builds upon historical and conceptual NCSBN papers on delegation by reaffirming the delegation decision-making process while adapting it to the realities of the current nursing workplace. It discusses issues impacting the preparation of nurses to delegate as well as the use of delegation in the management of nursing care.

The Paper, and its companion piece, a new article and chapter for the *NCSBN Model Nursing Practice Act and Model Administrative Rules*, propose a regulatory model for the oversight of nursing assistive personnel in agencies and facilities with structured nursing organizations (i.e., settings which have designated chief nursing officer). This Paper refers to individuals working with nurses in these settings as Nursing Assistive Personnel (NAP).

This Paper also addresses nurses working in settings that do not have organized nursing structures, where nurses have struggled to determine the appropriate nursing role. It provides guidance to nurses working in non-acute health settings, social support agencies and other settings where there is not a structured nursing organization. While delegation has been the traditional type of interface with assistive personnel, this Paper provides a template for nurses to evaluate other types of interfaces with health team members and other workers, referred to in this Paper as Unlicensed Assistive Personnel (UAP). Working with UAP in these settings is a source of confusion and frustration for nurses, and the subject of many calls to boards of nursing. This Paper proposes a template to guide nurses in these situations.

Boards of nursing have jurisdiction over licensed nurses and the nursing care they provide. In facilities with a structured nursing organization, there are multiple nurses (including the chief nursing officer) who all are accountable to their licensing board. The board of nursing is the logical

agency to regulate assistants to nurses in these settings. Distinction is made between nursing assistive personnel who work in settings with structured nursing organizations (hospitals, long-term care/nursing homes, hospice and home care) and unlicensed assistive personnel who work in other types of settings. This is related to the recommendation that boards of nursing should regulate nursing assistive personnel. The roles, titles and settings of all unlicensed assistive personnel are varied, and while the board would have jurisdiction over the licensed nurse working in those environments, the board would not have jurisdiction over non-nurse program providers and personnel. It is important to assist nurses in understanding the nature of nursing roles and accountabilities in these settings.

The Paper concludes with position statements and recommendations for continued work needed to develop and promote approaches to effectively working with others. The Paper, the regulatory model and the templates look to the future. The objective is to protect the public through licensing of individual nurses and through the regulation of a continuum of nursing care.

II. Background

Nursing home reform was initiated by the Omnibus Budget Reconciliation Act of 1987 (OBRA), OBRA provided amendments to the Social Security Act (SSA) for Skilled Nursing Facilities (SNF) and Nursing Facilities (NF) that established requirements for the training and competency assessment of nurse aides working in long term care facilities. These requirements included that all nurse aides who work in Medicare and Medicaid funded nursing homes complete a State-approved training program that is a minimum of 75 hours (that includes 16 hours of supervised clinical training), pass a competency examination, and receive certification from the State where they are employed. State aide registries reside in different agencies in different states. Currently, there are thirteen (13) boards of nursing managing the registries. Home health aides are also included in the state registries, but there is no regulation of nurse aides working in acute care as well as other settings (OIG, 2002). The first NCSBN resource to address delegation was a concept paper written in 1990 by the Nursing Practice & Education Committee that discussed concepts and presented a delegation process. In 1996, a special subcommittee was convened to revisit the topic and update the Paper. In 1998, the Subcommittee produced a *Delegation Folder* that included a curriculum outline for teaching delegation to both nurses and assistive personnel (who receive the delegation). Other tools included a decision tree, a summary of the *Five Rights of Delegation*, glossary and bibliography. These widely cited documents provided a firm base for advancing concepts about working with others in the 21st century (NCSBN, 1998).

The Office of Inspector General published a Report, *Nurse Aide Training*, in November 2002. Its findings included the following:

- *Nurse aide training has not kept pace with nursing home industry needs.*
- *Teaching methods are often ineffective, clinical exposure too short and unrealistic.*
- *In-service training may not be meeting federal requirements.*

The OIG recommended that the Centers for Medicare & Medicaid Services (CMS) improve nurse aide training and competency evaluation program requirements. CMS reviewed a draft of this Report and concurred with the recommendations and indicated CMS would consider appropriate vehicles to implement a response (OIG, 2002). NCSBN concurs with this recommendation.

In September 2003, the NCSBN Board of Directors charged the Practice, Regulation & Education (PR&E) Delegation Subcommittee to develop a Position Paper, model legislative and administrative rule language pertaining to delegation and the regulation of nursing assistive personnel. This board action was in response to the increasing use of nursing assistive personnel, a resolution adopted by the 2003 NCSBN Delegate Assembly¹ and concerns brought to the board by the NCSBN

¹The 2003 Kentucky Board of Nursing resolution was that “NCSBN develops a Position Paper on the regulation of nursing assistive personnel which includes model act and rule/regulations with a report to the 2004 Delegate Assembly.”

Practice, Regulation & Education Committee and the PR&E Models Revision Subcommittee. Given the breadth and scope of the project, the Subcommittee recommended a two-year process, with an update report to the 2004 Delegate Assembly and a final Position Paper and resources for consideration by the 2005 Delegate Assembly. This work is the culmination of that effort.

III. Premises

The following premises guided the Subcommittee deliberations:

- A. Consumers have a right to health care that meets legal standards of care regardless of the setting. The safety and well-being of the client/client group must be the central focus of all decisions regarding delegation of nursing tasks and functions to nursing assistive personnel (NCSBN, 1997).
- B. State Nurse Practice Acts and Nursing Administrative Rules/Regulations define the legal parameters for nursing delegation (ANA 1994). Most states authorize registered nurses to delegate. Many states also authorize licensed practical/vocational nurses to delegate in specified settings and/or circumstances (NCSBN, 1997). Provision of any care that constitutes nursing or any activity represented as nursing is a regulatory responsibility of boards of nursing.
- C. Nursing is an outcome driven, knowledge-based, process discipline that is context dependent and requires critical thinking. Nursing cannot be reduced solely to a list of tasks. The licensed nurse's specialized education, professional judgment and discretion are essential for quality nursing care (NCSBN, 1997).
- D. There is a need and a place for competent, appropriately supervised nursing assistive personnel in the delivery of affordable, quality health care (NCSBN, 1997).
- E. All decisions related to delegation of nursing tasks must be based on the fundamental principle of protection of the health, safety and welfare of the public that is the underlying principle of nursing regulation. Decisions to delegate nursing tasks/functions/activities are based on the needs of clients, the stability of client conditions, the complexity of the task, the predictability of the outcome, the available resources to meet those needs and the judgment of the nurse (NCSBN, 1997).
- F. It is imperative for the delegating nurse to have an understanding of what the NAP's credential represents in terms of education and demonstration of skill. The supervising nurse also needs to be informed regarding the nursing assistive personnel's education and competency.
- G. The skill and art of delegation need to be developed, with both didactic content and opportunity to apply theory in a simulated context. The effective use of delegation requires a nurse to have a body of practice experience and the authority to implement the delegation.
- H. Nursing employers need to recognize that a newly licensed nurse is a novice who is still acquiring foundational knowledge and skills. In addition, many nurses lack the knowledge, skill and the confidence to delegate effectively, so ongoing opportunities to enforce the theory and apply the principles of delegation is an essential part of employment orientation and staff development as well as a topic for continuing education offerings, mentoring opportunities and other continued competence strategies.
- I. The practice pervasive functions of assessment, planning, evaluation and nursing judgment cannot be delegated (NCSBN, 1997).
- J. While a licensed nurse must be actively involved in and be accountable for all managerial decisions, policymaking and practices related to the delegation of nursing care, there is both individual accountability and organizational accountability for delegation (JONA, 1999; ANA 2005). Organizational accountability for delegation relates to providing

sufficient resources, staffing, appropriate staff mix, implementation of policies and role descriptions, opportunity for continuing staff development and creating an environment conducive to teamwork, collaboration and client-centered care.

IV. Data Collection

SURVEY OF BOARDS OF NURSING

NCSBN Member Boards were surveyed regarding needs and concerns pertaining to delegation and nursing assistive personnel. An electronic survey was distributed by e-mail in November 2003 asking for input regarding delegation and nursing assistive personnel. The critical challenges identified by respondents included:

- Evolving work settings, with expanded use of nursing assistive personnel, fragmentation in regulation, the use of untrained personnel in some settings (e.g., schools, jails, community homes), and assistive personnel in physician offices.
- Variation in terminology and titles.
- Lack of standardized training and competency assessment issues.
- Accountability and responsibility issues.
- Lack of understanding by employers regarding the scope of issues and problems.
- RN discomfort with the delegation process and lack of both authority and time to appropriately delegate and provide adequate supervision.

The survey respondents suggested a variety of resources that would be helpful to address these challenges, ranging from an updated Position Paper to standardized curriculums to standards for use and training across all settings.

REVIEW OF CURRENT STATE NURSE PRACTICE ACTS AND RULES/REGULATIONS

Member Board Nurse Practice Acts and Nursing Administrative Rules/Regulations documents were reviewed for the terms *delegation*, *direction*, *assignment*, *supervision*, *management* and *nursing assistive personnel* (*nursing assistants*, *nurse aides* and *unlicensed nursing assistive personnel*) (see Appendix A — *Analysis of Nurse Practice Acts and Administrative Rules Regarding Nursing Assistive Personnel and Delegation*).

Forty-eight (48) boards have some reference to delegation in either the nurse practice act or rules; of these, 35 boards references appear in nurse practice acts and 43 boards references appear in the rules. Forty-four (44) boards included a definition of delegation in either the practice act or rules. Thirty-nine (39) boards authorized delegation by RNs; 23 boards authorized delegation by LPN/VNs. Fifteen (15) boards addressed delegation in standards of nursing practice. Thirty-two (32) boards addressed delegation or supervision in the grounds for discipline. Five boards specifically addressed delegation in the curriculum portion of education rules. Six boards inferred delegation when no specific language exists. One state advised that nurses do not delegate in that jurisdiction.

Thirty (30) boards have separate portions of the act or rules that address delegation, often providing criteria for delegation. Twelve boards provide lists of nursing functions that may be delegated or lists of nursing tasks that should not be delegated. Some states are silent regarding delegation in Nurse Practice Act, but have lengthy rules about the topic. Currently, 13 nursing boards manage the nurse aide registry in their respective states. Twenty-five (25) address nurse aide/nursing assistant training, 20 boards medication aides, and 23 boards have sections of the law or rules regulating some aspect of nurse aide/nursing assistant activities.

There is much variation in the titles of nursing assistive personnel (e.g., unlicensed nursing personnel, nursing assistant, nurse aide, patient care attendant, patient care aide, etc). At least

two states license nursing assistive personnel and three states have a second level of nursing assistive personnel. Ten boards have one or more advisory opinions addressing delegation, supervision or nurse aides/nursing assistants. Other resources include guidelines (eight boards), and decision trees (eight boards).

There was no clear consensus as to the best regulatory approach. A quagmire of semantics permeates delegation and the use of assistive personnel. Some states' use of delegation reflects how that term is defined in this Paper. Other states define delegation as what a nurse can direct another licensed nurse to do. In one state, nurses never delegate; in others only RNs may delegate. There are nursing assistants, certified nurse assistants, nurse aides, nurse techs, nurse extenders, medication aides, medication assistants, and the list of titles goes on and on. It is no wonder that nurses and other members of the health care team are confused, to say nothing of the public. But is nursing practice really that different from state-to-state? Do the nursing assistive personnel in one state really work that differently than the nursing assistive personnel in a neighboring state?

OTHER RESOURCES

A number of nursing organizations have developed position statements and guidelines regarding delegation and nursing assistive personnel. The Subcommittee reviewed and analyzed various organization position statements regarding delegation and nursing assistive personnel. See Appendix B, Analysis of Position Statements Regarding Nursing assistive personnel and Delegation. In addition, other professions were contacted regarding other approaches for working with unlicensed personnel

Surprisingly, an extensive literature search did not identify many recent articles published on delegation. The main concepts addressed in the literature included the implementation of delegation, staff mix, education and training, and regulation. The results of the literature review are available in Appendix C.

A legal case review was conducted. There were not a great number of cases on point, none involving nurses. The cases tended to vary by different fact patterns and courts. In some, the person receiving the delegation was perceived to have been practicing a profession without a license. In others, the professional was held accountable for aiding and abetting unlicensed practice. There were also cases that found it appropriate for unlicensed personnel to perform tasks or functions under the direct supervision and responsibility of a professional (see Appendix D).

STAKEHOLDER PERSPECTIVES

The Subcommittee identified numerous stakeholders including recipients of care, families, nurses, other members of the health care team, employers, nurse liability insurers, legislators and other policy makers as well as nursing assistive personnel themselves. As part of its external outreach, comments and feedback on a draft of this Paper were requested of stakeholders (see Appendix E).

In addition, the Subcommittee members and staff conducted focus groups of nurses, nursing assistants and nurse managers to get input from nurses working in a variety of clinical settings regarding delegation. The common themes were that nursing assistants feel unprepared to provide routine cares effectively. Student nurses may receive theory regarding delegation in nursing education programs but not opportunities to apply the theory in clinical settings. New nurses are not prepared to delegate — this is a skill that must be developed post graduation, e.g., by working with a mentor. Many participants in the focus groups believed that nursing assistants need more training. Another theme was that communication was identified as being a critical factor in successful delegation.

Stakeholders were also offered the opportunity to meet with the Subcommittee, either in person or via telephone conference call. Comments from those interactions are also summarized in Appendix E.

V. Delegation Decision-Making Process

A. PREPARATION

Delegation is a complex skill requiring sophisticated clinical judgment and final accountability for patient care. Delegation and supervision content can be presented in a didactic educational setting through theory and through case studies and exercises. It is part of the curriculum for all RN educational programs. However effective delegation cannot be practiced in a limited clinical learning experience. Delegation is best learned through actual work with colleagues. Effective delegation requires experience as a practicing nurse (Grumet, 2005).

An ongoing nursing delegation process allows for the nurse to accomplish nursing care for more clients than one individual could provide alone. The first consideration is the authority to delegate that comes from the jurisdiction's Nurse Practice Act and Nursing Administrative Rules.

Secondly, both the delegating nurse and the nursing assistive personnel receiving delegation should be prepared to enter the nursing delegation process. The nurse is prepared to delegate through appropriate education, skills and experience, which include the following:

- Understanding of the delegation process.
- Understanding of the role and scope of functions of the nursing assistive personnel.
- Being in a line of authority that allows the nurse to enforce the delegation.
- Necessary knowledge, skill and professional judgment to perform the nursing tasks/ functions/activities to be delegated.
- Access to pertinent client information.
- Access to pertinent staff information as well as relevant agency policies, procedures and guidelines.
- Opportunity to provide communication, surveillance and supervision.
- Consistent availability of the nurse to the nursing assistive personnel for consultation and procedural direction.

The nursing assistive personnel should also be prepared to receive delegation. This includes the following:

- Appropriate education, skills and experience, including:
 - The assistant's role and scope of functions.
 - The relationship between the assistant, the nurse and the health care team.

Once there is documented/demonstrated evidence of the nurse's current competency in the use of delegation and the nursing assistant's current competency in receiving delegation, it is appropriate to begin the steps of the delegation process.

B. PROCESS

The steps of the delegation process used by the nurse are outlined below.

Step One – Assess and Plan

An understanding of client needs is a critical aspect of determining appropriate nursing tasks/functions/activities to delegate to nursing assistive personnel. Assessment includes:

- The nature, complexity, variability and urgency of care.
- Priority of long and short term client care needs.
- Level of clinical decision making.
- Level of predictability of client's health care status and patterns of response to health care interventions.
- Range and severity of potential adverse outcomes associated with the performance of the task/activity/function.
- Range and complexity of actions required to intervene if adverse outcomes occur.
- Nature and likelihood of any emergency or risk management responses.
- Active client/family involvement in decision making.
- Therapeutic benefits and risks associated with delegating task/function/activity.

Similarly, the delegating nurse needs to have information about the staff members' knowledge, skills and abilities. Assessment includes:

- The cognitive and technical abilities needed to perform the task/function/activity.
- Information as to the level of responsibility and scope of the assistive person's role.
- Context in which the nursing task/function/activity is to be performed.
- Expected outcomes of the nursing care task/function/activity.
- Potential adverse effects of both delegated task and client condition (so assistant can be eyes and ears for nurse).

The nurse should have an appreciation of the client care context as well as the resources available for support of the provision of nursing care. Using all this information, the nurse plans for the episode of care, specifying each task and the knowledge and skills required to perform the task. If the nurse determines that client needs can be met while maintaining safety for both the client and nursing staff, the nurse proceeds to step two.

Step Two – Communication

The nurse provides directions and addresses any unique client requirements and characteristics, and clear expectations of:

- How the task is to be accomplished .
- When and what information is to be reported, including:
 - Expected observations to report and record.
 - Specific client concerns that would require prompt reporting.
 - Priorities for accomplishing tasks, while acknowledging the need for flexibility should client conditions or needs change.

The nurse individualizes the communication to the nursing assistive personnel and client situation and assesses the assistant's understanding of expectations, providing clarification if needed. The nurse's communication should be *clear, concise, correct* and *complete* (Hansten & Jackson, 2004, p.174). The nurse should verify comprehension with the nursing assistive personnel (Zimmerman, 27), and communicate his or her willingness and availability to guide and support assistant.

Finally, the nurse assures appropriate accountability by verifying the person receiving the delegation accepts the delegation and the responsibility that accompanies it.

Communication must be a two-way process. Nursing assistive personnel should have the opportunity to:

- Ask questions regarding the delegation and seek clarification of expectations if needed
- Inform the nurse if the assistant has not done a task/function/activity before, or has only done infrequently.
- Ask for additional training or supervision.
- Affirm understanding of expectations, including those regarding communication of specific client concerns as well as progress toward completion of the delegation.
- Determine the communication method between the nurse and the assistive personnel when the two are located at different sites.
- Determine the communication and plan of action in emergency situations.

The final aspect of communication is that of documentation. Timely, complete and accurate documentation of provided care facilitates communication with other members of the health care team and records the nursing care provided.

Step Three – Surveillance and Supervision

The purpose of surveillance and monitoring is related to nurse's responsibility for client care within the context of a client population. The frequency of observations varies with needs of client and experience of assistant. In determining the level and nature of appropriate supervision, the nurse considers the:

- Client's health care status and stability of condition
- Predictability of responses and risks
- Setting where care occurs
- Availability of resources and support infrastructure.
- Complexity of the task being performed.

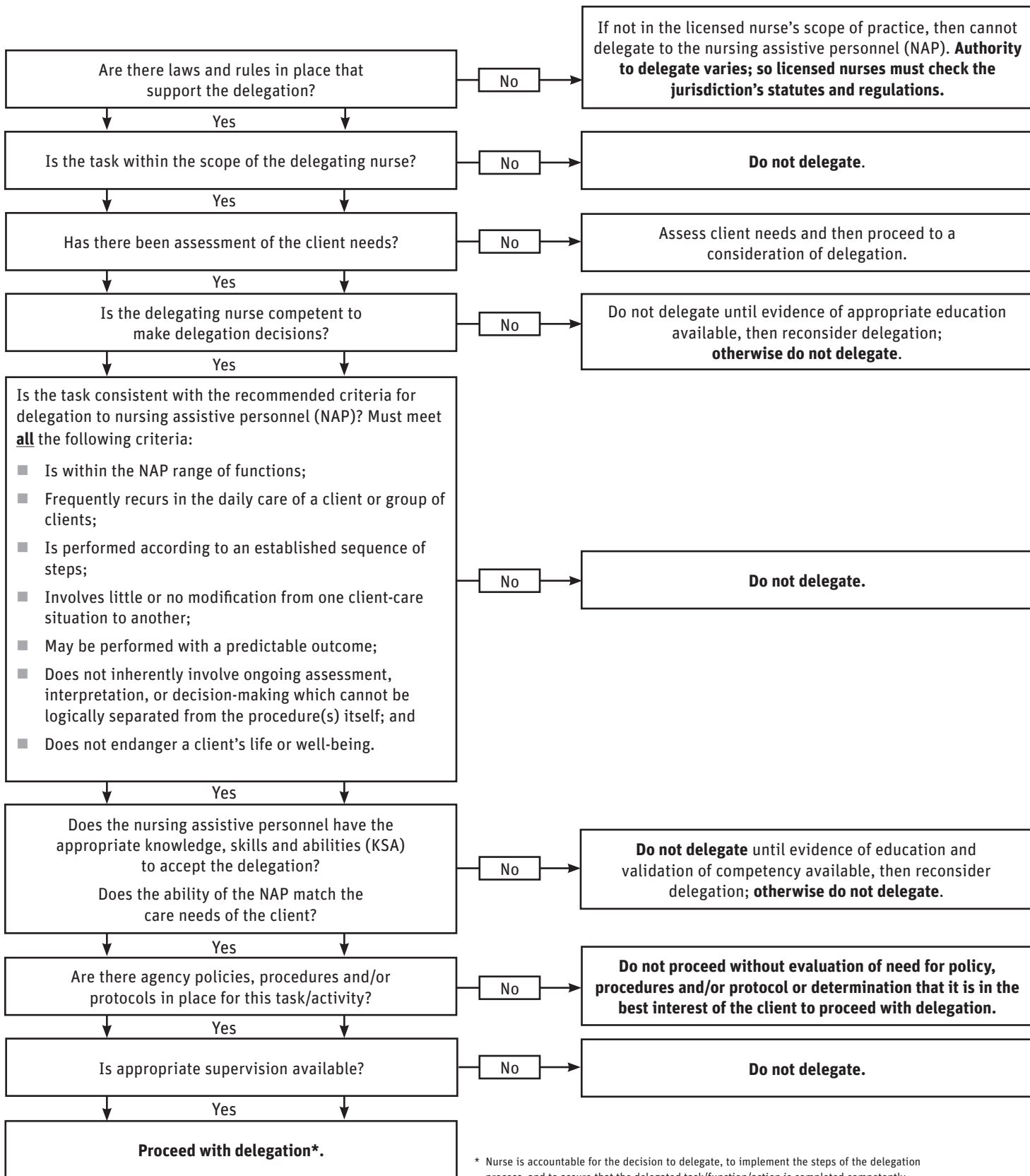
The nurse supervises the delegation by monitoring the performance of the task or function and assures compliance with standards of practice, policies and procedures. The nurse determines frequency of onsite supervision and assessment based on the needs of the client, the complexity of the delegated function/task/activity and the proximity of location and needs of the nurse's location.

The nurse is responsible for:

- Timely intervening and follow-up on problems and concerns. Examples of the need for intervening include:
 - A task not completed in a timely manner.
 - The implementation of a task/function/activity not meeting expectations.
 - Unexpected change in a client's condition.
- Alertness to subtle signs and symptoms (which allows nurse and assistant to be proactive, before a client's condition deteriorates significantly).
- Awareness of assistant's difficulties in completing delegated activities early rather than later (which facilitates addressing problems and allowing completion of delegation).

Decision Tree – Delegation to Nursing Assistive Personnel

Step One – Assessment and Planning



* Nurse is accountable for the decision to delegate, to implement the steps of the delegation process, and to assure that the delegated task/function/action is completed competently.

The Delegation Decision Tree on the other side of this Paper represents the first step in the delegation process. The other three steps are summarized below.

Step Two – Communication

Communication must be a two-way process

<p><i>The nurse:</i></p> <ul style="list-style-type: none"> ■ Assesses the assistant’s understanding of <ul style="list-style-type: none"> ■ How the task is to be accomplished ■ When and what information is to be reported, including <ul style="list-style-type: none"> □ Expected observations to report and record □ Specific client concerns that would require prompt reporting. ■ Individualizes for the nursing assistive personnel and client situation ■ Addresses any unique client requirements and characteristics, and expectations ■ Assesses the assistant’s understanding of expectations, providing clarification if needed ■ Communicates his or her willingness and availability to guide and support assistant ■ Assures appropriate accountability by verifying that the receiving person accepts the delegation and accompanying responsibility. 	<p><i>The nursing assistive personnel:</i></p> <ul style="list-style-type: none"> ■ Asks questions regarding the delegation and seek clarification of expectations if needed ■ Informs the nurse if the assistant has not done a task/function/activity before, or has only done infrequently ■ Asks for additional training or supervision ■ Affirms understanding of expectations ■ Determines the communication method between the nurse and the assistive personnel ■ Determines the communication and plan of action in emergency situations. 	<p><i>Documentation:</i></p> <p>Timely, complete and accurate documentation of provided care</p> <ul style="list-style-type: none"> ■ Facilitates communication with other members of the health care team ■ Records the nursing care provided.
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Step Three – Surveillance and Supervision

The purpose of surveillance and monitoring is related to nurse’s responsibility for client care within the context of a client population. The nurse supervises the delegation by monitoring the performance of the task or function and assures compliance with standards of practice, policies and procedures. Frequency, level and nature of monitoring vary with needs of client and experience of assistant.

<p><i>The nurse considers the:</i></p> <ul style="list-style-type: none"> ■ Client’s health care status and stability of condition ■ Predictability of responses and risks ■ Setting where care occurs ■ Availability of resources and support infrastructure. ■ Complexity of the task being performed. 	<p><i>The nurse determines:</i></p> <ul style="list-style-type: none"> ■ The frequency of onsite supervision and assessment based on: <ul style="list-style-type: none"> ■ Needs of the client ■ Complexity of the delegated function/task/activity ■ Proximity of nurse’s location. 	<p><i>The nurse is responsible for:</i></p> <ul style="list-style-type: none"> ■ Timely intervening and follow-up on problems and concerns. Examples of the need for intervening include: <ul style="list-style-type: none"> ■ Alertness to subtle signs and symptoms (which allows nurse and assistant to be proactive, before a client’s condition deteriorates significantly) ■ Awareness of assistant’s difficulties in completing delegated activities ■ Providing adequate follow-up to problems and/or changing situations is a critical aspect of delegation.
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Step Four – Evaluation and Feedback

Evaluation is often the forgotten step in delegation.

<p><i>In considering the effectiveness of delegation, the nurse addresses the following questions:</i></p> <ul style="list-style-type: none"> ■ Was the delegation successful? <ul style="list-style-type: none"> ■ Was the task/function/activity performed correctly? ■ Was the client’s desired and/or expected outcome achieved? ■ Was the outcome optimal, satisfactory or unsatisfactory? ■ Was communication timely and effective? ■ What went well; what was challenging? ■ Were there any problems or concerns; if so, how were they addressed? ■ Is there a better way to meet the client need? ■ Is there a need to adjust the overall plan of care, or should this approach be continued? ■ Were there any “learning moments” for the assistant and/or the nurse? ■ Was appropriate feedback provided to the assistant regarding the performance of the delegation? ■ Was the assistant acknowledged for accomplishing the task/activity/function?

Providing adequate follow-up to problems and/or changing situations is a critical aspect of delegation.

Step Four – Evaluation and Feedback

In considering the effectiveness of delegation, the nurse addresses the following questions:

- Was the delegation successful?
 - Was the task/function/activity performed correctly?
 - Was the client’s desired and/or expected outcome achieved?
 - Was the outcome optimal, satisfactory or unsatisfactory?
 - Was communication timely and effective?
 - What went well; what was challenging?
 - Were any problems or concerns; if so, how were they addressed?
- Is there a better way to meet the client needs?
- Is there a need to adjust the overall plan of care, or should this approach be continued?
- Were there any “learning moments” for the assistant and/or the nurse?
- Was appropriate feedback provided to the assistant regarding the performance of the delegation?
- Was the assistant acknowledged for accomplishing the task/activity/function?

C. ADAPTATION OF THE DELEGATION DECISION-MAKING PROCESS

For a model process to be useful, it has to be realistic. When one considers the hundreds of decisions made by a nurse in daily practice, going through all these steps for each is impossible. Therefore, the Subcommittee members offer the following:

- The *assignment*, typically developed by a nurse manager or charge nurse from the previous shift, is used in many work settings. Assignments are based on the client needs, available staff and resources, job descriptions, scope of practice for licensed nurses and scope of functions for nursing assistants. The assessment of staff resources for assignments is based largely on the organization’s evaluation of an employee’s credentials upon hire and periodic performance evaluations.
- The nurse must determine the level of supervision, monitoring and accessibility she or he must provide for assistive personnel. There is a difference in the level of supervision related to the different roles of licensed nurses and assistive personnel as well as routine tasks versus delegated tasks and the proximity of the supervising nurse. The nurse continues to have responsibility for the overall nursing care.
- To delegate effectively, nurses need to be able to rely on knowing nursing assistive personnel’s credentials and job descriptions, especially for a first time assignment. Nursing administration (typically through human services/personnel) has responsibility for validating credentials and qualifications of employees. This is especially important in work settings where nurses frequently work with temporary staff or with other facility employees on an irregular basis.
- Effective nurses are selective, identifying those situations that require thoughtful application of the delegation process.
- Traditionally, one nurse has done all the steps in the delegation process for him/herself. In today’s fast paced health care environment different nurses may do different steps (all steps need to be accomplished).

D. IMPORTANT CAVEATS

- The art and science of nursing is complex and knowledge based, thus the nursing process in its entirety cannot be delegated. **The practice-pervasive functions of assessment, planning, evaluation and nursing judgment cannot be delegated.**
- Discrete health care tasks/functions/activities may be delegated if they are within the nurse's scope of practice. The nurse cannot delegate functions and activities not in the nurse's scope of practice.
- Delegation is client specific. Having done a task for one client does not automatically mean an assistive person can do the task for all clients. In addition, delegation is also situation specific: doing a task for one client in one situation does not mean the nursing assistive personnel may perform the task for this client in all situations.
- The more complex or unpredictable the care and the care environment, the more likely nursing care should be provided by a licensed nurse.
- A task delegated to an assistive person cannot be redelegated by the assistive person
- A huge challenge for the delegating nurse is the current variation in nursing assistant preparation and training — frequently, a nurse cannot assume one assistant's training is the same as another assistant's training.
- Trust is central to the working relationships between nurses and assistive personnel. Good relationships have two-way communication, initiative, appreciation and willingness to help each other. Breakdown in communication may occur when assistive personnel work with more than one nurse. Many assistive personnel are task-oriented and are not trained to prioritize orders from nurses, so need guidance as to how to order activities (Potter & Grant, 2004).
- The nursing assistant has responsibility not to accept a delegation that he/she knows is beyond his/her knowledge and skills. The nursing assistant is expected speak up, and ask for training and assistance in performing the delegation, or request not to be delegated a particular task/function/activity.
- Nurses who were educated under a primary care model may not realize what they do not know about delegation. "In a 1995 nationwide survey of more than 40 EDs, 78% of the RNs indicated their delegation skills as good or excellent, yet 35% scored poorly on an accompanying test that evaluated their related knowledge" (Zimmerman, 10).
- Both nurses and nursing assistants need the appropriate interpersonal and communication skills and organizational support to successfully resolve delegation issues.
- An effective delegator recognizes that "an assistant is a resource for achieving results" (Linney, 1998).
- "Nurses have come to realize that doing tasks is not the essence of nursing... The profession is entering another phase of evaluation. It is learning to work with others, with new technologies, and in new settings in new ways" (Hansten & Jackson, 2004, p. 23).

VI. OTHER TYPES OF INTERFACES

Nurses work with and through others, resulting in multiple interactions and relationships. The means by which such an interaction and communication is achieved is an *interface* (Webster, p. 653). It is important that the nurse determine the type of interface that is expected in a nursing role because this has significance for how he or she may approach the role as well as the accountability of the nurse. Many interfaces include delegation in settings with structured nursing organization. But more and more nursing is provided in settings where there is not a structured nursing organization. Sometimes, the nurse working in a setting without structured nursing organization has a position with both the opportunity and authority to delegate and supervise unlicensed assistive personnel. In other settings, however, the nurse's position does

not provide the opportunity to supervise or the authority to enforce delegations. These latter situations can cause confusion of role, responsibility and accountability for the nurses working in these situations with unlicensed assistive personnel.

Teaching — The nurse whose only interface with staff members is a teaching function is accountable for the content and the methods used in teaching. A nurse brought in for this special function does not have the opportunity to enforce the learning. Looking at how staff members apply what they have learned to their practice and functions is an important outcome that can be used to evaluate the teaching effectiveness, but this type of teaching usually does not provide an opportunity to be involved in staff follow-up.² Examples of this type of episodic teaching are: teaching staff selected procedures in an assistive living facility; adult day care setting where the primary focus of the setting is not health care; and a nurse working for an equipment company who trains staff to use a new technology.

Accepting an assignment to supervise — There are situations when a nurse may be assigned to supervise a staff member who has been delegated tasks by another licensed provider (e.g., in a physician's office). There are other situations where the authority to provide tasks or procedures (that would be considered nursing in a health care environment) has been granted by a statute or rule/regulation separate from the Nurse Practice Act or rules/regulations (e.g., a school secretary being directed by the school principal to give medications to a student). Situations where a nurse is responsible for supervising unlicensed assistive personnel who have been delegated tasks by another licensed provider can be professionally uncomfortable as well as challenging. There may be a lack of clarity on how the nurse is expected to be involved. These situations fall outside of traditional delegation and assignment. These situations require a reasoned analysis to determine the nurse's role and responsibility. The nurse should take into consideration the knowledge, skills and abilities of the unlicensed assistive personnel (see Decision Tree for Accepting Assignment to Supervise). The abilities of the UAP should match the needs of the client and the environment should support the nurse's ability to supervise.

The nurse is responsible for the decision whether to accept an assignment to supervise. The nurse should verify that he or she has the authority to supervise. The nurse should determine that the supervised activity is within the nurse's scope of practice, that the nurse is appropriately educated and competent to perform and supervise the activity. The nurse should have the opportunity and proximity to provide the appropriate level of monitoring. The nurse should decline an assignment to supervise if the nurse:

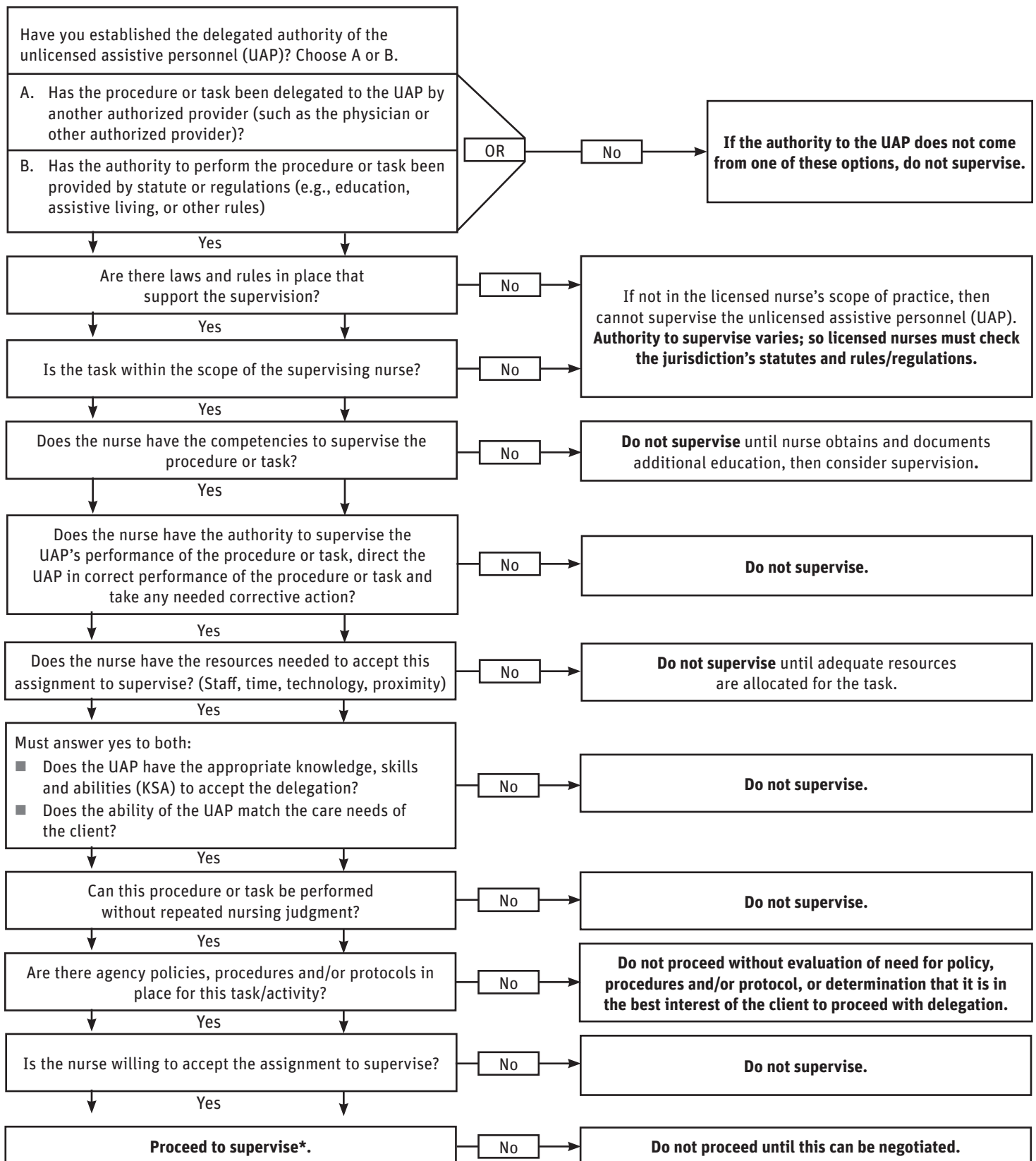
- Does not have to the authority to intervene and take corrective action if needed
- Has never performed that activity to be supervised
- Does not have the opportunity and/or proximity to provide effective monitoring
- Would not be able to intervene if there were a problem.

Real life situations may involve a nurse caught in the ethical dilemma of knowing that she/he should not accept an assignment to supervise but also knowing that to refuse could cause a threat to her/his employment. On one hand, the nurse could be disciplined for accepting an assignment beyond the nurse's personal scope of practice and/or accepting an assignment that presents a risk to the client. On the other hand, the nurse could experience the loss of livelihood with resultant implications for the nurse and her/his family's economic security. Nurses should be aware of different options and strategies in dealing with these situations and make informed decisions.

If there were client harm, the nurse's accountability would focus on the elements of supervision. One example of situations where the nurse may be supervising staff performing activities delegated by others is the nurse working with medical assistants in a physician's office. Here, the physician has delegated procedures and tasks to a medical assistant and assigns supervision to the nurse. The school nurse is another example of a nurse providing nursing services in a

²The episodic teaching referenced above should not be confused with the teaching provided in formal nursing education programs that involve student clinical and require ongoing instructor supervision and interaction.

Decision Tree – Accepting Assignment to Supervise Unlicensed Assistive Personnel



The Decision Tree on the other side of this Paper represents the first step in the accepting an assignment to supervise. The other steps are summarized below.

Accepting an Assignment to Supervise

The nurse supervises by monitoring the performance of the task or function and assures compliance with standards of practice, policies and procedures. Frequency, level and nature of monitoring vary with needs of client and experience of assistant.

<p><i>The nurse considers the:</i></p> <ul style="list-style-type: none"> ■ Client's health care status and stability of condition ■ Predictability of responses and risks ■ Setting where care occurs ■ Availability of resources and support infrastructure ■ Complexity of the task being performed. 	<p><i>The nurse determines:</i></p> <ul style="list-style-type: none"> ■ The frequency of onsite supervision and assessment based on: <ul style="list-style-type: none"> ■ Needs of the client ■ Complexity of the delegated function/task/activity ■ Proximity of nurse's location 	<p><i>The nurse is responsible for:</i></p> <ul style="list-style-type: none"> ■ Timely intervening and follow-up on problems and concerns. Examples of the need for intervening include: <ul style="list-style-type: none"> ■ Alertness to subtle signs and symptoms (which allows nurse and assistant to be proactive, before a client's condition deteriorates significantly) ■ Awareness of assistant's difficulties in completing delegated activities ■ Providing adequate follow-up to problems and/or changing situations is a critical aspect of delegation.
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The nurse is responsible for the decision whether to accept an assignment to supervise. Nurses should be aware of different options and strategies in dealing with these situations and make informed decisions.

The nurse should be prepared to provide feedback to the delegating provider regarding the effectiveness of the task or procedure. This feedback may include whether:

- The task/function/activity was performed correctly
- The client's desired and/or expected outcome was achieved
- There were any problems or concerns; if so, how were they addressed
- There are suggestions for adjusting the plan of care.

setting where health care is secondary to the primary purpose of providing education. A school nurse might determine it necessary to decline supervision of an individual whose authority to do a procedure comes from the principal and statutes/rules governing education. One example of negotiating the expected interface would be that the nurse suggests providing instruction to perform a task with a return demonstration rather than supervise.

Another concern is regarding individuals with functional disabilities who need interventions that enable a client to remain in an independent living environment. Tasks and functions that go beyond the typical activities of daily living and would be considered nursing interventions in health care settings may be considered health maintenance functions³ (HMF) or tasks in assisted living settings. The Texas Board of Nurse Examiners has developed rules to address this type of interface, where the nurse is required to do the initial assessment and then unlicensed assistive personnel do the HMF as well as activities of daily living (ADL). The Oregon Board of Nursing enacted rules specifically to provide guidance for nurses who teach noninjectable medication administration to unlicensed personnel as well as standards for the delegation of specific tasks of nursing care to unlicensed persons.⁴

In summary, to determine the nature of an interface with another health care provider, the nurse should consider:

- What is the nurse's scope of practice and role?
- What is the nurse's experience and education related to the proposed activity?
- Is there a line of authority and where is the nurse in it?
- What aspect of care is being implemented?
- Does the nurse have the power to enforce decision-making?
- Does the nurse have the necessary resources, access to monitoring and ability to follow-up?
- Is it a limited contact or an ongoing relationship?

VI. DISCUSSION

Many nurses are reluctant to delegate. This is reflected in NCSBN research findings and the literature review as well as in anecdotal accounts from nursing students and practicing nurses. There are many contributing factors, ranging from not having educational opportunities to learn how to work with others effectively to not knowing the skill level and abilities of nursing assistive personnel to simply the work pace and turnover of clients. At the same time, NCSBN research shows an increase in the complexity of the nursing tasks/functions/actions performed by assistive personnel. With the demographic changes and resultant increase in the need for nursing services plus the nursing shortage, nurses cannot provide the needed care without assistive support.

VII. CONCLUSIONS

The topic of delegation has never been timelier. Delegation is a management tool. Used effectively, it can result in safe and effective nursing care, free the nurse for attending to more complex client care needs, develop the skills of nursing assistive personnel and promote cost containment for the organization. There is no clear consensus as to the best regulatory approach for the regulation

³Texas Rules Chapter 225 provide for an RN assessment for determining whether clients living in an independent living environment have requirements for activities of daily living, health maintenance activities or nursing tasks. If a client requires ADL or HMF, delegation by the nurse is not required. If a client requires nursing tasks, then RN involvement in the ongoing care is required.

⁴The regulatory approach in Oregon Rule 851-047-0000 addresses delegation to unlicensed persons in settings where an RN is not regularly scheduled and not available to provide direct supervision. In the Oregon rules, the RN is responsible for assessing a client situation to determine whether or not delegation of a task of nursing can be safely done, safely implementing the delegation process by following the Oregon Board's process for delegation, and for reporting unsafe practices to the facility owner, administrator and/or the appropriate state authorities.

of nursing assistive personnel and delegation at this time. However, facing a shortage of epic proportions, the nursing community needs to plan how we can continue to accomplish nursing care while assuring the public access to safe, competent nursing care. This Paper and the proposed model language provide a first step.

VIII. POSITION OF THE NATIONAL COUNCIL OF STATE BOARDS OF NURSING

- A. **It is the position of the National Council of State Boards of Nursing (NCSBN) that the state boards of nursing should regulate nursing assistive personnel across multiple settings, as set forth in proposed Article XVIII, Chapter Eighteen of the NCSBN Model Nursing Practice Act and Nursing Administrative Rules.**

Rationale:

Many licensed nurses work with nursing assistive personnel in facilities and agencies where there is a nursing organization that comprises a major portion of the institutional infrastructure. The board of nursing is responsible for the regulation of nursing care, thus the board of nursing is the logical entity to regulate assistants to nurses in these environments. The proposed regulatory framework for nursing assistive personnel will enhance public protection by supporting the delegating/supervising nurse and nursing assistive personnel in these health care settings. Developing national standards for basic training and competency testing for nursing assistive working in these settings will promote consistency and safety among nursing assistive personnel.

- B. **There are other types of interface with health care providers and workers in settings where there is not a structured nursing organization and where health care plays a secondary role, e.g., group homes, adult day care and assisted living facilities. In these settings, the nurse's role is typically not one of delegation. Nurses need to assess other types of interactions to identify the nursing role and responsibility for the particular type of interface.**

Rationale:

These are challenging settings for nurses and nursing regulation. Boards of nursing do not have authority over the personnel in charge of these programs, but they do have jurisdiction over the licensed nurses who work in these settings. The nurse's role is often episodic, often one of teaching or consulting. The nurse is not in a position of authority to delegate or enforce the delegation, more often the nurse advises. There is an interaction between the nurse and the agency workers — but it is a different sort of interface than delegation. The focus of these homes and facilities is the support of daily living by providing meals, offering opportunities for social interaction and meeting housekeeping, laundry and other personal needs in a “homelike” setting. There are other types of settings where there is not a nursing structure but there is a nurse role to provide nursing services. This Paper offers a template to assist nurses to evaluate a role, the type of interface and articulate the nurse's responsibility in a particular setting.

One of the competencies identified by the Institute of Medicine (IOM) for all health care professionals is working within the health care team. Knowing the characteristics and roles of different providers and identifying how they relate to the nursing role is an important step toward mastering this competency. For nurses working in other types of settings, where the emphasis is on support of living and health care is secondary, knowing the characteristics and roles of different workers is also an important step toward effective teamwork.

- C. **Delegation is the act of transferring to a competent individual the authority to perform a selected nursing task in a selected situation, the process for doing the work. Assignment describes the distribution of work that each staff member is to accomplish on a given shift or work period.**

Rationale:

The management strategy of delegation is a tool nurses use to direct others in the provision of nursing care and is defined as transferring authority to a competent person to perform a selected task in a selected situation. In previous NCSBN papers, “assigning” the verb, was

defined as the act of designating nursing activities to be performed by another nurse consistent with that nurse's scope of practice. Using the verb assign in this manner is a variation of delegation. Since the process for both is the same, this Paper uses the verb "delegate" to describe the process of working through others and the noun "assignment" to describe what a person is directed to do, (reflecting the common usage of language among nurses working in clinical settings.

- D. Nursing assistive personnel, regardless of title, should receive adequate basic training as well as training customized to the specific work setting. Basic education should include how the nursing assistant functions as part of the health care team, with an emphasis on how to receive delegation. Nursing assistive personnel Individuals who successfully complete comprehensive educational and training requirements, including passing a competency examination, will be certified as nursing assistive personnel.**

Rationale:

Nursing assistive personnel provide services to vulnerable clients, often of an intimate nature. It is difficult work. Improved education and training will better prepare nursing assistants to do this work. Individuals who complete the education, training and competency evaluation discussed above earn the recognition of a title and the responsibility of a range of functions.

In addition, it is imperative for the delegating and supervising nurse to have an understanding of what a nursing assistant credential represents in respect to training and demonstration of skill, something that is currently difficult to do. The use of nursing assistive personnel is expected to increase. It is very important that nurses have an accurate estimation of at least their training, and ideally their experience, to be able to effectively direct the services nursing assistive personnel provide.

IX. RECOMMENDATIONS

The PR&E Delegation Subcommittee makes the following recommendations:

- A. That the NCSBN Delegate Assembly adopts the position statement that appears in Section VIII of this Paper.
- B. That research is needed in the following areas:
1. Research to identify best practices for use of nursing assistive personnel.
 2. Research to study the outcomes of delegation from:
 - a. Perspective of client
 - b. Perspective of nurse
 - c. Perspective of nursing assistive personnel
 - d. Perspective of employer.
 3. Research to support staff mix, other staffing concerns.
 4. Outcomes research to look at medication assistant errors (e.g., frequency, type and cause).
 5. Quantify client outcomes — well-being, not having problems (what works)

Rationale:

Data is needed to identify the safest ways to work with assistive personnel to accomplish what nurses alone cannot do.

- C. That the following resources be developed:

1. National discipline tracking

Rationale:

NCSBN includes tracking of discipline taken against nursing licenses as part of Nursys®. This is one of the benefits of NCSBN Membership for boards of nursing. NCSBN does not track assistive personnel actions. The only national reporting available is through the Healthcare Integrity and Protection Data Bank (HIPDB), but boards are charged a fee for each inquiry, which is cost prohibitive given the numbers of nursing assistants. Although NCSBN has previously explored the possibility of tracking assistive personnel discipline actions, the Board of Directors did not find this to be feasible at that time. The Subcommittee recommends revisiting this issue. More information available about this mobile population would support board of nursing review of applicants for nursing assistant certification.

2. Toolbox (includes updating of previous NCSBN delegation resources)
 - a. How to delegate
 - b. How to receive delegation
3. Information about how other states regulate (e.g., see Attachment A)
4. Models for monitoring and coaching nursing assistive personnel
 - a. Curriculum content outlines
 - b. Nursing students
 - c. Practicing nurses
 - d. Nurses returning to practice
 - e. Nursing assistive personnel

Rationale:

Nurses are not born delegators – it is a skill that must be learned, practiced and mastered. Assistive personnel also need resources to support them in their work. Nurses and assistive personnel, as well as other health care personnel, need to learn teamwork and how to work together.

D. That boards of nursing and/or NCSBN pursue the following collaborations:

1. Work with stakeholders, state agencies and legislatures toward placement of nursing assistive personnel regulatory frameworks with the board of nursing.

Rationale:

Thirteen boards of nursing currently manage the nurse aide registries created by OBRA in the late 1980s. Some boards are involved in other aspects of regulating nursing assistive personnel. Adequate stakeholder buy-in and consensus is needed to make this happen.

2. Work with the Center for Medicare and Medicaid and other federal agencies to revisit OBRA regulations.
3. Work with state agencies that currently regulate nursing assistive personnel.
4. Work with the American Nurses Association, the American Association of Colleges of Nursing, the National League for Nursing, the American Organization of Nurse Executives and other nursing organizations to promote innovation in how nursing students learn how to work with assistants, including delegation, as well as theory application as part of clinical studies

Rationale:

The current regulatory system for assistive personnel is fragmented at best and absent at worse. It is time to revisit OBRA, to promote other approaches to develop comprehensive basic training and competency assessment for assistive personnel. CMS has acknowledged the need to upgrade the OBRA requirements, providing a window of opportunity for collaboration.

-
5. Educators of health professionals, allied health and paraprofessionals and assistive personnel need to collaborate to better prepare students to work as a health care team.

Rationale:

It is not conscionable to train practitioners and assistants in silos and then expect them to instantly work together effectively after graduation. Valuing the contributions of all health team members must begin when they are students.

Appendices

- A. Review of Member Boards Statutes and Rules/Regulations
- B. Summary of Position Statements Regarding Assistive Personnel and Delegation
- C. Literature Review
- D. Case Law Review
- E. Individuals Who Provided Comments on Working With Others: A Position Paper
- F. Definitions

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Appendix A

Review of Statutes and Rules/Regulations (Spring 2004)

Board	Delegation Definition	RN Scope	LPN/VN Scope	Delegation Section	Task Lists Can or Cannot	NA Section	NA Registry	NA Ed/Training	Cert or Lic NA	Med Asst	Discipline Grounds	Other Resources
AL	X											
AK	X	X	X	X		X		X	X		X	X
AS												
AZ	X	X	X			X	X	X				
AR	X	X	X	X							X	
CA-RN	X					X						X
CA-VN												
CO	X			X		X	X	X		X	X	
CT												
DE	X	X		X						X		
DC	X	X		X		X						
FL	X	X	X	X	X	X	X	X	X		X	
GA-PN												
GA-RN												
GU	X	X				X	X	X			X	
HI	X	X		X	X		X					
ID	X			X		X	X	X		X	X	
IL	X	X										
IN	X	X									X	
IA	X	X	X		X						X	
KS	X	X		X		X		X		X	X	
KY	X	X	X	X		X						
LA-PN												X
LA-RN	X	X		X							X	X
ME	X	X		X		X	X	X		X	X	
MD	X	X	X	X			X	X	X	X	X	
MA	X	X	X	X						X		X
MI	X	X		X								
MN		X				X		X		X	X	
MS	X	X										X
MO	X											X
MT	X	X		X	X					X	X	
NE	X	X	X		X			X		X	X	X
NV	X	X	X	X			X	X			X	X
NH	X		X			X	X	X	X	X	X	
NJ				X		X		X	X	X	X	X
NM	X	X						X		X	X	

Board	Delegation Definition	RN Scope	LPN/VN Scope	Delegation Section	Task Lists Can or Cannot	NA Section	NA Registry	NA Ed/Training	Cert or Lic NA	Med Asst	Discipline Grounds	Other Resources
NY											X	
NC	X	X	X	X	X	X	X	X	X	X	X	X
ND	X	X	X			X	X	X		X		
NMI												
OH	X	X	X	X	X			X		X	X	
OK	X	X	X			X		X	X		X	X
OR	X	X		X	X	X	X	X	X	X	X	
PA												
PR												
RI	X	X	X	X								
SC		X	X	X	X	X					X	
SD	X	X	X	X	X		X	X		X		
TN		X									X	
TX	X			X	X					X		X
UT	X	X	X	X							X	
VT	X	X	X	X		X	X	X	X		X	X
VI						X	X	X	X			X
VA				X		X	X	X	X		X	
WA	X	X	X	X						X		
WV-PN	X		X								X	X
WV-RN	X	X										X
WI	X	X									X	X
WY	X	X	X	X	X	X	X	X	X		X	X
Totals	44	39	23	30	12	23	18	25	13	20	32	19

KEY

Delegation definition – NPA or rules include a definition of delegation.

RN scope – RN authorized to delegate.

LPN/VN scope – LPN/VN authorized to delegate.

Delegation section – Entire section or chapter of statute and/or rules devoted to delegation.

Task lists can or cannot do – Statute and/or rules includes either a list of what tasks can be delegated or a list of what cannot be delegated.

NA section – Entire section or chapter of statute and/or rules devoted to assistive personnel.

NA registry – Board of nursing responsible for Nurse Aide Registry.

NA ed/training – Statute and/or rules addresses the education and training of assistive personnel.

Cert or Lic NA – Board either certifies or licenses nursing assistants.

Med Asst – Regulation of medication assistants by the board (interpreted broadly – if statute or rule addressed medication administration or reminding by assistive personnel, was included).

Discipline Grounds – Board’s grounds for discipline in statute and/or rules specifically reference delegation/supervision.

Other Resources – Board has developed resources to support nurse delegation (e.g., decision trees).

Appendix B

Summary of Position Statements Regarding Assistive Personnel and Delegation (Fall 2003)

Organization	Delegation/ Decision Making	UAP Role	UAP Titles	UAP Training	Nursing Education	Accountability	Regulation
Academy of Medical-Surgical Nurses	Globalization of market forces and evolving health care reform provide opportunity to analyze nurses' traditional roles and assume responsibility for judicious delegation of nursing tasks to UAP. The RN uses professional judgment to determine what to delegate.	Redesign of traditional nursing roles does not replace RNs with UAP; it gives RNs the opportunity for appropriate support for the delivery of nursing care.	Variety of job classifications	Must be commensurate with the activities that will be delegated. Competency of UAPs should be evaluated annually and provided ongoing education.		RNs are accountable for patient outcomes from nursing care. RNs must participate in decisions regarding UAP job descriptions and UAP job duties within the clinical setting, and be knowledgeable about the competency of each UAP and intervene when needed	Support the control and monitoring of UAP through the use of existing mechanisms that regulate nursing practice (state board of nursing), including the clarification of the delegation process and what may be delegated and restrictions.
American Association of Spinal Cord Injury nurses (AASCIN) 1995	Budgetary and resource considerations not valid reasons for wrongful delegation; RN does not have to teach UAP who do not demonstrate the ability to learn and perform care.	RNs asked to increase delegation and use of UAPs; UAP not substitute for RN; UAP should be under direct supervision of RN; UAP role varies by setting.	<ul style="list-style-type: none"> ■ Nursing aides ■ Personal care attendants ■ Family members ■ Friends ■ Appointees of the client 	At request of client or client's agent the RN may teach the client's care to UAP. The client or agent then accepts responsibility for the UAP supervision and the type and quality of UAP care; exception when UAP is from an agency		The RN has a legal scope of practice and a legal authority to perform nursing acts; UAPs do not	Employers and RNs who participate in wrongful delegation should be sanctioned
American Federation of Teachers (AFT), 1995	The RN must remain the single authority over delegation of nursing tasks and responsibilities to UAP based on the nurse's evaluation of the training and competencies of the unlicensed person and the nature of the tasks to be performed.	Performance of non-nursing duties such as environmental maintenance; clerical tasks; and directly assisting patients with ADL such as hygiene, feeding and ambulation. Increasingly licensed personnel are being pressured to inappropriately delegate.	Standardized job titles and job description are needed	Minimum education and training requirements needed at state level		The RN retains responsibility for all tasks he/she delegates	
American Nurses Association (ANA) 1997	Direct patient care activities are delegated by the RN and involve ADL; indirect patient care activities focus on environmental maintenance, such as housekeeping, transporting clerical, and stocking. In delegation the RN uses professional judgment to determine the appropriate activities to delegate.	UAP provide support services to the RN; in virtually all health care settings UAP are inappropriately performing functions within the legal scope of nursing.		The nursing profession should define and supervise the education, training and utilization of UAP		The RN is responsible and accountable for the provision of nursing practice. The RN supervises and determines the appropriate use of UAPs. Therefore, it is responsibility of the nursing profession to establish and the individual RN to implement standards for the practice and utilization of UAPs.	Definitions of nursing in state practice acts.

Organization	Delegation/ Decision Making	UAP Role	UAP Titles	UAP Training	Nursing Education	Accountability	Regulation
American Nephrology Nurses' Association (ANNA) 1983, revised and reaffirmed 2003	Never delegate a nursing care activity that requires the specialized skill, judgment and decision-making of an RN or the core nephrology principles needed to recognize and manage real or potential complications.	The RN shall have either instructed the UAP in the delegated activity or verified the UAP competency. Administration of medications is beyond the scope of practice of UAP, and shall be limited to those medications considered part of the routine hemodialysis treatment (e.g., normal saline and heparin via the extra corporeal circuit and intradermal lidocaine).	<ul style="list-style-type: none"> ■ Dialysis technicians ■ Patient care technicians ■ Reuse technicians ■ Nephrology technologists (All under supervision of RN) 	Assistive personnel in dialysis need not be licensed; but must complete a standard program of education and training for UAP in dialysis preferable in a junior college or vocational school with ongoing CE requirements.		The RN is accountable and responsible for all delegated nursing care activities and interventions — must be present in the patient care area for ongoing monitoring and evaluation of the patient's response to the therapy. The RN is legally accountable and clinically responsible for the complete documentation of the entire nursing process.	UAP must function under the state nurse practice act; ANNA prefers specific language referring to UAP in dialysis settings.
Arizona Nurses Association (ANA) 1992, renewed 2002	Delegation presumes the delegator has greater knowledge and a delegated task is only a subcomponent of a larger whole	Written job descriptions with clear parameters that define and limit the responsibilities of the position. RNs should never delegate to any member of the health team a function for which that person is not qualified.		Core curriculum developed and supervised by RN that includes but is not limited to: <ul style="list-style-type: none"> ■ Communication ■ Customer service ■ Safety ■ Clinical practice issues. 		<p>RN is originator of delegation and retains responsibility for outcomes.</p> <p>The employing organization has a responsibility to assure that the appropriate training, orientation and documented competencies are in place for the UAP so that the RN can be reasonably assured that the UAP can function safely.</p>	
Association of periOperative Registered Nurses (AORN) 1995, reaffirmed 1999	Restructuring of traditional roles does not replace perioperative RNs, but provides opportunity to focus leadership skills on coordinating patient care and directing activities of the nursing team. The perioperative RN may delegate appropriate patient care activities.			Perioperative RNs define and supervise the training and utilization of UAP who provide direct and indirect care in the perioperative setting. UAP must receive appropriate training and demonstrate competency before assuming new and expanded responsibilities, and must be commensurate with the delegated activities.		Perioperative RNs are accountable for patient outcomes resulting from nursing care provided during the perioperative experience.	

Organization	Delegation/ Decision Making	UAP Role	UAP Titles	UAP Training	Nursing Education	Accountability	Regulation
Association of Rehabilitation Nurses (ARN) 1995, revised 2003	UAPs needed to “achieve the goal of assisting individuals in the restoration and maintenance of maximal physical, psychosocial and spiritual health.”	Basic scope ADL tasks plus support of RN assessment; secondary scope consists of those tasks that require additional training and demonstration of competence prior to being performed by the UAP (includes insertion catheters, NG feedings, bowel programs, single dressing changes, glucose testing, ECGs and bladder scans).	Institutional, residential, outpatient and community settings under the supervision of RN.	Qualifications: <ul style="list-style-type: none"> ■ HS diploma or equivalent ■ Nurse aide training certificate or a minimum of documented four weeks on the job training ■ CPR training ■ Additional training prior to performing tasks in secondary scope of care ■ Demonstrated initial and ongoing competence in both categories. 			Tasks delegated by RN shall not exceed any restrictions in the scope of care as set forth by the state.
Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN) 1997, 2000	Clear written parameters for direct supervision by RNs; includes lengthy list of nursing activities that should not be delegated.	Need written job descriptions that clearly delineate the duties, responsibilities, qualifications, skills and supervision of UAPs.	UAP should be clearly identifiable to patients as unlicensed.	Orientation and training of UAPs, including didactic content, knowledge base evaluation and clinical skills verification consistent with performance expectations and role responsibilities.		UAPs work under supervision of and are accountable to RN. The RN remains responsible and accountable for the overall nursing care.	Need to evaluate state practice act to ensure that UAP job descriptions and delegated activities are consistent with rules and regulations.
Massachusetts Organization of Nurse Executives (MONE) 1994, 2002	Supervision of UAP remains with the licensed nurse.	Delegation must occur within the delegatee’s job description, organizational policies and procedures. Individual health care facilities need flexibility in developing institution specific programs.		Should be determined by nursing leadership in individual facilities.		Differing concerns and debates have focused on primary area of accountability and decision making.	MA Board of Registration in Nursing has regulations on delegation and supervision.
National Association of Neonatal Nurses (NANN), 1999	RN may assign or delegate tasks to assistive personnel based on the assessed patient need, the potential for harm, the complexity of the care and the knowledge and skill of the UAP.	Tasks based on needs, potential for harm, complexity and UAP KSAs	<ul style="list-style-type: none"> ■ Nursing assistants ■ Nursing Aides ■ Orderlies Also list as assistive personnel LPN/VNs, respiratory therapists (RTs) and emergency medical technicians (EMTs).	UAP in this area must have appropriate education in the care of the high-risk newborn and family, even when carrying out support services for the RN.		Neonatal RN responsible for the assessment, planning delivery and evaluation of newborn care.	
National Association of School Nurses (NASN)	Key factors for effective and competent use of assistive personnel are role definition, adequacy of training and appropriate delegation and supervision.	Assistive personnel can be used to supplement professional school nursing services but should not be used to supplant school nurses or be permitted to practice nursing without a license.	<ul style="list-style-type: none"> ■ School staff ■ Clerical aides ■ Health/nursing assistants (HA) Also listed as paraprofessionals are: LPN/VNs, Certified Nurses Aides and RNs who do not meet requirements for school nurses.	The professional school nurse should take lead in helping school districts determine whether and how to use assistive health personnel.		The school nurse is the only one who can legally delegate nursing activities to assistive personnel.	State nursing practice acts determine scope of practice and what nursing activities may be delegated or given to assistive personnel.

Organization	Delegation/ Decision Making	UAP Role	UAP Titles	UAP Training	Nursing Education	Accountability	Regulation
New Jersey State Nurses Association (NJSNA) 1995, revised 1999	The RN may transfer responsibility for carrying out specified tasks to UAP to assist health care consumer through delegation of nursing tasks. RN in charge of delegating has confidence in the UAP and has adequate time allowed. Delegation may be direct or in-direct.	RNs must develop and implement standards, policies and procedures for UAPs to assist health care consumer in meeting basic needs. UAP does not practice nursing and does not provide total nursing care.	<ul style="list-style-type: none"> ■ Nurse aides ■ Orderlies ■ Assistants ■ Technicians ■ Home health aides In hospitals, LTC, schools, prisons or community settings et al.	Require education developed, taught and evaluated by RNs. UAP preparation is skill-oriented to assist health care consumer in meeting basic human needs. UAP competency is evaluated by an RN and does not require a written examination.		The RN retains accountability for the outcomes of care.	NJ Board of Nursing, the same that governs nursing, should regulate UAPs.
New York State Nurses Association (NYSNA) 1996	Does not address delegation, speaks of RN assignment of tasks and care to other members of nursing staff, including UAP.	Concern regarding shift in use of UAPs to more complex tasks and patients with higher acuity. RNs must express concern when the inappropriate use of UAPs is suggested or employed.		Identification of tasks, patients, circumstances in which care can be assigned to UAPs is responsibility of the nursing profession – RNs need to be involved in establishing the parameters of care and in the standardization of preparation.	Forums should be established to prepare RNs to use UAPs appropriately.	RNs accountable for the delivery of safe, competent care to those patients entrusted to them.	
Oncology Nursing Society (ONS) 1997, revised 2000, 2002	RN validates UAP competency, completes ongoing client assessment, provides ongoing supervision of UAP, performs evaluation of client response to care and interprets and makes decisions regarding care.	Performance of repetitive, common tasks and procedures that do not require the professional judgment of an RN.				Nurse retains accountability for delegated tasks and decisions.	Use existing mechanisms for regulation of nursing practice to regulate UAPs.
Society of Gastroenterology Nurses and Associates (SGNA) 1996, 2001		Perform duties under direct, on-site supervision of delegated patient care.	<ul style="list-style-type: none"> ■ GI assistants 				
Society of Otorhinolaryngology and Head-Neck Nurses (SOHN), 1996, 2003	Lists criteria to be considered in decision to use UAPs.	Supports safe and appropriate use of UAP, supervised by RN who identifies tasks and [level of] supervision.		Promotes UAP education and training programs consistent with SOHN mission and vision.		RN accountable for patient safety, nursing care and maintains responsibility for patient assessment, care planning and evaluation.	
The American Association of Nurse Attorneys (TAANA)		Increased in recent years partially due to managed care and decreased Medicare reductions; used in more settings, doing more complex tasks; supervising nurses have increased responsibility.	<ul style="list-style-type: none"> ■ Certified nurses aide ■ Home health aide ■ Personal care assistant ■ Personal care attendant ■ Certified phlebotomist ■ Clinical assistant ■ Nursing Assistant ■ Orderly 	Recommend standardized curriculum and testing by state; similar to OBRA 1987 requirements for long term care assistants.	Recommend that nursing schools add team nursing to curriculum and/or supervision and delegation to assist working with UAPs.	Nurses ultimately responsible for the provision of nursing care.	Recommend Board provide guidance and direction, including criteria for determining what can be delegated, what cannot, and direction on the type of supervision needed.

Organization	Delegation/ Decision Making	UAP Role	UAP Titles	UAP Training	Nursing Education	Accountability	Regulation
Tri-Council(1995)	Must be made by RN based on the patient, the task, the preparation of the UAP and other factors.	Increased use due to economic pressures; increased concerns about role and use of UAP.				Nurses accountable for all nursing care provided including policies, procedures and standards.	Board of nursing

Appendix C

Literature Review

When “delegation” is entered as a keyword in search engines such as CINAL, MEDLINE, ABI-INFORM, LEXIS-NEXIS, EBSCO host, ERIC, and Psych INFOR, many articles come up until the search years are limited to 1998-2004. Surprisingly, an extensive literature review did not identify many recent articles published on delegation. The main concepts addressed in the available recent articles include:

Implementation

- Delegation “dos and don’ts” — protect your practice (MNA Online Publications)
- Moen (2001) references both ANA and NCSBN work in writing about how to make delegation work.
- Buppert (2004) writes from the APRN perspective of whether it is safe to delegate to UAP and the business implications.
- Clarke (2003) discusses several high-profile research studies linking nursing staffing and client safety.
- Parsons (1998) described increased confidence in RN delegation after training using a *Nursing Assessment Decision Grid*, as well as increasing job satisfaction experienced by RNs relative to autonomy and promotional opportunity.

Staff Mix

- Changes in staff mix (with increase numbers of nursing assistive personnel) causes role confusion for both RNs and assistants (Zimmerman, 2000; Potter & Grant, 2004; Hall, 1998); especially when job descriptions/level of training and expectation are unknown (Thomas & Hume, 1998; Barter, McLaughlin & Thomas, 1997).
- Thomas, et al, (2000) states that RNs do not feel confident with UAP skills.
- Unruh (2003) notes that the number of LPNs has decreased and may contribute to increased workload for RNs.
- Bernrueter & Cardona (1997) observed a dramatic rise in the number of UAP with mixed feelings from RNs about UAP value.
- Potter & Grant (2004) note that UAP working with multiple RNs can cause UAP confusion (because UAP are not taught to prioritize, they are task oriented).
- Kido (2001) suggests making staff mix public knowledge.
- Clarke (2003) observes more RNs equal less adverse outcomes.

Communication

- Good communication helps nurture the RN and UAP relationship (Thomas & Hume, 1998; Potter & Grant, 2004).
- Parsons, 1998, notes that lack of communication makes relationships poor (UAP not relaying information because they are not trained to recognize things that nurse are and RNs are not trained how to deal with less skilled workers).
- Emphasis on group function may help improve RN-UAP interactions (Anthony, Casey, Chau & Brennan, 2000).

Education/Training

- There is a lack of UAP education, or a lack of consistency of UAP education (Thomas, et al, 1998; Kido, 2001).
- Education of UAP recommended (Barter, McLaughlin and Thomas, 1997).
- Another barrier is the lack of RN educational preparation regarding delegation skills (Thomas & Hume, 1998; Hopkins, 2002; Anthony, Standing & Hertz, 2001).
- Recommend teaching delegation skills (Thomas & Hume, 1998; Parsons, 1998; Anthony, Standing & Hertz, 2001).
- Barter, McLaughlin & Thomas (1997) suggest that UAP have formal training with a defined scope.
- Hopkins (2002) developed a continuing education tool.
- Conger (1999) adjusted the Nursing Assessment Decision Grid NADG 1993/1994, to teach nursing students delegation tools.
- The U.S. Department of Labor's *Occupation Outlook Handbook* advises that minimum education and training is generally required for entry-level nursing, psychiatric and home health aides, that job prospects will be very good because of fast growth and high replacement needs, but that earnings are low.
- Kopishke (2002) provides a historical perspective on the use of nursing assistive personnel and how nurses must prepare themselves to head the team of caregivers found in today's acute care facilities.
- Numerous continuing education offerings address delegation and supervision.

Regulation

- There is a need to work with Boards of Nursing to assure regulatory language is clear to support delegation to UAP in OR setting (Habgood, 2000).
- Recommendations that states mandate minimal educational requirements and competency evaluation for UAP in acute care settings, with a movement to establish national regulation of educational requirements to ensure the competency of UAP in acute-care hospitals (Thomas, Barter & McLaughlin, 2000).
- The best foundation for teaching what can and cannot be delegated is the nursing practice act in the state (Hall, 1996).
- The National Council of State Boards of Nursing adopted its first delegation paper in 1990. The Paper was updated in 1997, and in 1998, a Delegation Resource folder was developed (included the Paper, curriculum outline for teaching delegation to both delegating nurses and the recipients of delegation, decision tree, decision grid and other resources). Delegation was also addressed in the NCSBN *Model Nursing Practice Act and Model Nursing Administrative Rules* in 2004.

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Appendix D

Review of Case Law

Tom Abram, attorney with Vedder, Price, Kaufman & Kaufman in Chicago, provided a legal case review in 2004 regarding delegation and nursing assistive personnel. A case law search found no cases holding a nurse accountable for actions performed by a UAP whether or not the activity was delegable according to the state statutes. Two Illinois cases, People v. Stults, 683 N.E.2d 521 (Ill. App. Ct. 1997) and People v. Cryns, 763 N.E. 2d 904 (Ill. Ct. 2002) discussed actions brought against unlicensed personnel for practicing nursing without a license (neither involved delegation). This review was updated with materials from the Federation of Associations of Regulatory Boards (FARB) in 2005.

Some cases were identified where courts have addressed the use of UAP in other professions.

- In State ex inf. Danforth v. Dale Curteman, Inc., 480 S.W.2d 848 (Mo.,1972) unlicensed individuals claiming to be technicians working under the supervision of ophthalmologists were found to have illegally engaged in the practice of optometry.
- The appellate court affirmed the trial court's decision to revoke the physician's license after he ordered an unlicensed person to administer injections to clients, holding that "when a doctor directs an unlicensed person to perform a medical act, the question is not whether the unlicensed person may be disciplined for the act, but whether the doctor's conduct is unprofessional..." Kolnick v. Board of Medical Quality Assurance, 161 Cal. Rptr. 289 (Cal. Ct. App. 1980).
- In the presence of conflicting evidence, a jury found that a client's injury was not caused by a flu shot administered by an unlicensed and untrained individual. The appellate court affirmed because it could not state the jury was clearly wrong. However, in its opinion, the court stated that the standard of care that nurses are subject to is the same as the standard applied to physicians. Novak v. Texada, et. al., 514 So.2d 524 (Ct. App. La. 1987).
- In Portable Embryonics, Inc. v. J.P. Genetics, Inc., 810 P.2d 1197 (Mont., 1991) unlicensed individuals claiming to be technicians who performed non-surgical bovine embryo transfers were found to have illegally engaged in the practice of veterinary medicine.
- A doctor was convicted of aiding and abetting unlicensed medical assistants in the illegal practice of medicine. People v. Gandotra, 14 Cal.Rptr.2d 896 (Cal.App.2 Dist., 1992)
- The Colorado Supreme Court found that an unlicensed lab technician was not a "health care professional," within the meaning of a statute designed to protect individuals from negligent acts of health professionals but that the statute still applied under the circumstances of the case. Scholtz v. Metropolitan Pathologists, P.C., 851 P.2d 901 (Colo. 1993).
- The appellate court affirmed the trial court decision that unauthorized dentistry took place when a dentist authorized the unlicensed assistant's acts, and inadequately supervised, was held to be unprofessional conduct by a dentist, Fotovatjah v. State of Washington, 1998 Wash. App. LEXIS 1689 (Wash. App. 1998).
- However in PM&R Associates v. Workers' Comp Appeals Board, 94 Cal.Rptr.2d 887 (Cal. App.5 Dist., 2000) doctors use of unlicensed medical assistants to assist physicians in performing physical therapy tasks was not illegal.
- And in State Farm Mut. Auto. Ins. Co. v. Universal Medical, 881 So.2d 557 (Fla.App. 3 Dist., 2004), unlicensed medical assistants authorized to administer physical modalities under the direct supervision and responsibility of a physician.
- A discipline of a veterinarian who had allowed an unlicensed veterinary technician to position a dog for x-ray and to operate an x-ray machine was upheld on appeal. Gilman v.

Nevada State Board of Veterinary Medical, 89 P.3d 1000 (Nev., 2004).

- In People v. Santi, 785 N.Y.S.2d 405 (N.Y., 2004), a doctor was convicted of aiding and abetting an unlicensed medical assistant in the illegal practice of medicine.

Appendix E

Individuals Who Provided Comments on Working with Others: A Position Paper

Submitted Written Comments:

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Debra Werner, RN, MSN, Assistant Director/Practice Unlicensed Assistive Personnel, New Mexico State Board of Nursing
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Met with the PR&E Delegation Subcommittee on April 26, 2005, at NCSBN offices:

Donald A. Balasa, JD, MBA, American Association of Medical Assistants
Judy A. Jondahl, MS, RN, CLNC, American Association of Medical Assistants

Appendix F

Definitions

- **Accountability** is being responsible and answerable for actions or inactions of self or others in the context of delegation (NCSBN, 1997). There are different levels of accountability:
 - Licensed nurse accountability involves compliance with legal requirements as set forth in the jurisdiction's law and rules governing nursing. The licensed nurse is also accountable for the quality of the nursing care provided, for recognizing limits of knowledge and experience and for planning for situations beyond the nurse's expertise (NCSBN, 2004). Licensed nurse accountability includes the preparedness and obligation to explain or justify to relevant others (including the regulatory authority) one's judgments, intentions, decisions, actions and omissions... and the consequences of those decisions, actions and behaviors (SA, 2004).
 - Nursing assistive personnel accountability relates to being answerable for the assistant's actions and behavior.
 - Organizational accountability relates to providing sufficient resources, staffing, appropriate staff mix, opportunity for continuing staff development and creating an environment conducive to teamwork, collaboration and patient-centered care.
- **Assignment** describes the distribution of work that each staff member is to accomplish on a given shift or work period.
- **Competence** is the ability of the nurse to act with and integrate the knowledge, skills, values, attitudes, abilities and professional judgment that underpin effective and quality nursing and is required to practice safely and ethically in a designated role and setting (SA, 2004).
 - Licensed nurse competence is built upon the knowledge gained in a nursing education program and the experiences of implementing nursing care. The nurse must know herself or himself first, including strengths and challenges, assess the match of her or his knowledge and experience within the requirements and context of a role and setting, and gain additional knowledge as needed and maintain all skills and abilities needed to provide safe nursing care. Competence requires the application of knowledge and the interpersonal, decision-making and psychomotor skills expected for the practice role (NCSBN, 1996).
 - Nursing assistive personnel competence is built upon formal training and assessment, orientation to specific settings and groups of patients, interpersonal and communication skills, and the experience of the nurse aide in assisting the nurse provide safe nursing care.
- **Client directed care** is a situation in which a client maintains all or most of self-care responsibilities, including direction of unlicensed nursing assistive personnel (NCSBN, 1997).
- **Delegation** is transferring to a competent individual the authority to perform a selected nursing task in a selected situation. The nurse retains accountability for the delegation (NCSBN, 2004).
- **Education** infers the transfer of generic information and skill, and includes components of information (teaching) and skill training and assessment (training).
- **Nursing care tasks/functions/activities** are those nursing interventions that may be delegated/assigned to nursing assistive personnel and are not restricted or prohibited by legislation, regulation and/or agency policy (adapted from SA, 2004).

- Medication assistant is an individual who receives specialized training preparing for a role in administering oral and topical medications and who works under the supervision of a licensed nurse.
- Nursing assessment is “the gathering of objective and subjective information relative to a client, confirmation of the data, and communication of the information” (*NCLEX-RN® Test Plan, 2004*).
- Nursing assistive personnel are unlicensed personnel to whom nursing tasks are delegated and who work in settings with structured nursing organizations.
- Professional judgment is the intellectual (educated, informed and experienced) process that a nurse exercises in forming an opinion and reaching a clinical decision based upon an analysis of the available evidence (SA, 2004).
- Rescission of delegation is the process of taking back a delegation, typically due to serious change in client condition (stable to unstable), nature of therapies or other situation requiring change in planning for a group of clients.
- Range of functions are the tasks and activities learned in an approved nursing assistant and competency evaluation program that are typically performed by nursing assistive personnel for clients who are stable and predictable, supervised by a licensed nurse who may need to limit the range of tasks based on client needs.
- Scope of practice is the parameters of the authority to practice granted to a nurse through licensure.
- Supervision is the provision of guidance or direction, oversight, evaluation and follow-up by the licensed nurse for the accomplishment of a nursing task delegated to nursing assistive personnel.
 - Direct Supervision involves the presence of the licensed nurse who is working with other nurses and/or nursing assistive personnel to observe and direct the assistant’s activities. The proximity of this supervision is such that immediate intervention is possible if problems occur (SA, 2004).
 - Indirect supervision occurs when the licensed nurse is not present and supervision is provided by other than direct observation of the nurses and/ or nursing assistive personnel. The absence of proximity of the licensed nurse requires processes being in place for the direction, guidance, support and monitoring of the LPN or nursing assistive personnel activities (SA 2004).
- Surveillance and monitoring is the process of observing and staying attuned to client status and staff performance.
- Teaching/providing information is to impart knowledge, to cause to know something (Merriam Webster, p. 1281).

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