فهرست

Chapter 1

Assignment and Delegation

1) The unit is staffed with an experienced registered nurse, an experienced licensed practical nurse, and unlicensed assistive personnel (UAP). Which tasks can the charge nurse appropriately delegate to UAP? **Select all that apply**.

1. *Apply protective skin ointment after perineal cleansing*

2. *Determine if a client has adequate relief after administration of an analgesic*

3. *Document daily weight for a client with congestive heart failure*

4. *Feed a client who had a stroke 24 hours after admission*

5. *Perform passive range-of-motion exercises for a client on a ventilator*

✓Answer: 1, 3, 5

Scope of practice		
RN	**LPN/LVN**	**UAP**
• Clinical assessment • Initial client education • Discharge education • Clinical judgment • Initiating blood transfusion	• Monitoring RN findings • Reinforcing education • Routine procedures (eg, catheterization) • Most medication administrations • Ostomy care • Tube patency & enteral feeding • Specific assessments*	• Activities of daily living • Hygiene • Linen change • Routine, stable vital signs • Documenting input/output • Positioning

* Limited assessments (eg, lung sounds, bowel sounds, neurovascular checks).

LPN = licensed practical nurse; **LVN** = licensed vocational nurse; **RN** = registered nurse; **UAP** = unlicensed assistive personnel.

Unlicensed assistive personnel (UAP) are assigned tasks for stable clients by the registered nurse (RN), who directs and manages overall client care. The RN cannot delegate the nursing process. UAP can perform active and passive range-of-motion exercises **(Option 5)**. Under the direction of the RN, UAP can apply protective ointment (such as zinc oxide) after cleaning a client **(Option 1)**.

UAP can obtain data but the RN is responsible for interpreting (evaluating) it. For example, UAP can obtain objective data such as the client's height and weight, but the RN will analyze this data to determine the need in the nursing care plan (eg, effect on drug dosing) **(Option 3)**.

(Option 2) UAP can collect data (eg, an objective pain score), but the RN is responsible for evaluating if the relief is adequate. The word "adequate" refers to the evaluation of treatment and is not part of UAP scope of practice. The RN may consider other aspects (eg, vital signs, body language) when making such evaluations, especially in a nonverbal client.

(Option 4) A stroke is not considered stabilized until approximately 48 hours have passed without changes. The client's risk of losing the gag reflex is still high as the stroke could be evolving. UAP should feed only stable clients.

• Performing passive and/or active range-of-motion **exercises (Option 5)**

• Measuring output (eg, urinary, drainage)

(Option 2) The tracheostomy is a surgically created airway with a high risk of infection. Only licensed individuals (eg, registered nurse, licensed practical nurse) should perform tracheostomy care.

(Option 3) Although an elevated head of bed (HOB) is necessary to prevent ventilator-acquired pneumonia and improve chest expansion, teaching is not within the scope of the UAP and should be performed only by nurses. However, after nurses provide teaching, the UAP may remind the family to keep the HOB elevated.

Educational objective:

When caring for a ventilated client, nurses may consider delegating the following tasks to unlicensed assistive personnel: vital sign measurement, oral care, personal hygiene, blood glucose testing, passive or active range-of-motion exercises, and measurement of urine and drainage output

3) The postpartum nurse receives report on 4 mother-baby couplets. Which tasks can be delegated to unlicensed assistive personnel? **Select all that apply**.

1. *Assisting the mother with morning hygiene*

2. *Demonstrating neonate bathing technique*

3. *Documenting intake and output on the mother*

4. *Evaluating caregiver interaction with the neonate*

5. *Obtaining an axillary temperature on the neonate*

6. *Swaddling the neonate after diaper changes*

✓Answer: 1, 3, 5, 6

Scope of practice		
RN	**LPN/LVN**	**UAP**
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* Limited assessments (eg, lung sounds, bowel sounds, neurovascular checks).

LPN = licensed practical nurse; **LVN** = licensed vocational nurse; **RN** = registered nurse; **UAP** = unlicensed assistive personnel.

Assisting clients with **activities of daily living** is within the scope of practice of unlicensed assistive personnel (UAP). Helping the mother with morning hygiene, documenting intake and output, taking vital signs of stable clients, and swaddling the neonate may be delegated to **UAP**. The registered nurse (RN) should follow the **5 rights of delegation** when planning care.

(Option 2) The RN assumes responsibility for initial client teaching and demonstration of home care. Once teaching and demonstration are complete, the UAP can assist the mother with bathing the neonate.

(Option 4) The RN should assess caregiver interaction with the newborn to identify any attachment issues. Elements of the nursing process (assessment, planning, and evaluation) and tasks requiring nursing judgment cannot be delegated.

Educational objective:

The registered nurse is responsible for any care requiring clinical judgment. Unlicensed assistive personnel can assist with activities of daily living, documenting intake and output, positioning, and taking the vital signs of stable clients.

4) The charge nurse in the emergency department assigns a client to a new nurse who has been off orientation for a week. Which client assignment is **most appropriate?**

1. *3-year-old with a temperature of 102.4 F (39.1 C) who had a seizure at home 30 minutes ago and is very irritable*

2. *8-year-old with a closed fracture of the clavicle following a fall who is talkative and rates pain as a "2" on the 0-10 FACES pain scale*

3. *32-year-old with asthma who has an upper respiratory tract infection and a peak expiratory flow rate that is 45% of personal best*

4. *72-year-old prescribed antibiotics 3 days ago to treat acute sinusitis who reports shortness of breath and has a rash*

✓Answer: 2

A fractured clavicle (collarbone) is not uncommon in children age <10 years and is usually treated conservatively. A new nurse should be competent in performing the basic skills needed to care for a client with a musculoskeletal injury (eg, pain and neurovascular assessments, analgesia administration, sling application). The 8-year-old client, who has minimal pain as indicated by the score of 2 on the FACES **pain assessment tool**, is the most stable. As a result, this is the most appropriate assignment for the new nurse.

(Option 1) A seizure can be associated with a fever-related illness (febrile seizure). This client who is very irritable and has fever may have an underlying serious infection such as meningitis and should undergo diagnostic testing (eg, blood cultures, imaging, lumbar puncture). Therefore, this is not an appropriate assignment.

(Option 3) A **peak flow meter** measures airflow out of the lungs. The client who has a severely reduced peak expiratory flow rate (<50% of personal best) needs emergency intervention and is not an appropriate assignment.

(Option 4) The client with dyspnea and a maculopapular **drug rash** is most likely experiencing an antibiotic-related allergic reaction, which can range from

mild to life-threatening anaphylaxis. This client is not an appropriate assignment.

Educational objective:

A new nurse should be competent in performing the basic skills needed to care for a client with a musculoskeletal injury (eg, pain and neurovascular assessments).

5) The nurse supervisor tells the psychiatric nurse to go to the telemetry unit ("Float") as the unit is short staffed and has 2 clients with cardiac arrest. The nurse is not familiar with this client population and does not want to go. What is the **best** response by the psychiatric nurse?

1. *Clarify the skills/knowledge that the nurse is able/unable to perform*

2. *Read the policy and procedure book for the unit before providing care*

3. *Refuse to go due to concerns about client safety*

4. *Tell the supervisor to send someone else instead*

✓Answer: 1

When asked to "float" to help out in another unit, the nurse should clarify the duties to be performed. Many skills/knowledge, such as vital signs and routine medication administration, are the same in all units. The nurse should be given a unit orientation. The nurse should then clarify applicable skills. For instance, the nurse could perform basic care but not feel comfortable watching the telemetry cardiac monitors or assisting with insertion of a pacemaker. These limitations are usually understood and respected. The qualified and experienced registered nurses on the unit perform specialized client needs, and the "float" nurse performs basic client needs.

The nurse is liable to provide safe care for the assigned duties and perform them in a competent manner. The nurse should personally document any concerns raised with the supervisor and avoid discussing personal feelings about the "float" with clients or other staff.