CHAPTER 9
DELEGATION AND ASSIGNMENT

Section 1. Statement of Purpose

(a) The purpose of the board in adopting rules and regulations in this chapter is:
   (i) To establish acceptable standards of safe delegation of nursing tasks.
   (ii) To provide criteria for the board to evaluate safe and competent delegation of nursing tasks.

Section 2. Definitions

(a) “Authority” means the source of the power to act.

(b) “Delegation” is transferring to a competent individual the authority to perform a specific nursing task in a selected situation. The nurse retains the responsibility and the accountability for the delegated tasks.

(c) “Assignment” is the performance of designated nursing activities/tasks by a licensed nurse or certified nursing assistant that are consistent with the scope of practice of a licensed nurse or the role description of a certified nursing assistant; the distribution of work that each staff member is responsible for during a given work period.

(d) “Evaluation” is the final and critical step of delegation; to review the nursing care provided, the effectiveness of the nursing interventions and the need to change any part of the plan of care in order to better meet patient needs.

Section 3. Principles of Delegation

(a) All decisions related to delegation and assignment are based on the fundamental principles of protection of the health, safety and welfare of the public (the statements in Section 3 are directly from the Joint Statement on Delegation, American Nurses Association and the National Council of State Boards of Nursing, 2006).

   (i) The registered nurse takes responsibility and accountability for the provision of nursing practice.

   (ii) The registered nurse directs care and determines the appropriate utilization of any nursing assistant involved in providing direct patient care.

   (iii) The registered nurse may delegate components of care but does not delegate the nursing process itself. The functions of assessment, planning, evaluation and nursing judgment are pervasive to nursing practice and cannot be delegated.

   (iv) The decision of whether or not to delegate or assign is based upon the registered nurse’s judgment concerning the condition of the patient, the competence of members of the nursing team and the degree of supervision that will be required of the registered nurse if a task is delegated.

   (v) The registered nurse delegates only those tasks for which she or he believes the other health care worker has the knowledge and skill to perform, taking into consideration training, cultural competence, experience and facility/agency policies and
procedures.

(vi) The registered nurse individualizes communication regarding the delegation to the nursing assistant and client situation. The communication should be clear, concise, correct and complete. The registered nurse verifies comprehension with the nursing assistant and that the nursing assistant accepts the delegation and the responsibility that accompanies it.

(vii) Communication must be a two-way process. Nursing assistants must have the opportunity to ask questions and/or for clarification of expectations.

(viii) The registered nurse uses critical thinking and professional judgment when following the five rights of delegation:

(A) The right task;

(B) Under the right circumstances;

(C) To the right person;

(D) With the right directions and communication; and

(E) Under the right supervision and evaluation.

(b) Chief nursing officers are accountable for establishing systems to assess, monitor, verify and communicate ongoing competence requirements in areas related to delegation (Joint Statement on Delegation, American Nurses Association and the National Council of State Boards of Nursing, 2006, pg 2).

Section 4. Accountability

(a) The delegating licensed nurse retains accountability for:

(i) Nursing care when delegating nursing tasks or interventions to ensure patient safety;

(ii) The decision to delegate;

(iii) Verifying the delegatee’s competency to perform the tasks;

(iv) Providing direction or supervision;

(v) The performance of the delegated task;

(vi) Evaluating the effectiveness of the delegated nursing task or interventions performed under direction or supervision.

Section 5. Standard for Delegation of Basic Nursing Tasks and Skills

(a) The licensed nurse delegates tasks based on the needs and condition of the patient, potential for harm, stability of the patient’s condition, complexity of the task, predictability of the outcomes, ability of the staff to whom the task is delegated, and the context of other patient needs.

(b) Nursing assistant may complement the licensed nurse in the performance of
nursing functions but shall not substitute for the licensed nurse.

(c) Delegation shall be task-specific, client-specific, and nursing assistant specific.

(d) The standards of nursing assistant practice evolve from the performance of delegated nursing related tasks and services regardless of an individual's title or care setting.

(e) The delegator shall be a licensed nurse.

(i) When delegating a nursing task, the delegator shall:

(A) Make an initial assessment of the client's nursing care needs before delegating the task;

(B) Verify the nursing assistant’s competence to perform any nursing task prior to delegation;

(C) Verify appropriate continuing education for each nursing assistant for each task to be performed;

(D) Communicate with nursing assistant allowing the opportunity to ask questions, provide feedback, or clarification;

(E) Inform the patient/client of the decision to delegate;

(F) Provide appropriate direction or supervision;

(G) Remain accountable for the delegated tasks;

(H) Evaluate client outcomes and make adjustments accordingly;

and

(I) Make clear to the nursing assistant that the delegated task cannot be re-delegated.

(l) Delegation is unnecessary if the particular activity or task is already within the legally recognized scope of practice of the individual (delegate) who is to perform the activity or task;

(1.) An element of assignment exists in all delegation; however, for the purpose of these rules, assignment means that an individual designates another to be responsible for specific patients or selected nursing functions for specifically identified patients;

(2.) Both “assignment” and “delegation” decisions must be made by the licensed nurse on the basis of the skill levels of the care givers, the care needs of patients or clients, and other considerations.

(ii) The delegating nurse must delegate only those tasks which:

(A) Are within his/her area of responsibility and scope of practice;

(B) A reasonable, prudent nurse would find, within his/her sound nursing judgment, appropriate to delegate;
In the opinion of the delegator, can be properly and safely performed by the nursing assistant without jeopardizing the client's welfare;

Do not require the nursing assistant to exercise nursing judgment, complex observations or nursing assessments, critical decision making or interventions except in an emergency situation; and

Are client specific, task specific, and nursing assistant specific and outcomes are predictable.

Section 6. **Degree of Direction or Supervision.**

(a) The degree of required direction or supervision for the nursing assistant shall comply with the following criteria:

(i) Direction or supervision means a licensed nurse providing appropriate guidance in the accomplishment of a nursing task, including but not limited to:

(A) Periodic observation and evaluation of the performance of the task; and

(B) Validation that the task has been performed according to established standards of practice.

(ii) Delegation will ensue after an evaluation of factors including but not limited to the:

(A) Stability of the client;

(B) Training and capability of the delegatee;

(C) Nature of the nursing task being delegated; and

(D) Proximity and availability of the delegator to the delegatee.

(iii) The delegating nurse or another qualified nurse shall be readily available either in person or by telecommunication.

Section 7. **General Nursing Functions And Tasks That May Not Be Delegated**

(a) The following nursing functions require nursing knowledge, judgment, and skill and may not be delegated:

(i) The nursing process

(A) Assessment;

(B) Development of the nursing diagnosis;

(C) Establishment of the nursing care goal;

(D) Development of the nursing care plan; and

(E) Evaluation of the patient’s progress, or lack of progress, toward goal achievement.
(ii) Nursing interventions, including but not limited to the following:

- Administration of medications;
- Calling or relaying of physician or health care provider orders including prescriptions;
- Any procedure requiring the use of sterile technique including wound or dressing care;
- Insertion or removal of peripheral or central intravenous catheters;
- Insertion or removal of nasogastric or other feeding tubes;
- Insertion or removal of urinary foley catheters or suprapubic catheters;
- Removal of:
  - Endotracheal tubes;
  - Chest tubes;
  - Jackson-Pratt drain tubes (JP tubes);
  - Arterial or central catheters;
  - Epidural catheters; and
  - Any indwelling device.
- Patient triage.

(b) The authority to receive verbal orders from providers.

(c) Teaching or counseling patients or a patient’s family relating to nursing care and nursing services.

Section 8. Decision Tree for Delegation to Certified Nursing Assistants/Nurse Aides

Joint Statement on Delegation
American Nurses Association (ANA) and the National Council of State Board of Nursing (NCSBN)
National Council of State Boards of Nursing (NCSBN)
# Decision Tree for Delegation to Nursing Assistive Personnel (Revised for the State of Wyoming)

**Step One – Assessment and Planning**

<table>
<thead>
<tr>
<th>a. Are there laws and rules in place that support the delegation?</th>
<th>NO</th>
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<tbody>
<tr>
<td><strong>YES</strong></td>
<td><strong>If not in the licensed nurse’s scope of practice, then cannot delegate to the nursing assistive personnel. Authority to delegate in states varies. It may be found in the Wyoming Rules and Regulations, Chapter IX.</strong></td>
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<th>b. Is the task within the scope of the delegating nurse?</th>
<th>NO</th>
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<td><strong>YES</strong></td>
<td><strong>Do not delegate</strong></td>
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<th>c. Has there been assessment of the client needs?</th>
<th>YES</th>
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<td><strong>Assess client needs and then proceed to a consideration of delegation</strong></td>
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<th>d. Is the delegating nurse competent to make delegation decisions?</th>
<th>NO</th>
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<td><strong>YES</strong></td>
<td><strong>Do not delegate</strong></td>
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| e. Is the task consistent with the recommended criteria for delegation to certified nursing assistants/nurse aides (CNA)? Must meet all the following criteria: |
| --- | --- |
| **Is within the CNA range of functions** |
| **Frequently recurs in the daily care of a client or group of clients;** |
| **Is performed according to an established sequence of steps;** |
| **Involves little or no modification from one client-care situation to another;** |
| **May be performed with a predictable outcome;** |
| **Does not inherently involve ongoing assessment, interpretation, or decision-making which cannot be logically separated from the procedure(s) itself; and** |
| **Does not endanger a client’s life or well-being** | NO |

| **YES** | **Do not delegate** |
f. Does the nursing assistive personnel have the appropriate knowledge, skills and abilities (KSA) to accept the delegation?

Communication must be a two-way process

- Does the ability of the CNA match the care needs of the client?
  - YES
  - NO

- Are there agency policies, procedures and/or protocols in place for this task/activity?
  - YES
  - NO

- Is appropriate supervision available?
  - YES
  - NO

Do not delegate until evidence of education and validation of competency available, then reconsider delegations; otherwise do not delegate

Do not proceed without evaluation of need for policy, procedures and/or protocol or determination that it is in the best interest of the client to proceed to delegation.

Do not delegate

i. Proceed with delegation*

Step Two – Communication

Communication must be a two-way process
**a. The nurse:**
- Assesses the assistant’s understanding
- 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
- Individualizes for the nursing assistive personnel and client situation
- Addresses any unique client requirements and characteristics, and clear expectations of:
  - Assesses the assistant’s understanding of expectations, providing needed clarification
  - 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

**The nursing assistive personnel**
- **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
- Determine the communication method between the nurse and the assistive personnel
- Determine the communication and plan of action in emergency situations.

**Documentation:**
- **Timely, complete and accurate documentation of provided care**
- Facilitates communication with other members of the healthcare team
- Records the nursing care provided.

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<th><strong>Step Three — Surveillance and Supervision</strong></th>
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<td>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.</td>
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a. 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 determines:
- The frequency of onsite supervision and assessment based on:
  - Needs of the client
  - Complexity of the delegated function/task/activity
  - Proximity of nurse’s location

The nurse is responsible for:
- Timely intervening and follow-up on problems and concerns. Examples of the need for intervening include:
- 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.

Step Four – Evaluation and Feedback

_Evaluation is often the forgotten step in delegation._

a. 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 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: