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.

- 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.

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 e ectively 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 suofcompetenchcomecl

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

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 di erent from state-to-state? Do the nursing assistive personnel in one state really work that di erently 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, sta 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 di erent 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 sta 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 e ectively. 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 o ered 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

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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.
- A rm 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 di erent 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 di culties in completing delegated activities early rather than later (which facilitates addressing problems and allowing completion of delegation).

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

The nurse:	The nursing assistive personnel:	Documentation:

■ Assesses the assistant's understanding 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.
■ 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.
	■ 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
	■ A rms understanding of expectations
	■ Determines the communication method between the nurse and the assistive personnel
	■ Determines the communication and plan of action in emergency situations.
		Timely, complete and accurate documentation of provided care
		■ Facilitates communication with other members of the health care team
		■ 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 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.

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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).
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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 sta 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 sta members apply what they have learned to their practice and functions is an important outcome that can be used to evaluate

Decision Tree — Accepting Assignment to Supervise Unlicensed Assistive Personnel

Have you established the delegated authority of the unlicensed assistive personnel (UAP)? Choose A or B.

A. Has the procedure or task been delegated to the UAP by another authorized provider (such as the physician or other authorized provider)?

B. Has the authority to perform the procedure or task been provided by statute or regulations (e.g., education, assistive living, or other rules)

Does the nurse have the resources needed to accept this assignment to supervise? (Sta , time, technology, proximity)

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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 functions[3] (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 e ectively 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 e ectively, it can result in safe and e ective 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

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[3]Texas 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.

[4]The 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.

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 di cult 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 di cult 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 e ectively direct the services nursing assistive personnel provide.

IX.

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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. Nurs/Span/ActualText<FEFaBT/T1_1 1 Tf9.5 0 0 9.5 80 424.3336 Tm(e.)Tj/Span/ActualText<FEFF0009>BgC 6 09>Be.5 65 532.3336 T

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.					

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Organization	Delegation/ Decision Making	UAP Role	UAP Titles	UAP Training	Nursing Education	Accountability	Regulation
American Nephrology Nurses' Association (ANNA) 1983, revised and rea rmed 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).	■ 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: ■ Communication ■ Customer service ■ Safety ■ Clinical practice issues.		RN is originator of delegation and retains responsibility for outcomes. 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.	
Association of periOperative Registered Nurses (AORN) 1995, rea rmed 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.	

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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.	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 sta , 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 C sah(care)6(can)5(be)5(assigned)6(t6p7s)re JETEMC /Span </MCID 2593 6		

Appendix C

Literature Review

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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, McLaugh721m and homas, e99810(,7)20().

Moen, D. (2001). Delegation: Making it work for you. **Nurse Week**, retrieved April 12, 2004, from http://cyberchalk.com/nurse/courses/nurseweek/nw2001/30unite/ce28a.htm

Parsons, L.C. (1998). Delegation skills and nurse job satisfaction. **Nursing Economic$**, 16(1), 18-26.

Potter, P., & Grant, E. (2004). Understanding RN and unlicensed assistive personnel working relationships in designing care delivery strategies. **Journal of Nursing Administration**

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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 a rmed 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 doctor may Tmiptat[(licensede coo per)-10(bu a

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:

Dale Austin, Senior Vice President and Chief Operating O cer, Federation of Sate Medical Boards of the United States

Jean E. Bartels, PhD, RN, President, American Association of Colleges of Nursing (AACN)

Linda Bell, RN, MSN, Clinical Practice Specialist, American Association of Critical-Care Nurses (AACN)

Marilyn A. Bowcutt, RB, MSN, President, American Organization of Nurse Executives (AONE)

Myra Broadway, JD, MS, RN, Executive Director, Maine State Board of Nursing

Vicki Buchda, MS, RN, Mayo Clinic

Patricia Calico, DNS, RN, Branch Chief, Advanced Nurse Education, Division of Nursing, Bureau of Health Professions, HRSA

Dan Coble, RN, PhD, Executive Director, Florida State Board of Nursing

Rene Cronquist, RN, JD, Assistant Director for Nursing Practice, Minnesota State Board of Nursing

Bridget Culhane, RN, MN, MS, CAE, Oncology Nursing Society (ONS)

Norma Freeman, Nursing Policy Consultant, Canadian Nurses Association (CNA)

Barbara R. Grumet, BA, JD, Executive Director, National League for Nursing Accrediting Commission (NLNAC)

Connie Kalanek, PhD, RN, Executive Director, North Dakota State Board of Nursing

Lorinda Inman, MSN, RN, Executive Director, Iowa State Board of Nursing

Wanda Miller, RN, MA, FNASN, CSN, Executive Director, National Association of School Nurses

Barbara Newman, RN, MS, Director of Nursing Practice, Maryland Board of Nursing

Kim Powell, RN, Montana State Board of Nursing

Susan A. Randolph, MSN, RN, COHN-S, FAAOHN, President, American Association of Occupational Health Nurses Inc. (AAOHN)

Anita Ristau, MS, RN, Executive Director, Vermont State Board of Nursing

Pamela Randolph, RN, MS, Education Consultant, Arizona State Board of Nursing

Mary Jean Schumann, MSN, RN, MBA, CPNP, Director — Department of Nursing Practice and Policy, American Nurses Association (ANA)

Debra Scott, MS, RN, Executive Director, Nevada State Board of Nursing

Margaret Walker, MBA, BSN, RN, Executive Director, New Hampshire State Board of Nursing

Kathy Weinberg, RN, MSN, Associate Director — Nursing Practice/Nursing Education, Iowa Board of Nursing

Marla Weston, MS, RN, Executive Director, Arizona Nurses Association

Barbara Zittel, RN, PhD, Executive Secretary, New York State Boards for Nursing

Participated on April 26, 2005, Conference Call:

Myra Broadway, JD, MS, RN, Executive Director, Maine State Board of Nursing

Dean M. Burgess, MSN, RN, COHN-S, Professional Practice Manager, American Association of Occupational Health Nurses Inc. (AAOHN)

Nancy Ciarrocca, Academy of Medical-Surgical Nurses (AMSN), Pinnacle Health

Ginny Delorimier, Minnesota

Rita Gallagher, PhD, RN, C, Senior Policy Fellow, American Nurses Association (ANA)

- 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 parameterpan /MCIotMh7 1 Tf9.5 0 0 9.5 193.9999 460.5331 Tm(Scxipe of prac

National Council of State Boards of Nursing (©2005)

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