Prioritization and delegation

Assignment or delegation, the five rights, who does what, and who you see first

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1 AT A GLANCE

Assign the stable and predictable; keep the new, the unstable, the teaching and the titration. When you rank clients, find the one who's changing, not the one who's loudest or busiest.

Assignment or delegation?

	Assignment	Delegation
What	Routine care already inside the person's role, learned in basic training	A specific nursing activity **beyond** their usual role, after extra education and checked, documented competence
Example	An aide's vital signs; helping a stable client walk	In some settings, a trained aide gives certain medications, if policy allows
★ **Who's accountable**	The nurse still makes sure it's done, completely and correctly	**The delegating nurse stays accountable for the client.** The delegatee is responsible for doing the task correctly

Ground rules: Only a licensed nurse with authority delegates, and only tasks inside their own scope. The delegatee can't pass it on. Assessing, deciding and evaluating stay with the nurse. RN to RN at shift change is a handoff.

The five rights of delegation

Right	Answer yes to
Task	Is it in the person's job description, or the setting's written policies?
★ **Circumstance**	Is the client **stable and predictable**? This right changes fastest: a change sends the task back to you to reassess
Person	Does this person have the skills and knowledge? The nurse, the employer and the person share that check
Directions and communication	What to collect, how, by when to report, anything special. No changes without checking with you. Get a **read-back**, not a nod
Supervision and evaluation	Will you follow up, check the client's outcome, and be there to step in?

In doubt: If delegating doesn't feel right in the moment, do it yourself.

Who usually does what

Role	Usually takes
★ **RN keeps**	Initial assessments (admission, first after surgery); planned teaching and discharge; creating and **evaluating** the care plan; **unstable or unpredictable clients**; titrations, high-risk IV infusions, and IV push medications in most settings
LPN/VN	Stable clients with predictable needs: scheduled medications, routine dressings, enteral feedings, data collection. Reinforces the RN's teaching; doesn't plan it
Assistive personnel	Daily living care; vital signs and weights on stable clients; intake and output; moving and transporting clients. Can remind about teaching, not plan it

Follow policy: These are typical patterns. Your state's practice act and your facility's policy decide.

Delegate it, or keep it?

Request	Who	Why
Walk a stable client, day 2 after surgery	Assistive personnel	Stable, routine
Feed a client with dysphagia after a stroke	RN, or an aide with specific feeding training	Not routine: aspiration risk
★ **Recheck blood pressure; client now dizzy and pale**	RN	**Unstable**: needs assessment
Reinforce the RN's crutch teaching	LPN/VN	Reinforces; new teaching stays with the RN
Titrate a heparin infusion	RN	High-risk IV infusion, titration
Admission assessment of a new client	RN: you, or another RN by handoff	First assessment needs judgment

Who first? The ranking tools

Tool	What goes first
Maslow	Physiological needs (oxygen, fluids, food, sleep, elimination), then safety, then belonging, esteem, self-actualization
★ **Airway, breathing, circulation**	Two physical needs: the **ABC problem first**; send a team member to help the other client
CURE tool	**Critical** (act now: breathing trouble, chest pain, airway at risk), then urgent (discomfort, safety risk), then routine (medications, assessments), then extras
★ **Cues**	Acute before chronic; actual before potential, usually; unexpected before expected; a change from the client's own baseline

Study tools: Useful teaching tools, not rules NCSBN publishes. When they seem to disagree, go back to the client's own cues.

Educational use only. Not a substitute for clinical judgment, your facility's policy or the provider's orders. Where practice varies, follow facility policy and state law. No patient information.

Prioritization and delegation

1 AT A GLANCE, CONTINUED

Acuity or intensity?

	Means	Pushed up by
Acuity	How much care a client needs because of how sick they are	Unstable vital signs, oxygen therapy, high-risk IV drugs, several drains, uncontrolled pain
Intensity	How much time the care takes	Help with bathing, wound care, many medication passes

Watch: Busy isn't the same as sick: the exam cares most about acuity. A score is a starting point; the client may have changed.

Managing the shift

- Brain sheet: each client's key facts, times and tasks on one page.
- Assess during bedside handoff: what's infusing, what's nearly empty, how the client looks. Pick who's first right after report.
- Fixed times first: time-critical medications, scheduled procedures, a client leaving for dialysis or surgery.
- Estimate how long each task takes, group tasks in one visit, gather equipment first, and use your team.
- Re-rank after every change: a critical lab result means calling the provider before routine discharge teaching.

Assess first or act first?

- **Usually assess first.** A client who says she feels short of breath needs you to look, listen and measure before you act.
- **Act first when the cue gives the action:** no pulse, no breathing, or a closing airway.
- ABC ranks clients who are alive and breathing. Adult cardiac arrest runs CAB: compressions first.
- A breathing client who's getting worse: airway and breathing still come first.

2 PRIORITY AND SAFETY CALLS

★ The client changes during a delegated task: the delegatee tells you now, and **you reassess**. The task comes back to you.

★ Measuring isn't evaluating: the aide can get the pain score, but you judge whether the pain medicine worked.

Two clients need you: go to the airway, breathing or circulation problem, and send a team member to the other. Both get care.

A change reported at handoff, like a client who needed new oxygen overnight, moves her near the top, even if she looks settled now.

Supervision: direct means watching the care happen; indirect means checking results and records. Follow up with the person, then see the client yourself.

Feedback: what went well, what didn't, and the plan. A correct reading reported an hour late is a reporting problem.

Someone isn't competent for a task? Tell the nurse leader, so they get training before they're asked again.

Assign by acuity, not head count. A float nurse gets clients who match her skills, an orientation, and pairing with someone who knows the unit.

3 EXAM ANCHORS

1. Assign the stable and predictable; keep the new, the unstable, the teaching and the titration.
2. Delegation traps: a routine task on an unstable client, and an evaluation hidden inside a measurement.
3. Who-first distractors: the loudest client, the longest task, the most familiar diagnosis, a chronic value that's expected.
4. Changed beats abnormal but stable: a heart rate that jumps from 82 to 118 bpm after surgery comes before chronic pain due a scheduled dose.
5. The RN keeps assessment, teaching, evaluation and unstable clients, and stays accountable for every client.
6. Assess first unless the cue gives you the action; adult cardiac arrest is compressions first.

4 SELF-QUIZ

1. Right circumstance means a client who is stable and _____.
2. RN to RN at shift change is a _____, not delegation.
3. To confirm directions, ask the aide to repeat the plan _____.
4. Acuity is how sick a client is; _____ is how much time the care takes.
5. In the CURE tool, needs that mean act now are _____.
6. An adult in cardiac arrest gets chest _____ first.

ANSWER KEY 1. predictable · 2. handoff · 3. back · 4. intensity · 5. critical · 6. compressions

5 SOURCES

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Built from RN PocketPal course lessons: Delegation, assignment and supervision (c01-l02); Prioritizing care and managing time (c01-l03). Every line on this sheet comes from those lesson scripts.

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