

Delegation Categories

Specific Wording Changes within the Graphic Model (A, D)

- Like language in UAP bubble intro – would like to have in all to make sure all understand the expectation to only accept delegation if have competence to accept.
- UAP can say it is beyond my abilities but that option is not in RN and LPN balloons
- Seems like title of the paper would be more accurate to talk about all levels of nursing rather than just LPN.
- It clarifies – I do think under the LPN role it should include monitors performance, progress, and outcome.
- As a minor point – the first statement in the LPN section does not appear grammatically correct:
LPNs possess a legal source and organizational source of authority to direct/ delegate UAPs & is bounded by the LPNs legal scope of practice and the individual’s competence
Should the “is” be “are”? Or, should it read “it is”?
- “Assure nursing care addresses the patient’s needs” – change this wording in LPN bubble – it is too high level for that scope of practice
- In the narrative – statement that LPN delegates tasks etc but in the graphic depiction use the term delegates care – inconsistent use of terminology
- Need parallel statements regarding responsibilities of delegation for both RN and LPN
- Please add that if someone accepts delegation and they cannot or do not perform that delegation satisfactorily they are held responsible ultimately though an investigation is made into all possible influences.
- Term patient doesn’t fit
- Neither model show documentation.
- Under first bold statement – LPN and RN first part is the same – think this fuzzy

Supervision/assignment – where is it?(D)

- Supervision – where is it in the model?
- This model doesn’t speak to assignment – other models do and seem to be helpful in relation to tasks and in relation to someone at same scope, for example RN doesn’t delegate to another RN. Model should be more comprehensive and more about the assessment and rest of delegation process

- Can LPN delegate to another LPN? – Doesn't specify in either RN to RN or LPN to LPN in model – How is supervision different from monitoring? – This is semantics – I thought LPN couldn't delegate but this says they can – so what about difference between supervision and monitoring – If they can delegate – why can't they supervise?
- What about LPN to LPN delegation – why isn't it in this model – NCSBN said is it OK and what is difference between LPN and RN and assignment?
- Using “direct” is not clear either

Redelegation (D)

- Yes but what happens when RN delegates to LPN who delegates to UAP when RN thinks only LPN appropriate?
- The model does not suggest at all that whatever the LPN delegates within their scope should be communicated to the RN that is overseeing the LPN. This is a must since the RN is accountable for the care of the patient the LPN is caring for. Also, the model does not state whether an LPN can delegate a function that has been delegated to the LPN from the RN. This model should explicitly provide direction on this.
- LPN Role - The model appears to focus on the LPN role as “delegator” and is missing the LPN role and responsibilities related to “delegatee” with LPN acceptance of delegated tasks from the RN. Is there an “indirect” delegation responsibility missing here? What about tasks delegated to the LPN by the RN, then delegated to the UAP by the LPN? While the delegation flows into the process as illustrated, there is an element of communication back to the RN that appears to be missing.
- Can RN delegate to LPN and LPN redelegate to UAP?
- In this model – it looks like RN delegates to LPN and LPN delegates to UAP – this is inconsistent with my practice
- I see a lot of redelegating – to the LPN – Assessment and supervision with no loop back to RN – because RN is the only one able to do this (delegation) – LPN never does this on my unit.
- Can LPN delegate task delegated to them by RN to UAP? – not clear in model need to clarify
- Where is the accountability between RN and LPN when RN delegates to LPN delegates to UAP – should be more clarity about this accountability
- Is there a rule that you can't redelegate – where there is not an RN on site – Can he or she redelegate (LPN) – NCSBN says this?

Matches Findings (A,D)

- If LPNs can direct UAPs and in relation to a change in patient status and therefore directs a new addition to the plan of care- is this within the scope of practice of the LPN? If this is the reality of long term care it is a troubling issue because this will affect all care settings
- LPNs who are the recipient of delegated medical orders – can delegate – must communicate to UAPs to change plan of care

Stable – who determines (D)

- How is stable defined and by whom
- Don't see anything that tells LPN NOT to determine stable – make more clear how?
- I don't think you can make it more clear
- Is fuzzy in relation to stable patients – how do you make a judgment and what if LPN and RN have different judgments? How do you decide who is to determine who is stable?
- Have to clarify stable in relation to LPN and how that is differentiated and who is determining stability

Definitions (A,D)

- Define delegation and assessment.
- The board should do position papers explaining and defining the terms as per current nurse practice act.

Education (D)

- Nursing staff just need to be educated as to these roles and why.
- But as a CNO I need to understand and articulate that to the next level. From my group I see such lack of understanding and awareness of the current NPA.
- I also believe it will encourage nurse managers to include the information in job descriptions, orientation programs, and policies. The result, nursing staff will have a clearer understanding of their roles and the expectations of their supervisors.
- Some course should be taught in nursing school, AD, BAC, Masters. We need consistency. Frustrating when there is no consistency in organizations among nurses at a facility much less organizations – who follow through on leadership.
- In LTC often there is no RN on duty. All activities are delegated to LPN's. The BON could assist in educating RN's and LPN's in the delegation process – grey areas- and even present some case studies.
- Talk to all hospital administrators so all understand the same and have questions answered.

Concern for confusion when non-nurses use the model (A,D)

- What is the audience for this – may be difficult format for UAPs
- Would like feedback loop for all delegation – it won't be clear to RNs or LPNs. A lot of nuances and practicing nurses will have trouble. Begs a lot of questions.

Organization Issues - concern about organizational implementation of nursing roles (A,D)

- There is an expectation in some work settings and the RN isn't there to make a decision. The LPN is in conflict there.
- Supervising/delegation is important and MDH and Board differ – MDH for example require RN coverage 8 hr/day so that is what agencies use– and therefore are not there (RN) and who is ultimately responsible
- Who is accepting delegation and don't have resources and therefore forced to be involved in care and maybe don't know any better?
- The role of LPN authority will always be a challenge. LPN's are expected to supervise UAP's, be knowledgeable about the resident condition/changes however LPN becomes limited and still expected to function as an RN in her absence. We ask more of the LPN for the convenience of staffing.
- If you change the scope of the LPN practice to include delegation, it gives the organization more chances to authorize changes in practice.
- I believe the proposed model changes the practice of nursing to benefit and make it easier on employers as opposed to providing for and assuring the safety of patients.
- Authority (legal versus organizational) is where the rubber meets the road in RN practice – nurses get caught between accepting delegation & legal and organizational authority – between legal scope and what the organization is asking them to do
- Yes, however practice varies. The institution may determine what UAP's are going to do, implying the RN has to accept the direction for delegation even when he or she doesn't want to delegated the task. LTC may determine that LPN's can do more than their legal scope allows. What recourse does the RN or LPN have if they don't agree with the organizational authority telling them to practice outside their scope of practice?
- In long term care – no RN on night shift – CNO sets up structure – but where does buck stop: Is the CNO really accountable”
- No. They both have authority but what if they don't agree? Just because my school board tells me I should delegate something doesn't mean I do that if it is not safe for this particular instance. How does the BON then become involved?
- Good to have organizational authority in black and white, but is hit and miss as the hospital wishes.
- Model makes it more clear who is responsible and who is accountable. Organization needs to take responsibility as well. Some organizations make up their own authority.
- Facility decides what UAP does and train them and if RN decides not to delegate to them – they really don't have a choice – therefore UAPs are doing things based on facility rules not on RN judgment

- What if there is no organizational authority for an RN – for example in home care – when RN is not employed by the institution but is on contract?

General negative statement (A,D)

- Am not comfortable with delegation going too deep – maybe the board is creating a model from what is happening now – I have been working in acute care for 16 years – like what is now used – this is possibly inappropriate
- I look to the Board of Nursing to identify high standards that will best serve and protect the public. Practice should reflect these standards. It seems there is currently an effort to lower the standards to meet the practices. I do not agree with this.
- The law is clear – what concerns me is the boards confusion. The clinical realm practices within the nurse practice law- I think the licensing persons need to enforce the law that is already established – making the practice and governing bodies clear – removing confusion!
- Make the model reflect what is supposed to be occurring instead of expanding roles to support what shouldn't be occurring.
- I am very worried about the safety of the public in the long term care, home health care, and public health settings (including schools) if this draft goes forward as is.
- Confusion is perpetuated by this. They (employers) understand that patient belongs to RN because of what we know of NPA as of now – it would be the same as changing the banking laws to conform to what is going on in practice and we can see where that would take us

General positive statement (A,D)

- I believe it does reflect the roles and differentiates.
- Model reflects roles as long as someone is properly trained, job responsibility may be delegated to them.
- Agree with everything
- Delegation is an important part of the various roles. Understanding the guidelines will help everyone – the clarification is needed especially related to the role of the LPN. For organizational and legal also.
- Who is ultimately responsible? Nurse is responsible for judgment in delegation – delegates must accept or not accept and are accountable – If LPN screws up – LPN is ultimately responsible.
- Whole face of health care has changed – this work is addressing that in this model – since last practice act revision
- I like legal versus organizational authority – helps answer questions like – can LPNs do IVs?
- To understand – must know roles/responsibilities – I have been an LPN for 35 years – like this – yes – I am legally responsible for my actions

- Delegation model – shows what is happening in practice
- Delegation is hard for me to teach – because LPNs are in charge in LTC – this helps me teach in LTC – would be useful
- OK for depicting nursing activities related to delegation
- Higher acuity in health care – must use to maximum use of their abilities to make safe judgments – LPNs are prepared to make a contribution – must validate what (in the model) LPNs can do very well
- This model is positive because of increasing responsibility and respect for clinical judgment and keep steps of process in there and be clear about link between model and narrative
- These changes (both models) should be implemented. We have all struggled with the role of LPN in the scope of practice and the delegation. This is great work. Please implement these clarifications.
- At Koronis Manor Nursing Home the Rn's and LPN's are currently working in a pattern which is consistent with your models and it is working well for staff, residents, and family members.
- Yes this fits my understanding of delegation and supervision.
- The meeting was helpful in understanding what the goals are for the models.
- The model is consistent but practice not always.
- The model reflects our understanding of the roles of APRN, RN, LPN, UAP
- Just stress they are guidelines and specific clarification is available.
- I think the model is long overdue. MNA has interpreted the nursing practice act and has limited the use of other staff. We need to work as a team to provide care in any setting. The Board needs to support the practice of all licensed staff. The Board is in control of the licenses and the roles yet practice is regulated by interpretation of other nursing organizations.
- Am on board with LPN delegation –

Model Unclear (A,D)

- I am asking for clarification – because RN is legally bound to what LPN delegates – does this mean there is some assessment and clinical judgment on part of the LPN in order to determine appropriate delegation? - and I don't see legal authority for LPN unless loop goes back to RN
- “Delegation” vs “assigning” tasks were not defined. Not clear in relation to legal authority vs. organizational authority. The law regarding LPN's and UAP's need to be clarified.
- Could use clarification – delegate from care plan vs. plan of care by another. Delegated and independent nursing functions.

Model Clear (A,D)

- She agrees the model is clear regarding legal and organizational authority. The ultimate responsibility is each licensed staff has a role and a license to practice. Each of us should understand the level of our practice and realize our responsibility.
- The model is very clear.
- I believe the process of delegation is clear in the model.
- The model does reflect my understanding of the delegation process and is clear and understandable regarding the influence of legal authority and organizational authority
- The model clearly identifies who may delegate, scope of each role identified clearly.
- The CNO, APRN, RN and UAP roles seem clear.
- Model is clear.
- Yes, clarifies – I was not aware of the APRN role. It is my experience all RN's have same role. The position defines their duties and responsibilities. Legal authority vs organizational authority is clear however the legal authority and organizational authority is always subject to questions – interpretation by individuals.
- It is clear. Every hospital puts their own spin on it. I (LPN) can make informed decision on delegation to the PCA/NA.
- The model is clear regarding the influence of legal and organizational authority to delegate
- Yes it clarifies because it is what I learning in nursing school. It addresses competence which is good. It is clear regarding the influence of legal and organizational authority because it states who has legal authority.
- The model reflects my understanding of the roles because the LPNs in our hospital work closely with the RNs in caring for our patients and follow through with care of the patients as delegated by the RN. The model clarifies because as an LPN I carry out tasks as directed by the RN and report my findings to her.
- The model for delegation is clear but may not be followed in practice. I have talked with LPN's in LTC who have delegated to RN's on more than a rare occasion.
- The model clarifies and differentiates roles and influence of legal and organizational authority.
- The delegation model is more clear – the other model (assessment) is less clear – we haven't been able to differentiate – this has been going on for 40 years
- I could use this in practice – clearer than other model
- Focus on authority is good clarification
- I believe it does clarify and differentiate roles and it's time we utilize staff to their capacity and quit arguing over technicalities.

- It does clarify who is responsible and who has the authority to delegate and definitely shows who reports to who and the responsibility of each.
- The delegation model clarifies and differentiates roles
- Model clarifies who is responsible and who to delegate to, therefore provides more direction.
- I think this will help clarify roles and responsibilities.
- Delegation model clarifies
- LPN's possess a legal and organizational source of authority to delegate/direct to uaps as bounded by the LPN's legal scope of practice and delegatee competence. Determining what to delegate and expected results determine to whom to delegate, communicate the delegation. The model clarifies.
- The identification and differentiation of legal and organizational authority helps to clarify the very complex topic of delegation.
- The proposed model for delegation is quite clear between roles and does reflect our understanding of the delegation process, with one exception. Currently, we would not expect a LPN to delegate to an UAP.
- The proposed model for delegation is clear. There is a distinct difference between roles regarding delegation.

Reformat Visual Presentation (A,D)

- Page 7 shows a graphic organizer – once well read, it is clear. Possibly lining up all the levels and listing the roles, responsibilities may make it easier to see the differences.
- It is clear, but a table would be more clear.
- Should be tiered – RN to LPN to UAP – If LPN delegates to UAP then this doesn't show LPN can delegate independently - doesn't address what stability is and who determines stability – How should LPN determine frequency of monitoring – parameters of what UAP reports back.
- Turn so is hierarchical
- Can the model include a feedback loop?
- We need three levels –
 - RN-case manager
 - RN – direct care
 - UAP – basic care
 - APN's need more training to fit this model

Positive Visual presentation (A,D)

- Recognize can't have full definition – need narrative, picture which helps sort it out.
- Like how legal and organizational authority are represented – think this is important

- The model reflects my understanding of the roles – RN and LPN staff delegate appropriate tasks to UAP. Open communication in both directions is important. The model is easy to visualize – nurses are working in many settings today – the model is fluid and would work for various settings.
- Overall, the model captures nicely the legal and organizational delegation functions and is visually pleasing.
- Yes, the placement and verbiage on the model make the legal authority and organizational authority influence clear. One note: In our organization currently, some APN roles report through the CNO but those that have practice agreements with physicians do not report through to the CNO. This limits the CNO authority base for these APN to influence. While this may vary from institution to institution, we believe APNs not reporting to the CNO is not uncommon.

General critique of model foundations (A,D)

- Does regulation follow practice or does practice follow regulation especially in relation to practicing outside of scope of practice – not recorded by the Board does not mean it is not happening – do we change the law or do we stop them?
- It has always been that the LPN does not delegate which is different from this model. It indicates that both RN and LPN delegate and this is confusing.
- Assessment and delegation should only be done by an RN
- It is confusing because it indicates that both RN and LPN delegate and my understanding has always been that the LPN does not delegate. Delegation should only be done by an RN or APRN, or CNO
- No. LPN's can delegate from the greater delegation to the RN. It is not lateral or without direction even to UAP – scope.
- The APRN and RN are the only ones who can delegate nursing tasks – the LPN and UAP can not delegate.
- The model does not clarify the roles of the levels of nursing in delegation. I also do not agree that LPNs delegate care. They work as part of a team in providing care that is laid out in the care plan by the RN. Again the RN uses her/his nursing process to develop that. The LPN and UAP report what they observe. The LPN directs the UAP but does not delegate.

Disagreement w/ legal/organizational authority of LPN (D)

- Legal authority does not cover LPN – RN develops care plan – in long term care – LPN knows tasks – does tasks but can't tell UAP to do enema for example. In this model – employer is dictating scope of practice – and ability of LPN to practice independently and sense danger with this without supervision by an RN – allowing employer to tell us what to do – not good patient care. The LPN is not prepared to do this.
- LPN is not an independent nurse and they must be under RN or MD at all times. RN is only independent nurse by law. This must be very, very clear.

- Be careful with organizational authority – is this expanding scope and does it conflict – LPN doesn't delegate – it is RN
- No, regarding legal/organizational authority - it is expanding the role more than what it is today

Change NPA (A,D)

- I think the current practice of the RN being the sole provider of care and the fear of their license needs to be addressed in the statutes. I think the model shows who is responsible and why.
- Why do we need charts when it is already written – just write nurse practice act to clarify rather than charts

Inconsistent NPA (A,D)

- It is not consistent with NPA
- but not consistent with NPA
- This is reality but incongruent with NPA
- The delegation model is not consistent with current MN regulations. The professional nurse in Subd 15 delegates care.
- statute unclear
- There is confusion between language of model and nurse practice act – should be consistent
- The narrative specifies that LPN may delegate – where is this in the nurse practice act? (Presenter referred to definitions of nursing assistant and nurse in statute MN Stat 148.171 Subd 9 & 12). Inappropriate to put “LPN delegates” when it is not in the law.
- Is not consistent w/ current regulation in my reading.
- The model expands the LPN role and is not consistent with regulation.
- The professional nurse (RN) is the only level of nursing who is to delegate to other nursing and non nursing personnel. If an LPN is able to delegate they must also train, supervise and evaluate and this is not supported by the NPA.
- The model was confusing for me. Delegation has in most part been the role/scope of practice for the RN. It is not consistent with regulation in my facility where I am employed.
- This is expansion of role in this model – not congruent with statute – at minimum – is inconsistent with statute even if you come in the back door – delegation by an LPN
- As an LPN educator – PN students are told they cannot delegate, only assign and students nurse's ask difference between assign and delegate
- Not congruent with current regulations
- This is dramatically expanding LPN practice in relation to NPA – very little difference in scope

- Read from rules – not consistent with rules and statutes
- Since the term supervision is not included within the definitions of practical nursing, we would interpret the model to be a change to current MN nursing regulations.

Consistent NPA (A,D)

- I believe it is congruent with current MN regulations.
- is congruent with NPA.
- is congruent with NPA.
- Congruent with NPA
- Consistent with MN regulation.
- Consistent with the NPA
- It is consistent with current regulation.
- Consistent with current regulation
- Is consistent with current MN nursing regulations.
- Model is consistent with current MN regulation
- It is to a certain extent consistent with MN NPA
- is consistent with current NPA.

Valuing LPN Practice (A,D)

- I feel that working with in a hospital in a rural setting is advantageous in the fact that there are fewer people on staff and therefore we work with the same RN's and LPN's on a daily basis which creates a sense of trust among us. Hospital policies and procedures further define our roles.

Thank You (A,D)

- Appreciate the board's attempt to clarify
- I think the committee has done a great job. It is something that has been needed for quite a while.
- We need to concentrate on the concepts vs. so much time and energy on the words. Very well done.
- Thank you for holding this meeting in Duluth. It is easier to drive one hour vs. three hours to the Twin Cities. Very nice program.
- Well done!
- Thank you for accepting the challenge to define the role of LPN and RN duties.

Minnesota Board of Nursing - Nursing Practice Committee
Analysis of Stakeholder Feedback 12

- Thank you for doing such a nice job of clarification on these topics.
- Thank you so much for all of your hard work with this. Lots of hard work and research. Please express this to your team.
- Thank you for your hard work on this longstanding concern.
- Thank you for the opportunity to share our comments
- Thank you.