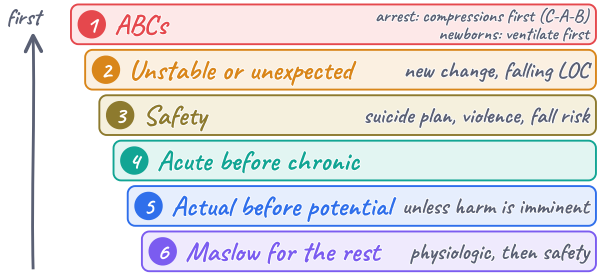
ER BASICS · ONE-PAGER

Prioritization and Delegation

Who to see first, five rights, scope, SBAR and escalation for NCLEX-RN and PN

19 sources + more detail
erbasics.com/sheets/prioritization-delegation.html
checked Oct 2026

PRIORITY The filters, in order



1 Who to see first

Use these filters together. ABC threats usually come first, then unstable or unexpected changes, then safety.

1. ABCs; in cardiac arrest, compressions first (C-A-B); newborns: ventilate first
2. Unstable or unexpected: new change, abnormal vital signs, falling LOC
3. Safety: suicide plan, violence, fall risk, wrong drug or client
4. Acute before chronic
5. Actual before potential, unless harm is imminent
6. Maslow for the rest: physiologic needs, then safety

PATTERN	SEE FIRST	CAN WAIT
Airway	New stridor or lip swelling after a drug	Stable trach, routine care due
Mental status	New restlessness or confusion	Confusion at baseline
Post-procedure	Just back; BP falling, HR rising	Day 3, pain controlled
Labs	Abnormal value with symptoms or ECG change	Stable value, routine follow-up

EXAM TIP Pick the client who worsens fastest without a nurse. Too little data? Assess first. Obvious danger? Act.

2 Five rights of delegation (NCSBN/ANA 2019)

Delegation hands a specific task to a competent delegatee who accepts it. The nurse stays accountable for the client, the delegatee for the task. Nursing judgment is never delegated.

RIGHT	ASK YOURSELF
Task	In the job description or written agency policy?
Circumstance	Is the client stable? A change means the nurse reassesses
Person	Trained, with validated competence?
Directions and communication	What, how, when to report; delegatee asks questions, changes nothing alone
Supervision and evaluation	Nurse follows up, evaluates, stays available

- Assignment: routine care within a person's usual role
- Delegation: a task beyond the usual role, after extra training
- Not competent? Delegatee declines. Unsure it is safe? Nurse does it
- No re-delegation; delegatee reports back if unable to finish
- Whole-client transfer is a handoff; RNs can still delegate tasks to RNs
- Agency policy can be stricter than state law, never looser

The 2026 RN test plan lists all five rights. Management of Care (15–21% of items) is its largest subcategory.

3 Who does what

Exam-level scope; state law and facility policy set real scope.

ROLE	USUALLY OK	NOT THIS ROLE
AP (UAP, CNA, tech)	ADLs, ambulation; VS, I&O, weight (stable); routine specimens	Assess, teach, judge; unstable clients; meds unless allowed
LPN/VN (LVN in some states)	Stable clients: data collection, routine meds, dressings, catheters, feedings	Admission/first post-op assessment, creating care plans, first teaching, evaluation, titration
RN	Admission/post-op assessment, care plan, teaching, evaluation, starting blood, unstable clients	Delegating assessment, initial teaching, evaluation or judgment

EXAM TIP The RN keeps Assess, Teach, Evaluate and the Unstable client. If an option needs any of these, do not delegate it.

SAFETY Feeding a client with dysphagia or a recent stroke is not routine AP work. The nurse does it, or AP with extra training, per policy.

4 NCLEX-PN: the LPN/VN lens

The 2026 NCLEX-PN calls this Coordinated Care (18–24% of items, its largest subcategory). The LPN/VN cares for clients with common problems and predictable outcomes.

- Collects data; the RN does the comprehensive assessment
- Contributes to the care plan; reinforces teaching
- Uses the five rights; assigns to AP or other LPN/VNs; monitors AP
- Tells the RN or supervisor when a status change means the assignment must change
- Delegates to AP only where state law allows

EXAM TIP PN items favor "collect data", "reinforce" and "report to the RN" over "assess", "teach" and "evaluate".

5 SBAR, handoff and chain of command

STEP	SAY	EXAMPLE
Situation	Who you are, which client, the problem now	4 West RN; John J, 68: BP 84/50, was 126/78
Background	Diagnosis, key history, treatment	Day 1 after bowel surgery, on heparin
Assessment	What you think is wrong	HR 124, pale; I think he is bleeding
Recommendation	What you need, by when; repeat back the reply	Please see him now; hold heparin?

- Handoff: face to face when possible, structured (SBAR or I-PASS)
- Receiver asks questions and confirms understanding
- Read back verbal orders and critical results; sender confirms (check-back)

Escalating an unresolved safety concern:

1. Tell the person directly (CUS: concerned, uncomfortable, safety issue)
2. Restate if ignored (two-challenge rule)
3. Charge nurse
4. Nursing supervisor or manager
5. Next medical or administrative level, per facility policy

SAFETY Never carry out an order you believe is unsafe; clarify and escalate. Anyone may stop the line for a serious safety breach. Deteriorating client? Call rapid response; staff concern alone is a common trigger.

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