Management of Care refers to the RN's responsibility to organize, coordinate, delegate, supervise, and evaluate client care to ensure that care is safe, appropriate, timely and effective.

CORE PRINCIPLE: The RN is the clinical coordinator and decision-maker.

Don't think: Who has time to do this task?
Think: Who is the most appropriate and qualified person to safely perform this task for this client?

ON THE NCLEX ASK YOURSELF:

- Which tasks are strictly done by the RN?
- Is the client stable or unstable?
- Is the person performing the task trained to do it?

DELEGATION AND ASSIGNMENT:

These concepts are closely related but should not be confused.

Before assigning a client, make sure to assess whether the client's needs and condition matches the nurse's capabilities.

REMEMBER: C-C-R-E-S-S

C lient stability: Is the client stable or unstable?
C omplexity: how complicated is the condition?
R equired skills: does the nurse have the skills?
E xperience: do they have similar clients before?
S cope: Is this within their professional scope?
S upervision:Can supervision be provided?

Remember: The task is delegated, but clinical judgment remains with the RN

The RN retains responsibility for:

- Determining whether the task is appropriate
- Selecting the appropriate person
- Providing clear instructions
- Supervising the task
- Reviewing the results
- Taking action when necessary

Delegate the TASK but not the NURSING JUDGMENT.

FIVE RIGHTS OF DELEGATION:

- Right person
- Right task
- Right circumstance
- Right communication
- Right supervision

	ASSIGNMENT	DELEGATION
Focus	Transfers both responsibility and accountability for the client	Responsibility for a specific task
Main question	**WHO** will care for this client?	**WHAT** will the person do in the care of this client?
Example	A charge nurse ASSIGNS a stable COPD client to the new staff nurse	The staff nurse DELEGATES measuring intake and output of CKD client.

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SCOPE OF PRACTICE

refers to the activities a healthcare professional is legally authorized and competent to perform based on their education, licensure, training, regulations, and facility policies

RN- Registered Nurse
LPN/LVN- Licensed Practical/Vocational Nurse
UAP- Unlicensed Assistive Personnel

ROUTINE CARE: Something that is done repetitively (e.g. ambulating, wound cleaning, turning client)

	RN	LPN/LVN	UAP
Scope	comprehensive nursing care and clinical judgment	routine nursing care for stable clients with predictable conditions	basic, routine care under nursing supervision
Type of client	ALL, whether stable or unstable	stable and predictable	stable and predictable
Clinical judgment	Performs independent nursing judgment	uses existing plan of care; identifies and reports changes	none required
Specific tasks	• ADPIE + Health education (NEVER DELEGATE FIRST AND LAST ASSESSMENT & TEACHING) • Both invasive and non-invasive • All types of medication administration	• Uses existing APIE or participates in making APIE + REINFORCING Education already provided by RN • ROUTINE TASKS • NO IV medications (Oral, ID, IM, SQ only)	• Data collection only (e.g., routine vital signs, I&O) — UAP do NOT assess • Basic and routine tasks • Hygiene and Grooming • Does NOT provide teaching • NO MEDICATIONS

Example
Post-op client has just been transferred to the unit for monitoring. Who will take the vital signs?

Answer: RN
Why: INITIAL assessment is ALWAYS done by RN. Next V/S can be delegated to LPN/UAP once the client is confirmed stable by the RN.

PRIORITIZATION

This is the process of determining which client needs attention FIRST, what action should be done FIRST, and what can safely wait.

Remember: The NCLEX is testing if you can spot the urgent problem and act before problems become life threatening.

THE GOLDEN RULE OF PRIORITIZATION

When several clients need care, think:
LIFE > SAFETY> FUNCTION> COMFORT

—LIFE
Airway, breathing, circulation, severe neurological changes (e.g., difficult to arouse, suddenly drowsy)
—SAFETY
Suicide, falls, violence, medication errors, environmental dangers
—FUNCTION
Mobility, nutrition, elimination, neurological function
—COMFORT
Pain, anxiety, routine symptoms, psychosocial

GENERALPRINCIPLES

- ABCs
- Maslow's Hierarchy of Needs
- Acute over Chronic Conditions
- Actual over Risk Diagnosis
- Unstable over Stable Condition
- Unexpected over Expected Assessments

1. A-B-Cs
AIRWAY- HIGHEST PRIORITY
If the airway is threatened, STOP everything else.

Warning signs:
- Stridor
- Choking
- Severe airway obstruction
- Drooling with airway compromise
- Tongue or airway swelling
- Epiglottitis

BREATHING
After airway, look for
- Hypoxia
- Severe dyspnea
- Cyanosis
- Tachypnea
- Increased work of breathing
- Abnormal respiratory pattern
- Restlessness due to hypoxia

CIRCULATION
After airway and breathing look for circulation problems.
Warning signs:
- Hypotension
- Altered mental status
- Cool, clammy skin
- Pallor
- Weak pulses
- Diaphoresis
- Prolonged Capillary Refill Time >2 secs

Remember: Before using ABCs and comparing clients, first remove clients who are:
- Stable
- Chronic- (e.g., COPD, DM)
- Expected (client with COPD with SpO2 of 90 %, client with pneumonia experiencing productive cough)
- Routine (bathing, feeding, wound dressing)

2. Maslow's Hierarchy of Needs
Prioritize from the bottom of the pyramid and then upwards.

PHYSIOLOGICAL (air, water, nutrition)
OVER SAFETY OVER PSYCHOSOCIAL (love, family,
intimacy) NEEDS.

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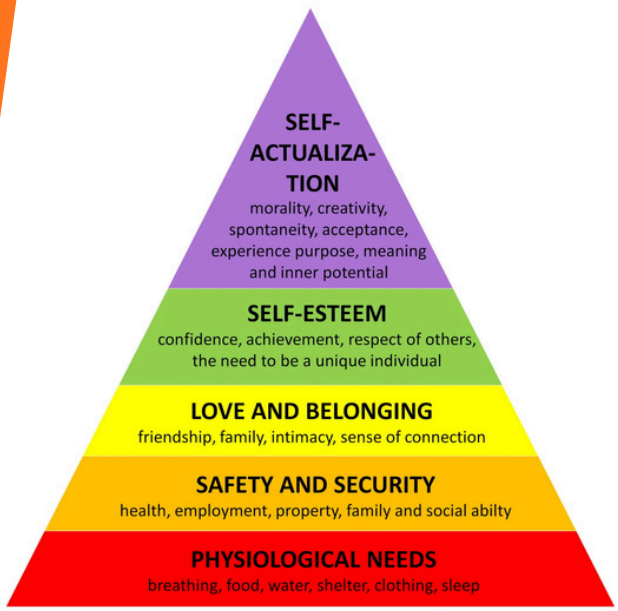

3. Acute over Chronic
Prioritize clients with new or sudden onset conditions over clients with chronic conditions.

Example:
Who will you see first, a 67-year-old woman complaining of sudden chest pain or 65-year-old man with history of COPD complaining of productive cough?
Answer: Sudden chest pain

4. Actual Over Risk Diagnosis
Prioritize a problem that is ALREADY EXISTING over a problem that is NOT YET PRESENT.

Example: A client with SpO2 of 90% from 98% or Vomiting client at risk of fluid loss?
Answer: Hypoxia

5. Unstable over Stable Clients
Prioritize clients who are experiencing CHANGES OR FLUCTUATIONS in assessments, or whose assessment data are abnormal, over clients with STEADY OR MINIMAL changes in assessments or assessment data within normal limits.

Example: Client with fluctuating SBP between 190 and 90 or client's BP steady at 90/60
Answer: Fluctuating BP

6. Unexpected over Expected Findings
Prioritize clients with new or unexpected assessment findings over clients with expected findings.

Example: Client with COPD suddenly developing bilateral edema or client with COPD with SpO2 of 89%.
Answer: New edema

Keywords: new, sudden, deteriorating, unexpected

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