# Prioritization and Delegation

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



## 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.

## 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.

## 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.

## 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".

## 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.

**Sources** (19) are listed with links at rnbasics.com/sheets/prioritization-delegation.html. For education and exam preparation only. Not medical advice; follow current guidelines and your institution's protocols. RN Basics is an independent study aid not affiliated with any certifying body.