

Scope of Practice Decision Tree

The purpose of this diagram is to help you decide whether or not to perform a specific action.

1. Describe the act to be performed, then review the Scope of Practice for your licensure level.

RN

LPN

APRN

2. Does the Nurse Practice Act expressly permit or prohibit this act for the license you hold?

Unsure

Permitted
(within scope for your license)

Go to
#4

Prohibited

3. Is the act consistent with your scope of practice?

Yes

No



4. Do you personally possess the depth and breadth of knowledge to perform the act safely and effectively?

Yes

No



until you gain additional knowledge

5. Do you personally possess current clinical skills to perform the act safely?

Yes

No



until you attain the clinical skills

6. Is the performance of the act within the accepted standard of care?

Yes

No



because performing the act may place both you and your patient/client at risk!!!

7. Does the agency have a policy and procedure in place for this activity?

Yes

No



because performing the act may place both you and your patient/client at risk!!!

8. Are you prepared to accept the consequences of your action?

Yes

No



because accountability is not assumed!

Perform the act

Notify appropriate person(s).



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RN, LPN and NA/UAP Duties 2024

Task	RN	LPN	NA/UAP
Medications: Oral	X	X	
Medications: Rectal	X	X	
Medications: G/J Tube	X	X	
Medications: IV Push	X		
Medications: IV Maintenance	X	X	
Medications: IV Antibiotics	X	X	
Medications: SQ	X	X	
Medications: IM	X	X	
Medications: Non-titrating Drips	X	X	
Medications: Titrating	X		
Medications: PCA	X	X	
Confirm & Verify Medication History	X	X	
Admission Assessments *	X		
Admission History Review	X		
Daily Assessments (after admission)	X	X	
Plan of Care: Initial	X		
Plan of Care: Updates	X	X	
Education (Initial)	X		
Education (Reinforce)	X	X	
Dressing Changes	X	X	
Wound Assessments (Initial)	X		
Wound Assessments (after initial)	X	X	
Tube Feedings	X	X	
Bathing	X	X	X
Ambulation	X	X	X
Oral Feeding	X	X	X
Toileting	X	X	X

Task	RN	LPN	NA/UAP
Performing EKGs	X	X	X
Interpreting Telemetry	X	X	
Vital Signs: Blood Pressure	X	X	X
Vital Signs: Pulse	X	X	X
Vital Signs: Temperature	X	X	X
Vital Signs: Pulse Oximetry	X	X	X
Central Line Assessments	X		
Central Line Flushes	X	X	
Central Line Dressing Changes	X	X	
Central Line Removal	X		
Apply/Discontinue Telemetry	X	X	X
IV Starts	X	X	
Remove Peripheral IV	X	X	
Clear IV Pumps for I&O	X	X	
Record I&O	X	X	X
Post Fall Assessment & Documentation	X		
Assign to NA/UAP	X	X	
Delegation to LPN	X		
Emergency Severity Index & Triage in ED	X		
Complete AM-Post Acute Care (if not initial one)	X	X	
Sign-off MD/APRN Orders	X	X	
Obtain telephone orders	X	X	
Obtain verbal orders	X	X	
Obtain electronic orders	X	X	
Change CBI Fluids	X	X	
Empty Urinary Catheters	X	X	X
Insert Urinary Catheters	X	X	
Remove Foley Catheters	X	X	
Patient Death Documentation	X	X	
Straight Cath	X	X	
Bladder Scan	X	X	X
Pain Assessment	X	X	
Pain Re-assessment	X	X	
Perform Hourly Rounds	X	X	X
Respond to Alarms	X	X	X
Restraint Initial Assessment & Documentation	X		
Restraint Reassessment Documentation	X	X	
Assign Education Videos	X	X	
Answer Call Bells	X	X	X

Task	RN	LPN	NA/UAP
Remove TR Bands	X		
Remove Fem Stops	X		
Complete Wound Forms	X	X	
Participate in Interdisciplinary Rounds	X	X	X
Trach Care	X	X	
Trach suctioning	X	X	
Oral suctioning	X	X	X
Oral care	X	X	X
Co-sign Insulin	X	X	
Co-sign Standing Order Infusions	X	X	
Co-sign Titrating Infusions	X		
Blood Transfusion: Vital Sign Documentation	X	X	X
PCA Pump Management	X	X	
Discharge Process (RN must do initial teaching)**	X		
Therapeutic Phlebotomy***	X	X	
Flush Nephrostomy Tubes in LTC	X	X	

*Once a care plan is established the LPN may do assessments.

** LPN can reinforce discharge teaching/plan. RN must do all initial assessments.

*** Must be under direct supervision of RN

Updated 4/10/24