Introduction

The law regulating the practice of nursing in Ohio and the rules promulgated by the Ohio Board of Nursing regarding implementation of nursing law are the standard by which Ohio licensed nurses are judged in relation to their ability to retain their licenses and practice nursing that safeguards the citizens of Ohio who seek health care. It is critical for nurses to be familiar with laws and rules that affect their practice. Since 2001, it has been a requirement for every licensed nurse in Ohio to attain at least one contact hour of
nursing law/rule continuing education every licensure period for license renewal. This independent study fulfills that requirement and gives the nurse information to relate the law and rules to nursing practice in any setting.

Review of General Information

The law regulating the practice of nursing in Ohio is generated by the Ohio General Assembly and signed by the governor of the state. Ohio has had a law regulating nursing practice since 1915. Legislative updates and changes occur periodically; the last major revision of the Ohio Nurse Practice act was in the mid-1980’s, though minor revisions have occurred periodically since that time. The official document is referred to as Chapter 4723 of the Ohio Revised Code, or notated as 4723 ORC.

The Ohio Board of Nursing is an agency of the state government created by the legislature to protect the public through regulation of nursing care. Among other things, the Board is empowered to regulate pre-licensure nursing education programs, make rules for practice, license nurses, and discipline nurses who have been found in violation of nursing law and rules. While registered and licensed practical nurses are the predominant groups regulated by the board is nursing, the board also has authority to regulate dialysis technicians, community health workers, and medication aides-certified. These latter three groups do not get licenses – they are issued certificates by the Ohio Board of Nursing and are considered among the groups of unlicensed assistive personnel.

There are thirteen members of the Board – eight registered nurses, four licensed practical nurses, and one consumer. Of the eight registered nurse members, one must represent one of the advanced practice categories (certified nurse practitioner, clinical nurse specialist, certified nurse midwife, or certified registered nurse anesthetist). Any licensed nurse in Ohio is eligible for appointment to the Board. Information about becoming a board member is available on the Ohio Board of Nursing web site at www.nursing.ohio.gov. Appointments are made by the office of the Governor of the State of Ohio, with attention to both geographic and practice diversity. The Board meets every other month at its office in Columbus, Ohio. All meetings are open to anyone who wishes to attend. While those attending are observers only, there is a public comment session in each meeting’s agenda, so anyone wishing to address the board can get on the agenda to do so.

The board of nursing also has advisory groups and ad hoc committees. Members of advisory groups are appointed by the board. Ad hoc committee members are selected as needed. These meet either by schedule or on an as-needed basis – information is available in Momentum or on the board’s web site. These are also public meetings.

The board exists for the primary purpose of protecting the public. The board is not an advocacy group for nursing; rather, it is a regulatory board to ensure public safety through the safe practice of nursing or safe function in the other roles under the jurisdiction of the board (dialysis technician, community health worker, medication aide-certified).
One of the functions of the Ohio Board of Nursing is to develop rules for practice. The rules are based on the law, which is in the Ohio Revised Code. Rules are in Chapter 4723 of the Ohio Administrative Code (OAC). All of the chapters of the rules book can be found in their entirety on the Ohio Board of Nursing web site, www.nursing.ohio.gov. Click on the “law and rules” link on the home page. Then you’ll find that each chapter is listed by both number and name – click on the chapter that you wish to read and you’ll have access to the full document.

Standards of Practice

There is a requirement that nurses maintain competent practice. There are various behaviors associated with competence that are noted in the chapter, including maintaining knowledge, demonstrating competence and accountability, and clarifying orders if in doubt. The rules do not specifically state what the nurse must do to be competent, as there are many ways to do this, and competence requirements will be different in different practice venues. It is the obligation of each nurse to assess his/her own competence and be sure that competence is maintained in the face of a rapidly changing healthcare system.

How do you maintain your competence? Maintaining knowledge is mentioned in the rules as one way to do this. Think about ways you keep informed about your practice. Do you read nursing journals? Visit professional web sites? Attend professional meetings and conferences? One thing you are required to do, as a licensee in the state of Ohio, is accrue twenty-four contact hours of continuing education every licensure period. The board notes, in the rules chapter on continuing education, that topics related to personal development are not appropriate for contact hours; you are required to obtain education specifically related to your professional development as a nurse.

The information learned in your basic nursing program is not adequate to guide your practice. Even within a year or two of graduation, new evidence may suggest changes in the way things are done. Doing something because “this is the way we’ve always done it” would not be an appropriate rationale for action in a disciplinary investigation. There are scientific principles that guide nursing actions, and nursing research is continually either validating or disproving common nursing behaviors. New data is typically published as an evidence-based practice document or issued by a professional organization as a “practice standard”. Maintaining competence means keeping current on changes that affect your particular type of nursing practice.

How do you maintain your competence if you are in clinical practice? Hospitals and other healthcare facilities typically have a means to do periodic assessments of employees to determine their competence in relation to performance of job skills. However, if you are practicing in a non-hospital setting, such as occupational health or school nursing, you may need to seek assistance from outside your organization if you find yourself dealing with an unfamiliar situation. Remember, too, that competence is not just performance of a skill - it requires application of critical thinking and clinical judgment regarding how, when, and why to provide what care to which individuals for what reasons.
What happens if you perceive yourself as being competent to practice on your assigned clinical unit, but you are asked by your nurse manager to “float” to another department or unit? Your accountability for safe nursing practice does not just relate to your assigned work area; it applies to everything you do under the auspices of being a licensed nurse. Therefore, if you float to another area, you are expected to be competent in the care you provide there. Keep several things in mind. First, you are accountable for your own practice. Your employer is not. You are the one who needs to make a decision, on a case-by-case basis, whether you consider yourself competent to perform a specific function. You have the right and responsibility to do those things you are competent to do; likewise, you have the right and responsibility to ask for assistance in those things for which you do not feel competent. The assistance may take several forms, including asking another nurse to perform the particular task, asking for someone to assist you in performing the task, or asking for education and training so that the task can be performed safely in the future.

Another facet of competence is to clarify orders if you have any doubt about their appropriateness for a particular patient or situation. Examples might include questioning medication types and/or dosages and timing of administration of certain treatments or medications. Critical thinking and assertive communication are essential tools for nurses to use to advocate for patient safety. When you see something that causes you to question patient safety, you are expected to speak up on behalf of the patient.

The rule (4723-4-03[E] OAC) specifically states that “a registered nurse shall, in a timely manner:

(1) implement any order for a client unless the registered nurse believes or should have reason to believe the order is
   (a) inaccurate;
   (b) not properly authorized;
   (c) not current or valid;
   (d) harmful, or potentially harmful to a client; or
   (e) contraindicated by other documented information.”

The next rule, 4723-4-03(F) OAC says that: “when clarifying an order, the registered nurse shall, in a timely manner:

(1) consult with an appropriate licensed practitioner;
(2) notify the ordering practitioner when the registered nurse makes the decision not to follow the order or administer the medication or treatment as prescribed;
(3) document that the practitioner was notified of the decision not to follow the order or administer the medication or treatment, including the reason for not doing so; and
(4) take any other action needed to assure the safety of the client.”

Similar wording in rules 4723-4-04(E) and 4723-4-04(F) covers the same issues for the LPN, who functions under the direction of the registered nurse or licensed physician.
Think about your accountability to your patient, and to your license, when you encounter situations where a medication is ordered or a treatment is proposed that might cause harm to the patient. Some nurses have said that they feel intimidated by other healthcare professionals and believe that when an order is issued, it must be followed. There have been many documented incidents of bullying and intimidation in the healthcare environment, and most facilities have adopted “no tolerance” policies for this behavior. There is clear evidence that every person involved in the patient’s care has a role to play in advocating for that patient. Report intimidating behavior to your supervisor so that it can be addressed through appropriate channels. Above all, remember that you have an obligation to speak up to protect your patient.

Yet another component of competent practice is to function as a member of the healthcare team. It is critical to remember that we’re not in this patient care business alone – we must work collaboratively with physicians, respiratory therapists, social workers, dietitians, laboratory technicians, physical and occupational therapists, and all other groups who are involved in total patient care. No one of us can do everything alone; we need each other and we need the skills and insights that each team member brings to the patient care team. That means, too, that we must share important information so that the whole team has a complete picture of what is happening with the patient and how different providers’ activities affect each other. Yes, there are HIPAA requirements to protect patient privacy, but it is allowed, and expected, for you to share information with other members of the healthcare team related to a patient’s plan of care. If you have questions about information that should be shared as opposed to information that should remain confidential, check with your facility’s privacy officer, risk manager, or other appropriate person to be sure of both legal requirements and your facility’s policies and procedures. Do not, however, allow patient safety to be compromised by lack of adequate information sharing.

Several sections of the rules chapter on standards of practice relate to client safety. One requirement is that licensed nurses must display their credentials when they are providing direct care. That means that the patient should always be able to see your RN or LPN credential. There is nothing in rule about name badges, use of pictures, use of first names/last names, or any other associated data – the rule in 4723-4-06(A) OAC only says that “At all times when a licensed nurse is providing direct nursing care to a client the licensed nurse shall display the applicable title or initials set forth in division (C) of section 4723.03 of the Revised Code to identify the nurse’s relevant licensure as a registered nurse or as a licensed practical nurse.”

Your facility may have a specific policy regarding ID badges, and of course you need to adhere to facility policy. However, you are accountable to the Board of Nursing for following the rules, so if your facility policy says that credentials are not to be worn, or are not required, you need to address this issue within your facility to be sure you are in adherence with rules.
If you work in an area where you do not have direct patient contact, such as a case management position where your work is telephonic, you are also required to disclose your credentials via telecommunication (email, voice mail, text messages, faxes, or any other type of non-face to face communication). This disclosure must be provided to clients as well as to those with whom you interact in the client’s behalf, such as physicians, therapists, etc. The credential refers to RN or LPN designation – not your title or role within your organization, such as "staff nurse" or "case manager".

It is worth noting that the Board of Nursing regulates registered and licensed practical nurses and those noted earlier in this study (dialysis technicians, community health workers, and medication aides-certified). The Board does not, however, have authority over others, such as medical assistants, receptionists in medical offices, or nursing assistants/technicians. Facility policy may require that these people wear or state their credentials, but only those regulated by the Board of Nursing are required to do so by OBN rule.

**Documentation** is another area addressed in rules related to safe practice. The stipulation is that documentation must be “complete, accurate, and timely” (4723-04-06 [E] OAC). What does this mean? Complete is pretty self-explanatory – information must be comprehensive and address the issue at hand, including your assessment, your interventions, and your evaluation of your nursing actions. Accurate is also clear, at least in theory. Your information should be a true picture of what happened or what was observed and written without bias, prejudice, or alteration of fact. Unfortunately, there have been cases in which nurses have been found to have falsified patient records. This is a violation of rule and jeopardizes the nurse’s license. Additionally, the nurse could find him/herself in court defending a claim of insurance, Medicare, or Medicaid fraud.

What about the timeliness of your documentation? How is “timely” defined? There is no definition for this word in 4723-4 OAC. If there was a disciplinary investigation into your practice, it would be up to you to justify that your charting was completed in a timely manner. A decision on what is “timely” might be based partially on the patient’s condition – certainly providing care takes priority over documenting, but the more serious the patient’s condition, the more important it is to have documentation completed quickly. Remember that your documentation serves as a communication tool to let other members of the healthcare team know what you have assessed and implemented. One approach many healthcare facilities have taken to facilitate timely documentation is to move the chart closer to the patient. Rather than having all charts in a centralized location, charts kept closer to the patient’s room are easier to access, so it is more likely that charting will be completed at the time care is being provided. Computerized documentation has aided this process – computers in patient rooms or on wheeled carts can expedite the documentation process. Note that there is nothing in law or rule that addresses how charting is done. While many facilities are moving to a computerized system, the “old” process of paper and pen documentation still works. The tool is not the issue – the requirement for complete, accurate, and timely documentation is the issue.
Nurses are expected to “delineate, establish, and maintain professional boundaries” (4723-4-06[I] OAC). What is a professional boundary, and how do you know when you’ve reached one? There is no definition for this term in rules, and it is the responsibility of each individual nurse to examine his/her own behaviors in relation to this issue. Generally, establishing "professional boundaries" refers to separating personal issues and relationships from professional issues and relationships. If you become too personally entrenched in the life and unique situations of your patient, you lose the ability to provide safe and effective care. You are more likely to show favoritism or to focus your activities differently than you would for other clients. Avoiding professional boundary violations protects both your practice and your patient’s integrity.

There are a number of standards of practice that relate to how we promote client safety. These include:

♦ 4723-4-06 (J) (1) OAC: “Provide privacy during examination or treatment and in the care of personal or bodily needs; and (2) Treat each client with courtesy, respect, and with full recognition of dignity and individuality.”

♦ 4723-4-06 (K) OAC: “A licensed nurse shall not: (1) Engage in behavior that causes or may cause physical, verbal, mental, or emotional abuse to a client; (2) Engage in behavior toward a client that may reasonably be interpreted as physical, verbal, mental, or emotional abuse.”

♦ 4723-4-06 (L) OAC: “A licensed nurse shall not misappropriate a client’s property or: (1) Engage in behavior to seek or obtain personal gain at the client’s expense; (2) Engage in behavior that may reasonably be interpreted as behavior to seek or obtain personal gain at the client’s expense; (3) Engage in behavior that constitutes inappropriate involvement in the client’s personal relationships or financial matters; or (4) Engage in behavior that may reasonably be interpreted as inappropriate involvement in the client’s personal relationships or financial matters.” There is a further clarification that “For the purpose of this paragraph, the client is always presumed incapable of giving free, full, or informed consent to the behaviors by the nurse set forth in this paragraph.”

♦ 4023-4-06 (M) OAC: “A licensed nurse shall not: (1) Engage in sexual conduct with a client; (2) Engage in conduct in the course of practice that may reasonable be interpreted as sexual; (3) Engage in any verbal behavior that is seductive or sexually demeaning to a client; or (4) Engage in verbal behavior that may reasonable be interpreted as seductive, or sexually demeaning to a client.” Again, there is clarification that “For the purpose of this paragraph, the client is always presumed incapable of giving free, full, or informed consent to sexual activity with the nurse.”

Some of the above items are self-explanatory. The requirement to avoid misappropriating (stealing) or seeking personal gain from a patient seems straightforward, as does the requirement that the nurse not be “abusive”. However, abuse can take physical, verbal,
mental, and emotional forms. A comment may be perceived by a patient or family member in a different way than it was intended by the nurse. Sometimes, nurses will talk among themselves and may make a comment that is overheard and perhaps misunderstood by a patient or family member. It is better to err on the side of caution – just avoid behaviors or words that may be perceived as hurtful, even when you are not talking directly with the patient.

There is a standard of practice related to RN and LPN use of nursing process. The registered nurse has five steps listed in his/her use of the nursing process: assessment, analysis, planning, implementation, and evaluation. The LPN has four steps listed for use of nursing process: assessment, planning, implementation, and evaluation. It is important to note that, by law (4723.01[F] ORC) the LPN carries out the steps of the nursing process upon receiving direction from the RN, a licensed physician, or a dentist, podiatrist, optometrist, or chiropractor, depending on the practice setting. In other words, the RN has the independent authority to implement the steps of the nursing process. The LPN functions at the direction of the RN or one of the other persons noted and does not have independent authority to assess a patient and thereby develop and implement a plan of care. The chart on the last page of this study identifies the specific items within each element of the nursing process that the RN or LPN is expected to perform. Note the terms “critical thinking and clinical judgment”, “nursing diagnosis”, and “expected outcomes” that appear within the RN functions. It is through use of critical thinking about a patient’s condition and plan of care that the registered nurse is able to determine who among the health team members is the most appropriate person to address the patient’s needs. Should a registered nurse be assigned to this patient today? Can direction be given to the LPN to take care of the patient? Can specific tasks related to the patient’s needs be delegated to an unlicensed assistant? These are clinical judgments made by the registered nurse based on use of critical thinking and analysis skills.

Delegation

Delegation is another issue that is referred to in Chapter 4 of the Ohio Administrative Code 4723 as a standard of practice. This is such an important process, though, that a whole chapter in the rules book has been devoted to it. Chapter 4723-13 OAC is specifically focused on how the registered nurse delegates to unlicensed assistive personnel or how he/she directs the LPN to delegate. Delegation is defined in 4723-13-01(C) OAC as “transfer of responsibility for the performance of a selected nursing task from a licensed nurse authorized to perform the task to an individual who does not otherwise have the authority to perform the task.”

There are several notable things about this definition. First, it refers to performance of a task, not provision of nursing care. You can delegate the performance of tasks that assist in providing care for the patient, but you as the licensed nurse are accountable for providing care. Think about the nursing process – you assess, analyze (RN), plan, implement, and evaluate. You are not delegating the whole nursing process; the task to be performed is only one part of the process of providing care. Second, the definition refers to licensed nurse. That means that either an RN or LPN can delegate to an unlicensed
person. Remember that the LPN practices at the direction of the RN, the physician, or a
dentist, chiropractor, optometrist, or podiatrist, so the LPN can delegate once he/she has
received direction to do so. For the RN, delegation is an independent decision. Third, it is
critical to remember that, even though an aide or assistant has been taught how to
perform tasks, this person has no authority to decide how, when, or on whom to perform
the task – that is your decision as the licensed nurse. The aide or assistant has no
authority to perform the task until receiving specific delegation to do so.

Detailed rules govern the process of delegation. The purpose of the rules is to be sure the
nurse uses good judgment in deciding who is best prepared to perform a given task; the
ultimate goal is safe patient care. The nurse who delegates a task to an aide becomes the
“delegating nurse”. If you delegate a task to an aide, then your shift ends and you leave
the unit, the oncoming nurse who replaced you becomes the “delegating nurse” for that
aide. It is important that communication between nurses and between the nurses and the
aides be very clear. The aide should always know who he/she is receiving delegation
from; this will be the person the aide should go to if there are questions or issues that
arise in the process of performing the task. An aide should never be performing tasks
without delegation.

According to 4723-13-05(D) OAC, prior to delegating a task, the nurse needs to *know*:

“(1) That the nursing task is within the scope of practice of the delegating nurse…”

“(2) That the nursing task is within the knowledge, skill, and ability of the nurse
delegating the nursing task”

“(3) That the nursing task is within the training, ability, and skill of the unlicensed person
who will be performing the delegated nursing task”

“(4) That the nursing task is delegable as defined in this rule”

“(5) That appropriate resources and support are available for the performance of the task
and management of the outcome”, and

“(6) That adequate and appropriate supervision by a licensed nurse of the performance of
the nursing task is available…”

The next part of the rule, 4723-13-05(E) OAC, states that prior to delegating a nursing
task the nurse needs to *do* the following:

♦ Identify the patient on whom the nursing task may be performed and a specific
time frame for performance of the task

♦ Evaluate conditions related to the delegation, including:
  ✓ The condition of the patient
  ✓ The type of care the patient requires
The complexity and frequency of the care needed
The stability of the patient
A review of evaluations performed by other licensed health care professionals

♦ Determine that the task is delegable if:
  ✓ The task requires no judgment based on nursing knowledge and expertise on the part of the unlicensed person performing the task
  ✓ Results of performing the task are reasonably predictable
  ✓ The task can be safely performed according to exact, unchanging directions, with no need to alter the standard procedures for performing the task
  ✓ The performance of the nursing task does not require complex observations or critical decisions be made with respect to the nursing task
  ✓ The nursing task does not require repeated performance of nursing assessments, and
  ✓ The consequences of performing the nursing task improperly are minimal and not life-threatening.

The nurse is accountable for the delegation. If you become aware that the person to whom you have delegated is not performing the task safely, or that conditions have changed so that it is no longer appropriate for the delegatee to perform the task, you are expected to intervene, and withdraw delegation if needed.

Think about the above list. You are expected to know the patient. Your assessment of the patient’s condition will help you in deciding who is the best person to perform a nursing task. If the patient’s condition is unstable and changing quickly, if equipment or procedures need to be altered because of special circumstances, or if it is important to monitor the patient carefully during performance of the task, it probably is not wise to consider delegation. Remember that you will be held accountable for your decision to delegate.

Delegation rules (4723-13-06 OAC) speak to what you should teach an unlicensed assistive person if you are providing education for him or her to perform a delegated nursing task. Your teaching needs to include information about universal precautions and infection control, information about why the task is performed and what goal it is intended to accomplish, and information on how to correctly perform the task. Once those issues have been addressed, your next job is to demonstrate the task, then have the unlicensed person provide a return demonstration showing that he/she can indeed satisfactorily perform the task.

Your job is not over once you have delegated the task. Rule 4723-13-07 OAC addresses supervision of the unlicensed assistive person performing a delegated task. As previously noted, you are accountable to be available to the assistant so that, if questions or unexpected issues arise, you can provide guidance and support. If you leave before the delegated task is completed, whoever relieves you becomes the “delegating nurse”.
“Supervision”, within the context of this rule, means “initial and ongoing direction, procedural guidance, and evaluation, and may include direct observation of the performance of the nursing task. The delegating nurse shall evaluate the performance by the unlicensed person of the delegated nursing task, the need for further instruction, and the need to withdraw delegation.”

This rule further stipulates that, if the patient is receiving care in a facility designed for the purpose of providing health care (like a hospital or nursing home), supervision must be direct, on-site supervision. In other words, the delegating nurse must be physically present in the facility while the delegated task is being performed. On the other hand, if the purpose of the place where the task is being performed is not specifically for the purpose of providing health care (like a public school or occupational health clinic), a registered nurse must perform an assessment of the patient to determine what supervision is appropriate. Factors to consider in this assessment must include the number of individuals requiring care and the health status of these individuals; the types and number of tasks to be delegated; the continuity, dependability, and reliability of the unlicensed person who will be performing the delegated task; the distance between settings and accessibility issues if the supervising nurse is covering more than one facility; and the availability of emergency assistance if the nurse is too far away from the setting to arrive in a timely manner if an unexpected problem occurs.

Summary

This independent study has addressed a number of issues covered in Ohio nursing law and rules regarding standards for practice, delegation, and other elements of importance to the licensed nurse. Laws and rules change from time to time; it is imperative that the licensed nurse review them periodically and adhere to them consistently. This will safeguard the nurse’s license, and, most importantly, promote patient safety.

References and Resources

Ohio Revised Code, Chapter 4723
Ohio Administrative Code, Chapter 4723
Momentum, Quarterly publication of the Ohio Board of Nursing
Ohio Board of Nursing Web Site: www.nursing.ohio.gov
### Use of the Nursing Process

<table>
<thead>
<tr>
<th>Assessment</th>
<th>RN</th>
<th>LPN</th>
<th>Assessment (contribute to)</th>
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<tbody>
<tr>
<td>Collect data (in person, direct, delegate)</td>
<td>Collect data</td>
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<td>Subjective</td>
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<td>Objective</td>
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<tr>
<td>Document collected data</td>
<td>Report to members of healthcare team</td>
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### Analysis and Reporting

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<tr>
<th></th>
<th>RN</th>
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<tbody>
<tr>
<td></td>
<td>Identify, organize, and interpret data</td>
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<tr>
<td></td>
<td>Establish, accept, or modify a nursing diagnosis</td>
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<td></td>
<td>Report to members of healthcare team</td>
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### Planning

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<th>RN</th>
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<tr>
<td></td>
<td>Develop, maintain, or modify the nursing plan of care, including establishing desired client outcomes and interventions</td>
<td>Contribute to the development, maintenance, or modification of the nursing plan of care</td>
</tr>
<tr>
<td></td>
<td>Communicate the nursing plan of care and modifications to members of the healthcare team</td>
<td>Communicate the nursing plan of care and modifications to members of the healthcare team</td>
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### Implementation

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<th>Implementation</th>
<th>RN</th>
<th>LPN</th>
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<tbody>
<tr>
<td></td>
<td>Execute current valid order or regimen</td>
<td>Administer prescribed medications and treatments</td>
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<td></td>
<td>Provide direct nursing care commensurate with education, knowledge, skills, and abilities</td>
<td>Provide direct basic nursing care at direction of RN, physician, dentist, optometrist, chiropractor, podiatrist, or CNP, CNS, CNM, or CRNA</td>
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<tr>
<td></td>
<td>Assist with care</td>
<td>Assist with care at direction of those noted above</td>
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<td>Collaborate with other nurses and other members of the healthcare team</td>
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<td></td>
<td>Delegate nursing tasks in accordance with applicable rules</td>
<td>Delegate nursing tasks in accordance with applicable rules</td>
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### Evaluation

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<th>RN</th>
<th>LPN</th>
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<tr>
<td></td>
<td>Evaluate, document, and report client’s response to nursing interventions and progress toward expected outcomes</td>
<td>Contribute to evaluation of client’s response to nursing interventions</td>
</tr>
<tr>
<td></td>
<td>Reassess health status, revise nursing diagnosis or nursing component of plan of care, make changes to nursing interventions as necessary</td>
<td>Contribute to revision of nursing component of plan of care based on evaluation data</td>
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<tr>
<td></td>
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<td>Document and communicate responses to nursing interventions</td>
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Developed by Pamela S. Dickerson, PhD, RN-BC
Based on Ohio Board of Nursing rules in effect as of 2/1/11, Chapter 4723-4-07 OAC and Chapter 4723-4-08 OAC