The Relationship between Data Collection by Unlicensed Assistive Personnel (UAP) and Nursing Assessment

The statutory definition for the practice of nursing includes the diagnosis and treatment of actual or potential health problems (ORS 678.010 (8). This identification of actual or potential health problems is accomplished through nursing assessment.

By administrative rule, OAR 851-045-0030 (2)
(e**) "Comprehensive Assessment"** means the extensive collection and analysis of data for the purpose of judging a client's health status and actual or potential health needs. Comprehensive assessment involves, but is not limited to, the synthesis of the biological, psychological, social, sexual, economic, cultural and spiritual aspects of the client's condition or needs, within the environment of practice for the purpose of establishing nursing diagnostic statements, and developing, implementing and evaluating a plan of care;

(h) **"Focused Assessment"** means an appraisal of a client's status and situation at hand, through observation and collection of objective and subjective data. Focused assessment involves identification of normal and abnormal findings, anticipation and recognition of changes or potential changes in client's health status, and may contribute to a comprehensive assessment performed by the Registered Nurse.

In order to conduct a nursing assessment, health data must be collected. For the purpose of this policy, **"Data Collection"** is defined as the gathering of client information for the purpose of contributing to an assessment of a client's condition, needs, or changes in condition.

Health data that is collected is used by the Registered Nurse (RN) or Licensed Practical Nurse (LPN) when performing a nursing assessment. Although unlicensed assistive personnel (UAPs) may collect data to contribute to the nursing assessment, UAPs may not perform the actual nursing assessment. Nursing assessment, whether comprehensive or focused, remains within the purview of nursing.

Therefore, whenever data is collected in order to assist with identification of actual or potential health problems, the RN or LPN, under the clinical direction of the RN or other licensed provider who has the authority to make changes in the plan of care, must perform a nursing assessment of the client to ensure that nursing knowledge and skill are applied when making clinical judgments or decisions.

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