

Delegation: A Core Competency for the Graduate Nurse

Carolyn Eschak

University of Victoria

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Supervisor: Carol McDonald, RN, PhD, Associate Professor, School of Nursing

Project Committee Member: Lynne Young, RN, PhD, Professor, School of Nursing

### Abstract

Delegation is central to nursing practice, thus, it is an expectation that the graduate nurse will have the knowledge, skill, judgment, and personal attributes to delegate nursing care effectively in today's complex healthcare environment. There has been inadequate preparation in prelicensure nursing education to prepare graduates for this essential competency. The goal of this project is, through an integrative literature review, to provide foundational knowledge of delegation in nursing. Themes arising from this review are then used to inform a curriculum blueprint designed for the instruction of the competency of delegation in a four year undergraduate nursing degree program. A theoretical framework of Caring Science, constructivist learning theory, and transformation pedagogy guides this process. The intent of this project is to offer to nurse educators and students support in their collaborative engagement with delegation as a core competency for the nursing graduate.

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## Delegation: A Core Competency for the Graduate Nurse

The work of the 21<sup>st</sup> century registered nurse (RN) is that of navigating patients through a complex health system; nurses occupy the roles of advocate, coordinator of care, educator, and supervisor of traditional nursing services (Villeneuve & MacDonald, 2006). No longer can the nurse be the sole provider of direct patient care as we look to a future with a worsening shortage of nursing labor and burgeoning patient needs. The American Nursing Association (ANA) and the National Council of State Boards of Nursing (NCSBN) (2006) declare “The abilities to delegate, assign, and supervise are critical competencies for the 21<sup>st</sup> century nurse” (n.p.). Delegation is an expectation of the nursing graduate in British Columbia, included within the leadership category of the entry to practice competencies (College of Registered Nurses of British Columbia, 2009). Hansten (2011) muses that through delegation “nurses would embrace their accountability as a freedom to facilitate the patient’s/family’s journey to their preferred outcomes rather than technicians complacently completing a checklist of tasks” (p.51). Since delegation is a core competency for the graduate nurse it is urgent that we examine how best to place this vital ability in the hands of future nursing leaders.

Dr. Fraser Mustard (1990) stated at a National Nurses’ Symposium,

Can you as nurses, evolve a healthcare system in which you relate not only to your role in the system, but also in which you relate to the broad changes in your society now taking place? Nobody has done that yet. If you, as a group, could do that, you would provide some leadership for the country (as cited in Canadian Nurses Association, 1993).

This project is my contribution to the voice of the group; as nurses we must take the opportunity to disseminate in praxis the richness of our nursing knowledge and in that quest we must delegate nursing tasks effectively. Delegation is not new to nursing; Florence Nightingale stated “But in both [hospitals and private houses], let whoever is in charge keep this simple question in

her head, (not, how can I always do this right thing myself, but) how can I provide for this right thing to be always done?" (as cited in NCSBN, 2005). As a nurse educator, my reply to Nightingale is that this can be accomplished through educating nurses and nursing students to delegate effectively. My answer resonates with the Canadian Association of Schools of Nursing (2011) statement that nursing education must respond to the changes in health care environments by preparing students to deliver safe, effective, competent, and ethical nursing care in complex, diverse settings. This project, through an integrative literature review, provides foundational knowledge about the competency of delegation in nursing which is used to ground the curriculum blueprint for the undergraduate nursing study of delegation. I am guided in this task by a theoretical framework of Caring Science, constructivist learning theory, and transformational pedagogy. It is my intent to add to the discourse of delegation in nursing and particularly nursing education through these offerings.

#### Statement of Problem

Delegation is a competency expected of the entry level nurse and essential to today's nursing care delivery systems. Three questions guide the purpose of this project: What is a nursing competency? What is the state of nursing knowledge of the competency of delegation? What undergraduate nursing curriculum blueprint incorporates themes relevant to developing knowledge, skills, judgment, and personal attributes key to delegation? Following a discussion that provides a definition of a nursing competency, an integrative literature review is presented to ensure that the curriculum blueprint created is underpinned with nursing knowledge from research and peer reviewed expert opinion. A significant component of this paper is the discussion of the literature findings and their relevance to the nursing roles of today. A chart of the articles is offered in Appendix A with a brief statement of the key findings or themes of each



article. Utley-Smith (2004) advises that professional practice is not static and the competencies of the profession must be continually reassessed and appropriately integrated in nursing curricula. A starting point for the goal of assessing and integrating delegation into nursing curricula is to secure a definition for a nursing competency and to explicate the theoretical framework which guides this project.

## **Background**

### **Competency Defined**

The future of nursing education is well served through a competency-based structure if those competencies remain relevant to the society within which nurses practice (Institute of Medicine, 2010; Villeneuve & MacDonald, 2006). The concept of a competency is applicable in all health care disciplines but a common definition for the term does not exist (Scott-Tilley, 2008). Scott-Tilley (2008) concludes that competencies in nursing bridge the gap between practice and education through enhancing the clinical judgment and accountability of students and ultimately improving patient outcomes.

CRNBC (2009) defines competencies as “Statements about the knowledge, skills, attitudes and judgments required to perform safely within an individual’s nursing practice or in a designated role or setting” (n.p.). Competency is “a complex know-how resulting from the integration, mobilization and marshalling of a set of capabilities and skills (which may be of a cognitive, affective, psychomotor, or social nature) and of (declarative) knowledge used effectively in situations with common characteristics” (Tardiff, 2006 as cited in Goudreau, Pepin, Dubois, Boyer, Larue & Legault, 2009). A collaborative of Canadian professional nursing bodies assembled to delineate entry level competencies for the graduate nurse define competency as “the ability of the registered nurse to integrate and apply the knowledge, skill,

judgments and personal attributes required to practice safely and ethically in a designated role and setting...personal attributes include but are not limited to attitudes, values, and beliefs” (Black, Allen, Redfern, Muzio, Rushowick, Balaski, Martens et al., 2008, p.173). Each of the definitions reviewed offer that competency includes knowledge, skill, and personal attributes which issue from the cognitive, affective, and psychomotor realm. The concept of a nursing competency underpinning this project encompasses the elements of knowledge, skill, judgment, and the personal attributes of attitude, belief, values, and self assessment. This definition will ground the discussion of delegation as a core competency for nursing.

### **Delegation as a Core Competency for Nursing**

The importance of delegation is clearly articulated by professional nursing associations and experts but has this translated to the preparation of graduate nurses through exposure to the content and clinical experience of delegation? Hansten (2011), in an open letter to nurse educators, issues a call to action to address the lack of delegation proficiency evident in the practices of registered nurses and new graduates alike. According to Utley-Smith (2004) nurse leaders rank as second highest the importance of the competency required by graduate nurses to coordinate and supervise ancillary staff in the implementation of the plan of care. The response of 3,265 front line nurse leaders to a survey assessing the proficiency of graduate nurses with regard to 36 competencies was to rate delegation as the lowest ranked competency with only ten percent of nurse leaders satisfied with the new graduate proficiency (Berkow, Virkstis, Stewart, & Conway, 2009).

The importance of delegation to patient outcomes is highlighted by Gravlin and Bittner’s (2010) study, which implicates ineffective delegation as a significant cause of missed patient care. Hansten (2011) comments that national error and patient data, studies of missed care, and

anecdotal evidence gathered through 20 years of educating nurses to delegate, supports her conclusion that nurses lack basic knowledge in delegation and it is urgent that a new generation of nurses be educated to lead at the bedside. Nurses must assume the leadership responsibility of delegation in their roles today. Inadequate preparation for this competency compromises their ability to lead the care giving team with the goal of optimal patient outcomes.

Delegation is a conduit through which professional nurses can ensure that the delivery of nursing care that is knowledge-based. In a discussion paper of the Canadian Nurses Association (CNA) (1993) the comment is made that “While the physical tasks of caring are taken for granted as part of ‘women’s’ work”, the knowledge base of nursing and nurses’ professional judgment and skills as decision makers and problem solvers in the provision of care are largely invisible” (CNA, 1993, p.5). This view of nursing has changed, in part because of the nursing shortage, and it is a pivotal time for nurses to assume leadership roles (Long, 2004). Now, more than ever, there is a need for nurses to “be prepared as knowledge workers, problem-solvers, and assertive leaders to meet patient needs in today’s and tomorrow’s complex health care environments” (Long, 2004, p.87). Delegation is the leadership tool which allows nurses to utilize their knowledge informed practice at the bedside through prioritizing skilled nursing care.

### **Theoretical Framework**

#### **Caring Science**

Caring Science holds a holistic view of humanity; humans are one with each other and share our place within the larger universe (Hills & Watson, 2011). Within the caring relationships between humans are the spaces for transformative growth and change both personal and evolutionary. The relational worldview of Caring Science honors the multiple sources of knowing humans draw upon as they construct wisdom and personal knowing through a process

of attaching meaning and understanding to new content (Hills & Watson, 2011). By extension, Caring Inquiry incorporates empiric evidence but embraces a wide range of inquiry that offers a multiplicity of evidence forms (Hills & Watson, 2011). The practical enactment of Caring Science occurs as praxis, a “reflective practice informed by disciplinary foundational values, theories, philosophical-ethical stance; informed by meaning, context, relations, and knowledgeable caring-healing practices; honoring deeply spirit-filled dimensions of humankind” (Hills & Watson, 2011, p.15).

The Caring Science lens with which to view the competency of delegation was carefully selected for the focus it places on authenticity and egalitarian human relationships (Hills & Watson, 2011). As Hills and Watson (2011) explain, the power within Caring Science must be distributed through the sharing of knowledge which has reciprocity with power and control. One may maintain authority without exerting an authoritarian, power over stance (Hills & Watson, 2011). Within the delegation relationship authority is held by those with the requisite knowledge and skills necessary for the provision of nursing care that ensures optimal patient outcomes. Delegation is an invitation to share this knowledge and, by extension, share power through a carefully orchestrated process of transferring knowledge and responsibility for a nursing task while maintaining accountability for the nursing process and the outcome of nursing care. Within the caring relationships between nurse, delegatee, patient, and family are the spaces for valuing human dignity and growth, for transformative learning, and authentic sharing.

From the ontological and epistemological perspectives, Caring Science allows the nursing knowledge of delegation to be informed by multiple ways of knowing and honors the evidence and understanding that is gained through praxis. The communication and relational skills required of delegation are informed by a view that holds respect for egalitarian

relationships and sharing of knowledge with a goal of transformational learning. Both constructivist learning theory and transformational pedagogy are approaches compatible with a Caring Science lens.

### **Constructivist Learning Theory and Transformational Pedagogy**

Constructivism maintains that learning is a process of socially constructing knowledge through integrating new content with previously held knowledge in ways that are meaningful to the learner (Young & Maxwell, 2007). As Young and Maxwell (2007) observe, constructivism in the realm of nursing education offers a relational learning environment wherein multiple ways of knowing are embraced and the content and method of teaching are compatible. Educators may enhance this constructivist learning process by creating opportunities for students to experience challenge to their worldview; encouraging their active engagement with the content of this challenge (Young & Maxwell, 2007). Pedagogical strategies which employ this technique draw upon transformational pedagogy.

Cranton (2002) declares that transformative learning is eloquently simple; an event challenges the worldview of an individual who upon critical examination opens his or her self to alternative views. The worldview held has been transformed through this meaning making process. Transformational pedagogy is predicated on this theory and the educator facilitates this process with students. Cranton (2002) relates that following an activating event, assumptions held are critically examined through a self reflective process. Learners must be open to alternative views as they engage in discourse that assesses and challenges their viewpoint. Assumptions are revised and a more open perspective gained; behaviors that demonstrate the transformed viewpoint are evidence of transformational learning (Cranton, 2002). According to Hills and Watson (2011) the transformational learning within a Caring Science requires four

components: “collaborative caring relationships”; “critical caring dialogue”; “reflection-in-action”; and a “culture of caring” (p.62). The application of transformational pedagogy within a Caring Science focuses upon the creation of strong, caring relationships between instructors and learners.

The choice of a Caring Science lens, constructivist learning theory, and transformational pedagogy to inform the undergraduate curriculum focused upon delegation as a competency for nursing resonates with delegation as a collaborative, knowledge-driven process. Student learning in an environment with collaboration, discourse, and shared power offers the opportunity that as “what is taught resonates with how it is taught” (Young & Maxwell, 2007, p.19). A constructivist learning approach, with transformational pedagogical strategies, offers teachers and students the environment to approach delegation with the intent to develop praxis grounded in caring relationships between team members. The bedside nurse has a pivotal opportunity and responsibility to translate the knowledge of nursing at the ‘bedside’ as the steward of nursing care through the delegation process. The theoretical framework that underpins this project has been selected with the optimism that student learners will become these stewards of nursing knowledge, able to use their relational skills to share knowledge, power, and the goal of safe care for patients with their delegates.

### **Methodological Approach**

Conducting an integrative literature review allows a cross section of data, both empirical and theoretical to inform nursing science and theory driven practice (Whittemore & Knafl, 2005). Using the literature framework suggested by Whittemore and Knafl (2005) I conducted a search of the Cumulative Index to Nursing and Allied Health Literature (CINAHL) and MEDLINE using the key words; nursing, delegation, and competence\*. A supplementary method of accessing articles was the hand searching of references of articles that were highly relevant to the topic. The exclusionary criterion was applied that

delegation must be discussed in terms of at least three of the elements of the definition of competency articulated above. Articles were not excluded by date however those predating 1995 were scrutinized for relevance to today's health care context.

Articles were reduced at three points: during the initial reading of the CINAHL/MEDLINE or hand searched article, when reread for the preparation of a summary, and during the conversion from summary to reduced data strings. The final count of articles was 42; 25 from the CINAHL/MEDLINE search and 17 from hand searching the references of highly relevant articles. Refining the 20 research based articles and 22 theory based articles resulted in the following breakdown: nine qualitative studies, nine quantitative studies, two mixed method studies, seven descriptions of a project or educational intervention, three statements of a professional organization, and twelve other theoretical articles.

An interactive process of constant comparison across data sources was used; data was organized in conceptual categories, one of the diverse methods suggested by Whitemore and Knafl (2005). Data was reduced from article summaries and the rereading of articles, then coded with the number assigned to the article and combined in a word document with other data in that conceptual category. Data in each category was compared in an iterative fashion that at times, required clarification through reference to the original article. The data was grouped according to emergent themes within the conceptual category. This process provided the structure for the discussion of literature findings guided by the categories described subsequently. A table of the 42 articles, found in Appendix A provides a brief summary of the key themes or findings of each article.

## **Integrative Literature Review**

### **Overview**

The literature reviewed spans twenty years with the earliest article published in 1992 and the most recent in 2012. The data drawn from the literature is organized in seven conceptual categories: delegation and the nursing role, the benefits of delegation, delegation defined, delegation as a competency for nursing, the outcomes of delegation, delegation and education,

and delegation and the stewardship of nursing care. The data in some categories is voluminous and is organized under subthemes which emerged as the data was reviewed and reduced. The intent is to capture both theoretical and research based content which will provide a foundation of knowledge used to ground a nursing curriculum blueprint. The data that issues from expert opinion and research based literature is combined in each conceptual category though I make clear data drawn from study results. I begin the examination of the literature, as many of the articles do, with a discussion of delegation and the nursing role.

### **Delegation and the Nursing Role**

Delegation has had an impact on nursing practice throughout history; Nyberg (1999) comments that nurses were the original assistive personnel and that many tasks within the scope of nursing practice today were once only delegated from physicians. The message from national and international nursing organizations is that globally nurses must address the need for nursing expertise in delegation; specifically knowledge of nursing accountability in delegation and how to delegate (CNA, 2005 cited in Saccomano & Pinto-Zipp, 2011). In British Columbia the use of delegation in nursing is ever increasing and it is vital that nurses demonstrate competence in delegation (CRNBC, 2007). Delegation is predicted to grow as the health care workforce better employs the skills of providers and as professional boundaries are challenged through role extension (Carr, 2005). The scope of nursing practice evolves in response to health care needs and according to Schluter, Seaton, and Chaboyer (2011) the motivating forces prompting changes in nursing practice today are the interfaces between nurses, other health professionals, and nurse assistive personnel (NAP).

The evolving role for Registered Nurses (RNs) from primary caregiver to the supervisor of, and delegator to, other care providers has been driven by the emergence of nurse assistive



personnel (NAP) (Alcorn & Topping, 2009; Anthony, Standing & Hertz, 2000; Coburn & Sturdevant, 1992; Conger, 1994; Curtis & Nicholl, 2004; Gravlin & Bittner, 2010, Hasson, McKenna & Keeney, 2012). Nurses now manage patient care processes for optimum patient outcomes as opposed to performing primary nursing roles where the RN provided the bulk of direct care (Conger, 1994; Kleinman & Saccomano, 2006; Nyberg, 1999; Saccomano & Pinto-Zipp, 2011). The RN role today makes vital the contributions of other caregivers and the skill of the RN as decision maker and provider of complex care (Ericksen et al., 1992 in Conger, 1994).

In their study examining the attitudes of RNs towards the role of the NAP, Alcorn and Topping (2009) surveyed 128 RN participants in an acute National Health Service Trust in the United Kingdom. Ninety-four percent of RNs disagreed that the development of assistive personnel would replace the RN role and 58% of RNs agreed that developing the role of the NAP would enhance patient care. The majority of nurses (88%) viewed it a part of the RN role to develop and teach the NAP (Alcorn & Topping, 2009). In short, the majority of RNs viewed their role as distinct from the NAP, and believed that patient care was enhanced by the contributions of the NAP with their development supported by RNs. Carr (2005) conducted a small study of community nurses in the U.K. Focus group data was gathered and analyzed. It was found that nurses are enthusiastic about the potential that delegation provides them to utilize their time and skills more effectively. However these nurses also express concern of role erosion citing the example of reduced number of working hours with the addition of skill mix to the team (Carr, 2005).

To this point the role development of the RN has focused primarily on clinical practice with little attention to the leadership role and delegation abilities inherent in that role (Saccomano & Pinto-Zipp, 2011). Quality patient care outcomes in the context of care delivery

through a mix of skilled providers requires that RNs use their time efficiently to identify patient problems, prioritize care, and optimize care delivery through the delegation of care (Kleinman & Saccomano, 2006). Challenging the RN is that delegation is now required in the complex settings of increased patient acuity and the extensive use of technology in care (Standing, Anthony & Hertz, 2001) and community or home settings where indirect supervision of delegation is required (Burbach, 1999). Alcorn and Topping (2009) comment that the demands and diversity of the RN role today may leave nurses confused about what constitutes delegation and where their accountability lies. The crucial ability to delegate, now facing the 21<sup>st</sup> century nurse, is the means to contend with the chaotic health care environment and its complex demands for nursing care (ANA & NCSBN, 2006).

#### **Delegation in today's healthcare environment.**

The reality of the healthcare workplace today holds fiscal restraint, nursing shortages, increased patient acuity, short hospital stays, advanced technology, and a changing skill mix of providers; changing the role of the RN through a focus on delegation and professional decision making (Anthony & Vidal, 2010; McInnis & Parsons, 2009; Parsons, 1998; Parsons, 2004; Schluter et al., 2011; Standing & Anthony, 2008; Thomas & Hume, 1998). Contributing to the focus on delegation is government policy which has shifted care from institutions to the community (Carr, 2005). The solution proposed for contending with increasing numbers of health consumers with disabilities and chronic health conditions is through nurse delegation to NAP providing services that allow recipients to remain in their homes (Reinhard, 2011).

Internationally the workload and responsibility of nurses has increased in response to health science and technological advances, new patterns of care delivery in institutions and the community, demographic changes, and disease patterns (International Council of Nurses, 2008).

Within this healthcare context, delegation is vital for the efficient use of nursing resources in the provision of safe, competent patient care (Kleinman & Saccomano, 2006; Powell, 2011; Quallich, 2005), in a collaborative and interdisciplinary environment (Kaplan & Ura, 2010). Nurses in Carr's (2005) study articulate that as they practice delegation a new clinical reality emerges. The clinical reality for nurses today requires skill and strategy to ensure basic and technical nursing care is delivered through a renegotiated patient proximity with the addition of the delegatee to the care team (Schluter et al., 2011).

### **Patient proximity and the nursing role.**

A key theme that emerges from Schluter et al.'s (2011) study of the nursing scope of practice is the view nurses hold of the "good" nurse working in close proximity to the patient, providing total care, and safeguarding the patient by ensuring all aspects of care are complete (p.1211). Studies of nursing care reinforce the view that close patient proximity provides the RN the opportunity to recognize subtle changes in patient status allowing early nursing intervention thereby decreasing adverse events and mortality, and improving patient outcomes (Kleinman & Saccomano, 2006). The evolving changes in healthcare have changed the proximity that the 'good nurse' may have experienced in the past. For nurses in the long term care environment the reality is that delegation is the primary method of ensuring that professional nursing standards reach the patient as 90% of nursing care is performed by Licensed Practical Nurses (LPN) and NAP (Corazzini, Anderson, Rapp, Mueller, McConnell & Lekan, 2010).

The act of delegation in all settings distances the nurse from the patient potentiating missed cues which herald a change in the patient's condition (Boucher, 1998). Nurses voice concerns that the delegatee will not 'see' the patient's needs as the delegator would, creating premature closure of nursing assessment once the delegation is set in motion (Carr, 2005). Carr

(2005) adds this potential reduction in the ability to identify patient needs is a disincentive to nurse delegation in the hospital setting and the community where supervision is challenged geographically as well. According to Schluter et al. (2011) the changing reality of patient proximity means that safe, effective care leading to positive patient outcomes must be negotiated in nursing care through practices such as delegation.

In Alcorn and Topping's (2009) study, 63% of RNs disagreed that developing the role of the HCA would result in a loss of patient contact for RNs; 20% agreed that contact would be lost. Alcorn and Topping note though a heavily contested issue in the literature, the majority of the 128 participants of this study are positive about the RN retaining proximity to the patient. Carr's (2005) study revealed that nurses voiced difficulty in delegating routine care due to their concern about the ever evolving needs of patients. Hansten (2008) notes that though we lack evidence about how to maintain nursing vigilance through the use of assistive personnel we can apply common sense in assuming that skilled delegation will prevent omitted care and unobserved patient decline.

### **Negotiation of a new patient proximity through delegation.**

Negotiation is the underlying pattern in nursing care which promotes safe, effective care for patients through collaborative efforts such as delegation in the context of a new clinical reality for nurses (Schluter et al., 2011). Nurses articulate that safeguarding patients through renegotiated proximity involves deciding what can be safely delegated and what cannot be (Schluter et al., 2011). Boucher (1998) observes that safe nursing care requires the nurse to maintain a presence with patients. The distance between nurse and patient can be bridged through effective delegation and skilled communication that provide the patient's voice and clinical cues to reach the nurse through the NAP (Boucher, 1998). The negotiation of

occupational boundaries is a key element of delegation that requires debate in order to promote nurses' understanding of their roles and increase their confidence in delegation as a valuable competent of nursing practices (Carr, 2005). Change is difficult, and RNs have expressed frustration with the changes to the RN role that they believe accommodate the agenda of the wider health care community rather than that of nursing leadership (Spilsbury & Meyer, 2005 as cited in Schluter et al., 2011).

Nurses articulate that their role as the guardians of patient care requires them to assume tasks not completed by others whilst knowing this work should be delegated to allow them better use of their knowledge and skill (Schluter et al., 2011). Negotiation is limited by the frustration, stress, and anger that often stems from the attempt to provide total patient care rather than to delegate care within care delivery systems requiring delegation (Schluter et al., 2011). Though delegation is essential in today's workplace, Hansten (2008) suggests many nurses, both novice and experienced, do not know how to delegate. In summary, nurses who perceive that good nursing requires direct bedside care are confronted with a clinical reality that demands delegation of patient care in the context of constrained resources and shortages of skilled personnel. There is challenge for the practicing nurse coping with changes to the nursing role and workplace; by extension there will be significant challenge for the graduate nurse unless the education system has prepared them for this role.

### **Graduates encounter a new clinical reality.**

There is an expectation that the graduate nurse will have the delegation and supervisory abilities required for collaborative practice in today's multidisciplinary care teams (Henderson, Sealover, Sharrer, Fusner, Jones, Sweet & Blake, 2006; Saccomano & Pinto-Zipp, 2011; Simones, Wilcox, Scott, Goeden, Copley, Doetkott & Kippley, 2010; Thomas & Hume, 1998).

According to Hertz, Yocom, and Gavel (2000) 85% of novice RNs report that they delegate on average 2.6 times per day and about 33% that they evaluate the care performed by other caregivers on average 2.4 times per day (as cited in Kleinman & Saccomano, 2006). Canadian graduates comment that delegation is an entry job expectation and most express concern about their lack of knowledge regarding delegation and the roles of other providers (Thomas & Hume, 1998). Graduates of baccalaureate programs find themselves assuming charge nurse roles even as novice nurses because of their credentials, and they voice that floating between institutions and encountering varied descriptions of nurse extenders make establishing the relationships that facilitate delegation difficult (Thomas & Hume, 1998).

Nurses describe that novice nurses encounter more conflict with delegation to NAP and comment that this conflict compromises the opportunity to achieve effective delegation in their practices (Potter, Deshields & Kuhrik, 2010). In Bittner and Gravlin's (2009) qualitative study, novice nurses are adamant that their role uncertainty in delegation prevents them from delegating care to the NAP; their inability to delegate makes their work load onerous. The literature makes clear that nurses, including new graduates, are working in environments that require them to be managers of patient care with the ability to delegate effectively and supervise that delegated care for optimum patient outcomes. With a sense of the importance of delegation in nursing and the urgency that this issue commands I turn to examine what benefits delegation may confer on the practice of new graduates and established nurses alike.

### **The Benefits of Delegation**

The literature makes clear that nurses must be responsive to changes in health care that demand their skills as leaders at the bedside. There are benefits for nurses that issue from the practice of delegation. Effective delegation allows the nurse time to perform more complex

activities that are specific to the RN role (McInnis & Parsons, 2009; ANA & NCSBN, 2006), satisfaction related to nursing autonomy (McInnis & Parsons, 2009; Quallich, 2005), enhanced time management (Curtis & Nicholl, 2004; Quallich, 2005), and promotional opportunities through professional and personal growth (Curtis & Nicholl, 2004; McInnis & Parsons, 2009; Thomas & Hume, 1998). According to Corazzini et al.'s (2010) descriptive study of 33 nursing leaders, delegation compels the RN to monitor staff, to match resident needs with staff skills, and allows more time for nurses to observe residents thereby assessing the outcomes of delegation and refining the processes for managing patient needs. Teamwork is improved through the positive work environments created through empowering staff (Corazzini et al., 2010; McInnis & Parsons, 2009) with increased responsibility and involvement that encourages them to take their roles seriously (Corazzini et al., 2010). McInnis and Parsons (2009) add that delegation builds confidence in and trust between team members through enhanced communication, teamwork, and leadership skills. The RN assists with developing the abilities of the assistive personnel (ANA & NCSBN, 2006); benefits for the delegatee are enhanced knowledge and skills, increased competence, confidence, morale, motivation, job performance, and interpersonal skills as well as understanding and appreciation for the work of others (Curtis & Nicholl, 2004).

Focus groups of Canadian baccalaureate graduate nurses articulate the following benefits of delegation: a broad perspective of nursing care delivery; the promotion of teamwork and satisfying staff relationships; the ability to hold authority; decreased stress and risk of physical injury to nurses through efficient time management and shared physical labor; and the provision of quality care for clients (Thomas & Hume, 1998, p.40). Curtis and Nicholl (2004) suggest that the benefits of delegation allow leadership for nurses through improved managerial skills such as conflict resolution, evaluation, people management, and policy construction. Delegation offers

the potential for RNs to provide nursing services to a greater number of clients and to promote the efficient use of another's knowledge and skill including the client who may elect to direct facets of her or his health care (CRNBC, 2007). Client teaching by the RN supports the client's ability to provide direction during the delegated task performance; improving the likelihood of safe, optimum client outcomes (CRNBC, 2007). Nurses contribute to work system stability when delegating as redundancy is decreased and accountability ensured (Corazzini et al., 2010), and the best use of human resources is achieved (Curtis & Nicholl, 2004). With regard to nurses desiring proximity to their patients, Gravlin and Bittner (2010) comment that delegation may decrease the work environment inefficiencies that keep the RN from the bedside. From a system perspective delegation clearly has the potential to offer cost effective care for patients (ANA & NCSBN, 2006; Curtis & Nicholl, 2004; Quallich, 2005) however when practiced effectively there are benefits for all the participants of the delegation of care. As I shift to a detailed examination of delegation the obvious entry point is to clarify what nursing delegation is.

### **Defining Delegation**

#### **The professional regulatory body defines delegation.**

Perhaps the most vital component of this section is to begin with the declaration that the definition of delegation for each practicing nurse to fully understand and practice within is that of the nursing regulatory body which regulates his or her practice. Within Canada, nurses are guided in their definition of delegation by the provincial professional nursing regulatory body which regulates their practice (Hirst & Foley, 2001; CRNBC, 2007). Delegation in the United States of America (USA) is legally defined by each state's nursing regulatory body, the Board of Nursing, which oversees the Nurse Practice Act (NPA) addressing delegation (Burbach, 1999; Henderson et al., 2006; Reinhard, 2011; Simones et al., 2010). Legislation in Australia restricts



the practice of nursing to licensed nurses placing delegation under the RNs' supervision (Schluter et al., 2011). In the United Kingdom there is no legal definition of delegation leaving open to interpretation the tasks that can be delegated (Cipriano, 2010 as cited in Hasson et al., 2012). The language of these regulatory documents is often broad and open to interpretation (Quallich, 2005; Simones et al., 2010) and the boundaries of nursing practice are always in flux due to the continual change in the context of healthcare (Simones et al., 2010).

Though nurse delegation in the USA is addressed at the state level, nursing practice often lags behind as nurses have inadequate knowledge and skill to implement delegation in practice (Reinhard, 2011). The state boards of nursing throughout the USA commonly field questions about delegation, supervision, and the scope of nursing practice from nurses at all levels of practice (Simones et al., 2010). Quallich (2005) cautions that nurses in the USA remain confused about delegation in part because of the vague guidance offered by nurse practice acts which leave nurses unsure of their legal role in delegation when delegation becomes a job requirement. Clearly, each nurse must seek out the definition of delegation as defined by their regulatory body as an entry point to understanding the concept of delegation in order that they may build practical knowledge upon this understanding.

The ANA and NCSBN (2006) issued a joint statement on delegation intended to support safe, effective delegation in nursing practice and promote recognition of delegation as an essential competency. The definition of delegation provided within the Joint Statement defines delegation as "the process for a nurse to direct another person to perform nursing tasks and activities" which involves "the transfer of authority (NCSBN)" or the "transfer of responsibility (ANA)" while the nurse retains accountability for the delegation (n.p.). This definition is used throughout much of the literature to underpin the discussion of delegation (Anthony et al., 2000;

Anthony & Vidal, 2010; Anthony et al., 2001; Conger, 1999; Curtis & Nicholl, 2004; Kleinman & Saccomano, 2006; McInnis & Parsons, 2009; Nyberg, 1999; Potter et al., 2010; Quallich, 2005; Reinhard, 2011; Timm, 2003; Weydt, 2010). CRNBC (2007) defines delegation as the transfer of task performance from the RN to the unregulated provider; the task is within the RN scope and outside of the role description and training of the unlicensed caregiver. According to CRNBC (2007) the delegated task is client specific and in the best interest of the client; the delegating RN retains responsibility and accountability for the decision to delegate and the process of delegation including supervision.

### **Definition and associated concepts.**

Knowledge of the Nurse Practice Act that governs delegation in practice is enhanced with a thorough understanding of the concepts inherent in delegation: authority, responsibility, and accountability (Weydt, 2010). Burbach (1999) explains that authority is both formal and functional. Formal authority is granted through professional licensure (Burbach, 1999; Weydt, 2010) and through one's position in an organization (Burbach, 1999). Functional authority is grounded in one's experience, knowledge, and personality characteristics (Burbach, 1999, Conger, 1999). The span of authority allows the nurse to delegate tasks held within the scope of nursing practice; the nurse may delegate tasks but not those functions that comprise the nursing process (ANA & NCSBN, 2006; Burbach, 1999; College of Registered Nurses of British Columbia, 2007).

Responsibility, according to the American Nurses Association (2001), is the liability for duties performed in a specific role (as cited by Weydt, 2010). Weydt (2010) clarifies that responsibility accompanies the task; therefore responsibility for task completion and the quality of task performance is transferred from delegator to delegatee. The act of delegation transfers

both authority and responsibility from the RN to the delegatee for the performance of a specified task (Burbach, 1999; Coburn & Sturdevant, 1992, Weydt, 2010; ANA & NCSBN, 2006). While authority and responsibility for a task may be transferred, the RN retains accountability for all aspects of the nursing process, for supervision of the delegatee, and the evaluation of the care outcomes (ANA & NCSBN, 2006; Burbach, 1999; CRNBC, 2007; Hirst & Foley, 2001; Kleinman & Saccomano, 2006).

Accountability is determined by the nurses' scope of practice delineated by the professional body regulating nursing practice (Burbach, 1999). According to CRNBC (2007) accountability is "the obligation to answer for the professional, ethical and legal responsibilities of one's activities and duties"(p.24). Burbach (1999) concludes that the RN's accountability extends to the patient, professional organization, and employer; to delegate prudently in a way that does not threaten patient safety. The complexity in the relationship between accountability, responsibility, and authority must be underscored as RNs often struggle with the notion of surrendering responsibility and authority whilst retaining accountability (Alcorn & Topping, 2009; Burbach, 1999). The design of traditional care models such as primary nursing kept the RN at the bedside facilitating accountability for care outcomes (Kleinman & Saccomano, 2006). As discussed previously, the changing patterns of care delivery compel RNs to renegotiate their patterns of ensuring accountability with an altered patient proximity.

Assignment, not a component of delegation, is often confused with delegation and nurses must understand the difference between the two concepts (Burbach, 1999; CRNBC, 2007; Weydt, 2010). Assignment occurs when the RN directs another staff member to perform tasks seated within the role description of the assigned caregiver whereas delegation requires that the transferred task falls within the RN scope but outside the scope of the delegatee (CRNBC, 2007;

Burbach, 1999; Parsons, 2004; Weydt, 2010). There is no transfer of authority involved in assignment; the caregiver receiving the assignment is accountable and responsible by way of the authority conferred by their scope of practice or job description (Burbach, 1999). In both delegation and assignment the RN remains responsible and accountable for the functions of the nursing process: assessment, planning, interventions, and evaluation (CRNBC, 2007).

Supervision, like assignment, may be confused with delegation. The delegating RN must supervise the delegatee's task performance through directing and monitoring the activity. This singular aspect of delegation is not to be confused with the supervision of staff working within their scopes of practice (Burbach, 1999). Burbach (1999) clarifies that assignment and general supervision require no transfer of authority. The deceptively simple definition of delegation as the transfer of task and retention of accountability is made complex by the multifaceted concepts which the RN must have knowledge of.

Timm (2003) offers this comprehensive definition of delegation, the end product of a concept analysis of delegation, which summarizes the relationships between the concepts of authority, responsibility and accountability:

Delegation is a legal and management concept and a process that involves assessment, planning, intervention, and evaluation in which selected nursing tasks are transferred from one person in authority to another person, involving trust, empowerment, and the responsibility and authority to perform the task. In delegation, communication is succinct, guidelines are closely delineated in advance and progress is constantly monitored in which the person in authority remains accountable for the final outcomes (p.264).

Timm's (2003) definition of delegation, congruent with that of the joint statement, illustrates the view that delegation has two major components, the concept and the process of delegation.

Parallel views are that delegation is a condition and a process (Potter et al., 2010), a structure and a process (Standing & Anthony, 2008), and the decision to delegate and the process of delegation

(CRNBC, 2007). To this point the definition of delegation has focussed on delegation as a concept, condition, or structure; I turn now to the discussion of the procedural aspects of delegation.

### **Delegation defined as a process.**

Delegation is a process, similar to the nursing process, with the procedural steps of assessment, planning, intervention, and evaluation (Burbach, 1999; Timms, 2003). These steps underpin CRNBC's (2007) process of delegation which includes six key elements: "Determine agency policy regarding delegation"; "Establish that the unregulated care provider has the necessary knowledge and skill to perform the task"; "Establish supervision and support mechanisms"; "Establish the type and amount of ongoing nursing care required by the client"; "Clarify responsibility and accountability"; and "Evaluate outcomes" (p.17-18). CRNBC (2007) offers flow charts to guide both the decision to delegate and process of delegation; a similar decision making tree is offered to support the delegation process described by ANA and NCSBN (2006).

According to ANA and NCSBN (2006) delegation is a decision making process, informed by the "five rights of delegation" and consisting of the following steps: "assessment, planning, communication, surveillance and supervision, evaluation, and feedback" (n.p.). The "five rights of delegation" encompass: "The right task"; "Under the right circumstances"; "To the right person"; "With the right directions and communication"; and "Under the right supervision and evaluation" (ANA & NCSBN, 2006, n.p.). The literature demonstrates wide acceptance for the five rights of delegation as foundational to the delegation process (Anthony et al., 2000; Anthony & Vidal, 2010; Anthony et al., 2001; Conger, 1999; Kleinman & Saccomano, 2006; McInnis & Parsons, 2009; Potter et al., 2010; Standing et al., 2001). Potter et al. (2010)

state that the 'five rights' place appropriate emphasis on the approach an RN should take to delegation as well as the communication and supervision essential for effective delegation. In their study assessing student knowledge of delegation, Henderson et al. (2006) utilized the five rights of delegation as the criteria for defining delegation. The findings in this study reveal some students confused the five rights of medication with the five rights of delegation. Despite this Henderson et al. (2006) recommends that educators adopt the five rights to guide student practice as this is the criteria utilized by the NCSBN to assess entry level nursing knowledge.

The American Association and College of Nurses (1995) has constructed a decision grid for delegation which supports the evaluation of nursing interventions for suitability as delegated tasks (as cited in Burbach, 1999). The grid assists the nurse to assess delegation as a client centred process but does not include assessment of the competency of the delegatee. Conger (1994) developed the Nursing Assessment Decision Grid (NADG) as a tool to instruct delegation decision making. The NADG guides the nurse through a series of steps which analyze nursing tasks and patient problems; increasing the skill of the RN to delegate appropriately and confidently (Conger, 1994; McInnis & Parsons, 2009; Parsons, 2004). Though tools are available to guide the nurse through the process of delegation, critical thinking, clinical judgment, and confident decision making are required.

### **Delegation as an art and skill.**

Delegation is an art and skill (Burbach, 1999; Coburn & Sturdevant, 1992; Conger, 1994); skill is required to work through others, monitoring and evaluating the outcome of the delegation (Coburn & Sturdevant, 1992). Essential attributes of the delegator are the abilities of: critical thinking (Hansten, 2008, Hirst & Foley, 2001), clinical judgment (Hansten, 2008, Hirst & Foley, 2001; Weydt, 2010), positive attitude (Hirst & Foley, 2001) emotional intelligence, and

innovative, flexible leadership (Hansten, 2008). The complex skill set that defines delegation must be guided by professional principles (Anthony & Vidal, 2010) and requires academic preparation and clinical practice to develop (Anthony et al., 2001). Anthony & Vidal (2010) comment that it is vital that nurses do not rely on standardized policies alone when making delegation decisions. The complexity of the health care environment demands nurses take a flexible, creative approach to delegation that reflects both patient need and the context of care rather than the dogmatic approach of following policy alone (Anthony & Vidal, 2010). Few studies have examined how nurses, the skilled artists, define delegation however the perceptions gathered by researchers in the studies included in this review are informative.

### **Nurses define delegation.**

Fifty-eight home care case managers (38 RN) in Calgary, participants of Hirst and Foley's (2001) study, define delegation as the transfer of responsibility from one person to another for the performance of a task but the retention of accountability. This definition is congruent with that of the ANA and NCSBN (2006) Joint Statement. Findings from this qualitative study also make clear the complexity of delegation according to the case managers' views that the following roles are essential when delegating care: "assessor", "planner", "provider/facilitator", "evaluator", and "advocate" (Hirst & Foley, 2001, p.304). The main assumptions articulated by these focus group participants, depicted in a model of delegation, are as follows: Delegation is an individual case manager's responsibility; delegation is made of a task not a client; "delegation is based on observable and verifiable practices according to the professional practice legislation, ethics, knowledge, skill and safety"; delegation is an active process that requires the delegator to identify client need and contextual factors, maintain responsibility, and supervise as required; delegation practices are integral to professional

practice; and contextual factors must be considered in delegation decisions ( Hirst &Foley , 2001, p.305).

The definition of delegation provided by 10 of 17 acute care nurses in Standing et al.'s (2008) study is congruent to that of the Joint Statement of The ANA and NCSBN (2006). Standing et al. (2008) found problematic that the remaining participant definitions of delegation included assigning lunch breaks, directing physicians, and supervising NAP. Equally concerning to Standing et al. (2008) was that many participants did not view nursing care which fell within the job description of the UAP as delegated care. According to the CRNBC definition of delegation, the tasks in the latter example would not be delegated care but rather assigned care. This example illustrates the importance for nurses to be familiar with the definition of delegation provided by their regulatory body.

Potter, Deshields & Kuhrik's (2010) qualitative study finds the ten RN participants describe the process of delegation in terms of the 'five rights' of delegation with particular emphasis on the importance of the 'right person'. The RN participants verbalized the importance of supervising and monitoring the performance of the NAP, and demonstrate their accountability through providing feedback to the NAP or by completing unfinished tasks (Potter et al., 2010). Standing et al., (2001) note that in their qualitative study of 35 licensed nurses, the conceptualizations of delegation held by the nurses were not always clear and their narratives demonstrated confusion about what constituted delegated care. Alcorn and Topping's (2009) survey results of 148 RNs found that 98% of RNs viewed themselves as accountable for care delegated to an NAP. Carr's (2005) study found community nurses described delegation as a hand off of less complex care but noted their difficulty in disentangling the less complex tasks from the complexity of holistic care.



In summary, there is a lack of research which provides the nursing perspective of delegation. In the studies reviewed many nurses hold definitions of delegation congruent to the definitions of their professional nursing bodies; some nurses confuse the concepts of delegation, assignment, supervision, and accountability. The confusion of nurses is warranted if we note the complexity of the definition of delegation drawn from the literature reviewed. Delegation is both a concept and process; the conceptual understanding of delegation requires knowledge of the related concepts of authority, accountability, responsibility, and supervision. The art and skill of delegation are applied during the process of delegation; a process that may be guided by principles and delegation decision making models. Nurses are cautioned though that the delegation decisions made and processes followed must consider the unique patient needs and desired outcomes if the delegation of care is to be safe and patient centered. The complexity of delegation as a concept and a practice is best served through the approach of delegation as a competency for nursing.

### **Delegation as a Competency for Nursing**

The conceptual definition of a nursing competency underpinning this project includes the elements of knowledge, judgment, skill, and the personal attributes of attitude, beliefs, values, and self assessment. Each of these elements will be examined through the contributions of the literature review to provide a foundation of knowledge about the competency of nursing delegation. The exploration is underpinned by the assumption that mastery of the competency of delegation will have the outcome of successful or effective delegation.

Effective delegation is a term used frequently in the literature reviewed but rarely defined; rather, the facilitating factors or barriers are often discussed. Anthony and Vidal (2010) provide a simple definition of effective delegation as delegation which results in safe, quality

outcomes for patients. Boucher (1998) offers that effective delegation allows the nurse to hear the patients' voice and to interpret clinical cues through the NAP. There are two components to effective delegation; the first is relinquishing the authority and responsibility for the task to a subordinate and the second is providing the 'what' and 'why' of the task but allowing the subordinate to determine the 'how' (Coburn and Sturdevant, 1992). As we discuss the individual elements of the competency of delegation, the overarching goal is the mastery of effective delegation which promotes safe, quality outcomes for patients and confers the benefits of delegation on the delegator, delegatee, and the health care system.

### **Knowledge.**

The literature reviewed has little direct discussion on the ways of knowing that underpin delegation or the ontological and epistemological nature of knowledge required for delegation. However, using what the literature does suggest as a knowledge base for delegation these elements are analyzed for the underlying assumptions about the nature of knowledge required of the competency. The literature provides evidence that the knowledge base of delegation is multifaceted and that within the process of delegation knowledge is cocreated and is contextual.

Nurses, when delegating, must be mindful of the dynamic quality of information regarding the patient, delegatee, and the context of delegation (Anthony and Vidal, 2010). Hanston (2008) adds that nurses must assess these factors at a single point in time to determine that delegation is appropriate. Hasson et al. (2012) state that "An awareness to the requirements of what can be delegated and to whom it can safely be assigned, as well as understanding the criminal, civil, employment and professional frameworks, guiding the process is central to the act of delegation"(p.2). Delegation creates relationships between individuals within an organization, and the nature of the relationship determines what authority is held within a

particular dyad (Burbach, 1999). Each of these statements contributes to an understanding of delegation as requiring conceptual knowledge, experiential knowledge, and knowledge that is mindful of the participants and the immediate context of delegation. Through a Caring Science lens, the knowledge of delegation is cocreated within the delegation relationship, bound in the context of delegation, and influenced by the participants' practical, propositional, experiential, and presentational knowledge.

Clearly, the knowledge required for delegation is multifaceted and the acquisition of this knowledge, according to Kaplan and Ura (2010), demands conceptual and critical thinking. Experiential learning as the theoretical framework for delegation curriculum, promotes knowledge acquisition through the processes of transformative experience, critical, and reflective thinking (Kling, 2010; Lekan, Corazzini, Gilliss & Bailey, 2011). Nurses must draw upon ethical knowledge in delegation; the desire to safeguard patients when delegating is prevalent throughout the literature (Anthony & Vidal, 2010; Corazzini et al., 2010; Gravlin & Bittner, 2010; Hirst & Foley, 2001; Kleinman & Saccomano, 2006; McInnis & Parsons, 2009; Powell, 2011; Schluter et al., 2011). The knowledge of delegation must be grounded in the social, basic, behavioral, and management sciences (Krainovich-Miller, Sedhom, Bidwell-Cerone, Campbell-Heider, Malinski, Carter, 1997 as cited in Anthony et al., 2001). Implicit in the terms 'art and skill', noted in the definition of delegation, is that other modes of knowledge such as aesthetic, intuitive, and ethical knowledge inform the nurse. The complexity of delegation requires that the nurse draw from multiple ways of knowing to enact the judgment and utilize skills essential for effective delegation.

Perhaps the most vital knowledge, required for effective delegation, is that the nurse can identify the nursing knowledge implicit in a task to be delegated. Nursing is a process more

complex than the many tasks it encompasses and though tasks may be delegated, nursing functions cannot be delegated (Boucher, 1998; Burbach, 1999, Schluter et al., 2011). By extension nurses must be able to identify those higher level elements of practice requiring the expertise of their education and experience that must be the focus of practice (Parsons, 2004). An understanding of the tasks that can be delegated also requires knowledge of the scope of practice and accountability of the RN, and the competency and training of the delegatee (Alcorn & Topping, 2009; ANA & NCSBN, 2006; Coburn & Sturdevant, 1992; CRNBC, 2007; Gravlin & Bittner, 2010; McInnis & Parsons, 2009; Parsons, 2004); policies and procedures of the agency (ANA & NCSBN, 2006; CRNBC, 2007; McInnis & Parsons, 2009; Parsons, 2004); and the principles of delegation (ANA & NCSBN, 2006; Parsons, 2004; Quallich, 2005).

During a discussion about their delegation practices, focus group participants admitted confusion about the practice scope of the NAP and cited inadequate knowledge to interpret delegation in terms of institutional policy (Bittner & Gravlin, 2009). Study results demonstrate that licensed nurses who describe fewer negative outcomes from delegation have increased total years of experience in nursing; the researchers speculate that the global knowledge of delegation in nursing is transferrable between work settings (Standing et al., 2000). In contrast there were fewer negative delegation events for NAP who had remained on a single nursing unit for a lengthier period of time, potentially reflecting that their knowledge was concrete and contextually bound (Anthony et al. (2001).

Boucher (1998) notes that novice nurses may identify tasks that can be delegated to the NAP readily as they share with the NAP a more concrete, task-orientated perspective. The experienced nurse, by contrast, thinks globally and considers numerous factors in making the decision to delegate (Boucher, 1998). Alcorn and Topping (2009) agree suggesting that novice

nurses have not developed their grasp on the unique contributions of nursing that clarifies the differences between the NAP and RN roles. In Anthony et al.'s (2001) study there was no significance shown between the level of nursing education or experience related to participants' self rated comfort, confidence and competence with delegation. Participants were uniform in ranking the adequacy of their educational preparation for delegation as only fair although they rated themselves highly when asked if they were prepared for delegation. Anthony et al.'s (2000) study noted that the educational preparation of the licensed nurses, which ranged from LPN to advanced degree nurses, did not significantly impact the outcome of delegation. This may support the findings from other studies that note a majority of nurses develop their knowledge of delegation through work experience (Anthony et al., 2001; Gravlin & Bittner, 2010; Parsons, 2004; Standing et al., 2001; Thomas & Hume, 1998) and that there is inadequate knowledge acquisition about delegation in the settings of nursing education (Conger, 1994; Conger, 1999; Gravlin & Bittner, 2010; Hasson et al., 2012; Henderson et al., 2006; Kleinman & Saccomano, 2006; McInnis & Parsons, 2009; Simones et al., 2010).

Thomas and Hume (1998) document that RN study participants articulate that they learned to delegate through trial and error resulting in feelings of insecurity, incompetence, and frustration. According to Carr (2005) a lack of knowledge about delegation results in "reluctance in delegation or dilution of delegation" (p.77). Graduate nurses are not familiar with the competencies of delegation, supervision, or their scopes of practice (Simones et al., 2010); even though the standards for nursing practice include delegation as a competency (Hasson et al., 2012). In Hasson et al.'s (2012) study, 78% of students do not believe that their education prepared them to work with the NAP, and 81% claim that their university studies did not provide them with a description of accountability related to their role in delegating to NAP. There is

evidence that both the practicing nurse and student perceive that their ability to delegate is compromised by inadequate preparation; an inadequate knowledge base can be assumed. There is also evidence that through nursing practice nurses develop the knowledge that provides them a sense of competence and confidence and promotes positive patient outcomes from delegation. As I turn to examine the nursing judgment that takes place in delegation it becomes apparent that the knowledge base the nurse draws upon will impact the process of decision making.

### **Judgment.**

The nursing judgment exercised in delegation must be guided by the goal of quality care outcomes for patients (ANA & NCSBN, 2006; Anthony & Vidal, 2010; Coburn & Sturdevant, 1992). Perhaps the most notable judgment, discussed above, is to ensure that no element of the nursing process is considered for delegation (Quallich, 2005). Bittner & Gravlin's (2009) study examining nurses' critical thinking in delegation found that nurses consider the patient's condition, and the experience, competency, and work load of the NAP when making decisions about delegation. These findings align with the recommendations of the ANA Code of Ethics which states that delegation requires three areas of judgment: the patient's condition, the competence of the nursing team members, and the level of supervision required; the five rights of delegation serve to facilitate these judgments (as cited in Weydt, 2010). CRNBC (2007) provides three similar categories requiring the nurses' judgment: "care needs of the client"; "the unregulated care provider"; and "the care environment"; (p.13). A decision making model prompts the nurse to consider a range of factors within each category; factors are ranked from lower risk to higher risk giving the nurse a visual score of risk involved with delegation (CRNBC, 2007).

Conger's (1994) Nursing Assessment Delegation Grid (NADG) guides the nurse's delegation decisions through the identification of the tasks to be delegated, and an examination of the patient's problems, knowledge base, ability to manage, and motivation before assigning the appropriate staff member. The participants of four small focus groups in Carr's (2005) study identified four dimensions that were considered when they made delegation decisions: delegator, delegatee, patient needs, and structural factors. The delegator determines the safety of the delegation, assesses the patient's needs and considers structural factors such as the availability and proximity of delegates; the delegatee must know their limits and ask for help appropriately, (Carr, 2005). Again, the judgment of these nurses in the U.K. is congruent with the recommendations for decision making of the professional bodies above (ANA & NCSBN, 2006; CRNBC, 2007). Effective delegation requires skilled decision making at every step of the delegation process from the selection of task and delegatee, through assessment, communication, task execution, and completion to evaluation and the provision of feedback (Curtis & Nicholl, 2004).

A vital judgment the nurse must make is the adequacy of the delegatee's background and skill level to perform the task; this requires assessment beyond the job description and practice scope of the delegatee (Bittner & Gravlin, 2009; Boucher, 1998; Nyberg, 1999). The choice of a competent delegatee does not relinquish the nurse from ongoing monitoring and the application of judgment during the delegation process. Focus group participants in Bittner and Gravlin's (2009) study voiced their frustration with the inability of the NAP to determine reportable findings and identify abnormalities and concerns. There was an expectation by nurses of critical thinking and decision making on the part of the NAP in the processes of accepting, implementing, and reporting on delegated tasks (Bittner & Gravlin, 2009). Boucher (1998)

cautions that nurses must not assume the NAP can think critically or interpret clinical cues as having the potential for problems. Clearly nurses must not only make sound judgments in planning and executing the delegation process; they must also retain the responsibility for ongoing critical thinking and judgments as the delegation evolves.

***Using knowledge and judgment rather than policy.***

In the complex environment of healthcare, nurses must seek a balance between following prescriptive standardized policies and the ability to be flexible and adaptive in their practice (Anthony & Vidal, 2010). The need to weigh the benefits of policies is new to healthcare providers and especially for nursing practice with long established traditions of standardization through policy and procedure (Anthony & Vidal, 2010). The choice to follow prescriptive policy or to use other information to make judgments is evident in the findings of Corazzini et al.'s (2010) study. RNs who delegate utilizing the institutional job descriptions and focus on enforcing institutional policy tend to pass accountability on to the delegatee and to view the results of delegation as unrelated to resident care outcomes. In contrast, RNs who underpin delegation decisions with their knowledge of the scopes of practice utilized routine and creative strategies to monitor staff during delegation and were found to utilize patient outcomes as a measure of the success of delegation. However, the second group of nurses must negotiate uncertainty in their delegation as they factor in varying levels of staff skill, confidence, and availability without the benefit of prescriptive policy to rely upon. The RNs utilizing a scope of practice approach have the knowledge essential to enact the delegation process and navigate the conflict that may occur between the legislation that guides nursing delegation and the policies and staffing levels of an individual organization (Corazzini et al., 2010).



Delegation decisions based on lists of tasks rather than individual judgments, compromises the critical thinking required in delegation decision making (Weydt, 2010). Carr's (2005) study reveals two broad categories of decision making exhibited by nurses when delegating. The first is convenience driven, pragmatic decisions focused on the availability of the delegatee or to even workloads and cover absences. The second is the redistribution of work because another caregiver is more suitable to meet the patient's needs in terms of knowledge base, effectiveness, or economically (Carr, 2005). Carr comments that the first model of decision making is task focused and conflicts with the holistic philosophy held by nurses. Hirst and Foley's (2001) findings reveal that case managers' varied delegation practices reflect operational challenges such of fiscal restraint, access to the appropriate care provider or having that person accept the task, and a lack of knowledge of the scope of practice of a professional discipline.

Anthony and Vidal (2010) and Weydt (2010) implore nurses to use critical thinking in delegating rather than a rote response guided by institutional policy however as Carr (2005) and Hirst and Foley (2001) acknowledge there are complexities in the care environment that challenge nurses beyond the ambiguity of formulating a unique, contextualized response or to follow policy. Delegation is influenced by contextual factors such as availability of staff, allocation of resources, funding limits, lack of expertise and implementation challenges. These factors were at times what prompted case managers to decide to perform nursing tasks independently in order to ensure the work was done (Hirst & Foley, 2001).

The method of assigning staff can impact the context of the delegation process as it may alter the reciprocal knowledge and trust that RNs and their delegates share (Weydt, 2010). Also taxing the nurse is the chaotic environment of healthcare with frequent interruptions and multiple

demands on the cognitive processes of the nurse (Bittner & Gravlin, 2009, Gravlin & Bittner, 2010). Anthony et al. (2000) found that there were no statistically significant relationships between practice setting characteristics and the outcome of delegation; rather, it was the type of supervision and method of determining patient outcomes that was deemed significant.

Nursing judgment is a vital component of the competency of delegation and throughout the process of delegation it must be exercised. The nurse must examine the needs of the patient to determine if there are tasks which may be performed by another provider that do not require a nursing function within the task performance. If a suitable task is identified the nurse must judge that the delegatee selected has the competence and experience to perform the task and that the care environment does not pose challenges that would make task performance unsafe. As noted the care environment offers multiple challenges in staffing level, use of technology, and the varying levels of patient acuity. Nurses are encouraged to utilize their knowledge of the scopes of practice of providers, personal knowledge of the delegatee's competence, and to tolerate uncertainty with policy in selecting the most suitable person for task performance. This is a position that a novice nurse would be challenged to take without adequate preparation and support through this process. In fact, the study findings of nurses' delegation decisions illustrate that even experienced nurses utilize institutional policy or task focused decision making as opposed to mindful, critical thinking about the unique individuals and context of the delegation. The nurse who delegates using job description or policy alone is drawing upon a narrow propositional knowledge base. Judgments in the delegation process require the nurse to draw upon multiple ways of knowing to underpin the application of practical knowledge in a relational context. Knowledge and judgment must be supported by skill if the nurse is to enact the delegation process in the practice setting.

**Skill.**

Though delegation is often referred to as a skill in the literature, a careful examination reveals that delegation requires a composite of skills. The procedural skills of assessment, decision making, monitoring, supervision, and evaluation are frequently discussed in the context of the delegation process detailed previously. The literature reviewed focuses on the following skills: communication and relational, and to a lesser degree the skills of supervision, and evaluation.

***Communication.***

Skilled communication is essential for effective delegation (Anthony & Vidal, 2010; Bittner & Gravlin, 2009). Communication is required to provide directions, identify knowledge deficits, clarify expectations and time frames, guide and establish care priorities, the provision of respectful bidirectional feedback (Nyberg, 1999), and conflict resolution (Burbach, 1999; Potter et al., 2010). Schluter et al.'s (2011) study finds that skilled communication allows the RN to piece together findings from direct care with those gained through discussion with other team members; maximizing the meaningfulness of patient encounters to ensure the delivery of safe, effective care.

Hansten (2008) explains that strategic times for communication occur at shift report; when establishing a plan of care with the nurse, patient, and NAP; and when determining checkpoints during the shift for review, and evaluation. Timely communication is emphasized (Anthony & Vidal, 2010; Potter et al., 2010); information decay and saliency impact the quality of communication and frequent, mindful communication with bidirectional feedback is essential to enhance saliency and minimize information decay.(Anthony & Vidal, 2010). Delegation is facilitated when the organization's care delivery model is understood by all employees, and

provides clear direction regarding assignments, roles, and the communication processes for establishing patient priorities and outcomes (Hansten, 2008). Nurse Managers can facilitate team communication by developing reporting guidelines, providing supportive education and opportunities to resolve conflict (Potter et al., 2010).

When good communication and teamwork is compromised the process of delegation is fraught with conflict (Potter et al., 2010). In Potter et al.'s (2010) study, both nurses and NAP identify conflict as a theme in their discussions of delegation; the NAP linking conflict more directly to poor communication. Nurse participants in Bittner and Gravlin's (2009) study identified that communication was lacking between nurses and NAP, compromised by language barriers, instructions not understood by NAP, or that NAP often had little or no information about the patients in their care. Nursing narratives attribute positive outcomes of delegation to attentive NAP following directions and protocols; conversely negative outcomes are attributed to the NAP not receiving or following directions or their nonadherence to policy (Standing et al., 2001).

Nurses were focused on the importance of communication in Standing and Anthony's (2008) study and individual nurses sought to increase the accountability and cooperation of NAP through the use of strategies employing written, verbal, or both types of communication. Disparate levels of comfort with communicating to delegates are expressed by nurses; nurses describe a range of approaches from polite, respectful communication to refusal to delegate as a result of frustration with the complexity of communication required (Standing & Anthony, 2008). The correction of poor performance, a source of frustration and conflict, is essential for quality outcomes and a component of skilled communication (Nyberg, 1999). Anthony and Vidal (2010) propose that mindful communication be integrated as a principle of delegation

requiring the RN to share with the NAP the salience of the task and expected outcome, and information that increases the potential for positive outcomes. Trusting relationships are closely linked to effective communication; as trust develops there is an increased sharing of information, particularly tacit information, essential to safe patient care (Anthony & Vidal, 2010). Skilled communication and relational skills are intricately connected and both essential for effective delegation.

***Relational skills.***

Delegation occurs within a relational context; the interpersonal relationship between the RN and NAP is the heart of effective delegation (Standing & Anthony, 2008). Safe patient care is facilitated by the positive delegation relationship as it improves collaboration, coordination of care, and communication which engenders trust and sharing (Reina, Reina, Rushton & Hylton, 2007 as cited in Anthony & Vidal, 2010) and diminished opportunity for missed care and unintentional outcomes (Anthony & Vidal, 2010). The comfort nurses expressed with delegation in Standing and Anthony's (2008) study was linked to their trust for the NAP; trust that was developed through trial and error as the RN-NAP dyad worked together and evaluated care over a period of time. Focus group participants expressed universal agreement that a positive, trusting, respectful relationship was the most important component of effective delegation that influenced every aspect of patient care and the team function (Bittner & Gravlin, 2009). This relationship requires that nurses demonstrate trust for the NAP (Anthony & Vidal, 2010; Burbach, 1999; Coburn & Sturdevant, 1992; Hirst & Foley, 2001; Nyberg, 1999; Quallich, 2005; Standing & Anthony, 2008), while continuing to hold the delegatee responsible for the delegation plan (Burbach, 1999) and giving credit for a job well done (Burbach, 1999; Standing & Anthony, 2008). Integral to strong delegation teamwork is team knowledge of the role; scopes

of authority and contributions of caregivers; and, a sense of belonging for all team members (Nyberg, 1999).

According to Weydt (2010) delegation is “the invitation for participation” and a positive tone conveying this invitation along with honest, open, and direct communication are foundational characteristics for effective teamwork (p.4). Coburn and Sturdevant (1992) comment that delegation has the potential to enhance relationships between delegator and delegatee as seen in the relationships between students and staff in the clinical intervention described. Nurses with relational skill view delegation as a means to develop other team members; to establish trust, promote self-esteem, and demonstrate respect for the delegatee’s unique personality and abilities (Quallich, 2005). Nurses delegating to nursing students described the students as willing to work, motivated to learn, and eager to develop a positive reputation; in turn they described relationships with students as functioning on a higher level and being more satisfying than those with the NAP (Standing & Anthony, 2008). In my view, the literature implies that nurses should seek to establish relationships with the NAP that would function on this ‘higher’ level through mentoring the development of the knowledge and skills of the NAP as a partner in the delivery of safe, quality patient care; and through effective bidirectional communication.

The relational underpinnings of Caring Science ground the exploration of the discourse of hierarchical attitudes in health care which contrast to the egalitarian team approach which the literature supports as the approach for effective delegation. As noted previously, inadequate research has gathered the perspectives of nurses toward delegation but there is evidence in the literature that nurses struggle with the concepts of power inherent within the delegation relationship. Nurses who value the team approach may feel guilty about the hierarchical

assumptions that delegation imposes in any context (Curtis & Nicholl, 2004; Quallich, 2005). Nurses who have worked as NAP in the past may feel disloyal to their NAP colleagues as they assume the role of delegator (Bittner & Gravlin, 2009). According to Tappen (1995) the solution is for team members to appreciate that human beings are equal but may hold unequal status in the hierarchies of organizations (as cited in Curtis & Nicholl, 2004).

In Standing and Anthony's (2008) study nurses describe power inequity as a source of strife noting the need for respect in the delegation relationship. Other RN participants, however, voice that this respect should be withheld until it is earned by the NAP. Similarly a range of attitudes were expressed by RNs towards the work of NAP ranging from recognition of the heavy workload of the NAP to the belief that the NAP are lazy (Standing & Anthony, 2008). Some nurses in Potter et al.'s (2010) consider it a management concern to enforce the completion of delegated tasks. Negative attitudes result in poor relationships between staff; with poor partnerships nurses resist delegation (Corazzini et al., 2010; Lekan et al., 2011; Potter et al., 2010; Quallich, 2005) and to avoid front line resentment nurses may perform care independently (Corazzini et al., 2010). Previously it was noted that the inability of nurses to negotiate patient proximity through delegation resulted in frustration and onerous workloads as they attempt to provide total patient care. Resistance to delegation is intricately connected to the nurses' assumptions about knowledge, power, and the provision of care which promotes positive patient outcomes.

Other relational barriers to delegation are: under-delegating due to the RN's fear of the NAP's resentment (Curtis & Nicholl, 2004), over-delegation or 'dumping' which exhausts the delegatee (Bittner & Gravlin, 2009; Curtis & Nicholl, 2004; Quallich, 2005), and refusing to let the NAP share in patient care responsibilities (Curtis & Nicholl, 2004). As noted previously,

novice nurses confide that their role uncertainty and fear of making errors results in a choice to under-delegate which adds to their workload. Nurse participants in Standing and Anthony (2008) articulate discomfort with the role of evaluating the NAP; they express fear of conflict, of damage to the RN-NAP relationship, and that their concerns about the performance of the NAP will not receive administrative support.

Some study participants in Standing and Anthony (2008) describe the use of reciprocity to gain the cooperation of NAP by assisting with the workload of the NAP. Yet other participants complain that this establishes some nurses as ‘nice’ nurses and that the NAP manipulates nurses using these sentiments (Standing & Anthony, 2008). In summary, RNs must hone their skill in developing and maintaining professional relationships with their delegates that are focused on collaboration for positive patient outcomes, and trusting, respectful interactions that promote growth in all members of the care team. Both relational skills and skilled communication underpin the ability of the RN to supervise and evaluate the performance of the NAP.

### *Supervision and Evaluation.*

Among the five rights of delegation are the “right supervision and evaluation” (ANA & NCSBN, 2006, n.p.). The nurse must monitor the performance of the task, assure compliance with policies and standards of practice, and determine the frequency and nature of the supervision required.<sup>1</sup> Evaluation demands that the nurse review the outcome achieved, evaluate the delegates’ performance, provide appropriate feedback, and reflect on the changes needed to

<sup>1</sup> The assumption is made that the nurse remains current with the standards of practice; this is challenging with the rapid changes that occur in the environment of Evidence-Based Practice.



the process of delegation or plan of care (ANA & NCSBN, 2006). It is imperative that the RN evaluate and follow up with the reporting procedure and corrective action required when errors are made by the delegatee; art and skill are necessary to enact changes that improve the delegation plan and provide correction to the NAP (Burbach, 1999).

Study results demonstrate the importance of skilled supervision. In Anthony et al. (2000) a significant relationship was determined between the positive outcomes of delegation and the routine observation of the delegates' performance by the RN. The manner of supervision was also shown to be significant as there were more negative events when there was no direct supervision of the delegatee (Anthony et al., 2000). The 'right direction' is the most common deficiency in negative narratives provided by participants in Standing et al.'s (2001) study, closely followed by deficits in the right supervision. Dissatisfaction with the level of supervision achievable in the community was a disincentive to the nurses in Carr's (2005) study to delegate.

It is concerning that the majority of student nurses in Hasson et al.'s (2012) study do not think it is necessary to supervise the NAP when they are performing delegated tasks. Supervision is an essential skill which must culminate in the evaluation of patient outcome and the performance of the delegatee. According to Curtis and Nicholl (2004) evaluation is essential to prevent or mitigate errors, to improve communication, and to provide feedback and celebration. The evaluation of patient outcomes can be accomplished through: patient assessment; examining if critical paths are followed and patient care standards are met; and obtaining feedback from the NAP about their performance and their need for future support (Burbach, 1999). Both supervision and evaluation, though unique skills, demand communication and relational expertise.

Alcorn and Topping (2009) conclude that RNs should undertake skill development to ensure they are equipped to delegate and supervise others, and ideally these opportunities should occur during undergraduate programs and preceptorship in order that graduates have these abilities. Delegation demands well honed communication, relational, and supervisory skills; a challenging prospect for both novice and experienced RN. Providing the prelicensure nursing student the opportunity to practice these high level skills will enhance their future practice as will the personal attributes they bring to delegation in the form of attitudes, beliefs, values, and their self assessment abilities.

### **Personal attributes.**

The personal attributes that nurses bring to the process of delegation reflect the assumptions they hold about delegation. The literature examines these assumptions through the views articulated by nurses or the impact that personal attributes have on the effectiveness of delegation. As noted previously there is a need for further research that provides insight into the views of nurses, the experiences that have informed these views, and the educational experiences that promote transformational learning.

The personal traits described by delegating case managers of delegateses integral to effective delegation are motivation and a willingness to learn (Hirst & Foley, 2001). Both RNs and NAP identify motivation or work ethic as valuable in their coworkers and as a source of conflict in the delegation relationship when work ethics vary (Potter et al., 2010). Nurses articulate that often the NAP do not comprehend the RN role or grasp the purpose of delegation; an example provided by nurses are the NAPs' negative comments that nurses are not working when they are charting (Standing & Anthony, 2008). Six NAPs, focus group participants of Potter et al.'s (2010) qualitative study, describe delegation as a process for the RN to pass on

work; in contrast the ten RNs described delegation in terms of the ‘five rights’ of delegation. The assumptions of the RN and NAP about what constitutes the work of delegation may underpin their negativity about each other’s work ethic. RN and NAP interviews reveal that all staff develop an awareness of those individuals willing to participate in teamwork as opposed to those who pose difficulty for team members; staff react by avoiding collaboration with those with difficult personalities (Potter et al., 2010).

Graduate nurses comment that the personal qualities of the RN essential to delegation are excellent people skills, skilled communication, respect, fairness, providing feedback, acknowledging good work, flexibility, openness to alternative views, and a willingness to work alongside staff (Thomas & Hume, 1998). The graduates note that their youth makes delegation more difficult if they are shy or have a bossy approach (Thomas & Hume, 1998). This is reinforced by the comments of older nurses who perceive that if novice nurses are “snippy” senior NAP may resist delegation and conflict ensues (Potter et al., 2010, p.162). Recent graduates note that developing trust in the delegatee is essential as job descriptions alone do not determine the willingness, reliability, or competency of the individual (Thomas & Hume, 1998). These graduates articulate that when delegating they contend with feelings of insecurity, loss of control, and role confusion that elicit job dissatisfaction, guilt, and self doubt. They implore nurse educators to convey to future students the knowledge that nurses cannot do it all themselves and that perfection is unattainable (Thomas & Hume, 1998).

Attitudinal barriers to effective delegation, articulated in participant interviews, include the negative attitudes of both the delegating nurse and delegatee (Corazzini et al., 2010). Perceived over-delegation evokes the resentment of the delegatee who then resists the delegation; reciprocally perceived by the delegator as a poor attitude toward delegation. In either

case, the conflict spurs delegators to become selective about who they delegate to; resulting in ineffective delegation and exacerbating already impaired staff relationships (Corazzini et al., 2010). Curtis and Nicholl (2004) note resistance to delegation occurs because of the differing perspectives of the delegator and delegatee; delegatees resistance to authority; and delegators who fail to allow delegatees to exercise creativity and independent thinking. The inability for the delegator to surrender authority to the delegatee and to allow the delegatee choice in their method of task performance is a major barrier to effective delegation (Sturdevant & Coburn, 1992). Quallich (2005) comments that it is vital that nurses evaluate delegatee resistance to determine the cause; does the delegatee feel unprepared for the task or is the delegatee resistant to authority?

RN resistance to delegation may be in response to the fear verbalized by professional nursing organizations of role erosion that may see nurses losing authority over managing the care for patients while retaining responsibility for outcomes (Sikma & Young, 2001 as cited in Reinhard, 2011). Burbach (1999) concurs that nurses may perceive delegation as giving away nursing. Study results find that the delegation of basic activities often elicits guilt in the RN who perceives these tasks should be completed independently; the perception that delegation and laziness do not equate is a common hurdle for nurses (Schluter et al., 2011). A lack of self confidence may cause the RN to fear that delegation diminishes the RN role and is disloyal to the discipline (Quallich, 2005). Resistance to delegation occurs on both sides of the delegation partnership and is representative of diverse attitudes, beliefs, and values toward delegation. As noted previously, the complexity of the healthcare environment, lack of educational preparation for delegation, and the inadequacy of resources that support effective delegation compound to provide experiential knowledge that informs the personal attributes of nurses and NAP.

The conclusion of Potter et al. (2010) is that effective delegation is contingent on collaborative RN-NAP relationships defined by frequent, timely communication and strong initiative. Interviewed separately both RN and NAP groups revealed the identical themes of conflict, communication, and teamwork; an indication that both groups perceive these as vital to the process of delegation (Potter et al., 2010). Standing et al.'s (2001) study documents follow up phone interviews with 27 of the original 148 participants, licensed nurses from across the USA. The majority, 92.6%, state comfort with delegating to their NAP; the source of this comfort for 40% is experience with delegation and for another 40% knowledge of and confidence in the NAP (Standing et al., 2001). Standing and Anthony (2008) acknowledge that attitude is a key factor in the delegation relationship, however there is a need for further research and scrutiny of the impact of personal attributes on the competency of delegation. I turn now to examining another subject of inquiry for the delegating nurse and nurse researcher alike, the outcome of delegation.

### **Outcomes of Delegation**

The evaluation of patient outcomes following the delegation of nursing care is an essential component of the delegation process (ANA & NCSBN, 2006; Boucher, 1998; Burbach, 1999; CRNBC, 2007; Corazzini et al., 2010). The effectiveness of the RN's delegation skills should be measured by the positive or negative outcome for the patient (Dunham-Taylor, 2000 as cited in Saccomano & Pinto-Zipp, 2011). According to Standing et al. (2001) there has been little research performed which examines the outcomes of patient care after delegation. Standing et al. (2001) conduct a study designed by the NCSBN to examine the outcomes of the delegation of care to unlicensed personnel and draw from the narratives of 148 licensed nurses across the USA. The questionnaire portion of the study asks nurses to provide narratives of two

examples of delegation which they have personal knowledge of; one that has resulted in a positive outcome, and the other a negative or potentially negative outcome (Standing et al., 2001).

The majority of both negative and positive narratives describe NAP who occupy traditional nurse extender roles; assisting with bathing, feeding, and ambulating patients (Standing et al, 2001). The delegated tasks are categorized as lower or higher level activities and 54.2% of the negative outcomes are represented by lower level activities while 67.6% of the higher level activities resulted in positive outcomes. The negative outcomes range from emotional upset to fractures, injury, and death and are attributed to the NAP not receiving or following directions or not adhering to policy. Conversely, positive outcomes are attributed to the NAP following directions, protocols, and being attentive. Follow up phone interviews with nurse participants clarify that the NAP was implicated in 76.4% of negative narratives; nurses describe these NAP as lacking skill, knowledge, and judgment or being overconfident. In the remaining negative narratives client factors contribute to the negative outcomes such as family or client pressuring the NAP to act contrary to orders (Standing et al., 2001). Nurses attribute 75% of the positive outcomes to NAP performance underpinned by characteristics such as competency, integrity, motivation, and a disposition to follow through on tasks. Participants providing these narratives overwhelmingly rate as high their own comfort, confidence, and competence regarding delegation (Standing et al., 2001).

The nurses providing these narratives in Standing et al.'s (2001) study relate the success or failure of delegation to the NAP performance; there is no indication that the RNs relate the outcome of delegation to their own performance, as is the recommendation in the comment of Dunham Taylor (2000) above. One wonders if the majority of positive outcomes in the higher

level category of care occur because the RN provides better instructions and closer supervision for these activities. In my view, the findings of Standing et al. (2001) also portray the lack of control these nurses feel in the outcomes of delegation as they do not articulate behaviors which they may enact to alter the outcome of delegation.

As part of a triangulated study with Standing et al. (2001), Anthony et al.'s (2000) quantitative study explores how practice setting characteristics; the educational and experiential backgrounds of licensed nurses and NAP; and nurse supervision influence the outcomes of the delegated nursing activities. Delegation leading to positive patient outcomes is associated with the experience of the caregivers (generalized experience for the licensed nurse and site specific experience for the NAP); the degree of planned, intentional, direct supervision by the nurse, and the evaluation of outcomes by the nurse. These findings inform the view of delegation as a collaborative enterprise that requires skilled performance by all participants with emphasis on the RN skills of supervision and evaluation of outcomes.

Nurses in Standing and Anthony's (2008) qualitative study note positive outcomes for the patient result when the nurse delegates to a competent NAP; affording the nurse the time to attend to higher level nursing skills such as patient teaching. In contrast, negative outcomes occur when the NAP do not report abnormal findings, fabricate assessments, or do not complete care. Nurses acknowledge that they remain accountable for the tasks delegated and state concern about patient well being throughout the delegation process. With negative delegation outcomes a pattern of resistance to delegation develops, and nurses articulate that they prefer to complete tasks independently to assure a safe outcome for the patient (Standing & Anthony, 2008). This study reinforces the earlier findings of Standing et al. (2001) that nurses relate positive patient outcomes and the benefits of delegation accrue from delegation to a competent NAP. Nurses in

Standing and Anthony (2008) clearly struggle with the supervision and evaluation of NAP performance; in contrast they enjoy the teaching role with nursing students and NAP. The conclusion of the researchers is that basic nursing curriculum must provide students with experiences that focus on communication and relational skills between coworkers (Standing & Anthony, 2008). I would add that there are implications for a strong voice for RNs in the ethical and competency requirements of the NAP role in healthcare.

Ineffective delegation is related to missed care; five of the nine missed care elements are those most often delegated: ambulation, hygiene, documentation, delayed or missed feeding, and turning (Bittner & Gravlin, 2009). According to Gravlin and Bittner (2010) these care activities are implicitly delegated as they fall within the job description of the NAP and may not be recognized by nurses as delegated care. These findings offer support for Standing et al.'s (2001) study conclusions that a factor of the negative patient care outcomes occurring in the lower level activities result from inadequate supervision by nurses. Nurses in focus groups express resignation and frustration with the omitted care occurring every shift; causing them dissatisfaction in their work and prompting thoughts of leaving the organization (Bittner & Gravlin, 2009)

It is evident from this discussion of the outcomes of delegation that inadequate research has been performed and that the bulk of research is that of Standing, Anthony, and Hertz and the missed care studies of Bittner and Gravlin. Evaluation is an essential component of the nursing process and outcome evaluation a significant component of the health care culture of today. As Standing and Anthony (2008) comment there is a culture of safety in health care which is gaining momentum. The accountability of nurses for the safe, quality outcomes of delegation is a



compelling reason to conduct further research to establish delegation practices that optimize outcomes of care.

## **Education and the Competency of Delegation**

### **The need for delegation education.**

The Institute of Medicine (2003) stresses that it is vital to transform health care provider education in order to improve patient outcomes and stresses the need for student nurses to develop strong patient management skills such as delegation (Conenwett et al., 2007 as cited in Sharpnack, Goliat & Rogers, 2011). The ICN (2008) advises that nursing education programmes must prepare nurses for the responsibility of delegation, supervision, and the coordination of patient care services. It is imperative that the educational preparation of nursing students reflect the work environment that graduates will enter and all educational systems must include delegation in their nursing curriculum (Saccomano & Pinto-Zipp, 2011). Thomas and Hume (1998) declare that “Nurse educators can no longer be laissez-faire about preparation of students...a systematic approach, making the implicit explicit, is needed to prepare nurses to delegate with competence and confidence” (p.41).

Alcorn and Topping’s (2009) study to elicit the views of 148 RNs regarding delegation concluded that it is necessary to embed in undergraduate nursing programs the foundational skills that will support graduates to exercise professional accountability as they delegate and supervise NAP. The foundational skills students acquire are essential for their transition to the workplace and should be a shared focus of a joint program between the curriculum of nursing education and workplace orientation programs (Saccomano & Pinto-Zipp, 2011). Delegation education is required at all levels of nursing education including orientation programs and continuing education activities (Parsons, 2004; Weydt, 2010). Reinhard (2011) points out that

education may address the concerns, resistance, and negative attitudes nurses hold towards delegation. Many nurses have been poorly prepared for the challenge of delegation and many nurses have provided care within a primary care model of nursing where they are responsible for all aspects of direct patient care (Kleinman & Saccomano, 2006). A majority of nurses have not learned to delegate in their basic nursing programs (Conger, 1999; Henderson et al., 2006; McInnis & Parsons, 2009; Parsons, 2004; Standing et al., 2001). Nursing faculty may have inadequate experience with, or knowledge of, delegation; they too may harbor feelings of resistance and negativity towards delegation. Continuing education can prepare faculty to support students to develop the competency of delegation in the context of today's health care environment.

In Standing et al.'s (2001) study of 148 licensed nurses, 15.8% of nurses described educational programs as their preparation for delegation and 42.1% stated experience alone had prepared them to delegate. There is speculation that the majority of nurses learn to delegate through their work experience (Anthony et al., 2001; Kleinman & Saccomano, 2006). Forty-six percent of the 78 RN subjects of Parson's (2004) study were taught to delegate in nursing school; the remaining participants describe having a limited exposure to staff development and continuing education in their workplaces. In this study, 50% of RNs in the long term care setting reported that they had developed their delegation skills through job experience alone, compared to 19% of acute care RNs (Parsons, 2004). Gravlin and Bittner (2010) note that 48.6% of nurses in their study had never taken part in an employer provided course about delegation.

Delegation is not introduced until near the end of the educational process despite being an essential high level leadership skill for the nurse graduate (Kaplan & Ura, 2010); there is an urgent need to strengthen the graduate nurses' leadership competencies of delegation and

supervision (Lekan, Corazzini, Gilliss & Bailey, 2011; Simones et al., 2010). Thomas and Hume (1998) find that the educational experience of the new graduate subjects of focus groups has not prepared them to delegate, rather, they have attained their abilities to delegate through trial and error in the workplace. Saccomano and Pinto-Zipp's (2011) study finds no significant difference in the level of nurses' confidence with delegation in relation to their educational preparation however when combined with clinical experience it emerged that baccalaureate graduates initially had more confidence though this was not sustained as those with less education demonstrated more confidence as they acquire experience.

The majority of the educational projects and studies that will be described are directed toward student nurses however practicing nurses require the tools and strategies to improve their abilities to effectively delegate care (Corazzini et al., 2010; Hirst & Foley, 2001), especially in the context of a rapidly changing health care environment. Nursing service administrators must provide RNs with continuing education opportunities to develop delegation skills if nurses are to be skilled leaders as well as skilled clinicians (Parsons, 1998). Delegation practices do not transfer readily from hospital to community thus there is a need for education in the transfer of skills from one healthcare setting to another (Carr, 2005). Lekan et al. (2011) suggests that the collaboration of staff from academic and practice setting is essential for knowledge dissemination that ensures best practice in both settings and supports student and staff learning alike. There is a compelling case for increasing the importance of delegation as a competency in nursing education at all levels. Now I turn to examining the pedagogical strategies which are suggested within the literature to prepare nursing students and nurses to be competent with delegation.

**Strategies to teach delegation.**

Thomas and Hume (1998) claim that an extensive literature review determined that many articles have been published about delegation, often focused on the management role versus the staff nurse's role, but that little research and few sources address the preparation of students through developing the knowledge, skills, and attitudes to delegate effectively. More recently, Simones et al. (2010) make the same claim that there is a lack of information regarding the instruction of the concepts of delegation, supervision, and the scope of practice in nursing education. Further, the use of simulation to aide in this instruction is largely lacking. The literature reviewed in this paper offers general suggestions for nursing education derived from the results of specific studies or projects designed to inform the instruction of delegation in nursing curriculum.

A review of general suggestions indicates that nursing students should engage with content that addresses professional and regulatory guidelines, communication skills, conflict resolution, leadership and management abilities (Hall-Johnston, 1996, Krainovich-Miller et al. 1997 as cited in Anthony et al., 2001), and that students be exposed to the challenges of delegation in various health care contexts (Anthony et al., 2001) through practice experiences, including simulation experiences. Henderson et al. (2006) adds that content should address delegation as a concept and a process, that content be introduced early in the program, and be threaded through classroom and clinical curriculum. Basic nursing curriculum should contain learning experiences in human relations and communication that extend beyond relationships with patients and families to include relationships with coworkers (Standing & Anthony, 2008).

Educators must ensure clinical opportunities that allow delegation practice (Hansten, 2008; Weydt, 2010). Simones et al. (2010) challenge that the application of practical skills in

delegation and supervision is not feasible for students because of the chaotic, stressful healthcare environment with high patient acuity, staff shortages, and an increased number of students.

However, simulation offers a valuable resource to teach clinical aspects of care and delegation through practice scenarios and ensuing feedback and discussion (Simones et al., 2010; Weydt, 2010). Other strategies that may be utilized to teach delegation are case studies, seminars, clinical experience, the use of the Nursing Assessment Decision Grid, and the analysis of Nurse Practice Acts (Thomas & Hume, 1998). Henderson et al. (2006) comment that measurable methods for tracking student success in their learning of delegation should be adopted.

Nurse educators and researchers have responded to the call for increased emphasis on delegation in nursing curriculum. Early work by Margaret Conger (1994) is refined by Parsons (1998) and Conger herself in 1999. In recent years educators have used a variety of pedagogical strategies including the use of simulation to teach delegation. The following section provides detail of the creative strategies and in some cases the evaluation of these strategies, designed to promote the competency of delegation in nursing education.

### **Educational projects and interventions.**

Conger (1994) designed the NADG in 1993 to guide the delegation decision making skills of nurses in practice. She used a preexperimental design utilizing a pretest, treatment, and post-test layout to evaluate the abilities of a convenience sample of 97 staff nurses to improve their delegation decision making abilities. The post-test results, following a teaching intervention using the NADG, demonstrate significant improvement in all three aspects of delegation decision making: nursing task identification, patient problem analysis, and the assignment of responsibilities to the RN or LPN. Significant differences between low and high performers on the pretest disappeared on the post-test in the categories of patient problem

analysis and assignment; the lower performers continue to demonstrate a statistically significant lower score with nursing task analysis. However, in the post-test the lower performers demonstrate significant improvement unlike the high performers who show no improvement. The only significant demographic variable related to performance on the post intervention delegation test was whether English or non-English were the primary languages. This study demonstrated that the NADG is a tool that can be utilized in the classroom setting to guide delegation decision making (Conger, 1994).

The NADG was utilized in Parson's (1998) experimental study designed to ascertain whether a structured educational intervention would yield a significant increase in the delegation decision making ability of nurses or their job satisfaction. The NADG scores were examined preintervention, immediately post-intervention, and at a one month follow up in two groups of RNs: a control group receiving a mimic intervention and an experimental group receiving instruction in the NADG. Results demonstrated significant improvement between the mean pretest and post-test scores across the three parameters, task analysis, problem analysis, and assignment of patients, for RNs in the experimental group. These nurses also reported increased confidence with making delegation decisions and an increased intent to use delegation decision making in their present and future practice. With regard to six elements of job satisfaction, nurses in the experimental group demonstrate a significantly higher measure on the scores of promotional opportunity and autonomy. The findings of this study of 87 nurses from six medical-surgical units of one hospital cannot be generalized but do confirm Conger's earlier study that the NADG can be an effective tool to guide decision making in delegation. This study adds that nurses with higher scores in delegation decision making also show an increased sense of autonomy and promotional opportunity.

Conger (1999) continued to evaluate the NADG, in this study extending the use of the tool from classroom to the clinical area. Students were introduced to the concepts of delegation in the classroom and used the NADG to analyze decision making for patient vignettes. Following these sessions the students completed eight clinical days where they collaborated with an NAP to provide care for two to three patients. The students completed journal entries each shift reflecting on two delegation decisions made and provided rationale for those decisions. Outcome evaluation was completed over four semesters with 25 volunteer students. The analysis of student journals demonstrated their fear of the unknown, anger at the use of the nurse extender role, fear of delegating to an older provider, and fear of dumping on the NAP through delegation. Students report the skills that enabled collaborative delegation were clear communication and establishing rapport with NAP. Students describe numerous opportunities where they taught the NAPs about competent, effective patient care techniques and report that they learn from the NAP when working along with them. On occasion the students encounter conflict with the NAP or have difficulty establishing rapport with an NAP; at times the students choose not to delegate when they perceive it an inappropriate choice. Student evaluations of the experience are positive; they describe feeling confident about their ability to manage patient care, prepared for the position of staff nurse, and they remark that their knowledge of delegation served them well each shift (Conger, 1999). Conger concludes that the use of the NADG guides the students' delegation decision making and this is reflected in both the classroom and clinical settings.

Two studies are presented in Henderson et al.'s (2006) article. The first study examines student responses for evidence of delegation content within the nursing program and the second study compares pre- and post-intervention measures following a delegation exercise. Using the NCSBN 'five rights' of delegation the researchers gathered 210 student surveys from associate

degree nursing students in year one to three. Overall, 20% of students define delegation correctly according to the criteria set that year one students identify two rights, year two students identify three rights, and year three students must identify all five rights. The breakdown of correct answers is 46% of year one, five percent of year two, and zero percent of year three. The researchers conclude that the concept of delegation was not addressed as planned in the curriculum.

The second study of 21 level two and three students who participate in an eight step delegation decision making exercise. Although on the post-test all students omitted at least one of the 'five rights' there is significant improvement from the pretest to post-test results. The researchers conclude that delegation should be addressed early in nursing programs with the emphasis on application of abilities as the program progresses. Educators lack resources for teaching delegation but the researchers advise that the importance of delegation should compel educators to incorporate the knowledge and skills required for delegation into nursing curriculum (Henderson et al., 2006).

The simulation-based learning experience (SBL) of 97 senior nursing students is the subject of Kaplan and Ura's (2010) descriptive report. Groups of ten to twelve students participate in three simulated patient experiences orchestrated by faculty behind one way mirrors; students listen to report, complete assessments, prioritize, and delegate care. Debriefing following the SBL experience reviews patient assessment, analysis of, and implications for, patient and family-centred care, student attitudes toward delegation, and their strategies to delegate effectively. Findings are that 46% of students agree, and nine percent strongly agree that they feel more confident in their ability to prioritize and delegate care following the SBL. Twenty-two percent strongly agree and 47% agree that the simulation experience and debriefing



session increase their understanding of prioritizing and delegating care. Faculty note student behaviors demonstrate adaptation to the role of delegator even though students have limited experience with delegation. The authors conclude that the impetus behind this curricular intervention is to bridge the role between student and novice nurse through increasing the students' knowledge and confidence with the advanced leadership skills of delegation and prioritization of patient care (Kaplan & Ura, 2010).

Kaplan and Ura (2010) is a departure from the previous four studies in that it employs simulation and offers the potential of this medium to address the issue of providing students experience in delegation despite the complexity of the clinical environment. As Kaplan and Ura (2010) point out, students are familiar with limited, direct care patient assignments and the simulation experience requires them to delegate, communicate with other providers, and reveals areas of strength and weakness in assessment, communication with other providers, listening, and reporting skills. The studies of Conger (1994)(1999), Parsons (1998) and Henderson et al. (2006) employ a more prescriptive approach to delegation guided by the NADG tool or the 'five rights' of delegation. In contrast Kaplan and Ura (2010) utilize a pedagogical approach that constructs knowledge using experiential learning. The constructivist, transformational theoretical framework is fully represented through placing students in a simulation experience that promotes experiential learning and the reflective learning that follows the exercise. As Kaplan and Ura (2010) comment the SBL exercise will be incorporated into the curriculum due to its success from both the student and faculty perspectives.

Both Kaplan and Ura (2010) and Sharpnack et al. (2011) are compelled by the IOM call to transform nursing education for improved safety and quality of patient outcomes. Kaplan and Ura (2010) provide a detailed summary of the application of the cited IOM (2003) quality and

safety measures in their delegation simulation exercise; these measures are identified as core competencies for Canadian baccalaureate education (CASN, 2011). Sharpnack et al. (2011) use a simulation experience that incorporates standardized patients to promote student leadership skills in delegation, prioritization, and allocation of patient care resources. Faculty create a dynamic, simulation exercise with quality and safety errors embedded that is undertaken by 66 students of a nursing leadership course over three consecutive semesters; they are randomly assigned to two groups. One group completed a standardized assessment (SA) before participating in the scenario whereas the other group completed the SA following the exercise. Findings revealed that the first group of students score on the 68 percentile for both the baccalaureate program and nationally; the second group score 83% and 73% respectively. Student comments demonstrate their disappointment in their proficiency and faculty note the majority of students found it difficult to prioritize tasks for more than one patient and to delegate to NAP. During the debriefing sessions students articulated that the simulation exercise was valuable, and that if the exercise was offered earlier in the program it would allow them to enhance their leadership skills. Sharpnack et al. (2011) conclude that this simulation exercise addresses the need for graduate nurses to meet the practice requirements of the work setting and to improve their leadership skills through the use of a realistic simulation experience.

The expectation that new graduates, RNs and LPNs, enter the health care setting prepared for collaborative work in multidisciplinary settings underpins Simone et al.'s (2010) collaborative simulation project to address the competencies of delegation and supervision; including knowledge of the scope of practice. The simulation project took a year to plan, implement, and evaluate. The implementation phase has RN and LPN students participate in a simulation scenario that involves their collaboration in the care of 5 patients; including the

nursing functions of assessment, prioritization, and delegation of care. Multiple faculty members are involved in evaluating students as individuals and as teams during debriefing sessions where students complete questionnaires and receive feedback on their performance. This study found that students are positive about the opportunity to gain practical experience, to collaborate with other student groups, and to care for more than one or two patients simultaneously. Faculty note varied individual performances by students but that as a team delegation was appropriate, members communicated well, and students perform within their scopes of practice. The project, a collaborative initiative that engaged three schools of nursing, provides a unique opportunity to learn about teaching student leadership in delegation, supervision, scope of practice, and culturally competent care (Simones et al., 2011).

As with Kaplan and Ura (2010), Sharpnack et al. (2011), and Simones et al. (2011), the gap between the preparation of prelicensure nurses and their readiness for the practice environment resonates with the problem addressed by Lekan et al.'s (2011) study. An educational innovation grounded in constructivism, experiential learning, and self efficacy has students conduct heart failure assessments of clients and teach the NAP to observe and report signs and symptoms of the disease. During a seven week gerontological course for senior nursing students, a leadership model combines clinical, online, and classroom experiences to facilitate the development of leadership competencies and evidence based practice. Pedagogical strategies include the use of preclinical preparation, faculty role modelling of clinical teaching strategies, student implementation of a teaching plan, and the use of reflective journaling. Findings from the analysis of quantitative data of 51 of the 56 students demonstrates significantly increased knowledge of heart failure and of the 40 students completing the RN Delegation and Supervision Scale, there was a non-significant trend toward higher post-test

scores on readiness for delegation. Eighty percent of students in this study agreed or strongly agreed that delegation provides RNs the time to attend to the work that they need to do; 70% of students agreed or strongly agreed that delegation provides the RN a leadership role in long term care. Demonstrating ambiguity, 60% of students agreed or strongly agreed that delegation in long term care contributes to poorer quality of care and one third of students felt that delegation in the nursing home environment placed the RN at risk of losing their nursing license. The researchers remark that this educational intervention “provides a rich, authentic encounter that integrates multiple concepts, examines multiple perspectives, and provides tools for confronting the organizational complexity of the care environment and the physiologic complexity of older patients in this setting in a learn-by-doing approach”(Lekan et al., 2011, p.210). A vitally important comment made in concluding remarks of this study is that nurses in all settings and at all levels need to view themselves as leaders thus nurse educators must foster these leadership competencies in prelicensure education (Lekan et al., 2011).

Students in Lekan et al. (2011) comment that teaching the NAP and LPNs facilitated stronger relationships with these providers and the dissemination of nursing knowledge regarding heart failure to these caregivers. Similar sentiments are expressed by students in Kling’s (2010) clinical leadership project; through teaching and mentoring, relationships are forged and interest in the role of nurse educator developed. Senior nursing students gain experience in the role of nurse educator and nurse leader as they direct the care of patients through assigning, delegating, and supervising junior students (Kling, 2010). Kling cites Kolb’s (1984) learning theory based on knowledge creation through the transformation of experience as the theoretical underpinnings of the project. All of the 34 students who complete the evaluation questionnaire believe that the experience assists them to learn how to coordinate care and to

delegate tasks at least a little bit. Kling (2010) comments that the project has exceeded stated goals promoting the development of competence and confidence in time management, making assignments, delegation, supervision of patient care, and providing or receiving feedback.

Believing that changing models of care have made it essential that nursing curricula place emphasis on delegation, content was added to a nursing leadership course (Powell, 2011). The approach included didactic content, case studies, and a clinical placement involving a preceptored experience that allows students to consolidate skills gained in the classroom. Students reflect on the use of delegation skills in their reflective journals and faculty meet with students and preceptors to discuss the student's acquisition of leadership skills through delegation. Outcome measurement of student performance, measured through standardized exams for leadership, demonstrates that the overall scores increase by 20 points and are above the national average (Powell, 2011).

In a recent paper, Hasson et al. (2012) confirm Powell's (2011) account that changing models of healthcare delivery have made urgent the need for RN competence in the delegation of patient care. Two phases of a sequential transformative mixed method research design are described by Hasson et al. (2012). In the first phase, 45 student participants are involved in focus groups or individual interviews thus providing data regarding their preparation and experience with delegation to NAP that grounds a student survey for phase two. There are 439 participants in phase two representing three levels of nursing students; over half of the participants had worked as NAP prior to entering the nursing program. Participants of phase one note they are familiar with the role boundaries between RN and physician but have not been provided content about the accountability, training, and supervision of the NAP. Many phase one participants express the belief that students should provide patient care independently,

however, some students in the higher levels recognize the need to delegate but are constrained by inexperience and a lack of confidence. Students note that when they are unable to delegate patient care they are unable to participate in the clinical learning opportunities available to students with better time management. Students in the third level state they learn, out of necessity, to delegate independently during their final level of nursing education (Hasson et al., 2012).

In phase two 78% of students do not believe their education has prepared them to work with the NAP and 81% reveal that they have not been exposed to a description of the accountability issues related to working with the NAP. The researchers attribute the differences between students who have been exposed to this content to the individual approaches of nurse educators (Hasson et al., 2012). This suggests, in my view, that there are varying levels of knowledge and experience regarding the competency of delegation within nursing faculty. Student responses in phase two demonstrate that 54% of students believed they were not taught how to delegate (Hasson et al., 2012). Nineteen percent of respondents saw themselves as educated to delegate, and 26% were undecided. Of concern is the finding that 80% of students in phase two approve of the NAP working unsupervised. In a subsequent question only 25% of students agree that the nurse should supervise NAP working with patients; there was no significant difference between those with or without the experience of working as an NAP in the past. According to Hasson et al. (2012) this study highlights that participants perceive a lack of classroom and clinical preparation to supervise and delegate NAP; delegation skills have been learned independently resulting in resistance to delegation or fear and uncertainty with the process.

A plethora of evidence that delegation education is valued by students is provided in these project descriptions, and a variety of strategies are offered to pattern delegation education upon. In all cases there is acknowledgement that delegation education is best undertaken through a multi pronged approach of pedagogical strategies. There is consensus that it is challenging to offer students the clinical experience of delegation but that experience is essential to consolidate theoretical knowledge. Simulation offers an alternative strategy that may prove valuable to nurse educators as they strive to increase experiential opportunities for students. Nursing students must be provided educational experiences which prepare them to delegate in practice but also to prepare them as the future leaders resolved to ensure that a standard of excellence in nursing care reaches the bedside.

### **Delegation a covenant of care**

This literature review began with the discussion that the nursing role in today's global health care setting requires the competency of delegation and as Anthony and Vidal (2010) emphasize "delegation is here to stay, delegation is here to stay"(p.8). Delegation is integral to safe patient care; within the trusting relationships between RNs and NAP is the potential for safe, quality care and decreased opportunity for missed care and unintentional outcomes (Anthony & Vidal, 2010). Professional nurses must ensure that nursing care, the cornerstone of nursing practice, is maintained (Bittner & Gravlin, 2009) as nurses perceive that they are the stewards and brokers of healthcare resources (Weydt, 2010). The public relies on RNs to ensure the quality of care is maintained throughout the delegation process; ANA notes that nurses have a social contract with society and accountability to the public (as cited in McInnis & Parsons, 2009). As Hirst and Foley (2001) note, delegation raises ethical concerns for nurses regarding the fair allocation of resources; who receives delegated services and whom is cared for by the

nurse or family? According to Corazzini et al. (2010) nurses must keep the discussions of delegation issues and the contents of the Nurse Practice Acts that guide delegation in the forefront of nursing discourse.

Nurses in all clinical settings and levels of responsibility must be leaders (Lekan et al., 2011), and they must have a voice in health care organizations about the safe and effective use of delegation (Nyberg, 1999). According to the ICN (2004) national nursing associations must endorse practice models that utilize appropriate delegation of care by RNs to promote maximum effectiveness of the nursing team and safe, quality patient care. Chief nursing officers are accountable for monitoring the competence of their nurses' abilities to delegate (ANA & NCSBN as cited in Potter et al., 2010). Nurses in Bittner and Gravlin's (2009) study identified the following issues in system support for effective delegation: inadequate staffing levels, a lack of clerical assistance, shortages of supplies and equipment, and the need for support from nurse leaders. Carr (2005) adds that study findings show a key requirement for successful delegation is a consistent workforce of delegates with standardized skills. If nurses become more involved with planning models of care delivery and the decisions involved with this process they would have an enhanced comfort level with both delegation and supervision practices (Anthony et al., 2001). This extends to RNs becoming more involved in evaluating and reforming the competencies of the NAP to ensure their partners in the delivery of safe, quality patient care have the appropriate skills and knowledge (Nyberg, 1999).

The findings of this section are not voluminous but they are powerful. RNs must be leaders at the bedside and leaders in the stewardship of nursing care. The practice sites of nursing will always be in flux as the challenges of patient needs, technology, and healthcare resources evolve. The models of care delivery of the present require nurses to have competency



in delegation and the prediction is that the role of the RN will encompass more leadership responsibilities in the future. Nurses cannot take a reactive stance to the evolution of healthcare, we must be leaders of change that is responsive to the society within which we practice and are compelled by the public's trust to ensure that an excellent standard of nursing care thrives.

### **Summary of the Literature Review**

The review of literature began with a discussion of the nursing role today in relation to the competency of delegation. Globally there is need for nurses to have expertise in delegation in response to models of care delivery that maximize the human and fiscal resources of healthcare. Enacting the leadership ability of delegation requires that each nurse negotiate a proximity to the patient that involves working through others yet ensures a standard of safe, quality care. There is evidence that many nurses have not been exposed to delegation in their nursing education and that their abilities have been developed ad hoc in the workplace. As a competency for nursing this is not acceptable and the need for a standardized approach to delegation has been raised by professional nursing associations (ANA & NCSBN, 2006; CRNBC, 2007).

The complexity of delegation is revealed in the effort to define delegation. Each nurse must adopt the definition of delegation rendered by the professional regulatory body that provides their nursing licensure. The literature cautions that these definitions vary in their prescriptive wording and that nurses may be left to interpret the definitions using nursing knowledge and clinical and ethical judgment. The concepts of authority, accountability, responsibility, and assignment must be understood in relation to definition of delegation. A procedural script for delegation may accompany the definition provided by the professional nursing organization or the nurse may be guided by the statements of a national nursing

organization such as the Joint Statement of the ANA and NCSBN (2006) or a decision making model such as Conger's (1994) NADG. Student nurses are guided in the competencies they must attain by the national nursing body that oversees the standardized nursing exams required for licensure.

To delegate effectively nurses draw from multiple ways of knowing and apply their knowledge to the contextual and relational environments that delegation occurs within. Critical thinking underpins the judgment that must be exercised in the delegation process. Nurses draw on the skills that serve them throughout the nursing process: communication, relational skills, assessment, planning, supervision, and evaluation. From the research conducted regarding nursing attitudes toward delegation it is clear that a wide array of attitudes exist and that these attitudes impact the delegation process.

Some nurses view that delegation confers the opportunity to attend to those nursing functions that require the specialized knowledge base and skill of the RN. Delegates are viewed as empowered through: an increased access to nursing knowledge, involvement in the care planning processes of the patient, and the responsibility for carrying out tasks that fall outside of their job descriptions. RNs view their role in developing the abilities of the NAP in a positive light however raise the contextual realities of difficult time management and staff shortages that compromise these affirming attitudes toward delegation. In contrast, some nurses view delegation as role erosion; denying patients the proximity of an RN for all direct care activities and compromising the safe, quality care that the RN may provide. The discourse of delegation in nursing provides much opportunity for analyzing the professional, ethical, and personal views of nurses and student nurses.

It is vital that nurse educators approach teaching delegation in nursing education with the view that all nurses require this leadership ability. Nursing leadership is required at all levels of health care planning to ensure that the standards of nursing care established reach the patient, either through direct nursing care, or the ability to safely supervise competent, caring providers. Delegation compels nurses to work through others and nurses must have a voice in the standards of training and role descriptions of their assistive providers. Nurses must lead the discussions in healthcare that render decisions about models of care and the skill mix of providers within these models. Likewise, nurse educators in academic and workplace settings must collaborate to ensure the seamless transition of delegation education from prelicensure education through orientation to continuing education experiences.

The literature focused on the education of nurses and students with regard to delegation is compatible with a theoretical lens grounded in constructivist learning, transformational pedagogy and Caring Science. The studies reviewed and projects described contribute to the knowledge of educators about the importance of ensuring adequate curricular content and clinical experiences related to delegation. There has been inadequate attention devoted to delegation in the past and evidence that structured learning experiences improve students' level of competence in delegation. It is likely that there is a wide range of experience, knowledge, and confidence among nurse educators regarding the competency of delegation. Adequate preparation is vital for nurse educators to teach delegation, and they must be provided the opportunity to engage with delegation content and experiences reflective of delegation practices in the context of health care today. The collaborative approach between instructors to plan simulation exercises in delegation is an example of a project that could meet the learning needs of the faculty and improve the curricular approach for students.

Simulation exercises provide students a realistic environment in which to develop their experiential knowledge of delegation. A variety of pedagogical strategies are described that construct foundational knowledge of delegation through the exploration of content and practical experiences; these strategies often employ self reflection and engagement in transformational learning opportunities. The content of the literature review has provided a composite of nursing knowledge of delegation. This knowledge provides the foundation of a curriculum blueprint for undergraduate nursing studies.

### **Curriculum Blueprint**

Curriculum is defined “as the interactions that take place between and among students, clients, practitioners, and teachers with the intent that learning takes place” (Hills & Watson, 2011, p.142). The curriculum blueprint offers a framework which guides these interactions while the instructional design, “the means by which knowledge comes to life and is applied to actual nursing situations”, awaits the creativity of the individual educator ( Jillings & O’Flynn-Magee, 2007, p.393). The theoretical framework explicated in the background section influences the application of findings from the literature review in the design of the curriculum blueprint. The curriculum blueprint is not a static document; rather, it will be adapted as the needs of students, teachers, and patients dictate through their interactions in the collaborative learning environment.

Biggs (2002) states a constructivist alignment approach begins by asking “What do we want the student to be able to do as a result of learning?”(as cited in Joseph & Juwah, 2012). The intent of this curriculum is to have the student demonstrate the knowledge, skills, judgment, and personal attributes that provide evidence of their ability to enact effective delegation at the level of a graduate nurse. Hansten (2011) cautions that it is unrealistic to expect graduate nurses

to be proficient delegators; rather, they must be armed with basic concepts that can be applied under the mentorship of experienced nurses. The curriculum blueprint offers a guide without being prescriptive in the content utilized to meet the goals suggested. If nursing is to remain relevant and responsive to the society which it is practiced within then “nursing curricula need to be reexamined, updated, and adaptive enough to change with patients’ changing needs and improvements in science and technology”(Institute of Medicine, 2010, p.2).

The curriculum blueprint, viewed in appendix B, begins with the description of the curriculum; an overview of what the student should attain through the curriculum offered. Ten goal statements detail the “knowledge, values, and competencies” that students will demonstrate upon program completion (Jillings & O’Flynn-Magee, 2007p.395). The goals developed are applicable to each of the four years of an undergraduate degree program; however, constructivist theory imposes the expectation of incremental student knowledge acquisition and praxis each year. The suggested approach to engage students with each of the ten goals is presented in a chart format that allows the educator an overview of the expectations for student achievement and specific expectations for each goal. The individual nurse educator will interpret and adapt the blueprint to reflect the theoretical framework and pedagogical foundation that underpins their approach to nursing education.

The literature review provides expert opinion and research findings which establish a foundation for the curriculum blueprint. Delegation education, as suggested, is initiated early and is constructed over a four year period. Students in the first year begin to build knowledge and skills that will inform their clinical judgment and impact the personal attributes they bring to delegation. As noted, the long term care environment is a rich environment for student learning of the scopes of practice and roles of providers; students will observe the delegation of nursing

care every shift. The focus on using communication and relational skills is broadened to incorporate a focus on building relationships with each of the health care team providers through ensuring students work with or shadow these providers over the course of the clinical rotation. Students will acquire practical observations and experience that inform the literature collected about scopes of practice and job descriptions.

The first year of nursing is considered a time to consolidate basic skills. Basic delegation skills would encompass a first year student recognizing delegation, identifying the participants of the delegation process, knowledge of the participant roles and scopes of practice, discussion of the unique patient needs and circumstances, identifying the nursing task transferred, and the outcome of this task transfer for the patient. The theoretical and experiential knowledge built in first year provides the substance for the exploration of discourse in the second year.

During the second year of the nursing program, the overarching focus is for student engagement with the critical view of effective delegation. Using the theoretical and experiential knowledge they have acquired, students will engage in an instructor facilitated exploration of the concepts of delegation and begin to identify the relationships between accountability, responsibility, and authority. Students will use their own experiences detailed in a first year assignment to begin a rudimentary exploration of the concepts of power, knowledge, and control.

A problem based approach may be facilitated by the instructor which encourages students to identify their learning needs regarding the process of effective delegation. In groups, students can research these various topics and present their findings to the class through a variety of methods. For example, a student group could compose short skits demonstrating skilled communication versus ineffective communication in the delegation process. The instructor's role is to utilize strategies such as critical questioning to ensure that vital content regarding

effective delegation is researched by students and that class discussions encourage a variety of perspectives.

Student exploration of the tools which support effective delegation may take the form of a group discussion or an individual assignment. Clinical experiences and self reflection should be used to consolidate student understanding and meaning making of the concepts of delegation, the identification of delegation as a process requiring a composite of skills, and the exploration of a tool such as the five rights of delegation or a decision making tree as a framework for this process. Clinical instructors may utilize peer delegation to facilitate the students' use of communication, relational, supervisory, and evaluation skills and to grasp their accountability for the care of the patients assigned to them.

The focus of the third year is to solidify the skills of delegation and provide students the opportunity to identify their own strengths and weaknesses in order that they construct a learning plan to self direct learning over the remainder of their program. Instructor facilitated or simulation exercises provide students a safe venue to explore the practical aspects of delegation and to attain facilitator, peer, and reflective feedback on their performance. The literature reviewed offers simulation exercises, clinical opportunities to delegate to junior students, NAP, and LPNs, and strategies to employ the use of tools such as the NADG. The learning plan created in the third year will be refined in the fourth year of the program.

The final year of the program offers the supportive environment for the student to examine their personal knowledge and practice of delegation and to refine their learning plan to reflect their needs and the context of their preceptorship. Simulation exercises and clinical projects may be continued however the attempt should be made to incorporate delegation into the clinical practices of students. Students will construct an evaluation tool for their preceptor's use

that will guide the preceptor in planning learning opportunities for the student and the student's evaluation. The evaluation tool and the learning plan provide the student the tools for planning their learning goals as they transition to the workplace and assume responsibility for their continued competence self assessments in their professional role.

I have provided detail of the interplay between theoretical and practical experiences that allow students to build praxis as they attach meaning to propositional knowledge through collaborative experiences. Transformational pedagogy is threaded through the curriculum in the approach to classroom, laboratory, and clinical learning. Students collaborate with peers, health care staff, and patients; practice self reflective activities; and experience a variety of contexts for delegation in the process. Instructor facilitated discourse provides the opportunity for a critical view of delegation and to frame the practical experiences with new perspectives.

Interdisciplinary education would offer an excellent opportunity for students to collaborate in delegation exercises and to place the disciplinary roles and scopes of practice in a human context. Activities such as having senior NAP students evaluate the basic skills of first year nursing students assists both groups of students to gather knowledge of each other's approach to care and scopes of practice.

The literature is clear that the multiple ways of knowing required for the clinical judgment that underpins effective delegation must be informed by theoretical and experiential knowledge. Grounding this quest for knowledge in a Caring Science approach ensures students have a supportive environment for developing the competency of delegation; egalitarian, respectful relationships are an expectation of this environment and modelled by instructors. The nursing discourses of knowledge, power, and stewardship of safe, quality patient care are foundational to Caring Science; delegation competency may be threaded through the exploration



of these discourses. CASN (2011) advises that baccalaureate nursing curricula should have “Learners develop mastery in effective, knowledge-based, team-practice that is safe and ethical” (p.2). This curriculum seeks to meet this objective by preparing graduates with knowledge, skills, judgment, and the personal attributes which promote effective delegation practices and safe, quality outcomes for patients. The curriculum blueprint I have constructed is a beginning not an end; it offers a starting place to address the urgent need for nurse educators to support the student attainment of the core competency of nursing delegation.

### **Conclusion**

The impetus for this project issued from my own transformational learning as I studied at the graduate level of nursing and simultaneously worked as an instructor of Health Care Assistant students. The uniform concern of my graduate peers, myself, and the HCA students for safe, high quality patient outcomes was remarkable as was the collaborative effort to support peer learning towards this goal. My assumption that in an ideal health care system each patient ‘deserved’ total primary care delivered by a registered nurse was challenged and I opened myself to the possibility that a mix of care providers could be the ideal team of providers. Delegation of nursing care with the requisite components of authority, accountability, responsibility, and supervision provides a process for the delivery of nursing care by other providers that maintains the standards of care of the registered nurse.

The decision to perform an integrative literature review provided the opportunity for me to move forward with the construction of a knowledge base grounded within the nursing literature that approached the subject of delegation from both a theoretical and research perspective. Early on in my reading I realized I was not alone in not being exposed to delegation in my undergraduate education or my lack of knowledge about the scope of practice or job

descriptions of providers such as NAP. Perhaps most transformational for me was the realization that nursing leadership at the bedside required skilled delegation if nurses were to utilize their knowledge and abilities to the full scope of their practice.

The creation of a curriculum blueprint, grounded in the content of the literature review, offered the opportunity to build constructively the knowledge introduced in my Master's in Nursing Education program. The choice to situate this curriculum in Caring Science issues from my own belief that the reciprocal sharing of knowledge and power within the relationships of providers offers the promise of strong teamwork and the shared goal of positive outcomes for patients. I offer this project as my voice in the discourse of delegation with the belief that the right mix of providers for patient care is a group united by their caring approach and the goal of optimum patient outcomes.

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## Appendix A

### Table of Articles Reviewed

Type of Article	Author and Date	Key Themes or Findings
Qualitative study	Alcorn & Topping (2009)	The intent of the study is to obtain the view of RNs regarding their responsibilities with NAP, specifically toward delegation, development of the NAP, and accountability. Results suggest RNs are aware of their accountability, believe that NAP should be regulated and with adequate preparation the NAP could be held accountable for their practices. Authors conclude prelicensure RN education should equip the graduate to supervise and delegate to NAP.
Qualitative study	Bittner & Gravlin (2009)	Qualitative, descriptive study with the intent to understand the use of critical thinking by nurses in the delegation of nursing care. The findings explore the content of nursing judgment and the nurses' expectations of the NAP with regard to critical thinking. Insight is gained into the factors that contribute to effective delegation. Ineffective delegation is implicated in missed care and negative patient outcomes.
Qualitative study	Carr (2005)	Study addresses the gap in knowledge regarding delegation decision making by nurses. Study findings indicate this group of community care nurses formulate decisions based on the human and contextual facets of their work; decisions are categorized as pragmatic or those based on patient need. Holistic nursing care may be at odds with the delegation of routine nursing care.
Qualitative study	Corazzini, Anderson, Rapp, Mueller, McConnell & Lekan (2010)	This study examines how RNs in leadership roles in the long term care setting delegate care. Two key approaches are identified; one which considers the scope of practice of caregivers while the other utilizes job description. Insight is provided into the benefits of delegation and barriers to effective delegation.
Qualitative study	Hirst & Foley (2001)	The views of community case managers in Calgary, Alberta are examined with respect

		to delegation. Findings discuss the definition of delegation provided by participants; the relational context of delegation including traits of the participants which contribute to effective or ineffective delegation; barriers to delegation; and the contextual factors which impact delegation. A delegation model is constructed representing the study findings.
Qualitative study	Potter, Deshields & Kuhrik (2010)	The perceptions of RNs and NAP delivering oncology care are examined with regard to delegation. Both groups identify conflict, communication, and teamwork as key themes; RNs also consider the roles of providers whereas the NAP focus on accountability, initiative, and patient centeredness. Effective delegation is dependent on the quality of relationships, communication, and the dedication to teamwork of the nursing care team.
Qualitative study	Schluter, Seaton & Chaboyer (2011)	This study examines nursing roles and scopes of practice, finding that the context of healthcare today has required the RN to renegotiate their proximity to patients and to seek teamwork strategies that protect patient well being. The interfaces between care providers are the catalyst for changes in nursing practice; challenging the ability of nurses to deliver safe, quality care in the face of increasing patient acuity, short hospital stays, nursing shortages, and changes to the skill mix of care providers. Successful negotiation requires creativity, strong communication skills, and respect for the contributions of all care team members.
Qualitative study	Standing & Anthony (2008)	Phenomenologic study which describes the perspective of acute care nurses of the meaning, process, and outcomes of delegation. Findings reveal nurses have varied conceptual definitions of delegation which highlight the need for nurse educators to address the concepts of delegation in prelicensure and continuing education. The relational and communication aspects of delegation underpin the quality of the process of delegation. The significance of

		delegation is the outcomes for patients and nurses; both positive and negative outcomes may result.
Qualitative study	Standing, Anthony & Hertz (2001)	Study addresses the lack of research into the clinical outcomes following the delegation of direct nursing care to NAP. Study findings indicate that negative outcomes are most frequently attributed to improper directions and not adhering to institutional protocol. Positive outcomes resulted from NAP following directions, remaining attentive, and adhering to policy. The quality of communication and need for RN supervision are highlighted in these results.
Quantitative study	Anthony, Standing & Hertz (2000)	An American nationwide survey of nurses which seeks to identify the impact of practice setting characteristics, the education and experience of nurses, and type of supervision on the outcomes of delegated care. Findings reveal that positive outcomes of delegation are associated with increased overall nursing experience and direct supervision which is planned and intentional.
Quantitative study	Anthony, Standing & Hertz (2001)	This study examines nurses' self reported rating of their ability to delegate and supervise in relation to their educational backgrounds, experience, practice settings, geographic locale, and work responsibilities. Findings reveal that nurses rank their abilities to delegate highly; their educational preparation for delegation is given the lowest ranking. There were no statistical differences noted related to education, experience, practice site, or geographic region. Nurses in acute care indicated they delegated more frequently than home care nurses.
Quantitative study	Conger (1994)	A pre-experimental study design examines the effectiveness of a decision making guide, the Nursing Assessment Decision Grid, to teach nurses to delegate. Post-test results demonstrate statistically significant increases in the RNs' abilities to identify nursing tasks, identify clinical problems and to create an assignment which allocates

		appropriate functions to RN or LPN caregivers. The suggestion is made to test the tool in clinical practice.
Quantitative study	Gravlin & Bittner (2010)	This study investigates the frequency and reasons cited by RNs and NAP for missed patient care in the quest to identify factors which contribute to effective delegation. Findings reveal that missed care is common and most frequently occurs in the routine activities performed by NAP. The top three reasons provided by RNs for missed care reflect their inability to manage patient flow, changing patient acuity and unit needs, and that missed care was not reported by the NAP. Factors contributing to effective delegation are good communication, positive attitudes and relationships, and the competence and knowledge of the NAP.
Quantitative study	Henderson, Sealover, Sharrer, Fusner, Jones, Sweet, & Blake (2006)	Based on background evidence that the majority of nursing graduates have not been taught to delegate these two studies examine students' knowledge of and the ability to use delegation in clinical practice. In study one, 20% of students correctly define delegation; although level 3 students provide the highest percentage of the five rights of delegation, none of the students can identify all five. In study two there is a significant increase in the ability of students to identify the five rights of delegation following a classroom intervention. Researchers recommend introducing delegation content early in the curriculum and placing emphasis on the practical application and measurement of ability.
Quantitative study	Parsons (2004)	This study utilizes Conger's NADG model to measure the delegation knowledge of RNs practicing in acute and long term care (LTC). A researcher developed survey is used to collect data related to nursing experience, level of education, demographic information, comfort level with delegation, job satisfaction and previous exposure to delegation decision making. There were no statistically significant differences in the scores achieved by acute care RNs and LTC

		RNs related to the tasks of Conger's NADG. Fewer than half of participants learned to delegate in their nursing education; they learned to delegate on the job or through workplace education. Though job satisfaction was moderately high, comfort levels with delegation for both groups were relatively low. The author concludes that these findings support the need for delegation education as an essential skill for nurses.
Quantitative study	Parsons (1998)	The study purpose is to determine if an educational intervention using Conger's NADG would result in a significant increase in delegation decision making knowledge and job satisfaction. The results demonstrate significant improvement between pre and post test scores in the experimental group across the three parameters of task analysis, problem analysis, and patient assignment. With respect to job satisfaction, significantly higher ratings in the categories of promotional opportunity and autonomy were demonstrated. The researcher concludes these findings support the NADG as a tool for nurse delegation decision making.
Quantitative study	Saccomano & Pinto-Zipp (2011)	This study explores the relationship between leadership style, confidence in delegation, and demographic variables. There were no significant differences found related to the type of leadership style and confidence in delegation. Likewise, there were no significant differences in total confidence scores in relation to educational preparation. It was only when education was correlated with experience that confidence in delegation was shown to be higher initially for nurses with at least a bachelor's degree. This was not sustained as with experience those with less education developed increased confidence. The researchers conclude further research must establish where and when delegation content and experiences should be incorporated into nursing curriculum.

Quantitative study	Sharpnack, Goliat & Rogers (2011)	This study used standardized assessment scores and assessments of the competence of students with regard to leadership, quality and safety proficiencies following an educational intervention. The intervention consisted of a simulation exercise which utilized improvisational actors in patient roles. Following the exercise students demonstrated increased scores on standardized exams and generally identified the experience as positive. Researchers conclude that the simulation exercise allows students to transfer knowledge from theory to practice.
Mixed method study	Hasson, McKenna & Keeney (2012)	This paper describes two phases of a three stage, mixed method research study that looked at the influence of the NAP role on undergraduate nursing students' clinical experience. Phase one utilized interview and focus groups to ascertain the students' level of preparation and experience with delegation to NAP. These findings were used to develop a questionnaire used to gather quantitative data in phase two from a purposive sample of undergraduate students across 3 levels. Phase two results demonstrated the following: 78% of students did not believe their education prepared them to work with NAP; 81% that their education did not provide them a description of the accountability issues related to the NAP; 54% believed they were not taught to delegate; and 80% of students approved of NAP working unsupervised. This study highlights that student participants perceive a lack of classroom and clinical preparation to delegate to NAP.
Mixed method study	Lekan, Corazzini, Gilliss & Bailey (2011)	Analysis of a program intervention designed to address the need for prelicensure students to be prepared for clinical leadership including the competency of delegation. Pedagogical strategies include preclinical education, faculty role modelling of teaching strategies, student implementation of a teaching plan, and reflective journaling. A nonsignificant trend toward delegation

		<p>readiness was noted following the completion of the leadership module. Student reflections contained the following themes: leadership self efficacy; managing the credibility gap; communication; RN accountability in delegation and supervision; and knowledge translation and dissemination to staff. The authors conclude that this program intervention fosters self efficacy and leadership skills in students through classroom and practical experiences.</p>
Expert opinion paper	Anthony & Vidal (2010)	<p>Effective delegation is vital to safe patient outcomes and quality nursing care. The purpose of this article is to explore how mindful communication contributes to effective delegation and directly or indirectly impacts quality and safety outcomes. Mindful communication focuses on information saliency and decay; essential considerations for effective delegation. Nurses must exercise mindfulness in considering the unique facets of the patient and context rather than blind reliance on standardized practices. Delegation occurs within a relational context and the quality of communication that takes place is dependent on the level of trust within the relationship between delegator and delegatee.</p>
Expert opinion paper	Boucher (1998)	<p>Delegation distances the nurse from the patient potentiating missed assessments that would indicate changes in the patient's condition. Effective delegation allows the nurse to maintain a presence with the patient that promotes assessments and interpretations that ensure safe patient care. The essential elements of effective delegation are discussed and presented in a case study format.</p>



Expert opinion paper	Burbach (1999)	Burbach discusses the importance for nurses to understand the principles of delegation and that most nurses have had inadequate preparation for this role. Delegation is approached as a management and legal concept, art and skill, and a decision making process. Information is provided through the discussion of concepts related to delegation, as a question and answer format, and in a post-article test format.
Expert opinion paper	Coburn & Sturdevant (1992)	The authors detail the trends in nursing delivery which make essential the ability to delegate and observe that nurses lack delegation proficiency. Detail is provided of an educational intervention in a leadership course that is designed to provide students the opportunity to utilize delegation theory in practice. Students assume the role of the RN with LPNs to provide care directly or through delegation. The project was a successful collaboration between educators and service providers and enhanced the ability of students to make judgments about delegation and to identify the barriers and facilitators of effective delegation.
Expert opinion paper	Conger (1999)	Conger follows through with the suggestion in Conger (1994) to test the use of her NADG with students in the clinical area. She describes an educational intervention of classroom study of the decision making model followed by a clinical rotation of eight shifts collaborating with an NAP and delegating care. A reflective journal allows outcome evaluation and review. The author concludes that the theory students are exposed to in the classroom setting is reinforced during the clinical rotation and that students learn from the decisions made in practice.
Expert opinion paper	Curtis & Nicholl (2004)	Delegation is emphasized as a key component of nursing practice with benefits for delegators, delegatees, and for organizations. The six stages of effective delegation are explained and barriers to effective delegation explored. The authors conclude that motivation and practice are

		essential to delegation mastery.
Expert opinion paper	Hansten (2008)	Hansten remarks that delegation, key to the use of nursing knowledge and skill at the bedside, continues to be lacking in nursing practice and education. Ineffective delegation results in missed care and errors; RNs must learn to collaborate with NAP to enhance their surveillance of the patient. Hansten provides recommendations to improve the competencies of delegation and supervision.
Expert opinion paper	Kaplan & Ura (2010)	This is a descriptive report of a simulation based learning (SBL) experience designed to enhance the students' confidence and abilities to effectively prioritize and delegate care for multiple patients. The use of simulation addresses the challenge for students to apply the conceptual and critical thinking required for prioritizing and delegating care in practice. The feedback of students is extremely positive and their comments indicate insight into the responsibilities that must be bridged as they transition from the student role to that of novice nurse.
Expert opinion paper	Kleinman & Saccomano (2006)	A detailed discussion is provided related to the challenges of providing nursing care within the healthcare system of today. The benefits of providing care solely by RN providers is contrasted with today's care delivery models that use a mix of skilled providers. The need for the nurse to be proficient at delegation and supervision is emphasized as is the lack of preparation of nurses for these leadership abilities. The authors recommend that education programs focus on providing classroom and clinical experiences in delegation grounded in the social, management, and behavioral sciences.
Expert opinion paper	Kling (2010)	It is challenging to provide students the opportunities to exercise leadership skills in the clinical area. An educational experience is developed for senior students to assign, delegate, and evaluate the patient care delivered by junior nursing students. Senior

		students develop their leadership skills, reinforce their clinical nursing skills, and gain a positive perspective on the role of the nurse educator.
Expert opinion paper	McInnis & Parsons (2009)	The complexity of the health care system has escalated and with the nursing shortage nurses hold a pivotal role in delegating and supervising assistive personnel to provide activities and tasks that once only an RN provided. The public relies on the nurses' understanding of their accountability and responsibility in the delegation process. This paper provides a summary of the delegation process, the concepts related to delegation, and the benefits of effective delegation for the nurse and ultimately for patients.
Expert opinion paper	Nyberg (1999)	Through the lens of the perioperative environment, Nyberg describes the historical evolution of nursing care that has evolved to include a mix of care providers. She describes the benefits for nurses of effective delegation but also provides the conditions necessary to avoid the pitfalls of delegation. Nurses require continuing education that supports their proficiency in the delegation process. Perioperative nurses must critically explore the delegation of tasks to NAP and must ensure that their nursing judgement remains embedded in the care of the patient. Nurses must be involved in developing the training and evaluation of NAP to ensure safe, quality patient care.
Expert opinion paper	Powell (2011)	Powell describes a curriculum revision to add content about delegation to a nursing leadership course. Didactic classroom content and online completion of case studies prepare students for their clinical placement where the student assumes the responsibilities of the RN in a preceptored environment. Students utilize reflective journaling and conferences held between faculty, student, and preceptor ensure that course objectives are being met. Standardized exams completed by the students indicate that leadership scores have

		increased substantially and are above national average.
Expert opinion paper	Quallich (2005)	This paper addresses the uncertainty and confusion that nurses have related to the vague language in Nurse Practice Acts and the numerous types of assistive personnel. Recommendations for effective delegation practices are provided and obstacles to delegation are discussed with an emphasis on the nursing attitudes that cause resistance to delegation.
Expert opinion paper	Reinhard (2011)	This paper addresses the concern that the consumer demand for home care services must be met through the delegation of nursing care or that patients will require institutional care; a costly choice for both patient and the health care system. The perspective of the nursing profession towards delegation is discussed, noting nurse resistance, even though nurses have historically partnered with families and informal caregivers to provide care. A pilot project in New Jersey which supports consumers to self-direct their care is described. Educational sessions for RNs and NAP as part of the pilot project result in some RNs expressing they feel more positive about the delegation process and the prospect of improving care for their home care clients through delegation.
Expert opinion paper	Simones, Wilcox, Scott, Goeden, Copley, Doetkott & Kippley (2010)	This paper describes a simulation project offered through the collaborative efforts of nursing faculty at three Minnesota schools of nursing. The simulation exercise provides a teaching strategy and evaluation tool; students engage with the concepts of delegation, scope of practice, culturally competent care, and supervision. RN and PN students work collaboratively in teams to provide care in the simulated exercise. Student evaluation is positive and faculty plan to continue the project and collaborate with other disciplines in future simulation exercises.
Expert opinion paper	Thomas & Hume (1998)	The perceptions of Canadian graduates from a Midwestern Canadian university are

		<p>acquired using a focus group format. Graduates express concern about their lack of knowledge of delegation and the roles, job descriptions, and skills of health team members. They describe receiving less than one hour of instruction about delegation and their clinical assignments provide experience in total patient care. Graduates state the need for leadership skills such as effective communication, conflict management, assertiveness, negotiating skill, supervision, time management, and clinical decision making. The authors suggest using varied strategies such as case studies, seminars, clinical learning, and analyzing nurse practice acts.</p>
Expert opinion paper	Timm (2003)	<p>Timm provides a concept analysis of delegation arriving at a definition of delegation that incorporates conceptual definitions from management, legal, and professional nursing organizations with the definition of delegation as a process from nursing literature. She uses a four step process; the final step details the antecedents and consequences of delegation.</p>
Expert opinion paper	Weydt (2010)	<p>Weydt discusses the importance of delegation and provides a comprehensive discussion of the related concepts of authority, accountability, and responsibility. The nursing judgment required for delegation is acknowledged and the relational context of delegation is emphasized. Weydt offers a lengthy discussion of delegation and the patterns of assignment that promote or challenge the process of delegation. Suggestions are offered to strengthen the delegation skills of both pre-licensure students and practicing RNs.</p>
Statement of a Professional Organization	American Nurses Association & National Council of State of State Boards of Nurses (2006)	<p>This is a collaborative statement of two associations addressing the urgent need for nurses to be competent to delegate, assign, and supervise assistive personnel. The statement provides a description of the terminology used, and lists the principles of delegation of both organizations which</p>

		include the NCSBN's five rights of delegation. The curricula of nursing schools must incorporate the competency of delegation and offer didactic content as well as simulated and realistic opportunities to delegate. A decision tree for delegation decision making is included.
Statement of a Professional Organization	College of Registered Nurses of British Columbia (2007)	This document provides a thorough statement on the accountabilities and responsibilities of the RN delegating and assigning care in the province of British Columbia. Detailed definitions are provided for delegation and assignment and the two concepts are compared and contrasted. The act of delegation includes the decision to delegate followed by the process of delegation. A decision making rubric accompanies the description of this process. Delegation and assignment are discussed in various care settings. A glossary of terms is included.
Statement of a Professional Organization	International Council of Nurses (2008)	A position statement which offers a global perspective from an international nursing organization regarding the use of assistive nursing personnel. The position is taken that RNs must define, monitor, routinely appraise, and direct the role, education, standards and practice of assistive personnel. The standards of care which assistive personnel must meet are set and supervised by the RN. The concern is offered that task shifting may result in fragmented, unsafe care unless nurses have a voice in the standards of that care.

## **Appendix B**

### **Curriculum Blueprint for Delegation Education in a Four Year Undergraduate Nursing Degree**

#### **Curriculum Description**

This curriculum prepares the student nurse to delegate at a novice nursing level upon graduation. The competency of delegation is a requirement of the graduate nurse and one that is attained through knowledge acquisition, developing skills and judgment through clinical experience, and attaining such personal attributes as attitude and confidence that contribute positively to competence. The curriculum is initiated in the first year of the program and should be threaded throughout the four years allowing for knowledge to be constructed both formally and experientially. A theoretical framework is suggested which is grounded in Caring Science, constructivist learning theory, and transformational pedagogy.

#### **Curriculum Goals**

**Goal One:** Students will articulate a conceptual definition of delegation that emerges from their examination of delegation within the literature of their professional nurse regulatory body. The definition will include the related concepts of authority, accountability, and responsibility, and will contrast delegation and assignment.

**Goal Two:** Students will describe the delegation process congruent with the conceptual definition of delegation of their nursing regulatory body, and they will discuss delegation decision making models that enhance the ability of the nurse to make sound judgments.

**Goal Three:** Students will examine the Scope of Practice of the Registered Nurse that provides the authority to delegate and will contrast their Scope of Practice with that of the LPN and the job description of the Nurse Assistive Personnel within their nurse regulatory and institutional boundaries. Students will articulate familiarity with the acquisition of the aforementioned documents and the policies and procedures related to delegation of the institutions they practice within. Students will differentiate between nursing tasks and nursing functions with respect to delegation.

**Goal Four:** The concept of effective delegation will be explored and students will discuss what determines effective delegation including the facilitators, barriers and contextual factors that impact effective delegation. The benefits for patients, delegators, delegates, and the organization related to effective delegation will be discussed. The concepts of resistance to delegation, over-delegation, and under-delegation will be contrasted with effective delegation.

Goal Five: An examination of the consequences of delegation will be conducted by the student that demonstrates the ability to select a method of examining and measuring patient outcomes, and the outcomes for the delegator, delegatee, and the organization. Students will discuss outcomes in terms of patient safety, quality care, missed, or omitted care and will discuss the relationship between these factors and the human, organizational, and environment contexts of delegation.

Goal Six: Students will examine the competency of delegation required of the graduate nurse and discuss the related concepts of knowledge, skills, judgment, and personal attributes that underpin attaining competence. They will reflect upon their personal and experiential knowledge, skill, and such personal attributes as attitude to create a learning plan that addresses their acquisition of these components of delegation at a novice level of proficiency.

Goal Seven: The relational context of delegation will be examined and students will discuss the elements of trust, power, empowerment, rapport, and cultural safety in terms of the relationships between delegator, delegatee, and the organization. The perspectives of the RN, student, assistive personnel, and patient /family in terms of the relationships with others in the delegation process will be examined.

Goal Eight: Students will articulate and demonstrate behaviors congruent with skilled communication techniques related to the following skills within the delegation process: developing a plan of care through appropriate nursing assessments; interview of the delegatee; providing clear directions and expectations of task performance to the delegatee; clarification of task expectations; providing supervision, support, and intervention to the delegatee; conflict resolution; evaluation of task performance and patient outcome; and provision and receipt of feedback.

Goal Nine: The nursing role related to delegation will be discussed in the context of the current healthcare setting with a focus on the leadership roles of RNs, care delivery redesign, community care, and the use of nurse assistive personnel. Students will examine the discourse of delegation drawing from nursing literature the diverse views on such issues as the benefits of delegation, loss of patient proximity through delegation, and the fear that a nursing license is on the line during the delegation process.

Goal Ten: Students will articulate the role of delegation in nursing leadership and examine nursing delegation in varied clinical and organizational contexts. The role of the nurse as a steward of nursing care will be examined and discussed in terms of the involvement of nurses in developing the roles of nurse assistive personnel and planning of patient care delivery systems.



**Suggested Approach:**

A potential approach is provided in the curricular framework below which utilizes the course goals and provides a focused approach to goal attainment.

	Year One	Year Two	Year Three	Year Four
Focus	Defining and recognizing delegation	Critical examination of effective delegation	Developing the competency of delegation	Examining the performance of delegation in personal practice
Goal One	Exploring the professional literature and defining delegation	Attaching personal meaning to the concepts of accountability, responsibility, and authority	Demonstration of practice behaviors that demonstrate accountability, responsibility, and authority in delegation	Self assessment of delegation praxis with identification of strengths and weakness in theory to practical application.
Goal Two	Identifying the delegation process in the clinical environment	Exploration of the delegation process with a focus on delegation decision making models	Application of the delegation process in simulated experiences or clinical projects	Demonstration of delegation and problem solving through instructor led or preceptored clinical experience
Goal Three	Locating the supporting literature and observation and interview of the NAP, LPN, and RN to acquire knowledge of the roles and scopes of practice	Examining the tasks that can be delegated in contrast to nursing functions	Demonstration of assignment and delegation through simulation or instructor facilitated clinical project	Addressing delegation of tasks in the plan of patient care and adjusting the plan as patient condition or assignment changes
Goal Four	Evaluating an observed event of delegation in the clinical area	What makes delegation effective? Classroom and clinical identification of facilitators, barriers, human,	Delegation through simulated or instructor facilitated clinical exercise with self reflection and	Evaluating the benefits of delegation in own practice with respect to outcomes for patient, self, team, and

		and contextual factors which impact on delegation	critique of effective delegation. Identification of barriers, facilitators within own experience	organization. Identifying resistance to delegation, avoiding, under or over delegation practices.
Goal Five	Evaluation of the outcome of the observed delegation in terms of patient response and interaction between caregivers	Discussion, developing a plan for evaluation of delegation outcomes and implementation through observations, interview, and experience	Self, peer, and facilitator assessment of outcomes of a simulated delegation exercise or delegation project. Identifying factors which impact the outcome as human, organizational or contextual.	Integration of delegation outcome evaluation into evaluation of care plans of a multiple patient assignment under the preceptorship of an RN or instructor led clinical practicum.
Goal Six	Labelling knowledge, skills, judgment, and personal attributes used by delegator in observed event	Exploring the concept of competency and discussion of the knowledge, skills, judgment and personal attributes required for effective delegation. Utilize these with reflection on delegation in the clinical area.	Self evaluation and creation of a learning plan to address acquiring the knowledge, skills, and personal attributes to make sound judgments in the delegation process. Establishing measurable goals to be attained during clinical rotation.	Updating learning plan prior to preceptorship with planning for transition to employment. Discussion of continuing education through orientation, CE in the workplace and annual continued competence evaluation.
Goal Seven	Developing collaborative relationships within the care team that foster	Examining relationships within the care team, identifying collaboration,	Self reflection, identifying strengths and weakness in relational skills	Developing a professional style of leadership through identifying

	the shared goal of safe, quality patient care	trust, conflict and rapport. Instructor led introduction to discourse of power in delegation and examining empowerment.	during delegation in clinical area or simulated exercise, address in learning plan. Incorporate peer and instructor feedback.	mentors, preceptor feedback, self reflection, incorporating peer and instructor feedback. Behaviors demonstrate transformational learning.
Goal Eight	Identifying and analyzing patterns of communication in the delegation process, including self reflection on interactions with NAP, LPN, RN, peers, instructor, patients, and families	Examine the discourse of delegation and communication, examining language for knowledge, power, control, empowerment, collaboration, and celebration of team accomplishments.	Practicing professional communication in simulated and clinical delegation opportunities. Evaluating outcomes of communication with health care team, patients and families, peers, and instructor	Integrating the professional behaviors of skilled communication into practice. Identifies skilled mentors, seeks feedback from others to improve communication skills within the team environment, including problem solving and conflict resolution.
Goal Nine	Preclinical and clinical discussion of the roles and relationships within the healthcare team related to delegation	Examines the roles of nursing related to delegation historically, in the present healthcare context, and discusses future trends.	Focus on patient proximity in the nursing role, maintains proximity that assures accountability and promotes positive patient outcomes through planning, performing, and reflection in an instructor led or simulated	Using knowledge of the nursing role in delegation to plan for transition to the role of novice nurse, aware of accountability, legal obligations, and scope of practice. Identifies mentors during preceptorship and evaluates learning plan.

			environment	
Goal Ten	Identifying nursing care and delegation of nursing care, following the task through delegation to outcome.	Attaching meaning to responsibility and accountability; discussing, planning, and delegating to peers to transfer responsibility but maintain accountability.	Working with the health care team in an instructor led or simulated project to delegate care and experience accountability for patient outcomes.	Develops perception of the care delivery design in the workplace, issues of skill mix, and communication within the workplace. Questions instructor, preceptor, and mentors about delegation practices that impact stewardship of nursing care.
Overarching goal	Understands the definition of delegation, accesses resources which support understanding, and observes that delegation occurs through a process	Critically evaluates delegation as a concept and process which involves knowledge, skill, judgment, and personal attributes. Recognizes that effective delegation is related to human, organizational, and other contextual factors.	Develops behaviors which demonstrate understanding of responsibility, accountability, and authority in a simulated or instructor led project. Develops a learning plan to acquire the competency of delegation.	Enacts learning plan to incorporate the competency of delegation into graduate practice. Aware that proficiency in delegation requires experience and identifies support for continuing education in the transition through orientation to the workplace.

### Suggested Learning Activities/Assignment

First Year Nurses: The first clinical rotation often occurs in the long term care environment; an environment rich with delegation practices. Students are assigned to “catch delegation in action” and to create a written record of the event; complete with process recording. They will compare this event to the Scope of Practice documents of their eventual nurse regulatory body, the job

descriptions of the nurse extender and the policies of the institution to determine if the event was an act of delegation. They would support their conclusion with evidence from the supporting documents and create a visual depiction (possibly a concept map) of the transfer of the nursing task between providers with emphasis on the patient outcome. The expectation would be that the student can determine if delegation actually took place using appropriate references, and integrate the concepts of authority, accountability, responsibility, and the assessment of patient outcome. This assignment is to be saved for analysis in the second year of the program.

**Second Year Nurses:** Students would complete a group project, researching effective delegation and presenting their findings through a class presentation that could take the form of a didactic presentation, narrative display, video, or simulated event.

Following instructor led facilitation of discourse about language and power in delegation, students would critique their first year assignment with a focus on identifying the presence of power and empowerment in the recorded event. The suggested paper length is 2 pages maximum. Alternately students could use their first year event recording and superimpose a delegation decision making model upon this event. A pictorial or written approach would be used to analyze the delegation event in terms of a model or decision making tree.

**Third Year Nurses:** Students will complete a learning plan for delegation which will guide their learning through year 3 and 4. Students will participate in a simulation exercise or clinical project focused on delegation. It is suggested that educators review the following six articles for activities which may be congruent with the resources available to them and adapted to their curricular approach. Students will complete a learning plan for delegation which will guide their learning through year 3 and 4.

Coburn, J. M. , & Sturdevant, N.J. (1992). The acquisition of delegation skills: collaboration between education and service. *Nurse Educator*, 17(6), 32-34.

Kaplan, B., & Ura, D. (2010). Use of multiple patient simulators to enhance prioritizing and delegating skills for senior nursing students. *Journal of Nursing Education*, 49(7), 371-376.

Kling, V. G. (2010). Clinical leadership project. *Journal of Nursing Education*, 49(11), 640-643.

Powell, R. M. (2011). Improving students' delegation skills. *Nurse Educator*, 36(1), 9-10.

Sharpnack, P. A., Goliat, L., & Rogers, K. (2011). Using standardized patients to teach leadership competencies. *Clinical Simulation in Nursing*. Retrieved from <http://www.sciencedirect.com.ezproxy.library.uvic.ca/science/article/pii/S1876139911002465#FCANote> doi: 10.1016/j.ecns.2011.10.001

Simones, J., Wilcox, J., Scott, K., Goeden, D., Copley, D., Doetkott, R., & Kippley, M. (2010). Collaborative simulation project to teach scope of practice. *Journal of Nursing Education*, 49(4), 190-197.

Fourth Year Nurses: Students will update the learning plan devised in the third year to reflect the competency of delegation in the area of preceptorship. Students will prepare an evaluation rubric for delegation proficiency which is critiqued by the instructor and then given to the preceptor to complete at a midterm and final point. The feedback from this document would be a component of the final preceptorship discussion with the student.