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DELEGATION SKILLS: ESSENTIAL TO THE CONTEMPORARY NURSE

Scholarly Project
Submitted in Partial Fulfillment
Of the Requirements for the Degree of
Master of Arts, Nursing, Nurse Educator Concentration

St. Catherine University
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May, 2011

ST. CATHERINE UNIVERSITY
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This is to certify that I have examined this
Master of Arts scholarly project
Written by

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and have found that it is complete and satisfactory in all respects,
and that any and all revisions required by
the final examining committee have been made.

Graduate Program Faculty

Professor Valinda Pearson

Date

DEPARTMENT OF NURSING

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Abstract

Developing economic rationalism is putting more low cost unlicensed assistive personnel (UAP) at the bedside. They are employed to perform repetitive, low-risk patient care activities that in the past were routinely done exclusively by the registered nurse (RN). This new model of practice is considered the viable option or alternative to care provided primarily by the RN, whereby the demand for UAP is only going to grow (Kleinman & Saccomanno, 2006). Most nurse graduates and practicing nurses lack the expertise to delegate direct care to unlicensed personnel. Registered nurses practicing in a variety of health care settings report a lack of knowledge, skills, and attitudes for delegation decision-making skills. This is a result of inadequate education on the subject during nursing school. The purpose of this paper is to present the educational gaps, barriers to delegation, and recommendations for improvement in teaching and practicing delegation. Nursing education needs to teach delegation at the onset of entry into the program and establish a curriculum with specific competencies related to delegation. The use of a conceptual framework and delegation decision-making model guides nurses in making delegation decisions. A professional nurse who lacks the knowledge, comprehension, and competence to delegate care appropriately not only puts the patient at risk for injury, but also puts his or hers own license to practice in jeopardy. The ability to delegate effectively must become a universal competency and fundamental skill of the registered nurse (RN).

Delegation Skills: Essential to the Contemporary Nurse

Today, health care organizations are reorganizing their workforce to reduce labor cost. They are reducing the levels of registered nurse (RN) staffing and increasing the use of unlicensed assistive personnel (UAP). Health care organizations are creating nursing care delivery models that include nursing teams made up of a RN leader and other assistive personnel including UAP. Team nursing is designed to leverage the training, skills and license of the RN so he or she can satisfy the needs of more patients.

In team care, UAPs are expected to perform many low risk nursing care tasks under the direction of a RN. The assessment and complex care tasks are still performed by the RN who has critical thinking and clinical skills. Nursing teams are considered the alternative to one nurse providing all levels of nursing care tasks. The demand for UAP to perform basic nursing tasks is expected to grow. McLaughlin et al. (2000) reported that thirty-one percent of responding hospitals planned to reassign non-nursing personnel to the nursing department.

The role of the RN as a member of a nursing care team is that of a leader, care plan designer, care-coordinator, and quality controller. The RN has accountability for all of the care delivered by the team. To protect the patient, the RN must become a delegator and supervisor more than a performer of care. The RN must add delegation to his or her list of nursing skills. According to the American Nurses Association (ANA) & National Council of State Boards of Nursing Joint Statement on Delegation (2006) the abilities to delegate, assign, and supervise are competencies for the 21st century nurse. The role of the modern day nurse has evolved to that of delegating, directing, guiding, and oversight of care. The RN needs delegation skills to protect the health, safety and welfare of patients.

The purpose of delegation is to ensure that safe care reaches the bedside. Nurses have a covenant of safe care with patients. To fulfill this commitment, nursing should embrace, not dread, delegation. Delegation is now an entry-level nursing practice skill requirement. Questions about delegation have been added to the National Council Licensure Examination (NCLEX) (National Council of State Boards of Nursing, 1995).

Effective delegation creates more time for the RN to perform the high value added nursing tasks, those that require judgment and critical thinking. The RN must be focused on patient population assessment, care planning and managing the delivery of care. The RN creates the care plan and works the plan with a team of assistants, which include unlicensed assistive personnel.

A RN can only succeed if he or she is an effective delegator. The literature shows there is a gap between the expected skill levels and actual abilities of new graduate nurses relative to delegation. A 2009 survey of hospital and health system nurse executives (n = 3,265) indicated only 10% were satisfied with new nurses' ability to delegate care tasks. Of 36 competencies surveyed, satisfaction with delegation skills was ranked the lowest (Berkow, Virkstis, Stewart, & Conway, 2009). Before today's team care model, the care model was primary care where one nurse on each shift had total care responsibility for a small number of patients and the RN had little need to delegate nursing care tasks to others. This led to a decrease in curricular emphasis on delegation (Powell, 2011).

A common theme throughout the literature is that nurses express frustration and confusion about delegation. In 2006, a Joint Statement by the ANA and National Council of State Board of Nursing (NCSBN) clarified some confusion about the definition of delegation. The impetus for defining delegation was the overall workload of the RN, in that there is more

work to be done than there are nurses to do it. The clearest definition was provided by NCSBN in the Joint Statement on Delegation (2006), which said delegation is the transfer of authority to perform a nursing task from one person to another, while retaining accountability for the outcome. For the transfer to be complete, the person to whom the task is delegated must accept responsibility for the successful completion of the task.

It is the RN's job to allocate scarce health care resources and ensure that proper nursing care reaches the bed side. There is evidence that not all nurses understand this. In a study of an orthopedic unit on the use of UAP, the nurses were asked to give their impressions of delegation. Some of the nurses made the comment, "I don't delegate because it is part of the UAP's job" (Standing & Anthony, 2008, p. 9). This study also found that, although staff nurses believed they were prepared to delegate, the nurse manager noted staff nurses were deficient in their delegation abilities (Standing & Anthony, 2008). These findings demonstrate a gap between the abundance of published information on delegation and the understanding of delegation.

Ineffective delegation can lead to missed care. Research outlined the increase in the occurrence of "omitting" or "missing" care due to ineffective delegation by the RN as a substantial issue with "missed care" (Kalisch, Landstrom, & Hinshaw, 2009).

Another research study concluded that 59% of student nurses graduated without any education or training on the process of delegation. The research identified a gap in nursing education programs as one of the reasons for an absence of understanding of the standards of delegation of nursing duties to other persons including UAP (Henderson et al., 2006).

Statement of Problem

A common theme in the literature is that nurses feel they do not understand the principles, strategies, processes, and barriers of delegation. A professional nurse who lacks the

understanding and skill to delegate not only puts the patient at risk, but also puts his or her own license to practice nursing in jeopardy. Nursing education has the responsibility, capability, and capacity to solve this problem.

As the leader of a nursing care team, the RN is accountable for the outcomes. Effective delegation skills are paramount to achieving the desired outcomes. Given the increased employment of lower cost UAPs in health care settings, there is an expectation that the responsible, licensed, professional, registered nurse is competent in the skill of delegation. When the RN is asked to define the principles of delegation and responds with vague answers, he or she demonstrates a lack of knowledge and understanding of the principles and processes of delegation.

Statement of Purpose

The objectives of this paper are:

1. Raise awareness within nursing education of the need to improve delegation curriculum and recommend education strategies to close this curriculum gap.
2. Emphasize the purpose of delegation, as the success of any endeavor is clarity of purpose.
3. Provide an impetus to put delegation competency at the level of critical nursing skills.
4. Identify the barriers to delegation.

Literature Review

Every discussion of delegation should begin with defining the meaning of delegation. Cipriano (2010) defined it well when she said nurses have the authority to assign selected activities of care to other qualified and competent helpers while protecting the health, safety, and

welfare of every patient. In the context of nursing, delegation is the transfer of authority to perform a task from one individual to another while retaining accountability for the outcome (Cipriano, 2010). The RN retains accountability and responsibility for care, but the person who accepts the assigned work also accepts responsibility for performing the work. The purpose of delegation was put into perspective when Corazzini et al., (2010) said delegation by RNs is a primary mechanism for ensuring that professional nursing standards of care reach the bedside.

The concept of team nursing is most advanced in the long term care industry where it has been reported lower cost UAPs provide over 90% of the direct care that nursing home residents receive (Corazzini, et al., 2010). The use of licensed practical nurses (LPNs), nursing assistants, and UAPs to deliver nursing care has become the norm in long term care facilities.

Kalisch et al. (2009) concluded missed nursing care is a universal phenomenon. They found nine elements of care are routinely missed and five of these, ambulation, turning, feeding, hygiene, and intake and output documentation are usually delegated to the UAP. Ineffective delegation was cited by nursing staff as one reason for missed care. The consequences of missed care present threats to patient safety and patient safety is the focus of the practice of nursing. The Centers for Medicare and Medicaid will not reimburse healthcare providers for complications contracted in hospitals (Kalisch et al., 2009). Negative patient conditions due to missed care can cause sizeable losses to provider organizations.

An earlier study on delegation decision-making by RNs found nurses are not comfortable with their delegation skills. The hospital nurses reported learning delegation skills “on the job” 19% of the time. In the same study, nurses caring for patients with spinal cord impairment, where care teams are more complex, reported learning delegation skills “on the job” 50% of the

time. A conclusion of this study supported the need for educational interventions to elevate delegation on the list of basic nursing competency skills (Parsons, 2004).

Cipriano (2010) pointed out delegation remains an underdeveloped skill among nurses, and one that is difficult to measure. It relies on personality, communication style, and cooperation. The success or failure of delegation depends on a positive two-way relationship of mutual respect and trust between the RN and the helper who assumes responsibility for specific tasks. This dynamic exchange between the RN and the helper requires constant evaluation, feedback, and modification to achieve the results needed to meet patient care goals.

The awareness and urgency for increased access to improved delegation education is not universal in the nursing profession. Berkow et al., (2009) in a Nursing Executive Center Research study found nearly 90% of academic leaders believe their nursing students are fully prepared to provide safe and effective care, compared with only 10% of hospital and health system executives. Findings also revealed nurses entering the workforce are not prepared to perform as supervisors. In a survey of nurse executives, directors, and nurse managers (n = 3,265), when asked about satisfaction with 36 expected competencies of new graduate nurses, only 10% of the leaders said they were satisfied with new graduate nurses' delegation competency.

When delegating, everyone's role needs to be defined and made clear. Potter, Deshields, and Kuhrik (2010) found participants described conflict as a central theme during delegation and successful delegation is characterized by effective communication, teamwork and initiative. Participants further pointed out that assistive personnel saw their role as being very similar to that of RNs other than the responsibility of passing medications. Assistants were not aware of the clinical decision-making and patient care management responsibilities of the RNs. It was

concluded that nursing assistants need to learn the scope of the RN's role within the context of day-to-day patient care, so that the assistants can recognize when it is necessary for a RN to delegate tasks quickly without being questioned.

Corazzini et al. (2010) reported on two different approaches to delegation in the long-term health setting, "follow the job description" and "consider the scope of practice". Registered nurse long-term care leaders (n = 33) were interviewed. There was no significant difference in the care outcomes between the two approaches. However, the "follow the job description" group said their environment was organized and predictable as compared to the "follow the scope of practice" group who said they had to accept uncertainty in their daily work environment as they had to continuously negotiate the boundaries of the staff, scope of practice, and corporate policies and procedures. Although only half of the State boards of nursing allow LPNs to delegate care, there is often delegation and assignment of care tasks from the RN to the LPN to the nursing assistant. Cipriano (2010) noted successful partnerships in delegation results in assistants feeling empowered and having a sense of trust.

The literature suggests that interpersonal skills are the key to successful delegation. Curtis and Nicholl (2004) found effective delegation requires skills such as: sensitivity to the capabilities of the team members; ability to communicate clearly and directly; knowledge of the stages involved in effective delegation; and a vision of how delegation can benefit delegators, delegates and organizations.

Ineffective delegation has not been eliminated and additional education is needed. Henderson et al. (2006) stated "Currently, there is paucity of resources for teaching delegation, hence these should be developed and disseminated. Nursing educators should respond by incorporating this knowledge and skill application in nursing curricula" (p. 9).

Bittner & Gravlin (2009) reported ineffective delegation of basic nursing care can result in poor patient outcomes, potentially impacting quality measures, satisfaction, and reimbursement for the institution. Considering this, there is potential for inappropriate and ineffective delegation in acute care.

Delegation is one of the most difficult tasks that RNs face in the practice of nursing. A review of the findings of research shows that many practicing RNs are confused about delegation and want a better understanding of the guidelines. Employers hold higher expectations than ever before that the new graduate nurse will be knowledgeable and skilled in delegation. All of this is occurring at a time when hospitalized patients are sicker with shorter length of stays.

Barriers to Delegation

Nursing should not underestimate the barriers to delegation. Developing a well-rounded understanding of delegation requires knowledge on the barriers to delegation. A review of the literature identifies seven barriers to delegation.

The first barrier is a lack of clinical leadership experience. Corazzini et al. (2010) documented a paucity of RN-level clinical leadership as a barrier to effective delegation. To delegate effectively, the RN must be a leader. Delegation can be a source of frustration unless the RN has the traits and characteristics of a leader.

A second barrier is the occurrence of poorly developed partnerships between licensed RN staff and unlicensed personnel. Corazzini et al. (2010) identified poor partnerships across licensed and unlicensed staff as a barrier to effective delegation. Facing poor partnerships, nurses resisted delegating care and simply did it themselves to avoid eliciting front-line staff resentment. Issues of poor partnerships can sometimes be resolved with leadership skills.

A third barrier is attitude. Corazzini et al., (2010) determined attitudinal barriers prevented effective delegation. The research team lead by Potter and associates (2010) identified five sources of conflict as age, work ethic, role confusion, personality, and dissension. Attitudes are cited as a barrier to delegation throughout much of the literature. Conflicting attitudes among care team members can create resentment within the nursing care team and hamper delegation. Attitudes come from the values of people. Since the population on a care team is diverse, there is a diversity of values within the team. Diverse values are based on generational, cultural, social, religious, political, and other factors.

Fourth, the lack of trust is a barrier to delegation. The RN will not delegate care until he or she can trust the assistant. Quallich (2005) said uncertainty comes from the lack of uniformity among individuals to whom tasks can be delegated and the RN has the duty to determine the individual's competency in a particular situation prior to delegation. Likewise, the UAP has the duty to demonstrate their abilities to earn the trust of the RN. It should be appreciated that many nurses are perfectionists and not naturally inclined to delegate especially while knowing they may have to deal with the consequences of mistakes. Trust is the key component of any relationship and must be developed for effective delegation to become routine.

Fifth, the absence of a clear chain of command is a barrier to delegation. Corazzini et al., (2010) found nurses who had to "follow the scope of practice" while delegating said they had to accept uncertainty in their daily work environment as they had to continuously negotiate the boundaries of the staff, scope of practice and corporate policies and procedures. They faced inherent conflict between how their facilities are organized, structured or staffed (chain of command) and what professional nursing organizations required. Hierarchical confusion needs to be removed. The UAP needs to know for whom they work and to whom they report.

Reporting structures and job descriptions need to be reconciled with the RN role and scope of practice rules. The UAP needs to know essentially that they work for the RN and the RN reports to the patient. Research reports delegation works better when there is a clear reporting structure. Bittner et al., (2009) suggests nurse leaders need to address issues here. Where a clear chain of command exists, Corazzini et al., (2010) reports RNs are effectively delegating despite policy and procedure conflicts within nurse practice acts. A study by McInnis and Parsons (2009) revealed organizations should augment the delegation process and safeguard the authority of the RN by continuously educating the entire staff.

Sixth, the absence of clear role definitions is a barrier to delegation. Role definitions can significantly reduce conflicts during delegation. Potter et al., (2010) discovered respondents described conflict as the central theme during delegation. The major cause of the conflict was assistive personnel saw their role as being the same as the RN except the RN had the responsibility to pass medications. The study reported assistive personnel had no awareness of the clinical decision-making and patient care management responsibilities of RNs. The role of the RN is most credible if it is presented by someone other than the RN.

Seventh, collective bargaining is a barrier to delegation. The 1947 Taft-Hartley Act makes it a law that nurses who are supervisors are not allowed to join a union. Some nurses need to avoid delegation because they may become categorized as supervisors and thereby will be denied their right to collective bargaining (Whitehead, Weiss, & Tappen, 2010; Matthews, 2010).

Ineffective delegation of nursing care can result in poor patient outcomes (Bittner & Gravlin, 2009). To avoid ineffective delegation, barriers to delegation need to be removed. If barriers are not removed, even a RN with Dreyfus Model stage-five-expert proficiency in

delegation cannot delegate without putting the patient at risk. The Dreyfus Model is the obtainment and development of a skill, which the nurse progresses through five stages of proficiency or mastery. The progression of proficiency include: novice, advanced beginner, competent, proficient, and expert. At the expert stage of proficiency the nurse has an intuitive grasp of each situation and a deep understanding of the total situation (Benner, 1984). If the barriers to delegation are not removed the only option for the stage-five-expert proficient nurse is to revert back to using analytic problem solving.

Some aspects of the aforementioned barriers are beyond the control of the individual nurse. The nurse needs the support of the nursing profession and health care industry as a whole to break down the barriers. The nursing profession is in a position of authority and has the stature and responsibility to speak out to society about issues of barriers to delegation. Nursing education leaders are in the best position to initiate and facilitate a dialogue.

All delegation education curricula should include a discussion of the barriers and strategies to deal with them. To help nurses, nursing educators can create constructs that help the student nurse identify a barrier and then educate on how to address the barrier and break it down. The nurse educator can contribute to removing barriers to delegation by guiding the student nurse to withhold delegation until an identified barrier is resolved. Brook (2009), a nurse and an attorney, tells the nurse it is not only acceptable but necessary to say no sometimes to avoid placing the patient at-risk.

Definitions of Terms

Communication is moving information from one mind to another. The method of human communication is language and it relies on words. Communication can only occur if there is a common understanding of the words. At the outset of any discussion of delegation it is

necessary to verify that the meaning of the words is understood. Presented below are the words used to describe the concept of delegation in the practice of nursing.

Accountability: “The state of being responsible or answerable. Nurses are licensed members of the knowledge-based health care profession. They must answer to patients, nursing employers, the board of nursing, and the civil and criminal court system when the quality of patient care provided is compromised or when allegations of unprofessional, unethical, illegal, unacceptable, or inappropriate nursing conduct, actions or responses arise” (ANA, 2006, p. 4).

Assignment: The distribution of work that each staff member is responsible for during a given work period (ANA, 2006). This word is typically used where workers are organized in a clear hierarchical reporting structure.

Authority: The legal authority or permission to do an act (ANA, 2006).

Critical thinking: A rational reasoning process that involves applying knowledge, skills, attitudes and values for the purpose of making a decision that affects patient care. Critical thinking uses clinical and professional judgment in each phase of the nursing process.

Registered nurses need to have the ability to exhibit certain habits of the mind and practice an array of cognitive skills that give them the ability to be resourceful and inventive to achieve positive outcomes and avoid errors and omission of care (ANA, 2006).

Delegation: The RN has the authority to direct another individual to perform a nursing care task while the RN retains accountability for the outcome (Cipriano, 2010). The loop must be closed, the nurse must verify the delegated task is performed successfully, don't delegate and assume all is well and good.

Nursing assistive personnel (NAP): Individuals who are trained to function in an assistive role to the licensed registered nurse. The NAP provides patient care activities as

delegated by the RN regardless of the title of the individual to whom nursing tasks are delegated. The term includes, but is not limited to, nurses' aides, medication aides, orderlies and attendants or technicians (ANA, 2006).

Unlicensed assistive personnel (UAP): Includes nursing assistants, personal care attendants, and medical assistants. The UAP has minimal education, training and skills. They also perform skills and activities that require specialized training, including taking vital signs, doing finger sticks for blood glucose monitoring, and transferring patients using mechanical lifts (Corazzini, et al., 2010).

Delegation Model

Throughout the nursing profession the use of theoretical models has provided a foundation that guide the nurse in the delivery of nursing care. The 2006 Joint Statement on Delegation by the ANA & NCSBN developed a model that articulates the process or steps of the delegation process. A model the nurse can use to guide and reassure that he or she makes the right decision is most helpful.

The ANA (2006) Principles of Delegation Model (refer to Figure 1) has remained constant since 1950. The model addresses the overarching and nurse-related principles of the delegation process. The constructs of this model are the five rights of delegation: right task, right circumstance, right person, right direction, and supervision.

Conceptual Framework

A brief discussion of a framework is appropriate to describe how the utility of a framework can assist in the delegation process. The Situated Clinical Decision-Making Framework (refer to Figure 2), a conceptual framework used to assimilate context, foundational knowledge, decision-making processes, and thinking processes is ideal to guide the RN and

student nurse in the delegation of nursing tasks. This framework is situated within the context of nursing practice, the nurse as an individual, and the scope of nursing practice. It provides a *modus operandi* to help nurses reflect on the decisions they make in their clinical practice and develop expertise. The primary benefit of this framework is it nurtures the development of the nurse's knowledge, skill, and confidence (Gillespie & Paterson, 2009).

The applicability of the Situated Clinical Decision-Making Framework to this topic on delegation are: (a) this framework has been used in the acute care settings to assist the practicing nurse in decision-making; (b) the foundations of knowing the profession, knowing the self, knowing the case, knowing the person, and knowing the patient aligns well in the practice and skill needed to delegate appropriately; and (c) the current health care environment of increased patient acuity and introduction of UAP, constitutes the need for knowledge and understanding of decision-making to delegate effectively and safely. This framework is a means to assist the nurse educator in teaching the principles of delegation. It helps the student and RN reflect on how they use delegation in nursing practice (Gillespie & Paterson, 2009).

Recommendations and Strategies

The extant literature reveals there is a gap between delegation information and an understanding of delegation. The time is now for nursing education to ensure the contemporary nurse has the knowledge, skills, and attitudes to appropriately delegate. There is no perfect answer, solution or curriculum design that can close the gap. However, the following recommendations captured from the various research studies are presented for review and consideration. In general, teaching the constructs of delegation in nursing education should be based upon several principles.

First, the early introduction to the concepts of the nurse as a leader and delegation must occur in the nursing education experience. Concepts must be presented in a clear, safe, non-intimidating way to let students know that it is not an immediate performance expectation but that it will come into better focus as they grow. The concept of delegation of nursing tasks must be presented. They must be made aware of which nursing tasks can be delegated and which cannot. Most importantly, they must know that basic delegation skills will be expected in their first nursing job (Huston, 2008).

Second, there has been a shift in care delivery models. Powell (2011) reported nursing decreased the education emphasis on delegation when the nursing care delivery model shifted to primary care in the early 1980s. Now that the emphasis is on team nursing, delegation has become a critical competency of new graduating nurses.

Nurse educators need to introduce the principles of delegation early and throughout the curriculum, and track learning progress. Incorporating the use of simulation-based learning into course curriculum would promote student confidence and increase assessment skills in the skill of delegation (Kaplan & Ura, 2010).

Introduce the concept of delegation and strengthen leadership skills in the fundamental nursing course. O'Neal (2004) determined when students are given the opportunity to practice the art of delegation in the clinical setting they are more prepared to manage a team. Providing students the opportunity to learn the concepts of delegation in the classroom and practice these skills in the clinical environment would better prepare the student to delegate effectively (Utley-Smith, 2004).

There is a need to promote student interaction and retention of knowledge and skills through didactic instruction expanded with several active learning techniques (Powell, 2011).

The provision of classroom and clinical opportunities to students in the principles of delegation in preparation for the role of the RN is critical (ANA, 2006).

The use of delegation case studies as a learning activity will encourage the student to decide who they should delegate to and what task to delegate (Powell, 2011) The inclusion of written information on roles and scope of practice of other health care team members in case study sessions is beneficial to learning (Kaplan & Ura, 2010). The case studies need to be well developed, qualified and emphasized in the enhanced curriculum.

To be effective in delegation requires a leadership and management competency. Powell (2011) recommended the inclusion of delegation content into a leadership and management didactic and active learning activities as a strategy to bridge the gap in knowledge and competency. In Powell's study (2011), the Health Education Systems standard examination for leadership was used to evaluate clinical and content effectiveness of the process of delegation. Following the inclusion of delegation content the leadership score increased (Powell, 2011).

There needs to be standardization of terminology. To address the "considerable variation in the language" (p. 1) issue brought forth by the ANA and NCSBN (2006) the words used in the entire content of the delegation education curriculum should be scrutinized for consistency. The language has to be disciplined, precise, and as simple as possible.

It is important to extend the concept of interpersonal relationships and communication from the perspective of the patient and family to the coworkers. Standing and Anthony (2006) demonstrated that the RN experienced difficulty in asking or telling a UAP to complete a task.

Delegation skills need to be woven into the fabric of nursing education. The development of delegation skills begins during pre-licensure nursing education. It is crucial that nursing education provide adequate and appropriate clinical experiences for students to see

delegation as a skill set that can be perfected with practice. Nurse educators need to be mindful of the importance of delegation skills in providing effective nursing care. Nursing education program curriculum needs to include the concept of the team nursing care model into their teaching threads. The primary nursing care model, which many of the nurse educators know and understand, needs to be archived.

When the RN applies the principles of delegation, he or she is transformed from a primary care nurse to a contemporary nursing care team leader. The traits of a leader are integrity, intelligence, trust, respect and compassion for others, and communication.

Conclusion

There have been many changes in the nursing profession in the 100 years since Florence Nightingale. In the mid-1980s, there was a shift to all-RN staffing which resulted in nursing care being delivered solely by highly skilled nurses. Today, there is a focus on the nurse as a supervisor of a team of care givers with a spectrum of knowledge and cognitive skills. Since the RN is accountable for the outcome of the care delivered by the team, the RN must be skilled in delegation.

Contemporary nurses are required to have delegation skills as much as the traditional assessment and critical thinking nursing skills. The key to performing in the role of a care team leader is an understanding of the purpose and principles of delegation. The nurse is an advocate of the patient and the purpose of delegation is to ensure that quality care and patient safety reaches the bedside.

Delegation is a difficult skill to acquire. It is basically a management and leadership skill. Nursing students need to be introduced to the concept of a nurse as a leader of a care delivery team early in their education experience. They need to be provided with opportunities to

practice delegation skills in clinical settings. They need to know which nursing tasks can be delegated and which cannot. Most importantly, they must know that basic delegation skills will be expected in their first nursing job where they will be required to lead and supervise care delivery.

As the lack of understanding of delegation was studied, it became clear that barriers to delegation beyond the control of the nurse were significant. Nursing educators, executives, and leaders should not underestimate the barriers to delegation. The nursing profession and nursing education need to keep a focus on these issues. Discussion of the barriers needs to be part of the teaching landscape.

Nursing curricula needs to include delegation learning opportunities that can allow students to develop confidence and competency in the skills of delegation. The development of an academic-clinical relationship has the potential to lead to opportunities for innovative and transformative collaboration in care delivery and student learning. However, the curricula should not lose sight of the importance of simulation-learning as a suitable or viable option to provide the student real-life experiences on the how, what, when and who of delegation.

Contemporary nurses need to acquire an expert level of competency in delegation. It is essential to their practice of nursing. The ANA and NCSBN (2006) “stretched to the limit” description of the state nurses are in today is not a situation that society wants nurses to be in when they are making critical patient care decisions.

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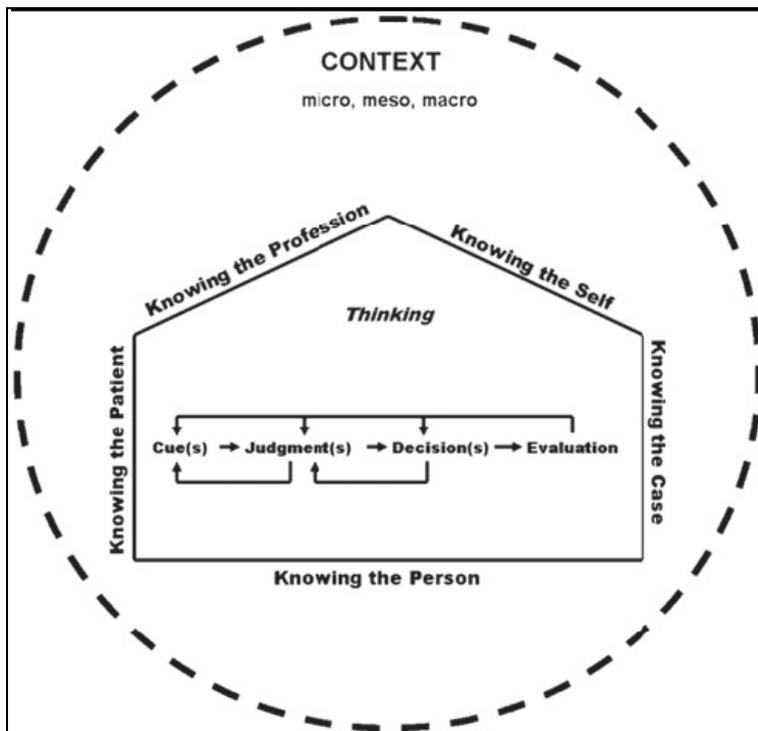
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FIGURE 2: The Situated Clinical Decision-making Framework



Schematic Representation of the Situated Clinical Decision-Making Framework, (Gillespie & Paterson, 2009, p. 165)