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Delegation in Long-term Care: Scope of practice or job description?

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Abstract

This study is a qualitative, descriptive study of how registered nurses (RNs) (N=33) in leadership roles in institutionalized long-term care settings delegate care, including their strategies and processes for delegating care, and their perceptions of barriers to effective delegation and potential benefits of delegation. Findings indicate two key approaches to delegation, including the “follow the job description” approach, emphasizing adherence to facility-level roles and job descriptions, and the “consider the scope of practice” approach, emphasizing consideration of multiple aspects of scope of practice and licensure, and the context of care. While the former resulted in more clarity and certainty for the RN, the latter facilitated a focus on quality of resident care outcomes as linked to the delegation process. Barriers to effective delegation were comparable among RNs using either approach to delegation, and almost all RNs could describe benefits of delegation for long-term care.

Keywords

delegation; nursing homes; long-term care; professional nursing practice; nurse practice acts; quality of care; nursing assistants; licensed practical nurses; registered nurses; qualitative research; scope of practice

In long-term care, delegation is the regulatory mechanism which allows licensed practical or vocational nurses (LPNs/LVNs) and nursing assistants (NAs) to provide over 90% of the direct care that nursing home residents receive (Beck, Ortigara, Mercer, & Shue, 1999; Paraprofessional Healthcare Institute, 2004). Delegation by RNs, therefore, is a primary mechanism for ensuring that professional nursing standards of care reach the bedside. Delegation includes activities such as planning for task delegation, assuring accountability,

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supervising performance, evaluating performance of delegated tasks, and reassessing and adjusting the care plan (NCSBN, 1995). Alarming, professional nurses now comprise only 14% or less of the total long-term care nursing staff. As a result, the licensed and unlicensed nursing staff that provides almost all direct care to residents, do so in the context of few opportunities for guidance by RNs. The purpose of this study is to describe how RNs in leadership roles in institutionalized long-term care settings delegate care, including their strategies and processes for delegating care, and their perceptions of barriers to effective delegation and potential benefits of delegation.

Little empirical research has examined delegation in long-term care (Hall et al., 2005) despite growing recognition of the critical role of delegation in quality of long-term care (Mueller, 2005). In a sample of 148 nurses from a national sampling frame, of which 91% were RNs and 31% were nurses in long-term care settings, Anthony et al. (2000) examined the relationships between dimensions of nurse delegation and care outcomes. They found that routine observation, evaluation of outcomes, and direct, nurse-observation of NAs performing delegated care tasks were associated with better patient outcomes. There was no significant relationship between the means of communication (such as personal contact or written) used to delegate care tasks and patient outcomes. Analyzing the same data, Standing et al. (2001) found that the failure of unlicensed assistive personnel to either receive and/or follow licensed nursing directions was related to 37% of adverse outcomes from delegated care tasks. While these studies did not focus exclusively on long-term care, they highlight the importance of understanding how delegation occurs, because of the relationships between delegation processes and patient care outcomes.

The unique staffing structure in institutionalized long-term care creates particular challenges for registered nurses trying to effectively delegate in these practice settings. The institutionalized long-term care organizational structure, on average, comprises only 2 RN FTEs, 11 LPN FTEs and 35 nursing assistant FTEs to provide care for a nursing facility with, on average, 107 beds (Harrington et al., 2005). Although LPNs may work in a variety of acute or long-term care settings, their presence is proportionately greatest in long-term care (Lacey & Shaver, 2004). Likewise, while nursing assistants may work in diverse healthcare settings, only long-term care depends so extensively on unlicensed nursing staff. As a result, RNs provide the least direct patient care in nursing homes relative to other care settings; the majority of nursing tasks are provided by LPNs and NAs. Registered nurses therefore delegate the direct care of nursing residents to this cadre of LPNs and NAs, and also may delegate to LPNs the supervisory responsibilities for direct care staff that perform the nursing tasks. Furthermore, a little over one-half of state boards of nursing allow LPNs to delegate care, as well (NCSBN, 1995). Both in terms of the pyramid staffing structure and the scope of practice of the LPN in relation to the RN, professional nurses in nursing homes are challenged to develop effective delegation processes to ensure quality of care.

Ultimately, RNs in long-term care have little guidance on how to delegate and are both reluctant to delegate and concerned about the impact of delegated care on their license and on patient care (Kane, Conner, and Baker 1995). Reinhard, Young, Kane & Quinn (2003) reviewed how nursing delegation regulations facilitate or inhibit the administration of medication in assisted living settings, using a multi-method approach that included

interviews with state board of nursing executives, as well as focus groups with assisted living nurses. They concluded that, overall, nurses experience confusion regarding how to ensure patient safety and adhere to practice regulations, in part due to perceived incomplete and contradictory delegation guidelines and regulations.

Because of the paucity of RNs in institutionalized long-term care settings, RNs in long-term care typically hold leadership positions; the Director of Nursing may be the only RN on site or on call in a skilled nursing facility (Fleming & Kayser-Jones 2008). Thus, improving practice models of nurse delegation in long-term care requires knowledge of how RNs in leadership positions delegate. The purpose of this study is to further our understanding of how RNs in leadership roles in institutionalized long-term care delegate care, to facilitate the development of more effective practice models of nurse delegation. Three research questions were asked in this study:

For RNs in leadership roles in institutionalized long-term care settings,

1. What are the strategies and processes used to delegate care?
2. What are the barriers to effective delegation of care?
3. What are the potential benefits to delegation of care?

Methods

Study Design and Sample

The study design was a descriptive, qualitative study of delegation by registered nurses in leadership positions in long-term care. Leadership positions in long-term care were defined broadly to include RNs serving as nursing home administrators or owners, Directors of Nursing, Assistant Directors of Nursing, or as corporate-level consultants to Directors of Nursing in corporate-owned, nursing home chains. A constructivist-interpretative paradigm (Denzin & Lincoln 2005) guided the qualitative inquiry, whereby we assume that a singular understanding of delegation in long-term care does not exist. Rather, patterns may emerge across multiple understandings of the delegation process that are co-created by nurse leaders and our research team, through in-depth interactions between the nurses and the researchers as part of the data collection and analysis processes.

Data are part of a larger, comparative case study of nursing homes sampled for diversity in resident case-mix, as well as performance on facility-level outcome measures of quality indicators (CMS, 2004), and licensure and certification surveys. This larger study (Anderson, Ammarell & Bailey et al 2005) explored interactions among nursing home staff to understand relationships between nurse management practices, such as delegation, and resident care. To further explore delegation, a supplemental, national convenience sample of 33 RNs in leadership positions augmented the nursing home data. Participants were drawn from this supplemental sample for this analysis.

Demographic characteristics of the sample are summarized in Table 1.

The majority of the sample included Directors of Nursing in skilled nursing facilities. Practice settings were geographically diverse, representing all four geographic regions defined by the United States Census Bureau; two nurse consultants cited responsibility for facilities in multiple states. The majority of the nurses were prepared at the Bachelor's level and over half reported having at least one specialty certification related to gerontological nursing care. Nurses reported a wide range of length of time in their current position, from 3 months to 16 years.

Data collection

IRB approval was obtained by the Duke University Medical Center for the conduct of the research prior to beginning data collection. Respondents were sampled using a convenience sampling strategy of nurses who met the study's criteria for RNs holding leadership positions in institutionalized long-term care. The researchers established a booth in an exhibit hall at a national conference of an organization with a membership base that included RNs in long-term care leadership positions. When an individual approached the booth, one of the researchers would engage the individual in conversation to ascertain their eligibility and interest in participating in a research project about delegation. If interested, informed consent was obtained, and the individual was interviewed by one of the researchers in either a curtained part of the exhibit booth, or a private conference room adjacent to the exhibit hall. Which researcher interviewed an individual was determined solely by who was available at the time the individual approached the booth. Data collectors included four nursing science researchers, including three prepared at the doctoral level and one at the master's level. Three of the four hold specialty certifications related to care of the elderly. The researchers conducted interviews until the replication of themes of delegation processes and perceptions emerged to assure rigor (Crabtree & Miller, 1992). Data collection occurred over a three-day time period of the conference.

Thirty of the 33 interviews were conducted as semi-structured, individual, depth interviews. One interview was conducted as a 3-person group interview as the respondents wished to be interviewed together. In each interview, the interviewer followed an interview protocol comprised of the following four, open-ended questions about delegation: (1) How do you think about delegation in your facility? (2) How does delegation of care happen in your facility (ties)? (3) What effect do you think delegation of care has on quality of care? (4) Do you think delegation relates to RN control over nursing care in nursing homes? Additional probes were provided in the protocol to be used as needed to ensure that respondents discussed strategies, accountability, supervision, outcomes, and care planning in relation to delegation of care. Interviews were tape recorded and transcribed, and entered into a qualitative data analysis computer program, Atlas. TI (Muhr & Friesen, 2004), for analysis.

Analysis

Congruent with the constructivist-interpretative paradigm, data analysis was conducted using a grounded hermeneutic editing approach (Addison 1999), whereby data analysis is inherently linked to the data collection process and progresses in a circular pathway that repeatedly alternates between interpretation and understanding. As previously described, the researchers reviewed emergent themes until saturation and duplication of themes emerged

during data collection, linking data collection to data analysis. This process provided multiple opportunities for the team to clarify initial understandings and ensured reflexivity, an important component of constructivist-interpretative qualitative work.

Once data collection was complete, the first author re-read the interview data transcripts and identified any discussion in relation to the three research questions, including delegation strategies and processes, perceived barriers to effective delegation, and potential benefits of delegation. Within each of these three domains, open coding, including in vivo coding (Addison 1999), was conducted of 19 of the 31 separate interview transcripts (the 3 respondents in the group interview generated one interview transcript) to capture all aspects of what the respondents described, resulting in a final code list of 103 concepts. This process facilitated the circular progression from initial interpretation and understanding, to deeper understanding and interpretation. After coding 19 transcripts, saturation of coded concepts emerged; transcripts of the remaining 12 interviews were read for confirming or disconfirming evidence (Crabtree & Miller, 1992), which yielded no new codes. Next, each domain was then read and analyzed in relation to the coded concepts for emergent themes. Visual networks of coded concepts within each domain were constructed, and annotations were made of each theme and the relationships of concepts to themes. Domains were reviewed by two additional research team members to assess reliability of emergent themes, and validity of the network of concepts to themes.

Results

What are the strategies and processes used to delegate care?

When asked how delegation occurs in the RNs' facilities, two primary approaches emerged in relation to their leadership roles, "Follow the Job Description," and "Scope of Practice."

"Follow the Job Description"—In the "Follow the Job Description" approach, RNs felt that job descriptions and facility-level rules and policies relevant to specific jobs determined delegation processes. When RNs used this approach to delegation, they would emphasize how they were responsible to ensure that nursing staff followed the rules and policies connected to a specific job description, whether by monitoring or enforcing rules, or by in-service education. Following the chain-of-command was a commonly described approach to delegation. A Director of Nursing described the chain of command as, "It's kind of like down the chain I hold...the RNs accountable for holding their charge nurses accountable, for holding their CNAs accountable. Everybody is held accountable. Right down the line." Another Director of Nursing described how the chain of command maps onto how she delegated,

...in long term care you really have to, uh, from the unit manager has to delegate jobs on out to the charge nurse, the charge nurse has to delegate on out to that CNA, that CNA who is probably the lead of the group has to delegate out to those others to make sure that, that every job at the end of the day gets done.

Because the focus of delegation was on the job description and chain of command rather than scope of practice, this Director of Nursing found no conflict with stating that unlicensed assistive personnel may delegate, although delegation is beyond the scope of practice of

certified nursing assistants. In fact, as another Director of Nursing explained, the job description may ultimately supercede the level of licensure and scope of practice,

I am the RN in charge, I have several RNs on staff. Uh, one of my RNs is my ADoN...the rest are charge nurses as well as the LPNs. And it could be that I have an RN and an LPN working together because I have 2 nurses on one unit, but the one who's in charge is the one who's in that charge position, and sometimes it's not the RN, it's the LPN. So that LPN at that point is over the RN because of what she's doing.

Procedures and facility systems implemented by the RNs were oriented toward monitoring successful task completion, rather than resident outcomes. The most common strategy to ensure task completion was "checking", which involved primarily checking written documentation. As one Director of Nursing described, "If ...[you] ...delegate...a double check, what I call a triple check, you know, you still have to check what you asked that person to do...you have to double check [to see that] what you asked them to do was done". Another described, "I can see did the work get done or did not get done...how much got done. I can read the report sheet, I can read the charting, I can read the assessments, I can see my wound sheets."

Successful task completion became the key evaluated outcome of delegated care and this was done primarily through checking documentation and paperwork. In fact, several of the RNs who described 'follow the job description' as their approach to delegation had difficulty responding to interview probes about evaluating delegated care outcomes. In one example, the interviewer probes, "How are outcomes of delegated care evaluated?" and the Director of Nursing responded, "Uum, well, like I said before, you know, I look at, 'Did it get done?' That's the big thing. Did it get done". The RN did not differentiate between supervising task completion of delegated care and evaluating the outcomes of delegated care. In another example, the interviewer provided more explanation for the Director of Nursing to respond,

Interviewer: Ok, how are the outcomes of the delegated care evaluated?

DON: Um, I don't know, I can't answer that.

Interviewer: Ok, let me, let me throw out an example and see if that helps. For example...in long term care a lot of things related to...continence...bathing...toileting and feeding are usually delegated care. How would you evaluate the outcomes related to that care?

DON: Well we have different groups or different committees, we have a weight variance group, and we have a falls group, and so we evaluate those things at those weekly meeting that we have.... we track it to trend if there is any increase of problems...everything gets tracked for trends and then every month we review it.

Once the interviewer probed for outcomes of resident care, the DON was able to provide a comprehensive response to how her facility assesses for resident care outcomes. However, both the resident care outcomes and the systems used to track these outcomes were considered completely distinct from delegation and the delegation processes used to provide

the care that lead to these outcomes. Ultimately, adherents to this perspective defined successful delegation as staff following the chain of command and accurately completing the assignments connected to their role, irrespective of scope of practice.

“Consider the Scope of Practice”—When RNs ascribed to the ‘Consider the Scope of Practice’ approach, they deliberately grappled with scope of practice regulations and how to organize care across licensed and unlicensed nursing staff. One Director of Nursing described how she thinks about delegation in her facility, “Um, the first focus is really on regulations, based on, you know, what is allowable, and then looking at the experience and the confidence of my staff members.” Delegation by considering scope of practice required that multiple factors be considered, rather than simply considering the job description. An RN described how her staff needed to understand scope of practice to be able to think through appropriate and inappropriate delegation,

DON: [My RNs] ...cannot delegate assessment to a LPN or a CNA. Assessment has to be done by an RN, so in the case an assessment gets made, and the LPN can always evaluate someone and then call the attention of the supervisor who is an RN or the charge nurse, who is an RN. And also, the RN cannot delegate something which is out of scope of practice for the CNAs. So it's important for the RN and LPN to know what can be delegated to a CNA.

In this facility, all licensed staff who could delegate needed to consider scope of practice to effectively work with nursing assistants in providing care. At times, these nurses recognized gaps and pitfalls in care systems resulting from paying attention to scope of practice differences among staff. In effect, they faced inherent conflict between how their facilities might be structured and staffed, and what professional and practical nursing regulations required. One DON described what happens as a result of not having 24 hour RN-level on-site coverage of nursing care in the context of delegation regulations,

Interviewer: Then how does accountability occur [when the RN is available by telephone]? DON: By indirect supervision. Indirect supervision is the nurse is accountable and responsible for what's being delegated so she is also responsible for the person she delegates it to and it would be a task that would be acceptable by regulations, and by nurse practice act.

Interviewer: Ok...how is she making sure that that task is done?

Response: She may not, um...it would almost be by assumption or by outcome.

The DON acknowledged the limitations to effective delegation when supervising by telephone, when there is no ability to provide immediate supervision. However, this DON articulated another important difference in the ‘consider the scope of practice approach’ compared to the ‘follow the job description’ approach. Specifically, she acknowledged how the delegating nurse may look at outcomes as a means of ensuring that the original, delegated care task was completed. Another DON described how, even if the delegating RN is not on-site at the time the task is provided, the RN can track the care outcomes that are linked to that delegated care,

DON: the nurse would work with the individual, do a return demonstration with that individual and then follow up with that individual and sometimes it's, you know, well, 'Call me back if you have any questions', or it could also be um, communication by phone after the task. And a lot has to do with resident outcome...depending on what was delegated...Certain things that are delegated, you know, you would be hoping for just status quo, certain other things that would be delegated, you might be looking for some type of patient improvement.

Because delegated care in this approach was viewed as linked to resident care outcomes, RNs can draw upon resident care outcomes to inform the delegation process, rather than seeing resident care trends as distinct from the delegation process. As such, these RNs often had both routine and non-routine ways of evaluating outcomes, and were open to how outcomes might inform systems-level changes. Examples of strategies included asking questions or directly observing the outcomes of the delegated care, in addition to the documentation favored by the 'follow the job description' adherents. One DON discussed how his evaluation of outcomes of delegated care might lead to system-level changes of routine assignments for certain staff, "If it's something that is, has been delegated...and it was a positive outcome, then that may indeed change the service plans, so that that task may continue to be performed by the person it was delegated to."

In contrast to the 'follow the job description' approach, RNs who sought to draw upon scope of practice regulations to inform staff work had to accept a degree of uncertainty in how to structure care. However, this uncertainty fostered a focus on assessing resident quality of care outcomes of the delegation process.

Barriers to Effective Delegation

Several, key barriers emerged across the interviews, regardless of delegation strategy used. These included poor partnerships across licensed and unlicensed staff, attitudinal barriers, and a paucity of RN-level clinical leadership.

With regards to poor partnerships across licensed and unlicensed staff, RNs described the need for front-line staff, especially the nursing assistants, to feel a part of the team and be willing to partner with the licensed nursing staff to provide delegated care. One DON described how delegation is ineffective if you do not foster this partnership, "We talked... about having to have the buy-in of the front line." Her colleague, a fellow DON, responded, "That's right...being very strict...and not bending doesn't always work...the CNAs like to be told...that they're important, which they are ...while you're delegating your care you should also encourage them to partake in making a decision..." One DON described how poor partnerships in her facility had resulted in delegation being perceived as burdening front-line staff with additional work,

Interviewer: Ah, so this idea of...[LPNs]...not delegating because they would impose on someone else extra work, but what about the idea about pitching in and helping each other?

DON: Oh, ...[front-line staff]...pitch in and help.

Interviewer: Oh they do

DON: Yes, but, 'Don't tell me to go do so and so on top of what I have'.

Facing poor partnerships across licensed and unlicensed nursing staff, nurses resisted delegating care and simply did it themselves to avoid eliciting front-line staff resentment. Effective partnerships, by contrast, facilitated delegation that enhanced front-line staff teamwork and sense of participation in care decisions.

Attitudinal barriers consisted both of attitudes of the delegating nurse, as well as the staff member to whom the nurse is delegating. RNs discussed how delegation could be viewed as the nurse simply assigning his or her work to other staff members, resulting in staff resentment, "Some DONS delegate everything, and then they just sit behind the desk and leave all the work to everyone else". Other RNs discussed how certain staff would be more or less receptive to receiving delegated care assignments, whereby certain staff members would be resentful at receiving what was perceived as additional work. RNs described the need to know your staff and understand to whom to delegate certain tasks, "If you delegate to the person who has a bad attitude...that's not gonna have good outcomes, so you just need to know who to delegate to. Who your good people are." Attitudinal barriers therefore resulted not only in ineffective delegation, but exacerbated poor staff partnerships, which were previously described as a barrier. 'Knowing your staff' was identified as a key strategy for DONs to mitigate attitudinal barriers.

The paucity of RN-level clinical leadership was seen as a barrier to effective delegation both by those RNs who differentiated between RN and LPN scope of practice and those who did not. Specifically, RNs who differentiated between RNs and LPNs, remarked upon LPN difficulties when expected to perform in a leadership role in long-term care, "Delegation isn't taught...in LPN school which is who mostly works in nursing homes. LPNs are put in positions of trying to delegate to NAs who are their peers only a year ago, and this is a real problem." These RNs also noted that having fewer RNs meant staff missed out on clinical expertise for effective delegation, as described by one DON, "There's times where I wish RNs had more time to spend on the floor...because they have the expertise in psych that other nurses don't have." Nurses who did not differentiate between RNs and LPNs in terms of functional role, still cited frustrations with LPN skills as a barrier to effective delegation. The DON of an assistant living facility describes how she relies on LPNs to delegate in the absence of RN-level clinical leadership, yet is frustrated because she cannot recruit LPNs who are adequately trained to function in this capacity,

DON: I believe that um, the LPNs should have the autonomy to be able to delegate tasks because there isn't always RNs there. You know...we are unusual in our assisted living that we even have LPNs 24 hours a day, most assisted livings don't and often...an LPN that's the director of nursing. So um, LPNs have a lot more autonomy in an assisted living setting. And I rely on them. Um, but it's getting um, an LPN who is capable of doing that.

With few RNs to provide clinical leadership, DONs looked to LPNs to contribute to effective delegation in ways that were either beyond their scope of practice or beyond their educational preparation. As a result, DONs expressed frustration at the adverse impact of current licensed nurse staffing resources in long-term care on the quality of delegation.

Benefits of Delegation

All of the nurses who participated in the interviews could articulate benefits of delegation. The most frequently cited benefit of delegation was that delegation was seen as a solution to the fact that an RN in a leadership role could not do everything. One DON described the necessity of delegation as, “Well, I mean we have to have delegation because if not, then one person can’t do it all.” Ultimately, several RNs felt that this resulted in a more positive work environment where nursing staff to whom care had been delegated had a sense of empowerment and took their job more seriously. This is described by one DON, “It kind of empowers the people that you delegate to and makes them want to do a good job because they know it’s gonna be checked on...Plus, it’s kind of like, ‘Wow she trusts me to do this’.” As a result, delegation could help RNs, as well as other nurses, avoid burnout, and promote pitching in and teamwork to share what needs to be done.

Other benefits of delegation mentioned by RNs included benefits for work processes, including more stability in the work system, especially with regards to system redundancy and accountability. RNs in leadership roles expressed the need to ensure that their facilities would operate well even when they were not present in the building, “Yes, I think delegation is very, very important because...you have to think you know, suppose you’re not there, the place has to still run the way that you want.” Moreover, delegation allowed them to monitor staff to ensure accountability. As one DON elaborated, “You actually have more control if you can delegate because you can monitor better! If I have to do everything, I can’t see anything that’s going on when I’m trying to pass meds.” Essentially an extension of the “can’t do it all” benefit, delegation fostered systems for monitoring staff.

Delegation also benefited staff in managing resident issues. Several RNs described how delegation facilitated more frequent observations of residents, as well as provided a process for managing more difficult residents or resident family members. A DON described how, as nursing assistants are delegated morning care tasks, she monitored them through conducting rounds, “so when we’re walking through and doing the rounds, if residents are still in bed, or they’re not dressed appropriately...nails aren’t clean, hair’s not combed, you know, that things aren’t being done, and then we interview... [the staff].” In addition to facilitating observations, delegation was seen as a means of matching resident needs with nursing assistant skills. As one DON explained, “Delegation to me has to be a process that you don’t just write names on a sheet of paper and hand them out. Your charge nurses have to know their residents and they have to know the CNAs”. Appropriately matching staff member to resident through delegation was seen as beneficial for both the staff member and the resident. While delegation was not described as directly benefiting quality of care, delegation was viewed as indirectly affecting quality of care by facilitating resident observations and managing challenging residents or family members.

Discussion

The long-term care RN leaders participating in our study showed two very different approaches to delegation, with mixed effects on how they viewed outcomes of care. One subset of RNs in our study described their approach to delegation as considering regulations guiding scope of practice and delegation, and then doing their best to match processes of

care with the regulations. These nurses had to accept more uncertainty in their daily work environment, as they negotiated the boundaries of staff skill, scope of practice, and facility-level or corporate-level policies and procedures. By combining routine, predictable approaches to monitoring staff behaviors (such as documentation), with openness to non-routine delegation strategies (such as direct observation and follow-up with the resident) with unpredictable outcomes, these RNs were able to focus on outcomes of delegation as outcomes of resident care.

By contrast, another subset of RNs in our study focused almost exclusively on delegation as ‘following the job description’, and limited their strategies to one of enforcement and compliance of facility-level job policies and procedures. These RNs saw little conflict between facility or corporate policies and expectations about who should deliver care and professional nursing practice standards. Further, these RNs saw few functional differences between RNs and LPNs—differences that they encountered were a source of frustration, rather than viewing the differences as the result of different licensure levels. Ultimately, nurses ascribing to the ‘following the job description’ approach viewed outcomes of delegation as unrelated to resident quality of care or quality of life.

The approaches that RNs in our study used to delegate care, challenge the belief of many that Nurse Practice Acts are prescriptive sets of rules and regulations that simply add to lists of rules and regulations that already proliferate in licensed long-term care facilities. Rather, as some of the nurses in this study revealed, Nurse Practice Acts highlight core issues of professional and practical nursing practice that may be in conflict with the policies and procedures of settings of care. To view delegation as a tool to increase the effective participation of licensed and unlicensed personnel in care provision, rather than as making assignments or adhering to “chain of command”, means accepting potential conflict with facility-level or corporate-level rules. As Fleming and Kayser-Jones (2008) describe, such conflict may ultimately impede a DON’s ability to foster quality care and to maintain stable nursing staff. They found that DONs who did not have strong administrative and staff support for their leadership were stymied in their ability to effect systems changes and provide quality care. Consequently, future research that relates delegation approaches to resident outcomes will provide empirical support for nurse leaders to diffuse potential conflict and enact permanent systems-level changes.

We are challenged as a nursing community to make delegation content from Nurse Practice Acts central to our discussions of licensed and unlicensed nursing staff care and to view the underlying issues as the core of professional and practical nursing practice. Barriers identified by the nurses in this study reflect barriers that have been identified by others employing qualitative research methodologies, including the quality of the relationships between the delegating nurse and the delegatee (Bittner & Gravlin 2009; Rubin, Blaji & Barcikowski 2009; Thomas & Hume 1998), as well as the staffing and nurse resource needs to ensure adequate licensed nurse supervision as an important component of delegation (Bittner & Gravlin 2009; Hall et al 2005). These findings, therefore, indicate the need for future research using a statistically representative sample of DONs, staff RNs and LPNs in long-term care that measures these and additional barriers and facilitators to safe and effective delegation practices. Additional implications of the research relate to continuing

education needs of RNs in relation to RN and LPN scope of practice and the delegation process, and the need to link RNs to extant delegation resources that may be available at the state or national levels to guide practice.

This study is a qualitative, descriptive study with a convenience sample of nurse leaders in long-term care. As such, it is not representative of RNs in long-term care and cannot be used to make inferences to the larger, U.S. population of RNs in long-term care. While participating RNs were geographically diverse, considerable between-state variability in RN delegation scope and specificity as codified in state nurse practice acts (Kane, Connor & Baker 1995; Reinhard, Young, Kane & Quinn 2006) merits explicit consideration in future research of how such between-state variability relates to DON delegation practices. Nevertheless, the study does illustrate strategies and processes that RNs are using to delegate in institutionalized long-term care settings, including perceived barriers to effective delegation, as well as potential benefits. Findings suggest that nurse leaders in long-term care require tools and strategies to further their ability to effectively delegate care in a way congruent with professional and practical nursing practice, to ultimately improve the quality of care that residents receive.

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Table 1

Sample demographic characteristics (N=33)

Characteristic		N (%)
Position	Director of Nursing	26 (78.8)
	Assistant Director of Nursing	1 (3.0)
	Corporate Clinical Consultant	4 (12.1)
	Nursing home owner	1 (3.0)
	Nursing home administrator	1 (3.0)
Facility-type	Skilled nursing facility	27 (81.8)
	Assisted living	3 (9.1)
	Other	3 (9.1)
Region of employment	Northeast	10 (30.3)
	Midwest	5 (15.2)
	South	12 (36.4)
	West	4 (12.1)
	Multiple regions	2 (6.1)
Highest degree completed	ADN or Diploma	12 (36.4)
	BSN	13 (39.4)
	MSN	3 (9.1)
	Graduate degree in non-nursing field	5 (15.2)
Specialty Certification	AANC, Gerontological Nursing	9 (27.3)
	CRRN	2 (6.1)
	NADONA	13 (39.4)
Ethnicity	Non-Hispanic White	20 (60.6)
	African-American	8 (24.2)
	Asian	3 (9.1)
	Other	2 (6.1)
Sex	Female	29 (87.9)
	Male	4 (12.1)
		<u>Mean (sd)</u>
Age		53 (7.0)
Tenure in current position (months)		66 (50.6)