NURSE DELEGATION DECISION MAKING: IMPACT ON NURSE JOB SATISFACTION

by

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A DISSERTATION

Submitted in partial fulfillment of the requirements for the degree of Doctor of Science in Nursing in the School of Nursing in the Graduate School, The University of Alabama at Birmingham

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ABSTRACT OF DISSERTATION
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Since 1985, health care has undergone tremendous changes. Today's patients are more acutely ill and have shorter lengths of stay in the hospital than patients in the past. In addition, the health care industry has shifted from providing primary nursing care to caring for a group of patients. These changes have made it imperative that nurses make sound delegation decisions for safe, efficient care delivery.

The purpose of this experimental study was to ascertain if a structured educational intervention (versus a mimic intervention) was followed by a statistically significant increase in nurse delegation decision making knowledge and nurse job satisfaction. The delegation decision making group reviewed specific information on task identification, problem identification, and how to determine team members' patient assignment. The mimic intervention group received information on changes in care delivery systems and how this would impact the RN role in the hospital. Both educational sessions lasted 90 minutes.

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Kast and Rosenzweig's (1985) organizational framework guided this research study. The sample consisted of 92 RNs employed on six different medical-surgical units. Subjects completed the Nursing Assessment Decision Grid at preintervention, immediate postintervention, and 1-month following the intervention. Subjects also completed the Price-Mueller Job Satisfaction Survey and a researcher-developed confidence and intent to use delegation decision survey at preintervention and 1-month postintervention.

Findings supported a statistically significant increase ($p < .05$) in Nursing Assessment Decision Grid scores for the delegation decision making intervention group. Gains were sustained for the 1-month follow-up. Two of the six measures of job satisfaction, specifically autonomy and promotional opportunity, were statistically significant for the delegation decision making intervention group. Further, there was a rise in scores for confidence and intent to use delegation decisions in the delegation decision making intervention group.

Implications for nursing education, nursing service, and nursing research are made. Replication of this research and further intervention studies among hospital nurses are recommended.

Abstract Approved by: Committee Chairman [redacted]

Program Director

Date 8/30/95 Dean of Graduate S

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CHAPTER I

Introduction

Nurse administrators, working in a difficult economic climate, face the problem of providing services to patients while remaining within the confines of their budget (Gollard & Soo Hoo, 1993). Adding to the challenge is the fact that in today's changing health care environment, hospitalized patients require more extensive nursing care than they did in the past (Ledwidge, 1988; Wood, Bailey, & Tilkemeier, 1992). Therefore, it has become increasingly important to maximize the registered nurses' (RN) patient care time in the hospital setting (Secretary's Commission on Nursing, 1988). Nurse administrators need to provide RNs with the tools to give the safe patient care delivery needed to meet the comprehensive needs of cognizant consumers (Thomas, 1992).

Inpatient care delivery in the United States has changed from the system of primary care practiced in the 1970 to 1985 period (Pinkerton, 1987; Poteet, 1984) to the management of a group of patients. In this system, a group of patients is cared for by nurses of varying educational backgrounds (Conger, 1993). In today's health care system, RNs must function as delegators and coordinators of patient care. RNs must now delegate care to other health care

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workers or nurse extenders. The decisions they make about delegations will be important in the delivery of efficient care and patient satisfaction with nursing care.

Nurses' satisfaction with their role of delegation is vital to the smooth functioning of patient care delivery within the hospital (Shannon, 1994). Therefore, as RNs develop new skills and advance knowledge of patient care management, nurse job satisfaction increases (Gibson, 1994).

Patients entering today's hospitals have higher acuity levels and shorter lengths of stay than in the past (Millar, 1991). Technical and basic aspects of patient care need to be fulfilled (Blegen, Gardner, & McCloskey, 1992; Thomas, 1992). To accomplish this, the ability of RNs to delegate and supervise nursing care to nurse extenders will become an important component of nursing practice (Conger, 1993; Sovie, 1990). Neither educational programs nor clinical experience has prepared most RNs to function in the delegation decision making role. This lack of expertise can interfere with efficient care delivery and affect patient satisfaction with nursing care.

Participative management, a style widely utilized in many organizations, involves including many people in the decision making process (Senge, 1990). Nurses who are educated in delegation decision making will have increased involvement in the administrative role (Nakata & Saylor, 1994). A participative group management style enhances nurse job satisfaction, increases involvement in decision

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making processes, and improves unit goal setting within the organization (Aumiller & Rudloff, 1986). When cooperative delegation decision strategies are used, individual nurses become aware of their importance to the patient care unit (Aumiller & Rudloff). This meaningful involvement converts the nurse from a mere worker to a committed, satisfied, and concerned employee within the hospital (Allen, Calkin, & Peterson, 1988).

Conger's Delegation Decision Making Model (Figure 1) identifies three major components related to determining the most appropriate staff member to provide patient care. They are identifying the required nursing tasks, identifying the patient problems, and evaluating the most appropriate staff member to care for the patient (Conger, 1993). The model includes evaluation of the capabilities of personnel, based upon education, job description, hospital policy, licensing regulations, and demonstrated competence. By incorporating the three components embodied within the delegation decision making model, a decision can be made about the most appropriate staff member to provide care to a patient.

Problem

The following question was addressed: "Will a structured educational intervention (versus a mimic intervention) be followed by a statistically significant increase in nurse delegation decision making knowledge and nurse job satisfaction?"

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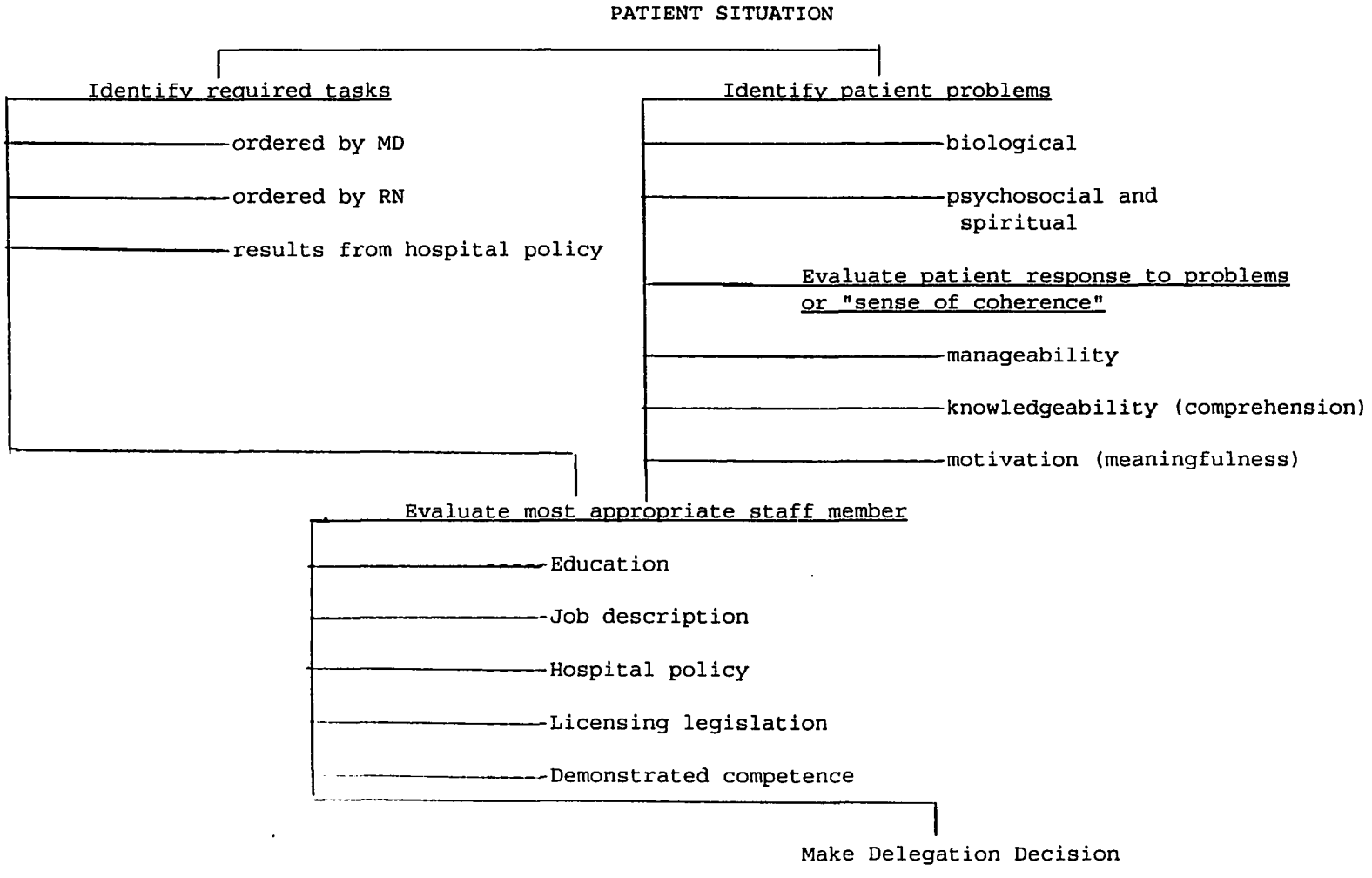

Figure 1. Delegation decision making model.

Purpose

The purpose of this study was to ascertain if the structured educational intervention (versus a mimic intervention) was followed by a statistically significant increase in nurse delegation decision making knowledge and nurse job satisfaction.

Research Questions

The following questions were generated:

1. Is there a difference in nursing assessment decision grid scores pertaining to nurse delegation decisions at time 1 (preintervention), time 2 (immediate postintervention), and time 3 (1-month follow-up) among RNs who received two different educational interventions?

2. Is there a difference in RN job satisfaction scores at time 1 (preintervention) and time 3 (1-month follow-up) among RNs who received two different educational interventions?

Hypotheses

The following null hypotheses were posed:

Ho1: There is no difference in nursing assessment decision grid scores pertaining to nurse delegation decisions at time 1 (preintervention), time 2 (immediate postintervention), and time 3 (1-month follow-up) among RNs who received the two different educational interventions.

Ho2: There is no difference in RN job satisfaction scores at time 1 (preintervention) and time 3

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(1-month follow-up) among RNs who received two different educational interventions.

Definition of Terms

The following terms were theoretically and operationally defined for the purpose of this research study.

Delegation--Theoretically, a process in which one entrusts to another the responsibilities that formerly had been carried out by the delegator (Bennett & Hylton, 1990; Lorey, 1981; Manthey, 1988); operationally, the ability of the RN to assign tasks to team members.

Delegation Decision--Theoretically, a decision based upon required nursing tasks, patient problems, and the capabilities of the staff member (Conger, 1993); operationally, the ability of the RN to make proficient delegation decision making skills as measured by the Nursing Assessment Decision Grid.

Nurse Job Satisfaction--Theoretically, the extent to which employees like their work (Agho, 1993) and have a positive, affective orientation to their job (Blegen & Mueller, 1987); operationally, the nurse's level of job satisfaction as measured by the Price-Mueller job satisfaction survey (Price & Mueller, 1986).

Nurse--Theoretically, a "theoretical system of knowledge which prescribes a process of analysis and action related to the care of the ill or potentially ill person" (Roy, 1976, p. 3); operationally, a RN who cares for an ill, potentially ill, or dying person.

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Nurse Extender--Theoretically and operationally, nurse extenders are personnel utilized to augment the RN in the work force of the acute care hospital. Nurse extenders may include nursing assistants (NA), licensed practical nurses (LPN), emergency technicians, or other health care workers (Ericksen et al., 1992; Jacobson, 1990; Manthey, 1988).

Conceptual Framework

Sociotechnical systems theory has emerged in the nursing administration literature as a mechanism for dealing with the myriad of changes occurring in the health care environment. Nursing service administrators find sociotechnical systems theory highly significant as it seeks to describe and evaluate multiple aspects of the patient-nurse-environment system (Happ, 1993; Tonges, 1992). Sociotechnical theory, as currently applied in nursing service administration, addresses contemporary issues facing nurse administrators (i.e., the pragmatic appeal of redesigning care delivery and utilizing nurse delegation decision skills in light of concerns about length of hospital stay, nurse job satisfaction, patient satisfaction, cost, and other patient outcomes). Sociotechnical theory within organizations provided the conceptual foundation that guided the research. The study was built upon the theory developed by Kast and Rosenzweig (1970, 1985).

Kast and Rosenzweig's Organizational Framework

Kast and Rosenzweig (1970, 1985) presented the organization as a general, open, sociotechnical contingency

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system in continual interaction with the environment (Figure 2). Survival of the system is contingent on a continual flow of materials, energy, and information into, through, and out of the system.

Kast and Rosenzweig's (1985) theory articulated that the organization is both a technical and a social system. The technical system affects the type of inputs into the organization, its transformations, and its outputs. The social system determines the effectiveness and efficiency of technology utilization. According to Kast and Rosenzweig, the technical and social system work in harmony to attained the desired outcomes.

The contingency view of organizations and their management expressed by Fremont and Rosenzweig (1973) suggests that each organization is unique. The contingency view rests on a body of knowledge and research endeavors that focus on interrelationships among primary concepts and subsystems in organizations (Kast & Rosenzweig, 1974). In terms of the model, Kast and Rosenzweig state:

> The contingency view of organizations and their management suggests that an organization is a system composed of subsystems and delineated by identifiable boundaries from its environmental suprasystem. The contingency view seeks to understand the interrelationships within and among subsystems as well as between the organization and its environment and to define patterns of relationships or configurations of variables. It emphasizes the multivariate nature of organizations and attempts to understand how organizations operate under varying conditions and in specific circumstances. Contingency views are ultimately directed toward suggesting organizational designs and managerial actions most appropriate for specific situations. (p. 21)

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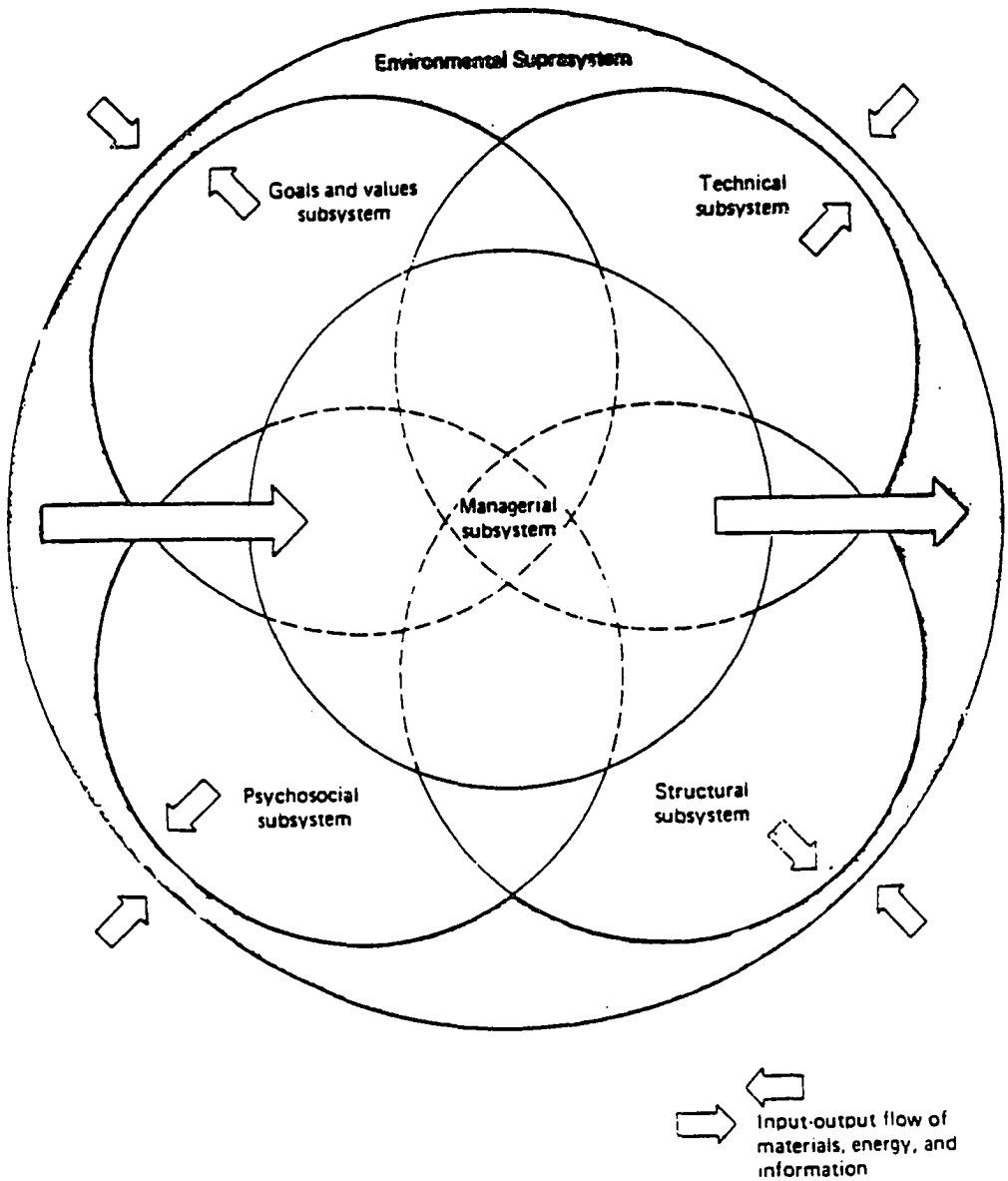

Figure 2. Kast and Rosenzweig's (1985) organizational framework

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For this research, the system under study was medical-surgical units within a hospital. The social components of a patient care system within medical-surgical units include the unit culture, management model, and nursing care delivery (Happ, 1993). The technical components of a patient care system include biotechnical equipment as well as the written policies, procedures, and protocols that guide the work of provision of care. Figure 3 illustrates a schematic representation of a traditional medical-surgical unit sociotechnical system (Happ; Kast & Rosenzweig, 1985).

Kast and Rosenzweig (1985) proposed the following five subsystems within the environmental suprasystem: Goals and values, technical, psychosocial, structural, and managerial. These subsystems combine to form the foundation of the internal organization.

Kast and Rosenzweig (1985) postulated that organizational performance comprised three dimensions: effectiveness, efficiency, and participant satisfaction. Effectiveness is concerned with goal accomplishment. Efficiency refers to the ratio of output to input. Participant satisfaction reflects employee job satisfaction and their continued employment. Good task performance is positively associated with satisfaction, a state of being which facilitates being both effective and efficient.

Kast and Rosenzweig's Theory as a Basis for Research

Since the organization under study was medical-surgical units within a hospital, the goals and values

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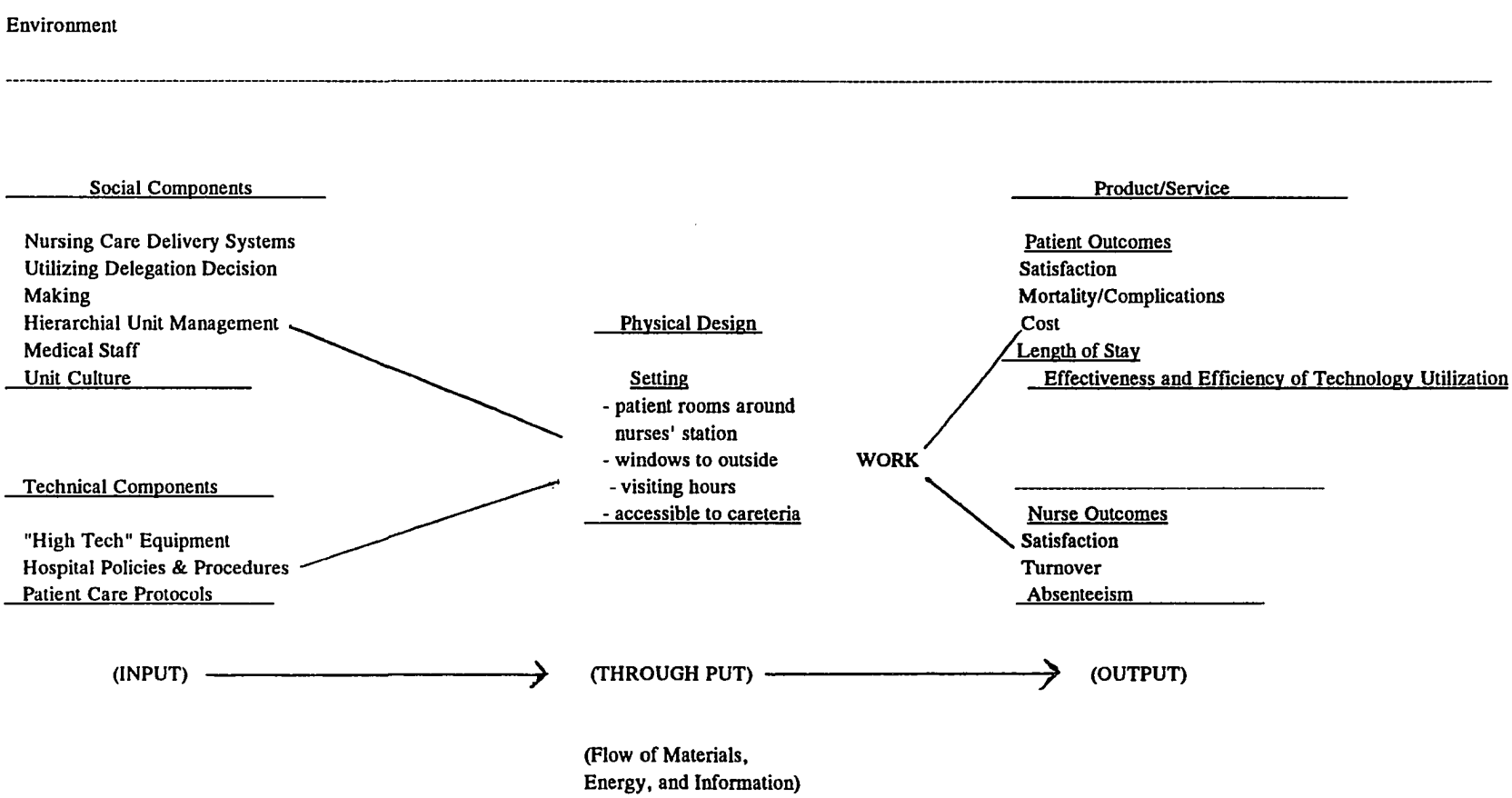

Figure 3. Schematic representation of medical-surgical sociotechnical system.

subsystem should reflect the targeted outcomes specified in the organization's philosophy and mission statement as well as the patient's plan of care. While the organization takes many of its values from the broader sociocultural environment, it is also influenced by social values (Kast & Rosenzweig, 1985), such as individual health and well-being.

The technical subsystem of a hospital medical-surgical unit includes administrative nurse managers, nursing personnel, and ancillary staff. Since the primary technical role of the hospital is health care provision, nursing personnel would serve as the primary technical subsystem. Their individual roles include care delivery which utilizes the nursing process, delegation decision making, patient teaching, and involvement in research (Conger, 1993, 1994).

The psychosocial subsystem consists of individual behavior, role relations, and group dynamics. It is affected by values, expectations, and aspirations of the people within the organization who motivate behavior. The psychosocial subsystem is affected by external environmental forces as well as the tasks, technology, and structure of the internal organization (Kast & Rosenzweig, 1985).

The structural subsystem of a hospital involves ways in which tasks are differentiated and integrated within the organization. Structure is drawn from organizational charts, employee job descriptions, hospital policies,

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licensing regulations, and patient care procedures. The structural subsystem concerns chain-of-command, communication, and work flow within the organization.

The managerial subsystem spans the entire organization and consists of technical, organizational, and institutional levels (Kast & Rosenzweig, 1970, 1985). Staff nurse personnel comprise the technical level; charge nurses and administrative managers comprise the organizational level; and the chief executive officer and hospital board of trustees comprise the institutional level.

The environment and subsystems within the environmental suprasystem are specific to individual organizations. Congruence among the subsystems and the environment render a more efficient organization. Effective delegation decisions made by RNs may enhance efficient care delivery and promote positive outcomes for patients and nurses.

In summary, the nursing organization is viewed as an open sociotechnical system operating in a changing health care environment. Germane to this study, inputs are educational sessions in delegation decision making, application of knowledge learned in the medical-surgical work setting, and the output of RN job satisfaction. Subsystems within the environmental suprasystem are interrelated and form the foundation for medical-surgical units, a subgroup of the nursing organization.

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Significance

Some of the greatest challenges for nurse administrators are the emerging changes in the delivery of nursing care services. The American Organization of Nurse Executives (1993) identified nursing care delivery systems as a research priority for 1993-1994. The conversion from primary nursing to caring for a group of patients has significantly altered the RN role. RNs are delegators and coordinators of care to groups of patients and work with less skilled workers (Conger, 1993, 1994). Often educational preparation and/or clinical experiences have prepared the RN to function in the delegation decision role in the provision of care. This situation can interfere with efficient care delivery, effecting patient satisfaction with nursing care and nurse job satisfaction.

Delegation decision making has been identified as one of the most critical elements for practicing nurses (Conger, 1993, 1994; Gill, 1979). Decision making is a skill that can be learned, at least to some degree (Jenkins, 1985). RNs' potential to become effective decision makers can be greatly enhanced through education and practice.

Nurses come in contact with patients more than any other category of hospital personnel. High levels of nurse job satisfaction are linked to knowing what is expected on the job, performing a variety of tasks, having the opportunity to use their skills and abilities, and having adequate information about their role (Agho, 1993).

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Hansten and Washburn (1992) have associated effective task delegation by RNs with increased staff morale and patient satisfaction with nursing care.

This study provides knowledge about the effects of RN delegation decision making skills on nurse job satisfaction. The information garnered from this research will provide nurse administrators with information that may enhance organizational efficiency and effectiveness.

Assumptions

The following assumptions were made:

1. Nurse delegation decision making skills are essential to the effective and efficient management of selected medical-surgical units within the hospital organization.

2. Delegation decision making skills can be taught.

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CHAPTER II

Review of Literature

This chapter presents a review of related research and literature pertinent to the research study. Delegation decision making, teaching delegation, and job satisfaction are the major concepts reviewed. Research related to nurse job satisfaction, demographic variables, and correlates of satisfaction in hospital nursing are integrated throughout this section.

Delegation Decision Making

Decision making in health care organizations is often accomplished through small work groups (Schoonover-Shoffner, 1989). The decisions that are made by RNs are often critical to the effective functioning of the organization. Group dynamics, a component of the psychosocial subsystem in Kast and Rosenzweig's framework, can influence smooth, effective work flow within an organization.

Researchers have studied the phenomenon of "decision making" in small groups for many years (Brilhart, 1986; Hirokawa & Poole, 1986; Tubbs, 1988). Effective analysis of the problem as an initial activity in the decision making situation is a key management strategy.

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Advocates of employee participation in decision making, who include many hospital administrators, industrial-organizational leaders, and management executives, believe that the vast majority of employees want active involvement in their work role (Stanton, 1993). Involvement in decision making stimulates employee enthusiasm and supports participatory management (Sashkin, 1986).

Management and delegation are so closely intertwined that it is difficult for one to succeed without the other. McConkey (1974) defined management as the art of accomplishing work through other people. Management cannot be effective unless delegation of work is an integral component of the process. Drucker (1963) stated that delegation is the achievement of definite, specified results, results that were previously determined on the basis of needs, by motivating subordinates to accomplish tasks for which the manager is ultimately accountable. The results are clearly defined in advance in terms of output required and time allowed, and the manager continually monitors the subordinates' progress.

A teaching intervention for nurse delegation decision making is needed due to the lack of formal education and relevant nursing job experience. As partnership-team models for nursing care delivery proliferate in the 1990s, methods to teach nurses to practice in this type of setting are needed (Metcalf, 1992; Millar, 1991). As RNs are increasingly asked to manage groups of patients with the

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assistance of lesser skilled workers, the ability to delegate care safely is crucial. The structural subsystem within a nursing unit maintained that task differentiation can positively affect work flow.

Delegation by professional nurses, who are the primary technical subsystem of a nursing unit, is the foundation of the hospital organization (Douglas, 1984). Organization, the way work is assigned, is a key concern for nurses in providing quality care and in achieving positive patient outcomes (Crowley, Marshall, & Till, 1990). Nursing care delivery systems provide the structure for work organization and are consistent with concepts within the sociotechnical system of a medical-surgical unit (Happ, 1993; Tonges, 1992). When patient workloads are overwhelming, it is easy to become disorganized. Trends in nursing and health care indicate that delegation will be one of the most important leadership skills for nurses in the future (Coburn & Sturdevant, 1992).

The economic climate of the 1990s dictates that the RN role must change to one of organizing the care for a group of patients by less educated and skilled personnel. Delegation by the RN is a vital skill in patient care provision (Bennett & Hylton, 1990; Lengacher et al., 1993). Many staff RNs are not well prepared to delegate responsibility (Cronin & Makleburst, 1989). Wiggins, Farias, and Miller (1990) found that RNs working with nurse extenders in a team delivery system identified the need for more education in delegation decision making.

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To respond to further challenges within the work setting, nurse administrators need to identify flexible and innovative care delivery models to maximize work efficiency (Millar, 1991; O'Brien & Stepura, 1992). Many of these models incorporate nurse extenders, including unlicensed nurse aides. Nursing administrators need to be cognizant of the key issue of delegation. RNs need to be aware that basic care tasks, such as bedmaking, can be safely delegated to unlicensed nurse aides (Blegen, Gardner, & McCloskey, 1992), and those tasks should be clearly delineated in a job description summary (Gardner, 1991).

Improving patient care operations efficiencies and effectiveness through work redesign requires leadership, succinct directives, and a participatory process for decision making (Smeltzer, Formella, & Beebe, 1993; Townsend, 1990). St. Luke's Hospital, an affiliate of the Mayo Clinic, redefined its hospital organization as a result of moving into a newly-designed hospital. St. Luke's implemented a setup phase to analyze the institution's financial viability by comparing its performance to other institutions. Direct care activities were determined through questionnaires distributed to multidisciplinary workers. The role of the RN was redefined, with the goal of increasing the time spent on direct care activities requiring professional expertise. Delegation of basic patient care tasks to nurse extenders increased RN time spent with patients from 54% to 68%.

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Delegation by RNs was an important input into this newly reorganized hospital.

Many organizations are shifting from autocratic management styles to participatory styles that empower the worker (Peterson & Allen, 1986a, 1986b). Effective decision making strategies are essential ingredients to safe and effective nursing practice (Corcoran-Perry & Bungret, 1992; Glendon & Ulrich, 1992). When decision making strategies are implemented, individual nurses become aware of the importance of their role within the hospital (Aumiller & Rudloff, 1986). This meaningful involvement transforms the nurse from a worker to a committed, satisfied, and involved member of the organization (Allen, Calkin, & Peterson, 1988).

Decision analysis has gained popularity in the professions of engineering and medicine; however, there has been little nursing research conducted to evaluate the usefulness of decision analysis in guiding nurse decisions (Corcoran, 1986). Critics contend that nursing is not amenable to decision analysis because it is intuitive in nature and processes information differently than other disciplines (Benner, 1984). The small amount of decision analysis in the nursing literature refers to its use in the field of nursing administration (Concoran, 1986; Daniel & Terrell, 1978).

Panniers and Walker (1994) conducted research to explore the usefulness of applying decision analysis to nursing decisions about a complex, emergent patient

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problem. The instrument measuring decision analysis is a decision tree which consists of a chronological arrangement of decision nodes (the choices the decision maker has) and chance nodes (events controlled by chance). The decision analysis instrument includes a summary of possible outputs. A convenience sample of 31 nurses categorized their intuitive ideas into five different treatment options for a complex dressing change utilizing the delphi technique. Eleven nurses (35%) demonstrated agreement between their first ranked intuitive choice and the choice supported by the decision-analyst model. When the ranking of the five treatment options derived intuitively was compared to the ranking prescribed by the decision-analytic model, results supported disagreement between nurses' intuitive and quantitative choices.

Conger (1994) examined the ability of 93 staff RNs to make delegation decisions before and after exposure to the Nursing Assessment Decision Grid. Each participant completed a pretest and was asked to identify all nursing tasks and patient problems found in two sample patient vignettes. Each was asked to prepare an assignment sheet showing the responsibilities of both the RN and LPN working in the dyad.

Registered nurses were taught components of the Nursing Assessment Decision Grid during the intervention phase (Conger, 1994). Subjects were divided into small working groups of three to four members and given different vignettes to analyze using the Nursing Assessment Decision

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Grid. Nursing task identification and patient problems found in the vignettes were identified, and RN and nurse extender responsibilities assigned.

Participants completed a posttest that consisted of the same two patient vignettes during the pretest using analytic techniques learned during the intervention phase (Conger, 1994). An RN was teamed with a LPN, and an assignment sheet for the activities of both members of the dyad was included.

Of the 93 subjects examined for differences in nursing task analysis and patient problem identification, data from only 63 participants were analyzed for assignment making. Some of the nurses did not fill out the assignment sheet as directed. RNs showed a statistically significant increase in their ability to identify tasks and patient problems. Nurses were able to make better delegation decisions about the care of patients in the sample vignettes.

The process for making a delegation decision does not change for differing levels of nurse extenders. The delegation decision model describes the evaluation process for arriving at a delegation decision (see Figure 1). When making a delegation decision, RNs should give first priority to licensing legislation. The Alabama Board of Nursing (1992) has written standards of practice for RNs and LPNs (Appendix A). The RN should consider the staff members' level of education and the policies of the organization. All RNs, regardless of position, should make delegation decisions (M. Conger, personal communication,

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February, 1995). This statement supports involvement of technical and organizational levels of the managerial subsystem in the delegation decision process.

The delegation decision making model was published in 1993. Conger's (1994) research utilizing the nursing assessment decision grid is the only publication related to the use of this model.

Teaching Delegation

RNs have a legal responsibility to others when making work assignments (American Nurses' Association [ANA], 1993). This is particularly true when they are delegating to unlicensed assistive personnel, such as nurse aides. The ANA defines delegation as "the transfer of responsibility for the performance of an activity from one person to another while retaining accountability for the outcome," and assignment as "the downward or lateral transfer of both the responsibility and accountability of an activity from one individual to another" (p. 6).

Two key responsibilities in making work assignments are appropriate delegation of duties and adequate supervision (Barter & Furmidge, 1994). There is a significant difference between delegating to a licensed nurse and delegating to unlicensed personnel. The assignment must fall within the person's scope of practice as designated by state regulation (Appendix A) and job description summaries (Crowley, Marshall, & Till, 1993). The person must understand the assignment and be competent to complete the assignment. The RN should delegate work

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based on such factors as qualifications of the staff member, prior work experience in the patient care unit, and individual readiness to complete a new task (Poteet, 1984). Task completion by the employee demonstrates their capabilities and allows RNs to assess individual competence. This is helpful in making future decisions about work assignments and planning learning needs of staff.

RNs may delegate the physical care of patients, when it can be completed safely by individuals with less training (Poteet, 1984). When possible, the RN should delegate the entire task. The instructions must be clear, the objectives and results of task completion should be agreed upon prior to implementation, and a realistic time table for completion needs to be set. Both parties must adhere to the plan, and the RN should be available for consultation.

The delegation of challenging tasks, along with routine ones, will help motivate employees (Poteet, 1984). Challenging assignments stimulate employee job interest and motivate employees to enhance or build their skill level. Delegating favorable assignments, along with mundane ones, demonstrates the RN's willingness to be fair and stimulate employee growth.

When patient care assignments are completed, it is important to recognize individual accomplishments (Poteet, 1984; Williams, 1992). Recognition of employee

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accomplishments, both in public and in private, stimulates individual enthusiasm to carry out future assignments.

Summary

Trends in nursing care delivery and health care indicate that delegation will be a major leadership skill for RNs as we approach the 21st century. RNs must become proficient at identifying patient problems and at determining required tasks and procedures requisite for quality patient care. Finally, RNs must be very adept in making delegation decisions to the appropriate level nurse extender. The literature supports the need for further investigation of decision making within the nursing profession.

Job Satisfaction

Job satisfaction, the extent to which employees like their work, is one of the most studied concepts in organizational research (Agho, 1993). The earliest systematic attempt to study job satisfaction dates back to the beginning of the century (Kornhauser & Sharp, 1932; Smith et al., 1969). Initial job satisfaction studies focused on the individual as a worker and wage earner (Slavitt, Stamps, Piedmont, & Haas, 1978). Later, the focus changed to viewing the employee as an individual with humanistic needs (Smith et al.).

Employers began to study humanistic attributes of workers in the 1930s. Hoppock (1935), a sociologist, found that job satisfaction is related to the individual's ability to relate to others, the nature of the work, and

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the individual's adaptability to work conditions. He suggested that a person's job satisfaction is relative to the degree that the job meets the person's needs.

Mayo (1945) studied job satisfaction in the late 1920s and the early 1930s from a psychological viewpoint. Research conducted at the Hawthorne Plant of the Western Electric Company in Chicago found group interaction as the single most important factor in job satisfaction. The Hawthorne study focused on working conditions of a chosen group of factory employees. Findings revealed morale increased when factory workers interacted in the experimental group, whether the changed condition was better or worse.

Research conducted by Levine (1993) examined data on more than 8,000 employees of nearly 100 manufacturing plants in the United States and Japan. Levine measured the effects of differences in wages on work place attitudes and behaviors. Findings supported the argument that increased job satisfaction occurs in the United States and Japan when salaries are high. Levine (1993) also found that satisfied employees reported they worked harder than they had to and were less likely to leave their positions. Japanese workers making a significantly higher salary than other workers in the plant experienced discomfort about this fact. This result indicates an important role of distributive justice and social functioning within the country of Japan. Age, gender, education, and years of experience demographics were not included in the study.

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In another study, Lefkowitz (1994) stated that women have been wrongly accused of having bad work attitudes. When the researcher controlled statistically for the fact that men studied tended to have higher-paying (and higher-level) jobs than women, there were virtually no differences between them in the many job attitudes measured in this study. The population included 361 women and 371 men from various positions. Subjects' position included the following: YMCA staff and managers; part time Hispanic and Black college students; university faculty and staff; managerial, professional, and technical employees from engineering and research; advertising agency personnel; and female executives. Men in the study had a tendency to rate themselves higher on initiative, maturity, achievement, self-actualization, and the need for power and authority. Women rated themselves higher on motivation for high financial reward and importance of advancement. The fact that women surveyed made less money even when they held comparable jobs to males may account for the higher score on these two variables. Lefkowitz stated that findings from many previous studies over the past several years, in fields such as industrial organizational psychology, organizational behavioral science, management studies, and sociology, have generated a stereotype of women as inferior workers.

Nurse Job Satisfaction

Nahm (1940) conducted one of the earliest nurse job satisfaction studies. She concluded that nurse job

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satisfaction was related to supervisory relations, individual adjustment, promotional opportunities, and relationships with family and friends.

Abdellah and Levine (1957) developed an instrument to measure nurse job satisfaction during a time of critical nurse shortage. The focus of research was related to turnover rates as a measure of job satisfaction.

Considerable research effort has been devoted to identifying determinants of job satisfaction and studying its effects on job outcomes and employees' behavior toward the organization (Agho, Mueller, & Price, 1993). The review of literature for this investigation included relevant studies on job satisfaction of nurses in acute care settings. Since job satisfaction for this study was measured in terms of overall job satisfaction, routinization, instrumental communication, autonomy, integration, distributive justice, and promotional opportunity, research addressing these aspects of nurse job satisfaction was reviewed. Definitions of these variables, some of which are used in this study, are contained in the Price-Mueller Model which appears in Table 1. These variables were found to be significant in earlier tests of the model and have been identified as determinants of job satisfaction (Price & Mueller, 1986).

The job satisfaction of nurses, most of whom are employed by hospitals, is of interest for three reasons. First, job satisfaction is related causally to turnover (Price & Mueller, 1991, 1986; Weissman, Alexander, & Chase,

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Table 1

Definitions of the Variables in the Price-Mueller Model

Variable	Definition
Routinization	degree to which jobs in an organization are repetitive (Price & Mueller, 1986)
Centralization	degree to which power is concentrated in an organization
Instrumental communication	degree to which information about the job is formally transmitted by an organization to its members
Integration	degree to which the members of an organization have close friends in their immediate work unit
Pay	money and its equivalents which individuals receive for their services to the organization
Distributive justice	degree to which rewards and punishments are related to performance inputs into the organization
Promotional opportunity	degree of potential vertical occupational mobility within an organization
Role overload	extent to which demands of the job are excessive
Professionalism	degree of dedication to occupational standards of performance
Job satisfaction	degree to which individuals like their jobs

1981). Turnover creates instability in the organization and increases labor cost associated with orientation of new employees.

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Second, job satisfaction is a possible determinant of effective job performance. Weissman and Nathanson (1985) demonstrated that nurses' job satisfaction levels were related to patient satisfaction with nursing care delivery.

Third, job satisfaction can be viewed as an end in itself (Blegen & Mueller, 1987). Hospital executives and nurse administrators, as well as staff nurses, may see job satisfaction as important in its own right.

In another study, Nakata and Saylor (1994) studied the relationship of management style and staff nurse satisfaction in the changing economic climate of the 1990s. The study utilized a nonexperimental, cross-sectional survey design to collect data from hospital staff nurses. Data were obtained from 102 nurses from a 298-bed, general, acute care, private, not for profit hospital in California. The results indicated a positive correlation (r = .48, p = .0001) between perceived management style and staff nurse job satisfaction. The closer the management style was to the participative group management style, the higher the level of staff nurse job satisfaction. Sources of job satisfaction, such as responsibility, autonomy, advancement potential, and pleasant work environment, can be related to management style. Sources of job dissatisfaction related to management style included poor planning, poor administration, and inadequate explanation of decisions affecting the nursing unit.

Boumans and Landerweed (1994) surveyed 561 nurses from 16 randomly selected general hospitals in the Netherlands.

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The sample consisted of 305 nurses from 20 intensive care units and 256 nurses from 16 general units. Subjects in this descriptive, correlational study completed four survey questionnaires. The outcome measures were work-related variables, including work pressure, autonomy, feedback and clarity, job satisfaction, experienced job satisfaction, health complaints, absence frequency, social support, need for autonomy, and coping strategies. The results of the study showed that nurses who work in intensive care units had higher job satisfaction scores than nurses who work in nonintensive care units. Critical care nurses were also less frequently absent from their job. Researchers concluded that non-intensive care unit nurses may have a greater need for interventions such as direction and guidance from management in the work setting.

In 1993, Agho surveyed 162 nurse employees at a 327-bed Veteran's Administration Medical Center located in the upper midwestern United States. Job satisfaction, the dependent variable, was measured by the components of routinization, participation, instrumental communication, integration, pay, distributive justice, and promotional opportunity. These components are embedded in the Price-Mueller model. Dispositional affectivity, a personality variable, has been conceptualized as a two-dimensional construct: positive affectivity and negative affectivity. Positive affectivity is defined as the degree to which an individual is predisposed to be happy; negative affectivity reflects an individual's predisposition to experience

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discomfort. Multiple regression procedures were used to analyze the data. The major determinants of job satisfaction were found to be routinization, instrumental communication, and positive affectivity. The impact on job satisfaction of participation, instrumental communication, integration, and distributive justice were found to be moderated by positive affectivity. Negative affectivity moderated the impact of promotional opportunity on job satisfaction. These measures explained 45% of the variance of job satisfaction.

Mottaz (1988) surveyed 1,303 employees representing eight occupational groups. The data were collected from several diverse organizations located in a large midwestern metropolitan area. Within each organization, sample or stratified random sampling procedures ensured an adequate representation of workers: nonsupervisory nurses (N = 312), university faculty (N = 167), elementary school teachers (N = 108), police officers (N = 440), secretaries (N = 112), factory foremen (N = 68), and factory workers (N = 249). The survey contained questions on overall job satisfaction, perceptions of work rewards, and work values. Elementary school teachers had the highest overall work satisfaction. RNs ranked 5th for overall work satisfaction when compared to the eight occupational groups. The study found that task significance, nature of supervision, and task involvement are major determinants of nurse job satisfaction. Salary was perceived as less rewarding.

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Length of time on the job was a demographic variable that was associated with increased job satisfaction.

Blegen and Mueller (1987) surveyed 270 registered nurses from five short term, acute care hospitals in the Rocky Mountain area. Data were collected twice, 8 months apart in this descriptive, correlational study. Measures form the Price-Mueller model were used to measure job satisfaction. Variables that reached statistically significant levels included, in order of importance, routinization, promotional opportunity, and distributive justice. The nursing literature does not address the variable of routinization often. The researchers suggested that hospital routineness leads to nurse job dissatisfaction. Demographic variables of age and working the day shift were positively associated with job satisfaction.

In another nurse job satisfaction study, Lorenzi (1993) conducted research to determine if increased knowledge of comprehensive nursing guidelines for sickle-cell patients in crisis would impact nurse job satisfaction. A total of 18 subjects participated in the pretest-posttest experimental design. During the pretest phase, each subject completed a demographic questionnaire, a knowledge base tool, and a job satisfaction tool. Subjects attended 10.5 hours of educational sessions on sickle cell disease, treatment, interventions, and relaxation training during the teaching intervention phase. Three months and 6 months after the guidelines were in

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effect, subjects again completed the knowledge base and job satisfaction tool. T tests were performed at each time interval. The results of the analyses demonstrated that there was a statistically significant increase in knowledge between the pretest and the 6-month time interval. The t tests showed no significant increase in overall job satisfaction. However, t tests from individual questions demonstrated a statistically significant increase in job satisfaction in the areas of nurse/physician collaboration and knowledge of sickle-cell disease.

Klinefelter (1993) studied role efficacy and its relation to job satisfaction of hospital nurses. A total of 354 nurses participated from 10 Florida hospitals. Findings of this correlational study indicated a relationship between job satisfaction and role efficacy. Nurses in higher level positions had higher efficacy scores and a greater sense of job satisfaction. It was suggested that nurses at higher level positions share more exposure and a broader perspective of the organization because they have a greater opportunity to interact with other units. Nurses at lower levels had a narrower focus of the hospital organization. Staff nursing reported a low level of satisfaction with the ability to give and receive assistance from coworkers, a feeling of isolation from other units, and a decreased ability to extend their role beyond the organization and make a contribution to society.

Cavanagh (1992) studied the job satisfaction of 221 staff nurses who worked in Los Angeles utilizing the

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Price-Mueller questionnaire. Findings affirmed that statistically significant factors in nurse job satisfaction were nurse involvement in decision making (autonomy), benefits, task variety (routinization), promotional opportunity, and level of education.

Summary

By examining the studies in the literature, the investigator concluded that task variety (routinization), management style, work style, work group relations, individual role adjustment, and involvement in decision making (autonomy) were positive predictors of job satisfaction. Findings were conflicting for salary and the nature of supervision for nurses employed on different hospital units. Job dissatisfaction and turnover were associated with "poor" management, inadequate explanation of decisions, and lack of guidance for nurses working outside of critical care areas.

Positive descriptors of job satisfaction were associated with age, education, shift worked, and position within the organization. Professionals outside of the field of nursing ranked pay and position as job satisfiers. There are conflicting findings related to gender and job satisfaction outside of the field of nursing. Nurses in management positions expressed a higher level of job satisfaction and role efficiency. It was hypothesized that their exposure to the entire organization enhanced job satisfaction.

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Job satisfaction has been studied extensively. Numerous researchers have determined important factors that contribute to nurse job satisfaction. Further investigation is needed to confirm findings from previous studies and to determine if nurse delegation decisions affect nurse job satisfaction.

The 1990s will be a challenging period for a nurse in a leadership role. Staff development is needed in the area of nurse delegation decisions in light of the increase in partnership-team models for nursing care delivery. An increase in delegation performance could enhance nurse job satisfaction. Continuing education may be a source of job satisfaction for RNs. Delegation decision making and nurse job satisfaction were the major focus in this study.

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CHAPTER III

Methodology

The purpose of this experimental study was ascertain if a structured educational intervention (versus a mimic intervention) was followed by a statistically significant increase in nurse delegation decision making knowledge and nurse job satisfaction. Elements of this chapter include the research design, setting, population, sample, human subjects, instrumentation, data collection procedure, data analysis, and limitations.

Research Design

This study utilized an educational intervention with an experimental design utilizing repeated measures (see Figure 4). The purpose of this experimental study was to test the effect of structured educational intervention.

Setting

The study was conducted at a 282-bed suburban hospital in central Alabama. A convenience sample of six medical-surgical units were selected for participation in this study. Study units were medical oncology, rehabilitation, surgical, medical diabetes, telemetry, and orthopaedics. This setting was chosen because, not having a 1:1 nurse patient ratio, its nurses care for many clients.

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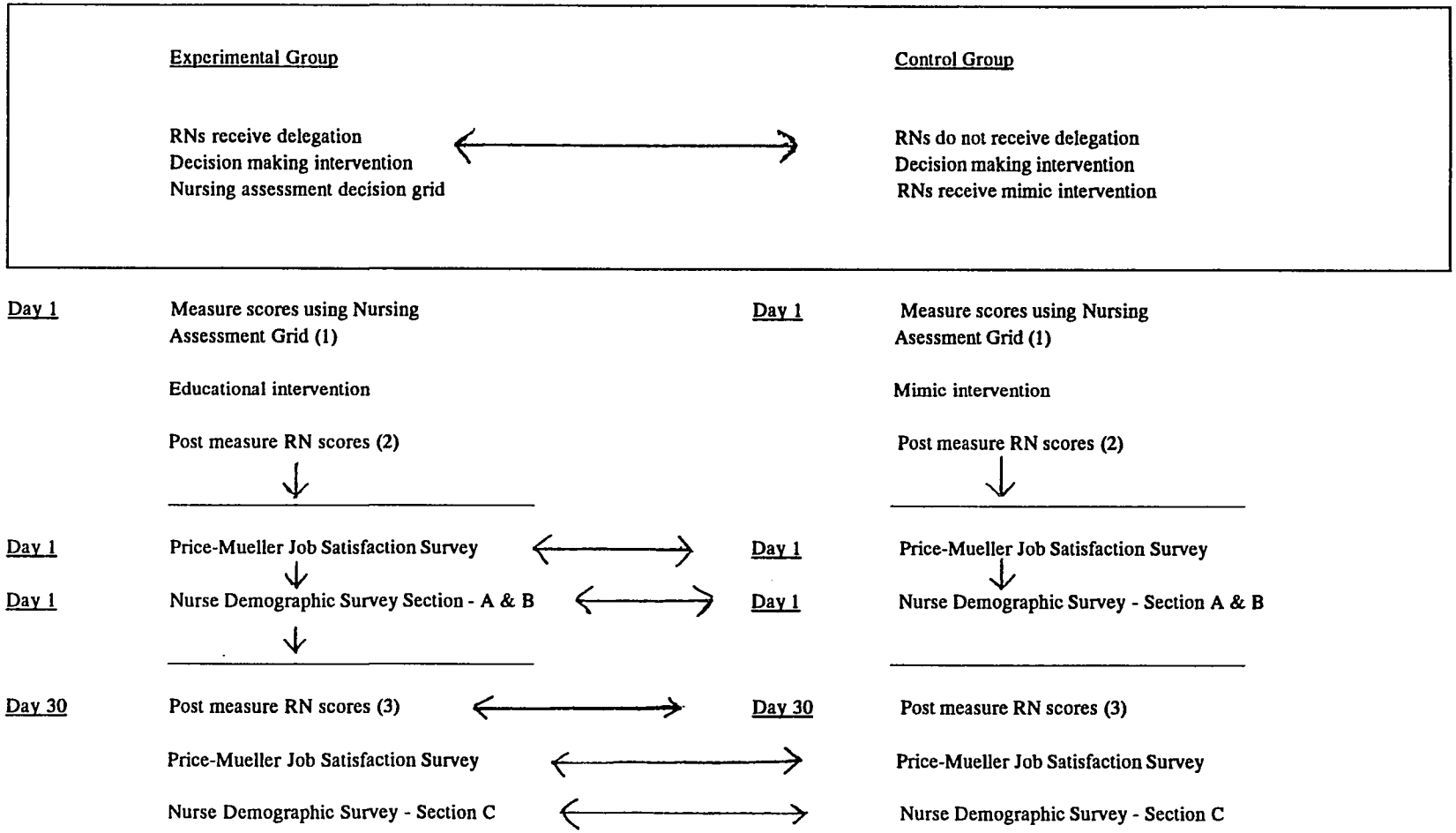

Figure 4. Research design.

Population and Sample

The total number of available participants was 126 registered nurses. From this sample, 92 subjects (educational intervention group, n = 47; mimic intervention group, n = 45) were recruited for this investigation. In order to allow for attrition, subjects were excluded if they planned to sever employment during the testing period. To determine a moderate effect size between the two educational intervention groups for a power of 80%, with an alpha level of .05, 40 RN subjects in each group were needed (SPSS for Windows, 1994).

Human Subjects

The study was approved by the administration of Medical Center East and the University of Alabama at Birmingham's Institutional Review Board (Appendix B). Nurse subjects in both experimental and control groups were informed that the study involved participation in an educational intervention for delegation decision making skills and their role would include completing an initial pretest and posttests at two different time intervals. Nurse subjects completed a demographic survey and a job satisfaction questionnaire at two different time intervals. Subjects received a letter inviting them to participate in the study. They indicated their willingness to participate by signing the informed consent component at the bottom of the letter (Appendix C).

Participation in the study was voluntary and subjects could withdraw at any time. Registered nurses were invited

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to attend a meeting regarding the research project, regardless of their decision to complete the pretest-posttest.

Confidentiality of nurse subjects was maintained. Questionnaires were coded and kept by the investigator. Code numbers were destroyed after data analysis.

Instrumentation

Tools used for data collection included a researcher-developed tool, the Price-Mueller Job Satisfaction Survey, and the Nursing Assessment Decision Grid. Permission to use the Price-Mueller Job Satisfaction Survey and the Nursing Assessment Decision Grid was obtained (Appendix D).

The researcher-developed tool gathered information regarding demographic data and delegation decisions (Appendix E). The internal consistent reliabilities of the multiple item researcher-developed tool (Appendix E, Section C) were determined using Cronbach's alpha. The Cronbach's alpha for confidence with delegation, current utilization of delegation decisions, and extent of future utilization of delegation decisions ranged between .94 and .95, respectively, with .95 the average.

Delegation decision scores were obtained by visual analogue scales (VAS) developed by the researcher. A VAS is a straight line, the end anchors of which are labeled as the extreme boundaries of a sentence or of the response to be measured (Wewers & Lowe, 1990). The subjects were instructed to put a line through the number closest to their response level. Investigators have determined the

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VAS to be a valid and reliable measurement, and if the respondent understands the method, the measurement is at least ordinal in nature (Wewers & Lowe).

Price-Mueller Job Satisfaction Survey

The Price-Mueller Job Satisfaction Survey (Price & Mueller, 1986) measures five facets of job satisfaction--routinization, integration, distributive justice, autonomy, and promotional opportunity. Included first in the survey are six items developed by Brayfield and Rothe (1951) which measure generalized job satisfaction (Agho et al., 1992; Brooke, Russell, & Price, 1988; Price & Mueller, 1981, 1986).

There are a total of 30 questions on the job satisfaction survey (Appendix F) rated on a 5-point Likert scale. Scores range from 30 (dissatisfaction) to 150 (satisfaction). The instrument was developed, and the convergent validity, discriminant validity, and face validity were tested. All variables in the instrument were measured with multiple item scales that have been shown to be valid and reliable. Cronbach's alpha for the variables ranged from 0.72 to 0.95, with an average of 0.85 (Agho et al., 1993; Blegen & Mueller, 1987; Price & Mueller, 1981, 1986).

Routinization, the degree to which employees complete repetitive tasks, is measured by four items. In responding to these items, participants use a 5-point scale that ranges from "required to be very creative" to "no creativity required" (Price & Mueller, 1986).

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Integration (often referred to as work group cohesion) refers to the degree to which members have close friends in the immediate work group. This construct measures the effect coworkers have on each other (Price & Mueller, 1981, 1986).

Distributive justice refers to the fairness of rewards and punishments related to performance. Participants indicate on a 5-point scale ranging from "to a very great extent" to "not at all" their response to such questions as "To what extent are you fairly rewarded in view of the amount of experience that you have?"

Promotional opportunity refers to upward job advancement within an organization (Price, 1977; Price & Mueller, 1981). Respondents indicate on a 5-point response scale ranging from "to a great extent" to "not at all" the extent to which the job they have is a stepping stone to another job. Four questions evaluate this construct.

Autonomy refers to the degree of power an individual exercises concerning performance at work and decision making on the job (Price & Mueller, 1981). Autonomy, also referred to as participation, is measured by four items. Respondents indicate on a 5-point scale ranging from "very much" to "very little" the extent to which they are left on their own to complete their work.

Nursing Assessment Decision Grid

Developed to guide RNs to delegate patient care to nurse extenders, the Nursing Assessment Decision Grid provides the nurse with an objective, quantifiable method

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to assign care of patients (Conger, 1993, 1994). A score of 1 on required tasks and identified patient problems indicates that the LPN can function independently; a score of 2 requires the LPN to be taught; a score of 3 requires RN completion of the task.

Upon score completion, the RN reviewed the data in a patient vignette and made delegation decisions about the care of the individual patient. Patients that predominantly have items scored as "3" will need to be cared for by the RN. Patients who have a few items scored as "3" can be cared for by the nurse extender with the RN providing supervision. This procedure provides the RN with an objective, quantifiable method to assign care of patients.

Content validity of the delegation decision tool was established during the pilot testing of the instrument through the use of a group of clinical nurse specialists (CNSs). Thirty-seven CNSs completed a pretest and posttest. Sstatistically significant improvements in problem analysis (t = 5.86) and assignment making (t = 3.06) were obtained following instruction for use of the instrument.

The reliability of the scoring of the participant responses on the pretest and posttest was established during the pilot study. Of 138 subscores on the pretest and posttests, a 92% agreement between two raters was obtained, thereby establishing interrater reliability.

Data Collection Procedure

The 92 subjects were randomly assigned to one of two groups through a coin toss; heads--the educational

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intervention group--or tails--the control (mimic intervention) group. To prevent contamination, subjects were asked not to discuss the intervention during the study period.

RN subjects in the delegation decision making intervention group read a sample patient vignette and completed assessment of care requirements utilizing the nursing assessment decision grid. RNs were told that their team member, for purposes of the exercise, was an LPN. Completion of the assessment sheet occurred at preintervention, immediately post intervention, and subsequent post intervention, 1 month following the intervention. RNs in the control unit followed the same procedure, except during the inservice phase of the teaching plan. During this time frame, the control group received a mimic intervention. The mimic intervention included information on changing delivery systems and an elaboration on information received during the introductory phase of the teaching plan. The mimic intervention group did not receive any teaching on components of the nursing assessment decision grid or the delegation decision making model.

RNs from the six units who participated in the study completed Section C (subsequent post intervention) of the demographic data sheet and the Price-Mueller Job Satisfaction Survey 30 days after implementation of the educational intervention.

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Pilot Study

The pilot study was conducted after approval by the Institutional Review Board of Medical Center East and the University of Alabama at Birmingham. The pilot study involved a miniature, trial version of the planned study (Nieswiadomy, 1987). The purpose of the pilot study was to determine the feasibility of the study, test instruments that would be used, and identify potential problems in data collection.

A convenience sample of six nurses were chosen from the medical-surgical setting. The validity of the nursing assessment decision grid was determined in a pretest-posttest design. A statistically significant difference in delegation decision making (t = 3.20) was obtained following instruction.

The internal consistent reliabilities of each subscale of the Price-Mueller Job Satisfaction Survey were determined using Cronbach's alpha. In the pilot study, the internal consistency for the total test score was 88.[1] The Cronbach's alpha for job satisfaction, routinization, integration, distributive justice, promotional opportunity, and autonomy were .71 .59, .71, .79, .83, and .66, respectively, with .72 the average.

Intervention

RNs in both experimental and control intervention groups attended a scheduled inservice which was available on all three hospital shifts. The nurse delegation decision making intervention inservice was 90 minutes in

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duration (Appendix G). The investigator served exclusively as the instructor for all 22 educational sessions.

The inservice objective was to teach RNs the steps of making delegation decisions, based on Conger's (1993) delegation decision model. The RN identified required patient tasks, identified patient problems, and assigned the appropriate level of staff member to deliver patient care for selected medical-surgical vignettes.

RNs in the experimental group were taught specific information contained in the delegation decision making model. Task identification included identifying required tasks ordered by the medical doctor, identifying required tasks ordered by the RN, and determining procedural requirements in hospital policy (Conger, 1993). An example of a required task resulting from hospital policy would be changing the IV (intravenous) site every 3 days. Identification of patient problems included biological, psychosocial, and spiritual aspects of care. The evaluation of the appropriate level of staff member to deliver patient care was based upon education, job description, hospital policy, licensing legislation, and demonstrated competence.

RNs in the control group were given different information during Step III of the nurse delegation decision making intervention plan. The control group received a mimic intervention that included information regarding patient care delivery systems and an elaboration of how these changes in the health care delivery system

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would impact the role of the RN in the hospital setting. The importance of making sound delegation decisions in light of the changes in health care was discussed. However, RNs in this group were not given specific information on how to make delegation decisions based on Conger's (1993) model.

The specific case study that was scored was based upon a patient vignette of a postoperative mastectomy patient. Both experimental and control groups identified required patient tasks, identified patient problems, and assigned the most appropriate staff member to deliver patient care. There were 11 required patient tasks, 9 patient problems, and 20 ratings required to determine the appropriate level of staff member to deliver patient care. There was a total of 40 points for this patient vignette.

Data Analysis

The data were analyzed using the SAS Release 6.04 (1988). A two-sample *t* test was used to test for a significant difference across the mean pretest and posttest scores where the three components of the Nursing Assessment Decision Grid were addressed: (a) the ability to identify nursing tasks, (b) the ability to identify clinical problems, and (c) the ability to make an assessment delegating appropriate functions to RN and nurse extender team members. Descriptive statistics were used to describe the nurse sample. To test for differences between groups and over time, a repeated measure analysis of variance (ANOVA) was employed.

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Limitations

Limitations include the following:

1. A nonprobability sampling method (convenience) limited the study to only six medical-surgical units in one hospital.

2. Data on nurse demographic sheet regarding delegation decisions were collected by self-report and not directly observed. Therefore, these data are subject to the limitations associated with self-report.

3. Contamination could have occurred if the subjects discussed the intervention during the study period.

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CHAPTER IV

Findings

This chapter presents the findings from statistical analyses used to answer the two research questions posed in this study. This chapter addresses the findings from the sample, the comparability of the two education intervention groups, the research questions, and a summary of findings.

Sample

The sample consisted of 90 RNs working in medical-surgical units from a suburban hospital in central Alabama. The sample was mainly female (98%), with 2 of the 90 subjects being male. The mean age of the sample was 40.91 years (SD = 9.14), with a range of 24 to 66 years. The mean number of years of nursing experience was 12.97 years (SD = 9.01), ranging from 0 years (new graduate) to 40 years. For years of employment at the study hospital, the mean number was 6.94 years (SD = 5.50). Seventy-nine (87.7%) were employed full time; 6 (6.7%) were part time; and 5 (5.6%) were per diem. Nursing educational preparation was as follows: (a) 24 (26.7%) were diploma graduates, (b) 51 (56.7%) were associate degree nurses, (c) 12 (13.3%) were baccalaureate degree nurses, and (d) 3 (3.3%) were master's degree nurses. Employee position was distributed among four groups. Sixty (66.6%) were staff

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nurses; 19 (21.1%) were charge nurses; 6 (6.7%) were assistant head nurses; and 5 (5.6%) were head nurses. Of the sample, 38 (42.2%) worked day shift, 30 (33.3%) worked afternoon shift, and the remaining 22 (24.4%) were employed on the night shift. Tables 2 through 6 depict detailed demographic characteristics of the sample.

Table 2

Age of Sample by Group

Group	Range	Mean	SD
Delegation Decision Making Intervention Group	24-66	39.0	10.14
Mimic Intervention Group	24-53	43.0	7.86
Total	24-66	40.91	9.14

Note. Not adjusted for missing raw data.

Delegation Decision Making

Previous exposure to delegation decision making was reported by 75.5% of the subjects (Table 7). These subjects reported varied methods of exposure to the concept (Table 8): 61.7% were exposed to the concept in nursing school; 64.7% through staff development; 42.6% through continuing education; and 5.8% by on the job training. Of the entire sample, 46.6% of the subjects reported exposure to delegation decision making in nursing school.

The last question on the researcher-developed survey asked subjects to comment on difficulties they had anticipated with delegation decision making. Twenty

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Table 3

Demographic Characteristics of the Sample

	DDM (n = 47)		MI (n = 43)		Total (n = 90)	
Characteristic	f	%	f	%	f	%
Gender						
Male	2	2.0	-	-	2	-
Female	45	98.0	43	100.0	88	97.7
Employment Status						
Full time	40	85.1	39	90.7	79	87.7
Part time	4	8.5	2	4.7	6	6.7
Per diem	3	6.4	2	4.	5	5.6
Shift Worked						
Day shift	24	51.1	14	32.6	38	42.2
Afternoon shift	16	34.0	14	32.6	30	33.3
Night shift	7	14.9	15	34.9	22	24.4
Position						
Head nurse	2	4.3	3	7.0	5	5.6
Assistant head nurse	4	8.5	2	4.7	6	6.7
Charge nurse	7	14.9	12	27.9	19	21.1
Staff nurse	34	72.3	26	60.5	60	66.6

DDM = Delegation Decision Making Intervention Group
MI = Mimic Intervention Group

subjects (22%) reported resentment from coworkers, 9 subjects (10%) commented on inadequate nurse to patient ratios in nursing school, 8 (9%) RNs were concerned with fairness, and 5 (6%) reported that they would rather do the work "by myself."

Nurses' previous use of delegation decision making in clinical practice ranged from 2 to 10 on a 10-point visual analogue scale. Table 9 shows means, range, and standard deviations for both intervention groups.

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Table 4

Educational Preparation of the Sample

	DDM (n = 47)		MI (n = 43)		Total (n = 90)	
Educational Preparation	f	%	f	%	f	%
Master of Science in Nursing (MSN)	3	6.4	-	-	3	3.3
Bachelor of Science in Nursing (BSN)	9	19.1	3	7.0	12	13.3
Associate Degree in Nursing (ADN)	27	57.4	24	55.8	41	56.7
Diploma	8	17.0	16	37.2	24	26.7

DDM = Delegation Decision Making Intervention Group
MI = Mimic Intervention Group

To test for comparability of the two educational groups at post intervention, t tests were performed on confidence, present use, and future intentions to use delegation decisions in nursing practice (Table 10). The delegation decision making intervention groups' confidence as well as present and future intentions to use delegation decision increased. This was not the case for the mimic intervention group.

There are a total of 12 questions on the multiple item researcher-developed tool to measure confidence, present use, and future intentions to use delegation decision making (Appendix E, Section C). Questions are rated on a 10-point visual analogue scale. At postintervention, scores ranged from 2 to 10 for the 12 variables. Cronbach's

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Table 5

Means, Standard Deviations, Years of Nursing Experience, and Years of Employment at the Study Hospital by Unit for Each Group

	DDM (n = 47)				MI (n = 43)			
Characteristic	f	%	$\bar{x}$	SD	f	%	$\bar{x}$	SD
Years of Nursing Experience								
Medical oncology	10	11.3	11.32	11.84	6	6.8	16.33	9.68
Rehabilitation	7	8.0	14.13	11.32	5	5.8	17.00	5.14
Surgical	10	11.3	14.22	11.01	9	10.2	10.44	7.29
Medical diabetes	6	6.8	6.16	6.04	6	6.8	10.33	6.88
Telemetry	6	6.8	10.66	4.36	9	10.2	13.00	6.68
Orthopaedics	7	8.0	10.28	7.97	7	8.0	22.57	7.97
Years of Employment at Study Hospital								
Medical oncology	10	11.2	6.10	4.50	6	6.7	16.33	9.68
Rehabilitation	8	9.0	4.87	3.90	5	5.6	6.80	7.25
Surgical	10	11.2	9.72	6.56	9	10.1	6.44	6.44
Medical diabetes	6	6.7	3.83	3.71	6	6.4	6.50	4.63
Telemetry	6	6.7	8.00	6.06	9	10.1	6.33	5.36
Orthopaedics	7	7.8	5.14	2.73	7	7.8	12.57	7.54

alpha for the variables ranged from 0.949 to 0.958, with an overall score of 0.956.

Table 6

Means and Standard Deviations of Sample for Years of Nursing Experience and Employment at the Study Hospital

Characteristic	Range	Mean	SD
Years of nursing experience	new graduate - 40	12.97	9.01
Years of employment at study hospital	new graduate - 25	6.94	5.50

Note. Not adjusted for missing raw data.

Table 7

Self-Reported Exposure to Delegation Decision Making (DDM) Prior to Intervention

	DDM (n = 47)		MI (n = 43)		Total (n = 90)	
Characteristic	f	%	f	%	f	%
Exposed to DDM concept	34	37.8	34	37.8	68	75.5
Not exposed to DDM concept	13	14.4	9	10.0	22	24.5
Total						100.0

DDM = Delegation Decision Making Intervention Group
MI = Mimic Intervention Group

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Table 8

Methods of Exposure to Delegation Decision Making

	DDM (n = 47)		MI (n = 43)		Total (n = 90)	
Characteristic	f	%	f	%	f	%
NS	8	11.7	6	8.8	14	20.6
OJT	-	-	3	4.4	3	4.4
SD	7	10.2	6	8.8	13	19.1
CE	-	-	1	1.4	1	1.4
CE/SD	4	5.9	5	7.4	9	13.2
NS/OJT	-	-	1	1.4	1	1.4
NS/SD	4	5.9	4	5.9	8	11.7
NS/CE	2	2.9	3	4.4	5	7.3
NS/CE/SD	9	13.2	5	7.4	14	20.6

NS = Nursing School
OJT = On the Job Training (*subject listed in other methods column)
SD = Staff Development
CE = Continuing Education

Table 9

Mean, Range, and Standard Deviation for Nurses' Previous Use of Delegation Decision Making in Clinical Practice

Group	Range	Mean	SD
DDM (n = 34)	2-10	6.60	1.88
MI (n = 34)	3-10	7.03	1.94
Total (n = 68)	2-10	6.80	1.91

DDM = Delegation Decision Making Intervention Group
MI = Mimic Intervention Group

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Table 10

T Tests Between Groups at Postintervention

Category	N	Mean	SD	St. Error	T	DF	p
Confidence							
DDM Group	46	8.3260	1.0636	.1568	-2.7696	68.9	.0072*
MI Group	41	7.5170	1.5779	.2464			
Present							
DDM Group	46	8.0579	1.6090	.2372	-2.4240	85.0	.0175*
MI Group	41	7.1056	2.0486	.3199			
Future							
DDM Group	46	8.6884	1.1850	.1747	-5.0818	70.7	.0001*
MI Group	41	7.0813	1.6878	.2635			

DDM = Delegation Decision Making Group
MI = Mimic Intervention Group
*alpha = .05

Research Question 1

The following research question was posed: Is there a difference in nursing assessment decision grid scores pertaining to nurse delegation decisions at time 1 (preintervention), time 2 (immediate postintervention), and time 3 (1-month follow-up) among RNs who received two different educational interventions?

A repeated measure analysis of variance (ANOVA) was used to test for evolving differences between the delegation decision making group and the mimic intervention group with respect to (a) task identification, (b) problem identification, and (c) the ability to make a rating for team members' assignment. In Table 11, means and standard deviations for the variables at the three time intervals are shown. Table 12 contains results of the ANOVAs for the three variables, respectively. A significant improvement ($p < .001$) was found between mean time 1 (preintervention) scores and time 2 (immediate postintervention) and time 3 (1-month follow-up) scores across all three parameters (Table 13). Since improvement differences in nursing assessment decision grid mean value scores were all statistically significant, the null hypothesis of no difference between groups was rejected.

Table 14 contains comparability of t tests for nursing assessment decision grid scores at Times, 1, 2, and 3 for the demographic variables of position, unit worked, and educational level. A statistically significant improvement ($p = .0066$) for nursing assessment decision grid scores was

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Table 11

Mean and Standard Deviations for Nursing Assessment Decision Survey at Times 1, 2, and 3

	Time 1		Time 2		Time 3	
Variable	Mean	SD	Mean	SD	Mean	SD
Tasks						
DDM	5.2127	1.5871	7.6808	1.4311	7.3695	1.1422
	(n = 47)		(n = 47)		(n = 46)	
MI	5.3488	1.2702	6.1627	1.4949	5.9024	1.3000
	(n = 43)		(n = 43)		(n = 41)	
Problems						
DDM	3.6808	1.1629	5.7021	1.5164	5.5652	1.2587
	(n = 47)			(n = 47)	(n = 46)	
MI	3.8372	1.1737	4.1860	1.2199	4.2439	1.0193
	(n = 43)			(n = 43)	(n = 41)	
Ratings						
DDM	6.3617	2.2882	11.1063	3.1432	11.8695	2.4820
	(n = 47)			(n = 47)	(n = 46)	
MI	6.3488	2.6893	7.6976	3.2933	8.0243	2.8938
	(n = 43)			(n = 43)	(n = 41)	
Total						
DDM	15.2553	4.0296	24.4893	5.0037	24.8043	3.9192
	(n = 47)			(n = 47)	(n = 46)	
MI	15.5348	4.3003	18.0232	5.3295	18.1463	4.3849
	(n = 43)			(n = 43)	(n = 41)	

Note. There were 11 required tasks, 9 patient problems, and 20 rating points possible.
DDM = Delegation Decision Making Intervention Group
MI = Mimic Intervention Group

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Table 12

Analysis of Variance for Effect of Intervention Group by Time Over Three Intervals for Total Test Score

Source	DF	SS	MS	F	Probability of F
Group	1	1215.52	1215.52	106.64	.0001
Subject (Group)	88	3420.15	38.87	3.41	.0001
Time	2	2190.85	1095.43	96.11	.0001
Group X Time	2	685.97	342.98	30.09	.0001
Group Effect	1	1215.52	1215.52	31.28	.0001

alpha = .05

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Table 13

Comparability of T Tests for Nursing Assessment Decision Grid Scores at Times, 1, 2, and 3

	Time 1			Time 2			Time 3		
Variable	t	DF	p	t	DF	p	t	DF	p
Tasks	0.4464	88	.6564	-4.9207	88	<.0001	-5.6032	85	<.0001
Problems	0.6343	88	.5275	-5.1943	88	<.0001	-5.3388	85	<.0001
Rating	-0.9805	88	.9805	-5.0189	88	<.0001	-6.6710	85	<.0001
Total	0.3184	88	.7519	-5.9361	88	<.0001	-7.4788	85	<.0001

alpha = .05

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Table 14

Comparability of T Tests for Nursing Assessment Decision Grid Scores at Times 1, 2, and 3 for Position, Unit, and Educational Level

	Time 1			Time 2			Time 3		
	t	DF	p	t	DF	p	t	DF	p
Position									
Head Nurse	0.1936	3.0	.8588	-0.3162	3.0	.7726	-0.3297	3.0	.7633
Assistant Head Nurse	-1.4380	4.0	.2238	-2.1633	4.0	.0965	-2.3797	4.0	.0760
Charge Nurse	1.3804	17.0	.1854	-3.0944	17.0	.0066	-5.0427	16.0	.0001
Staff Nurse									
Unit									
6E	-1.3494	6.2	.2243	-4.0545	13.0	.0108	-4.5382	12.0	.0007
6W	0.6872	11.1	.5061	-1.7940	17.0	.0906	-2.0833	16.0	.0536
7E	-0.1265	11.0	.9016	-3.0351	11.0	.0113	-5.6075	10.0	.0002
7W	0.3149	12.0	.7582	-3.6293	12.0	.0035	-4.6690	12.0	.0005
8E	0.6324	15.0	.5367	-0.9606	15.0	.3520	-0.6595	15.0	.5196
8W	0.5459	6.2	.6041	-2.1875	10.0	.0536	-4.6060	10.0	.0010
Education									
Diploma	-1.3819	22.0	.1809	-5.4995	22.0	.0000	-5.2514	22.0	.0000
ADN	1.5975	38.3	.1184	-3.0856	49.0	.0033	-4.8417	46.0	.0000
BSN	-0.1252	10.0	.9028	-2.2379	10.0	.0492	-1.8870	10.0	.0885

Note. Three Master's of Science (MSN) prepared nurses were randomly assigned to the experimental group

6E = Telemetry
6W = Surgical
7E = Rehabilitation
7W = Orthopaedics
8E = Oncology
8W = Medical Diabetes

Diploma = Diploma Nurse
ADN = Associate Degree Nurse
BSN = Bachelor of Science in Nursing
Alpha = .05

found at Time 2 (immediate postintervention) for nurses in the charge nurse positions. Scores increased (p = .0001) at Time 3 (1-month follow-up). Staff nurses had a statistically significant improvement for nursing assessment decision grid scores at Time 2 (immediate postintervention (p < .001). This was sustained at Time 3 (p < .001) (1-month follow-up). Significant improvement for nursing assessment decision grid scores was found at Time 2 (immediate postintervention) for Orthopaedic (p = .0035), Rehabilitation (p = .0113), and Telemmetry (p = .0007) units. Scores increased at Time 3 (1-month follow-up) for Orthopaedic (p = .0005), Rehabilitation (p = .0002), and Telemetry (p = .0007) units. Further, the Medical Diabetes Unit had a statistically signicant increase (p = .0010) at Time 3 (1-month follow-up). The demographic variables of educational level revealed a statistically significant improvement at Time 2 (immediate postintervention) for diploma nurses (p < .001), associate degree nurses (p = .0033), and baccalaureate nurses (p = .0492). Gains were sustained for diploma nurses (p < .001) and associate degree nurses (p < .001) at Time 3 (1-month follow-up).

Research Question 2

The following second research question was posed: Is there a difference in RN job satisfaction scores at Time 1 (preintervention) and Time 3 (1-month follow-up) among RNs who received two different educational interventions?

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A t test was used to test the null hypothesis that no differences would evolve between the delegation decision making group and the mimic intervention group with respect to (a) general job satisfaction, (b) routinization, (c) work group cohesion, (d) distributive justice, (e) promotional opportunity, and (f) autonomy. Table 15 shows means and standard deviations for the job satisfaction variables at Time 1 (preintervention) and Time 3 (1-month follow-up). Statistically significant differences in job satisfaction of nurses in this study were found for the categories of promotional opportunity ($p = .0119$) and autonomy ($p = .0003$) (Table 16).

Fisher's protected least significance difference test was used to test for pairwise significance between units and between educational levels. Very few differences between the nursing units and educational levels were found at Time 1 (preintervention) and Time 3 (1-month follow-up).

Findings Relevant to Demographic Variables

To measure variance for all demographic variables, Fisher's protected least significant difference test was utilized. Age, years of experience, years of employment at the study hospital, educational level, shift, and unit worked were not significant indicators of confidence and intent to use delegation decision making. However, the charge nurses were more confident ($p = 0.01$) than staff nurses with delegation decision making. Charge nurses and assistant head nurses reported a statistically significant intent to utilize delegation decisions in

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Table 15

Means and Standard Deviations for Price-Mueller Job Satisfaction Survey Scores at Times 1 and 3

	Time 1		Time 3	
Variable	Mean	SD	Mean	SD
General Job Satisfaction				
DDM	3.8546 (n = 47)	0.5502	3.8659 (n = 46)	0.6112
MI	3.9767 (n = 43)	0.5803	3.9065 (n = 41)	0.4442
Routinization				
DDM	4.1861 (n = 47)	0.4646	4.2192 (n = 46)	0.4675
MI	4.2906 (n = 43)	0.4079	4.1951 (n = 41)	0.4384
Work Group Cohesion				
DDM	3.5372 (n = 47)	0.6988	3.5640 (n = 46)	0.4736
MI	3.6715 (n = 43)	0.5331	3.5054 (n = 41)	0.6981
Distributive Justice				
DDM	3.0159 (n = 47)	0.6683	3.0489 (n = 46)	0.6904
MI	3.0232 (n = 43)	0.6021	3.0853 (n = 41)	0.5798
Promotional Opportunity				
DDM	3.1489 (n = 47)	0.6182	3.3500 (n = 45)	0.5968
MI	3.0697 (n = 43)	0.5127	2.9085 (n = 41)	0.5325
Autonomy				
DDM	3.9680 (n = 47)	0.6585	4.3260 (n = 46)	0.6430
MI	4.1627 (n = 43)	0.5821	3.8902 (n = 41)	0.6915

Note. Not adjusted for missing raw data.
DDM = Delegation Decision Making Intervention Group
MI = Mimic Intervention Group

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Table 16

Comparability of Two Sample T Tests for Price-Mueller Job Satisfaction Survey by Group

T Test Per Group	N	Mean	SD	St. Error	T	DF	p
General Job Satisfaction							
DDM	46	0.0217	0.4715	0.0736	-1.1167	85.0	0.2673
MI	41	-0.0894	0.4562	0.0673			
Routinization							
DDM	46	0.0344	0.4924	0.0726	-1.4412	81.8	.1534
MI	41	-0.0975	0.3574	0.0558			
Work Group Cohesion							
DDM	46	-0.0516	0.2796	0.0412	-0.6999	85.0	.4859
MI	41	-0.1006	0.3710	0.0579			
Distributive Justice							
DDM	46	0.0326	0.6359	0.0947	-0.0616	84.6	.9510
MI	41	0.2430	0.6067	0.0937			
Promotional Opportunity							
DDM	45	0.1722	0.7087	0.1056	-2.5765	76.7	.0119*
MI	41	-0.1585	0.4668	0.0729			
Autonomy							
DDM	46	0.3478	0.7646	0.1127	-3.7356	85.0	.0003*
MI	41	-0.2926	0.8346	0.1303			

Note. Not adjusted for missing raw data.
DDM = Delegation Decision Making Intervention Group
MI = Mimic Intervention Group
*alpha = .05

practice (p = 0.01 and p = 0.04, respectively). Additionally, charge nurses and assistant head nurses scored higher than head nurses, but not at significant levels.

Baccalaureate prepared nurses had the highest overall nursing assessment decision grid scores when compared to nurses with other educational backgrounds (Table 17); however, this analysis was not statistically significant. The age range of 20-29 years cohort scored higher than the 40-49 age group (p = 0.01) and the 30-39 age group (p < .001). The age group of 60-69 years cohort scored higher than the 40-49 year-old group (p = 0.02) and the 50-59 year-old group (p = 0.03). However, it should be noted that only two nurses were in the age 60-69 age cohort. The 30-39 age cohort scored higher than the 40-49 year-old group (p = 0.01) and the 50-59 year-old group (p = 0.01). The 0-9 year group scored higher than the 10-19 years of employment group (p = 0-.03) and the 20-29 year group (p = .001). Nurses employed 0-9 years scored higher than those employed 20-29 years (p = 0.04). No statistical significance was noted with position and shift worked. The oncology unit had the highest overall score on the nursing assessment decision grid ($\bar{x}$ = 22.4901) (Table 18). Oncology nurses scored significantly higher than the surgical unit (p = 0.01) and the orthopaedic unit (p = 0.01). This was an interesting finding because the patient vignette described a postoperative mastectomy scenario. The oncology unit is a medical specialty unit. The

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Table 17

Overall Mean and Standard Deviations for Nursing Assessment Decision Grid Scores by Educational Level

	Tasks		Problems		Ratings		Total	
Educational Level	Mean	SD	Mean	SD	Mean	SD	Mean	SD
ADN	6.2733	1.5923	4.5666	1.3971	8.5800	3.5012	19.4133	5.7593
BSN	6.6388	2.0021	5.2222	1.6232	9.5000	4.2325	21.3611	7.1719
Diploma	6.0694	1.5684	4.2361	1.4774	8.1527	3.1873	18.4444	5.5636
MSN	7.2222	2.0480	4.2222	1.3944	9.3333	4.0926	20.7777	6.3595

ADN = Associate Degree Nurse
BSN = Bachelor of Science in Nursing
Diploma = Diploma Nurse
MSN = Master of Science in Nursing

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Table 18

Overall Means and Standard Deviations for Nursing Assessment Decision Grid Scores by Unit

	Tasks		Problems		Ratings		Total	
Unit	Mean	SD	Mean	SD	Mean	SD	Mean	SD
6E	6.6818	1.5215	4.6136	1.4819	8.6363	3.5899	19.9318	5.8643
6W	5.9464	1.5186	4.7678	1.7055	7.4642	2.9906	18.1785	5.2781
7E	6.1842	1.9009	4.5526	1.6390	8.5788	3.7512	19.3157	6.7457
7W	5.9523	1.8339	4.2619	1.4825	7.1904	3.4446	17.4047	5.0528
8E	6.9019	1.6279	4.6862	1.3782	10.9411	3.0686	22.4901	5.5941
8W	6.0555	1.4331	4.3055	0.9202	8.7777	3.4814	19.1388	5.2652

6E = Telemetry
6W = Surgical
7E = Rehabilitation
7W = Orthopaedics
8E = Oncology
8W = Medical Diabetes

orthopaedic and surgical nurses care for postoperative patients. Additionally, postoperative mastectomy patients are placed on the surgical unit in the study hospital.

There were no statistically significant findings with demographic variables relevant to nurse job satisfaction with the exception of nursing units. The oncology nurses were more satisfied than the orthopaedic nurses ($p < .001$) and the medical diabetes nurses ($p = .001$).

Summary of Findings

Of the 92 nurses who agreed to participate in the study, 90 attended the educational sessions. Three nurses went on medical leaves of absence, leaving 87 subjects available for postintervention data collection.

Analyses reveal an increase in confidence and intent to use delegation decisions in practice for nurses who received the delegation decision making educational intervention. They revealed no such changes in the mimic intervention group. This multiple item scale had an acceptable reliability level of 0.956.

Nursing assessment decision grid scores improved significantly at postintervention and gains were sustained for the 1-month follow-up evaluations. It is important to note that oncology nurses had the highest mean scores when compared to other units. Additionally, the oncology nurses scored significantly higher than surgical and orthopaedic nurses.

Job satisfaction scores were unchanged for variables of generalized job satisfaction, routinization, work group

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cohesion, and distributive justice. A statistically significant difference was noted at the 1-month follow-up for the variable of promotional opportunity (advancement) and autonomy (decision making) in the delegation decision making group.

In summary, among 87 RNs who participated in delegation decision education intervention, a repeated measure analysis of variance revealed a statistically significant evolving difference in the delegation decision making intervention group. Gains were sustained at Time 3 (1-month follow-up).

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CHAPTER V

Discussion, Conclusions, Implications, and Recommendations

The purpose of this experimental study was to ascertain if a structured educational intervention (versus mimic) would be followed by a statistically significant increase in nurse delegation decision making behavior and nurse job satisfaction. The sample included 90 RNs employed in a 282-bed suburban hospital in central Alabama. The instruments used in this study were the Price-Mueller Job Satisfaction Survey, the Nursing Assessment Decision Grid, and a researcher-developed Demographic and Confidence-Intent To Utilize Delegation Decision Survey. Organizational sociotechnical systems theory provided the conceptual framework for the study. Descriptive statistics, analysis of variance (ANOVA), Fisher's protected least significance difference and t tests under the SAS, Release 6.04 (1988) program were used to analyze the data and test the hypotheses. This chapter includes a discussion of the findings of the two research questions, the researcher-developed survey for confidence and intent to use delegation decisions, and the conceptual framework as well as a discussion of conclusions, implications, and recommendations.

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Research Question 1

"Is there a difference in nursing assessment decision grid scores pertaining to nurse delegation decisions at Time 1 (preintervention), Time 2 (immediate postintervention), and Time 3 (1-month follow-up) among RNs who received two different educational interventions?

Mean Nursing Assessment Decision Grid overall scores at Time 1 (preintervention) were relatively low for both the delegation decision making group ($\bar{x}$ = 15.2553) and the mimic group ($\bar{x}$ = 15.5348). An improvement was noted at Time 2 (postintervention) in the delegation decision intervention group ($\bar{x}$ = 24.4893), and the effect was sustained at Time 3 (1-month follow-up), with a ($\bar{x}$ = 24.8043). This is in congress with the findings of Conger (1994) where subjects improved significantly from their pretest scores. Overall scores included (a) task identification, (b) problem identification, and (c) the ability to make a rating for team members' assignment.

Mean Nursing Assessment Decision Grid scores improved slightly at Time 2 (postintervention) in the mimic intervention group ($\bar{x}$ = 18.0232) and ($\bar{x}$ = 18.1463) at Time 3. Improvement was not statistically significant for this group.

The fact that Nursing Assessment Decision Grid scores were higher in the nurse delegation decision intervention group at Time 2 (postintervention) and Time 3 (1-month follow-up) tends to support the claim that a structured teaching intervention was effective for increasing

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delegation behavior (self-report). Based upon these findings, the null hypothesis of no difference between groups was rejected.

The findings from this study concluded that the oncology nurses had the highest overall mean nursing assessment decision grid score ($\bar{x}$ = 22.4901). Oncology nurses scored significantly higher than the orthopaedic nurse ($\bar{x}$ = 17.4047) and the surgical nurses ($\bar{x}$ = 18.1725). It is interesting to note that the patient vignette used for testing purposes described a postoperative mastectomy patient that would have been assigned to the surgical unit in the study hospital. It should also be noted that the setting for the structured educational intervention took place on the nursing units. Nurses were excused from their assigned unit to attend the inservice. However, it should be noted that there were occasional interruptions if the RN was needed to answer questions, assist with patient care, or take a telephone call.

Age of subjects was an indicator of nursing assessment decision grid scores. The 20-29 year-old age group scored significantly higher than the 40-49 year-old age group. The 30-39 year-old age group scored higher than the 40-49 year-old group and the 50-59 year-old group. The two subjects in the 60-66 year-old age group scored significantly higher than the 40-49 year-old and 50-59 year-old age groups. The group employed 0-9 years revealed a more statistically significant improvement in nursing assessment decision grid scores than nurses employed 20-29

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years. RNs with 0-9 years of experience scored significantly higher than those nurses with 10-19 and 20-29 years of experience. Interestingly, Conger's (1994) study showed little effect for the demographic variables of age, years of nursing experience, and educational preparation.

Baccalaureate prepared nurses had the highest overall nursing assessment decision grid mean score at Time 3 ($\bar{x}$ = 21,3611) when compared to the other three educational groups; however, this was not statistically significant. Position and shift worked in the hospital had little influence on scores at Time 2 (immediate postintervention) and Time 3 (1-month follow-up).

Based on these findings, use of the nursing assessment decision grid was effective in teaching delegation decisions in medical-surgical patient care settings. Teaching sessions were occasionally interrupted if a nurse was needed on the assigned patient care unit.

Research Question 2

"Is there a difference in RN job satisfaction scores at Time 1 (preintervention) and Time 3 (1-month follow-up) among RNs who received two different educational interventions?"

Results for the current study are expressed as average scores between two educational intervention groups in each of the six facets of the Price-Mueller Job Satisfaction Survey at Time 3 (1-month postintervention). Each item is scored as follows: 5 = highest satisfaction, 4, 3, 2, 1, = lowest satisfaction. Subjects were most satisfied with

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autonomy (decision making) (p = .0003) followed by promotional opportunity (p = .0119). RNs did not significantly experience general job satisfaction (p = .2673), distributive justice (p = .9510), routinization (p = .1534), or work group cohesion (p= .4859) for n = 87, with alpha at .05.

The highest source of job satisfaction in this study was autonomy (decision making). The second source of nurse job satisfaction was promotional opportunity (advancement). Routinization (task variety), general job satisfaction, work groups cohesion (integration), and distribution justice were not significant indicators of nurse job satisfaction in this study.

The demographic variables of age, years of nursing experience, years of employment at the study hospital, educational level, and shift and unit worked were investigated for their influence at Time 1 (preintervention) and Time 3 (1-month follow-up), and little effect was found. The only significant finding for effect of demographic variables was for the oncology nurses. RNs on the oncology unit had statistically significant job satisfaction scores when compared to the orthopaedic unit (p = .009) and the medical diabetes unit (p < .001). One possible explanation for this finding is that, in general, oncology patients have longer lengths of hospital stay, higher readmission rates, and more time to form relationships with the nursing staff than patients with other diagnoses.

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Very few nurse job satisfaction studies utilize an experimental design (Lorenzi, 1993). Most of the nurse job satisfaction research utilizes descriptive and descriptive correlational designs (Agho, 1993; Agho et al., 1993; Blegen & Mueller, 1987; Boumans & Landerweed, 1994; Cavanagh, 1992; Klinefelter, 1993; Mottaz, 1988; Nakata & Saylor, 1994).

Findings Relevant to Researcher-Developed Survey for Confidence and Intent to Use Delegation Decisions

Subject scores for confidence as well as present use and intent for future use of delegation decisions in nursing practice increased for the delegation decision making intervention group. The scores did not increase for the mimic intervention group. The demographic variables of age, years of nursing experience, years employed at the study hospital, level of education, and shift and unit worked were not significant predictors of nurses' confidence and intent to make delegation decisions in practice. Less than half of the sample reported learning delegation skills in nursing school. The demographic variable of position worked did have a significant effect. Charge nurses had higher scores for intent to use delegation decisions in practice. Also, assistant head nurses' scores increased for intent to use delegation decision skills in the work setting. This finding was not surprising. Charge nurses and assistant head nurses in the study hospital direct work flow related to patient care activities on each shift.

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Findings Relevant to the Conceptual Framework

The conceptual framework was based upon the Organizational Sociotechnical Systems Theory of Kast and Rosenzweig (1970, 1985). The hospital was viewed as an open system containing five subsystems within the environmental supra system: goals and values, technical, psychosocial, structural, and managerial. Job satisfaction and delegation behavior comprised the psychosocial subsystem; organizational structure and demographic variables composed the managerial and technical subsystem; the organizational culture and hospital mission described the goals and values subsystem; and the ability to identify patient care tasks, to identify patient problems, and to make patient assignment was addressed in the structural subsystem.

In the psychosocial subsystem of the hospital organization, promotional opportunity (advancement) and autonomy (decision making) were the only two of the six variables measuring job satisfaction that had statistical significance. Delegation behavior was significantly higher in the delegation decision making intervention group than it was in the mimic group. Delegation behaviors were more prevalent among the charge nurse and assistant head nurse positions than other positions.

Organizational structure and demographic variables represented the managerial and technical subsystems. Assistant head nurses and charge nurses direct the patient care work flow in the study hospital. These two job

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categories comprised 27.8% (25 subjects) of the sample. Head nurses have a 24-hour management accountability. Their role involved budgeting, staffing, scheduling, and numerous committee assignments. For this reason, assistant head nurses and charge nurses work on the same shift as the head nurse.

The hospital organization's goals and values subsystem was reflected in its mission and philosophy statement. The Medical Center East hospital mission involves delivery of high quality, cost effective health care. Assignment of the appropriate level of nurse to satisfy patient care demands meets these goals. Additionally, the hospital mission statement enumerated, "We believe in supporting and rewarding teamwork which necessitates that all employees have a clear understanding of their role in the organization" (p. 1). Varying levels of nurse education, experience, and position delineated role expectations within this organization.

Task differentiation and problem identification represented the structural subsystem of the hospital. Nurses of varying skill level were assigned to patient care commensurate with their education, licensure, job description, hospital policy, and demonstrated competence (Conger, 1993). RNs and nurse extender skills were integrated within the workforce to render the necessary requisites of effective and efficient care delivery in the medical-surgical units. RNs in the delegation decision making intervention group had significantly higher nursing

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assessment decision grid scores in task identification, problem identification, and the assignment of team members than the RNs in the mimic intervention group.

These results indicated the relationship between the input of delegation teaching and the application of this knowledge within the medical-surgical units of a hospital. Nurses involved in the delegation decision intervention group had statistically higher overall nursing assessment decision scores. Additionally, nurses in the delegation decision intervention group scored higher in confidence and intent to utilize delegation decisions than the mimic intervention group. Furthermore, the variables of promotional opportunity (advancement) and autonomy (decision making) were facets of job satisfaction that were increased by the intervention.

Conclusions

On the basis of the findings of this study, the following conclusions were drawn, subject to the limitations previously cited.

1. There was a statistically significant increase in nursing assessment decision grid scores for the delegation decision making educational intervention group. This was not the case with the mimic intervention educational group.

2. There was a significant effect for time in the delegation decision making educational group from Time 1 (preintervention) to Time 2 (immediate post intervention) and from Time 1 (preintervention) to Time 3 (1-month follow-up). Therefore, the delegation decision making

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educational group received an effective strategy. Additionally, gains were sustained at Time 3 (1-month follow-up).

3. Some nurse demographic variables emerged between nursing assessment decision groups, specifically certain age cohorts, years of nursing experience, years in position with the 0-9 year group, and unit worked. Oncology nurses had the highest mean nursing assessment decision grid score. Moreover, their scores were statistically significantly higher than surgical and orthopaedic nurses.

4. Scores for confidence and intent to use delegation decisions increased in the delegation decision making group. This did not occur in the mimic intervention group.

5. Charge nurses and assistant head nurses reported higher intent to use delegation decision making; charge nurses scored higher in confidence in the use of delegation decision making than nurses in other employment positions. In the delegation decision making group, little effect was found with other demographic variables.

6. Nurse job satisfaction variables of autonomy (decision making) and promotional opportunity (advancement) were statistically significant between educational intervention groups. Generalized job satisfaction, routinization, work group cohesion, and distributive justice were not statistically significant between educational intervention groups.

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7. None of the demographic variables had significant effect on nurses' job satisfaction with the exception of unit worked. The oncology nurses had statistically significant higher scores in the Price-Mueller Job Satisfaction Survey than nurses employed on the orthopaedic and medical diabetes units.

8. Due to the amount of interruption during the inservice, the nursing unit was not the most conducive setting for the educational interventions.

9. Kast and Rosenzweig's (1970, 1985) organizational sociotechnical systems theory and the subsystem concepts were used effectively in guiding this research.

Implications

The results of this study have far-reaching implications for nursing education, nursing service, and nursing research. Each of these implications is discussed.

Nursing Education

Over half of the nurses involved in this study were never taught delegation skills in nursing school. Delegation decision making needs to be taught in nursing programs at all levels. Delegation behaviors must be integrated in all clinical nursing courses.

Patients entering hospitals today are more acutely ill and have shorter lengths of stay than did patients in the past. Further, changing care delivery models are utilizing less skilled staff. Use of unlicensed assistive personnel increases the challenge of delivering safe patient care. RNs employed in the hospital must be equipped with the

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knowledge requisite for delivering safe, high quality patient care, which include skills in delegation.

Student nurses in undergraduate programs need to have reasonable patient loads, especially toward the end of their course of study. This will prepare them for the realistic nurse to patient assignment ratios they will encounter in the hospital setting.

Nursing Service

The average age of the staff RN was 42 years old in 1991 (Curran, 1991). In this study, the mean age was 41, and these nurses had been out of nursing school for more than 10 years. They had far surpassed the limited exposure to delegation skills taught while in school. During these changing times in the health care industry, it is more important than ever that nursing service administration provide RNs with the education necessary to develop their skills to adapt to their evolving role. Staff development sessions are needed to teach nurses skills on delegation behavior in light of changing care delivery models and the introduction of unlicensed assistive personnel in the hospital setting. Increased understanding of RN role expectations in delegation performance could enhance confidence and job satisfaction.

Nurse educators and nursing service leaders need to collaborate more in the area of theoretical and clinical application of biopsychosocial aspects of patient care. Nursing service and nursing education administrators should encourage continuing education for staff and managerial

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nurses. Additionally, nurse faculty should be encouraged to maintain clinical practice skills. This will provide equilibrium between nursing education and nursing service, and should encourage students entering the profession to view the role of RNs pragmatically.

Nursing Research

Additional research is needed to provide adequate understanding of delegation behaviors in the hospital clinical practice setting. Currently, there is a dearth of nursing research literature addressing clinical decision making in the acute medical-surgical settings. More research is needed and findings should be disseminated to all RNs in the profession.

Other research design and methodologies may be used to compare findings with the current study. Further, other patient care units in the hospital should be evaluated to gain more knowledge affecting confidence, intent to use delegation skills, and nurse job satisfaction.

Recommendations

The following recommendations are offered.

1. Delegation decision making needs to be taught in nursing schools at the diploma, associate degree, and baccalaureate degree levels.

2. Delegation decision making skills should be integrated into all clinical courses in nursing schools.

3. Nursing service administrators should provide staff development sessions to RNs in delegating behavior,

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especially in light of changes occurring in the health care industry.

4. Collaboration between nursing service and nursing education administrators should occur to facilitate high quality, pragmatic educational experiences for students and safe care delivery for hospitalized patients.

5. The relationships among variables of nurse job satisfaction, confidence, and intent to use delegation skills among hospital RNs, using both longitudinal and cross-sectional studies, should be investigated.

6. Other variables in the hospital environment that may contribute to delegation behavior and nurse job satisfaction should be investigated.

7. Inservices should be conducted away from the nursing unit.

8. The study should be replicated to support its findings. Different patient care units, including other health care settings and different design and methodologies, should be used to measure the same variables.

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APPENDIX A

Alabama Board of Nursing Standards of Practice

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ALABAMA BOARD OF NURSING

Chapter 610-X-6

Standards of Practice for Registered Nurses

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610-X-6-.01 Nursing Process

(1) The registered nurse shall be responsible and accountable for the quality and quantity of nursing care given to patients.

(2) The registered nurse shall conduct and document nursing assessments of the health status of individuals and groups by:

(a) Collecting objective and subjective data from observations, examinations, interviews and written records and reports in an accurate and timely manner.

1. The appropriate data includes but is not limited to: biophysical and emotional status, growth and development, cultural, religious and socioeconomic backgrounds: client knowledge and perception about health status and potential for maintaining health status; ability to perform activities of daily living; patterns of coping and interacting; consideration of client's health goals; environmental factors; and, available and accessible human and material resources.

(b) Sorting, selecting, reporting and recording relevant information.

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(c) Continuously validating, refining and modifying the data by utilizing all available resources including each contact with the client, the family and significant others.

(3) Utilizing all data obtained by assessment, the registered nurse shall develop and document nursing diagnoses which serve as the basis for the plan of care.

(4) The registered nurse shall develop and modify the plan of care based on assessment and nursing diagnosis. This includes identifying priorities; setting realistic and measurable goals; prescribing nursing intervention(s); and, identifying measures to maintain comfort, support human functions and responses, maintain an environment conductive to well-being and provide health teaching and counseling.

(5) The registered nurse shall implement the plan of care by:

(a) Prescribing and initiating nursing interventions by giving direct care, assisting with care or delegating care.

(b) Providing an environment conducive to safety and health.

(c) Verifying that orders are accurate and properly authorized and that there are no documented contraindications to implementing the order.

(d) Documenting nursing interventions, and responses to care.

(e) Communicating nursing interventions and responses to care to other members of the health care team.

(6) The registered nurse shall evaluate the responses of individuals or groups to nursing interventions and shall involve the clients, significant others, and appropriate health team members in the evaluation process.

(a) The registered nurse shall document and communicate evaluation data appropriately.

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(b) The registered nurse shall use evaluation data as a basis for reassessing client health status, modifying nursing diagnoses, revising plans of care, and prescribing changes in nursing interventions.

Authority: Code §§ 34-21-1(3), 34-21-2(1). History: Effective September 27, 1982.

610-X-6-.02 Delegation, Management and Supervision

(1) The registered nurse shall be responsible and accountable for the quality and quantity of nursing care given to patients by nursing personnel under his/her supervision.

(2) The registered nurse shall delegate selected nursing functions to others in accordance with the education and demonstrated competence of the person.

(3) The registered nurse shall supervise others to whom nursing functions are delegated.

(4) The registered nurse shall assist personnel and students under his/her supervision to develop the optimum skills for continued competency in performing client care activities.

(5) The registered nurse shall provide nursing leadership in formulation, interpretation, and implementation of the objectives and policies of nursing service.

Authority: Code §§ 34-21-1(3), 34-21-2(1). History: Effective September 27, 1982.

610-X-6.03 Additional Responsibilities

(1) The registered nurse shall be responsible and accountable for practice based on and limited to the scope of her/his education, demonstrated competence, and nursing experience.

(2) The registered nurse shall obtain instruction and supervision as necessary when implementing new or unfamiliar nursing techniques or practices.

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(3) The registered nurse shall have knowledge and understanding of the laws and rules regulating nursing and function within the legal scope of nursing practice.

(4) The registered nurse shall accept individual responsibility and accountability for his/her own actions, judgments and competency.

(5) The registered nurse shall collaborate with other members of the nursing team and with inter and intradisciplinary health team members.

(6) The registered nurse shall consult with qualified nurses and other appropriate sources and make referrals as necessary.

(7) The registered nurse shall conduct his/her practice without discrimination on the basis of age, race, religion, sex, national origin or handicap.

(8) The registered nurse shall conduct his/her nursing practice by respecting the dignity and rights of clients.

(9) The registered nurse shall respect the client's right to privacy by protecting confidential information unless obligated to disclose in a court of law under proper authorization or legal compulsion.

(10) The registered nurse shall respect the physical and mental well-being of clients and the property of clients, their significant others, and the facility.

(11) The registered nurse should participate in the evaluation of nursing through peer review.

(12) The registered nurse should contribute to the formulation, interpretation, implementation, and evaluation of the objectives and policies related to nursing practice within the employment setting.

(13) The registered nurse shall report unsafe nursing practice or practice conditions to appropriate authorities.

Authority: Code §§ 34-21-1(3), 34-21-2(1). History: Effective September 27, 1982.

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610-X-6-.04 Quality Control for Practice Beyond Basic Educational Preparation

(1) A registered nurse may, after the successful completion of an organized program of study and supervised clinical practice, carry out functions beyond the basic educational preparation provided the functions are recognized by the Board as being within the legal scope of practice for a registered nurse.

(2) The employing agency shall notify the Board in writing of all proposed programs of study.

Authority: Code §§ 34-21-1(3), 34-21-2(1). History: Effective September 27, 1982. Amended October 29, 1984.

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ALABAMA BOARD OF NURSING

Chapter 610-X-7

Standards of Practice for Licensed Practical Nurses

Table of Contents

610-X-7-.01 Nursing Process

610-X-7-.02 Additional Responsibilities As a Member of the Health Team

610-X-7-.03 Quality Control for Practice Beyond Basic Educational Preparation

610-X-7-.01 Nursing Process

(1) The licensed practical nurse shall contribute to the nursing assessment by collecting, reporting and recording objective and subjective data in an accurate and timely manner. Data collection includes:

(a) Observation about the condition or change in condition by the client.

(b) Signs and symptoms of deviation from normal health status.

(2) The licensed practical nurse shall participate in the development and modification of the plan of care by providing data; contributing to the identification of priorities and setting realistic and measurable goals; and, assisting in the identification of appropriate nursing interventions to maintain comfort, support human functions and responses, maintain an environment conducive to well-being, and provide health teaching and counseling.

(3) The licensed practical nurse participates in the implementation of the plan of care by:

(a) Providing direct care for clients whose conditions are stabilized or predictable.

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(b) Assisting the registered nurse in caring for clients whose conditions are critical and/or fluctuating.

(c) Providing an environment conducive to safety and health.

(d) Documenting nursing interventions and responses to care.

(e) Communicating nursing interventions and responses to care to appropriate members of the health care team.

(4) The licensed practical nurse shall contribute to the evaluation of the responses of individuals or groups to nursing interventions administered by self and others.

(a) The licensed practical nurse shall document and communicate appropriate data.

(b) The licensed practical nurse shall contribute to the modification of the strategy of care on the basis of evaluation.

Authority: Code §§ 34-21-1(4), 34-21-2(1). History: Effective September 27, 1982.

610-X-7-.02 Additional Responsibilities As a Member of the Health Team.

(1) The licensed practical nurse shall consult with appropriate registered nurses and other appropriating sources and seek guidance as necessary.

(2) The licensed practical nurse shall obtain instruction and supervision as necessary when implementing new or unfamiliar nursing techniques or practices.

(3) The licensed practical nurse shall have knowledge and understanding of the laws governing nursing and function within the legal boundaries of practical nursing practice.

(4) The licensed practical nurse shall accept individual responsibility and accountability for his/her own actions and competency.

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(5) The licensed practical nurse shall conduct his/her practice without discrimination on the basis of age, race, religion, sex, national origin or handicap.

(6) The licensed practical nurse shall conduct his/her nursing practice by respecting the dignity and rights of clients.

(7) The licensed practical nurse shall respect the client's right to privacy by protecting confidential information, unless obligated to disclose in a court of law under proper authorization or legal compulsion.

(8) The licensed practical nurse shall respect the physical and mental well-being of clients and the property of clients, their significant others, and the facility.

(9) The licensed practical nurse should participate in the evaluation of nursing through peer review.

(10) The licensed practical nurse shall function under the direction of a registered nurse, licensed physician, or licensed dentist.

(11) The licensed practical nurse should contribute to the formulation, interpretation, implementation, and evaluation of the objectives and policies related to practical nursing practice within the employment setting.

(12) The licensed practical nurse shall report unsafe nursing practice or practice conditions to appropriate authorities.

Authority: Code §§ 34-21-1(4), 34-21-2(1). History: Effective September 27, 1982.

610-X-7-.03 Quality Control for Practice Beyond Basic Educational Preparation

(1) A licensed practical nurse may, after the completion of an organized program of study and supervised practice, perform functions beyond basic educational preparation provided the functions are recognized by the Board as being within the legal scope of practice for the licensed practical nurse.

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(2) The employing agency shall notify the Board in writing of all proposed programs of study.

Authority: Code §§ 34-21-1(3), 34-21-2(1). History: Effective September 27, 1982. Amended October 29, 1984.

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APPENDIX B

Institutional Review Board Approval

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Eastern Health System, Inc.

Corporate Development

Lynn C. Parsons MSN, RN, CNA
[redacted]

Dear Ms Parsons:

Your proposed research titled, "Nurse Delegation Decision Making: Impact on Nurse Job Satisfaction and Patient Satisfaction with Nursing Care Delivery" has received administrative review and it has been determined formal review by the full committee is not required at the present time.

Please accept this correspondence as approval to continue your research at Medical Center East.

If you have any questions please call me at [redacted].

Sincerely,
[redacted]
Herman G. Brehmer
Vice President-Planning
and Development
Eastern Health System, Inc.

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THE UNIVERSITY OF ALABAMA AT BIRMINGHAM
THE UNIVERSITY OF ALABAMA AT BIRMINGHAM
Office of the Institutional Review Board for Human Use

FORM 4: IDENTIFICATION AND CERTIFICATION OF RESEARCH PROJECTS INVOLVING HUMAN SUBJECTS

THE INSTITUTIONAL REVIEW BOARD (IRB) MUST COMPLETE THIS FORM FOR ALL APPLICATIONS FOR RESEARCH AND TRAINING GRANTS, PROGRAM PROJECT AND CENTER GRANTS, DEMONSTRATION GRANTS, FELLOWSHIPS, TRAINEESHIPS, AWARDS, AND OTHER PROPOSALS WHICH MIGHT INVOLVE THE USE OF HUMAN RESEARCH SUBJECTS INDEPENDENT OF SOURCE OF FUNDING.

THIS FORM DOES NOT APPLY TO APPLICATIONS FOR GRANTS LIMITED TO THE SUPPORT OF CONSTRUCTION, ALTERATIONS AND RENOVATIONS, OR RESEARCH RESOURCES.

PRINCIPAL INVESTIGATOR: LYNN C. PARSONS

PROJECT TITLE: NURSE DELEGATION DECISION MAKING: IMPACT ON NURSE JOB SATISFACTION AND PATIENT SATISFACTION WITH CARE DELIVERY

____1. THIS IS A TRAINING GRANT. EACH RESEARCH PROJECT INVOLVING HUMAN SUBJECTS PROPOSED BY TRAINEES MUST BE REVIEWED SEPARATELY BY THE INSTITUTIONAL REVIEW BOARD (IRB).

_X_2. THIS APPLICATION INCLUDES RESEARCH INVOLVING HUMAN SUBJECTS. THE IRB HAS REVIEWED AND APPROVED THIS APPLICATION ON 2-8-95 IN ACCORDANCE WITH UAB'S ASSURANCE APPROVED BY THE UNITED STATES PUBLIC HEALTH SERVICE. THE PROJECT WILL BE SUBJECT TO ANNUAL CONTINUING REVIEW AS PROVIDED IN THAT ASSURANCE.

_X_ THIS PROJECT RECEIVED EXPEDITED REVIEW.

_____ THIS PROJECT RECEIVED FULL BOARD REVIEW.

____3. THIS APPLICATION MAY INCLUDE RESEARCH INVOLVING HUMAN SUBJECTS. REVIEW IS PENDING BY THE IRB AS PROVIDED BY UAB'S ASSURANCE. COMPLETION OF REVIEW WILL BE CERTIFIED BY ISSUANCE OF ANOTHER FORM 4 AS SOON AS POSSIBLE.

____4. EXEMPTION IS APPROVED BASED ON EXEMPTION CATEGORY NUMBER(S)_____.

DATE: 2-8-95

[redacted]
RUSSELL CUNNINGHAM, M.D.
INTERIM CHAIRMAN OF THE
INSTITUTIONAL REVIEW BOARD

The University of Alabama at Birmingham
1170R Administration Building • 701 South 20th Street
Birmingham, Alabama 35294-0111 • (205) 934-3789 • FAX (205) 975-5977

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OFFICE OF INSTITUTIONAL REVIEW BOARD

Addendum to IRB Application

The number of nurse subjects will be 80. The probable duration of the entire study will be from 3/1/95 through 5/8/95.

[redacted]
Lynn C. Parsons
2/8/95

Enc.—original IRB form attached

APPROVED

[redacted] 3-6-95
Russell Cunningham, MD
Interim Chairman-IRB

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Addendum to IRB Application

The patient satisfaction component to my study has been deleted. The title of my study will be, Nurse Delegation Decision Making: Impact on Nurse Job Satisfaction.

[redacted]

Lynn C. Parsons
2/17/95

Enc: original IRB form attached

APPROVED

[redacted] 3-6-95

Russell Cunningham, MD
Interim Chairman-IRB

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APPENDIX C

Informed Consent

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Dear ,

You are invited to participate in a research study addressing nurse delegation decisions and job satisfaction. Nurses who practice in medical-surgical units will be study participants.

This study is being conducted by Lynn C. Parsons, who is pursuing a doctorate in Nursing Administration at The University of Alabama in Birmingham. Information gained in this research project will be used in my doctoral dissertation.

In participating in this study you will be asked to complete a job satisfaction survey and demographic form at two different time intervals. You will be asked to attend an inservice at the beginning of the study and complete a pretest and posttest form. A second posttest will occur within 30 days of the inservice.

In this study you are free to withdraw your consent and discontinue participation at any time. The services you provide in this organization will neither be enhanced nor diminished as a result of your decision to volunteer or not volunteer in this study. To insure confidentiality the information gathered in this study will be coded with numbers and kept by the investigator. Code numbers will be destroyed after the data is analyzed.

Thank you for your time.

Lynn C. Parsons, RN

I have read the above information, understand it fully, and wish to participate in the project.

Employee Signature:_____ Unit:_____ Date:_____

I decline participation.

Employee Signature:_____ Unit:_____ Date:_____

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APPENDIX D

Letters of Consent

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THE UNIVERSITY OF IOWA

October 3, 1994

Lynn C. Parsons
[redacted]

Dear Ms. Parsons:

This letter is to give you permission to use our questionnaire instruments in your research.

Sincerely,

[redacted]

James L. Price, Chair

JLP:vas

Department of Sociology | 140 Seashore Hall W | Iowa City, Iowa 52242-1401 | 319/335-2502 FAX 319/335-2509

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DEPARTMENT OF NURSING

April 25, 1994

Lynn Parson
[redacted]

Dear Ms Parson

I am pleased that you are interested in knowing more about the Delegation Decision Model. From the work that I have done with this model, I have found that staff nurses have been very receptive to it and have found it useful in helping them practice with the use of nurse extenders in the clinical setting.

It appears to me that you are interested in two components of this program. The first is to teach this model in the classroom setting. The second is to study its effectiveness in the clinical area. The article in the Journal of Continuing Education provides the protocol for the classroom testing of the materials. I have enclosed a copy of the article in which the development of the tool is described. Also enclosed is a chart and a wallet sized card of a chart I have developed to assist the nurse to remember the principles involved in the delegation process. These are available for sale from me for distribution to your staff if you are interested.

I am enclosing materials to help you evaluate the usefulness of the model in class presentation to your staff. My only requirement is that if you decide to use any of these materials, you give credit for the development of the model to me. I am enclosing objectives for the program along with a suggested course outline. In addition is a packet of materials needed to teach the class.

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In addition I am enclosing a copy of a suggested protocol for use in the clinical setting. I am currently working on data from a clinical study in which we evaluated the use of the model in the clinical setting and am preparing a preliminary report of this work for presentation at the Western Institute of Nursing Research conference in April. I will be happy to share with you the preliminary findings from this study when this paper is ready for presentation.

I have included several vignettes for use in the teaching phase of the program. If you want to do pre and post testing of the students, the vignette on Mrs. Black as appears in the Journal of continuing Education (Vol 25, 1 p. 23) has completed answers that have been validated by a group of 5 clinical nurse specialists.

You may also choose to develop a scoring guide on a vignette of your choosing using your own identified nursing clinical specialists as your validation group. If you choose this route, you can develop a patient vignette that is related to the type of nursing problems encountered by nurses on the unit from which your sample is drawn. This may be done during your pilot phase of your study.

Please let me know what your interest in this program is so that I can give you further assistance in developing teaching programs for delegation decision making. I will be happy to talk with you at any time as you evaluate these materials.

I look forward to hearing from you,

Sincerely,

[redacted]

Margaret M. Conger, RN, EdD
Assistant Professor - Nursing
Northern Arizona University
[redacted]

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APPENDIX E

Researcher-Developed Tool

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Nurse Demographic Data

Participant Number _____

SECTION A

1. How old were you on your last birthday? _____

2. How many years of nursing experience do you have as of 1/1/95? _____

3. How many years of employment do you have at this hospital as of 1/1/95? _____

4. Educational Preparation (check all that apply).

_____A. LPN
_____B. Diploma RN
_____C. ADN
_____D. BSN
_____E. Bachelor other (list) _____
_____F. MSN
_____G. Masters other (list) _____
_____H. Other (list) _____

5. Shift primarily worked (check one).

_____A. Day
_____B. Evening
_____C. Night

6. Position at hospital (check one).

_____A. Head Nurse
_____B. Assistant Head Nurse
_____C. Charge Nurse
_____D. Staff Nurse

7. Employment Status (check one).

_____A. Full time
_____B. Part time
_____C. PRN

8. Have you been exposed to the concept of delegation decision making in the past? (Circle one.)

A. Yes
B. No

9. If answer to question 8 was yes, please indicate the method that you were exposed to delegation decision making. (Circle all that apply.)

A. Nursing school
B. Continuing education conference
C. Staff development in the work setting
D. Other (list) _____

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SECTION B - Confidence and Intent to Use Delegation Decisions

10. How confident are you with delegation while at work? (Please put line through number.)

1 2 3 4 5 6 7 8 9 10

No Confidence Highly Confident

11. Have you currently utilized delegation decisions in your daily practice? (Please put line through number.)

1 2 3 4 5 6 7 8 9 10

Never Very Often

12. To what extent will you utilize delegation decisions in your daily practice after exposure to the inservice (class)? (Please put aline through number.)

1 2 3 4 5 6 7 8 9 10

Never Very Often

13. What difficulties do you anticipate with delegation decision making? (Please list.)

SECTION C - Post Measure Nurse Demographic Survey

10. How confident are you with delegation while at work? (Please put line through number.)

1 2 3 4 5 6 7 8 9 10

No Confidence Highly Confident

11. Do you currently utilize delegation decisions in your daily practice? (Please put line through number.)

1 2 3 4 5 6 7 8 9 10

Never Very Often

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12. To what extent will you utilize delegation decisions in your daily practice after exposure to inservice (class)? (Please put line through number.)

1 2 3 4 5 6 7 8 9 10

Never Very Often

13. How confident are you with delegating to LPNs? (Please put line through number.)

1 2 3 4 5 6 7 8 9 10

No Confidence Highly Confident

14. Do you feel that the delegation decisions you make are likely to be correct? (Please put line through number.)

1 2 3 4 5 6 7 8 9 10

Not Correct Highly Correct

15. Will you be more likely to utilize delegation decisions in your daily practice after attending teaching session? (Please put line through number.)

1 2 3 4 5 6 7 8 9 10

Not Likely More Likely

16. How frequently do you currently utilize delegation decisions in your daily practice? (Please put line through number.)

1 2 3 4 5 6 7 8 9 10

Not Frequently Very Frequently

17. How confident are you with delegating to nursing assistants? (Please put line through number.)

1 2 3 4 5 6 7 8 9 10

No Confidence Highly Confident

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18. Before the teaching session in delegation decision making, how likely were you to utilize delegation decisions in practice? (Please put line through number.)

1 2 3 4 5 6 7 8 9 10

Not Likely Very Likely

19. Do you feel secure in making delegation decisions at work? (Please put line through number.)

1 2 3 4 5 6 7 8 9 10

Not Secure Highly Secure

20. As a result of the teaching sessions, will you be more inclined to utilize delegation decisions in your nursing practice? (Please put line through number.)

1 2 3 4 5 6 7 8 9 10

Not Inclined Highly Inclined

21. How often do you utilize delegation decisions in your daily nursing practice?

1 2 3 4 5 6 7 8 9 10

Never Many Time a Day

22. What difficulties do you anticipate with delegation decision making? (Please list.)

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APPENDIX F

Price-Mueller Job Satisfaction Survey

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STUDY OF NURSE JOB SATISFACTION & PATIENT SATISFACTION WITH NURSING CARE DELIVERY

Introduction

This survey is part of a research project which seeks to gain a better understanding of job satisfaction among nurses who are employed by hospitals. This research will ultimately provide insights on the determinants of nurse job satisfaction.

The study is being conducted by Lynn C. Parsons, who is pursuing a doctorate in Nursing Administration at The University of Alabama at Birmingham. The research based on these questionnaires will be used in her doctoral dissertation.

Answers to all questions are voluntary and confidential. Your participation is sincerely requested, for there is no other way of finding out what you feel about your job. Information will be used for the purpose of statistical analysis only. At no time will the identity of any individual be revealed. None of the completed questionnaires will ever be seen by anyone at the hospital. Questionnaires will be destroyed at the end of the study.

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Price-Mueller Job Satisfaction Survey

Job Satisfaction

Listed below are some statements about job satisfaction. How much do you agree with each of these statements? (Check one for each statement.)

STATEMENT	Strongly Agree	Agree	Neither Agree nor Disagree	Strongly Disagree	Disagree
1. I find real enjoyment in my job.	( )	( )	( )	( )	( )
2. I like my job better than the average person does.	( )	( )	( )	( )	( )
3. I am seldom bored with my job.	( )	( )	( )	( )	( )
4. I would not consider taking another kind of job.	( )	( )	( )	( )	( )
5. Most days I am enthusiastic about my job.	( )	( )	( )	( )	( )
6. I feel fairly well satisfied with my job.	( )	( )	( )	( )	( )

Job Variety--Routinization Items

7. To what extent does your job require that you keep learning new things?

( ) Must always be learning new things
( ) Quite often
( ) Sometimes
( ) Rarely
( ) Never required to learn new things

8. To what extent does your job require a high level of skill?

( ) A very high level of skill is required
( ) Quite a high level
( ) Somewhat high
( ) Rather low level
( ) Very low level of skill is required

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9. How creative does your job require you to be?

( ) Required to be very creative
( ) Quite creative
( ) Somewhat creative
( ) Very little
( ) No creativity required

10. How much does your job let you use your skills and abilities?

( ) My job makes very good use of my skills and abilities.
( ) Good use
( ) Some use
( ) Very little use
( ) My job makes no use of my skills and abilities

People at Work--Work Group Cohesion

The next set of questions deals with people in your immediate work group, that is, the individuals with whom you have the most contact at work.

11. To what extent are individuals in your work group friendly?

( ) Very friendly
( ) Quite
( ) Somewhat
( ) Very little
( ) Not friendly at all

12. How often do you do things socially with individuals in your work group outside of work?

( ) Never
( ) Not very often
( ) From time to time
( ) Quite often
( ) Very often

13. To what extent are individuals in your work group helpful to you in getting your job done?

( ) Very helpful
( ) Quite
( ) Somewhat
( ) Very little
( ) Not helpful at all

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14. To what extent do you trust individuals of your work group?

( ) A great deal of trust
( ) Quite a lot
( ) Some
( ) Very little
( ) No trust at all

15. How often do you discuss important personal problems with individuals in your work group?

( ) Very often
( ) Quite often
( ) From time to time
( ) Not very often
( ) Never

16. To what extent do individuals in your work group take an interest in you?

( ) Not interested at all
( ) Very little
( ) Somewhat
( ) Quite
( ) Very interested

17. To what extent will individuals in your group do favors for you at considerable cost to themselves?

( ) Will do almost no favors for me
( ) Will do some
( ) Will do moderate amount
( ) Will do many
( ) Will do almost any favor for me

18. How much do you know about the individuals in your work group?

( ) Know a great deal about them as persons
( ) Quite a lot
( ) A moderate amount
( ) Some
( ) Know almost nothing about them as persons

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Rewards of the Job--Distributive Justice

Fairness in the following questions means the extent to which a person's contributions are related to the rewards received. Money, recognition, and physical facilities are examples of rewards.

19. To what extent are you fairly rewarded considering the responsibilities that you have?

( ) To a very great extent
( ) To a great extent
( ) To some extent
( ) Very little extent
( ) Not at all

20. To what extent are you fairly rewarded taking into account the amount of education and training that you have had?

( ) To a very great extent
( ) To a great extent
( ) To some extent
( ) Very little
( ) Not at all

21. To what extent are you fairly rewarded for the amount of effort that you put forth?

( ) To a very great extent
( ) To a great extent
( ) To some extent
( ) Very little extent
( ) Not at all

22. To what extent are you fairly rewarded in view of the amount of experience that you have?

( ) To a very great extent
( ) To a great extent
( ) To some extent
( ) Very little extent
( ) Not at all

Job Advancement--Promotional Opportunity

23. To what extent is the job that you have now a stepping stone to another job?

( ) To a very great extent
( ) To a great extent

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( ) To some extent
( ) A little
( ) Not at all

24. How likely is it that the job you have now is part of a regular series of positions by which people move to a higher level?

( ) Very likely
( ) Quite likely
( ) Somewhat likely
( ) Barely likely
( ) Not at all likely

25. How extensive is the practice of internal promotions where you work in the hospital?

( ) All promotions are from within
( ) Mostly from within
( ) Some from within
( ) Few from within
( ) No promotions from within

26. Where you work in the hospital, how extensive is the practice of beginning at the bottom and working up?

( ) Everybody must start at bottom
( ) Almost everyone must start at bottom
( ) Quite a few
( ) Some
( ) No one starts at the bottom

Decision Making in the Job -- Autonomy

27. How much freedom do you have to do what you want on your job?

( ) Very much
( ) Much
( ) A moderate amount
( ) Little
( ) Very little

28. How much are you left on your own to do your work?

( ) Very much
( ) Much
( ) A moderate amount
( ) Little
( ) Very little

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29. To what extent are you able to act independently of your supervisor in performing your job functions?

( ) Very much
( ) Much
( ) A moderate amount
( ) Little
( ) Very little

30. To what extent does your job allow you the opportunity for independent thought and action?

( ) Very great extent
( ) Great extent
( ) Some extent
( ) Little
( ) Very little

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APPENDIX G

Nurse Delegation Decision Making Intervention Plan

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Nurse Delegation Decision Making Intervention Plan

Objectives:

On completion of this inservice, the learner will be able to:

1. Make delegation decisions needed to determine patient assignments through use of the Nursing Assessment Decision Grid.

2. Determine which level of nurse can safely carry out required patient care.

Content Outline:

I. Introduction (10 minutes total)

   A. Discuss changes in nursing care delivery systems during the past 20 years.

   B. Discuss the impact of changes on the RN role in the hospital setting.

II. Pretest Phase (20 minutes)

   A. Have RNs read the sample vignette on Mrs. Black (attached).

   B. Have RNs identify required patient care tasks patient problems and rate which level of nurse should provide patient care.

   C. Give RN rating guidelines for decision process as follows:
   Items rated as a 3 require professional intervention
   Items rated as a 2 can be delegated to an LPN under direct RN supervision
   Items rated as a 1 can be delegated to an LPN independently.

III. Inservice (40 minutes)

   A. Review the Delegation Decision Making Model. Distribute copies of the model to inservice participants.

   B. Teach RNs the components within the Nursing Assessment Decision Grid (attached). Distribute copies of the instrument to nurses.

   C. Have RNs read sample vignette on Mrs. Smith (attached).

   D. Have RNs complete assessment sheet. They may work in small groups.

   E. Review vignette and correct answers on assessment sheet (attached).

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F. Items scored as "3" will need to be cared for by an RN. Patients with only a few items scored as "3" could have their care delegated to an LPN under RN supervision.

IV. Posttest Phase (15 minutes)

A. Have RNs read the sample vignette on Mrs. Black that was distributed in the pretest phase.

B. Have RNs complete another assessment sheet utilizing skills taught for the Nursing Assessment Decision Grid.

C. Review correct answers on assessment sheet for Mrs. Black (attached).

V. Wrap Up (5 minutes)

A. Have RNs submit completed pretest and posttest forms.

B. Answer any participant questions.

TOTAL INTERVENTION TIME = 90 minutes

Notation: Nurses in the control group will receive a mimic intervention during step III. The mimic intervention will include information on changing delivery systems and an elaboration of information received during the introductory phase of the teaching plan.

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Sample Patient Vignette Mrs. Black

Mrs. Black is a 52-year-old executive at a local "upscale" department store. She is one day postop following a modified radical mastectomy. She has a family history of breast cancer. Her older sister recently died from cancer of the breast.

Her pain management is with a PCA pump that has kept her quite comfortable and also alert. She is still NPO and is receiving IV fluids with one piggyback antibiotic medication per shift. She has been very nauseated during the night with frequent vomiting despite several compazine suppositories.

She has orders to start ambulation today but has not yet gotten beyond sitting on the side of the bed. She has been there twice; each time she became very hypotensive and had to be put back to bed.

Mrs. Black lives alone in the area. She has a daughter who is married and lives in another state. The daughter has called three times in the past 24 hours to check on her mother's condition.

Conger, M. M. (1994). The nursing assessment decision grid: Tool for delegation decision. Journal of Continuing Education, 25(1), 21-27.

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Nursing Assessment Decision Grid

Step 1

A. List on the assessment work sheet all tasks required.

B. Rate each task using the following scale:

1. LPN can do independently
2. LPN needs to be taught
3. RN must do

Step 2

A. Consider each of the client's subsystems listed below. List on your assignment sheet any that are causing stress (imbalance) at this time.

Biological subsystem problems:

1. circulatory
2. respiratory
3. musculoskeletal--skin, bone, muscle
4. Gastro-intestinal
5. renal
6. reproductive
7. regulatory
   a. neurological
   b. endocrine
   c. immune

Psychosocial and spiritual subsystem problems

1. anxiety
2. family process
3. fear
4. grieving
5. hopelessness
6. spiritual distress

B. Rating Scale for each problem identified, rate the rapidity of change occurring at this time using the following scale:

1. stabilized
2. showing moderate change
3. rapidly changing

Step 3

A. consider the patient's and family's sense of coherence with the present situation in terms of knowledge, ability to manage the situation, and motivation to cope with the situation.

B. Rating scale

1. Knowledge
   1 - has adequate knowledge
   2 - needs some instruction/review

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	3 - needs intense instruction
2. Manageability	1 - able to manage the problem
	2 - needs minimal assistance to manage the problem
	3 - needs extensive assistance to manage the problem
3. Motivation	1 - not motivated to work on problems at this time
	2 - shows moderate motivation to work on problem
	3 - highly motivated to work on problem

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Sample Patient Vignette Mrs. Smith

Mrs. Smith is an 80 year-old woman who was admitted during your shift with a diagnosis of possible CVA and possible hip fracture. She had a fainting spell earlier in the day during which she fell on her front sidewalk and injured her hip.

At this time, the woman is confused as to time, place, and person. Her daughter states that this confusion has arisen since her fall. The daughter had talked with her by phone early in the morning and had observed no signs of confusion at that time. The patient has been incontinent of urine twice since admission and has an order for a Foley catheter to be inserted. She also has an order for a feeding tube to be inserted. The patient also is scheduled to have an x-ray of her hip and a CT scan of her head. Both are expected to be done during this shift. No treatment has been ordered yet for a possible hip fracture.

Conger, M. M. (1993). Delegation decision making. Journal of Nursing Staff Development, 9(3), 131-135.

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Completed Assessment Sheet Mrs. Black

Tasks Identified	Rating
Physical assessment	2
IV assessment	2
Medication administration	1
ADL	1
Ambulation	1
Assess PCA therapy	3
IVPBs	3
Care plan review	3
Intake & Output	1
Teach about PCA	3
Assess nausea	1

Problems Identified	Rating
Anxiety R/T chemotherapy	3
Fluid/electrolyte imbalance, R/T vomiting	3
Hypotension R/T fluid volume deficit	3
Decreased comfort—pain R/T mastectomy procedure	3
Fear R/T diagnosis of cancer	3
Grief R/T recent death of sister	3
Knowledge deficit R/T proposed therapy	3
High risk for body image changes R/T mastectomy	3
High risk for respiratory depression R/T pain medication	2

Assessment of Situation

Knowledge (patient or family)
1 = has adequate knowledge
2 = needs some information
3 = needs extensive instruction

Manageability (patient or family member is)
1 = able to manage the problem
2 = needs minimal assistance to manage the problem
3 = needs extensive assistance to manage the problem
NA = too early to assess

Motivation (patient or family is)
1 = not motivated to work on the problem at this time
2 = shows moderate motivation to work on the problem
3 = highly motivated to work on problem
NA = too early to assess

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Decision Process
Items rated as a 3 require professional intervention
Items rated as a 2 can be delegated to an LPN under direct RN supervision
Items rated as a 1 can be delegated to the LPN on an independent basis

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Completed Assessment Sheet Mrs. Smith

Tasks Identified	Rating
Initial assessment	3
Care plan initiated	3
Foley cath inserted	1
Incontinent care—linen change	1
Feeding tube inserted	1
Assist with transport to x-ray	1
Positioning—turn every 2 hours	1
Neurologic checks	1
Reorient to time/place	1
Circulation checks	2
Frequent vital signs	1

Problems Identified	Rating
Circulation—possible hypovolemia r/t 3rd spacing, decreased circulation distal to fracture	3
Respiratory—potential for pneumonia	3
Musculoskeletal—need for alignment/positioning	2
GI—potential for aspiration	2
Neurologic—LOC changes, need for restraints	2
Pain—assessment of level	1
Skin—potential for breakdown	2
Anxiety—patient and family	3

Assessment of Situation

Knowledge (patient or family)
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Footnotes

[1]The fact that the reliability for the total test score is larger than that of the subscores is to be expected, since the former is based on a larger number of test items.

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GRADUATE SCHOOL
UNIVERSITY OF ALABAMA AT BIRMINGHAM
DISSERTATION APPROVAL FORM

Name of Candidate Lynn C. Parsons

Major Subject Nursing Service Administration

Title of Dissertation Nurse Delegation Decision Making:
Impact on Nurse Job Satisfaction

Dissertation Committee:

[redacted] Chairman

[redacted]

Director of Graduate Program [redacted]

Dean, UAB Graduate School

Date 8/30/95

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