

Improving Patient Care Outcomes Through Better Delegation- Communication Among Nurses and Assistive Personnel

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Nurses who currently work within inpatient, acute care settings typically function in chaotic, fast-paced environments. The hospital work environment has become more challenging over the last several decades due to the increasing complexity of patients, chronic illnesses, workforce shortages, increasing patient medication usage, shorter hospital stays, and changing care delivery models. Care delivery models now include unlicensed assistive personnel (UAP) in the provision of direct care and require nurses to be accountable for the care they deliver. In order to provide safe and efficient care nurses must utilize appropriate delegation techniques to meet quality outcome expectations.

Purpose

The purpose of this project was to determine if improving the delegation-communication practices among nurses and UAP's improved patient outcomes of falls and pressure ulcer rates, and improved patient satisfaction with care on an adult acute care pulmonary/medical-surgical unit.

Review of Literature

Since the release of the Institute of Medicine's report *To Err is Human* (IOM, 1999), there has been a significant shift in health care toward safety and quality. As a result of this report, national organizations such as The Joint Commission (2015) and National Patient Safety Foundation (2015) have set agendas to improve patient safety. In order to meet these goals the

IOM report provided recommendations that focus on improving processes for coordination of care and team effectiveness to achieve care that is safe, effective, patient-centered, timely, efficient, and equitable (Wolfe, 2001). The IOM's Committee on Quality of Health Care has offered 10 guiding rules for patient-clinician relationships in order to meet the goals of improved patient safety through systems improvement. One of the guiding rules centers on cooperation among clinicians which "ensures an appropriate exchange of information and coordination of care" is occurring in the work environment (Wolfe, 2001, p. 234).

Over the last two decades as health care systems have implemented processes to improve communication and team effectiveness, much attention has been given to nurse-physician and nurse-patient communication strategies. This is evidenced by products such as the SBAR guidelines (situation, background, assessment, recommendation) that improve communication, as well as goal setting for patient-centered care. However, less attention has been given to the delegation effectiveness between registered nurses and UAP's in acute care settings. Despite the addition of UAP's and their written job descriptions, nurses are often confused about delegation aspects and roles responsibilities of the UAP (Kleinman & Saccomano, 2006; Mueller & Vogelsmeier, 2013; Potter, Deshields, & Kuhrik, 2010). Many times nurses struggle with which tasks they can delegate because of the many different levels of UAP's including; nursing assistants, technicians, aides, and patient care assistants (Standing & Anthony, 2008). Furthermore, other contributing factors to delegation difficulties between nurses and UAP's include the following: role uncertainty, lack of trust, accountability, fears of reciprocity, lack of communication, staffing mixes, and attitudes (Bittner & Gravlin, 2009; Standing & Anthony, 2008). Ultimately, safe care depends on safe delegation and that requires nurses to appropriately plan and communicate delegated tasks. Failure to safely and appropriately delegate care

activities could result in poor patient outcomes. With the current health care emphasis on quality and safety, connections between delegation, safety, and outcomes are becoming increasingly evaluated. Reimbursement has also become linked to optimal outcomes and in order for health systems to remain competitive they must support processes that increase safety and improve patient outcomes, such as delegation practices. Unfavorable patient outcomes can have a significant financial impact on a health system through reduced reimbursement, costly patient care, poor ratings on public reporting sites, and reduced recruitment ability.

Common delegated tasks to UAP's include; turning, bathing, feeding, ambulating, and personal care, all of which have a significant impact on patient outcomes. Ineffective delegation practices that result in omitted or delayed care can lead to less than optimal and costly patient outcomes including; catheter associated infections, development of pressure ulcers, deep vein thrombosis, falls, and reduced patient satisfaction (Anthony & Vidal, 2010; Bittner & Gravlin, 2009).

Use of good communication techniques is the foundation for effective delegation between nurses and UAP's that lead to safe and effective care. Research related to patient safety cites communication breakdown as the number one factor leading to errors. In order for nurses to enhance safety in what has become a very complex health delivery system, they must use good communication and delegation techniques with the interdisciplinary team. A gap exists between nurses' knowledge and ability to maintain professional, effective delegation-communication techniques with assistive personnel.

Project Design and Methods

For this quality improvement project a single-group pretest-posttest design was used to determine the effect of a delegation-communication learning intervention on both registered

nurses and UAP's preparedness and knowledge of delegation. Project outcomes focused on their ability to effectively use delegation-communication to reduce falls and incidence of pressure ulcers, and improve patient satisfaction with care.

Institutional Review Board Approval

IRB exempt status was granted by the hospital and university review boards in which the study was conducted. All participants were made aware of the project goals and that their participation was voluntary.

Sample

The sample was drawn from RNs and UAPs employed on a single, 32-bed adult, acute care inpatient unit in a large academic hospital. Excluded were the clinical nurse specialist, clinical supervisor, and manager due to their participation as clinical champions of this project.

Data Collection

To establish baseline rates of delegation practices and to identify areas for potential improvement, observation of delegation practices among RNs and UAPs was conducted by the principal investigator. An observation guide was developed with common themes derived from the literature review and delegation principles derived from the American Nurses Association (ANA, 2005) and National Council of State Boards of Nursing (NCSBN, 2002) joint statements on delegation (see Figure 1).

Baseline observations evaluated six RNs and five UAPs during the day shift to assess the delegation-communication practices common on the unit. Initial observations revealed that the unit had no shared shift report between RNs and UAPs. Each member received report independently from their corresponding peers. Patient assignments often required UAPs to work with multiple RNs during a shift as well. Throughout the observation days it was noted that care

activities conducted by the RNs and UAPs seemed to occur in isolation from one another. Information sharing between nurses and UAP's occurred only when there were changes in patient condition, specific questions, or movement on/off the unit. However, the communication focused on specific needs without providing a reason or relationship to the patient's condition. Frequent social discussions were observed among all staff in the unit conference room, where documentation occurs and staff members commonly take breaks or eat meals.

After the baseline observations were completed, RNs and UAPs were asked to participate in a pre-learning intervention survey to assess delegation knowledge deficits, delegation competency, supervision issues, use of mindful communication techniques, and delegation decision making. Surveys were tailored to registered nurse or UAP sample participants. The surveys were developed using Qualtrics™ software, an approved platform within the study institution. Survey links were provided to all registered nurses and UAP's on the unit through employee email as well as on two I-pads placed on the unit to increase participation and access.

After the pre-intervention surveys had been completed the principal investigator (PI) designed learning interventions for improving delegation communication techniques based on the pre-intervention survey results, literature review, baseline observations, and greatest knowledge deficits among the staff. The delegation communication learning was designed in a PowerPoint format and included information on the purpose of the project, significance to practice, brief literature review, ANA (2005) principles of delegation, and case scenarios contrasting substandard and high-level delegation communication examples. Included in the learning intervention was the video entitled "Delegating Effectively" and the delegation decision tree developed by the ANA in conjunction with the NCSBN (2002) and available to the public on the NCSBN web site. In order to increase participation and access to learning, the information

was delivered via several formats that included; employee email with links to the NCSBN video, unit I-pads, and a flip chart placed in the unit conference room.

After two months of delegation learning availability, RNs and UAPs were asked to participate in a post-intervention survey to measure learning, use of delegation techniques, communication, and delegation decision making. Data from the National Database of Nursing Quality Indicators (NDNQI) on pressure ulcers and falls, as well as Press-Ganey patient satisfaction levels were also extracted from institutional databases pre and post intervention.

Instruments

Two versions of a Delegation Competency survey were utilized for this study, one for the RNs and one for the UAPs. The survey tools combined two instruments from the literature review and were modified for use in this study. Aspects from a tool developed by Hopkins (2002) to evaluate learning needs and use of delegation were utilized with only the RN sample in the pre-intervention data gathering. Four questions asked for the best answer from three response choices in a delegation scenario. Responses were evaluated as “has a good grasp, delays delegation decisions, or tends not to delegate” according to an established scoring pattern (p. 153). While reliability has not been established on the Hopkins tool, it was derived from a literature review, has face validity, and provided a guide for tailoring learning interventions to staff needs.

A second tool developed by Kaernsted and Bradadottir (2012) to assess preparedness to delegate and mindful communication techniques was modified with additional questions and used for both RNs and UAPs. The tool had a reported Cronbach’s alpha reliability coefficient of 0.63. Personal communication with the author provided the PI with permission to use and modify

the questions. The questions were used in the pre and post-intervention surveys for both RNs and UAPs.

Both versions of the pre-intervention surveys included seven demographic questions, ten questions on supervision issues and role knowledge, and twelve questions on preparedness to delegate and mindful communication techniques. The ten questions regarding supervision issues and role knowledge were answered on a 3-point Likert scale of 1=completely, 2= partially, and 3=not at all, with lower scores being more favorable responses. The twelve questions on preparedness to delegate and communication techniques were given on a 5-point Likert scale with 1= always to 5 = never. Again, lower scores were more favorable.

The post-intervention surveys repeated the ten questions on supervision issues and role knowledge as well as the twelve questions on preparedness to delegate and communication techniques. In addition to the initial demographic questions, questions were also asked of both groups as to which delegation learning interventions they completed, including PowerPoint review, video review, I-pad use, or flipchart review; they were then asked to select the most effective of the learning methods they used.

Results

The sample of RNs included 23 nurses who ranged in age from 20 to 59, 87% female and 70% with a BSN (see Table 1). Fourteen UAPs participated with an age range of 18 to 59 with 71% female and the majority having either a high school diploma or GED (29%) or a vocational certificate (29%) (see Table 2).

Delegation Use

Analysis of RN delegation use with the Hopkins (2002) derived scenario questions revealed a tendency to delay the decision to delegate among the RN sample. Means for the four

scenario questions ranged between 2.22-2.65. Means of 1.00 designated poor ability to delegate, 2.00 designated a tendency to delay the decision to delegate, and 3.00 designated a good grasp on delegation. The task of delegating a bed bath for a long-term, stable patient had the highest mean at 2.65. Lower means were noted in scenarios associated with receiving a new patient from the emergency department (2.22), making assignments to either UAPs or RNs (2.43), and assigning orthostatic blood pressures to a UAP (2.48).

Preparedness to Delegate, Role Knowledge, and Mindful Communication

Pre and post intervention surveys that evaluated RN preparedness to delegate as well as supervision and use of mindful communication techniques were compared using a one-way ANOVA at the $p < .05$ level to measure the effectiveness of the learning intervention. Twenty-two data points were measured with four items showing significant improvement post-intervention. They included: How well can you explain the performance appraisal for tech's where you work? [$F(1,35)=9.0, p=.005$], Can you describe ways in which you could facilitate clearer communication between you and the tech? [$F(1,35)=6.1, p=.018$], How often do you seek feedback from tech's on whether you have explained the task sufficiently? [$F(1,35)=4.8, p=.036$], and How often do you seek feedback from techs to improve your delegation skills? [$F(1,35)=7.7, p=.009$]. The remaining 18 items did not reach significance.

Pre and post surveys for the UAPs were also compared using a one-way ANOVA at the $p < .05$ level. The twenty-two data points analyzed found two items with significant improvement. They included: How often do you give staff feedback following delegation from a registered nurse? [$F(1,19)=4.4, p=.050$] and How often do you think that you lose respect because of delegation? [$F(1,19)=4.8, p=.042$]. The remaining 20 items did not reach significance.

Patient Outcomes

Patient outcomes assessed during this project included: NDNQI rates of falls and pressure ulcer development. Also, Press-Ganey patient satisfaction responses to: *promptness to call button, pain control, and staff working together to care for them*. Prior to beginning this project the unit fall rate was 2.169 per 1000 patient days during the month before the project was started. Falls decreased to zero in the two months following completion of the learning intervention. Hospital acquired pressure ulcer rate, Stage II data prior to the intervention was 3.7%. After the learning intervention and post-intervention survey, the rate decreased to zero. Press-Ganey data prior to the delegation-communication project demonstrated less than optimal ratings in promptness to call button (86.7%), pain control (86.3%) and staff working together to care for them (90.2%). Post-intervention data revealed an improved promptness to call button (88.7%), slightly poorer pain control rate (85.5%), and an unchanged rate of staff working together to care for them (90.2%).

Limitations

While this project provides some evidence supporting the effectiveness of a learning intervention to improving delegation-communication between nurses and UAP's, it is limited by its small convenience sample and short duration on a single unit. Survey questions were drawn from two different studies, one of which had no reported reliability testing. A matched pre and post-test design would have been ideal for more accurate measurement of learning but due to staff turnover independent samples were used. Another important limitation to note was a recent turnover of registered nurses on the unit and a large amount of orientation occurring simultaneously. This may have influenced the low response rate on the post-intervention survey and contributed to the significant variation in "years at current employment" on the pre-intervention demographic data. Respondents reported equally 0-3 years (30%) and over 10 years

(30%), which is a large variation in years (see Table 1), and reflects the turnover during the project. In addition, a planned post-intervention observation phase was omitted due to lack of stable staff for comparing delegation communication.

Discussion

The overall results reveal that delegation-communication difficulties are complex and occur across a variety of experience levels of nurses and UAP's. Nurses tended to delay the decision to delegate in some circumstances except when choices centered on vital signs or bathing, which is common in job descriptions of UAP's. Results show promise for improving patient outcomes such as falls and pressure ulcers with more deliberate attention to delegation-communication. All registered nurses reported in the post-intervention survey that they did complete a learning intervention. The majority of RNs (50%) used the flip chart accessible on the unit with the on-line PowerPoint sent via email as the second most used intervention (43%). The UAP's reported learning intervention use was equally divided between the on-line PowerPoint (38%) and not completing any learning intervention (38%). One participant wrote in a response as; "spoke with another person about what needed to be addressed". This could reflect the value of learning by professional nurses, the educational level of participants, or the accountability associated with delegation for nurses that motivated them to complete the learning interventions. Results show that despite the on-line accessibility of learning, staff chose to review the content during work hours in a hard copy format such as a flip chart or PowerPoint attached to their employee email.

Implications for Practice

Implications for practice include adding delegation-communication teaching to new-hire orientation and requiring yearly practice competencies for both nurses and UAP's in order to

increase role understanding and support a culture of delegation on the unit. Once staff members have foundational knowledge of delegation principles, exercises can be conducted in using the ANA and NCSBN principles of delegation, the delegation decision tree, and mindful communication techniques. Staff would then benefit from participating in simulated communication and delegation practices to build effective skills and bolster confidence in effective delegation-communication.

The initiation of RN and UAP huddles after reporting times would increase face to face interactions and opportunities for sharing of information and delegation. Continued use of independent handoff reporting encourages that care activities occur in isolation from one another, further contributing to poor communication practices. Evaluating care delivery models that promote consistent RN and UAP assignments to build relationships and trust is essential to improving communication techniques and improving patient safety.

References

- American Nurses Association. (2005). Joint ANA and National Council of State Boards of Nursing Position Statement. Retrieved from:<http://nursingworld.org/MainMenuCategories/Policy-Advocacy/Positions-andResolutions/ANAPositionStatements/Position-Statements-Alphabetically/Joint-Statement-on-Delegation-American-Nurses-Association-ANA-and-National-Council-of-State-Boards.html>
- Anthony, M.K. & Vidal, K. (2010). Mindful communication: a novel approach to improving delegation and increasing patient safety. *Journal of Issues in Nursing*, 15, 1-12. doi: <http://dx.doi.org/10.3912/OJIN.Vol15No2Man02>
- Bittner, N.P. & Gravlin, G. (2009). Critical thinking, delegation, and missed care in nursing practice. *Journal of Nursing Administration*, 39, 142-146.
- Hopkins, D.L. (2002). Evaluating the knowledge deficits of registered nurses responsible for supervising nursing assistants. *Journal for Nurses in Staff Development*, 18, 152-156.
- Institute of Medicine. (1999). *To err is human: Building a safer health system*. Retrieved from <http://nationalacademies.org/hmd/reports/1999/to-err-is-human-building-a-saferhealthsystem.aspx>
- Kaernsted, B. & Bragadottir, H. (2012). Delegation of registered nurses revisited: attitudes towards delegation and preparedness to delegate effectively. *Nordic Journal of Nursing Research & Clinical Studies*, 32, 10-15.

Kleinman, C.S. & Saccomano, S.J. (2006). Registered nurses and unlicensed assistive personnel:

An uneasy alliance. *The Journal of Continuing Education in Nursing*, 37(4), 162-170

Mueller, C. & Vogelsmeier, A. (2013). Effective delegation: Understanding responsibility,

authority, and accountability. *Journal of Nursing Regulation*, 4, 20-24.

National Council of State Boards of Nursing. (2002). Delegating effectively video. Retrieved

from: <https://www.ncsbn.org/378.htm>

National Patient Safety Foundation. (2015). Guidelines for Patient Safety. Retrieved from:

<http://www.npsf.org/?page=professionals>

Potter, P., Deshields, T., & Kuhrik, M. (2010). Delegation practices between registered nurses

and nursing assistive personnel. *Journal of Nursing Management*, 18, 157-165. doi:

10.1111/j.1365-2834.2010.01062.x

Ray, J.D. & Overman, A.S. (2014). Hard facts about soft skills. *American Journal of Nursing*,

114, 64-68.

Standing, T.S. & Anthony, M.K. (2008). Delegation: What it means to acute care nurses.

Applied Nursing Research, 21, 8-14. doi: 10.1016/j.apnr.2006.08.010

The Joint Commission. (2015). National Patient Safety Goals. Retrieved from:

http://www.jointcommission.org/standards_information/npsgs.aspx

Wolfe, A. (2001). Institute of Medicine report: Crossing the quality chasm: A new health care system for the 21st century. *Policy, Politics, and Nursing Practice*, 2, 233-235. doi:

10.1177/152715440100200312

Table 1: RN Demographics (n=23)

<i>Item</i>	<i>Grouping</i>	<i>%</i>
Age of Participant in years	20-29	30
	30-39	39
	40-49	26
	50-59	4
Gender	Male	13
	Female	87
Educational Level	ADN	30
	BSN	70
Years in Nursing	Less than a year	9
	1-5	30
	6-10	30
	11-15	13
	16-20	13
	Greater than 20	4
Years at your Current Employment	0-3	30
	4-7	17
	8-10	22
	Over 10	30

Table 2: UAP Demographics (n=14)

<i>Item</i>	<i>Grouping</i>	<i>%</i>
Age of Participant in years	19 or less	7
	20-29	36
	30-39	14
	40-49	29
	50-59	14
Gender	Male	29
	Female	71
Educational Level	High School/ GED	29
	Associates Degree	14
	Bachelor Degree	14
	Vocational Certificate	29
	On the job training	14
Years at your Current Employment	0-3	36
	4-7	14
	8-10	14
	Over 10	36
Years of experience in your current role	Less than a year	14
	1-5	36
	6-10	14
	11-15	21
	16-20	7
	Greater than 20	7

Figure1: Observation Guide & Behaviors for Delegation-Communication

RN	Tasks Delegated	Knowledge & Role Expectations	Relationships	Communication Technique	Omitted Care	ANA Delegation use. (5 Rights)
R1.	<ol style="list-style-type: none"> 1. Turning 2. Ambulation 3. Bathing 4. Feeding 5. I/O's 6. Toileting 7. V/S 8. Glucose 9. Weight 10. Personal care (hair, shave, oral, dressing). 	<p>RN: 8. Provides appropriate level of oversight.</p> <p>RN: 9. Task is within the UAP scope of practice and has the KSA to achieve the pt outcome.</p> <p>RN: 10. Expects UAP to do their assigned jobs.</p> <p>RN: 11. Completes tasks that could be delegated.</p>	<p>Relationships:</p> <ol style="list-style-type: none"> 1. Exhibit trust 2. Respect 3. Positive attitude 4. Acceptance of delegated tasks 5. Willingness to work as a team 6. Disrespectful 7. Negative attitude with delegation 	<p>RN: 1. Clear, concise, correct, and complete.</p> <p>RN 2. Assesses UAP understanding (who, when, where, why, how to do the task)</p> <p>RN 3. Communicates patient specific requirements/needs</p> <p>RN 4. Communicates willingness to guide and support</p> <p>RN 5. Communicates care expectations</p>	<p>Omitted care:</p> <ol style="list-style-type: none"> 1. ambulation 2. turning, 3. feeding 4. hygiene 5. I/O documentation. 	<p>ANA 5 rights of delegation:</p> <p>RN: 1. Right task, circumstance, person, directions & communication, supervision & evaluation)</p> <p>RN: 2. follows up on delegated task and desired outcome.</p> <p>RN: 3. Is there a need to adjust the overall plan.</p> <p>RN: 4. provided feedback to UAP on outcomes related to delegated task.</p>
UAP's						
U1.	<ol style="list-style-type: none"> 1. Turning 2. Ambulation 3. Bathing 4. Feeding 5. I/O's 6. Toileting 7. V/S 8. Glucose 9. Weight 10. Personal care (hair, shave, oral, dressing). 	<p>UAP: 1. Reports abnormal findings</p> <p>2. Reports concerns</p> <p>3. Follows up on tasks delegated to them</p> <p>4. Completes tasks in timely manner,</p> <p>5. Understands own limitations</p> <p>UAP: 6. Interrupts RN specific duties for tasks appropriate to UAP's.</p> <p>UAP: 7. Does not complete task or follow up with RN</p>	<p>Relationships:</p> <ol style="list-style-type: none"> 1. Exhibit trust 2. Respect 3. Positive attitude 4. Acceptance of delegated tasks 5. Willingness to work as a team 6. Disrespectful 7. Negative attitude with delegation 	<p>UAP:</p> <ol style="list-style-type: none"> 1. asks questions 2. clarifies expectations 3. seeks clarification 4. asks additional questions <p>UAP: 5. confirms understanding of task.</p> <p>UAP: 6. determines communication plan.</p>	<p>Omitted care:</p> <ol style="list-style-type: none"> 1. ambulation 2. turning, 3. feeding 4. hygiene 5. I/O documentation. 	

*Numbers signify specific behaviors and delegation-communication aspects for documentation and analysis.