RN and LPN perceptions of front-line delegation

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RN AND LPN PERCEPTIONS OF FRONT-LINE DELEGATION

An Abstract of a Thesis
Submitted
In Partial Fulfillment
of the Requirements for the Degree
Master of Arts

Martha E. Colwell
University of Northern Iowa
July 1996
ABSTRACT

Healthcare organizations face increasing demands to provide the most efficient and economical care possible. Emerging patient care delivery systems require that front-line RNs take on a broader scope of responsibility for patient care, particularly in the area of delegation. Research identifies that staff RNs experience much difficulty in delegating patient care (Conger, 1993; Hansten & Washburn, 1994). The purpose of this study was to explore RN and LPN perceptions of front-line delegation in their working relationships. In particular, the study sought to: (a) determine how changing roles of RNs and LPNs influenced front-line delegation; (b) answer how RNs viewed front-line delegation in comparison to LPNs; and (c) identify barriers to front-line delegation. The research was a qualitative study utilizing an open-ended interview guide to interview 4 non-managerial RNs and 4 LPNs who worked in a midwestern, mid-sized private hospital. Individual, one hour interviews were audio-taped and transcribed. Data analyses were conducted using the constant comparison technique to record, code, and analyze data. Symbolic interactionism provided a theoretical framework for conducting the study. Results indicate that (a) nursing role changes continued to influence front-line delegation over one year after the hospital's implementation of a new patient care delivery system; (b) RNs and LPNs shared similar perceptions of delegation, including perceived barriers to delegation; and (c) RNs tended to learn delegation skills from vicarious role modeling rather than formal training.
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This study by: Martha E. Colwell

Entitled: RN and LPN Perceptions of Front-line Delegation

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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>List of Tables</th>
<th>vi</th>
</tr>
</thead>
<tbody>
<tr>
<td>List of Figures</td>
<td>vii</td>
</tr>
</tbody>
</table>

## Chapter I. INTRODUCTION
- Statement of the Problem .......................................................... 2
- Significance of the Study ......................................................... 2
- Assumptions .............................................................................. 3
- Delimitations ............................................................................ 4
- Limitations ............................................................................... 4
- Definitions of Terms ................................................................. 4

## Chapter II. REVIEW OF LITERATURE
- Management Constructs ................................................................. 7
- Leadership Theories ..................................................................... 10
- Healthcare Trends and Nursing Issues ....................................... 16
- Nursing Models of Delegation .................................................... 19
- Qualitative Research Approaches .............................................. 23
- Summary .................................................................................... 26

## Chapter III. PROCEDURES AND METHODOLOGY
- Research Design ........................................................................ 29
- Subjects and Selection ................................................................. 30
- Methods of Data Collection ......................................................... 31
- The Researcher .......................................................................... 31
- Theoretical Framework and Data Analysis .................................. 32

## Chapter IV. RESULTS
- Demographic Data ..................................................................... 34
- Organizational Context ................................................................. 36
- Changing RN and LPN Roles ....................................................... 37
- Perceptual Themes of Delegation ................................................ 40
- Barriers to Delegation ................................................................ 43
- How RNs Learn Delegation ......................................................... 45
- RN-LPN Working Relationships ................................................... 47
- Summary ....................................................................................... 49
<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Socio-Demographic Description of Study Participants</td>
<td>35</td>
</tr>
</tbody>
</table>
## LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Fiedler's Leadership Contingency Theory</td>
<td>13</td>
</tr>
<tr>
<td>2. Adaptation of Vroom and Yetton's Normative Model of Decision Participation</td>
<td>15</td>
</tr>
</tbody>
</table>
CHAPTER I
INTRODUCTION

Rapidly changing healthcare trends and economics are prompting hospitals to dramatically alter patient care and the way work is performed (Baker, 1995). Hospitals face higher costs with rising liability, demand for medical technology capabilities, and increased payroll related to healthcare professional shortages. At the same time, total quality initiatives have pressed healthcare organizations to focus on the customer, increase quality, and decrease costs (Marszałek-Gaucher & Coffey, 1990). Also, the emergence of managed care in the nineties has forced hospitals to cut costs substantially.

Faced with the need to dramatically lower costs, healthcare organizations are expanding the use of nurse extenders to augment the registered nurse (RN) in patient care. "These nurse extenders may be nursing assistants (NA), licensed practical nurses (LPN), emergency technicians, or other newly emerging health care workers" (Conger, 1994, p. 21). Nursing extenders have also been identified as "assistive personnel" (Herrick, Hansten, O'Neil, Hayes, & Washburn, 1994).

New patient care delivery systems utilizing nurse extenders require that the RN take on a broader scope of responsibility for patient care, particularly in the area of delegation. Registered nurses in many acute care settings find that they must become delegators and coordinators of nursing care rather than assume the traditional role of primary caregiver (Conger, 1993). Coburn and Sturdevant (1992) assert that continued financial constraints in healthcare will make delegation one of the most important leadership skills for nurses in the future.

If indeed delegation becomes a more critical task function for the front-line, hospitals must address the appropriateness and effectiveness of delegation in their organizational and staff development. The focus of this study was to provide an assessment of how RNs and LPNs perceive the delegation process in their working
relationships. This information could provide new insight into competencies, behaviors, and attitudes needed to foster effective and appropriate front-line RN delegation.

**Statement of the Problem**

The purpose of this study was to explore RN and LPN perceptions of front-line delegation in their working relationships. Inherent sub-problems investigated include the following:

1. How do changing roles and responsibilities of RNs and LPNs influence front-line delegation?
2. Do RNs and LPNs view delegation differently?
3. What do RNs and LPNs perceive to be barriers for delegation in their working relationships?

**Significance of the Study**

"Delegation is universally accepted as important, but we still don't know a lot about its dynamics" (D. L. Gardner-Huber, assistant professor at University of Iowa College of Nursing, personal communication, October 19, 1995). While the nursing literature emphasizes delegation as a critical skill for the front-line RN, researchers repeatedly identify the difficulty registered nurses experience in delegating effectively (Conger, 1994; Hansten & Washburn, 1992a; McFarland, Leonard, & Morris, 1984; Sullivan & Decker, 1992; Vestal, 1987). The task of delegating is a complex skill which requires more than telling another to do something (Laird & Laird, 1957). Further research in understanding the dynamics of front-line delegation is needed to assist RNs in developing this complex competency.

Prior to the early nineties, much of the nursing literature addressed delegation from the supervisory or managerial perspective as opposed to delegation occurring at the peer level (Manthey, 1990; McAlvanah, 1989; Olivant, 1984; Poteet, 1984). However, as changing patient care delivery systems require staff RNs to delegate more, recent nursing
research has addressed front-line delegation more frequently (Blegan, Gardner, & McCloskey, 1992; Coburn & Sturdevant, 1992; Conger, 1994; Herrick et al., 1994). This research concludes that delegation is a skill staff RNs are not well prepared to do. Conger (1993) identified several studies reporting that delegation decision-making has not been included in nursing training or been a skill developed in clinical practice.

Adding to the difficulty and complexity of delegation for the front-line RN is the often poorly defined working relationship between RNs and LPNs. Traditionally, healthcare has been very hierarchical and specialized in job roles and functions. Each state board of nursing defines the legal scope of practice for RNs and LPNs. In the state of Iowa the legal scope of practice for the LPN identifies technical skills that may or may not be performed. However, functions of assessment and patient education are addressed in a more general way. As a result, hospitals across the state define the LPN role differently and even within a given hospital. Further, the LPN role may change over time as the hospital seeks to clarify the LPN role as defined by the Nurse Practice Act. The result is a great deal of role confusion. (M. Haugen, clinical nurse specialist, personal communication, October 26, 1995). Frustration, tension, and resentment occurs between RNs and LPNs as job roles and responsibilities seem to fluctuate arbitrarily over periods of time (Manthey, 1989).

Research has addressed the RN perspective of delegation, but it is often focused on the scope of practice and legal issues. In addition, research rarely has analyzed the individual and group experiences of delegation from the viewpoints of both RNs and LPNs. This study was conducted to address the lack of information available about delegation from the perceptions of front-line RNs and LPNs.

Assumptions

This study was conducted under the following assumptions:

1. The subjects' responses in the in-depth interviews were honest.
2. While not seeking to generalize, the sample selected was representative of LPNs and RNs who worked on nursing units utilizing both RNs and LPNs in midwestern, mid-sized private hospitals.

**Delimitations**

For the purpose of this study, the following delimitation was established:

1. Subject sampling for the in-depth interviews included 4 LPNs and 4 RNs in a midwestern private, mid-sized hospital.

**Limitations**

For the purpose of this study, the following limitations were recognized:

1. Though randomly selected, subjects' choice to voluntarily participate may have biased the results.

2. Because the research interviewer was employed at the hospital and had worked previously with two of the nursing units on the issue of delegation, both history and interpersonal biases may have affected the results.

**Definition of Terms**

The following terms were operationally defined for this study:

- **Accountability.** "The outcomes a worker is expected to produce and the standards by which they're measured" (Weiss, 1988, p. 9).
- **Acute Care.** Short term patient care, usually requiring intensive, 24 hour care.
- **Appropriate Delegation.** Delegation which is legally within the scope of practice, as determined by each state's nurse practice act.
- **Assignment.** "Giving to someone else a task within his/her own practice" (Example: An RN assigning a task to other RNs who have the same scope of practice) (National Council of State Boards of Nursing, 1990, p. 3).
- **Authority.** "The right and the power to make and follow through on decisions" (Weiss, 1988, p. 9).
Capitation. A type of healthcare insurance plan in which hospitals assume greater financial risk for providing healthcare services than traditional fee-for-service plans.

Clinical. Relating to direct involvement and observation of the patient.

Delegate. (noun) The person receiving the delegation.

Delegation. "The process of assigning or transferring authority to another and securing commitment for completion of assignments requiring that authority" (National Council of State Boards of Nursing, 1990, p. 1).

Delegator. The person making the delegation.

Diagnostic Related Groups (DRGs). A prospective payment system implemented in the 1980s which determined reimbursement rates paid by third-party payers for healthcare services rendered.

Empowerment. "Giving workers the training and authority they need to manage their own jobs" (Holzman, 1993, p. 39).

Feedback. The process of determining the extent to which a message transmitted has been successfully received, and its impact (Dickson, Hargie, & Morrow, 1989).

Frontline Staff. Healthcare personnel whose primary job function is providing direct, face-to-face patient care.

Licensed Practical Nurse (LPN). A person licensed by the state board of nursing to "perform services of supportive or restorative care under the supervision of a registered nurse or a physician" (Iowa Code 152.3, p. 2).

Managed Care. Structured healthcare plans which control access of patient care through case management and other cost containment measures.

Nursing Diagnosis. "Identify and use discriminatory judgment concerning physical and psychosocial signs and symptoms essential to determining effective nursing intervention" (Iowa Code 655-6.1[152], p. 1).
Nurse Practice Act. "The general term applied to the law, or statutes, written in each state to regulate the practice of nursing" (Hansten & Washburn, 1994, p. 50).

Practice of Nursing. "The practice of a registered nurse or a licensed practical nurse" (Iowa Code 152.1, p. 1).

Primary Nursing. A delivery of patient care which utilizes a staff of only RNs to provide all of the care needed for a given group of assigned patients.

Registered Nurse (RN). A person licensed by the state board of nursing to "formulate nursing diagnosis, . . . conduct nursing treatment of human responses to actual or potential health problems...through supportive and restorative services,...and execute regimen prescribed by a physician" (Iowa Code 152.2, p. 1-2).

Responsibility. "A set of tasks and duties an employee is expected to achieve" (McConkey, 1974, p. 8).

Scope of Practice. The range of tasks, roles, and functions a healthcare professional is legally able to perform.
CHAPTER II
REVIEW OF LITERATURE

The purpose of this study was to explore RN and LPN perceptions of front-line delegation in their working relationships. The literature related to delegation in the RN-LPN working relationship is reported in this chapter. For organizational purposes, the literature is presented under the following topics as they relate to delegation:
(a) management constructs, (b) leadership theories, (c) healthcare trends and nursing issues, (d) nursing models of delegation, (e) qualitative research approaches, and (f) summary.

Management Constructs

The construct of delegation appears most often in applied management literature and typically depicts issues between a superior and a subordinate. While most organizational structures identify RNs and LPNs as a peer- rather than a superior-subordinate relationship, management literature can offer a basic understanding of delegation and its dynamics.

Definitions of delegation range from the simple to the complex, but usually address similar themes. Drucker's classic definition of a manager as "one who accomplishes tasks through others" ("Drucker on," 1984, p. 4) is often cited as a fundamental definition of a delegator. Indeed, management and delegation are so closely related that one can hardly succeed without the other. Poteet states that "management cannot be truly effective unless delegation of work and authority is an integral component of the process.... Delegation uses the energy of other persons to get the work completed" (1984, p. 19).

Taylor (1984) asserts that delegation is the process of turning work over to a subordinate. Because it is more than just handing out assigned tasks, supervisors must understand themselves and their subordinates and utilize effective communication skills. The National Council of State Boards of Nursing likewise emphasizes delegation as a
"process of assigning or transferring authority to another and securing commitment of assignments requiring that authority" (1990, p. 1). McConkey (1974) highlights the complexities of delegation in this detailed definition:

Delegation is the achievement by a manager of definite, specified results, results previously determined on the basis of a priority of needs, by empowering and motivating subordinates to accomplish all or part of the specific results for which the manager has final accountability. The specific results for which the subordinates are accountable are clearly delineated in advance in terms of output required and time allowed and the subordinates' progress is monitored continuously during the time period. (p. 11)

Recurring themes in the management literature about delegation include responsibility, authority, and accountability. The manager's effective interplay of these three elements results in successful delegation. Responsibilities are "the set of tasks and duties a subordinate is expected to achieve" (Weiss, 1988, p. 8). In order to achieve those responsibilities the employee must have authority; that is "the right and the power to make and follow through on decisions" (Weiss, 1988, p. 9). Accountability addresses the "outcomes a worker is expected to produce and the standards by which they're measured" (Weiss, 1988, p. 9). The American Association of Critical-Care Nurses defines accountability as "the state of being responsible, answerable or legally liable for an action" (1995, p. 3). McFarland et al. conclude that effective delegation includes "assignment of the task, the allocation of authority, and the expectation of responsible and accountable completion of the work" (1984, p. 120).

A manager's challenge is being able to integrate responsibility, authority, and accountability effectively. For example, a manager must be able to delegate a level of authority that is commensurate with an employee's responsibilities. Baillie, Trygstad, and Cordoni (1989) propose that a supervisor allocate different levels of authority when delegating tasks based on the employee's competencies and willingness. These levels of authority give the employee varying rights and powers to make and follow through
decisions. Levels of authority might include: (a) study a problem and give information so that the supervisor makes the decision; (b) study a problem, offer recommendations, but not take action; (c) take action in part and confer with supervisor before going further; (d) take action and inform the supervisor; and (e) take action, but not check back with supervisor (Baillie et al., 1989). Delegating levels of authority in this manner requires that a supervisor not only understand an employee's ability to accept responsibility, but also the organization's policies in allocating authority.

The component of accountability also adds to the supervisor's challenge in delegating. Since a manager's job is to get things done through other people, managers remain accountable for their own actions and the actions of their subordinates (Hansten & Washburn, 1994). Thus, delegating work increases the responsibility of final accountability for the manager.

Difficulty in balancing the complexity of authority, responsibility, and accountability often results in many barriers to effective delegation. Delegator barriers frequently identified in the literature include inability to surrender control/authority, lack of trust/confidence in subordinates, risk aversion, lack of experience or education in delegating skills, poor communication skills, absence of selective controls for feedback, lack of commitment to employee development, poor planning, and lack of administrative support (Coburn & Sturdevant, 1992; Hansten & Washburn, 1994; McConkey, 1974; Newman, 1956; Sullivan & Decker, 1992).

Delegation is a two-way process; therefore, it is important to identify barriers subordinates experience. Common barriers related to assuming delegated responsibilities include fear of criticism, lack of role clarity, dependency, lack of authority/resources allocated, task overload, lack of trust, lack of self-confidence, and inadequate positive incentives (Hansten & Washburn, 1994; Newman, 1956; Sullivan & Decker, 1992).
Delegation is not simply a mechanical process that routes the flow of work in a logically constructed organizational chart (Laird & Laird, 1957). It is a complex interaction where delegator and delegate must both reach agreement as to the content and meaning of delegation (McConkey, 1974). Laird and Laird emphasize that successful delegation hinges upon the relationship between leader and followers (1957). Therefore, it is helpful to review leadership theories which focus on the leader-follower relationship and the context in which delegation takes place.

Leadership Theories

Leadership requires the presence of followers and is the relationship between followers and the person who is leading (Sullivan & Decker, 1992). Laird and Laird (1957) indicate that the leader-follower relationship influences the effectiveness of delegation.

Leadership is defined as "an interpersonal influence by which the efforts of a group are directed, through the communication process, toward the achievement of a specified goal or goals in a given situation" (McFarland et al., 1984). This concept of leadership highlights five variables that must be addressed in the leadership process: the leader, followers (or groups), situation, process of communication, and goals (McFarland et al., 1984). The following abridged review of leadership theories will be limited to the leader-follower relationship and situational variables in which delegation occurs. Two types of leadership theories will be reviewed: leadership behavior theories and situational contingency theories. The researcher selected these two categories of leadership theories based on their frequent references to delegation issues in the nursing management literature.

Leadership Behavior Theories

Leadership theories emphasize different variables in the leadership process to varying degrees. For example, leadership behavior theories identify the leader as the
primary cause of performance/human resource management (Schermerhorn, Hunt, & Osborn, 1991). These theories have in common an emphasis on leaders utilizing people-centered and task-oriented behaviors to influence work outputs.

Examples of leadership behavior approaches were formulated in classic research studies at University of Michigan and Ohio State University. Likert's studies at the University of Michigan divided leader behaviors into employee-centered and production-centered categories (Likert, 1987). Supervisors who were employee-centered showed a strong interest in the welfare and motivation of subordinates, while production-centered supervisors placed a stronger emphasis on getting work done. In general, Likert's research found that employee-centered supervisors influenced higher productivity in work groups than production-centered supervisors (Likert, 1987).

Researchers at Ohio State University identified and studied two dimensions of leader behavior similar to the University of Michigan studies, consideration and initiating structure. A leader scoring high in consideration was sensitive to workers' feelings and was similar to the employee-centered supervisor. A leader high in initiating structure was very concerned with delineating task requirements and might be viewed as similar to the production-centered supervisor (Stogdill, 1974). Extended research at Ohio State concluded that effective leaders scored high on both consideration and initiating structure behaviors (Stogdill, 1974).

Blake and Mouton's managerial grid mirrors the University of Michigan and Ohio State research in that it also assesses two dichotomous leadership dimensions, concern for people and concern for production (Blake & Mouton, 1985). These researchers identified various ways managers used authority by visually representing their leadership styles on a grid. Concern for people was measured on the vertical axis of the grid, while concern for production or getting results was measured on the horizontal axis. Blake and Mouton found that the ideal leader scored high on both dimensions. Managers scoring high on
concern for people and production fostered committed followers, a strong sense of teamwork, and interdependence (Blake & Mouton, 1985). These researchers believed that leadership behaviors are dynamic, and therefore, can be learned (Blake & Mouton, 1985).

Situational Contingencies and Leadership

While leadership behavior approaches offer helpful insight into choices of effective leader behaviors, they do not address the interplay of other variables in the leadership process. Situational contingency models of leadership address how a combination of variables produces effective leadership in one situation and not another. Situational theories state that leadership is a relationship that exists between leaders and followers which is influenced by situational forces (Grohar-Murray & DiCroce, 1992). The leader's impact varies according to the particular aspects of the situation; therefore, the leader chooses appropriate styles and behaviors which best meet the needs of the followers and the situation (Schermerehorn et al., 1991).

Situational theories became popular in the 1950s and are still prevalent in current leadership thinking today (Schermerehorn et al., 1991). Because the context of delegating nursing care varies widely from routine tasks to emergency responses, situational contingency approaches are often advocated in the nursing leadership (Grohar-Murray & DiCroce, 1992; Hein & Nicholson, 1994; McFarland et al., 1984; Sullivan & Decker, 1992; Vestal, 1987).

One of the earlier situational contingency approaches is Fiedler's leadership contingency theory. Fiedler's theory maintains that group effectiveness depends on a successful match between the leader's style and the demands of the situation (Fiedler, 1967). Fiedler identified three dimensions of situational control that influence which leadership style should be utilized. These dimensions are: (a) position power, (b) task structure, and (c) leader-member relations, (Fiedler, 1967) (see Figure 1). Position power
describes the amount of organizational authority available to the leader; task structure relates to the number of correct solutions to a situation; and leader-member relations deal with subordinate loyalty and support towards the leader (Fiedler & Chemers, 1974).

Figure 1. Fiedler's Leadership Contingency Theory.

Depending on the situational variables, Fiedler advocates using a task-motivated or relationship-motivated leadership style. For example, a task-motivated style is most productive when a disliked leader faces ambiguous tasks (Fiedler & Chemers, 1974). Leadership contingency theory also identifies leadership styles to pursue when there is weak positional power; therefore, this model may be relevant for staff RNs. For instance, front-line RNs must delegate tasks without possessing the positional power to discipline or administer financial rewards. Depending on the mix of other variables with weak
positional power, Fiedler's model suggests a task-motivated or a relationship-related style for staff RNs. However, it has been noted that Fiedler's leadership contingency theory is "a complex three-dimensional model which is not easy to understand nor is it conclusively supported by research" (Hein & Nicholson, 1994, p. 58).

One situational contingency approach that may be useful to RN delegation and decision-making is Vroom and Yetton's *normative model of decision participation*. Vroom and Yetton's model suggests that managerial decisions utilize varying degrees of subordinate participation (Vroom & Yetton, 1973). Situational variables impacting participative leadership styles in this model are: (a) whether the leader has all of the information needed to make a decision, (b) whether staff members' acceptance of the decision is required to implement it effectively, and (c) whether the leader can accept the delegated decision made by subordinates (Vroom & Yetton, 1973).

Vroom and Yetton (1973) utilize a complex decision tree to guide leaders in choosing appropriate levels of subordinate participation. Decker and Breaugh adapted Vroom and Yetton's model to help nurse managers decide when to use each of the following decision-making styles: tell, sell, consult, join, and delegate (Sullivan & Decker, 1992) (see Figure 2). These leadership styles demonstrate a continuum of allocating authority to subordinates ranging from the manager making the total decision (telling) to delegating all decision authority to staff (delegating). Schermerhorn et al. (1991) state that while the decision tree seems complex and cumbersome, it is helpful in recognizing how time, quality requirements, information availability, and subordinate acceptance can affect decision outcomes. Also, because the participative levels of decision-making are similar to allocated authority levels in some nursing delegation models, Vroom and Yetton's normative model of decision participation may help the front-line RN better grasp delegation issues.
Finally, another situational contingency model that frequently is associated with leaders, followers, and the issue of delegation is Hersey and Blanchard's *situational leadership theory* (also known as *life cycle theory*). Hersey and Blanchard (1982) emphasize the "readiness" or maturity of followers as a contingency variable in leadership. Readiness is the degree to which employees have the *willingness* and *ability* to accomplish a specific task (Hersey & Blanchard, 1982). Willingness to take responsibility is a psychological component, while ability to take responsibility refers to the technical competence of the follower related to the specific task (Hersey & Blanchard, 1982).
Situational leadership theory requires the leader to adjust directive behaviors (i.e., giving guidance and structure) and supportive behaviors (offering emotional support) according to the willingness and ability of followers to perform their job functions (Blanchard, Zigmari, & Zigmari, 1985). Depending on the follower's readiness for task completion, the leader chooses one of four styles: (a) telling (or directing), (b) selling (or coaching), (c) participating (or supporting), or (d) delegating (Hersey & Blanchard, 1982).

Hersey and Blanchard's situational leadership approach requires a leader to be able to diagnose the demands of the situation and then choose the appropriate leadership response. The situational leadership approach can be used with individuals or groups (Hersey & Blanchard, 1982). Leaders must give specific attention to followers and their feelings about an assigned task as well as assessing changing levels of readiness in workers (Blanchard et al., 1985).

Situational leadership theory proposed by Hersey and Blanchard has been popular in nursing leadership literature (Grohar-Murray & DiCroce, 1992; Hein & Nicholson, 1994; McFarland et al., 1984; Vestal, 1987). Like Vroom and Yetton's normative model of decision-making, Hersey and Blanchard's model offers guidelines for allocating authority and responsibility that can be applied in front-line RN delegation. Vestal (1987) proposes that RNs assuming front-line leadership must think about the task to be performed, the ability of the person performing it, and the nature of the situation before deciding what leadership approach to take. Because situational leadership theory addresses these variables specifically, the researcher believes the approach will continue to be favored in the future.

Healthcare Trends and Nursing Issues

In addition to understanding situational variables in leadership, it is important to grasp contemporary and historical healthcare issues which have an impact on nursing and front-line delegation. The following examination of contemporary issues focuses on the
tremendous economic pressures prompting changes in nursing care, while an overview of historical trends highlights the influence of traditional management structures in healthcare.

Many factors are increasing demands on healthcare providers to provide the most efficient and economical care possible. Hospitals have experienced intense economic pressures since the initiation of diagnostic-related groups (DRGs) for Medicare and Medicaid patients in the early eighties (Sullivan & Decker, 1992). Prior to 1983, an increase in patient length of stay, use of multiple diagnostic tests, and increase in use of supplies generated more income and higher profits for hospitals (Vestal, 1987). However, when Medicare, Medicaid, and insurance companies began using diagnostic-related groups and other prospective payment systems, third-party payers began reimbursing according to fixed prices for healthcare services (Marszalek-Gaucher & Coffey, 1990). Hospitals would make a profit only if the cost of hospitalization was less than the pre-determined amount set by the corresponding DRG category (Grohar-Murray & DiCroce, 1992). Prospective payment systems greatly increased hospitals' financial risk when utilization of resources exceeded the expected demand for a specific diagnostic category (Vestal, 1987).

The implementation of DRGs was a dramatic incentive for healthcare organizations to cut costs; it also has radically altered the nature of healthcare delivery. Major insurance companies now demand price ceilings when reimbursing hospitals for care received (Grohar-Murray & DiCroce, 1992). Also, Medicare reimbursement continues to be cut with all healthcare providers as Congress seeks to tighten the Federal budget (Sullivan & Decker, 1992). Hansten and Washburn (1994) identify that Medicare and Medicaid reimbursement has run as low as 60 cents for every dollar of hospital costs.

Insurance companies and the government continue to shift to managed care insurance plans that tightly monitor and control access of healthcare services in order to reduce reimbursements (Sullivan & Decker, 1992). The recent emergence of capitated
healthcare plans requires hospitals to assume even greater financial risk in providing healthcare services. In capitated plans, an insurance provider agrees to pay a healthcare organization a per-capita rate up front for each employee covered under the insurance plan. The healthcare provider agrees to the plan and hopes to provide as few services as possible. Otherwise, the more that employees use healthcare services, the less the hospital makes in profit.

In response to third-party payers' demands to reduce costs while maintaining a high quality of care, many hospitals have implemented total quality programs (Vestal, 1987). These total quality initiatives have pressed healthcare organizations to focus on the customer, increase quality, and decrease costs (Marszalek-Gaucher & Coffey, 1990). Marszalek-Gaucher and Coffey (1990) identify that total quality programs must reduce layers of hierarchy and increase employee involvement and empowerment in order to be effective.

This focus on quality requires a fundamental reorganization in the way people work and interact, since healthcare institutions have historically functioned as bureaucracies (Sullivan & Decker, 1992). Traditional bureaucratic management centralizes power and decision-making and focuses heavily on control, order, compliance, vertical hierarchy, and restricted communication (Evered & Selman, 1989). These authoritarian management styles can "strip control and discretion from subordinates, thereby heightening the sense of powerlessness for employees" (Conger & Kanungo, 1988, p. 478).

Prior to the nineties, physicians and healthcare managers traditionally inhibited the transfer of decision-making and power to lower levels of hospital organizations. Until the recent introduction of managed healthcare, doctors controlled the majority of decisions related to types, methods, frequency, and duration of healthcare services (Marszalek-Gaucher & Coffey, 1990). Working in healthcare's historical context of minimally
allocated authority, it is not surprising that front-line RNs feel uncomfortable in assuming decision-making and delegating roles.

Yet as hospitals redesign staffing patterns to decrease costs, front-line RNs must increase decision-making and delegating roles. This is because many restructured patient care systems expand the use of assistive personnel to augment the RNs' caregiving functions. This restructuring changes the RN's role from primary caregiver to delegator and coordinator of care (Conger, 1993).

Registered nurses may have difficulty adjusting to their delegating role for several reasons. As mentioned earlier, healthcare bureaucratic structures historically have not fostered allocation of authority for front-line professionals. Therefore, staff RNs may not feel competent delegating, which is the process of transferring authority to another. Second, research supports that delegation skills training has not been included in nursing education programs (Conger, 1994; Poteet, 1984). Finally, "many nurses, especially those who entered practice in the 1980s, have experience only in total-registered nurse or primary nursing systems of care delivery, which did not use unlicensed assistive personnel; therefore, they [are] not accustomed to supervising assistive personnel" (Barter & Furmidge, 1994, p. 36).

In summary, historical and contemporary healthcare issues have dramatically impacted nursing and front-line delegation. As economic issues emphasize the need for more front-line delegation, hospitals must address organizational structures and paradigms which hinder the development of delegation in staff RNs. If, indeed, delegation will be one of the most important leadership skills for nurses in the future, it is critical for healthcare organizations to foster appropriate and effective models of nursing delegation.

**Nursing Models of Delegation**

Models of nursing delegation in the literature incorporate many facets of leadership theories and management constructs related to delegation. In addition, many nursing
delegation models utilize the theory of nursing process which is based on assessing, planning, intervening, and evaluating nursing decisions (Hansten & Washburn, 1994; Milstead, 1993). This section of the review of literature will discuss the following models of nursing delegation: Hansten and Washburn's "Four Rights" of delegation, Neumann's 4S Model, the American Association of Critical-Care Nurses' (AACN) Decision Grid for delegation, and McMurray's Four-Item Model. All these models address delegation as it uniquely applies to front-line RN delegation.

Hansten and Washburn have developed a four-step model which proposes "Four Rights" in the total process of delegation. These "rights" include: (a) the right task (the one that can be delegated), (b) the right person (the one qualified to do the job), (c) the right communication (clear description of the objective and the delegator's expectations), and (d) the right feedback (evaluation in a timely manner) (Hansten & Washburn, 1992b).

Delegating the right task is critical because of the legal implications related to licensure. Each state has a nurse practice act which defines the legal scope of practice RNs and LPNs can deliver to the public. In order to delegate an appropriate task, RNs must know their state's nurse practice act as well as the policies of their employing institution (Hansten & Washburn, 1994). Recommendations from national nursing boards and organizations must also be applied when delegating nursing tasks. The National Council of State Boards of Nursing (NCSBN) maintains that "the responsibility and accountability to the public for the overall nursing care remains with the registered nurse" (AACN, 1995, p. 3). The American Nurses Association (ANA) asserts that patient care activities requiring independent, specialized nursing knowledge, skill, or judgment should not be delegated (Milstead, 1993). While portions of data retrieval for assessment and evaluation can be delegated, the RN always remains accountable for the total nursing process with patients (Hansten & Washburn, 1992b).
The second "right" in Hansten and Washburn's delegation model is choosing the *right person*. Hansten and Washburn maintain that selecting the right person can be the most challenging part of the delegation process. A delegating nurse must identify a staff member who is best qualified, motivated, and can be trusted (Hansten & Washburn, 1992c). A RN is more likely to succeed in selecting the right person when he or she clearly understands the state nurse practice act, the staff's job descriptions and roles, and the delegate's strengths, weaknesses, preferences, and motivations (Hansten & Washburn, 1992c).

When delegating, the RN must tailor the third "right," *communication*, to the person and the task at hand. Effective communication in delegation requires content as well as process skills in interacting with others. The content of the communicated message must be clear, concise, and complete (Hansten & Washburn, 1992d). Hansten and Washburn (1992d) advocate the journalistic format of *who, what, when, where, why,* and *how* to guide RNs in the content of delegated tasks.

The second dimension of effective communication, process skills, deals with styles of interpersonal interactions. Hansten and Washburn (1994) believe that training in assertion skills helps RNs to be able to focus on clear, effective communication and to avoid the pitfalls of passive or aggressive communication. In nationwide seminars on delegation training, Hansten, Washburn, and their associates report that nurses have evaluated the opportunity to practice assertive communication exercises as most valuable (Herrick et al., 1994).

The final "right" in Hansten and Washburn's model of delegation is *feedback*, which completes the process of delegation. Feedback includes monitoring work outcomes that have been clearly defined in terms of expectations, timelines, and consequences. Hansten and Washburn (1994) advocate the following seven-point feedback model when
delegating: (a) get the delegate's input before proceeding, (b) give credit to the delegate's efforts, (c) share perceptions of observations and assessments in a timely manner, (d) discuss gaps in perceptions and causes of the problem, (e) get the delegate's solution to the problem, (f) agree on an action plan, and (g) set a time to check on progress.

Since delegation is a complex process and skill for nurses to apply, Hansten and Washburn encourage front-line RNs to apply the nursing process, a theory familiar to nurses. The nursing process is a systems approach for delivering patient care and includes: (a) assessing all factors affecting the current situation, (b) planning systematically what needs to be done, (c) intervening to implement the plan, and (d) monitoring for feedback and evaluation (Hansten & Washburn, 1994). Applying the nursing process to delegation offers nurses a familiar framework to identify the right task, the right person, the right communication, and the right feedback when delegating.

When teaching their model of delegation to nurses, Hansten and Washburn find that many nurses experience grieving issues when changing their role from primary caregiver to delegators and coordinators of patient care (1994). The researchers often provide time and group work to address the paradigm shift in their workshops, so that RNs can embrace their new roles and effectively implement the delegation model (1994).

Hansten and Washburn's "Four Rights" model of delegation is the most in-depth as well as most applied model in the nursing literature. Other nursing models highlight select components of the delegation process. Neuman's 4S Model primarily addresses the importance of choosing the right task and the right person in delegating. Neuman's model emphasizes that a RN review four points—safety, staffing, schooling, and supervision—before delegating anything. The safety and supervision factors stress the importance of understanding the right task, while staffing and schooling issues address the need to find the right person (Neumann, 1989).
Another model, the AACN's Decision Grid for delegation, utilizes five factors based on the nursing task and the patient's condition. The decision to delegate is determined by the following five factors: (a) potential for harm, (b) complexity of task, (c) problem solving and innovation necessary, (d) unpredictability of outcome, and (e) level of patient interaction (AACN, 1995).

A fourth model, McMurray's Four-Item Model, stresses appropriate communication and feedback in nursing delegation. McMurray (1991) advocates a four-step process identified as CAAP: (a) communication to establish checkpoints between the RN and the delegate, (b) appreciation to build trust, (c) advocacy to monitor progress without interfering, and (d) participation to progressively delegate jobs with more responsibility.

In reviewing the nursing delegation models, one can see that delegation is a complex interaction of relationships requiring many management and leadership skills. The ability to identify the right task, the right person, the right communication, and the right feedback is a demanding task for RNs who are assuming increased roles as delegators of care. Research on the complex phenomena of delegation is needed to assist nurses in understanding and attaining their changing roles in professional nursing.

**Qualitative Research Approaches**

Research about delegation in hospital settings must be flexible enough to address the many situational contingencies in a rapidly changing healthcare environment. A qualitative research approach is often more appropriate than quantitative research for observing the contextual features of a rapidly changing phenomenon and, therefore, is well suited for studying the complex dynamics of front-line delegation.

Qualitative research stresses "the socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry" (Denzin & Lincoln, 1994, p. 4). It involves an interpretative, naturalistic
approach to its subject matter. Qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meaning people bring to them. Qualitative design is holistic and searches for understanding of the whole picture (Janesick, 1994). The naturalistic inquiry in qualitative research contrasts with the rigorously controlled variables and research environment in quantitative research (Baumgartner & Strong, 1994).

Qualitative approaches are often more flexible than quantitative research approaches when studying organizational dynamics. For example, a quantitative survey "may be too static to capture the ebb and flow of organizational activity, especially when [the organization] is changing very fast" (Hartley, 1994, p. 213). Qualitative studies offer the researcher freedom to explore social processes in organizational and environmental context and can be useful in capturing the emergent properties operating in changing organizations (Hartley, 1994).

Multiple methodologies are utilized in qualitative research, but the most widely used qualitative method in organizational research is the interview (King, 1994). Qualitative interviews are considered exploratory, in-depth, or unstructured, whereas quantitative interviews tend to be close-ended and more easily tabulated (Baumgartner & Strong, 1994). While quantitative interviews seek to test a hypothesis, the purpose of a qualitative interview is to see the research topic from the perspective of the interviewee and "to understand how and why he or she comes to have this particular perspective" (King, 1994, p. 14).

A key feature of the qualitative research interview is the nature of the relationship between interviewer and interviewee (Cassell & Symon, 1994). The quantitative researcher seeks to minimize the impact of interpersonal processes with the interviewee in order to obtain objective and accurate information from the 'subject'. In contrast, the qualitative researcher maintains that there is no such thing as a 'relationship-free' interview.
The qualitative researcher sees the interviewee as a 'participant' who actively shapes the interview rather than "passively responding to the interviewer's pre-set questions" (King, 1994, p. 15).

Another key element of qualitative research is the use of a theoretical framework to guide strategies for collecting, describing, or explaining data. A theoretical framework is an interpretive paradigm which represents "belief systems that attach the user to a particular worldview" (Denzin & Lincoln, 1994, p. 2). The qualitative researcher utilizes various theoretical framework to give meaning to the collected data. Without an interpretive paradigm to guide the research study, qualitative researchers may end up with massive amounts of data with little or no meaning.

Symbolic interactionism is a theoretical framework used by qualitative researchers in sociology and anthropology since the turn of the century (Baumgartner & Strong, 1994). The symbolic interaction perspective assumes that people do not act according to biologically pre-determined responses, but rather they interpret meaning from phenomena through interaction with others. How people interpret and impart meaning to objects, people, and events determines how people act (Baumgartner & Strong, 1994). "Thus, symbolic interactionism is concerned with understanding the concept of self in relation to the definition of a [social] situation" (Henderson, Bedini, & Hecht, 1994, p. 75). The researcher of this thesis believes that symbolic interactionism is useful for organizational research, in that it offers a theoretical framework for how organizational dynamics are perceived in terms of ongoing interactions among its members.

Qualitative research employs several approaches to ensure reliability and validity. Lincoln and Guba (1985) propose that the rigor or "trustworthiness" of qualitative data interpretation be measured by its credibility (or internal validity), transferability (or external validity), dependability (or reliability), and confirmability (or objectivity). Qualitative researchers use corroboration and triangulation in order to develop credibility
and dependability. Triangulation is a process of cross-validation using multiple researchers, research methods, and data sources (Baumgartner & Strong, 1994).

Other steps that will help researchers to increase the trustworthiness of qualitative studies include: documenting a detailed description of the research plan, utilizing a step-by-step audit trail, documenting the researcher's role in relation to the participants, having study participants provide feedback on the conclusions, and providing thick descriptions of data (Baumgartner & Strong, 1994). Qualitative research does not seek transferability in terms of generalizing to a reference population but rather seeks to enhance understanding behavior in a given social setting (Janesick, 1994).

In conclusion, qualitative research differs from quantitative research in researcher roles, research designs, strategies, methods of collection, and analysis. Qualitative research is particularly flexible in studying processes and how people make sense of their experiences (Baumgartner & Strong, 1994). A qualitative research approach is especially appropriate for exploring the process of delegation and how RNs and LPNs interpret this phenomenon.

**Summary**

Healthcare organizations face increasing demands to provide the most efficient and economical care possible. Emerging patient care delivery systems require that front-line RNs take on a broader scope of responsibility for patient care, particularly in the area of delegation. Coburn and Sturdevant (1992) predict that continued financial constraints in healthcare will make the issue of delegation a critical leadership skill for nurses in the future.

Research identifies that staff RNs experience much difficulty in delegating patient care effectively. The review of literature offers several explanations for this discrepancy. Conger (1993) found that delegation decision-making has not been included in nursing education nor been a skill developed in clinical practice. Another factor has been that
healthcare organizations historically have centralized power and thus limited decision-making by front-line personnel (Sullivan & Decker, 1992). Total quality initiatives and economic pressures have prompted changes in hospitals' traditional management styles, but it has required major paradigm shifts in how work is organized and how people interact (Marszalek-Gaucher & Coffey, 1990).

Hansten and Washburn (1994) report that many nurses have difficulty shifting roles from primary caregiver to the delegator and coordinator of patient care. Nursing education has reinforced that RNs are responsible for a patient's total care with the result being that nurses often feel reluctant to delegate and relinquish some of that care. Also, during the period of 1970-85, many nurses were educated in primary nursing care systems which utilized all or mostly all registered nurses. This generation of nurses lacked experience in delegating to assistive personnel (Hansten & Washburn, 1994). A final difficulty in delegation has been fluctuating interpretations of state nurse practice acts and hospital policies to define roles and job functions between RNs and LPNs.

The literature review highlights that delegation is a complex process involving many management and leadership skills. Effective delegation requires leaders to master and balance skills in assigning responsibility, allocating appropriate authority levels, and maintaining accountability for work completion. Successful delegation hinges upon the relationship between leader and followers and is influenced by many situational variables (Laird & Laird, 1957). Leadership theories such as leadership behavior and situational contingencies can be helpful for RNs assuming front-line leadership as they assess the task to be performed, the ability of the person performing it, and the nature of the situation (Vestal, 1987). Models of nursing delegation address delegation as it uniquely applies to front-line RN delegation. In particular, Hansten and Washburn's "Four Rights" model assists the RN in integrating multiple situational variables such as the right task, the right person, the right communication, and the right feedback when delegating (1994).
In conclusion, as healthcare economics require RNs to take an increasing role in delegation, hospitals must address front-line delegation issues in their organizational and staff development. Existing research has focused on the scope of practice and legal issues related to nursing delegation, but research rarely has addressed the individual and group experiences of front-line delegation from the viewpoints of both RNs and LPNs. Many gaps in the research exist. For example, do RNs and LPNs view front-line delegation differently? What do RNs and LPNs perceive to be barriers for delegation? How do perceived roles and responsibilities of RNs and LPNs influence front-line delegation?
CHAPTER III
PROCEDURES AND METHODOLOGY

The purpose of this study was to explore RN and LPN perceptions of front-line delegation in their working relationships. In particular, the study sought to: (a) determine how changing roles of RNs and LPNs influenced front-line delegation; (b) answer how RNs viewed front-line delegation in comparison to LPNs; and (c) identify barriers to front-line delegation. This chapter contains a description of the research design, the subjects and their selection, the researcher, methods of data collection, the theoretical framework, and data analysis.

Research Design

A descriptive research study was conducted using a qualitative approach. It was the researcher's belief that traditional quantitative approaches were insufficient to uncover the changing nature of front-line delegation in a healthcare setting. Delegation is a complex interaction where delegator and delegate must both reach agreement as to the content and meaning of delegation (McConkey, 1974). As rapidly changing contingencies in the healthcare environment influence RN-LPN working relationships, the researcher believed that a qualitative research design would best identify the evolving dynamics occurring in front-line delegation.

Qualitative research designs are often more flexible than quantitative research approaches when studying organizational dynamics. For example, a quantitative survey "may be too static to capture the ebb and flow of organizational activity, especially when [the organization] is changing very fast" (Hartley, 1994, p. 213). The researcher utilized a qualitative approach to explore social processes in an organizational context and to capture the emergent properties operating in a changing healthcare organization.

Qualitative approaches allowed the researcher to identify evolving issues of front-line delegation through an exploration of specific cases; therefore, in-depth qualitative
interviews were used to gather data. Rather than testing a hypothesis, the purpose of the qualitative interviews was to ascertain how delegation was perceived in terms of ongoing interactions among RNs and LPNs.

Approval for interviewing the respondents was obtained in the following order: (a) from the UNI Human Subjects Review Board, (b) the research committee of the target hospital, and (c) Informed Consent statements signed by each interviewee (see Appendix A).

**Subjects and Selection**

The subjects included four non-managerial staff RNs and four LPNs who worked in a midwestern, private, mid-sized hospital. Participants were randomly selected (using a fishbowl technique of random selection with replacement) from all nursing units which utilized both RNs and LPNs in the delivery of patient care. Initially, the researcher sought LPNs and RNs from medical-surgical units in order to increase homogeneity of the sampling. However, this sampling offered a small pool of LPNs (N = 5). In addition, the medical-surgical units were extremely busy during the data collection period, so the sampling unit was expanded to include all seven nursing units which utilized RNs and LPNs.

Randomly selected nurses from seven nursing units were then invited to participate in an in-depth interview with the researcher (see Appendix B). The administration and research committee of the hospital agreed to allow the researcher to interview nursing staff during the nurses' scheduled working shifts. One hour interviews took place during each nurse's working shift with the exception of one RN. A busy workload had preempted this RN's scheduled interview with the researcher, but she volunteered to interview immediately following her shift.

Both RNs and LPNs were chosen in order to obtain a delegator-delegate perspective and to better understand the dynamics of the RN-LPN relationship. All
participants were women; the gender variable of the sampling reflected generalizability to a nursing population, as 97% of all nurses are women (Sullivan & Decker, 1992).

Methods of Data Collection

Respondents were initially invited to participate in a one hour interview with the researcher at a convenient location in the hospital. The interviews took place over a period of four weeks and were audio tape-recorded and transcribed. Participants were given an opportunity to review the transcripts and make any corrections or additions to the interview.

The researcher utilized an interview guide format with open-ended questions and appropriate probes to encourage participants to talk about their own experiences, perceptions, and thoughts about the topic of front-line RN delegation (see Appendix C). Questions for the one-on-one interviews were developed from the research literature, the interviewer's own personal knowledge and experience in the area, and informal unstructured discussions with people who had personal experience in the research topic.

Prior to the interview, interviewees completed a brief closed-ended questionnaire about their nursing experience and education (see Appendix D). In addition to the transcriptions of each interview, the researcher's field notes and observations of the interviews were treated as data.

The Researcher

The primary instrument for data collection and analysis in this qualitative study was the researcher. The researcher had worked in the hospital selected for this study as a non-nursing, front-line healthcare professional for eighteen years in both non-nursing and nursing departments. During the last five years, the researcher worked periodically with nursing and non-nursing hospital departments that sought assistance for organizational development issues such as interpersonal relationships, organizational change, work stress, empowerment, and delegation.
Prior to the study, the researcher had extensive experience conducting patient interviews which utilized a structured leisure assessment with mostly closed-ended questioning. The qualitative nature of this research study necessitated a more open-ended interviewing approach than previously used by the researcher. The researcher was very aware of the need to apply an open-ended approach so as not to influence the perspectives and conclusions of the interviewees. Increased awareness and proficiency in guiding a more open-ended interview grew as the nurse interviews progressed.

A second researcher assisted in the data analysis for three of the transcribed interviews. In addition to corroborating for emerging themes, the second researcher read three transcripts to provide feedback on the researcher's role as the primary instrument of data collection. The second researcher's analysis (as well as expertise in organizational communication) helped to increase credibility and dependability through triangulation between researchers.

**Theoretical Framework and Data Analysis**

Symbolic interactionism provided a theoretical framework for conducting the study. According to Henderson et al. (1994) symbolic interactionism is based on the assumption that human behavior is not static nor pre-determined, but rather dynamic. People interpret meaning and define things through interaction with others. How individuals interpret phenomena influences how they act (Baumgartner & Strong, 1994). Since the symbolic interactionist perspective allows for fluidity and complex interactions, the researcher applied the framework as a relevant paradigm for the complex processes which occur in delegation.

Data analyses were conducted using the constant comparison technique, which is a systematic method for recording, coding, and analyzing qualitative data (Henderson et al., 1994). The researcher used constant comparison as a validation process to confirm the
raw data. Constant comparison involved reading all interview transcripts while listening to the taped interviews to develop a broad understanding of the content.

All transcripts were read multiple times by the researcher. First, all interviews were read to identify and code possible meanings related to delegation. Transcripts were read repeatedly to compare initial codings across interviews, to construct categories, and check if the data fit these categories. Categories and themes emerging from the data were placed on display boards to compare and contrast RN and LPN responses. This process of analysis allowed themes of meaning to emerge which were based on the perceptions or realities expressed by the interviewees.

A second researcher independently read and analyzed three of the interview transcripts. The two researchers met two times to discuss the coding and interpretation of the data. Corroboration and triangulation between the researchers were used to increase credibility and dependability. In addition, the researcher compared data from the closed-ended questionnaire, transcripts, field notes, and observations to support or challenge emerging themes. Also, a 30 minute second stage interview was conducted with one of the original interviewees to "check" the emerging interpretations of the data. The interviewee was selected based on availability during her work schedule. Finally, the researcher interviewed a clinical nurse specialist who had helped to implement the changed nursing care policy at the hospital research site. The researcher met with the clinical nurse specialist two times to corroborate emerging themes on the interviewees' perceptions related to the hospital's changed patient care delivery and charting system.
CHAPTER IV
RESULTS

The purpose of this study was to explore RN and LPN perceptions of front-line delegation in their working relationships. The following inherent sub-problems were investigated:

1. How do changing roles and responsibilities of RNs and LPNs influence front-line delegation?

2. Do RNs and LPNs view delegation differently?

3. What do RNs and LPNs perceive to be barriers for delegation in their working relationships?

The study utilized an interview guide with open-ended questions to interview 4 non-managerial RNs and 4 LPNs who worked in a midwestern, mid-sized private hospital. The one hour, individual interviews were audio-taped and transcribed. Data analyses were conducted using the constant comparison technique to record, code, and analyze data. The researcher applied symbolic interactionism as the theoretical framework for interpreting the emerging themes. Symbolic interactionism focuses on how people assign meaning to what is happening to them according to the context of social interactions (Henderson et al., 1994). For the purpose of reporting the data, the researcher assigned fictional names to the subjects.

The results of the study are presented in the following order: (a) demographic data, (b) organizational context, (c) changing RN and LPN roles, (d) perceptual themes of delegation, (e) barriers to delegation, (f) how RNs learn delegation, (g) RN-LPN working relationships, and (h) summary.

Demographic Data

All the LPNs (n = 4) in the study had worked 15 or more years in nursing. Two of the RNs had 15 or more years in nursing, while the remaining RNs (n = 2) had worked...
Table 1

**Socio-Demographic Description of Study Participants**

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<th></th>
<th>LPNs (n = 4)</th>
<th>RNs (n = 4)</th>
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<tr>
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four or fewer years as an RN. Hansten and Washburn (1994) reported that the average nurse has at least 15 years experience. It is interesting to note that the randomly selected sample mirrored strong similarities to the general nursing population on the variable of nursing experience. All subjects of the study were Caucasian females. Additional demographics are offered in Table 1.

Organizational Context

Cassell and Symon (1994) stated that qualitative approaches offer the researcher freedom to explore social processes in their organizational and environmental context. This researcher sought to understand the organizational context of nursing care changes within the hospital and its impact on front-line delegation by using qualitative interviews. The hospital in the study had implemented a new patient care charting system in the past year-and-a-half which increased RN responsibilities in patient care and delegation and simultaneously decreased LPN responsibilities in patient education and assessment. This change in the RN roles appeared to reflect the national trend of RNs assuming increased roles as delegators and coordinators of nursing care (Conger, 1993).

The researcher interviewed one of the hospital's clinical nurse specialists before and after the nurse interviews to better understand the organizational context of the role changes for LPNs and RNs as well as to triangulate data from the RN and LPN interviews. The clinical nurse specialist indicated that the introduction of the new patient care charting system in March 1995 highlighted the hospital's need to better differentiate RN and LPN roles related to nursing assessment, patient education, and accountability. The hospital administration historically utilized a conservative approach in defining LPN roles in nursing assessment and patient education, and had implemented policies they believed coincided with the intent of the Iowa Nurse Practice Act.

The new charting system prompted the hospital to re-evaluate the LPN role and to provide specification as to what LPNs could and could not do. The outcome of this re-
evaluation was that responsibilities of LPNs in nursing assessment and patient education were markedly curtailed in the new charting system and delivery of patient care. For example, LPNs could no longer admit a patient since the nursing assessments now were performed only by RNs. Also, LPNs were no longer allowed to perform front-line patient teaching such as the initial teaching of newborn baths to maternity patients. With the new charting system, LPNs were allowed to do follow-up, but not initial patient teaching.

**Changing RN and LPN Roles**

**Sense of Loss**

A dominant emerging theme of the RN and LPN interviews identified that the decrease in nursing responsibilities for LPNs had a major impact on the dynamics of front-line delegation in this hospital. Both RNs and LPNs expressed that the LPNs had experienced significant losses related to their decreased nursing responsibilities. Loss of status, loss of significance, loss of recognition, loss of respect, and loss of credibility were discussed at length by all 4 LPNs and 3 of the RNs. Both RNs and LPNs commented that they had heard LPNs state frequently that now they were just "glorified aides" and that they had been "degraded." Gretchen, RN, noted:

That [admitting] role has been taken away from our LPNs with a lot of hard feelings . . . . Many of them feel angry and frustrated and they just say, "I don't like this, I don't want to do this" and you can tell a lot of undertone is just a lot of resentment that they can't do it [anymore].

Anita, LPN, shared the loss of recognition and status in having decreased charting responsibilities:

I think it's almost taking a privilege away that we've done for a long time, and taking charting away, I'm sure makes the person feel demoted so to speak. You can't do what you have been doing . . . . Maybe an LPN coming out of school would not feel that way, but for someone that's worked as long as I have, charting is what we are used to. So taking that away makes you kind of feel like that you are not as professional as you were.
RNs Fran, Gretchen, and Helen respectively noted sarcastic or resigned LPN responses following the change that expressed loss of respect and credibility:

"I'm just an LPN, what do I know?"

"Well, do you really think I can do that?"

"It's like . . . I was good enough twenty years ago to do it, but now I'm not."

**Acceptance**

The interviewees identified that the LPNs were in various stages of dealing with their new roles. Cathy, LPN, expressed that "a lot of good LPNs have left here because of the changes." For the LPNs who had stayed, the interviewees reportedly observed the following feelings in the LPNs: anger, sarcasm, resentment, unhappiness, irritation, frustration, and defensiveness. At the same time they also observed various stages of role acceptance by the LPNs. LPNs Barb, Anita, and Dionne voiced similar feelings of acceptance. Sharing her observation of the general LPN consensus to the role change, Barb stated, "They [the LPNs] accept it, but they don't like it . . . . Maybe I don't like it either, but that's they way it is and that's they way it's going to be."

Cathy, LPN, expressed the most acceptance of the changed LPN role:

I don't have a problem with it. I went to [LPN] school to do hands-on care for patients and that is what I do . . . . Healthcare is going to change and it has changed ever since I have been a nurse for [over fifteen years] and it is going to keep changing, that is the way it is. You either go with the flow or you find a different job.

**Professional Identity**

A central theme to all the LPNs interviewed was that their professional identity as an LPN was very important to them in the midst of their role changes. All 4 LPNs ascribed a strong personal meaning to their work as LPNs. Anita, Barb, Cathy, and Dionne respectively voiced a deep attachment to their identity as an LPN:
"It's kind of like a mothering job . . . ministering to [the patients'] needs".

"I will always in my heart be an LPN."

"I like my job and I love coming to work here . . . . There has not been a day where I have never wanted to get up and come to work."

"I love [my job], and I wouldn't want to be any other place in the hospital."

In the midst of the loss of job responsibilities, LPNs still seemed to assign personal meaning to their professional identity as LPNs. In contrast to the LPNs, the RNs interviewed did not assign such a deep personal meaning to their professional identity as RNs. Two of the RNs spoke about different aspects of their jobs that were very satisfying. One RN found satisfaction in the harmonious relationships she had with co-workers and stated, "Everybody [is] so nice, and I was so happy that I got [this job] because of the people that work here on our floor." Another nurse shared the personal and professional growth she enjoys as an RN. The researcher's field notes recorded the RN's comments: "There's so much to learn--the human body--it's incredible." Yet none of the RNs ascribed the meaning of who they were as professional RNs to the same degree in which LPNs assigned personal meaning to their profession as LPNs.

One LPN felt that the RNs' increased responsibilities due to the role change may have caused the RNs to feel "a little bitter," since RNs had to assume sole responsibility for tasks previously shared by the LPNs. However, the RNs in this study did not voice resentment about their own increased responsibilities. The majority of RN concerns centered on the LPNs' adjustment to role change. One RN wondered if LPNs would experience "less job satisfaction," since they had "lost some of those options."

The RNs did discuss the RNs' ultimate responsibility and accountability for nursing care, but it was stated in a more matter-of-fact manner. Helen, RN, stated, "I know that we're [RNs] accountable for what we do, and we are accountable for what [the LPNs]
do." Fran, RN, shared, "We [RNs] are responsible for [the LPN's] patients, so if something went wrong with her patient, they are going to come to us and not [the LPN]."

**Perceptual Themes of Delegation**

When asked to describe their experiences with delegation, both RNs and LPNs shared many common perceptions. Interviewees were asked to describe an ideal delegator, specific examples of effective and ineffective delegation, and what makes delegation work. Their observations are presented in the following paragraphs.

**Leadership Behaviors**

Both RNs and LPNs identified the importance of both production-centered and employee-centered competencies when delegating. Production-centered behaviors which both LPNs and RNs identified as important were organizational skills, decisiveness, and assertiveness. Barb, LPN, stressed that a good delegator must "be organized" in her own work in order to delegate to others. Gretchen, RN, concurred that the ideal delegator was "well-organized [and] she knew what had to be done and who was going to do it."

Decisiveness was emphasized by 2 of the LPNs and 3 of the RNs. Fran, RN, highlighted the importance of decisiveness and assertiveness when delegating:

> Once they delegate, they need to stand by it. If people start to complain, [don't] change it just to make one person happy. Once they delegate the task it should stay that way. Unless something comes up that it needs to be changed, but stand by what they assign and not change it . . . I think it is important [to not say], "Well I'm sorry I have to do this to you." I think it is important to say, "It's your turn," and . . . don't be apologetic about it.

Both RNs and LPNs believed it was helpful to balance concern for production with concern for people when delegating. Ellie, RN, stressed the importance of nurturing styles that showed appreciation of staff when delegating. She gave example statements of "I am glad we got through it [together]" and "I'm glad we work as a team." Dionne, LPN,
mentioned the value of being "warm" with others; Anita, LPN, stated the ideal delegator should be "pleasant," and Barb, LPN, emphasized "professional respect" when delegating.

**Situational Approaches to Delegation**

Both RNs and LPNs cited the need to apply various delegating approaches based on the situation and personalities involved. When describing their perceptions of delegation, all RNs and LPNs stated at some point in the interview that delegation approaches depended on the LPN, the RN, and/or the situation. While they identified certain qualities as important in delegating, they also felt the RN needed to use different approaches for different people and different situations. Anita, LPN, cited the need for discernment when delegating:

[RNs] have to have . . . good discernment to know who to really pick to be where you want them to be . . . . They have to have discernment to know what jobs this person can do for them that would be versatile.

Helen, RN, described how RNs must be attuned to various contingencies when delegating nursing tasks:

[An ideal delegator must have] sensitivity to the situation, sensitivity to the skill level of the people, because that makes a big difference on whether they succeed on what you ask them to do. If they don't have the ability or have the aptitude or the inclination, it's too frustrating . . . . I think a delegator is someone that can read the situation on what needs to be done and ask appropriately.

When citing an example of effective and ineffective delegation, 4 RNs and 2 LPNs described crisis care situations. Five out of the 8 respondents shared incidents where nurses responded to a patient who was in respiratory or cardiac arrest. In relating their experiences with emergency care situations, they highlighted the decisiveness of the delegator, the readiness of those responding, the clarity of the task, and working together to meet the critical needs of the patient. Cathy, LPN, shared the following incident:

We had to ship this person [to intensive care] and we all worked so well together it was almost like nobody needed to tell anybody what to do . . . . Everybody was
there to help and when the crisis was over, things got back to normal, and the day went on and that happens a lot up here . . . You know what is going on. Somebody yells at you to get the ambu bag or this isn't the right suction head. Go find one. It is not like a command or an order. It is like everybody knows what to do. You do it for the patient and if somebody lips off to you while you are getting it done, you forget it because you are there to do it for the patient.

Gretchen, RN, described delegating in a crisis situation in similar terms:

It is sort of like everybody knows what to do whether they are an RN or LPN. The thing is that in a crisis situation there has always got to be somebody in authority that makes the decision . . . . There are orders going out and someone says, "I got, I got, I got it." It's just like everybody knows the next order. If you're free, you do it . . . . Because we have been trained together, you work together . . . . It is just sort of a mesh. You just sort of do it together, and that is where I have always found nursing to be.

Gretchen went on to note that she does not observe "quite the [same] mesh in non-critical" nursing situations. She found that RNs delegated in a more democratic style during non-critical situations. For example, she noted that front-line delegation in a non-critical situation "is not like a chain of command," but rather a "camaraderie." Gretchen commented that the RN is more likely to say "Alright, I'm busy . . . . Who can do this?" in non-crisis situations. Gretchen's comments on the varying delegation approaches in critical and non-critical nursing situations suggested that one style was not better than the other, just different.

The Analogy of Team

When asked what makes delegation work, all RNs and all LPNs repeated the common theme of working together as a team. Dionne, Cathy, Fran, Ellie, and Helen's respective comments highlighted this theme:

"If you work together as a team it works better."

"You have to have people that are willing to work together . . . . If you don't have a team, then it's not good nursing care."

"You do it together."
"We all work together as a team."

"It helps when everybody is willing to do their part."

Both RNs and LPNs felt that a staff RN had to "pitch in" (Barb, LPN) and "pull their weight" (Ellie, RN) with patient cares in order to make front-line delegation work. Cathy, LPN, expressed, "[An RN] can't be a paper shuffler, they still have to get out there and know what is going on." Helen, RN, concurred, "For me to have an appreciation for what is going on, and to be better able to delegate, I have to be in there doing [patient care] too."

Fairness of assignments was mentioned frequently by both RNs and LPNs. Seeking input from LPNs on task assignments was seen as significant by the RNs in promoting front-line delegation and teamwork. RNs Fran and Ellie discussed the importance of task input several times. Fran shared:

I think it helps when you are allowed to give input in the tasks you are going to receive . . . . If you have input in what you are going to be doing for the [shift], it just makes everything go more smoothly.

In working as a team, both RNs and LPNs mentioned the importance of expressing respect to each other. Conveying respect to the LPN was discussed frequently. Both RNs and LPNs stated that "dumping all the dirty jobs" on the LPN did not build respect. Gretchen, RN, emphasized the need to show appreciation to the LPNs and expressing it in a respectful way. Cathy, LPN, shared that the RN should be able to ask the LPN for help, but she should "ask and not tell, request not order."

**Barriers to Delegation**

**Role Change**

Respondents in the study most frequently identified the role change for LPNs as a major barrier to delegation. Fran, RN, stated, "I think just how the LPN's role has changed is a barrier . . . . [LPNs] feel that's a barrier because they aren't able to do a lot of
things because they are an LPN, whether they are capable or not." Anita, LPN, also
described the LPN's changed role as a barrier and limiting boundary. "We're [LPNs]
called professionals, but yet we don't do what people consider ... professional, like the
paperwork."

One RN reported that RNs felt barriers in delegating to LPNs when the role
change was implemented due to strong reactions expressed by some LPNs. The RN
shared that an LPN "[got] upset real easy ... because she felt all her responsibilities were
taken away from her as far as patient care .... She was just unbearable to work with." Feelings and moods related to the role change were frequently mentioned. One LPN
discussed how "unhappy" the LPNs were related to their decreased responsibilities. One
RN thought it was important to learn how to delegate during the role change so that the
LPNs were not "getting mad at you."

Other Barriers

As reported in the succeeding paragraphs, RNs and LPNs observed a variety of
other barriers in front-line delegation. Both RNs and LPNs identified the following
delegator barriers: time constraints, unclear communication and feedback, dealing with
individual personalities, lack of experience in delegating (especially in younger,
inexperienced RNs delegating to older, experienced LPNs), lack of assertiveness, fear of
conflict, lack of trust, and expressing lack of respect when delegating to LPNs. Common
barriers for LPNs responding to delegation were identified by both RNs and LPNs as
difficulty with role changes, adherence to tradition, lack of role clarity, inadequate
recognition, and resentment when delegated a disproportionate number of unpleasant
tasks.

Gretchen, RN, discussed several of these barriers:

I think that [lack of good communication] is the downfall of the greatest deal of
deviation ... If you don't say it right or precisely, it can be misconstrued ... If
you are really in a hurry, . . . you fire something as you go by somebody [and] you don't really have their attention . . . . Saying things in haste because you are so preoccupied with what you are doing that you say it short, curt, and you hurt [feelings] . . . . It is how you say [it], the fluctuation in your voice, it is the tone of voice, it is the attitude that you give them that [they're] no better than, you know, a 'gopher' . . . . Not giving [the LPNs] credit for what they know and that they can do it, that is probably one of the biggest barriers because it is like [the LPN] is saying you don't trust me.

Individual personalities and communication styles were barriers identified by both RNs and LPNs. Ellie, RN, shared her thoughts about barriers to delegating. "We are all individuals. Just their individual personality, I guess, is one of the biggest barriers." Barb, LPN, noted, "I know some of the RNs may not ask a certain LPN to do something because they know how she will react, because they know she will feel she is being dumped on . . . so they probably won't ask her." Helen, RN, identified, "Lots of times it's just easier to do it yourself than to hassle with it."

Both RNs and LPNs observed some younger RNs hesitated in delegating to older LPNs, while older LPNs might resist responding to delegation. Dionne, LPN, shared, "Sometimes the RN hesitates about [delegating] . . . . I suppose because they don't want [the LPNs] to get mad [at them]." Ellie, RN, related that a new RN might feel intimidated delegating to an older, experienced LPN who was "trying to show [she was] better than the RN," since the new RN was "low man on the totem pole." Helen, RN, noted that adherence to medical tradition and the mindset that "it's been this way for how many years, and you think you want to change it?" accounted for some resistance to delegation.

How RNs Learn Delegation

Formal Training

While not a primary research question, a dominant theme emerging from the interviews was how RNs learned to delegate. The RNs shared that they remembered little or no training related to delegation decision-making in their nursing education. When asked what their nurses training taught them about delegation, the RNs' responses ranged
from "absolutely nothing" to having a semester course on leadership, but not "even [being able to] remember" what was taught. One of the younger RNs stated that her training provided the opportunity to "shadow a nurse manager for a day to see what kind of management style she used." The RN stated that the shadowing experience helped "a little bit" to understand delegation but "[did] not recall" the nurse manager commenting on delegation. One of the LPNs who was completing her RN degree mentioned receiving instruction on "open-ended questioning" and "chain-of-command" issues, but did not think she had "come across [delegation] too much."

**Role Modeling**

Rather than formal training, nurses in the study reported their most effective method of learning how to delegate was through positive role modeling from their nurse supervisor. The interviewees discussed several similar experiences highlighting the effectiveness of vicarious role modeling. When asked how the hospital could help teach front-line delegation, Helen, RN, shared, "Probably just having good examples and good role models, because I think you learn from that. You learn from your manager, and hopefully you pass it on."

As Helen shared her perceptions of delegation, one could see how her earlier role models had shaped her own delegation approach. When sharing a critical incident in her nursing career where she witnessed effective delegation, she recounted her first experience with a patient who had died:

[My head nurse] said, "You go in and prepare the body." I looked at her, and I said, "I have never done that." And she said, "OK," and she showed me what to do and helped me do it, and afterwards she said, "Now the next time, would you be able to?" She said, "Are you OK?" and she was not a tender person at all. But she told me, the first time she was with a dead body, that they told her to prepare the body and locked her in the room and said she couldn't come out until it was done. And she said, "I don't want you to feel that." . . . . And that is something I will never forget.
Years later this delegation approach was evident in her own preferred delegation style; she shared, "I think what I do well is saying, 'OK, let's do this together.' But as far as delegating, I'm willing to do the work too, and I think that that is an asset."

All of the RNs cited qualities and behaviors of a specific nurse who had modeled delegation to them. Three of the 4 RNs identified their nursing supervisor as their role model for delegating. Ellie, RN, spoke at length of her supervisor's positive leadership skills and often prefaced her perceptions of delegation by sharing how her supervisor did it. Ellie admired her nursing supervisor's professional respect for others and the friendly and orderly way she ran the unit. She shared:

[My boss] has always been professional . . . . The people that work here are good to look up to and follow and watch and learn by . . . . I think we all do like [my boss] does, you know, monkey see, monkey do . . . . She always just says, "Will you do this?" and then we always do it, and then we do that to the next person, and the LPN to the aide, and whatever.

Ellie's own preferences for delegating emphasized a similar professional respect and consideration for LPNs, which her boss had modeled.

Cathy, LPN, noticed similar role modeling in her nursing supervisor. She observed, "I am sure that if it weren't for our team specialist, our charge nurses would not be as good [at being] charge nurses. She sets the example for how things should get done on the unit." The interviewees consistently observed that front-line nurses acquired delegation skills by directly observing and imitating their supervisor's delegation styles rather than through structured training programs.

RN-LPN Working Relationships

The dynamics of how the RNs and LPNs worked together varied from unit to unit and from person to person. No consistent theme emerged from the respondents. For example, when asked how interpersonal relationships between the RNs and LPNs affected delegation, respondents varied in responses. Some RNs and LPNs felt it hindered
delegation, while other RNs and LPNs believed close, social friendships added to the trust and effectiveness of delegation. One LPN noted, "If you're not that friendly, I mean real close, you get along a little better I think," while another LPN observed, "I think that when you work with somebody that you know socially, they are more apt to pick up and help you than somebody that you don't run around with." RNs also differed. One RN believed that a "if you have a good relationship with an LPN and . . . [the LPN] gets upset, . . . you may have a hard time delegating because you don't want to upset her." Yet another RN found that "if there is a close friendship, . . . I think you are more sensitive to people that you care about . . . . If I'm partnered with a certain [staff person], then my comfort level goes up, because I know she will take care of me . . . . I trust her."

Conflict Resolution

Interviewees also identified varying abilities to deal with conflict on their units. One LPN and 1 RN perceived positive working relationships and the ability to resolve conflict on their respective units. However, they each reported very different styles in how their units addressed conflict. One relayed a very direct, matter-of-fact approach that was utilized effectively. She stated:

If we get [angry], . . . we let [each other] know right away. Most of them just shrug it off anyway because we've worked together [so long] . . . . [You might say], "Quit being bitchy" and go on with our day . . . . [They might respond], "I know I'm acting that way, and I'm sorry," so they just go on their way . . . . It has always been give and take up here . . . . They're not condescending . . . . Most of them are very good to work with.

The other nurse reported a diplomatic style with high consideration towards others that was effective in dealing with conflict. She observed:

If a problem would arise, be able to go to them and say, "We're having a problem between us." If there is ever a problem, . . . [our head nurse] always calls us in and has a meeting, and everybody gets to talk, and we get it settled there . . . . [Our head nurse] is kind of a friend, but you know she is in charge.
Other LPNs and RNs observed more tenuous co-worker relationships in their nursing unit with less support or teamwork. Two of the RNs made the following comments:

"I've noticed over the years that nurses don't support each other."

"Nurses are such a funny group anyway" (when discussing perceptions of role changes).

The RN who made the last remark observed that "the importance of [maintaining sterile] techniques" in nursing care may keep nurses from "transcend[ing] some of the [role] boundaries" in working with each other. However, no consistent or clear theme emerged from the interviews in defining the impact of interpersonal relationships and conflict resolution on delegation.

The Analogy of Family

In reference to the varying viewpoints of their working relationships, some respondents very clearly identified their perceptions of RN-LPN relationships as analogous to the dynamics occurring in family relationships. In the midst of different working styles and communication approaches, one LPN noted, "We're all really good people, like one big happy family." One RN also used the family analogy when expressing tolerance for co-workers in spite of differences:

I think you just accept it in [their] personality. When you work with the same people, it becomes like a small family . . . . What you accept from one person may be unacceptable from another person . . . as long as things get done and it gets done in a safe way.

Summary

The purpose of this study was to explore RN and LPN perceptions of front-line delegation in their working relationships. In particular, the study sought to: (a) determine how changing RN and LPN roles influenced front-line delegation; (b) answer how RNs
viewed front-line delegation in comparison to LPNs; and (c) identify barriers to front-line delegation.

The impact of the changed role of the LPNs having decreased responsibilities was the most dominant theme to emerge from the research interviews. Much discussion focused on the losses experienced by the LPNs and how these losses influenced front-line RN delegation. RNs and LPNs reported that the LPNs were in various stages of acceptance related to their decreased responsibilities. A central theme to all the LPNs interviewed was that they ascribed a significant and personal meaning to their professional identity as LPNs in the midst of their role change, whereas the RNs did not assign such a deep personal meaning to their professional identity as RNs following the role change.

In general, the study found that LPNs and RNs shared many common views of front-line delegation. For example, both stressed the need to balance production-centered with employee-centered competencies when delegating to LPNs. Both RNs and LPNs cited the need to apply various delegating approaches based on the situation and personalities involved. In particular, both groups identified unique situational variables which influenced crisis care delegation: the decisiveness of the delegator, the readiness of those responding, the clarity of the task, and working together to meet the critical needs of the patient.

RNs and LPNs in the research identified similar perceived barriers to delegation. Frequently cited barriers were time constraints, lack of training, unclear communication and feedback, dealing with individual personalities, lack of experience, lack of assertiveness, fear of conflict, lack of trust, lack of respect, difficulty with role changes, adherence to tradition, lack of role clarity, inadequate recognition, and resentment when delegated a disproportionate number of unpleasant tasks. The LPN's changed role of having decreased responsibilities was identified by both RNs and LPNs as an additional major barrier for front-line delegation in this hospital.
Although not an original question of the research, the study revealed that nurses reported having little or no training on delegation decision-making in their nursing education. Rather than formal training, nurses in this study reported positive modeling from their nurse manager as their most effective method of learning how to delegate.

Finally, nurses reported different approaches which were effective in working with each other. Both RNs and LPNs used the terms "team" and "family" to describe what makes delegation work in their relationships. However, their observations for maintaining positive interpersonal relationships and dealing with conflict varied with no clear consensus.
CHAPTER V
SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

The purpose of this study was to explore RN and LPN perceptions of front-line delegation in their working relationships. In particular, the study sought to: (a) determine how changing roles of RNs and LPNs influenced front-line delegation; (b) answer how RNs viewed front-line delegation in comparison to LPNs; and (c) identify barriers to front-line delegation. This study was a qualitative study utilizing an open-ended interview guide to interview 4 non-managerial RNs and 4 LPNs who worked in a midwestern, mid-sized private hospital. The researcher interviewed the respondents over a four week period. Individual, one hour interviews were audio-taped and transcribed.

Data analyses were conducted using the constant comparison technique to record, code, and analyze data. A second researcher read and analyzed three of the interviews separately to triangulate the researcher's interview methods. Constant comparison was used by the two researchers individually and then collectively to come to consensus concerning the coding and interpretation of the data. The researcher also interviewed a clinical nurse specialist at the hospital before and after the nurses' interviews to corroborate the researcher's field notes, observations, and emerging themes with the organizational context of the hospital's administrative policies. In addition, the researcher met with one of the original interviewees for a 30 minute follow-up interview to check the emerging interpretations of the data.

Symbolic interactionism provided a theoretical framework to understand how front-line delegation is perceived as a distinctive pattern related to ongoing interactions in RNs and LPNs. The researcher sought to understand how RNs and LPNs assigned meaning to delegation issues in the context of role changes occurring in their organization and how they interacted with others.
Conclusions

Based on the examination of the study results in view of the research literature, themes emerged to: (a) explain how changing RN and LPN roles influenced front-line delegation; (b) answer how RNs and LPNs viewed front-line delegation; and (c) identify barriers to front-line delegation.

Changed Roles and Loss

A dominant emerging theme of the RN and LPN interviews identified that nursing role changes continued to influence front-line delegation in this organization over one year after the implementation of the role change. The hospital's changed policy increased RN roles in assessment, patient education, and accountability while decreasing the LPNs' responsibilities in these patient care areas. The study showed that the role change of decreased responsibilities for LPNs impacted front-line delegation, apparently much more so than the role change of increased responsibilities for RNs.

As mentioned earlier, Herrick et al. (1994) found in workshops they conducted about changing nursing roles that RNs needed structured opportunities to grieve for their changing roles from primary caregiver to delegators and coordinators of patient care. However, this research study concluded that the majority of the RNs and LPNs' concerns were not being directed at the RNs' need to grieve over their changed roles, but rather the significant losses as experienced by the LPNs. These losses were identified as losses of significance, status, recognition, respect, and credibility due to the decreased responsibilities, level of challenge, and status of job tasks for LPNs.

The research findings of this study could offer important implications for organizations experiencing restructuring, particularly in settings where demotions or perceptions of demotions occur. This study identified that when decreased job responsibilities were perceived to have reduced status, the changed nursing roles triggered significant grief and loss experiences in the RN-LPN working relationships. Three RNs
and 4 LPNs discussed this change as significant in how it influenced front-line delegation. The grieving process impacted not only LPNs whose responsibilities were decreased, but also RNs who had to address those loss issues when delegating to LPNs.

Further research is needed to explore how organizations can address grief and loss issues when staff experience a decrease in their job responsibilities. Downsizing and work reorganization in healthcare will persist into the next decade. Hospitals will continue to dramatically alter the way work is performed in response to rapidly changing healthcare economics (Baker, 1995). As hospitals implement changes in patient care delivery, administrators must address how to best transition staff through perceived demotions and disempowerment, especially at a time when total quality initiatives in healthcare require increased employee involvement and decision-making in order to improve quality and decrease costs (Marszalek-Gaucher & Coffey, 1990). In order to increase organizational responsiveness to rapid change, hospitals must respond to grief and loss issues which impede employee involvement and empowerment.

Another central theme to all the LPNs interviewed was that they ascribed a deep personal meaning to their work as LPNs in the midst of their role changes. While most were frustrated with their diminished nursing roles, all LPNs voiced a passion and pride in their professional identity as LPNs. In contrast, the RNs interviewed did not discuss a consistently significant meaning or personal attachment to their professional identity as RNs.

Data from the interviews did not offer clear reasons for the differences in RNs and LPNs. One of the findings was that the role changes implemented in the hospital triggered a significant grief and loss experience for the LPNs. As part of the grieving process, the researcher hypothesizes that LPNs have had to work through those losses and assign meaning and relevance to what their roles were and are now. The prevalent feelings of demotion may have triggered more uncertainty with regard to their future viability as
healthcare professionals and prompted more self-reflection towards the personal meaning of their work.

**Perceptual Themes of Delegation**

In examining how RNs and LPNs viewed delegation, it was concluded that RNs and LPNs shared many similar perceptions about front-line delegation. Much of their discussion in the interviews support the research literature on leadership behavior theories, situational contingency theories, and nursing models of delegation. The fact that the interviewees identified themes from a variety of perspectives in the research literature supports that delegation is a complex interaction where delegator and delegate must both reach agreement as to the content and meaning of delegation (McConkey, 1974).

A recap of the research literature highlights the strong correlation between delegation and leadership. Laird and Laird emphasized that successful delegation hinges upon the relationship between leader and followers (1957). Management literature suggests that Drucker's classic definition of a manager, "one who accomplishes tasks through others," is also a fundamental definition of a delegator ("Drucker on," 1984, p. 4). The researcher concludes from the research literature that delegation is both a leadership and a management task requiring complex leadership skills. As described in the following paragraphs, both RNs and LPNs identified delegation in terms of leadership theories which focused on the leader-follower relationship and the context in which delegation takes place.

RNs and LPNs identified a combination of task and people-oriented leadership behaviors for delegation similar to leadership behavior theories advocated by Blake and Mouton (1985), Likert (1987), and Stogdill (1974). The interviewees emphasized the importance of decisiveness, assertiveness, and organizational skills while also being appreciative, respectful, warm, and pleasant to others.
All RNs and LPNs identified the need for a delegator to choose different styles and behaviors which best met the needs of the individual followers and situations. These observations support the appropriateness for situational contingency models of leadership (Fiedler, 1967; Hersey & Blanchard, 1982; Vroom & Yetton, 1973). Situational contingency models of leadership maintain that a leader's approach varies according to the particular aspects of the situation.

Since all the interviewees identified the relevance of situational contingency leadership models, the researcher concurs with Vestal (1987) that RNs assuming front-line leadership must think about the task to be performed, the ability of the person performing it, and the nature of the situation before deciding what delegation approach to take. Hersey and Blanchard's situational leadership theory would offer a useful tool in assessing the willingness and ability of LPNs as a contingency variable in delegating. RNs cited the level of willingness from LPNs as the most critical variable in delegating after RNs and LPNs experienced role changes in this hospital setting. Understanding Hersey and Blanchard's situational leadership theory would help RNs deal with resentment, frustration, and defensiveness from LPNs when delegating in the midst of role changes.

It also may be helpful to apply Vroom and Yetton's normative model of decision participation to solicit varying degrees of LPN input, depending upon whether the RN has all of the information needed to make the decision and whether an LPN's acceptance of the decision is required to implement it effectively. For instance, since LPNs' acceptance of the changed roles was met with resentment and defensiveness, Vroom and Yetton would recommend a "consulting" rather than "telling" approach when delegating. It is interesting to note one LPN's support of this approach when she shared that an RN should "ask and not tell, request not order" when delegating.

Fiedler's leadership contingency theory supported how the interviewees viewed front-line delegation approaches during crisis and non-crisis nursing situations, particularly
where there was weak position power and good leader-member relations. For example, emergency situations where task structure was high required a task-oriented style, whereas non-emergency situations where task structure was low suggested a relationship-motivated leadership style. Both RNs and LPNs concluded that task clarity in crisis situations made it easier to accept a task-oriented delegation approach. However, because Fiedler’s leadership contingency theory is "a complex three-dimensional model which is not easy to understand nor is it conclusively supported by research" (Hein & Nicholson, 1994, p. 58), this researcher concludes it may not be practical to apply to a wide range of situational contingencies in front-line RN delegation.

In addition, the respondents supported Hansten and Washburn's nursing model of delegation (1994) which stresses that the right person must be matched for the right task. Interviewees cited the LPN's level of willingness most frequently in trying to match the right person with the right task. Hansten and Washburn concluded that a RN is more likely to succeed in selecting the right person when he or she clearly understands the staff's job description and role, as well as the delegate's strengths, weaknesses, preferences, and motivations (1992c). The interviewees' observations that a RN chooses appropriate styles and behaviors which best meet the needs of the LPN and the situation confirms Hansten and Washburn's emphasis in matching the right person for the right task. Since the respondents cited many components of Hansten and Washburn's model as important in delegation, the researcher proposes that the model be utilized in front-line delegation training.

Both RNs and LPNs supported Hansten and Washburn's identified need (1992d) for the right communication and feedback in delegation. Respondents emphasized that communication needed to be respectful, assertive, appreciative, and clearly stated. They concurred with most of the feedback requirements of Hansten and Washburn's model when delegating: (a) get the LPN's input before proceeding, (b) give credit to the LPN's
efforts, (c) share observations in a timely manner, (d) discuss gaps in perception and causes of problems, (e) get the LPN's solution to the problem, and (f) agree on an action plan. However, interviewees did not agree with Hansten and Washburn feedback requirement to set a time to check on progress, particularly when the RN and LPN had worked together for several years.

It is interesting to note that most of the RN and LPNs' perceptions of front-line delegation centered around the leadership rather than management literature about delegation. While interviewees discussed responsibility and accountability issues identified in the management literature, there was very little discussion about authority issues as identified in the management literature (McFarland et al., 1984; Weiss, 1988). The researcher believes that the focus on leadership rather than management perspectives is logical in that front-line RNs do not have the authority of a management position to implement delegation. Rather, front-line RNs must delegate tasks without possessing the positional power to discipline or administer financial rewards. Therefore, front-line RNs and LPNs would be attuned to the importance of leader-follower dynamics rather than positional power or management authority in implementing approaches which are best suited for front-line delegation.

In citing examples of effective or ineffective delegation, 6 out of the 8 respondents described crisis care situations. Four major themes emerged as to what made delegation effective in emergency situations: (a) the decisiveness of the delegator, (b) the readiness of those responding, (c) the clarity of the task, and (d) working together to meet the critical needs of the patient. In crisis care situations, task clarity and the immediate need to respond are very evident. Healthcare professionals are taught specific protocols to follow in critical care situations. Prescribed roles are more clearly delineated in emergency situations, whereas in non-emergency situations, roles are more fluid and ambiguous. One RN's observations aptly characterized these varying approaches when she identified a
more democratic "camaraderie" in non-crisis situations versus a definite "chain of command" approach in crisis situations. Since roles vary depending on the situation, the researcher concluded that it is not prudent to apply one leadership theory to front-line delegation. Rather, RNs should pursue situational contingency theories of leadership, whereby the RN selects a delegation approach based on situational demands in the patient care environment.

**Barriers to Delegation**

Perceived barriers to delegation as cited by both RNs and LPNs were similar to barriers identified in the nursing literature (Coburn & Sturdevant, 1992; Hansten & Washburn, 1994; Newman, 1956; Sullivan & Decker, 1992). These barriers were time constraints, unclear communication and feedback, dealing with individual personalities, lack of experience, lack of training, lack of assertiveness, fear of conflict, lack of trust, lack of respect, adherence to tradition, lack of role clarity, inadequate recognition, and resentment when delegated a disproportionate number of unpleasant tasks.

In addition, the changed role for LPNs of having decreased responsibilities was identified by both RNs and LPNs as a barrier for front-line delegation in this hospital. The changed roles triggered strong feelings of demotion and disempowerment among the LPNs. This, in turn, created feelings of hesitancy for RNs delegating to LPNs as well as feelings of frustration for LPNs responding to that delegation.

As mentioned earlier, the researcher advocates that hospitals provide assistance in helping RNs and LPNs identify and address grief and loss issues related to changed roles. While hospitals must comply with licensure boundaries for LPNs, it is also important for healthcare organizations to promote growth and empowerment in their LPN staff. As discussed in the research literature, healthcare organizations must maintain their responsiveness to rapid economic change by increasing employee involvement and empowerment (Marszalek-Gaucher & Coffey, 1990). Hospitals must look for ways to
maintain involvement and growth for LPNs after work restructuring results in decreased job responsibilities and feelings of disenfranchisement. LPN involvement and career growth are necessary and desirable. Since downsizing, reorganization, and change in patient care delivery will continue into the next decade, it is prudent for healthcare organizations to find ways to evoke the best performance from LPNs. In an era of tightening financial resources, organizations must maximize the potential of human resources.

**Delegation Skills Training**

The study revealed that RNs remembered little or no delegation skills training from their nursing education. This supports earlier studies which reported that delegation has not been included in nursing training (Conger, 1994; Poteet, 1984). Other literature indicated that lack of training in delegation skills can be a barrier for staff RNs (Blegan et al., 1992; Coburn & Sturdevant, 1992; Herrick et al., 1994). Herrick et al. found that RNs receiving on-the-job training reported role-playing assertive communication as most helpful for developing delegation skills. The researcher suggests that applied assertiveness training and conflict resolution skills be included in nursing education and continuing education programs in order to increase delegation competencies.

**Importance of Role Modeling**

As with all qualitative designs, themes emerge in the research process that were not initially pursued in the research study. The importance of vicarious role modeling as a means of gaining delegation skills in front-line RNs emerged from the data. Nurses repeatedly identified a nurse supervisor's behaviors that they had observed which had influenced their own preferred styles of delegating. Most of the supervisor's behaviors had been positive role modeling, although some behaviors were viewed as negative.

The research study supported that social learning theory is very instrumental in the development of delegation skills. Social learning theory suggests that a person observes
others' behaviors and uses this observation to plan future action. Through vicarious modeling, a person acquires behaviors by directly observing and imitating others (Schermerhorn et al., 1991).

It was found that nurse supervisors play a critical role in modeling and developing front-line RNs' delegation skills. Front-line nurses acquired delegation skills by directly observing and imitating their supervisor's delegation styles rather than through structured training programs. Recognizing the pivotal influence nurse supervisors have in shaping delegation decision-making with front-line RNs, the researcher supports the need to provide middle management personnel with training and feedback opportunities for delegation skills development so that conscious decisions about modeling can be made.

Interpersonal Relationships

No consistent theme emerged as to how interpersonal relationships and conflict resolution approaches affected delegation. Responses were varied in discussing the impact of these two issues on delegation. However, two words, "team" and "family," were often used to frame the perspectives of RN-LPN working relationships. When discussing delegation, all RNs and LPNs used the word "team" to emphasize the importance of working together to deliver quality patient care. Working together "as a team" was a common theme to all respondents when asked what makes delegation work. Although all interviewees emphasized that delegation approaches had to be geared to the individual person and situation, 1 LPN and 1 RN used the word "family" to describe how a certain amount of tolerance and acceptance was needed for each other in the midst of individual styles and personalities. The researcher believes that the terms "team" and "family" could be words which have shared meaning to LPNs and RNs in their perceptions of delegation. Sharing the commonalities of these meanings could assist RNs and LPNs in pursuing a shared vision of how delegation is best accomplished in their nursing unit.
In defining RN-LPN working relationships, one might hypothesize that their working relationships are influenced by gender (since 97% of nurses are women), by the type of personality that pursues a "helping" profession, or by traditional styles of healthcare management. However, none of the respondents ever referred to their working relationships in terms of their gender and rarely in terms of their hospital's style of management. Respondents did cite nurturing and expressive approaches to delegation which are stereotypically feminine; also the need to address feelings and moods when delegating was frequently mentioned. Yet, they also noted matter-of-fact and task-oriented approaches to delegation which are stereotypically masculine. Therefore, the researcher concludes that their varied work relationships are more likely to be related to individual styles and personalities. This conclusion is supported by the RN and LPNs' frequent observations that delegation approaches must be geared to different staff and situations.

**Recommendations**

The conclusions of the present study lead to several recommendations for continued investigation. Problems for further study about front-line delegation are delineated as follows.

**Changing Roles**

In responding to the LPNs' feelings of demotion from their decreased responsibilities, further research is needed to address how hospitals can encourage growth and empowerment in LPN personnel in the midst of complying with licensure boundaries. Possible options could be structured promotion and opportunities for LPNs to pursue RN education as well as establishing programs to validate LPNs in certain front-line teaching responsibilities. Further study can increase understanding of the grieving process during role change in organizational restructuring, particularly when the role change is viewed as a demotion. How can organizations continue to promote front-line motivation,
empowerment, and critical thinking after staff demotions? How can front-line delegators enhance productive team-building during organizational transition?

Further study is needed to explore the personal meaning that RNs' ascribe to their work and identity, particularly as it related to their role change of increased responsibility. Do RNs, as one LPN postulated, feel "bitter" or dissatisfied with their role change? Why did the RNs express more concern for the LPNs' changed roles than for their own changed roles?

**Perceptual Themes of Delegation**

Further study is needed to confirm the relevance of leadership behavior theories, situational contingency theories, and Hansten and Washburn's model of nursing delegation in front-line delegation. Additional research is needed to see if RNs and LPNs in other research settings share common perceptions of delegation, including barriers to delegation.

Also, the researcher recommends further study to define how front-line delegation in critical care situations differs from front-line delegation in non-critical care situations. When role and task requirements are crystal clear in emergency care situations, is front-line delegation more easily implemented? While different from non-crisis situations, can leadership approaches in emergency situations be applied to delegation of routine nursing tasks?

Additional research is warranted to study how shared terminology such as "team" and "family" is used by RNs and LPNs to assign meaning to delegation. How can the commonalities of these meanings assist RNs and LPNs in pursuing a shared vision of how delegation is best accomplished in their nursing unit? What meaning do RNs and LPNs give to the word "team" as hospitals move from traditional to more empowering management approaches?
How RNs Learn Delegation

Research about how hospital organizations can apply social learning theory in developing front-line delegation would be an outgrowth of this investigation. Since front-line RNs vicariously observed and modeled their supervisor's behavior, research is vital in developing training, feedback, and support for middle management's leadership development. Additionally, further study is needed to verify the conclusion of Herrick et al. (1994) where RNs reported the benefits of assertiveness training in developing delegation skills.

Interpersonal Working Relationships

A study is needed to confirm the research conclusions that RN-LPN working relationships are influenced primarily by individual styles and personalities. Further research is warranted to determine the influence of gender and traditional styles of healthcare management in RN-LPN working relationships. Does gender or traditional styles of healthcare management significantly influence front-line delegation, particularly in interpersonal relationships and conflict resolution approaches? Are individual styles and personalities the primary influence of preferred delegation approaches?

Methodology

Continued research is needed to improve the methodology of qualitative research. In assessing the trustworthiness of the qualitative data, the researcher makes the following methodological suggestions for future studies. It is recommended that a researcher duplicating this study conduct a pilot study with at least two interviewees to ensure consistent open-ended questioning throughout the study. The researcher's field notes indicated that the researcher became more skilled and adept at letting the interviewee "unfold her thoughts more naturally" and not "interrupt her flow of thoughts" after the first few interviews. Data from the latter interviews tended to be richer and more in-depth than the early interviews.
It is recommended that a researcher duplicating this study with a similar sample size conduct follow-up interviews with 50% of the respondents to validate emerging themes more conclusively. Conducting member checks with 4 of the 8 interviewees would have ensured increased saturation of the data and increased dependability and confirmability in comparing RN and LPN perspectives on front-line delegation.
References


Appendix A

INFORMED CONSENT FORM

Dear Participant,

You are being asked to participate in a study of RN and LPN perceptions of frontline-delegation in your healthcare organization.

Your participation in this research project will involve a one-on-one interview with researcher, Marty Colwell, approximately 45-60 minutes in length.

Your participation is voluntary. The interview will be audio-taped and transcribed to ensure accuracy of your comments and observations. All data collected from the interview will be destroyed upon completion of degree requirements by the researcher. All responses are confidential. In any form of this paper your participation will remain anonymous.

If you have any question about the project, or participation in it, contact me, Marty Colwell, at (319) 234-4078. Information regarding this project also may be requested from Dr. Debra Jordan, Graduate Advisor, Leisure Services, UNI (273-6346). Contact may also be made at any time with the Human Subjects Coordinator at UNI (273-2748). It is your right to discontinue participation at any time.

If you choose to participate, please sign and return this Informed Consent Form in the enclosed addressed, stamped envelope anytime before January 15, 1996.

I agree to participate in the project as stated above. I acknowledge that I have received a copy of this consent statement. I give my permission to Marty Colwell, a UNI student, to interview me and to use the interview for thesis research.

____________________________________________________  __________________________
signature of subject                                  date

____________________________________________________
printed name of subject

____________________________________________________  __________________________
signature of researcher                                date
Appendix B

COVER LETTER

3405 Monticello Ave.
Waterloo, Iowa 50701

December 28, 1995

Dear Nursing Associate:

I am writing this letter to request your participation in a study which I am conducting as part of my master's degree at the University of Northern Iowa. The purpose of the research is to study RN and LPN perceptions of front-line delegation in healthcare organizations.

For my study, I would like to interview you individually at the hospital for about 45 minutes on the topic of front-line delegation. Interviews will be audio-taped and transcribed to ensure accuracy and then destroyed upon completing research requirements.

You have been randomly chosen among the medical-surgical nursing staff to participate in this project. Enclosed with this letter you will find an informed consent form. If you choose to participate in the interview, please sign the informed consent form and return it in the enclosed addressed, stamped envelope anytime before January 15.

Your interview responses will remain confidential. No one will be able to identify you in the reporting of the data. In any final form of this paper your participation will remain anonymous. A report of the findings of this study will be shared with the hospital administration and yourself, if requested. No identification of individuals will be presented from the interviews.

You are not obligated to participate in this project, but your help with my research would be greatly appreciated. As healthcare organizations seek to deliver quality care in a rapidly changing environment, your insights will provide important information about how nurses can best deliver patient care. I value your honest thoughts and appreciate your time to help me with this project!

Thank you,

Ms. Marty Colwell
Graduate Student, Youth and Human Services Agency Administration
University of Northern Iowa
Appendix C

INTERVIEW GUIDE

Thank you for your willingness and time to be interviewed today. Your comments and observations are very important to this research project. There are no right or wrong responses. I am very interested in your perspectives on delegation in healthcare settings.

Our interview will be audio-taped and then transcribed. Only my research committee, a transcriber, a researcher independent of this organization, and myself will have access to this interview. A report of the findings of this study will be shared with the hospital administration and yourself, if requested. No identification of individuals will be presented. No one will be able to determine your identity in the reporting of the data. You are not obligated to participate in this project and may stop at any time, but your help with my research is greatly appreciated.

1. As a LPN/RN, tell me what your basic job responsibilities are in working with patients.

2. Besides LPNs and RNs, what other nursing staff work with you on your floor? How are the roles and responsibilities divided up in delivering patient care?

3. If I listened in on RNs delegating tasks on your unit, what would I hear them saying? How would they be communicating that delegation? How would they feel about that role?

If I listened in on LPNs responding to that delegation, how would I see them responding? How would they feel about that role? What questions or concerns might they have about front-line RNs delegating to them?

4. Tell me about a critical time in your nursing career where you witnessed effective and appropriate delegation taking place. For you, what were most important factors in making that delegating process effective and appropriate?

5. Tell me about a critical time in your nursing career where you witnessed ineffective and inappropriate delegation taking place. For you, what were most important factors in making that delegating process ineffective and inappropriate?

6. From your perspective, what are the biggest barriers RNs experience in delegating to LPNs? From your perspective, what are the biggest barriers LPNs experience in being delegated to by an RN?

7. What are the things that help delegation work?
8. If you could select the ideal delegator, what qualities and skills would he or she have?

9. From your own observation, tell me about how the interpersonal relationship between the RN and LPN affects the delegation process.

10. For you, what skills does an RN need to have in order to delegate?

11. Tell me about what your nurses training taught you about RN delegation to an LPN? Tell me about what your nurses training taught you about LPN delegation to assistive nursing personnel.

12. Tell me what your understanding is of the functions and roles of RNs and LPNs according to Iowa's State Nurse Practice Act. What tasks should be delegated to LPNs?

13. For you, what could (your organization, RNs, LPNs, the Iowa State Board) do to make RN delegation to LPNs more appropriate and effective?

14. From your experience, has RN delegation to LPN changed over the years? Tell me what you have noticed.

15. If you were advising staff development programs, what issues/skills would you see as important to teach nurses effective and appropriate delegation?
Appendix D

NURSING BACKGROUND QUESTIONNAIRE

1. How many years have you practiced nursing?
   ____ 0-4 years  ____ 10-14 years
   ____ 5-9 years  ____ 15 or more years

2. What is the highest nursing degree you have attained?
   ____ Licensed practical nurse  ____ Diploma program, RN
   ____ Associate program, RN  ____ Baccalaureate degree, RN

3. How many years have you worked in this hospital?
   ____ 0-4 years  ____ 10-14 years
   ____ 5-9 years  ____ 15 or more years

4. How many years have you worked in your present unit?
   ____ 0-4 years  ____ 10-14 years
   ____ 5-9 years  ____ 15 or more years

5. What percentage are you hired to work?
   ____ 20%  ____ 80%
   ____ 40%  ____ 100%
   ____ 50%  ____ Other (Please specify: _____)
   ____ 60%

6. What is your age group?
   ____ 20-24 years old  ____ 40-49 years old
   ____ 25-29 years old  ____ 50-59 years old
   ____ 30-39 years old  ____ 60-65 years old

7. What roles have you held as a nurse? (Check all that apply.)
   ____ Staff nurse
   ____ Charge nurse
   ____ Head nurse
   ____ Nurse Manager
   ____ Other (Please specify: ______________________)