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# Registered Nurse Leadership Style, Confidence Level, and Delegation Practices to Unlicensed Assistive Personnel: an Exploration of Confidence

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# REGISTERED NURSE LEADERSHIP STYLE, CONFIDENCE LEVEL AND DELEGATION PRACTICES TO UNLICENSED ASSISTIVE PERSONNEL: AN EXPLORATION OF CONFIDENCE

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## Abstract

Background and Purpose of the Study: Leadership and confidence in delegation are two important explanatory constructs of nursing practice. The relationship between these constructs, however, is not clearly understood. To be successful in their roles as leaders, regardless of their experience, RNs need understand how to best delegate. This study explored and described the relationship between RN leadership styles, demographic variables and confidence in delegation in a community teaching hospital.

Methods: Utilizing a cross sectional survey design, RNs employed in one acute care hospital completed questionnaires that measured leadership style (Path-Goal Leadership Questionnaire, PGLQ) and confidence in delegating patient care tasks (Confidence and Intent to Delegate Scale, CIDS).

Results: Contrary to expectations, the data did not confirm a relationship between confidence in delegating tasks to UAPs and leadership style. Nurses who were diploma or associate degree prepared were initially less confident in delegating tasks to UAPs as compared to RNs holding a

bachelor's degree or higher. Further, after five years of clinical nursing experience, nurses with less educational experience reported more confidence in delegating tasks as compared to RNs with more educational experience.

Conclusions: The lack of a relationship between leadership style and confidence in delegating patient care tasks were discussed in terms of the PGLQ classification criteria and hospital unit differences. As suggested by the significant two – way interaction between educational preparation and clinical nursing experience, changes in the nurse's confidence in delegating patient care tasks to UAPs was a dynamic changing variable that resulted from interplay between amount of educational preparation and years of clinical nursing experience.

# CHAPTER I

## INTRODUCTION

The ability to delegate tasks to others is an essential skill for the Registered Nurse (RN). The process of delegating requires the RN to remain accountable for the task. However, the delegated individual also assumes responsibility for the task and answers to the RN. Thus, delegation describes a "...dynamic process that involves responsibility, accountability and authority" (Sullivan & Decker, 2005, p. 144). The Board of Nursing Examiners (BNE) rules and regulations (2007) §225.4(6) defines delegation as the act of authorizing an unlicensed person to provide nursing services while retaining accountability for how the unlicensed person performs the task.

The RN must consider certain criteria before making a decision to delegate a task. These criteria are in accordance with the policy described in BNE §225.6(a) & (b), which states that if the client is 16 or older, the RN begins by making an assessment to determine if the care task can be delegated to an unlicensed person. Then the RN develops an overall picture of the patient's health status by systematically checking each of the following six elements. First, the RN determines if the adult delegate is capable of participating in the healthcare decision and exhibits the ability and willingness to participate in the management and direction of the task. Second, the RN assesses the adequacy and reliability of the support systems that are

available to the delegate. Third, the RN appraises the degree of stability and predictability of the patient's health status relative to the task to be performed. Fourth, the RN judges the knowledge base of the delegate regarding the health status of someone in their care, or him or herself. Fifth, the RN evaluates the ability of the delegate to communicate with an unlicensed person in traditional or non-traditional ways. Finally, the RN determines how frequently the patient's status needs to be reassessed. After taking into account the stability of the patient, the training, experience and capacity of the unlicensed person, and, the nature of the nursing task that is to be delegated, BNE §225.9 further requires the RN to determine the necessary level and frequency of supervision.

In the current health care arena, RNs serve as both clinicians and managers. However, during their professional education RNs primarily receive training for their clinical tasks. Glass and Todd-Atkinson (1999) report that staff nurses express discomfort with delegation and leadership skills. While undergraduate nursing courses include content about leadership skills and styles, many RNs report finishing school not feeling confident in their ability to delegate appropriately. While the mandate to delegate is as much a part of the RN's duties as clinical tasks, there are few, if any, educational experiences at the undergraduate level that directly address the development of leadership and delegation skills. Further, a review of the existing literature confirms that no studies to date focus on the relationship between RN leadership style and confidence in delegating patient care tasks. Given that

RNs acknowledge discomfort and/or a lack of confidence with delegation and leadership skills and that no studies address this relationship, the current investigation may be the first attempt to describe that relationship and evaluate how demographic characteristics such as educational preparation and nursing clinical experience influence the RNs' ability to delegate.

## Background of the Problem

Traditionally, the RN assumed complete care of the patient's needs unassisted by ancillary personnel, such as unlicensed assistive personnel (UAP), clinical nursing assistants or nurses' aides (Cook, 1996). Because of this emphasis, many RNs never developed the skills needed to delegate patient care appropriately to others, nor were they given educational interventions targeting the development of leadership skills (Badinovic, Wilson & Woodhouse, 1999; Barter & Furmidge, 1994). Today, the presence of sicker patients, fewer RNs, and numerous cost and budgetary restrictions (Lookinland, 2005; Norrish, 2001) are changing the face of health care. To alleviate some of the stress resulting from these issues, healthcare organizations are utilizing the services of UAPs who provide direct patient care that are consistent with national standards of practice and state nurse practice acts. While the presence of UAPs in health care organizations was intended to alleviate the demands placed on RNs, these same individuals are now saddled with the responsibility of supervising the direct patient care

provided by UAPS in addition to their clinical nursing responsibilities (Norrish). In 1992, The American Nurses Association (ANA) defined delegation as "the transfer of responsibility for the performance of an activity from one individual to another while retaining accountability for the outcome" (p. 4). Consequently RNs act in a supervisory capacity over UAPs bearing the responsibility for someone while they have not supervised their training. According to the ANA principles (1992) delegation situations as described above place the RN in jeopardy if the UAP does not perform the assigned duties in an expeditious and professional manner. Consequently, RNs require both clinical and delegation/leadership skills (Kleinman & Saccomano, 2006). Unfortunately, RNs are often poorly prepared to perform either delegation or supervision activities (Hutson, 1996).

## Factors Affecting Delegation

When not adequately prepared for supervisory functions, RNs often do not have the necessary level of confidence to lead and delegate (Kleinman & Saccomano, 2006). Each time patient care tasks are delegated to a UAP, the RN needs to assess the clinical situation, simultaneously evaluate patient care needs and appraise the competence of the UAP in performing the specific patient care task. The integration of information from several sources simultaneously represents a complex assessment process that the RN must accomplish, often in stressful situations and under time pressure. When the

RN must take action, but has had little or no opportunity to learn or develop the needed leadership and delegation skills in a nursing program, or while practicing as a licensed RN, the RN assumes great personal risk.

The concept of delegation is not new. The ability to delegate patient care tasks to others dates back to the early nursing efforts of Florence Nightingale (Nightingale, 1969). Identified by nursing practice as an entry level skill, delegation is an important component of RN knowledge as this concept is currently included on the national licensure exam for RNs (NCSBN, 1995). In fact, the ANA (1992) consistently urges nursing programs to add supervision, delegation and legal content to existing educational curricula. However, newly graduated RNs report a lack of preparation for delegation and leadership activities (Conger, 1999) despite the profession's acknowledgement of its importance.

Forty-one percent of RNs report that they were not exposed to delegation and leadership content in their nursing curriculum (Parsons, 1998; Henderson, 2006). Further, since students, , are not considered employees of the institution, during a clinical experience, they rarely practice delegation (Feldman, 2005). Yet, once employed, RNs must be ready to delegate. In today's health care environment, prioritizing direct care activities for patients and creating a team approach to patient care through appropriate delegation is desirable as it helps healthcare providers achieve optimal patient outcomes (Teitel, 2002; Tschannen, 2004). However, the potential for negative and adverse patient outcomes resulting from ineffective supervision of UAPs

exists (Anderson, 2006; Kalisch, 2006; Kopishke, 2002). This may be due to a lack of knowledge about delegation on the part of both the UAP and the RN, or on the RN's limited experience with delegation. Until the RN has effective delegation and leadership skills, overcoming these difficulties is nearly impossible. Hence, the situation demonstrates a need forr educating RNs in the areas of leadership as well as clinical competency and exemplifies a situation that may be alleviated by requiring continuing education programs during the nurse's employment.

*Relevance of Leadership Style*

While few staff nurses may be born with the ability to intuitively delegate and lead, most must learn these skills through educational experiences (Davis, 1995; Jung,1991). Since it is the staff nurse who holds the ultimate responsibility for delegating tasks to UAPs (Kleinman & Saccomano, 2006), the RNs leadership style may impact delegation. Thus, a key feature of the RN and UAP relationship may rest on the leadership style of the RN. For example, Vale (2000) evaluated how the leadership style of nurses impacted their nursing assistants. Vale found that nurses' leadership style centers on service and individuals, supporting the theory that leadership style is important in executing the goals and objectives of a health care organization.

Given the increasing complexity and competitive environment of health care organization, the nurse's ability to take on an active successful leadership role with the UAP is vital to the RNs' success or failure in

delegation. RNs effective delegation is judged by the results in positive or negative patient outcomes (Dunham-Taylor, 2000). The RNs needs to lead in a manner that influences and motivates the UAP. In addition, RNs can be empowered into a leadership role which promotes positive outcomes while be effective delegators.

Some of the early investigations into the effects of leadership style on performance focused on transformational leadership. This leadership style allows leaders to develop their subordinate's potential for positive patient outcomes sourced in the agreement on the importance of the tasks (Trofino, 1995). By first agreeing to the importance of the tasks, the RNs transfers principles of beliefs, values, and knowledge for positive outcomes into a mutually agreed upon approach to the tasks with the UAP. When delegation occurs with trust, respect, and a mutual exchange of information and ideas, it provides an environment for team cohesiveness and strengthens outcomes beneficial for the patient and the institution (Bass, 1978; Burns, 1985).

In describing the impact of transformational leadership on the cooperation of subordinates, Bass (1985) posits five key components of leadership that is both transformative and empowering: The key features described include: 1) charisma, the admiration of the leader by followers; 2) idealized influence, the leader is emulated by followers; 3) inspirational motivation, the provision of challenge and meaning to the work; 4) intellectual stimulation, the questioning of assumptions; and 5) individual consideration, individually mentoring staff on the basis of their needs. Trofino (1995) added

empowerment to the concept of transformational leadership. In the development of the leadership role, RNs, who have been uncomfortable with this new task of delegation, are being challenged to take on a role which has inherent difficulties. Some of the concerns are related to fear of litigation, undeveloped sense of autonomy, inadequate knowledge of training issues related to the UAP role and supervision (Anthony, 2001; Kopishe, 2002; Kleinman & Saccomano, 2006).

Similarly, Path-Goal theory (House, 1971; House and Mitchell, 1974) proposes that the leader should inspire followers by enabling them to see how their task-related performance could assist in achieving their mutually agreed upon goals. House and Mitchell contend that considerate and respectful leaders inspire their subordinates to achieve positive and effective results. Thus, an RN trained to recognize and use the techniques of path goal theory may more delegate more effectively patient care tasks to UAPs.

Contextually, the health care organization and therefore the culture, values, and beliefs of the individuals in that organization are mutually dynamic in the process of leadership. Researchers divide organizational behavior into two parts: "micro" organizational behavior, which refers to individual or group dynamics in an organization, and "macro" organizational theory, which refers to the study of whole organizations, how they adapt, and the strategies and structures that guide them (Robbins, 2004). The aim of these two approaches is to impact the outcomes of organizational performance, as well as individual satisfaction, personal growth, and development (Frese, 2000).

At present, the role development of RNs has focused on clinical practice with little attention to the managerial role. The leadership role and its inherent delegation to other staff (UAPs) are sorely missing. There are gaps in the literature related to the RNs ability and comfort level in the delegation process. Since leadership style is a key component of managerial success it becomes possible to assume that leadership style is a key indicator of the success or failure of the RNs ability to manage UAPs effectively. The RN leadership style may be the key to successful delegation.

## Purpose of the Study

The purpose of this cross sectional survey research design is to describe the nature and the relationship between the registered nurse's leadership style and confidence in delegating patient care tasks to unlicensed assistive personnel.

## Significance of the Study

There are no descriptive or systematic investigations in the nursing literature that describes the relationship between the RN's leadership style and confidence in delegating patient tasks to UAPs. Additionally, researchers have not systematically examined other variables that may influence an RN's confidence in delegating patient care. Yet, it is well documented that RNs can either shape or maintain positive or negative quality outcomes with patient care. Consequently, this study may serve as a catalyst for more discourse

and subsequent investigations directed at identifying and examining variables and experiences that contribute to the RN's confidence in delegating patient care.

## Research Questions and Hypothesis

Given the absence of information about the relationship between registered nurses' leadership style and confidence in delegating patient care tasks, three research questions guided this investigation.

RQ 1: How do RNs with different leadership styles compare in terms of their confidence in delegating patient tasks to UAPs?

RQ 2: Is there a relationship between demographic characteristics and confidence in delegating patient tasks to UAPs?

RQ 3: Is there a relationship between leadership style, clinical nursing experience, educational preparation and the RN's confidence in delegating patient tasks to UAPs?

### *Hypotheses*

Based on the three research questions, the following hypotheses were evaluated.

H1a: RNs who demonstrate a supportive leadership style will report more confidence in delegating patient care tasks to UAPs than RNs with directive, participative or achievement leadership styles.

H2a: RNs with at least a baccalaureate degree will report more confidence in delegating patient care tasks to UAPs than RNs with educational preparation less than a baccalaureate degree.

H2b: RNs with 5 or more years of nursing clinical experience will be more confident in delegating patient care tasks to UAPs as compared to RNs with fewer years of nursing clinical experience.

H2c: There is a positive relationship between nursing clinical experience and confidence in delegating patient care tasks to UAPs.

H3a: Respondents, who demonstrate a supportive leadership style, have at least a bachelor's degree and 5 years or more years of nursing clinical experience will report more confidence in delegating patient care tasks as compared to RNs with other leadership styles, lower levels of educational preparation and less nursing clinical experience.

# Chapter II

## REVIEW OF THE LITERATURE

To function effectively, healthcare management systems must provide efficient and effective leadership, because a well-led healthcare unit is a confident unit in which employees feel empowered to discuss their problems and to solicit help and advice to advance the common good. There are no biases on these units, and staff RNs feels confident in their ability to delegate less critical duties to UAPs. Unfortunately, leadership skills are integrated into most nursing programs in the U.S., but are not isolated and taught as a separate skill (Feldman, 2005). Thus, the issue of RN confidence in delegation requires continuing education courses to teach delegation and supervision skills to RNs who do not have experience with this form of team nursing (Conger, 1994). While the literature is replete with research on leadership styles and how these styles affect an organization, little research exists on understanding this relationship as unique to RNs who are working with and delegating to UAPs and the role of leadership style in RN delegation. This literature review is an overview of leadership styles in general, and leadership characteristics of nurses in particular. Leadership and delegation take place in organizations, the culture and values of which may affect outcomes. Included is a review of the impact of an organization on its

personnel. Finally a discussion of the history of leadership style, and its impact on delegation follows.

## Leadership Style and Measurement Tools

According to Chemers (2000), leadership involves the social process that results when an individual enlists the support and aid of others to accomplish a common task. While early research into leadership theory focused on personality traits and behaviors, this proved to be an unproductive line of inquiry because of the recognition of the more complex nature of the phenomenon. Early researchers including Stogdill (1948) concluded that, even though it was important to identify individual differences in effective leaders, the great variety of situations in which leaders operate makes it unlikely that a single trait serves as a universal predictor that can distinguish leaders versus non-leaders. This finding eventually led to leadership theories that included the interaction between situational contingencies (collective routines and practices) and leadership traits (Chemers). Early researchers attempted to explain the variability of leadership behaviors in terms of consideration (showing concern for the feelings of subordinates), initiation of structure (the use of standard operating procedures by the leader and his or her emphasis on high quality work [Halpin & Winer, 1957]), accrual (employee benefits); and legitimacy (leaders demonstrating task-related competence as well as loyalty to group values [Hollander 1964; Hollander & Julian, 1970]).

*Early Studies of Leadership*

The relationship in the leader-subordinate role arose as a response to Stogdill's (1948) requirement for a leadership model based on the interaction of leadership traits with situational parameters. Early work with this model (Cleven & Fiedler, 1956; Fiedler, 1958, 1995) produced conflicting results as to the definition of the word leader, as defined by Fieldler and Chemers (1976). They defined a leader as one who directs situations and who practices "I am the leader; you will follow me" behaviors. Conversely, a relationship-oriented leader was a leader who thrived on personal connections with subordinates and enjoyed receiving feedback from them. The relationship-oriented leader believed in "making the work environment pleasurable."

Based on the need to further refine the early leadership models identified by Stogdill, Chemers and Fielder, Fielder (1967) re-examined and recombined three leadership variables into a dimension called 'situational favorableness' (Fiedler, 1967) or 'situational control' (Fiedler, Chemers, & Maher, 1976). Fiedler's theory of situational favorableness assumed that the leader is most effective when the leader manages the situational factors of the group he or she is leading. Being successful or achieving a desired outcome, the leader in this theory must adapt his or her personality style to the situation and the style of the subordinates. Therefore, Fielder's situational theory focused on three situational factors: (a) the degree of cooperation and support offered by followers, (b) group task structure and clarity, and (c) the

formal authority of the leader to reward and direct followers. These situational factors are believed to reflect the extent to which the overall situation provides the leader with a sense of predictability of group behavior, and control over the processes of the group he or she is leading. A successful leader, as defined by Fieldler matches situational theory to leadership style and not the reverse. Finally, group performance depends on the interaction between the leader and the situation, as well as the leader's effectiveness with the group, to become successful as an operational unit.

Leadership effectiveness is dependent on the extent to which the leader has influence within the leadership situation (Fielder, 1967). Here, leadership effectiveness involves the coordination of the leader's position power with task structure and leader- member relations. To begin the leader's influence depends on a leader's position power, which refers the power inherent in the leaders position itself. Second, task structure refers to the degree to which the task at hand is low in multiplicity, how many paths of action can result in completion and high in verifiability, and the extent to which the outcome can be determined. Also included is clarity of goals and specificity, how specific a decision is as a course of action. Lastly, a leader-member relation refers to the degree of mutual trust, respect, and confidence between the leader and his or her subordinates. Other influences on the effectiveness of leadership, according to early studies, included the degree of stress in a situation, and the heterogeneity (differences among) or homogeneity (sameness within) of the group (Fiedler, 1967).

Fiedler (1967) described a curvilinear relationship between group performance and leadership style since the task-oriented leader will tend to perform most effectively in very favorable or unfavorable situations. With regard to the psychometrics of his tool in measuring mental traits, capacities, and processes, the relationship-oriented leader is most effective in intermediate situations in terms of favorableness. Fiedler identified intermediate favorableness as a situation where the leader is not well accepted, even though the position power is high, and the task is either structured or relatively unstructured.

Fiedler's contingency model (1967) drew some criticism due to its inductive method of construction and the use of small study samples in a laboratory setting. Fiedler classified leadership styles by what he called the least - preferred coworker (LPC) The LPC is a scale to identify the individual's leadership orientation. The most controversial criticism is the validity of the LPC scale. Critics wondered what the LPC scale was actually measuring (Northouse, 2007 & McKenna, 2000). Another criticism of Fielder's LPC model was that it neither sufficiently explained what happens if the leader did not match the work place environment, nor explain why certain leadership styles are more effective in differing situations (Northouse, 2007). The complex nature of the contingency model predictions and the assumptions made that a leader can be both task-oriented and relationship-oriented depending on the situation were also criticized. Fiedler believed that training did not help, and he also believed that it was better to modify the situation.

Vroom and Yetton (1973) found the contingency approach inspiring, and attempted to address and define leadership performance based on this model. They used a more deductive theoretical base to provide a new normative model. Vroom and Yetton took earlier generalized situational theories that noted how situational factors caused unpredictable leader behavior, and reduced those behaviors to a more limited set of behaviors. The "normative" aspect of the model came from defining the model according to rational logic rather than by long observation. Leadership based on their model was most likely to work when there were clear and accessible opinions about the decision's relevance and acceptance factors.

In the same study (Vroom & Yetton, 1973), situational factors in the normative model were integrated with the decision strategies of leaders to produce a new model of decision-making effectiveness. This means a range of decision-making strategies were conceptualized as being available to leaders. These strategies ranged from autocratic styles, in which the leader makes the decisions and followers are allowed minimal input, to consultative styles, in which the leader bases decisions on the opinions and advice of the followers, and participative or group styles in which the leader and the group make decisions together on an equal footing.

A decision tree is formed in the normative model (Vroom & Yetton, 1973) where situational parameters are represented as a series of questions. When a leader is seeking a decision strategy of maximum effectiveness, he or she is required to analyze situational factors that include the structure and

clarity of the task and the surrounding information. The decision tree then predicts how much participation the situation calls for (Figure 1), and delegation follows. The degree of support for both the organization and the leader is derived from the followers, the level of conflict between subordinates, and the time urgency of a decision are all factors that influence how the leader follows the branches of the decision tree (Chemers, 2000). Figure 1 is a representation of a decision tree as it would be used for RN delegation.

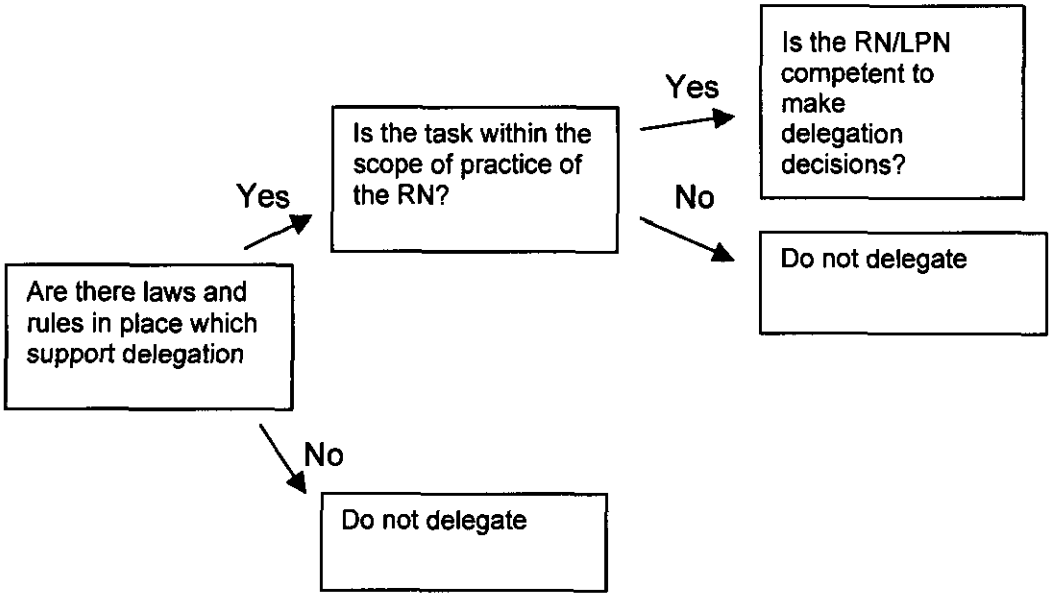


Figure 1. Example of a delegation decision-making tree (adapted from National Council of State Boards of Nursing, 1997).

*Normative and Contingency Models*

The normative model of leadership (Vroom & Yetton, 1973) includes three effective leadership styles: autocratic, consultative, and participative or group leadership styles. According to this model, the autocratic style is the

(b) The leader's task is viewed as gaining group support to solve problems and effectively implement solutions.

(c) Directive approaches, such as autocratic leadership prove to be most effective when the leader is given the certainty of taking charge by a supportive group and a clear task.

(d) When the environment is less orderly and less clear, a participative style of leadership is most effective as autocratic direction and bold action are not appropriate.

Because normative and contingency models do not necessarily allow input from workers, the leader controls how the workers do the task without participation from the workers, which could result in employee dissatisfaction and a decline in worker performance. In addition, the two models differ in their prescriptions for very low control situations, when the path to reach the goal is not clear. In low control situations, the contingency model recommends more direct action from the leader to obtain more immediate group performance, while normative decision theory emphasizes more participative strategies so that a supportive environment develops over time (Chemers, 2000).

The emphasis of contingency theory is on the situational variables that surround leaders, known as organizational behavior. They must deal with such elements as traits, skills, and behaviors. By contrast, the normative leadership model suggests strategies on how to make decisions in specific situations.

*The Path-Goal Theory*

Path-Goal theory (House, 1971; House & Mitchell, 1974), states that leaders should choose a leadership style that takes into account the characteristics of members of the group and the task to be completed. The main purpose of the leader is to motivate followers by enabling them to see how their performance could assist them in achieving their personal goals, a vastly different approach from that taken by the earlier theories, which focused on providing support within the environment of the task as opposed to group or individual motivation. A leader's structuring behavior would motivate subordinates when the task environment of the subordinate was deficient in structure due to a highly complex task or insufficient training/experience.

If a leader provides a subordinate with structure, a "leader directive-employee behavior" relationship results, and the employee perceives this as being overly pushy or as providing uncomfortably close monitoring. Such a situation might produce negative results. In those cases where a subordinate needs emotional or psychological support in difficult work circumstances, the leader should display consideration behavior - concern for the subordinate's feelings and respecting subordinate's ideas. This behavior reflects friendship, mutual trust, respect, and warmth in the relationship between leader and follower and is beneficial to the employee. In an engaging and intrinsically

interesting work environment, consideration behavior is superfluous. Thus, leader behavior that is viewed as supportive to subordinates will most likely result in higher motivation and more positive outcomes (Chemers, 2000).

Some critics say that the Path-Goal Theory is inadequate and untested, largely due to its complexity (Evans, 1996; Schriesheim & Nieder, 1996; Yukl, 1993). House (1996) conceded that Path-Goal Theory requires followers to be confident and able to receive particular extrinsic rewards such as pay raises, awards, or titles based on job performance. The theory is not likely to work when uncertainty is high or when leaders or followers are under a great deal of stress, which makes it unlikely that the leaders will make accurate and rational expectancy estimates (House & Aditya, 1997).

In their "substitutes for leadership" theory, Kerr and Jermier (1978) extended the Path-Goal Theory, claiming that if the purpose of the leader is to provide elements that are missing from the job environment of the subordinates, then the leader's behavior might be unnecessary or redundant if other sources provide these missing elements. For example, leader structuring behavior would be unnecessary if a job provided ample task-relevant feedback. Leader consideration could also be redundant if a cohesive and compatible work environment provided emotional support. The researchers found that, in conditions such as these, leader behaviors provide minimal or negative relationships, which result in low satisfaction, motivation, or performance by subordinates, allowing the environment to control the subordinates.

Normative and contingency models are known as "substitutes for leadership" theories. Researchers question their predictions, arguing that the behavior of a leader is crucial for subordinates, no matter what the circumstances exist (Podsakoff, Niehoff, Mackenzie, & Williams, 1993). Research on the contingency theory suggests that group leader actions strongly impact followers and the successful completion of their task, depending on how these actions interact with the relevant features of the task and interpersonal environment (Chemers, 2000). The contingency theory, a more researched-based and grounded theory, takes a different approach from the "substitutes for leadership" theory. Contingency theory places the focus on the environment of leadership rather than on the leader.

*The Life -Cycle Theory*

Hersey and Blanchard (1982) developed the Life Cycle Theory, a situational theory of leadership that postulates four leadership styles:

1. Selling, where the main function of the leader is to provide assistance to members doing a task who lack the skills for that task. With the leader's direction and guidance, members are coached through the skills of the task. Direction and supervision are the key components of this style of leadership as the leader encourages and motivates the group.

2. Telling, suitable for members who are new or inexperienced and need a lot of help, direction, and support to complete the assigned task. Structure and guidance to the group come from the leader who directs them on what, how, when, and where to do various tasks.

3. Delegating is where the leader chooses to delegate tasks since the group members are both capable and willing to assume accountability for directing their own behavior. The leader trusts the group to do perform their functions and observes from a distance.

4. Participating, where group members have the capability to do the job. However, the group may be reluctant to start or complete the task. In this leadership style, both the group members and the leader contribute to the decision-making process and implement them together. The leader puts emphasis on relationships and individuals' feelings within the group and centers on feelings of importance in members. The leader provides moral support and encouragement and acts as a resource person and helper in this role. (p.132)

Each of these four leadership styles is appropriate for various situations that arise which are defined by the maturity level of subordinates. The leadership style in this theory arises out of the degree to which the followers are prepared and willing to accomplish a task. Hersey and Blanchard (1982) view their theory as representing a life-cycle model, comparable to a parent-child relationship in which parental control gradually decreases as the child matures. The theory has a positive effect on certain types of employees, specifically, employees who are recently employed and require high levels of leadership task structuring (House & Aditya, 1997).

*The Cognitive Resource Theory*

The Cognitive Resource Theory (CRT) of leadership (Fiedler & Garcia, 1987) was an outgrowth of Fiedler's) (1967) interest in situational control and the impact of situationally-induced stress on followers and leaders. CRT is a person-by-situation interaction theory in which experience and intelligence constitute the "person" variables, and stress experienced by followers and leaders make up the "situational" variable.

Fiedler and Garcia (1987) identified intelligence as positively correlated with performance, and experience negatively correlated with performance under conditions of low stress. They found that the opposite was true under conditions of high stress. Also, the performance of more experienced individuals is lower than that of less experienced individuals when job- or leader-related stress is low. Therefore, in highly stressful situations a highly intelligent person would rely more on experience than on intelligence to be effective, even though the tendency is to apply both and, consequently be less effective.

According to the CRT intelligence and experience interfere with each other. These findings seem to be counterintuitive and have been substantiated in numerous fields and laboratory studies (Fiedler, 1995). According to the authors of CRT, individuals apparently cannot think both logically and analytically while simultaneously reacting to stress and emergencies based on prior or previous experience history. (Fiedler,1996). Stress undermines rationality and results in a narrowed focus. The consequence is that authoritarian decision-making becomes necessary, resulting in follower dependence on authoritarian leaders (House & Aditya, 1997).

In contrast to Path Goal Theory, in CRT, for leader intelligence to contribute positively to group performance, the leader must tell the group what to do, while the followers must listen to the leader and carry out the orders the leaders give them (Fiedler, 1996). Here, directive leadership under

poor leader-follower relationships will only be effective if the leader has total control of followers' behaviors. Thus, either the leaders must not be under stress or, if they are, they must be able to use relevant experience to deal with the situation.

Neither directive nor participative leadership will be effective in CRT if the leader does not possess control of the behaviors of his or her followers and when the leader-follower relationships are deficient. In these cases, followers will not listen to the leader and they will not do what they are directed to do (House & Aditya, 1997). According to House and Aditya, 1997, directive leadership will be ineffective in low stress situations when intelligence is lacking, or in high stress situations when experience is lacking. In low stress situations where there are strong leader-follower relationships, participative leadership will be the most effective when group members are more intelligent than their leader. They concluded that, when relationships are good, the leader will be attentive to the followers and will listen to them. Under conditions of high stress and good leader-follower relationships, participative leadership is most effective when members of the group possess more experience than the leader does, and the leader is willing to listen to them. Participative leadership will be ineffective when leader-follower relationships are poor, since neither the leader nor the followers are willing to listen to each other. Table 1 summarizes the various types of leadership, according to House and Aditya.

Table 1

*Summary Types of Leadership and Characteristics of Those Types According to House and Aditya* (1997)

| Type of Leadership | Characteristics |
|---|---|
| Directive leadership | • Keeps subordinates informed<br>• Identifies expectations<br>• Provides guidance |
| Supportive Leadership | • Concerned for subordinates' feelings<br>• Approachable |
| Achievement-oriented leadership | • Challenging goals<br>• Shows confidence for subordinates |
| Participative leadership | • Consults with subordinates before decision making |

Important recommendations for situational management and leader selection arise from CRT (House & Aditya, 1997). First, individuals with the .necessary experience, intellectual abilities, and job-relevant knowledge enter leadership positions. Second, those leaders work under conditions that allow them to effectively use the cognitive resources for which they were hired.

In a study related to CRT involving officer candidates, Fiedler (1996) conducted a stress reduction program using an experimental methodology. Fiedler found that officer candidates were more effective on an in-basket management simulation task requiring intelligence (but not experience) for effectively carrying out the task. In addition, the use of intelligence appeared to increase through reduction in stress (Fiedler, 1996).

In yet another related study (Chemers, 2000), the leader, in an attempt to make decisions, uses problem solving tools and techniques to incorporate group support. The leader commands the support of the group to implement the leader's plan. It is the leader's intellectual effort that enables goal acquisition. In CRT, the leader cannot act alone and uses social and interpersonal skills to solicit the support of others. Chemers defines leadership as "a process of social influences in which one person is able to enlist the aid and support of others for accomplishment of a common task."

Chemers (2000) argued that it is important for leaders to establish the importance and legitimacy of their authority by showing their competence and trustworthiness to their followers. Followers believe such leaders possess charismatic levels of trust and capability when they are effective in managing their image. These leaders then guide, coach, and support their followers in a manner that enables followers to contribute to the goal attainment of the group, while personal goals and needs are also being satisfied. To accomplish this, the leader must make sure that he or she understands the values, abilities, and personalities of his or her subordinates so effective support and coaching can be provided. The motivational environment provided by leaders is sometimes so effective that followers are able to merge their personal goals with the collective group goals, becoming transformed in the process (Chemers, 2000).

Finally, to be truly effective, leaders must use their own abilities and skills as well as those of their followers, to accomplish the group's mission. In

use of resources, the first step is to create a sense of personal empowerment and confidence so that each member of the group is able to put forth his or her best effort. During the second step, the leader focuses resources on the task environment in such a way that the best fit results between the group process and the demands of the environment. Intelligent decision-making and sensitive information processing are essential for this to happen (Chemers, 2000). Chemers posited that leadership efficacy and group collective efficacy are the most essential components for effective leadership performance. Leadership rewards include calm decision-making, ambitious goal setting, bold action, sensitive interpersonal relations, and long-term perseverance which result in sustained common effort towards a common goal.

In the preceding section, in reviewing the literature on leadership it is evident that leaders are more effective when they base their behavior on situational factors. This means that leaders must use a set of learned behaviors to guide subordinates to reach their goals and perform effectively for the overall good of the institution (Hershey and Blanchard, 1982, Fiedler & Garcia, 1987, House & Aditya, 1997, Chemers, 2000).

Continuing the discussion of leadership styles, the following section presents research related to nursing leadership styles, specifically transformational and transactional, and, where appropriate, draws analogies to the theories reviewed above.

## Current Leadership Styles in Nursing

The previous section reviewed the literature on leadership in general. In this section, literature on leadership in nursing will be the focus. The section begins with an examination of transformational and transactional leadership, and compares the two styles. Within nursing literature, these two leadership styles are identified as pertinent to nurse leader. The transformational style tends to be authoritative, with clear structures, rewards, and punishments made very clear (Straker, 2005a). The transactional style tends to be participatory, with creativity, individual work, and potential exploratory projects emphasized (Anderson, 1998; Straker, 2005b).

### *Transformational Leadership*

Burns (1978) was the first to introduce the concept of transformational leadership. Transformational leaders appeal to higher ideals and moral values, such as equality and justice. Transformational leadership extends beyond the needs of individuals favoring a team approach. Factors such as having a common purpose, intrinsic rewards, higher psychological needs such as self-actualization, and development of commitment between the followers and leader are the focus of the transformational leader (Bass, 1985; Bennis & Nanus, 1985).

Transformational leadership installs pride and motivation, the sharing of an organizational vision, directions to staff about attaining organizational goals, and the demonstration of openness to new ideas or input of staff. Bass

and Avolio (2000) suggested that transformational leadership behaviors are positive forms of leadership. Shader, Broome, Broome, West, and Nash (2001) claimed that greater work satisfaction among staff nurses can be associated with effective nursing leadership that uses transformational leadership styles. Transformational leadership is also essential to the retention of nurses (Ribelin, 2003), suggesting that transformational leadership suits the nursing sector. This issue of retention, although not a focus of this study, does bring up a certain question for future studies of the important aspect of the positive experience of delegation and nurse retention.

However, not all researchers agree with Shader et al. (2001). For example, Kleinman (2004a) believed there is a lack of evidence that leadership qualities are important in higher retention rates for nurses. Kleinman found that it is not clear which style of leadership has the best effect on staff retention because there are discrepancies between the leadership perceptions of nurse managers and staff nurses. However, transformational leadership is a leadership style seen more frequently in recent years because there is evidence that this type of leadership results in more committed followers than other leadership styles (Avolio, 1999; Bass, 1998). Transformational leadership also results in greater satisfaction and effectiveness amongst followers than transactional leadership does, even though the most effective leaders appear to use elements from both approaches (Kleinman, 2004b).

Transformational leadership results during dynamic leader-follower dyads. A break with the past occurs, and new behaviors result. Transformational leadership requires the leader to acquire new knowledge and skills, (Medley & Larochelle, 1995). Gray-Toft and Anderson (1985) first supported the idea that effective leadership positively influences the satisfaction of nurses toward their jobs. These researchers discovered that the open discussion of ideas, and consideration of staff by managers, were essential elements that create job satisfaction among nurses. The nurse researchers of the early 1990s supported the notion that those nurse executives viewed as excellent administrators displayed transformational leadership characteristics (Dunham & Klafehn, 1990).

It was also during this period of time that the relationship between staff turnover and a participative management style was first investigated (Volk & Lucas, 1991). Certain leadership characteristics were identified as directly correlated with staff retention (McDaniel & Wolf, 1992; Shobbrook & Fenton, 2002; Taunton, Boyle, Woods, Hansen, & Bott, 1997). Included in these characteristics were transformational behaviors such as staff consideration, and an organizational structure in which staff nurses shared in the responsibilities (Kleinman, 2004a). Such characteristics lead to increased job satisfaction for nurses, as well as increased retention (Scott, Sochalski, & Aiken, 1999).

*Transactional Leadership*

Bass (1985) claimed that transactional leaders motivate followers by appealing to emotions; in fact, they do not care about the ultimate effects on such matters as followers' moral values. Transactional leadership has three main components: (a) contingent reward, in which staff is rewarded for producing desired work; (b) active management by exception, in which the leader's goal is to ensure work performance is rewarded or corrected as required and goals are met; and (c) passive management by exception, where the leader waits until problems arise and then deals with the issue, usually after mistakes have occurred.

The non-leadership sub-component is also an important part of transactional leadership (Bass, 1985). A laissez-faire leader is the opposite of a leader; here the leader avoids making decisions, relinquishes responsibility, and does not use his or her full authority (Antonkis, et al., 2003). With this style of leadership, the leader willfully decides not to take action. Therefore, the laissez-faire element of leadership is a passive and ineffective style of leadership (Block, 2003).

Transactional leaders focus on day-to-day operations and they may use constructive or corrective feedback (Burns, 1978). Transactional leaders appeal to the self-interests of their followers. This type of leadership begins as collaborative process based on meeting a set of established goals and objectives and assessing outcomes (Antonakis, Avolio, & Sivasubramniam, 2003). The transactional leader guides or prompts their followers in the

direction of these goals and clarifies roles and task requirements (Robbins, 2003). Empowering followers to accomplish goals is not the focus of transactional leadership.

Organizational leaders who desire to create an organization that responds quickly to change must focus on empowering employees (Naisbit and Aburdene 1990). Empowerment is a leadership style that closely resembles transformational leadership in that it possesses the same qualities. Empowerment is essential for the subordinates to perform competently and confidently in regard to the delegated tasks. Empowerment is one of the components of successful leadership style

*Empowerment as a Leadership Style*

Empowerment allows others to do things the way they wish after receiving direction and authority to act (Rajotte, 1996). A shared set of values, along with a customer focus, is part of this style of leadership. People take the initiative in a situation and are creative, while feeling ownership. Empowered employees provide significant advantages to the customer and the institution. Empowered employees exhibit a greater commitment to the organization, and these employees are likely to have greater trust for their leaders impacting the outcomes of their jobs. (Rajotte,1996; Avolio 2004).

In this type of leadership, shared values focusing on the customer provide a common vision. Clearly stated values form the foundation for a common sense of purpose. Improving what people do, including continued

education, is part of the process. The customer is a central focus of the common goal. Few and easily breached boundaries exist between divisions and cooperation exists between management levels in departmental hierarchy (Rajotte, 1996). People at all levels solve their own problems, while feeling free to ask for assistance when required. The net result is an organization that is effective and efficient in its operation because of the flat and lean organizational structure that results. Supervisors serve as effective mentors. Employees function best when they provided with a sense of belonging, economic security, control, recognition, and self worth (Rajotte).

Empowerment is the ability to complete tasks through other people (McConnell, 1995). The leadership style of empowerment is an important tool that can be used in delegation as the RN needs to possess skills of empowerment (i.e., facilitation, advising, training, and being a teammate) when delegating to UAPs (McConnell, 1995). Through the use of empowerment when delegating, the RN shares his or her power with the UAP. This sharing of power between the RN and the UAP can help subordinates gain satisfaction by increasing the subordinate's knowledge and power base, where the subordinate feels more fulfillment and is self-directed, leading to goal attainment for the institution.

In a study involving 331 nurses in a regional hospital in Hong Kong, Mok and Au-Yeung (2002) discovered that a significant positive correlation existed between the organizational climate and the psychological empowerment of staff. It appeared that teamwork and leadership significantly

affected empowerment. The authors found that, while relationships between nurses and management need to be strong with management assigning the right people to the appropriate task, leaders need to be encouraging, supportive, and forthcoming to subordinates with information about job-related organizational information. Management encouragement and support, rewards, autonomy, and developmental opportunities were essential elements of the organizational environment for the enhancement of a sense of empowerment (Mok & Au-Yeung).

An earlier study by Kanter (1993) echoes the findings of Mok and Au-Yeng (2002). Kanter claimed that empowering work environments are those in which access to resources, support, and information exist, while opportunities to learn and develop are available to employees. Empowerment cannot be one sided; it should be a partnership between the RN and UAP to commit to the institution and its goals. Both the RN and UAP are equally important to the institution and each recognized for their participation in quality patient care (Kanter).

## Organizational Behavior

One component affecting all communication, regardless of leadership style, is organizational behavior, which cannot be ignored in any discussion of delegation in organizations. Researchers divide organizational behavior into two parts: (a) "micro" organizational behavior, which refers to individual or group dynamics in an organization, and (b) "macro" organizational theory,

which refers to the study of whole organizations, how they adapt, and the strategies and structures that guide them (Robbins, 2004). The aim is to impact the outcomes of organizational performance, including the delegation of tasks and leadership style, as well as individual satisfaction, personal growth, and development (Frese, 2000). The study of these elements combine to form the basis by which an organization seeks to improve the way it operates.

In existing organizational research, the notion of organizational culture is important in the study of employee behavior, despite disagreements over some elements of definition and measurement. Researchers agree that culture refers to the shared, socially maintained patterns of beliefs and values that help individuals interpret their organizational experience (Schein, 1997). Organization values are, therefore, of particular importance in determining how well an individual fits the organizational context (Bilsky & Jehn, 2002), and consequently, how well RNs are able to supervise UAP's and delegate tasks. The congruence between individual and organizational values has implications regarding the strength of the organizational culture (Caldwell & O'Reilly, 1990). The relationship between leadership and culture is complex, but it is generally accepted that the leader's behavior does influence value adoption by employees, which is directly related to the effect of delegation. It is up to leaders to model the behaviors that represent organizational values (Argyris & Schon, 1978). This has placed a heavy burden on leaders who attempt to demonstrate recommended leadership styles. Organizational

leadership style is most often driven from the top, but because communication is key in the transmission of these styles, it is particularly difficult to develop a common culture in organizations where people tend to work in autonomous or semi-autonomous units (Frese, 2000); therefore, the introduction of a leadership style presents a major challenge management. The question of which style of these two very different leadership styles is more appropriate to use lies in the situation and context of the organizational environment.

*Communication in Organizations.*

The management process must be able to accommodate the leadership requirements of all staff needs. Effective communication through ongoing interaction is important to this process Communication is an essential part of delegation. Communication between the RN and UAP must be continuous and mutual to ensure that the UAP understands the tasks and rationale for required patient care. This communication exchange between the RN and UAP is necessary to share ideas and information freely, develop trust and respect, and eventually establish a good working relationship facilitating team work (Potter & Grant, 2004; VanCura & Gunchick, 1997). What this suggests is that effective delegation by the RN is a direct result of appropriate communication skills.

Keeping in mind that two-way communication is an essential part of the delegation process, the RN must provide the UAP with directions, ensure that proper prioritization of patient care occurs, and establish timeframes and rules

for reporting back to the RN. One guideline for the RN to use during communication with the UAP may be the five rights of delegation (NCSBN, 1997b). Recalling the five rights of delegation (right task, circumstance, person, communication style, and supervision needs) would assist the RN in making proper delegation decisions to ensure outcomes such as higher efficiency, increased motivation, and skills development.

*Differing Cultural and Professional Backgrounds*

Bryant (2003) pointed out that organizational management necessitates the integration of leaders who differ greatly in their influence and who come from different cultural and professional backgrounds. The interplay between leadership and culture is constant with conflicts continually arising due to emotional and personal tensions. It is, therefore, essential for leaders to react appropriately to problems, reach effective resolutions to crises, and reward and punish followers appropriately. These are all relevant to an organization's culture.

## Comparing Transformational and Transactional Leadership Styles

According to Bass (1985), components of transformational and transactional styles of leadership have important influences on leader performance effectiveness, successful organizational outcomes, and the satisfaction of their followers. Bass believed that leaders generally demonstrate both leadership styles, with one dominating. The Multi-factor Leadership Questionnaire (MLQ; Bass, 1985) is designed to measure a broad range of leadership styles, and was extensively tested by Bass and Avolio

(1993). The model includes important leadership theory constructs spanning more than 40 years, generalized across a wide range of cultures, organizations, and organizational management levels.

Although several versions of the MLQ exist, its subsets relate to organizational outcomes, leader performance, satisfaction of followers, appraisal of performance, and success and effectiveness of group stimulation (Hendle, Fish, & Galon, 2005). The MLQ has been revised many times during the last several decades in response to criticism surrounding its component factors and psychometric properties, such as the instability of MLQ factors and multicollinearity among transformational leadership scales (Antonakis et al., 2003). The developers undertook additional psychometric testing, using various statistical methods to add or delete items. This led to the development of the current MLQ version, MLQ5X (Antonakis et al., 2003; Avolio & Bass, 2004). The current MLQ-5X captures elements of both transactional and transformational leadership styles, a valuable tool for nursing leadership research.

Transformational leadership results in long-term effectiveness, an advantage because the style addresses the higher order needs of individuals (Medley & Larochelle, 1995). The transformational leader does not use these behaviors. The transformational leader motivates through the use of charisma, intellectual stimulation, and individualized consideration. Transformational leaders are charismatic, and followers want to identify with them, trust them, and develop intense feelings about them. Transformational

leaders differ from leaders who are merely charismatic. This is because the transformational leader is able to accomplish change by motivating employees to exceed task expectations (Medley & Larochelle). Therefore, organizations characterized by leaders who use transformational leadership are more successful than those organizations that do not use this style

By contrast, the transactional leader uses contingent reward, management-by-exception (Bass, 1985), maintenance of the status quo, negative feedback, and the flexible use of reward and punishment. In transactional leadership, an exchange of rewards and punishments encourages effort. Although transactional leadership can lead to short-term solutions, it often does not result in long-term effectiveness. The transactional leader does not intervene as long as standards are being maintained. He or she uses motivational techniques that increase confidence and raises the values of work related outcomes for his or her followers (Medley & Larochelle, 1995).

Today, limited evidence exists indicating which management leadership behaviors contribute the most to the retention of staff nurses. It is also not clear which leadership behaviors promote staff turnover (Kleinman, 2004b). It is clear, however, that less favorable perceptions of manager's leadership style exists in those staff nurses who are limited in their interactions with their staff managers. Thus, it is vitally important for unit managers to maintain a high degree of visibility and contact with their nursing subordinates (Kleinman).

Transformational leaders are more satisfying and effective leaders than transactional leaders (Bass 1997, 1999; Bycio, Hackett, & Allen, 1995; Dunham-Taylor, 2000). Moderators such as goal clarity, organizational culture, availability of resources in a unit, and conflicts have an effect on the ability of transactional and transformational leadership to predict unit performance and individual/group performance (Hendel et al., 2005). Empowerment is a leadership style that closely resembles transformational leadership in that it possesses these same qualities.

## Factors affecting Nurse Leadership

In hospitals where head nurses function as immediate supervisors, the job satisfaction of staff nurses positively or negatively reflects upon nurse managers by the type and quality of leadership used by the head nurses (Medley & Larochelle, 1995). In fact, an increasing amount of nursing research has provided evidence that there is a significant relationship between staff nurse satisfaction, hence less nurse attrition and head nurse leadership style. Medley and Larochelle studied 278 staff nurses randomly selected from a sample of nurses at 100- to 300-bed acute-care Florida hospitals. Findings indicated that staff nurses perceived their head nurses as exhibiting both transformational and transactional leadership styles. Staff nurse job satisfaction was positively correlated with the transformational leadership style of head nurses ($r = .0469$; $p < .001$).

By contrast, there was no significant correlation between retention and transactional leadership. Staff nurses perceived transactional leadership as

negative and unfavorable. The results indicate that head nurses who use transformational leadership skills had staff nurses with higher job satisfaction. This implies that the use of these transformation and transactional leadership styles can play a role in staff retention (Medley & Larochelle).

In the study by Medley and Larochelle (1995), the provision of rewards was associated with transformational leadership styles, but not with transactional leadership styles. This finding was important because outstanding performance does not result in special recognition or tangible financial rewards in the field of nursing, often leading to job dissatisfaction for nurses (Medley & Larochelle). Based on the findings in their study, Medley and Larochelle concluded that head nurses who scored highly on transformational leadership measures were more likely to be associated with staff nurses who were more satisfied with their jobs and had longer associations with the staff nurses than was the case for transactional leaders.

Important economic implications for hospitals could arise if it is true that transformational leaders prevent turnovers and increase retention (McGuire & Kennely, 2006; Naude & McCabe, 2005). Nurse retention is important because it costs less to retain a well-trained nurse than to have to frequently hire and train new ones. It is estimated that the cost of recruiting new staff can be almost double what is spent in annual staff nurse salaries (Krugman et al, 2006). Participants in the Medley and Larochelle study were not dissatisfied with their job nor were they highly satisfied. For these

participants, satisfaction was rated on such factors as professional status within the organization, autonomy, and compensation.

## Leadership in Successful Organizations

A need exists for nurse leaders who are confident and proactive, rather than negative and reactive. Since organizations with confident infrastructures produce excellent and resilient outcomes, confident staff members should be a goal for the organization (Kerfoot, 2004). Kanter (2004) claimed that true leadership comes not from the leader, but rather how he or she develops confidence in everyone else. To build confident organizations, leaders need to communicate to everyone a belief that meeting high standards is possible while invoking a feeling that a purpose exists that is worth achieving.

Kanter (2004) provided many instances of how, when leaders believe in their followers and create winning teams and organizations, despite daunting odds, by investing in them, a feeling of purpose results. She goes on to suggest three ways in which the leader can successfully build a winning organizations: (a) instill a culture of confidence that contains confident and positive interactions among members of the organization, (b) construct an infrastructure that promotes confidence through a defined growth strategy and pathway, and (c) serve as a flashlight to focus light on inspirational and exciting activities.

Kerfoot (2004) suggested that successful departments and units in nursing contain confident staff members. It is clear to patients when staff members are strong and confident rather than intimidated, fearful, and

uncertain. Organizations that possess an environment of confidence contain a culture that is continually able to renew itself, along with its members, and provide opportunities that allow for regeneration.

Rath and Clifton (2004) used the metaphor of a bucket to describe how people interact: The "invisible bucket" that each person possesses is continually emptied or filled according to what others do and say. Each person has a dipper used to fill the buckets of others or to empty them of positive emotions. When he or she fills someone else's bucket, his or hers is also filled. The opposite is also true. Everyone makes a conscious decision every day to fill or empty the buckets of other people and, consequently, their own buckets and, thus, having some control over the outcomes of the situation.

According to Rath and Clifton (2004), behavior comes out of cultural rules. The empting of buckets of others is the norm in hostile dysfunctional cultures. The reason that these behaviors persist is that no strong message is communicated that these behaviors are not part of the value system of the organization. However, it is possible for leaders to create cultures in which filling each other's buckets is the norm. Leaders thus have a clear choice: They can foster a culture in which filling buckets is the norm or in which emptying buckets is the norm (Rath & Clifton). Therefore, an institution occupied by personnel with "full buckets" would have more positive energy than one employing people with "empty buckets" – and the outcome would be more productive and cost-effective for the institution

Building staff confidence is an important process in long-range planning and attention to the basic cultural infrastructure of an organization. Producing confidence is a necessary focus. It does not happen merely as a result of hype and pep talk (Kerfoot, 2004). An effective leader builds an organization where high standards are important to all and where defining the infrastructure in such a way that attainment of these standards is possible exits. In order to build a confident staff, strong, experiential, and educational activities provided to the staff as part of a defined plan enable the staff to progress (Kerfoot). Confidence is the result of an infrastructure that is well articulated and provides a roadmap to excellence, as well as continuing confidence and advancing skills for the staff. Those critical care units that have received the Beacon Award given by the American Association of Critical Care Nurses to individual care units are excellent examples of high achieving and confident organizations (Kerfoot). Although this example serves to validate the importance of organizational confidence for advancing skills, one might consider the importance of confidence in the development of nursing leadership from Kerfoot's theory .

Although a strong infrastructure is crucial, it is not enough. A frequent source of complaint in organizations is a perceived lack of staff recognition for notable achievements (Kerfoot, 2004). The concept of "Shine a Light on what is Right" is used by Rath and Clifton (2004) as a method by which to "fill buckets". Just as a flashlight focuses attention on and highlights the object in its beam, leaders intensely focus on those exemplars that acknowledge staff

achievements and build staff confidence. At the beginning of every meeting, "Fabulous Bragging" focuses the flashlight on notable achievements in order to recognize excellence while other tools such as recognition events and publications highlight achievements of caring and confident individuals (Kerfoot).

Incorporating fun activities also focuses on team confidence, by encouraging people to get to know each other and become more confident with and around each other, through these types of interactions. Learning is a major component in such an organization, rather than assigning mistake and blame, so that people learn from their mistakes and become more confident in their endeavors, instead of feeling disgraced because of them. This helps employees feel more confident. Therefore the internal structure of confident organizations promotes self-confidence and growth in each of its staff members who support each other and tell positive stories (Kerfoot, 2004).

There is a downside to too much or too little confidence. In Kanter's (2004) opinion, overconfident people tend to go too far, assuming that they are invulnerable. Under-confidence results in too little investment in people, lack of innovation, poor morale and disenfranchisement of staff. Kerfoot (2004) concluded that it is essential to build an infrastructure that inspires confidence in the organization and in each other: The "flashlight" needs to shine on inspirational activities and people (Rath & Clifton, 2004).

Confidence is a key part of delegation effective delegation requires a balance between the RN's confidence in their ability to delegate and

effectively communicating that confidence by their actions in delegation. RNs often report either lack of ability or confidence to delegate effectively (Hutson, 1996; Parsons, 1998). A study of 87 RNs who had been out of school for an average of 13 years and worked in a tertiary care institution showed that over half the RNs stated they never learned delegation skills in school. For those who had, the RNs in this study felt their delegation skills were not adequate to meet patient care demands in a restructured health care system (Parsons). In a focus group session, the RNs expressed uncertainty related to questions about who to delegate to, what to delegate, and under what circumstances they should delegate (Thomas & Hume, 1998). Both Conger (1994) and Parsons reported that clinically-based educational programs focusing on the use of a delegation decision grid resulted in increased effectiveness and confidence in delegation.

Strong employee relations are positively correlated with trust and negatively correlated with conflicts (Bass & Avolio, 1994; Ekvall, 1996; Hendel et al., 2005). Trust, or simply believing in the people delegated to, is an essential part of successful delegation. The RN must trust the UAP with the transfer of authority for effective delegation to be successful (Quallich, 2005). Trust relates to UAP competence, as well. The RN must be familiar with the skills of the UAP on the unit. Without this knowledge, the possibility of delegating tasks may be limited, or tasks may be assigned inappropriately. In summary, the most effective form of leadership is generally transformational or empowering (Evans, 1994).

Emergence of UAP Expanded Role, Training and Nursing Concerns

To address the problems of continuing health care industry change, together with a decrease in nursing personnel and increasingly tighter budgets, "the use of the registered nurse–unlicensed assistive personnel(UAP) model is an undeniable reality that fills the void created by the current shortage of nurses and decreases the costs of providing patient care" (Kleinman & Saccomano, 2006, p. 162). The American Nurses Association (2004) described an unlicensed assistive healthcare worker as an individual "who is trained to function in an assistive role to the licensed nurse in the provision of patient/client activities as delegated by the nurse. These activities can generally be categorized as either direct or indirect care" (p. 4-5). State boards of nursing have recognized the UAP as a non-professional or paraprofessional whose role is to assist the registered nurse in the provision of health care (ANA, 1992).

The New York State Nurses Association (NYSNA) has described the role, scope of practice, and responsibilities of UAPs in terms such as health related, non-nursing functions, clerical, dietary, and transportation (NYSNA, 2004). Health related functions include taking vital signs, measuring intake and output, mobility measures such as transfers from bed to chair or wheelchair, providing range of motion exercises, bathing patients, collecting specimens, collecting data on patients' conditions, including pain, and reporting changes to the registered nurse. Housekeeping functions consist of environmental cleaning such as stripping and cleaning beds, general and

special equipment cleaning. Ordering supplies, processing requests, charting vital signs are clerical tasks. Transportation functions include escorting non-acute patients, delivering supplies, specimens, and blood, and delivering linen. Dietary functions include documenting food and oral intake and delivering nourishments (NYSNA, p. 3-4). The role of the UAP, therefore, is to assist the nurse in many non-nursing specific ways, providing direct patient care consistent with national standards of practice and state nursing practice acts.

In 2002, the Bureau of Labor Statistics reported that there were 2.1 million health care aides; these included 1.4 million nursing assistants, 615,000 home health aides, and 65,000 psychiatric aides (Snyder, 2003). The Bureau predicted that this workforce group would continue to grow with the increased demand, but nurse leaders have been cautious about the use of UAPs. Their concerns relate to increased risk regarding adequacy of supervision and appropriateness of training for the specific tasks at hand (Kophiske, 2002).

Historically, UAPs learn on the job with no formal preparation for the role or its complex tasks, and these individuals provide little direct patient care and their responsibilities are limited (Hall-Johnson, 1996). Today, these individuals are increasingly more involved in direct patient care and their responsibilities have greatly expanded. It is for this reason that the education of UAPs must provide high quality patient care is imperative.

Identifying the knowledge base required in the educational preparation of UAPs means identifying minimum competencies and willingness to provide time for significant education and training for the role. The NYSNA (2004) created a description of UAP qualifications that included the UAP having a secondary school education or its equivalent, good moral character with no evidence of being convicted of a crime (raising a question as to the individual's moral character), and completion of an approved training program.

The need for training and education for the UAP has been present for decades. Zimmerman (1995) and Barter, McLaughlin, and Thomas (1994) reported that 70% of hospitals did not require UAPs to have a high school diploma or nursing assistant certification, 59% offered less than 20 hours of classroom orientation, and 41% provided less than 40 hours of on-the-job training. Nursing units with a lower ratio of RNs to UAPs negatively impacted the nurse's ability to provide adequate supervision to UAPs. Interestingly, in this environment, an increase in infection rates and medication errors was noted (Kido, 2001). In fact, a direct correlation existed in two research studies between a reduction in nursing staff and increased blood borne central venous catheter infections (Kido; Zimmerman). These findings have lead to the belief among many RNs that it is not safe to delegate certain tasks to UAPs.

As nurses maintain responsibility and liability for the actions of unlicensed personnel, it is imperative they understand the scope of practice of

unlicensed workers. There needs to be a consistent approach to UAP training and education RNs must be aware of the specific skill levels the UAP possess, and what skills the RN can delegate. Ultimately, the RN must supervise the UAP to ensure the UAP is providing safe patient care and meeting patient goals or outcomes.

### *Impact of Health Care Advances on UAPs*

Kleinman and Saccomano (2006) point out that hospital stays are decreasing, while patient acuity is increasing. People live longer, use more health care resources, and require more acute care services for chronic health conditions than in previous decades. Conditions that would have resulted in death now result in long-term treatment because of increasingly sophisticated and advancing technology and new medications.

Many compounding factors affect health care today. As the aged population increases, more skilled healthcare is required to take care of the needs of an aging population. Unfortunately, by 2010, the supply of RNs will be less than demand because of retiring and aging nurses and an increasing demand for nursing care (American Association of Colleges of Nursing, 2004). The American Association of Colleges of Nursing (AACN) reports that nursing school enrollments have increased 4.98% in this last year, 2006 - 2007. Despite the growth in enrollments, nursing schools have turned away as many as 30,000 applicants primarily due to the shortage of nursing faculty (AACN, 2007). In addition, hospitals are experiencing decreasing

reimbursement and have to initiate cost-saving measures to remain viable. One way hospitals are addressing cost-saving is through restructuring of the job responsibilities of nurses, as nurses salaries typically account for more than half of a hospital's total budget (Kopishke, 2002). This restructuring of the traditional nursing-staffing model is a priority in the changing health care industry (Kleinman & Saccomano, 2006).

*Financial Constraints*

Addressing the nursing shortage and dealing with the increasing financial difficulties of hospitals has necessitated a dramatic change in staffing patterns. This change has lead to alternative care delivery models such as the use of UAPs, who have become the new nurse substitute. The UAP purpose is to help fill the current void between the nursing shortage and decreasing patient care costs, as well as to providing clinical support to RNs (Huston, 1996). The American Nurses Association (1992) described the role of the UAP as a health care worker trained to serve as assistants to RNs in delivering patient care delegated by the nurse. Anthony (2001) suggested that changing models in nursing care have produced an increasingly diversified composition in the work force: nurses (i.e., RNs, LPNs, and licensed vocational nurses) are responsible for delegating and supervising the UAP in direct nursing care.

*Rating Performance*

Davis (1995) pointed out that nurse executives need to learn how to restructure work assigned to nurses more effectively. This ability has become

an important leadership skill. Since proficiency in delegation is central to the success of newly designed models for nursing care that are focused on the patient, it has become necessary for nurses to alter their behavior to delegate their responsibilities so that they can perform their responsibilities more effectively (Badovinac, Wilson, & Woodhouse, 1999).

In a study conducted by Badovinac et al. (1999) a convenience sample of 15 RNs, nine UAPS, and 40 patients covering 2 months of unit experience in 1997, the researchers discovered that UAPs seemed to be performing their duties adequately and that the patients rated the care they received as being very satisfactory. In rating the UAPs' performance in taking over certain RN tasks, both the UAPs and RNs were somewhat satisfied. When rating the time available for professional activities after delegation of work to UAPs, a Pearson correlation ($r=.61$, $p< .05$) indicates a statistically significant relationship between RN satisfaction with tasks delegated to UAPs and the performance of those tasks. The authors concluded that further research is indicated on a larger scale due to the relatively small sample size.

Badovinac et al.'s (1999) results supported earlier research by Bethel and Ridder (1994) and Cone, McGovern, Barnard, and Riegel (1995). These studies evaluated RN roles in changing models of care, RN use of delegation to UAPs, and overall job satisfaction among nurses and support staff. Findings suggest that the RNs and the clinical support staff (UAPs) were somewhat satisfied in their roles and duties and there was no change in patient satisfaction. However, positive patient outcomes do not always follow

from patient satisfaction. Concerns have been expressed that using lower-paid UAPs is gaining in popularity and may not be in the best interests of consumers, particularly when the education and training of UAP is inferior or when the staff mix is inappropriate (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Kido, 2001; Minick & Harvey, 2003). Although some recent research has shown that a significant correlation exists between ratio of RNs to non-RN staff, and adverse outcomes for patients and adequate patient care. Appropriate UAP training must be provided to the UAP, and an appropriate mix of UAP to RN must exist, allowing for timely RN supervision of the UAP (Kleinman & Saccomano, 2006).

*Comfort with Delegation*

Although RNs are responsible for the planning, supervision, and evaluation of UAP work, some are not comfortable with this responsibility. RNs are often younger and less experienced in a healthcare setting than the UAPs to whom they must delegate. Some nurses, embarrassed by their discomfort and inability to act in the role of supervisor or manager and direct the work of the UAP, choose instead to do the task themselves. As most UAPs and RNs report directly to the unit nurse manager, the RNs may not delegate as they are sensitive to the issue of responsibility without authority. Legitimate authority must be provided in order for nurses to manage UAPs effectively and confidently (Kleinman & Saccomano, 2006; Kourdi, 1999).

The National Council of State Boards of Nursing (NCSBON, 1997a) identified "Five Rights of Delegation". These include: first the right task; the task must be "releasable" for a particular patient. Second, the right circumstances; factors such as available resources and the appropriateness of the patient setting must be considered. Third, the right person; the right task must be delegated by the right person to the right person to be performed on the right person. Fourth, the right direction/communication; the task must be described clearly and concisely. Its objectives, expectations, and limitations must be included. Last, right supervision: appropriate monitoring must be provided and both evaluation and intervention must be provided as required. Feedback must also be provided.

These five rights provide further responsibilities and principles for nursing service administrators and the staff nurse when they develop an implementation program for delegation (NCSBON, 1997a).

As described by Williams and Cooksey (2004), effective delegation requires several steps. These include assessing patient needs, as well as the UAPs skill level and knowledge; identifying those tasks that can be assigned safely; prioritizing tasks and constructing a completion timeframe; communicating with the UAP and encouraging the UAP to ask questions; evaluating progress and providing appropriate feedback; and revising the plan as the needs of the patient change. As shown in Table 2, here are the steps the RN must utilize to make delegation decisions.

Table 2

*Delegation Decision Making Process (adapted from NCSBON, 1997b)*

| Task | RN Responsibility |
|---|---|
| I. Assessing the situation | A. Identifying the patient needs, while consulting the plan of care.<br>B. Considering the setting and circumstances.<br>C. Assuring that adequate resources are available such as supervision. |
| II. Planning for the delegation of specific tasks | A. Specifying the nature of the task along with the skills and knowledge that are needed to perform it.<br>B. Requiring the delegate to document or demonstrate his or her current competence for each task.<br>C. Determining how patient, significant others, and other patients will be impacted. |
| III. Assuring appropriate accountability | A. As a delegator, accepting accountability for task performance.<br>B. Verifying acceptance of delegation and accountability of the delegate for correctly performing the tasks. |
| IV. Supervising task performance | A. Provide clear expectations and directions for task performance.<br>B. Monitor task performance to assure policy compliance.<br>C. Provide the necessary intervention.<br>D. Ensure appropriate task documentation. |
| V. Evaluation of the complete delegation process | A. Patient evaluation.<br>B. Task performance evaluation.<br>C. Obtaining and providing feedback. |

Williams and Cooksey (2004) pointed out that supportive and repetitive task are the most appropriate ones to delegate to UAPs. By delegating these tasks, RNs are able to focus on nursing responsibilities that are complex in nature. Routine tasks that can be delegated to a UAP include taking vital

signs for stable patients, changing linens, giving baths and other comfort measures. UAPs can also feed patients who are able to eat safely with the ability to swallow with an intact gag reflex and provide ambulatory assistance to steady and stable patients.

RN work that should not be delegated is work involving ongoing or initial assessments. These require nursing diagnoses, professional judgment, and interventions that require the application of professional skill and knowledge. Examples of these tasks include the administration of medication, admission assessments, and the development of care plans. The workload of the team should also be considered and not be uneven through delegation of duties and tasks (Williams & Cooksey, 2004).

## Educating Nurses for Leadership

In recent years, the realm of nursing knowledge has grown. The scope of nursing practice and nursing knowledge that has enriched the profession has led to changes in nursing roles and nursing practice. Nurses now function in a wide variety of roles, including leadership roles, which will continue to proliferate in the next century. As today's health care environment continues to change, sometimes in an unpredictable fashion, it is clear that the role of the registered nurse will continue to change. In this rapidly changing health care environment, RNs must develop leadership skills to prepare themselves for necessary skills needed in planning patient care. To achieve these skills,

the RN must take advantage of educational opportunities in nursing leadership and decision making.

The integration of these skills can develop an RN who has both the clinical and leadership skills essential for practice in today's healthcare environment. RNs need a range of skills to function effectively in today's health care environment. Nurses now must work in collaboration with many different levels of personnel such as other staff, patients, physicians, and third party stakeholders, and effectively integrate the needs of these groups in their patient plan. Nurses must be able to make decisions in a rapidly changing healthcare environment and understand the mission and future of the organization to motivate and empower others through a system of shared leadership which integrate into the day to day operations to contribute to team objectives. (Huber, 2006). Therefore, educational programs that build on basic RN professional education can help RNs improve and integrate leadership knowledge and skill into their practice base so that they can confidently delegate to UAPs in a safe manner.

Additionally, as RN roles and functions change, the educational programs that prepare them must change as well. Education in the health professions is now competency-based. Heller, Drenkard, Esposito-Herr, Romano, Tom, and Valentine (2004) identified essential individual core competencies needed in nursing leadership. These competencies included interpersonal skills, communication skills, organizational navigation, crisis management, time management, and adoption of an appropriate leadership

style. Kimball and O'Neill (2002) reported that competency-based education rethinks the way nurses are educated and integrated into the health care delivery system. It is important for educators to provide varied instructional strategies. Employers should take advantage of orientation and ongoing educational in-service activities to prepare nurses for the delegation and supervision activities required in the practice setting. Regardless of whether education takes place academically or clinically, program content should include principles of change, conflict, leadership, management, and communication as well as instruction on professional and regulatory guidelines (Hall-Johnson, 1996; Krainovich-Miller et al., 1997).

## The RN/UAP Model

To meet the challenges of continuing change in the health care industry and to maintain organizational viability in increasingly competitive markets, the use of the RN/UAP model is now a reality. However, this care delivery model must be implemented only after providing for and assessing the effectiveness of education and training programs in enhancing supervision and the development of confidence with delegation skills. Eight-five percent of new RNs reported they delegate an average of 2.6 times per day and one-third reported they evaluate the care performed by others on average of 2.5 times per day (Hertz, Yocom, & Gawel, 2000). The reported frequency of delegation and supervision highlights the need for nurses to develop these skills.

Specific educational strategies may include the use of case studies and role-playing to practice delegation skills in the classroom. Preceptors who are identified as experts in delegation can also be used to guide new staff in learning to delegate confidently and supervise UAPs safely and effectively. It is imperative that educators in basic nursing programs include appropriate content on supervision and delegation as these skills are requisite in nursing practice settings, particularly in acute care. It is equally imperative that nursing service administrators provide nurses with the continuing education necessary to develop delegation and supervision strategies if they have not had this content in their basic academic programs. Delegation knowledge is crucial to the successful functioning of the RN/UAP team. (Marquis & Huston,2000; Rocchiccioli & Tillbury,1998).

The discipline of Nursing combines the practice and caring aspects of nursing with the theories and methods of leadership. Nurses both provide care and manage the care environment, a unique service because of the interaction of the two roles. Nurses are individuals who have knowledge of the discipline and the clinical base of nursing as well as knowledge of health care leadership and management skills.

*Training for Delegation*

Nurses are uncertain about whom they should delegate to, what they should delegate, and what the circumstances are under which they should delegate (Thomas & Hume, 1998). Effective delegation depends on what is

delegated, the skills of doing the delegating, and the UAPs knowledge and skills. Nurses must be taught how to delegate and supervise, especially since they increasingly work with UAPs of varying abilities (Kleinman & Saccomano, 2006). This type of education provides nurses with the skills that they need in the face of changing patient care models. Even with this education, nurses must fill in the gaps that exist between formal education and job requirements early in their careers by taking advantage of continuing education opportunities (Kleinman & Saccomano).

Educating UAPS. UAPs have trained on the job in the absence of formal role preparation along with complex tasks in the past, but it is now necessary to prepare UAPs more formally. Thus, identifying minimum competencies is necessary. UAP qualifications are determined by the NYSNA (2004) as a secondary school education or equivalent, good moral character and the absence of any legal convictions that would raise doubts about the UAPs moral character, and completion of a training program which is state approved (Kleinman & Saccomano, 2006).

A competency-based training program exists (Barczak & Spunt, 1999) in which specific technical skills are developed, performance deficiencies identified, and training prepares the student for the complex duties of a UAP. Several competencies are identified: age-related patient care, basic clinical skills (e.g., vital signs, venipuncture wound care, specimen collection, and population-based care such as seizure precautions, IV line priming, and central lines), and equipment-based competencies (e.g., use of patient lifts,

IV/feeding pumps, monitors, and suction). The course included return demonstration on equipment and clinical skills. Participants need to perform consistently at specified established levels and RN instructors evaluate them. Graduates thus possess adequate skills for functioning on nursing units as health team members, if they pass the course and testing.

Educating RNs. Educating RNs to develop confidence in delegation can be challenging. The challenge is even greater for nurses with many years of experience in primary nursing care models and where they were educated. (Henderson et al (2006); Kleinman & Saccomano (2006); Kroll (1997); Kroll & Hoogendijk (1996). In order to implement changes in patient care delivery, teaching delegation principles in continuing education and staff development courses is essential for staff RNs. Nurses usually express a desire to learn delegation guidelines so they know what they are allowed to delegate to UAPs and how to do it confidently.

When courses and in-services contain material on delegation, it is essential to analyze the state's nursing practice act to identify what can and cannot be delegated (Hall-Johnson, 1996). Since patient care models quickly evolve, data on how to evaluate outcomes such as quality, satisfaction, and cost are important to collect. Since RNs are responsible and liable for the acts of their UAPs, they must understand the UAPs scope of practice and each individual UAPs specific skill levels (Kleinman & Saccomano, 2006). Both academic and clinical program content needs to include principles of conflict, change, management, leadership, and communication, and must

include instruction based on and about regulatory and professional guidelines (Hall- Johnson, 1996; Krainovich- Miller et al., 1997).

A multifactorial approach (social, behavioral, and management sciences) to delegation should be addressed in a classroom and clinical practice setting. In this context RNs can be trained in an integrative manner which includes the transfer of theory to clinical nursing practice. Educators identified as experts in delegation can help RNs practice skills of delegation in the classroom setting (Kleinman & Saccomano, 2006). Therefore, RNs learn delegation and supervision skills through educational in-service activities provided on an ongoing basis. The need to have assistants who are prepared within the discipline has been approached successfully by other disciplines. These disciplines (PT, OT, SW) have a hierarchy of staff who have various levels of training and support positive outcomes for the discipline. Using this hierarchy model for delegation may assist the need RN develops along the journey as a delegator.

## Delegation in Other Disciplines

A paraprofessional, like a UAP is a person trained to assist a licensed professional such as a teacher, registered nurse or other professionals, but who are not licensed to practice in the profession (Department of Health and Human Services, 2004). Paraprofessionals have been and continue to be used in professional disciplines for many years (Hultgren, 2004). The use of adequately trained paraprofessionals is viewed as a way to attain successful

service outcomes within a cost effective system of quality service delivery. The use of paraprofessionals becomes more common in areas where there are shortages of qualified professional personnel, such as in teaching and the health professions (Department of Health and Human Services, 2004). These paraprofessionals must be supervised by the professional staffs who take on the additional responsibility of supervision, which they may not be prepared for.

In 2005, Nancarrow and Mackey evaluated the use of occupational therapy assistant's in Australia. Occupational therapy assistants filled service gaps in service delivery due to lack of qualified occupational therapists. An Occupational Therapy Assistant (OTA) as defined by the Canadian Association of Occupational Therapists (2003), is an individual who is directly involved in the provision of occupational therapy services, under the supervision of a Registered Occupational Therapist (OTR). The OTAs have no formal education and obtain most of their training for their role as a delegator, creating problems with delegation by the OTR. (Loomis, Hagler, Forward, Swimmer & McMillan, 1997). Similar issues of lack of confidence with delegation and supervision occur with the occupational therapy assistant mirroring the RNs concern with delegation. Occupational therapists report that it would be beneficial to delegate tasks to the OTA. They became OTRs to perform clinical care with patients, not to be a manager. Additionally OTRs report they do not have the skills or training to supervise the OTA, indicating the need for further education (Nancarrow, 2005) a similar issued voiced by

RNs and the need for advanced training in supervision and delegation in order to perform this skill effectively.

With the passing of the Individuals with Disabilities Education Act in the mid 1970's, teacher education utilizes the involvement of paraprofessionals (Shirley & Matlock 2004). Similarly to the OTA, and UAP, in education the paraprofessional assists the teacher in the classroom with instruction where the teacher has the ultimate responsibility for the student plan and outcome (Hultgren, 2005). Educators use paraprofessionals in a variety of educational settings including, working with children with disabilities, literacy education and working with the blind or visually impaired (Etscheidt, 2005; Wallace, 2001). Similar issues of supervision, delegation and the need for proper education are prevalent with teacher use of paraprofessionals (Wallace, 2001). Teachers report difficulties recognizing tasks to delegate to paraprofessionals. Teachers are unsure if paraprofessionals are prepared to carryout their responsibilities. In addition teachers are unfamiliar with the role of paraprofessionals in the classroom and they have little or no time to collaborate to develop appropriate plans. With the number of paraprofessionals in teacher education booming (Hultgren, 2004), it is imperative that teachers are trained appropriately in the collaborative efforts of supervision and delegation needed to provide the necessary education outcome. "Teachers must have adequate preparation, training support and time to carry out the critical supervisory functions" needed to work with paraprofessionals (Wallace, 2001 p 530).

## Summary

In this chapter, a review of the literature presents the many leadership models proposed over the years, including various contingency models. From the literature review it can be suggested that Transformational leadership style is the best leadership style for nurse managers to use because these types of leaders appeal to higher ideals and moral values such as equality and justice, although the most effective leaders combine elements of both transactional and transformational leadership (McGuire & Kennerly, 2006).

The literature identifies that it is crucial for subordinates to allow nurse managers to perform their duties without regard to biases and preconceived beliefs. Overall, nurse managers must realize that staff nurses need to delegate certain less critical duties to UAPs because of shrinking nursing staffs and budgets for hospitals. To do this effectively, nurses must be taught delegation and supervision skills in continuing education courses. The end result will be confident and strong organizations offering the best in patient care.

Leadership is the ability to lead other individuals toward reaching group or institutional goals (Northhouse, 2007). Multiple theories of leadership have are presented in this review of the literature. These theories include early leadership theory, transactional leadership, transformational leadership, as well as a variety of leadership models such as contingency theory, path goal theories, and the normative model of leadership. RNs with transformational

traits share values and vision with the group and should be energizing to their followers (UAP), encouraging them to take action that share higher organizational goals (Robbins & Davidhizar, 2007).

Followers of the Path-Goal theory of leadership are responsible to know the organization goals and make the "paths" of these goals attainable by reducing barriers. An effective leader must be able to take into account the subordinate (UAP) and his or her traits, skills, and behaviors, all combined in a way that is appropriate for a particular situation, again leading to institutional positive outcomes (Northouse, 2007). Leadership skill plays a key role in understanding group behavior. The success or failure of any organization depends on the quality of their leaders. Registered nurses are often first line supervisors of their subordinates (UAP), often supervise without any formal training. Nurse more often have served as resources for UAP and now must serve in a direct leadership role requiring more accountability and responsibility, areas where registered nurses are not confident.

RNs must utilize leadership theories as a frame of reference to effectively delegate. These leadership theories must to guide them in how to share information with UAPs. When the RN utilizes proper leadership theory, it enables the RN to develop trust and be confident in giving authority to the UAP. Therefore this enables the UAP to perform competently in their role. The combination of all leadership skills becomes the trademark of the successful RN leadership style and develops confidence with the task of

delegation and enables the RN to effectively delegate in a patient safe manner.

# Chapter III

## METHODOLOGY

Using a cross sectional survey design, a single convenience sample of RNs employed in one acute care hospital completed questionnaires that measured leadership style (Path-Goal Leadership Questionnaire, PGLQ), confidence in delegating patient care tasks (Confidence and Intent to Delegate Scale, CIDS) and provided demographic information.

### Sample and Setting

To determine the number of study participants required for the analysis of a three way independent groups factorial, the GPOWER (2007) software package specified that for a medium-effect size of 0.25, an alpha level of .05, and a power level of .80, the necessary sample size needed to include 158 participants (GPOWER, 2006). A convenience sample of volunteer RNs were solicited from the nursing staff employed at the Community Medical Center in Toms River, the largest non-teaching hospital in New Jersey. This institution, with tertiary levels of patient care service, has approximately a 587-bed capacity, has received Magnet status for excellence, and is a recipient of the distinguished hospital award for clinical excellence. The hospital employs a nursing staff of 600 RNs, of which 92% meet the criteria for inclusion in the

proposed study. A research assistant, provided by the institution, to assist the primary investigator identified potential subjects (i.e., RNs).

## Instrumentation

The registered nurse participants responded to two validated and reliable instruments and a demographic information sheet as described in the following sections.

### *The Path-Goal Leadership Questionnaire*

The non-manipulated independent variable was leadership style, as measured by the Path-Goal Leadership Questionnaire (PGLQ) (Indvik, 1985). As cited in Fulk & Wendler (1982), Indvik developed the PGLQ based on the previous research by House and Dressler (1974), and House (1976). The PGLQ captures a broad range of leadership styles including directive, supportive, participative and achievement styles.

The PGLQ provides a quantitative measure of leadership style using 20 questions, each of which is evaluated on a seven - point Likert scale ranging from 1 to 7 and assigned the following labels, 1 = *never*, 2 = *hardly ever*, 3 = *seldom*, 4 = *occasionally*, 5 = *often*, 6 = *usually*, and 7 = *always*. The 20 items represent four leadership styles as follows: 1) directive leadership, where the leader provides guidelines about how to do the task; 2) supportive leadership, where the leader shows concern and support for the well being of the subordinate; 3) participative leadership, where the leader asks for ideas from or participation by subordinates; and 4) achievement leadership, where

the leader sets goals to enhance work performance. Table 3 provides an example of two statements from the PGLQ for each of the four leadership styles.

Table 3

*Statements in the Path Goal Leadership Questionnaire*

| Leadership Style | Sample Questions |
|---|---|
| Directive Style | I let subordinates know what is expected of them.<br>I explain the level of performance that is expected of subordinates. |
| Supportive Style | I say things that hurt subordinates' personal feelings.<br>I behave in a manner that is thoughtful of subordinates' personal needs. |
| Participative Style | I consult with subordinates when facing a problem.<br>I listen receptively to subordinates ideas and suggestions. |
| Achievement-oriented style | I let subordinates know that I expect them to perform at their highest level.<br>I encourage continual improvement in subordinates' performance. |

The PGLQ measures each leadership style by summing the RN's responses to 5 questions. In each of the aforementioned, the PGLQ assigns 5 questions. As the respondent evaluates each question by assigning a number from 1 to 7, each leadership style has a possible range of scores from 5 to 35. For all leadership styles the higher the score, the more predominant the leadership style.

The five questions used for each leadership style are:

Directive: Sum the scores on items 1, 5, 9, 14 and 18*.

Supportive: Sum the scores on items 2, 8, 11*, 15 and 20.

Participative: Sum the scores on items 3, 4, 7*, 12 and 17.

Achievement-oriented: Sum the scores on items 6, 10, 13, 16* and 19.

As shown above, each leadership style has one asterisked item. The asterisk signifies that the item is reversed scored. Each registered nurse's response will receive a total score for each of the four leadership styles and will be assigned to the leadership style group (i.e., directive, participative, achievement–oriented or supportive) in which he or she has the highest score. As each participant in the study can only be a member of one leadership style group, this type of categorization reflects a between-subjects independent variable.

According to Northouse (2007), the leadership scores can be further refined by examining whether the participant earns a score above or below the designated common score shown below. In all leadership styles, scoring 5 points below the designated common score indicates a "low" score whereas scoring 5 points above the common score suggests a "high" score (Table 4).

Table 4

Northouse's (2007) Scoring Interpretation

| Leadership Style | Common Score | Low Score | High Score |
|---|---|---|---|
| Directive | 23 | Below 18 | Above 28 |
| Supportive | 28 | Below 23 | Above 33 |
| Participative | 21 | Below 16 | Above 26 |
| Achievement-oriented | 19 | Below 14 | Above 24 |

Although no specific hypotheses were advanced regarding the effect of strong (high) or weak (low) dimensions of a leadership style on the registered nurses' confidence in delegating patient care tasks, Northouse's criteria provides an avenue for further exploring the impact of leadership style once the research questions and corresponding hypotheses are addressed.

Validity and Reliability of the PGLQ. Based on Indvik's (1985) report, the PGLQ has been found to have good validity and reliability. Indvik states "the fact that these items had reliability, predictable correlations, and were used to support hypotheses from the theory coalesced to suggest evidence of validity" (Indvik, personal communication, 2008). Indvik measured the reliability of the PGLQ based on responses from a volunteer sample of 497 nursing staff and their subordinates. Using Cronbach's Alpha, Indvik reported the internal consistency of the four leadership styles assessed by the PGLQ as: directive .83, supportive .84, participative .80, and achievement oriented

.87. These reliability estimates are considered appropriate for non-experimental investigations (Rosenthal & Rosnow, 1991). Given the similarity of these estimates, it is reasonable to assume that the four leadership styles are equally and effectively measured by the PGLQ for this population.

Whereas Indvik (1985) reported the reliability of the 20 statements comprising the PGLQ by using Cronbach's Alpha, she also addressed the validity of the PGLQ by reporting the findings from a factor analysis (principal components with varimax rotation). Indvik stated that these analyses confirmed that the conceptual grouping of leadership styles was supported by the data. She stated that secondary loadings were not more than 50% of the primary factor loadings, which were reported at a minimum of .40. Based on these values, Indvik (1985) concluded that all scales emerged conceptually intact. Therefore, the PGLQ's good internal consistency and content validity makes it a valid instrument by which to assess registered nurse leadership style in this study. Appendix C contains the version PGLQ that was used in this study.

*Confidence and Intent to Delegate Scale*

The dependent variable was confidence in delegation as measured by the Confidence and Intent to Delegate Scale (CIDS). The CIDS developed by Parsons (1999), is currently the only available tool to measure a nurse's confidence in delegating patient care tasks. The tool encompasses three

aspects of delegation: confidence with delegation decisions, present use of delegation decisions and future intent to use delegation decisions in practice.

As shown in Appendix I, the CIDS includes16 items of which the first seven required nominal responses. Items 8 through 16 ask respondents to evaluate different aspects of their willingness to delegate using a 10-point Likert scale. Labels are assigned to a rating of "1" and "10." The words "never", "not correct" or "not likely" refer to the value of 1 and the phrases "many times a day," "highly correct" or "more likely" refer to the value of 10. The ratings 2 through 9 do not have any assigned labels. For each of the confidence items, participants were instructed to circle only one of the 10 responses.

A total confidence in delegating score was calculated for each person by summing the responses to CIDS items 8, 10, 11, 12 and 13, the items of interest to this PI. As each of these statements was measured on a scale ranging in value from 1 to 10, the possible range of total CIDS scores represents values between 5 and 50. Although the total CIDS score was the primary dependent variable, the researcher also evaluated the nurses' confidence in delegating by analyzing each of the five CIDS items separately in secondary analyses. The rationale for including these secondary analyses stemmed from the exploratory nature of this study and the fact that the CIDS items were revised to allow them to reflect issues in the current literature regarding confidence in delegating patient care tasks.

Parsons (1999) reported the internal reliability of the CIDS based on the responses from a convenience sample of 87 RNs employed in one 282-bed tertiary acute care hospital. These registered nurses participated in an intervention study designed to test the effect of a structured teaching intervention on delegated decision making using a mixed measures design. The registered nurses served as members of either an experimental or a control group whose confidence in delegating was assessed both before and after an educational intervention was applied. Reliability was assessed using Cronbach's Alpha and reported at .94 for confidence with delegation, .95 for the present use of delegation and for the intent to use delegation in practice. These individual estimates for each dimension of CIDS yielded an overall reliability average of .95 (Parsons, 1999).

Although Parsons (1999) reported the reliability of the CIDS, she did not provide validity information regarding this tool. This was viewed as problematic given that the wording of some original items included in the CIDS needed modification to reflect current issues with confidence in delegation. These modifications were suggested by the results of a thorough review of the published literature describing issues with confidence in delegation. The modified version of the Confidence and Intent to Delegate Scale (CIDS) was then evaluated in a pilot study (Appendix G & H) using experts in health care and research to provide a measure of content validity. Content validation of this type allows the researcher to ensure that the survey will adequately capture the appropriate information necessary to address the

posed research questions (Hyrkas, 2003; Rubio, 2003). The CIDS items were reviewed for appropriateness, clarity, and sequencing. Overall, the experts reported that the survey was clear and appropriate and that the questions were presented in the proper sequence. Based on the feedback of the health care and research experts, several additional minor changes were made to the wording of some of the items with the hope of improving the clarity of the survey. The final version of this tool is presented in Appendix I. .

*Demographic Profile*

In addition to the PGLQ and the CIDS, the respondents completed a demographic tool (Appendix I) designed to elicit pertinent information about the RN's educational background, clinical nursing experience and age.

## Procedure

Prior to the implementation of this study, the investigator met the corporate senior vice-present of Patient Care Services and Nursing Education and Research to discuss the purpose and implications of the study and solicited the hospital's participation. Following approval from the institutional review boards at both Seton Hall University and the participating institution, the investigator presented the research proposal to the nurse executives. Upon determining the eligible nursing units, research participants were recruited by a research assistant provided by the Directors of Nursing Education and Research.

Potential study participants received envelopes in their nursing units' mailboxes. A solicitation letter (Appendix E) was attached to the outside of the envelope. Potential participants answered four questions to determine their eligibility to participate in the study. As shown in Appendix E, these eligibility criteria were included in the solicitation letter and required potential study participants to respond to four questions: (1) Are you a full time RN? (2) Have you been employed a minimum of 6 months? (3) Have you been working with UAPs for a minimum of 6 months? (4) During the last 5 years did you have formalized leadership training/educational experience (e.g., charge nurse, head nurse or nurse manager)? The potential participants were instructed that if they answered **NO** to any of the four questions they were **NOT** eligible to participate in this study. The ineligible registered nurses were thanked for their willingness to participate and instructed to return the envelope (unopened) to the drop box on their unit. On the other hand, those participants who answered **YES** to **ALL** four questions, were told that they **WERE** eligible to participate.

The eligible and willing registered nurses completed the consent form (Appendix F), the PGLQ (Appendix C), the CIDS (Appendix I) and the demographic form (Appendix I), as outlined in the cover letter. Participants completed the surveys, individually, in an area with no distractions and not in a group setting. They were instructed not to provide group responses. The nurse participants then placed the envelopes containing the completed forms in a locked collection box at a designated location on each unit.

Within the two week designated data collection period, the PI periodically removed returned envelopes from the collection boxes on each unit. Additionally during this period, the PI placed a reminder notice (Appendix D) in each unit's mailboxes, requesting that eligible participants complete and return the forms. At the close of the two weeks, the PI removed all data collection boxes from the nursing units.

Anonymity and confidentiality of all responses were maintained throughout the duration of this study. Personal information such as names and addresses, social security numbers and date of birth, was not collected. The design of the study presented minimal risk to the participants, as it did not include any experiential treatment of the subjects or exposure to physical or psychological harm. The researcher solicited demographic information and data on participants' perceptions of nonverbal communication using two validated and reliable survey instruments. No formal debriefing with the participants after the study occurred. However, the subject health care facility was given an executive summary of the findings. No individual participants requested the summary.

Upon receipt of the completed surveys, data was entered into a secured database. The PI designated an expert data entry individual who was not familiar with the research topic to score the PGLQ and CIDS. Trained by the PI in scoring the two measures, this procedure maintained the PIs objectivity with the collected data and permitted an unbiased evaluation of the proposed hypotheses.

## Data Analysis

Statistical Package for the Social Sciences (SPSS, version 15.0) was used to analyze the data. Descriptive statistics including means, medians, percentages, standard deviations (SD), kurtosis and skewness were calculated for the CIDS scores. These summary statistics were used to determine whether the assumption of normality required by parametric inferential tests was satisfied.

Munro (2005) states that researchers can use several measures to assess symmetry. Pearson's Skewness Coefficient (Munro) was calculated for the CIDS scores in this study, including both the total score (used in the primary analysis) and the five individual items (focus of the secondary analyses). The Pearson Coefficient defines skewness in SD units. The difference between the mean and median values is divided by the standard deviation. Munro indicates that for a perfectly symmetrical distribution, the mean will equal the median and the skewness coefficient will be zero. She reports that skewness values will fall between -1 and +1 SD units. For the Pearson coefficient, Hildebrand (1986) maintains that skewness values above 0.2 or below -0.2 indicate severe skewness. Severely skewed data cannot be used to evaluate the proposed hypotheses using parametric inferential procedures. If the responses were severely skewed, two options were available. First, the data could be transformed using a square root, log, inverse, etc transformation in an attempt to reduce or eliminate the skewness of the responses. If successful, a parametric inferential test would then be

used evaluate the stipulated hypotheses. Second, if the transformed scores failed to address the violation of normality, or if the researcher chose, the hypotheses of this study could be compared using appropriate non-parametric procedures. In both cases, significant findings from overall tests such as a one-way between subjects ANOVA or its non-parametric counterpart, the Kruskal Wallis H Test, would need additional follow-up tests. Performing these comparisons would inflate the probability of a type I error. Accordingly, the Bonferroni correction would be applied to all analyses, parametric and non-parametric, to avoid the increased probability of a type I error from occurring. As explained by Munro (2005), the Bonferrroni correction protects against a type I error by dividing the desired level of significance by the number of comparisons and this value, rather than alpha, is the standard by which significance is established. For example, with an alpha level of .05 and three comparisons, the significance level would be equal to or less than .0167 for the paired comparison to be significant.

To evaluate Research Question 1, how do RNs with different leadership styles compare in terms of their confidence in delegating patient tasks to UAPs, total confidence scores were calculated for the primary analysis. If the total confidence scores were normally distributed, a one-way between subjects ANOVA compared the confidence in delegating tasks scores for the four leadership style groups. A significant finding from this overall F test required further examination using a post hoc test with the Bonferroni correction. On the other hand, if the total confidence scores failed

to satisfy the assumption of normality, research question 1 was evaluated using the Kruskal-Wallis H Test, the non-parametric counterpart to the between subjects ANOVA. A significant finding from the nonparametric analysis was further examined by a series of Bonferroni corrected Mann Whitney U Tests comparing paired leadership style groups for differences in confidence.

In this study, confidence in delegating patient care tasks was examined using both a primary and secondary analyses. Whereas the primary analysis focused on the total CIDS scores, the secondary analyses addressed the research questions by comparing the nurses' confidence scores on each of the five CIDS questions comprising the total confidence score. If the responses to individual CIDS items satisfied the assumption of normality, the one-way between subjects ANOVA compared the confidence in delegating tasks for the four leadership style groups. Significant findings from this overall F test required further examination using a Tukey's post hoc test with the Bonferroni correction( $p < .0167$). Similarly, if the confidence scores on any of the five individual CIDS items failed to satisfy the assumption of normality, research question 1 was evaluated using the Kruskal-Wallis H Test and significant findings were further explored with Bonferroni corrected Mann Whitney U Tests ($p < .0167$).

To address research question 2, how do the respondents' demographic characteristics alter their confidence in delegating patient tasks, two types of analyses were conducted. First, parametric and/or

nonparametric analyses evaluated the impact of educational preparation and nursing clinical experience separately on confidence in delegating patient care tasks. For normally distributed total confidence scores, independent groups ANOVAs compared the nurses' confidence with the participants grouped by educational preparation (Hypothesis 2a) or clinical nursing experience (Hypothesis 2b). No additional post hoc comparisons were identified as the nurses were grouped into two groups for both demographic variables. On the other hand, if the total confidence scores did not satisfy the assumption of normalcy, Hypothesis 2a and 2b were evaluated using the non-parametric Mann Whitney U Tests. As the Mann Whitney U Test compares the rankings in two independent groups, no additional post hoc comparisons were required.

As presented in Hypothesis 2a, educational preparation was divided into two categories. The total confidence scores of nurses with at least a baccalaureate degree were compared to the total confidence of nurses with less than a baccalaureate degree. Defined in this manner, educational preparation represented a non-manipulated, two group categorical variable, thereby eliminating the need for post hoc comparisons. Hypothesis 2b similarly divided clinical nursing experience into two categories. In this hypothesis, the average total confidence score of nurses with less than 5 years experience was compared to that of nurses with 5 or more years of experience. Defined in this way, clinical nursing experience also represented a non-manipulated two group categorical variable. Thus, the evaluation of

modify the RNs confidence in delegating patient tasks to UAPs, was addressed by a three - way ANOVA. The main effects of leadership style, clinical nursing experience and educational preparation were addressed by previous hypotheses and not further examined in this analysis. The results of this analysis focused on the two and three-way interactions among leadership style, clinical nursing experience and educational preparation and compared the total confidence scores for individuals grouped by these variables.

# Chapter IV

# RESULTS

## Characteristics of the Sample

One hundred ninety-seven survey packets were returned in sealed envelopes that were marked "done." Of these packets, 19 sealed envelopes contained completely blank surveys and another 6 included partially completed surveys with either the leadership or confidence in delegation questions left unanswered. These incomplete questionnaires reduced the sample by 13%. Finally, an additional 12 surveys were excluded from the returned packets as these respondents did not have a dominant leadership style. Both the incomplete surveys and the inability to classify the respondent with a dominant leadership style produced a final sample of 158 useable surveys, representing a 20% reduction from the 197 returned packets.

### *Nurse Participants*

The final sample of 158 nurse participants in this study included 14 (8.9%) males and 144 (91.1%) females, with the average age of 43.58 years (SD = 10.40). While the overwhelming majority (68%) of nurse participants was Caucasian, the sample included approximately 10% Native Americans, 10% African Americans, 10% Hispanics and 2% marked "other" ethnic groups. The participants reported an average of 15.64 years of total nursing experience (SD = 11.18), with approximately 11.86 (SD = 9.18) years spent at this hospital and an average of 8.13 (SD = 7.72) years spent on a specific

unit. Finally, approximately half (n = 82 or 51.9%) of the nurses held either a diploma (n = 22 or 13.9%) or an associates degree (n = 60 or 38%), while 66 (41.8%) participants reported having earned a Baccalaureate degree (n = 66 or 41.8%) in nursing and the final 12 (6.3%) equally represented non-nursing bachelor degrees or masters degrees.

Leadership scores for the 158 nurse respondents were obtained by calculating the totals for the supportive, directive, participative and achievement subscales of the PGLQ. Based on these calculations, respondents were categorized into the leadership style for which they earned the highest score (Northouse, 2007). This categorization identified 93 nurses with a supportive leadership style, 53 with a directive style, 12 with a participative style and 0 with an achievement style. The categorization by leadership style was then used to examine the differences in confidence in delegating tasks to UAPs.

With respect to each hypothesis, confidence in delegating tasks to UAPS was evaluated in two ways. The primary analysis utilized the total confidence scores, calculated by summing the responses to the 5 delegation items (8, 10, 11, 12 and 13) of interest on the survey. The secondary analyses were based on the participant's responses to each of these 5 delegation items.

Prior to the evaluation of any hypotheses, the total CIDS scores and the responses to the 5 individual CIDS questions were subjected to skewness tests to determine if the data was normally distributed, a key assumption

required of parametric analyses. As presented in Table 5, the Pearson Skewness Coefficient provided evidence that the total CIDS scores and three of the five individual items were not severely skewed and hence supported the normality assumption. Thus, the primary analyses, based on the total confidence scores, were evaluated by the parametric inferential test, the between subjects ANOVA with Bonferroni corrected post hoc comparisons where necessary. However, for the secondary analyses, using the individual item responses, either a Bonferroni corrected parametric or non-parametric tests were used. Parametric tests were used in evaluating items D8, D10 and D12 whereas non-parametric analyses compared the responses for items D11 and D13 as the responses of these two questions were severely skewed by Hildebrand's (1986) criteria.

Table 5

Measures of Normality

| CIDS Score | Kurtosis | Mean | Median | SD | Skewness |
|---|---|---|---|---|---|
| Total CIDS | 44.05 | 39.8 | 41.00 | 11.01 | - 0.11 |
| D8 | 0.01 | 7.74 | 8.00 | 1.96 | - 0.13 |
| D10 | 0.26 | 7.94 | 8.00 | 1.84 | - 0.03 |
| D11 | 4.13 | 8.42 | 9.00 | 1.68 | - 0.34* |
| D12 | 0.10 | 8.11 | 8.00 | 1.96 | - 0.06 |
| D13 | 1.18 | 8.27 | 9.00 | 1.97 | - 0.37* |

* severely skewed as per Hildebrand's (1986) criteria

## Findings

*Hypothesis 1: RNs who demonstrate a supportive leadership style will report more confidence in delegating patient care tasks to UAPs than RNs with either directive or participative styles.*

*Primary Analysis*

The results of a one way between subjects ANOVA did not reveal any significant differences in total confidence in delegating patient care tasks to UAPs for the nurse respondents when grouped by dominant leadership style, $F(2, 155) = 1.44$, $p = .24$ (Appendix K). This finding failed to support the researcher's hypothesis that RNs who demonstrate a supportive leadership

style will report more confidence in delegating patient care tasks to UAPs than RNs with either directive or participative styles.

Close inspection of the standard deviations in Appendix K reveals that the 93 nurses classified as having a supportive leadership style varied considerably in terms of their total confidence scores, at least as compared to the directive and participative leadership groups. In an effort to account for the variability in this group, two additional analyses were executed. First, using each of the demographic variables (years of clinical nursing experience, age, years worked in the hospital and years worked on the unit) as a covariate, the confidence scores of the supportive, directive and participative leadership groups were again compared. The results of the ANCOVAs did not reveal any significant differences in total confidence among the nurses when grouped by leadership style. In other words, the demographic variables that served as covariates did not reduce the variability in the confidence scores. The supportive, directive and participative leadership groups were also compared in terms of the demographic variables of age, years of nursing experience, years worked in the hospital and years worked on the unit. The only demographic variable that differed significantly among the supportive, directive and participative leadership style groups was the number of years that the nurses worked at the hospital, $F(2, 155) = 4.06$, $p = .02$ (Table 6).

Table 6

Years of Hospital Employment of Nurses with Supportive, Directive or Participative Leadership Styles

| Leadership Style | M | SD | F | p |
|---|---|---|---|---|
| Supportive | 11.03 | 8.95 | 4.06 | .02* |
| Directive | 14.35 | 9.47 | | |
| Participative | 7.23 | 5.80 | | |

* $p \leq .05$

Bonferroni corrected post hoc comparisons revealed that nurses with a participative leadership style worked an average of 7.23 years (SD = 5.80) at this hospital, significantly below the average of 14.35 years (SD = 9.47) reported by nurses with a directive leadership style. However, nurses with a supportive leadership style (M = 11.03; SD = 8.95) did not differ significantly in years of service from either the participative or directive leadership groups. Nurses with supportive, directive and participative leadership styles did not differ significantly in terms of the demographic variables of age (Appendix L), years of nursing experience (Appendix M) or in terms of years worked on their respective hospital units (Appendix N).

As the demographic information provided by the nurse participants failed to account for the considerable variability in total confidence scores of the nurses with a supportive leadership style, this group of nurses was further

categorized into low, medium and high groups using the criteria suggested by Northouse (2007). This classification scheme identified 16 nurses with a low supportive leadership style (leadership scores below 28), 51 with a medium or common supportive leadership style (leadership scores between 28 – 33) and 26 nurses with a high supportive leadership style (leadership scores greater than 33). Using this classification scheme, significant differences in the average total confidence scores emerged within the group of 93 nurses classified as having a supportive leadership style, $F(2, 90) = 4.51$, $p = .01$ (Table 7). The Bonferroni corrected post hoc comparisons showed that nurses with a high supportive leadership style were significantly more confident in delegating patient care tasks to UAPs than nurses with a low supportive leadership style. The nurses categorized in the medium or common supportive leadership group did not differ significantly from either of these two extreme groups. Therefore, only nurses with high supportive leadership styles exhibited significant confidence in delegating tasks to UAPs.

Table 7

Total Confidence Scores for Nurses with Low, Medium and High Supportive Leadership Styles.

| Supportive Subgroup | M | SD | F | p |
|---|---|---|---|---|
| Low | 30.81 | 25.35 | 4.51 | .01* |
| Medium | 39.16 | 7.59 | | |
| High | 42.50 | 7.11 | | |

* $p \leq .05$

In summary, the data from the primary analysis did not identify any significant difference in confidence among the nurses grouped by leadership style. This analysis failed to support the researcher's hypothesis that nurses with a supportive leadership style would be more confident in delegating patient care tasks to UAPs than nurses with a participative or directive management style. However, when the nurses with a supportive leadership style were further separated into low, medium and high groups, the high group of nurses with supportive leadership style reported significantly more confidence in delegating patient care tasks to UAPs than those with a low supportive leadership style.

*Secondary Analyses*

In addition to the comparisons among the leadership style groups based on the total confidence scores, nurses with supportive, directive and participative leadership styles were also compared separately on each of the

five CIDS delegation questions. These secondary comparisons were executed using both parametric and non-parametric analyses, depending on whether the responses to the question were normally distributed. The results (presented in Appendix O to Appendix S) showed that nurses with supportive, directive or participative leadership styles did not differ on any of these five delegation questions

Next, the 93 nurses with a supportive leadership style were separated by level of support (low, medium and high) and compared in terms of their responses on each of the 5 delegation questions. The results of the parametric and non-parametric analyses with the Bonferroni correction did not reveal any significant differences among the low, medium and high supportive leadership groups on any of the five CIDS items. These delegation questions failed to yield significant differences in confidence among the low, medium and high supportive leadership nurses and are summarized in Appendix T through Appendix X.

In summary, whether confidence in delegating tasks was construed as a total score (as in the primary analysis) or evaluated separately for each of the five delegation questions (the secondary analyses), the outcomes failed to provide support for the researcher's hypothesis that nurses with supportive leadership styles would be more confident in delegating patient care tasks to UAPs than nurses with other leadership styles. However, when the nurses with the supportive leadership style were further separated into groups based on the strength of their leadership style, those nurses with high supportive

leadership style reported significantly higher overall confidence than nurses within the low supportive category. All secondary comparisons using the individual delegation items were not significant.

*Hypothesis 2a: RNs with at least a baccalaureate degree will report more confidence in delegating patient care tasks to UAPs than RNs with educational preparation less than a baccalaureate degree.*

*Primary Analysis*

The 158 participants included 82 nurses with less than a baccalaureate degree and 76 with a baccalaureate degree or more of educational preparation. These groups of nurses were compared in terms of their confidence in delegating patient care tasks to UAPs using a one way between subjects ANOVA. The outcome of the analysis did not reveal any significant differences in total confidence scores as a function of educational preparation, $F(1, 156) = 0.43$, $p = .51$. Registered nurses with at least a baccalaureate degree exhibited an average total confidence score of 40.39 ($SD = 13.65$) as compared to an average total confidence score of 39.24 ($SD = 7.84$) for nurses with less educational preparation than a baccalaureate degree. These findings do not provide support for the researcher's hypothesis that RNs with at least a baccalaureate degree will report more confidence in delegating patient care tasks to UAPs than RNs with educational preparation less than a baccalaureate degree.

*Secondary Analyses*

As with the evaluation of Hypothesis 1, the confidence scores for the nurse respondents were also compared separately for each of the delegation items. Bonferroni corrected between subjects ANOVAs identified one significant difference in confidence when the nurse participants were grouped by educational preparation. Nurses with at least a baccalaureate degree indicated that they were significantly more confident delegating to UAPs while at work than nurses with less educational preparation, $F(1, 156) = 3.80$, $p = .05$ (Table 8).

Additionally, the Mann Whitney U Test showed that the distribution of ranked values were also significantly different for nurses in the two educational preparation groups. Nurses with at least a baccalaureate degree reported that they felt that their delegation decisions were significantly more likely to be correct based on their nursing experience as compared to nurses with less educational preparation, ($p = .05$) (Table 9). Except for these two questions all other comparisons of confidence in delegating patient care tasks to UAPs did not identify any significant differences for nurses grouped by educational preparation (Appendix Y to Appendix AA).

Table 8

Confidence Scores for Delegation Question #8 for Nurses Grouped by Educational Preparation

| Delegation Question: How confident are you delegating to UAPs while at work? | | | | |
|---|---|---|---|---|
| Educational Preparation | M | SD | F | p |
| Less than Bachelor's | 7.45 | 1.89 | 3.80 | .05* |
| At least a Bachelor's | 8.55 | 1.99 | | |

*p ≤ .05

Table 9

Confidence Scores for Delegation Question #11 for the Nurses Grouped by Educational Preparation

| Delegation Question: Do you feel the delegation decisions you make are likely to be correct based on your nursing experience? | | | | | |
|---|---|---|---|---|---|
| Educational Preparation | N | Mean Rank | Sum of Ranks | U | p |
| Less than Bachelor's | 82 | 73.32 | 6012.00 | 2609.00 | .05 |
| At least a Bachelor's | 76 | 86.17 | 6549.00 | | |

*p ≤ .05

*Hypothesis 2b: RNs with 5 or more years of clinical nursing experience will be more confident in delegating patient care tasks to UAPs as compared to RNs with fewer years of nursing clinical experience.*

*Primary Analysis*

Upon review of the demographics, 39 nurses reported having fewer than 5 years of nursing clinical experience while the remaining 119 participants indicated that they had 5 or more years of clinical nursing experience. Using these groups, the respondents were compared in terms of their average confidence scores in delegating patient care tasks to UAPs. A one-way independent groups ANOVA did not reveal any significant differences in total confidence scores for nurses grouped by years of clinical nursing experience, $F(1, 156) = .06$, $p = .80$ (Appendix BB). Nurses with more years of nursing experience reported that they were as confident in delegating patent care tasks to UAPS as nurses with less clinical nursing experience.

As with the other hypotheses, the differences in confidence in delegating tasks to UAPs were also examined separately for each of the questions comprising the total confidence score. As shown in Appendices CC to GG, neither the parametric nor the non-parametric analyses from the secondary analyses identified significant differences between nurses with more years of clinical nursing experience as compared to nurses with less clinical nursing experience.

In summary, the data from both the primary analysis (using total confidence scores) and the secondary analyses (each delegation item separately) failed to confirm the researcher's hypothesis that RNs with more years of clinical nursing experience will be more confident in delegating patient care tasks to UAPs as compared to RNs with less years of nursing clinical experience.

*Hypothesis 2c: There is a positive relationship between nursing clinical experience and confidence in delegating patient care tasks to UAPs.*

As shown in Table 10, Pearson Product Moment Correlations revealed a significant positive relationship between the number of years of nursing clinical experience and confidence in delegating patient care tasks to UAPs as defined by delegation question 11. Thus, as the nurse participant's clinical experience increased so did the nurse's reported confidence in the accuracy of the delegation decisions, $r(156) = .23$, $p = .005$. All other correlations between nursing clinical experience and confidence scores did not reach significance. These analyses provided partial support for the researcher's hypothesis that there is a positive relationship between nursing clinical experience and confidence in delegating patient care tasks to UAPs.

*Table 10*

Correlations between Years of Clinical Nursing Experience and Confidence in Delegating Patient Care Tasks to UAPs (N = 158)

| Measures of Delegating Confidence | r | p |
|---|---|---|
| Total Delegation Confidence | .08 | .33 |
| D8 question: How confident are you with Delegating to UAPs while at work? | .07 | .38 |
| D10 question: Do you feel the delegation decisions you make are likely to be correct based on your educational preparation? | .10 | .21 |
| D11 question: Do you feel the delegation decisions you make are likely to be correct based on your educational preparation? | .23 | .005* |
| D12 question: Based on what you learned in your educational preparation, are you likely to use delegation in your clinical nursing practice? | .05 | .56 |
| D13 question: Based on your nursing experience are you likely to use delegation in your clinical nursing practice? | .05 | .57 |

*$p \leq .05$

*Hypothesis 3: Respondents who demonstrate a supportive leadership style, have at least a bachelor's degree and 5 or more years of nursing clinical experience will report more confidence in delegating patient care tasks as compared to RNs with other leadership styles, lower levels of educational preparation and less nursing clinical experience.*

An examination of Table 11 shows the sample sizes in the cells formed by the combination of the variables of leadership style, educational preparation and amount of nursing clinical experience. Several cells within this table had very small samples. This observation prompted a modification to the leadership variable used in the three - way between subjects ANOVA.

Table 11

Number of participants in cells formed by the combination of leadership style, educational preparation and nursing experience

| Leadership Style | Educational Preparation | Nursing Experience | N |
|---|---|---|---|
| Supportive | Less than BA | Fewer than 5 years | 16 |
| | | Five or more years | 34 |
| | BA or higher | Fewer than 5 years | 10 |
| | | Five or more years | 33 |
| Participative | Less than BA | Fewer than 5 years | 2 |
| | | Five or more years | 3 |
| | BA or higher | Fewer than 5 years | 1 |
| | | Five or more years | 6 |
| Directive | Less than BA | Fewer than 5 years | 6 |
| | | Five or more years | 21 |
| | BA or higher | Fewer than 5 years | 4 |
| | | Five or more years | 22 |

These modifications were engineered because of two observations: [1] the intent of the hypothesis was to compare nurses with supportive leadership styles to those participants with different leadership styles and [2] the small sample sizes were primarily in the directive and participative leadership styles. Accordingly, the participative and directive leadership groups were combined into one leadership style referred to as non-supportive. The 2 X 2

X 2 between subjects ANOVA permitted the comparison of the supportive (n = 93) and non-supportive leadership styles (n = 65) while taking into account educational preparation and years of clinical nursing experience. As this combination of variables overlaps to some extent with the analyses executed to evaluate the previous hypotheses (e.g., evaluation of the main effects), several of the findings are repetitious and hence only the two and three way interactions are addressed at this point.

This parametric analysis identified a significant two-way interaction between educational preparation and clinical nursing experience, $F(1, 150) = 4.34$, $p = .04$ (Table 12). The differences in confidence to delegate patient care tasks changed with the combined demographic variables of educational preparation and clinical nursing experience. For those nurses with at least a bachelor's degree and less clinical experience, confidence in delegating patient care tasks to UAPs was initially greater than for nurses with less educational preparation and the same amount of clinical experience. However, confidence in delegating patient care tasks changed with increased clinical experience. The less educationally prepared nurses were more confident in delegating patient care tasks with more experience. This finding did not hold for the more educationally prepared nurses. The more educated nurses reported less confidence in delegating tasks to UAPs as clinical nursing experience increased. This change in confidence was true for all nurses, irrespective of whether they had a supportive or a non-supportive leadership style. Hence, the three way interaction between leadership style,

educational preparation and clinical nursing experience was not significant. Likewise, neither was any significance observed in the two-way interactions between leadership style and educational preparation or clinical nursing experience.

Table 12

Average Total Confidence in Delegating for Nurses Grouped by Years of Clinical Nursing Experience and Educational Preparation.

| | Clinical Nursing Experience | |
|---|---|---|
| | < 5 years | 5+ years |
| Educational Preparation | | |
| Less than a bachelor's degree | 36.34 | 40.59 |
| At least a Bachelor's | 44.45 | 39.62 |

$F(1, 150) = 4.34, p = .04$

As with the previous hypotheses, the combined effects of leadership style, educational preparation and nursing clinical experience could not be evaluated separately for each of the delegation questions as two of these items failed to support the assumption of normalcy. There is no non-parametric analysis that is the counterpart of the factorial ANOVA.

In review, the 2 X 2 X 2 between subjects ANOVA evaluating the total confidence scores identified a significant interaction between the nurses' educational preparation and years of clinical nursing experience on their reported confidence. The changes in confidence in delegating patient care tasks as clinical nursing experience increases, differed between nurses who

were diploma or associates degree prepared and nurses who earned at least a baccalaureate degree. Baccalaureate degree prepared nurses with less years of nursing experience reported more confidence in delegating patient care tasks to UAPs than diploma or associates degree prepared nurses with the same amount of experience. However, as nurses gained more clinical nursing experience, diploma or associates degree prepared nurses indicated more confidence in delegating patient care tasks and appeared to be undifferentiated, in terms of reported confidence, from nurses with at least a bachelor's degree.

# Chapter V

## DISCUSSION

To meet the challenges of continuing change in the health care industry and to maintain organizational viability in increasingly competitive markets, the use of the registered nurse - unlicensed assistive personnel (UAP) model is an undeniable reality. The UAP fills the void created by the current shortage of nurses and decreases the costs of providing patient care. Given the current and increased use of UAPs in health care settings, and the dearth of literature existing indicating that RNs do not feel adequately trained in leadership delegation, it seemed appropriate to ask how confident nurses in delegating patient care tasks to UAPs are. Further, determining the relationship between the nurse's leadership style and confidence in delegating tasks followed naturally from the first inquiry. Additionally determining the impact of the nurse participant's educational preparation and years of nursing experience on the nurse's confidence in delegating, also logically follows. Hence, this study examined the relationship between leadership style and how the demographic variables of educational preparation and clinical nursing experience influenced the nurse's confidence with delegation.

The expectation that RNs who demonstrate a supportive leadership

style will report more confidence in delegating tasks to UAPs than RNs with directive, participative or achievement oriented leadership styles was not supported by these findings. The nurses with a supportive leadership style were not significantly more confident in delegating patient care tasks to UAPS than nurses with directive, participative or achievement-oriented styles. The sample of nurses had an average of 43.58 years of age and nearly half held a diploma or associates degree. The lack of formal leadership education in the diploma or associate degree programs could be responsible for a sizeable percentage of this sample of nurses who have not been trained in leadership and delegation skills. If nurses are not trained in delegation skills in the course of their educational endeavors, the lack of a difference in confidence among nurses with different leadership skills should not be surprising.

This finding echoes the concerns of Glass and Todd-Atkinson (1999) who stated that few, if any, educational experiences at the undergraduate level directly address the development of leadership and delegation skills. Parsons (1998) supports these facts about the lack of educational experiences in a study of 87 RNs who had been out of school for an average of 13 years. The nurses in Parson's study stated that they 'never learned delegation skills in their nursing classes'. Thomas and Hume (1996), Kroll (1997) and Kroll and Hoogendijk (1996) also support this interpretation as they concluded that associate degree nurses and diploma school nurses lack the educational preparation for developing delegation skills. Rather, these

nurses developed delegation abilities through informal mentoring, on a trial and error basis, resulting again in frustration and the lack of confidence. Thomas and Hume (1996) reported that from the baccalaureate prepared nurses' perspective, theses nurses were unprepared academically and clinically to delegate as a part of their leadership repertoire and this resulted in their diminished confidence in delegating tasks to UAPs. Thus, based on their educational program, nurses began their careers feeling that they were not prepared to lead, manage, or delegate with any level of expertise. This would suggest that nurses need more academic and clinical preparation during their educational programs to learn to lead, manage and delegate. The benefit of including supervision and delegation roles in the curriculum could strengthen the skills and the confidence of the nurses (Henderson, et al, 2006; Parsons, 1997).

Since, leadership style did not provide evidence for any differences in confidence, the next step was to evaluate, both separately and combined, the demographic variables of educational preparation and clinical nursing experience, to assess their possible influences. Again, there was no significant difference in total confidence when nurses were grouped solely on the basis of their educational level. Likewise, nurses categorized by less clinical experience did not differ significantly in total confidence from nurses with more clinical experience. Perhaps this lack of significance suggests that education plays a role in confidence in delegating only when it is combined

with another demographic variable, such as nursing experience.

As suggested by the significant correlation and interaction, noted in this study, confidence appears to be linked more to the education and *experience of the nurses*. A *positive significant correlation* ($p = .005$) exists between the acquisition of nursing experience and the ability and confidence to delegate to UAP's. While this relationship might lead one to expect increased experience to have the same effect on confidence for all nurses, whether diploma/associate prepared or baccalaureate prepared, the data suggests otherwise. When nurses with less clinical experience were compared, the more educated nurses were more confident in delegating patient care tasks to UAPs than diploma or associate prepared nurses. However, with more clinical nursing experience, the less educationally prepared nurses report increased confidence in delegating patient care tasks. This finding is in direct contrast to the more educationally prepared nurses. Nurses with at least a baccalaureate degree and with more clinical experience, report less confidence in the delegation to the UAP's. Thus, when evaluating the confidence of nurses in delegating patient care tasks to UAPs, it is necessary to consider more than one demographic variable at a time. The implication of multiple demographic variables could be considered in further examination of the effect of both education and clinical experience on nursing delegation.

Despite the lack of a relationship between leadership style and

confidence, the data from this study confirmed that the educational preparation and nursing experience play a role in the nurses' confidence in delegating patient care tasks to UAPs. This finding may reflect the differences in training that diploma and associate degree nurses receive as compared to baccalaureate prepared RNs. The diploma and associate degree nurses were lacking in their educational preparation in areas of delegation activities. Studies confirm that the diploma, associate degree and baccalaureate nurses (trained in primary care nursing) felt ill prepared to delegate, based on their educational preparation (Davis and Farrell, 1995; Conger, 1999). Nurses with more clinical experience felt that their clinical decisions were more correct but felt that this was based in their educational preparation. This would imply that the nurses with a baccalaureate education had something in their curriculum that allowed them to feel more confident in the delegation earlier in their clinical experience. Interestingly, the relationship between educational preparation and clinical nursing experience noted is also consistent with findings from Anthony (2001), who reported that nurses generally rated their ability to delegate and supervise as high, although they indicated improvement in these skills correlated with increased experience in the nursing on the unit

Additionally, the difference in reported confidence between diploma and associate degree prepared as compared to baccalaureate prepared nurses as nursing experience increases might be explained by the clinical

experience of the baccalaureate prepared nurses. These nurses are more frequently assigned to the critical care environments that may have less opportunity to use delegation skills then in primary care type settings. Hence, as nurses' experience increased, they received less educational opportunities for ongoing development of delegation skills, so their confidence decreased. With time, as nurses' perform less delegation tasks, this simple lack of practice may actually decrease the nurses' confidence in delegation. This was supported by the findings of this study in which the nurses with baccalaureate education felt a decrease in confidence level as they increased clinical experience. Likewise, the conclusion advanced by Jung (1991) also supports the significant interaction. He stated that the more distance between the nurses' experience of instructional education, the less delegation activities they performed and hence the less confidence they felt.

## Limitations

All research investigations have limitations. Limitations in this study stem from design and instrumentation issues. Using a convenience sample of nurses employed in one hospital, a non-manipulated independent variable and a cross sectional design certainly can contribute to the limitations of this study. Limitations of the study design as well as issues in the measurement and classification schemes utilized in this study caution the reader to exercise care in the interpretation and generalization of these findings.

The shortcoming of any convenience sample is the limitation of participants to those present and completing the survey. There were several characteristics of this convenience sample that served as potential threats to the validity of this study. The nurses worked at one institution and the researchers handed the survey to each nurse. The nurses completed the questionnaires by themselves, before the start of their work shift, in a quiet room, that was free from distractions in the data collection phase. Although the informed consent assured anonymity to the participants and while the participants were assured that only the investigator would see their responses to the questionnaires, there was still a relatively large group of nurses who failed to complete the questionnaires yet marked the envelopes as "done."

Thus, the primary limitation of this research was that it did not account for RN delegation behaviors across all states in the nation. Instead, the investigation focused on delegation behaviors in one health care facility located in the northeastern region of the United States, which may not be representative of other hospitals in the United States.

As this project used self-reported questionnaires, there are several potential sources of error due to the response biases of the participants. For example, the respondents may misunderstand questions. Likewise, the registered nurses may or may not respond honestly to questions about their behaviors. Whether the participants exaggerate or minimize their answers, both strategies may distort the results and conclusions of the study. However, this response problem is inherent in any study in which participants

are asked to complete self-report measures. One finding of concern was the number of blank questionnaires returned in sealed envelopes marked "done" suggests that these efforts may have been insufficient. One way of addressing this problem in future studies might be to have the data collection under the direct supervision of the researcher, rather than asking nurse participants to complete a packet distributed in mailboxes to be dropped off to a receptacle when completed. Reliance on information from self-report questions may also serve as a source of bias and accordingly mask or distort the outcomes from the study. Nurses might be uncomfortable reporting what actually happens on the clinical unit. For example, when answering a self-report item, there might be a tendency for the participant to respond in a socially desirable manner (what the person thinks 'is expected') rather than state what he or she actually does or believes. Several respondents were unclassifiable into a leadership style as they circled the same response for every question comprising the PGLQ. Although it is possible for any study using self-report measures to introduce this form of response bias, the responses of the participants in the present study may be suspect given these two issues.

The measurement and classification problems that surfaced when the PGLQ leadership scale was used to classify each participant into a dominant leadership style may serve as a more serious threat to the internal validity of this study. Following the scoring guidelines of the PGLQ (Indvik, 1988), each respondent received four leadership scores formed by summing the

responses to the designated questions. The leadership style with the highest score was then designated the respondent's dominant leadership style. It is important to note that these guidelines do not take into account the fact that the dominant leadership style is designated 'dominant' whether the respondent scores 1 point or 10 points higher on this scale than the remaining three. Consequently, this classification process may need to be further evaluated to determine whether it misclassifies the respondent into the wrong dominant leadership style. At the very least, it may be necessary to implement Northouse's (2007) designation of low, common and high scores within each leadership style.

Finally, while a convenience sample of nurses from one acute care hospital completed the self-report questionnaires, the demographic information solicited from the respondents did not include the unit on which the nurse was employed. Thus, it is likely that some nurses worked on critical units such as ICU while other respondents worked on non-critical care floors. This difference in the unit may account for the differences in confidence, especially among the nurses with at least a bachelor's degree. If bachelor degree educated nurses are employed more on critical care than non-critical care units, they may not be able to delegate patient care tasks as their patients are too ill and require the knowledge and skills of an RN.

## Implications

This study explored the relationship between leadership style and

confidence in delegating patient care tasks. Despite the addressed limitations, the findings from this study have important research and educational implications for the nursing profession. The findings from this one acute care teaching hospital in New Jersey, supports confidence in delegating patient care tasks is greater for nurses who have at least a bachelor's degree of educational preparation. For nurses having less then a baccalaureate degree, the accumulation of nursing clinical experience increases that confidence.

As the study demonstrated a relationship between educational preparation, nursing clinical experience and confidence in delegating, it is imperative that delegation skills are systematically addressed in all nursing curriculums, even those that culminate in diplomas or an associate's degree. As health care continues to change, the preparation of nurses must continue to evolve, providing experiences that nurses are expected to handle once they assume a position within the health care industry. To expect that nurses will acquire the necessary delegation skills on the job by a hit or miss method is educationally unsound. As the demands of the health care industry, continue to change, so too must the educational preparation of the nurse at all levels. Each educational degree program must accommodate the change in practice expectations to more closely replicate actual practice experiences in order for each nurse to develop the skills and confidence to be able to perform on all levels, not solely administering care.

# Chapter VI

## CONCLUSIONS

Health care in the United States is riddled with ongoing change as health care institutions respond to the demands of cost containment, changing patient case mix indices, and enhanced consumer expectations (Norrish& Rundall, 2001). Responding to these changes in health care delivery without escalating cost is a present challenge for the health care institution. One way of addressing this dilemma has been the development and implementation of new care delivery models. In past decades, nurses were educated in a primary care model, where the focus was the direct care needs of patient. As a result, many nurses did not work with UAPs and may not have acquired the necessary delegation skills required. Today registered nurses are increasingly expected to organize and supervise the work of other healthcare workers. This is influenced by the current nursing shortage, the aging nursing work and financial health care deficits. Crucial to the success of this function is the ability to delegate routinely and effectively (Marquis and Huston 2000; Kourdi 1999; Rocchiccioli and Tilbury 1998).

The relationship between clinical nursing experience and the confidence in delegating patient care tasks depends on the educational preparation of the nurse. Nursing curriculum needs to formalize this educational process in order to assist the transition. For nurses prepared by diploma or associates degree, the accumulation of nursing clinical experience

results in more confidence. Perhaps more clinical internship time, where there are more UAP's, would provide opportunities for clinical supervision for the necessary acquisition of delegation skills to further the development of confidence through experience. However, for nurses with at least a bachelor's degree, higher confidence was reportedly associated with less clinical nursing experience. Conceivably, during their academic program, the baccalaureate nursing did actually receive more exposure to the process of delegation than they are aware of. In a qualitative study by (Thomas & Hume, 1997), minimal opportunities for delegation occurred later in the curriculum and in a clinical setting and may account for the confidence during the early nursing experience. For this group, the use of educational programs during orientation to the nursing role, within the work environment could support the previously learned delegation skills.

Of particular interest is the finding that the nurses' dominant leadership style is unrelated to confidence in delegating patient care tasks. The absence of a relationship between leadership style and confidence in delegating patient care tasks suggests utilizing Northouse's sub-classifications (low, medium and high) as revealed by the fact that nurses with a high supportive sub score were significantly more confident in delegating. Utilizing the PGLQ sub-classifications might refine the relationship between leadership style and confidence in delegating tasks.

The relationship between leadership style and confidence in delegating

may also depend on the nurse's clinical unit of employment and their need for delegation skills. If the clinical unit does not have the UAP model, then delegation skills will not have adequate opportunity to be developed or maintained. Hence, the nurse will lack confidence in delegation. In the case of new nurses, perhaps awareness by nursing administration for placement of new nurses should include opportunity to develop leadership and nursing delegation skills before the opportunity to work in specialty areas.

In addition, new research to establish a nursing curriculum that defines a formal design of where and when to place the theoretical and clinical approaches of delegation skills should be considered. To complement this, a joint program between university curriculums and institutional orientation program for new graduates working together to assess where the information should best be provided and/or reinforced for new graduate nurses should be investigated.

Despite the need for additional work, the use of the RN/UAP model is an undeniable reality. It is important that nursing educators provide a base from which new nurses can develop and advance delegation skills to facilitate transition into the work force. The knowledge of delegation skills is key to the successful functioning of the RN/UAP team. An adequately trained team working seamlessly together will be able to overcome delegation difficulties, such as what to delegate and who to delegate too. The effective use of UAP's can provide positive patient outcomes, increase nursing confidence and will

be cost enhancing for health care institutions.

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# APPENDICES

# Appendix A

## Original Survey

### Confidence and Ability to Delegate Questionnaire

### Section 1: Demographic Information

. Gender: ____Male ____Female

2. Age: ____20-24 ____25-29 ____30-34 ____35-39
____40-44 ____45-49 ____50-54 ____55+

1. Years in Nursing _____

2. Ethic Background

___African American
___Caucasian
___Native American
___Hispanic
___Other_____

3. Total number of years of nursing experience_____

4. Total number of years in this nursing unit_____

5. Total number of years in this hospital_____

6. Educational Background

___ Diploma in Nursing
___Associates Degree in Nursing
___Bachelor of Science in Nursing
___Bachelor's degree in other field
___Master's degree in Nursing
___Dual Master's degree __MSN/MBA_____Other
___Masters degree in other field
___Doctoral degree in Nursing
___Doctoral degree in other field

Section 2: Delegation Questions

1. Have you ever been exposed to the concept of delegation; the transfer of responsibility for the performance of an activity from one individual to another. (The delegator retains the responsibility for actions/outcomes of the delegate.

____yes ____no

If yes, please answer questions 2 and 3, if no please proceed to question 4.

2. Please indicate in all situations in which you were exposed to delegation: material that exposed you to delegation decision making?

____nursing school ____continuing education conference
____On the job training ____Staff development in the work setting
____other_____ ____Post graduate education

3. Please indicate approximately what percentage of your nursing school educational preparation included knowledge about or education on delegation?

<25% 25-50% 50-75% >75%

4. Are you familiar with the scope of practice of the UAP (Unlicensed Assistive personnel/Nursing Assistants)?

_____yes _____no

5. Do you currently use delegation skills on your unit?

____yes ____no

6. Is the job description for a UAP consistent with their scope of practice on your unit?
___yes ___no

7. Do you know your legal responsibility when supervising a UAP/ nursing assistant?
___yes ___no

8. How confident are you with delegating to UAP's while at work?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| No Confidence | | | | | | | | | Highly Confident |

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

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| Never | | | | | | | | | Many Times a Day |

10. Do you feel the delegation decisions you make are likely to be correct based on your educational preparation?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| Not Correct | | | | | | | | | Highly Correct |

11. Do you feel the delegation decisions you make are likely to be correct based on your nursing experience?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| Not Correct | | | | | | | | | Highly Correct |

12. "Based on what you learned in your educational preparation, are you likely to use delegation decision making?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| Not Likely | | | | | | | | | More Likely |

13. "Based on your nursing clinical work experience, are you likely to use delegation decision making?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| Not Likely | | | | | | | | | More Likely |

14. Are you more likely to utilize delegation skills in your daily practice with a UAP with whom you more regularly work the same shift as compared with a UAP with whom you don't share shifts with regularly?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| Not Likely | | | | | | | | | More Likely |

15. Are you more likely to delegate to a UAP who you perceive to have a higher level of job competence than to a UAP you perceive to be of lower job competence?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| Not Likely | | | | | | | | | More Likely |

16. Are you more likely to delegate to a UAP with whom you have a greater level of general communication than to a UAP with whom you don't share much communication?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| Not Likely | | | | | | | | | More Likely |

**Thank you for your Participation.**

# APPENDIX B

## Definition of Terms

*Registered Nurse* is a nurse who has graduated from a formal program of nursing education (diploma school, associate degree or baccalaureate program) and is licensed by the appropriate state authority

*Unlicensed Assistive Personnel* - a non professional or paraprofessional whose role is to assist the registered nurse in the provision of health care services. The UAP "is trained to function in an assistive role to the licensed nurse in the provision of patient/client activities as delegated by the nurse" (ANA, 1992)

*Delegation*- the transfer of responsibility for the performance of an activity from one individual to another while retaining accountability for the outcome" (Anthony, 2001)

*Registered* Nurse Leadership styles refers to the prominent leadership style of the registered nurse utilized influence the unlicensed assistive personnel in accomplishing their goal as measured by the Path Goal Leadership Questionnaire

*Confidence in Intent to Delegate Survey* comprising of the Confidence and Intent to Delegate Questionnaire including intent to delegate, how often delegation takes place and how confident the registered nurse is feels delegating tasks.

*Communication Exchange* – structured communication time between the Registered Nurse and the UAP to prioritize tasks and set goals. (VanCura , 1997).

Appendix C

PATH GOAL LEADERSHIP QUESTIONNAIRE

For this quiz you are asked to rate each of the statements below on a scale from 1 to 7, as indicated below. In assigning a score to each question, rate the question based on how TRUE the statement is ABOUT YOUR OWN BEHAVIOR. Do not skip any questions.

1 = Never 2 = Hardly Ever 3 = Seldom 4 = Occasionally 5 = Often
6 = Usually 7 = Always

_____ 1. I let subordinates know what is expected of them.

_____ 2. I maintain a friendly working relationship with subordinates.

_____ 3. I consult with subordinates when facing a problem.

_____ 4. I listen respectively to subordinates' ideas and suggestions.

_____ 5. I inform subordinates about what needs to be done and how to accomplish it.

_____ 6. I let subordinates know that I expect them to perform at their highest level.

_____ 7. I act without consulting my subordinates.

_____ 8. I do little things to make it pleasant to be a member of the group.

_____ 9. I ask subordinates to follow standard rules and regulations.

_____ 10. I set goals for subordinates' performance that are quite challenging.

_____ 11. I say things that hurt subordinates' personal feelings.

_____ 12. I ask for suggestions from subordinates concerning how to carry out assignments

_____ 13. I encourage continual improvement in subordinates' performance.

_____ 14. I explain the level of performance that is expected of subordinates.

_____ 15. I help subordinates overcome problems that stop them from performing their task

_____ 16. I show that I have doubts about their ability to meet most objectives.

_____ 17. I ask subordinates for suggestions on what assignments should be made.

_____ 18. I give vague explanations of what is expected of subordinates on the job.

_____ 19. I consistently set challenging goals for subordinates to attain.

_____ 20. I behave in a manner that is thoughtful of subordinates' personal needs.

# APPENDIX D

## Reminder Note for Returning Surveys

## NOTICE

Please be aware that the deadline for returning the completed questionnaire for the research project entitled ""*Registered Nurse Leadership Style, Confidence Level and Delegation Practices to Unlicensed Assistive Personnel: An Exploration of Confidence*" is

_____2008

If you have any questions, please feel free to contact me at 914-673 6542.

Once again, thank you very much for your Participation and your contribution to this study

Sincerely,

Scott J. Saccomano
Primary Investigator

# APPENDIX E

## Solicitation Letter

Dear Staff Nurse,

My name is Scott J Saccomano, and I am a doctoral student at Seton Hall University's School of Graduate Medical Education. I am conducting a research project entitled "*Registered Nurse Leadership Style, Confidence Level and Delegation Practices to Unlicensed Assistive Personnel: An Exploration of Confidence",* which will culminate in my dissertation.

You are being invited to participate in this research study because you are a staff member of a patient care unit using Unlicensed Assistive Personnel. Please begin by answering the following questions:

Are you a full/part time RN?
yes no
Have you been employed a minimum of 6 months?
yes no
Have you been working with UAPs for a minimum of 6 months?
yes no
During the last 5 years you have **NOT** had formalized leadership training/education/experience (charge nurse, head nurse or nurse manager).
yes no

If you answered **NO** to any of the above questions you are **NOT** eligible to participate in this study. Thank you for your time and please return this envelope to the drop box on your unit.

If you have answered **YES** to **ALL** of the above questions you **ARE ELIGIBLE** for participation in the study, please **open** the envelope and begin and return the completed surveys to the drop box.

The purpose of my research is to explore the relationship of staff nurse leadership styles and their confidence in delegating tasks to unlicensed assistive personnel.

Your participation in the study will include the completion of 3 questionnaire found inside this folder, which will take you approximately 30 minutes in total to complete. These questionnaires include the following:

1. Staff Nurse Demographic Profile. The purpose of this questionnaire is to collect demographic information including age, gender,

ethnicity, years of nursing experience, years of employment and educational background.

2. The Path Goal Leadership Questionnaire. This questionnaire asks you to rate your behaviors while working with subordinates or unlicensed assistive personnel
3. The Confident and Intent to Delegate Survey. This questionnaire asks you to rate your ability to delegate tasks to unlicensed assistive personnel

You will not be identified by name or description in any reports or publications about this study. All information in this study will be kept strictly confidential. Your participation in the research study is entirely voluntary. You may decide not to participate at any time. If you decide not to participate, you will not be penalized or lose any benefits to which you are otherwise entitled. To maintain confidentiality, all data will be stored on a USB memory key and kept in a locked secure physical site.

# Appendix F

SETON HALL UNIVERSITY

**Informed Consent for Staff Nurses**

***Affiliation***

My name is Scott Saccomano and I am a doctoral student in the School of Graduate Medical Education at Seton Hall University. I ma conducting a research project that will culminate in my dissertation.

***Purpose***

You are being invited to participate in this research study because you are a staff member of patient care units that employees Unlicensed Assistive Personnel (UAP's). Studies have shown that leadership and delegation are two important factors that influence care on nursing units. However the relationship between leadership style and confidence in using delegation skills is not clear. Thus the purpose of this study is to explore and explain the relationship between RN leadership style and confidence in delegation.

***Procedure***

You will be asked to complete 3 questionnaires found inside this folder:

(1) Staff Nurse Demographic Profile. The purpose of this questionnaire is to collect demographic information including age, gender, ethnicity, years of nursing experience, years of employment and educational background.
(2) The Path Goal Leadership Questionnaire. This questionnaire asks you to rate your behaviors while working with subordinates or unlicensed assistive personnel. A sample question that you will encounter in this form includes: (I let subordinates know what is expected of them).
(3) The Confident and Intent to Delegate Survey. This questionnaire asks you to rate your ability to delegate tasks to unlicensed assistive personnel. A sample question that you will encounter in this form includes: (How confident are you delegating to UAP's (Nursing Assistants)?

It is very important that you complete the questionnaire before the start of your shift in a quiet room such as a "break room" or an empty patient room, with the door closed and free from distraction. The time required for to complete the questionnaires should be longer than 30 minutes. Upon completion, you will return the completed questionnaires in a drop box located in your nurse's station. You will keep the solicitation letter and this consent form. Please return the questionnaires with in 2 weeks of receipt.

Seton Hall University
Institutional Review Board

JUN 25 2008

Approval Date

School of Graduate Medical Education
Department of Graduate Programs in Health Sciences
Tel: 973 275 2076 • Fax: 973 275 2370
400 South Orange Avenue • South Orange, New Jersey 07079 • gradmed.shu.edu

Expiration Date

JUN 25 2009

*Voluntary Participation*

Your participation in the research study is entirely voluntary. You may decide not to participate at any time. If you decide not to participate, you will not be penalized or lose any benefits to which you are otherwise entitled. Consent to participate in this study is indicated by returning the enclosed questionnaires to the primary investigator via the drop box.

*Anonymity*

You will not be identified by name or description in any reports or publications about this study. A coding system, through the use of numbers and letter found in the top left hand corner of each questionnaire will be used to maintain complete anonymity at all times.

*Confidentiality*

All information in this study will be kept strictly confidential. All research data will be stored in a locked cabinet in the primary investigators office at Seton Hall University. The Primary investigator, S Saccomano is the only individual who will have access to all of the research data for a period of three years. There after all research data will be destroyed.

*Risks*

There is no foreseeable risk factor or discomfort of any part of this research project.

*Benefits of Participation*

There are no proposed direct benefits of the study for you. However, the results of this study will provide nurse managers, hospital administrators, educators and researchers about the relationship between leadership style and confidence in delegation. This could assist in the maintenance of nurse retention, high quality and cost effective patient care and patient satisfaction.

Compensation

There will be no monetary or any kind of compensation for participation in this study.

*Alternate Procedures*

There are no alternative ways to participate in this study.

Seton Hall University
Institutional Review Board

JUN 25 2008

Approval Date

Expiration Date

JUN 25 2009

Seton Hall University
3/2006

*Contact information*

You have the right to ask questions concerning this study at any time. If you have any questions concerning this study or your rights as a study participant, please contact the primary investigator, Scott Saccomano, through the office of Dr. Genevieve Pinto-Zipp, Dissertation Advisor and Chair of Graduate Programs in Health Sciences at Seton Hall University School of Graduate Medical Education at 973-275-2076

This project has been approved by the Seton Hall University Institutional Review Board (IRB) for Human Subjects Research. The IRB believes that the study procedures adequately safeguard the study participant's privacy, welfare, civil liberties, and rights. The office of the IRB at Seton Hall University maybe reached at 973-313-6314.

*Informed Consent*

I fully understand the purposes of this study and the lack of potential benefits of my participation. My consent to participate in this study is indicated by returning the completed questionnaires to the primary investigator.

Seton Hall University
Institutional Review Board

JUN 25 2008

Approval Date

Expiration Date

JUN 25 2009

Seton Hall University
3/2008

# Appendix G

## Pilot Study Results

A survey consisting of 8 demographic questions and 16 research questions was adapted based on a review of published research in the area of confidence in delegation (Appendix A). The research questions contain yes or no responses and Likert scale answers. Validation of the sequence, appropriateness, completeness and clarity of the survey questions was obtained by emailing copies of the survey to 10 experts in healthcare and research. Five research experts and 5 experts in nursing clinical practice were identified. Research experts were defined as possessing a terminal degree in health care or a related field, with 20 or more years of experience. Healthcare experts were defined as management experts, with master's degrees in nursing or health care related field with more then 10 years administrative experience in nursing clinical practice. Along with the copy of the survey, an introduction letter (Appendix 1) was provided which included a brief summary of the purpose of the study along with the researcher's contact information in case the expert had questions about the survey. The experts were asked to address 3 questions per survey question, these questions allowed the expert to report on whether the sequence, appropriateness, completeness and clarity of the questions were suitable for the study.

Each question for the experts contained 2 possible answers – yes and no. If the response was no, the experts were asked to provide suggestions for improvement. The experts were asked to return the survey to the GPHS

department secretary within a period of 2 weeks. Ten responses were received with in the study time frame. Based upon the responses received only a few questions need to be changed. The final survey can be found in Appendix 2.

## Results

### Analysis

Below are the summaries of the responses per question. Only comments received by three or more experts (30%) were considered for revision unless the researcher believed that the suggestions would improve clarity.

### Question 1

The purpose of question 1 was to determine whether or not a registered nurse has been exposed to the concept of delegation. The experts were asked whether the question was appropriate for the study, clear, in the correct sequence and complete. All 10 experts provided answers for this question. All respondents believed the question was appropriate for the survey. Only one respondent (10%) believed the question was not in the proper sequence. Six experts (60%) believe that the question was unclear. Because at least more then 3 experts (30%) reported a concern with the question, meeting the previously set criteria for making changes to the survey, the clarity of the question was modified in the final version of the survey. Specifically, the experts all agreed the question was cumbersome

with the definition in the middle of the question, and that the responsibilities of the delegator needed to be more clearly stated.

Question 2

The purpose of this question was to determine all situations nurses may have been exposed to the concept of delegation. The experts were asked whether the question was appropriate for the study, clear, in the correct sequence and complete. All 10 experts provided answers for this question. All respondents believed the question was appropriate for the survey. Only one respondent (10%) believed the question was not in the proper sequence. Four experts (40%) believed that the question was unclear. Because at least more then 3 experts (30%) reported concern with this question, meeting the previously set criteria for making changes to the survey, the clarity of the question was modified in the final version of the survey. The experts agreed that an additional category graduate education should be added to the survey. This question was modified for the final survey.

Question 3

The purpose of this question was to determine the percentage of nursing school education that included knowledge about delegation. The experts were asked whether the question was appropriate for the study, clear, in the correct sequence and complete. All 10 experts provided answers for this question. All respondents believed the question was appropriate for the survey. Three experts (30%) believe that the question was unclear. Because at least more then 3 experts reported concern with this question, meeting the

previously set criteria for making changes to the survey, the clarity of the question was modified in the final version of the survey. All experts believed the question is in the proper sequence. The experts suggested that the delineation of percentages should be a narrower focus, enabling the nurse to be more specific about the percentage of delegation content is taught.

Question 4

The purpose of this question was to determine the nurse's familiarity with the scope and practice of the UAP. The experts were asked whether the question was appropriate for the study, clear, in the correct sequence and complete. All 10 experts provided answers for this question. All respondents believed the question was appropriate for the survey. Five experts (50%) believed that the question was unclear. All experts (100%) believe the question is in the proper sequence. The experts recommended that the question be reworded to ensure the nurse read the scope of practice rather then using the word "familiar", which has a broader meaning. Although the experts agree this question is in the proper sequence, once modifications were made this question was moved to question five in the final survey.

Question 5

The purpose of this question is to evaluate if nurses have used delegation skill on their unit. The experts were asked whether the question was appropriate for the study, clear, in the correct sequence and complete. All 10 experts provided answers for this question. All respondents believed

the question was appropriate for the survey. Three experts (30%) believed that the question was unclear. Two experts (20%) believed the question was is in the proper sequence. Because at least more then 3 experts reported concern with this question, meeting the previously set criteria for making changes to the survey, the clarity of the question was modified in the final version of the survey. It was felt by the researcher that the survey sequence was more logical moving this to question 4,

Question 6

The purpose of this question was to determine the nurse's knowledge of the job description of the UAP. The experts were asked whether the question was appropriate for the study, clear, in the correct sequence and complete. All 10 experts provided answers for this question. All respondents believed the question was appropriate for the survey. All experts (100%) believe that the question was clear. One expert (10%) believes the question is not in the proper sequence. Because these suggestions do not meet the previously set criteria of three experts providing the same suggestion the question will remain unchanged in the final survey.

Question 7

The purpose of this question was to determine if the registered nurse is aware of the legal responsibility when supervising a UAP. The experts were asked whether the question was appropriate for the study, clear, in the correct sequence and complete. All 10 experts provided answers for this question. All respondents believed the question was appropriate for the survey. Two

experts (20%) believe that the question was clear. All experts (100%) believe the question is not in the proper sequence. Because these suggestions do not meet the previously set criteria of three experts providing the same suggestion the question will remain unchanged in the final survey.

Question 8

The purpose of this question was to determine the nurse's confidence in delegation to UAP while at work. The experts were asked whether the question was appropriate for the study, clear, in the correct sequence and complete. All 10 experts provided answers for this question. All respondents believed the question was appropriate for the survey. One expert (10%) believes that the question was clear. One expert (10%) believes the question is not in the proper sequence. Because these suggestions do not meet the previously set criteria of three experts providing the same suggestion the question will remain unchanged in the final survey.

Question 9

The purpose of this question was to determine the nurse's utilization of delegation in their daily practice. The experts were asked whether the question was appropriate for the study, clear, in the correct sequence and complete. All 10 experts provided answers for this question. All respondents believed the question was appropriate and clear for the survey. One expert (10%) believes the question is not in the proper sequence. Because these suggestions do not meet the previously set criteria of three experts providing the same suggestion the question will remain unchanged in the final survey.

Question 10

The purpose of this question was to determine how correct the nurse's delegation decisions are based on educational preparation. All 10 experts provided answers for this question. All respondents believed the question was appropriate, clear and in the proper sequence for the survey. Because these suggestions do not meet the previously set criteria of three experts providing the same suggestion the question will remain unchanged in the final survey.

Question 11

The purpose of this question was to determine how correct the nurse's delegation decisions are based on nursing experience. All 10 experts provided answers for this question. All respondents believed the question was appropriate, clear and in the proper sequence for the survey. Because these suggestions do not meet the previously set criteria of three experts providing the same suggestion the question will remain unchanged in the final survey.

Question 12

The purpose of this question was to determine the use of delegation based on what they have learned in their educational program. The experts were asked whether the question was appropriate for the study, clear, in the correct sequence and complete. All 10 experts provided answers for this question. All respondents believed the question was appropriate, and in the proper sequence. Two experts (20%) believe the question is not clear.

Because these suggestions do not meet the previously set criteria of three experts providing the same suggestion the question will remain unchanged in the final survey.

Question 13

The purpose of this question was to determine the use of delegation based on what they have learned in their nursing experience. The experts were asked whether the question was appropriate for the study, clear, in the correct sequence and complete. All 10 experts provided answers for this question. All respondents believed the question was appropriate and in the proper sequence for the survey. One expert (10%) believes that the question was clear. Because these suggestions do not meet the previously set criteria of three experts providing the same suggestion the question will remain unchanged in the final survey.

Question 14

The purpose of this question was to determine nurse's use of delegation with a UAP that they regularly work the same shift. The experts were asked whether the question was appropriate for the study, clear, in the correct sequence and complete. All 10 experts provided answers for this question. All respondents believed the question was appropriate for the survey. One respondent (10%) believed the question was not in the proper sequence. Two experts (20%) believe that the question was unclear. Because these suggestions do not meet the previously set criteria of three

experts providing the same suggestion the question will remain unchanged in the final survey.

Question 15

The purpose of this question was to determine nurse's use of delegation with a UAP that is perceived to have a higher level of job competence. The experts were asked whether the question was appropriate for the study, clear, in the correct sequence and complete. All 10 experts provided answers for this question. One expert (10%) believes the question was not appropriate for the survey. One expert (10%) believes the question was not in the proper sequence. One expert (10%) believes that the question was unclear. Because these suggestions do not meet the previously set criteria of three experts providing the same suggestion the question will remain unchanged in the final survey.

Question 16

The purpose of this question was to determine nurse's use of delegation with a UAP in which they have a greater level of general communication with the UAP. All 10 experts provided answers for this. All experts (100%) believe that the question is appropriate, clear and in the proper sequence.

Additional Suggestions

Experts were provided the opportunity to make additional suggestions on all questions to improve the survey. About 50% of the experts believed that the wording" delegation decision making" was cumbersome. They

believed that it was confusing to the reader as to worded, presenting two concepts, delegation and decision making. Suggestions were made to remove the phrase and rework the questions that specifically used the phrase "delegation decision making", questions number 2,12 13 were modified in the final survey with this suggestion.

Results Summary

Only 5 questions were modified based on the input from the experts. The first change was to the wording of question 1. In the final version of the survey, the question has more clarity about delegation and the delegator.

Another change was to add an additional category, graduate school to question In the final version the choices will be as follows: nursing school, continuing education conference, on the job training, staff development in the work setting, other and post graduate education.

Another change involved narrowing down the percentages of delegation education, to provide for a more concise number the intervals were changed to intervals of 10 (i.e. 0 -10%, 10 – 20 %, etc).

Question 4 was modified and moved to become question 5 in the final survey. The question was modified to be more definitive about the understanding of the scope of practice of the UAP

Question 5 was out of sequence per most experts, so this question was moved to become question 4 in the final survey.

## Conclusion

The purpose of this paper was to describe the development and validation of a survey to be used to determine confidence in delegation by registered nurses when working with UAPs. The survey was developed after a thorough review of published literature describing issues with confidence in delegation. Validation of the survey was performed by experts in healthcare and research and to ensure that the survey was appropriate, clear and information was presented in the proper sequence. Validating the survey for content validity.

Survey validation allows the researcher to ensure that the survey will adequately capture the appropriate information necessary to conduct the research. Overall the experts believed that the survey was clear and appropriate and the questions were presented in the proper sequence. Only minor changes were made to the final version of the survey and all were made to improve the clarity of the survey. All changes are incorporated into the final survey, Appendix I.

# Appendix H

## Expert Survey

September 21, 2007

Dear Healthcare Educator/Administrator:

I am a doctoral student at Seton Hall University in the School of Graduate Medical Education. Your name was provided to me as an expert in healthcare and research by Dr. Genevieve Pinto-Zipp, Chair, Graduate Programs in Health Sciences. I would appreciate your input on the appropriateness, clarity, and sequence of the questions in the attached draft survey. After the final version of the survey has been developed, a sample of Registered Nurses in New Jersey will be invited to participate in its completion during the study.

The purpose of this study is to further explore, describe and examine the nature of the relationship between Registered Nurse leadership style and confidence in delegation of tasks to unlicensed assistive personnel in acute care hospitals. The secondary purpose is to bridge the gap in the literature concerning leadership-delegation knowledge specifically in the context of Registered Nurse leadership style in the patient care units today. Finally this study will serve as a catalyst for more discourses and investigation on the influence of leadership style and delegation to unlicensed assistive personnel.

Please provide your responses and comments in the grey box below each question on the enclosed survey. Please also use the following definitions when providing your feedback:

Appropriate: The survey question and answers are suitable for this study.

Clear: The survey question and answers are easy to understand.

Sequence: The survey questions and answers are presented in a logical order.

Your thoughtful response to this request should take no longer than 20 minutes. Please return your comments to Joann DeBerto, secretary, Seton Hall Graduate Programs in Health Science, no later than October 1, 2007. Joanne DeBerto's email address is **debertjo@shu.edu** . Upon completion of the data analysis, the final results of the study will be provided to you.

Sincerely,

Scott J. Saccomano

Confidence and Ability to Delegate Questionnaire

Section 1: Demographic Information

1. Gender: _____Male _____Female

2. Age in years: _____20-24 _____25-29 _____30-34 _____35-39
_____40-44 _____45-49 _____50-54 _____55+

4. Ethic Background

___African American
___Caucasian
___Native American
___Hispanic
___Other_____

5. Total number of years of nursing experience_____

6. Total number of years in this nursing unit_____

7. Total number of years in this hospital_____

8. Educational Background

___ Diploma in Nursing
___Associates Degree in Nursing
___Bachelor of Science in Nursing
___Bachelor's degree in other field
___Master's degree in Nursing
___Dual Master's degree __MSN/MBA_____Other
___Masters degree in other field
___Doctoral degree in Nursing
___Doctoral degree in other field

Section 2: Delegation Questions

1. Have you ever been exposed to the concept of delegation (the transfer of responsibility for the performance of an activity from one individual to another while retaining accountability for the outcome" decision making in the past?
   _____yes _____no

If yes, please answer questions 2 and 3, if no please proceed to question 4.

Is Question #1 appropriate for this survey, yes or no?
If no, what are your suggestions for improvement?

Is Question #1 clear, yes or no?
If no, what are your suggestions for improvement?

Is Question #1 in the correct sequence, yes or no?
If no, what are your suggestions for improvement?

2. Please indicate all situations that exposed you to delegation decision making.

_____nursing school
_____on the job training
_____other_____
_____continuing education conference
_____staff development in the work setting

Is Question #2 appropriate for this survey, yes or no?
If no, what are your suggestions for improvement?

Is Question #2 clear, yes or no?
If no, what are your suggestions for improvement?

Is Question #2 in the correct sequence, yes or no?
If no, what are your suggestions for improvement?

3. Please indicate approximately what percentage of your nursing school educational preparation included delegation.
<25% 25-50% 50-75% >75%

Is Question #3 appropriate for this survey, yes or no?
If no, what are your suggestions for improvement?

Is Question #3 clear, yes or no?
If no, what are your suggestions for improvement?

Is Question #3 in the correct sequence, yes or no?
If no, what are your suggestions for improvement?

4. Are you familiar with the scope of practice of the UAP (Unlicensed Assistive personnel/Nursing Assistants)
_____yes _____no

Is Question #4 appropriate for this survey, yes or no?
If no, what are your suggestions for improvement?

Is Question #4 clear, yes or no?
If no, what are your suggestions for improvement?

Is Question #4 in the correct sequence, yes or no?
If no, what are your suggestions for improvement?

5. Do you current use delegation skills on your nursing unit?
_____yes _____no

Is Question #5 appropriate for this survey, yes or no?

If no, what are your suggestions for improvement?

Is Question #5 clear, yes or no?
If no, what are your suggestions for improvement?

Is Question #5 in the correct sequence, yes or no?
If no, what are your suggestions for improvement?

6. Is the job description for a UAP consistent with their scope of practice on your unit?
_____yes _____no
Is Question #6 appropriate for this survey, yes or no?
If no, what are your suggestions for improvement?

Is Question #6 clear, yes or no?
If no, what are your suggestions for improvement?

Is Question #6 in the correct sequence, yes or no?
If no, what are your suggestions for improvement?

7. Do you know your legal responsibility when supervising a UAP/nursing assistant?

_____yes _____no

Is Question #7 appropriate for this survey, yes or no?
If no, what are your suggestions for improvement?

Is Question #7 clear, yes or no?
If no, what are your suggestions for improvement?

Is Question #7 in the correct sequence, yes or no?
If no, what are your suggestions for improvement?

.

8. How confident are you with delegating to UAP's while at work?

1 2 3 4 5 6 7 8 9 10

No Confidence Highly Confident

Is Question #8 appropriate for this survey, yes or no?
If no, what are your suggestions for improvement?

Is Question #8 clear, yes or no?
If no, what are your suggestions for improvement?

Is Question #8 in the correct sequence, yes or no?
If no, what are your suggestions for improvement?

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

1 2 3 4 5 6 7 8 9 10

Never Many Times a Day

Is Question #9 appropriate for this survey, yes or no?
If no, what are your suggestions for improvement?

Is Question #9 clear, yes or no?
If no, what are your suggestions for improvement?

Is Question #9 in the correct sequence, yes or no?
If no, what are your suggestions for improvement?

10. Do you feel the delegation decisions you make are likely to be correct based on your educational preparation?

1 2 3 4 5 6 7 8 9 10

Agree Disagree

Is Question #10 appropriate for this survey, yes or no?
If no, what are your suggestions for improvement?

Is Question #10 clear, yes or no?
If no, what are your suggestions for improvement?

Is Question #10 in the correct sequence, yes or no?
If no, what are your suggestions for improvement?

11. Do you feel the delegation decisions you make are likely to be appropriate based on your nursing experience?

1 2 3 4 5 6 7 8 9 10

Agree Disagree

Is Question #11 appropriate for this survey, yes or no?
If no, what are your suggestions for improvement?

Is Question #11 clear, yes or no?
If no, what are your suggestions for improvement?

Is Question #11 in the correct sequence, yes or no?
If no, what are your suggestions for improvement?

12. "Based on what you learned in your educational preparation," are you likely to use delegation decision making?

1 2 3 4 5 6 7 8 9 10

Not Likely More Likely

Is Question #12 appropriate for this survey, yes or no?
If no, what are your suggestions for improvement?

Is Question #12 clear, yes or no?
If no, what are your suggestions for improvement?

Is Question #12 in the correct sequence, yes or no?
If no, what are your suggestions for improvement?

13. "Based on your nursing clinical work experience," are you likely to use delegation decision making?

1 2 3 4 5 6 7 8 9 10

Not Likely More Likely

Is Question #13 appropriate for this survey, yes or no?
If no, what are your suggestions for improvement?

Is Question #13 clear, yes or no?
If no, what are your suggestions for improvement?

Is Question #13 in the correct sequence, yes or no?
If no, what are your suggestions for improvement?

14. Are you more likely to utilize delegation skills in your daily practice with a UAP with whom you more regularly work the same shift as compared with a UAP with whom you don't share shifts with regularly?

1 2 3 4 5 6 7 8 9 10

Not Likely More Likely

Is Question #14 appropriate for this survey, yes or no?
If no, what are your suggestions for improvement?

Is Question #14 clear, yes or no?
If no, what are your suggestions for improvement?

Is Question #14 in the correct sequence, yes or no?
If no, what are your suggestions for improvement?

15. Are you more likely to delegate to a UAP who you perceive to have a higher level of job competence than to a UAP you perceive to be of lower job competence?

1 2 3 4 5 6 7 8 9 10

Not Likely More Likely

Is Question #15 appropriate for this survey, yes or no?
If no, what are your suggestions for improvement?

Is Question #15 clear, yes or no?
If no, what are your suggestions for improvement?

Is Question #15 in the correct sequence, yes or no?
If no, what are your suggestions for improvement?

16. Are you more likely to delegate to a UAP with whom you have a greater level of general communication than to a UAP with whom you don't share much communication?

1 2 3 4 5 6 7 8 9 10

Not Likely More Likely

Is Question #16 appropriate for this survey, yes or no?
If no, what are your suggestions for improvement?

Is Question #16 clear, yes or no?
If no, what are your suggestions for improvement?

Is Question #16 in the correct sequence, yes or no?
If no, what are your suggestions for improvement?

# Appendix I

## Final Survey

### Confidence and Intent to Delegate Survey

### Section 1: Demographic Information

1. Gender: ____Male ____Female

2. Please specify your age_____

3. Ethic Background (please check only one)

   ___African American
   ___Caucasian
   ___Native American
   ___Hispanic
   ___Other_____

3. Total number of years of RN nursing clinical experience_____

4. Total number of years in this nursing unit_____

5. Total number of years in this hospital_____

6. Educational Background (highest degree completed)

   ___ Diploma in Nursing
   ___Associates Degree in Nursing
   ___Bachelor of Science in Nursing
   ___Bachelor's degree in other field
   ___Master's degree in Nursing
   ___Dual Master's degree __MSN/MBA_____Other
   ___Masters degree in other field
   ___Doctoral degree in Nursing
   ___Doctoral degree in other field

Section 2: Delegation Questions

1. Have you ever been exposed to the concept of delegation; the transfer of responsibility for the performance of an activity from one individual to another. (The delegator retains the responsibility for actions/outcomes of the delegate.

   ____**YES** ____**NO**

   If **YES**, please answer questions 2 and 3, if **NO** please proceed to question 4.

2. Please indicate in all situations in which you were exposed to delegation: material that exposed you to delegation decision making?

   ____nursing school ____continuing education conference
   ____On the job training ____Staff development in the work setting
   ____other_____ ____Post graduate education

3. Please indicate approximately what percentage of your nursing school education included knowledge about or education on delegation.

   _____0 – 9% _____50 – 59%
   _____ 10 –19% _____60 – 69 %
   _____ 20 - 29% _____70 – 79%
   _____ 30 – 39% _____80 – 89%
   _____ 40 – 49% _____90 – 100%

4. Do you currently or have you in the past used delegation skills on your nursing unit in this hospital.

   ____yes ____no

5. Have you read the scope of practice of the UAP (Unlicensed Assistive personnel/Nursing Assistants) as permitted in your state?

   ____yes ____no

6. Is the job description for a UAP consistent with their scope of practice on your unit?

   ___yes ___no

7. Do you know your legal responsibility when supervising a UAP/ nursing assistant?

___yes ___no

8. How confident are you with delegating to UAP's while at work?

1 2 3 4 5 6 7 8 9 10

No Confidence — Highly Confident

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

1 2 3 4 5 6 7 8 9 10

Never — Many Times a Day

10. Do you feel the delegation decisions you make are likely to be correct based on your educational preparation?

1 2 3 4 5 6 7 8 9 10

Not Correct — Highly Correct

11. Do you feel the delegation decisions you make are likely to be correct based on your nursing experience?

1 2 3 4 5 6 7 8 9 10

Not Correct — Highly Correct

12. "Based on what you learned in your educational preparation, are you likely to use delegation in your clinical nursing practice?

1 2 3 4 5 6 7 8 9 10

Not Likely — More Likely

13. "Based on your nursing experience, are you likely to use delegation in your clinical nursing practice?

1 2 3 4 5 6 7 8 9 10

Not Likely — More Likely

14. Are you more likely to utilize delegation skills in your daily practice with a UAP with whom you more regularly work the same shift as compared with a UAP with whom you don't share shifts with regularly?

1 2 3 4 5 6 7 8 9 10

Not Likely — More Likely

15. Are you more likely to delegate to a UAP who you perceive to have a higher level of job competence than to a UAP you perceive to be of lower job competence?

1 2 3 4 5 6 7 8 9 10

Not Likely — More Likely

16. Are you more likely to delegate to a UAP with whom you have a greater level of general communication than to a UAP with whom you don't share much communication?

1 2 3 4 5 6 7 8 9 10

Not Likely — More Likely

Appendix J

# COMMUNITY MEDICAL CENTER

*An affiliate of the Saint Barnabas Health Care System*

RONALD E. DIELMAN
President and Chief Executive Officer
Saint Barnabas Health Care System

MARK D. PELLA
Executive Vice President
Saint Barnabas Health Care System
and
Executive Director
Community Medical Center

January 7, 2008

Scott Saccomano, APRN-BC, GNP
21 Bucyrus Avenue
Carmel, New York 10512

**RE: IRB #: 07-019**
**Registered Nurse Leadership Style and Delegation to Unlicensed Assistive Personnel: An Exploration of Confidence**

Dear Mr. Saccomano:

The above referenced protocol was submitted to the Institutional Review Board of Community Medical Center for Initial Review and met the requirements of **Expedited Review Category 7**. This protocol was reviewed on January 7, 2008 and approved on its scientific, safety, ethical and socio-economical merits in accordance with Institutional and Federal regulations of the Institutional Review Board.

This approved initial review will be subject to review within twelve (12) months of the above approval date by the Community Medical Center Institutional Review Board. Pease note that this approval will expire on **January 6, 2009**.

The full Institutional Review Board of Community Medical Center will be notified of this approval at their next convened meeting and will be reflected in the minutes.

Sincerely,

Paul Simon, DO
Associate Chairman
Institutional Review Board

PS\tmn

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# Appendix K

Total Confidence Scores for Nurses with Supportive, Directive or Participative Leadership Styles (N = 158)

| Leadership Styles | N | M | SD | F | p |
|---|---|---|---|---|---|
| Supportive | 93 | 38.88 | 12.91 | 1.44 | .24 |
| Directive | 53 | 41.85 | 7.31 | | |
| Participative | 12 | 37.83 | 7.18 | | |

# Appendix L

Average Age of Nurses with Supportive, Directive or Participative Leadership Styles

| Leadership style | M | SD | F | p |
|---|---|---|---|---|
| Supportive | 39.11 | 27.76 | 0.17 | .84 |
| Directive | 41.13 | 22.01 | | |
| Participative | 37.25 | 8.32 | | |

# Appendix M

Years of Nursing Experience for Nurses with Supportive, Directive or Participative Leadership Styles.

| Leadership Style | M | SD | F | p |
|---|---|---|---|---|
| Supportive | 14.73 | 11.49 | 2.95 | .06 |
| Directive | 18.30 | 10.99 | | |
| Participative | 10.92 | 6.51 | | |

# Appendix N

Years Worked on Hospital Unit for Nurses with Supportive, Directive or Participative Leadership Styles

| Leadership Style | M | SD | F | p |
|---|---|---|---|---|
| Supportive | 5.28 | 17.13 | 1.86 | .16 |
| Directive | 9.84 | 8.74 | | |
| Participative | 4.85 | 3.98 | | |

Appendix O

Confidence Scores for Delegation Question #8 for Nurses Grouped by Leadership Style

Delegation Question: How confident are you delegating to UAPs while at work?

| Leadership Style | M | SD | F | p |
|---|---|---|---|---|
| Supportive | 7.33 | 1.98 | 2.62 | .08 |
| Directive | 8.23 | 1.86 | | |
| Participative | 7.25 | 1.91 | | |

# Appendix P

Confidence Scores for Delegation Question #10 for Nurses Grouped by Leadership Style

Delegation Question: Do you feel the delegation decisions you make are likely to be correct based on your educational preparation?

| Leadership Style | M | SD | F | p |
|---|---|---|---|---|
| Supportive | 7.84 | 1.91 | 2.16 | .12 |
| Directive | 8.28 | 1.63 | | |
| Participative | 7.17 | 1.95 | | |

# Appendix Q

Confidence Scores for Delegation Question #11 for Nurses Grouped by Leadership Style

Delegation Question: Do you feel the delegation decisions you make are likely to be correct based on your nursing experience?

| Leadership Style | N | Mean Ranks | $X^2$ | p |
|---|---|---|---|---|
| Supportive | 53 | 85.20 | 2.60 | .27 |
| Directive | 93 | 78.39 | | |
| Participative | 12 | 62.96 | | |

# Appendix R

Confidence Scores for Delegation Question #12 for Nurses Grouped by Leadership Style

Delegation Question: Based on what you learned in your educational preparation, are you likely to use delegation in your clinical nursing practice?

| Leadership Style | M | SD | F | p |
|---|---|---|---|---|
| Supportive | 8.06 | 1.99 | 0.43 | .65 |
| Directive | 8.28 | 1.91 | | |
| Participative | 7.75 | 2.09 | | |

# Appendix S

Confidence Scores for Delegation Question #13 for Nurses Grouped by Leadership Style

Delegation Question: Based on your nursing experience, are you likely to use delegation in your clinical nursing practice?

| Leadership Style | N | Mean Ranks | $X^2$ | p |
|---|---|---|---|---|
| Supportive | 53 | 86.50 | 2.21 | .33 |
| Directive | 93 | 76.67 | | |
| Participative | 12 | 70.54 | | |

# Appendix T

Confidence Scores for Delegation Question #8 for Nurses with Low, Medium and High Supportive Leadership Styles.

Delegation Question: How confident are you with delegating to UAPs while at work?

| Supportive Subgroup | M | SD | F | p |
|---|---|---|---|---|
| Low | 0.25 | 25.51 | 3.06 | .06 |
| Medium | 7.25 | 2.14 | | |
| High | 8.31 | 1.57 | | |

Appendix U

Confidence Scores for Delegation Question #11 for Nurses with Low, Medium and High Supportive Leadership Styles

Delegation Question: Do you feel the delegation decisions you make are likely to be correct based on your nursing experience?

| Leadership Subgroup | Mean Rank | $X^2$ | p |
|---|---|---|---|
| Low | 95.13 | 2.80 | .06 |
| Medium | 83.53 | | |
| High | 73.74 | | |

# Appendix V

Confidence Scores for Delegation Question #10 for Nurses with Low, Medium and High Supportive Leadership Styles

Delegation Question: Do you feel the delegation decisions you make are likely to be correct based on your educational preparation?

| Supportive Subgroup | M | SD | F | p |
|---|---|---|---|---|
| Low | 7.63 | 1.54 | 2.94 | ns |
| Medium | 7.47 | 1.94 | | |
| High | 8.54 | 1.84 | | |

# Appendix W

Confidence Scores for Delegation Question #12 for Nurses with Low, Medium and High Supportive Leadership Styles

Delegation Question: Based on what you learned in your educational preparation, are you likely to use delegation in your clinical nursing practice?

| Leadership Subgroup | M | SD | F | p |
|---|---|---|---|---|
| Low | 7.38 | 1.89 | 1.84 | .17 |
| Medium | 7.92 | 2.07 | | |
| High | 8.54 | 1.50 | | |

# Appendix X

Confidence Scores for Delegation Question #13 for Nurses with Low, Medium and High Supportive Leadership Styles

Delegation Question: Based on your nursing experience, are you likely to use delegation in your clinical nursing practice?

| Supportive Subgroup | Mean Rank | $X^2$ | p |
|---|---|---|---|
| Low | 43.90 | 2.90 | .07 |
| Medium | 62.37 | | |
| High | 77.11 | | |

# Appendix Y

Confidence Scores for Delegation Question #10 for the Nurses Grouped by Educational Preparation

Delegation Question: Do you feel the delegation decisions you make are likely to be correct based on your educational preparation?

| Educational Preparation | M | SD | F | p |
|---|---|---|---|---|
| Less than Bachelor's | 7.74 | 1.89 | 1.89 | .17 |
| At least a Bachelor's | 8.14 | 1.76 | | |

# Appendix Z

Confidence Scores for Delegation Question #12 for Nurses Grouped by Educational Preparation

Delegation Question: Based on what you learned in your educational preparation, are you likely to use delegation in your clinical nursing practice?

| Educational Preparation | M | SD | F | p |
|---|---|---|---|---|
| Less than Bachelor's | 7.91 | 2.03 | 1.77 | .19 |
| At least a Bachelor's | 8.33 | 1.88 | | |

# Appendix AA

Confidence Scores for Delegation Question #13 for Nurses Grouped by Educational Preparation

Delegation Question: Based on your nursing experience, are you likely to use delegation in your clinical nursing practice?

| Educational Preparation | Mean Rank | Sum of Ranks | U | p |
|---|---|---|---|---|
| Less than Bachelor's | 72.88 | 5976.00 | 2570 | .07 |
| At least a Bachelor's | 86.64 | 6585.00 | | |

# Appendix BB

Total Confidence Scores for Nurses Grouped by Clinical Nursing Experience

| Nursing Experience | M | SD | F | p |
|---|---|---|---|---|
| Less than 5 years | 39.41 | 7.73 | 0.06 | .80 |
| 5 or more years | 39.92 | 11.91 | | |

Appendix CC

Confidence Scores for Delegation Question #8 for Nurses Grouped by Clinical Nursing Experience

Delegation Question: How confident are you delegating to UAPs while at work

| Clinical Nursing Experience | M | SD | F | p |
|---|---|---|---|---|
| Less than 5 years | 7.51 | 1.98 | 0.06 | .80 |
| 5 or more years | 7.81 | 1.95 | | |

Appendix DD

Confidence Scores for Delegation Question #10 for Nurses Grouped by Clinical Nursing Experience

Delegation Question: Do you feel the delegation decisions you make are likely to be correct based on your educational preparation?

| Clinical Nursing Experience | M | SD | F | p |
|---|---|---|---|---|
| Less than 5 years | 7.59 | 1.79 | 1.86 | .18 |
| 5 or more years | 8.05 | 1.85 | | |

# Appendix EE

Confidence Scores for Delegation Question #11 for Nurses Grouped by Clinical Nursing Experience

Delegation Question: Do you feel the delegation decisions you make are likely to be correct based on your nursing experience?

| Clinical Nursing Experience | Mean Ranks | Sum of Ranks | U | p |
|---|---|---|---|---|
| Less than 5 years | 71.91 | 2804.5 | 2024.5 | .22 |
| 5 or more years | 81.99 | 9756.50 | | |

# Appendix FF

Confidence Scores for Delegation Question #12 for Nurses Grouped by Clinical Nursing Experience

Delegation Question: Based on what you learned in your educational preparation, are you likely to use delegation in your clinical nursing practice?

| Clinical Nursing Experience | M | SD | F | p |
|---|---|---|---|---|
| Less than 5 years | 8.02 | 1.83 | 0.10 | .75 |
| 5 or more years | 8.14 | 2.10 | | |

Appendix GG

Confidence Scores for Delegation Question #13 for Nurses Grouped by Clinical Nursing Experience

Delegation Question: Based on your nursing experience, are you likely to use delegation in your clinical nursing practice?

| Clinical Nursing Experience | Mean Rank | Sum of Ranks | U | p |
|---|---|---|---|---|
| Less than 5 years | 75.05 | 2927.00 | 2147 | .47 |
| 5 or more years | 80.96 | 9634.00 | | |