How does the delegation of tasks by Registered Nurses to Health Care Assistants occur in residential care for older people? Interpretive Multiple Embedded Case Study

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Declaration

I declare that this thesis, submitted to National University of Ireland, Galway for the degree of Doctor in Philosophy (Ph.D.), has been composed by me and is based on my own work, unless stated otherwise. No other person's work has been used without due acknowledgement in this thesis.

Publications arising from this research

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NU639	Systematic Review & Research Synthesis	20
NU1103	Leadership & Interprofessional Collaboration	20
NU1104	Research Practice	10

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List of Acronyms

ADoN	Assistant Director of Nursing
ANA	American Nurses Association
BCCNM	British Columbia College of Nurses and Midwives
CNM2	Clinical Nurse Manager 2
CSO	Central Statistics Office
DoH	Department of Health
DoHC	Department of Health and Children
DoN	Director of Nursing
HCA	Health Care Assistant
HIQA	Health Information and Quality Authority
HSE	Health Service Executive
ICN	International Council of Nurses
MTA	Multi-task Attendant
NMBA	Nursing and Midwifery Board of Australia
NMC	Nursing and Midwifery Council
NMBI	Nursing and Midwifery Board of Ireland
NSCN	Nova Scotia College of Nursing
NCSBN	National Council of State Boards of Nursing (USA)
NCNZ	Nursing Council of New Zealand
NIPEC	Northern Ireland Practice and Education Council
OECD	Organization for Economic Cooperation and Development
QQI	Quality & Qualifications Ireland
QQI L5	Quality & Qualifications Ireland Level 5
REC	Research Ethics Committee
RN	Registered Nurse
UK	United Kingdom
UN	United Nations
US	United States

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I dedicate this to the memory of Martina, my amazing, resilient, and courageous sister, who encountered a battle in life she could not win.

Your absence has gone through me
Like thread through a needle.
Everything I do is stitched with its color.

"Separation" W.S. Merwin

Abstract

There is a need to develop safe and effective nursing teams within residential care for older people (RCOP) with an appropriate and sustainable skill mix to meet the increasing demands of the ageing population. This requires that registered nurses (RNs) and healthcare assistants (HCAs) work collaboratively to their full scope of practice. In RCOP, where there are often less RNs than HCAs, delegation of tasks emerges as a critical issue. The aim of this study was to explore how delegation of tasks by RNs to HCAs occurred in RCOP settings in Ireland.

An interpretive, multiple case study research design was applied. Two cases were selected for in-depth study. The sub-units of analysis were the perspectives and experiences of the staff, the staff profiles and allocation model, documents relating to delegation, and the process of delegation in the real world of practice. The data sources were: focus-group interviews, individual interviews, direct observations during predicted periods of delegation, and documentary review. The framework for within-case and cross-case analysis was the interactive data analytical approach of Miles et al. (2020). The theoretical lens of organisational role theory, applying the Kahn et al. (1964) role episode model (REM), was used to understand, interpret and explain the findings.

Three themes were developed in relation to how the delegation of tasks by RNs to HCAs occurred in RCOP: *Creating the conditions*, *How it happens*, and *Knowing what I should do*. The facilitators and barriers for effective RN delegation were identified.

The role of the RN in RCOP is changing, and this has affected the context and process of effective delegation. With increasing demands for care of older people and increasing shortages of RNs in RCOP services the shifting of nursing tasks to HCAs has occurred. The findings of this study can guide the development of more effective RN delegation, contribute to improving RN and HCA role clarity, and ultimately support safe and quality care of vulnerable older people.

Chapter 1: Introduction

1.1 Introduction

This study seeks to understand how registered nurses (RNs) delegate tasks to healthcare assistants (HCAs) in the context of residential care for older people (RCOP). The role of the RN is changing in RCOP, moving from the traditional role of providing direct care to the residents to a more administrative and supervisory role. HCAs, who previously undertook cleaning and catering roles on a ward, are now providing most of the direct resident care and support. The introduction of the HCA to nursing teams was considered an appropriate and safe solution to the transition of nurse education to third-level institutions and a global shortage of nurses (Fealy et al., 2006; DoHC, 2001). This expanded role of the HCA is expected to occur through delegation from the RN, with the RN retaining accountability for overall resident care delivery. Delegation refers to when a healthcare worker, usually a registered practitioner, transfers a task or activity that is normally within their scope of practice to another healthcare worker but retains accountability for the task outcome (Dudley et al., 2021; Kærnested and Bragadóttir, 2012; Anthony et al., 2001). A registered nurse (RN) must make decisions on delegation of tasks and responsibilities based on protection of the patient or resident, taking account of "potential for harm", "complexity of care" and "unpredictability of outcome" (Mueller and Vogelsmeier, 2013, p.22). With increasing older-age population profiles, rising demand for RCOP services and increasing RN shortages, attention is more focused on effective nursing teams in RCOP. Effective RN delegation is critical for safe nursing care delivery. However, despite expectations from the nurse regulator, policymakers and employers that RNs delegate effectively to HCAs, there have been no previous studies in Ireland on the process of RN delegation.

This introductory chapter provides the background and context of the research study. RN delegation and associated terms are defined. An overview of factors that influenced the focus of this study, including ageing population, impact of increasing age profile on service redesign in RCOP services, the RN and HCA role, and working relationship are outlined. The rationale for the research and researcher motivation are presented. Finally, an outline of how the thesis is organised is provided.

1.2 Background and Context

The background and context of RN delegation, RCOP services in Ireland, changing RN and HCA roles, and evolving nursing care teams in RCOP are described in this section. The objective is to understand nursing teams in RCOP in the context of the changing role of RNs and the history of the introduction of the HCA in care delivery. It is important to understand RN delegation and other terms that are used in the context of delegation, including assignment, supervision and scope of practice. These definitions are explored and analysed next.

1.2.1 Defining Delegation

Professional regulators and nurse associations provide definitions for delegation (Nursing and Midwifery Board of Australia, 2020a; Nursing and Midwifery Board of Australia, 2020b; British Columbia College of Nurses and Midwives, 2020; National Council of State Boards of Nursing/ American Nurses Association, 2019; Nova Scotia College of Nursing, 2019; Nursing and Midwifery Council, 2018; National Council of State Boards of Nursing, 2016; Nursing and Midwifery Board of Ireland, 2015; Nursing Council of New Zealand, 2012). An analysis of these definitions reveal that, despite similarities in defining delegation, there are some variances in terminology (Table 1.1). All definitions refer to the transfer of an activity or task as opposed to a function, with NMBI (2015) including the transfer of a 'particular role'. The *delegator* (the RN) is defined as the person responsible for making the decision on to whom and what task or activity to delegate (Nursing and Midwifery Board of Australia, 2020a; Northern Ireland Practice and Education Council, 2019; National Council of State Boards of Nursing/American Nurses Association, 2019). The *delegatee* is the person who is delegated nursing care tasks or activities (the HCA) (NMBAa, 2020; NIPEC, 2019; NCSBN/ANA, 2019). NMBI (2015) states that the RN is accountable for the decision to delegate while the delegatee is accountable for appropriately performing the delegated task or activity. The Northern Ireland Nurse Education Council states that the RN is accountable for the overall plan of care and the decision to delegate, and that the RN is not accountable for the decisions and actions of the delegatee (HCA) (NIPEC, 2019). This is a more direct statement on the accountability of the delegatee than provided by the United Kingdom (UK) Nursing and Midwifery Council and the Nursing and Midwifery Board of Ireland (NMBI). NMBI (2015) does not refer to the delegator retaining accountability for overall care. However, the United States of America (USA) National Council of State Boards of Nursing (NCSBN) and American Nurses Association (ANA) (2019) refer to the RN retaining accountability for care of the patient while the delegatee is responsible for the delegated task. The ANA Principles for Delegation (2012) state that the delegatee is responsible for performing the delegated task or activity, while the RN retains accountability for patient outcomes associated with nurse delegation. The nurse regulators

in Ireland and the UK do not provide specific guidance on decision-making criteria for RNs to delegate or on the process of delegation. Although the term 'delegation' is consistent across the regulatory definitions, there is lack of consistency in terminology in the definition; for example, transfer, allocate or assign (Table 1.1).

Table 1.1: Examples of Definitions of Delegation in Nursing

Definition of Delegation	Nurse Regulator/Nurse Association and Year
"Delegation takes place where the nurse or midwife (the delegator) who has the authority for the delivery of healthcare, transfers to another person the responsibility of a particular role or activity that is normally within the scope of practice of the delegator… The delegator must be available to provide the necessary and appropriate level of supervision required by the delegate… Supervision may be 'direct' or 'indirect'". (NMBI, 2015a, p. 21)	Nursing and Midwifery Board of Ireland, 2015)
"the process by which a nurse or midwife (delegator) allocates clinical or non-clinical tasks and duties to a competent person (delegatee). The delegator remains accountable for the overall management of practice, for example, in a clinical context: the plan of care for a service user, and accountable for the decision to delegate. The delegator will not be accountable for the decisions and actions of the delegatee." (NIPEC, 2019, p.5)	Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC), 2019
"Delegation is defined as the transfer to a competent individual, of the authority to perform a specific task in a specified situation." (NMC, 2018, p.3)	Nursing and Midwifery Council (UK), 2018
"Delegation generally involves assignment of the performance of activities or tasks related to patient care to unlicensed assistive personnel while retaining accountability for the outcome. The registered nurse cannot delegate responsibilities related to making nursing judgments." (ANA, 2012, p.5).	American Nurses Association, 2012
"Delegation is the transfer of responsibility for the performance of an activity from one person to another with the former retaining accountability for the outcome." (NCNZ, 2012p.5)	National Council of New Zealand, 2012
"Delegating to an unregulated care provider occurs when the required task is performed primarily by registered nurses and is outside the role description and training of the unregulated care provider. The delegated task is always client-specific and the delegation is determined to be in that client's best interest. As with assigning, registered nurses delegate tasks, not functions to unregulated care providers. The registered nurse is responsible and accountable for the overall assessment, determination of client status, care planning, interventions and evaluation of care. Overall client care and the decision-making used to determine that care cannot be delegated. The delegating registered nurse is responsible and accountable for providing ongoing supervision to assess the unregulated care provider's ability to perform the delegated task. The unregulated care provider is accountable to the delegating registered nurse for performing the delegated task as taught and for reporting to the delegating registered nurse according to the care plan and agency policies." (p. 5)	British Columbia College of Nurses and Midwives (BCCNM), December 2020
"Transferring responsibility for the performance of an activity while retaining accountability for the outcome."	OECD, 2020, p.12

Delegation is different to assignment and supervision, as outlined in the following section.

1.2.1.1 Assignment

The Nursing and Midwifery Board of Australia (NMBA, 2020) defines delegation and the principles of delegation, stating that delegation is different from allocation or assignment of tasks, but does not provide a definition of task assignment or allocation. However, in the US, delegation is differentiated from *assignment* (NCSBN/ANA, 2019; NCSBN, 2005; Weydt, 2010; Matthews, 2010). Delegation is a task from the RN's practice given to someone else, and assignment or allocation is described as the RN giving a task to the HCA that is within the job description and core tasks of the HCA role (NCSBN/ANA, 2019; NCSBN, 2005). The ANA (2012, p.5) defined assignment as "the distribution of work that each staff member is responsible for during a given work period". Similarly, in Canada, task assignment from an RN to a HCA is differentiated from delegation when the task or activity is within the HCA core skillset (Saari et al., 2018). In Canada, the British Columbia College of Nurses and Midwives (BCCNM, 2020) provides a definition of assignment, together with identification of responsibilities of the employer and the RN. It defines assignment as follows:

> "Assignment occurs when the required task falls within the unregulated care provider's role description and training, as defined by the employer/supervisor. The employer is responsible and accountable for developing role descriptions that clearly outline the tasks that can be assigned to an unregulated care provider in that agency/health authority… After determining care needs, the registered nurse assigns tasks, not clients or functions, to unregulated care providers. The registered nurse is responsible and accountable for assigning tasks within the role description of the unregulated care provider and for providing guidance to the unregulated care provider." (BCCNM, 2020, p.4)

There is no reference to assignment or allocation in Irish and UK nursing regulations or guidance. However, the review of the role and function of the HCA in Ireland identified the need to recognise the difference between tasks assigned and delegated to the HCA (HSE, 2018).

The term *supervision* is used with delegation in many nurse regulatory publications.

1.2.1.2 Supervision

The nurse regulator in Ireland describes supervision as "overseeing, direction, guidance, support and evaluation" (NMBI, 2015a, p.21). Similar definitions are found in papers from nursing organisations where supervision is defined as an active process of providing guidance, direction, oversight or evaluation of an individual's performance of a task or activity (NIPEC, 2019; ANA, 2012; NCSBN, 2006). NMBI (2015a) classifies supervision as direct or indirect. Direct supervision is defined as when the RN is with or working alongside the HCA when the HCA is undertaking a task or activity that has been delegated to them (NMBI, 2015a). Indirect supervision occurs when the RN does not observe the HCA undertaking a delegated task or activity (NMBI, 2015a). These terms are not evident in other nurse

regulator literature. In the US, the NCSBN/ANA (2019) differentiates delegation from 'handoff', defining handoff as the transfer of patient care responsibility from one RN to another RN. There is no reference to *implicit* or *explicit* delegation in the nurse regulator literature reviewed. However, RNs are expected to make delegation decisions within their professional scope of practice guidance.

1.2.1.3 RN Scope of Practice

RN scope of practice is "the range of roles, functions, responsibilities and activities, which a registered nurse… is educated, competent, and has the authority to perform" (NMBI, 2015a, p.3). In Ireland, similar to other countries, the NMBI provides guidance to RNs for decision-making in practice, enabling the RN to work to their full scope of practice. Nurse regulators in Australia, New Zealand, Canada and the US provide specific guidance to RNs for delegation through a decision-making framework (decision tree or decision matrix) or a delegation guidance document (NMBA, 2020; BCCNM, 2020; NCSBN/ANA, 2019; NSCN, 2019; NCSBN, 2016; NCNZ, 2012). However, the UK and Ireland outline professional expectations on delegation only within the Code of Professional Practice and the Scope of Practice (NMBI, 2021; NMC, 2018; NMBI, 2015a). The decision-making frameworks for RN delegation provide a step-by-step decision-making process for safe delegation by posing questions in relation to scope of practice, competence of the delegatee, if there are policies or procedures to support delegation, and the capacity to supervise and evaluate the delegation. There was no indication as to why these countries have addressed the difference in terminology, but there is an associated high level of publications on RN delegation and supervision in Canada and the US.

In the US, the National Council of State Boards of Nursing (NCSBN), of which 59 US nursing regulatory bodies (NRBs) are members, and the American Nurses Association issue advice and guidance for nurses about delegation (NCSBN/ANA, 2019; Anderson, 2018; NCSBN, 2016). A common guide for RNs on the process refers to five 'rights' in delegation: the right task, the right circumstance, the right person, the right direction and communication, and the right supervision and evaluation, to be undertaken within the scope of practice of the RN (Anderson, 2018; NCSBN, 2016). The 'right task' refers to the task or activity being delegated to the right person, *the delegatee,* ensuring that the task matches their job specification, education, skills and competencies, and is supported with delegation workplace policies and guidelines (Anderson, 2018; NCSBN, 2016). Delegation should only occur in the 'right circumstances' based on the acuity and dependency needs of the patient; if the patient case is complex or unstable, delegation is often not appropriate. The RN is accountable for the decision of who to delegate to, ensuring that the delegatee is the 'right person', competent and skilled, to undertake the task. The 'right communication' must be direct, two-way communication between the delegator (RN) and the delegatee (HCA/unregistered care staff), enabling clear instructions to be given

and understood, and confirmation of competence and scope of practice, i.e. 'right direction and communication'. The RN is responsible for the 'right supervision and evaluation' of the delegatee in completing the delegated task, including assessing patient outcomes and ensuring that care is appropriately documented (Anderson, 2018; NCSBN, 2016).

The NCSBN had proposed a decision-making process as the regulatory model for RN delegation to HCAs (NCSBN, 2005). This process was presented as four steps: (i) Assess and Plan, (ii) Communication, (iii) Surveillance and Supervision, (iv) Evaluation and Feedback. Step one, Assess and Plan, was supported with a decision-making tree for the RN, posing critical questions to be answered, with a flowsheet supporting 'yes' and 'no' decisions (NCSNN, 2005). This decision-making process and decision-making tree are comparable with the Irish regulator's *Scope of Practice decision-making flowchart* (NMBI, 2015a). However, the NMBI flowchart is generalised to a role or activity that the RN will undertake rather than the RN's decision-making for delegation (NMBI, 2015a). In 2014 the NMBI commissioned a national review of the scope of nursing and midwifery practice framework and conducted a national stakeholder survey of RNs and midwives (n=2354). The review focused predominantly on the RN expanding their practice safely, including medically delegated clinical tasks (Fealy et al., 2014). Fealy et al. (2014) found that clarification of the core nursing role and function would clarify scope of practice and thus decisions regarding delegation of nursing tasks and activities. Although RNs were aware of their accountability in delegation, there were concerns about delegation to non-registered staff and establishing the competence of those they delegated to (Fealy et al., 2014). The NMBI (2015) Scope of Practice was developed on the basis of this review, including an enhanced section on RN delegation.

The following section describes the wider context within which the study is conducted. As the average age of the population increases, there are incremental increasing health and social care needs, including residential care. The redesign of health service delivery is described. However, the global shortage of nurses is resulting in an increase in non-registered nursing staff delivering care and support in RCOP settings. This results in a need for effective RN delegation to support safe, quality care.

1.2.2 Changing Population Demographics

The United Nations (UN) projects that the number of people aged 65 or over globally will more than double to 1.5 billion by 2050, with people aged 80 and over tripling (United Nations, 2019). Similarly, the Organization for Economic Cooperation and Development (OECD, 2020) predicts that the number of people over 80 years old will rise, in OECD countries, from 57 million in 2016 to more than 1.2 billion

in 2050. This predicted population growth of the older age cohorts is also evident in Ireland. The Central Statistics Office (CSO, 2017) projects that the number of people aged 65 years and over will increase from 629,800 (2016) to 1.6 million by 2051 (Central Statistics Office, 2019). The predicted increase by 2051 for those aged 80 and over is from 147,800 in 2016 to 540,000 (CSO, 2019). It is expected that most older people will maintain their independence or have care delivered at home (Department of Health, 2018). However, an increasing number of older people will require residential care and support. The redesign of health and social care delivery in Ireland has included the recognition that there are additional capacity requirements for the increasing older population.

1.2.2.1 Health Service Redesign and Capacity

In Ireland, the Report of the Oireachtas Committee on the Future of Health (Houses of the Oireachtas Committee on the Future of Healthcare, 2017) advocates for a health service redesign to enable delivery of care primarily in the community. This political cross-party report provides current and future Irish governments with a strategy for healthcare redesign and delivery. The strategy is implemented in the Irish public health service through a system-wide approach, named Sláintecare (Government of Ireland, 2019). The Health Service Capacity Review report (DoH, 2018) provided a systematic analysis of the health system in Ireland, with predictions for capacity requirements for 2017 to 2031. The report predicts a 59% increase in the number of people aged 65 years and older and a 95% growth in the number of people aged 85 years and older by 2031 (DoH, 2018). The 65+ cohort were identified as the largest users of all healthcare services. Those aged 85+ represented 40% to 50% of those receiving care in older persons services (DoH, 2018). Furthermore, the report projects a requirement for 13,000 residential care beds and a 120% increase in home care (including home care packages and home help) in Ireland.

International healthcare policy aims to ensure that older people remain in their homes as long as possible (Barken and Armstrong, 2018; Burrow et al., 2017; Shannon and McKenzie-Green, 2016). Sláintecare takes the same approach. Residential care for older people (RCOP) is a term that describes the long-term care facilities for people who can no longer live independently, or be supported to live, in their own home. Terms used to describe residential care for older people include: nursing home, community nursing unit, geriatric hospital, long-term care facility and rest home. Many RCOP facilities also provide short-stay respite care (Health Information and Quality Authority, 2016). In Ireland RCOP, services are managed by public, voluntary or private organisations (HIQA, 2016). There are implications for workforce planning as many of those admitted to RCOP facilities have multiple complex chronic illnesses and advanced cognitive impairment, and rely greatly on assistance with the

activities of daily living (Barken and Armstrong, 2018; Shannon and McKenzie-Green, 2016; Mueller and Vogelsmeier, 2013).

In many countries there are independent bodies responsible for monitoring and inspecting the quality of RCOP through regulation and registration of RCOP facilities. In Australia, this falls to the Australian Aged Quality Agency; in England to the Care Quality Commission; in Northern Ireland, to the Regulation and Quality Improvement Authority, and in the Republic of Ireland to the Health and Information Quality Authority (HIQA). Regulation ensures that RCOP operators provide quality care, safety and dignity for residents (Meenan et al., 2015). This is achieved through regulatory inspection of facilities, announced, unannounced and themed; enforcement, and registration to operate (Meenan et al., 2015). HIQA operates under the Health Act 2007 (amended), which provides "the legislative basis for the monitoring, inspection and registration of residential services ('designated centres'), where older people live, against the associated regulations and these Standards" (HIQA, 2016, p.5). HIQA has the authority and responsibility to regulate RCOP (designated centres) through inspection and monitoring, registration of the RCOP facility, and legislative powers of enforcement. *HIQA Standards for Residential Care Settings for Older People in Ireland* (2016) outlines quality and safety within eight standards that form the basis for inspection (see Table 1.2). Although all quality and safety themes are relevant to this study, themes 5, 6 and 7, related to management, organisational support and governance, are particularly pertinent in the context of delegation. The availability of an adequate and appropriate supply of RNs, HCAs and clinical nurse managers to match residents' care needs, as outlined in the HIQA standards, can significantly affect delegation.

Table 1.2: Quality and Safety Themes Described in the Standards (HIQA, 2016, p.6)

Theme 1. Person-centred Care and Support – how residential services place people at the centre of what they do.
Theme 2. Effective Services – how residential services deliver best outcomes and a good quality of life for people, using best available evidence and information.
Theme 3. Safe Services – how residential services protect people and promote their welfare. Safe services also avoid, prevent and minimise harm, and learn from things when they go wrong.
Theme 4. Health and Wellbeing – how residential services identify and promote optimum health and wellbeing for people. Delivering improvements within these quality themes depends on services having capability and capacity in four key areas, as outlined in the following themes:
Theme 5. Leadership, Governance and Management – the arrangements put in place by a residential service for accountability, decision-making, risk management as well as meeting its strategic, statutory and financial obligations.
Theme 6. Use of Resources – using resources effectively and efficiently to deliver best achievable outcomes for people for the money and resources used.
Theme 7. Responsive Workforce – planning, recruiting, managing and organising staff with the necessary numbers, skills and competencies to respond to the needs and preferences of people in residential services.
Theme 8. Use of Information – actively using information as a resource for planning, delivering, monitoring, managing and improving care.

The HIQA standards (2016) are designed to promote a person-centred approach to care of all residents. This requires care and support in RCOP to have moved from a traditional approach to nursing care and routine tasks to a person-centred approach to care. Person-centred care focuses on "treating people as individuals; respecting their rights as a person; building mutual trust and understanding; and developing therapeutic relationships" (McCormack and McCance, 2016, p.1). Since 2007 there have been proactive efforts to adopt person-centred practice in RCOP services across the Irish public health service, moving from a task-orientated approach to care delivery (Buckley et al., 2018; McCormack et al., 2010). An evaluation of practice developments in RCOP care environments found that the work environment and working relationships had a significant impact on staff's ability to adopt a person-centred approach (Buckley et al., 2018; McCormack et al., 2010). Heavy workload caused stress among RNs and inhibited them from spending time engaging in person-centred relationships with residents and their families. Ryan and McKenna (2015) reported that staffing factors other than staff numbers affected quality of care in RCOP. Education and experience of staff, staffing stability (e.g. use of agency staff replacements) and management affected whether a person-centred or task-oriented approach to care delivery was adopted (Ryan and McKenna, 2015).

1.2.2.2 Nursing Shortage

Occurring in tandem with the identification of challenges to maintain safe staffing levels in RCOP is an increasing global shortage of nurses, currently estimated at 5.9 million (WHO, 2020a). The World Health Organization (WHO) estimates there will be a shortage of 18 million healthcare workers by 2030; that 50% of the global health workforce are nurses and midwives, accounting for 50% of the current shortage of health workers (WHO, 2020b), and that by 2030 an additional 10.6 million nurses and midwives will be required (WHO, 2020a). This projected pattern will increase RN workloads and ratios of RNs to residents/patients. This is likely to result in further task shifting from RN to HCAs, increasing the responsibility and accountability of the HCA (Dudley et al., 2021; Huang et al., 2011). Previous studies found that the global shortage of nurses and staff cost efficiencies affects nursing team configuration and skill mix, patient safety and quality of care (OECD, 2020; Drennan et al., 2018; Aiken et al., 2017; Anthony and Vidal, 2010). However, there is less empirical evidence as to the skill mix of RNs and HCAs working together in nursing teams to ensure patient safety and quality of care. To understand this working relationship, an overview of the RN and HCA roles is outlined in the following section.

1.3 Nursing Care Teams in ROCP

Skill mix is the term applied in nursing to the mix of qualifications, grade and experience of registered (licensed, professional, registered) nursing staff and unregistered (unlicensed, HCA) care staff on a nursing care team (Butler et al., 2019; Lavander et al., 2016; Department of Health, 2016; Walker et al., 2015; Huang et al., 2011). The introduction of skill mix in nursing care teams resulted in expansion and extension of roles, task shifting and delegation (Drennan et al., 2018; Johnson et al., 2015). With the introduction of HCAs to nursing teams, there is a requirement for RNs to take on the additional responsibility and accountability for delegation and supervision of care. HCA roles have become embedded in direct resident care. Direct care is care that takes place in the presence of the patient or resident; it includes delivering basic nursing care focused on the activities of daily living, e.g. assistance with personal hygiene, assistance at meal times, mobilisation and the measurement of vital signs (Drennan et al., 2018; Lavander et al., 2016; Harrington 2015). Direct nursing care also includes physical assessment, physical and psychological care delivery and administration of clinical interventions to a patient or resident (Dellefield et al., 2012). Indirect nursing care is described as nursing tasks or activities not undertaken with the patient or resident, e.g. documentation, reporting, care planning, supervision, and management (Dellefield et al., 2012). HCA indirect care tasks include transporting patients, preparation for clinical procedures, supporting relatives, answering the telephone, arranging appointments (Drennan et al., 2018).

Resident acuity refers to the complexity and severity of a resident's health needs. Dependency refers to the support the resident needs with activities of daily living. The acuity and dependency of nursing home residents increase as many of those admitted to RCOP facilities have multiple complex chronic illnesses or advanced cognitive impairment, and rely greatly on assistance with daily activities (Barken and Armstrong, 2018; Shannon and McKenzie-Green, 2016;; Mueller and Vogelsmeier, 2013; Muller et al., 2012). The increase in resident acuity and dependency affects the requirements for nursing care teams, with a skill mix of registered and unregistered care staff to provide high-quality, safe, person-centred care (Department of Health, 2020; OECD, 2020; Barken and Armstrong, 2018; Shannon and McKenzie-Green, 2016). As a result of the COVID-19 pandemic, the Minister for Health established an Expert Panel on Nursing Homes to learn from the pandemic and to recommend improvements and changes in RCOP services. The 'COVID-19 Nursing Homes Expert Panel Report' (DoH, 2020) stated that "staffing, the role of staff and the conditions of employment in nursing homes are critical areas that need focused attention" (DoH, 2020, p.6). The recommendations included the examination of appropriate skill mix and nurse staffing levels based on dependency levels. As a direct response to the recommendations in the report (DoH, 2020) the Department of Health is leading on the development of a framework for safe nurse staffing and skill mix in RCOP services, identifying the main nursing team roles as the RN and the HCA. It is anticipated that this will provide clarity on the model of care and the roles of the RN and HCA in RCOP.

1.3.1 The Registered Nurse (RN)

In defining nursing, the WHO states:

> "Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. It includes the promotion of health, the prevention of illness, and the care of ill, disabled and dying people." (WHO, 2020b)

There is no internationally agreed role description for the RN. RN roles and responsibilities differ across countries due to historical and cultural influences in the development of the RN role (Kusi-Appiah et al., 2018; Lavander et al., 2016). However, there is general consensus that the RN role includes the promotion of health, prevention of illness and delivery of care (ICN, 2002). In most Western countries, a registered (licensed) nurse is a title protected by legislation. To gain registration to practice, RNs are predominantly required to be educated at degree level, and regulated by a professional regulator to protect the public against poor or unethical practice (Kusi-Appiah et al., 2018; Lavander et al., 2016; ICN, 2002). RNs, as registered professionals, are responsible and accountable for their practice, and thus are answerable for decisions they make in their practice both legally and

professionally. They are accountable to the patient, the public, their regulatory body, their employer and any relevant supervisory authority.

In the 1990s nurse education in Ireland moved from certificate or apprentice-style training to diploma level (1994) and then degree level education in 2002 (Fealy, 2006). This affected staffing levels as the apprenticeship system of nurse training had involved substantial training time in clinical practice areas. Nursing students were part of the workforce, undertaking direct care and non-direct care tasks (DoHC, 2001). The transition of nursing students to more academic based education coincided with the expansion of the HCA role to direct care in patient care teams (Conyard et al., 2020; Drennan et al., 2018; Alcorn and Topping, 2009; Department of Health, 2001). Undergraduate nursing students are assigned to clinical sites on supernumerary placements and the HCA is assigned to support the delivery of care (Kessler et al., 2015; Alcorn and Topping, 2009). The transition of nursing students from the workforce and the replacement with HCAs in care delivery transformed the responsibility and scope of practice of the RN to that of delegator and supervisor of HCAs (Drennan et al., 2018; Burrow et al., 2017; Alcorn and Topping, 2009). In a response to advances in health care delivery (improved diagnostics, technology and interventions), increasing acuity of patients and the shortage of doctors, the role of the RN expanded (Nissanholtz-Gannot, 2016; Bodenheimer and Bauer, 2016; Maier, 2015). RNs are achieving higher levels of education and academic qualifications, enabling RNs to work at higher levels of clinical and advanced practice. Task shifting between RNs and doctors occurs when RNs undertake tasks previously undertaken by doctors, including patient assessment, ordering tests, diagnosis, prescribing and patient discharge (Maier and Aiken, 2016). Task shifting to RNs occurs in response to the shortage of doctors, and to improve quality and efficiency of care delivery (Maier and Aiken, 2016). However, task shifting from doctors to RNs increases the workload of RNs.

1.3.2 The Health Care Assistant (HCA)

The term Health Care Assistant (HCA) has been used in healthcare settings since the 1980s. In Ireland and other countries, numerous grades and job titles are aligned to that of HCA, but Health Care Assistant is most commonly used. Titles for non-registered care staff are listed in Table 1.3. In this thesis, the title Health Care Assistant (HCA) is used to encompass these roles.

Table 1.3: List of Titles for Health Care Assistant

Unregistered Care Staff Role Title	Jurisdiction
Healthcare Assistant, Health Care Assistant, Care Assistant, Nursing Assistant, Health Care Support Worker, Multi-Task Attendant, Maternity Healthcare Assistant, Nursing Auxiliary, Clinical Support Worker, Attendant, Personal Assistant, Community Support Worker, Nurses Aid, Nursing Auxiliary	Ireland and UK
Health Care Assistant, Nursing Assistant, Care Assistant, Certified Care Assistant, Auxiliary Staff/Worker	Mainland Europe
Certified Nurse Assistant, Health Care Assistant, Personal Care Assistant, Nursing Aide, Auxiliary Nurse, Assistant Patient Care, Health Care Aide	USA and Canada
Health Care Assistant, Assistant in Nursing, Personal Care Attendant, Community Care Aide, Patient Care Assistant	Australia and New Zealand

These unregistered staff grades originally incorporated housekeeping, cleaning and catering responsibilities (Conyard et al., 2020; Glackin, 2016). Since the 1990s and early 2000s, the HCA role has evolved into a direct caring role (Drennan et al., 2018; Glackin, 2016; Waldie, 2010). In addition to non-direct care responsibilities, HCAs now provide the majority of direct nursing care and support to vulnerable and frail older people (Conyard et al., 2020; OECD, 2020; HSE, 2018; Drennan et al., 2018; Hewko et al., 2015; Braeseke et al., 2013). However, nationally and internationally there continues to be a lack of standardised job description, job titles and grades, minimum education and training criteria and career progression pathways, along with significant pay variances (Conyard et al., 2020; OECD, 2020; Drennan et al., 2018; Burrow et al., 2017; Saari et al., 2018; Spilsbury et al., 2013, Braeseke et al., 2013). As many HCA grades are unregulated and unregistered, it is difficult to estimate the demographics, qualifications and number of HCAs in Ireland and worldwide (Conyard et al., 2020, Drennan et al., 2018; Afzal et al., 2018; Shannon and McKenzie-Green 2016; Hewko et al., 2015, Estabrooks et al., 2015; Braeseke et al., 2013; Munn et al., 2013; Spilsbury et al., 2013).

In Ireland, the Report of the Commission on Nursing recommended that the HCA role be revised to support RNs delivering direct patient care (Government of Ireland, 1998). In a review of the effective utilisation of the RN role, the HCA role was defined as assisting in delivery of care under direct supervision and delegation of an RN (DoHC, 2001). This 2001 report recommended:

> "That health care assistants engage in both direct patient care and indirect care activities following delegation by and under the supervision of a registered nurse or midwife.
>
> "That in carrying out their tasks/duties health care assistants report to and take direction from a registered nurse/midwife." (DoHC, 2001, p.5)

The multi-task attendant (MTA) role in Ireland as a clinical support role with responsibilities for cleaning, catering and caring. Many HCA staff in Ireland employed prior to 2006 remain employed on

MTA contracts. In 2006 a national HCA job specification was developed in the HSE. In the 'Review of the Role and Function of Health Care Assistants' undertaken 17 years later (2018), the HCA role is described as providing:

> "… assistance, support and direct personal care to patients and residents in a variety of healthcare settings such as hospitals, clinics, nursing homes, aged care facilities, as well as community and domestic settings. They generally work in support, or under delegation, direction and supervision, of health professionals." (HSE, 2018, p.28)

There are also variances with HCA educational requirements. HCA education in Ireland was developed in the 1990s with the National Council for Vocational Awards (NCVA), at Level 5 award. From 2001, with the introduction of the HCA grade as a direct care role, a number of education and training courses were developed for HCAs. This was initially through the NCVA but later through the Further Education and Training Awards Council (FETAC), and since 2012 through Quality & Qualifications Ireland (QQI) (Conyard et al., 2020; Drennan et al., 2018; Department of Health and Children, 2001). The HCA education programmes are at certificate level in Healthcare Support, Health Services Skills and Community Health Services; each consists of a QQI (FETAC) Level 5 award, with specific modules relevant to clinical location, e.g. maternity, theatre (Conyard et al., 2020; Drennan et al., 2018; Department of Health and Children, 2001). Optional caring modules are available, e.g. Care of Older Person, and Activities of Living. However, until 2009, the HCA education accreditation was not a mandatory requirement for employment to the role. In the HSE national HCA job specification, a QQI L5 health service skills qualification is required, or the applicant had to be employed as a HCA or in a comparable role (HSE, 2006). In 2009, HIQA Standards required that all HCAs newly recruited must commence a healthcare support QQI Level 5 programme within two years of commencing employment (HIQA, 2009). Therefore, MTAs or HCAs employed prior to 2006 were not required to have a caring qualification. This has led to ambiguity in the HCA and MTA roles (Glackin, 2016) and is at variance with other countries (e.g. Canada, US, Germany, Greece, Hungary) where a caring qualification is required to work as a HCA (Conyard et al., 2020). In addition, across all jurisdictions there is a recognised gap between the educational requirements for the HCA and the level of work and care interventions delivered by HCAs to patients and residents with complex needs (OECD, 2020; Drennan et al., 2018; Shannon and McKenzie-Green, 2016; Braeseke et al., 2013). HCAs are increasingly delivering direct care either in partnership with the RN or independently, with evidence emerging of the associated requirement for effective delegation and supervision by RNs to HCAs (Kessler et al., 2015; Day et al., 2014; Cavendish, 2013; Dellefield et al., 2012). As the complexity of resident care needs increases, the workload and role of the HCA is increasing in RCOP (Burrow et al., 2017). In RCOP the ratio of RNs to HCAs can be as low as 30:70, with the average ratio of RN:HCA in

Ireland reported as 50:50 (HSE, 2016). This is a lower RN ratio than that in acute nursing services where the average ratio of RNs to HCAs ranges from 75:25 to 85:15 (Drennan et al., 2019; DoH, 2016).

1.3.3 RN Delegation in RCOP

The RN is responsible and accountable for care delivered by unregistered staff and thus is accountable for delegation (NMBI, 2015a; Muller and Vogelsmeier, 2013; Muller et al., 2012). In RCOP, when the number of RNs is low in relation to the numbers of residents and HCAs, the RN's level of responsibility and accountability for care delivery is increased. The role of the RN in RCOP settings is becoming increasingly complex due to increasing acuity and dependency, decreasing RNs, increased workload, increasing documentation and administrative responsibilities, low levels of onsite support from medical and other health professionals, decreasing direct resident care hours and increasing staff supervision (Shannon and McKenzie-Green, 2016). The lower ratio of RNs in RCOP creates a challenge to provide adequate mentorship, supervision and assessment of HCAs (Burrow et al., 2017). This additional responsibility can be a burden to RNs, especially where there are variances in the HCA education or qualification levels (Wells et al., 2019; Burrow et al., 2017).

The delegation of tasks is a complex process, requiring knowledge, skill and experience of the RN in making safe delegation decisions to a HCA who is educated, competent and responsible for undertaking the delegated task (NMBI, 2015a; Anthony and Vidal, 2010; Kærnested and Bragadóttir, 2012; Weydt, 2010; Reesha, 2010). The International Council of Nurses states that the scope of nursing is:

> "not limited to specific tasks, functions or responsibilities but is a combination of knowledge, judgement and skill that allows the nurse to perform direct care giving and evaluate its impact, advocate for patients and for health, supervise and delegate to others, lead, manage, teach, undertake research and develop health policy for health care systems." (ICN, 2013, p.1)

With the changing role of the RN and the increasing role of the HCA in care delivery, a high proportion of direct care is delivered by HCAs in RCOP. Delegation, and how delegation occurs, are critically important in the context of resident safety and quality of care (Anthony and Vidal, 2010). Poor outcomes can result from care left undone due to unsuccessful delegation of tasks (Kalisch, 2006). Inadequate delegation by RNs to HCAs affects the delivery of safe patient care and patient outcomes (Magnusson et al., 2017; Johnson et al., 2015; Saccomano and Pinto-Zipp, 2011; Potter et al., 2010; Anthony and Vidal, 2010; Standing and Anthony, 2008). However, no research on RN delegation in RCOP has been conducted in Ireland and there are few studies focusing on the process of RN delegation in RCOP.

1.4 Rationale for Research

As the demand for care of older people increases and the shortage of RNs continues, along with associated challenges in RN recruitment in RCOP, there is a need to clarify the RN role in delegation to HCAs. It is anticipated that the high number of HCAs on nursing teams creates challenges for the RN to effectively delegate and supervise. Yet the RN role in delegation of tasks to HCAs remains unexplored in this context. With an ageing population and predicted ongoing challenges in recruiting both RN and HCA staff, it is now imperative to gain an understanding of how delegation of tasks occurs in the high-care, high-demand environment of an RCOP.

1.4.1 Researcher Motivation

The researcher is a senior nurse in the Irish public health service and, as a nurse and clinical nurse manager, experienced the transition of the HCA from a domestic support role to responsibility for delivering direct patient care. During this period RNs were expected to develop their understanding and competence in delegating tasks to HCAs. More recently, as a strategic workforce planner, I became aware of the extent to which understanding how RNs and HCAs work together to deliver safe and effective nursing care is an important question in the context of recruitment and retention in nursing services, in particular RCOP. The challenges in relation to recruiting RNs, the expanding role of the RN and the impact on their capacity to deliver direct care, and the increasing changes in skill-mix ratios, as more HCAs replace RNs in posts, have proved complex to address. Furthermore, these challenges have been exacerbated by the COVID-19 pandemic and the resultant drop in job satisfaction and increased staff burnout. These factors affect quality and safe care, but, within all this, how RNs delegate to HCAs is poorly understood in the Irish context. Delegation and how it occurs between RNs and HCAs in RCOPs is therefore a crucial issue of concern that needs to be examined. It affects delivery of nursing care in RCOP not only in Ireland but also in many other countries. As a nurse workforce planner, I am involved in the DoH Taskforce for Safe Nurse Staffing, and am a member of the HSE National Steering Group for implementation of the first phase of Sláintecare. This study is timely as it coincides with the response by the Department of Health COVID-19 Nursing Home Review (DoH, 2020), the Taskforce for Safe Nurse Staffing and Skill Mix, and the implementation of Sláintecare.

1.5 Research Aim and Objectives

This aim of this study is to explore how the delegation of tasks by Registered Nurses (RNs) to Health Care Assistants (HCAs) occurs in nursing teams in RCOP services. The objectives are to:

1. explore how delegation of tasks is understood and experienced by RNs in the context of the role and responsibility of the RN and the HCA in RCOP;
2. explore how delegation of tasks is understood and experienced by HCAs in the context of the role and responsibility of the HCA and the RN in RCOP, and
3. explore the context and process of delegation by RNs to HCAs in RCOP.

1.6 Thesis Outline

The thesis is presented in six chapters, followed by a reference list and appendices. Following this introductory chapter,

- Chapter 2 presents a critical analysis and synthesis of the relevant literature, including the search strategy.
- Chapter 3 describes the study methodology and outlines the potential research approaches and justification for the chosen approach.
- Chapter 4 describes the research methods applied in the study, including sampling and data collection methods, data analysis and approaches taken for ethical approval and ensuring rigour.
- Chapter 5 presents the research findings, set out as findings from each case, and a cross-case analysis.
- Chapter 6 discusses the findings in the context of existing evidence and through the theoretical lens of organisational role theory, identifies the limitations of this study and its contribution to knowledge, and makes recommendations for future work.

1.7 Chapter Summary

This chapter has presented the background and context for this research study. Many nurse regulators provide guidance and direction in relation to delegation, and define delegation. American, Canadian and Australian nurse regulators distinguish delegation from assignment or allocation; NMBI does not. Health service and capacity planning were described in the context of caring for older people. Given that the objective of planned health reforms is to care for people in their homes for as long as possible, the impact of the increase in the older population who avail of residential care is described. This includes the increasing acuity and dependency needs of residents, which affects nursing teams and skill mix. In tandem with the ageing population, the impact of a shortage of nurses is described, along with the expanding role of the RN. The evolution of the HCA as having a direct resident care role is outlined, along with the lack of role clarity and increased workload for both the RN and HCA. The

chapter concludes with an outline of the research aim and objectives, and an overview of the chapters that follow. The next chapter presents a review of the literature on RN delegation

Chapter 2: Literature Review

This chapter presents the literature review concerning RN delegation to HCAs, in six sections. Section one describes the literature search strategy. Section two outlines the role of the RN as delegator. Section three describes the role of the HCA as delegatee. Section four reports on the enablers of and barriers to effective delegation. Organisational role theory is described in section five. A summary of the literature review in the context of gaps in the literature and the rationale for this research study completes the chapter.

2.1 Literature Search Strategy

The objective of the literature search was to identify the current evidence in relation to delegation by RNs to HCAs. The literature search strategy involved a seven-step process (Table 2.1).

Table 2.1: Literature Search 7-Step Process

Step 1	Establish a systematic search strategy
Step 2	Establish inclusion and exclusion criteria
Step 3	Identification: Search process
Step 4	Screening: title and abstract review
Step 5	Eligibility: full text retrieval and review
Step 6	Included papers: identify themes
Step 7	Report on literature review findings

In the first step, a systematic search strategy was established. A population, intervention, comparison and outcome (PICO) search tool was applied as the search strategy (Table 2.2). The aim of the research was not to compare and therefore no comparator search terms were included.

Table 2.2: PICO Search Strategy

PICO search strategy on how delegation of tasks by registered nurses (RNs) to care assistants (HCAs) is occurring in patient care teams in older persons residential care services: **Population**: RGN OR RN OR registered nurse OR nurs* OR licensed nurse OR professional nurse OR HCA OR CA OR health care assistant OR care assistant OR unlicensed assistive personnel OR nursing aide OR non licensed nurse **Intervention:** explicit delegation OR implicit delegation OR assign OR designate OR supervision OR professional tasks OR observation and recording patient behaviour OR task delegation OR medication administration OR role transfer **Comparison =** No search criteria applied for comparator **Outcome =** Effectiveness of delegation OR errors OR limitations OR accountability OR issues OR quality of care OR responsibility OR shortcomings OR performance OR efficiency OR effect OR standard

Step two of the search strategy established the inclusion and exclusion criteria for identifying and selecting publications on delegation and supervision of tasks in healthcare (Table 2.3). The rationale for the 2009 publication date restriction was that it was from this period that the role of the HCA in direct care provision began to feature in the literature.

Table 2.3: Inclusion and Exclusion Criteria for Identifying and Selecting Publications

Inclusion criteria	Exclusion criteria
Published in English. Research studies and policy documents related to delegation in nursing care teams, registered and unregistered nursing care grades. Publication date was restricted to 2009-2021. Seminal works predating the search were included.	Published in language other than English. Research studies, discussion papers on delegation external to healthcare environment. Papers on delegation between professional grades (e.g. doctor to registered nurse delegation). Papers in context of delegation in low-and middle-income countries. Publication date prior to 2009.

Step three involved a comprehensive search process for subject headings and key terms of relevant databases to identify key literature. Subject headings and key words were identified from the PICO and a systematic search process was used for each database (Table 2.4). A controlled vocabulary search – e.g. MesH (Medical Subject Headings) – was used to identify key publications. The 'free text' keywords or terms mapped to the vocabulary search identified related words, providing assurance of the quality of the search. Boolean and truncation functions were applied in each database to provide concentrated and specific results. The academic databases searched were: Pubmed, CINAHL Scopus,

Web of Science, Cochrane Database of Systematic Reviews, and online dissertations and theses predominantly accessed through ProQuest. Grey literature was included from searches on Google Scholar, Lenus and Open Grey, and from relevant health organisations and agencies, including the World Health Organization (WHO), Europa, departments of health and the Irish public health service.

Additional papers, within the inclusion criteria, were identified through other sources (i.e. referenced papers and citations from excluded publications). To confirm that the search was comprehensive, the university librarian undertook a confirmatory search of the subject headings and key words. No new publications were identified in the librarian search.

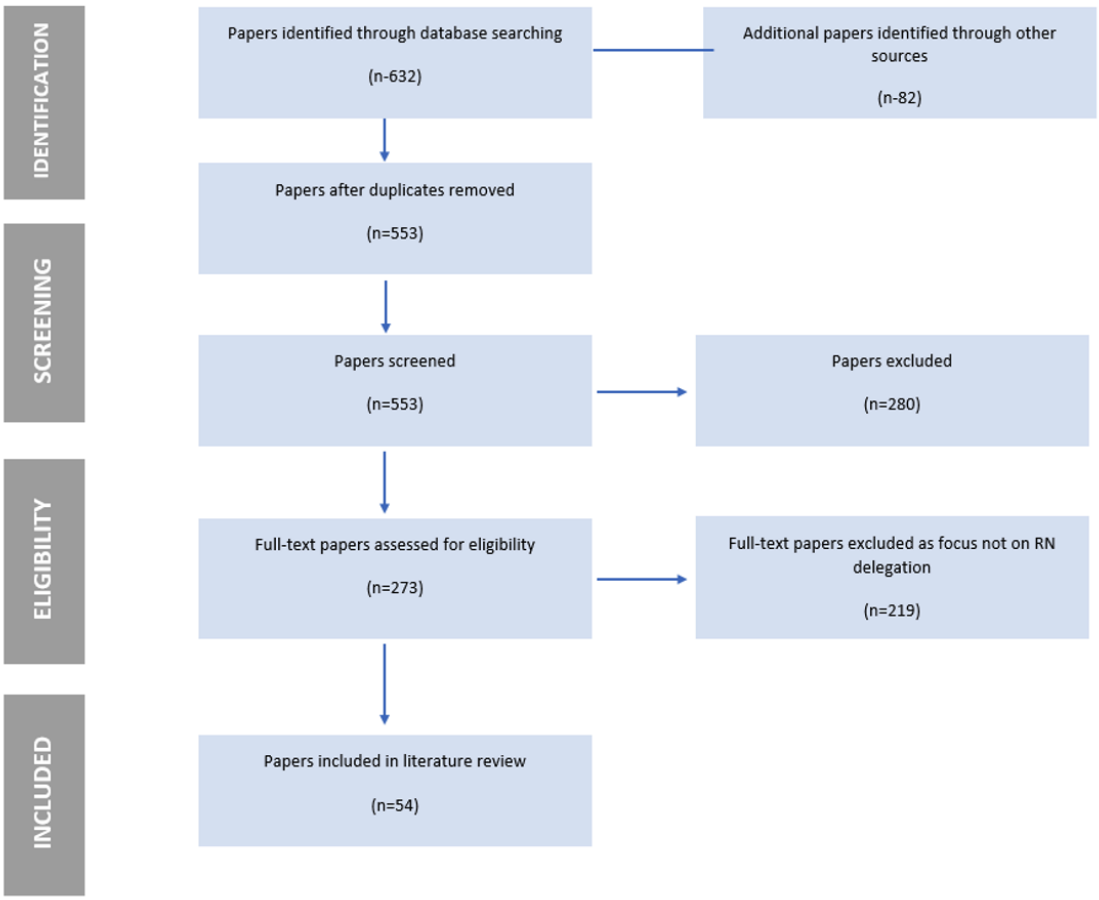
Table 2.4: Subject Headings and Key Words

Subject Headings and Key Words
S#1 Nurse's Aide" OR "Care Assistant" OR "Nursing Assistant" OR "unlicen?ed practitioner" OR "health care assistant OR personal care worker health care assistant* or healthcare assistant* or HCA or nurs* assistant* or unlicensed assistive personnel or unlicensed nurs* or nurs* aide*) OR AB (health care assistant* or healthcare assistant* or HCA or nurs* assistant* or unlicensed assistive personnel or unlicensed nurs* or nurs* aide*
S#2 nurs* OR nursing OR midwife OR midwifery OR rn OR registered AND nurse OR "licen?ed nurse" OR RN OR RGN OR urs* or midwife* or midwives or RN or RGN) OR AB (nurs* or midwife* or midwives or RN or RGN
S#3 TITLE-ABS-KEY (delegation OR assign OR designate OR supervise* OR "professional task" OR "task delegation" OR "role transfer" OR assign* or designate* or supervis* or delegation or role* transfer) OR AB (assign* or designate* or supervis* or delegation or role* transfer
-ABS-KEY ("effectiveness of delegation" OR limitations OR accountability OR "quality of care" OR responsibility OR effect* OR standard OR standards) AND PUBYEAR > 2008 AND (LIMIT-TO (SUBJAREA , "MULT") OR LIMIT-TO (SUBJAREA , "NURS") OR LIMIT-TO (SUBJAREA , "HEAL"))
S#4 limitation* or accountability or responsib* or standard or standards or effect or quality of care) OR AB (limitation* or accountability or responsib* or standard or standards or effect or quality of care) MH "Quality of Nursing Care") OR (MH "Quality of Care Research") OR (MH "Quality of Health Care")
S#5 S#1 AND S#2 AND S#3 AND S#4

In step four, the screening phase, titles and abstracts were reviewed for relevance to the PICO, and only relevant papers were included. For step five, full-text papers (273) were retrieved and assessed for eligibility. The term health care assistant (HCA) is used throughout this review as synonymous with terms used to describe the role of unregistered care staff in nursing teams in papers from different countries. On closer review, a number of papers did not focus on RN delegation, or referred to other roles, e.g. licensed nurse practitioner, assistant practitioner.

Step 6 identified papers (54) eligible for inclusion in the review. A systematic process was used in the review of papers, identifying their aims, methodology (for research publications), themes and quality. Papers excluded at this stage, following full text review, did not focus on delegation between RNs and HCAs. Step seven consisted of the report on the literature review, as presented in this chapter. Although not a systematic review, a PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) flow diagram is used to summarise and display the search results (Figure 2.1). The diagram displays the collection of all searches undertaken across all databases.

Figure 2.1: PRISMA Flow Diagram Showing the Search/Retrieval Process, and Screening for Literature Review



A total of 54 papers met the inclusion criteria for the literature review (see Appendix 1). The research studies were quantitative studies (n=14), qualitative studies (n=20), and mixed-methods design studies (n=6). There were literature review publications (n=12) that were either integrative, scoping or systematic reviews. Grey literature papers (n=2) were included: an OECD report and a project report

for the European Commission. Three themes were developed in the review: the role of the RN as delegator, the role of the HCA as delegatee, and the factors that enable or hinder effective delegation.

2.2 Role of the RN as Delegator

This section reviews the literature related to the role of the RN as delegator and is reported under three areas: changing RN Role, scope of practice and accountability, and process of delegation.

2.2.1 Changing RN Role

A number of researchers have examined the changing role of the RN (Coffey et al., 2017; Lavander et al., 2016; De Vliegher et al., 2016; Lee et al., 2015; Roch et al., 2014; Huang et al., 2011; Gravlin and Bittner, 2010; Bittner and Gravlin, 2009; Alcorn and Topping, 2009). All of these researchers found that, as the number of RNs decreased and the number and ratio of HCAs to RNs increased, there was an increase in the delegation role of the RN.

2.2.1.1 Changing RN Role in Direct Care

In Ireland, Coffey et al. (2017) undertook a systematic literature review and national focus groups to inform the development of a strategy and educational framework for gerontological nursing. Focus groups interviews were conducted with RNs who worked in various clinical services, including RCOP, and service users and service user representatives (Coffey et al., 2017). Interestingly, very few clinical ward-based RNs were included, and HCAs were not included in this national study. Findings from the focus groups identified:

> "the need for more frontline nurses, nurses at the bedside, optimum skill-mix, and that nurses need to make time to nurse which could involve more streamlined processes, less administration and delegation of some duties." (Coffey et al., 2017, p. 125).

Participants also identified the need for RNs to be more involved in direct care and support of the residents in RCOP settings.

However, in contrast to Coffey et al. (2017), other research on the RN role found that RNs were delegating more, and were undertaking more administration responsibilities. The researchers found that the role of the RN had changed to include more coordination and management of physical and psychological care, resident care planning, medication management, documentation, adherence to regulations and standards of practice, leadership, resource allocation, delegation and supervision of unregistered staff (Lavander et al., 2016; Chu et al., 2016; De Vliegher et al., 2016; Lee et al., 2015;

Roch et al., 2014; Dellefield et al., 2012; Bach et al., 2012; Spilsbury et al., 2013; Huang et al., 2011; Gravlin and Bittner, 2010).

Dellefield et al. (2012) examined how RNs divided their time in a nursing home in the USA. Direct nursing care included physical assessment, physical and psychological care, and administration of clinical interventions to a patient or resident (Dellefield et al., 2012). RN clinical time was observed using an RN Observation Measure (RNOM) in a RCOP setting. Applying a quantitative methodology, work sampling and observational data were collected for 38 days over a five-month period. A convenience sample of RNs working on the day shifts were recruited as participants. The findings from the observational study demonstrated that the RNs spent 59% of time on indirect care and 31% on direct care. Of the indirect care time, 73% was spent on documentation and 27% on supervision and management (Dellefield et al., 2012). The finding that the majority of direct care in the RCOP settings was provided by HCAs is supported by other studies and reviews across countries (Dudley et al., 2021; Wells et al., 2019; Barken and Armstrong, 2018; Beeber et al., 2018; Saari et al., 2018; Lavander et al., 2016; Hewko et al., 2015; Denton et al., 2014; Berta et al., 2013; Munn et al., 2013; Bystedt et al., 2011).

2.2.1.2 Changing RN Role

The changing role of the RN and a requirement to delegate care tasks to HCAs has resulted in RN role conflict and role ambiguity (Chu et al., 2016; De Vliegher et al., 2016; Kessler et al., 2015; Roch et al., 2014; Bach et al., 2012; Huang et al., 2011; Gravlin and Bittner, 2010; Bittner and Gravlin, 2009; Alcorn and Topping, 2009).

A systematic review, undertaken by Lavander et al. (2016), synthesised the evidence on working-time use and division of labour among RNs and HCAs. Lavander et al. (2016) included six studies where working time among RNs and HCAs was examined through six categories: direct care, indirect care, documentation, unit-related work, personal time, and non-nursing duties. Despite the RNs' different educational backgrounds, certain similarities were observed across studies. Lavander et al. (2016) found that the RN role was moving away from the bedside, with HCAs undertaking direct patient care activities. Regardless of country, RNs spent less than half of their working time in direct patient care, with documentation taking up one-fifth of their working time. Lavander et al. (2016) recommended further research, through work sampling or observational studies, to examine the role of the RN and the time spent in direct care, especially in the context of the amount of time spent on documentation. They also recommended better clarity in job descriptions, roles and responsibilities, and lines of accountability for RNs and HCAs. A well-conducted Canadian mixed-methods study on the impact of organisational climate on nursing care practices identified RN workload, role conflict and role clarity

as key factors affecting the RN role (Roch et al., 2014). Organisational climate was defined as the collective perceptions of staff of their work environment (Roch et al., 2014). This sequential study was undertaken in two phases, quantitative first and then qualitative. In phase one, a survey, with questions related to nurse caring practices, was distributed to 648 RNs in one acute hospital. In phase two, a qualitative case study with embedded units of analysis was carried out. The results from the survey (n= 292) informed the sampling and interview design for phase two. From the phase one participant cohort, individual interviews were conducted with 15 participants: direct-care RNs (n=4), HCAs (n=3), charge nurses (n=2), front-line managers (similar to CNM grade) (n=2) and clinical nurse specialists (n=2). Free text comments from the phase one survey were included as a data source, in addition to internal and external hospital document data sources. The diminished RN direct caring practice role emerged in the findings, with reported ambiguity about the RN professional role and heavy workload affecting the RN capacity to deliver direct care (Roch et al., 2014). What were considered core roles of the RN – e.g. monitoring a patient's physical and mental well-being, and patient clinical discharge – were undertaken by HCAs. The RNs reported monitoring patients through HCAs in the absence of supervision or evaluation of care delivery (Roch et al., 2014). Limitations acknowledged in the study related to the survey instrument used to measure organisational climate. An adapted version of the CRISO Psychological Climate Questionnaire (CRISO-PCQ) was used, with some items grouped or omitted. In addition, due to the low number of participants, factorial validity of the instrument could not be tested. The study was undertaken at one site, with a 45% (n=292) participant response rate affecting the generalisability of findings. Patient outcomes were not measured (Roch et al., 2014).

In contrast, an earlier study by Huang et al. (2011) found that RNs' perceptions of their role change with the introduction of HCAs were positive, with increased job satisfaction and increased quality of patient care. Three medical wards in three hospitals were used to investigate RNs' perceptions of a new skill-mix model when HCAs were introduced to the nursing team. A cross-sectional design using a self-administered questionnaire was used to collect data from 38 RN participants. It was found that there were dependent, independent and interdependent functions in the RN role (Huang et al., 2011). *Independent role* functions included patient assessment, care planning, patient and family consultant and educator, team leader, delegation, supervision and management of patient care (Huang et al., 2011). The *interdependent role* included: coordinator and consultant for the health care team, work assignment within the unit, monitoring and reporting on patients. The *dependent role* was the implementation of the doctor's instructions (Huang et al., 2011). It was found that the independent and interdependent RN roles had changed since the introduction of HCAs, with an increase in RN leadership and delegation roles (Huang et al., 2011). Across all studies reviewed, there was a

consistent theme that the RN role was changing, with an increased reliance on HCAs to deliver care. Only two studies reported on the positive impact of RN delegation on the RN role.

2.2.1.3 Enabling Impact of Delegation on RN Role

Two studies identified the positive impact of delegation on the RN role (Walker et al., 2015; Lee et al., 2015). It was found that appropriate and effective delegation of tasks to HCAs provides time and opportunity for RNs to work to their own role and scope of professional practice (Walker et al., 2015; Lee et al., 2015). In a comparative case study on nursing roles and responsibilities in primary care teams in New Zealand, delegation within a skill-mix team was recognised as an important factor in enabling RNs to work to their scope of clinical practice (Walker et al., 2015). The delegation of tasks to HCAs, who were adequately educated and experienced to undertake the task, and delegation through standing orders contributed to development and a positive change in the RN role (Walker et al., 2015). This enabled the RN to work to their full scope of clinical practice, and was reported as a benefit to patients, the GP and RNs (Walker et al., 2015). A mixed-methods, before-and-after study by Lee et al. (2015) aimed to evaluate the community care aide (CCA) (similar to HCA role), within a nurse delegation and supervision model, on the introduction of a new model of medication administration in the community in Australia. The new model expanded the role of the HCA from support with personal care to include medicines support. CCAs received training on medicines support and RNs received training on delegation and supervision. Focus groups and individual interviews were conducted with CCAs, RNs and service users (older people cared for at home), and home visit data from two community nursing services in Victoria were analysed. Overall, CCAs were positive about expanding their role and incorporating this into holistic care delivered on visits to clients. RNs were comfortable delegating to CCAs as polices were established and training provided to support the delegation of low-risk medication care tasks. CCAs, RNs and clients all reported that this initiative enabled the RN to undertake complex visits, for example complex medication administration and wound care dressings (Lee et al., 2015).

These two studies identified the opportunities for delegation enabling RNs to work to their full scope of practice. However, challenges were noted in relation to the RN's accountability in delegation; these will be discussed next.

2.2.2 RN Scope of Practice: Accountability for Delegation

The previous chapter outlined how nurse regulations provide a basis for RNs to delegate, through guidance on RN scope of practice and delegation. A number of studies explored the RN professional scope of practice in the context of accountability for delegation (Walker et al., 2021; De Vliegher et

al., 2016; Fealy et al., 2014; Corazzini et al., 2010; Gravlin and Bittner, 2010; Alcorn and Topping, 2009; Bittner and Gravlin, 2009; Standing and Anthony, 2008). Most of these studies found that the RN did not have a clear understanding of their responsibilities and accountability in delegation. A seminal study by Standing and Anthony (2008) described delegation from the perspective of the RN. This phenomenological study used in-depth interviews to collect data from RNs (n=17) in acute-care settings in the US. RN scope of practice and accountability in delegation was described. The findings demonstrated that RNs did not have a clear understanding of their role in delegation and their accountability in the context of delegation. Although the majority of RNs (n=10) could describe RN accountability in delegation as aligned to the accepted definitions in the US (ANA), there were different interpretations of the tasks and activities that were considered as delegation. Ten RNs reported that all tasks and activities performed by HCAs were delegated tasks, while seven RNs reported that delegated tasks were only those that the RN specifically asked the HCA to complete, described as explicit delegation. The concept of trust was important for RNs in delegation to HCAs as the RNs understood that they were accountable for the care delivery. Standing and Anthony (2008) recommended further research to explore delegation from the perspective of the HCA.

In another well-cited study, which sought to understand RNs attitudes to delegation and accountability for HCAs, a questionnaire was distributed to 219 RNs in an acute hospital in the UK (Alcorn and Topping, 2009). There was a 68% response rate, with the majority of RNs understanding their accountability and responsibility in delegation. More than 90% of respondents agreed that the RN and HCA roles were different, and understood that the RN remains accountable for delegated tasks; 71% of RNs stated that adequately prepared HCAs should be accountable for all the care they deliver. The study authors admit that poorly developed questions in the Likert-scale survey questionnaire may have contributed to ambiguity for respondents, as measuring attitudes through Likert scales may force responses (Alcorn and Topping, 2009). There are similar limitations in the design of both studies, by Standing and Anthony (2008) and Alcorn and Topping (2009). In both cases, the authors acknowledged that their studies were limited to acute care and one health care setting, and only RNs were included. There is also a risk that RNs may indicate in surveys or interviews that they understand their professional accountability and scope of practice in delegation to HCAs, but may not actually demonstrate this in practice. The addition of observational methods may support the credibility and dependability of future studies. Despite these limitations, these studies make a significant contribution to our understanding of delegation from the perspective of RNs. However, in a scoping review by Birks et al. (2016), which explored RN scope of practice in Australia, there was consistent reporting of poor understanding by RNs about how to interpret and apply their scope of practice to delegate to HCAs. They found that scope of practice was an elusive concept and there was

a need to provide clarity on RN scope of practice (Birks et al., 2016). Muller et al. (2012) found that in RCOP the increase in acuity and dependency of residents affected the requirement for RNs to work to their scope of practice to undertake clinical assessments, monitor the physical, social and mental health status of residents, make nursing diagnoses, and prioritise care delivery (Muller et al., 2012).

2.2.3 Process of Delegation

The process of delegation is also an important concept within the literature (Walker et al., 2021; Campbell et al., 2020; Saari et al., 2018; De Vliegher et al., 2016; Allan et al., 2015; Munn et al., 2013; Kaernested and Bragadóttir, 2012; Bystedt et al., 2011; Corazzini et al., 2010; Gravlin and Bittner, 2010; Potter et al., 2010; Alcorn and Topping, 2009; Bittner and Gravlin, 2009; Standing and Anthony, 2008; Anthony et al, 2001). The process of how and when RNs delegate to HCAs is important to understand.

Standing and Anthony (2008, p.11) state: "The process of delegation, representing the interpersonal aspects of delegation, is constructed from the dimensions of the delegation relationship and communication."

The clarification of routine care tasks that are within the role and responsibility of the HCA, and the nursing activities and tasks safely undertaken by a HCA are important aspects in the process of RN delegation. HCAs are referred to as undertaking the 'routine nursing tasks' or replacing RNs in delivery of routine care (Kessler et al., 2015). Fallon et al. (2018) undertook narrative research on task-orientated care as recounted by former nursing students in Ireland. Twelve participants who were former students in the apprenticeship-training model described their experiences. Task-oriented care was described as a model of nursing care that focused on routine tasks rather than the patient's personal care needs (Fallon et al., 2018). It was proposed that, with the introduction of team nursing and primary nursing care, task-orientated care was no longer a common practice. However, when implementing a programme of practice development to develop a culture of person-centred practice in RCOP services in Ireland, McCormack et al. (2010) found that task-orientated and routine practices remained. McCormack et al. (2010) recommended that routine be balanced with resident choice; for example, mealtime and personal care. HIQA (2016) recommends a person-centred approach to care in RCOP as the standard of quality care. There has been significant investment in nursing teams in RCOP to promote a person-centred care ethos, requiring a change in approach to care from the traditional task-orientated approach to focusing on the personal needs of the resident (McCormack et al., 2016; Ryan and Mckenna, 2015). Care tasks and activities that unregulated care providers (HCAs) undertook in home care were identified in a scoping review of studies from Canada, Sweden, Belgium,

UK, USA and New Zealand (Saari et al., 2018). A five-stage process for the review was applied and 28 articles were chosen for inclusion. The review reported under three themes: *personal care and core skills, delegated tasks and added skills*, and *specialty roles* (Saari et al., 2018). Although routine care tasks and activities were performed by HCAs as aligned to their role, there were variances in how additional care activities were described across the reviewed literature. Terms used to describe this addition to the HCA role were: expanded role, nursing activities, clinical procedures, task shifting, upskilling, and advanced, delegated or assigned care. The varying terms with associated meanings create confusion in relation to delegation by RNs. The authors concluded that organisations should review the practices for HCAs working on their own, the level of supervision and team support that should be available, and the level of clinical knowledge and skills required to deliver quality care. There are also recommendations for guideline development in relation to the process of RNs transferring care tasks and activities to HCAs (Saari et al., 2018). This need for RN guidance and support in delegation to HCAs had been recognised previously (Munn et al., 2013; Bystedt et al., 2011; Kaernested and Bragadóttir, 2012; Alcorn and Topping, 2009).

More recently, Walker et al. (2021) reported on delegation and supervision practices of RNs to HCAs in acute hospital wards in Australia. Despite numerous studies undertaken on RN scope of practice and accountability for delegation to HCAs since Standing and Anthony in 2008, the findings from Walker et al. (2021) are similar. In the instrumental, descriptive case study, Walker et al. (2021) undertook semi-structured interviews (n=24), focus groups (n=11) with an average of six participants, and documentary review with nursing leaders (n=20), RNs/ENs (n=74) and HCAs (n=10) in hospital wards where HCAs worked on nursing teams. Although the authors report that participant recruitment was guided by data adequacy and accessibility to study participants, it was unclear if the participant cohort was an adequate representation of RNs and HCAs. It was unclear as to the total number of nurse leaders, RNs and HCAs in the study site (potential participants), or how participants were selected. The authors used data analytical processes proposed by Miles et al. (2014). This was part of a larger research study examining the HCA role in acute hospital settings (Walker et al., 2021). There was a lack of clarity as to the RN's role as delegator and the RN accountability for delegation to HCAs. There was a variance in HCAs' perception of the need for RNs to delegate and supervise HCA practice. There were also differences in opinions between nurse leaders and RNs on the necessity of the RN to delegate to HCAs or to undertake direct supervision of HCAs who knew what to do. Walker et al. (2021) reported on concerns that collegiality, trust and demonstrating respect for the HCA role were more important than delegation and supervision. They described how delegation was complex, and identified delegation education, organisational structures and policy to support RN delegation, and

role clarification as factors to support delegation and supervision. Similar to the majority of studies on RN delegation, this study was limited to one healthcare setting and to acute hospitals.

No recent studies on delegation in RCOP were found. Corazzini et al. (2010) reported on a descriptive, qualitative study to understand how RNs delegated in RCOP as part of a larger, comparative case study of RCOP; semi-structured interviews were conducted on a convenience sample of 33 RNs in leadership positions in RCOP settings. They reported that delegation occurs by either following the RN scope of practice, or by applying the HCA job descriptions to guide delegation (Corazzini et al., 2010). RNs reported reluctance to delegate to HCAs due to concerns in relation to RN professional accountability for their decision to delegate and concerns for patient outcomes in the case of tasks delegated to the HCA (Corazzini et al., 2010). RNs reported challenges in monitoring how the delegated task or activity affected resident outcomes (Corazzini et al., 2010). The authors did acknowledge that the study was not representative of RNs in RCOP settings and therefore was limited in generalisability and transferability in the US or other jurisdictions (Corazzini et al., 2010). Nevertheless, similar findings in relation to RNs' concerns about their legal and professional accountability for delegation to HCAs, especially in relation to direct care decisions, were identified in other studies (Munn et al., 2013; Potter et al., 2010).

2.2.4 Section Summary

This section has presented the findings related to the role of the RN in the context of delegation as reported in the literature. Other than the paper by Coffey et al. (2017) in Ireland, there was consensus that the RN role in direct care was changing. RNs are regulated as a professional group and regulators provide direction to RNs on their scope of practice. Despite the positive impact of RN delegation, there was also confusion in relation to RNs' understanding of their accountability to delegate. This included challenges in adapting to the role of delegator. There was a gap in knowledge in relation to how delegation actually occurred.

2.3 Role of the HCA as Delegatee

This section reviews the literature related to the role of the HCA as delegatee. It is divided into three parts: the changing role of HCA in direct care, the role of HCA as delegatee, and delegation and missed care.

2.3.1 The Changing Role of HCA in Direct Care

In numerous reviews and publications, it was reported that most direct care in RCOP was provided by HCAs (OECD, 2020; Wells et al., 2019; Afzal et al., 2018; Barken and Armstrong, 2018; Chu et al., 2016; De Vliegher et al., 2016; Hewko et al., 2015; Holmberg et al., 2013; Berta et al., 2013; Bach et al., 2012; Muller et al., 2012; Corazzini et al., 2010). However, researchers across different countries examined HCA job descriptions and found that these were unclear and open to local interpretation, and that job titles and educational requirements differed (OECD, 2020; Wells et al., 2019; Drennan et al., 2018; Afzal et al., 2018; Glackin, 2016; Hewko et al., 2015; Spilsbury et al., 2013; Braeseke et al., 2013; Corazzini et al., 2010).

A scoping review by Afzal et al. (2018) on the role of unregulated care providers in Canada found that HCAs did not have a defined scope of practice, and that they undertook tasks previously undertaken by RNs. In addition to the caring roles and responsibilities of the HCA, they were reported as responsible for observing and documenting important clinical interventions such as fluid and diet intake, vital signs and specimen collection, and providing emotional support to patients (Afzal et al., 2018). These tasks are defined by Canadian nurse regulators as “Controlled Acts”, and can only be undertaken by the HCA through delegation in Canada. Afzal et al. (2018) also found that there were no consistency or standards in HCA education or job descriptions. As part of a national review of the HCA role and function in Ireland, a literature review was commissioned to inform this work. The aim of the review was to present a report based on national and international evidence on the education, role and function of the HCA (Drennan et al., 2018). Despite a large volume of publications on the HCA role, there was a reported dearth of high-quality research from randomised control trials, systematic reviews or meta-analysis (Drennan et al., 2018). This scarcity of high-quality research and reviews has been acknowledged by others (Afzal et al., 2018; Hewko et al., 2015; Braeseke et al., 2013; Spilsbury et al., 2013). However, in recent years there has been an increase in more methodologically robust research (Drennan et al., 2018). There was consensus in the literature that the role of the HCA has expanded into delivery of direct care, but no consensus on how competence of the HCA to undertake delegated tasks or activities was assessed (Drennan et al., 2018). The findings in this review are similar to those of previous research (Afzal et al., 2018; Hewko et al., 2015; Braeseke et al., 2013; Spilsbury et al., 2013) and subsequent reports (OECD, 2020; Wells et al., 2019). In RCOP, the core role of the HCA has evolved to that of delivery of direct care to residents (OECD, 2020; Cronin et al., 2020; Wells et al., 2019; Saari et al., 2018; Barken and Armstrong, 2018; Berta et al., 2013). The increasing complexity and acuity of residents in RCOP settings affect RN delegation decisions, as delegation must be safe and the qualifications, competence and experience of each HCA must be considered in the delegation process (Muller et al., 2012; Gravlin and Bittner, 2010). In tandem with these changes, the

reduction in RN staffing levels and the increase in RN workload affects effective delegation to HCAs (Wells et al., 2019; Walker et al., 2015; Roch et al., 2014; Kalisch, 2006).

2.3.2 Role of HCA as Delegatee

Numerous reviews and publications have shown variances in the understanding by HCAs of their role as delegatee and the delegatory relationship between RNs and HCAs (Kusi-Appiah et al., 2018; Roche et al., 2016; Lee et al., 2015; Roch et al., 2014; Denton et al., 2014; Holmberg et al., 2013; Berta et al., 2013; Munn et al., 2013; Muller et al., 2012; Hasson et al., 2013; Bach et al., 2012; Potter et al., 2010; Gravlin and Bittner, 2010; Bittner and Gravlin, 2009).

In RCOP settings, due to the high ratio of HCAs to RNs, the HCA regularly delivers care independently of the RN, and undertakes an increasing number of delegated RN tasks and activities (Kusi-Appiah et al., 2018). However, only one study focusing specifically on the HCA as delegatee was found. Holmberg et al. (2013), in a large qualitative study, explored how the clinical work environment supported or impeded HCA care delivery to residents in RCOP. Researchers undertook 150 interviews and 27 focus groups with HCAs in seven nursing homes in the US (Holmberg et al., 2013). Thematic analysis revealed two themes: the HCA as nurturer of the nursing home resident, and HCAs feeling unnurtured within their workplace. HCAs reported that holistic care to the resident was within their core role. They also reported conflict caused by poor teamwork and communication. The relationship with nurse supervisors was reported as poor, and HCAs reported feeling that they were resident caregivers and that RN supervisors did not respect their role (Holmberg et al., 2013). The focus-group data in this study were collected for a primary study of HCAs' perceptions of their health needs and the factors in the nursing home work that affected their health. Although this was reported, it was not acknowledged as a limitation.

2.3.3 Delegation and Missed Care

The effectiveness of delegation by RNs to HCAs has an impact on safe resident care and missed care (Saqer and AbuAlRub, 2018; Kusi-Appiah et al., 2018; Roche et al., 2016; Roch et al., 2014; Holmberg et al., 2013; Gravlin and Bittner, 2010; Potter et al., 2010; Bittner and Gravlin, 2009). Missed care is when an acceptable standard of nursing care is not delivered or completed (Kalisch and Xie, 2014; Kalisch, 2006). Reasons identified for missed care include staff shortages, ineffective use of staff resources, poor communication and poor delegation within nursing teams (RNs and HCAs) (Kalisch, 2006). Tasks missed or left undone may affect patient safety and wellbeing. In studies on delegation and missed care, there were reports of missed care including patient ambulation and mobilisation, feeding, personal care and toileting (Gravlin and Bittner, 2010; Bittner and Gravlin, 2009).

As a follow-up on research findings by Kalisch (2006) that ineffective delegation resulted in missed care, Bittner and Gravlin (2009) undertook a qualitative descriptive study to understand how RNs use critical thinking to delegate nursing care. The study was undertaken in a 300-bed acute hospital with RNs from medical and surgical wards. Focus-group interviews, with 4-8 participants each, were undertaken with RNs (n=27). The data analysis methods were not reported, but seven categories were identified from the data: "tasks delegated, knowledge expectation, relationships, role uncertainty, communication barriers, system support, and omitted care" (Bittner and Gravlin, 2009, p.144). RNs reported that before delegating to a HCA they considered the patient's clinical condition, and the competence, experience and workload of the HCA. RNs reported that they were unclear of HCA roles and responsibilities, and of what tasks could be delegated to HCAs, but also reported that they did not follow up with the HCA on delegated tasks (Bittner and Gravlin, 2009). The RNs expected the HCA to report significant findings in relation to patients and to have a high level of clinical knowledge, including patient assessment and prioritising skills (Bittner and Gravlin, 2009). Every RN participant in this study reported incidences of care omission or missed care on every shift and every day of nursing care tasks delegated to HCAs. The authors recommended that the findings be used to guide senior nurse leaders to implement strategies to mitigate against missed care.

Gravlin and Bittner (2010) followed the latter study with a quantitative descriptive study to measure RN and HCA reports of frequency and reasons for missed care, and to identify factors related to successful delegation. A survey tool to measure missed care, the MISSCARE Survey-2, and a delegation questionnaire were the data collection tools. The surveys were distributed to a convenience sample of RNs (n=568), nurse managers (n=16) and HCAs (n= 232) on medical and surgical wards in three acute hospitals in the US. The response rate varied across categories, with 241 RNs (42%), 99 (43%) HCAs and 16 (100%) nurse managers responding. The authors provided no detail on data analysis methods. The findings show that 47% of RNs and 59% of HCAs reported never being provided with education or upskilling on delegation. However, 82% of RNs reported being satisfied with the delegation process (Gravlin and Bittner, 2010). Similar to previous research, there were reports of regularly missed care including turning, ambulating, feeding, mouth care and toileting. In addition to HCA competence and knowledge, communication and relationships between RNs and HCAs influenced effective delegation (Gravlin and Bittner, 2010). The limitation of this study was that it was undertaken in medical and surgical wards in three acute hospitals in the same region of the US; therefore the findings may not be transferable to other regions or health care settings, e.g. RCOP. The response rate was considered adequate, with 42% of RNs and 43% of HCAs responding, but this was less than 50% of participants. Given that the data was self-reported, the data on missed care are subjective. Despite the limitations, the two studies (Bittner and Gravlin, 2009; Gravlin and Bittner,

2010) provided an evidence base for connecting poor or ineffective delegation with missed care of patients. Subsequent studies and reviews similarly reported that inadequate delegation by RNs to HCAs affects the delivery of safe patient care and patient outcomes (Magnusson et al., 2017; Kaernested and Bragadóttir, 2012; Saccomano and Pinto-Zipp, 2011; Johnson et al., 2015; Huang et al., 2011). Very few studies have explored the impact of the role of the HCA on patient or organisational outcomes (Drennan et al., 2018; Afzal et al., 2018; Kusi-Appiah et al., 2018). The majority of studies reviewed in relation to delegation and missed care were small and undertaken on one site.

2.3.4 Section Summary

The review of Irish and international studies revealed that the role of the HCA in delivering care is incrementally becoming embedded as the HCA core role. HCAs delivered most of the direct care to patients and residents. However, there was a lack of clarity and consensus on HCA job specifications (roles and responsibilities). An absence of standardisation of HCA minimum education and training eligibility, and for HCA competency assessment in the area of clinical practice, were found across all jurisdictions. All of these findings are associated with challenges for RNs in delegating tasks to HCAs, especially in relation to accountability for care being delivered safely and as delegated. The risk of missed care as a result of poor or ineffective delegation was identified.

In the next section, the factors that were identified as enabling and hindering effective delegation will be presented.

2.4 Factors that Enable or Hinder Effective Delegation

A number of factors that enable or hinder effective delegation were reported in the literature. Enablers for effective delegation were: workplace and organisational supports for effective delegation; RN education, experience and confidence to delegate; and the delegatory relationship. Factors identified as barriers to effective delegation were: a lack of clarity on HCA job title, role and responsibility; RN uncertainty about HCA competence as delegatee to undertake delegated tasks; and HCA resistance to delegation.

2.4.1 Workplace Policies, Guidelines and Support for RNs to Delegate Effectively

There are expectations that employers have policies and procedures to guide delegation by RNs, and provide education on delegation (NCSBN/ANA, 2019; NMBI, 2015a). However, the studies reviewed revealed that there was insufficient evidence of the availability of workplace guidelines, policies and

resources to support RNs to delegate effectively (Beeber et al., 2018; Drennan et al., 2018; De Vliegher et al., 2016; Hewko et al., 2015; Braeseke et al., 2013; Bystedt et al., 2011; White et al., 2011; Gravlin and Bittner, 2010).

With the introduction of the HCA grade into nursing teams in Ireland, it was recommended that employers enable integration of the HCA role into the workplace, and that local guidelines be developed to support the integration of the new role (Department of Health and Children, 2001). The NMBI sets out the responsibilities of the workplace to develop nursing policies and resources in delegation and for the supervision of a HCA (NMBI, 2015a). The review of the HCA role in Ireland also identified the significance of employers providing organisational policies and resources to RNs in delegation and supervision of HCAs (Drennan et al., 2018).

A number of responsibilities for the employer have been identified, including: ensuring the provision of adequate staffing of both RNs and HCAs to provide safe care (Drennan et al., 2018; Bystedt et al., 2011), ensuring appropriate qualifications and competence of nursing care teams (Drennan et al., 2018; De Vliegher et al., 2016; Hewko et al., 2015; Bystedt et al., 2011; Gravlin and Bittner, 2010), and providing education and competence development opportunities for RNs and HCAs (Drennan et al., 2018; Hewko et al., 2015; Bystedt et al., 2011; Gravlin and Bittner, 2010). However, many studies have indicated that workplace policies, guidelines and supports to improve organisational support for RNs to delegate were either not evident or not enacted. This resulted in recommendations on improving role clarity, and providing delegation guidelines and decision frameworks within the workplace (Hughes et al., 2017; Saari et al., 2018; Chu et al., 2016; Lee et al., 2015).

2.4.2 RN Education, Experience and Confidence to Delegate

A key enabler of effective delegation is for RNs to be educated, experienced and confident in delegation. A number of studies found that newly qualified nurses (NQNs) avoided delegation because they lacked confidence and perceived some HCAs as more experienced than they were themselves (Allan et al., 2018; Magnusson et al., 2017; Allan et al, 2016; Allan et al., 2015; Johnson et al., 2015; Hasson et al., 2013).

An ethnographic case study undertaken in three acute hospitals in the UK, which generated a number of publications, explored the delegation and supervision skills of NQNs (Allan et al., 2018; Magnusson et al., 2017; Allan et al., 2016; Johnson et al., 2015; Allan et al., 2015). Thirty-three NQNs were observed, through participant observation and 28 of these NQNs were interviewed, as well as 10 HCAs and 12 ward managers to explore how NQNs delegate to and supervise HCAs at ward level. This study provided evidence of the challenges of adapting to the role of delegator when transitioning from

nursing student to NQN. The findings identified the importance of support and supervision for NQNs in the process of delegating to HCAs by preceptor RNs and, most importantly, ward managers (Allan et al., 2018; Magnusson et al., 2017; Allan et al., 2016; Johnson et al., 2015; Allan et al., 2015). The NQNs and HCAs were observed as working alongside each other with little interaction (Johnson et al., 2015; Magnusson et al., 2017); Johnson et al. (2015) described this as "working in parallel". More experienced nurses accepted that some HCAs were aware of the HCA responsibilities for routine care delivery (Johnson et al., 2015). The NQNs depended on the HCAs to deliver care, understand if the patient's condition changed, and report back accordingly (Allan et al., 2018; Magnusson et al., 2017; Johnson et al., 2015; Allan et al., 2015). Reporting on the same study, Magnusson et al. (2017) described five delegation styles used by NQNs (Table 2.5), with the "do it all" style being the most common. NQNs were found to have avoided delegation because they believed that some HCAs were more experienced and because they lacked confidence (Magnusson et al., 2017). These findings support those from an earlier study by Hasson et al. (2013) where nursing students reported doing all tasks themselves rather than delegating. NQNs reported a fear of creating tension in the nursing team or facing HCA resistance to the delegation. Hasson et al. (2013) found that this reluctance to delegate developed during undergraduate education.

Table 2.5: Delegation Styles of NQNs (adapted from Magnusson et al., 2017)

The do-it-all nurse: completes most of the work themselves.
The justifier: over-explains reasons for decisions and is sometimes defensive.
The buddy: wants to be everybody's friend and avoids assuming authority.
The role model: hopes that HCAs will copy their best practice but has no way of assuring how this is done.
The inspector: is acutely aware of their accountability and constantly checks the work of HCAs.

Delegation and supervision were not found to be significant components of education in undergraduate nurse education or preceptorship programmes, and were described as "invisible learning" (Allan et al., 2016; Hasson et al., 2013; Standing and Anthony, 2008; Anthony et al., 2001). The four steps of invisible learning were described as: learning through mistakes, learning from challenging experiences, learning from colleagues, and "muddling through" (Allan et al., 2015). These findings echoed earlier research on nurses' belief in their abilities to delegate, which found that RNs who felt unprepared to delegate reported trial-and-error learning which was reported as inefficient and possibly having serious implications for patients and staff (Anthony et al., 2001; Hasson et al., 2013). NQNs reported lectures on delegation and supervision during undergraduate education but that these did not prepare them for it in practice (Allan et al., 2016; Johnson et al., 2015). Indeed many studies found that poor preparation for the delegation role and learning on the job were potential

risks to patient safety and outcomes (Hasson et al., 2013; Alcorn and Topping, 2009; Anthony et al., 2001).

However, the requirement for RN education to effectively delegate and supervise was not restricted to NQNs (Saqer and AbuAlRub, 2018; De Vliegher et al., 2016; Yoon et al., 2016; Lee et al., 2015; Kaernested and Bragadóttir, 2012; Saccomano and Pinto-Zipp, 2011; Gravlin and Bittner, 2010; Potter et al., 2010; Bittner and Gravlin, 2009; Standing and Anthony, 2008; Anthony et al., 2001).

Two studies used a Confidence and Intent to Delegate Scale to investigate RNs' confidence to delegate (Yoon et al., 2016; Saccomano and Pinto-Zipp, 2011). The Saccomano and Pinto-Zipp (2011) study undertaken in the US explored RN leadership style and confidence in delegation; they found that RNs were not adequately prepared for delegation and supervision responsibilities and that delegation education and experience affected effective delegation (confidence to delegate). Using a cross-sectional survey design, the researchers determined through a G*Power software package that 158 participants were required. Of the RNs in one acute hospital who met the eligibility criteria (n=552), 29% (n=158) completed a leadership questionnaire (Path-Goal Leadership), the Confidence and Intent to Delegate Scale questionnaire, and a demographic questionnaire. This low response rate for a population of 600 RNs is of concern. There was no relationship found between leadership style and confidence to delegate. However, it was found that nurses educated to baccalaureate degree level had more confidence in delegation than nurses educated to diploma or associate degree level. Nurses who had accumulated clinical experience (regardless of qualification level) were more confident in delegation (Saccomano and Pinto-Zipp, 2011). The authors provided no rationale for the increased confidence in delegation of RNs with more clinical experience. In a later study in RCOP in Korea (Yoon et al., 2016), where a similar methodological design was applied, leadership style was associated with confidence in delegation. Using a descriptive correlational design, the Confidence and Intent to Delegate Scale and a Multifactor Leadership Questionnaire were completed by 199 RNs from 13 long-term care hospitals in Korea. Again, in this study, confidence in delegation statistically correlated with RN length of clinical experience. RNs with more than five years' clinical experience in their current workplace had more confidence to delegate than RNs with less than five years' experience. In addition, the findings revealed that RNs who had engaged with professional development and training, were familiar with the HCA job description, were aware of the RN legal responsibility with supervision, and applied a more transformational than transactional style of leadership, were more confident in delegation than other RNs. However, in this study there was a relationship between leadership style and confidence in delegation. The authors reported that "transformational leadership was the most statistically significant factor influencing delegation confidence" (Yoon et al., 2016, p.680). The

difference in findings between the two studies on the impact of leadership approach and confidence in delegation would indicate the need for further research in this area.

Kaernested and Bragadóttir (2012), in a quantitative study to identify the attitudes of RNs to delegation, reported under-delegation and over-delegation as being related to RN confidence. A descriptive correlation design was used to identify the attitudes of Icelandic RNs to delegation and their preparedness to delegate effectively, and to determine whether attitude and preparedness were related to age, experience and education in delegation, workload, and job satisfaction. All RNs (96) working in five medical units in an acute hospital were invited to participate, with a 74% response rate (n=71). Most participants reported a positive attitude to delegation and that they were prepared to delegate. The majority reported spending a lot of time on jobs that others could do. However, this was a small sample, undertaken in a single hospital, where RNs self-reported. RNs delivered most of the direct care in this Icelandic setting. Therefore, the transferability or generalisability of the findings to the Irish context may be limited.

2.4.3 Delegatory Relationship

A number of researchers identified the importance of the delegatory relationship between RNs and HCAs as an important factor for effective delegation (Campbell et al., 2020; Allan et al., 2016; De Vliegher et al., 2016; Bellury et al., 2016; Lee et al., 2015; Johnson et al., 2015; Potter et al., 2010; Bittner and Gravlin, 2009; Standing and Anthony, 2008). Effective team working, communication, mutual trust and respect were identified as critical dependencies in this relationship. Effective teamwork is defined as when two or more individuals with specific roles interact interdependently and effectively to achieve a common and shared goal (Bellury et al., 2016).

To understand how RNs and HCAs perceived teamwork, a qualitative descriptive study was undertaken in an acute hospital in the US with a workforce of HCAs (n=200) and RNs (n=700) (Bellury et al., 2016). Participants were recruited from nine acute wards of approximately 266 RNs, and the majority of HCAs worked in the nine wards. HCAs representing 16.5% of the HCAs participated in three focus-group sessions. Of the RNs (n=266) in the nine wards, only 6.8% (n=18) completed an open-ended electronic survey. In this review, the findings are considered in the context of the low response rate. The RNs (6.8%) did not reflect the RN population and this was acknowledged as a limitation in the study. The findings were reported under three themes, described as “coordinating mechanisms”: shared mental models, closed-loop communication, and mutual trust (Bellury et al., 2016). Shared mental models were described as individual knowledge that contributed to collaborative team working and centred on shared understanding of team goals, and team member tasks. Closed loop

communication referred to ensuring that communication was received as intended. The perceptions of teamwork were different between RNs and HCAs, with HCAs reporting that the functional team consisted of HCAs only working together, with the HCAs and RNs working in parallel teams (Bellury et al., 2016). However, the RNs reported that they all worked as a team, with the HCA in a support role, working under RN delegation and supervision (Bellury et al., 2016). HCAs described how individual personalities and work styles affected working relationships and team working, explaining that whether the HCA had a good or a bad day depended on who was on duty. Closed loop communication was reported as uncommon, with one-way requests from the RN to the HCA predominating (Bellury et al., 2016). RNs reported a lack of time for effective communication because of a busy ward, and that communication was ignored by the HCA. HCAs reported that too much communication could be negative if the RN was calling their name all day to undertake tasks and activities (Bellury et al., 2016). Other studies have also identified as critical for effective delegation: RNs and HCAs working together to develop working relationships, to build trust, to support communication and knowledge exchange (Campbell et al., 2020; Kærnested and Bragadóttir, 2012; Potter et al., 2010; Corazzini et al., 2010; Bittner and Gravlin, 2009).

The importance of RNs and HCAs working together in a team has been identified as critical for delivering quality and safe care (Drennan et al., 2018; Bellury et al., 2016; Kessler et al., 2015; Lee et al., 2015; Roch et al., 2014; Potter et al., 2010; Bittner and Gravlin, 2009; Standing and Anthony, 2008). However, there is evidence of challenges in integrating the HCA into the nursing team. In the review of the role and function of the HCA in Ireland, there was evidence that the HCA worked as a valued member of the patient care team (Drennan et al., 2018), but it was found that the integration of the HCA into the care teams was not consistent in all work areas. The HCA worked in support of, and under the supervision of a RN, and collaborative working was required for safe integration of the HCA into the nursing care team (Drennan et al., 2018). These findings were reflected in an integrative review in Canada of the perceptions of RNs and HCA of their own and others roles; this found that RNs and HCAs had little understanding of their fellow team members' roles (Kusi-Appiah et al., 2018).

Numerous studies have stressed the importance of effective communication in the delegatory relationship. Bystedt et al. (2011) reported that effective delegation was achieved through good communication and willingness to collaborate. A phenomenological study in a municipal hospital for older people in Sweden was conducted to explore how RNs perceived delegation to HCAs. RNs (n=12) were interviewed in relation to how they delegated. Three prerequisites for delegation to occur were identified: RN focus on their own work situation, RN focus on HCA, and RN focus on patients (Bystedt et al., 2011). The RNs' focus on their own work included how RNs reconciled delegating a task and not undertaking the task themselves – leading to feelings of lack of control and vagueness regarding their

responsibility. The RNs' focus on the HCA included taking opportunities for mentoring, optimising the HCA role and delegating fairly, but also concern about the competence of the HCA. The RNs reported understanding that HCAs were educated and competent to undertake delegated tasks, but that it was a challenge to know the competence of each individual HCAs; that they delegated to HCAs for continuity and timeliness of patient care, but this did not resolve concerns about RN staffing shortages and the complexity of patient care needs. The RNs also reported concerns about patient outcomes when tasks were delegated to and performed by HCAs (Bystedt et al., 2011), and concerns in relation to RN accountability and responsibility for the delegated task. It was reported that, as the number of RNs in the workplace decreased, the level of RN delegation would increase (Bystedt et al., 2011).

The findings by Bystedt et al. (2011) on the RN responsibility for good communication when delegating to HCAs was supported in other research. Effective communication focused on sharing information, manner of communication, and working together as a partnering team (Chu et al., 2016; Kærnested and Bragadóttir, 2012; Bystedt et al., 2011; Potter et al., 2010; Bittner and Gravlin, 2009). In a review of the literature by Chu et al. (2016) the organisational structures and processes for effective RN supervisory performance in RCOP were identified. The RN structures included the RNs' perceptions of their supervisory role, as well as their personal qualities. The processes for effective supervision included effective communication skills such as being flexible, understanding, being a considerate listener, respect, value, recognition and acknowledgement of HCAs.

The findings in relation to mutual trust and respect to support effective delegation were identified in previous studies (Chu et al., 2016; Bellury et al., 2016; Lee et al., 2015; Johnson et al., 2015; Roch et al., 2014; Holmberg et al., 2013; Kærnested and Bragadóttir, 2012; Bittner and Gravlin, 2009; Standing & Anthony, 2008). The HCA lack of understanding of the role of the RN was identified as a contributor to poor teamwork (Campbell et al., 2020; Lee et al., 2015; Johnson et al., 2015; Roch et al., 2014; Standing and Anthony, 2008). Johnson et al. (2015) found that RNs reported that HCAs may not understand the documentation responsibilities of the RN; the attendance to documentation responsibilities may have been perceived by HCAs as the RN avoiding direct care work. The RN responsibilities for administrative tasks resulted in the RN not being available to work with the HCA, and the HCAs therefore relied on each other for support rather than the RN (Johnson et al., 2015). Holmberg et al. (2013) reported similar findings, with HCAs reporting incidences of poor teamwork when RNs do not answer call bells or are not working with HCAs providing direct care. Effective delegation by RNs needed to be supported by practising and nurturing mutual trust and respect in teams (Chu et al., 2016; Kærnested and Bragadóttir, 2012; Bittner and Gravlin, 2009). Trust was identified by RNs as important, especially for RNs to trust the HCA to undertake the delegated tasks (Kaernsted and Bragadóttir, 2012). In a mixed-method study to evaluate the HCA role within an RN

delegation and supervision model for administration of medication to older people living at home, RNs reported that effective delegation resulted in high levels of trust and confidence in HCAs to undertake delegated tasks (Lee et al., 2015). The HCAs were provided with education and training in advance of their new delegated responsibility. The increased HCA competence resulted in RNs reporting high levels of trust and confidence in HCAs. They reported that delegating to HCAs sometimes eliminated the need for duplicate nurse and HCA visits and enabled them to visit people with more complex needs. HCAs enjoyed their expanded role and were accepted by clients and carers. This trust and confidence in the HCA was achieved through good working relationships, positive staff attitudes, training and support for HCAs and RNs (Lee et al., 2015).

2.4.4 Lack of HCA Role Clarity

The lack of clarity and challenges in describing or understanding the role of the HCA, in the absence of standardised HCA job titles and job descriptions, was described in section 2.3.1. This lack of HCA role clarity was identified as a barrier to effective delegation (Kusi-Appiah et al., 2018; Drennan et al., 2018**;** Yoon et al., 2016; Glackin, 2016; Hewko et al., 2015; Munn et al., 2013; Spilsbury et al., 2013; Corazzini et al., 2010; Bittner and Gravlin, 2009). The lack of standardisation of minimum education and qualifications for the HCA role was also identified as a significant barrier for effective delegation (OECD, 2020; Conyard et al., 2020; Barken and Armstrong, 2018; Glackin, 2016; Walker et al., 2015; Braeseke et al., 2013; Spilsbury et al., 2013; Gravlin and Bittner, 2010; Corazzini et al., 2010; Standing & Anthony, 2008). A review of educational standards and legal regulations of employment for health care assistants was undertaken as part of a collaborative EU project (Braeseke et al., 2013). The study sought to establish the core skills and competence required or demanded by the employer. HCA data were collected from nurse regulators and educators in 15 countries (14 EU countries and Switzerland); 12 out of 15 countries had no standardisation of HCA education or training, and three countries did not have a process for regulating or licensing HCAs to practise as health care workers (Ireland, UK and Switzerland). The report recommended further attention to: the clarification of the HCA's scope of responsibility and accountability, how HCAs were supervised, and recognition of the difference between delegation and allocation of tasks. The overall recommendations were to align education and skill preparation of HCAs within a competency assessment process to match work requirements, and for a full-time education programme, of two to three years duration at level 4 European Qualification (equivalent to QQI L5 in Ireland), leading to an accredited qualification or licence. These findings were supported in reviews of evidence on HCAs and nursing teams across different jurisdictions where the lack of clarity about education level and minimum qualifications created confusion as to what could be delegated to the HCA – internationally (OECD, 2020); in Australia (Wells

et al., 2019; Munn et al., 2013), in Canada (Afzal et al., 2018; Saari et al., 2018; Hewko et al., 2015), in New Zealand **(**Shannon and McKenzie-Green, 2016**)** and in Ireland (HSE, 2018; Drennan et al., 2018). The prevailing lack of standardised education, qualifications and regulation of HCAs leads to ambiguity for the RN as delegator, and these are therefore barriers to effective delegation.

2.4.5 RN Uncertainty about HCA Competence

RN uncertainty about HCA competence to undertake delegated tasks was identified as a barrier to effective delegation (Walker et al., 2021; OECD, 2020; Saari et al., 2018; De Vliegher et al., 2016; Glackin, 2016; Roche et al., 2016; Bystedt et al., 2011; Corazzini et al., 2010; Bittner and Gravlin, 2009). There is an expectation that, when an RN delegates a task or activity, the HCA is competent, as the delegatee, to undertake the task or activity (NMBI, 2015a). In a quantitative, cross-sectional population-based study in Ireland to record HCAs and qualified carers' wellbeing, career satisfaction and change within the vocational roles, Conyard et al. (2020) reported that 16% of respondents did not have a qualification in caring. In the study, two validated research questionnaires – the General Well-being Schedule (GWBS) and the Minnesota Career Satisfaction Survey (MCSS) – were distributed to HCAs and qualified carers selected through the Healthcare Assistant and Carers Association Ireland (Conyard et al., 2020). Of the estimated 70,000 HCAs and carers in Ireland, a sample size of 1,052 participants was required for the statistical analysis, and 1,846 participants completed the questionnaire. The process of participant recruitment and selection was not clarified in the report, with no reference to inclusion and exclusion criteria. The participant demographics were presented as an organogram (one page of the report). In contrast there was detailed reporting of the statistical analysis methods. Despite the gaps in reporting on the methodology, the findings support previous findings in Ireland (Glackin, 2016) and internationally (OECD, 2020; De Vliegher et al., 2016; Roche et al., 2016; Bystedt et al., 2011; Corazzini et al., 2010; Bittner and Gravlin, 2009). The lack of standardisation in education and qualification requirements for HCAs employed in caring roles created confusion as to the level of competence of the HCA to undertake delegated tasks. The uncertainty about competence resulted in confusion as to the tasks and activities that could be delegated to individual HCAs, and resulted in HCAs being delegated different tasks by different RNs (Conyard et al., 2020; Glackin, 2016). Therefore, where RNs delegated tasks to HCAs beyond the HCA's knowledge and competence, this affected patient safety, patient outcomes, and the working relationship between the RN and HCA (Glackin, 2016; Johnson et al., 2015; Kærnested and Bragadóttir, 2012).

There was some evidence that HCAs worked independently of the RN (Dudley et al., 2021; Campbell et al., 2020; DeVliegher et al., 2016). De Vliegher et al. (2016) recommended that delegating tasks to HCAs who work independently of the RN must be carefully considered based on the qualifications,

experience and competence of the HCA, and stated that supervision of HCAs is important to promote communication, evaluate patient needs, and provide quality assurance. De Vliegher et al. (2016) explored the experiences of HCAs who deliver care in the patient's home in relation to delegation of nursing tasks, the supervision of care delivered, and how independent working affects the RN and HCA. In this qualitative study, in-depth group interviews were conducted with HCAs (n=12), RNs (n=12) and nurse managers (n=8) in community nursing services in Belgium. There were scant details on research design, including participant recruitment and selection. Semi-structured interview questions covered integration of the HCA into the team, delegation and supervision, success factors, and barriers in the HCA role. Overall, the findings reported positively on the HCA inclusion in care teams, but RNs required education and skill development in delegation and supervision of the HCA. The HCAs were restricted in providing care to less complex patients; the RNs provided care to the more complex cases.

2.4.6 HCA Resistance to Delegation

As the role of the HCA expands to a more direct patient care role, resistance by HCAs to delegation by RNs has been identified as a barrier to effective delegation. A much-cited study to understand delegation practices between RNs and HCAs was undertaken by Potter et al. (2010). The methodological approach was a qualitative descriptive study with group interviews of RNs and HCAs. This was a small study, in five oncology wards, interviewing only 10 RNs and 6 HCAs through semi-structured group interviews. Despite the limited numbers, the findings provided compelling evidence on the delegation practices between RNs and HCAs, and it is one of the few studies that included both HCAs and RNs as study participants. The RNs and HCAs were interviewed separately, and interview data were reported using thick descriptions. Conflict was identified as a significant factor in the interactions of delegation practices. Five sources of conflict were identified from the RN interviews: age, work ethic, role, personality and management. RNs reported that some senior HCAs resisted delegation by newly recruited or young RNs, but also that younger RNs may not manage conflict arising from delegation practices well. This affected team-building, working relationships and effective delegation. RNs also reported a reluctance to engage with HCAs who would not undertake delegated tasks; they would instead undertake the task themselves or expect organisational managers to manage the HCAs who were reluctant to accept delegation (Potter et al., 2010). Other studies identified HCA resistance and negativity in relation to the delegation and supervision role of the RN (Bellury et al., 2016; Kessler et al., 2015; Bach et al., 2012).

2.4.7 Lack of understanding of the role of the RN as delegator

There were two studies that focused on the changing role of the HCA on nursing teams in the UK, where there was a lack of understanding of the role of the RN as delegator, and the expectations of the RN in relation to scope of professional practice and accountability for patient care (Kessler et al., 2015; Bach et al., 2012).

In a study exploring the role of HCAs in the care of older people in two acute trusts in the NHS, much attention was given to the boundary work and associated tensions between HCAs and RNs (Bach et al., 2012). Bach et al. (2012) found that HCAs undertook a high proportion of direct care, providing personal care, undertook baseline observations, and were able to detect distress in vulnerable patients. The study is described as involving two case study sites, using interviews as the main data collection method, but is unclear as to the exact methodological approach applied. With a study sample of RNs (n=26) and HCAs (n=34), interviews, document review and a demographic survey were undertaken. RNs acknowledged that the HCA had more direct care contact with the patients and that the HCA reported to the RN (Bach et al., 2012). The lack of understanding between the RN role and the HCA role created conflict between RNs and HCAs working together. The RNs reported distinct differences between the role of the HCA and that of the RN, describing the HCAs as helpers and assistants, and pointing to the higher levels of RN education requirements, and the RN role of holistic nursing practice as opposed to task-orientated care. In contrast, HCAs reported little variance between their role and that of the RN, as they described working as a team with the RN, not working under the supervision of an RN, and doing everything except the medications (Bach et al., 2012). HCAs reported that they were allocated the 'dirty' work while RNs spent a long time 'writing'. HCAs reported a lack of respect for HCAs and described how this was a cause of tension between RNs and HCAs. The authors proposed that, as RNs have taken on more technical, managerial and administrative roles, the patient-centred, holistic care role of the RN has diminished (Bach et al., 2012). The authors proposed that HCAs work independently of RNs, with no recognition of the RN delegation role.

Again in the UK, when Kessler et al. (2015) reported on the "hoarding and discarding of tasks in nursing", the lack of understanding between the RN role and the HCA role were barriers to RNs and HCAs working together. This paper reported on data from a larger mixed-method study on the HCA role in acute-care settings. Although the methodology is not reported, the authors refer to four case study hospitals, with participants from general medical and general surgical wards (n=29 wards) (Kessler et al., 2015). Interviews were conducted, including 115 interviews with RNs and HCAs, there were direct observations of HCAs and RNs in each case study site, and survey data were collected from patients, RNs and HCAs. The aim of the study, which was part of a larger study, was to understand the

implications of professionalisation, expertise in care work, and how the distribution of care tasks occurred. The focus was on the impact of the HCA role in acute healthcare settings, and how RNs engage with the HCA role. Again, the RNs reported that they valued the HCA support with care delivery. They also stressed the importance of trust in HCA competence and capability. The HCAs reported, and were observed, delivering a high proportion of direct care with no reference to RN delegation. The direct care responsibilities of the RN as central to their role was challenged as the authors reported little evidence of RN direct care role. This 'discarding' of direct care activities by the RN whilst retaining the role of care provider, or 'holistic hoarding', was proposed as a reason for role conflict (Kessler et al., 2015). However, neither research study identified the professional responsibility of the RN in delegation to HCAs, or referred to RN accountability for patient care as outlined by professional nurse legislation and regulations.

The findings of conflict and lack of clarity in the role of the HCA as delegatee are important in the context of RCOP settings. The lack of understanding by HCAs as to delegation are in itself a barrier for effective delegation. More widely, the lack of recognition of the RN role as delegator is an indication of a lack of understanding of RN delegation responsibilities when working with HCAs.

2.4.8 Section Summary

Studies and reviews identified the enablers and barriers for effective delegation by RNs to HCAs. The importance of workplace and organisational support for RNs to delegate was identified. This was through the provision of delegation education to RN, supported with delegation policies and guidelines. The significance of RN years' of experience and confidence was found to be an important factor influencing effective delegation. The importance of effective teamwork and the delegatory relationship between RNs and HCAs was found to be an enabler. This was dependant on collaborative communication, mutual trust and respect. Many studies and reviews identified the lack of clarity in the role of the HCA, due to a lack of standardisation of job titles, job descriptions, and essential education and qualification requirements for HCAs, as a significant barrier to effective delegation. These factors contributed to RN uncertainty about HCA competence to undertake delegated tasks. As the HCA role became more embedded in direct patient care, especially in RCOP, there was evidence of increasing resistance by HCAs to RN delegation. Interestingly, only two of the delegation studies reviewed included observation of the process of RN delegation (Roche et al., 2016 and Magnusson et al., 2017; Allan et al., 2016; Allan et al., 2015; Johnson et al., 2015). The other studies relied on quantitative methods – survey questionnaires – or participant interviews.

2.5 Role Theory

Role emerged as central to understanding the role of the RN as delegator and the role of the HCA as delegatee. The application of theory can guide qualitative research, providing a framework to analyse research data, or a lens to interpret and provide a broader understanding of complex phenomena (Creswell, 2014; Reeves et al., 2008). The following section outlines the origins, meaning and perspectives of role theory, with a focus on organisational role theory and the concept of role stressors.

2.5.1 Role Theory

Role theory is used in social sciences to explain, discuss or study social issues. Social role theory writers use *role* either in reference to characteristic behaviours or to describe social roles to be played (Biddle, 1986). Role is "a set of behaviors expected of individuals in specific social categories" (Miles, 2012, p.27). Criticisms of role theory include the lack of consensus on definitions and of concrete evidence for propositions (Biddle, 1986). However, role theory continues to be a popular concept to explain and describe human behaviours. The continued empirical testing of role theory propositions is contributing to the use of role theory in sociology, anthropology and psychology (Biddle, 1986).

2.5.2 Origins of Role Theory

Role theory is "a science concerned with the study of behaviors that are characteristic of persons within contexts and with various processes that presumably produce, explain, or are affected by those behaviors" (Biddle, 1979, p.4). Role theory became prominent when social scientists, anthropologists and psychologists began developing theory relating actors in theatres to real social life settings (Wickham and Parker, 2007; Biddle, 1979). Linton, Moreno and Mead are credited with the conceptual development of role theory, when *role* was used to study social issues. In the 1930s Linton, an anthropologist, defined social role as a set of "expectations" aligned to an individual's behaviour and status in society (Biddle, 1979). Moreno, a psychologist and psychiatrist, developed the concept of role-playing within role theory (Biddle, 1979). During the same period social philosopher George Herbert Mead published seminal work on role theory to understand and explain the social interaction of individuals. Mead's theory on role was of the human 'self' based on the belief that an individual's self-image emerges from social interactions or social group (Subrt, 2017; Biddle, 1979). In role theory, it is recognised that roles exist within *social systems*, or organisations, where individuals occupy *social positions* (Biddle, 1979).

Organisational role theory proposes that individuals in organisations are expected to behave in a set manner, and undertake tasks and work within a hierarchical structure established as a norm for the role they occupy (Kahn et al., 1964, Katz and Kahn, 1978). Roles in organisations are assumed to be aligned to defined social positions, developed from normative expectations, with specific tasks and responsibilities (Rizzo et al., 1970; Biddle, 1986). Roles enable others in a group to know what to expect as normal behaviour from a role occupier. Members of a group are expected to behave in a particular manner as aligned to the role they occupy. However, what is considered a norm may vary among individuals and role conflict may transpire. In the 1960s, Merton, Gross and Kahn introduced the context of role structure and role stressors in organisations. Kahn et al., in *Organizational Stress: Studies in Role Conflict and Ambiguity* (1964), presented the Role Episode Model (REM) to measure organisational role ambiguity and role conflict.

2.5.3 Role Episode Model

The REM is a theoretical framework used in organisational research to analyse and understand the dyadic interactions between the *focal person* and *role sender*, encompassing the expectations, perceptions and behaviours of the *role set members* (Kleinman and Palmon, 2000; King and King, 1990; Katz and Kahn, 1978; Kahn et al., 1964). The REM describes the cyclical process that occurs between the role sender and the focal person (Figure 2.2).

The role sender and focal person are the *role set members.* The *role sender* is an individual in the organisation who sends role expectations to the focal person, and can be any individual in the organisation that has expectations of the focal person's behaviour (Gilbert et al., 2019; Tan, 2014; Kleinman and Palmon, 2000; Kahn et al., 1964). The role sender is in some way dependant on the focal person's actions and behaviour (Tan, 2014; Kahn et al., 1964). This leads the role sender to have an opinion and expectation of what the focal person's responsibilities are (*role pressures)*, and it is against these that they measure the performance of the focal person. The process of role sending includes the sender efforts to influence the focal person to conform to an expected role (Tan, 2014; Kahn et al., 1964). The expectations sent to the focal person affect their experience and response.

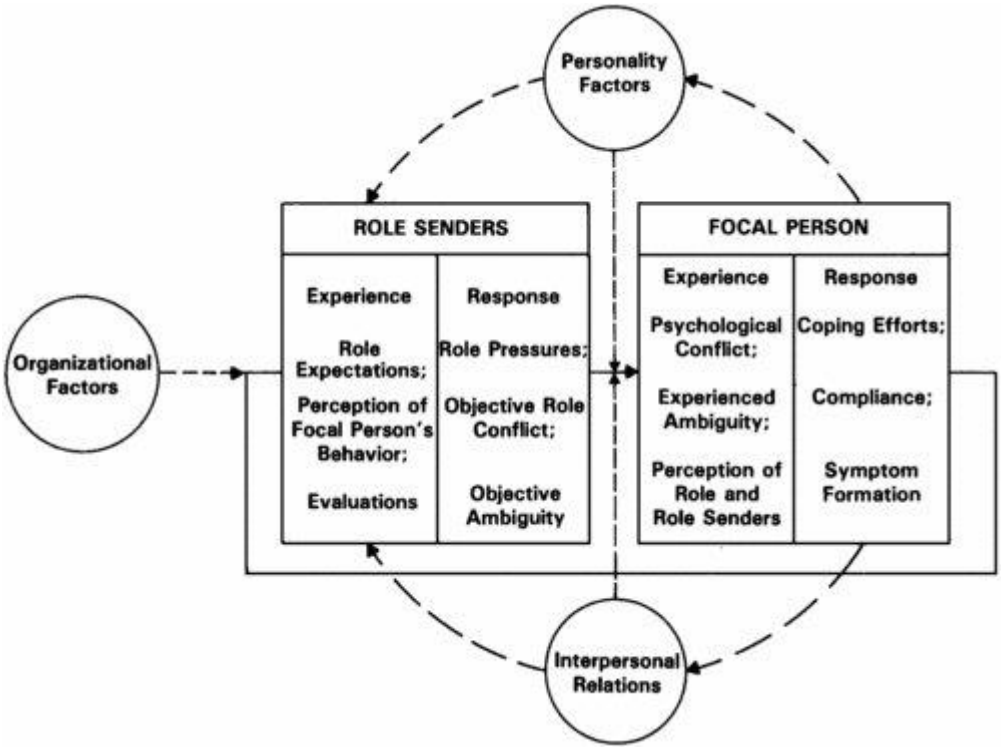
The *focal person* or *role incumbent* receives the expectations of the role sender (*role forces*), and sends signals to others of their role expectations (Kahn et al., 1964). Focal persons also are senders to themselves, by having a perception, belief and expectation of what their own role is or is not. The focal person has their own organisational identity, and they behave in a manner to match this role perception (Kahn et al., 1964). If the focal person finds the role episode coercive, unrealistic or inappropriate they will resist, and the role sender will be expected to alter the demands.

The REM consists of four factors: the role expected to be enacted (role expectation), the role assigned to the focal person by a role sender, the received role as understood or perceived by the focal person, and the role that is performed (the role behaviour) (Gilbert et al., 2019; Katz and Kahn, 1978; Kahn et al., 1964). The role episode between role sender and focal person is iterative and continuous between role sending and feedback.

2.5.3.1 The Role Episode

The *role episode* consists of a cycle of communications between the role sender and focal person and continues until mutual expectations are achieved or the role episode is suspended. These expectations or role pressures influence the focal person's behaviour, and this behaviour then influences expectations (Kahn et al., 1964). The focal person processes the role pressures, resulting in perceived *role forces* to respond to expectations, which may give rise to psychological stress (Stevenson and Duxbury, 2019; Kahn et al., 1964). This cycle does not occur in isolation. Within the role episode there can be objective influences – such as an actual condition in the workplace, e.g. inadequate staffing levels or a vague job description – or subjective influences; that is, the experiences, perceptions or emotions of the focal person. Factors that influence the role episode were identified as set member personality, interpersonal relations and organisational factors.

Figure 2.2: Role Episode Model by Kahn, Wolfe, Quinn, Snoek and Rosenthal (1964, p.26)



2.5.3.2 Organisational Factors

Organisational factors include the size, complexity, staffing model, hierarchical structures and purpose of the work organisation (King and King, 1990; Kahn et al., 1964). Organisational factors include the focal person's position in the organisation (Bosselut et al., 2021; Gilbert et al., 2019; Kahn et al., 1964). They influence the expectations and pressures that the role sender places on the focal person; e.g. the focal person works to the roles and responsibilities articulated in the organisation's job specification and contract of employment, or the established model of care delivery in a healthcare setting. Regular redesign of the organisation (e.g. redesign of health services), changes in social structure (e.g. skill mix), and changes in environment (e.g. regulation standards) impose new demands on organisation members. These new demands can "increase tension, anxiety, fear and hostility, with decreased job satisfaction, loss of self-confidence" (Rizzo et al., 1970, p.154). In addition, lack of consensus at organisational level about roles and assigning role responsibility and accountability increases role conflict (Rizzo et al., 1970, Kahn et al., 1964). When there are multiple and conflicting standards in an organisation, where prioritisation or importance is not clearly articulated – described by Rizzo et al. (1970) as *dual hierarchy* – the focal person must decide the priority of accomplishment. This increases role conflict, and the focal person selects the standards that are most relevant to them and by which their performance will be evaluated (Rizzo et al., 1970).

2.5.3.3 Personality Factors

Personality factors are the motives, values and beliefs of set members (King and King, 1990: Kahn et al., 1964). The personality of the focal person affects the expectations of the role senders and the behaviour of the focal person (Kahn et al., 1964). Individuals who occupy similar roles may differ as to the boundaries of their role; e.g., some RNs may consider delegation to HCAs not within their role, or some HCAs may not consider recording clinical vital signs as within their role. Kahn et al. (1964) also suggest that role stressors (overload, ambiguity and conflict) may affect an individual's behaviours and personal characteristics (e.g. anxiety, frustration). Personality factors also affect, and can be a response to, interpersonal relations (Bosselut et al., 2012; Kahn et al., 1964)

2.5.3.4 Interpersonal Relations

Interpersonal relations refer to the interdependencies and relationships between role set members (Kahn et al., 1964). Interpersonal relations can be a formal structure of roles in the organisation (RN role as professional nurse, HCA role of unregistered care support), informal interactions (working together, taking meal breaks together, camaraderie) and sharing common experiences (delivering care together, working within similar governance and rules of employment). In REM the relationship

between the focal person and role sender is influenced by the role sender's expectations of the focal person's behaviour (Kahn et al., 1964). Role pressures will be interpreted by the focal person based on interpersonal relations with the role sender. Hierarchical relationship, power balance, respect and authority are factors that influence the interpersonal relations between focal person and role sender (Katz and Kahn, 1978).

2.5.4 Role Clarity and Role Stressors: Role Conflict, Role Ambiguity and Role Overload

The expectation for individuals who occupy a particular role is that they have role clarity. Role clarity is when an individual is aware of their responsibilities, tasks and activities, and what behaviours are accepted as normal in the role they occupy (Vullinghs et al., 2020; Rizzo et al., 1970). A role stressor is any variable within an occupational role that creates negative consequences for the role holder (Kahn and Quinn, 1970). Role stressors occure within the role episode (King and King, 1990; Katz and Kahn, 1978; Kahn et al., 1964). Role stressors are role ambiguity, role conflict and role overload (Katz and Kahn, 1978). Role ambiguity occurs when there is uncertainty as to what is expected from an individual, often when responsibilities and boundaries are not clearly defined (Miles, 2012; Katz and Kahn, 1978). Rizzo et al. (1970, p.156) described role ambiguity as role uncertainty about "duties, authority, allocation of time, and relationship with others" and also uncertainty about the "existence of guidelines, directives, policies; and the ability to predict sanctions as outcomes of behaviors".

Role conflict occurs when there is incompatibility in the different expectations of an individual and can be either within a role (intrarole conflict) or between roles (interrole) conflict (Miles, 2012; Katz and Kahn, 1978; Rizzo et al., 1970). There can be conflict between the time, resources or capabilities of the individual and defined role behaviour. For example, in intrarole conflict, an RN is expected to deliver direct patient care as a core part of the role of a RN, but is also expected to fulfil a clinical administration role. In interrole conflict, the nurse may also be a parent, a daughter or a student, and this may create conflict. Role overload occurs when workload, responsibilities and demands are greater than the capacity of the role holder to achieve in the time available (Vullinghs et al., 2020; Katz and Kahn, 1978; Rizzo et al., 1970). Role overload can develop from expectations of the employer, the organisation or the individual themselves. Role overload is the "conflict between several roles for the same person which require different or incompatible behaviours, or changes in behaviour as a function of the situation" (Rizzo et al., 1970, p.155). Role stressors have been associated with work-related stress, reduced job satisfaction, high turnover rates (increase in employees leaving the organisation), negative change in employee behaviour (e.g. high absence rates, resistance to change), reduced work performance, and reduced organisational efficiency (Chênevert et al., 2019; Katz and Kahn, 1978; Rizzo et al., 1970).

2.5.5 Limitations of Organisational Role Theory

There are limitations to role theory, in that it is not categorical in relation to what motivates behaviours, or why individuals behave in an expected manner (Miles, 2012). Role theory proposes that the reality of a role is as it is defined. However, there may be different interpretations as to the role that may not reflect actual behaviours; e.g. the understanding of the role of a HCA may not correspond to the actual behaviours of HCAs (Miles, 2012). Kahn et al. (1964) provide a theoretical base to study role ambiguity and role conflict but have been criticised as requiring further examination (King and King, 1990). Kahn et al. (1964) at times suggest that there is an inter-relationship between role conflict and role ambiguity, and at other times that the role stressors occur independently of each other (King and King, 1990). King and King (1990) also argue that the focus on the focal person only should be revised as there is a need to study the sender role in all their roles. King and King (1990) also question the utility of the contextual variables, organisation, personal and interpersonal factors, and how they interact with the model. Despite the criticisms, King and King (1990) recommend that there is value in applying the REM to improve the understanding of role constructs.

The REM continues to be used to understand, interpret and explain phenomena. In an exploratory, theory-building case study of female hospital workers, the REM was included with the cognitive stress appraisal theory of Lazarus and Folkman as a lens to examine role overload (Stevenson and Duxbury 2019). Omansky (2010) used the REM as a framework in her integrative review to describe nurses' experiences in their role as student preceptor or mentor. The nurse preceptor was the 'focal person' and the 'role senders' were the nursing students, nurse educators, managers and the organisation (Omansky, 2010). Bosselut et al. (2012) used the REM to examine the relationship between role ambiguity in youth team sports. The REM was also applied to the auditor and client relationship in an auditing firm (Kleinman and Palmon, 2000), and in accountancy to understand and analyse the tax accountant and client relationship (Tan, 2015). The behaviour of the tax accountant, as the focal person, was influenced by the behaviour of the client, by mutual perceptions and by interpersonal relations.

2.5.6 Summary: Theoretical Lens of Organizational Role Theory

Role theory and its origins and perspectives have been described. Organisational role theory was described, and definitions of role clarity, role conflict, role ambiguity and role overload were provided. The REM is a framework used in organisational role theory to understand the dyadic work relationship for role stressors. Role stressors occur when role expectations and behaviours between the role-set members are incongruent. This study sought to understand the delegator role of RNs and the HCA's

role as delegatee through the theoretical lens of organisational role theory and in particular the role episode model (REM). In this study, the REM was applied to interpret the findings in relation to how RNs adapt their behaviour and role based on the expectations of role senders.

2.6 Summary of Literature Review

A systematic approach to the literature review was presented on RN delegation in healthcare. The search strategy was described and the findings relevant to the research question were described within the context of key headings. The changing roles of the RN and HCA, the process of delegation, and the delegatory relationship were described. The enablers and barriers to effective delegation found in the review were synthesised within key areas. Finally, organisational role theory, specifically the Role Episode Model (REM), was described.

The sources of the literature were from a variety of countries and continents, demonstrating that RN delegation is a relevant topic for nursing and patient care teams internationally. Despite this, there remains gaps in knowledge and understanding of the RN and HCA in the process of delegation. Despite nurse regulators providing direction on delegation and scope of practice, there was confusion in relation to delegation by RNs to HCAs. Although there was consistent evidence of the importance of RN education on delegation, there remains a reported lack of RN education on how to safely and effectively delegate. The literature review found that nursing research on delegation by RNs to HCAs was increasing as the role of the HCA becomes more embedded in the delivery of direct patient and resident care. However, there was no research on RN delegation in Ireland. The evidence demonstrated that the changes in the RN and HCA roles were more pronounced in RCOP where the ratio of RNs to residents has decreased, as is the ratio of RNs to HCAs. Across all jurisdictions, there was a lack of agreement on the role and responsibility of the HCA. The lack of standardisation in the HCA role, qualifications and competence creates confusion for the RN in decision-making for delegation and accountability. However, little was known about the actual process of delegation between RNs and HCAs, and the impact of effective RN delegation to HCAs on patient outcomes.

Most of the studies were qualitative design studies, with three studies using case study. The importance of using different data sources to get a more in-depth and robust understanding of the phenomenon was identified – e.g. by including RNs and HCAs as data sources. The analysis of the literature also revealed that the use of multiple methods increased objectivity and provided more in-depth knowledge, e.g. combining observational methods and documentary reviews with interview and quantitative methods. All of these findings support the selection of CSR for this research. There

were no studies identified in the search relating to delegation of tasks by RNs to HCAs in patient care teams in the Republic of Ireland.

Chapter 3: Research Design

3.1 Introduction

The literature review on delegation by RNs to HCAs found that the roles of the RN and the HCA were changing, and there was a dearth of evidence on delegation by RNs to HCAs in RCOP services. In previous research on delegation, HCAs were not often included as study participants, and the process of delegation was not explored. This chapter presents the research paradigm, strategy and methods used to address the research question of how delegation by RNs to HCAs occurs in residential care settings in Ireland. The study objectives were to:

- Explore how delegation of tasks is understood and experienced by RNs in the context of the role and responsibility of the RN and the HCA in RCOP
- Explore how delegation of tasks is understood and experienced by the HCA in the context of the role and responsibility of the HCA and the RN in RCOP
- Explore the context and process of delegation by RNs to HCAs in RCOP

The challenges of the nurse as researcher, the ethical considerations for this study, and reflexivity are described. Justification of the interactive model of data analysis as proposed by Miles et al. (2020) is provided. The process for ensuring research rigour in qualitative research is described.

3.2 Research Paradigm

A paradigm is a set of assumptions, values and practices that represent a way of viewing the world, "a set of beliefs and feelings about the world and how it should be understood and studied" (Guba, 1990, p.17). There are three philosophical assumptions that guide a researcher in choosing a qualitative research design, ontology, epistemology, and methodology (Guba, 1990). *Ontology* is the nature of reality (what truth is). *Epistemology* is the way in which knowledge is developed and the relationship between the knower and knowledge. The *methodology* determines how knowledge is gathered (Guba, 1990). The ontological, epistemological and methodological assumptions of the researcher are the paradigmatic beliefs that guide the research (Lincoln and Guba, 1985). The main paradigms described in the literature are: positivism, post-positivism, constructivism, interpretivism, pragmatism, and critical (transformative/emancipator) paradigms (Creswell, 2014; Petty et al., 2012; Chilisa, 2012; Weaver and Olson, 2006; Crotty, 1998). A summary of the paradigms, with ontological and epistemological assumptions and methodological approaches aligned to each, are explained and summarised in Appendix 2. Yin, Stake and Merriam are prominent case study research (CSR)

methodologists; each developed case study approaches guided by their different philosophical assumptions. Yin's epistemology is aligned to a realist-positivist or post-positivist orientation, while Yin acknowledged that CSR could also take an interpretivist orientation (Harrison et al, 2017; Hyett et al., 2014; Yin, 2014). Yin's more positivist approach begins with a theoretical framework and a set of issues to organise the research study (Yin, 2014). Yin assesses research quality by using construct validity, internal validity, external validity, and reliability (Yazan et al., 2015; Abma and Stake, 2014; Yin, 2003). Merriam and Stake, however, have a more interpretivist/constructivist philosophical perspective, where meaning is co-created by the researcher and research participants (Cleland et al., 2021; Harrison et al., 2017; Yazan, 2015). Merriam is described as a constructivist, (Cleland et al., 2021; Harrison et al, 2017; Hyett et al., 2014), and Stake as a constructivist/interpretivist (Harrison et al, 2017; Hyett et al., 2014; Merriam, 2010). The constructivist and interpretivist positions of Merriam (1998) and Stake (2006, 1995) guide approaches for CSR where issues emerge and are interpreted during the research process. The interpretivist approach as described by Stake (1995, 2006) is appropriate to understanding the meaning of complex phenomena. To explore how RN delegation to HCAs occurs, the researcher was interested in understanding and interpreting the context, behaviours and perspectives from the real-life setting. Therefore, the researcher's philosophical assumptions were positioned in interpretivism.

3.2.1 Interpretivism

The interpretivist paradigm relies on the subjective perceptions of not only the participants but also recognises the impact of the researcher's own background and experiences (Houghton et al., 2012; Klein and Myers, 1999). Interpretivism is associated with the Verstehen tradition of sociology, translated as "meaningful understanding" (Dowling, 2004; Denzin and Lincoln, 1994). Ontologically, interpretivism adopts an interpretive approach to understanding, socially constructed knowledge, lived experiences and participants' views of the phenomenon (Abma and Stake, 2014; Mackenzie and Knipe, 2006; Stake, 1995). Epistemologically, the approach is subjective, interpreting and understanding the meaning and reality of individual or group experiences of the phenomenon. Researchers also understand and acknowledge their role and influence in the research (Stake, 1995). Interpretive researchers include multiple perspectives that are socially constructed, interrelated and context-bound (Abma and Stake, 2014; Klein and Myers, 1999; Stake, 1995). The limitations of this paradigm include the subjectivity of the experiences, difficulty of replication and generalisation, and the possible influence of the researcher on the findings.

3.2.2 Justification for Selecting Interpretive Paradigm

The aim of this study was to explore how RN delegation to HCAs occurs in RCOP services. It was important to understand and interpret how delegation was understood and experienced by RNs, as the delegators, and by HCAs, as the delegatees, and how RNs and HCAs interacted. It was also important to understand delegation in the context of residential care for older people settings in Ireland. In the absence of evidence on the process of delegation in RCOP settings, a social enquiry to understand the subjective, lived experiences and perceptions of delegation as experienced by RNs and HCAs was undertaken. The research strategy focused on the context, behaviours and perspectives of the people who experienced delegation and therefore was reflective of the interpretive paradigm.

3.3 Research Strategy

Research strategies provide specific direction for the procedures and methods in a research design (Creswell, 2014; Farquhar, 2012). Research designs are predominantly either quantitative or qualitative, or a mixed-methods design (Creswell, 2014; Farquhar, 2012). For this study a research strategy was required that allowed for exploration of the phenomenon of delegation when there was little existing evidence of how delegation occurred in the real-life context. Qualitative research is of specific relevance to the study of social relations as it explores the experiences, feelings and behaviours of individuals or groups (Holloway and Galvin, 2017). In qualitative research, the researcher acknowledges their values and biases (Creswell, 2013). A qualitative research design was chosen for this study as delegation occurs within social relations on nursing teams. Exploring the perceptions and experiences of those who experienced delegation would therefore illuminate the context, processes and necessary requirements for delegation to be effective within nursing teams. The most commonly applied approaches to qualitative research are narrative research, phenomenology, grounded theory, ethnography, and case study (Merriam and Tisdell, 2016; Creswell, 2013). This study applied case study research. In the next section, case study research is described, including the fundamentals of CSR design, and the approaches of the three prominent CSR methodologists, Yin, Stake and Merriam, are presented, and the selection of CSR is justified.

3.4 Case Study Research

Case study research (CSR) is a flexible research approach used in qualitative research to explore complex phenomena in the context of their natural environment, especially when the boundaries between phenomena and context are not obvious (Cleland et al., 2021; Houghton et al., 2017; Harrison et al., 2017; Yin, 2014; Denzin and Lincoln, 2011; Casey and Houghton, 2010; Merriam, 2009;

Flyberg 2006; Merriam, 1998; Stake, 1995; Eisenhardt, 1989). CSR is widely used in health and nursing research (Cleland et al., 2021; Houghton et al., 2017; Carolan et al., 2016; Houghton et al., 2013; Casey and Houghton, 2010; Anthony and Jack, 2009). CSR dates to the early 20th century when anthropologists from the Chicago School of Sociology introduced case study research methods to study culture and social groups (Harrison et al., 2017; Carolan et al., 2016; Stewart, 2012). CSR became an increasingly popular methodology in education, anthropology, sociology and political science research during the 1960s and 1970s (Harrison et al., 2017; Carolan et al., 2016). Qualitative CSR is grounded in 'lived reality', in that the researcher has an opportunity to be close to the real-life situation and thus view human behaviours, using multiple data sources, making it easier to gain understanding of complex social relationships (Casey and Houghton, 2010; Merriam, 2009; Anthony and Jack, 2009; Flyberg, 2006; Stake, 1995). This is a key attribute of case study research, enabling the phenomenon to be studied in its real-life context, and therefore providing an opportunity to understand the phenomenon as it relates to the context (Karlsson, 2016; Baxter and Jack, 2008; Flyberg, 2006). A case study can build, extend or challenge a theoretical perspective (Crowe et al., 2011; Yin, 2004). A recognised strength in case study research is that the study can explain why and how a phenomenon is or is not happening (Gerring, 2016; Yin, 2014; Anthony and Jack, 2009). CSR, however, can be considered as lacking in rigour and difficult to replicate (Karlson, 2016; Yin, 2014), while the large amount of data generated can be challenging to manage and report on succinctly (Houghton et al., 2017).

CSR approaches are chosen for an intense and in-depth analysis of a phenomenon. The objective of CSR is to explore a case extensively in its natural environment or setting, within a bounded system (Frey, 2018; Yin, 2009; Stake, 2005). Case study research allows for flexibility; a variety of research methods can be used (Harrison et al., 2017; Yin, 2014; Hyett et al., 2014; Stake, 2009; Merriam, 1998). There are fundamental or central characteristics of case study design regardless of which CSR approach is applied. These include: defining the case, the context, selecting the case, and using multiple sources of data (Gerring, 2016; Yin, 2014; Stake, 2009, 2000, 1995; Merriam, 1998).

3.4.1 Defining the case

Defining the case involves identifying a real-life, contemporary bounded system (Casey and Houghton, 2010). The *case* is the phenomenon of theoretical significance and can be an individual, social group, organisation, event, process or culture (Miles et al., 2020; Gerring, 2016; Yin, 2014; Merriam, 1998; Stake, 1995). Merriam, Stake and Yin identify similar characteristics in their definitions of a case (Table 3.1). The case is the unit of the study (Merriam, 1998; Stake, 1995, 2000) or, more commonly termed, the unit of analysis of a particular phenomenon or entity (Harrison et al., 2017; Karlsson, 2016; Gerring,

2016; Yin, 2014; Stake, 2009; Baxter and Jack, 2008; Merriam, 1998). A key characteristic of the case is that it is a bounded system, i.e. identifying and framing the parameters of what is to be studied (Harrison et al., 2017; Karlsson, 2016; Yin, 2014; Sandelowski, 2011; Casey and Houghton, 2010; Gerring and McDermott, 2007; Yin, 2003; Merriam, 1998; Stake, 1995). A case is bounded by a) time, b) size (the object of study can be a country, social group, organisation, individual, social experience or behaviour) and c) context (when, where and why the phenomenon occurs) (Miles et al., 2020; Gerring, 2016; Yin, 2009, Yin, 2003; Baxter and Jack, 2008; Merriam, 1998). For example, in the study by Burnett and Akerson (2019) (Table 3.1) the case was bound to the group of undergraduate students who experienced the poverty simulation experience.

3.4.2 Case Context

The case is studied in the natural environment and real-life setting of the phenomenon (Harrison et al., 2017; Yin, 2003; Merriam, 1998). Context can include social, cultural, historical, economic and organisational factors (Harrison et al., 2017). The context provides key insight into the case. For example, in the poverty simulation study (Burnett and Akerson, 2019) the context was an undergraduate student learning experiment in a university in the US. Variables in a context may include social, cultural, organisational, economic or political factors (Cleland et al., 2021; Harrison et al, 2017).

3.4.3 Selecting the Case

Case selection depends on the purpose of the study; decisions on study settings, people, events and social processes are critical (Cleland et al., 2021; Harrison et al., 2017; Yin, 2003). In CSR a case is selected on what can be learned from the case (Gerring, 2016; Abma and Stake, 2014; Stake, 2000).

3.4.4 Multiple Sources of Data

A key strength of CSR is that multiple sources of data are used to explore a complex and multifaceted phenomenon, providing an in-depth analysis of the case (Stake, 1995; Merriam, 1998; Yin, 2003; Yin, 2004; Houghton et al., 2017). Individual interviews, focus group interviews, observation and artefacts (including documents) are the most common data sources (Harrison et al., 2017; Yin, 2014; Casey and Houghton, 2010; Merriam, 1998; Stake, 1995). Triangulation of data sources and analysis is a feature of CSR to develop an in-depth and comprehensive understanding of the case (Frey, 2018; Yin, 2014; Creswell, 2013; Casey and Houghton, 2010). Thick descriptions, another fundamental of CSR, involves more than describing the research phenomenon, but also provides the context, the social relations, the emotions and perceptions of the people involved (Abma and Stake, 2014; Ponterotto, 2006).

3.4.5 Different Case Study Design

The different case definitions by Yin, Stake and Merriam are summarised, together with CS classifications and examples, in Table 3.1. All definitions refer to a phenomenon being studied (a unit, a group, a process), in-depth, in its real-life context, where the case is bounded. Although each CSR methodologist propose their own classification of a case study, there are similarities in meaning between some of the classification types.

Yin (2014) identifies different case study classifications as descriptive, exploratory and explanatory (Table 3.1). Descriptive case study provides an in-depth description of the phenomenon of interest, or *what happened* (Yin, 2014; Merriam, 1998). Data for the descriptive case study are acquired from multiple sources, often over a period of time (Merriam, 1998). An exploratory case study is often used when previous research on the phenomenon is lacking, and to identify the research question for future research or theory-building (Yin, 2014). An explanatory study seeks to explain the how and why of an occurrence, event or phenomenon (Yin, 2014). Stake (1995) describes three types of case study; intrinsic, instrumental and collective. An *intrinsic* case study is chosen when the researcher wishes to focus on that particular case (Atchan et al., 2016; Casey and Houghton, 2010; Stake, 1995). Similar to a *particularistic* case (Merriam, 1998), the objective is to understand the particularity of an individual case (Abma and Stake, 2014; Baxter and Jack, 2008). An *instrumental* case study (Stake, 1995), similar to the *heuristic* case study (Merriam, 1998), does not aim to represent the typical case but rather to achieve a general understanding of a phenomenon by studying a particular case, or is used to develop an existing theory (Atchan et al, 2016; Hyett et al., 2014; Abma and Stake, 2014; Casey and Houghton, 2010; Stake, 1995). Merriam (1998) identifies a case study as being either particularistic, heuristic, or descriptive (Table 3.1).

3.4.6 Types of Case Study

Cases are defined as being unique and holistic and thus contextually dependent (Yin 2009; Stake, 1995; Grünbaum, 2007). Eisenhardt (1989, p.534) defines a case study as focusing "on understanding dynamics within a single setting". A single case study is "a case study organized around a single case" (Yin, 2014, p. 240). Yin (2014) states that a case may be chosen because it is unusual, unique, or common, or, as Stake (1995, 2009) says, typical or representative. A typical case represents cases that are ordinary or average, and not extreme or different, in an attempt to be representative of other cases. An extreme case is selected to study unusual or different cases. A critical case is selected to provide the most information on the research phenomenon (Quinn Patton, 2015). Single cases can be holistic, with a single unit of analysis, or with multiple units of analysis (Yin, 2014) (Figure 3.1). A

single case with more than one unit of analysis is called a single case design with subunits (e.g. the case is a hospital and the subunits of analysis are different wards in the hospital).

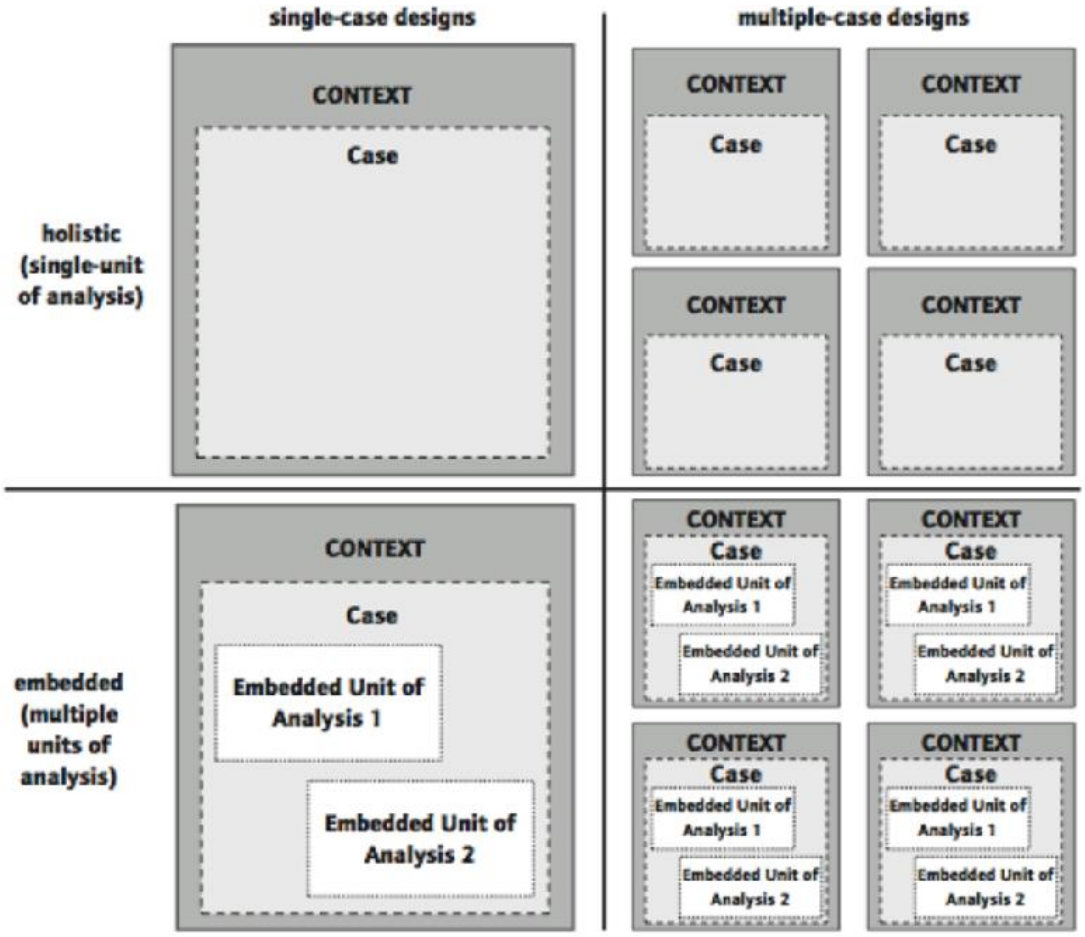
Table 3.1: Case Study Research – Definition, Classifications and Examples

Stake (1995, 2006)	
Definition of a case: "The case is a specific, a complex, functioning thing … The case is an integrated system" (Stake, 1995, p.2). A case has boundaries.	
Classification	**Example**
Intrinsic case study focuses on a particular case, there is a particular interest in the case.	Caught between a rock and a hard place: An intrinsic single case study of nurse researchers' experiences of the presence of a nursing research culture in clinical practice. Bøttcher Berthelsen, C. and Hølge-Hazelton, B. (2018)
Instrumental case study focuses on examining and understanding a particular behaviour, event or problem, as a case. Is often used to further develop an existing theory.	Preparing future health professionals via reflective pedagogy: a qualitative instrumental case study. Audrey J. Burnett, A.J. and Akerson, E. (2019)
Collective case study is a selection of multiple cases in an instrumental case study.	The perceived impact of advanced practice nurses (APNs) on promoting evidence-based practice amongst frontline nurses: findings from a collective case study. McDonnell, A., Gerrish, K., Kirshbaum, M.N., Nolan, M., Tod, A. and Guillaume, L. (2012)
Merriam (1998, 2009, 2010)	
Definition of a case: "a single entity, a unit that is selected for study around which there are boundaries… a single person, a program, a group, an institution, a community or a specific policy" (Merriam, 2010, p.456)	
Classification	**Example**
Particularistic case study: focuses on a particular phenomenon, event, issue or situation (also used by Stake, 2006, similar to intrinsic).	Bullying, disability and work: a case study of workplace bullying. Vickers, M.H. (2009)
Heuristic case study focuses on understanding a phenomenon, which can result in new meanings or confirm what is already known.	When a Parent of a Student With a Learning Disability Is Also an Educator in the Same School District: A Heuristic Case Study. Haley, K., Allsopp, D. and Hoppey, D. (2018)
Descriptive case study focuses on providing a thick, in-depth description of the phenomenon of interest.	A descriptive case study of the changing nature of nurses' work: The impact of managing infectious diseases requiring isolation. Kaba, A., Baumann, A., Kolotylo, C. and Akhtar-Danesh, N. (2017)

Yin (2003, 2009, 2018)		
Definition of a case: "A contemporary phenomenon within its real-life context, especially when the boundaries between a phenomenon and context are not clear" (Yin, 2003, p.13)		
Classification		**Example**
Holistic (examines the phenomenon in general and focuses on understanding the case as one unit of analysis).		How do nurses use the early warning score in their practice? A case study from an acute medical unit. Foley, C. and Dowling, M. (2019)
Embedded (considers subunits which focus on different aspects and parts of the case).		An exploratory study of the experiences of children with a Statement of Special Educational Needs for Moderate Learning Difficulties in mainstream primary schools: A multiple-embedded Case Study. Stash, A (2012), Thesis
Explanatory case studies can describe or explain a phenomenon, but also allow for explanation of casual relationships and arguments within the data, *how or why something happened*.		The three paradoxes of patient flow: an explanatory case study. Kreindler, S.A. (2017)
Exploratory case study is helpful when there is limited evidence or knowledge on the phenomenon of interest, and propositions or hypothesis for further studies can be developed.		Investigating Disability Inclusion in Turkey: An Exploratory Case Study Sakiz, H. (2015), PhD Thesis
Descriptive case study describes the case in detail, allowing for a documented detailed description of the case, *what happened.*		Using Strengths, Weaknesses, Opportunities, and Threats Analysis to Pursue a Doctor of Nursing Practice Education: A Descriptive Case Study. Davis, J. and Morrow, M. (2020).

While a case involves a real-life, contemporary bounded system, *cases* are multiple bounded systems (Hyett et al., 2014). A multiple case study, also referred to as a collective (Stake, 1995) or comparative (Anderson, 2016) case study, can be used to increase rigour, gain a wider understanding of a phenomenon, explore the phenomenon for similarities or differences within and between cases, verify a theory, and provide some level of generalisability (Stake, 1995; Yin, 2003; Baxter and Jack, 2008; Casey and Houghton, 2010; Atchan et al., 2016). Multiple cases are selected because they are either diverse in theoretical perspective, or contrasting cases or confirmatory cases. Multiple case study design is chosen when the researcher seeks to undertake within-case and cross-case analysis to explore similarities or variations that will contribute to interpretation of the case (Yin, 2003; Baxter and Jack, 2008, Stake, 1995). Miles, Huberman and Saldana (2020) explain multiple cases are used "to see processes and outcomes across cases, to understand how they are qualified by local conditions, and thus to develop more sophisticated and more powerful explanations." (p.95).

Figure 3.1: Types of Case Study Design (Yin, 2014, p.50)



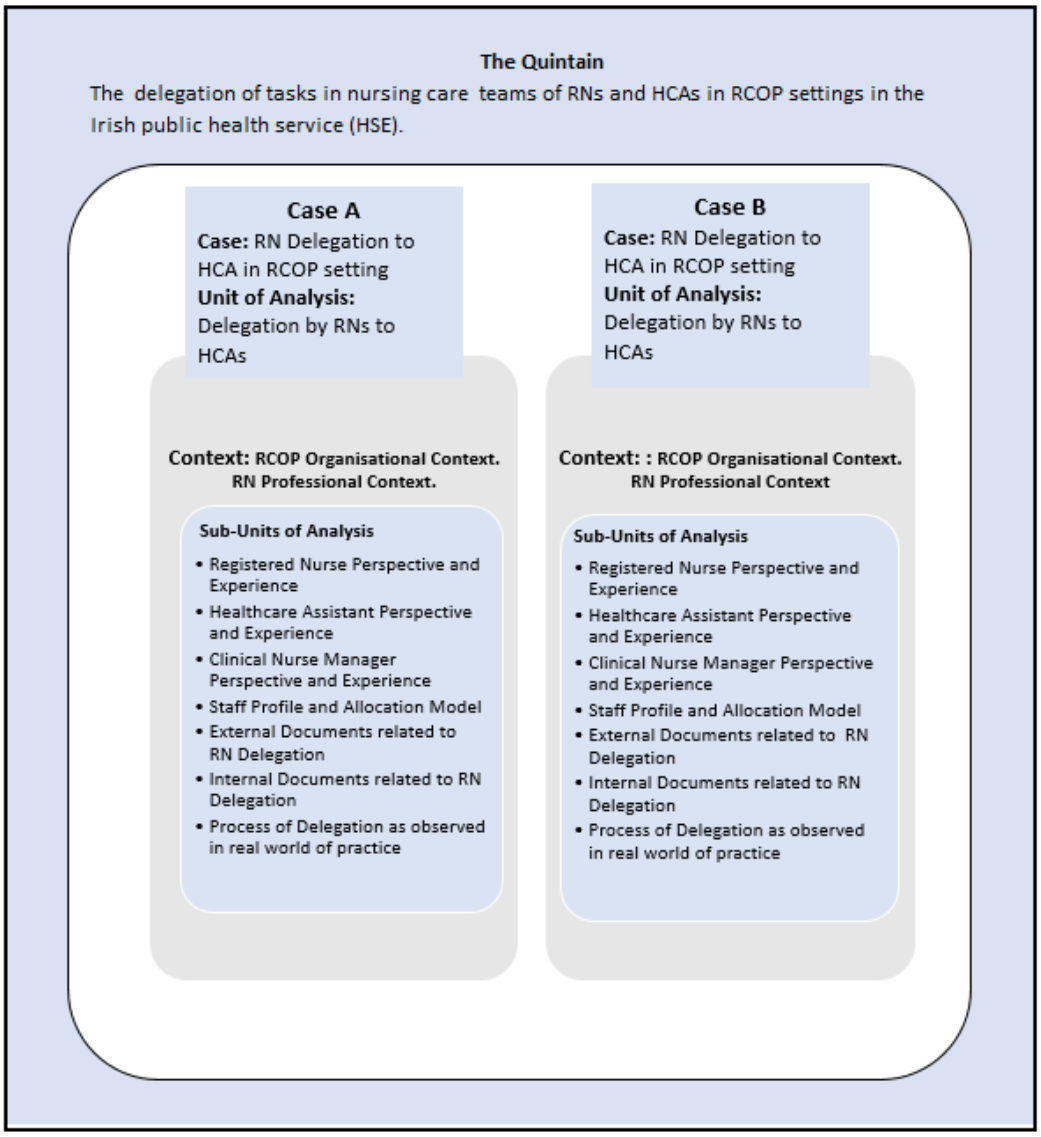
In multiple case study design, each case can be a single unit of analysis, or, if there is more than one unit of analysis, these are subunits of analysis (Figure 3.1). Including two cases with multiple subunits of analysis allows the researcher to explore what is common and specific within each case and across two cases (Hyett et al., 2014; Tsang, 2013). In a multiple case study, each case is a singular entity; Stake (2006, 1995) uses the term *quintain* to encompass the individual cases of a case study as a collection. According to Stake (2006), the single case is of interest because it belongs to a collection of other cases. Binding together cases that share the phenomena of interest as a collection allows the focus to move from understanding the case to understanding the quintain (Carolan et al., 2016; Casey and Houghton, 2010; Stake, 2006).

3.4.7 Justification for Selecting Instrumental Multiple CSR

Although many of the interpretive approaches could be applied to study the complex phenomenon of delegation and its multiple perspectives, qualitative CSR was selected to develop an understanding of

delegation in the real-world context of RCOP. An instrumental, multiple case study was considered the most appropriate approach for this study as there was limited evidence on or knowledge of RN delegation and *how* delegation occurs between RNs and HCAs in RCOP services. The case was RN delegation to HCAs in RCOP services; the unit of analysis was delegation by RNs to HCAs. The case was bounded to delegation of tasks between RNs and HCAs in RCOP sites (Figure 3.2). Two cases (multiple case) were selected as this allowed an in-depth, detailed study of different aspects and parts (subunits of analysis), both within a case and between cases (Figure 3.2). Each subunit contributed unique insight to the case. Each case was explored as a single entity analysis, but also the quintain allowed the researcher to explore what was common and specific within each case and across the two cases (Figure 3.2). The quintain in this CSR is delegation in nursing teams of RNs and HCAs in RCOP services in the Irish public health service. This included Case A and Case B with subunits of analysis in the wider context. Context-related knowledge is helpful for professionals and policymakers, and CSR can provide this by reporting on the reality of a phenomenon as opposed to what is available through existing policy and regulations. In-depth descriptions and real-life narratives support informed decision-making, and bottom-up practical perspectives can influence top-down unrealistic perspectives (Abma and Stake, 2014). This was of significant relevance to this study.

Figure 3.2: Multiple Case Study, Delegation by RNs to HCAs in RCOP



3.5 Data Collection Methods

A key strength of CSR is that it uses multiple sources and multiple data collection methods that enable a more in-depth and robust case study (Bradshaw et al., 2017; Casey and Houghton, 2010; Yin, 2004). The CSR approach uses data collection methods that are guided by the case and the sources of data within the natural environment of the case (Stake, 1995). Fieldwork in the real-life setting is integral to the research design, where subjectivity of the researcher and participants are consistent features, and therefore reflexivity is integral in CSR for credibility. Triangulation is used in qualitative methods to validate data through the use of two or more different methods to verify the data and contribute to rigour (Quinn Patton, 2015; Houghton et al., 2013; Yin, 2004). The methods of data collection in this CSR study were focus-group interviews, individual interviews, non-participant observation, and

documents.

3.5.1 Interviews

Qualitative research interviewing is a conversation where the researcher asks questions and listens to the participant's answer (Rubin and Rubin, 2012). Holloway and Galvin (2017) state that the purpose of an interview is to elicit the participant's "feelings, perceptions and thoughts" (p.88). The role of the interviewer-researcher is to capture, interpret and find meaning in these data. In qualitative research, interviews are the most common data collection method (Holloway and Galvin, 2017; Quinn Patton, 2015; Qu and Dumay, 2011; May, 2011; Merriam, 2009; DiCicco-Bloom and Crabtree, 2006; Denzin and Lincoln, 1998). Interviews are often undertaken in conjunction with direct observation to explore what cannot be observed, such as feelings, thoughts and experiences (Quinn Patton, 2015; Merriam, 2009). Participants articulate their opinions, feelings and experiences, and their perceptions of the phenomenon being studied, thus providing the researcher with unique data (Holloway and Galvin, 2017; Rubin and Rubin, 2012; Merriam, 2009).

3.5.1.1 Interview Structures

Interviews are described as unstructured, semi-structured or structured. Structured interviews are based on predetermined questions that are asked of each participant in a similar format to a questionnaire or survey (Holloway and Galvin, 2017; Quinn Patton, 2015). In qualitative research, structured interviews are rarely used as the questions are closed and thus participants do not have an opportunity to answer in an open manner, reducing the opportunity for in-depth exploration (Holloway and Galvin, 2017; Quinn Patton, 2015; Creswell, 2014; Qu and Dumay, 2011). Unstructured or open interviews promote open and unprompted answers from the participants. The advantage of the unstructured interview is that it provides rich, in-depth data. The common limitations of this approach are that there is a huge amount of data that may not be related to the research question, and it can be challenging for the inexperienced researcher to analyse the data (Holloway and Galvin, 2017; Creswell, 2013). Semi-structured interviews are a common method in qualitative research (Holloway and Galvin, 2017; Creswell, 2014; Merriam, 2009). The advantage of this interview method is that, unlike the unstructured interview, the researcher maintains control of the interview through a series of predetermined questions, including specific questions and open-ended questions, and the opportunity to clarify understanding (Merriam, 2009). The most common types of interview approaches are individual interviews and focus-group interviews (Holloway and Galvin, 2017; Rubin and Rubin, 2012; Qu and Dumay, 2011; Merriam, 2009; DiCicco-Bloom and Crabtree, 2006). Semi-structured interview methods were used in this study, through individual interviews and focus-group

interviews.

3.5.1.2 Conducting Research Interviews

It is important to develop an interview plan (Quinn Patton, 2015; Yin, 2014; Dilshad and Latif, 2013; Morgan and Krueger, 1998; Stake, 1995). This enables a systematic and structured approach, ensures that the required data are sought, and identifies potential challenges and risks. The plan includes the process of introduction and recruitment of the study site and participants. An interview guide helps to ensure that the researcher maintains consistency between interviews (Quinn Patton, 2015; Creswell, 2014). The role of the interviewer includes welcoming the participants, making them feel comfortable and developing a relaxed and trusting environment (Holloway and Galvin, 2017; May, 2011; Krueger and Casey, 2010). Developing and maintaining a good rapport with the participant is critical (Creswell, 2013; Rubin and Rubin 2012; Merriam, 1998). This can be achieved by active listening, genuine interest in what the participant is saying, and a non-judgmental attitude. A key skill is to hear what is not being said, noting inferences and silences (Merriam, 1998). There is an acknowledged sequence or systematic process for interview questioning, progressing from ground-breaking and introductions to transition questions, to the key questions, probing questions and closing questions, and then at the end of the interview giving the participants an opportunity to contribute other information, or allowing a recap of the interview (Holloway and Galvin, 2017; Quinn Patton, 2015; Creswell, 2013; Rubin and Rubin, 2012). There are various ways to record an interview: video and/or audio recording, taking notes, and recording interview data notes immediately after the interview, including reflections. The ethical issues relating to the role of the researcher are described in Section 5 of this chapter.

There is no consensus on the number of interviews that should be conducted or how long the interview should last, but these should be guided by the research question and methodology (Holloway and Galvin, 2017). It is recommended that participants be advised of the estimated length of the interview, and that special attention be given to the length of interview with vulnerable groups such as children, people with disabilities, and older people (Holloway and Galvin, 2017).

3.5.1.3 Individual (one-to-one) Interview

The objective of the individual (one-to-one) interview is to explore the various experiences and opinions of the participants (Holloway and Galvin, 2017; Quinn Patton, 2015). Individual interviews may be structured, semi-structured or unstructured, as discussed above.

3.5.1.4 Strengths and Limitations of Individual Interviews

The individual interview has recognised strengths and limitations. It allows the researcher to gain

meaning from different participants of their individual experiences or opinions in their own words (Quinn Patton, 2015; Rubin and Rubin, 2012). Individual interviews are considered most appropriate for interviewing participants on sensitive topics, or where there is a power imbalance among participants (Kruger et al., 2018; Quinn Patton, 2015; Qu and Dumay, 2011). The semi-structured and unstructured interview allows the participant to answer questions in their own way, using their own language, and the feelings and experiences of the participant are heard (Qu and Dumay, 2011). On a practical level, it is often easier to recruit participants for individual interviews as a convenient time and venue can be agreed. The researcher can give full attention to the responses, body language and tone of voice of the participant (Rubin and Rubin, 2012). However, participant recruitment can be challenging, especially in the case of busy work environments, or if potential participants are not interested in talking about the research topic. In small studies and academic research studies, the researcher is often the interviewer. As the researcher has a substantial role in designing the questions and conducting the interview, the risk of bias may be considered greater in comparison to focus-group or group interviewing (Qu and Dumay, 2011). Findings cannot be generalised to the larger population as they are the opinions and experiences of individuals.

3.5.1.5 Focus-group Interviews

Focus-group interviews are commonly used in sociology and healthcare research, especially for exploratory research when the phenomenon to be explored is not well understood (Holloway and Galvin, 2017; Tausch and Menol, 2016; Bickman and Rogers, 2009). Focus-group interviews consist of a carefully planned series of discussions with a group of people who have similar experiences or characteristics, and are designed to elicit ideas and opinions on a defined phenomenon with which they are familiar, in an enabling and non-threatening setting (Holloway and Galvin, 2017; Tausch and Menol, 2016; Krueger and Casey, 2010; Bickman and Rogers, 2009). Since participants are selected based on who can best answer the questions, purposeful sampling is used (Hennink et al., 2019; Creswell, 2013; Krueger and Casey, 2010). The composition of the group is critical for group engagement, and therefore homogenous selection of participants (those with something in common as it relates to the phenomenon) is recommended (Krueger and Casey, 2010; Bickman and Rogers, 2009; Nyamathi and Shuler, 1990). The objective is not to reach consensus but to gather and examine different opinions and experiences (Krueger and Casey, 2010). Good focus-group interview skills and well-designed questions ensure open and dynamic interaction among participants. This enables the collection of rich data about the perceptions, beliefs, understanding and feelings of participants (Holloway and Galvin, 2017; Nyamathi and Shuler, 1990). A focus group is progressing effectively when

the participants are responding to each other rather than the moderator (interviewer) (Rubin and Rubin, 2012; Krueger and Casey, 2010; Merriam, 1998).

There is no consensus in the literature on the number of focus groups required; however, the number, size and length of the interview depends on the study, the participants and data saturation (Quinn Patton, 2015; Kruger and Casey, 2010). Krueger and Casey (2010) recommend more than one focus-group interview be conducted for each type of participant included in a study. Nyamathi and Shuler (1990) and Holloway and Galvin (2017) recommend three or four interviews, with a review after the third interview for data saturation. More recently, in a study to assess sample size and saturation in focus-group research, it was reported that three to six focus groups identified the most prevalent themes across a study (Hennink et al., 2019). There is no consensus on the size of focus groups. Originally focused on market research, large group sizes of eight to 12 participants were recommended. However, social science focus groups are now often reduced to smaller groups when the topic is controversial or complex, as small groups enable sharing of opinions and contribution by all participants (Nyumbai et al., 2018; Holloway and Galvin, 2017; Tausch and Menold, 2016). Group size therefore varies from four to 12, depending on the complexity of the topic and the participant group (Williamson, 2018; May, 2011; Krueger and Casey, 2010). However, it is recommended that the group size be sufficient to enable interaction, but not so large that all participants cannot contribute to the discussion (Hennink et al., 2019; May, 2011). There is no consensus on the length of a focus-group interview, varying from 40 minutes to three hours (Holloway and Galvin, 2017; May, 2011).

3.5.1.6 Strengths and Limitations of Focus-group Interviews

Focus groups enable participants to respond to and contribute to the responses of other participants. This synergy enables the data collection of ideas and opinions that may not occur during individual interviews (Stewart and Shamdasni, 2015; May, 2011; Bickman and Rogers, 2009; Nyamathi and Shuler, 1990). The researcher can observe non-verbal responses that can provide additional information (Dilshad and Latif, 2013; Bickman and Rogers, 2009), and also gain immediate feedback from participants, enabling responses to be clarified or probed further (Yin, 2014; Dilshad and Latif, 2013; Bickman and Rogers, 2009). Stewart and Shamdasni (2015) describe the advantages of focus groups, compared to individual interviews, as synergism, snowballing, stimulation, security and spontaneity.

As regards limitations, the open-ended questioning technique of focus-group interviewing can make data analysis and interpretation of results challenging (Bickman and Rogers, 2009). Similar to all self-reporting data collection methods, there is a risk of selective, under- and over-reporting by participants (George, 2012). It also takes substantial time and effort to organise a focus-group

interview (Tausch and Menold, 2016), and ensuring optimum attendance at a focus-group interview can be a challenge (Dilshad and Latif, 2013). In a study exploring the use of focus groups in healthcare, Tausch and Menold (2016) found that it was difficult to recruit health professionals. If the interviewer is not experienced or well prepared, they can introduce bias by providing inappropriate cues or personal opinions, or not engaging all participants. Without appropriate facilitation, more confident and opinionated participants may dominate the interview (Nyuba et al., 2018; Dilshad and Latif, 2013; Bickman and Rogers, 2009; Nyamathi and Shuler, 1990). Finally, the focus group may not be the most appropriate method for exploring sensitive or controversial topics (Kruger et al., 2018).

3.5.1.7 Justification for the Use of Interviews as Data Collection Methods

Delegation of tasks is an underdeveloped concept in nursing care teams and therefore there was a risk that individual participants would not be comfortable in discussing this topic individually. Conducting focus-group interviews with RNs and HCAs would provide insights as to how delegation occurred, as the participants would be prompted by the experiences, opinions and discussion of other participants. The contribution of one participant would promote contributions by others.

Individual interviews were not included in the initial research design, but during the data collection and data analysis it became apparent that the clinical nurse manager was integral in the process of delegating tasks. It was therefore important to include the clinical nurse managers from each ward, but individual face-to-face interviews were required because each site had only one or two CNM2s and thus focus-group interviews were not possible.

Another method of data collection often used in CSR is non-participant observation, which is discussed in the next section.

3.5.2 Observation Data Collection

Observation is the direct observation of the actions, interactions and behaviours of people in their natural environment to record a systematic description (Morgan et al., 2017; Jackson et al., 2016; Walshe et al., 2012; Merriam, 2009; Bowling, 2009; Baker, 2006; Kawulich, 2005). Such observation provides an insight into structures, organisational processes, behaviours and relationships that may not be identified or articulated in participants' self-reported or interview data (Morgan et al., 2017; Baker, 2006; Hammersley and Atkinson, 2007; Walshe et al., 2012; Yin, 2014; Aagaard and Matthiesen, 2016). Observation enables the researcher to observe how participants communicate with each other, how they group together, their non-verbal behaviours and expressions, and how processes or activities are undertaken. The researcher is in a position to understand and interpret actions, events,

practices and routines when observing the participants in their natural environment (Aagaard and Matthiesen, 2016; Baker, 2006). Observation methods are often applied in healthcare settings and have been used in studies on team working and health worker relationships (Morgan et al., 2017; Russell et al., 2012; Carroll et al., 2008).

3.5.2.1 Observation Roles

Baker (2006) provided a comprehensive overview of different observation roles as proposed by Gold, Spradley and Adler and Adler, summarised in Table 3.2. Gold (1958) originally identified four approaches for direct observation: complete participant, participant as observer, observer as participant, and complete observer (Table 3.2). The roles vary from *complete participant* observing as a participant, to observing in a role removed from the participants (*complete observer)* (Table 3.2). In contemporary research, the complete participant and complete observer are often not possible due to moral and ethical issues (Walshe et al., 2012). Spradley (1980) describes five observer roles: complete participation, passive participation, active participation, moderate participation, and non-participation. Adler and Adler (1994) describe three observer roles: *complete member* (central to activities on the site), *active member* observer (who participates in activities) and *peripheral member* (not central to activities). There are similarities in the above observation roles; for example, the complete participant (Gold, 1958), the complete member (Adler and Adler, 1994) and the complete participant (Spradley, 1980) roles are all very similar.

In current research publications, observation methods are generally described as either participant observation or non-participant observation (Eldh et al., 2020; Dodd et al., 2020; Takyi, 2015; Dalke et al., 2015; Walshe et al., 2012). The participant observation methods are aligned to the complete participant, complete membership, complete participation, participant as observer, active membership and active participation roles of Gold; Spradley, and Adler and Adler. The non-participant observation methods are aligned to the observer as participant, non-participation, passive participation and peripheral membership roles of Gold; Spradley, and Adler and Adler (Table 3.2).

Table 3.2: Comparison of Researcher Observation Roles (adapted from Baker, 2006)

Gold (1958)	Spradley (1980)	Adler and Adler (1994)
Complete participant – adopts a role similar to participants being observed, participants are not made aware that they are being observed.	*Complete participation* – researcher is a full participant in the setting they observe.	*Complete membership* – observer does not assume a covert role; observer and participant are equal.
Complete observer – remains totally removed from those observed, no interaction between researcher and participants, study participants unaware they are being observed.	*Passive participation* – similar to complete observer role, but participants are aware.	(No comparison)
Participant as observer – engages in activities with participant, participants aware of observation role.	*Active participation* – similar to participant as observer role.	*Active membership* – similar to participant as observer.
(No comparison)	*Moderate participation* – researcher balances observation and participation roles.	*Peripheral membership* – researcher maintains a balance between research observation and participation.
Observer as participant – a purely observation role, participants aware of their observation role.	*Non-participation* – no involvement with participants, observation can take place remotely (e.g. webcam observation)	(No comparison)

The participant observer is at some level a member of the group being observed, and the researcher role is integrated as a dual role to observe the participants' behaviour and the environment where the study is taking place (Morgan et al., 2017; Coolican, 2014; Barner-Barry, 1986). The researcher learns about activities in a natural setting through observation and participation (Quinn Patton, 2015; Takyi, 2015; Kawulich, 2005). The close contact and relationship with participants enables the researcher to experience, and thus understand, the participants' lived experience (Takyi, 2015; Adler and Adler, 1998); they are not "merely a passive observer" (Yin, 2014, p.115). The challenge for the participant observer is to remember their dual role of researcher and participant. The participant role may need to be negotiated continuously with the gatekeeper and the study participants to ensure the researcher has a defined participant role on site (Walshe et al., 2012; Hammersley and Atkinson, 2007).

The non-participant observer has no, or minimal, relationship with the participants, observes the group from a distance and aims to have no impact on the observed behaviour (Morgan et al., 2017; Takyi, 2015; Coolican, 2014). Non-participant observation enables the researcher to remain more detached from participants (not 'going native'), thus supporting a more objective collection and analysis of data (Walshe et al., 2012; Takyi, 2015; Baker, 2006).

The challenge for the non-participant observer is to maintain their role as observer whilst 'blending in' to the environment and setting. This requires a delicate balance of being respectful and sociable with participants, whilst being unobtrusive. As the time spent on the study site increases, the participants become familiar with the researcher's presence and are more likely to behave as normal. The researcher-participant relationships are continuously negotiated and managed to ensure access and acceptance by participants.

3.5.2.2 Types of Observation

As with interviews, observation can be structured or unstructured. In unstructured observation, the researcher collects data on all interventions and practices without restriction or the use of a guide or plan (Adler and Adler, 1994). In the absence of existing knowledge, categories emerge from the observation data (Jackson et al., 2016; Casey, 2004). Structured methods of collecting observational data are undertaken when specific people, behaviours or events need to be observed and there are predetermined plans as to what requires observation (Merriam, 2009; Casey, 2004; Adler and Adler, 1994). Observational positioning refers to the location the researcher uses to collect data, and can be either single, multiple or mobile positioning (Casey, 2004). In single positioning, the researcher undertakes data collection from one position; in multiple positioning, moves around to collect observational data, and in mobile positioning follows an event or an individual for the observation period (Casey, 2004). Multiple and mobile observational positioning were chosen for this study.

3.5.2.3 Conducting Non-Participant Structured Observation

A systematic process is recommended in conducting non-participant structured observation data collection (Yin, 2014; Creswell, 2013; Hammersley and Atkinson, 2007; Stake, 1995). A structured observation plan is guided by the objectives of the study, the focus of the observation and the capacity of the researcher in relation, for example, to single researcher fatigue (Merriam, 2009). Creswell (2013) provides guidance on the content of the observation plan (Table 3.3)

Table 3.3: Guidance for Observation Data Collection Plan (adapted from Creswell, 2013)

- Site selection: who and what to observe, when and how long.
- Role of observer: observational protocol as a method of recording field descriptions.
- Reflexivity and reflections: aspects in recordings, environmental layout, events and researcher reactions and reflections.
- Sequential process of introductions of researcher to participants.
- Slow withdrawal from research site, with closure conversation with participants.
- Recording full and detailed notes immediately after observation.

The challenges in gaining site access to undertake observational data collection are well acknowledged (Jackson et al., 2016; Creswell, 2013; Hammersley and Atkinson, 2007; Baker, 2006; Barner-Barry, 1986). Gaining access commences with gaining the confidence of and permission from the research site decision-makers. Appropriate and respectful processes for site access are often incorporated with research ethics committee (REC) applications, especially in healthcare settings. Baker (2006) and Hammersley and Atkinson (2007) advise that the researcher establish who to observe and the best times to observe. The role of observer requires persistent negotiation, diplomacy, time and effort, with constant reassurance and informing of participants about the role of the observer (Brockman, 2011; Baker, 2006).

Hammersley and Atkinson (2007, p.66) refer to "impression management" – that is, how the personal appearance of the researcher can affect data collection. Non-participant observers are advised to dress closely to the participants' style or in a muted fashion so as to be as unobtrusive as possible (Hammersley and Atkinson, 2007). There is also a need to be identified as the researcher to avoid confusion with other individuals on the study site (Hammersley and Atkinson, 2007). This can involve wearing a name tag identifying the role, or carrying a clipboard or audio recording device. The manner in which the researcher speaks and behaves also affects the image they portray to participants, e.g., where they observe from, way of standing or sitting, pitch and tone of voice, how respectful and approachable they are to the participants. Planned impression management can build trust and increase acceptance by the participants; Lofland (1971) advises that the researcher put themselves in the role of an "acceptable incompetent" (p.69).

Time sampling and event sampling are used for observational data collection. *Time sampling* is when observation periods occur at specific times, e.g. morning periods (Casey, 2004). Barner-Barry (1986) describe *event sampling* as observation and recording of an event when the phenomenon of interest is observed; it depends on the length of time of the event and the intervals involved. Event sampling was used in the current study when RNs and HCAs were together, and when the event of RN delegation to the HCA might more likely be observed.

Prolonged engagement and persistent observation, which are key strategies in demonstrating rigour in qualitative CSR, refer to when the researcher is present on the study site long enough to build trust with the participants and to counteract the Hawthorne effect. The Hawthorne effect occurs when the behaviours and activities of participants and how they interact with each other alter in the presence of the observer (McCambridge et al., 2014). Stake (1995) and Merriam (2009) describe how in CSR the case is bounded, and how this guides the observation time and data required. Adler and Adler (1994) advise that observational data collection continue until data saturation is achieved. Baker

(2006) states that observation periods can range from one hour to several months to years. Hammersley and Atkinson (2007) advise against long, uninterrupted periods of observational data collection as it becomes unmanageable and exhausting, and gaps between observation and field notes raise challenges in accurate recall. It is recommended to undertake representative observations aligned to the observational plan combined with timely field notes and reflection time (Hammersley and Atkinson, 2007).

3.5.2.4 Strengths and Limitations of Observation

The strength of direct observation is that it takes place in real time and within the natural environment, and enables data collection within the context of the bounded case (Yin, 2014; Merriam, 2009). The researcher becomes the research instrument, capturing interactions between the participants, and the participants and the researcher, in real time, generating a unique meaning for the phenomenon (Hammersley and Atkinson, 2007; Merriam, 1998). Therefore, observation of behaviours, process and structures that are not available through other sources can provide unique knowledge (Morgan et al., 2017; Jackson et al., 2016; Yin, 2014; Barner-Barry, 1986). This allows the researcher to observe what participants do rather than, or in addition to, what they say they do (Morgan et al., 2017; Jackson et al., 2016;; Merriam, 1998). The observations can guide research questions for participant interviews (Kawulich, 2005).

One of the limitations of observation data collection is the risk of researcher bias, with selective observation, selective recording of data, and subjective interpretation of observed situations and interactions (Yin, 2014; Merriam, 2009; Baker, 2006; Barner-Barry, 1986). Strategies to address this include reflexivity, actively seeking rival explanations and using other methods of data collection (Baker, 2006). Permission to access sites to undertake direct observations can be a challenge, particularly in healthcare settings (Morgan et al., 2017; Barner-Barry, 1986). In addition, observations can be time-consuming and costly if the researcher is required to be on site for long periods and if more than one observer is required (Yin, 2014; Morgan et al., 2017).

3.5.2.5 Justification for Non-Participant Structured Observation Methods

Within the interpretivist paradigm, it is important to observe first-hand what is actually happening in practice. The researcher is a nurse but had limited experience of working in a RCOP, which prohibited a credible participant observer role. Furthermore, even if the researcher was competent to work as an active member of the team and had been able to take on a participant observer role, it was felt that being part of the nursing team whilst also engaging in data collection would, as identified by Morgan et al. (2017) and Jackson et al. (2016), be too challenging . Therefore, it was considered that

the role of non-participant observer was the most appropriate role to gather the data required. Multiple positioning was appropriate as the researcher could observe RN and HCA interactions in the nurse's office at handover report, and the resident dining areas at mealtimes. Mobile positioning enabled the researcher to observe a RN and HCA, paired to work together as a team, as they moved around the ward.

3.5.3 Document Review Data Collection Method

Documentary review for case study data collection is a process of collecting documents for analysis that are relevant to the phenomenon of interest. Documentary evidence is generally relevant to every case study (Yin, 2014; Stake, 1995). Bowen (2009) defines document analysis as "a systematic procedure for reviewing or evaluating documents – both printed and electronic (computer-based and Internet-transmitted) material" (p. 27). Documents are more generally defined as written text (Mogalakwe, 2009). Merriam (2009) defines the term document as incorporating written, visual and physical material related to the research study.

3.5.3.1 Types of Review Documents

There are three types of documentary data sources: "public records, personal documents, and physical material" (Merriam, 2009, p.1413). Mogalakwe (2009) describes the types of documents as public, private and personal. Documentary sources are included as a research data source because they are considered relatively permanent data that provide insights into the social context being studied (Mogalakwe, 2009). More simply, documents are produced or are available for a reason other than research but can provide an alternative perspective on the context and processes within case study. Because the documents are developed and designed for a specific purpose (e.g. legislation, regulations, national policy), the researcher must evaluate the source, the objective and who the document was originally prepared for (Mogalakwe, 2009). Bowen (2009) identifies five specific uses of documentary review:

1. It provides evidence on the context in which the study is being undertaken.
2. Data from the documents can prompt questions in the research.
3. It can provide supplementary data to other data collection methods.
4. It is a method for identifying chronological changes relating to the phenomenon or group studies.
5. It can be a means of verifying and corroborating findings from other data sources.

Stake (1995), Merriam (2009) and Yin (2014) refer to the importance of undertaking systematic

searches for documents, but it is also important to be open to and include unpredicted data sources. Documentary review is often used as a supplement for other methods as opposed to an independent data collection method (Merriam; 2009, Mogalakwe, 2009; Stake, 1995).

3.5.3.2 Categories of Review Documents

There are two categories of document: primary and secondary. Primary sources are first-hand accounts of the topic, with best sources recorded at the time and place the phenomenon took place, e.g. personal accounts or witness accounts of a phenomenon (Merriam, 2009; Mogalakwe, 2009). Secondary sources are documents where the phenomenon accounted for was not experienced first-hand by the author (Merriam, 2009; Mogalakwe, 2009).

3.5.3.3 Documentary Review Data Collection Approaches

The approach for documentary review includes "finding, selecting, appraising (making sense of), and synthesizing data contained in documents" (Bowen, 2009, p.28). Stake (2006) and Yin (2014) suggest that, with large volumes of documents, a system of sorting and scoring them in order of importance and relevance to the research question should be developed. Merriam (2009) recommends a systematic approach to the document review, including being open to all sources, and testing the authenticity and relevance of the documents. The researcher must source, select and appraise the documents considered relevant to the phenomenon. Each document selected is reviewed in detail and evaluated for relevance for inclusion in the documentary analysis. The researcher should review each document in the context of why, when, by whom and for what audience the document was produced, examining for balance, bias and quality of content (Bowen, 2009). The content of the document is reviewed objectively in the context of its original purpose and then in the context of the research study and objectives (Bowen, 2009).

Establishing the authenticity and accuracy of sourced documents is a critical step in documentary data analysis (Bowen, 2009; Merriam, 2009; Mogalakwe, 2009; Guba and Lincoln, 1981). Although Yin (2014) and Stake (1995) identify the importance of documentary data, they do not provide criteria for evaluating documentary data. The criteria for evaluating the relevance of documentary data were identified as *authenticity, credibility, representativeness* and *meaning* by Mogalakwe (2009). Bowen (2009) lists three of these, replacing meaning with accuracy. However, the difference between meaning and accuracy is not explained by either Mogalakwe (2009) or Bowen (2009). These criteria are defined as follows:

- *Authenticity* – seeking to determine that the document is from the author or source as stated, not forged or plagiarised

- *Credibility* – determining that the documents are prepared independent of the research study and are not a biased account
- *Representativeness* – determining if the documents reflect other similar documents
- *Meaning* – determining that the content in the document is clear and understandable
- *Accuracy* – seeking an assurance that the document provides an accurate account of what it set out to represent

3.5.3.4 Strengths and Limitations of Document Review

Documentary data provide a data source independent to what participants say what happens and what is observed. When the data in documents have been collected, the researcher can review and assess the relevance of the document in context of the research question and aims, and extract the relevant data (Bowen, 2009). Regarding limitations, a) when the data is produced for purposes not related to the research study, they may lack sufficient detail regarding the phenomenon of interest (Merriam, 2009; Bowen, 2009; Mogalakwe, 2009), b) researcher access to retrievable documents may be restricted or blocked (Yin, 2014), c) there may be difficulties in assuring the authenticity and credibility of the document (Merriam, 2009), and d) bias selectivity arises when selection of documents is incomplete (Yin, 2014).

3.5.3.5 Justification of Documentary Review Method

In addition to participant interviews and observations, it was equally important to review documentary evidence particular to each case, providing further insight into the process of delegation between RNs and HCAs. For this CSR, it was important to seek external and internal documents to support a comprehensive analysis of all relevant data sources in the context of each bounded case.

In advance of applying the CSR design and methods a pilot study was undertaken.

3.5.4 Pilot Study

A pilot study in research is the application of the study design on a small scale to test the methodological approach and guide improvements in the research design for the main research study (Yin, 2009, Creswell, 2013).

For novice researchers, a pilot study is recommended to refine the data collection plans regarding site access, participant recruitment, relationship-building, interview questions and interview skills, direct observation techniques, and documentary review approaches (Holloway and Galvin, 2017; Yin, 2014;

Creswell, 2013; May, 2011; Merriam, 2009; Stake, 1995). Issues in the interview design include appropriateness of venue, participant engagement, wording of questions in an understandable format, if the questions are delivering responses, the interviewing skills of the researcher, use of tape, video or image recordings, and the length of interview. The persistent challenge of site access, relationship-building and maintenance, and observation guide and techniques can be tested. The accessing and evaluation processes for documentary review can also be tested, identifying unpredicted challenges, resistance, or data protection issues. Data gathered in a pilot study are generally not analysed or reported on as this is not the objective of the pilot (Yin, 2014; Yujin, 2010). The main objective of a pilot case report is for the researcher to document learning from the pilot and subsequent amendments or changes to the methodological approach in the main study (Yin, 2014; Yujin, 2010). A pilot study was undertaken in this study and the lessons learned are discussed in Section 4.2.

The following section describes the data analysis methods.

3.6 Data Analysis

Merriam describes qualitative data analysis as “a complex process that involves inductive and deductive analysis” (Merriam, 2009; ebookLoc, 2144) or more simply as making sense out of the data. Stake (1995) describes analysis simply as “taking something apart” (Stake, 1995, p.71). Data analysis is a complex process of understanding and interpreting the data with the objective of describing or explaining. It is important that the data analytical approach selected best suits the research methodology and that the processes for the analytical approach are clearly and systematically adhered to and represented in the final report (Miles et al., 2020; Bonello and Meehan, 2019).

3.6.1 Categories of Data Analysis Methods

Qualitative data analysis methods can be divided into two categories: generic and specific theoretical or philosophical methods (Holloway and Galvin, 2017). Generic methods are not aligned to any particular theoretical or philosophical perspective, e.g. thematic analysis, content analysis. The second category has specific methods aligned to theoretical or philosophical perspective analysis; e.g. Glaser (1992) and Straus and Corbin (1998) for grounded theory, Smith and Osborn (2003) for interpretive phenomenology, Moustakas (1994) for hermeneutic phenomenology, and Silverman (2013) for conversation analysis (Holloway and Galvin, 2017; Braun and Clark, 2006).

3.6.2 Data Analysis in Qualitative Case Study Research

Qualitative content analysis or thematic analysis are the most common data analytical approaches used in CSR qualitative research (Vaismoradi and Snelgrove, 2019). The case study data analysis process recommended by Yin (2014) is a more quantitative approach, involving "examining, categorizing, tabulating, testing, or otherwise recombining evidence to produce empirically based findings" (p.132). Merriam (2009) and Stake (1995, 2006) apply qualitative research approaches but do not propose a data analysis technique for CSR; however, they recommend the use of a strategy for data analysis. Stake refers to two methods for case study data analysis: categorical aggregation and direct interpretation (Yazan 2015; Stake, 2006, 1995). Stake does not recommend these as all-encompassing strategies for analysis; rather he recommends that each researcher apply an analytical strategy that is most suitable for the study. *Categorical aggregation* is described as collation of complex data into categories or groups, while in *direct interpretation* the researcher finds new meanings within the case (Stake, 2006, 1995). Stake (2006) refers to the Miles and Huberman model of data analysis in relation to multiple case study research. Miles et al. (2020) propose a thematic analysis approach to data analysis. Therefore, thematic data analysis will be described, with a focus on Miles and Huberman's (1994) interactive model.

3.6.2.1 Thematic Analysis

Thematic analysis is a process of recognising emerging patterns from the data, and categorising the themes or patterns for analysis. DeSantis and Ugarriza (2000) define a theme as:

> "an abstract entity that brings meaning and identity to a recurrent experience and its variant manifestations. As such, a theme captures and unifies the nature or basis of the experience into a meaningful whole" (p.362).

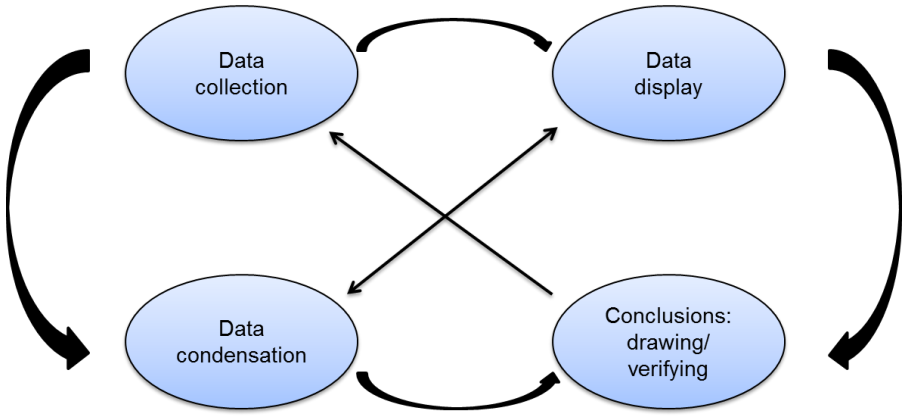
All thematic analysis approaches "aim to identify and make sense of patterns of meaning across a dataset" (Braun and Clarke, 2021, p.331). The most common thematic analysis approaches applied in qualitative data analysis are: *template analysis* (King and Brooks, 2018; Braun and Clark, 2021) and *interactive analysis* (Miles et al., 2020; Miles and Huberman, 1994). Template analysis is described as a generic form of thematic analysis that allows the researcher flexibility in application (King and Brooks, 2018). The six steps in template analysis (Braun and Clarke, 2006; Brooks et al., 2015; King and Brooks, 2018; Braun and Clark, 2021) are: becoming familiar with the data; undertaking initial coding, which can include *a priori* themes; clustering themes into meaningful groups; exploration and analysis of all emerging themes and sub-themes in a coding template; modification and development of the template with new themes; and the final template with all data related to the study. This six-step process starts with seeking patterns of meaning in the data and ends with reporting on the meaning

in the patterns (Braun and Clark, 2006, 2021). Template analysis does not provide guidance or steps on final interpretation or reporting of the thematic analysis as this is guided by the philosophical or theoretical approach of the study (King and Brooks, 2018). The other common thematic analysis approach is interactive analysis, where data are organised and displayed to enable interpretation and reporting (Miles et al., 2020; King and Brooks, 2018). The interactive model (Miles et al., 2020) used in this study is described next.

3.6.2.2 Interactive Model of Data Analysis

Although not specifically aligned to CSR, this analytical approach allows the development of descriptions and explanations across complex data sources and for within-case and cross-case analysis. The four components of data analysis in the interactive model are: data collection, data condensation, data display, conclusion drawing and verifying (Miles et al., 2020) (Figure 3.3). They occur in a consecutive, interactive and iterative process.

Figure 3.3: Components of Qualitative Data Analysis, Interactive Model (Miles, Huberman & Saldana, 2020, p.10)



Data condensation is described by Miles et al. (2020, p.8) as "the process of selecting, focusing, simplifying, abstracting, and/or transforming the data". They describe the condensation of data as strengthening the data as opposed to the term reduction, which implies weakening or dilution (Miles et al., 2020). Data condensation occurs early in the study when decisions on the research question, case selection and data collection methods are taken (anticipatory data condensation). During data analysis, the phases of coding, creating categories, recording of memos, and theme development are considered data condensation, as each is an analytic choice. Data display is when the data is organised and condensed in a format that enables analytic decisions (Miles et al., 2020). Data display is predominantly through *extended text,* where additional information is provided around the data,

resulting in additional text. Miles et al. (2020) strongly argue that data displays through networks, matrices or graphics are a significant component of robust data analysis. Good data display, where data are collated and presented in a compact format, enables the researcher to visualise and process the data more efficiently. Similar to the other components of the interactive model, *drawing and verifying conclusions* is an iterative and continuous process in this data analysis method. Verification includes anything from the researcher having an alternative or different thought during writing that brings them back to review jottings or annotations, to elaboration or arguing the conclusions with colleagues, or robust efforts to replicate the findings in another dataset (Miles, et al., 2020).

Miles et al. (2020) provide a systematic process for data analysis within the interactive model; it consists of: first-cycle coding; second-cycle coding; jotting; analytic memos; hypotheses, assertions and propositions; and closure and transition.

Many first-cycle coding approaches can be used, but there are three predominant methods: descriptive coding, in vivo coding and process coding (Miles et al., 2020). Descriptive coding is when a summary word or phrase is used to describe the core topic in the passage. (Miles et al., 2020). In vivo coding prioritises the research participant's voice by using their own words or phrases as the code. Process coding uses gerunds ('-ing' words) to code the data and captures the research participants' actions and processes. The researcher creates codes inductively and deductively. Codes are defined to ensure consistency in understanding and applying the code. First-cycle coding collates segments of the data which have meaning or are related to the concept studied.

Second-cycle coding or pattern coding reduces large amounts of coded data to units of analysis as categories, themes or concepts (Miles et al., 2020) (Table 3.4). Unlike a code, which organises and gives symbolic meaning to the data, categories group similar codes, and a theme is a higher level of data categorisation of broad concepts.

Table 3.4: Second Cycle Coding-Pattern Codes: Terms and Definitions (Miles et al., 2020)

Pattern Coding Term	Definition (as per Miles et al., 2020)
Pattern codes	"inferential or explanatory codes" (p.9)
Category	the collation of similar data from the pattern coding
Theme	"an *extended phrase* or *sentence* that identifies what a unit of data is *about* and/or what it *means"* (p.73)
Concept	"a word or short phrase that symbolically represents a suggested meaning broader than the single item or action" (p.66)

Pattern coding integrates data analysis to focus the researcher during data collection, assists the development of a 'cognitive map', and, for a multiple case study, provides structure for cross-case analysis (Miles et al., 2020). Miles et al. (2020) state that pattern codes consist of four, interrelated summarisers:

1. Categories or themes
2. Causes or explanations
3. Relationship among people
4. Concepts or theoretical constructs (Miles et al., 2020, p.80)

Jottings capture the researcher's reflections and commentary that occur during data collection and data analysis (Miles et al., 2020). They can be captured as brief annotations or comments, either manually or electronically on CAQDAS. They record the researcher's thoughts and perceptions in relation to, the researcher's relationship with participants, the need to review research methods (interview questions, non-participant observation techniques), and reminders to cross-reference data sources or follow up on an issue raised (Miles et al., 2020). The value of jotting is that they can contribute to a deeper and more detailed analysis of themes and concepts that are developed during data collection and analysis.

Analytic memos are used to record reflections and thought processes about the data, with the objective of moving data synthesis to a high level of analytic meaning (Miles et al., 2020). Miles et al. (2020) describe the development of analytic memos through the researcher's selection of codes and code definitions, problems with the study, a record of what the researcher finds interesting, surprising, or unpredicted, and a synthesis process for patterns, categories and themes (Miles et al., 2020).

At every stage of the study, from data collection through to reporting on the findings, the researcher is developing assertions and propositions, noting patterns and casual relationships. These are not considered as conclusions but are analytic interpretations that are *verified* as the analysis progresses. An *assertion* is a statement based on the synthesis of all the evidence and findings but is revised when "disconfirming evidence or discrepant cases require modification of the assertion" (Miles et al., 2020, p.93); a *proposition* is a statement of "a conditional event – an *if-then or why-because* proposal that gets closer to prediction or theory" (Miles et al., 2020, p.93). A formal and systematic means of representing the thinking of the researcher during the data analysis process can be developed through assertions and propositions.

In CSR both within- and cross case analysis is undertaken. Case analysis describes the data analysis that occurs within a single, bounded case. The objective of within-case analysis is to develop detailed

understanding of a single, bounded context (Miles et al., 2020). Cross-case analysis synthesises data across more than one case and includes comparing and contrasting data across cases. The two main purposes of cross-case analysis are to deepen understanding and explanation and to enhance transferability (Miles et al., 2020). Miles et al. (2020) propose that cross-case analysis allows deeper understanding of how local conditions influence a phenomenon, thus developing deeper and more powerful descriptions of the phenomenon. Using more than one case in a study allows the researcher to examine similarities and differences across cases. Multiple case analysis increases transferability, offering a reassurance that the "events and processes in one well-described setting are not wholly idiosyncratic" (Miles et al., 2020, p.95). However, in cross-case analysis similar findings may not emerge from all study sites and all cases may not be comparable. There is a need to keep disconfirming evidence or discrepant cases in mind all the time during analysis to demonstrate the researcher's level of subjectivity and to modify an assertion if required (Miles et al., 2020).

Miles et al. (2020) also identify two approaches for cross-case analysis: a *variable-oriented approach* and a *case-oriented approach*. The former starts with a concept or theory, and the cases are analysed for interrelationships within predetermined variables. This approach, generally used with a large number of cases, identifies probabilistic relationships among variables in cases. However, it may not allow for deeper analysis in a complex case study with subunits of analysis, and therefore findings are often general (Miles et al., 2020). The case-orientated approach analyses the data within each case as an entity, and then compares cases for similarities, differences and constant associations (Miles et al., 2020). Case-orientated analysis is recommended when the objective of the analysis if to find specific, rich and concrete findings from a small number of cases. However, the findings from case-orientated analysis are often particularistic and not generalisable (Miles et al., 2020).

Finally, the outcomes of the synthesised analysis from the case study (within and across case) are presented in a report of the findings. Figures, tables and matrices may be used to present the synthesis process and results.

3.6.3 Justification for Selecting Miles, Huberman and Saldana's Interactive Model of Data Analysis

Miles et al. (2020) support the interpretivist position that knowledge is socially constructed, and build on the original data analytical approach of Miles and Huberman (1994). The thematic data analysis approach, the interactive model (Miles et al., 2020), was considered appropriate for this study. It provided a systematic method for processing and analysing the data that was iterative and interactive. The detail in the model – from initiating the data collection and analysis to displaying the data, and the processes for drawing and verifying conclusions and reporting on the analysis – also provided

comprehensive guidance for the novice researcher. This interactive analysis approach was applied across all data sources as, according to Saldana (2018), "using the same analytic system across different data sources better ensures 'translation' and comparability across the data and leads to a more unified analysis" (ref. Saldana email, 2018).

3.7 Ethical Considerations in Qualitative Research, the Role of the Researcher, Nurse as Researcher, and Reflexivity

This section will discuss the ethical considerations in conducting CSR, and the role of the researcher, including the challenges of the nurse as researcher, and the reflexive approach.

3.7.1 Ethical considerations in qualitative case study research

Conducting CSR will always involve ethical considerations as the study of "a contemporary phenomenon in its real-world context" (Yin, 2014, p.78) involves human subjects. The core ethical considerations in qualitative research are that human beings are active research participants; the benefits, harm and risk; the worthiness of the project; informed consent; privacy, confidentiality and anonymity; and competence (Miles et al., 2020; HSE, 2017; Holloway and Galvin, 2017; NMBIb, 2015; Yin, 2014; Beauchamp and Childress, 2001). The objective of considering and responding to ethical issues in research is to protect participants from harm or risk. In Table 3.5, these considerations are outlined in the context of CSR conducted in healthcare. Healthcare researchers are ethically obliged to act in the best interest of patients, staff and participants, and actively empower them to make autonomous informed decisions (Holloway and Galvin, 2017). Internationally, the four principles of medical ethics of *autonomy, beneficence, maleficence* and *justice* (Beauchamp and Childress, 2001), *respect for persons, beneficence* and *justice* (Belmont report, National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979) guide ethical considerations. In the Irish healthcare and nursing context, guidance comes from:

- *Ethical Conduct in Research: Professional Guidance* (NMBI, 2015b)
- *Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives* (NMBI, 2014, 2021)
- *HSE Health Research Guidance Manual* (HSE, 2014)
- HSE National Consent Policy (HSE, 2017)
- HSE Open Disclosure Policy (HSE, 2013)
- Data Protection (Amendment) Act (2003)
- General Data Protection Regulations (2018) (came into effect during this study)

Healthcare services and universities have RECs to ensure safe and ethical research practices for patients, participants, organisations and researchers (Holloway and Galvin, 2017).

Table 3.5: Summary of Ethical Considerations, Supporting Principles and Practical Application

Ethical Consideration	Supporting Principles	Practical Application
Benefit and harm	Respect for a person's autonomy, beneficence (to do good), non-maleficence (to do no harm), justice (fairness), veracity (truth), fidelity (trust) and confidentiality	Development of a good-quality research proposal. Clear research aims and objectives. Transparent and appropriate sampling, e.g. purposive, random sampling. Participant recruitment demonstrates honesty about research aims and objectives, expectations from participants (e.g. time commitment for interviews, survey, observation data collection), anonymity, informed consent, time to decide, right to withdraw, data management and retention, and reporting. Information predates collection on topic. Informed consent. Engagement of a gatekeeper. Sound research methods. Safe data storage practices (transcriber confidentiality, de-identified data with codes or pseudo-names; hard-copy data stored in locked cabinets and offices; digitally stored data encrypted and password-protected). Data retention practices (data retained for period of study, then destroyed, hard-copy data shredded, electronic data deleted, audio and visual data destroyed). Appropriate and honest use of findings through honest, transparent, unbiased report of findings, reporting back to study site, use of research to promote knowledge and good practice.
Worthiness of project	The research study must be worth doing, the potential benefits affecting more than the researcher.	Identify a gap in empirical evidence. Identify an area where further or new knowledge is required. Consider the potential benefit for others, e.g. improving health and wellbeing, improving health services, contributing to policy and decision-making.
Informed consent	Informed consent and voluntary participation are critical in all health research where the participant is fully informed of purpose, benefits, risks and expectations of participants in the study, and independently chooses whether to participate or not.	Provide information to potential participants on the purpose of the study, risks and benefits, research methods to be used, expectations from participation in the study, processing of data and presentation of findings. Demonstrate adherence to GDPR, organisational and professional regulator guidance in relation to informed consent. Ongoing confirmation of consent to participate. Process consent for vulnerable participant groups.

Confidentiality and anonymity	Respect for participant privacy, protection of participants' identity. Pseudonymisation: personal or identifiable data (e.g. name, work location) are replaced with artificial identifies, e.g. codes or unique numbers. Anonymisation: data cannot be attributed to the participant or site, i.e. personal identity cannot be revealed.	Data are anonymised or pseudonymised to avoid identifying study site or participants. Tapes, notes, transcripts, demographic profiles, consent forms must be stored securely. Participants are advised of processes in place to protect confidentiality. Research report must maintain participant confidentiality and anonymity. Photographs, audio and video recordings are stored safely and destroyed following the research.
Competence	Researchers have the knowledge and expertise to conduct the research.	Novice researchers have a responsibility to develop research knowledge, skills and competence. They must engage in education and academic supervision to promote competence. Conducting a pilot study provides an opportunity to develop research skills.

Sources: Miles et al., 2020; HSE, 2017; Holloway and Galvin, 2017; NMBIb, 2015; Yin, 2014; Beauchamp and Childress, 2001).

To demonstrate worthiness, the research study should be of significance and relevance beyond personal academic, publication or career significance (Table 3.5). It is recognised that research in health can improve and promote advances in healthcare, contribute to wellbeing of individuals, and inform and contribute to policy development (HSE, 2017).

Informed consent involves providing full information on the proposed study (Table 3.5). This includes applying for REC approval, providing evidence and reassurances of the consent process (participant information, sample consent form, right to withdraw) and adherence to General Data Protection Regulations (GDPR 2018). Consent is an ongoing process throughout a study where the principles of participant autonomy, right to withdraw, data protection and assurance are applied (Holloway and Galvin, 2017; Yin, 2014). Researchers must also be aware of potential power imbalance between researcher and participants (patients, employees, students) when participants may feel constrained in refusing to participate or withdrawing from workplace-related research. Methods of recruiting participants must be transparent and appropriate; particular methods of recruitment of vulnerable groups are required, especially in the case of patients; people with an intellectual disability, mental health illness, or cognitive impairment; children, and frail older people (Holloway and Galvin, 2017; Murphy et al, 2015; Yin, 2014; Dewing, 2013).

In qualitative research, the researcher negotiates ongoing, informed consent where participants make decisions in relation to their role in the research. This is process consent (Tolich and Tumilty, 2020; Houghton et al., 2010). The process consent method is good practice, especially for including

people with a cognitive impairment in research (Jean et al., 2021; Tolich and Tumilty, 2020; Murphy et al., 2015; Dewing, 2013; Hellstrom et al., 2007). Dewing (2013) describes the five elements of the consent method as: background and preparation, establishing the basis for capacity, initial consent, ongoing consent monitoring, and feedback and support. This CSR was conducted in RCOP sites, but the residents were not the subjects of the research study. There was no requirement to access personal details or any identifiable information on residents. Residents would not be interviewed or requested to undertake a procedure or intervention. However, data collection would occur in the RCOP site, the resident's home, and a significant number of the residents were vulnerable or had a cognitive impairment. Therefore, obtaining resident consent through the process consent method was considered appropriate for this study. The three principles of informed consent (Belmont report, National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979) recommend; that adequate information is provided for participants to make a decision, that participants understand the information, and that consent is given voluntarily. These were incorporated in obtaining informed consent in this study.

An additional ethical consideration is research participants' entitlement to have all data pertaining to them protected and to an assurance of confidentiality. This can be a challenge in qualitative research with small samples, thick descriptions and the participant's voice included in the reports (Table 3.5). The researcher must be competent to undertake the role of researcher.

3.7.2 Role of the Researcher and the Nurse as Researcher

In CSR the researcher is close to the phenomenon during data collection, but also is the data analyst and reports on the findings. In addition, the nurse as researcher occupies two roles, the professional and the research roles, which may lead to conflict. Stake describes CSR as "highly personal research… researchers are encouraged to use their own personal perspectives in interpretation" (Stake, 1995, p.135). Merriam (2009) describes how, in the interpretive or constructivist approach to CSR, reality is not objective; instead, there are multiple interpretations of reality. There is a combination of the interpretations of the participant's reality and the researcher's interpretation of that reality, and Merriam (2009) describes the final findings or report as "another interpretation by the researcher of others' views filtered through his or her own" (Merriam, p.348).

Nurses involved in CSR in a healthcare setting must disclose and acknowledge how their perspective and opinions influence the research (Holloway and Galvin, 2017; Bradshaw et al., 2017). This is enabled through reflexivity and identification within the research report. The nurse researcher is ethically and professionally obliged to be competent to undertake the research study, primarily by

having a comprehensive understanding of the chosen research methodology and associated methods. This is critical in qualitative CSR where the researcher is the main instrument of data collection and analysis. The nurse researcher must consider the conflicting responsibilities of conducting research in a clinical setting. The primary responsibility is to patient safety and quality care, followed by staff safety and wellbeing. There can be conflict in the dual role if the nurse perceives that the research is causing distress to the participant, or when the nurse is professionally obliged to put the wellbeing and care of the patient before the research. For example, if the nurse is undertaking data collection by direct observation but a patient requires assistance, or if the patient appears uncomfortable or agitated during the observation, then the nurse will make a patient-focused, not research-focused, decision. There is also a risk of role confusion as participants view the researcher as a nurse colleague or nurse manager (Skene, 2012; Houghton et al., 2010). This should be addressed by reminding participants of the aim of the study and the role of the nurse researcher, and by adopting this role in the study site(s) (Houghton et al., 2010). The complexities of nurse as researcher can be reconciled by applying reflexivity in research. To ensure rigour in CSR, reflexivity is critical.

3.7.3 Reflexivity

Reflexivity is defined as the effect of the researcher on the research, and the effect of the research on the researcher (Attia and Edge, 2017). The absence of consensus on what reflexivity is has resulted in it not being widely applied in qualitative research (Engward and Davis, 2015; Darawsheh, 2014). The objective of using reflexivity is to increase rigour in research studies (Holloway and Galvin; 2017; Attia and Edge, 2017; Morley, 2015; Darawsheh, 2014; Houghton et al., 2013). There can be confusion between the terms reflection and reflexivity, with the terms sometimes used interchangeably (Morley, 2015). Reflection is the process of looking back on personal thoughts and actions in order to understand and learn from them at a higher level. In CSR the researcher must be conscious that their own position in the organisation may shape their perspective and their position in relation to participants, considering gender, culture, religion, socio-economic background and their values and beliefs, and how this affects the research study (Holloway and Galvin, 2017). Reflexivity acknowledges the researcher as integral to the research process, from the structure of the research question and study aims to the research design, decisions on data collection, data analysis and presentation of the finding (Holloway and Galvin, 2017; Rae and Green, 2016; Morley, 2015; Houghton et al., 2013).

It is also acknowledged that despite reflexivity being recognised as an integral part of qualitative research, many methodological publications do not identify particular frameworks or processes for engaging and demonstrating reflexivity (Holloway and Galvin, 2017; Czarniawska, 2016; Engward and Davis, 2015; Darawsheh, 2014). Many researchers use a reflexivity diary to collect, in a narrative

format, personal perceptions, assumptions, opinions, emotions, how decisions were made, challenges encountered, acknowledged biases and thoughts (Darawshed, 2014; Houghton et al., 2013). This can be a written or computer-based diary systematically maintained throughout the study. Although focusing on grounded theory, Engward and Davis (2015) describe how the Alvesson and Skolberg model for reflexivity can be used in qualitative research. Alvesson and Skolberg (2018, 2009) describe four levels of reflexivity, moving from how the data was collected to data analysis to questioning power, political-ideological context and influences, and, to how the researcher represents the findings. Rae and Green (2016) describe a matrix model to support reflexivity in qualitative research. The objective of the reflexivity matrix is to offer researchers a model for reflexivity that is "at once comprehensive and rigorous" (Rae and Green, 2016, p.1544).

Table 3.6: Reflexivity Matrix, Rae and Green, 2016, p.1545

	In the Overall Social Space	Within the Field of Specialists	Within Everything That is Linked to Membership of the Scholastic Universe
Pre-research	**Cell 1** How do researchers' broader motivations affect the reason to conduct research in the first place, the choice of topic and research question, and the choice of methodology? What is the researcher's conceptualization of "health?"	**Cell 2** What is the relationship between the researcher and the health care field? How is the choice of topic relevant to health care?	**Cell 3** Where does the researcher's interests (and conflicts of interest) lie within the relevant literature and it's interpretations?
Data collection	**Cell 4** What are the shared and divergent understandings between the researcher and participants with regard to research generally and to the health-related topic? Are there any differences of a social nature, for example, gender, education, or experience? To what extent are meanings negotiated between the researcher and participants, and how is this influenced by life experiences? Is the researcher prepared to undergo change as a result of his or her interaction with the research? What of the potential for change in the participant?	**Cell 5** Do the researcher and participants share the same language, especially if they come from different health disciplines? Are there any power differentials between the researcher and participant, based on positions held (present or past), health discipline, or education?	**Cell 6** Are questions (or prompts) inadvertently shaped by popular (perhaps fleeting) scholarly opinion?
Data analysis		**Cell 7** How does the researcher's experience with the field shape analysis? Are some data dismissed as being commonplace, whereas they might warrant deeper interrogation? To what extent does the researcher consider the balance of analytical authority to rest with the participant or with the researcher?	**Cell 8** How does the researcher moderate any drive for outcomes that might inadvertently lead to data omissions or fabrications?

The reflexivity matrix has eight cells, each providing a prompt for the researcher to reflect, consider and explore their role in the research, and how the research is affecting the researcher (Table 3.6). The first three cells occur during the pre-research phase, where the researcher's motivations and interest in undertaking the research are identified. Cells 4–6 cover the data collection phase where the differences and similarities between the researcher and participants are in focus, including social, demographic, experience, and power imbalances. Cells 7 and 8 capture reflexivity during the data analysis phase. Decisions on data inclusions and data reporting are explored in this phase (Rae and Green, 2016). This approach supports reflexivity through the different the stages of research.

3.7.4 Justification for Reflexivity and Ethical Approaches in this Study

As the research was undertaken on clinical sites, in the presence of residents and with clinical staff as participants, ethical considerations were of critical significance. It was important to provide assurances that the researcher adhered to high-quality ethical standards outlined in international, national and professional principles and guidance. The application of a structured reflexivity model facilitates this assurance and increases rigour.

3.8 Ensuring Research Rigour in Qualitative Research

Rigour concerns assessing the trustworthiness of the qualitative study by establishing that the most appropriate research tools were applied to the research design, indicating "thoroughness and competence" in qualitative research (Holloway and Galvin, 2017, p.304). This section describes the methods of ensuring research rigour in qualitative research, including justification for using the Criteria for Trustworthiness of Qualitative Research, adapted from Lincoln and Guba (1985) and Denzin and Lincoln (2011).

3.8.1 Approaches to Assess Rigour in CSR

Demonstrating rigour is a persistent challenge for qualitative research but it is critical to demonstrate that the research is reliable and trustworthy to influence policy and practice (Miles et al., 2020; Hadi and Closs, 2016; Houghton et al., 2013; Creswell, 2013; Denzin and Lincoln, 2011; Lincoln and Guba, 1985). There are common methods in all CSR which contribute to rigour. They include: defining the case as the unit of analysis; careful planning and design; reflexivity, whereby the researcher's philosophical position and bias is acknowledged and recorded; using multiple sources of data to ensure a rich, in-depth inquiry; a structured and systematic data analytical method; and thick descriptions from the data reported (Harrison et al., 2017; Hyett et al., 2014; Yin, 2014; Merriam,

2009; Stake, 1995). The final report should accurately represent sources from the data, with appropriate reference to participant quotes, document extracts and observation periods (Miles et al., 2014; Rowley, 2002). However, there is no agreed approach for assessing the criteria of quality of qualitative research, including case study (Miles et al., 2020; Holloway and Galvin, 2017).

The most common approach for assessing rigour in qualitative and QCS research is the Criteria for Trustworthiness of Qualitative Research (; Yin, 2014; Houghton et al., 2013; Merriam, 2009; Tong et al., 2007; Stake, 1995; Lincoln and Guba, 1985). Lincoln and Guba (1985), and later Denzin and Lincoln (2011), translate the standard tenets of rigour, validity and reliability into qualitative terms and describe the criteria for trustworthiness of qualitative research as credibility, transferability, dependability, and confirmability (Table 3.7). More recently, Miles et al. (2020) aligned the different standards of criteria for quality research into five categories:

1. Objectivity/Confirmability
2. Reliability/Dependability/Auditability
3. Internal Validity/Credibility/Authenticity
4. External Validity/Transferability/Fittingness
5. Utilisation/Application/Action Orientation (Miles et al., 2020, p.304)

The criteria for trustworthiness (Miles et al., 2020; Denzin and Lincoln, 2011; Lincoln and Guba, 1985) are summarised in Table 3.7. The following section briefly describes each standard, including the additional criterion proposed by Miles et al. (2020), addressing how the study's findings benefit the participants (utilisation, application or action orientation).

Table 3.7: Criteria for Trustworthiness of Qualitative Research as Applied to this Case Study

Criteria for Trustworthiness (Lincoln and Guba, 1985; Denzin and Lincoln, 2011)	**Criteria for Quality of Conclusions** (Miles et al., 2020)	**Definition**	**Achieved through**
Credibility	Internal Validity/ Credibility/Authenticity	Believability of findings and extent to which findings presented match participant perspective	Thick descriptions. Triangulation of multiple sources of data and methods. Prolonged engagement. Persistent observation. Negative case analysis. Peer debriefing.
Transferability	External Validity/ Transferability/Fittingness	Extent to which decisions can be made about usefulness of study findings in other contexts	Providing thick descriptions. Purposive sampling. Cross-case analysis.

Dependability	Reliability/ Dependability/Auditability	Similar to reliability of quantitative data, and how stable the data are	Creating a case study database. Chain of evidence.
Confirmability	Objectivity/Confirmability	Accuracy of data	Creating an audit trail. Triangulation of methods and data sources. Reflexivity.

Credibility demonstrates truth, value, accuracy and how the findings are related to reality (Miles et al., 2020; Lincoln and Guba, 1985) (Table 3.7). The descriptions must be meaningful, in context and 'thick'. Triangulation across methods and sources generally produces conclusions that are aligned to each other and are replicable. Methods triangulation, when multiple methods are used (e.g. interviews, observation, documents) and data source triangulation is when two or more types of participants are included in data collection (Patten and Newhart, 2017; Yin, 2004). Triangulation of data is routine in CSR (Yin, 2014; Merriam, 1998; Stake, 1995).

Transferability relates to whether, in a particular case study, the study findings are transferable to other contexts, or how far they can be generalised (Miles et al., 2020; Lincoln and Guba, 1985). The challenges of demonstrating this criterion in qualitative CSR is acknowledged by Miles et al. (2020), especially in relation to constructing theory and generalisation from complex, site-specific contexts. The analytical ability of the researcher to find levels of understanding of relevance beyond the case is critical (Miles et al., 2020). Thick descriptions and purposive sampling are used to demonstrate this criterion. A full and detailed description of the case (participants, setting, processes), including sample selection, is provided in the findings (thick descriptions) to allow the reader to assess transferability to another setting (Miles et al., 2020; Lincoln and Guba, 1985). If the findings are applicable or can be compared to other settings, and are congruent with or confirm existing theory, this will support rigour. It is recognised that in CSR a case is not selected as a representation of other cases and does not aim to address statistical generalisations (achieving statistical sampling from a wider population based on representativeness) (Miles et al., 2020; Bradshaw et al., 2017; Yin, 2014; Stake, 2006; Fossey et al., 2002; Merriam, 1998; Stake, 1995). However, through purposive or theoretical sampling criteria, analytical generalisation may be possible; that is, how selected cases (sample) fit with the theoretical framework or evolving theory (Miles, Huberman and Saldana, 2020; Ebneyamini and Sadeghi Moghadam, 2018; Gerring, 2016; Eisenhardt, 1989). Miles, Huberman and Saldana (2020) identify the two objectives of cross-case analysis as to "enhance generalizability or transferability of our findings to other similar settings" and "deepen understanding and explanation" (p.95). The use of more than one case can add confidence to the findings (Miles et al., 2020). Replication logic refers to repetition of the study in different cases and comparisons being made across cases (Yin, 2003; Eisenhardt, 1989).

Therefore, the numbers of cases are selected on conceptual or analytical rather than statistical grounds (Miles, Huberman and Saldana, 2014).

Dependability demonstrates that the study is consistent and remains stable across researchers and methods (Miles et al., 2020; Lincoln and Guba, 1985). Dependability is achieved by creating a case study database and chain of evidence (Miles et al., 2020; Houghton, 2013; Lincoln and Guba, 1985). This includes demonstrating a well-constructed research question and study design, transparency of the researcher role in the study, and alignment of the findings to the data sources.

Confirmability refers to the accuracy of data and acknowledges the bias of the researcher (Miles et al., 2020; Yin, 2014; Houghton et al., 2013; Lincoln and Guba, 1985). The personal assumptions, values and biases of the researcher are acknowledged (Miles et al., 2020). To demonstrate objectivity and confirmability, the researcher provides a transparent and full representation of research methods and procedures. Rival explanations and conclusions are considered. This includes reporting on data collection and data analysis methods. Research data are retained and are available for analysis by others (within the research ethic approval process).

External Utilisation/Application/Action Orientation, the fifth category, is not always included in testing for rigour in qualitative research, but it is important to test if the study has value for the researcher, the participants, and those for whom the study is prepared, especially in the case of policy and evaluation studies (Miles et al., 2020). Miles et al. (2020) describe the importance of identifying what the study does for its participants and how the knowledge and recommendations from a study are considered worthwhile and provide insight.

To demonstrate rigour in this study, the criteria for trustworthiness of qualitative research by Lincoln and Guba (1985) were applied, as these criteria are most commonly referenced in interpretive CSR as the method for analytical rigour. The utilisation standard, as proposed by Miles et al. (2020), outlined in Table 3.7, was applied in the assessment of rigour. The criteria for trustworthiness of qualitative research encompasses the practical standards recommended to judge the quality of CSR, as outlined in Table 3.7 (Miles et al., 2020; Hadi and Closs, 2016; Houghton et al., 2013; Lincoln and Guba, 1985).

3.8.2 Data Management and CAQDAS

In qualitative CSR, there is a need to manage the large amounts of data from different sources and cases. Although it is possible to manage data manually, computer-assisted qualitative data analysis software (CAQDAS) is useful for coding, storing and organising qualitative data (Miles et al., 2020; Creswell, 2014). Computer software to assist a researcher in qualitative data analysis, such as Atlas, NVivo and MAXQDA, supports the coding, categorising and analysis of large amounts of data; the

researcher must study the outputs to identify emerging patterns or correspondence. CAQDAS enables easy access to and easily retrievable data (Bonello and Meehan, 2019; Holloway and Galvin, 2017; Creswell, 2013 and 2014). Identified categories can be searched and cross-checked. It provides a capacity to map and matrix codes, categories and ultimately themes and concepts (Bonello and Meehan, 2019; Creswell, 2013, 2014), and enables researcher jottings and memos to be included in the analysis. The researcher can visually demonstrate the process of data analysis as screen shots and reporting from the data (Bonello and Meehan, 2019; Creswell, 2013, 2014). Creswell (2013) states that CAQDAS enables the researcher to examine the data more forensically. However, the researcher needs to be technologically adept and competent in using the software programme (Holloway and Galvin, 2017; Bonello and Meehan, 2019; Creswell, 2013, 2014). There is also a risk that introducing a machine may distance the researcher from the data (Bonello and Meehan, 2019; Holloway and Galvin, 2017; Creswell, 2013 and 2014), and that the software programme may not have all the capabilities required for the research analysis (Creswell, 2013 and 2014).

NVivo 11, later updated to NVivo 12 was used in this study for data management, and supported data analysis and reporting. It enables the research data to be stored, arranged, annotated and retrieved in different configurations. 'Free nodes', 'tree nodes', 'parent and child nodes, 'annotations', 'memos' and 'see also' links are used in the software. The features enable all phases of the data analysis to be demonstrated and are used as part of the study audit trail.

3.9 Chapter Summary

This research methodology chapter has outlined the research paradigm, approaches and methods considered, and those used in this study. The researcher's methodological decisions, including data collection methods, were described and justified. Following a review of data analysis methods, the justification for applying the matrix analysis approach of Miles, Huberman and Saldana (2020) was outlined. The critical topics of reflexivity, ethical considerations, the role of the researcher and the dual role of nurse researcher were also discussed. Finally, methods for ensuring rigour were described, including justification for the criteria used in this study. The following chapter describes how the researcher applied these methods to this study.

Chapter 4: Research Methods

4.1 Introduction

This chapter provides a description of how the case study to explore RN delegation to HCAs was conducted. First, an overview of the pilot study is presented, where key learnings informed the methods in the main study. The methods used in the case study, including the site selection and site access processes, are described. The sampling process, data collection methods and data analysis process used, along with justifications for decisions, are presented. The ethical considerations, criteria for establishing trustworthiness in the study and chapter summary conclude this chapter.

4.2 Pilot Case Study Site

The purpose of the pilot case study was to test the research design and data collection methods, including site selection, data collection tools and recruitment strategies. The pilot study also provided an opportunity to test the practicality of gaining access to a clinical working environment that included real-life situations that were new to a novice researcher.

4.2.1 Pilot Site Description

The key learning from undertaking the pilot related to site selection, the consent process for residents, data collection methods and reflexivity. The pilot site was a RCOP where 20 long-term residents, male and female, were cared for in two wards. The staff complement was 11 RNs and 10 HCAs. The skill-mix ratio of RNs to HCAs was 50:50. The Clinical Nurse Manger 2 (CNM) was predominantly in an administrative role between both wards. One nurse and one HCA were assigned to each ward during the day, with an additional HCA working between the two wards. There was one RN and one HCA on night duty working between both wards, with an additional HCA working a 'twilight shift' of 8pm to 12 midnight. The pilot study was conducted over four months using focus-group interviews, non-participant observations and documentary review. The key findings of the pilot study are described below.

4.2.2 Site Selection

The size of the site and the low number of RNs and HCAs working there was identified as important. To obtain reliable observation data on the process of delegation required a minimum of one consenting RN and one consenting HCA on duty at the same time. The conduct of focus groups required four participants per focus-group interview. The availability of adequate numbers for focus-

group interviews and for observation data collection was challenging. Therefore, the case study inclusion criteria were amended to have a higher bed capacity in order to have higher staffing numbers to recruit sufficient staff participants.

It also became apparent that many of the sites with smaller bed numbers were not compliant with the National Quality Standards for Residential Care Settings for Older People (HIQA, 2009) and were undergoing refurbishment and change. This resulted in two sites initially selected as pilot study sites not being suitable to participate. Therefore, the site selection criterion for the main study was amended to a bed capacity of 40+.

4.2.3 Participant Recruitment

The researcher, who made regular informal visits to the site over a three-week period with the aim of building relationships with the staff, encountered apprehension about engaging in the study. Only three RNs and two HCAs agreed to participate. On reflection, the three-week timeline for relationship-building was too short. Although not gathering data during this period, the researcher developed an awareness and knowledge of the site, the staff and residents and the routine of the site. Through informal discussions between staff and the researcher, it emerged that staff had concerns and were suspicious of the motives of the researcher. Their initial concerns were that the researcher was a regulatory inspector, might report to 'management' what was observed and heard at interview, and was assessing their clinical practice and care delivery. It took numerous visits over two months on the pilot site to reassure staff that the objective of data collection was for research purposes only. Through relationship-building and additional communication and information sessions during the site visits, participant recruitment subsequently increased to 70% of all RNs and HCAs. As a result, the recruitment process and timelines for the main study were extended and additional time was built in for relationship-building.

During the site access process, the Director of Nursing (DoN) approved releasing staff to attend the interviews. The DoN had also preapproved time in lieu for consenting staff participants to attend for interview when they were off duty if staff preferred this option. However, staff were clear that they would only be willing to attend for interview while on duty. As the pilot site had a maximum of three RNs and five HCAs on duty for any shift period, this restricted the number of participants who would be available for a focus-group interview. This reinforced the need for a site with more bed capacity in order to access adequate numbers of RN and HCAs.

4.2.4 Consent process for residents

Residents were not included as primary study participants, however, because the study was conducted in their 'home' and observation data collection methods were to be applied. The researcher did not plan to undertake observations in residents' bedrooms or personal spaces, but would do so in the communal sitting-room, dining-room and corridors. Residents did not need to be identified, and resident data (care plans, nursing notes) were anonymised prior to data collection. Therefore, resident personal data were not accessed or processed. Informed written consent was sought from residents through the participant consent process. Resident consent packs, each with a letter of invitation, research study information leaflet, consent form and a stamped addressed envelope, were distributed by the gatekeeper. A more simplified information leaflet was included in the resident consent pack (appendix 3). Information sessions were delivered by the researcher to the resident forums in each CS site and the researcher attended the CS sites to respond to resident or family queries. A number of residents with cognitive impairment could not provide written consent, and it became apparent that seeking written consent increased anxiety and concern for residents and their families. In addition, the gatekeeper and Director of Nursing advised that many residents were reluctant to sign the consent form as they were concerned that signing a form may be related to care fees and charges. Therefore, the researcher was restricted in observational data collection in the pilot site due to a low number (six) of consenting residents. As the researcher wished to include the residents as secondary participants in the study, amendments to the REC applications were sought, requesting that residents who had capacity to consent but were reluctant to provide written consent could provide verbal consent. The gatekeeper in each CS site was identified as most appropriate to seek verbal consent from residents who did not provide written consent but were willing to participate in the study. The gatekeeper knew the residents, were aware of each resident's decision-making capacity, were best placed to understand the preferences of the residents and understood the principles of informed consent (3.7.1). Both RECs approved the application for amendments to accept written or verbal informed consent from residents.

4.2.5 Focus-group Interviewing

Four focus-group sessions were scheduled in the pilot site, with two HCA groups and two RN groups, comprising three to five participants in each group. However, as the participants were only available when on duty, it was challenging to convene a focus group with more than three participants. There was a need to plan focus groups when adequate numbers of RNs and HCAs were on duty. Staff appeared to be comfortable and amenable when interviewed in groups. Core areas where the researcher skills were enhanced included preparation of interview room, setting the scene, and

respectful listening. The researcher also became more aware of how to phrase questions so they were not leading the participants, and how to maintain neutral facial expression and an impartial presence. Some of the questions were modified as it became clear that participants did not understand them fully; e.g. *Tell me what you think are the opportunities (positive possibilities) in the future in relation to delegation?* was changed to *What are the opportunities for delegation going forward?* And *To what extent do you think team working within the patient care team is related to delegation? If so, how?* was changed to *How do nurses and healthcare assistants work as a team?* This learning was reflected in amendments to the interview question schedule for the main study.

4.2.6 Learning on Documentary Review

For the documentary data collection, the researcher designed a list of possible documents that were related to delegation of tasks, and requested the DoN to complete the list. The approach for appraising and synthesising documents was tested. This was found to be a reliable system of synthesising the documents available for analysis. For the resident care chart review, it had been anticipated that a clerical officer would copy the charts and de-identify the residents by 'blacking out' their names and other identifiable data. Copies would be reviewed on site and shredded immediately after. However, the DoN was reluctant to support this, estimating that a minimum of ten working hours were required, which equated to two working days. An alternative proposal was that an RN on the pilot site would assist the researcher. The RN attended with the researcher in each unit's nursing office, and the RN covered the name of residents on the resident documents, therefore anonymising the data. Using this approach, the researcher reviewed in one afternoon all residents' daily nursing care plans that were available on the ward. This approach, which protected the confidentiality of the resident and staff and was an efficient method of collecting specific data from a large volume of documents, was applied in the main study.

4.2.7 Learning on Non-Participant Observation

In addition to the challenges of low numbers of RN and HCA participants to observe and the reluctance to participate, other learning occurred, including the importance of spending time building relationships. With approximately thirteen visits to the pilot site, over a three-month period, staff became more friendly and familiar with the researcher, greeting her by her first name on arrival, and staff invited her to join them on coffee breaks. Prolonged engagement and immersion enabled the researcher to build up a relationship with participants and staff became familiar with the researcher on the wards. Staff who originally had not wished to participate in the study approached the researcher requesting and consenting to participate.

The researcher also found that recording field notes and memos immediately after non-participant observations contributed to quality data collection and developing an understanding for the case; for example, memos were recorded to ask at interview when the researcher could not observe RN and HCA together, e.g. in a resident's room when the door was closed.

4.2.8 Reflexivity

Personal thoughts, perceptions and observations were recorded in a reflexive diary. This required skill development; the researcher had experience of undertaking reflection in her role as a nurse but the reflexivity required her to focus on her reflections in the context of the study, including how she formed opinions on the case, the site and the participants. The researcher was concerned that the reflexive diary did not provide a method to facilitate systematic reflection of the researcher's role in all phases of the research study, and thus subsequently sought a more structured reflexivity process to apply in the case study: a reflexivity matrix (section 4.10.1).

4.2.9 Summary of Pilot Study Experience and Learning

The experience and learning from the pilot study guided amendments to the case study methods for the main study sites. The minimum bed capacity for the site selection criteria was increased to 40 beds. The process of site access, site entry and participant recruitment was reviewed and additional time (of up to 6 months) and site visits were included to support relationship-building. The inclusion of residents in the study, whilst respecting their privacy and rights, was addressed through process consent. The pilot study enabled the (novice qualitative) researcher to test data collection processes and techniques. Procedures were revised within the focus-group interviews, non-participant observations, documentary review and reflexivity methods to reflect the learning. The pilot case study also provided clarity on the appropriateness of the study design.

4.3 Main Study

Two cases were selected as this allowed an in-depth, detailed study of different aspects and parts (subunits of analysis) within a case and between cases. The methods applied in this multiple case study are described in the following sections. Figure 4.1 presents the case study, identifying Case A and Case B, the context, the subunits of analysis and the quintain.

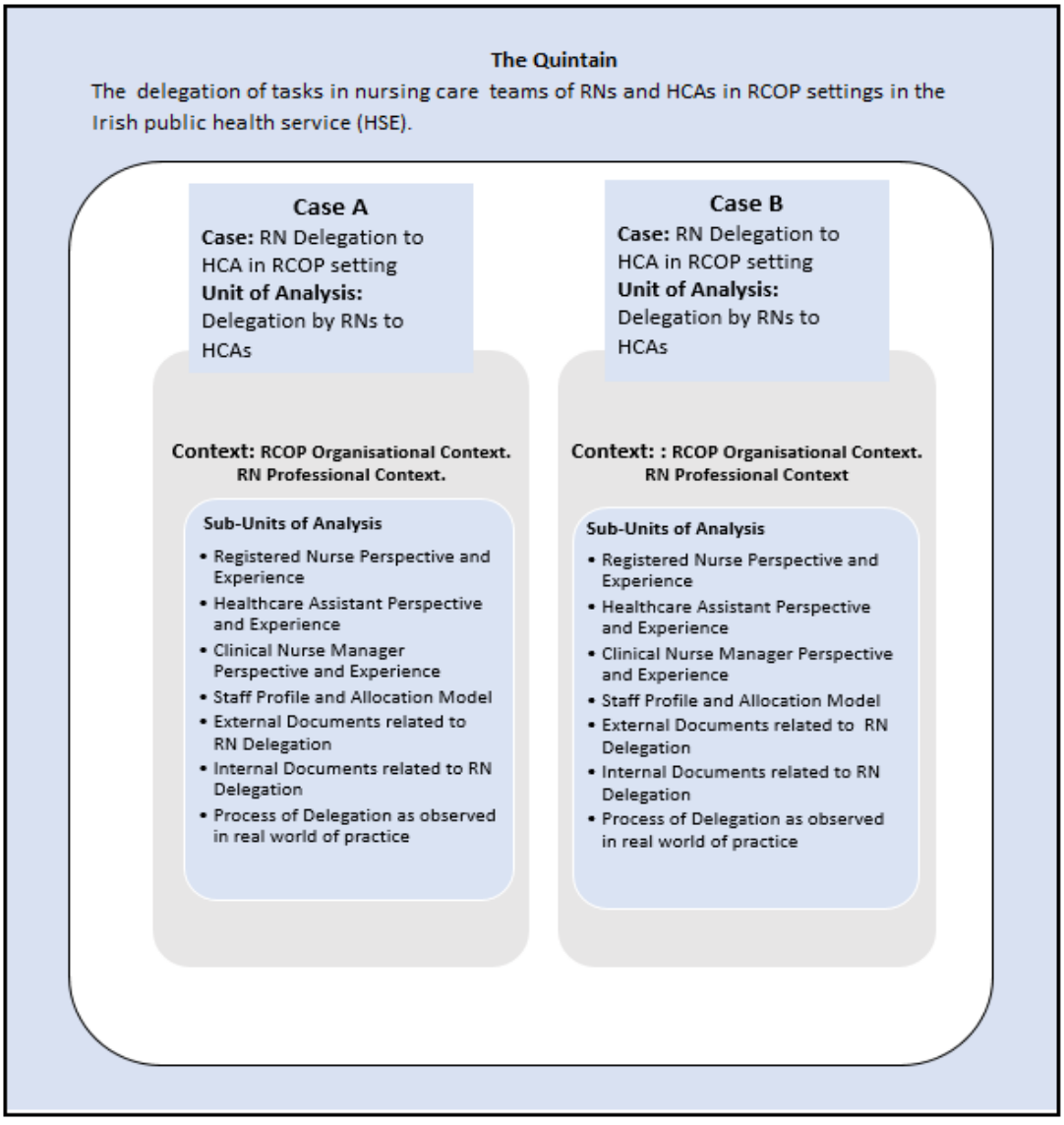
4.4 Case Study Site Selection and Site Access

All HSE RCOP sites on the east coast of Ireland were considered potential sites for this study as they reflect a typical span of bed numbers and RN:HCA skill mix in Ireland. As the regulations and standards

for the provision of care (HIQA Standards) guide RCOP service design and compliance, the selection of average size settings was deemed most appropriate. Many of the smaller and larger RCOP sites were in a process of reconfiguration to comply with HIQA standards. Cases in multiple case study research must be similar in some ways (Stake, 2006). Although both case study cases were undertaken within public health older person service sites and are a purposeful sample within the 'typical' case selection criteria, there were, as outlined below, variables in the context that differentiated one from the other:

- Geographic location: Case A and Case B were in different geographic locations along the east coast of Ireland.
- Governance: Case A and Case B were within different Community Healthcare Organisation Areas and therefore managed by different HSE senior management teams.

Figure 4.1: Multiple Case Study: Delegation by RNs to HCAs in RCOP



4.4.1 Case Study Site Selection Criteria

The criteria for site selection were based on typical rather than unique cases. A typical case (Stake, 2009; Yin, 2014) was selected for this study as the objective was to represent cases that were ordinary or average, and not extreme or unique, in an attempt to be representative of other cases. The researcher also restricted the site selection to public health service only as the researcher works in and contributes to workforce planning in the public health service. Based on the learning from the pilot, sites with fewer than 40 and more than 100 beds were excluded. *Typical*, for this CSR, was defined as a HSE RCOP setting, of average bed size, with an RN:HCA skill mix of 60:40 to 40:60 , and in a stable environment – that is, an RCOP setting that was not undergoing refurbishment, bed size or staffing changes, to comply with HIQA standards for a designated centre of care. The inclusion and exclusion criteria for case study site selection are outlined in Table 4.1.

Table 4.1: Site Selection Inclusion and Exclusion Criteria

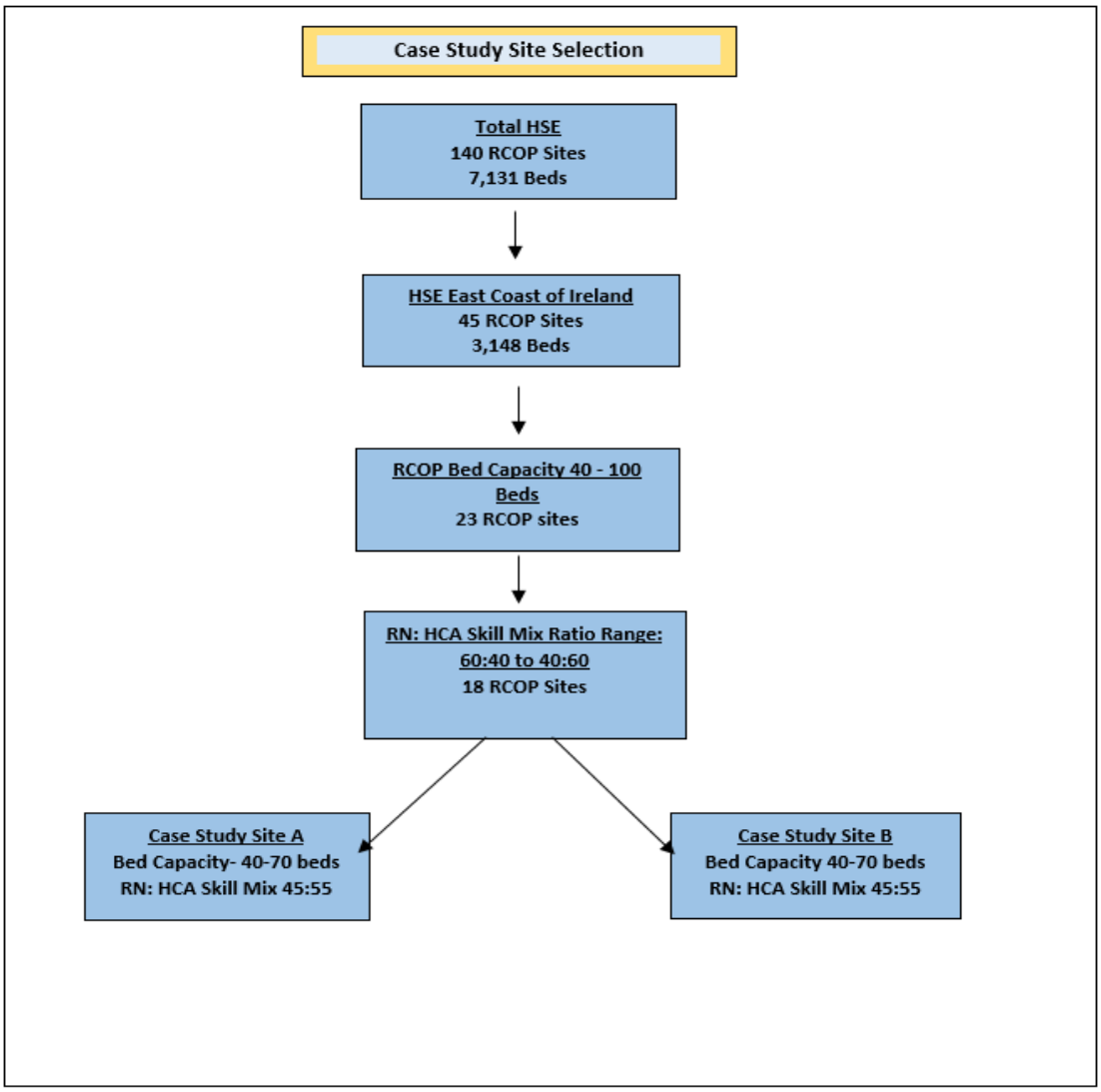
Site Selection Inclusion and Exclusion Criteria	
Inclusion Criteria	**Exclusion Criteria**
• Health Service Executive (HSE) residential care for older people facility (RCOP) site • Approximate skill mix ratio of RNs to HCAs of 60:40 to 40:60 • More than 40, fewer than 100 resident beds • Located on the east coast of Ireland • Director of Nursing (DoN) support for site access Nominated gatekeeper to control researcher access to the site and participants	• Non-HSE RCOP site • RN:HCA skill mix ratio outside 60:40 to 40:60 • No DoN to support site access • No gatekeeper • Significant site refurbishment

The sampling framework for site selection was based on the HSE April 2016 bed register for Older Peoples Services (HSE, 2016) data (Figure 4.2). All RCOP sites in the HSE that met the inclusion criteria were included in the selection process (n=18). These sites were then randomly selected. Names of the selected RCOP sites were placed on paper slips in a container. A work colleague blindly picked two individual paper slips and identified the sites to be approached for selection. The researcher then contacted each site to establish if they were willing to participate in the study. The first two sites initially agreed to participate, but they had to withdraw due to refurbishment, thus not meeting the inclusion criteria. Another selected site withdrew due to a reducing ratio of RNs and thus could not assure the researcher that there would be a minimum number of RNs available for observation and interview data collection. The next two sites on the random selection list agreed to participate.

4.4.2 Justification for RN:HCA Skill Mix Ratio 60:40 to 40:60 Selection

The ratio of RNs to HCAs in nursing teams in RCOP is currently planned and funded at approximately 50:50 skill mix, although RN:HCA ratios vary across services. As identified in the literature review, with higher ratios of RNs to HCAs there would be less delegation as more nurses are available to deliver direct care. In nursing teams with lower ratios of RNs to HCAs there would be more delegation to HCAs, as lower numbers of RNs are unable to deliver all care to all residents, and often prioritise non-direct care responsibilities and other care activities. Also, the ratio of RNs in RCOP was progressively decreasing, and nursing homes with higher RN ratios were not common or stable (could change between working shifts). Therefore, RCOP sites with a RN:HCA skill mix ratio range of 60:40 to 40:60 were included in the sampling framework to select the study sites.

Figure 4.2: Case Study Selection



4.5 Case Study Site Access

In advance of data collection, the researcher engaged with the two case study sites to build relationships and trust (Table 4.2). The process of initiating site access and seeking ethical approval to undertake the research was undertaken in advance of data collection. Information on the study was provided in writing and verbally to staff and residents in each case study site (Table 4.2). The site access process commenced two months in advance of data collection.

Table 4.2: Site Access and Participant Recruitment Process – Overview and Timeline

Action	Detail	Case A	Case B
Initiate Site Access	Introductory Meetings with Director of Nursing and Clinical Nurse Managers. Confirm within criteria for site selection. March 2017: Selected site withdrew as temporarily relocation due to site refurbishment, therefore no longer within selection criteria. April 2017: Selected site no longer suitable due to staff shortages and industrial relation issues, therefore no longer within selection criteria	Aril – May 2017	October 2016 April 2017
Research Ethics Approval	HSE REC Approval – November 2016 NUIG REC Approval – December 2016 Amendments sought and approved by both RECs May 2017	Approved	Approved
Participant Recruitment	Commenced site visits and information sessions, ward visits and non-data collection observation sessions. Invitation to Participate Packs (labelled *Resident* and *Staff*): Invitation Letter, Information Leaflet, Consent Form and stamped addressed envelope; delivered to Gate Keeper. Participant Reminder through Gate Keeper	Commenced 24th May – end June 2017. 2nd June 12th June	Commenced 22nd May – end June 2017 1st June 12th June
Staff Introductions and Information Sessions	Formal Staff Meetings Case A- All meetings were scheduled between 8am to 9am Case B- All meetings were scheduled between 11am and 12 midday	24th May 30th May 31st May 2nd June	26th May 29th May 1st June 7th June
Resident Introductions and Information Sessions	Met RCOP Resident Groups formally and explained study, resident involvement, and process consent. Answered questions. Informally met and had discussion with residents during site visits. Received phone call from 3 family members of 3 residents in relation to the study. They requested explanation on the study and how data collection would affect the resident. They were reassured and were supportive of the study.	Resident Meetings: 24th May & 30th May. Informal site visits & ward level discussions to end June 2017	Resident Meeting: 22nd May. Informal site visits & ward level discussions to end June 2017
Data Collection	Commence Case Study Data Collection	June 2017	June 2017

In advance of the study, the researcher contacted the site service managers and DoNs to arrange introductions, explain the proposed study and seek permission to access the site. Site participation

depended on the approval and consent of each site DoN and service manager. The researcher met with the DoN to discuss the study and data collection methods. The DoN nominated a gatekeeper, who on both sites was an assistant DoN, and who distributed study information packs, arranged and confirmed convenient times and dates for information sessions, and established capacity for undertaking interviews on site. The researcher visited the sites in advance of data collection to introduce herself on the case study site wards, explain the study to as many staff and residents as possible, and to build relationships.

4.6 Participant Selection and Recruitment

The sample population were RNs and HCAs working in nursing care teams – namely, RNs, CNM2s and HCAs in RCOP facilities. All inpatient wards/units of the RCOP were included. The research study participants were divided into two groups: primary research participants; RNs and HCAs who worked in the selected RCOP, and secondary participants; residents in the selected RCOP (Table 4.3). The terms *primary* and *secondary* participants were used by the researcher to distinguish between staff and residents as study participants. Participants were selected based on the inclusion and exclusion criteria presented in Table 4.3.

Table 4.3: Research Participant Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
Primary Research Participants: Registered Nurses and Care Assistants - Registered nurses, i.e. nurses registered on the live register of the Nursing and Midwifery Board of Ireland, who worked on the study site ward. - Care Assistants who provided direct patient care and work on the study site ward.	*Primary Research Participants: Registered Nurses and Health Care Assistants* - Employees on the ward or unit who were neither a Registered Nurse or a Health Care Assistant.
Secondary Research Participants: Residents in Residential Care Unit - Residents on the two sites who consented to participate in the study.	*Secondary Research Participants: Residents in Residential Care Unit* Residents on the two sites - unwilling to participate in the study - did not have capacity to consent to participate in the study - who clinical staff on site identified as having a profound cognitive impairment and/or who would become distressed by the presence of the researcher. -

Posters explaining the study, inviting participation and including dates and times for onsite information sessions were advertised within the study sites. Residents, RNs and HCAs were invited to

participate by letter of invitation, which included a consent form, information leaflet and stamped addressed envelope (s.a.e.) (Appendix 3). There were two information leaflets designed for the residents information pack. One resident information leaflet was similar to the staff information leaflet; the second, shorter version was designed with simpler language and images to assist understanding for those with a cognitive impairment. The letters were distributed to all residents, RNs and HCAs by the assistant DoNs one month in advance of the proposed date to commence data collection. In addition to the information packs and general information sessions, the researcher attended resident forums on each case study site to meet with residents and explain the study (Table 4.2). Where the residents, their family and/or carers requested, the researcher met with them to explain the study. The researcher also responded to a number of telephone calls and onsite face-to-face enquiries from close family residents who had reviewed the information pack on behalf of the resident.

The researcher attended the sites and provided formal information sessions at times and dates that were convenient to the sites; three information sessions were delivered on both the Case A and Case B sites (Table 4.2). However, the researcher continued to visit the sites on an informal basis in June and July 2017 to meet with as many staff as possible, to enable them to become familiar with the researcher. These periods in turn enabled the researcher to build trust and familiarity with staff. The RNs and HCAs willing to participate returned the signed consent form in the s.a.e. directly to the researcher. Staff consenting to participate in observation data collection incrementally increased from June to October 2017 to:

- Case A: 1 CNM, 13 RNs (representing 72% of RNs), 17 HCAs (71% of HCAs)
- Case B: 2 CNMs, 17 RNs (representing 85% of RNs), 27 HCAs (93% of HCAs)

4.6.1 Obtaining Resident Consent

The residents were secondary research participants as there was no requirement to observe or interview them. However, delegation of tasks by the RN to the HCA could occur in the presence of a resident and therefore the residents were potential secondary participants in the study. The DoNs and CNMs on the case study sites estimated that approximately 70% of residents had a significant cognitive impairment and had difficulties with communication. This was addressed from an ethical perspective. It was acknowledged that best practice recommends the inclusion of patients/residents with a cognitive impairment in research studies that are relevant to them. The pilot study found that some of the residents who had capacity to give consent were wary of signing forms, but were willing to give verbal consent. Both RECs approved amendments to accept written or verbal consent from residents

who were willing to be included as secondary participants. Therefore, the gatekeeper sought verbal consent, as they knew the residents, were aware of each resident's decision-making capacity, and were best placed to understand the preferences of the residents. This approach was used because, as secondary research participants, there was no personal data being collected. Subsequently, at each observation data collection period process consent was applied where the gatekeeper and researcher confirmed with the resident their willingness and agreement to be included at each particular data collection period. In Case A 17% of residents and in Case B 20% of residents provided written consent, and a further 12% (Case A) and 10% (Case B) were recorded as providing verbal consent to participate.

The researcher applied the process consent method to include as many residents as possible while respecting the dignity, confidentiality and personal preferences of each resident to be included or excluded as participants. No identifiable resident data were sought, and non-participant observations were not undertaken in the residents' bedrooms or during personal care or interventions that would have intruded on their privacy and dignity. The gate keeper managed researcher access to areas where residents were present. The low resident participation rate resulted in observation data collection being challenging, as the identification of consenting residents was required when undertaking observations in communal areas of the wards. For observation data collection, the researcher confirmed consent with resident participants on the day of observation, as it was understood that residents might not wish to be included in data collection every day due to their personal feelings or circumstances on a given day. This was communicated directly by the resident to the researcher (verbally or non-verbally), or by care staff on the site who were familiar with the resident's preferences. Where a resident had not provided consent, and when a resident did not wish to be included (as conveyed through verbal and non-verbal communication or communication from the gatekeeper, caregiver or family member), the researcher did not undertake observation data collection in their presence.

4.7 Data Collection Methods

Data collection through focus-group interviews, non-participant observations and documentary review occurred over a nine-month period on both sites. Data collection and data analysis occurred concurrently. During data analysis it became apparent that data from CNM2s would enhance understanding of delegation. Data collection was therefore extended to allow for individual interviews with CNMs on both sites.

4.7.1 Non-Participant Structured Observations

The researcher developed a non-participant structured observation template, adapted from a HSE

practice development guide. The template guided data collection based on the process of delegation (Table 4.4). This guided the researcher to focus on observing for evidence of delegation and to observe how CNM2s, RNs and HCAs worked together in their normal work environment and shared tasks. Observational data collection only occurred when a minimum of one consenting RN and one consenting HCA were on duty. The researcher arranged regular visits to the sites and confirmed through reviewing the duty roster when consenting participants were on duty.

Table 4.4: Non-Participant Observational Data Collection Template

<table>
<tr><td colspan="4">Non-participant Observational data will be undertaken by Deirdre Mulligan. The focus of observation is the process of delegation by Registered nurses to Health Care Assistant in HSE Residential Care Units. The observations will form part of a research study for a Doctorate in Nursing Practice (DNP) programme</td></tr>
<tr><td colspan="2" rowspan="2">Focus of Observation:

Delegation of Tasks by Registered Nurses to Health Care Assistants</td><td>Residential Care Unit</td><td></td></tr>
<tr><td>Date</td><td></td></tr>
<tr><td>Time</td><td>Verbatim quotes from participants</td><td>Observation Notes</td><td>Observer Reflection/Comments/Questions</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="4">Adapted from: Enhancing Care for Older People: A Guide to Practice Development Processes to Support and Enhance Care in Residential Settings for Older People (HSE, 2010, p.69).</td></tr>
</table>

The observations occurred during periods when RNs and HCAs worked together and delegation was expected to occur. Therefore, the researcher attended during day duty and night duty handover reports, after the handover report, peak resident care delivery periods (morning personal care and assisted meal times) and staff meal break periods. The observation periods were continuously negotiated and managed as different staff were on duty during observation periods. Initially, it was challenging to organise data collection when there was one consenting RN and one consenting HCA on duty together. However, as participant numbers increased this became less of an issue.

The researcher prior to and during data collection was aware of the importance of impression management, and thus wore her work identification badge and a visitor badge to identify herself and reassure staff and residents that, although she was a HSE employee, she was in the RCOP facility as a researcher. She wore plain trousers and top and low, soft-heeled shoes to be less obvious and to walk around the wards quietly. Mobile positioning allowed the researcher to move between areas to capture any potential periods of delegation. The researcher restricted interactions with the participants and positioned herself as discreetly as possible during observations, e.g. sat on a stool behind a nurses station in the corridor, sat at edge of office during and after the handover report. In each data collection period, the researcher explained the study again if required, answered any questions and confirmed with the resident that they were still happy to participate. As the observational data collection progressed, the staff and residents appeared to take less notice of the researcher's presence. Field notes of observations were collated using a small tape recorder and also on the observation template (Table 4.4). After data collection, reflections and memos were recorded. The researcher undertook a total of 27 hours of non-participant observational data collection.

4.7.2 Interviews

Focus-group and individual interviews were used in this study. The application of the interview methods is outlined below.

4.7.2.1 Focus-group Interviews

The researcher developed a guide with procedures for conducting the focus-group interviews. The interview questions were developed using the themes from the literature review, guided by the research question and objectives of the study. A semi-structured interview format was used, which allowed the focus to remain on the phenomenon being studied while enabling participants to describe their experiences, opinions and understanding of delegation.

Interview times were guided by the gatekeeper and DoNs; periods of least ward activity were proposed as most appropriate for interviews. This was 2pm in Case A, and 11am in Case B. Interviews were undertaken in a private room, away from the main activity of the wards. The researcher arrived to the interview room in advance to set up the room. The chairs were arranged in a circular format, room temperature and ventilation were set for the comfort of the participants, the audio recorder was tested, and water and snacks were provided. At the start of each interview, participants were welcomed, the objective of the research study and focus-group interview was reiterated, and participants were reminded that the interviews would be were recorded but their personal identification would be protected, with no names recorded in transcription or field notes. Confirmation of written informed consent was undertaken by the researcher. Demographic data on interview participants were recorded at each interview. Participant names were not recorded as it was considered that participants would speak more freely and candidly if they could not be identified (see Tables 4.5 and 4.6 for the interview participant profiles).

Table 4.5: Case Study A: Interview Participant Profile

Staff Grade	Number of Participants	Age (years)	Working	Years Working in this Nursing Home	Highest Level of Education Received
Registered Nurse	6	40–59 = 6	Full-time = 4 Part-time = 2	0–5 years =2 11–20 years =4	Diploma = 2 Degree = 4
Health Care Assistant	7	20–39 = 1 40–59 = 6	Full-time = 3 Part-time = 4	0–5 years = 2 6–10 years = 1 11–20 years =4	QQI Level 5 = 7

Table 4.6: Case Study B: Interview Participant Profile

Staff Grade	Number of Participants	Age (years)	Working	Years Working in this Nursing Home	Highest Level of Education Received
Registered Nurse	10	20–39 = 2 40–59 = 7 50–65 = 1	Full-time = 5 Part-time = 5	0–5 = 2 11–20 = 4 21 + = 4	Certificate = 2 Diploma = 1 Degree = 7
Health Care Assistant	8	20–39 = 1 40–59 = 5 50–65 = 2	Full-time = 3 Part-time = 5	11–20 = 3 21+ = 5	Junior Cert = 2 Leaving Cert = 1 QQI Level 5 = 4 Diploma = 1

The interview questions were asked as outlined in the interview guide but allowance was made to explore other concepts or issues raised by participants if related to the research question. All interviews were conducted following a similar process, from opening to closing the interview, e.g.

welcome, icebreaking discussion, moving from open-ended discussion to more topic-focused discussion (see Appendix 4). Ground rules were agreed at the beginning of each interview, including respectful listening, only one person speaking at a time, confidentiality of discussions, assurance of participant pseudonymity, and reminding participants of obligations for disclosure. Participants were reminded that there were no right or wrong answers, that everyone did not have to agree with each other, and that it was their personal experiences and opinion that was being explored. This reassured them and contributed to an honest and open discourse where they did not always agree with each other. Time was allowed for participants to consider, answer and discuss with each other. At times the researcher probed with additional questions based on the participants' responses, and allowed silences to enable participants to answer or respond to each other. Clarity was sought on vague responses or when a new concept emerged.

Despite DoNs approving time-in-lieu for consenting participants to attend for interview when they were off duty, on both sites, RNs and HCAs were reluctant to attend outside their working hours. The low ratio of RNs on duty on each roster shift dictated the number of RNs available for interview. Persistent RN shortages during data collection in Case A resulted in a reduced number of RNs on duty in each ward on most days. Therefore, it was not possible to have more than four RNs at a focus-group interview. Following extensive planning, communication and rescheduling, a second focus group was organised in Case A, with five RNs scheduled to participate. On the day, however, only two RNs participated. The researcher proceeded with the interview as it was unlikely that access would be gained to these staff members again and gathering the RN perspective was important Therefore, in total four focus-group interviews were conducted on each case study site: two focus groups with HCA staff, four in each group (one group with three HCAs) and two with RN staff with four to five RNs (one group with two participants).

4.7.2.2 Individual 1:1 Interviews

As data collection and data analysis cycles progressed, it became apparent that the CNM2 (Ward Manager) had an integral role in delegation of tasks to HCAs in both Case A and Case B, but a much stronger role in Case B. The researcher therefore sought to explore why there were differences or variations between wards and CNM2 practices of delegation. A focus-group interview was not possible because there was only one CNM2 in Case A and two CNM2s in Case B. Therefore, 1:1 individual interviews were used. Demographic data on interview participants was recorded at each interview (Table 4.7).

Access to the CNM had been ongoing during the study. The original staff participant information pack had been distributed to the CNMs. All three CNM2s had returned the completed informed consent

form at the initiation of the study. The researcher had developed a good relationship with the three CNMs on site visits. Interviews were conducted during working hours at times convenient for the CNM2, in a quiet room away from the ward. An interview guide (see Appendix 5) was developed for the individual interviews, guided by the focus-group interview guide and questions. Procedures for conducting the interview were included, including welcome, icebreaking discussion, moving from open-ended discussion to more topic-focused discussion. Interviews were audio-recorded. The CNM2s were assured of confidentiality and data protection. The individual interview data were included for analysis with the other data sources, thereby increasing rigour in this study by establishing thick descriptions, triangulation and confirmability.

Table 4.7: CNM2 Interview Participant Profile Case A and Case B

Case A CNM 2 Individual Participant Profile				
Number of Interviews	**Age Group**	**Length of time working in RCOP site**	**Working Full-time (FT) or Part-time (PT)**	**Highest Level of Education**
1	20 – 39 years old	0 – 5 years	FT	Master's Level 9
Case B CNM 2 Individual Participant Profile				
Number of Interviews	**Age Group**	**Length of time working in RCOP site**	**Working Full Time (FT) or Part Time (PT)**	**Highest Level of Education**
1	40 – 59 years old	21 years +	FT	PG Diploma
1	40 – 59 years old	21 years +	FT	Degree

4.7.3 Documentation Review

Documentary evidence particular to each case, which provided further insight into the process of delegation by RNs to HCAs, was included as data sources. A criterion for inclusion of documents was developed, guided by the document analysis procedure. This inclusion criterion contributed to the rigour of the study by developing a system for establishing authenticity and relevance of the sourced documents (Table 4.8). The sources of the documents included in the documentary analysis were identified as either external or internal to the case study sites. There were no time limits as the researcher sought documents dating back to the participants' original employment period, e.g. job specifications and training records. These criteria enabled the researcher to include all relevant document data sources of each bounded case. External documents were sourced online or by email

request within the organisation. External regulation and standards documents were included (Table 4.8). On receipt of ethical approval, internal documents were sourced. Directors of Nursing identified internal documents by completing a short survey (see Appendix 6) of internal policies, protocols, procedures and guidelines (PPPGs) relating to delegation, education relating to delegation and other internal documents (Table 4.8). The review of staff training records, nursing daily records and documents that identified task responsibility or guidance on delegation were considered significant data sources to provide a rich description of the phenomenon.

Two ratings were created, one based on relevance to delegation in the context of RNs to HCAs in RCOP, and one based on the credibility or trustworthiness of the document (Table 4.8). The criteria were as follows:

- Source: External documents reviewed as they related to the phenomenon (delegation of tasks by RNs to HCAs). Internal documents providing evidence of how delegation of tasks by RNs to HCA occurred in each case. This reassured the researcher that documents from all available sources were included, providing a variety of perspectives.
- Relevance Rating: If delegation was a key theme of significant focus, it was given a relevance rating of between 4 (highest) and 0 (lowest). This guided the researcher on the level of importance of the documents reviewed and included in the analysis. No documents sourced were given a 4 rating. If delegation by RNs to HCAs was integral to the topic in the document it was rated at 3, e.g. NMBI scope of practice. If delegation was not referred to but the document was of relevance to the research question, it was rated at 2, e.g. staff nurse job specification. If delegation was not referred to in a document included in the review it was rated at 1, e.g. resident care records.
- Credibility and Trustworthiness of Document (unbiased evidence): The rating – 4 for most credible and trusted to 1 for least credible and trusted – included consideration of the document author(s) being recognised as an expert in relation to delegation by RNs. This guided the researcher in critically considering the authenticity and accuracy of documents reviewed.

Table 4.8: Case Study Document Analysis and Rating for Inclusion Results

Document Title	Author	Source (Internal/External)	Year	Relevance Rating	Credibility of document
Code-of-Professional-Conduct-and-Ethics-2014 & 2021 NMBI	NMBI	External	2014/21	3	4
Scope-of-Nursing-and-Midwifery-Practice-Framework	NMBI	External	2015	3	4
Nurse-registration-education-programme Standards and Requirements	NMBI	External	2016	2	4
National Standards for Residential Care Settings for Older People in Ireland	HIQA	External	2016	2	4
Case A 2015 HIQA Inspection Report	HIQA	External	2015	2	3
Case A 2017 HIQA Inspection Report	HIQA	External	2017	2	3
Systematic Literature Review Role of Nurse in OPS 2017	HSE	External	2017	3	3
Case A Nursing Daily Activity Sheet Narrative Notes	HSE	Internal	2018	2	4
Case A Ward Communication Diary		Internal	2018	2	4
Case A Internal Documents	HSE	Internal	2018	2	3
Job Specification Multi Task Attendant	HSE	External	2013	2	4
Job Specification Health Care Assistant	HSE	External	2013	3	4
Job Specification Staff Nurse General (Older Persons Services)	HSE	External	2016	3	4
NMBI working with older people: professional guidance	NMBI	External	2015	3	4
Case B 2016 HIQA Inspection Report	HIQA	External	2016	2	3
Case B 2017 HIQA Inspection Report	HIQA	External	2016	2	3
Job Spec for Staff Nurse Older Persons Services Case B	HSE	Internal	2013	2	4
Job Specification HCA Case B	HSE	Internal	2007	3	4
Job Specification MTA Case B	HSE	Internal	2007	2	4
Job Specification Multi Task Attendant	HSE	External	2013	2	4
Job Specification Staff Nurse General (Older Persons Services)	HSE	External	2016	3	4
Case B Nursing Care Plan	HSE	Internal	2018	2	4
Case B Ward Communication Diary	HSE	Internal	2018	2	4
Case B Internal Documents Ward G	HSE	Internal	2018	3	3
Case B Internal Documents Ward C	HSE	Internal	2018	2	3
Case A HIQA Standards and HIQA Inspections Review	HIQA	External	2018	2	3
FETAC Level 5 Module Descriptor Care Support 2004	FETAC	External	2004	2	3
Guidance for the assessment of centres for older people	HIQA	External	2017	2	4
HCA Education Programme Care Skills Module Descriptor	HSE	External	2016	2	4
HCA Education Programme Care Support Module Descriptor	HSE	External	2016	3	4
Programme Descriptor for Healthcare Support QQI L 5	Laois Offaly Education & Training	External	2013	2	4
Job Specification Clinical Nurse Manager 2 Older Persons Services	HSE	External	2014	3	4

The researcher developed a Nursing Care Plan Review Template (Appendix 7) to guide the focused review of residents' nursing care plan records for documented evidence of delegation by RNs or HCAs in the case. As requested by the researcher, an RN was in attendance in the nursing office on each of the four wards during the documentary review as a reassurance that resident confidentiality was not breached. Each resident had a hard-copy medical record. The nursing documentation for daily updates was sourced as the Daily Activity Sheet and Narrative Notes (Case A) and Daily Progress/Evaluation Form (Case B).

In Case A the Daily Activity Sheet was a tick-box template completed once during each day and night shift. It recorded care delivered through an identified number system which the RN or HCA marked in each section. This included personal care (personal hygiene care), nutrition and hydration (all mealtimes identified and special diet arrangements), continence and elimination (listed and numbered), care documents, and a section for the RN or HCA to sign (signature and status). The resident Narrative Notes, completed by RNs only, included a free text section to record specific care-related issues for the resident. In Case B the Daily Progress/Evaluation Form was used by RNs to document daily updates on care, generally completed once during the day shift and once during the night shift. This was a free-text document completed only by an RN. There was no Daily Activity Sheet in Case B; resident personal care, continence, elimination and nutrition was not recorded in one common document.

In both cases the Ward Communication Diary was a hard-bound, A4 paper diary, stored in the nurses office of each ward. It identified particular activities scheduled to occur or that had occurred, e.g. resident appointments in external hospitals, blood results and urine laboratory results for individual residents, equipment maintenance, and notes regarding stores orders. In both Case A and Case B, an RN reviewed the diary in the presence of the researcher, looking for words or terms associated with delegation as per the Nursing Care Plan Review Template (Appendix 7). Each page (date) in the diary was reviewed for evidence of delegation. In Case B the staff on duty recorded who the nurse-in-charge of shift was (asterix marking RN name) and the allocation to teams. The Nursing Care Plan Review Template was used to guide ward diary review and data collection. This approach protected the confidentiality of the residents and staff, and was an efficient method of collecting specific data from a large volume of documents. Breach of confidentiality and data protection risks were reduced. Case A provided documentary evidence of staff task lists for RNs and HCAs that were included. Case B did not have similar lists or guidance documents.

4.7.4 Data Collection Methods Summary

Triangulation of data sources was used in this CSR to draw conclusions across different sources, providing an in-depth understanding of the case. All methods were considered primary sources of data. Data collection from the different sources occurred over the same period; i.e. interviews, non-participant observations and documentary review were scheduled over the same period. This allowed the researcher to ask questions at interview in relation to observed or documented data, and to observe what was described at interviews and in documents. For example, HCAs and RNs described at interview that all RNs did not delegate and rather it was the CNM or a nurse-in charge; the researcher sought to confirm this during observation periods. The large volume of data from each case was managed using NVivo data management software.

4.8 CAQDAS Data Management

CAQDAS (Computer Assisted Qualitative Data Analysis Software), NVivo 11, later updated to NVivo 12, was used in this study for data management. The researcher undertook NVivo training and developed her competence in using NVivo software to support data analysis and subsequent reporting. All data, external and internal documents, transcribed observations and interview data were transferred to NVivo, in separate folders. All data for Case A and all data for Case B were set up separately on NVivo to enable within-case and cross-case analysis. NVivo supported the application of the interactive model and fundamental steps chosen therein for data analysis. In first-cycle coding, the initial codes were referred to as free nodes in NVivo. Second-cycle coding, pattern codes, were described in NVivo as data display, where using tree nodes, nodes with clusters of data related to each other, were created. Relationship nodes identified how different themes and categories were related and provide a visual of these relationships. Jottings were captured as 'annotations' and analytic memos as 'memos' on NVivo. Data were set up as a 'project' on NVivo, each dated as they were developed. The previous NVivo projects were retained and stored. This created an audit trail, allowing the researcher to review earlier projects to demonstrate analytical progress and decisions through each step of the analytical approach.

The application of NVivo is included in the following description of the interactive data analytical approach.

4.9 Interactive Data Analysis Approach

There is no consensus on a generic analytical approach for case study research, but a systematic approach is required for data analysis that can demonstrate a chain of evidence linking the case study

findings to the multiple sources of data. The interactive model of thematic data analysis as proposed by Miles et al. (2020) was used in this study as it allowed data to be organised and displayed, supporting robust interpretation and reporting. In the interactive data analytical approach, there are four fundamental components: data collection, data condensation, data display, and conclusion drawing/verification. These components were consecutive and interactive throughout the data collection and analysis process. The application of the interactive model of data analysis is described in the next section. To provide structure and detail, the model is described under the headings of the analysis process described by Miles et al. (2020).

The initial step in the process was preparation of the data for analysis following *data collection*. There were four data sets: focus-group interviews, individual interviews, non-participant observations, and internal and external documentary data. Following each data collection period, the audio recordings from interviews and observations were transcribed verbatim. The accuracy of the transcriptions were verified by listening to the audio tapes or reading the notes while simultaneously reviewing the transcriptions, allowing the researcher to become immersed in the data. All documents and transcribed data were imported to NVivo as *sources*. Documents sourced external to the study sites were transferred to NVivo and stored as external sources. Data from the ward diary, resident nursing notes and other documents sourced internally at the study sites were stored as internal sources. All data for Case A and Case B were set up separately on NVivo to enable within-case and cross-case analysis. Four folders were set up as sources for *Focus Group Interviews, CNM2 Interviews, Observations,* and *Documentary Review* for each case. Homogenous groups, rather than individual participants, were set up on NVivo as data sources, name-tagged for each homogenous group, i.e. RN, HCA, CNM2.

The selection of the research question, the selection of typical cases, and the methods for data collection involved *anticipatory data condensation* in that the selection decisions in themselves condensed the data. The first- and second-cycle coding, creation of memos and subsequent theme development (described below) involved analytic decisions. As the analytical process progressed, the data were continually condensed and organised, enabling analytic decisions. This *pattern coding*, as described by Miles et al. (2020), was the analytical process of reducing the large amount of data from different sources and methods from codes to categories to themes. This occurred during the within-case and cross-case analysis. The matrix and display functions in NVivo provided the researcher with visual displays, enabling *data display*. The *drawing and verifying of conclusions* was an interactive process as the researcher continually examined the data for new patterns.

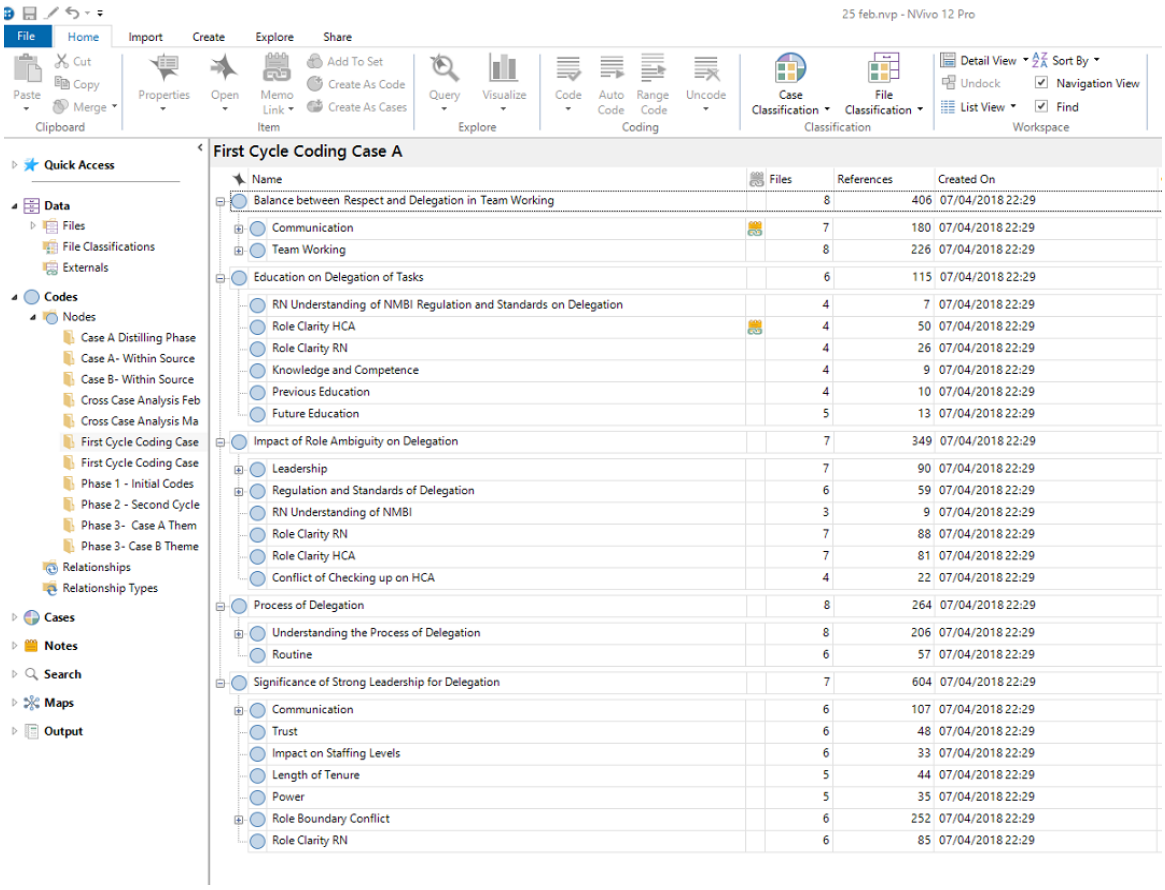
This data analytical process is described under the headings: first-cycle coding, second-cycle coding,

jotting, analytic memos, assertions and propositions, and closure and transition.

First-cycle coding

First-cycle coding used descriptive and *in vivo* coding to label the topic in a sentence or passage of data. Each data source was reviewed, line by line, in detail to identify a summary word, phrase or paragraph that described the core topic within passages of text. Codes were created and placed within *nodes* in NVivo, as *free nodes.* Deductive codes were developed from the research question and literature review (e.g. respect, relationship). Inductive codes were developed during data collection and first-cycle coding, and were also assigned to free nodes in NVivo (e.g. conflict of checking up on HCA) (Figure 4.3). All codes (free nodes) were defined with descriptions to ensure consistency in understanding and accuracy in the application of the codes. These descriptors were collated as a *codebook* in NVivo. The definitions and descriptions were continually revised through the codebook reports to ensure the coded data matched the code name. In the first-cycle coding there were initially 65 codes in Case A and 59 codes in Case B across all datasets. NVivo provided a matrix display functionality, allowing for visual display of the codes, the sources and references to each (sample of Case A first-cycle coding, Figure 4.3).

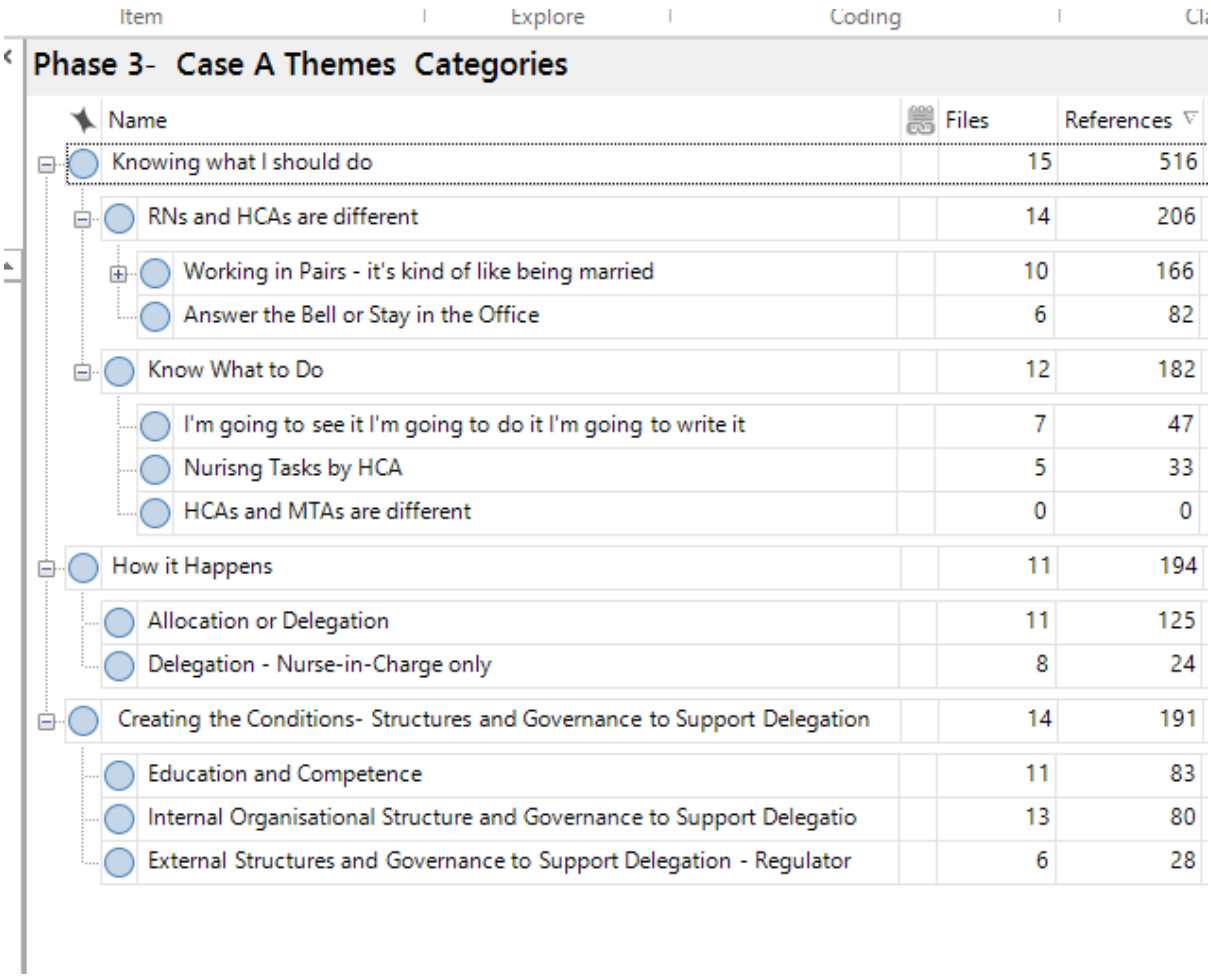
Figure 4.3: First Cycle Coding (source: NVivo-12 screenshot Case A project)



Second-cycle coding, pattern codes

In the second-cycle coding, or pattern coding, the data were reordered, renamed, merged and distilled. Here the first-cycle codes were clustered into meaningful groups of categories. Similar to the codes, each category was defined. As some categories became too large to analyse, subcategories were developed. Using NVivo, the free nodes were reconstructed and collated into clusters (tree node). The categories and sub-categories (tree nodes) were aggregated as parent nodes (category) with child nodes (sub-categories). For example, in Case A second-cycle coding (Figure 4.4), the parent node *Knowing what I should do* contained two categories (child nodes), with sub-categories in each category. This hierarchical structure (parent nodes and child nodes) organised the data and guided the researcher's thinking.

Figure 4.4: Case A Second Cycle Coding (source: NVivo screenshot Case A project)



This iterative cycle of reviewing and revising second-cycle codes continued until all data had been analysed. Rival explanations are central to QCSR to clarify and consider alternative meanings, causes,

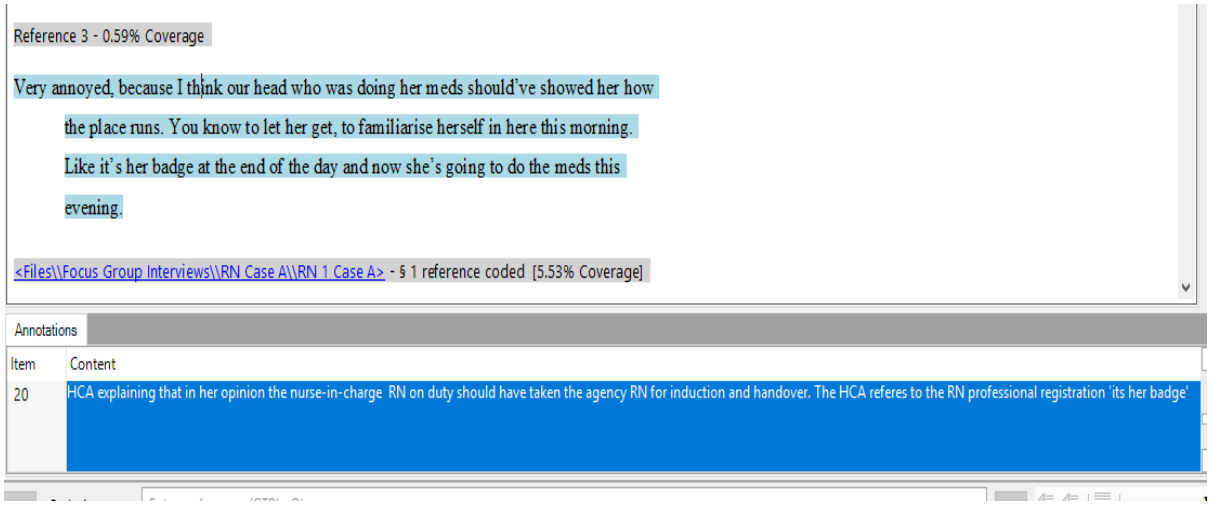
interventions and contexts. During second-cycle coding, rival explanations to the emerging patterns were considered. For example, the researcher had made early assumptions for why RNs did not delegate tasks, assuming that RNs did not want to delegate to HCAs who worked in the units a long time. However, rival explanations emerged, including conflicting role expectations between RN and HCA, and lack of clarity in roles and responsibilities. Persistent and apparently obvious patterns were crosschecked across all data sources to confirm the category. Questionable or weaker categories were revisited when other data sources were added. The nodes were continually revised by reorganising, merging and renaming the parent and child nodes (codes and categories). As the analysis progressed, assertions and propositions were used to interpret the data. In the final stages of the pattern coding, overarching themes were constructed from the categories.

4.9.1 Jottings and Analytic Memoing

Throughout the data collection and data analysis, the researcher recorded memos. These were often aligned to field notes taken during or immediately after data collection, but were also recorded during data immersion when reviewing transcripts, listening to audio recordings, and reviewing the data on NVivo. Handwritten memos were transferred to NVivo as *jottings* or *analytic memos* for inclusion in the data analysis. Jottings and analytic memos were also integral to the reflexivity process (described below).

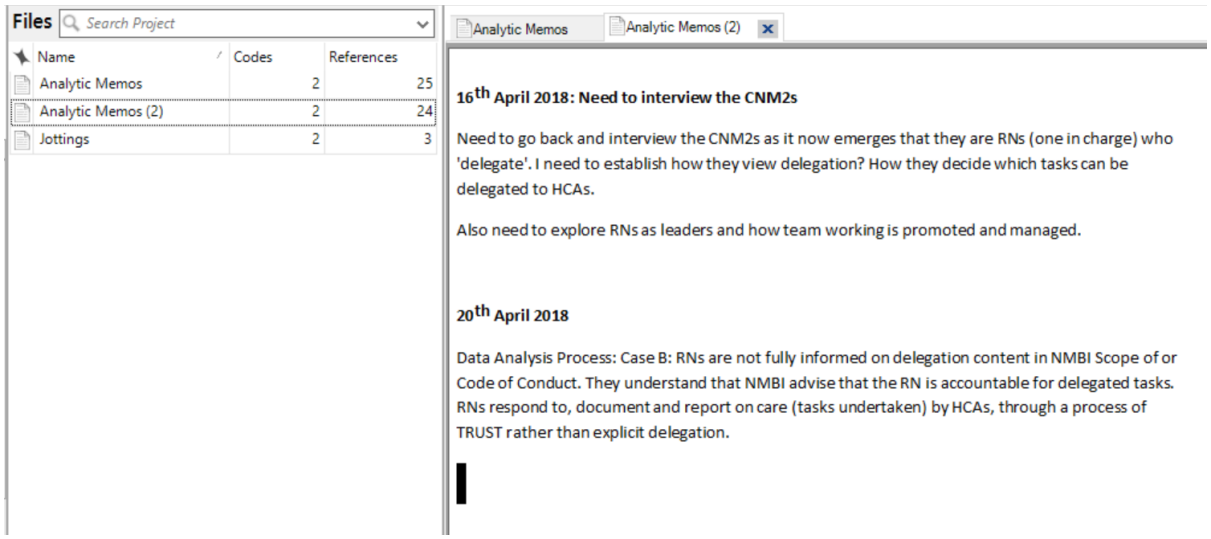
The researcher recorded personal thoughts, beliefs, reflections and assumptions as jottings, recorded as *annotations in NVivo*. The annotations function allowed the researcher to record the jottings beside sections of the data (see example in Figure 4.5). The jottings recorded in the annotations provided an 'aide memoir' for sections of data, and facilitated connections across the data. They also identified areas where the researcher may have held preconceived ideas and expectations. For example, the annotation in Figure 4.5 captured the researcher's jottings concerning the RN role in delegating or assigning tasks when HCAs reported that the nurse-in-charge had a responsibility to assign the agency staff.

Figure 4.5: Sample Memo (source: NVivo-12 screenshot Case A project annotation)



Analytic memos were used to record reflections and thought processes during the data analysis, focusing on the data synthesis and the transition through the levels of analysis. For example, the need to interview the CNM2s was noted during analysis, and how the RNs relied on 'trust' in place of delegation (Figure 4.6). Analytic memos recorded unpredicted or interesting findings in the data, thereby contributing to the analysis.

Figure 4.6: Example of Analytic Memo (source: NVivo-12 screenshot)



Through second-cycle coding, jottings and analytic memoing, the initial patterns emerged from the data for each case. These patterns were further analysed, synthesised and reordered to develop assertions and propositions.

4.9.2 Hypotheses, Assertions and Propositions

An *assertion* has been defined as "a declarative statement of summative synthesis, supported by confirming evidence from the data and revised when disconfirming evidence or discrepant cases require modification of the assertion" (Miles et al., 2020, p.93). Developing assertions and propositions promoted further analytical thinking, generating more focused and coherent explanations of the data. Examples of some of the assertions applied to the data are presented in Table 4.9. The assertions and propositions formalised the synthesis of data into a higher level of interpretation.

Table 4.9: Assertions

Assertions
Theme 1: Creating the Conditions
Assertion 1. There is no evidence of education specific to RN delegation.
Assertion 2. RNs understand their professional responsibility to delegate to HCAs.
Assertion 3. There is no evidence of policies, procedures or guidelines to support delegation by RNs to HCAs.
Theme 2: How it Happens
Assertion 4. There is no evidence of delegation by RNs to HCAs.
Assertion 5. Because of the 'routine' nature of care delivery and the length of tenure of HCAs working in RCOP sites, HCAs report no requirement for delegation.
Theme 3: Knowing What I Should Do
Assertion 6. There is RN role conflict for RNs as they must prioritise office-based work over direct care delivery.
Assertion 7. HCAs do not need the RN to delegate to them because they know what they have to do.

A proposition is defined as a "statement that puts forth a conditional event – an if-then or why-because proposal that gets closer to prediction or theory" (Miles et al., 2020, p.93), or more simply as a declarative statement that is either true or false. Proposition statements were created to summarise the synthesis of the data. Examples of proposition statements 'if-then' and 'why-because' that were created are outlined in Table 4.10.

Table 4.10: Propositions

Propositions
Theme 1: Creating the Conditions
Proposition 1. If the ratio of RNs to HCAs decreases then the requirement for RNs to delegate increases.
Proposition 2. RNs do not delegate because there is an absence of organisation policies, procedures, guidelines and support for RN delegation.

Proposition 3. If RNs and HCAs were educated and competent in relation to their roles as delegator and delegate respectively, then there would be more delegation.

Theme 2: How it Happens

Proposition 4. HCAs working in a RCOP ward do not require tasks or activities delegated to them because they provide the majority of direct resident care within their role as a HCA.

Proposition 5. If the RCOP registration regulations (HIQA Standards) reflected the delegation and supervision role of the RN, then there would be more delegation by RNs to HCAs.

Theme 3: Knowing What I Should Do

Proposition 6. If the RN role consists of predominantly office-based work (documentation) and drug administration, then RN role conflict and role ambiguity will occur.

Proposition 7. Because there is no standardisation of the HCA job entry qualification requirements, education requirements or role responsibilities, then it is difficult to delegate safely.

Proposition 8. If the HCA does not understand the professional responsibility of the RN to delegate, then there will be role conflict.

The assertions and propositions supported the organisation and summary of the data synthesis. They also progressed the synthesis to a higher level of analysis, through in-depth analysis of comparisons and differences across sources, methods and cases, seeking rival explanations, and challenging the perceptions and position of the researcher.

4.9.3 Conclusion-drawing and Verification

The conclusion-drawing and verification of conclusions component is reported as within-case and cross-case analysis. However, similar to the other components, this was a continual and iterative process throughout the analytical process. The earlier assertions, propositions and patterns were verified or disconfirmed continually in the context of jottings and annotations.

Within-case and cross-case analysis

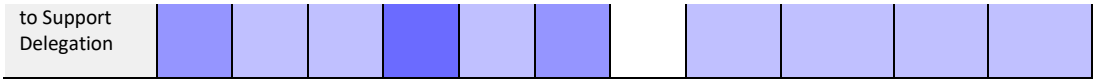
Within-case analysis of Case A was initially undertaken. Within each case, the subunits of analysis were documents, non-participant observations, focus-group interviews (RNs and CAs), and individual CNM2 interviews. Each subunit of analysis was analysed independently of all other sources, applying the interactive model of thematic analysis (Miles et al., 2020). The subunits of analysis were then collectively analysed within Case A. Three themes were developed. Each theme had numerous categories and sub-categories, which were continuously analysed and condensed in the data analytical process. A report on Case A findings was recorded to capture the case context. Similarly, within-case analysis of Case B was undertaken independent of Case A. A similar thematic analytical approach was

adopted. Similar themes were generated in Case B, and findings were also recorded as an independent record of the case. NVivo software enabled the researcher to view the themes and categories, interrogate the sources of data and condense the data. The process of linking back each category to the sources and data references enabled the stages of analysis and synthesis to be transparent.

Cross-case analysis was then undertaken, applying the case-orientated approach (Miles et al., 2020) whereby cases were compared for similarities, differences and constant associations (relationships). This analysis was undertaken using NVivo to merge the two sets of data (parent and child nodes) from Case A and Case B (Table 4.11). Miles et al. (2020) recommended the use of matrices and networks to display condensed data. These were generated to compare and contrast data between the two cases. Assertions and propositions were used to analyse related nodes across cases. NVivo 12 allowed the presentation of data that was coded into these nodes from both Case A and Case B. For example, the matrix (Table 4.11) across both cases provided a visual display to compare the number of references (coding) per theme and category between cases. The number of references coded per category demonstrated the degree of reference to each category from each data source. However, this did not confirm that the category was present or absent. For example, despite no evidence of the categories of delegation education or competence assessment in either case, the analysis from the observation data in Case A provided more knowledge in relation to how this absence existed, whereas this category was not as strong from Case B observation data analysis. HCAs in Case A were observed making resident care decisions (e.g. prioritising which resident to assist) independent of RN assignment, delegation or supervision. Matrix displays arranged coherently allowed for careful comparisons, identifying similarities and differences.

Table 4.11: Cross-case Analysis – Number of References Coded per Category and Theme (extract from NVivo 12)

	Case A HCA	Case B HCA	Case A RN	Case B RN	Case A CNM2	Case B CNM2	Case A Documents	Case B Documents	External Documents	Case A Observations	Case B Observations
Creating the Conditions	44	27	53	92	11	46	0	2	26	20	3
Education and Competence	18	13	31	47	7	27	0	0	12	19	2
External Structures and Governance to Support Delegation	3	4	9	26	2	3	0	0	18	0	0
Internal Structures and Governance	33	19	27	58	5	34	0	2	18	2	1



In the data display stage of data analysis, network displays allowed the visualisation of the categories and themes (nodes) that linked with each other. This enabled key patterns to be identified across the two cases. Three themes were developed: *Creating the conditions* (structures and governance to support delegation), *How it happens* (delegation), and *Knowing what I should do* (role). The findings from the interactive model for data analysis will be presented in Chapter Five.

4.10 Reflexivity, Ethical Considerations, Role of Researcher and Nurse as Researcher

4.10.1 Reflexivity

For reflexivity, the researcher maintained a personal diary throughout the study, from initiation to completion. To provide structure to this diary, Rae and Green's Reflexivity Matrix was applied (see Section 3.7.3). The matrix consisted of eight cells identifying reflexivity through phases of the study (Table 4.12). In the pre-research phase, the researcher reflected and considered her subjective position in the study as a researcher, as a nurse, and as an individual. In Cell 1 the researcher considered her role as a nurse, her current responsibilities, and how this role motivated the research on RN and HCA staffing and team working. In Cell 2, she recorded her position as an RN, her previous experience and perceptions that might influence the study. Cell 3 identified where the interest in delegation in healthcare teams was aligned to the wider context. Cells 4 to 6 recorded researcher reflexivity during the data collection period, reviewing and monitoring memos throughout the study cycle.

Table 4.12: Case Study Reflexivity Matrix (adapted from Rae and Green, 2016)

Reflexivity Matrix (adapted form Rae and Green, 2016)			
Pre-Research	**Cell 1.** The researcher considered her role as a nurse working in a corporate office in the HSE, and her nurse workforce planning responsibilities in this role. This role and the current challenges in nurse recruitment and retention were motivations in undertaking research on RN and HCA staffing and team working. The researcher' experience of delegation by RNs to HCAs was primarily in acute hospital services but the incremental change of RN to HCA ratios in RCOP was a key reason for the focus in RCOP. The choice of methodology was guided by the researcher's philosophical assumptions as described earlier.	**Cell 2**. The researcher recorded her position as an RN at the beginning of the study. The researcher had experience of delegating tasks to HCAs in previous clinical roles and this was acknowledged. Peer discussions initially guided the researcher, e.g. initial title of study was delegation in nursing care teams, however some RN colleagues objected to including HCAs in the term nursing care team and thus the title reworded to patient care teams. This title was revisited throughout the study by the researcher to reconcile her thinking as the study progressed.	**Cell 3.** The interest in delegation in health care teams was closely aligned to current literature on delegation; however, there was a gap in the literature on delegation in the Irish healthcare settings. During the data collection and data analysis phases of the study the researcher continuously applied reflexivity.
Data Collection	**Cell 4.** The researcher recorded her opinions, feelings and reactions during data collection and reviewed and monitored these memos throughout the study cycle, especially for data analysis and reporting the findings. For example, the researcher changed her opinion on why RNs did not delegate: From: RNs did not understand their professional responsibility to delegate. To: HCAs were working in the RCOP so long and the work was so routine there was no requirement for RNs to delegate routine tasks. To: the HIQA Standards do not differentiate between RNs and HCAs for supervision. To: Participants did not appear to understand the significance of delegation and were surprised that this was the topic of a research study. The researcher continuously advised particiapnts that they were key contributors to the study and the consistent questioning on what they understood and expetreinced as 'routine activities' contributed to participants and researcher negotiatign meaning.	**Cell 5.** The researcher and participants shared the same language, especially terminology used in health care, e.g. the relevance of HIQA regulations and inspections in the sites; the routine care delivered to residents, i.e. assistance with activities of daily living, medication administration rounds, documentation. There was potential for power differentials between the researcher and participants, based on positions held by the researcher in clinical management and in senior nurse leadership. However this was not apparent with RNs or HCAs during the study as the researcher at introductions explained her role and position in the organisation, but explained that her role in the study was as an academic student.	**Cell 6.** Questions were objectively shaped by the identified themes from the initial literature review. Reflexivity was applied during data collection and data analysis and as these were iterative stages in the study therefore the reflexivity captured how the analytical thinking of the researcher emerged.
Data Analysis		**Cell 7.** As the study was focused on a particular phenomenon in context of a case all data relating to the phenomenon was included in the analysis. Triangulation enabled the researcher to check methods and sources credibility and confirmability. The qualitative design of the study enabled the voices and experiences of the participants to be prioritised therefore the balance of analytical authority rested with the participant and the researcher.	Cell 8. The researcher uses reflexivity to monitor her subjectivity and the risk of introducing bias. The approaches to data collection, data analysis and rigour in the study also demonstrate the researcher's efforts to prevent data omissions or fabrications.

The reflexivity diary captured the progression of the analytical thinking of the researcher (Table 4.12). Cells 7 and 8 recorded the reflexivity notes during the data analysis. Reflecting on personal perceptions, assumptions and acknowledged biases in the context of the data collection and analysis supported the researcher in understanding the phenomenon and her own impact on the research.

4.10.2 Ethical Considerations

The ethical considerations for this study included: benefits, harm and risk; the nurse as researcher; informed consent; privacy, confidentiality and anonymity; and worthiness of the project.

As the study was taking place in a clinical setting, the researcher was aware of the risks to the rights, safety, dignity and well-being of participants. As a HSE employee, a nurse and a novice researcher, it was essential to adhere to and demonstrate high ethical standards in conducting this research. The research was conducted adhering to the Irish healthcare and nursing guidance documents (Chapter 3, Section 3.7.1).

Ethical approval was sought and obtained from the HSE RECs (see Appendix 8) and from the university REC, as not all potential clinical sites were overseen by an organisational REC (see Appendix 9). The researcher applied an ethical approach to site selection to demonstrate transparency and unbiased site selection. The impact of conducting research on a clinical site that was in a process of change or instability was considered, e.g. sites undergoing disruptive refurbishment or with reduced staffing levels were not selected. Site entry was gained following written and verbal communication to the site manager and DoN on each site. The research proposal and information on how the study would be conducted were shared. Site entry permission forms were signed by the site manager and DoN. A series of introduction and information sessions were undertaken prior to data collection. Participant recruitment was undertaken through a transparent and systematic process, taking full account of the impact and assessed risks of the research on primary and secondary participants (see Section 4.6). There were no foreseeable serious risks to the participants. Assurances were provided that non-participation would not affect staff or residents' status or treatment on the RCOP site. Participants and gatekeeper were advised that the HSE policy for open disclosure would be applied in the event of any concerns arising.

Attention was given to the relationship between participants and nurse researcher. The researcher works as a senior nurse in the public health service (HSE) and therefore was conscious of the potential power imbalance between her and staff on the case study sites. The researcher applied reflexivity to monitor risk of coercion due to her senior position and to demonstrate that this was managed. The inclusion of the gatekeeper in distribution of research material, managing researcher site entry, non-identification of individual staff, responses by s.a.e. (not directly to researcher) and assurances that participation was voluntary contributed to managing the potential power imbalance. The researcher had not worked in HSE RCOP services and therefore the staff in the case study sites did not know her. The researcher developed an awareness of her own values, opinions and perspectives, especially in relation to gender, age, status, education and ethnicity. There was a risk that the researcher, as an RN, might be biased or that HCAs might perceive the researcher to be biased in favour of the RNs' accounts and behaviours. The researcher reassured HCAs that similar and equal approaches were taken for RNs and HCAs, and monitored for bias through reflexivity. For example, following focus-group interviews, the following was recorded in the diary (reflexivity matrix: cell 5: *"disappointed with RNs that they do not understand their professional obligation, and that they were not explicitly delegating tasks"* and "*Annoyed with HCAs that they are not respecting RN in her/his role to delegate"*. However, the researcher's position on this changed in the reflexivity diary (reflexivity matrix: cell 4 and cell 7) because, as the data collection and analysis progressed, she developed in-depth understanding of how

the context of the case influenced RN and HCA behaviours and practices, and monitored her personal reflections on this.

A process to obtain informed consent was applied. Letters of invitation, information documents, posters and the consent forms showed that participation in the study was voluntary, with a right to refuse to participate and withdraw from the study, and time to consider participation. The documents were organised as packs, with s.a.e. addressed to the researcher. Each pack was prepared for staff (RNs and HCAs) or residents. The gatekeeper distributed the information and consent packs on each ward, and the follow-up reminder communication. This reduced the risk of coercion to participate. The researcher provided information sessions on the study and was available to answer questions through regular site visits and providing her email and telephone number. As older people in RCOP are recognised as a vulnerable group, and in response to reports that most residents had a moderate to severe cognitive impairment, additional safeguards for respect were applied. Resident study packs included different versions of documents, with one version having less text and larger font size, and images for ease of understanding. Non-participant observations were restricted to communal areas, and did not occur during personal care or interventions to the residents that might infringe on their privacy and dignity. Process consent was applied. At the beginning of each data collection session, the gatekeeper and CNM2 advised the researcher of residents who were not participants and consenting residents who did not wish the observation session to occur in their presence. In addition, the researcher assessed if residents did not wish the observation to occur in their presence by checking with the resident if they were happy for observation to proceed. When observation continued with a particular resident present, the researcher reviewed and reconfirmed the initial consent on each occasion. This included listening to the resident, observing body language and facial expression. If there was an indication of objection – e.g. poor eye contact; facial expression changed indicating unhappiness, anxiety or withdrawal; signs of agitation or shouting – the researcher did not proceed with the data collection.

The researcher was cognisant of the participants' entitlement to privacy, confidentiality and anonymity, and did not record details that would identify the site or participants. Pseudonyms were applied to the case study sites as Case A and Case B, and the wards as Ward A1, Ward A2, Ward B1 and Ward B2. No personal details of individual participants were required or stored. RNs were identified as a homogenous group and not as individuals. This was similar for HCAs and the CNMs. The only identifiable documents were the consent forms that the researcher managed under data protection legislation and organisational policy for data storage and retention. Study data were not shared or viewed by any person other than the researcher and supervisors. An external company that

worked within a confidentiality agreement transcribed the audio files. Personal identifiable data for staff or residents were not accessed or collected. Documents with the site name (site entry forms, communication emails and participant consent forms) were the only identifiable documents in this study. Electronic data were stored in locked and password-controlled electronic storage systems (e.g. emails). Hard-copy data were stored in a locked filing cabinet in a locked office (e.g. site-specific job specifications, consent forms). Interview audio tapes were transcribed with no participant identification included. Audio tapes were stored in a locked cupboard in a locked office. Access to identifiable data (personal data, medical records) was not required, and no interventions or activities were required from the secondary research participants. Non-participant observation data collection was not undertaken during personal care. The researcher restricted presence on wards to communal areas. As a registered nurse and employee of the HSE, the researcher has knowledge and awareness of clinical ward decorum and expected activity. There was no interruption of or interference with care.

Finally, the importance of undertaking research in clinical sites that would be of benefit either directly or indirectly was considered. It was expected that the study would lead to better understanding of RN and HCA working relationships and how delegation could be improved. Effective delegation and teamwork have a positive impact on resident care and outcomes, and therefore this study was considered ethically worthy.

4.11 Criteria for Assessing Rigour

The criteria for evaluating the trustworthiness of the qualitative research developed by Lincoln and Guba (1985) and augmented by Miles et al. (2020) were applied to ensure rigour in the study (Table 4.13).

Table 4.13: Criteria for Trustworthiness of Qualitative Research as Applied to this Case Study

Criteria for Trustworthiness	What it is	Achieved through
Credibility	Believability of the findings and extent to which the findings presented match the participant perspective	• triangulation of the multiple sources of data and methods • prolonged engagement • persistent observation • negative case analysis • direct quotes from participants
Transferability	Extent to which decisions can be made about the usefulness of the study findings in other contexts	• providing thick descriptions • purposive sampling • reflexive journal • cross case analysis
Dependability	Similar to reliability of quantitative data, and how stable the data are	• creating a case study database • creating an audit trail for data collection stages and processes • chain of evidence
Confirmability	Accuracy of data	• creating an audit trail for data collection stages and processes • participant demographics • triangulation • reflexivity
Action orientation	Value of the research to participants, the employer and the researcher	• case study report • findings reviewed in context of current evidence

Adapted from Lincoln and Guba (1985), Denzin and Lincoln (2011) and Miles et al. (2020).

4.11.1 Credibility

In relation to credibility, the researcher aimed to demonstrate the believability of the findings and the extent to which the findings presented matched the participant perspective. T*riangulation* – that is, using different data sources and methods in the research design – tested the credibility of the research. The inclusion of multiple sources of data enhanced the credibility of the findings, especially the different perceptions and experiences of the different staff grades of delegation. The reporting on cross-analysis of data sources enhanced credibility. Multiple data collection methods – i.e. focus-group interviews, individual interviews, non-participant observation, internal and external documentary review – provided an assurance that delegation was robustly explored and analysed. *Prolonged engagement* on the sites allowed the researcher to become familiar with the routines and staff on each site. This regular, persistent and prolonged engagement, together with reflexivity, allowed the researcher to become familiar with periods when RNs and HCAs worked together, and

therefore when instances of delegation might occur. The researcher undertook observation periods on four wards during periods when RNs and HCAs worked together (Tables 4.14, 4.15). In Case A observation, the participants were the CNM2 (n=1), RNs (n=13), representing 72% of RNs, and HCAs (n=17), representing 71% of HCAs.

Table 4.14: Case A Observation Periods

Date 2017	Time	Case A Site Observations		Total Minutes
5th July	13.30-15.30	Ward A2	Ward A1	120
12th July	8.00-9.30	Ward A2	Ward A1	90
12th July	12.00-14.30	Ward A2	Ward A1	150
24th July	19.30-21.30	Ward A2	Ward A1	120
26th July	07.45-09.45	Ward A2	Ward A1	120
10th Oct	19.45-21.45	Ward A2	Ward A1	120
			Total	720 (12 hrs)

In Case B, both CNM2s (n=2), RNs (n=17, representing 85% of RNs, and HCAs (n=27), representing 93% of HCAs, consented to participate in observation data collection. The higher participation rates in Case B enabled more periods when a consenting RN and a consenting HCA were on duty together (Table 4.15).

Table 4.15: Case B Observation Periods

Date 2017	Time	Case B Site Observations		Total Minutes
4th July	13.30-15.30	Ward B1	Ward B2	120
13th July	12.00-15.00	Ward B1	Ward B2	180
14th July	07.45-9.45	Ward B1	Ward B2	120
18th July	20.00-21.30	Ward B1	/	90
25th July	07.50-09.50	Ward B1	/	120
25th July	19.30-22.00	Ward B1	/	150
10th Oct	07.45-09.30		Ward B2	105
			Total	885 (15 hrs)

Persistent observation required that a participant RN and a participant HCA be on duty for the observation periods in order to observe the process of delegation. The high participation numbers of RNs and HCAs on each ward enabled persistent observations of the phenomenon in context, providing

rich descriptions of delegation. *Negative case analysis* was undertaken during data analysis, where a set of assertions and propositions were tested against the data. Including different staff grades in the study led to conflicting accounts and different viewpoints. In this, the researcher presented disconfirming evidence, which increased understanding of delegation. The inclusion of direct quotes from those who experienced delegation contributed to credibility.

4.11.2 Transferability

Transferability was achieved through purposive sampling, providing thick descriptions and maintaining reflexivity. *Thick descriptions* were provided in reporting of the study. This included the context of the case, where site descriptions, the participants' demographic profiles and the environment are described. The methods applied are described in detail, providing rich descriptions of how the research was undertaken. The findings are presented through direct quotes from interview participants. In addition, documents from the documentary review together with the non-participant observation data contribute to the thick descriptions. Reflexivity, jottings and annotations provided rich data as to how the researcher interpreted the data and analysis. The *purposive sampling* of a 'typical' case was supported with detailed descriptions of criteria and process of study site selection, and inclusion and exclusion criteria of participants. The two cases were selected as typical cases to represent how delegation occurs in RCOP settings. This would support the findings to be transferable to other similar settings. By applying the reflexivity matrix model (Rae and Green, 2016), *researcher reflexivity* was captured in a structured and systematic approach through the different stages of research: pre-research, data collection and data analysis (Rae and Green, 2016). This acknowledgement and reporting of the researcher role in the study supports transferability.

4.11.3 Dependability

To demonstrate trustworthiness in relation to how the data changed during the study, it was important to present detail of data collection methods, data analysis, reflexivity, and transparency of decisions and reflexivity for all stages of the research. Dependability was demonstrated by creating a case study database and an audit trail (Table 4.16). A *case study data base* was created, where all documentation relating to study initiation was retained, including the research proposal and records of academic supervisor meetings and discussions. The audit trail was retained in the case study database, with dates of all stages of the research process.

Table 4.16: Case Study Audit Trail

- Research ethics committee correspondence (REC applications, approvals and associated documentation)
- Criteria for case selection, inclusion and exclusion criteria for case and participant recruitment
- Site access documentation (correspondence to site manager, correspondence to arrange site entry, information letters and posters, participant information pack and consent form)
- Study site descriptions, including context, environment, staffing and governance
- Timetable of data collection periods, identifying dates, times spent on each data collection episode
- Data collection tools, including interview guidance, document and observation data collection templates
- NVivo project versions (n=24) retained on file to demonstrate any changes in distilling or recategorisation during data analysis, providing a systematic and transparent trail of data analysis. This provided clarity and transparency for the researcher's analytical approach to all phases of analysis.
- Matrices and networks providing visualisation of data analysis and emergent categories and themes
- Jottings and analytic memos recorded throughout the study

4.11.4 Confirmability

Confirmability to assure that the findings reflect the focus of the research and are not biased by the researcher was demonstrated by the creation of *an audit trail, reporting on participant demographics, triangulation* and a *reflexivity matrix*. The researcher applied a *reflexivity matrix* to capture thoughts, decisions making choices, options and rationale throughout the study. The audit trail (NVivo reports extracts) and a reflective journal describe the researcher's experience.

4.11.5 Action Orientation

Adopting the fifth category for measuring rigour in qualitative research (Miles et al., 2020), the researcher includes action orientation, to test if the study has value for the researcher, the participants, and those for whom the study is prepared (Miles et al., 2020). The study findings will be presented in the context of the literature reviewed (Chapter 6). The final thesis and presentation of findings will be presented to the case study sites and organisational decision-makers.

4.12 Chapter Summary

This chapter has provided a description of the methods used in this QCSR. The pilot study provided significant learning in advance of the study. A detailed description of case study site selection, case site access and participant selection methods was presented. Each method of data collection was described, including non-participant observation, focus-group interviews, individual interviews and documentary review. The approach to reflexivity and the ethical considerations were presented. The

interactive model for data analysis was described, including the approach to within-case and cross-case analysis. Finally, the approach to assessing trustworthiness in the study was outlined. The following chapter describes the findings.

Chapter 5: Findings

5.1 Introduction

This chapter describes the findings from the thematic analysis. Three themes were developed; *Creating the conditions, How it happens,* and *Knowing what I should do*. Each theme has a number of categories. The first section provides a description of each case study site, including the staffing profile. Descriptions and findings that could identify the case study sites are not reported so as to maintain confidentiality (e.g. bed numbers, participant gender and nationality). The case study sites were selected to represent a *typical* residential care setting in the Irish public health service to explore and understand delegation by RNs in this context. Section 3 describes the within-case analysis. Section 4 presents the findings from the cross-case analysis. Similar themes were developed in both cases and the findings report on significant similarities, associations and differences. Although the themes are presented as separate themes, many are interconnected; these relationships and interdependencies are discussed in Chapter 6.

5.2 Case Site Descriptions

Case A and Case B sites and staff profiles are described separately. In writing the description of the case study sites, particular attention was paid to maintain confidentiality and protect the identity of the clinical sites and participants (e.g. profile of CNM2, bed numbers). The researcher removed detail in the descriptions of the environment and staffing that could breach anonymity. The study participants were identified as homogenous groups and not as individuals. The homogenous groups were consenting participants who were either RNs, HCAs or CNM2s.

5.2.1 Case A Description

The Case A site was located on the outskirts of a large city. It was a purpose-built RCOP. The unit was a single-storey building with bed capacity of between 40 and 70. There was a day hospital but this was not included in the study. There was a Director of Nursing (DoN), Assistant Directors of Nursing (ADoNs) and a team of Clinical Nurse Managers (CNMs), each of whom supervised staff nurses, HCAs, catering, cleaning and administrative staff. There were two inpatient wards, and both were included in the study. In each ward, most rooms were for single occupancy but there were a few double rooms. The two wards, Ward A1 and Ward A2, were in a block format with a central area featuring an outdoor garden. The day rooms opened onto a patio and garden. Each ward occupied half of the square block and they were interconnected. The walls were painted with bright colours and large windows letting

in plenty of light. Efforts had been made to make the wards homely, with colourful furniture, curtains and soft furnishings (pictures, clocks and ornaments). The sounds from radios and TV sets in residents' rooms and sitting-rooms were often be heard through the ward during the day. There were open visiting hours during the day and evening. Visitors could walk with or support their relatives to move around the ward and into the outside area.

5.2.1.1 Case A Staff profile

The model of nursing care was team nursing, whereby resident care was distributed to a team to work together providing care to a cohort of residents on the ward. The teams in Case A consisted of either an RN and HCA, or two HCAs. The skill mix ratio of RNs to HCAs was 45:55 but could drop to 40:60 due to RN staff replacement challenges, as reported by the DoN and CNM2s. A profile of staffing was provided by the site gatekeeper during the data collection period (Table 5.2). There was one CNM2, who worked across both wards in Case A. The CNM2 worked full-time and was less than five years' employed as a CNM2 (Table 5.2). The CNM2 reported to an assistant DoN based on site and the DoN who was not full-time on site (cross-site cover with other RCOP sites). The CNMs engaged predominantly in an administrative and education role. On each ward there were generally three RNs and three HCAs on each day shift. Shift patterns on both wards were 7.45am–8.45pm, 8am–5pm for RNs and HCAs. Night duty was from 7.45pm to 8.45pm for RNs and HCAs.

Table 5.1: Case A Staff Profile

Staff Grade	Headcount	Whole-time Equivalent	Working	Years working in this nursing home
	HC	**WTE**	**Full-time (FT) Part-time(PT)**	**0-5 6-10 11-20 21+**
CNM 2	1	1	FT	0-5
Registered Nurse	18	19.9	FT=13 PT=5	11-20 = 13 21+ = 5
Health Care Assistant	24	20	FT=15 PT=9	0-5 = 3 6-10 = 4 11-20 = 12 21+ = 5

The CNM2 was predominantly in an administrative role between both wards but delivered direct patient care at peak activity times, e.g. meal times. There were two or three RNs and three HCAs on each ward during the day to care for 20 to 30 residents on each ward (range provided to protect anonymity). All staff worked 7.45am to 8.15pm on day shifts. On night duty one RN and one HCA

worked on each ward. Staff on sick leave were replaced by agency staff; in the main, HCA agency staff replaced both HCA and RN absences due to unavailability of agency RNs.

5.2.2 Case B Site Description

Case B site was located on the outskirts of a large provincial town. This purpose-built RCOP had in recent years undergone restructuring and refurbishment. The unit was a single-storey building. The day hospital was an additional service and was not included in the study. There was a DoN, an ADoN and a team of CNMs, each of whom supervised a number of RNs, HCAs and catering, cleaning and administrative staff. There were two wards, and both were included in the study. Ward B1 comprised a large number of beds providing extended, transitional and respite care services; Ward B2 was a dementia care unit with smaller bed numbers. Both wards were designed as single or two-bed rooms. One ward had fewer than 20 beds; the other ward had more than 35. Ward B1 was built in a block format, with the central area having access to an outdoor garden area. There were efforts to make the wards homely, with bright colours, different styles of armchairs and soft furnishings (pictures, clocks, ornaments). Ward B2 was linked to the central area by a corridor; coded doors operate in this area in the interest of resident safety. Ward B2 was smaller in floor space compared to Ward B1. There was a quieter and calmer atmosphere in this ward. There were open visiting hours during the day and evening. Visitors could walk with or support their relatives to move around the ward and out into the enclosed outside area.

5.2.2.1 Case B Staff Profile

The model of nursing care was team nursing, with three designated team areas in Ward B1 and two designated team areas in Ward B2. The skill mix ratio of RNs to HCAs was 50:50 or 45:55. The site gatekeeper provided a profile of staffing during the data collection period (Table 5.3). The CNMs on both wards engaged in clinical practice in addition to their administrative role. On Ward B1 there were a minimum of three RNs (including the CNM) and four HCAs on each day shift. RN shift patterns varied from 8am to 8pm, 8am to 5pm, 8am to 4pm, 8am to 2pm. HCAs worked from 8am to 8pm. Each day one RN started shift at 7.45am, usually the CNM, but in her absence the nurse-in-charge for the day. This early start facilitated the night-duty RN's handover to the CNM2 or Nurse-in-Charge and then the night shift staff finished their shift.

Table 5.2: Case B Staff Profile

Staff Grade	Headcount	Whole-time Equivalent	Working	Years working in this nursing home
	HC	**WTE**	**Full-time (FT) Part-time (PT)**	**0-5 6-10 11-20 21+**
CNM 2	2	2	FT	11-20 = 2
Registered Nurse	20	18	FT=16 PT= 4	0-5 = 1 6-10 = 7 11-20 = 11 21+ = 1
Health Care Assistant	29	22	FT=19 PT= 10	6-10 = 3 11-20 = 23 21+ = 3

The CNM2 provided the handover report to the day staff team. On night duty there were two RNs and two HCAs on Ward B1 and one RN and one HCA on Ward B2. Staff on sick leave were replaced by agency staff; predominantly, HCA agency staff replaced both HCA and RN absences due to the unavailability of agency RNs. The HCAs were employed in historical contracts as Multitask Attendants (MTAs), but some had completed the HCA QQI L5 programme. Similar to Case A, the variance between HCAs and MTAs was being negotiated at national level.

The findings from the data analysis of Case A and Case B are described in the next sections.

5.3 Findings from Case A and Case B Within-Case Analysis

The within-case data analysis approach for Case A and Case B has been described in Chapter 4. Thematic analysis was used to conduct the within-case analysis of all data sources in each case. The data sources were analysed individually and then collectively. This analysis revealed similar themes and categories for Case A and Case B. Three themes were developed: *Creating the conditions, How it happens*, and *Knowing what I should do*. Each theme had related categories and, within theme 3, two additional sub-categories were generated (Table 5.3). However, to protect anonymity of the case study sites and the study participants, instead of the within-case analysis, the detailed findings from the cross-case analysis are presented.

Table 5.3: Themes, Categories and Additional Subcategory

Theme	Category	Additional Subcategory
	External Structures and Governance to Support Delegation	

Creating the Conditions	Internal Structures and Governance to Support Delegation	
	Education and Competence	
How it Happens	Allocation or Delegation	
	Delegation – Nurse-in-charge only	
Knowing What I Should Do	RNs and HCAs are different	Working in pairs – "it's kind of like being married"
		Answer the bell or stay in the office
	"Know What to Do"	"I'm going to see it, I'm going to do it, I'm going to write it"
		HCAs and MTAs are different

5.4 Findings from Case A and Case B Cross-Case Analysis

Significant similarities, differences and associations found between Case A and Case B were related to the research question. As thematic data analysis was applied to all data sources, the findings across all data sources are presented within each theme. The first theme, *Creating the conditions*, is presented in the next section.

5.4.1 Theme 1: Creating the Conditions

The theme *Creating the conditions* focused on the structures and governance (at policy, strategic and operational management levels external to and within the case study sites) that supported delegation by RNs to HCAs. The level of RNs' awareness of their professional responsibilities in delegation was also relevant to this theme. The theme divides into three categories: *External structures and governance to support delegation*, *Internal structures and governance to support delegation,* and *Education and competence*.

5.4.1.1 External Structures and Governance to Support Delegation

This category describes how the professional, national and local regulation and standards influenced how RN delegation was interpreted in practice. As both case study sites were within the HSE, the structures and governance to support RN delegation external to the study sites were similar. Other than NMBI Code of Professional Conduct (2014) Scope of Practice (2015) publications, there was scant evidence of external governance to support delegation. This included minimal if any reference to RN delegation in policies, protocols, procedures and guidelines (PPPGs), job specification, or regulatory

standards and requirements. There were hard copies of the NMBI Code of Practice (2014) and Scope of Practice (2015) in the nurse's office at both case study sites. These were the only publications available at both sites for guidance on delegation. CNM2s and RNs understood that NMBI provided guidance on scope of practice and RN accountability for patient care. However, when asked, the CNM2s and RNs could not articulate the NMBI direction on delegation of HCAs.

> *Delegation of task, now there's a scope of practice you see; we have our scope of practice. I did not come across any (delegation).* **Case A RN Focus Group Interview 2**

Similarly, when the RNs in Case B were asked about delegation guidance from NMBI to RNs, they were aware of the Scope of Practice but not the detail on delegation:

> *Well we delegate what we know they are competent of doing …*
>
> **Interviewer:** And in relation to *An Bord Altranais (NMBI), anything they produced, are you aware of anything?*
>
> *The Scope of Practice… we would only do what we feel we are capable and competent of doing.*
>
> ***Interviewer:*** *And in relation to, specifically to delegation, are you aware of anything in the code, or the scope?*
>
> *No.* **Case B RN Focus Group Interview 2**

The CNM2s were aware of the RN responsibility in relation to explaining and allocating tasks to the HCA, and they 'thought' that RNs did delegate to HCAs:

> *Again the nurse that's working with the carer (HCA), it's really her responsibility to explain what they're doing, you know, and who needs what care, what attention they need so really it's up to whatever nurse.*
>
> ***Interviewer:*** *And do you think all nurses all delegate to HCAs?*
>
> *Yes, I think they do, I think they do. Because the work has to be done.* **Case B Ward B1 CNM2 Interview**

For both cases, the HCAs were not aware of NMBI or NMBI guidance for RNs in delegation of tasks to unregistered care staff.

> *I've never heard of it, no.* **Case A HCA Focus Group Interview 2**

However, the HCAs were aware that the RNs were registered to practice and were accountable for care delivery.

In contrast, the importance of adhering to HIQA Safe Care Standards (HIQA, 2016), compliance for registration as a designated centre and the associated HIQA inspections emerged as important. During the data collection period unannounced HIQA inspections occurred on both sites. It was apparent during observation periods and from interview data that the inspections and subsequent reports were of high importance to all staff in the RCOP sites. The inclusion of the HIQA inspection reports in the analysis provided additional insightful data. The importance of RN documentation and record keeping responsibilities were evident. In the HIQA inspections resident care plans, nursing records, rosters, staff education and training records were available for review by the regulator.

HIQA reported both Case A and Case B sites as compliant and reported positively on the environment, the care delivered and the relationship between staff and residents.

> *The inspectors found that there was a person-centred approach to the residents in the centre that respected their privacy and dignity.* **Case A HIQA Inspection Report 2017, p.17**

> *Inspectors found that residents received care in a dignified way that respected their privacy and dignity. Inspectors observed staff interacting with residents in a kind and empathetic manner, and were knowledgeable of their backgrounds and personal preferences, such as what name they prefer to be called.* **Case B HIQA Inspection Report 2017, p.9**

> *Feedback from residents and their relatives during the inspection was positive about the quality of healthcare that was provided with in the centre.* **Case A HIQA Inspection Report 2017, p.14**

There was no reference to delegation in HIQA standards or inspection reports. Interestingly HIQA identified RNs and HCAs collectively as “staff” the only distinction was for the person-in-charge, CNM2 and ADoN roles. Although delegation was not referred to, the supervision of staff role was only aligned to the CNM2 and ADONs role.

> *The inspectors found that the centre had appropriate arrangements in place to supervise staff in their work. Nursing and care staff were supported and supervised in their day to day work by the clinical nurse manager and the ADONs.* **Case A Inspection report, HIQA, 2017, p.6**

The reflexivity memos for this analysis identified that the researcher had expected that all RNs would supervise HCAs within their delegation role. It was interesting that HIQA reports endorsed the supporting and supervising of nursing and care staff as a CNM2 or ADON role.

> *I expected that HCAs would be supervised and supported by all RNs. It was interesting that HIQA Inspector identified the responsibility of support and supervision of nursing and care staff as with only the CNM2 and the ADON. Does this impact on RNs and HCAs perceiving their roles as different.* **Reflexivity: Data Analysis Memo**

There were no national delegation PPPGs sourced. The memos from data collection and early analysis signalled that this was an unexpected finding and generated questions as to why this was so.

> *The fact that there are no policies or guidance related to RN delegation leads me to think that delegation is not an important (or relevant) topic for RNs in these services. This is surprising with the low ratio of RNs to HCAs.* **Memo: Phase 1 data analysis**

As data analysis progressed, the possible reasons for the absence of PPPGs was recorded in memos.

> *So if there is little if any delegation observed or reported by RNs, HCAs and CNM2s, and if there is confusion between delegation, assignment and allocation, then I should not be surprised about absence of PPPGs.* **Memo: Phase III DA: (Propositions/ Assumptions)**

With the dearth of evidence for external structures and governance to support delegation, evidence for this was sought internally in case study sites.

5.4.1.2 Internal Structures and Governance to Support Delegation

This category describes the structures and governance supports provided by the employing organisation. It focused on evidence within the case site of internal (PPPGs) to guide the RNs in their roles in delegation, articulation of delegation roles and responsibilities within job specifications, and how staffing levels or skill mix affected delegation. There was little evidence of internal structures and governance to support RN delegation; this in itself was an interesting finding. There were no delegation PPPGs from local employers in the individual case sites. Interview participants confirmed that there were no delegation PPPGs in either case study site. RN and HCA job specifications were reviewed for evidence of delegation responsibilities. The impact of decreasing numbers of RNs was generated from the interview data.

The analysis of job descriptions revealed variances in reporting relationships, roles and responsibilities of RNs and HCAs. The CNM2's job descriptions were not available for Case A or Case B. The HSE CNM2

for Older Persons Services (HSE, 2015) did not refer specifically to delegation, but did refer to the supervision and staff deployment responsibility of the CNM2 in RCOP:

> *Provide the necessary supervision, co-ordination and deployment of nursing and support staff to ensure the optimum delivery of care in the designated area(s).* **HSE, 2015, p.3**

In Case A, job specifications for RNs and HCAs, issued prior to 2015, were not available for review due to centralisation of human resources and employee data external to Case A RCOP at the time of the study. RNs employed after 2014 were appointed on a HSE nationally agreed RN (Staff Nurse) Older Persons Services Job Specification. Only 9% of participants in Case A and 2% of participants in Case B were working less than six years in the RCOP site; therefore the more recent HSE RN and HCA job descriptions were not relevant to the majority of participants in this study. However, earlier job specifications, sourced external to Case A, did not refer to the RN role or responsibilities for delegation and supervision of HCAs (Health Board, 2004; HSE, 2013; HSE, 2014). More recent RN job specifications (HSE, 2016; HSE, 2018) did identify delegation and supervision as a clinical responsibility:

> *Delegate to and supervise the work of other grades of staff within the remit of their role, as appropriate* **HSE, Staff Nurse General (Older Persons Services), 2016, p.2**

There were no local HCA job specifications available in Case A. For Case B, a local site-specific job specification for HCAs' principal duties and responsibilities stipulated:

> *The post holder will be responsible for supporting the Registered Nurse in duties associated with the delivery of care and management of the ward/healthcare environment and other support duties as appropriate.* **Case B HSE HCA Job Specification, 2007, p.1**

A more recently dated job specification (2013) stipulated that the HCA duties and responsibilities included supporting the RN with care delivery and managing the ward environment, and providing "person centred care under the supervision" (p.2) of an RN. This HCA job specification identified the CNM2 or deputy CNM2 in the reporting relationship:

> *Health Care Assistant will report to and work under the supervision and direction of a Registered Nurse (Clinical Nurse Manager or his / her deputy).* **HSE Health Care Assistant Job Specification, 2013, p.1**

However, the 2014 HCA job specification included the RN in the reporting relationship:

> *The post holder will on a day-to-day basis report back to the registered nurse. The direct line manager is the Clinical Nurse Manager 2, Clinical Nurse Manager 3, or their deputy.* **HSE, HCA Job Specification, 2014, p.1**

The Case B HCA job specification identified tasks that were "assigned" and "delegated", but there was no evidence of definitions or distinctions between these terms.

> *To carry out assigned and delegated tasks involving direct resident care and duties associated with the delivery of care and management of the ward/healthcare environment and other support duties as appropriate*. **HSE Case B HCA Job Specification, 2007, p.1**

Similar to the local HCA job specification, the national job specification referred to assigning and delegating:

> *Carry out assigned and delegated responsibilities involving direct care and all activities of daily living under the supervision of a Registered Nurse e.g. to assist residents maintain standards of personal hygiene, dietary intake, physical, mental health and any personal needs.* **HSE Case B HCA Job Specification, 2014, p.1**

In Case B, the CNM2s and HCAs reported that the majority of HCAs were employed on multi-task attendant (MTA) contracts of employment. MTA job specifications varied but most outlined the responsibilities of the MTA in direct care delivery, while also including cleaning and catering duties. The MTA job specification identified the purpose of the MTA post as:

> *To undertake cleaning, catering and client care duties as required to ensure a first class service to clients.* **HSE Multi Task Attendant, Job Specification, 2007, p.1**

> *To provide direct and indirect day-to-day care for patients. Support the provision of a high quality, clean and customer focussed service including:*
>
> *Assisting healthcare staff in caring for patients*
> *Attending to housekeeping, catering, laundry, portering or general duties as assigned.*
> *Duties assigned to the Multi Task Attendant will vary depending on the care setting.* **HSE Multi Task Attendant Job Specification, 2015, p.1**

The MTA reporting relationship was to the charge nurse (CNM) or deputy, and they would carry out delegated tasks under supervision, but the RN was not specifically identified as a supervisor.

> *… to undertake all activities of daily living with clients as directed by the Charge Nurse and report any changes in client condition immediately i.e. skin integrity or pain*. **HSE Multi Task Attendant Job Specification, 2007, p.1**

> *Carry out assigned and delegated responsibilities involving direct care and all activities of daily living under supervision.* **HSE Multi Task Attendant Job Specification, 2015, p.1**

The national HSE MTA job descriptions stated that completion of a QQI L5 programme was desirable, but not essential. In later-dated HCA and MTA job specifications (2013, 2015), the eligibility criteria sought completion of a QQI L 5 programme, or a minimum of one year experience's in a health area setting. There was no documented evidence in Case A or Case B as to which HCAs were employed on a HCA contract or MTA contract, nor which HCAs had completed a QQI L5 programme. There were no identifications or distinctions between HCAs on different employment contracts or with different care qualifications at ward level.

Although not included in the objective of the study or in the data collection (e.g. interview questions on staffing levels), the impact of RN staffing levels and RN:HCA skill mix emerged as a significant organisational factor related to RN delegation. The CNM2s, RNs and HCAs reported staff shortages, that they required more staff, and that more staff would improve delegation. However, RNs reported wanting more RNs and HCAs wanted more HCAs.

RNs in Case A and Case B described how the ratio of RNs to HCAs had been decreasing. The RNs in both cases described how fewer RNs affected the RN workload and increased work pressure as they relied on the HCA to undertake tasks. The decreasing numbers of RNs affected skill mix and the RN role in direct resident care. The RNs stated that the reduced number of RNs did not make delegation of tasks more difficult, but did affect the RN workload. However, it was later found that the assignment and allocation were misinterpreted as delegation. RNs indicated that having one less RN on shift duty (two instead of three) increased RN work pressure.

> *No it doesn't make any easier, or harder to delegate if we have four carers on. It doesn't make it harder. But it does impact on the nurses more, like nurses often are pressurised and they're doing more… you have to help the girls [HCAs] down there [on the ward/resident care] and you have to do everything.* **Case A RN Focus Group Interview 1**

> *… the less nurses the more you delegate. Pressure. The more the pressure.* **Case A RN Focus Group Interview 2**

RNs reported that HCAs were doing more care delivery than previously, and because of this both RN and HCA roles had changed. HCAs were now working more on their own, without an RN when delivering care.

> *Well I think they're [HCAs] doing a lot more…*
> *They're working together now and that's all new, like we've all changed completely the way… now they're working because of the complement of nurses now that's giving them… they're having to work on their own.* ***Case B RN Focus Group Interview 1***

The CNM2 indicated that three RNs on duty was preferable. Having only two RNs on duty increased the workload on RNs in relation to interventions and care that only an RN could deliver (e.g. wound care, resident admissions).

> *Ideally it should be three [RNs] to three [HCAs] … sometimes as I said when the ward [workload] is light it might be ok but sometimes it can be a bit pressurised on the nurses… if we have an admission it's dealt with by two nurses... Or they have a wound dressing. The third nurses could have done it whereas the care staff [HCAs] would not have the knowledge to do it.* **Case A CNM2 Interview**

Case A HCAs preferred having more HCAs on the wards to deliver direct care. Having four HCAs and two RNs made it easier for the HCAs. The HCAs explained that two RNs would be adequate.

> *… because that third one [RN] is expected to be a carer [work similar to a HCA in direct care delivery] and they're not.* **Case A HCA Focus Group Interview 1**

Case A HCAs also explained that the RNs spent their time in the office. HCAs expected that the RN on duty would assist the HCAs with direct care rather than be in the office.

> *If you have three nurses and three carers, some three nurses will just stay in the office. Even we might have one, no admissions that day like, no respites. And the three of them will stay in the office. And another day you don't mind, we could have two admissions and the three of them would still be in the office. So what I don't understand is how one can't be freed up.* **Case A HCA Focus Group Interview 2**

In Case A the impact of reduced levels of RN skill mix was a current issue, whereas in Case B this was described as a challenge in the future or something that was incrementally occurring over time. RNs were concerned about care delivery when there were often two HCAs paired to work as a team, when previously there had always been an RN and a HCA as a team pair:

> *When I started here first, it was 'even-stevens'. There was a nurse and a carer [HCA]. But now that's gone and you put two carers [HCA] together and I'm working with a healthcare assistant. You're still trying to think what's going on, am I missing anything, is everything okay over there (other side of ward), you know.* **Case B RN Focus Group Interview 2**

In both cases, when staff absence or vacancies were replaced by agency RNs and HCAs, this was identified as creating an additional workload, with the HCA or RN 'minding' the agency HCAs.

> *A lot of nurses are being replaced by agency carers. So you're kind of down in numbers…*
>
> *Like you're even minding agency staff that come in, you know.* **Case B RN Focus Group Interview 2**

The responsibility for introducing and familiarising a new agency RN or agency HCA to the ward was shared, but the agency staff worked predominantly with the permanent HCA staff (this will be reported in more detail within Theme 3). Case B RNs explained that, in the future, with fewer RNs on duty, the RNs would have to delegate and the HCAs would have to take on more nursing care responsibilities.

> *Because it's going to get to the stage, where there's going to be less nurses on the unit. And there's one probably, maybe one or two nurses in the future and we'll have to delegate. It'll be a carer-run unit more than a nursing unit.*
>
> *And probably that was one thing that came out of the unit [Ward B2] down there, while there was only one staff nurse on. They [HCAs] had to take on a bit more roles.* **Case B RN Focus Group Interview 2**

Case B HCAs described the challenges of responding to the care needs of a number of residents when there were staff shortages:

> *And you care and you really push yourself because it is the individual at the end of the day, like it falls on them [the resident] and, like, when it comes to meal times and drinks and even their appearance you push yourself and you're working with two or three and you get them done but you're killed and that's with… no, they know we're short-staffed.* **Case B HCA Focus Group Interview 1**

However, in contrast to the descriptions of being short-staffed, HIQA inspection reports in Case A and Case B during data collection did not identify staffing deficits. HIQA standard 7.2 for safe, effective and

person-centred staffing does not include recommendations as to appropriate and safe RN or HCA staffing numbers (HIQA, 2016). HIQA seeks evidence that:

> *At all times there are sufficient numbers of staff with the necessary experience and competencies to meet the needs of residents and which reflect the size, layout and purpose of the service… Staff have the necessary skills, appropriate to their role, to provide care and support to residents and to coordinate care effectively with other organisations and professionals.* **HIQA, 2016, p.75**

HIQA on-site inspections occurred during the data collection period on both sites. From these inspections, HIQA reported that the staffing was adequate (HIQA, 2017) and that the level and skill mix of staff to meet the assessed needs of residents was appropriate.

> *There was suitable staff numbers and skill mix to meet the needs of the residents… Residents spoken with confirmed that staffing levels were good and that they did not have to wait long periods for staff to attend to their needs*. **Case A HIQA Inspection Report, 2017, p.18**
> *… there was an appropriate level and skill mix of staff to meet the assessed needs of residents, particularly those with dementia*. **Case B HIQA Inspection Report, 2017, p.11**

In relation to skill mix, HIQA Inspections reported that the care provided to residents was person-centred; HIQA did not distinguish between care delivered by the RN or the HCA, referring to RNs and HCAs as 'staff'.

The only evidence of internal structures to support delegation was some job specifications identifying the CNM2 and RN roles in delegation. However, this reference was only apparent in more recent job specifications. Otherwise, there were no internal structures or governance measures evident in place to support RN delegation.

5.4.1.3 Education and Competence

This category describes education or competence development in delegation that RNs or HCAs engaged in, and education and competence developments required in relation to delegation of tasks in the future. This focused on RN education and competence as a delegator, and the HCA education and competence as related to their role as delegatee.

No education programmes specifically for RN delegation were found either nationally or locally. There was no evidence of national or local competence assessment structures or processes for assessing either competence of the RN to delegate, or competence of the HCA as delegatee. No episodes of education on delegation were observed in Case A or Case B. Staff education and training records were

reviewed, with no evidence of delegation education found. There was no reported education specific to delegation. CNM2, RNs and HCAs reported that they had not undertaken education in relation to delegation. CNM2s described how RNs were expected to supervise HCAs when working with them, and the CNM2 assessed HCA competence by observing the resident. The RNs and HCAs did not describe this, nor was RN supervision or assessment of HCA competence observed in practice. Some RNs aligned the completion of the QQI L5 programme as an assurance of competence. RNs in Case B were unsure of HCA competence level. However, external to the case study sites, effective delegation was identified as a learning outcome required for undergraduate nurse education in the standards for education (NMBI, 2016).

CNM2s indicated that education on delegation would improve RN role clarity and confidence in delegation.

> *Well for CNMs, for nurses, staff nurses… Some are more kind of, some have more confidence than others in delegating.* **Case B Ward B1 CNM2**

Education on delegation would also provide role clarity so that others would not interpret delegation as an RN being 'bossy' or delegating a task that the RN did not want to do themselves:

> *… because some people are definitely better at it (delegation and allocation) than others and if there is an understanding in the roles and people understand why the delegation has been done. It's not because somebody is bossy, or they don't want to do it themselves or… you know. So I think, yes, if anybody can give education, certainly.* **Case B Ward B2 CNM2**

RN supervision or assessment of HCA competence in care delivery was not observed in either case. In the absence of delegation, there was no standardised approach to assessing competence of a HCA to deliver direct care. The RNs and CNM2s described three ways of how they perceived the HCAs as competent. First, if the HCA worked a long time in the RCOP service and if the RN had worked with the HCA delivering direct care, the RNs 'knew' the HCA and trusted them. Second, the RNs were confident that the HCA knew what to report back to the RN on resident wellbeing or any concerns. Thirdly, if the HCA had completed the QQI L5 programme this was considered an indication of HCA competence because workplace assessment of competence by a supervisor (RN) is required within the QQI L5 programme. In Case A there was scant evidence of competence assessment of the HCA as delegate, with the CNM2 referring to HCAs having completed the healthcare support programme as an assurance of competence.

> *… since I was here I have only two recruits that is new […] and they made part of that, two recruits made part of our FETAC level (QQI L5 programme). They did the FETAC level here… They [HCAs] are accountable for their actions as most of our care staff (HCAs] are FETAC-trained… because all of them know what is normal and… if they are worried about anything they have to come and report to us.* **Case A CNM2 Interview**

In Case B, the CNM2s assessed HCA competence through communication from the RNs who worked with the HCA, and the direct assessment by the CNM2.

> *Well normally when they're working with a nurse, the nurse would relate back to me, even after the first day, let me know.*
>
> ***Interviewer:*** *And if you felt that they weren't displaying competence after a while, what do you do?*
>
> *… I would work with them and I would observe them, you know. And if they weren't then I would discuss it with them and then bring it further. You know, just to see, maybe they're, something's not explained properly to them. Maybe they didn't get a proper induction but normally here, myself or whoever is in charge would do the induction on the first day. And explain what we expect from them*. **Case B Ward B1 CNM2 Interview**

The CNMs indicated that knowing the individual HCA was key to assurance of HCA competence. The CNM2 described how, when she saw the resident, she knew which HCA had delivered care to the resident properly.

> *But you do know the staff… you do know some are more competent than others, it's not even, they're more particular with their work, you know, that they'll do a job properly. You look at the person's [resident's] fingernails even and you know that, you know who's looked after them, you know. Stuff like that, even though the others, they know what to do, they just mightn't be as particular.* **Case B Ward B1 CNM2 Interview**

The relevance of the HCA QQI L5 qualification was identified as important to RNs in both cases. The RNs described how HCAs with healthcare support qualifications were more observant and reported back to the RNs.

> *And also like the process has been changed up to FETAC Level 5 now and that's made a difference. I find they're willing to take on a bit more responsibility and, you know, they're documenting now a bit as well. They [HCAs with QQI L5 qualification] report back. They're more aware of what they have to do and they're more observant as well with the residents.* **Case B RN Focus Group Interview 1**

In the absence of national standards for HCA education, there were variances between education providers as to whether delegation was included in QQI L5 learning modules or not. In education modules and programme content dated pre-2018, there were no references to delegation. In recent HCA QQI L5 programmes (HSE, 2019), RN delegation was identified as part of the HCA Care Support (Level 5) programme content.

5.4.1.4 Summary

Despite RNs having an awareness of NMBI guidance on RN scope of practice, they were not aware of the detail on the RN role as delegator. In contrast, adherence to HIQA standards and requirement were important in each case. There were no PPPGs or education specifically for delegation. As RN staffing numbers decreased and HCA numbers increased, there was an acknowledgment that this would increase the requirement for RN delegation. There was no standard approach to assessing HCA competence in care delivery and resident support. HCA competence was built on trust and knowing the HCAs who worked in the unit for a long time. In addition, the HCAs who had completed the QQI L5 programme were assumed to be competent in their role. The RNs relied on the HCAs knowing what was important or relevant to report back to the RNs. The level of education the HCA had received in relation to their role as delegatee was not clear, as delegation as a topic was only evidenced in more recent QQI L5 education programme content.

5.4.2 Theme 2: How it Happens

This theme describes how delegation of tasks from RNs to HCAs occurred in RCOP study sites. An objective of this CSR was to understand how and when an RN delegated a task or activity to a HCA. There was little evidence regarding the RN/HCA delegation process and of how it happens. However, the findings provided insight into the possible reasons for this, identifying confusion and reticence by RNs in relation to delegation. There were two categories in this theme: *allocation or delegation* and *delegation–nurse-in-charge only.*

5.4.2.1 Allocation or Delegation

This category describes the different interpretations between delegation and allocation or assignment of tasks and activities, where participants used the terms *delegation* and *allocation* interchangeably. Job specifications use the term *assignment*. This was important in understanding if nursing tasks – e.g. clinical observations, documentation – were tasks assigned to the role of the HCA or still requiring delegation.

Delegation was described in the study information sheet and at information sessions, yet at all interviews there was a consistent misinterpretation of what delegation of tasks and activities meant in practice. In response to questions relating to delegation, all participants referred to staff allocation as delegation. Participants described the allocation of tasks and team allocation, and this was observed. Allocation refers to work and tasks distributed equally, and implies that there were no hierarchical levels among team members. The assignment of tasks to HCAs (e.g. resident baths, resident routine weighing) or the allocation of HCAs to work in particular areas (e.g. dining-room duties, resident sitting-room supervision) was interpreted by participants as delegation. This misinterpretation of allocation as delegation was found across both cases. In both study sites, the *allocation list* was recorded for each day (in the diary date page), by the CNM2 or nurse-in-charge. RNs and HCAs were allocated, identified by RN and HCA name (initials), as a team to residents at the beginning of a shift. Team allocation was observed when individual RNs and HCAs were assigned to work in pairs in team areas, communicated at the end of morning handover reports. Shift handover reports took place in the nurses offices on all wards. The night nurse (RN) gave the report to staff in the morning, and the RN in charge of the day shift gave the report at night. No HCAs gave the report. In Case A, HCAs were predominantly allocated in pairs to work together, and the HCAs worked independently. Therefore, there were few opportunities for delegation to be observed (Table 5.4).

Table 5.4: Direct Observation Period Ward A1 Morning Handover Report and Team Allocation

8.10am All team in Nurses Office at end of morning report, four HCAs, two RNs and Director of Nursing (DoN)…
8.20am Report over. One RN organises the teams; RN working independently and two pairs of HCAs allocated as teams. Day work organised by discussion. Led by two RNs (day duty) but tasks assigned between all (RNs and HCAs) with consensus…
Other RN working alone with hoist in a resident's room. HCAs working alone, each in a resident's room attending to hygiene needs.
8.30am A1. One RN at Nurses Desk area with drug round trolley. Another RN administering medications in resident's room.

Similarly in Case B, allocation and staff assignment was observed at shift handovers, clarifying that the 'delegation' described by interview participants was not delegation. RNs were not observed transferring a nursing task to an individual HCA, confirming that the HCA was competent to undertake the task, supervising or following up with the HCA to evaluate task completion. In Case B, RNs were paired in teams with HCAs. No delegation was observed (Table 5.5).

Table 5.5: Direct Observation Period Ward B1 Morning Handover report and Team Allocation

Ward B1 Morning Observation 25th July 2017

7.50am: CNM2 in Nurses Office with Night Duty RNs, Handover report. Door closed...

07.57am: Day duty staff arriving on duty, congregating outside Nurses Office. Office door remains closed. Handover report continuing in office with CNM2 only.

08.00am: Night duty RNs leave office go off duty. Day staff stream into office. Taking seats… CNM2 gives handover report to team...

Areas allocated to teams of two staff by CNM2 that appears to be listed in Ward Diary. RN and a HCA; RN and a HCA, then pairs of HCA permanent and agency, 1 HCA assigned to kitchen.

No specific/explicit tasks delegated to individual team members. No delegation observed.

At end of report, everyone leaves. I follow 1 RN & HCA. No tasks delegated. They appear to know where and what they are going to do.

In Case A the CNM2, when asked how delegation occurred, described the allocation of staff, explaining that in each ward there were generally six staff rostered on day duty, divided into three teams of two to work in designated areas of the ward. RNs had specific tasks (e.g. resident care planning) and HCAs had specific tasks (e.g. resident property lists).

> *… as the start of the handover we are starting with six [staff] so our team has been divided into three groups… when we make the shower allocations… each of the staff nurses have been delegated, they have own care plans and things as a part of their own role that will be one delegation. For care staff, each of the care staff are responsible for ward jobs, and you know property list of the residents so that has been delegated to them too. Then on a daily basis there might a few other delegations like if there was a family member or something like that to talk.*
>
> **Case A CNM2 Interview**

There was a similar interpretation of delegation by Case B CNM2s:

> ***Interviewer:*** *In relation to the delegation of tasks from nurses to HCAs, what do you think is the role of the CNM2 in relation to delegation of tasks, in your ward?*
>
> *[Slow response] I suppose the allocations. To ensure that the allocations are… [done].*
>
> ***Interviewer****: Will you explain what allocations are?*
>
> *Just to allocate where the staff are working. We try to keep, we'll say, have a registered nurse and a carer working together. Allocate them to each corridor. Here we have six corridors so we would try to have, it's not always possible to have a staff nurse and a carer [HCA]. Sometimes we've two carers.* **Case B Ward B1 CNM2 Interview**

RNs described allocation when asked about delegation, describing how HCAs and RNs were allocated to work in pairs as a team.

> *In the morning, we have the allocation of the staff, one nurse would be paired with one carer but sometimes, because of staffing shortage, a carer could be paired with another carer and then that's the way we do it. We allocate the ward to go, what patient to go to and who you're working with.* **Case B RN Focus Group Interview 1**

The HCAs in Case A and Case B also used the term 'allocate' when describing how the nurse in charge took responsibility for team allocation after the morning handover report.

> *In the morning we're told where our team is. At report. On the changeovers [shift handovers] we're allocated… Then at lunchtime we'd be told, you'd be allocated then where to go, either down the ward, or in the dining room. By the charge [nurse-in-charge], yea, in the morning time usually it's all done.* **Case A HCA Focus Group Interview 2**
>
> *Yeah, yeah, well we go in in the morning, we're allocated with a nurse and a care assistant, you know, we're paired off. Yeah we are paired off.* **Case B HCA Focus Group Interview 1**

There was no evidence from the documentary analysis of delegation terms or tasks delegated to individual HCAs in the ward communication diaries. No instances of RN delegation to HCAs were observed, nor instances where delegation may have been required. RNs and HCAs were observed working with each other in a familiar, supportive manner. This finding was confirmed at interviews where participants admitted that they did not think there was a need to delegate to HCAs. In Case A, RNs described how the HCAs asked to work in pairs with the most care-dependent residents because the HCAs knew the residents.

> *The staff are here I suppose that long that they're very familiar with what needs to be done.*
>
> ***Interviewer:*** *Do nurses have to delegate then to them?*
>
> *No, they [HCA] know, they'll know, they just carry on…, some are really, really good, very good, experienced and they would know to report anything… There's not a great need [to delegate], not when they're experienced.* **Case B CNM2 Interview B1**

The RNs explained that RNs did not delegate to the HCAs because there was not a great need to delegate to long-term HCAs, as HCAs knew what to do and the RNs were confident that the care or task would be undertaken.

> *You don't need to delegate because they know…*
>
> *Some are very responsible, you know, you know it'll be done…*
>
> *No, they're quite capable of delegating to each other. If there's some agency, or something*

> *else on, you know, they just explain what is to be done. You know what's done at certain times and how to do it.* **Case B RN Focus Group Interview 2**

The RNs in Case B described how tasks were delegated to the HCAs through a list of ward tasks or duties. There was an expectation within this that HCAs knew their responsibilities and duties.

> *I think there's also a list of their responsibilities as well, they know what to do, like you don't have to tell them what to do every day, especially the ones that are here always.*
> *There's a list of duties.*
> *They have duties that they know that if you're, for example, if you're assigned to the kitchen and you know what to do about any, you know, any, if you're working like a short day or long day, then you're responsible for the laundry or anything like that. The regular staff know anyway.* **Case B RN Focus Group Interview 1**

Separate task lists identified duty tasks for HCAs, MTAs and RNs. On the RN task list, supervisory responsibilities of HCAs were outlined.

> *Check that the Care Attendant has stocked up patients' lockers with incontinence wear, cleansers, etc. Ensure that the Care Attendant is aware of his/her duties. These include kitchen duties, updating the Activity Board to state the day, the date, and any activities that will be happening that day (check notice board for activities, e.g. Concert on Saturday, Mass on Sunday).* **Case B Ward B2 Night Nurse's Duties List**

The Mealtimes/Medications/Staff Lunchtimes list identified the responsibilities and tasks for both RNs and HCAs. This list was the only evidence of 'delegation' terminology in ward documents, where the last sentence identified the delegation role of the nurse-in-charge:

> *Nurse-in-charge to use professional judgement in delegating tasks in accordance with the dependency needs of the Resident.* **Case B Ward B1 Mealtimes/Medication/Staff Lunchtimes (RNs & MTAs) List**

In Case A, there was evidence of nursing tasks undertaken by HCAs. These tasks were clinical observations, urinalysis and documentation. However, in the absence of Case A HCA job specifications or related evidence, it was not possible to establish if these tasks were identified within the participant's HCA job specification roles and responsibilities. The national HCA and MTA job specifications pre-2014 had no reference to clinical observations, urinalysis or documentation. More recent HSE MTA (HSE, 2015) and HCA (HSE, 2014) job specifications did not identify clinical observations or urinalysis, and vaguely identified the responsibility for documentation:

> *Contribute to the maintenance of updating of patient/client/ resident documentation* **(HSE, 2015, p.1)**

Therefore, it was difficult to establish if these tasks were assigned within the HCA role or delegated. For HCAs who had completed a module within the QQI L5 programme on clinical observations, this included measuring and recording vital signs and communicating them to an RN.

In Case A, the CNM2 and RNs tended to assume that the HCAs were educated and competent in recognising abnormalities in clinical observations, and would respond appropriately when abnormalities were detected.

> *… if they are doing obs [clinical observations] of a patient and if they are worried about anything they have to come and report to us… because all of them know what is normal.* **Case A CNM2 Interview**

RNs in Case A described how the HCAs undertook clinical observations and urinalysis on their own initiative and without RN delegation:

> *I have full confidence with the two of them [two HCAs working together delivering resident support and care]. Whatever happens, whatever they saw, whatever they noticed, like something different from yesterday or the day before. they will report it… the healthcare assistant I was working with this morning dipped the lady's [resident's] urine and showed it to me and I put it in the book. And that lady's on an antibiotic now… They will just quickly say I'm going to check the blood pressure or something because so and so is not right*. **Case A RN Interview 2**

When HCAs in Case A were asked if they undertook and recorded clinical observations and urinalysis, the HCAs confirmed that they did. However, some HCAs reported that they did not record these clinical tasks, but reported to the RNs who recorded them.

> ***Interviewer:*** *And do you do [clinical] observations, and do you record any of this?*
> *We do them, we don't record. We give it to the nurse anyway. Yea, she logs them.*
> **Case A HCA Focus Group Interview 2**

In contrast, Case B HCAs did not routinely assess clinical observations or urinalysis. The HCA job specifications did not provide clarity as to whether these tasks were HCA role expectations or required delegation. The CNM2 explained that HCAs in Case B did not assess or record clinical observations:

> ***Interviewer:*** *And do the HCAs do [clinical] observations in this ward?*

They don't… They would assist to weigh somebody but they wouldn't actually do the obs.
Interviewer: *And is that because the culture was that they [HCAs] didn't do it, or is it that they don't want to do it, or nurses prefer to do them?*
Oh no, the culture is that they don't do it. **Case B CNM2 Ward B1 Interview**

The CNM2 (Ward B2) explained that the RNs remained, sometimes two hours after their work shift finish time, to complete their documentation. The CNM2 was asked if there was anything else the HCAs could do that would help nurses not to be here two hours after their shift finished:

Yes maybe I know when they [HCAs] do their FETAC and they do an add-on [module] when they do obs [clinical observation module] but I am yet to see any of them doing the observations. They still see that as the nurse's role, you know, the observations.
Interviewer: *And is that tied into their job evaluation with the union [MTA contract of employment]?*
No. I don't know. I don't know why they are not doing it. I just think they are all mad [eager] to get this course… and yet at the same time we [RNs] will just check it [the clinical observations]. They [HCAs] may be a bit unsure of themselves as you know observations comes with years of experience. But you are not asking anybody to make a diagnosis on the spot.
Interviewer: *And do you ask, are the HCAs asked to do it (clinical observations)?*
If they are asked to do it they will go down but "will you just check that again, [CNM2 name]'? [HCA asks CNM2 to check]. **Case B CNM2 Ward B2 Interview**

Case B RNs could not explain why the HCAs did not undertake clinical observations, or why the RNs could not delegate these tasks to the HCA.

Well, a number of HCAs are on level five [QQI L5 programme completed]; they don't give blood pressure or anything. All that's left to us. Even though they've been trained.
Interviewer: *Why don't they do it?*
It's just not common practice here. Even though you say and will you do it and they'll do it. But you have to go back then, do you want to do those blood pressures again. You've to ask every time. Like they'll play you if they want as well and they don't do.
Case B RN Focus Group Interview 2

It was difficult to establish why HCAs in Case A undertook clinical observations and urinalysis without delegation, and why HCAs in Case B did not undertake clinical observations, despite RNs reporting role overload and some HCAs had completed the QQI Level 5 programme.

5.4.2.2 Delegation Nurse in Charge

This category describes the relevance of the *nurse-in-charge* in relation to delegation. In both cases one RN was identified on each roster shift as *nurse-in-charge*, and only this nurse was expected to delegate or assign tasks on that shift. This was an unexpected finding.

> *I was unaware of nurse-in-charge model of staffing. This concept of nurse-in-charge did not emerge in pilot or literature review.* **Memo; Phase 1 Data Analysis.**

The nurse-in-charge was described by all participants as one RN designated as the nurse-in-charge of each shift, and as the RN who 'delegated'.

> *So, we've got a little star beside the nurse's name, to say that person is in charge of the shift. So she'll do the delegating, she'll look after the doctors. She'll make sure everybody goes on their break and they're back on time and the smooth running of the ward as well. And it can normally be the person that's a long day. Because you've a long day in the eight to five, so you want continuity of care.* **Case B RN Focus Group Interview 2**

The CNM2 in Case A, although present at handover reports, did not take the role as nurse-in-charge. The CNM2 had clinical management responsibility for the two wards. The CNM2 in Case A was observed predominantly working independently of the RNs and HCAs, and was not observed delegating or allocating tasks to either RNs or HCAs. The CNM2 explained that she had minimal input into the allocation of staff, and it was only the designated nurse-in-charge who delegates.

> *Like I don't have much input into that [allocations] so the nurse-in-charge as I said she is the person who is responsible to delegate… who is going to which team.* **Case A CNM2 Interview**

This was supported by RNs in Case A who described how the nurse-in-charge role rotated between the RNs, and that role was to 'delegate' the RNs and HCAs to teams, and to specific daily (routine) tasks (e.g. resident support with feedings, resident supervision).

> *One of the nurses will be made in charge. So that in charge [RN] then delegates the task. She says who goes to which team, like which two people go to which team…. So the [nurse] in charge changes every day, every day there is a different [nurse] in charge. So all the nurses act as [nurse] in charges, all the nurses yea.* **Case A RN Focus Group Interview 1**

There were differences between cases as to how the CNM2 perceived their role as nurse-in-charge and their role in relation to delegation. In Case B, the nurse-in-charge was always the CNM2 when the CNM2 was on duty.

> *A CNM2 of course has a very important role with the team and I suppose just every morning at their report she will explain the allocations, let everybody know and go through the diary and explain what has to be done... so she is really I suppose the most important person there for delegation.* **Case B Ward B1 CNM2 Interview**

This assignment of the role of charge nurse on a day shift on all wards was confirmed from observation data (Table 5.6).

Table 5.6: Direct Observation Period Ward B2 Morning

Ward B2: 16 Residents**.** Two day duty RNs & three HCAs.
8.05am Night duty handover report over. Night duty RN leaves office to go off duty.
One RN (nurse-in-charge) using ward communication diary as a reference, allocates staff to teams and areas. Provides an update on residents and particular care to be delivered or appointments for individual residents…
08.10am Nurse-in-charge RN tells HCAs of change in duty allocations, i.e. HCA changed to kitchen duties, from team allocation. No response from HCAs, silence. RN writes on sheet.
08.12am HCAs chatting amongst themselves, social conversation. Waiting……. RN gives handover sheet to one HCA (who later is confirmed as an agency HCA). All leave office.
HCAs go off down ward corridor. No delegation observed. HCAs appear to know what to do. They separate and set up linen/care trolleys for their team areas.

There were similar findings in both cases as to the HCAs' descriptions of the nurse-in-charge role, and it was only the nurse-in-charge who was responsible for team allocation.

> ***Interviewer:*** *So if I'm the nurse in charge, but there's two other nurses today, would they delegate to healthcare assistants?*
> *No, no. It'd just be the nurse in charge. Just the one that's in charge, yea***.** **Case A HCA Focus Group Interview 1**

HCAs preferred when only one RN was in charge and reported that they did not like if others told them what to do. If more than one RN was allocating tasks it would "cause a lot of trouble" and "a lot of friction".

> *I think the person in charge should be doing the job [allocations], you know, and you should, you know, I personally think that's the best way. Too many chiefs. Yeah, too many chiefs because I do think it can cause a lot of trouble, you know, among the staff… I've no problem if someone's in authority telling me but I do have a problem people that aren't in authority, I really don't think they [other RNs] should be because I think it causes a*

lot of friction. **Case B HCA Focus Group Interview 1**

There were no examples of the nurse-in-charge delegating, but there was agreement that if delegation were to take place it would be the responsibility of the nurse-in-charge.

5.4.2.3 Summary

There was little evidence of delegation in Case A or Case B. Allocation to teams or assignment of tasks was described when participants were asked about delegation. Because job specifications for the study participants were not available for review, it was difficult to understand if the tasks and activities assigned were within the HCA role expectations or were additional to the role of the HCA that required delegation. On each shift, one RN was designated as the nurse-in-charge. The other RNs on duty had no responsibility for assignment to HCAs. Due to the routine nature of the work and the HCAs' familiarity with the residents, the need for delegation was not identified. Therefore *routine* or task-orientated care was the dominant approach to care.

5.4.3 Theme 3: Knowing What I Should Do

The theme *Knowing what I should do* describes how RNs, HCAs and CNM2s perceived delegation in the context of their role and others' roles. *Knowing what to do* brings together data in understanding the RN knowing when and how to delegate, their role as delegator. This theme also includes interpretations of the HCA knowing which tasks and activities were within their role as delegatee. The theme divides into two categories. The category *RNs and HCAs are different,* describes how RNs and HCAs were perceived as different or similar. Two additional subcategories were developed, *working in pairs – "it's kind of like being married",* and *answer the bell or stay in the office. The category Knowing what to do,* describes the RN and HCA roles in delegation, and had two subcategories*,* "I'm *going to see it, I'm going to do it* and *I'm going to write it",* and *HCAs and MTAs are different.*

5.4.3.1 RNs and HCAs are Different

The category *RNs and HCAs are different* describes the conflicting evidence as to RNs' and HCAs' perceptions of the difference between their roles. Sub-categories within this were: *Working in pairs – "it's kind of like being married",* and *Answer the bell or stay in the office.*

There was conflicting evidence as to RNs' and HCAs' perceptions of the difference between their roles. RNs were aware of their responsibility for resident care, but also for their administrative responsibilities, especially documentation. RNs described being faced with inconsistent demands in their role in the context of their dual roles – direct care role and administrative role. The RN direct

care role was working with the residents delivering care and support, alongside the HCA. The administrative role, described as an expanding role, included documentation, care planning, medication administration, wound care, family and carer consultations, and interactions with other medical, health and social care professional colleagues.

> *… when we started nursing, [documentation]… was that 'patient had a good day', 'slept well', but now things have been changed with a lot of improvements... along with our documentation the amount of assessments have increased. The amount of care plans have increased. The amount of documentation has increased.* **Case A CNM2 Interview**

In Case B, the RNs did not think that the HCAs were undertaking nursing tasks or activities, but the RNs undertook activities that were not within their role. Across both sites RNs reported a need to clarify the role of the RN in care of older people:

> *In our roles definitely. Because I think we are, a lot of nurses do a lot of that isn't ours.*
> *Yea, I don't think the care assistants are doing work that's ours…*
> *But I think first of all we need to see what our role is, you know, clarify it first of all, in care of the elderly.* **Case B RN Focus Group Interview 2**

The RNs explained that HCAs did not like when the RN checked resident care after the HCA had reported on this. The RN checked on the resident because of their professional accountability and responsibility, referred to as 'trying to cover yourself'.

> *It's on the nurses as well, if you report to them, carers are giving out because, I don't know, she doesn't trust me, when I told her it was dry she still went there and checked it because for us that's just a bug with yourself. You want to go out there and see yourself if it's okay, not to check,…because you're trying to cover yourself.* **Case B RN Focus Group Interview 1**

However, when the RNs explained to the HCAs that the RN was professionally accountable for care delivery, the HCA did not always understand this.

> *I said something and the carer at the time said, 'well I'm not answerable to you'. I said 'you are answerable to me', I said, 'no matter what, the buck ends with me'. And I says 'if anything happens… it's my registration, you've nothing, no code of conduct', like she said 'I'm here 17 years'. I said 'well it doesn't matter'.* **Case B RN Focus Group Interview 2**

The requirement for RNs to concentrate on administrative and documentation responsibilities was evident in both cases. RNs also explained that HCAs did not understand the additional roles and responsibilities of an RN, especially the increase in documentation and administrative responsibilities.

> *I think there is so much expected of the nurses here. That you know, when you go do anything from a nurse's point of view. That they (HCAs) don't understand, I really don't think they do…. And then the documentation is huge here and it takes a huge piece of the time.* **Case B RN Focus Group Interview *2***

However, one RN commented that the only difference between an RN and a HCA was the RN's medication administration responsibilities.

> *the medication round… this is the only difference with really a nurse and a carer like, to give medication because other than that we do the same job as they are.* **Case B RN Focus Group Interview 1**

The RNs explained how their administrative role had expanded and RNs were not available to work with the HCAs as much as previously:

> *So our role has changed massively, so that has a knock-on effect with everybody, you know… They [HCAs] would probably say, at the moment that you know the nurses, is all that they do is, I'm in the office and I have to do medication or I have to do paper work. But that's the way it is and I don't think sometimes they realise that you know***. Case A RN Focus Group Interview 2**

The HCAs expected the RNs to prioritise direct care responsibilities. When RNs did not undertake all direct resident care, the HCAs did not understand the difference in roles and responsibilities. Instead, the HCAs in Case A perceived that the RN and HCA roles were similar.

> *You'd say, well right the nurse is higher than you. But in this place, we're all the same so we are... But they have a degree that's all really... Yea they have a degree. But you're actually the one who knows the resident more and everything about them. And having a relationship better than the nurse would.* **Case A HCA Focus Group Interview 2**

HCAs described how the RNs might leave them when they were delivering direct care and not return because the RNs got distracted responding to their administrative role.

> *The nurses are going off, they go off and do other things. They leave you. And they mightn't come back….*

> ***Interviewer:*** *And what do they go off to do?*
> *The drug round and then they might get distracted by a dressing. Phone calls.*
> **Case A HCA Focus Group Interview 2**

If an RN asserted their position, the HCAs perceived this to be more related to individual RN personalities as opposed to the distinct difference in the RN role.

> *It's like if somebody offered an opinion on a certain situation and probably to be cut short and I'm told, I am the nurse… Well if that's what they need to feel superior… Most people are nice, like I mean I have to say here we have a good rapport but there is the odd person that likes to show their authority. I think it's just the personality.* **Case B HCA Focus Group Interview 1**

The perception by HCAs that there was no difference between a HCA and RN, together with the HCA perceptions that they knew what to do in their care roles, resulted in resistance from HCAs when the RN assigned or requested the HCA to undertake a task.

> *Sometimes you'll hear from carers, they'll say, 'who does she think she is, does she think because she's a nurse, you know, she just can tell us what to do'… You know, sometimes they fight with you because of certain persons [certain HCAs]* **Case B RN Focus Group Interview 1**

The HCAs described being frustrated and annoyed when an RN assigned a task to the HCA that they thought the RN should do him/herself. The HCAs explained that the RN was "doing nothing", resulting in conflict – "It can boil like this very quickly".

> *Sometimes, you'd have a nurse that would say, will you just do such a thing, like that just like that. But… she's doing nothing and it can boil like this very quickly. Yea, like 'can you just wash them wee cups', but I'm standing here. And you're just like, like I've just walked up that corridor. And she just, did she just say to me wash them wee cups….*
> *I find they don't do the teas. Like so we have to do the teas in the afternoon, it takes a long time. So then they're like, where's the carer I haven't seen them, I haven't seen them. But they don't realise more team work, they would be saying it does actually take a long time to give out those teas.* **Case A HCA Focus Group Interview 1**

Some RNs and HCAs described HCA tactics of resisting task assignment by pretending they did not hear the RN:

> *… if it doesn't happen and it falls on deaf ears.* **Case A RN Focus Group Interview 2**

> *And that's just a little sign of her power. And I have to let on that I can't hear her.* **Case A HCA Focus Group Interview 1**

There was a reluctance from RNs to address the HCA resistance to assigned tasks. The RNs described that the RNs worked closely with the HCAs and thus working relationships were very important. Therefore, to change practice or ask HCAs to do something could be interpreted as the RN being "a Hitler type".

> *You know, so take, to take that on board and not be a Hitler type... Or maybe times if you go to do something different, where we don't normally, we don't normally do it like that. And or it doesn't as [named nurse] said, is it, it can be very institutionalised.* **Case A RN Focus Group Interview 2**

> *What I should've done is spoke up and say, can you please just go over there. Like I didn't know how many times it needed to be said. But like, here you go again, I get on with the person and I like the person. And I just was putting it down to, well maybe they're just having a really bad day, or something I don't know.* **Case A RN Focus Group Interview 2**

When asked what needs to be improved for effective delegation to occur, RNs explained that there was a need for clarity from the organisation as to the differences between RN and HCA roles. The rationale was that RNs did not want to risk changing the good relationships with HCAs by addressing this themselves or by adopting the role of delegator.

> *I think it needs to come from the top too [more senior level in organisation]. To decide what is nursing and what is care attendants. I think that's what we need to do. There's no-one comparing that [the difference between the RN role and the HCA role]… we get on so well with the carers … Yea people just run with that relationship.* **Case B RN Focus Group Interview 2**

Two subcategories were developed from the analysis as, "working together – its' kind of like being married" and "answer the bell or stay in the office".

5.4.3.2 Working in Pairs – "It's kind of like being married"

This subcategory describes how RNs and HCAs worked together in pairs to deliver care. RNs and HCAs were allocated to work in pairs as a team in designated team areas of the ward. When there were fewer RNs than HCAs on duty, two HCAs were paired to work together. RNs and HCAs worked together delivering resident care predominantly in the morning, supporting residents with personal care,

toileting and mobilisation. The researcher expected that this was when delegation would occur. RNs were asked to describe how delegation happens, but their responses never described delegation but rather allocation.

In both cases, at the end of the morning shift and the night shift handover reports some RNs commenced resident medication administration. The other RN(s) on duty were at times observed working with a HCA in pairs but the RNs predominantly worked independently of the HCA. RNs were observed completing administrative tasks or working independently with resident care delivery (Table 5.7). RNs and HCAs worked together with more dependent residents. However, in Case A, HCAs were more often paired together as a team pair, whereas in Case B a HCA and RN were paired together.

Table 5.7: Direct Observation Period Ward A1 and Ward A2 Morning Handover Report and Team Allocation

CNM 2 working between both Units. 7.55am Ward A2. In office is one night duty RN, two day duty RNs, the CNM2, three HCAs and a fourth HCA arrives later in report. One day duty RN appears to take lead for day. Sitting beside night duty RN at desk… 8.20am Ward A2. Report over. No delegation or allocation observed. Four HCAs paired up to work together and leave office. One RN takes drug trolley from office and commences medication round. One RN tidying up area outside office. CNM2 remains in office at documentation. 8.30am Ward A2. RN (who had been tidying up outside office) now in resident's room with HCA. They are working together lifting residents in bed with hoist and bed bathing. They are talking together, agreeing work/care processes. No delegation observed. 8.45am Ward A1 and Ward A2. One RN on each ward with drug trolley administering medication. CNM2 going between the Nurses Offices on both wards. The second RN on each unit and the HCAs are working independently. 8.50am Ward A2. CNM2 feeding highly dependent resident in their room on her own.

When RNs and HCAs worked together in delivering resident care, the RN did not adopt a delegatory or supervisory role in the team. Case A RNs described being allocated in pairs with the HCA, and there was no difference between the roles. However, the HCA might be left to work on their own.

> *One nurse and one carer goes to one team, like we make three teams. We are six in the unit. So we make three teams. So one nurse and one carer mostly goes to each team. That time to half eleven [8am to 11.30am], we are one team, like one nurse and one carer. But during that period the nurse in between lets the carer do some of the patients on her own…*
>
> *Yea we work together; it's nothing there that is the carer's job in the room. And that is the nurse's job. We all work together.* **Case A RN Focus Group Interview 1**

In Case B, when the RN and HCA paired together, the RNs were observed taking a lead in task decisions, e.g. when working in pairs, observed on corridor between resident's rooms, RN heard saying to HCA "Will we move [resident name] first?", "If we go this way…". On Ward B2 both RNs and HCAs were predominantly observed delivering care on their own, but beside each other. That is, the RN would be in a resident's room delivering care and in the resident's room next door the HCA would deliver care. They were heard continuously checking in with each other. RNs explained that this was often because the residents with advanced cognitive impairment got upset or agitated if more than one staff member was with them (Table 5.8).

Table 5.8: Direct Observation Period Ward B2 Morning Team Allocation

Ward B2. 8.20am: Two RNs and three HCAs on duty One RN and one HCA in room with resident bedside (behind screens). Two HCAs in different resident's rooms, at bedside (behind screens). One RN in another room with resident at bedside (behind screens). I (non-participant observer) was positioned outside one room where RN and HCA are delivering bedside care for a resident. The resident is continuously chatting to the RN and HCA. They are talking back. Besides this three way conversation there is no delegation of tasks heard. The resident is assisted with washing, dressing and mobilisation to dining area with no delegation observed. 08.26am: On other side of B2. In three different residents' rooms adjoining each other the other RN and the two HCAs are working independently. Each assists a resident from bed, personal hygiene needs and dressing. Two HCAs meet up to assist a resident walking to the Dining Area. Three female residents now seated at tables in the Dining Area. Kitchen/catering staff (not HCAs) serving drinks (tea) to residents. 8.30am: HCA and RN in resident room. Both chatting to resident. No delegation heard/observed. All five staff appear to know what tasks need to be done and are working together as a team. 8.35am: Now RN and HCA who were working together are working in adjoining rooms. They are each assisting a resident independently. However they remain in contact: HCA calls to RN next door: "Are you alright?" RN responds, "Yes, yes" Memo: Although each of the five staff are now working in different rooms with different residents, they remain next door to each other and check in with each other. 8.40am: RN leaves a room and knocks on next-door residents room, calls to HCA from door "When you are ready will you give me a hand with 'names resident'?" HCA responds to RN "yes". RN leaves and returns to room she is working in and resident care. Unit is quiet. No loud noise. Radio playing on low volume in Dining Area. Conversations between staff and residents they are caring for. 8.47am: HCA is now in room here RN requested assistance. RN and HCA now assisting residents form bed to chair. No delegation heard/observed. HCA quietly asks resident: "you ready to get up, are you?"

In both cases, RNs and HCAs confirmed that no delegation occurred in resident rooms when a RN and a HCA worked together:

> *It is just the routine like, for example, if she sees me that I'm doing that, she'll automatically go and get something else ready and all. And then we go together... It's all experience isn't it though, it's all experience... Once the patient is ready and all to get up, I go up and get the hoist and the other one will say, okay I'll get the towel. They'll [HCA] stay with the patient, get them ready.* **Case A RN Focus Group Interview 1**

In Case B, the RNs and HCAs explained that, when working in pairs with a HCA, the care was routine and there was no need for delegation or direction because everyone knew what to do. The RNs described how, when working with a HCA in a resident's room delivering care, they each knew what to do. They described a routine rhythm to knowing what to do as a working pair.

> *Yeah, [it depends] where you're standing, if you're this side [of the bed], the nurse is at that side, the carer is that side, this side would be you'll get the basin, you'll get the towel, you'll get the clothes, because she's on that side she'll get say the pad, she'll get the wipes, she's near the sink, so she'll get the water, you know.*
> *And she'll hear you saying give her the thing, the basin, get the water and give it to you and you do the wash, you know.*
> *So it's like routine, you don't need to tell each other. You don't need to delegate because they know… It's just automatic, no talking at all.*
> *We just talk to the patient in the morning like that, we're going to do that, that, the two of you are sure already and we know what we're going to do like, you know, so.* **Case B RN Focus Group Interview 1**

The HCAs in both cases described this familiarity of routine working in pairs and the routine of resident care. This routine was reflected in the HCAs automatically knowing what to do, going "on autopilot".

> *We probably do, because you do it automatically you could say, you get the clothes out there. And I'll get the water, or. Because we're so used to this. If I see, say, [name] getting the water I'll say, well here she's getting the water, I'll get the clothes... I just go on autopilot and everybody's… you just dance around each other. And just get everything done.* **Case A HCA Focus Group Interview 2**

When RNs and HCAs worked in pairs delivering direct care, no hierarchy of roles was observed or reported. The RNs did not adopt a more senior or higher-level care role; the pairs of staff 'just got on with it' and there was no delegation. The HCAs described working in HCA pairs as similar to 'being married' because of the familiarity between staff working together. They spoke of the need to be respectful to each other.

> *You don't delegate, you just get on with it.*
> *But I think, I think the personality, like I mean, you know...*
> *It's kind of like being married, you kind of know, with each other…*
> *It's a way of talking, the way you talk to someone, like definitely the issue is all about respecting someone and speaking to them properly and not demanding and telling them, you know, we ask politely, do you mind, that's all it is really.*
> *Well you instinctively know who you go to first every morning, like if you're hands-on you go to such-and-such, you know exactly where you're going.*
> *You know who is going to be looking for breakfast.*
> *It just falls into place.* **Case B HCA Focus Group Interview 1**

There were similar findings in both cases regarding the HCAs' perceptions of how the RNs' administrative role affected working in pairs together. The HCAs reported that if they were paired with certain RNs the HCA would do most of the work.

> *The nurses are going off, they go off and do other things. They leave you. And they mightn't come back.*
> *The drug round and then they might get distracted by a dressing. Phone calls, so you're talking. Administration stuff. And you're on your own, you've no partner then to get your patients up.*
> *And then you end up actually doing everything, so you do. And you're virtually working on your own at that stage […] Even though you're supposed to be working with [the RN].*
> *Because they're doing that and then they're walking off and they're doing the drugs. And you're probably after doing two people on your own, while they've been standing with their hand on their hip.* **Case A HCA Focus Group Interviews 2**

Despite RNs and HCAs being allocated in pairs to work together, this was not always evident in practice. The difference between RNs and HCAs contributed to RN role conflict. The conflict experienced by RNs in decisions to respond to resident care needs or their administrative responsibilities emerged as significant.

5.4.3.3 Answer the Bell or Stay in the Office

This subcategory describes the role conflict for the RNs in responding to the expectations of their direct care role (answer the bell) and their administration role (stay in the office), and the complexity of RN delegation. In both cases, there was RN role conflict in relation to the incompatibility of the RN delivering direct nursing care to the resident and the RN responsibility for documentation and administrative responsibilities. The RN was expected by their employer, NMBI and HIQA to have documentation completed and demonstrate adherence to legislation and standards. The RNs explained how the HCAs might not fully understand the level and importance of documentation.

> *I don't think they [HCAs] fully understand the level of documentation required by nurses now because it's so new and like, you know, if HIQA come in and your documentation is not up to level, it's the nurses that get it.* **Case B RN Focus Group Interview 1**

The importance of documentation and record-keeping was supported in the HIQA reports where there was a requirement for the resident care plan, nursing records, rosters, staff education and training records to be available for review by the regulator.

> *The inspectors reviewed a sample resident's nursing and medical records and found that in most cases the records contained all the requirements of Schedule 3 of the regulations. However inspectors found that some care plans did not adequately document the interventions required to meet needs such as communications and responsive (challenging) behaviours and that two medication administration records had not been signed by the administering nurse.* **HIQA Inspection Report Case A, p. 8**

RNs described how the HCAs did not understand that the RNs could not always assist them with direct care because they were undertaking their administrative responsibilities. There was a perception that HCAs thought the RNs were 'not doing anything' when they were in the office. RNs in Case A prioritised their administrative role.

> *Because they are in the wards naturally. And they come asking for if they cannot find [a resident], they come up asking for your help and you are not helping them naturally. So it is a natural reaction that they'll say that 'ah they are not doing anything… they are just in there' [in the office].* **Case A RN Focus Group Interview 1**

Similarly, in Case B, RNs explained how the HCAs expected the RNs to respond to calls for assistance with care.

> *When you're standing at the medication round… and then they [HCAs] want you and I've started going so slowly, 'can you help me?', that's what you hear. But what can we do, this is our time for this.* **Case B RN Focus Group Interview 1**

Despite this pressure to complete documentation and medication administration, RNs in Case B when called to help HCAs with resident care were pressurised to respond.

> *You've a half an hour for your documentation a day. And in that half hour, you've [medication] patches and all that kind of thing to do. You've to write up, medications. It's a very short time to do anything. And you're still called.* **Case B RN Focus Group Interview 2**

When asked how they overcame resistance from the HCAs to have tasks assigned or delegated to them, the RNs described different indirect approaches. They did not describe delegation. And when the HCA did not undertake the task, the RN did not follow up:

> *… just put it in a, I don't know, a jokey way. Or you just find a way around it… then, depending on what the task was, or what it was I was asking, I would just leave it.* **Case A RN Focus Group Interview 2**

The HCAs questioned the amount of documentation (writing) that the RN had to do and how long it took, and again related this to individual RNs:

> *But like, they spend a lot of their writing as well.*
> *… so you'd wonder what are they writing. The next time they sit there they could be writing the hoops. And you're kind of doing, you're doing a care plan. What is going on? It takes a whole day.*
> *It depends, some nurses could have it done like that [clicks her fingers] and other nurses it takes the whole day.* **Case A HCA Focus Group Interview 2**

When RNs told the HCAs that there were tasks that RNs were not responsible for, or when the RN did not respond to a resident call bell, this was interpreted as negative. The HCAs expected the RNs to answer the bells despite the RNs having additional administrative roles. The HCAs explained some RNs would not respond to a bell, even though RNs and HCAs were expected to respond to resident calls.

> *Well you would have certain people that would turn around and say, that's not my job.*
> *You'd have certain individuals would say, I'm not doing that.*
> *Well as we were saying earlier on like, we're familiar with each other, you know, but*

more often than not it's, there's always that vibe, if that's the right way of saying it, and to remind you of that.
Put you in your place so to speak, is it?
An example really would be a bell ringing.
And someone will just walk past and go.
They leave it for the girl in blue [laughs; reference to HCA uniform].
And we're all there told you answer a bell regardless of your unit but if you know there's people in the unit and you know they're going to walk past. **Case B HCA Focus Group Interview 1**

HCAs in Case A did not understand why the RNs responded to resident call bells but left the required task or activity for the HCA to undertake.

The nurses never do it now… we're just left to do it now that's the only thing, isn't it really? They don't put anyone to bed, they don't toilet anybody. They don't answer bells.
Yea and if they're answering a bell they're telling the care assistant to go and answer that bell. I'll just get a care assistant for you. They'll go down turn it off and say 'yea I'll get one of the girls to come to you'. **Case A HCA Focus Group Interview 2**

… you want to really go back and say, 'well what are you doing there now? 'did you go down and just knock off that bell and told them you'll get somebody for them?'. Instead of just dealing with them.
Like one particular nurse knocked off the bell and told that patient that I'll get somebody for you. And walked up the corridor and collared somebody and just said, 'will you just go down to that room there?'. I couldn't believe it happened.
It should be team work like you know, being told there's only like you know there's only five of us. So it's all hands on, you know. So it's not, like they're not doing medication, they're not doing documentation. But they are in the office. **Case A HCA Focus Group Interview 1**

When RNs were reported as not responding to the task from the resident call bell, there was no evidence that the RN delegated or assigned a task to the HCA. It was unclear if the RNs, by responding to a resident call bell, implicitly assigning a task to the HCA. There appeared to be an expectation that the HCA would be competent to undertake the required task or activity. The HCAs expected the RNs and HCAs to work as a team and share all tasks. The RNs confirmed that the HCAs might not fully understand why they had to do so much office-based work and documentation.

> *And they come to the nurses, if nurses are sitting down and doing some documentation. Or there is a discussion going on about a patient and all. They think, oh they are sitting down there and just standing and all. But they wouldn't realise that it is a discussion about the patient, you are talking about something very important.* **Case A RN Focus Group Interview**

Resident mealtimes were observed as a period when RNs and HCAs came together. Some residents could mobilise independently to the dining-room and required little assistance at mealtimes. However, a significant number in both study sites required assistance with feeding, in either bedroom or dining-room. Both HCAs and RNs highlighted the fact of RNs remaining in the office at resident mealtimes. In both Case A and Case B, the HCAs did not understand why the RNs did not assist with resident mealtimes. Again, the HCAs' perceived that the RNs were not working when they were in the office.

> *You know, they're in the office but you look in and you go, what, and then there's no writing, there's no nothing, and sometimes that can get very, very frustrating, when you need, you need people at certain times and meal times too…*
> *And sometimes you do feel you shouldn't have to keep asking…*
> *You shouldn't really.*
> *They should automatically know at this stage…*
> *They do know.*
> *People use the office to hide.*
> *[Laughing]*
> *And I think it's not fair because it causes a lot of, you know, tension and resentment.*
> *… if you've to feed one patient and it could take twenty-five minutes and then everybody else's dinner is going cold, you know. That's wrong.* **Case B HCA Focus Group Interview 1**

However, RNs reported that resident mealtimes created conflict and pressure as RNs had to prioritise either assisting at meal times or completing documentation.

> *I remember being up in [named unit] during the changeover and a health care assistant came in and opened the door and shouted in 'Dinners are down', and the nurses were all there.*
> *It happens.*
> *I couldn't believe that.* **Case B RN Focus Group Interview 1**

However, RNs were observed assisting at mealtime and there was no observed conflict between RNs and HCAs.

The CNM2 and RNs in Case A spent less time in direct care than in Case B, and were also more clear about prioritising their administrative role. In Case B the RNs spent more time working in resident care but were conflicted when there were dual expectations to complete their administrative and direct care roles within the time available. This contributed to RN role overload in Case B.

5.4.3.4 "Know What to Do"

The second category in Theme 3 was "*Know what to do"*, bringing together data on understanding the lack of clarity in the role of the RN as delegator and the role of the HCA as delegatee.

In both Case A and Case B, RNs were not observed delegating, and the interview analysis indicated a reluctance of RNs to delegate. RNs described how they asked colleagues to undertake tasks or activities that were within the HCA role, rather than delegation. However, there was lack of clarity as to what tasks and activities were within the HCA role, due to vagueness about HCA job specifications, HCA education level, and HCA competence to undertake direct care. There was also a reticence by RNs to ask certain individual HCAs to undertake a task.

> *I would find that I would have an issue myself, personally, asking certain, not everybody, but asking certain people, whether it was a carer or a nurse, 'Would you mind doing…?' And it's not even 'would you mind?', it's part of you know the daily tasks or whatever, so yea.* **Case A RN Focus Group Interview 2**

The challenges in delegation and assignment were described as an issue with individual HCAs:

> *It depends on the HCA...*
> *And some don't mind and are very obliging and others aren't always.*
> *Some are very responsible, you know, you know it'll be done, you know.*
> *Yeah, you'd be more reassured with certain [HCAs].* **Case B RN Focus Group Interview 1**

When asked how they responded to a HCA who did not undertake an assigned task, the RNs said they would go with the HCA and undertake the task with them.

> *We just go, we just go with them and if you've already taken something and then if you ask them and then they won't do it, then you'll go with them and then, you know, you do whatever together then.* **Case B RN Focus Group Interview 1**

The misinterpretation of allocation as delegation made it difficult to interpret if RNs knew how to delegate. Some RNs said they did not delegate because the HCAs had worked in the ward for a long time and they assumed that the HCA knew what to do.

> *Sometimes we assume they're going to do it because they've been here for a few years. We assume at this stage now they'd know, they know the routine, you know.* **Case B RN Focus Group Interview 1**

The impact of RNs not delegating was increased RN workload. This was more evident in Case B.

The Case B CNM2 said RNs should delegate because they knew that the HCAs were competent to undertake certain tasks and activities. However, RNs still wanted to undertake tasks themselves.

> *But I know there are some nurses that really when they are here exhausted and they are fantastic nurses and they don't understand why they are so tired it's because they are not delegating. And I have said it to them, I said 'you are not delegating enough' and she said 'but if I don't see it I don't know if it's done'. And I said 'but you know these people as well as I do. And we cannot do everything and I think she is, she was very frustrated…* **Case B Ward B2 CNM2 Interview**

In both cases there was no evidence that the RNs knew how to delegate, with no reference to supervision or evaluation of completed tasks. HCAs described how the HCAs worked together as a team, again relating this to their length of tenure, task-orientated work, and knowing what to do. This arrangement of HCAs working independently was more evident in Case A than Case B.

> *We really work, a lot of us, I suppose we're here a long time.*
> *But like we all, we work on our own initiative, like in here. We delegate by ourselves.*
> *Yea. We kind of know what we're doing you know. Like if [named HCA] put somebody to bed, then I'll say I'll have the next one into the bed, you know, share out the work.* **Case A HCA Focus Group Interview 1**

Case A HCAs were much stronger in describing how they communicated among themselves and organised their workload for the day. They described how, if an RN assigned tasks to the HCA, they did not need to be told what to do, and, if this happened, it was perceived by the HCAs as unnecessary – "*It's kind of a little bit, 'oh like, I know'*". The HCAs preferred to work without supervision, which was perceived as interference.

> *We [HCAs] kind of come down the corridor and we'd go, okay who will we get up first, or...*
> *Yea they kind of like, when somebody says it, it's kind of a little bit, 'oh like I know'. You might verbally discuss it beforehand and say like: 'who do you think we should get up first?' Like 'who are we getting up?' or 'we've leave Carmel back because she's for a shower' and we'll do this…*

We delegate by ourselves.

Yea. We kind of know what we're doing, you know. **Case A HCA Focus Group Interview 1**

The HCAs also described how the nurse-in-charge on a working shift would leave the HCA alone or not, distinguishing between an RN who would 'never leave you alone' as negative and an RN who 'doesn't bother you' as positive.

*And sometimes you'd see the nurse in charge and you'd go, 'oh my god, Jesus Christ I'm going to have a day of it'. Because they never leave you alone. And then you have the nurse that doesn't bother you. And you have a lovely day, you know***. Case A HCA Focus Group Interview 1**

In Case B the HCAs were also confident that they knew what to do without being asked or told:

Well personally we know ourselves.

Well we usually do it between us, you know.

You know, well we're given a ward in the morning when we look at the report and we just pair up and we usually…

… know what to do.

A nurse doesn't say 'you have to do this and must be doing that'.

We work together. **Case B HCA Focus Group Interview 2**

The HCAs described how they knew what to do and, because of the routine nature of work, delegation was superfluous.

Because everybody is on the same wavelength for mealtimes, for toileting, for activities, everything, you know, from mass to music to bath, to everything.

You can get the most out of your day, really…

You get to do extra.

Because the patients at times like to see a familiar face. **Case B HCA Focus Group Interview 1**

The HCA job specification stated that the HCA was expected to work autonomously at times, and this was verified from the interview and observational data. The autonomous role of the HCA was outlined in roles and responsibilities, and there was an expectation that the HCA could identify resident deterioration or risk incidents.

Works on one's own as necessary and uses initiative appropriately…

Takes personal responsibility for one's own actions and omissions...

Reports back to the relevant person or persons when required. To report to Nurse in charge immediately any deterioration in the residents condition, i.e. skin integrity. To report all incidents, near misses to nurse in charge immediately…

*Performs other duties appropriate to the post as directed by the Charge Nurse***.**

Case B HSE HCA Job Specification, 2007 (case B site named)

Despite the finding that RNs did not need to delegate and the HCAs did not require delegation, the responsibility of the RN to document care that they had not delivered or supervised created concern for the RN.

This category consists of two subcategories*,* "I'm *going to see it, I'm going to do it* and *I'm going to write it",* and *HCAs and MTAs are different.*

5.4.3.5 "I'm going to see it, I'm going to do it, I'm going to write it"

This subcategory describes how RNs understood their role in documenting care that the HCA delivered without RN delegation or supervision. The RNs explained that, because of the higher ratio of HCAs to RNs in RCOP compared to acute care, the HCAs knew the residents and provided more care and support to the residents than the RNs. This resulted in the RNs having to rely on and trust the HCAs to deliver care. The RNs also had to trust that the HCAs would report to the RNs about residents' wellbeing as RNs documented care the HCAs were expected to deliver.

Differences were observed between the two cases in relation to RNs providing direct resident care. In Case A, RNs and HCAs were observed working independently of each other (Table 5.9). This resulted in RNs relying on HCAs for delivery of care to residents and reporting back on same.

Table 5.9: Direct Observation Period Site Ward A1 and Ward A2 Afternoon

2.10pm Ward A2. When I arrived all RNs and HCAs were working independently.
2.20pm Ward A2. Two HCAs working together in resident's room, positioning resident.
2.35pm Ward A2. Two HCAs working together, one RN talking to a resident. (Memo: HCAs in pairs, watch is this a regular way of working in future observations).
2.37pm Ward A1. Two HCAs working together with residents. RN talking to CNM2 at Day room.
2.40pm Ward A1. HCA spoke with HCA who had just returned from her break. HCA who had returned asked other HCA which residents needed to be assisted. HCA then spoke with RN informing RN that she was back from break. HCA told RN that she was going to get teas (resident's tea). RN made no response only to agree.
2.45pm Ward A1. RN in Nurses Office. HCA in Day Room area opposite Nurses Station with eight residents, offering biscuits to resident. Other HCA making tea. No delegation witnessed. One resident singing.

2.50pm Ward A2. Three HCAs with residents in large Sitting Room. They are serving tea and biscuits from a trolley to the residents. Two RNs in Nurses Office discussing resident's notes.

However, in Case B, RNs and HCAs were observed working in team pairs, with RNs being close to HCAs when they were working with residents (Table 5.10).

Table 5.10: Direct Observation Period Ward B1

On duty 4 RNs, including nurse-in-charge, 10 HCAs (2 HCAs replacing 2 RNs who are off today). Nurse-in-charge in Nurses Office at paperwork… 13.15: 4 HCAs discuss and plan who needs which particular diet for dinner. Permanent HCA advises agency HCA where to get food. No RNs present in Dining Room. 13.20: Two RNs leave ward for their lunch break. Nurse-in-charge in nurse's office at desk at documentation. Two RNs and four HCAs remain on Unit B1 while other staff are gone to lunch break. RN and HCA in residents room and bed round trolley outside door. RN and HCA assisting resident with mobilisation to Dining Room. Two agency HCAs in Dining Room undertaking domestic tasks in kitchen area. 13.40: Two agency HCAs in Dining Area with Residents. Residents are finishing their lunch. Bed rounds in progress in two opposite areas of Unit B1. Two HCAs working as pairs in one section. RN and HCA working as pair in other section… 14.00: RN and HCA in Sitting Room with resident. Assisting resident to mobilise. No delegation observed. 14.10: RN comes to Dining Room and asks HCAs (agency x 2) if all tasks are finished. HCA (agency) reports to RN that a resident is lying down in room. RN asks "how did dinners go?" HCA report back and explains that one resident (named)did not eat well. RN discusses and advises re supplement feed and asks HCA to prepare and offer to suggested supplement to resident. 14.20: Agency HCA reports back to RN re resident and supplement diet, "she does not want it". RN offers alternative dietary suggestions for this resident for tea time meal later. HCA asks "what else do you want me to do?" RN replies that HCA should check television channels for a suitable programme for residents in sitting room. 14.25: HCA returns to RN and reports re TV programme and residents in sitting room.

The RNs in Case A explained that the HCAs possibly knew the residents better than the RNs. The RNs in Case A expected that the HCAs would observe, understand and report any concerns about the residents, describing how some HCAs spent more time with the residents and were more observant than the RNs. The RNs said that, if the HCAs were concerned about anything or observed some change in a resident's condition, they would ask the RN to 'look at it'.

> *Some of them [HCAs] are more thorough than nurses, you know. And like we would rely heavily on them… because there is more hands-on with the care. And they're able to give you just more of a detailed input, you know. Like say if you were new, you're a new staff nurse, they'd be able to tell you, you know more personalised things…*
> *I feel sometimes some of the carers are more observant than the nurses. Because we don't spend that much time with that patient. But carers are spending a lot of time, even their [resident] behaviour and they're sometimes go 'you know, Mary is not well', out of nowhere. Yea or 'her breathing was funny'.*
> *And then we [RN] do go back and just ask them [HCA] to find out whether the bloods were done. Whether you know, everything is okay there. There could be something wrong, like they are very expert in just observation and all.* **Case A RN Focus Group Interview 2**

The RNs explained that the HCA would know what to report to the nurse-in-charge without being told. The RNs did not articulate an understanding of the responsibility of the RN to follow up on assigned/delegated tasks and to ensure a process for robust reporting back. Rather they trusted that the HCAs would work on their own initiative and report back as required.

> *Oh we trust the carers completely, we trust, they are very good in checking the skin and all. Letting us [know]… even a scratch mark they see.* **Case A RN Focus Group Interview 1**

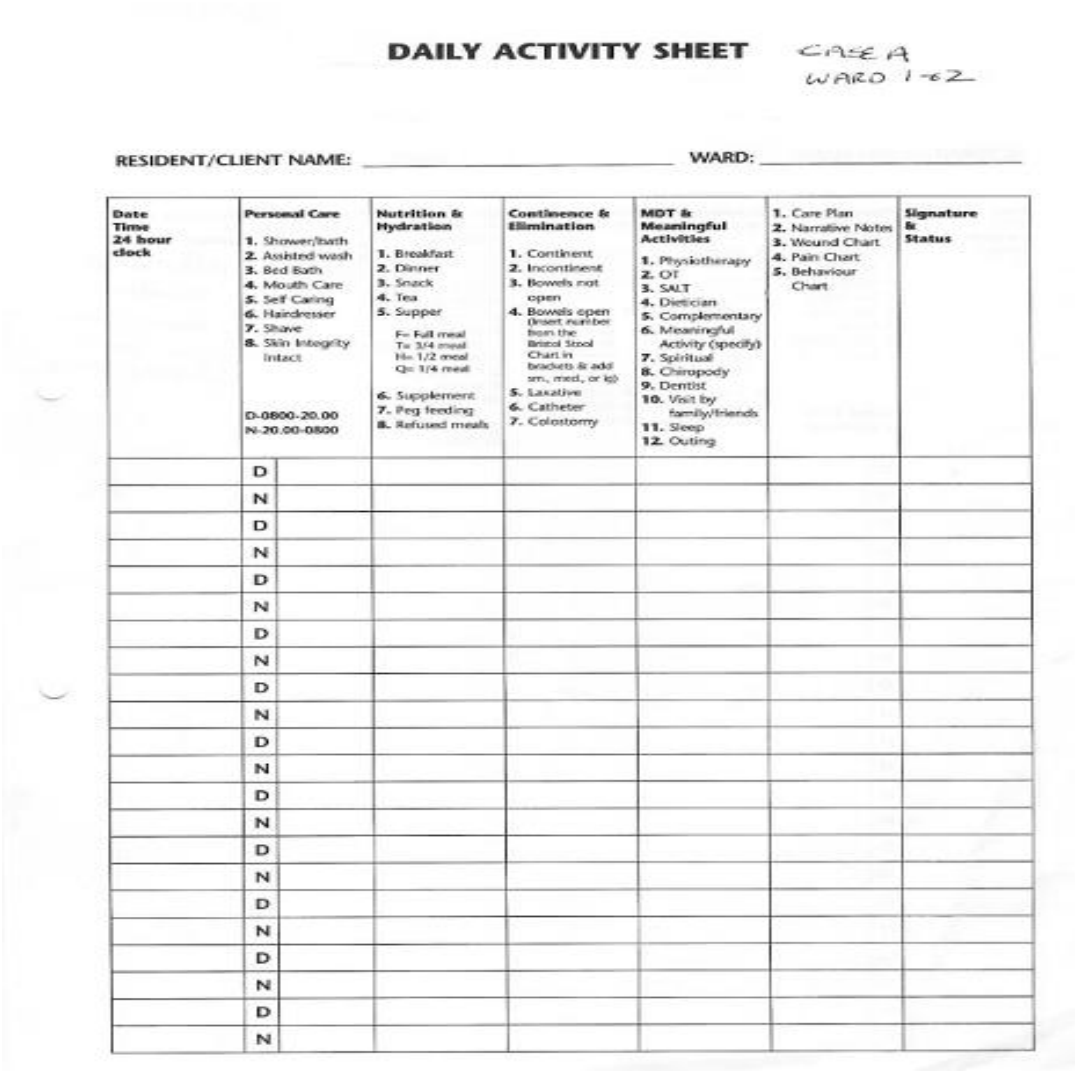
Similarly, in Case B the RNs expected the HCAs to know what needed to be reported to RNs relating to resident well-being.

> *It's informal but they let you know if there's anything they need to report or, you know, any differences.* **Case B RN Focus Group Interview 1**

> *I can't say there's ever being something that I haven't been told [by a HCA] that I should've been told.* **Case B RN Focus Group Interview 2**

The HCAs in both cases had some specific documentation responsibility, but in both case sites this documentation responsibility was not consistent. When the HCAs in Case A worked in pairs they were expected to document the Resident Daily Activity sheet, inserting the number aligned to the activity (see Figure 5.1). In the absence of the Case A site job specifications, it was difficult to understand if this documentation responsibility was assigned as part of the HCA role or a previously delegated task to HCAs who were in post for a long time.

Figure 5.1: Case A Resident Daily Activity Sheet



DAILY ACTIVITY SHEET CASE A WARD 1-62

RESIDENT/CLIENT NAME: _____ WARD: _____

Date Time 24 hour clock	Personal Care 1. Shower/bath 2. Assisted wash 3. Bed Bath 4. Mouth Care 5. Self Caring 6. Hairdresser 7. Shave 8. Skin Integrity Intact D-0800-20.00 N-20.00-0800	Nutrition & Hydration 1. Breakfast 2. Dinner 3. Snack 4. Tea 5. Supper F= Full meal T= 3/4 meal H= 1/2 meal Q= 1/4 meal 6. Supplement 7. Peg feeding 8. Refused meals	Continence & Elimination 1. Continent 2. Incontinent 3. Bowels not open 4. Bowels open (Insert number from the Bristol Stool Chart in brackets & add sm., med., or lg) 5. Laxative 6. Catheter 7. Colostomy	MDT & Meaningful Activities 1. Physiotherapy 2. OT 3. SALT 4. Dietician 5. Complementary 6. Meaningful Activity (specify) 7. Spiritual 8. Chiropody 9. Dentist 10. Visit by family/friends 11. Sleep 12. Outing	1. Care Plan 2. Narrative Notes 3. Wound Chart 4. Pain Chart 5. Behaviour Chart	Signature & Status
	D						
	N						
	D						
	N						
	D						
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The Daily Activity Sheets were updated for each resident by either an RN or a HCA; if completed by a HCA, it was to be co-signed by an RN. The day and night sections for each date were ticked. In the documentary review, the section for recording 'signature and status' (grade) was filled with staff name initials only. The CNM2 and RNs in Case A said the HCAs who worked in pairs had responsibility to document on the Daily Activity Sheet. When a HCA recorded care an RN needed to countersign; this was not always evident on the sheets reviewed. Frequently, the person's initials were difficult to read, making it impossible to identify the RN or HCA who had recorded care. In addition, while it was agreed that the HCA should complete the activity sheet, not all HCAs did this; some HCAs continued to report verbally to the RN.

> *Care attendants [HCAs] like you know, here we ask them to document too because if you are helping a patient you are responsible for, because sometimes some of our team doesn't have*

> *a nurse at all to pair up, so it might be one of the care staff [HCA]. And you know I can't say for somebody, you know sign for somebody to say that [a resident was] washed, dressed, fed, it's not fair like you know. So… we told the nurses that the ultimate responsibility for them to check whether everything was ok. But whoever is cleaning, the washing or dressing they are entering it into the care plans... The care staff are not writing it… or they are coming in and saying to the nurse about it.* **Case A CNM2 Interview**

Although the HCAs were allowed to record tasks completed in a tick box on the Daily Activity Sheet (Figure 5.1), they were not allowed to document in the resident care plans or narrative notes.

> *They would do the number one [daily activity sheet], do you know the numbers. They would do that one. And then if it was anything with the doctor, or with the families, either [named CNM2] would've written that in from doing the round. Or she would hand it over to us [RNs] and we would write it up. The HCAs aren't allowed write. They're not allowed, no.* **Case A RN Focus Group Interview 2**

Despite the RNs having less direct care time with residents, and their trusting the HCAs, RNs in Case A described how they would prefer to have direct contact with the residents to observe and assess them themselves.

> *I know I will trust them. But it's just like, you kind of you want to just be with the patient, okay. See are they really eating properly like, that's all they ate here. But did they really eat a whole meal…*
>
> *Contact and even just checking the bloods say, or the skin.*
>
> *I'd prefer to. Really have a look.*
>
> *Have a look rather than just only, I know they will give us the detail and I will tell them maybe later I'll want to see and have a look. See the difference*. **Case A RN Focus Group Interview 2**
>
> *You're not saying 'I'm going down to check up on you'. You're more saying, 'I agree with you but I need just to follow up myself'.* **Case A RN Focus Group Interview 1**

In Case B there was conflicting evidence in relation to the HCA responsibility in documentation. The CNM2 reported that the HCAs did not document care, but only recorded resident social activities. The reason provided for this was that the HCAs were not 'trained carers', i.e. HCAs with QQI L5 qualification. The CNM2 explained that, although she would like the HCAs to document care, this might not happen until all HCAs had completed the QQI Level 5 programme and were recognised as HCAs (not MTAs).

> ***Interviewer:*** *And in relation to the documentation, do the HCAs here on this ward, do they document any of the care?*
> *No, they don't.*
> *The only care that they would document would be the [social] activities….*
> ***Interviewer:*** *And why don't they document?*
> *Because we didn't always have trained carers [HCAs]. We had multitask attendants and that's why they would never look at the notes or that, so. Now the majority of the staff are, have the FETAC level 5 but I think until everybody has it and until they're actually recognized as carers I don't think, you know, the documentation… but certainly I would like to see it.* ***Case B Ward B2 CNM2 Interview***

The HCAs reported that they did not document care, regardless of whether they had completed the QQI L5 programme or not. The HCAs were reluctant to explain this, but eventually explained that, when the HCA roles were agreed and standardised nationally, they would probably have documentation responsibilities then. The HCAs also referred to the RN being 'frightened' if the HCAs had a documentation role because it would impinge on the RN role.

> *[Silence] Not at the moment.*
> *Nothing changed yet, sure it didn't.*
> *It'll probably change but it'll be a case that we will probably get a better role when health care assistant is recognised nationally but at this moment in time I think the nurses are frightened that that might happen because it means less of a position for them here.* **Case B HCA Focus Group Interview 1**

RNs acknowledged that they were not delegating documentation responsibility to the HCAs, but it appeared that HCAs were expected to record some care and interventions (e.g. resident fluid intake sheet, bed rail check sheet) but did not always do this. Similar to Case A, there was no evidence as to whether these documentation responsibilities were assigned (within the HCA job specification and QQI L5 education) or delegated. It was also unclear whether HCAs did not document because they were reluctant to document, or whether the RNs were reluctant to share or delegate this responsibility. The RNs explained how they had to follow up with each of the HCAs, "chase them" for a report, thus creating work 'overload' for the RN.

> *… compared to the other nursing homes or somewhere else maybe, that the carers are not being, you know, we're not really giving them responsibility to write…*
> *Documentation wouldn't be great with us…*
> *And they are allowed to record it but you look back and it's not done.*

And there's still always blood pressure and stuff like that.
Even as well a food diary, it's only a simple thing for the food diary, not all the time the nurses will give the food to a resident.
It's more carer, it's a combination, so they just report to you, only sometimes if you chase them. You could be chasing them that evening, do you know, what they ate for this, you know, rather than just getting a pen and then just obviously writing it in if you fed that resident, you know…
Or if you give someone a drink, what you give them, you know.
And bowels because with us it's very hard to chase up the residents…
Overloading what you should do then, yeah. **Case B RN Focus Group Interview 1**

There was a sense of annoyance as RNs in Case B explained the challenges of following up with HCAs in relation to recording resident fluid intake and resident safety checks because some of the HCAs did not want to document care.

The fluid chart is a very simple thing, the fluid chart. Where we have to go into the office to write in those fluid charts and you're thinking, well you can't be responsible for giving all the drinks of the day and if they're not written in. I have a big issue with that. And you're running around chasing people, did you feed, did you give that drink, how much did they, you know things like that.
We sign that we have checked.
You have to check every half an hour, you've to sign that you've checked. But some of them [HCAs] don't want to.
And why can't they fill in, we'll say, the likes of the fluid chart? If I'm a health assistant and I give drinks, why?
They should be able to.
They should be.
They can, they can.
I think they're afraid to put pen to paper.
Just when you're saying that I don't think they want to do that. **Case B RN Focus Group Interview 2**

However, there was also discrepancy between participants within Case B as to what the HCAs did and did not document.

On our ward [Ward B1] they [HCAs] don't now at the moment they don't, no. A lot of them don't.
Some of them will do it but there's a few [HCAs who will not document].
There are a few at the moment [Ward B1]. **Case B RN Focus Group Interview 2**

When HCAs were asked if they documented care they delivered, they described how they reported to the RN on duty with them on the care they delivered and the RN documented this.

Well we just tell the nurse about it…
The nurse will ask about the night's work that you've done, you know, and, you know, so then you have to give that report to her and she'll write it up. **Case B HCA Focus Group Interview 2**

In Case B the HCAs reported back rather than documenting themselves, or recorded on sheets for the RN to transcribe when the RN updated residents records. The RNs described how, with the reduction in number of RNs, there was more reporting back to them by the HCAs as an informal process of notes by the HCA to the RN.

I don't know if you find it, but I find there is a lot of reporting back.
I think since we've had lost the nurses, you know, there's huge piece of reporting back.
And I'm nearly saying you know, I leave a sheet on the desk and I say, just write all those wee bits and pieces down. Because sometimes I can forget…
***Q:** In relation to healthcare assistants at the moment, they don't sign most documentation?*
Some of them.
Others will, yea. **Case B RN Focus Group Interview 2**

In the absence of documentation being recognised as a HCA responsibility, reporting-back practices increased the workload of the RN, accountability of the RN, and the risk of missed care or poor communication. In Case B the RNs asked the HCAs for verbal updates on the residents and the RN then documented this.

[The RN] would ask the health care assistant, she'd go through her list of residents and she will ask for a report, the health care assistant would then give it and point out anything that needs [done]... **Case B CNM2 Interview B1**

In Case B the ambiguity of RN professional accountability for care given to the resident by HCAs was evident. This did not emerge in Case A. The RNs in Case B explained the importance of documenting all aspects of residents care, but indicated that the RN was signing for something they did not see.

> *I think in reporting back, like pressure sores and everything you know, it's nice to be able to see it.*
> *Because you know it can be missed and then it falls back on us.*
> *Yea and the culture is there that we've always been hands on and then took on the role of documentation... But we're so used to the fact, 'I'm going to see it. I'm going to do it, I'm going to write it'.*
> *And it's hard to document without seeing.*
> *That's true, it's very hard to write that up.*
> *I think we're, you know, putting ourselves into, in danger actually by writing because it's all about trust, we were saying about trust about them telling me, 'so I'll just write what you said to me' but I didn't really see it.*
> *Or hear it.*
> *When you're writing that and not seeing it.* **Case B RN Focus Group Interview 1**

The practice of the HCA reporting back to the RN on care delivered, and the RN then documenting this was based on 'trust', and the RN checking directly with the resident if they were concerned. The CNM2 in Case B described how she would provide direct care to the residents with higher dependency needs, working with the HCA, to see and check for herself.

> *A lot [of RNs] do find it very difficult because I suppose we do want to be hands-on and when you're documenting it with somebody you like to be there, the person that has taken care of them and attended to all their needs, but yet you're not doing it, you're writing about it but you're not actually hands-on so that can be difficult. For me I work in different areas here and I would go to the people [residents] with the highest dependency levels at times just for myself to check their skin. I'd work with them, you know, because it's the only way, I can't depend on people either telling me, you know, you have to see for yourself.* **Case B Ward B1 CNM2 Interview**

> *Well you go down and check.*
> *You can see the conditions of the patients.* **Case B RN Focus Group Interview 2**

The HCAs reported that they did not like when RNs checked on care the HCA had provided to the residents. An example provided concerned skin assessment during the admission process; HCAs

explained how RNs checked up on the HCA assessment, and some HCAs reported this checking as "hurtful" and "undermining". But the HCAs were aware that the RNs were accountable for, and documented, the residents' care plans.

> *But then you would have cases where you'd do a body check, you know, the ward sister might tell you to do a body check and then somebody comes back and doubts your word, you know, and looks at them again, that has happened…*
> *Doesn't take our word for it…*
> *It can be…*
> *… hurtful.*
> *… undermining…*
> *But there again at the end of the day the buck stops with them so they have to cover themselves.*
> *Okay, you can't blame them either in a way.* **Case B HCA Focus Group Interview 1**

> *It was interesting how the CNM2s and RNs perceive their role in checking resident care that the HCA delivers. Are RNs checking care events with HCA more for documentation than their role as responsibility for delegating care?* **Reflexivity Memo 16012018**

There was ambiguity as to the role of the HCA in documenting tasks or care they delivered across both cases. It was unclear if the ambiguity was from discrepancy in terms of their conditions of employment (MTA or HCA), HCA qualifications (QQI Level 5 healthcare support qualification), that some HCAs did not want the responsibility of documentation, or that RNs did not want to delegate some of the documentation tasks to HCAs.

5.4.3.6 HCAs and MTAs are Different

This subcategory in the theme *Knowing what I should do* describes how the role ambiguity in relation to HCAs employed on MTA contracts impacted on delegation of tasks.

The case study sites were unable to provide evidence as to which HCAs were employed on MTA contracts and which HCAs had completed the HCA QQI L5 programme. The topic of MTAs did not appear in Case A. However, the difference between a HCA and a multi-task attendant (MTA) emerged in Case B interviews. It was reported that many of the HCAs in Case B were employed on MTA contracts of employment, but were called HCAs. From the analysis of available job specifications in Case B, the MTA was contractually employed to attend to catering, housekeeping, portering and laundry duties, in addition to caring for residents. There was also ambiguity between MTAs working in HCA roles, who

had a QQI L5 qualification, and those who did not. In Case B, HCAs reported that all HCAs on the site were employed on MTA contracts of employment.

> *So everyone is a multi-task attendant here in this hospital.*
>
> ***Q:** And is that the best way, if you had a choice?*
> *No.*
> *No I wouldn't, I don't believe that it should, I think if you're a health carer [HCA] you should be a health carer, if you're a multi-task, because at the moment [you are a MTA] you're doing everything.* **Case B HCA Focus Group Interview 2**

The HCAs on MTA contracts had varying opinions on whether they required a change to HCA contract. One HCA said they did not need a piece of paper [a contract] to continue in the role they currently had, whereas another HCA on an MTA contract wanted to be recognised formally as a HCA and work only in that caring role as within the MTA role there were conflicting demands:

> *But then you can just concentrate on one [role].*
> *It's better for the resident as well, you know, to have separate jobs done by different people…*
> *I'd just like to be doing one job [as a HCA].*
> *… you can't give your full care if you have to do everything.*
> *You're trying to do all the different things*. **Case B HCA Focus Group Interview 2**

RNs reported that HCAs who had competed the healthcare support programme were more observant of the residents' condition and how to report back to the RN:

> *And also like the process has been changed up to FETAC Level 5 now and that's made a difference. I find they're willing to take on a bit more responsibility and, you know… they report back.*
> *They're more aware of what they have to do and they're more observant as well with the residents.* **Case B RN Focus Group Interview 1**

RNs were unsure if the HCAs, who were employed as MTAs, would document care. Another reason for HCA reluctance to document care was that some RNs would not want the HCAs doing this: "*Some of the nurses here wouldn't be very happy if I was doing their work".* This was interpreted as a lack of consistency as to how the RNs perceived the role of the HCA in documentation.

> *Well I know one of the nurses one time was down with us in [ward name] and this care assistant came to her and she said such a one's bowel has moved and she said 'will you write that in, I'm very busy at the moment, right'. She said 'oh I couldn't do that, some of the nurses*

here wouldn't be very happy if I was doing their work'. So there's still that perception, you know.

… have been said that they feel they can't go in, you see, it works both ways maybe.

When I asked, 'do you know why they're not writing?' and she… said because they're now changed, like I think that they're paid not as the health care assistant, they're still at the multi-task pay stage…

So that's the reason why. That's the crux of it. **Case B RN Focus Group Interview 1**

The disparity between MTA and HCA roles and responsibilities in Case B was a significant finding in the context of skill mix. HCAs who were employed as MTAs but had completed the QQI L5 programme reported that they would prefer to be in a HCA post.

5.4.3.7 Summary

The importance of knowing what the RN and HCA should be doing in their roles was an important finding in the context of delegation. In both case study sites, there was a routine, task-orientated approach to care. RNs and HCAs reported knowing what they were expected to do. RNs and HCAs perceived working as a team to be more important than the RNs taking on a role as delegator or task allocation. Within this theme, RN role stressors of role overload, role ambiguity and role conflict arose, aligned to the absence of delegation. There was no standardisation or clarity for HCA roles, responsibilities, QQI L5 qualifications and contractual arrangements. This created RN role conflict, with inconsistent and incompatible expectations for RNs as delegators. With the uncertainty of when and if RNs should delegate, and what authority each RN had to delegate, this created RN role ambiguity. In the absence of delegation, the concept of trusting the HCAs to undertake tasks and report back to the RNs emerged as important.

5.5 Chapter Summary

This chapter has presented the findings from the case study under the three themes: *Creating the conditions, How it happens* and *Knowing what I should do*. There were significant similarities across both cases as to RN delegation and the absence of delegation. Other than NMBI expectations for RNs to delegate, there were no external or internal structures to support delegation. RNs and HCAs reported receiving no education in relation to delegation. There were discreet but complex differences between Case A and Case B as to how RNs and HCAs worked together and how the RN role in delegation was understood. There was evidence of RN role conflict, with inconsistences and incompatibilities in demands on the role. The RN conflict of prioritising their administrative role, that only the RN could undertake, over their direct resident care role was evident. However, RNs did not

delegate to HCAs to resolve the resulting role overload. The HCAs did not understand this role conflict and also expected the RNs to support more in the delivery of direct care. Despite the frustrations and misunderstanding of roles, neither the RNs nor HCAs were willing to address this with each other. However, from the themes a number of factors that influence delegation emerged, with barriers and facilitators for RN delegation in RCOP services identified as: lack of RN role clarity, lack of HCA role clarity, organisational factors, teamwork, and staffing and skill mix. The following chapter discusses the study findings.

Chapter 6: Discussion, Recommendations and Conclusion

6.1 Introduction

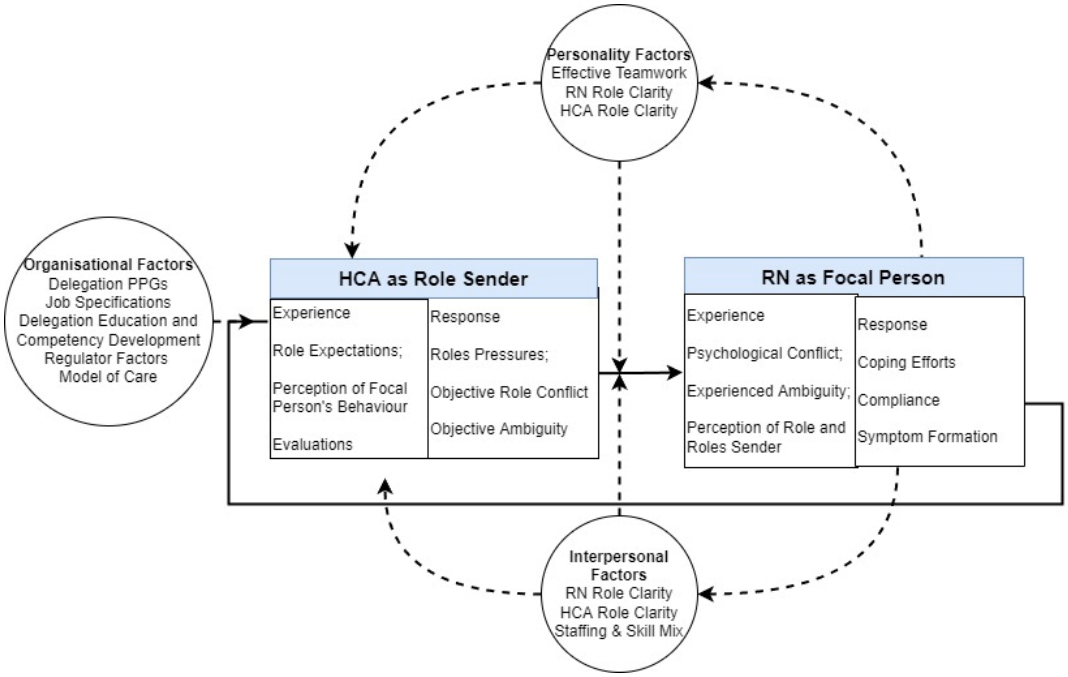
In this final chapter the findings are discussed in the context of previous research and literature. The key findings in this study were that delegation did not occur, and the factors that hindered and facilitated effective delegation were identified. The delegation factors for RNs in RCOP were identified as RN role clarity, HCA role clarity, organisational factors, teamwork, and staffing and skill mix. *Role* was identified as a significant finding, both the RN role as delegator and the HCA role as delegatee; this is discussed through the theoretical lens of organisational role theory as outlined in Chapter 2. Applying the *role episode model* (REM) supported the interpretation of the process of delegation (the role episode), the RN as delegator (the focal person), the HCA as delegatee (role sender), and the impact of organisational and interpersonal factors on delegation. The findings will be discussed under the headings of barriers to and facilitators of RN delegation in RCOP, as summarised in Table 6.1. Where the findings correspond, expand or contradict existing evidence, this will be discussed. The limitations of this study are also identified, along with contribution to knowledge and recommendations for future work.

6.2 Theoretical Lens of Organisational Role Theory

The role episode model (REM) (Kahn et al., 1964), as discussed in Chapter 2, seeks to understand role stressors in dyadic work relationships, and this was applied as the theoretical framework to help interpret and explain why delegation was not taking place. The RNs in this study perceived that they had different role expectations placed on them, resulting in role conflict, role ambiguity and role overload – what Kahn et al. (1964) terms as role stressors. Role stressors influenced the RN and HCA relationship and the absence of explicit RN delegation. In this case study (CS) the focal person was the RN, as delegator, the HCAs were the predominant role senders, and the role episodes were the interactions between the RN and HCA (see figure 6.1). Other role senders were the RNs themselves, CNM2s, the employers, NMBI and HIQA. The RN, as *focal person,* received the expectations of the role senders and sent signals to others of their role expectations. In role theory, Kahn et al. (1964) explained that the focal person's response and behaviours do not occur in isolation. Organisational factors, personality factors and interpersonal relationships affect the role episodes. These factors

were found to affect the RN/HCA dyadic working relationship (figure 6.1) and are discussed in the context of the barriers to RN delegation that became apparent within the findings of this study.

Figure 6.1 RN as Delegator and HCA as Delegatee in the Role Episode Model (adapted from Kahn, Wolfe, Quinn, Snoek and Rosenthal (1964, p.26)



6.3 Barriers to and Facilitators of RN delegation in RCOP

This study identified a number of barriers and facilitators to RN delegation (Table 6.1). The following section discusses each of these factors; RN role clarity, HCA role clarity, organisational factors, effective team working, and, staffing and skill mix, in detail.

6.3.1 RN Role Clarity

This CS found that there was a lack of clarity as to the role of the RN, including the impact of the expanding role in RCOP, their scope of practice, and their role as delegator (table 6.1).

RN role conflict was found between the RNs' own expectations of their direct nursing care role and their administrative role. In both cases the administrative role of the RN in RCOP was identified as a significant workload, with RNs often prioritising this role ahead of direct care. Although they did not focus on delegation, the use of RN working time was identified by Lavander et al. (2016) within six categories: direct care, indirect care, documentation, unit-related work, personal time and non-

nursing duties. RNs had to prioritise their increasing responsibilities in non-direct care (Lavender et al., 2016; Roch et al., 2014; Dellefield et al., 2012). Regardless of country, RNs were found to spend less than 50% of their direct care time in direct patient care, with documentation accounting for 20% of RNs' working time (Lavander et al., 2016). In RCOP services, RN direct care time was reported at only 31%, and 73% of the non-direct care time was spent on documentation (Dellefield et al., 2012).

RNs had to prioritise their administrative role, resulting in role conflict. In the absence of delegation, the RNs were conflicted in completing all their responsibilities, having direct contact with residents, and completing medication rounds and documentation responsibilities in each work shift. However, there were differences between Case A and Case B as to RN role expectations. In Case A, RNs were more accepting of their administrative role and assigning direct care to HCAs. They understood that the HCAs preferred if the RNs worked with them in direct care and support, but the increased administrative role prevented this. Case A RNs expected the HCA to deliver resident care independently, while RNs in Case B struggled to reconcile their concerns about professional accountability. Those RNs who could not reconcile the change in roles experienced role overload. The REM enabled more in-depth understanding of psychological conflict and stress experienced by RNs in the absence of effective delegation resulting in role stressors. In Case B, there were inconsistent and increasing workload expectations for the RN. However, they continued to deliver direct care, check up on resident care delivered by the HCA, undertook clinical observations and completed all documentation, in addition to other administrative responsibilities. Case B RNs were expected to follow up on care delivered by the HCA when the HCA had not reported back on task completion. This expanding administrative role of the RN is recognised globally, whereby RNs must delegate to HCAs in order to complete responsibilities that only the RN is qualified and registered to undertake (OECD, 2020, Drennan et al., 2018; Lavender et al., 2016; Birks et al., 2016; Roch et al., 2014; Dellefield et al., 2012). Previous research also identified the increasing responsibilities for the RN (Coffey et al., 2017; Lavander et al., 2016; De Vliegher et al., 2016; Lee et al., 2015; Roch et al., 2014; Dellefield et al., 2012; Huang et al. 2011; Gravlin and Bittner, 2010; Bittner and Gravlin, 2009; Alcorn and Topping, 2009). In these studies, the RNs' increased responsibilities were identified as: coordination and management of physical and psychological care, resident care planning, medication management, documentation, adherence to regulations and standards of practice, leadership, resource allocation, delegation and supervision of unregistered staff. This changing role required RNs to delegate nursing care tasks to HCAs (Dellefield et al., 2012). Participants in this CS identified similar RN responsibilities, but, unlike in these previous studies, participants did not identify the RN delegation as a critical role. In contrast , the RNs and HCAs in this study reported that delegation was not required.

RNs in this study understood their professional accountability for resident care in the context of NMBI (2015 and 2021) expectations for professional practice. However, there were differences in how RNs understood HCA accountability. RNs understood that they could be referred to the NMBI for investigation through their *fitness to practice* processes and/or to disciplinary procedures by their employer in relation to resident care and outcomes of care. Scope of professional practice guidance is provided by nurse regulators to support RN decision-making in practice, including guidance on delegation to non-registered care staff. The RN delegator role has been identified as a critical RN role (NMBI, 2015; ICN, 2013, Muller and Vogelsmeier, 2013).

Table 6.1: Barriers and Facilitators to RN delegation in RCOP

	RN Delegation Factors	Barriers to Effective RN Delegation	Facilitators of RN Delegation
1	**RN Role Clarity**	Lack of RN role clarity, with RN role conflict as expectations for administrative role, conflict with expectations for direct care role. RN role ambiguity of RN scope of practice and delegation.	Understanding the RN role, scope of practice, impact of their expanding role, and their role as delegator.
2	**HCA Role Clarity**	Expanding role of HCA in direct care in the absence of role clarity, with variations in role titles, job specifications, minimum qualifications, and minimum education standards. HCA role ambiguity as to their role as delegatee. HCAs employed as Multi-Task Attendants. Perceptions of no differences between the RN and HCA role.	HCA understands their role in direct care, and the HCA role as delegatee. Standardisation of HCAs employed contractually as HCAs. Scope and parameters of the HCA role are standardised and clarified.
3	**Organisational Factors**	Absence of structures and governance to support RN delegation.	Structures and governance are in place to support RN delegation.
3a	RN Delegation Policies, Protocols, Procedures or Guidelines (PPPGs)	Absence of delegation PPPGs at national and local level. Misinterpretation and misunderstanding of the differences between allocation, assignment and delegation.	PPPGs at national and local level provide evidence-based direction and guidance for RN delegation. Differences between allocation, assignment and delegation clarified.
3b	Job Specifications	Lack of clarity in RN job specifications as to responsibility and accountability for delegation. Lack of clarity in HCA job specifications as to the role of the HCA, including their role in direct care and as delegatee.	RN job specifications provide standardisation and clarification as to role and responsibility of the RN, incl. expanded role and RN role as delegator. HCA job specifications provide standardisation and clarification as to role and responsibility of the HCA, incl. direct care role and the HCA role as delegatee.
3c	Delegation Education and Competency Development	Absence of delegation education and competency development for RNs. Absence of a competency assessment process for HCAs undertaking direct care task and activities.	Delegation education and competency development explicitly included at undergraduate and postgraduate nurse education levels. Competency assessment process for role of the HCA in direct care.

3d	Regulatory Factors	Difference in expectations by regulators as regards RN role and accountability for delegation	Agreement by regulators (HIQA and NMBI) of RN role and accountability for delegation.
3e	Model of Care	Routine, task-orientated work allocation in nursing teams.	Person-centred, nurse-led approach to resident care and support.
4	**Effective Teamwork**	RNs and HCAs working in parallel or in silos. Poor communication, lack of respect in nursing teams. RNs' reluctance to delegate. HCAs' resistance to delegation.	RN and HCA working in effective teams. Effective team communication, demonstrating mutual trust and respect in RN/HCA nursing teams. RNs' knowing how and when to confidently delegate to HCA. RNs' and HCAs' understanding and accepting the differences between the RN and HCA role in the nursing care team and delegation.
5	**Staffing and Skill Mix**	More delegation is required with a skill mix of fewer RNs and more HCAs. HCAs' level of education and competence affects skill mix and thus delegation decisions.	Appropriate RN and HCA staffing levels and skill mix enable effective delegation. Adequate RN numbers allow adequate time to assess competence of HCA, mentor and supervise HCAs within the delegation process. RN delegation to new and replacement RNs and HCAs.

The NMBI definition of delegation formed the basis for interpreting and understanding what delegation was for RNs in this study (NMBI, 2015), whereby RNs were accountable for decisions to delegate and the HCAs were accountable for appropriate performance of the delegated task and activity. Despite this direction and guidance, RNs in this study did not delegate and could not describe the NMBI guidance on delegation. In previous research, RN accountability for delegation to HCAs has been studied in the context of the RN professional scope of practice (Walker et al., 2021; Birks et al, 2016; De Vliegher et al., 2016; Munn et al., 2013; Huang et al. 2011; Bysedt et al., 2011; Corazzini et al., 2010; Potter et al., 2010; Gravlin and Bittner, 2010; Alcorn & Topping, 2009; Bittner and Gravlin, 2009; Standing and Anthony, 2008). Similarly, these studies found that the RN did not have a clear understanding of their responsibilities and accountability in delegation to HCAs. This RN ambiguity as to their role as delegator was a consistent and important finding. Standing and Anthony (2008) similarly found that RNs understood their accountability for care delivery, but were uncertain as to what they could delegate to the HCAs as the uncertainty of HCA competence and skills impacted on their delegation decisions. Over a decade later evidence of this role ambiguity was found in this CS.

In the absence of delegation, Case A RNs did not articulate accountability for the actions of the HCA, but rather referred to how they 'trusted' the HCAs and that the HCAs implicitly knew when to undertake clinical interventions (e.g. check blood pressure, urinalysis). In contrast, the RNs in Case B were concerned about their accountability for documenting care delivered by the HCA, explaining that their registration was 'on the line' or 'the buck ends with me'. Therefore, in the absence of delegation, the sharing of information on residents (handover reports), updates and 'reporting back' on resident care were identified as important. Despite the RN concerns for their professional accountability, there was no consistent process for HCAs to report back to the RN and HCAs did not document all tasks or activities they undertook. Similar findings were identified in previous studies where RNs reported a reluctance to delegate to HCAs due to concerns in relation to RN accountability for tasks delegated and thus concerns for the RN professional registration, and challenges in monitoring how the delegated task or activity affected resident outcomes and quality of care (Walker et al., 2021; Bystedt et al., 2011; Corazzini et al., 2010; Bittner and Gravlin, 2009). RNs described how heavy workloads caused them to delegate more than they would like (Bystedt et al., 2011). In addition, RNs did not assess if the HCA understood or accepted the delegated task, RNs did not follow up to assess if a task had been completed but expected the HCA to report back to the RN, and RNs expected that the HCAs had a high level of assessment and prioritisation skills (Bittner and Gravlin, 2009). The risk of HCAs delivering care that was not delegated or supervised was reported on by Walker et al. (2021) and Roch et al. (2014). Similar to this CS, RNs reported monitoring patients through HCAs in the absence of supervision or evaluation of care delivery (Walker et al., 2021; Roch et al., 2014). Direct care responsibilities within the RN scope of practice were found to be undertaken by HCAs who were not educated to a level to undertake these responsibilities (Walker et al., 2021; Roch et al., 2014). Effective delegation includes supervising and assessing HCA competence. Ineffective delegation affects patient safety and quality of care and risks missed care (Campbell et al, 2020; Beeber et al., 2018; Saari et al., 2017; DeVliegher et al., 2016; Denton et al., 2014; Potter et al., 2010; Gravlin and Bittner, 2010).

Therefore, there is a need to ensure that RNs understand their scope of professional practice in relation to delegation. Effective delegation is ever more important as the RN role in RCOP services expands. This study is one of a few studies that have focused on delegation in RCOP services. The other studies were conducted in the US (Beeber et al., 2018; Corazinni et al., 2010), Sweden (Bystedt et al., 2011), and Korea (Yoon et al., 2016).

The concept of *nurse-in-charge* was a significant finding in the context of the RN role as delegator. One RN was assigned to the role of nurse-in-charge of each shift; therefore all RNs were not expected to assign, allocate or delegate tasks and activities to HCAs during a shift. In Case A, RNs were assigned

the role of nurse-in-charge. In Case B, when on duty, the CNM2 undertook the role of nurse-in-charge. This expectation by RNs, CNM2s and HCAs that only the RN who was nurse-in-charge of the shift would delegate or assign contributed to role ambiguity for RNs, as all RNs were then not expected to delegate. The HCAs in both cases described how they preferred that there was only one RN 'in charge', objected to the other RNs asking or telling the HCAs to undertake tasks or activities, and preferred if they were left alone. The different expectations from RNs, CNM2s, employers, HCAs, NMBI and HIQA contributed to the lack of clarity as to the expectations of the RN to delegate and contributed to role stressors. These findings raise concerns as to the professional accountability and responsibility of the RN for the HCA delivering resident care. This practice of only one RN on duty taking responsibility for assignment, delegation and task allocation was identified in only one previous study (Walker et al. 2021). In that study, some of the RNs in acute hospitals believed that the nurse-in-charge was responsible for delegation and supervision and not all nurses, but the RNs who took on the nurse-in-charge role contested this belief. The similarities in findings between the Walker et al. (2021) CS in an acute hospital setting in Australia and the findings in this CS contribute to the transferability.

The facilitators to effective RN delegation (table 6.1) requires an improved understanding of the RN role in RCOP. This includes role clarity on RN scope of practice, impact of their expanding role, and the RN as delegator in RCOP services.

6.3.2 HCA Role Clarity

In this CS it was important to understand the development of the HCA role in RCOP services so as to understand the absence of delegation. The HCA was recognised as a direct care provider in both cases, but there was a lack of clarity in relation to the HCA role, and specifically to their education, qualification and competence levels, the parameters of their role and their role as delegatee.

The absence of consistent and standardised HCA role descriptions resulted in ambiguity for the HCA, and therefore RN role ambiguity as delegator. The HSE standardised the HCA job specification eligibility criteria (HSE, 2006) with an expectation that all HCAs recruited would be qualified at a healthcare support level 5. Education and supports were also put in place at this time to enable HCAs and MTAs already in employment to engage in the QQI L5 education programme. As many of the HCAs in this CS were employed prior to 2006, the changes in eligibility did not apply. It was not possible to confirm nursing tasks that were integral to individual HCA responsibilities, and this information was not available at ward level to inform RNs. The lack of HCA role clarity attributed to the absence of standardised HCA job titles, job descriptions, minimum education, qualification, and competency requirements, is well recognised in previous research (Walker et al., 2021; OECD, 2020; Drennan et

al., 2018; Glackin, 2016; Clark and Thompson, 2015; Hewko et al., 2015; Braeske et al., 2010; Corazzini et al., 2010), and this study supports and contributes to this evidence. Braeseke et al. (2013) in their review of educational standards and legal regulations of employment for HCAs across 15 EU countries found that the majority of countries, including Ireland, had no standardisation for HCA education or training. Furthermore, they reported that three of the 15 countries concerned had no official regulation of HCAs, including Ireland. More recently, the OECD report (2020) on attracting and retaining healthcare workers for care of older people confirmed this lack of standardisation and clarity of the HCA role. Drennan et al. (2018) reported that this lack of organisational standardisation resulted in different interpretations of the parameters of the HCA role in Ireland, and this contributed to RN and HCA role ambiguity. This CS reinforces these findings in relation to HCA role ambiguity in the absence of standardisation. HCA role ambiguity added complexity to the RN role as delegator, especially in relation to the competence of the HCA as delegatee.

An additional barrier to delegation was that HCAs in Case B were employed on multi-task attendant (MTA) contracts. In Case B several MTAs had not transitioned to the HCA job specification and contract of employment. In addition, there was confusion as to which HCAs had completed the QQI L5 programme. Therefore, Case B RNs were uncertain of, and did not understand the scope of responsibility of the MTA in resident care delivery. RNs were more cautious about trusting the HCA to work independently, and RNs reported checking up on HCA care delivery. Conyard et al. (2020) found that 16% of carers (including HCAs) in Ireland did not have a caring qualification. This raises a concern that HCAs are delivering resident care that they are not adequately qualified or educated to perform. Roch et al. (2014) previously reported concerns about HCAs delivering care that was at the level of RN. In this CS, there was a reluctance by RNs to share nursing tasks with HCAs, and a resistance by HCAs to take on nursing tasks. Therefore, as RNs found the role episode of 'delegation' unrealistic or inappropriate, they were reluctant to delegate. The interpretation of role messages sent and received between the RN and HCA influenced behaviours in both roles. For example, when the RN did not know which HCAs were educated and competent to undertake specific nursing tasks, this resulted in the focal person (RN) attempting to solve ambiguity by avoiding sources of stress (not delegating) or using defence mechanisms (RN rechecking vital signs themselves). The importance of transparency in the delegation process, with the RN ensuring that the HCA works within the parameters of their role and competency level, was identified as important for effective delegation (Walker et al., 2021). Therefore, there is a need for RNs to understand the HCA role and responsibility in order to delegate safely and effectively.

Participants in this CS did not understand each other's roles and identified the need for RNs and HCAs to do so. Previously, Kusi Appiah et al. (2018) explored the perceptions of RNs, LPNs and HCAs of their own and each other's roles in contribution to patient care. As in this CS, they found that RNs, LPNs and HCAs had a poor understanding of each other's roles and RNs could not describe their own role. Kusi Appiah et al. (2018) highlighted the need to clarify roles and job descriptions. The complexity of different caring roles (RNs and HCAs) not knowing or understanding each other's roles impacted on patient care. The systematic review and meta-analysis by Munn et al. (2013) found that to recognise the HCA role as a delegated clinical role was dependent on professionals and HCAs understanding each other's roles. Munn et al. (2013) stated that "the introduction of assistive personnel (HCAs) forces the restructure of the role of the health professional (RN) to supervise and delegate tasks to assistants, and not perform them themselves" (p.14). In this CS, the absence of role clarification created role stressors as RNs had not transitioned to their role as delegator or supervisor, and there was ambiguity as to the HCA role as delegatee.

6.3.3 Organisational Factors

Certain organisational factors are required to support RN delegation; they are delegation policies, procedures, protocols and guidelines (PPPGs), clarity in job specifications, delegation education, consensus among regulators and a model of care that supports delegation. In the REM, the conditions to support RN delegation are aligned as organisational factors (Kahn et al., 1964). However, in this CS, the organisational factors to facilitate appropriate and effective delegation were not found.

6.3.3.1 RN Delegation Policies, Protocols, Procedures and Guidelines (PPPGs)

In this CS there were no delegation PPPGs in either case study. The only evidence of external structures or governance to support delegation was from the nurse regulator (NMBI, 2021; NMBI, 2015). Nurse regulators, including NMBI, expect employers to have PPPGs to guide delegation by RNs, and provide education on delegation (NCSBN/ANA, 2019; NMBI, 2015*).* However, there were no delegation PPPGs evident in this CS. Previous research also identified and recommended the need for workplace guidelines, policies and resources to support RNs to delegate effectively to HCAs (Walker et al., 2021; Beeber et al., 2018; Hughes et al., 2017; Saari et al., 2017; Chu et al., 2016; Lee et al., 2015). However, these previous studies did not examine what external structures or governance were in place to support RN delegation. Using a CS research design in this study, the inclusion of documentary sources provided a more holistic picture and thus contributed to better understanding of organisational supports for delegation. The RN delegation role and responsibility was not articulated within organisational structures.

When RNs, HCAs and CNM2s were asked what delegation meant to them, they confused delegation with *allocation.* The terms allocation and assignment were often used correctly by participants; for example, when participants described allocation to teams, or assignment to dining-room or sitting-room duties. However, they used the term delegation when it might have been more appropriate to use the term assignment. With assignment, tasks and activities are transferred to the HCA that are within the job description and core tasks of the HCA role (BCCNM, 2020 NCSBN/ANA, 2019; Saari et al., 2018; NCSBN, 2005). As with delegation, the RN retains responsibility and accountability for the overall care of the resident, care evaluation, the decision to assign, and the provision of guidance to the HCA. The HCA is accountable for the care they deliver (BCCM, 2020; Saari et al., 2018). The apparent misinterpretation and inaccurate application of the term delegation by the CNM2s, RNs and HCAs were significant findings in this CS, and were not identified in previous research on RN delegation. A reason for this may be that, unlike nursing regulatory bodies in other countries – for example, the US (NCSBN/ANA, 2019; NCSBN, 2005; Weydt, 2010; Matthews, 2010), Canada (BCCNM, 2020; Saari et al., 2018), and Australia (NMBA, 2020) – the NMBI does not define or reference the terms assignment and allocation. In Ireland, the review of the role and function of the HCA undertaken by Drennan et al. (2018) also highlighted the need to differentiate between assigned and delegated tasks to the HCA, but there were no recommendations of how this should occur. Therefore, the importance of clarifying the meaning of delegation, and related but different terms is needed, as well as how delegation should be operationalised in practice, in particular in RCOP.

6.3.3.2 Job Specifications

As previously discussed (Sections 6.2.1 and 6.2.2), there was a lack of standardisation in job specifications for all grades in relation to delegation responsibilities, with many earlier dated job specifications having no reference to delegation either for the RN as delegator or the HCA as delegatee. This inconsistent and often lack of reference to delegation in job specifications resulted in RN role ambiguity and role conflict. The absence of organisations articulating and clarifying the role and responsibility of the RN in delegation was a barrier for delegation. The employing organisation did not always articulate and clarify the responsibility of the HCA in direct care, or as delegatee. This lack of standardisation or clarity as to the roles of the RN and HCA in delegation resulted in role ambiguity.

6.3.3.3 Delegation Education and Competency Development

Within the professional scope of practice, RNs are expected to maintain their competence to practise, including competence as a delegator, through education, clinical experience and continuing

professional development (NMBI, 2015). In Ireland, undergraduate nurse education includes delegation education in the programme content (NMBI, 2016) but there is no structured RN education or training post qualification to support RNs in developing their competence in delegation.

In this CS, participants reported that they had not received education on delegation, and there was no process to assess RN competence as a delegator. Therefore, it was not surprising that this affected the RN competence and confidence to delegate. RNs felt unprepared in their role as delegator and were not confident in applying their scope of practice for delegation or assignment to HCAs. Many RNs had been educated in the apprenticeship approach and could not recall receiving education on delegation. Therefore, a trial and error approach to delegation was used whereby RNs applied different approaches to delegation and assignment. Other studies also identified how RNs, in the absence of education on delegation, trialled different approaches to delegate (Anthony et al., 2001; Johnson et al., 2014; Magnusson et al., 2017). RNs in this CS did not undertake some tasks, thereby implicitly sending an expectation to the HCA to undertake these tasks (e.g. answering resident call bell), but leaving the task to the HCA, or completing their documentation during resident mealtimes, and the HCA was thus required to assist residents.

Despite consistent evidence over the last twenty years regarding the importance of RN education on delegation, more recent studies, including this CS, continue to identify inadequate delegation education and competence development at undergraduate nurse education level and post qualification (Walker et al., 2021; Campbell et al., 2020; Allan et al., 2018; Magnusson et al., 2017; Allan et al, 2016; Yoon et al., 2016; Allan et al. 2015; Hasson et al., 2014; Johnson et al., 2014; Kaernested et al., 2012; Saccomano and Pinto-Zipp, 2011; Potter et al., 2010; Bittner and Gravlin, 2009). The positive impact of education on delegation to RNs was confirmed by Kaernested et al. (2012). They found that, when RNs were provided with education on delegation, including workplace-based education, 96% of RNs reported having sufficient experience to delegate. However, the extent to which this was operationalised or translated into practice is unknown. Campbell et al. (2021), in their integrative review of the literature, found limited evidence of interventions to improve delegation. Research on RN confidence in delegation found that RNs were not adequately prepared for delegation responsibilities (Yoon et al., 2016; Saccomano and Pinto-Zipp, 2011). Interestingly, Yoon et al. (2016) found that RNs who were aware of their professional responsibility in delegation had knowledge of HCA job specifications, and RNs who had undertaken professional development in delegation were more confident in delegation than other RNs. Both of these studies applied quantitative designs and relied on the responses of the RN participants as the data source; therefore, the extent to which this improved delegation in practice is unknown. In this CS, the benefits of

triangulation of different data sources and methods enabled an in-depth understanding of interpretations and perceptions of RN delegation beyond the RN accounts. Future studies might use the case study methodology approach used in this study to explore RN delegation and obtain a more in-depth understanding of the perceptions of RNs and HCAs, as well as observing the impact on actual clinical practice and patient outcomes.

RNs reported that HCAs' completion of a QQI L5 education programme was taken as an assurance of HCA competence to deliver direct care. This influenced both the RNs' and HCAs' perception of the need for delegation. However, in both cases there was no standardised approach to assessing the competence of the HCA to deliver unsupervised care. Assessment of HCA competence was by working with the HCA in delivering care, or RNs had to 'trust' that the HCAs delivered care safely and competently. This finding was also reported in previous studies (Walker et al., 2021; Dudley et al., 2021; Drennan et al., 2018; Saari et al., 2018; Glackin, 2016; Roch et al., 2014; Alcorn and Topping, 2009) where HCAs were found to deliver care outside their training, including care previously provided by RNs. However, previous studies did not identify or recommend how HCA competence in delivery of direct care could be assessed. Previous studies found that, when HCAs undertake tasks beyond the HCA's knowledge and competence, this affects patient safety, patient outcomes, and the working relationship between the RN and HCA (Walker et al., 2021; Campbell et al., 2020; Glackin, 2016; Johnson et al., 2015; Kærnested and Bragadóttir, 2012). This raises concerns in relation to RN accountability for delegated and assigned resident care delivered by unregistered care staff. The findings in this study support the need for HCA competence assessment in care delivery, and also the requirement for a standardised process on how to assess competence, especially when the HCAs deliver care independently. Effective delegation practices may support HCA competency assurance.

6.3.3.4 Regulatory Factors

The importance of regulators for professional practice (NMBI) and regulators for the operation of designated centres for RCOP (HIQA) recognising the RN role in delegation is identified as an important factor for effective delegation. However, this study found conflict between the NMBI as nurse regulator expecting all RNs to delegate and supervise HCAs, and HIQA referring to RNs and HCAs as staff, and expecting only CNM2s or ADoNs to have supervision responsibilities.

The importance of RCOP sites' adherence to HIQA regulation and standards emerged as important in this CS. HIQA has the authority to remove a RCOP service as a designated centre to deliver care. It was therefore not surprising that adherence to HIQA standards and requirements (2016) and the associated site inspections were of high importance to staff. HIQA documents do not distinguish

between the RN and HCA roles, recognising RNs and HCAs collectively as 'staff'. This may have diminished the expectation that all RNs delegate and supervise, and thus contributed to conflicting expectations for the RN role as delegator. The impact of the regulator processes and standards for RCOP centres on RN delegation is a significant finding. No previous studies on delegation explored how the processes of the RCOP regulator could be a barrier to enabling RN delegation. It would be important for NMBI and HIQA to agree as to the RN role and accountability for HCA delegation and supervision.

6.3.3.5 Model of Care

This CS found a task-orientated approach to care where care delivery was focused on routine tasks and activities. As many of the HCAs worked in the CS sites for a long time, they knew the residents and the routine, and this led to the expectation that HCAs would be competent in their direct care role. Several studies supported the finding that the HCA role had expanded to the direct care role of residents, often with HCAs providing most direct care (Dudley et al., 2021; Afzal et al., 2017; Coffey et al., 2017; Saari et al., 2017; Dellefield et al., 2012). In Canada, Afzal et al. (2017) found that 80% of direct care for older people was provided by unregistered care staff. In addition to the HCAs' caring and supportive roles, they were responsible for observing and documenting important clinical interventions (e.g. fluid and diet intake, vital signs and specimen collection), and providing emotional support to patients (Afzal et al., 2017). These nursing tasks are defined by the Canadian nurse regulators as 'Controlled Acts' and can only be undertaken by the HCA in Canada, through delegation. Contrasting with previous research, in this study there was a reluctance for HCAs in Case B to undertake nursing tasks. The reason for this was not clear. The study participants provided different possible reasons, such as the culture was never to assign or delegate these tasks to HCAs, HCAs had never undertaken these tasks, and RNs were reluctant to delegate. The lack of role clarity between HCA and MTA affected the RNs knowing what to delegate and the HCAs knowing what to undertake as delegatee. Therefore, the expectations of participants that HCAs could work in the absence of RN delegation, assignment or supervision is an important finding in the context of RCOP care transitioning from a task-orientated model of care to a more person-centred practice (Buckley et al., 2018; McCormack et al., 2010).

In the absence of organisational factors to support RN delegation, role stressors were evident. In this CS, RNs experienced role conflict when there were conflicting expectations for the RN role among different role senders. NMBI and, more recently, the employer through updated job specifications expect the RN to delegate to the HCA. However, there was no evidence that the RCOP managers expected RN delegation. HIQA did not distinguish the RN role as separate from the HCA. HCAs did not

expect the RN to delegate; in contrast they expected that the RN would not delegate. This also resulted in RN role ambiguity as the RNs were unclear as to their relationship with HCAs, which resulted in a reticence to delegate, or when delegation was resisted, uncertainty how to manage this. This role ambiguity and role conflict resulted in the RN undertaking tasks themselves and checking up on the HCA work, resulting in role overload. The absence or differences in expectations for RNs to delegate were perpetuated by lack of organisational factors to support delegation.

6.3.4 Effective Teamwork

Effective teamwork is defined as two or more individuals with specific roles interacting interdependently and effectively to achieve a common and shared goal (Bellury et al., 2016). The importance of RNs and HCAs working together in a team is identified as critical for delivering quality and safe care (Campbell et al., 2020; Hjelle, 2018; HSE, 2018; Drennan, 2018; Bellury et al., 2016; Kessler et al., 2015; Anderson and Spiers, 2015; Lee et al., 2015; Roch et al., 2014; Potter et al., 2010; Bittner and Gravlin, 2009; Standing and Anthony, 2008).

RNs and HCAs when working together were observed to have a good relationship. Participants reported that team working was good. However, in both cases, HCAs had a negative perception of RNs assigning a job to HCAs instead of completing it themselves, such as not helping with resident teas, or turning off a resident call bell but assigning the task to an HCA. The RNs reported role conflict and role overload in relation to whether they undertook their administrative responsibility (in the office) or responded to resident care needs. The HCAs also reported that it depended on which nurse was in charge if it would be a 'good day'. The findings were reflective of the study by Walker et al. (2021) finding a lack of consensus among nurse leaders, RNs and HCAs as to the expectations of the RNs to work with the HCA in direct care, with HCAs expecting that the RNs would work with the HCA. Holmberg et al. (2013) found that some HCAs reported feeling undervalued and disrespected in their role, and also that RNs would not respond to call bells, leaving this to the HCA. The Bellury et al. (2016) study also identified tensions in the RN/HCA working relationship; HCAs described how individual personalities and work styles impacted on working relationships and team working. They reported that it depended on who was on duty whether the HCA had a good or a bad day, and communication consisted predominantly of one-way requests from the RN to the HCA. These findings are important in the context of understanding and supporting the findings in this study.

RNs and HCAs were assigned to work together in pairs in team nursing in both CS sites. RNs and HCAs received handover reports together. Therefore, there was an expectation in commencing this study that the RN would delegate to HCAs. However, when an RN and HCA worked together delivering direct

care to a resident, the HCA knew what to do (routine tasks), and therefore there were no role episodes of assignment or delegation. The RN and HCA 'delegatory relationship' was identified in the literature review, where effective communication, mutual trust and respect were described as critical in the RN and HCA working relationship (Campbell et al., 2020; Allan et al. 2016; Glackin, 2016; De Vliegher et al., 2016; Bellury et al., 2016; Kessler et al., 2015; Anderson and Spiers, 2015; Lee et al., 2015; Johnson et al., 2014; Roch et al., 2014; Potter et al., 2010; Bittner and Gravlin, 2009; Standing and Anthony, 2008). Despite *trust* having been identified as an important factor for effective delegation (Campbell et al., 2020; Bellury et al., 2016; Corazinni et al., 2010; Bittner and Gravlin, 2009; Standing and Anthony, 2008), this CS found that RNs trusting the HCAs to undertake tasks may have occurred in place of delegation. Walker et al. (2021) also reported that, as the HCA became embedded into nursing teams, "there was a concern that too much trust and comfort between the nurse and NA (HCA) may have a negative impact on supervision practices… leading to nurses becoming 'quite blasé about supervision and delegation'" (p.6).

Participants in this CS stated that, when an RN and HCA were paired to work with each other, the RN might leave the HCA to undertake administrative tasks. HCAs therefore reported that they preferred when they were paired with another HCA. This was more evident in Case A, where two HCAs were frequently allocated to work together. In this CS, the HCAs did not understand or value the administrative role of the RN. HCAs described the RNs as 'hiding' in the office, doing too much writing. The expectations of the HCAs were twofold: that the RNs delivered direct care, and did not have to tell the HCAs what to do (delegate or assign). The separate working of RN and HCAs was described in previous studies as *parallel working (*Johnson et al., 2014; Bellury et al., 2016) or as *working in silos* (Campbell et al., 2020). In the study by Johnson et al. (2014) to analyse team working between NQNs and HCAs, RNs reported the challenges of balancing administrative tasks and direct patient care tasks. Johnson et al. (2014) found that the multiple demands on newly qualified RNs' time, particularly the pressure to maintain documentation, resulted in the RN and HCA working separately. Bellury et al. (2016) also referred to HCAs and RNs working as parallel teams, where the HCAs reported that the direct care team was only HCAs working together. However, there were concerns identified in previous research in relation to HCAs working independently of the RN, where HCAs delivered patient care beyond their training (Saari et al., 2017). It is accepted that there are routine tasks and activities identified within the HCA role and responsibilities (Walker et al., 2021; OECD, 2020; Drennan et al., 2018; Saari et al., 2017), and these can be allocated or assigned to a HCA. There are differences in how additional nursing care tasks are described for HCAs; e.g. expanded role, task shifting, advanced, assigned or delegated care (Saari et al., 2017). Therefore, there is a requirement for HCAs and RNs to

receive education on how to work together effectively in a team, with clarification as to what tasks and activities require delegation.

Within the RN/HCA working relationship, it was important to understand the context and process of delegation by RNs. When RN participants reported a reluctance to delegate, it was important to understand why. RNs prioritised the maintenance of good working relationships with HCAs above assignment or delegation. RNs explained that a good working relationship with the HCAs was very important and therefore they did not wish to appear 'bossy' or a 'Hitler type'. In addition, the RNs did not want to appear lazy or unfair to the HCAs and therefore were conflicted if not helping the HCAs. Similar findings were reported by Kaernested et al. (2012); when RNs were concerned that they were perceived as lazy, this was a deterrent to delegation, and RNs were uncertain when to delegate and when to follow up on delegated tasks (Walker et al., 2021; Bystedt et al., 2011)**.** RNs were not comfortable for being held responsible for activities that the HCAs performed and recommended that RNs focus more on the evaluation and evolution of the overall health status and care needs of the patient (DeVliegher et al., 2016). More recently, Walker et al. (2021) reported that RNs indicated that maintaining their relationships with the HCA was more important than delegation. These researchers also identified a need to improve communication and the RN/HCA teamworking relationship.

To compound the reluctance of RNs to delegate, HCAs in this CS did not want RNs assigning or delegating tasks to them, and the HCAs perceived that they knew what to do in their role. HCAs did not like when an RN asked the HCA to do a task, and often resisted doing it. The prioritisation of RN administrative responsibilities resulted in tension, frustration and a negative perception of the RN role. There was evidence that HCAs resisted assignment from RNs who were not the nurse-in-charge. RNs provided examples of when they asked a HCA to undertake a task or activity and the HCA resisted. The RNs then undertook the task themselves. HCAs confirmed this resistance when they explained that they sometimes pretended that they did not hear the RN, or just did their own thing regardless. In the study by Potter et al. (2010), RNs reported that resistance to delegation impacted on team building, working relationships and effective delegation. Similar to this CS, RNs reported a reluctance to engage with HCAs who would not undertake delegated tasks and they would instead undertake the task themselves or expect organisational managers to manage the HCAs who were reluctant to accept delegation (Potter et al., 2010).

The HCA perspective in this CS enabled a better understanding of RNs' reluctance to delegate, the associated HCA resistance to RN delegation, and how delegation could cause friction in the working relationship. HCAs reported that they were unaware of the RN role as delegator and believed there were few differences between the RN and HCA role. HCAs in this CS reported that the only difference

between an RN and HCA was that the RNs administered medication. Previous studies also reported that HCAs believed there were few differences between the RN and HCA roles, and the only difference between the HCA and RN was the medication administration responsibility (Bach et al., 2014; Potter et al., 2010). Similarly Bach et al. (2012) reported that HCAs felt they did not require RN supervision. In this UK-based study, HCAs described how they worked with RNs as team members and rejected that the HCA should work under the supervision of an RN.

In the REM, the HCA as role sender was dependant on the RNs' actions and behaviours, and had expectations of the RN role. According to the REM (Kahn et al., 1964), it was against these expectations that the role sender measured the performance of the RN. HCAs had expectations and made demands on the RN role in delivery of resident care. HCAs expected RNs to prioritise resident care delivery over administrative responsibilities. They described the RNs as avoiding direct care – for example, hiding in the office, or not undertaking tasks from resident call bells. It was expected that, when RNs and HCAs worked together in pairs, delegation would occur, and the interdependence relationship between the RNs and HCAs would be evident. However, no delegation occurred. RNs did not create an expectation of RN delegation; therefore, in addition to organisational factors, the RN/HCA interpersonal relations (Kahn et al., 1964) also affected the role episode. In the role episode of delegation, the RN would be expected to hold a position of power and authority. In a hierarchical relationship, power balance and authority are expected to influence the episode (Kahn et al. 1964). However, this hierarchical relationship for delegation between RNs and HCAs was not evident. Conversely, the HCAs and RNs identified that the HCA's knowing the residents and ward routines, and 'knowing what to do' placed the HCAs in a position of power, or created a perception that the HCAs were at a similar hierarchical level to the RN. RNs reported that they were reluctant not to assist HCAs as they could be 'blacklisted', meaning that HCAs would purposely not work with a particular RN. HCAs reported similar reluctance to challenge RNs. Therefore, hierarchical roles did not dictate the power relationship, but rather the risk of negative responses by homogenous groups influenced the role episodes. This demonstrated how interpersonal relationships impacted on RN/HCA role episodes. The absence of delegation creates concerns in relation to safety and quality of care if care delivery is not challenged. Similar concerns were reported by Walker et al. (2021) when RNs' lack of understanding about delegation created confusion and conflict in the RN/HCA relationship.

Role conflict arose from the different expectations and perceptions of what constitutes real work, resulting in resentment over who does what. Bach et al. (2012) reported on similar findings that RNs no longer wanted to undertake direct care tasks that were expected as central to the role, describing this as 'dirty work'. HCAs reported they were allocated the 'dirty' work while RNs spent a long time

'writing', and this created tension between RNs and HCAs (Bach et al., 2012). The expectations of the HCA, as role sender, that their role was similar to the RN helps understand why there was role conflict and role ambiguity, and thus no delegation. The negative impact of the use of terms such as 'dirty work' and administrative role should be considered in future research. Effective RN/HCA team working is identified as a facilitator to effective RN delegation.

6.3.5 Staffing and Skill Mix

Although not an original focus in the study, staffing and skill mix were found to have a significant impact on RN delegation. In both Case A and Case B, the impact of the reduced RN staffing levels and skill mix created concerns for the RN in relation to their inability to provide direct care to all residents, and therefore the need for the RN to rely on the HCAs to deliver care and report back to the RN. This RN accountability and responsibility for assigned tasks to HCAs was a concern for the RNs, especially the RNs in Case B. Other studies also found that the reduction in RN staffing numbers, lower RN to HCA ratios, and the increase in RN workload diminished effective delegation to HCAs (Bengtsson et al., 2021; OECD, 2020; Wells et al., 2019; Walker et al., 2015; Roch et al., 2014; Bystedt et al., 2011; Kalisch, 2006). These studies also found that the higher ratios of HCAs to RNs resulted in the increased role of the HCA as direct care provider, and less time for RNs to attend to the direct care needs of residents. Similar to this CS, when Roch et al. (2014) explored how RNs perceived their work practice environment, they found that RNs reported that workload, role clarity and role-related conflict affected the RN undertaking their caring practice role. These RN role stressors were related to the RNs' decreased capacity for direct care and an increased reliance on HCAs. RNs reported on how direct nursing care was delegated, shared or undertaken by other members of the nursing team (Roch et al., 2014). Therefore, this CS and previous studies have found that, with fewer RNs and more HCAs on nursing care teams, there is a requirement for more delegation and assignment. Concurring with previous research (Burrow et al., 2017), this study found that RN role stressors were increased in RCOP where the lower ratio of RNs made it a challenge for RNs to provide adequate mentorship, supervision and assessment of HCA competence. This additional responsibility for HCAs was found to be a burden to RNs (Walker et al., 2021; Burrow et al., 2017). Despite the need for organisational support for RN delegatory and supervisory responsibilities in practice (Walker et al., 2021; Chu et al., 2016) previously identified, in this study these supports were not evident despite increasing ratios of HCAs.

HCA participants described how they provided resident care independent of the RN and thus required more HCA staff. HCAs described how they had to rush their care delivery, resulting in a focus on completing tasks. Likewise, the scoping review by Afzal et al. (2017) reported that insufficient HCAs

resulted in poorer quality of care as HCAs rushed to complete routine tasks, with less time to spend with residents. Afzal et al. (2017) interestingly summarised how HCAs were becoming the 'arms and legs' of patients and the 'eyes and ears' of other healthcare workers. Similarly, this CS also found that RNs monitored residents through HCAs, and sometimes did so without supervision or evaluation.

To add further complexity in understanding how staffing levels and skill mix impacted on delegation, the RNs' role in delegation to agency staff was inconsistent. In both cases, agency RNs and HCAs were regularly engaged to replace staff absences. HCAs were expected to familiarise the agency staff in relation to the resident care needs, and mentor new agency staff, and agency HCAs predominantly worked with other HCAs rather than the RN delegating or assigning to the agency staff. This assignment of agency staff with HCAs, and not RNs, implied that safe and effective delegation processes were not occurring. HCAs and RNs reported a preference not to be paired with agency staff replacements in team nursing as this resulted in additional workload, responsibility and accountability. These findings are supported in previous evidence that delegation was considered time-consuming, adding to the RN workload and resulting in a reluctance by RNs to delegate (Walker et al., 2021; Hughes, 2017; De Vliegher et al., 2016; Huang et al., 2011). However, these previous studies did not identify agency staff replacement in nursing care teams as a significant factor to be considered in RN delegation. Therefore, it is important to recognise the role of the RN as delegator to new and replacement HCA and RN staff. The relative dearth of research on RN delegation, especially in the context of decreasing ratios of RNs in RCOP, is of concern. As the ratio of RNs to HCAs is significantly lower in RCOP services, HCAs deliver most of the direct resident care. The importance of effective RN delegation in RCOP is critical to resident safety and quality of care. Appropriate RN and HCA staffing levels and skill mix enable effective delegation by allowing adequate time to assess the competence of HCAs, and to mentor and supervise HCAs within the delegation process. This study found that, with fewer RNs in RCOP, there is an expectation that more delegation, assignment and supervision will occur. However, previous studies did not find that RN delegation was not occurring as expected in RCOP. This is an important contribution to knowledge as there has been no previous research on RN skill mix in RCOP in Ireland, or on how the lower RN ratios affect effective delegation. Therefore important findings for RCOP were that the fewer RNs the more delegation is required, but this was not reflected in practice, and agency RN and HCA replacements may not have the knowledge or competence to undertake specific tasks.

6.4 Discussion Summary

The findings from this study have been discussed in the context of the existing evidence on RN delegation. The HCA role was introduced into nursing teams to work under the direction, delegation

and supervision of an RN. However, in this study, HCAs worked with RNs in the absence of delegation. To understand why this anomaly occurred, the RN/HCA dyadic was interpreted through the REM in organisational role theory. The REM enabled an innovative and alternative approach to understanding RN delegation. The interpretation of delegation in the context of the expectations of the RN and of the various role senders contributes to understanding delegation in a more holistic manner. Few studies have included the perspectives and experiences of not only RNs but also HCAs and CNM2s as to how delegation occurs. The inclusion of these different groups in this CS research allowed for comparisons and illumination of different perspectives and experiences. The findings corresponded with findings in previous research in relation to the RN education on delegation and the lack of clarity on the HCA role. However, significant new findings emerged in this study in relation to the barriers to and facilitators of effective delegation. These factors are: RN and HCA role clarity, organisational factors, effective team work, and staffing and skill mix.

6.5 Contribution to Knowledge

This is the first study in Ireland exploring how RN delegation occurs, and one of the few studies that has examined delegation in RCOP. There were few previous studies that examined the actual process of delegation in practice, and few studies that triangulated observational data with other data methods. This study has developed and increased knowledge by:

- identifying the reality of the delegation and assignment practices of RNs in RCOP settings;
- providing an analysis of RNs' and HCAs' understanding and experiences of RN delegation in practice in RCOP;
- providing a benchmark for future nursing research focusing on the RN role in RCOP settings;
- contributing to existing evidence on the lack of role clarity for the HCA, with particular focus on the HCA role in direct care delivery;
- building on existing evidence in the application of organisational role theory as a theoretical lens to understand roles, dyadic relationships and role stressors in organisations;
- identifying and providing a comprehensive description of the facilitators and barriers to RN delegation to HCAs in RCOP settings;
- offering an example of applying both the interactive model and the analytical process proposed by Miles et al. (2020) as a data analytical approach; the detailed reporting on the application of this structured process contributes to knowledge of data analytical approaches and could be used by other researchers for CSR.

Based on the research findings and the discussion of the findings, the following section identifies recommendations for policy, organisation and education.

6.6 Recommendations for future work

In conclusion, the recommendations for policy and education, and implications for nursing practice in RCOP services are presented under the themes from the study findings. Recommendations for future research are also presented.

6.6.1 Creating the Conditions

There has been increased attention on RCOP services in the context of the ageing population and learning from the COVID-19 pandemic. In Ireland, recommendations of the Expert Review of Nursing Homes Report (DoH, 2020) include a review of nurse staffing and skill mix in RCOP settings. In addition, the recommendations of the Review of the Health Care Assistant Role in Ireland (HSE, 2018) are to be implemented. However, there is no recommendation specific to RN delegation. There is an opportunity to integrate the benefit of effective RN delegation with reviews of staffing and skill mix.

It is recommended that:

1. RN delegation should be considered in the context of reviews of staffing levels and skill mix in RCOP services and subsequent policy decisions.
2. The NMBI should provide guidance on the differentiation between delegation, assignment and allocation. RN accountability and responsibility for supervision should be clarified, as well as how competency levels of HCAs should be assessed.
3. Key stakeholders should develop a national policy for RN delegation in RCOP settings.
4. The role of RNs in RCOP should be clarified through standardising the roles and responsibilities in RN or staff nurse job specifications for RCOP settings.
5. The role of the HCA should be clarified through standardising the roles and responsibilities in HCA job specifications for RCOP settings.
6. HIQA registration regulations (HIQA Standards) and site inspections should reflect the delegation and supervision role of the RN, acknowledging that the RN and HCA roles are different in relation to accountability, management of care, supervision and delegation.

6.6.2 How it Happens

This study found that RN delegation did not occur. RNs were reluctant and not confident in delegation or assignment to HCAs. HCAs resisted RN delegation and assignment.

It is recommended that:

1. Consistent and standardised clarification of the distinction between RN delegation, assignment and allocation should be provided by the employer and nurse managers at recruitment, induction and operational levels.
2. RNs' professional accountability for delegation and assignment should be clarified and effectively communicated to RNs. The practice of nurse-in-charge should not diminish this accountability.
3. Digital solutions (e.g. eHealth records and digital care plans) should be developed for record-keeping so as to reduce documentation workload and enable more accessible record-keeping for RNs and HCAs. This would optimise HCAs' documentation of tasks and activities completed, enabling the RN to review and monitor the HCA recording of delegated and assigned care.

6.6.3 Knowing What I Should Do

The lack of RN role clarity and the evidence of RN role stressors indicates a need to facilitate and develop RN role clarity in the future. HCAs reported knowing what to do in their role and not requiring RN delegation. However, the boundaries between the professional RN role and the HCA role were misunderstood.

It is recommended that:

1. Undergraduate nurse education programmes and content should be reviewed to ensure that delegation and assignment knowledge and competencies are developed.
2. Delegation education and competence development are available to RNs in RCOP. RNs should be supported in practice to develop confidence and competence in effective delegation.
3. HCA education programmes should cover the role of the HCA as delegatee and the role of the RN as delegator.
4. A standardised competence assessment process for HCAs delivering (unsupervised) direct care should be developed.
5. Policymakers should consider registering and regulating HCA grades in Ireland.
6. The recommendations of the Review of the Role of the HCA (HSE, 2018), especially standardisation of minimum education, minimum qualification and job specifications, should be implemented.
7. Employers should review the job descriptions, minimum qualifications, roles and responsibilities of currently employed HCAs to provide standardisation and consistency for

the HCA role. This should include reconciliation of the MTA workforce who are working in the role of a HCA. Discrepancies between current HCAs and MTAs who have a predominant caring role, and those who have QQI L5 qualification should be addressed.

6.7 Recommendations for Future Research

This study aimed to explore how RN delegation occurred in RCOP and found that delegation did not occur. The findings form a basis for further research on the working relationship between RNs and HCAs in RCOP services with the aim of ensuring better understanding of how professional and occupational roles integrate as a nursing team.

It is recommended that:

- Research should be undertaken on the impact of implementing a delegation education programme, to evaluate if delegation practices improve and associated role stressors are reduced.
- Role theory should be integrated in further research on the RN role and RN delegation to provide further understanding of the factors that influence role stressors. The findings from this study should form the basis for further research on RN delegation practices in RCOP settings in Ireland.
- Further research on delegation should include both RNs and HCAs as participants.
- Further research should be undertaken on the documentation responsibilities of the RN and the associated workload to understand and distinguish the professional RN documentation obligations from documentation that could be delegated to HCAs.
- Further research should be conducted in social care settings to explore and understand the roles of and working relationships between HCAs and RNs to understand the delegatory relationship, along with similar research across public and private RCOP services to understand RN delegation in a wider context.
- Further research is required on the negative impact of the use of terms such as ‘dirty work’ and ‘administrative role’ in the context of the role of the RN.
- Further research should be undertaken to investigate the attainment and assessment of HCA competence in delivering (unsupervised) care.

6.8 Limitations of Study

The CS sites were restricted to public health service RCOP services. Different findings might have emerged in privately owned RCOP services. As with all qualitative research, there was a risk of

researcher bias. The researcher, as a nurse in the HSE, could have biased views in favour of RNs, and have preconceptions and assumptions concerning RN delegation, or 'lean' the methods toward a particular finding. The researcher addressed these risks through transparent and systematic approaches to rigour, including the application of reflexivity. The challenges of undertaking qualitative data collection methods in clinical settings have been identified in previous literature and in this study. Challenges encountered in this study included participant recruitment for interview and observation methods, and conducting research whilst protecting the rights and dignity of residents in the RCOP setting. Organising a time to conduct interviews required consistent negotiation on each CS site, with a risk that an adequate number of participants would not be available. For the direct observation data, the researcher restricted observations to protect the privacy and dignity of residents, and did not undertake direct observation of the RN and HCA delivering direct care in residents' bedrooms, and may therefore have missed some episodes where RNs delegated to HCAs. However, interview data confirmed that the instances of RNs and HCAs working together in a resident's room were infrequent, and that delegation did not occur during these periods. In addition, the observational data collected supported these findings.

6.9 Conclusion

The aim of the research was to explore how the delegation of tasks by registered nurses (RNs) to health care assistants (HCAs) occurred in nursing teams in residential care for older people (RCOP) services. This was achieved through the use of a multiple, interpretive case study research design. The data from multiple sources, direct observations, documentary reviews, RN focus group interviews, HCA focus group interviews, and CNM2 individual interviews were used to identify the key issues of the case, 'delegation by RNs to HCAs', within the boundaries of the case. Therefore, an in-depth analysis of the context and process of delegation, and the perceptions of RNs and HCAs of their own role and each other's role in the delegatory relationship were explored. The intensive investigation of the case resulted in an understanding of the case, and the interrelationships that impacted on the process of delegation. The results of the thematic data analysis were the development of three themes: *Creating the conditions*, *How it happens,* and *Knowing what I should do.* The results indicated that delegation of tasks by RNs to HCAs did not routinely occur. Hence, the research question in relation to how RN delegation to HCAs occurs in RCOP settings has been answered, but in doing so unexpected findings emerged in the context of the RN role and the HCA role in delegation. The analysis of the findings through the theoretical lens of organisational role theory provided a framework to understand the interrelationship between the many complex factors that inhibited effective RN delegation. Role stressors were important in understanding why delegation was not occurring. The

barriers and facilitators to effective RN delegation in RCOP were identified as: RN and HCA role clarity, organisational factors, effective team working, and staffing levels and skill mix. The findings of this study can contribute to improving the working relationship between RNs and HCAs in RCOP services an; guide the development of more effective RN delegation, which may improve communication, RN and HCA role clarity, and ultimately the care of residents.

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Appendix 1: Literature Review Summary

1st Author	Authors	Year	Country	Research Study Review Discussion Thesis Government/Policy	Design Quantitative Qualitative Mixed	Title	Aim	Population (RCOP Acute Community RNs HCAs)	Sample Size	Focus on delegation between RNs and HCAs
Afzal	Afzal, A., Stolee, P., Heckman, G.A., Boscart, V.M. and Sanyal, C.	2018	Canada	Review Scoping	systematic search strategy described	The role of unregulated care providers in Canada – A scoping review	To explore: the role of unregulated care providers; their potential role in interprofessional teams; the impact of unregulated care providers on quality of care & pt safety; and education & employment standards	Unregulated care providers (HCAs)		No. Role of HCA
Alcorn	Alcorn & Topping	2009	UK	Quantitative	24 item survey questionnaire with Likert scale	Registered nurses' attitudes towards the role of the healthcare assistant.	To elicit RNs views of RN responsibilities to HCAs in relation to delegation, development and accountability.	RNs Surgical Directorate NHS Acutes Hospital	Convenience sample 219 RNs. 148 questionnaires returned 68% RR	Yes
Allan	Allan, H. T., Magnusson, C., Horton, K.,Evans, K., Ball, E., Curtis, K.,and Johnson, M	2015	England	Qualitative	Ethnographic Case Study. Participant observations and indepth interviews	People, liminal spaces and experience: Understanding recontextualisation of knowledge for newly qualified nurses	To explore how newly qualifies nurses (NQNs) delegate to HCAs when delivering bedside care.	Three Acute Hospitals. Inpatient wards	Participant Observation. Interviews with 33 NQNs, 10 HCAs & 12 Ward Managers	A tool used to assist NQNs to delegate and supervise was developed and piloted with 13 NQNs. A process evaluation was undertaken.
Allan	Allan, H, Magnusson C, Evans, K, Ball, E, Westwood, S, Curtis, K, Horton, K and Johnson, M	2016	England	Qualitative	Ethnographic Case Study	Delegation and supervision of health care assistants' work in the daily management of uncertain and the unexpected in clinical practice: invisible learning among newly qualified nurses	To explore NQNs experiences of delegating and supervising HCAs	Three Acute Hospitals. Inpatient wards	Participant Observation. Interviews with 33 NQNs, 10 HCAs & 12 Ward Managers	Yes
Allan	Allan, H. T., Magnusson, C., Evans, K., Horton, K., Curtis, K., Ball, E. and Johnson, M	2017	England	Qualitative	Ethnographic case study. Participant one-to-one interviews only. No observations	Putting knowledge to work in clinical practice: Understanding experiences of preceptorship as outcomes of interconnected domains of learning	How preceptor support can support NQN with working across knowledge sources when delegating to HCAs. To develop, test and evaluate a preceptorship tool.	Three Acute Hospitals. Inpatient wards	Participant Observation. Interviews with 33 NQNs, 10 HCAs & 12 Ward Managers	Yes. A tool used to assist NQNs to delegate and supervise was developed and piloted with 13 NQNs. A process evaluation was undertaken.
Anderson	Anderson &Spiers	2015	Canada	Qualitative	Ethnographic	Alone in Eden: Care Aides' Perceptions of Consistent Assignments	To explore how organisations and transformation of care through a contemporary model of service delivery can affect care aides' experiences and perceptions of their roles and relationships with residents	5 Nursing homes in a city	Convenience Purposive sample. 22 Care Aides	No. Effect of consistent assignment of HCAs to residents

Anthony	Anthony, Standing & Hertz	2001	US	Quantitative	Descriptive cross sectional	Nurses' Beliefs About Their Abilities to Delegate Within Changing Models of Care	How do nurses rate their abilities to delegate and supervise direct care activities. Do nurses' beliefs about their abilities to delegate and supervise differ by education, experience, practice setting, region and job responsibilities	Says a national survey? National database provided by NCSBN. But low numbers. Acute, long term care and home health	Volunteer sample of 516 licensed nurses (403 RNs & 113 LPN/VNs). Respondents: Acute care=70; LTC= 46; Home health= 32. RNs 134,	Yes
Bach	Bach, S., Kessler, I. and Heron, P.	2012	England	Mixed Methods	Case Study; Interviews RNs & HCAs.Documents. Demographic questionnaire	Nursing a Grievance? The Role of Healthcare Assistants in a Modernized National Health Service.	Aim of Study not identified. Aim of paper: To what extent and in what way do nurses and HCAs engage in boundary work to establish difference between roles and demonstrate their contribution to patient care. What are the consequences of the boundary management strategies in terms of work, rewards and status.	2 NHS Trusts, care of older people speciality area	?? But 60 semi-structured interviews conducted. 34 HCAs & 26 staff nurses, sisters and senior nurses	No Role Boundary
Barken	Barken and Armstrong	2018	Canada	Qualitative	Ethnographic. Teams of 12 - 14 researchers observed, interviewed, and gathered the internal documents in LTRC facilities. Synthesis of presentations from a conference	Skills of Workers in Long-Term Residential Care: Exploring Complexities, Challenges, and Opportunities.	Re-imagining LTC- highlight practices that uphold the dignity and respect of care providers and residents.	Researchers, representatives of employers from the not-for-profit sector & unions- as part of the international, interdisciplinary multi-site ethnographic project "Re-imagining Long-Term Residential Care"	26 co-investigators from 12 academic disciplines in social sciences, and humanities in 6 countries (Canada, Germany, Norway, Sweden, US & UK); 5 union partners; 2 employer associations; &numerous postdoctoral fellow, graduate students, and community advocacy groups.	No. Skills of 3 occupational groups in LTRC: direct workers, nurses & doctors
Beeber	Beeber, A.S., Zimmerman, S., Mitchell M.C. and Reed, D.	2018	US	Quantitative	Cross sectional descriptive. Telephone survey relating delegation policies to services	Staffing and Service Availability in Assisted Living: The importance of nurse delegation policies	To examine the health services provided in residential care and assisted living, the staff providing these services, and the degree to which the services relate to state level delegation policies	RC/AL settings (245) in 8 US States. Administrators and healthcare supervisors	Staff from 245 RC/AL services participated.	Yes
Bellury	Bellury, L., Hodges, H., Camp., A. and Aduddell, K.	2016	US	Qualitative	Descriptive. 33UAPs focus group session,18 RNs open-ended electronic survey	Teamwork in Acute Care: Perceptions of Essential but Unheard Assistive Personnel and the Counterpoint of Perceptions of Registered Nurses	To gain insights into the perceptions of NAP and professional RNs on teamwork in acute care.	1 metropolitan hospital US.with 200 nursing assistive personnel (NAP) & approx. 700 RNs	33 NAPs & 18 RNs	Teamwork between RNs and NAPs
Berta	Berta, W., Laporte, A., Deber, R., Baumann, A. and Gamble, B.	2013	Canada	Qualitative	Focus Group Interviews	The evolving role of health care aides in the long-term care and home and community care sectors in Canada.	The type of work and scope of work that HCAs do as it relates to caring for older persons in Ontario	Six industry experts in focus group.	6 experts on HCAs and the long-term institutional care sector.	HCAs role with Older Persons care
Birks	Birks, M., Davis, J., Smithson, J. and Cant, R.	2016	Australia	Review Integrative	Integrative review	Registered nurse scope of practice in Australia: an integrative review of the literature	To explore the concept of scope if practice of RNs in Australia.	Australian papers		RN Scope of Practice

Bittner	Bittner, N.P. and Gravlin, G.	2009	US	Qualitative	Descriptive	Critical thinking, delegation, and missed care in nursing practice	To understand how nurses use critical thinking to delegate nursing care	300 bedded acute hospital. Medical and Surgical care nurses	Focus Group interviews- 27 participants	Yes
Braeske	Braeseke, G., Hernández, J. Dreher, B., Birkenstock, J., Filkins, J., Preusker, U., Stöcker, G. and Waszkiewicz, L.	2013	Europe	Grey Project EU Commission	Survey to 15 countries	Final Report on the Project Development and Coordination of a Network of Nurse Educators and Regulators (SANCO/1/2009) to the European Commission	To initiate a Europe wide exchange about educational standards and legal regulations of employment for assistant staff within the healthcare sector	Europe, senior nurse educators, nurse leaders, nurse regulators	15 countries	HCA education
Bystedt	Bysted, M., Eriksson, M. and Wilde- Larsson, B.	2011	Sweden	Qualitative	Phenemology. 12 RNs interviewed	Delegation within municipal health care	To describe how RNs perceive delegation to unlicensed personnel (UP) in a municipal healthcare context in Sweden	Municipal Hospital for older people. RNs	12 RNs	Yes
Campbell	Campbell, Amy Richmond, Diana Layne, Elaine Scott, and Holly Wei.	2021	US	Integrative Review	Whittemore and Knafl's integrative review methodology	Interventions to Promote Teamwork, Delegation and Communication among Registered Nurses and Nursing Assistants: An Integrative Review.	To understand the strategies to influence patient outcomes by synthesizing existing evidence on effective interventions for teamwork, delegation and communication between nurses and nursing assistants		Seven articles included. January 2000 to January 2019	Yes
Chu	Chu, C.H., Ploeg, J., Wong, R., Blain, J. and McGilton, K.S.	2016	Canada	Review Integrative		An Integrative Review of the Structures and Processes Related to Nurse Supervisory Performance in Long-Term Care	To identify the structures & processes related to supervisory performance of regulated nurses in LTC.	Nursing Supervisors (Charge Nurse) are regulated RNs or registered practical nurses (RPN) reporting to managers. Nurse supervisors supervise NAs in LTC		
Coffey	**Savage, E., Leahy- Warren, P., Mulcahy, H., Wills, T., McCarthy, V., Fehin, P., Ó Doibhlin, D., McLoughlin, K., Benefield, L. E., O'Sullivan, B. and Hegarty, J.**	2017	Ireland	Systematic Review & Qualitative	Focus Group Interviews	Systematic literature review and national focus groups to support the development of a strategic vision and educational framework for Gerontological Nursing		Focus groups were conducted across five locations, and 190 individuals participated in the focus groups. The majority of participants were nurses (55.3%), followed by older people themselves (20%), representatives from the general public, and the remainder comprising of health and social care professionals and service providers other than nurses		No
Corazzini	**Corazzini, K., Anderson, R.A., Rapp, C., Mueller, C., McConnell, E. and Lekan, D**	2010	US	Qualitative	Descriptive. Constructivist Interpretivist paradigm	"Delegation in Long-Term Care: Scope of Practice or Job Description?"	How RNs in leadership roles in institutional long-term care settings delegate care	RNs in leadership roles- NH administrators or owners, DoNs, ADoNs	Data of larger Case study of NHs with a diversity of case- mix, quality indicator performance, and licensure and certification surveys. 33 interviews, one interview had 3 participants	Focus on delegation by nurse leaders in LTC
Conyard	**Conyard, R.F, Metcalfe, A., Corish, S., Flannery, J., Hannon, P., Rusk, B., Yeates, S. and Codd, M.B**	2020	Ireland	Quantitative	Cross sectional, population based study	Healthcare assistants and qualified carers, A Trained, but untapped underutilised resource: A population-based study in Ireland.	To record well being, career satisfaction and change within the vocational roles of HCAs and Qualified Carers	HCAs and Carers in Ireland, estimated 70,000 total number in Ireland	2,000 HCAs and Carers	No

Dellefield	**Dellefield, M. E., Harrington, C., & Kelly, A.**	2012	US	Quantitative	Work sampling observational. Data was collected for 38 days over 5 months.	Observing how RNs use clinical time in a nursing home	To describe how RNs divided their NH practice in real time between direct and indirect care.	RNs in NHs	74 bed NH in San Diego. A purposeful, convenience sample of all 7 nurses in the day shift. RNs from all shifts were recruited, only day shift RNs participated.	
Denton	**Denton, M., Brookman, C., Zeytinoglu, I., Plenderleith, J. and Barken, R**	2014	Canada	Qualitative	Unknown methodology. Semi structured telephone interviews.	Task shifting in the provision of home and social care in Ontario, Canada: implications for quality of care	To explore the impact of task shifting on quality of care provided to older adults from the perspective of home healthcare workers	A large home & community care organisation.	46 home healthcare workers including HCWs, home-care worker supervisors, nurses and therapists.	Yes
DeVliegher	**De Vliegher, K., Declercq, A., Aertgeerts, B. and Moons, P**	2016	Belgium	Qualitative	12 indepth interviews with HNs, 12 with HCAs & 8 with HNM.	Health Care Assistants in Home Nursing: The Holy Grail or the Emperor's New Clothes? A Qualitative Study.	To explore the experiences of home nurses HNs, HCAs and home nursing managers with regard to delegation of nursing activities to HCAs, supervision of HCAs, and the impact of these changes on current and future work of HNs	20 organisations for home (community) nursing. Home nurses with direct patient contact and in direct contact with HCAs.	12, 12 & 8	Yes
Drennan	**Drennan, J., Hegarty, J. Savage, E. Brady, N., Prendergast, C., Howson, V., Murphy, A. and Spilsbury, K**	2018	Ireland	Review Literature		Provision of the Evidence to Inform the Future Education, Role and Function of Health Care Assistants in Ireland	To present a report based on the literature, on the education, role and function of the Health Care Assistant in Ireland and internationally			
Dudley	**Dudley N, Miller J, Breslin ML, Chapman SA, and Spetz J.**	2021	US	Qualitative	Case Study	The impact of Nurse Delegation Regulations on the Provision of Home Care Services: A Four-State Case Study.	To explore how home care workers and the agencies that employ them interact with their state's nurse practice act in the provision of care.	State Leaders of LTSS and home health agency leaders- (18) Home care workers/ HCAs- (27) NO RNs	18 Leaders + 27 HCAs + 0 RNs. Interviews (45) -26 leaders + 27 workers = 53!!	Yes
Glackin	**Glackin**	2016	Ireland	Qualitative	Case Study- Single Embedded	The Evolving Role of the Healthcare Assistant and its Implications for Regulation in the Republic of Ireland– A Case Study Approach	To explore the changing role of healthcare assistants in Ireland and consider the need	HCAs Focus Groups 3 different areas HSE (25 participants). 13 individual interviews senior managers. Archival documents.	Focus groups with HCAs, semi-structured interviews with	
Gravlin	**Gravlin, G. and Bittner Phoenix, N.**	2010	US	Quantitative	Descriptive	Nurses and Nursing Assistants' Reports of Missed Care and Delegation	for professional regulation in the public interest	RNs and Nas on 16 medical-surgical units in 3 acute hospital	senior managers and other key stakeholders and document analysis,	yes
Hasson	**Hasson, F., McKenna, H.P. and Keeney, S.**	2013	Northern Ireland	Mixed Methods	transformative MM research design. Focus Groups (32) interviews (13) & semi-structured questionnaire Delegating and supervising unregistered professionals: The student nurse experience	Delegating and Supervising unregistered professionals: The student nurse experience.	Part of larger study exploring how the interactions and perceptions of HCAs relate to and impact on pre- reg students clinical learning experience.	Pre-reg nursing students in ine HEI in the UK	Phase 1- 45 Pre-reg nursing students & Phase 2- 662 (439 returned 66% rr)	Yes
Hewko	**Hewko, S.J., Cooper, S.L., Huynh, H, Spiwek, T.L., Carleton, H.L., Reid, S. and Cummings, G.G**	2015	Canada	Review Scoping		Invisible no more: a scoping review of the health care aide workforce literature.	To evaluate the breadth and depth of the HCA workforce literature. (What does the existing literature tell us about the education, supply and use of HCAs, and the demand for HCAs, and injury and illness among HCAs.	HCAs (RCOP)	82 papers included	No
Holmberg	**Holmberg, M.D., Flum, M., West,C., Zhang, Y., Qamili, S. and Punnett, L.**	2013	US	Qualitative	Focus Group Interviews 27 interviews with 150 certified nursing assistants (CNAs)	Nursing Assistants' Dilemma: Caregiver Versus Caretaker	How the work environment supported or impeded the CAN caregiving to residents	Nursing Homes. CNAs	150 certified nursing assistants (CNAs)	No

Huang	**Huang, L.C., Lee, J.L., Yia-Wun, L., Ming-Yi, H., Jui-Fen, C. and Ting- Ting, M.**	2011	Taiwan	Quantitative	Cross sectional design with structured questionnaire	The Skill Mix Model: A Preliminary Study of Changing Nurse Role Functions in Taiwan,	To investigate changes in nurse perceptions of their role functions under the skill mix model in Taiwan.	Medical Wards in Hospital	Not stated available sample. 38 RNs in 3 Medical Wards in 3 Hospitals that had implemented the skill mix model	Yes
Johnson	**Johnson, M., Magnusson, C., Allan, H., Evans, K., Ball, E., Horton, K., Curtis, K. and Westwood, S.**	2015	UK	Qualitative	Ethnographic Case Study	Doing the writing' and 'working in parallel': how 'distal nursing' affects delegation and supervision in the emerging role of the newly qualified nurse.	Analysis of teamworking between NQNs and HCAs, and nurses' balancing of administrative tasks and bedside care	Three Acute Hospitals. Inpatient wards	Participant Observation. Interviews with 33 NQNs, 10 HCAs & 12 Ward Managers	Yes
Kaernested	**Kærnested, B., Bragadóttir, H.**	2012	Iceland	Quantitative	Descriptive Correlation design. Multiple choice questions.	Delegation of Registered Nurses Revisited: Attitudes towards Delegation and Preparedness to Delegate Effectively	To identify the attitudes of RNs towards delegation, their preparedness to delegate effectively, and to determine whether attitude and preparedness re related toage, experience, education in delegation, workload, and job satisfaction	All RNs (96) working in 5 medical acute care inpatient units at a university hospital in Iceland	96. 74% RR. 71 participants	RNs provide all direct care
Kessler	**Kessler, I., Heron, P. and Dopson, S.**	2015	UK	Mixed Methods		Professionalization and Expertise In Care Work: The Hoarding and Discarding of Tasks in Nursing.	Part of larger study: this paper draws on data on the nature and consequences of HCAs in acute health care settings. How different actors engage with the HCA role and how it affected them.	4 case study hospitals in diff parts of England. 29 general medical and surgical wards. This paper uses data from RNs and some HCA data	273 interviews- incld 115 RNs, 82 HCAs.	HCA role
Kusi-Appiah	**Kusi-Appiah, E., Dahlke, S. and Stahlke, S.**	2018	Canada	Review Integrative		Nursing care providers perceptions on their role contributions in patient care: An integrative review	To explore RNs, LPNs & HCAides perceptions of their own and each other's role contributions in pt care	RNs, LPNs & HCAides	14 articles retrieved	No, focused on roles, skill mix, perceptions on each others roles.
Lavander	**Lavander, P., Meriläinen, M, and Turkki, L**	2016	Finland	Review Systematic		Working time use and division of labour among nurses and health-care workers in hospitals - a systematic review.	To synthesise the existing evidence on working time use and division of labour among RNs and HCAs in hospital wards	RNs, Ens & HCAs		No. But use of working time examined through 6 categories: direct care, indirect care, documentation, unit-related work, personal time and non-nursing duties.
Lee	**Lee, C.Y., Beanland, C., Goeman, D., Johnson, J., Thorn, J., Koch, S. and Elliott, R.A.**	2015	Australia	Mixed Method	Prospective before- and-after study	Evaluation of a support worker role, within a nurse delegation and supervision model, for provision of medicines support for older people living at home: the Workforce Innovation for Safe and Effective (WISE) Medicines Care study	To assess whether the WISE Medicines Care Model could increase the number of home visits for medicines support, that were conducted by CCAs, explore nurses', CCA's, older peoples' and carers' experiences and satisfaction with CCAs expanded role, and identify enablers and barriers to delegation of medicine support to CCAs.	Community Nursing Service with Community Care Aides (CCA). 2 metropolitin sites with a large non- profit community nursing service		Yes
Magnusson	**Magnusson, C., Allan, H., Horton, K., Johnson, M., Evans, K. and Ball, E**	2017	England	Qualitative	Ethnographic Case Study	An analysis of delegation styles among newly qualified nurses	To explore NQNs experiences of delegating and supervising HCAs	Three Acute Hospitals. Inpatient wards	Participant Observation. Interviews with 33 NQNs, 10 HCAs & 12 Ward Managers	Yes 230 hrs of participant observations
Muller	**Mueller, C., Anderson, R. A., McConnell, E. S. and Corazzini, K**	2012	US	Quantitative	Cross Sectional Observational Descriptive	Licensed Nurse Responsibilities in Nursing Homes: A Scope-of-Practice Issue.	Examine LPNs role and responsibility as well as barriers and facilitators for working within their scope of practice	Licensed Practical Nurses (LPNs) in NHs in Minnesota and Nth Carolina	All LPNs in NC & MN who were licensed and reported practising in NH.	No. LPN Scope of practice. Domains of assessment, care planning, evaluation, delegation, and supervision.

Munn	**Munn, Z., Tufanaru, C. and Aromataris, E**	2013	Australia	Review Systematic and Meta Analysis		Recognition of the health assistant as a delegated clinical role and their inclusion in models of care: a systematic review and meta-synthesis of qualitative evidence	To synthesise available qualitative evidence regarding the appropriateness of strategies used to establish the health assistant role as a recognised delegated clinical role and to promote their inclusion in models of care.	HCAs	10 included studies	The introduction of assistive personnel forces the restructure of the role of the health professionals to supervise and delegate tasks to assistants, and not perform them themselves" p.14
OECD	**? In chapt**	2020	OECD	Policy		*Who Cares? Attracting and Retaining Care Workers for the Elderly* , OECD Health Policy				
Potter	**Potter, P., Deshields, T. and Kuhrik, M.**	2010	US	Qualitative	Descriptive. Small group semi structured interviews. RNs and NAPs interviewed separately	Delegation practices between registered nurses and nursing assistive personnel.	To understand how RNs and nursing assistive personnel (NAP) perceptions of delegation practices in delivery on oncology patient care	RNs and NAPs in 5 inpatient oncology wards	10 RNs and 6 NAPs	Yes
Roch	**Roch, Dubois, Clarke**	2014	Canada	Mixed Method	Cross sectional survey and a single case study design with embedded units of analysis	Organizational climate and hospital nurses' caring practices: a mixed-methods study.	?	RNs, Practical Nurses & HCAs. Urban hospital & quaterenary services	648 ED RNs survey questionnaire. Then Interviews, comments section Phase 1, & internal & external hospital documents. Interviews with 4 direct care RNs, 2 LPNs, 3 HCAs, 2 CNSs, 2 frontline managers.	
Roche	**Roche, M.A., Friedman, S., Duffield, C., Twigg, D.E. and Cook R.**	2016	Australia	Quantitative	Cross sectional population based. Observational work sampling by independent observer.	A comparison of nursing tasks undertaken by regulated nurses and nursing support workers: a work sampling study.	To determine which tasks unregulated nursing support staff spend their work time undertaking and to determine the differences between the work undertaken by licensed/regulated nurses on units which have HCAs and those on units which do not	All nursing staff on the participating wards invited (452). 3 public acute care hospitals. RNs, ENs & assistants in nursing (AIN). & clinical nurse leaders	RNs, ENs & assistants in nurse	Yes, delegation of direct care
Saari	**Saari, M., Xiao, S., Rowe, A., Patterson, E. Killaxkey, T., Raffaghello, J. and Tourangeau, A.E**	2018	Canada	Review Scoping		The role of unregulated care providers in home care: A scoping review	To articulate the unregulated care provider role by identifying patient care activities offered by unregulated care providers in home care	Unregulated care providers (HCAs)	28 studies	No
Saccomano	**Saccomano, S.J. and Pinto- Zipp, G.**	2011	US	Quantitative	Cross sectional survey	Registered nurse leadership style and confidence in delegation	Explore and describe the relationship between RN leadership styles, demographic variables and confidence in delegation in community teaching hospitals	Convenience sample of RNs employed in one acute care hospital completed questionnaires that measured leadership style (PGLQ), confidence in delegating patient care tasks (CIDS) and provided demographic information.	Large non-teaching hospital in NJ US. Magnet status and recipient of excellence award.	
Saqer	**Saqer,T.J. and AbuAlRub, R.F**	2018	Jordan	Quantitative	Cross sectional. Self reported questionnaire.	Missed nursing care and its relationship with confidence in delegation among hospital nurses	To identify the types & reasons for missed nursing care among Jordian nurses, ii) identify predictors of missed nursing care based on study variables; and iii) examine the relationship between nurses' confidence in delegation and missed nursing care	Hospital nurses from 6 hospitals	480 surveys distributed to RNs. 362 nurse respondents	Yes

Spilsbury	**Pender S, Bloor K, Borthwick, R., Atkin, K., McCaughan, D., Watt, I., Adderley, U. Wakefield, A and McKenna, H.**	2013	England	Mixed Method	Telephone interviews senior managers consensus, Secondary data from Electronic Staff Records data, & telephone interviews with managers	Support matters: a mixed methods scoping study on the use of assistant staff in the delivery of community nursing services in England	*as per title*	Community nursing services in NHS	37 senior managers interviewed (49% of those contacted);and then 30 managers interviewed at next stage.	no
Standing	**Standing, T.S., Anthony, M.K.**	2008	US	Qualitative	Phenemology . 17 indepth interviews	Delegation: What it means to acute care nurses	To describe delegation from the perspective of the acute nurse.	RNs in acute care	17 interviews with RNs	
Walker	**Walker, L., Clendon, J.M., and Nelson, K.M**	2015	New Zealand	Qualitative	Collaborative case Study: 3 cases; document review, observations and interviews, Interviews RNs & HCAs.Documents. Demographic questionnaire	Nursing roles and responsibilities in general practice: three case studies	To describe the different configurations of health professionals skill mix in 3 dissimilar primary care practices, their inter- and intra- professional collaboration and communication, and to explore the potential of expanded nurses roles and scope.	Primary care nursing teams. 8 participants in each case (RNs, NPs, Ens, PCPAs & GPs)		
Walker	**Walker, Felicity Ann, Madeleine Ball, Sonja Cleary, and Heather Pisani**	2021	Australia	Qualitative	Exploratory descriptive	Transparent Teamwork: The Practice of Supervision and Delegation within the Multi-tiered Nursing Team."	To examine supervision and delegation of NAs in an acute hospital setting in Victoria, Australia	Acute hospital. Nursing leaders (n=20), RNs/Ens n=74 and HCAs n=10	Semi-structured interviews, focus groups=11 with average of 8 participants, and documentary information	Yes
White	**White, M.J., Gutierrez, A, Davis, K., Olson, R. and McLaughlin, C**	2011	US	Quantitative	Descriptive	Delegation knowledge and practice among rehabilitation nurses	To study RN practices and knowledge of delegation to unlicensed assistive personnel	Association of Rehabilitation Nurses/Rehabilitation Nurses in Texas	Not stated how many rehabilitation nurses in Texas. Survey distributed to all ARN members. 243 people were sent invitation. 73 respondents Semi-structured interview-24, focus groups- 11 with average of	Yes
Wells	**Wells, Y., Brooke, E. and Solly, K.N.**	2019	Australia	Review	;	Quality and Safety in Aged Care Virtual Issue: What Australian research published in the Australasian Journal on Ageing tells us	To review studies published in Australian Journal of Ageing (AJA) about the aged care workforce, and to identify influences on quality of care and potential policy directions.	Workforce in aged care (residential and community based)	28 articles	No.
Yoon	**Yoon, J., Kim, M. and Shin, J.**	2016	Korea	Quantitative	Descriptive correlational	Confidence in delegation and leadership of registered nurses in long-term-care hospitals	To investigate the relationship between registered nurses' delegation confidence and leadership in Korean long-term-care hospitals.	199 registered nurses from13 long-term care hospitals in Korea.	Instruments were the Confidence and Intent to Delegate Scale and Multifactor Leadership Questionnaire.	Yes

Appendix 2: Summary of the paradigms with ontological and epistemological assumptions and methodological approaches

Paradigm	Positivism/Post Positivism	Interpretivist/ Constructivist	Critical Transformative Emancipatory	Pragmatic
Philosophical Assumptions	Realism, idealism	Hermeneutics Phenomenology	Critical Theory, feminist theory, race theory, queer theory, disability theory	Not committed to one philosophy. Pragmatism builds knowledge based on interactions between people or groups and resulting experiences and actions (Kaushik and Walsh, 2019).
Ontological Assumptions	One reality, context-free (positivist). Critical realism (post positivist)	Multiple socially constructed realities	Social reality defined by people in society and is socially constructed.	Reality and influence of human experience
Epistemological Assumption	Objective (positivist). Modified objective (post positivist) Focus on deductive reasoning	Subjective, idiographic	Knowledge is constructed through society and media. Researcher is objective and action-orientated.	Knowledge is values orientated. Researcher is subjective and objective based on research goals.
Methodological Approach	Quantitative; experimental; comparative study. Focus on accuracy, reliability, validity, and	Qualitative: phenomenology, ethnographic, case study, naturalistic. Researchers and participants create data.	Quantitative and qualitative research	Based on research question - quantitative and qualitative research

	statistical analysis.			
Data Gathering Methods	Scientific often with experiments and interventions, statistical analysis, demonstrating reliability, validity and generalisability, e.g. experiments, questionnaires, surveys	Interviews Participant Observation, images, documents.	Questionnaires, surveys, observations, Interviews Participant Observation, images, documents	Experiments, questionnaires, surveys, observations, Interviews Participant Observation, images, documents

Appendix 3

Staff Participant Information

Participant Information Leaflet

Registered Nurses and Health Care Assistants

Study title: **How does the explicit delegation of tasks by registered nurses to health care assistants occur in patient care teams?: A Case Study**

Researcher Name:__Deirdre Mulligan_____

Telephone number of Researcher: __087 9051771_____-

Research Supervisor Name:__Prof. Kathy Murphy_____

You are being invited to take part in a research study to be carried out in HSE Residential Care Units on the east coast of Ireland.

Before you decide whether or not you wish to take part, you should read the information provided below carefully and, if you wish, discuss it with your family, friends or take time to ask questions – don't feel rushed and don't feel under pressure to make a quick decision.

You should clearly understand the risks and benefits of taking part in this study so that you can make a decision that is right for you. This process is known as 'Informed Consent'.

You don't have to take part in this study and a decision not to take part will not affect on your work as a nurse or health care assistant within the HSE.

You can change your mind about taking part in the study any time you like. Even if the study has started, you can still decide not to continue in the study. You don't have to give us a reason. If you do opt out, rest assured it won't affect your role as a nurse or healthcare assistant in the future.

Why is this study being done?

The research study is to explore how delegation of tasks by Registered Nurses to Health Care Assistants occurs in patient care teams.

The health service is under constant pressure to reduce costs, become more efficient, improve safety and quality of patient care. In addition, there is a global shortage of doctors and nurses. The introduction to Health Care Assistants to patient care teams is part of the response to improving efficiencies and addressing the nursing shortage. Delegation occurs when the authority of undertaking a task is transferred from one person to another. In nursing delegation is usually defined by the professional nurse regulator and professional organizations which identifies the professional responsibility of nurses in relation to delegation of tasks to a non-registered team member. Therefore, delegation is under the direction of the nurse and it is the nurse who remains

professionally accountable at all times for the task that has been delegated. Although health care assistants are working as a member of the patient care teams for many years it is unclear as to how the explicit delegation of tasks occurs in patient care teams.

Who is organising and funding this study?

This is a research study undertaken as part of a doctorate in nursing practice (DNP) education programme. The researcher, Deirdre Mulligan, is a nurse working in the HSE. The programme fees are part funded by HSE NMPD Research and Innovation Funding.

Why am I being asked to take part?

There is little evidence of the level of delegation that occurs in patient care teams in Ireland. There are no published studies from Ireland where registered nurses and health care assistants were asked as to how delegation occurs. Therefore the researcher is seeking to ask nurses and health care assistants how does the explicit delegation of task by registered nurses to health care assistants occur. All nursing and health care assistant staff that work on the selected ward/unit are invited to participate in the study.

How will the study be carried out?

You, together with all your nurse and HCA colleagues, will receive an invitation letter, the information leaflet and a consent form by internal mail in your work place. The study is due to commence in November 2016 and will be completed on the three sites in eight months. The study will take place in your work unit and the other two selected units. It is hoped that as many nurses and health care assistants as possible from the selected unit will participate in the study.

You are invited to participate in a focus group interview to explore your opinions in relation to delegation. Four focus group sessions will be scheduled in each site, two HCA groups and two RN groups, comprising of 5-8 participants in each focus group. The interviews will be conducted in a quiet room in your workplace.

The researcher is also seeking permission to undertake direct observation of nurses and health care assistants in the workplace to observe when and how delegation occurs. The researcher will not interfere or disrupt your work during the observations. There is no requirement for any identifiable data so your personal details are not recorded at any time during the study.

What are the benefits?

You may not benefit directly from taking part in this study but the information obtained will help us to understand how delegation occurs. The findings can be used to identify how the delivery of nursing care can be improved in an effective and high quality manner.

What are the risks?

There are no foreseeable serious risks associated with the study.

Will it cost me anything to take part?

There will be no costs for you participating in the study.

Is the study confidential?

If you choose to participate the interview and observation data will be kept confidential. Any information that will identify you will be removed. No place, person, unit or hospital will be identifiable in anyway.

The findings from the study will be compiled as part of the researcher's academic thesis and may be used as an academic publication. There will be no information capable of identifying you in any reports or publications. In the unlikely event of a disclosure or there is an incident of concern regarding patient care the nurse researcher will respond as outlined within the guidance of the *Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives* (NMBI, 2014), *Ethical Conduct in Research: Professional Guidance* (2015) and the HSE Open Disclosure Policy (2013). The incident will be reported to the Clinical Nurse Manager and the Director of Nursing on the related site. Data that pertains to the incident will be retained. Individuals involved in the incident will be communicated with by the most appropriate person, informing them of the incident and the requirement to breach confidentiality.

Where can I get further information?

If you have any questions or need more information about the study now or at any time in the future, please contact:

Name: Deirdre Mulligan
Address : HSE Nursing and Midwifery Planning and Development Unit, St. Brigids' Complex Ardee, Co.Louth

Phone No: **087 9051771**

Participant Information Leaflet (A)

Residents

Study title: **How does the explicit delegation of tasks by registered nurses to health care assistants occur in patient care teams: A Case Study**

Researcher Name:__Deirdre Mulligan_____

Telephone number of Researcher: __087 9051771_____-

Research Supervisor Name:__Prof. Kathy Murphy_____

You are being invited to take part in a research study to be carried out in HSE Residential Care Units on the east coast of Ireland.

Before you decide whether or not you wish to take part, you should read the information provided below carefully and, if you wish, discuss it with your family, friends or take time to ask questions – don't feel rushed and don't feel under pressure to make a quick decision.

You should clearly understand the risks and benefits of taking part in this study so that you can make a decision that is right for you. This process is known as 'Informed Consent'.

You don't have to take part in this study and a decision not to take part will not affect the level or quality of care you receive in the future.

You can change your mind about taking part in the study any time you like. Even if the study has started, you can still decide not to continue in the study. You don't have to give us a reason. If you do opt out, rest assured it won't affect the level or quality of care you receive in the future.

Why is this study being done?

The research study is intended to find out how Registered Nurses and Health Care Assistants work together and how they share the work.

Health Care Assistants (HCAs) were introduced into patient care teams to provide direct help with patient care and as a response to the nursing shortage. Delegation occurs when the authority of undertaking a task is transferred from one person to another. In nursing, delegation is usually defined by the professional nurse regulator which in Ireland is the Nursing and Midwifery Board of Ireland (NMBI). NMBI give clear guidance to nurses and midwives of their responsibility in delegation to a colleague who is not a nurse. Although health care assistants are working as a part of the patient care teams for many years it is not clear as to how the nurses and health care assistants share work and patient care.

This research study will use a case study methodology where three 'typical' HSE Older Persons Residential Care Unit will be selected as the study sites. The case is *delegation by nurses to health care assistants.* Case study research will allow the researcher to be close to nurses and health care assistants in their workplace. The researcher will have an opportunity to find out what is really happening and this will help the researcher to understand delegation better.

Who is organising and funding this study?

This is a research study undertaken as part of a doctorate in nursing practice (DNP) education programme. The researcher, Deirdre Mulligan, is a nurse working in the HSE. The programme fees are part funded by HSE NMPD Research and Innovation Funding.

Why am I being asked to take part?

There is little known as to how delegation of tasks happens between nurses and HCAs teams in Ireland. The researcher would like to ask nurses and health care assistants as to how does delegation of tasks by nurses to health care assistants occur. The researcher would like to visit your residential centre and observe how delegation occurs. This may be happen when the nurse and health care assistant are with you. The researcher will not be observing during personal care or any time that would impact on your privacy and dignity. The researcher would also like to review nursing records to identify written evidence of delegation.

Your permission is being asked to undertake the study on the site.

How will the study be carried out?

You together will all other residents, will receive an invitation letter, the information leaflet and a consent form by internal mail in the residential care unit. The study is due to commence in November 2016 and will be completed on the three sites in eight months. The study will take place in your unit and the other two selected units. It is hoped that as many residents will consent to participate in the study. The researcher will interview the nurses and health care assistants.

The researcher is seeking permission to undertake direct observation of nurses and health care assistants in the workplace to observe when and how delegation occurs. The researcher will not interfere or disrupt your care during the observations. Although the researcher would like to review nursing records for written evidence of delegation, the researcher does not need to review any of your personal details, medical or clinical care.

What are the benefits?

You may not benefit directly from taking part in this study but the information obtained will help us to understand how delegation occurs. The findings can be used to identify how the delivery of nursing care can be improved in an effective and high quality manner.

What are the risks?

There are no foreseeable serious risks associated with the study.

Will it cost me anything to take part?

There will be no costs for you participating in the study.

Is the study confidential?

If you choose to participate the information (data) collected will be kept confidential. All information will be stored on secure hard drives and in locked filing cabinets in the researchers work office. There will be no personal information which could identify you. The sites identity will remain confidential, with pseudo names provided for each site, i.e., Pilot Site, Case A Site, and Case B Site. Data will be retained for the duration of five years and then destroyed. The hard copy data; field notes, direct observation sheets, consent forms and audio tapes will be shredded by the researcher. Electronic data will be deleted by the researcher. The findings from the study will be compiled as part of the researcher's academic thesis and may be used as an academic publication. There will be no information capable of identifying you in any reports or publications.

In the unlikely event of a disclosure or there is an incident of concern regarding patient care the nurse researcher will respond as outlined within the guidance of the *Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives* (NMBI, 2014), *Ethical Conduct in Research: Professional Guidance* (2015) and the HSE Open Disclosure Policy (2013). The incident will be reported to the Clinical Nurse Manager and the Director of Nursing on the related site. Data that pertains to the incident will be retained. Individuals involved in the incident will be communicated with by the most appropriate person, informing them of the incident and the requirement to breach confidentiality.

Where can I get further information?

If you have any questions or need more information about the study now or at any time in the future, please contact:

Name: Deirdre Mulligan
Address : HSE Nursing and Midwifery Planning and Development Unit, St. Brigids' Complex Ardee, Co.Louth

Phone No: **087 9051771**

Participant Information Leaflet: Residents (B)
(will be made available with Participant Information A and Consent Form as part of Process Consent)

Study title: **How does the explicit delegation of tasks by registered nurses to health care assistants occur in patient care teams: A Case Study**

My name is Deirdre Mulligan and I am a nurse in the HSE.

I am undertaking research as part of a doctorate programme in college. I am studying how nurses and health care assistants work together. The unit where you now live is one place I plan to interview and observe the nurses and health care assistants who work here.

Before you decide whether or not you wish to take part, you should read the information provided carefully and, if you wish, discuss it with your family, friends or take time to ask questions – don't feel rushed and don't feel under pressure to make a quick decision.

I will come and talk to you, those close to you and the staff who care for you if you wish.

You don't have to take part in this study and a decision not to take part will not affect the level or quality of care you receive in the future.

You can change your mind about taking part in the study any time you like. Even if the study has started, you can still decide not to continue in the study. You don't have to give us a reason. If you do opt out, rest assured it won't affect the level or quality of care you receive in the future.

I will visit the Unit where you now live for a number of days in (name month). I will talk to and watch the Nurses and Health Care Assistants working together. This may happen in an area where you are, so I must know if you are agreeable (consenting) to this happening. I will also review nursing reports to look for words and comments to show that nurses and Health Care Assistants are working together. I would like to look at nursing care records. However, your name and personal details will not be made available to me.

If you choose to participate the information (data) collected will be kept confidential. There will be no personal information which could identify you. The sites identity will remain confidential, with pseudo names provided for each site, i.e., Pilot Site, Case A Site, and Case B Site. There will be no information capable of identifying you in any reports or publications.

If you have any questions or need more information about the study now or at any time in the future, please contact:

Name: Deirdre Mulligan

Address : HSE Nursing and Midwifery Planning and Development Unit, St. Brigids' Complex Ardee, Co.Louth

Phone No: 087 9051771

Researcher Name:__Deirdre Mulligan_____

Telephone number of Researcher: __087 9051771_____-

Research Supervisor Name:__Prof. Kathy Murphy_____

Appendix 3

Cover Letter Resident

Nursing and Midwifery Planning
and Development
Health Service Executive Dublin North East
Mellifont Unit, St Brigid's
Complex
Kells
Road , Ardee, Co. Louth

Tel: +353 (0) 41 68 50677 / 60733

22nd May 2017

RE: Research Study:

How does the explicit delegation of tasks by registered nurses to health care assistants occur in patient care teams: a case study.

Dear Sir/Madam,

You are being invited to take part in a research study to be carried out in *name unit*. The research study is intended to find out how Registered Nurses and Health Care Assistants work together and how they share the work. This research study will involve the researcher visiting *name unit* to observe and interview nurses and health care assistants. This does not require interviewing you or interfering with your care in any way. The study is due to commence in June 2016 and will be completed on two HSE Nursing Home sites in five months.

I am undertaking this research study as part of a doctorate in nursing practice (DNP) education programme. I am the researcher, and I am a nurse working in the HSE.

I am requesting your consent and I have enclosed a consent form together with a stamped addressed envelope. Before you decide whether or not you wish to take part, you should read the information enclosed and, if you wish, discuss it with your family, friends. I will visit *name unit* in advance of the study starting. If you wish I can meet with you and those close to you to discuss and answer any questions. This process is known as 'Informed Consent'.

Thanking you in advance for your attention.

Yours Sincerely

Deirdre Mulligan

Deirdre Mulligan
Area Director Nursing and Midwifery Planning and Development
RGN, RM, RCN. NMBI PIN 35840. BSc, PgCert, MBA.

Cover Letter Staff

Nursing and Midwifery
Planning and Development
Health Service Executive Dublin North East
Mellifont Unit, St
Brigid's Complex
Kells Road , Ardee, Co.
Louth

Tel: +353 (0) 41 68 50677 / 60733

22nd May 2017

RE: Research Study:

How does the explicit delegation of tasks by registered nurses to health care assistants occur in patient care teams: a case study

Dear Colleague,

You are being invited to take part in a research study to be carried out in *name unit*. The research study is intended to find out how Registered Nurses and Health Care Assistants work together and how they share the work. This research study will involve the researcher visiting *name unit*. The study is due to commence in June 2017 and will be completed on two HSE Nursing Home sites in five months.

I am undertaking this research study as part of a doctorate in nursing practice (DNP) education programme. I am the researcher, and I am a nurse working in the HSE. I would very much value your participation as your opinions and experience are extremely relevant to the study question.

I am requesting your consent and I have enclosed a consent form together with a stamped addressed envelope. Before you decide whether or not you wish to take part, you should read the information enclosed. I have visited *name unit* informally in recent weeks and I may have met with you to discuss the proposed study. I will visit *name unit* in advance of the study starting. If you wish I can meet with you to discuss and answer any questions. This process is known as 'Informed Consent'.
Thanking you in advance for your attention and support.

Yours Sincerely

Deirdre Mulligan

Deirdre Mulligan
Area Director Nursing and Midwifery Planning and Development
RGN, RM, RCN. NMBI PIN 35840. BSc, PgCert, MBA.

Participant Consent Form: Residents

Study title: How does the explicit delegation of tasks by registered nurses to health care assistants occur in patient care teams: a case study

I have read and understood the *Information Leaflet* ***about this research project.***	*Yes ☐*	*No ☐*
The information has been fully explained to me and I have been able to ask questions, all of which have been answered to my satisfaction.	*Yes ☐*	*No ☐*
I understand that I don't have to take part in this study and that I can elect not to continue in the study. I understand that I don't have to give a reason for opting out and I understand that opting out will not affect the level or quality of care I receive in the future.	*Yes ☐*	*No ☐*
I have been assured that information about me will be kept private and anonymous.	*Yes ☐*	*No ☐*
I have been given a copy of the Information Leaflet and this completed consent form for my records.	*Yes ☐*	*No ☐*
Storage and future use of information: ***I give my permission for information collected about me to be stored or electronically processed for the purpose of <u>this</u> research.***	*Yes ☐*	*No ☐*

I consent to participating in direct observations with the researcher for this study

☐	☐

<u>I consent to participating in the nursing record review for evidence of delegation by the researcher for this study</u>

☐	☐

/ /

Participant Name (Block Capitals) | Participant Signature | Date

To be completed by the Researcher:

I, the undersigned, have taken the time to fully explain to the above participant the nature and purpose of this study in a way that they could understand. I have explained the risks involved as well as the possible benefits. I have invited them to ask questions on any aspect of the study that concerned them.

/ / /

----------Name (Block Capitals) | Qualifications | Signature | Date

Participant Information Leaflet (A)

Participant Information Leaflet (A)

Residents

Study title: **How does the explicit delegation of tasks by registered nurses to health care assistants occur in patient care teams: A Case Study**

Researcher Name:__Deirdre Mulligan_____

Telephone number of Researcher: __087 9051771_____-

Research Supervisor Name:__Prof. Kathy Murphy_____

You are being invited to take part in a research study to be carried out in HSE Residential Care Units on the east coast of Ireland.

Before you decide whether or not you wish to take part, you should read the information provided below carefully and, if you wish, discuss it with your family, friends or take time to ask questions – don't feel rushed and don't feel under pressure to make a quick decision.

You should clearly understand the risks and benefits of taking part in this study so that you can make a decision that is right for you. This process is known as 'Informed Consent'.

You don't have to take part in this study and a decision not to take part will not affect the level or quality of care you receive in the future.

You can change your mind about taking part in the study any time you like. Even if the study has started, you can still decide not to continue in the study. You don't have to give us a reason. If you do opt out, rest assured it won't affect the level or quality of care you receive in the future.

Why is this study being done?

The research study is intended to find out how Registered Nurses and Health Care Assistants work together and how they share the work.

Health Care Assistants (HCAs) were introduced into patient care teams to provide direct help with patient care and as a response to the nursing shortage. Delegation occurs when the authority of undertaking a task is transferred from one person to another. In nursing, delegation is usually defined by the professional nurse regulator which in Ireland is the Nursing and Midwifery Board of Ireland (NMBI). NMBI give clear guidance to nurses and midwives of their responsibility in delegation to a colleague who is not a nurse. Although health care assistants are working as a part of the patient care teams for many years it is not clear as to how the nurses and health care assistants share work and patient care.

This research study will use a case study methodology where three 'typical' HSE Older Persons Residential Care Unit will be selected as the study sites. The case is *delegation by nurses to health care assistants.* Case study research will allow the researcher to be close to nurses and health care assistants in their workplace. The researcher will have an opportunity to find out what is really happening and this will help the researcher to understand delegation better.

Who is organising and funding this study?

This is a research study undertaken as part of a doctorate in nursing practice (DNP) education programme. The researcher, Deirdre Mulligan, is a nurse working in the HSE. The programme fees are part funded by HSE NMPD Research and Innovation Funding.

Why am I being asked to take part?

There is little known as to how delegation of tasks happens between nurses and HCAs teams in Ireland. The researcher would like to ask nurses and health care assistants as to how does delegation of tasks by nurses to health care assistants occur. The researcher would like to visit your residential centre and observe how delegation occurs. This may be happen when the nurse and health care assistant are with you. The researcher will not be observing during personal care or any time that would impact on your privacy and dignity. The researcher would also like to review nursing records to identify written evidence of delegation.

Your permission is being asked to undertake the study on the site.

How will the study be carried out?

You together will all other residents, will receive an invitation letter, the information leaflet and a consent form by internal mail in the residential care unit. The study is due to commence in November 2016 and will be completed on the three sites in eight months. The study will take place in your unit and the other two selected units. It is hoped that as many residents will consent to participate in the study. The researcher will interview the nurses and health care assistants.

The researcher is seeking permission to undertake direct observation of nurses and health care assistants in the workplace to observe when and how delegation occurs. The researcher will not interfere or disrupt your care during the observations. Although the researcher would like to review nursing records for written evidence of delegation, the researcher does not need to review any of your personal details, medical or clinical care.

What are the benefits?

You may not benefit directly from taking part in this study but the information obtained will help us to understand how delegation occurs. The findings can be used to identify how the delivery of nursing care can be improved in an effective and high quality manner.

What are the risks?

There are no foreseeable serious risks associated with the study.

Will it cost me anything to take part?

There will be no costs for you participating in the study.

Is the study confidential?

If you choose to participate the information (data) collected will be kept confidential. All information will be stored on secure hard drives and in locked filing cabinets in the researchers work office. There will be no personal information which could identify you. The sites identity will remain confidential, with pseudo names provided for each site, i.e., Pilot Site, Case A Site, and Case B Site. Data will be retained for the duration of five years and then destroyed. The hard copy data; field notes, direct observation sheets, consent forms and audio tapes will be shredded by the researcher. Electronic data will be deleted by the researcher. The findings from the study will be compiled as part of the researcher's academic thesis and may be used as an academic publication. There will be no information capable of identifying you in any reports or publications.

In the unlikely event of a disclosure or there is an incident of concern regarding patient care the nurse researcher will respond as outlined within the guidance of the *Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives* (NMBI, 2014), *Ethical Conduct in Research: Professional Guidance* (2015) and the HSE Open Disclosure Policy (2013). The incident will be reported to the Clinical Nurse Manager and the Director of Nursing on the related site. Data that pertains to the incident will be retained. Individuals involved in the incident will be communicated with by the most appropriate person, informing them of the incident and the requirement to breach confidentiality.

Where can I get further information?

If you have any questions or need more information about the study now or at any time in the future, please contact:

Name: Deirdre Mulligan
Address : HSE Nursing and Midwifery Planning and Development Unit, St. Brigids' Complex Ardee, Co.Louth

Phone No: **087 9051771**

Staff Participant Consent Forms

Participant Consent Form: Registered Nurses and Health Care Assistants

Study title: How does the explicit delegation of tasks by registered nurses to health care assistants occur in patient care teams: a case study

I have read and understood the** Information Leaflet **about this research project.	☐	☐
The information has been fully explained to me and I have been able to ask questions, all of which have been answered to my satisfaction.	☐	☐
I understand that I don't have to take part in this study and that I can elect not to continue in the study. I understand that I don't have to give a reason for opting out and I understand that opting out won't affect my future affect my work as a nurse or health care assistant within the HSE.	☐	☐
I have been assured that information about me will be kept private and anonymous.	☐	☐
I have been given a copy of the Information Leaflet and this completed consent form for my records.	☐	☐
Storage and future use of information: ***I give my permission for information collected about me to be stored or electronically processed for the purpose of <u>this</u> research.***	☐	☐

1. I consent to participating in focus group interview with the researcher for this study

/ /

Participant Name (Block Capitals) | Participant Signature | Date

2. I consent to participating in direct observations with the researcher for this study

/ /

Participant Name (Block Capitals) | Participant Signature | Date

To be completed by the Researcher:

I, the undersigned, have taken the time to fully explain to the above participant the nature and purpose of this study in a way that they could understand. I have explained the risks involved as well as the possible benefits. I have invited them to ask questions on any aspect of the study that concerned them.

Name (Block Capitals)	***Qualifications***	***Signature***	***Date***

Appendix 4: Focus Group Interview Guide

The purpose of the focus group interview is to establish how explicit delegation of tasks by registered nurses (RN) to Health Care Assistants (HCA) is occurring in patient care teams in Ireland. Focus group interviewing will generate unique insights into shared experiences and social norms within the site setting. Through purposive sampling the RNs and HCAs working on the selected unit have been invited to participate in a focus group interview. Study information and confirmation of informed consent process will be undertaken in advance of the interview. Four focus group sessions have been scheduled in each site, two HCA groups and two RN groups, comprising of 3-6 participants in each focus group. The interviews will be focus group interviews, conducted in a quiet room in the workplace (on site).

Format of Interview

- Welcome and Introductions
- Participants will be re-issued with the information pack (information sheet and consent form) and asked to sign the consent form if they agree to proceed as a participant.
- Initiation of interview
- Recapping on study aims and objectives, participation is voluntary and you can withdraw from the interview at any time with no repercussions. Your identity will not be revealed and your information will be anonymised. All data is confidential and only for use in this research study. Participants will be reminded that in the event of disclosure of an area of concern or risk the researcher will apply the HSE Open Disclosure Policy (2013).
- Participants will be reminded that information discussed in the interview is confidential.
- The interview with your permission will be tape recorded and notes will be taken to ensure there is an accurate record of the proceedings.
- There is no right or wrong answers to the questions asked, the main objective of the interview is for you to share your valuable experience and opinions.
- The researcher will act as a moderator ensuring that all participants have an opportunity to answer questions.
- Participants will be asked to contribute, to be respectful of other participants, and provide opportunities for others to speak.
- 17 main questions may seem repetitive Note: May not all be asked)

Interview Guide

1. **Tell me about your experience of delegation of tasks by registered nurses to health care assistants in *Name Site*?**

2. **Tell me what you understand or know about what the nurse regulator, NMBI / An Bord Altranis position in relation to delegation of tasks by registered nurses to health care assistants?**

3. **How do you feel about delegation for your own role and responsibilities? (HCA or RN)**

4. **How do you feel about delegation for the role and responsibilities of the RN/HCA?**

5. **Tell me what you think are the opportunities (positive possibilities) for delegation going forward?**

6. **Tell me what you think are the challenges (could be the negative impact) in the future in for delegation between RN and HCAs?**

7. **From your experience tell me how delegation of tasks takes place? (explicit or implicit?)**

8. **When you work in pairs with a (RN/HCA) how does delegation occur?**

9. **When you work in pairs as a HCA team how does the nurse delegate? (assign tasks? Check in? HCA report back?)**

10. **How do you think delegation of tasks by RNs to HCAs can be improved, can you tell me about that?**

11. **What factors will influence how delegation of tasks by RNs to HCAs can be improved?**

12. **(Explain role boundary conflict if required as, *lack of clarity or certainty in what is required or expected in a specific role*). Do you think that role boundary conflict impacts on delegation of tasks? If so, how?**

13. **What is your experience of communication between RNs and HCAs in relation to delegation?**

14. **To what extent do you think team working within the patient care team is related to delegation?** *How is the way nurses and care assistants work as a team related to delegation?*

15. **Have you undertaken any education specific to delegation?**

16. **How do you feel about HCAs being registered as professionals?**

17. Is there anything else you think is important in relation to how delegation of tasks by registered nurses to health care assistants in patient care teams?
Thank participant for their time and contribution

Close interview

Appendix 5: Case B Document Review Internal Survey

[redacted]

RE: Research Study:
How does the explicit delegation of tasks by registered nurses to health care assistants occur in patient care teams: a case study

Documentary Review [redacted] Site B

Request to Director of Nursing and Nurse Managers:

Have you the following or similar documents:

1. Nursing and Midwifery Board of Ireland (2014) *Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives 2014.* Nursing and Midwifery Board of Ireland. **YES NO**
2. Nursing and Midwifery Board of Ireland (2015) *Scope of Nursing and Midwifery Practice Framework 2015.* Nursing and Midwifery Board of Ireland. **YES NO**
3. HSE Job Description Health Care Assistant (Older Person Services) **YES NO**
4. Local Job Description Health Care Assistant (Older Person Services) **YES NO**
5. HSE Job Description Multitask Attendant **YES NO**
6. Local Job Description Multitask Attendant **YES NO**
7. Policy/Procedure/Guideline/ Standard Operating Procedure for;
   - Delegation of Tasks **YES NO**
   - Team Nursing **YES NO**
   - Primary Nursing **YES NO**
   - Supervision **YES NO**
8. Education/ Training Material for;
   - Skill Mix **YES NO**
   - Team Working **YES NO**
   - Delegation **YES NO**
9. Other documentation relating to delegation of tasks between Registered Nurses and Health Care Assistants in Patient Care Teams? NIL .

List:

[redacted]

15-1-18

Assistant DON
Rec'd 5/2

Appendix 6: Nursing Care Plan Review Template

NURSING CARE PLAN REVIEW TEMPLATE

Nursing Care Plan review will be undertaken by Deirdre Mulligan. The focus of care plan review is to identify documented evidence of delegation by Registered nurses to Health Care Assistant recorded in the Nursing Care Plan. The researcher will review **anonymised** nursing care plans and identify instances of documented evidence of delegation.

Chart 1		
Key Word	**Context**	**Note/Comments**
Delegation (delegate/delegated)		
Requested (CA) to..		
Directed (CA) to..		
Asked (CA) to..		
Supervised (CA):		
Chart 2		
Key Word	**Context**	**Note/Comments**
Delegation (delegate/delegated)		
Requested (CA) to..		
Directed (CA) to..		
Asked (CA) to..		
Supervised (CA):		
Chart 3		
Key Word	**Context**	**Note/Comments**
Delegation (delegate/delegated)		
Requested (CA) to..		
Directed (CA) to..		
Asked (CA) to..		
Supervised (CA		

Chart 4		
Key Word	**Context**	**Note/Comments**
Delegation (delegate/delegated)		
Requested (CA) to..		
Directed (CA) to..		
Asked (CA) to..		
Supervised (CA):		

Appendix 7: HEC REC

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Regional Manager Consumer Affairs
HSE Dublin North East

Bective Street, Kells
Co. Meath

Tel: +353 (0) 46 9251264
Fax: +353 (0) 46 9251774

Loughtee Business Park
Drumalee, Cavan

Tel: +353 (0) 49 4377343
Fax: +353 (0) 49 4377379
Email: consumeraffairs.hsedne@hse.ie

24th November 2016

Ms Deidre Mulligan
Area Director
Nursing and Midwifery Planning & Development Unit
Mellifont Unit
St Brigids Complex
Ardee
Co Louth

Re/ Research Study Proposal:
"How does the explicit delegation of tasks by registered nurses to health care assistants occur in patient care teams: a case study"

Dear Ms Mulligan

I would like to advise you that the following documentation was reviewed by the HSE North East Area Research Ethics Committee on Thursday 17th November 2016 in the Board Room, HSE Dublin North East Office, Bective Street, Kells, Co. Meath.

Protocol Title: How does the explicit delegation of tasks by registered nurses to health care assistants occur in patient care teams: a case study

Application Date: 20th October 2016

Documentation Reviewed:

- Completed Application Form
- Completed Local Committee Declaration & Signatory Page
- Consent Form: Registered Nurses and Health Care Assistants
- Consent Form: Residents
- Participant Information Leaflet: Registered Nurses and Health Care Assistants
- Participant Information Leaflet (A): Residents
- Participant Information Leaflet (B): Residents
- Principal Investigator 2 paged CV
- Site/Service Specific Assessment Form for Research approved and signed by ... Services for Older People, ... PIC. ADON, ... Director of Nursing ...

- Insurance arrangements dated 9th September 2016 from Willis Towers Watson
- Focus Group Interview Guide
- Direct Observation Template
- Nursing Care Plan Review Template
- Site Information Poster

Applicant Name:	Ms Deidre Mulligan
Applicant Title:	Area Director of Nursing and Midwifery Planning & Development
Decision Date:	17th November 2016
Members Present:	Dr Brendan MacMahon (Chair) Ms Margaret Scott Ms Elaine Conyard Ms Marie Therese Lacy Ms Rosie Quinn Dr Catherine McDonough Ms Rosalie Smith Lynch Ms Deirdre Mulligan Mr Gerry Roddy
GCP Guidelines	This Committee operates in accordance with Good Clinical Practice Guidelines

The Committee has recommended a favourable opinion for the above research based on the application form and supporting documentation.

This favourable opinion is given provided that you comply with the conditions set out in the attached document.

If during the course of the research project, amendments or alterations to the proposed research are required, approval must again be sought from this Committee.

Please note a copy of the completed study should be forwarded to the Research Ethics Committee office on completion of same.

Yours sincerely,

Dr Brendan MacMahon
Chairperson
HSE North East Area -
Research Ethics Committee

Copied to'

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Regional Manager Consumer Affairs
HSE Dublin North East

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Ms Deirdre Mulligan
Area Director
Nursing and Midwifery Planning & Development Unit
Mellifont Unit
St Brigids Complex
Ardee
Co Louth

12/06/2017

Re/ **Research Study Proposal:**
"How does the explicit delegation of tasks by registered nurses to health care assistants occur in patient care teams: a case study"

Two amendments to above study
Amendment 1, Site Change
Amendment 2. Consent for Secondary Participants

Dear Ms Mulligan

I refer to your correspondence of the 6/6/17 & 9/6/17 regarding two amendments to the above study.

I wish to advise that I have had an opportunity to review same and approval is given for the two amendments as above.

This will be formally noted at the next REC meeting.

Yours sincerely,

Dr Brendan MacMahon
Chairperson
HSE North East Area -
Research Ethics Committee

Copied to/

Appendix 8: NUIG REC 16-Oct-15 Mulligan, D – Approval 161129

OÉ Gaillimh
NUI Galway

Leas-Uachtarán um Thaighde
Vice President for Research

29 November 2016

Ref: 16-Oct-15

Ms Deirdre Mulligan
Nursing and Midwifery Planning and Development
HSE Dublin North East
Clinical Strategy and Programmes Division
Mellifont Unit, St. Brigid's Complex
Kells Road, Ardee
Co. Louth A 92 DRNO.

Dear Ms Mulligan

Re. Ethics ref: 16-Oct-15 'How does the explicit delegation of tasks by registered nurses to health care assistants occur in patient care teams: a case study'

I write to you regarding the above proposal which was submitted for ethical review. Having reviewed your response to my letter, I am pleased to inform you that your proposal has been granted **APPROVAL.**

All NUI Galway Research Ethic Committee approval is given subject to the Principal Investigator submitting annual and final statements of compliance. The first statement is due on or before 29 November 2017.

See annual and final statement of compliance forms below. Section 7 of the REC's Standard Operating Procedures gives further details, and also outlines other instances where you are required to report to the REC.

Yours sincerely

Allyn Fives

Allyn Fives
Chair, Research Ethics Committee